

AGENDA | Trust Board - Part 1 (in Public)

Meeting to be held on Wednesday 7th October 2026, 9.30 am - 12.15 pm

Trust Boardroom, Third Floor, Springfield, Royal Stoke

Time	No.	Agenda Item	Purpose	Lead	Format	Page No.
9:30	PROCEDURAL ITEMS					
15 mins	01	Patient Story	Information	Mrs J Holmes	Verbal	-
5 mins	02	Chair's Welcome, Apologies and Confirmation of Quoracy	Information	Prof S Toor	Verbal	-
	03	Declarations of Interest	Information	Prof S Toor	Verbal	-
	04	Minutes of the Meeting held 12 th August 2026	Approval	Prof S Toor	Enclosure	2
	05	Matters Arising via the Post Meeting Action Log	Assurance	Prof S Toor	Enclosure	23
10 mins	06	Questions from Members of the Public in relation to matters on the agenda	Information	Prof S Toor	Verbal	-
10:00	CHAIR AND CHIEF EXECUTIVE UPDATES					
10 mins	07	Chief Executive's Report – October 2026	Information	Ms H Ashley	Enclosure	24
10:10	OUR PATIENTS					
10 mins	08	Briefing Summary: Report of the Public Inquiry into events at the Countess of Chester Hospital	Assurance	Mrs D Brayford	Enclosure	28
10 mins	09	National Maternity Triage Specification Board Assurance Framework	Assurance	Mrs D Brayford	Enclosure	39
10 mins	10	UEC Improvement Journey	Assurance	Mrs K Thorpe	Enclosure	81
10:40 – 10:55 COMFORT BREAK						
10:55	OUR PEOPLE					
10 mins	11	Annual Revalidation Update	Assurance	Dr D Adamson	To follow	-
10 mins	12	Workforce Race and Workforce Disability Equality Standard Reports 2026	Assurance	Mrs J Haire	Enclosure	87
10 mins	13	Equality, Diversity & Inclusion Annual Report 25/26	Assurance	Mrs J Haire	Enclosure	109
5 mins	14	Equality and Human Rights Commission Code of Practice 2026	Assurance	Mrs J Haire	Enclosure	135
11:30	PERFORMANCE					
	15	Integrated Performance Report – Month 5 and Committee Assurance Reports:				
15 mins	15a	Quality, Access & Outcomes Committee Assurance Report (02-09-26, 10-09-26 & 30-07-26)	Assurance	Prof K Maddock	Enclosure	137
		Mrs J Holmes/ Mrs K Thorpe		139 141 143		
10 mins	15b	- People, Culture & Inclusion Committee Assurance Report (24-09-26) - People Dashboard	Assurance	Mr M North	Enclosure	200
		Mrs J Haire		202		
15 mins	15c	- Finance & Business Performance Committee Assurance Report (03-09-26 & 28-09-26) - Finance Dashboard	Assurance	Ms T Bowen	Enclosure	215
		Mr M Oldham		217 220		
12:10	CLOSING MATTERS					
5 mins	16	Review of Meeting Effectiveness Link to feedback form: https://forms.office.com/e/tydNkMB2Mj	Information	Prof S Toor	Verbal	-
	17	Review of Business Cycle	Information	Prof S Toor	Enclosure	234
12:15	DATE AND TIME OF NEXT MEETING					
	18	Wednesday 9 th December 2026, 9.30 am, Trust Boardroom, Third Floor, Springfield, Royal Stoke				

Questions from the Public - Please submit questions in relation to the agenda, by 9.00 am 5th October to nicola.hassall@uhnm.nhs.uk

Minutes of Meeting

Trust Board – Part 1 | 12th August 2026, 9.30 am to 12.35 pm

Room 1, Postgraduate Medical Centre, County Hospital, Stafford



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
Mrs M Monckton	MM	Non-Executive Director	Voting
Miss W Nicholson MBE	WN	Non-Executive Director	Voting
Prof S Toor	ST	Non-Executive Director	Voting
Dr D Adamson	DA	Chief Medical Officer	Voting
Mrs C Cotton	CC	Director of Governance & Communications	Non-Voting
Mrs A Freeman	AF	Chief Digital Information Officer	Non-Voting
Mrs J Haire	JH	Chief People Officer	Non-Voting
Mr M Oldham	MO	Chief Finance Officer	Voting
Mrs K Thorpe	KT	Interim Chief Operating Officer	Voting
Mrs L Whitehead	LW	Director of Estates, Facilities & PFI	Non-Voting

Apologies Received:

Name	Initials	Title	
Ms H Ashley	HA	Director of Strategy	Non-Voting
Dr S Constable	SC	Chief Executive	Voting
Prof K Maddock	KM	Non-Executive Director	Voting
Mrs AM Riley OBE	AR	Chief Nurse	Voting

In Attendance:

Name	Initials	Title
Mrs N Hassall	NH	Deputy Director of Governance (minutes)
Mrs J Holmes	JHo	Deputy Chief Nurse (representing Mrs Riley)

Members of Staff and Public:

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No.	Agenda Item	Action
PROCEDURAL ITEMS		
1.	Patient Story	
056/2026	The Board received a patient story through a video presentation https://vimeo.com/1216947797/4a70071db6?fl=tl&fe=ec, featuring Michaela Brogan, Audiologist, who outlined improvements made to an audiology patient pathway and the positive impact of service redesign on patient experience. Ms Bowen sought assurance regarding the learning that could be applied from this approach to other services across the Trust. Mrs Haire advised that the initiative exemplified the cultural change the Trust was seeking to achieve through its quality improvement approach, empowering staff to identify and implement service improvements. She highlighted the importance of embedding audit and feedback mechanisms to evaluate outcomes and demonstrate the benefits of change. Mrs Cotton confirmed that the video would be shared more widely across the organisation and through social media channels to promote learning and showcase good practice. Mrs Holmes highlighted the role of the Patient Leadership Council in providing feedback and informing service developments. The recent appointment of a Deputy Director of Patient Engagement and Experience was also noted, with	

	the post expected to further strengthen the Trust's ability to understand and respond to patient needs. Mrs Freeman commented on the effective use of technology within the redesigned pathway, noting that embedding digital solutions as standard practice supported implementation and provided evidence of sustainable change. In response to a question from Ms Bowen regarding digital involvement, Mrs Freeman confirmed that digital teams had worked collaboratively with the service to establish virtual elements of the pathway and support implementation. Ms Small commended the Audiology Team for its innovation, patient engagement and commitment to creating an inclusive and welcoming service environment. Drawing on previous visits to the service, she highlighted the creative use of technology and noted that the team's achievements offered valuable learning for other areas of the Trust. She further recognised the significant reduction in waiting times achieved through the adoption of new ways of working and encouraged other services to consider similar approaches. The Trust Board noted the patient story and the learning arising from the service improvement initiative.	
2.	Chair's Welcome, Apologies and Confirmation of Quoracy	
057/2026	Ms Small welcomed members to the meeting. Apologies were received as noted above and the meeting was confirmed as quorate.	
3.	Declarations of Interest	
058/2026	No declarations of interest were noted.	
4.	Minutes of the Meeting held 10th & 24th June 2026	
059/2026	The minutes of the meeting held on 10 th and 24 th June were approved as a true and accurate record.	
5.	Matters Arising via the Post Meeting Action Log	
060/2026	PTB/626 – Mrs Cotton highlighted that the communications team had worked with Mr Maxwell regarding providing an accessible version of the Quality Account which was going through final checks before being made publicly available.	
6.	Questions from Members of the Public in relation to matters on the agenda	
061/2026	Mr Syme noted that the original trajectory had anticipated achievement of the 45-minute ambulance handover standard by 31 March 2026. He therefore sought clarification regarding the revised trajectory agreed with NHS England and the timescale over which the amended plan had been agreed. Mrs Thorpe acknowledged the point and advised that it reflected the discussion within the UEC update regarding whole-system ownership of the urgent and emergency care improvement programme. She explained that weekly meetings were held with NHS England and the ambulance service to	

	support progress towards the 45-minute handover standard. These discussions focussed on achieving performance improvements whilst maintaining patient safety and quality of care and recognising the wider pressures impacting community services. She reported that progress towards the standard would require a number of interdependent initiatives, including the embedding of revised ways of working within patient flow portals and urgent treatment centre pathways, alongside other linked improvement programmes. Mr Syme also referred to the undertakings agreed between the Trust and NHS England in September 2025. Whilst acknowledging the significant improvements made since that time, he sought assurance regarding what factors had been identified as inhibiting the delivery of consistent flow-enabling behaviours and what mitigations were being implemented to ensure such behaviours became embedded as routine practice rather than occurring intermittently. Mrs Thorpe advised that discussions regarding revisions to the undertakings and associated requirements were currently underway with NHS England. She reported that a further meeting was scheduled for early September as part of this process. The Trust Board noted the update and assurances provided.	
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CHAIR AND CHIEF EXECUTIVE UPDATES

7.	Chair's Update	
062/2026	Ms Small provided an update on her activities undertaken since the previous meeting. She reported that, following the Board's discussion regarding the Ockenden and Amos reviews at the previous meeting, she had undertaken a visit to Maternity Services accompanied by the Deputy Director of Midwifery. During the visit she met with staff and teams to gain a better understanding of both the challenges being experienced and areas of good practice. She advised that further visits were planned to explore specific areas in greater depth, including spending time with community midwifery teams to understand service delivery and staff experiences across the pathway. Ms Small also advised that she had attended a webinar led by Penny Dash which focussed on the recommendations arising from the Ockenden and Amos reviews. The session provided an opportunity for NHS Chairs to discuss the challenges facing organisations, actions being taken in response, and approaches to delivering the national 100 Day Sprint. She emphasised the importance of the Board maintaining oversight of this agenda and ensuring improvements were implemented for the benefit of women, families and service users. The Board noted that Ms Small had continued to work closely with regional colleagues, which included supporting the recruitment process for the Chair of Nottingham University Hospitals NHS Trust. Ms Small further reported that she had met regularly with Rebecca Farmer to support NHS England's understanding of the Trust's response to current performance challenges.	

	It was noted that Non-Executive Directors had attended a series of best practice sessions facilitated by Russell Hardy, which focussed on areas including reducing staff sickness absence, improving waiting times and sharing learning from other organisations. Ms Small advised that Non-Executive Directors had found these sessions beneficial in strengthening their understanding of improvement approaches and informing the assurance questions they asked of the Executive Team. Looking ahead, Ms Small advised that she intended to spend additional time with clinical and nursing teams during the coming month and looked forward to welcoming Martin North as a new Non-Executive Director. She also noted the forthcoming Annual General Meeting in September. Mrs Freeman advised that she had written to the Chief Nursing Information Officer at NHS England seeking clarification regarding the extent to which maternity system suppliers were being engaged nationally to support implementation of recommendations arising from recent reviews, rather than organisations developing local solutions independently. A response was awaited to clarify expectations. Mrs Haire reported that she, together with Simon Constable and Jane Holmes, had also visited Maternity Services following publication of the reviews. The purpose of the visit had been to understand how the findings and recommendations had been received by staff and to gain assurance regarding the wellbeing support available to colleagues. She noted that the visit had been valuable in understanding the impact on teams. Dr Adamson highlighted her joint executive responsibility for Maternity Services alongside Mrs Riley. Ms Bowen enquired whether there were opportunities for the Trust to contribute to future NHS England best practice events. Ms Small advised that Trusts were able to engage in such events when opportunities arose and that Executive colleagues were often involved in identifying and sharing good practice. Mrs Thorpe added that similar arrangements already existed within Chief Operating Officer networks, providing opportunities to share learning and bring examples of best practice back into the organisation. The Trust Board noted the update.	
8.	Chief Executive's Report - August 2026	
063/2026	Mr Oldham presented the report and highlighted that following the appointment of the new Secretary of State for Health, the Trust's existing strategy remained valid, with an increased focus now being placed on delivery and implementation. With regard to the Ockenden and Amos reviews, Mr Oldham reported that work was continuing to progress in response to the recommendations. An extraordinary meeting of the Quality, Access and Outcomes Committee had been scheduled for September 2026, with a further update to be presented to the Trust Board in October 2026. Mr Oldham also highlighted the completion of an independent external review of the Trust's electronic patient record (EPR) arrangements and digital maturity. Due to commercial sensitivities, the detailed findings would be considered within the Part 2 agenda. He noted that implementation of a full EPR solution was not currently financially affordable.	

The Board was advised of the publication of new NHS workforce standards and leadership frameworks. Mr Oldham reported that a review of the Trust's existing arrangements would be undertaken, with any proposed actions and developments reported through the People, Culture and Inclusion Committee. He emphasised the importance of identifying appropriate measures to assess the impact of any improvement actions implemented.

Mr Oldham further reported that the Trust's consultant body had voted in favour of industrial action and that arrangements were being progressed pending confirmation of the dates involved.

Recognition was also given to quality improvement work undertaken across the organisation, including recent acknowledgement received through the Datix platform.

Providing an update on strategic programmes, Mr Oldham advised that the newly established Strategic Programmes Executive Committee had held its inaugural meeting. The meeting had focussed on establishing governance arrangements and programme oversight. Initial discussions had identified a number of issues relating to the scale and complexity of the Trust's change portfolio and the need to ensure sufficient organisational capacity and capability to support delivery. He further reported that Mr Paul Cain-Renshaw was supporting work relating to the Trust's recovery programme and was undertaking a review of strategic programmes to assess their impact on the delivery of the Cost Improvement Programme. An initial draft report was currently being considered by the Executive Team.

Mr Oldham also advised that the Equality and Human Rights Commission had published an updated Code of Practice and that the Trust was awaiting further guidance from NHS England regarding implementation requirements.

Mrs Monckton congratulated the Radiotherapy Team on its recent achievements and welcomed the recognition received.

Professor Toor sought clarification regarding the Trust's approach to implementing the NHS Staff Standards and the recently published anti-racism principles. Mrs Haire advised that she was co-chairing the Trust's Anti-Racism Steering Group alongside Mrs Riley and that a programme of work was underway to support implementation. She noted that progress would be reported through the update on the Mann Review.

In relation to the NHS Staff Standards, Mrs Haire advised that the Organisational Development Team was considering how the standards aligned with the People Promises and People Plan commitments. A gap analysis was being undertaken to identify areas requiring further development and areas where existing arrangements were already mature. Further updates would be presented through the People, Culture and Inclusion Committee (PCIC).

Ms Bowen sought clarification regarding the frequency of meetings of the Strategic Programmes Executive Committee and the arrangements for Board oversight of programme delivery. Mrs Cotton advised that the Committee remained in its early stages of development. The inaugural meeting had considered the Terms of Reference and had agreed actions to develop programme scopes for each of the key strategic programmes. Once completed, these would inform the reporting arrangements and oversight framework. It was anticipated that updates from the Strategic Programmes Executive Committee would be reported to every meeting of the Trust Board.

	Mrs Cotton also advised that a dashboard-style reporting mechanism was being developed to complement existing highlight reports and provide enhanced assurance regarding delivery of the Trust's strategic priorities. Mr Oldham noted that several strategic programmes were already reported through existing governance arrangements, including the Cost Improvement Programme and Urgent and Emergency Care Programme. He emphasised the importance of bringing these programmes together to ensure interdependencies were understood and to avoid unintended consequences arising from individual programme delivery. Mrs Cotton added that one of the key purposes of the Strategic Programmes Executive Committee was to ensure effective coordination and alignment across the programme portfolio, providing clarity regarding the governance and oversight arrangements for each programme. Ms Small commended the Radiology Service for its recent quality improvement award and encouraged wider promotion of the achievement across the organisation. The Trust Board received and noted the update.	
9.	Board Assurance Framework – Q1	
064/2026	Mrs Cotton presented the Quarter 1 Board Assurance Framework (BAF) and advised that a comprehensive review had been undertaken for the new financial year, taking account of feedback received from Board committees during the previous year. The key changes had been summarised within the executive summary. Mrs Cotton reminded the Board that agreement had previously been reached to introduce a specific strategic risk relating to Urgent and Emergency Care (BAF 9) and confirmed that this had now been incorporated within the BAF. She advised that a number of further developments were planned for Quarter 2, including strengthening the alignment between BAF action plans and the Trust's strategic programmes. Work would also be undertaken to ensure that the BAF more accurately reflected the progress being made against the specific actions, recognising that the current narrative did not always fully capture the extent of improvements delivered. In addition, further work was planned to strengthen the mapping of assurances against controls in response to recommendations arising from Internal Audit. Mrs Cotton noted that the BAF had continued to receive significant assurance through internal audit reviews since 2019. The Board noted that the scrutiny undertaken by Board committees had been reflected within the individual committee highlight reports presented to the meeting. Mrs Thorpe commented on the recent discussions regarding BAF 1 at the Quality, Access and Outcomes Committee (QAOC) which had been helpful. She advised that work was underway to address the issues identified and that the Board would see further developments reflected within the Quarter 2 submission. Mrs Whitehead referred to BAF 5, observing that the narrative did not yet fully reflect progress against longer-term strategic actions. She suggested that the presentation of the actions should demonstrate progress in a more balanced manner. In response, Mrs Cotton acknowledged the point and advised that	

	there was a need to align the BAF more closely with strategic delivery plans to ensure stronger linkage between strategic actions, progress made and risk position. Ms Bowen noted that some target dates, particularly those relating to matters previously considered by the Finance and Business Performance Committee, would benefit from being more specific. She also welcomed the introduction of BAF 9, recognising Urgent and Emergency Care as a critical area of strategic risk for the organisation. Ms Small highlighted the important role of Board committees in reviewing and challenging the BAF on a quarterly basis to ensure that it accurately reflected the Trust's position. She noted that committee scrutiny continued to shape both the BAF and the agendas of the respective committees and commended the progress made in its development. The Trust Board noted the update and approved the Quarter 1 Board Assurance Framework.	
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OUR PATIENTS: QUALITY, ACCESS & OUTCOMES

10.	Urgent and Emergency Care Improvement Journey	
065/2026	Mrs Thorpe presented the update on the Urgent and Emergency Care Improvement Programme and acknowledged that performance remained below the level required, particularly in relation to the 45-minute ambulance handover standard. She advised that, whilst there had been some deterioration in performance following the improvements reported previously, more recent weeks had demonstrated a recovery in performance. Mrs Thorpe reported that the deterioration had been largely attributable to challenges in facilitating earlier patient discharges during the day, together with operational pressures associated with the recent heatwave. In particular, sustained periods of high temperatures and humidity had created additional operational challenges and led to a different pattern of patient attendance. She advised that a formal heatwave debrief was being undertaken to inform future summer planning arrangements, recognising that the duration and intensity of the recent weather conditions had differed from previous years. Mrs Thorpe thanked Mrs Whitehead and her team for the significant work undertaken at pace to maintain and improve the operation of air handling systems during this period. The Board noted that attendance levels during June had stabilised and remained broadly consistent with those experienced during winter months. Mrs Thorpe highlighted that this demonstrated that performance was influenced not solely by attendance levels but by patient flow, discharge effectiveness and the contribution of community services. She further advised that periods of improved performance had been associated with reduced reliance on escalation spaces, reflecting the beneficial impact of improved discharge processes and front door flow. Referring to the programme structure, Mrs Thorpe outlined the five improvement workstreams and advised that substantial work was being undertaken across pre-hospital care pathways, including close collaboration with Midlands Partnership University NHS Foundation Trust colleagues. She noted that changes within the Hospital Ambulance Liaison Officer (HALO) process were supporting improved clinical decision-making regarding patient conveyance and admission.	

Updates were provided on each of the principal workstreams. Workstream Two continued to focus on patient flow portals and frailty pathways. Delivery of the Urgent Care Triage Centre had experienced some delay and was now anticipated to be implemented in early September, which had impacted upon planned improvement trajectories. Work on inpatient wards remained focussed on facilitating earlier discharge, supported by the Quality Improvement Team and the continued development of ward ownership of patient journeys, including the implementation of criteria-led discharge processes. The post-acute workstream continued to focus on development of the Virtual Ward model, whilst a dedicated County Hospital workstream was pursuing criteria-led discharge and aligned closely with the objectives of the wider programme.

Mrs Thorpe reported that the Getting It Right First Time (GIRFT) team continued to provide support to the Trust. The involvement of new team members had brought additional challenge and perspective, whilst the appointment of Professor Briggs had helped maintain focus on delivering agreed actions and strengthening clinical ownership of the programme.

Dr Adamson advised that investment had been made in clinical leadership, with a number of key appointments now completed. She reported that the expanded leadership cohort was highly engaged in the improvement programme and had developed a strong understanding of the operational challenges facing services. She noted that constructive and productive discussions were taking place across the workstreams.

Mrs Thorpe further advised that work was underway to improve the accessibility and capacity of the Royal Stoke discharge lounge through the ongoing estate maintenance programme, increasing the available footprint and supporting improved patient flow.

Miss Nicholson welcomed the focus on proactive discharge planning and sought assurance regarding public engagement and communication of patient discharge expectations from admission. Mrs Thorpe advised that the Trust already had a communications strategy promoting the principle that "home care is best care" wherever clinically appropriate. She emphasised that discharge planning discussions were increasingly taking place at the earliest stages of a patient's admission. Dr Adamson added that anticipated discharge dates and discharge criteria were routinely discussed with patients and families at the outset of care, helping to ensure shared expectations throughout the patient's hospital journey.

Mrs Haire provided an update on leadership development, advising that the Organisational Development Team was working to identify a consistent set of leadership competencies to underpin the Trust's leadership model and support implementation of the NHS Leadership and Management Framework. She reflected on the mobilisation of leaders during a critical incident in July, triggered by operational pressures and MRI service challenges, noting the significant levels of collaborative working and joint problem-solving demonstrated across the organisation.

Mrs Haire sought assurance that staff wellbeing remained a key component of the improvement programme given the scale of change and operational pressures being experienced. In response, Mrs Thorpe confirmed that staff engagement and wellbeing had been embedded throughout the programme. She advised that affected teams had been involved from the outset of each workstream and that regular Plan-Do-Study-Act (PDSA) cycles were being used to ensure staff views continued to inform improvements.

Professor Toor sought assurance regarding the pace of delivery and the sustainability of improvements, particularly given the volume of activity underway across multiple programmes and leadership initiatives. Mrs Thorpe advised that the GIRFT team had helped to refine the programme plan and timescales, enabling the organisation to focus on those interventions that would have the greatest impact and were capable of delivery within the required timeframe. She emphasised that the programme had been designed and driven by frontline colleagues to ensure local ownership and sustainability of change.

Professor Toor highlighted the importance of clear accountability for delivery. Mrs Thorpe advised that strengthened performance monitoring arrangements, supported by increasingly granular key performance indicators and operational data, were enabling managers and clinical teams to monitor performance more effectively on a day-to-day basis and hold workstreams to account.

Mrs Whitehead provided an update regarding the environmental conditions within the estate. Whilst acknowledging the temporary measures implemented during recent months, she advised that a comprehensive technical review was underway to identify longer-term solutions and improve resilience to future periods of hot weather. She noted that implementation of these solutions would require capital investment and that the review remained ongoing. Mrs Whitehead also highlighted the significant achievement of delivering a major programme of statutory maintenance whilst maintaining operational services and commended the collaborative approach taken by clinical and estates teams.

Mrs Freeman sought assurance regarding the integration of the discharge lounge and virtual ward model into routine patient pathways, questioning whether these were now embedded within care processes or remained optional interventions. Mrs Thorpe confirmed that use of the discharge lounge had become an established component of discharge planning processes. With regard to virtual wards, she advised that further development was required. Whilst the model was successfully supporting a proportion of patients, the overall scale remained relatively small compared to the wider caseload and further expansion would take time to deliver. Dr Adamson added that future development would require a collaborative approach across services and highlighted the potential for both "step-down" and "step-up" pathways as the virtual ward model matured.

Ms Bowen sought assurance that improvements being delivered were sustainable. Referring to performance trajectories, she queried where these were monitored within the governance structure. Mrs Thorpe advised that detailed trajectories for individual workstreams were routinely reviewed through the QAOC. She noted that the Board report included the ambulance handover trajectory, with the weekly trajectory represented on the performance chart which fed into the monthly improvement trajectory.

In response to questions regarding programme governance, it was confirmed that each workstream included representation from the relevant supporting teams. Weekly reviews were undertaken to assess progress, identify interdependencies and ensure emerging issues were addressed promptly. Mrs Thorpe advised that these arrangements provided assurance that hotspot areas could be identified and responded to in a timely manner.

The Trust Board received and noted the update.

11.	NHS England Board Assurance Statement: Mortuary Oversight and Post-Death Care	
066/2026	Dr Adamson provided an update on the recent request from NHS England for organisations to review and provide assurance regarding local mortuary arrangements. She advised that an assurance statement had been submitted following virtual approval by the Board which provided assurance against five key areas, including governance arrangements, and covered all four mortuary sites for which the Trust held responsibility. Dr Adamson reported that significant progress had been made against the wider improvement action plan and that a further progress update would be presented to the QAOC in October. She also highlighted the positive engagement demonstrated by the mortuary workforce in driving the improvement programme forward. Mrs Haire referred to the recent Board visit to the mortuary, noting that the visit had been particularly valuable in demonstrating how governance arrangements operated in practice and how issues and concerns were identified and managed within the service. In response, Dr Adamson advised that the service operated daily huddles, regular audit processes and routine compliance checks to support oversight, quality and continuous improvement. Mrs Thorpe added that the statement had also been considered through the North Midlands and Cheshire Pathology Service (NMCPs) Board, which included representation from all organisations providing mortuary services and oversight across the wider system. This ensured assurance was obtained regarding arrangements across all relevant sites. Mrs Freeman sought assurance that responsibilities and accountabilities were clearly defined across partner organisations and queried whether any challenges had been experienced where actions relied upon partners rather than the Trust. Mrs Thorpe confirmed that no such concerns had been identified and advised that any cross-organisational issues would be managed through the established NMCPs governance arrangements. Ms Small referred to organisational culture, values and behaviours and sought assurance regarding how concerns could be raised within the service. Dr Adamson advised that she had met with the mortuary team and found a workforce that was engaged, clear regarding its responsibilities and actively involved in the improvement programme. She noted that staff had access to normal management escalation routes in addition to formal mechanisms for raising concerns and speaking up where required. Regular auditing and site visits also formed part of the assurance arrangements, with visits planned to the remaining mortuary sites. Mrs Monckton reflected on the Board's visit to the mortuary and commented that it had been a humbling experience which had provided valuable insight into the service. Mrs Thorpe advised that the NMCPs Board received regular reports covering all aspects of operational delivery, including workforce indicators. She noted that the wider NMCPs organisation had historically reported lower staff survey results and, as a consequence, a series of focused deep-dive reviews had been undertaken. Current improvement activity included a particular focus on workforce-related matters. Mrs Thorpe suggested that the Board may benefit from receiving a broader update on NMCPs to provide assurance regarding	

	the full range of services delivered by the organisation, beyond mortuary services alone. Mrs Haire supported this proposal and advised that significant attention had been devoted to workforce engagement and culture across NMCPs in response to staff survey findings, with evidence of improvement now emerging. Mrs Cotton agreed to discuss this further with Mrs Thorpe outside of the meeting. Mrs Holmes advised that the Safeguarding Team was developing a monthly audit tool to support quality visits to mortuary services. She noted that this would provide an additional source of assurance and would also be reported through NMCPs governance arrangements. The Trust Board received and noted the update.	CC
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OUR PEOPLE

12.	UHNM Response to Mann Review	
067/2026	Mrs Haire presented an update on the Trust's response to recent national reviews and guidance relating to anti-racism and inclusion. She advised that the recommendations presented a significant challenge for NHS organisations and set out a series of actions aimed at creating more inclusive workplaces for staff, patients and service users. Mrs Haire reported that UHNM welcomed both the review and its findings. The recommendations had been discussed by the Executive Management Team, with a particular focus on understanding the experiences of colleagues across the organisation and strengthening the overall staff experience. She advised that the Trust would continue to work closely with system partners and had already delivered a series of anti-racism engagement and awareness sessions. The Board noted that the proposed approach strengthened Board accountability through enhanced education and training, improved reporting arrangements through the PCIC, including relevant Insightful Board metrics. Mrs Haire highlighted the importance of triangulating information from multiple sources to support assurance and ongoing improvement. Continued emphasis would also be placed on leadership responsibility and alignment with the NHS Leadership and Management Framework. Mrs Haire referred to the Anti-Racism Steering Group which was focussed on ensuring momentum and sustained commitment to the programme, recognising that the pace of change had not yet met expectations. The steering group would seek to align and integrate related programmes of work and ensure that learning arising from maternity services and other areas was translated into wider organisational improvement. Professor Toor noted that the report had been discussed in detail at the PCIC and advised that the Committee had requested a detailed action plan, including delivery timescales, to enable ongoing scrutiny of progress. She highlighted that there had been robust discussion regarding the triangulation of evidence and outcomes and welcomed the use of the Trust's Sexual Safety Programme as an example of good practice in driving organisational change. She also emphasised the importance of considering how the Trust's broader	

zero-tolerance approach should be applied across related programmes of work.

In response, Mrs Haire advised that discussions at PCIC had built on previous work relating to violence and aggression. She acknowledged that the Executive Team remained dissatisfied with the pace of progress and was therefore focussing on ensuring agreed actions were implemented effectively and translated into meaningful change.

Mrs Monckton sought assurance regarding the pace of delivery and whether sufficient consideration had been given to prioritisation and associated risks. Mrs Haire advised that consideration was being given to how activity could be scaled up, including opportunities to work collaboratively with system partners and leverage economies of scale to maximise impact.

Dr Adamson highlighted that the programme also required a significant cultural and workforce shift. She emphasised that the Trust's commitment to zero tolerance must be reflected consistently in both decision-making and action, particularly when difficult cases arose. She noted that sustainable progress would require both organisational commitment and a fundamental change in behaviours and mindset.

Ms Bowen referred to workforce indicators within the report, noting that improvements remained limited and that the impact of interventions was not yet fully evident. She questioned whether the Trust could be assured that the correct interventions were being prioritised. Mrs Haire advised that the Task and Finish Group was overseeing a range of initiatives, including work relating to recruitment bias, career progression and organisational behaviours. She acknowledged her own dissatisfaction regarding the pace at which improvements were being reflected in outcome measures but noted that oversight had now been strengthened through the Steering Group and Executive-led governance arrangements. Work was underway to undertake a more detailed review of the available metrics and underlying data.

In response to a further question from Ms Bowen regarding data quality and reporting systems, Mrs Haire advised that the Trust held significant volumes of workforce data but needed to make better use of the information available to understand the experiences of different staff groups and inform targeted interventions.

Ms Bowen observed that the Trust's focus on sexual safety had initially resulted in an increase in concerns being reported, reflecting improved confidence in reporting and confidence in organisational responses. She queried whether a similar pattern should be expected as anti-racism initiatives developed. Mrs Haire agreed that an increase in concerns raised may be anticipated as awareness increased and staff confidence strengthened. She advised that monitoring such trends would be important in assessing whether interventions were reaching the intended audiences and creating an environment where concerns could be raised safely.

Dr Adamson added that one of the key lessons learned from the Sexual Safety Programme had been the importance of leadership development and training. She noted that work was underway to equip leaders with the skills, confidence and tools required to identify inappropriate behaviours, respond appropriately and support colleagues effectively.

Ms Small reflected on the strategic importance of providing assurance that staff were equipped with the skills and confidence both to challenge

	unacceptable behaviours and to respond appropriately when concerns were raised. She emphasised the need to understand how the organisation was enabling and empowering its workforce to do so. Dr Adamson advised that the Trust had recently seen an increase in bystander reporting and intervention arrangements through the Sexual Safety Programme which represented a significant cultural shift. She noted that increased confidence amongst staff to challenge behaviours and support colleagues was a positive indicator that the programme was achieving its objectives. Professor Toor observed that, whilst there was valuable learning to be taken from the Sexual Safety Programme, anti-racism required a distinct and nuanced approach. She emphasised that progress and outcomes should not necessarily be expected to follow the same trajectory. Mrs Freeman queried whether the Trust should consider reviewing its social media and pre-employment screening arrangements to better identify individuals whose values may be inconsistent with those expected by the organisation. Mrs Haire undertook to consider the issue further, including whether any opportunities existed locally and the extent to which changes would require national policy development. The Trust Board noted the update and endorsed the proposed recommendations.	JH
13.	UHNH Response to the National Resident Doctor Offer 2026	
068/2026	Mrs Haire presented an update on the implementation of national requirements relating to resident doctors and locally employed doctors (LEDs). She advised that the programme aimed to strengthen the employment offer for resident doctors and ensure that locally employed doctors were appropriately supported throughout their careers. The initiative sought to improve the working lives, development opportunities and overall experience of doctors working within the organisation. Mrs Haire reported that the recently published 10-Point Plan for Resident Doctors had been considered by the PCIC, which had received assurance regarding the progress made and the organisation's commitment to delivery. She noted that implementation would require a coordinated organisational response to ensure the commitments were translated into tangible actions and deliverables. The immediate priority was completion of the national readiness assessment. Dr Adamson emphasised that the programme was fundamentally about people and ensuring that doctors felt welcomed, valued and supported. She highlighted the importance of investing in individuals not only financially but also in their personal and professional development. Dr Adamson noted the importance of continuing efforts to improve opportunities for locally employed doctors and Specialty and Associate Specialist (SAS) doctors, ensuring that there were not effectively two separate cohorts of doctors experiencing different levels of support and opportunity. Mrs Monckton queried whether the Trust had sufficient Human Resources capacity to deliver the programme, given the number of competing priorities, and sought clarification regarding any potential financial implications. Mr Oldham advised that the financial implications would not be fully understood until further national guidance was available regarding funding arrangements.	

	He noted that careful consideration would be required regarding any additional training investment or posts required, ensuring resources were targeted appropriately and did not create unnecessary organisational overheads. In response to the capacity question, Mrs Haire advised that some investment had already been identified to support certain elements of delivery, including exception reporting processes. She further noted that implementation was being supported through partnership working with postgraduate medical education colleagues. Whilst acknowledging that there would be workforce and HR capacity implications, she advised that a multidisciplinary approach was being adopted to support delivery. Dr Adamson further advised that arrangements had been established to provide a role equivalent to a Director of Education for LED and SAS doctors, strengthening the support available to these groups. Mrs Freeman referred to professional membership fees, including Royal College subscriptions, and queried whether there could be wider implications for other professional groups who were required to maintain membership of professional bodies. Mrs Haire advised that this would depend upon the outcome of ongoing national discussions and that the Trust would respond accordingly once expectations became clearer. Ms Small emphasised the importance of effective reporting and consistent oversight of implementation arrangements by the Board to ensure progress could be monitored appropriately. The Board noted that progress updates on implementation of the 10-Point Plan for Resident Doctors would continue to be reported through the PCIC. The Trust Board received and noted the update.	
PERFORMANCE		
14.	Integrated Performance Report – Month 3 and Committee Assurance Reports:	
069/2026	<u>Quality, Access & Outcomes Committee Assurance Report (02-07-26 & 05-08-26)</u> Miss Nicholson presented the key matters considered by the Committee in July. The Committee noted the current position regarding access standards, as outlined previously by Mrs Thorpe, and reviewed performance relating to patient experience and complaints. Partial assurance had been provided in relation to complaints management, reflecting ongoing challenges in meeting response timescales. The Committee had considered actions being taken to improve the timeliness of complaint handling and how complaints data could be triangulated with other sources of patient feedback and quality information. The Committee also received a detailed briefing on the implications of the Ockenden and Amos reviews and the work already undertaken by the Trust in response. Consideration had been given to the governance arrangements required to oversee this work, and assurance was provided regarding the establishment of an Extraordinary Maternity Quality Committee to support enhanced scrutiny and oversight. The Committee further reviewed the Mortality Assurance Report. Whilst mortality indicators remained above expected levels, the Committee noted	

improvements resulting from ongoing clinical coding activity and was advised that the impact of these improvements would become increasingly evident within future reports.

Professor Toor advised that the Committee meeting in August had identified a number of areas requiring continued oversight. This included ongoing scrutiny of ambulance handover performance, where assurance had been received that the issues were being addressed in a robust manner through the Urgent and Emergency Care Improvement Programme.

Professor Toor further highlighted the findings of the recent Domestic Abuse re-audit, which had demonstrated improvements in performance and a positive trajectory, particularly in relation to staff awareness, knowledge and responsiveness. Whilst recognising this progress, the Committee had noted that further improvement was required in relation to the quality and consistency of documentation. The recent appointment of a dedicated Domestic Abuse Nurse was welcomed, and it was anticipated that this would support further improvements.

The Committee also considered the impact of clinical coding challenges on mortality reporting and received assurance that mortality indicators were beginning to improve as coding backlogs were addressed.

Mrs Monckton sought clarification regarding the rationale for establishing the Extraordinary Maternity Quality Committee and enquired whether the clinical coding issues presented any financial risk to the organisation. Mr Oldham advised that the coding issues referenced within the report largely related to historic activity from the previous financial year. He reported that priority had been given to elective coding activity and explained that further work was underway to quantify the impact of any uncoded activity and determine whether financial estimates would be required. Whilst there remained a potential financial risk associated with outstanding coding activity, this would be considered further as the work progressed.

The Board noted that the establishment of the Extraordinary Maternity Quality Committee would facilitate more detailed scrutiny and discussion of maternity-related issues, supporting improved oversight and assurance.

The Trust Board received and noted the update.

Quality & Access Dashboard

Mrs Holmes presented the Quality dashboard and highlighted the recent increase in Category 4 pressure ulcers. Whilst no single recurring theme had been identified, a number of cases involved non-concordance with care plans. The Board were provided with assurance that ongoing education, learning and targeted improvement activity remained in place to address the issue.

Mrs Holmes also highlighted that the recent increase in clostridium difficile cases reflected a wider national concern identified by the UK Health Security Agency and was not solely a local issue.

An update on the Patient Leadership Council was provided, which had met in June 2026. It was noted that a designated lead had been allocated to each Care Group, to strengthen engagement and feedback mechanisms.

The Committee also noted that an area had received a Bronze assessment within the Care Excellence Framework (CEF) within the West Building, with

intensive support being provided to enable the ward to progress through the framework and deliver sustained improvements.

Professor Toor welcomed the focus on patient falls and sought assurance regarding the interventions being implemented to improve performance, including issues identified during Board walkabouts relating to patient call bells. Mrs Holmes advised that a new programme had been introduced to support patients with mental health needs and those at high risk of falls. Two dedicated teams had been established to better understand the underlying causes of falls and deliver targeted interventions, including staff education and the use of diversionary therapies. She noted the importance of involving carers and families in care planning and ensuring that factors such as hydration, mobility and cognitive impairment were appropriately addressed. Progress was being monitored on a weekly basis.

Mrs Holmes further advised that concerns regarding patient call bells continued to be reviewed, including incidents where call bells had gone missing and the impact of call bell usage during the night on patient rest and recovery. The timeliness of staff responses to call bells was also being monitored.

Professor Toor welcomed the improvement in Friends and Family Test (FFT) performance and sought assurance regarding any learning that could be applied to maternity services. Mrs Holmes advised that a key area of focus was the move towards real-time digital collection of patient feedback. Discussions had taken place with a provider willing to support the development of a digital solution and this was being explored further. The Trust also continued to utilise volunteers to support the collection of patient feedback.

Professor Toor highlighted the significance of hospital-acquired pressure ulcers and sought assurance regarding the actions being taken to improve performance. In response, Mrs Holmes advised that additional review panels, enhanced education programmes, increased auditing activity and detailed case reviews had been implemented. Further work was also planned to raise awareness and improve understanding across clinical areas. It was agreed that further consideration would be given to how the Committee and Board could receive additional assurance regarding progress in this area.

Mrs Thorpe presented the elective performance update. She reported that the Trust remained within Segment 3 of the national oversight framework and that benchmarking continued to be undertaken through the National Oversight Framework. Continued improvements had been seen in cancer performance, and the impact of dermatology pathways on overall performance had been less significant than previously experienced.

Mrs Thorpe advised that performance against the DM01 diagnostic standard had been adversely affected by the loss of MRI capacity during periods of extreme heat and humidity. To mitigate the impact, a mobile MRI scanner had been commissioned, and additional support was being provided within echocardiography services.

The Board noted that, whilst the Trust had continued to reduce the number of patients waiting more than 65 weeks, a residual cohort remained. Services and directorates were continuing to work with additional capacity and targeted recovery plans to sustain the elective improvement trajectory.

Mrs Thorpe further reported that discussions with NHS England regarding the Trust's undertakings were ongoing. As part of the review and refresh process,

	the Trust had been asked to provide detailed recovery plans. The Trust remained within enhanced oversight arrangements for both urgent and emergency care and elective recovery and continued to receive support through national and regional programmes, including support from the GIRFT team. Mrs Cotton added that a review of the Trust's undertakings was scheduled to take place in the coming weeks. NHS England would wish to review the organisation's updated recovery plans, and assurance was provided that the relevant plans and supporting papers were embedded within the Trust's governance framework. The Trust Board received and noted the dashboard.	
070/2026	<u>People, Culture and Inclusion Committee Assurance Report (30-07-26)</u> Professor Toor presented the key matters discussed by the Committee. Professor Toor advised that the Committee had recognised the ongoing pressures and demands being experienced by the People Directorate and noted that this remained an area of continued discussion and focus, particularly given the breadth of programmes and priorities being progressed. This had contributed to a number of the partial assurance ratings reported by the Committee. The Committee had considered a range of reports relating to staff experience, workforce standards and organisational culture. In particular, a detailed discussion had taken place regarding the Violence Prevention and Reduction Report, which highlighted violence and aggression towards staff as a significant concern. The Committee had held a robust discussion regarding the practical implications of the Trust's commitment to a zero-tolerance approach and had requested further analysis of the available data to better understand hotspots, underlying themes and trends. It was agreed that this information should be triangulated with other available data sources to strengthen assurance and support targeted interventions. Professor Toor also reported that the Committee had provided partial assurance in relation to the Centre for Nursing and Midwifery Research and Education Excellence (CeNREE) Annual Report. Whilst the report demonstrated a range of achievements, strong staff engagement and successful utilisation of available funding, concerns had been raised regarding the sustainability of the programme, particularly in relation to workforce capacity and the ability to maintain delivery of future priorities. The Committee had additionally considered the Annual Fire Safety Report and received assurance regarding the strength of the governance arrangements in place. Members had requested additional contextual information in future reports to demonstrate the baseline position, including delivery of fire drills and progress against annual targets. The Annual Security Management Report had also received acceptable assurance. Mrs Monckton referred to the discussion regarding violence against staff and sought assurance regarding the wellbeing support available to colleagues who experienced abuse, violence or aggression. She also queried whether staff received appropriate conflict resolution and de-escalation training. Mrs Haire advised that the Trust had a comprehensive wellbeing offer available to staff, including Critical Incident Stress Management (CISM) support and specialist training provision. She noted that key areas of focus remained the reporting of	

incidents, organisational responses to concerns raised and ensuring effective engagement with the criminal justice system where appropriate.

Mrs Whitehead added that conflict resolution training was routinely provided. In situations where additional support was required, enhanced security arrangements and dedicated bedside security presence could also be deployed. She acknowledged that sanctions and enforcement remained a challenge and advised that regular meetings took place between Trust security teams and local police representatives. However, she recognised that further work could be undertaken in this area and linked this to the wider discussion regarding zero tolerance.

Ms Small sought clarification as to whether there was a defined action plan in place to address these issues. Professor Toor emphasised that the Committee's discussion had focussed on ensuring the Trust took accountability for protecting staff from violence and aggression within the workplace. She stressed that responsibility for reporting and responding to incidents should not rest solely with individual staff members and that this had been a key point of discussion within the Committee. The matter would therefore be brought back to PCIC for further consideration.

Ms Bowen queried whether the work relating to violence, harassment and aggression extended to incidents occurring through social media and online platforms. In response, Mrs Haire advised that the Trust was increasingly considering inappropriate social media activity as part of its wider zero-tolerance approach. Whilst the organisation had limited powers to act directly in some circumstances, staff were actively encouraged to report incidents so that appropriate support, monitoring and escalation could be undertaken where possible.

The Trust Board received and noted the update.

People Dashboard

Mrs Haire presented the People Dashboard and highlighted that the position for June remained mixed across a number of workforce indicators. Whilst several metrics remained relatively stable, sickness absence and employee engagement continued to be areas of significant focus.

Mrs Haire advised that the workforce metrics presented formed a key component of the evidence underpinning the workforce sustainability risk within the BAF. Whilst some indicators remained stable, the Trust had not yet seen sufficient improvement in the overall workforce metrics to justify a reduction in the current risk assessment.

The Board noted that sickness absence had increased during the month and reflected some of the pressures being experienced across the organisation. Although performance remained above the Trust's target of 4.1%, Mrs Haire advised that the Trust was not a significant outlier when compared with other organisations. To strengthen oversight and improvement activity, a Sickness Absence Assurance Board was being established from September 2026, jointly chaired by Mrs Haire and Mrs Riley. Discussions had already taken place with clinical colleagues regarding interventions most likely to improve attendance, and external consultancy support had been commissioned to assist this work.

	Mrs Haire further reported a gradual decline in appraisal compliance, reflecting the capacity pressures and competing priorities being experienced across the organisation. This remained a focus area for improvement. In relation to workforce capacity challenges within the People Directorate, Mrs Haire advised that delays were beginning to emerge in some areas of HR policy review and compliance work as a consequence of the same specialist staff supporting multiple organisational priorities. Particular pressures were being experienced in relation to Subject Access Requests (SARs) and compliance with statutory response timescales. An associated paper had been considered by the Executive Team and further discussions would take place with the relevant teams regarding alternative delivery models to address both legal compliance requirements and capacity constraints. Professor Toor highlighted the importance of exploring different methods of service delivery, noting the potential role that digital technology and artificial intelligence could play in supporting future improvements and increasing productivity. Mrs Freeman referred to recent correspondence from Jim Mackey regarding unlawful access to patient records and the expectation that organisations undertake more proactive monitoring of record access. She noted that increasing regulatory and compliance requirements of this nature were placing additional pressures on teams and were not always reflected through traditional workforce planning arrangements. In response, Mrs Haire confirmed that this area of work was already being progressed and would be reported through future assurance reports. She noted that the issue illustrated the increasing complexity of resource planning and the growing number of competing compliance requirements facing support services. The Trust Board received and noted the People Dashboard.	
071/2026	<u>Finance & Business Performance Committee Assurance Report (06-07-26 & 03-08-26)</u> Ms Bowen presented the key matters discussed by the Finance and Business Performance Committee, and highlighted the following: • An update regarding corporate capacity and investment considered workforce capacity pressures and the extent to which additional investment may be required to support delivery. The Committee discussed the process through which future proposals and priorities would be considered. • An update was provided on the Outpatient Transformation Programme which noted the progress being made. • The development of Strategic Delivery Plans were considered, with further reporting scheduled to come through the Committee in due course. • The Committee approved the implementation of Ambient Voice Technology and agreed to receive a further update after 12 months to evaluate the impact of the technology and associated benefits realised. • The Committee considered the increasing national focus on productivity and received an update on the Trust's approach to measuring and improving productivity, noting the importance of maintaining Board oversight of this agenda. • The latest Cost Improvement Programme (CIP) position was considered, including performance against both the original plan and the recovery plan.	

The Committee noted a significant increase in CIP delivery reported at Month 4.

- The Committee also received its first report regarding the Community Diagnostic Centre (CDC). It was noted that the report represented an initial position and did not yet contain a complete dataset.
- The proposed Helipad Investment Programme was approved, recognising the operational benefits and strategic importance of the scheme.

The Trust Board received and noted the update.

Finance Dashboard

Mr Oldham highlighted the Trust's financial position and the year-to-date deficit of £14.4 million, representing an adverse variance of £6.1 million against plan. Mr Oldham advised that discussions had taken place with NHS England regarding the recovery trajectory and that the CIP profile had been revised from Month 4 onwards to reflect a more realistic delivery trajectory.

Mr Oldham reported that the initial Month 4 position indicated a variance of £4.6 million adverse to plan. However, when assessed against the revised trajectory, year-to-date CIP delivery remained broadly in line with expectations.

The Board was advised that the revised trajectory required a significant acceleration in CIP delivery from Month 4 onwards. Mr Oldham acknowledged that achieving the required level of improvement would require sustained focus and organisational traction. He reported that external support was being provided by Mr Cain-Renshaw, who was undertaking a review of the Trust's recovery arrangements and supporting work to strengthen CIP delivery.

Mr Oldham noted that, whilst progress continued to be made in identifying savings opportunities, further work was required to ensure that operational improvements translated into sustainable financial benefits.

Mrs Monckton sought assurance regarding the level of grip, control and accountability in place to deliver the required improvement, noting the variance against plan at Month 4. She asked what mitigating actions were being implemented to ensure that the required transformation and financial recovery were delivered at pace. In response, Mr Oldham advised that the work currently being undertaken by Mr Cain-Renshaw was specifically examining the risks associated with delivery of the recovery plan and the Trust's forecast financial position. He noted that the review was considering organisational capacity, transformation arrangements and accountability structures to ensure sufficient focus on delivery. The findings and recommendations remained subject to validation and would be reported through the FBP Committee.

Mrs Monckton further questioned whether the organisation had sufficient resource and capacity to deliver the programme of work at the pace required. Mr Oldham advised that the review would provide further clarity regarding organisational priorities, capacity requirements and the governance arrangements needed to support delivery.

Ms Bowen noted that the Trust had secured external support focussed on both financial sustainability and CIP delivery, providing additional challenge and expertise to help accelerate progress and strengthen delivery.

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

GOVERNANCE		
15.	Audit Committee Assurance Report (06-08-26)	
072/2026	Mrs Monckton noted that discussion had already taken place regarding the capacity constraints affecting timely review of policies. She also commented on the quality of reports considered by the Committee, which highlighted the effective monitoring in place, provided by the Corporate Governance Support Manager, Jason Dutton. The Trust Board received and noted the assurance report.	
CLOSING MATTERS		
16.	Review of Meeting Effectiveness	
073/2026	Members were asked to provide feedback via Microsoft forms.	
17.	Review of Business Cycle	
074/2026	No further comments were provided.	
DATE AND TIME OF NEXT MEETING		
18.	Wednesday 7th October 2026, 9.30 am, Trust Boardroom, Third Floor, Springfield	

Post Meeting Action Log



Trust Board Part 1 - Open

As at 30 September 2026

Ref	Meeting Date	Agenda Item	Action	Assigned to	Due Date	Done Date	Progress Report	RAG Status
PTB/626	10/06/2026	Quality Account 2025/26	To consider the production of an easy read, more accessible summary version of the report.	Claire Cotton	31/08/2026	25/09/2026	Easy read versions being produced for both a shorter easier read to a length version. This is being led through Patient and Public Engagement with Maddie Roche as chair of the Trust group.	B
PTB/629	12/08/2026	NHS England Board Assurance Statement: Mortuary Oversight and Post-Death Care	To discuss how the Board could receive assurance and updates from the North Midlands and Cheshire Pathology Service going forwards.	Claire Cotton	04/11/2026		Updated from NMCPS Board to be provided to the Trust Board from November 2026 onwards.	GA
PTB/630	12/08/2026	UHNM Response to Mann Review	To consider any opportunities to enhance pre-employment screening to better identify individuals whose values may be inconsistent with those expected by the organisation.	Jane Haire	07/10/2026		Update to be provided.	GA

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

Chief Executive's Report

Trust Board (Part 1) | 7th October 2026

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 12th August 2026, some of which are not covered elsewhere on the agenda for this meeting.

1. Care Quality Commission (CQC) Inspection

The CQC inspected urgent and emergency care across both hospital sites, together with medical care at Royal Stoke, during August 2026. Immediate concerns were raised which included corridor care, medicines management and aspects of acute medical care. The Trust responded promptly, including closing the Emergency Department corridor to new patients, strengthening clinical and executive oversight, reviewing medicines arrangements and progressing a wider programme of improvement. The CQC subsequently confirmed that it was assured by the immediate actions taken. Work continues to demonstrate the sustainability and impact of the improvement actions, including through validated performance information and preparation for the forthcoming Well-Led assessment.

2. Opening of the new Urgent Treatment Centre at Royal Stoke

The new Urgent Treatment Centre at Royal Stoke opened in September as part of the Trust's wider urgent and emergency care improvement programme. The service provides treatment for adults and children with urgent but non-life-threatening conditions and is intended to support faster access to appropriate care while reducing avoidable pressure on the Emergency Department. The development forms part of a broader programme covering admission avoidance, front-door redesign, improved discharge, patient flow and alternatives to hospital admission.

3. Financial Recovery

The Trust has continued to experience significant financial and operational pressures during the first half of 2026/27. A financial recovery plan has been developed in response to NHS England requirements, setting out a range of existing, additional and pipeline interventions. The Board has recognised that the route to financial balance is ambitious and carries material delivery, workforce and quality risks. The next phase will focus on translating the proposals into detailed operational plans, with clear accountability, milestones, benefits, quality safeguards and escalation arrangements.

4. Thirlwall Inquiry

Following publication of the Thirlwall Inquiry report in September, NHS trusts and integrated care boards were asked to review the findings at their next available public Board meeting and consider whether similar events could occur within their organisations. Particular emphasis has been placed on professional curiosity, safeguarding babies and children, listening to families, enabling staff to speak up and ensuring concerns are escalated and acted upon. UHNM is considering the findings alongside its existing maternity and neonatal improvement work, the national 10 Point Plan and the recommendations arising from the Ockenden and Amos reviews.

5. Annual General Meeting

UHNH held its Annual General Meeting on 16th September, providing an opportunity to reflect on achievements and challenges during 2025/26 and to engage staff, patients, members of the public and partner organisations in the Trust's work. The event included the Chief Executive's review of the year, a financial overview and engagement stands covering patient experience, research and innovation, digital

services, equality and inclusion, Freedom to Speak Up, continuous improvement, population health and UHNM Charity.

6. National Recognition for UHNM Clinical Leadership and Research

Dr Sanjeev Nayak, Consultant Interventional Neuroradiologist, was named Clinician of the Year at the National B.A.M.E Health & Care Awards in recognition of his contribution to UHNM's 24-hour stroke thrombectomy service. In addition, three UHNM stroke and neuroscience research projects were selected for presentation at the European Stroke Organisation Conference 2026, providing international recognition for work exploring feeding support for patients following stroke.

7. National Recognition for Digital Leadership

Congratulations to Amy Freeman, Chief Digital Information Officer, on receiving two prestigious awards at the CIO 100 UK Awards on 24th September. Amy was recognised as a CIO 100 UK 2026 Award Winner, celebrating her leadership and contribution to digital transformation, and was also presented with the CIO 100 UK Award for Strategic Partnerships and Ecosystem Collaboration. The awards recognise both the innovative digital work being delivered at UHNM and Amy's wider contribution through her national advisory role with NHS England. This national recognition reflects UHNM's continued leadership in digital innovation, collaboration and service improvement.

8. Improving Access to Cancer-screening Information

UHNM Cancer Screening Services have worked with local deaf and hard-of-hearing communities and specialist services to develop British Sign Language videos covering bowel and lung cancer screening. The resources were co-produced with British Sign Language users to make screening information more accessible, inclusive and easier to understand. The bowel-screening video was subsequently premiered at a local deaf and hard-of-hearing community event.

9. Staff Survey

Preparations for the 2026 NHS Staff Survey are well advanced, with the Trust-wide campaign now underway following launch on 22nd September. The campaign, themed *"Be Seen, Be Heard, Be Part of It"*, aims not only to maximise participation, with an ambition of achieving a 50% response rate, but also to strengthen staff confidence that feedback leads to visible action and improvement. A comprehensive communications and engagement plan has been implemented, supported by executive sponsorship, Care Group engagement, leadership briefings and the promotion of local *"You Said, We Did"* examples to demonstrate how colleague feedback is shaping change across the organisation. Response rates will be monitored throughout the survey period, with targeted support provided to areas where participation is lower, helping to ensure that as many colleagues as possible have the opportunity to influence future improvement priorities.

10. Employee and Team Recognition

UHNM Team of the Month – Finance Team

UHNM's Finance Team was recently recognised as Team of the Month in acknowledgement of its achievement of Level One accreditation under the National Finance Accreditation Scheme and significant progress towards Level Two. The award recognises the team's commitment to continuous improvement, leadership development and the strengthening of financial support provided across the Trust.

UHNM Hero Award Winner: Children's Emergency Department

Colleagues in the Children's Emergency Department received a UHNM Hero Award after being nominated by the family of a young patient for the exceptional kindness, compassion and personalised care shown during his first birthday while receiving treatment at Royal Stoke University Hospital. The award reflects the department's commitment to delivering outstanding patient and family-centred care.

Part 2: Policy & Publications Update

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

Policy

- N/A

Publications

- Learning from national patient experience survey, 23rd September 2026 – report to bring together qualitative insights from 7 national patient experience surveys.

National Guidance and Letters

- Seasonal vaccination invitations, 29th September 2026 – NHS winter flu and COVID-19 vaccination invitations.
- Achieving excellent patient experience, 17th September 2026 – guidance to define what excellent experience looks and feels like across NHS-funded care.
- Implementing quality management systems in the NHS, 17th September 2026 – how quality managements systems work and includes an example implementation plan that organisations can adapt to their local context.
- Robotic assisted surgery framework agreement call-off guidance, 1st September 2026 – sets out NHS England guidance to support consistent and proportionate application of direct award provisions for robotic assisted surgery procurements.
- Unauthorised, inappropriate and unjustifiable access to confidential patient information, 25th September 2026 – letter from Sir Jim Mackey, CEO NHS England.
- Implementation of the resident doctors' deal, 25th September 2026 – letter from NHS England Deputy Chief Executive, National Medical Director and Director General, People.
- Thirlwall Inquiry Report and recommendations, 22nd September 2026 – letter from Chief Nursing Officer for NHS England and NHS England Chief Operating Officer.
- Implementation of Martha's Rule in emergency departments, 21st September 2026 – letter setting out plans to implement Martha's Rule in all emergency departments across England.
- Updates on controlled drugs, antibiotic prophylaxis and dental amalgam, 15th September 2026 – letter from the Chief Dental Officer.

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

Part 3: Consultant Appointments

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

Post Title	Reason for advertising	Appointed (Yes/No)	Start Date
Acute Medicine Consultant	Vacancy	Yes	TBC
Consultant in General Medicine	Newly created	Yes	2 post TBC 1 post 5.10.26
Consultant Microbiologist	Vacancy	Yes	TBC
Consultant Orthopaedic (Pelvic and Acetabular)	Vacancy	Yes	15.9.2026
Consultant Neurologist	Vacancy	Yes	TBC
Consultant Geriatrician with an Interest in Frailty	Vacancy	Yes	TBC
Consultant in Emergency Medicine	Vacancy	Yes	5 posts TBC
Consultant Cardiologist in Devices	Vacancy	Yes	TBC
Consultant Urogynaecologist	Vacancy	Yes	TBC

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

Post Title	Reason for advertising	Start Date
Consultant in Renal Medicine	Newly created	24.8.2026
Consultant in Obstetrics & Gynaecology	Newly created	22.9.2026
Acute Medicine Consultant	Vacancy	7.9.2026

No medical vacancies closed without applications / candidates during August and September 2026:

Medical Management Appointments

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

Post Title	Reason for advertising	Appointed (Yes/No)	Start Date
Clinical Director - Oncology	Vacancy	Yes	TBC
Emergency General Surgery Clinical Lead	Vacancy	Yes	TBC

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

Post Title	Reason for advertising	Start Date
Clinical Lead – Infectious Diseases	Vacancy	1.9.2026
Robotics Research Lead	Newly created	1.9.2026
End of Life Clinical Lead	Vacancy	30.9.2026
Clinical Director - Emergency Medicine	Vacancy	1.8.2026
Clinical Director for Acute Medicine	Vacancy	1.8.2026
Clinical Director - General Medicine Directorate	Vacancy	1.8.2026

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

Executive Summary

Trust Board (Part 1) | 7th October 2026

Briefing Summary: Report of the Public Inquiry into events at the Countess of Chester Hospital, 2015 to 2018



University Hospitals
of North Midlands
NHS Trust

Purpose:	Information	✓	Approval		Assurance		Agenda Item:	8.
Author:	Donna Brayford – Director of Midwifery							
Executive Lead:	Ann Marie Riley – Chief Nurse							
Alignment with our Strategic Priorities								
	Our People We will create an inclusive environment where everyone learns, thrives and makes a positive difference							✓
	Our Patients We will provide timely, innovative and effective services to our patients							✓
	Our Population We will tackle inequality and improve the health of our population							✓

Risk Register Mapping

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Executive Summary

Situation

The Thirlwall Inquiry was established following the conviction of Lucy Letby for the murder of seven babies and the attempted murder of seven others whilst employed as a neonatal nurse at the Countess of Chester Hospital between 2015 and 2016. The Inquiry was not tasked with revisiting matters of criminal guilt but was asked to examine how concerns were raised, escalated and managed; whether opportunities to prevent further harm were missed; the actions of managers, boards, regulators and external bodies; and what changes are required across the NHS to prevent similar events occurring in future.

The Inquiry heard evidence from 134 witnesses and reviewed events from the first neonatal deaths in 2015 through to Letby's arrest in 2018, alongside wider consideration of NHS governance, regulatory oversight and organisational culture. The final report, published on 15 September 2026, comprises more than 1,100 pages across three volumes and contains 17 recommendations directed at Government, NHS England, regulators and NHS providers.

On 21 September 2026, NHS England wrote to all Trusts advising that, whilst the Government considers the recommendations in full, a number of actions should commence immediately. NHS England has requested that all Trust Boards formally consider the findings of the Inquiry and seek assurance that equivalent circumstances could not arise within their own organisations.

Background

The Inquiry identified a series of systemic failures that enabled patient harm to continue over a prolonged period. Whilst the actions of an individual practitioner were central to the events examined, the Inquiry concluded that failures in organisational culture, leadership, oversight and escalation arrangements significantly contributed to missed opportunities to intervene.

The Inquiry's key findings were that:

- Clinicians recognised emerging patterns of harm but concerns were not acted upon with sufficient urgency.
- Senior leaders failed to respond appropriately to credible patient safety concerns.
- Relationships became polarised between clinicians and managers, hindering effective decision-making.
- Board oversight and assurance arrangements were insufficiently robust.
- Organisational reputation at times appeared to be prioritised over patient safety.
- Staff concerns were not consistently heard, valued or escalated effectively.
- External regulatory and oversight mechanisms failed to identify or respond to emerging risks.

The report concludes that patient safety must remain the overriding consideration in organisational decision-making and that stronger safeguarding, whistleblowing, managerial accountability and oversight arrangements are required across the NHS.

Assessment

The 17 recommendations collectively seek to strengthen patient safety, safeguarding, governance, oversight and organisational culture within NHS organisations. Key themes include:

- Enhanced neonatal safety measures, including CCTV monitoring, baby monitoring technology and strengthened controls over insulin storage and access.
- Improved safeguarding arrangements, including mandatory safeguarding training for all staff and Board members, revised employment requirements and a national Suspicion of Deliberate Harm Protocol.
- Strengthened mortality review processes through revised SUDIC requirements, enhanced medical examiner arrangements and improved pathology capacity.
- Improved use of data, interoperability of systems and real-time monitoring of neonatal outcomes.
- Greater managerial accountability through regulation, professional standards and a national barring system.
- Stronger support for speaking up, whistleblowing and organisational learning.
- Increased scrutiny of regulators and oversight bodies, including the Care Quality Commission and Parliamentary and Health Service Ombudsman.
- Formal monitoring of implementation of Inquiry recommendations across the NHS.

NHS England has already identified several actions requiring immediate local implementation. UHNM has commenced work in response to these requirements:

NHS England Immediate Action	UHNM Position
Board consideration of the Thirlwall Report	Scheduled for discussion at Trust Board on 7 October 2026. Further oversight and assurance arrangements to be considered.
SUDIC process awareness and compliance	Communication issued to relevant staff and the Board on 28 September 2026. Opportunities to review local and system learning, themes and trends from SUDIC reviews will be explored through future Board reporting.
National Bereavement Care Pathway	Draft implementation arrangements have been developed and will progress through established maternity and neonatal governance processes.
Insulin access and storage controls	Initial meeting held with Pharmacy and Security colleagues to explore implementation options and compliance with forthcoming requirements.
Safeguarding assurance	Review underway to determine how safeguarding compliance, assurance and escalation are monitored within Care Groups and reported through governance structures.

Whilst many recommendations are directed nationally and will require further guidance from Government, NHS England and regulators, the report provides important learning for all NHS organisations. In particular, it reinforces the need for strong Board oversight of patient safety, effective speaking-up arrangements, robust escalation processes, a culture of professional curiosity and challenge, and clear accountability for safeguarding and quality concerns.

Overall, UHNM has existing governance, safeguarding, Freedom to Speak Up and patient safety arrangements in place. However, the publication of the Inquiry provides an opportunity to review these arrangements against the Inquiry findings, identify any gaps, and strengthen assurance that concerns raised by staff are heard, escalated appropriately and acted upon promptly in the interests of patient safety.

Next Steps

A detailed Trust-wide action plan will be developed following consideration of the report and NHS England guidance. This will include a gap analysis against the Inquiry recommendations, identification of any additional assurance requirements, and regular progress reporting through the appropriate governance committees and Trust Board.

Key Recommendations

- To note the details of this briefing summary and next steps
- It is recommended that all Board members read the report in full to fully understand the impact on those involved in the Review

Summary of the Report of the Public Inquiry into events at the Countess of Chester Hospital, 2015 to 2018

1. Introduction

The Report of the Public Inquiry into events at the Countess of Chester Hospital, 2015 to 2018, led by The Rt Hon. Lady Justice Thirlwall DBE, was published on 15 September 2026.

The Inquiry was established following the conviction of Lucy Letby, a neonatal nurse at the Countess of Chester Hospital, for the murder of seven babies and the attempted murder of seven others between 2015 and 2016. The Inquiry was not tasked with re-examining her criminal guilt. Instead, it considered:

- How concerns were raised and handled.
- Whether opportunities to prevent further harm were missed.
- The actions of managers, executives, boards, regulators and external organisations.
- What changes are required across the NHS to prevent similar events occurring again.

The Inquiry heard evidence from 134 witnesses and examined events from the first neonatal deaths in 2015 through to Letby's arrest in 2018 and the wider NHS context and regulatory framework.

The report found that the collapse and deaths of some babies could have been avoided had safeguarding practices been followed. Delivering her report Lady Justice Thirlwall, said:

“My Report describes dysfunctional management and governance; a gulf between hospital leadership and clinicians; and failure to understand the fundamentals of safeguarding.

“There was a complete failure to protect babies on the neonatal unit at the Countess of Chester Hospital. This was because no-one seems to have understood that safeguarding action is required when a member of staff is suspected of causing deliberate harm and does not require colleagues to be sure of guilt.”

The Report found that senior nurses never accepted that the consultants' concerns were – or might be – justified, and that there was a prolonged delay by senior managers in calling the police. The report is critical of successive internal and external reviews commissioned by hospital leadership after concerns were raised about Letby. The reviews did not address whether deliberate harm was being caused or not. Rather than being believed when concerns were raised, clinicians were themselves made the subject of investigation within Letby's grievance process. Three consultants were told to apologise to Letby, and plans were formulated (although later abandoned) to bring Letby back onto the neonatal unit.

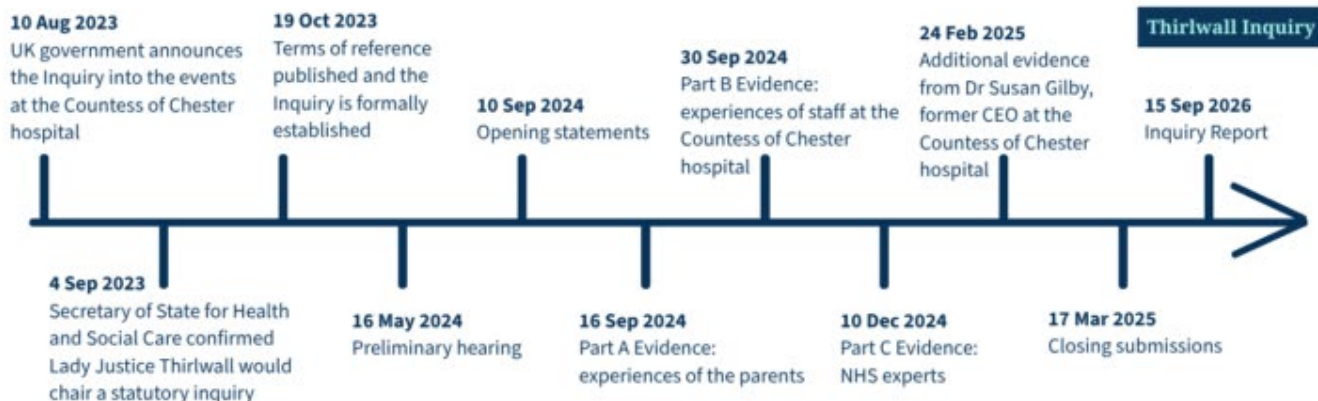
The Report reflects the anger some parents feel at the way they were treated by the Hospital which was palpable during the Inquiry hearings. They were kept in the dark for years about what was happening and about the fact that there were concerns that their babies may have been deliberately harmed. Their consent was not obtained before sharing their babies' medical records with external experts and other organisations; they were not informed about reviews; and only in 2018 did they learn that the collapses and deaths may have been the result of the actions of a nurse in whom they had put their trust.

Many parents took the view that protecting the reputation of the hospital was more important to senior managers than keeping them informed about what was happening. The lack of consideration shown to the parents at that time was reprehensible.

The Hospital's safeguarding policy did not mention the possibility of deliberate harm by a staff member, and to this day there is still no NHS-wide protocol on deliberate harm.

2. How the review was conducted

The Inquiry heard evidence from 134 witnesses and examined events from the first neonatal deaths in 2015 through to Letby's arrest in 2018 and the wider NHS context and regulatory framework. The infographic below provides a useful summary of the review process.



A

In **Part A**, parents of the babies who died or were injured at the Countess in 2015-6 shared their experiences through oral evidence and written statements.

B

In **Part B**, evidence from witnesses including managers, doctors, nurses, midwives and board members at the Countess of Chester Hospital.

C

In **Part C**, evidence from civil servants, former Ministers, professors and other experts in the NHS.



@Thirlwall_Inq



Thirlwall Inquiry



<https://thirlwall.public-inquiry.uk/>

Information on inquiries

A statutory inquiry is governed by the Inquiries Act 2005. It is independent of government and those the inquiry is investigating.

Inquiries are fact-finding exercises, meaning they are an inquisitorial rather than an adversarial. Inquiries can investigate the circumstances of a major disaster, accident or series of events involving serious wrongdoing, damage or loss of life.

Inquiries cannot prosecute people, such as in a criminal court. An inquiry cannot make findings of civil or criminal liability. Other investigative, prosecuting or regulatory authorities can investigate and take action alongside an inquiry.

Inquiries make recommendations about the lessons to learn from what it has investigated. The inquiry's recommendations may lead to future action or changes in policy and/or law.

An inquiry's Terms of Reference are set by the minister.

An inquiry Chair is responsible for discharging the Terms of Reference. They establish the structure and procedures which govern the inquiry, and are subject to a statutory duty to act fairly. The Chair acts in an independent capacity.

Under the Inquiries Act, an inquiry Chair has powers to compel witnesses to give evidence or to supply documents.

At the end of an inquiry, the Chair sets out their findings and recommendations in a report.

Chair: Lady Justice Thirlwall

Inquiry in numbers

Throughout the entire Inquiry:



134 witnesses have provided oral evidence



60 days of hearings held



383 witness statements obtained



92,666 documents & 1,043,441 pages of documents received



15,318 documents & 303,060 pages of documents disclosed to Core Participants

Terminology

Rule 9 Request under Inquiry Rules 2006 – written request for evidence, including witness statements and documents.

Section 21 notice - request for evidence which carries threat of criminal sanction for non-compliance.

Under Rule 13 of the Inquiry Rules 2006, the Inquiry must issue warning letters to those criticised, allowing them a reasonable opportunity to respond.

Under Rule 17 of the Inquiry Rules 2006, the Inquiry's Core Participants are entitled to receive early access to the report ahead of its publication.

Restriction Order - made by the Chair to restrict disclosure or publication of evidence and documents, or to restrict access to evidence hearings.

3. Key findings

Clinicians recognised a pattern of harm - Consultant paediatricians became increasingly concerned that unexpected collapses and deaths were occurring around a single nurse. By June 2016 clinicians believed there was a possibility of deliberate harm and sought urgent action.

Senior leaders failed to act on credible safety concerns - The Inquiry concluded that senior executives repeatedly failed to take adequate precautionary action despite receiving clear warnings from clinicians. Lady Justice Thirlwall was highly critical of:

- Failure to remove Letby from clinical duties when concerns became serious.
- Failure to prioritise patient safety over reputation and operational considerations.
- Delay in informing the Board fully.
- Delay in involving the police.
- Failure to consider safeguarding procedures.
- Excessive focus on alternative explanations rather than risk mitigation.

A culture of "doctors versus managers" developed - The Inquiry found that concerns raised by clinicians were frequently challenged, minimised or treated as a professional dispute. Rather than seeking collaborative investigation of serious concerns, executive leaders and some nursing leaders developed a "nurses versus doctors" narrative which distracted attention from the fundamental question of whether babies were safe. The Inquiry concluded that this culture contributed directly to delays and missed opportunities to prevent further harm.

Board oversight was insufficient - The Board was not promptly informed about the full nature and seriousness of the concerns. The Inquiry criticised delays in escalating concerns to Board level and found that executive leaders appeared reluctant to expose the emerging issues to wider scrutiny.

Organisational reputation was given undue weight - A recurring theme throughout the Inquiry is that concern about reputational damage influenced decision-making. The Inquiry found evidence of senior discussions focusing on:

- reputational implications;
- CQC ratings;
- media consequences;
- organisational impact of police involvement.

These considerations were allowed to influence decision-making before patient safety questions had been properly resolved.

Concerns raised by staff were not effectively heard - Although mechanisms such as whistleblowing and Speak Out Safely existed, staff members did not experience them as effective routes for resolving serious concerns. The Inquiry found that simply having a process is insufficient if organisational culture discourages challenge or if concerns are not acted upon.

Regulatory and oversight systems did not identify the risk - Multiple external organisations interacted with the Trust but none recognised the significance of emerging signals:

- CQC
- NHS England
- Coroners
- External reviews
- Professional regulators

The Inquiry concluded that information existed in different places but was not connected in a way that would identify the developing pattern quickly enough.

Wider NHS Findings

The Inquiry expanded beyond Countess of Chester Hospital and examined system-wide issues. Major themes included:

Culture - The Inquiry identified persistent NHS cultural issues:

- reluctance to challenge authority;
- defensiveness;

- fear of consequences from raising concerns;
- prioritisation of organisational reputation over transparency in some circumstances.

Leadership and Management -The Inquiry questioned the preparation, accountability and regulation of NHS managers and highlighted the absence of equivalent professional regulation compared with clinicians.

The report is presented over three volumes.

Volume 1: this volume covers the background of the Countess of Chester Hospital and details the initial sequence of events, information relating to Lucy Letby, details surrounding the baby collapses on the neonatal unit between 2015 and 2016, considers the Risk and Patient Safety Department, CQC inspection in February 2016 which did not identify or discuss the increase in neonatal mortality, the actions of hospital executives, and safeguarding failures which occurred at every level of the hospital.

Volume 2: This focuses on the period from June 2016 onwards and examines how concerns raised by consultant paediatricians about unexplained neonatal deaths and collapses were handled by senior leaders, regulators and external agencies. The overarching conclusion is that multiple opportunities to protect babies and escalate concerns were missed. There were failures to act on patient safety concerns, delay in contacting the police, failure of executive leadership, culture of reputation management, doctors were not listened to, failure of speak up and whistleblowing processes, inappropriate handling of the Lucy Letby grievance, RCPCH review was misused, regulatory and external bodies missed opportunities, safeguarding failures, and families were poorly informed.

Volume 3: This responds to the wider systemic implications across the NHS and sets out the inquiries final recommendations and appendices. It covers:

- Implementation of recommendations of inquiries, the choice around the government accepting recommendations, or in the event of recommendations being accepted by government these subsequently not being implemented.
- The background to the introduction of the statutory system of Medical Examiners, the current system, developments in medical examiners' guidance on neonatal deaths, medical examiners areas of expertise, consideration of had the medical examiner system been in place in 1025-1016, would any deaths had been avoided, and a number of suggestions on how to improve the medical examiner system
- CCTV and monitoring which concludes that all neonatal units should be fitted with in-cot cameras with live streaming video
- The issue of access to Insulin and how test are sought and how results are reported
- Data –retrospective audit and real time prospective monitoring, the roles and limitations of monitoring systems in identifying criminal acts, the data collected by MOSS and MBRACE-UK, and current reporting and viewing arrangements
- The volume of NHS targets, regulators and documents
- Training, accountability and regulation of managers, fit and proper person test, current government proposals on regulation, failure to deal with poor performance and the revolving door, NHS leadership and Management Framework
- Statutory and professional Duty of Candour and the governments consultation on the introduction of a professional duty of candour for NHS managers
- Culture of the NHS from the Mid Staffordshire Inquiry to the present, the constant risk that financial concerns drown out concerns for patient safety, no blame culture and its effects, blame for clinical and other errors
- FTSU guardian roles and its challenges
- Patient safety, safeguarding and employment law and the view that where safeguarding or other concerns about patient safety are raised in good faith, the balance to be struck by a responsible NHS employer between the risks of an employment claim and the risk to patient safety comes down firmly in favour of protecting the patient. Changes to HR policies in trusts include that changes be made to grievance policies so that where a grievance is raised after disciplinary procedures have started, the grievance will be considered either after the conclusion of the disciplinary process, or at the time of the disciplinary process. There is also noted a need for a suspicion of deliberate harm protocol and guidance
- Chapter 42 discusses the CQC

- Chapter 43 discusses the Health Services Safety Investigations Body (HSSIB)

4. Recommendations

Recommendation 1: CCTV and Monitoring (aligned to Chapter 33)

All cots and incubators in all neonatal units should be fitted with baby monitors (in-cot cameras with livestreaming video), so that parents can observe their baby remotely at any time. The funding for this should be centrally managed and ring-fenced, to ensure consistency and implementation across all neonatal units at speed. By 31 March 2027, NHS England should set out a roadmap for how this will be implemented.

Recommendation 2: Insulin (aligned to Chapter 34)

- Digital devices should be used to restrict access of insulin to authorised people and record access to insulin storage units. I acknowledge that steps are being taken to achieve this. By 31 March 2027, all neonatal units must meet the expected requirements for access control and storage of insulin set out in the NHS England Getting It Right First Time guide, GIRFT Neonatology: Guide to safe insulin use.
- Until access to insulin requires the provision of biometric data, each Trust should install CCTV cameras focused on storage fridges, cupboards or units. The cameras should store recordings for at least 28 days.
- The GIRFT Laboratory Handling of Insulin Requests in the Investigation of Hypoglycaemia guidance for the testing and reporting of insulin and C-peptide results, issued in October 2025, must be made mandatory and of national application.

Recommendation 3: Bereavement Care (aligned to Chapter 29)

The National Bereavement Care Pathway for neonatal death should be implemented nationally and in all Trusts by 31 August 2027.

Recommendation 4: Safeguarding and contracts of employment: (aligned to Chapter 41)

- All Trusts must provide safeguarding training to all staff (appropriate to their role and expertise) and Board members, including Non-Executive Directors. This training should include how to deal with concerns and suspicions about deliberate harm caused by staff.
- By March 2027, every existing contract of employment for work in an NHS hospital must be amended to include an obligation on the employee to follow all relevant safeguarding guidance, including the Suspicion of Deliberate Harm Protocol (at Recommendation 9), for dealing with concerns and suspicions about deliberate harm. Agency and bank staff contracts and all new contracts of employment must include the same obligation.

Recommendation 5: Operating systems (interoperability) (aligned to Chapter 35)

NHS England must provide, by 31 March 2027, a clear and timed route to ensuring that computer systems are harmonised across the NHS by December 2028. Work on the development of a mandatory information standard with requirements for interoperability between systems should be taken forward and implemented as soon as possible. This should mean that data relating to babies and neonates in hospital may be entered on a single occasion, be reviewed in a timely manner and facilitate continuous monitoring.

Recommendation 7: Data reporting (aligned to Chapter 35)

- All hospitals with a neonatal unit should name a 'lead reporter' with responsibility for inputting data regularly (at least weekly) and reviewing real-time data viewers on neonatal and maternity units in the MBRRACE system. Whilst the lead reporter does not necessarily need to be a clinician, they must be trained to understand and interpret the available data and able to explain and discuss it with clinicians.
- Save where data requires immediate action, in which case a report should be made to the Medical Director and the Board immediately, the lead reporter should report to Trust Boards at least every six months and advise:
 - a. whether any alerts or a need for investigation have arisen
 - b. the investigation or action plan in place.

Recommendation 8: Sudden Unexpected Death in Infancy and Childhood (SUDIC) (aligned to Chapters 12 and 28)

NHS England must:

- Immediately inform all Trusts with a neonatal unit that the SUDIC process applies to the sudden and unexpected deaths of babies who have never left hospital.
- Direct all Trusts that they must, within seven days, draw this information to the attention of all relevant staff and the Board.

DHSC must:

- Complete its review and revision of the SUDIC guidelines and ensure the revised guidelines are distributed to all Trusts by no later than 31 March 2027. The guidelines must include a clear statement that SUDIC applies to sudden and unexpected deaths of babies who have never left hospital.

SUDIC forms must:

- Be redesigned and shortened to keep bureaucracy to a minimum. The focus should be on what it is essential to know.

Recommendation 9: Suspicion of Deliberate Harm Protocol and guidance (aligned to Chapter 41)

Protocol:

- By 31 March 2027, NHS England must produce and distribute a one-page protocol setting out the steps to be taken by managers when concerns or suspicions are raised that a healthcare professional may have deliberately harmed a patient. The Suspicion of Deliberate Harm Protocol must make explicit that:
 - a. It is irrelevant whether the person to whom the concerns have been expressed does or does not believe they are true, as is the fact that the person raising the concern is not sure.
 - b. Where concerns or suspicions of deliberate harm are being raised in good faith, they must be acted upon immediately.
 - c. Only in cases where the concerns are obviously irrational or malicious (which assessment must be recorded) will no further action be justified.
 - d. Pending investigation of a member of staff, action to protect patients by moving the person suspected of causing harm is likely to be the first step.
 - e. The moving of a person suspected of causing harm and the investigation into suspicions and concerns about a member of staff is a neutral act.
 - f. Safeguarding steps must be followed, as a result of which the police will become involved.

Guidance:

- Guidance of no more than two pages should accompany the protocol. It must set out the factors to be considered when assessing the nature of the concerns and suspicions. The reader should be directed to guard against their own biases, loyalties and prejudices. The guidance should explain what should be said and when to those who are or who may be involved with any investigation (such as patients, parents and staff). This must include that patient safety comes first, and investigation is required. The guidance should also explain that failure to follow the protocol will be a breach of contract by an employee, as well as a breach of the relevant code of conduct.

Implementation:

- Trusts must embed the Suspicion of Deliberate Harm Protocol and guidance within their hospital.

Recommendation 10: Panel of experts (aligned to Chapter 41)

Serious consideration should be given by DHSC to the setting up of a panel of independent experts from all specialties to be called upon in situations where there are emerging concerns about an individual and harm to a patient or patients. A team from any specialty or combination of specialties would be drawn from the panel to conduct a swift, technical investigation into the concerns raised. This may most often be necessary where there are concerns that harm is being or has been caused inadvertently. The precise make-up of the panel should be determined by DHSC but could include, for example:

- a. two doctors and two nurses from each clinical specialty
- b. four senior managers
- c. four pathologists including paediatric and perinatal pathologists
- d. other experts as decided by DHSC.

Where necessary, a small team (always including clinicians from the relevant specialty/specialties) would be drawn from the panel to carry out an independent investigation into clinical concerns. Such investigations should always include safeguarding considerations (including contacting the police). In

addition to reporting their findings to the Trust and DHSC, the experts would be available to be called as witnesses in any proceedings that may follow.

Recommendation 11: Medical examiners (aligned to Chapter 32)

- The National Medical Examiner should, by 31 March 2027, prepare and distribute a one-page document setting out all the steps to be taken by a medical examiner when dealing with the death of a neonate.
- The revised SUDIC guidelines (see Recommendation 8 above) should be set out within the good practice guidelines for medical examiners, not merely signposted.
- Medical examiners should ask direct questions of the attending practitioner as to whether there is a concern that a child has been harmed or some other safeguarding concern. Where there may be such a concern, the medical examiner should ensure that there is a record made that day of the contact details of every doctor or nurse who attended to the baby during life.
- There should be a pool of neonatologists who can assist medical examiners with their work until such time as it is possible to appoint the appropriate number of regional neonatologist medical examiners. Ring-fenced funding should be provided for this purpose.
- The medical examiner system should be reviewed again in 2027 by DHSC. The review should include the adequacy of funding for medical examiners and their support staff and offices. In particular, the question of whether the funding should be ring-fenced must be addressed. Thereafter, reviews should be as directed by DHSC and NHS England.

Recommendation 12: Paediatric and perinatal pathologists (aligned to Chapter 28)

DHSC and NHS England must ensure that, by June 2033, there are 37 doctors in training posts as paediatric and perinatal pathologists, in line with the workforce requirement set out by the Royal College of Pathologists in the November 2025 Paediatric and Perinatal Pathology Workforce Report. The incentive scheme should remain in place and funded until at least 37 doctors are in training posts as paediatric and perinatal pathologists.

Recommendation 13: Accountability and regulation of managers (aligned to Chapter 37)

- DHSC and NHS England must develop and put in place a barring system for all managers (clinical and non-clinical) by September 2027. It should be reviewed in 2030 with a view to moving to a full statutory regulation system by September 2032.
- NHS England must require any Trust seeking approval for the movement of a senior manager to another Trust to demonstrate that:
 - a. The move is not proposed because of the manager's lack of capability or misconduct.
 - b. The manager meets the fit and proper person test.NHS England must not grant approval, and Trusts must not seek approval, unless they are able to demonstrate the matters at a. and b. above.
- In addition to the statutory duty for organisations, all managers must be subject to an individual duty of candour to all patients and colleagues. This should be included in the code of conduct and in the contract of employment for all managers.
- The NHS Leadership and Management Framework Code, a code of conduct for NHS managers published in July 2026, must be amended urgently to set out, at the beginning, the uncontroversial duty of every manager to put patients first. I suggest the following wording, with thanks to Mr Jarrold: 'I will make the care and safety of patients my first concern and act to protect them from risk.' What matters is that patients come first.
- In the Leadership and Management Framework Standards, the competency 'delivering across healthcare' should be first (it is currently third). The first and fundamental competency under this heading is, rightly: "I put patients first and report safety concerns and incidents."

Recommendation 14: Care Quality Commission (CQC) (aligned to Chapter 42)

- CQC should conduct without-notice inspections of hospital departments. Inspection teams should include at least two current practising experts in the relevant field (in this case paediatrics/neonatology).
- Inspectors should investigate what is happening in hospital departments and not accept what they are told at face value. Where processes are being inspected, questions must be asked to elicit the effectiveness of those processes.³
- Training should make explicit that CQC is responsible for ensuring the safety of patients in hospitals and not just for checking there are processes in place which, if implemented, should ensure patient

safety. Inspectors and team leaders must always approach an inspection of neonatal services not as a box-ticking exercise but as a way to determine that babies in hospital are safe.

Recommendation 15: Assessment of the performance of CQC (aligned to Chapter 42)

There must be a rigorous and consistent review and assessment of the performance of CQC by the Health and Social Care Committee, initially once a year and, once the committee is satisfied, once every three years, or such other frequency to be determined by the select committee.

Recommendation 16: Parliamentary and Health Service Ombudsman (aligned to Chapter 31)

The functions of the National Guardian's Office should be taken over by the Parliamentary and Health Service Ombudsman in England. The Ombudsman's powers must be increased to include:

- investigating complaints that whistleblowing in the NHS has not been dealt with adequately
- assisting whistleblowers by referring their concerns to the relevant NHS bodies and overseeing the response.

Recommendation 17: Implementation of recommendations (aligned to Chapter 31)

A new responsibility for auditing the implementation of the recommendations of statutory inquiries into NHS bodies should be given to the National Audit Office. Funding for appropriate additional staffing should be made available so that it may begin its work by September 2027.

On 21st September, Trusts received a letter from NHSE to note that:

The Secretary of State had delivered a statement in Parliament that committed to commencing a series of actions recommended in the final report, while the Government considers the Inquiry's recommendations in full. Specifically:

- Urgently work to develop plans for all cots and incubators in all neonatal units to be fitted with baby monitors (in-cot cameras with livestreaming video), so that parents can observe their baby remotely at any time. Taking learning from places where this is already used, we will develop a national approach to support neonatal units to implement this;
- Go further on new guidance on the safe use and storage of insulin and strengthened guidance for medical examiners reviewing neonatal death;
- Undertake a review of the 'Working Together to Safeguard Children' (April 2026) and safeguarding training nationally;
- Work through plans to regulate NHS managers through a barring scheme for senior leaders who fail in their responsibilities;
- Continue rollout of the National Bereavement Care Pathway for families experiencing neonatal loss.

The letter also highlighted actions needed now. Trusts should immediately progress the following actions in response to the Inquiry's findings:

- **Every Trust and ICB Board to review the Thirlwall report and to consider its findings at the next available public Board meeting:** Boards should reflect on whether it would have been possible for similar events to occur at their own organisation and seek assurance that sufficient measures are in place to keep the babies and children in their care safe, no matter what setting. Central to this is a culture of professional curiosity, where both Board members and staff feel empowered, supported, and confident to speak up, challenge concerns, and raise issues without fear. Any risks to this must be urgently discussed with the regional team.
- **Sudden and Unexpected Death In Children (SUDIC):** The Inquiry rightly made clear that no member of staff should ever assert that they did not know what to do in response to a sudden and unexplained death. The SUDIC protocol is applicable for every death (or collapse leading to death) of an infant or child under the age of 18 which would not have been reasonably expected to occur 24 hours previously and in whom no pre-existing medical cause of death is apparent, irrespective of the place of death. This includes sudden and unexpected deaths within neonatal units. All Trusts with a neonatal unit must urgently communicate to all relevant staff and the Board that the SUDIC process applies as set out above. This must be completed by no later than **Monday 28 September**. It is important to note that SUDIC reporting runs alongside your own internal reporting processes. ***This has been actioned.***
- **National Bereavement Care Pathway for stillbirth and neonatal death:** ICBs and providers should take immediate action to improve care of the bereaved as has already been set out in the NHS Medium Term Planning Framework (October 2025).

- **Insulin:** By 31st March 2027, all neonatal units must meet requirements for access control and storage of insulin as set out in the GIRFT neonatology Guide to safe insulin use (<https://gettingitrightfirsttime.co.uk/wp-content/uploads/2026/04/GIRFT-guide-to-safe-insulin-use-in-neonatal-services-FINAL-January-2026.pdf>). Until access to insulin requires the provision of biometric data, each Trust should urgently install CCTV cameras in neonatal units focused on storage fridges, cupboards or units by **30 November 2026** at the latest. The cameras should store recordings for at least 28 days.
- **Safeguarding:** Trusts and ICBs should ensure that all staff and Board members are compliant with safeguarding training requirements at the appropriate level and confirm that staff know who to raise and escalate concerns to. Boards must assure themselves that the safeguarding of babies and children is given the level of prominence required.

In addition, Trusts have been reminded that the Insightful Provider Board guide is intended to help Boards identify the information they need and the cultures, behaviours and governance required to ensure that information is used effectively.

Initial suggested assurance questions for consideration:

Domain	Key Assurance Question for the Board
Patient Safety Surveillance	How do we identify unusual patterns of deaths, deteriorations, serious incidents or near misses across services? Are there any unexplained harms, deaths or deterioration events that remain unresolved today?
Safeguarding	If concerns arose that a member of staff may be causing harm, what is the escalation pathway and who decides on LADO/police referral?
Executive Leadership	How do we assure ourselves that patient safety considerations outweigh operational, reputational or workforce concerns?
Freedom to Speak Up	Would staff raising serious concerns feel protected and supported? What evidence do we have that our Freedom to Speak Up arrangements actually work?
Clinical Escalation	How are concerns raised by consultants, matrons and senior clinicians escalated to Board level?
Mortality Governance	How are unexpected deaths, deterioration events and serious incidents reviewed for common themes?
Board Challenge	What evidence exists that the Board challenges executive assurance when concerns remain unresolved? Could we demonstrate to a regulator, coroner or inquiry that patient safety always takes precedence over reputation?
External Reviews	What question does each external review answer, and what question does it not answer?
Risk Management	Are our risk registers capturing the most significant patient safety risks?
Duty of Candour	How do we assure ourselves that families are informed openly and honestly when safety concerns arise?
Learning Culture	How do we know clinicians who challenge accepted explanations are listened to?
Regulatory Escalation	When would we involve NHS England, regulators, police or external safeguarding organisations?
Independent Scrutiny	What independent challenge exists when executive and clinical views differ?
Workforce Capability	Are leaders trained to recognise safeguarding concerns involving healthcare professionals?

Next Steps:

1. A comprehensive action plan will be developed and presented to Committee and Trust Board

Key Recommendations

The Trust Board is asked to note the details of this briefing summary and next steps. It is recommended that all Board members read the report in full to fully understand the impact on those involved in the Review.

Executive Summary

Trust Board (Part 1) | 7th October 2026

National Maternity Triage Specification Board Assurance Framework

Purpose:	Information	Approval	Assurance	✓	Agenda Item:	9.
Author:	Catherine Hegarty, Deputy Director Midwifery, Governance Donna Brayford, Director of Midwifery					
Executive Lead:	Mrs Ann-Marie Riley OBE, Chief Nurse/DIPC					
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		
41000	Consultant Staff Shortages	Extreme 20
33311	Ante-natal Consultant capacity	High 12

Executive Summary	
Situation The national maternity triage specification is a sub section of the NHS England's 10 point plan for maternity and neonatal services. This was developed by NHS England following the publication in June 2026 of National maternity reviews by Baroness Amos' independent investigation into maternity and neonatal services in England and Donna Ockendens independent review of maternity services at the Nottingham University Hospitals NHS Trust. The Maternity Triage specification sets out what good maternity triage services should look like, recognising maternity triage as a safety-critical clinical environment, as the emergency front door for urgent and unscheduled maternity care. It establishes consistent national principles to strengthen, protect and sustain this core part of maternity services, closing gaps in current provision and supporting seamless pathways from early pregnancy services into maternity triage, so that women and families receive safe, timely urgent care when they need it. The Trust is expected to take immediate action on maternity triage, and this document sets a clear vision for best practice that services should work towards. There is an expectation that organisations will have fully implemented the specification within 12 months of publication. Additionally, within 3 months of publication, organisations will have audited their current maternity triage services, completed a gap analysis against this specification, and developed an implementation plan, with progress reported through a public Trust Board meeting and shared with regional NHS England teams. Performance data demonstrates high demand on maternity triage services, with 5,755 triage attendances and 7,798 telephone triage calls reported year to date from May, alongside increasing service pressures and workforce challenges. UHNM are currently 29 % compliant against all ten principles. Background This specification aims to: - Set a high-level framework for what good maternity triage services should look like. - Improve safety and experience for women by reducing variation. - Reduce inequalities through consistent access and care. - Support accountability through a clear measurement strategy.	

- Provide a practical approach to implementation.

There are 10 principles within the Maternity Triage specification which outline the essential features of effective maternity triage services:

Principle 1 - Access and integration

Clear, local 24/7 pathways so women know where to go and are supported between services.

Principle 2 - Recognition as urgent care

Maternity triage is the safety-critical emergency front door for urgent and unscheduled care and must be recognised and treated as such.

Principle 3 - Assessment and care of women

Every woman receives timely assessment, prioritisation and a clear plan of care.

Principle 4 - Clear information for women

Information and messaging must be clear, welcoming and unambiguous: contact triage if you are worried.

Principle 5 - Telephone maternity triage

A dedicated 24/7 maternity helpline must be answered promptly and not diverted to labour ward.

Principle 6 - Service user voice and experience

Women's feedback must shape service design, improvement and experience.

Principle 7 - Facilities and estates

Triage needs safe, visible, fit-for-purpose space designed for urgent care.

Principle 8 - Staffing

Staffing must support timely assessment and prompt midwifery and medical review when escalation is needed

Principle 9 - Equity and equality

Services must use data and targeted action to identify and reduce inequalities.

Principle 10 - Data and measurement

Data must drive oversight, learning from incidents and continuous improvement.

Assessment

Key Risks Requiring Board Oversight

Risk 1: Workforce Capacity and Staffing Model

Risk Score: Extreme (20) and High Risks identified

The current staffing model is not fully aligned to the specification requirements for dedicated maternity triage staffing and does not consistently demonstrate compliance with RCOG standards for workforce capacity. There is ongoing reliance on existing workforce arrangements whilst a full midwifery and obstetric workforce review is undertaken. Consultant staffing shortages remain recorded as an Extreme organisational risk.

Potential Impact

- Delays in initial assessment and clinical review
- Increased risk of staff redeployment
- Reduced resilience during periods of peak demand
- Potential inability to sustain 15-minute assessment standard

Risk 2: Estates and Infrastructure Limitations

Risk Score: High

Current maternity triage facilities do not fully meet the specification requirements regarding physical separation from scheduled care, patient flow, waiting facilities and future expansion requirements. In addition, the absence of a dedicated Gynaecology Assessment Unit presents ongoing system flow challenges.

Potential Impact

- Delays in assessment and onward care
- Reduced patient experience
- Reduced operational resilience
- Limited ability to expand triage capacity to meet future demand

Risk 3: Data Quality, Measurement and Assurance

Risk Score: High

Several mandatory metrics cannot currently be captured consistently or are being collected through sampling methods. Data analyst support and audit capacity are required to provide robust performance monitoring and compliance assurance.

Examples include:

- Women attending without prior telephone triage
- Telephone callers not subsequently attending
- Equity stratified outcome data
- Comprehensive activity and waiting time measures

Potential Impact

- Inability to evidence compliance
- Reduced ability to identify emerging safety risks
- Limited assurance regarding inequalities and outcomes

Risk 4: Standard Operating Procedures and Governance

Three specification requirements remain assessed as "Not in Place":

1. Dedicated Maternity Triage SOP clearly distinguishing triage from day assessment activity.
2. Transparency to women regarding collection and use of maternity triage data.
3. Full compliance with some urgent care pathway requirements.

Potential Impact

- Variability in operational practice
- Reduced consistency in patient pathways
- Increased governance risk during external review

Risk 5: Inequalities and Service User Experience

The Trust currently partially meets requirements around health inequalities, co-production, culturally safe care and service user feedback infrastructure. Further work is required to enable robust triangulation of ethnicity, deprivation, language and outcome data.

Potential Impact

- Failure to identify emerging inequalities
- Reduced assurance against NHS England expectations
- Missed opportunities to improve patient experience

Positive Assurance

Notwithstanding the risks identified, significant progress has been achieved:

- Dedicated 24/7 telephone triage service established.

- BSOTS maternity triage system implemented.
- Strong governance arrangements and PSIRF integration established.
- No unplanned maternity triage service closures reported.
- 87.3% of women triaged within 15 minutes against an 85% target.
- Robust digital maternity record system supporting clinical documentation.
- Significant workstreams already established to deliver compliance trajectory.

Assurance Assessment

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

Rationale

The Trust has established a strong foundation and demonstrates substantial progress towards compliance; however, significant workforce, infrastructure, governance and data-related risks remain which require Board oversight and organisational support to achieve full implementation by July 2027. The number of actions may fluctuate as the BAF is a live document so risks may be added or taken off, as when they arise or are actioned.

Key Recommendations

The Trust Board is asked to:

1. Note the current position of Partial Assurance against the National Maternity Triage Specification.
2. Recognise the principal risks relating to:
 - Workforce capacity and consultant shortages.
 - Estates and infrastructure requirements.
 - Data collection and analytical capability.
 - Equality and patient experience infrastructure.
3. Support the development of business cases for:
 - Additional midwifery and obstetric staffing.
 - Gynaecology Assessment Unit development.
 - Audit and data analyst capacity.
 - Estates modifications and wayfinding improvements.
 - Perinatal Service Advocate and equality improvement infrastructure
4. Receive quarterly assurance updates regarding progress against the implementation trajectory, with escalation of any delays, workforce risks, safety concerns or financial implications.

National Maternity Triage Specification Summary Board Assurance Framework (BAF)

Chief Nurse / Director of Midwifery
Quarter 1, 2026/27



Summary & Overview

Overview from the Chief Nurse and Director of Midwifery

How are we doing against our trajectories and expected standards?

Not fully compliant with any of the 10 principles however work is in progress within all principles.
There are 3 standards that are not in place
92.6% of the specification is either fully in place or partially in place

What is driving this?

The NHSE Triage Specification has been developed following the publication of the Maternity reviews carried out by Baroness Amos and Donna Ockenden.
There are 10 principles within the specification with standards within each principle.
The expectation is that the organisation will have fully implemented the specification within 12 months of publication.
Within 3 months, a gap analysis is required against the specification which will then inform an implementation plan. This will also include audits against the metrics within the specification.

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

A full midwifery and medical staffing review is underway to facilitate 24 hours staffing cover on Maternity triage to meet capacity demands.
A facilities and estates review has been undertaken
Plans to update guidance, policies and SOPS to meet the Maternity triage specification
Communications campaign to ensure service users are clear on the location, open-access and functionality of Maternity triage
Enhanced training programme to further increase knowledge, skills and competence of staff working on maternity triage
Review of pathways to ensure elective and emergency admissions are referred to the most appropriate place
Improve methods of receiving service user feedback to inform service improvements and improve patient safety and experience.
Obtain accurate and sufficient data collection to gain insight into areas of focus

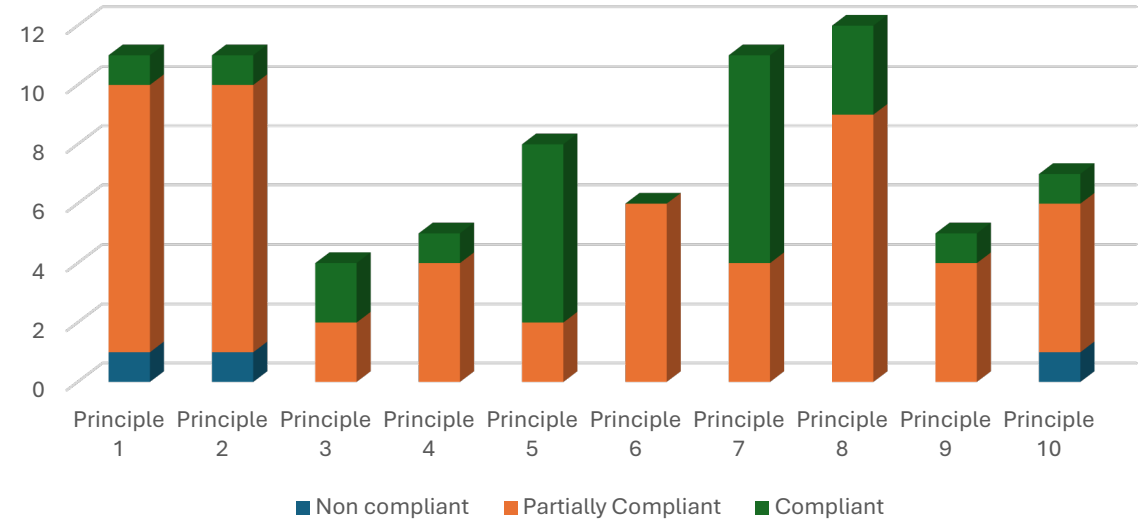
What can we expect in future reports?

Progress against actions and compliance with principles
Upward trajectory against target date of July 2027
Escalation of any concerns or challenges highlighted from audits and improvement group
Further service improvement developments and finance costs implicated within improvements.

At a Glance Summary

10 National Principles for maternity Triage Services		Fully in place	Partially in place	Not in place	Not relevant
1	Access and integration – Clear local 24/7 pathways so women know where to go and are supported between services	9%	82%	9%	0%
2	Recognition as urgent care – Maternity triage is the safety critical emergency front door for urgent and unscheduled care and must be recognised and treated as such.	10%	80%	10%	0%
3	Assessment and care of women – Every woman receives timely assessment, prioritisation and a clear plan of care.	40%	40%	0%	20%
4	Clear information for women – Information and messaging must be clear, welcoming and unambiguous; contact triage if you're worried	33%	67%	0%	0%
5	Telephone Maternity Triage – A dedicated 24/7 maternity helpline must be answered promptly and not diverted to labour ward	75%	25%	0%	0%
6	Service User voice and experience – women's feedback must shape service design, improvement and experience.	0%	80%	0%	20%
7	Facilities and estates – Triage needs safe, visible, for purpose space designed for urgent care	60%	40%	0%	0%
8	Staffing – staffing must support timely assessment and prompt midwifery and medical review when escalation is needed.	25%	75%	0%	0%
9	Equity and Equality – services must use data and targeted action to identify and reduce inequalities.	20%	80%	0%	0%
10	Data and Measurement – data must drive oversight, learning from incidents and continuous improvement.	14%	71%	14%	0%
The best joined-up care for all Total compliance		28.6%	64%	3.3%	4%

Compliance by Criteria

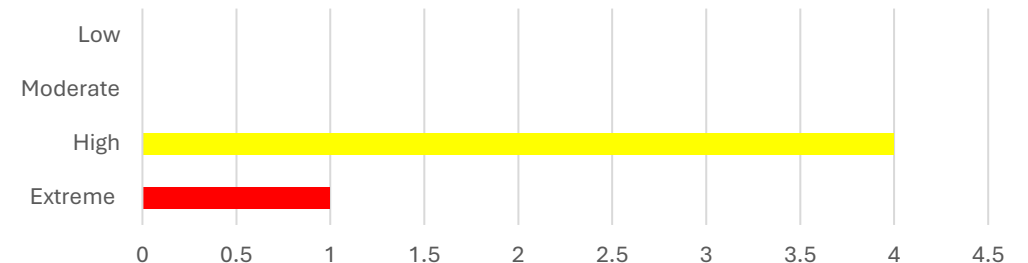


Overall Assurance Assessment

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



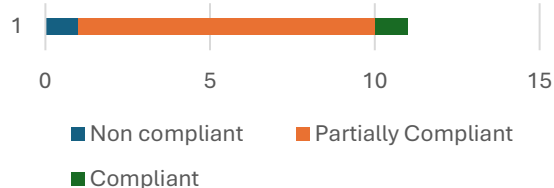
Risks



1

Access and integration

KLOE Compliance



Risk Register

21970	Lack of Gynaecology ward	High 10
25034	Lack of capacity to perform early viability scan	High 9
33311	Antenatal Consultant capacity	High 12
37359	MNVP infrastructure	High 9
41000	Consultant staff shortages	Extreme 20

Areas of Partial/Non Compliance

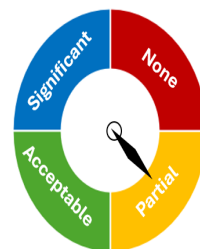
- 1.1 Work closely with Emergency Departments, Primary Care, Early Pregnancy, Gynaecology and wider maternity services, so women can easily access the right care from early pregnancy to six weeks postnatal.
- 1.2 Provide clearly defined 24/7 access route so women always know where to go with urgent concerns
- 1.3 Agree the most appropriate place of care for women at different stages of pregnancy and with different clinical needs
- 1.4 Ensure inclusive access arrangements so all women can access maternity triage safely and equitably
- 1.5 Maintain access routes such as telephone walk-in with an open-door policy
- 1.6 Provide accessible and consistent guidance and signposting for staff and service users for onward referral with coordinated handover
- 1.7 Define referral criteria across local maternity services
- 1.8 Establish communication and referral pathways between triage and key services
- 1.9 Plan ongoing care including sufficient bed capacity to support timely and safe admission
- 1.11 Provide a postnatal pathway to six weeks postnatal including guidance on care of baby where required

Metric:
Proportion of women who attend without prior telephone triage

Key Actions

Action	Deadline
Review of guidance and pathways	July 2027
Gynaecology Assessment Unit	Dec 2026
Maternity Signage	Dec 2026
Infrastructure for receiving service user feedback	Dec 2026
Development of communication resources and data collection	July 2027
Maternity and medical staffing	July 2027
Facilities and Estates	July 2027
Audit and data analyst	Oct 2026

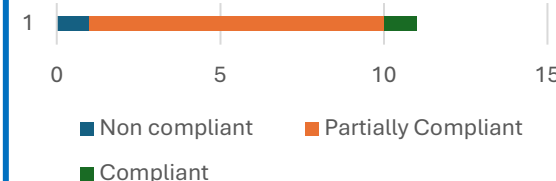
Assurance



2

Recognition as urgent care

KLOE Compliance



Risk Register

25034	Lack of capacity to perform early viability scan	High 9
33311	Antenatal Consultant capacity	High 12
37359	MNVP infrastructure	High 9
41000	Consultant staff shortages	Extreme 20

Areas of Partial / Non Compliance

- 2.1 Maternity triage services must be recognised across the whole system as a safety critical environment and the primary access for urgent care
- 2.2 Every woman should receive initial triage assessment within 15 minutes
- 2.3 Maternity triage is accessible to all women presenting without requiring an appointment
- 2.4 Embed a culture that validates and responds to women's concerns
- 2.5 Provide real time updates on expected waiting times based on risk categorisation
- 2.6 Operate with an open door approach
- 2.7 Keep maternity triage distinct from day assessment activity
- 2.8 Define maternity triage through a SOP that clearly defines it from day assessment
- 2.9 Sign post maternity triage throughout the hospital
- 2.10 Recognise maternity triage as a core part of the emergency care system

Metric:
Reason for attendance, categorised by urgency and type of concern

Key Actions

Action	Deadline
Review of guidance and pathways	July 2027
Maternity Signage	Dec 2026
Infrastructure for receiving service user feedback	Dec 2026
Development of communication resources and data collection	July 2027
Maternity and medical staffing	July 2027
Facilities and Estates	July 2027
Data Analysis and audit	Oct 2026

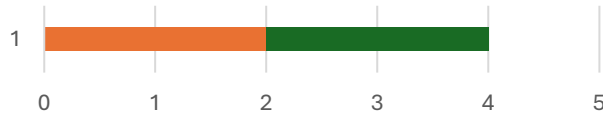
Assurance



3

Assessment and care of women

KLOE Compliance



■ Non compliant ■ Partially Compliant ■ Compliant

Risk Register

No risks identified

Areas of Partial/Non Compliance

- 3.2 Ensure triage assessment and clinical prioritisation are carried out by trained staff
- 3.5 Ensure triage models and staff training address unconscious bias and support equitable escalation, recognising higher risk and later presentation patterns among Black and Asian women

Action Plan

Action	Deadline
Implementation and training compliance of BSOTS competency assessment	Oct 2026
Maternity and medical staffing	July 2027
Training programme for addressing unconscious bias and supporting equitable escalation	Dec 2026

Assurance



4

Clear information for women

KLOE Compliance



■ Non compliant ■ Partially Compliant ■ Compliant

Risk Register

No risks identified

Areas of Partial/Non Compliance

- 4.1 Provide clear, consistent guidance on how and when to contact maternity services and where to attend
- 4.2 Offer information and advice in accessible formats
- 4.4 Provide consistent and personalised discharge information
- 4.5 Ensure effective signposting and discharge information through direct referral to the appropriate service

Metric:

Reason for attendance, categorised by urgency and type of concern, including non-triage specific concerns

Action Plan

Action	Deadline
Review of guidance and pathways	July 2027
Maternity Signage	Dec 2026
Infrastructure for receiving service user feedback	Dec 2026
Development of communication resources and data collection	July 2027
Facilities and Estates	July 2027
Audit and data analyst	Oct 2026

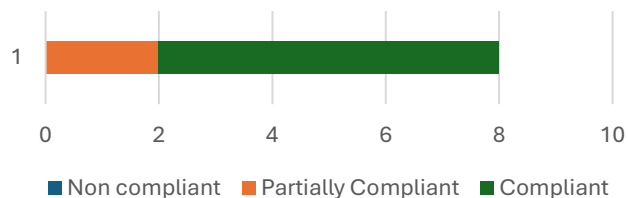
Assurance



5

Telephone Maternity Triage

KLOE Compliance



Risk Register

Areas of Partial / Non Compliance

- 5.2 Encourage telephone triage where appropriate but never make it only route to care
- 5.3 Ensure all women have open access to face to face maternity triage, where a woman remains anxious or concerned after telephone triage invite them to attend in person

Metric:

Proportion of women who call telephone triage but do not attend in person

Action Plan

Action	Deadline
Review of guidance and pathways	July 2027
Development of communication resources and data collection	July 2027
Audit and data analyst	Oct 2026

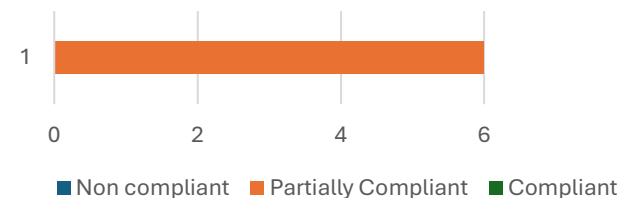
Assurance



6

Service User voice and experience

KLOE Compliance



Risk Register

37359	MNVP infrastructure	High 9
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Areas of Partial / Non Compliance

- 6.1 Develop a deeper understanding of their local populations, including social, cultural and geographical contexts
- 6.2 Gather feedback regularly through multiple channels and review to inform service improvement
- 6.3 Present monthly data and quality improvement work in accessible patient-facing and staff-facing formats and use it to improve service quality
- 6.4 Clearly inform women how to raise concerns or seek further review if dissatisfied with triage review outcomes including Marthas rule
- 6.6 Value qualitative lived experience alongside quantitative data
- 6.6 Work with MNVP and co-produce improvements, embedding service user voice

Metrics:

Qualitative and quantitative data of experience of women using maternity triage services

Frequency and diversity of feedback collected including review by ethnicity

Number of improvement actions implemented where issues identified including service user feedback, performance data, incidents, audits, complaints or staff feedback

Action Plan

Action	Deadline
Infrastructure for receiving service user feedback	Dec 2026
Development of communication resources and data collection	July 2027
Facilities and Estates	July 2027
Audit and data analyst	Oct 2026

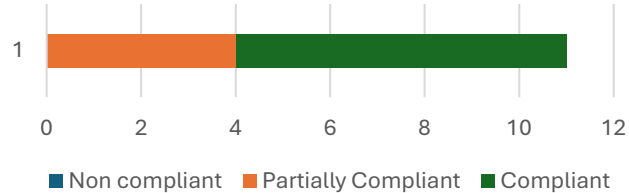
Assurance



7

Facilities and estates

KLOE Compliance



Risk Register

37359	MNVP infrastructure	High 9
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Areas of Partial / Non Compliance

- 7.5 Ensure appropriate facilities provide privacy and confidentiality
- 7.8 Meet accessibility standards including accessible WC's and clear signage in line with Health Building Note 09-02
- 7.9 Be physical separate from scheduled day assessment activity
- 7.10 Design the environment to promote womens sense of safety and comfort

Action Plan

Action	Dead line
Maternity Signage	Dec 2026
Infrastructure for receiving service user feedback	Dec 2026
Facilities and Estates	July 2027

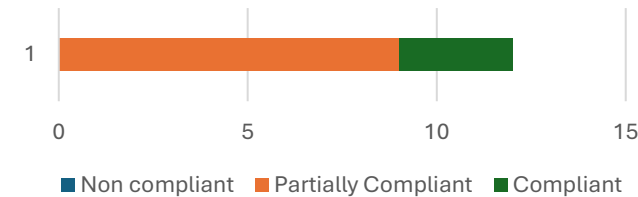
Assurance



8

Staffing

KLOE Compliance



Risk Register

41000	Consultant staff shortages	Extreme 20
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Areas of Partial / Non Compliance

- 8.1 Maternity Triage uses a staffing model informed by local activity and acuity
- 8.2 Ensure appropriate dedicated midwifery, medical and support staffing in line with RCOG good practice paper no. 17
- 8.3 Ensure a formal process defining circumstances in which triage staff may be redeployed
- 8.6 A documented competency framework for Maternity triage staff
- 8.7 Structured training for Maternity Triage staff
- 8.8 A documented escalation framework for Maternity triage
- 8.9 Documented policy defining how staff adjustments are made during periods of critical workload , demand or capacity pressure including well being of staff
- 8.11 Clear guidance defining triage type activity within Midwifery Led units

Metrics:

Proportion of women assessed including initial triage and medical review within expected timeframes based on category of urgency

Frequency of staff being redeployed from Maternity Triage

Action Plan

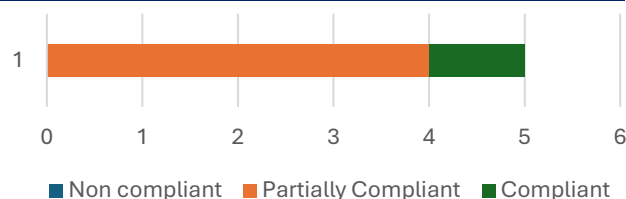
Action	Deadli ne
Review of guidance and pathways	July 2027
Maternity and medical staffing	July 2027
Audit and data analyst	Oct 2026

Assurance



9 Equity and Equality

KLOE Compliance



Risk Register

No risks identified

Areas of Partial / Non Compliance

- 9.1 Acknowledge and understand inequalities experienced by services users
- 9.3 Use demographic and outcome data to identify where poor outcomes are concentrated and use to inform service design, improvements and map inequalities
- 9.4 Work with local improvement initiatives and community-led organisations so that lived experience forms service improvements
- 9.5 Ensure all staff involved in maternity triage undertake training that supports culturally safe care

Metrics:

Equity and equality data should be captured as a defined subset of each primary dependent outcome measure, and reported both overall and stratified by ethnicity, deprivation (IMD) and spoken language

Action Plan

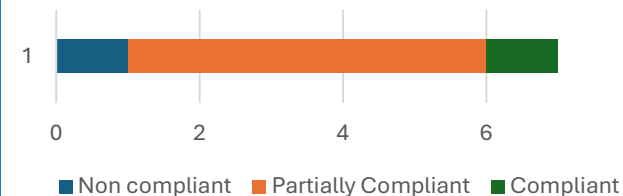
Action	Dead line
Maternity and medical staffing	July 2027
Training programme for addressing unconscious bias and supporting equitable escalation	Dec 2026

Assurance



10 Data and Measurement

KLOE Compliance



Risk Register

Areas of Partial / Non Compliance

- 10.1 Collect and review all data
- 10.2 Where a metric can't be captured identify improvements needed to enable future capture
- 10.3 Review data at appropriate intervals
- 10.4 Establish processes for teams to frequently review data
- 10.6 Include demographic variables including ethnicity, deprivation and disability
- 10.7 Be transparent with women about how data is collected and how it will improve care

Action Plan

Action	Deadli ne
Development of communication resources and data collection	July 2027
Audit and data analyst	Oct 2026

Assurance



Assurance Map



University Hospitals

Assurance Requirements	Directorate Governance Assurance	Care group Governance Assurance	Executive Quality & Safety Oversight Group – Maternity Assurance	Quality Access and Outcomes Committee	Trust Mortality Group	Board Assurance	PQSG	Regional oversight	Trust Board Maternity & Neonatal Safety Champions	PLT
Antenatal and Newborn Screening Programme	Annual Antenatal and Newborn Screening Programme (Annual Report)	x	x	x	x	x	x		x	x
Annual Mortality Report Obstetrics Gynaecology Neonatal	Annual Mortality Report Mortality Report	Annual Mortality Report	x	x	Annual Mortality Report	x	x		x	x
Annual Mbb race Report and action plan	Annual Mbb race report and action plan	Annual Mbb race report and action plan	Annual Mbb race report and action plan	Annual Mbb race report and action plan	Annual Mbb race report and action plan	As and when required by Trust Board and/or NHSE/I	Annual Mbb race report and action plan		x	x
Workforce (including maternity dashboard and neonatal dashboard)	Bi-annual Maternity Workforce Report (Position against Birthrate Plus)	Bi-annual Maternity Workforce Report (Position against Birthrate Plus)	Bi- Annual Maternity Workforce Report (Position against Birthrate Plus)	Bi-Annual Maternity Workforce Report (Position against Birthrate Plus)	x	As and when required by Trust Board and/or NHSE/I	Bi-Annual Maternity Workforce Report (Position against Birthrate Plus)		x	x
	Annual Workforce Plan To include Succession Planning Continuity of Carer Equity and equality Plan	Annual Workforce Plan To include Succession Planning Continuity of Carer Equity and equality Plan	Annual Workforce Plan To include Succession Planning Continuity of Carer Equity and equality Plan	Annual Workforce Plan To include Succession Planning Continuity of Carer Equity and equality Plan	x	As and when required by Trust Board and/or NHSE/I	x		x	x
Annual demand capacity mapping	Annual demand capacity mapping for planned caesarean section	Annual demand capacity mapping for planned caesarean section	Annual demand capacity mapping for planned caesarean section	Annual demand capacity mapping for planned caesarean section	x	x	x		x	x
Training	Quarterly Training Report To include Training Needs Analysis Core Competency Framework	Quarterly Training Report To include Training Needs Analysis Core Competency Framework	Quarterly Training Report To include Training Needs Analysis Core Competency Framework	By exception	x	By exception	x		x	x

Assurance Map

Training	Quarterly Training Report To include Training Needs Analysis Core Competency Framework	Quarterly Training Report To include Training Needs Analysis Core Competency Framework	Quarterly Training Report To include Training Needs Analysis Core Competency Framework	By exception	✖	By exception	✖		✖	✖
NHSE/I Maternity Self-Assessment	Annual NHSE/I Maternity Self-Assessment	Annual NHSE/I Maternity Self-Assessment	Annual NHSE/I Maternity Self-Assessment	Annual NHSE/I Maternity Self-Assessment	✖	By exception	✖		✖	✖
Thematic learning and actions report	Quarterly thematic to include MNSI, ENS, PMRT, PSIRF, MOSS, claims scorecard and relevant national reports	Quarterly thematic to include MNSI, ENS, PMRT, PSIRF, MOSS, claims and relevant national reports	Quarterly thematic to include MNSI, ENS, PMRT, PSIRF, MOSS, claims and relevant national reports	Quarterly thematic to include MNSI, ENS, PMRT, PSIRF, MOSS, claims and relevant national reports	✖	✖	✖		Quarterly thematic to include MNSI, ENS, PMRT, PSIRF, MOSS, claims and relevant national reports	✖
Neonatal and Gynaecology GIRFT Action Plan	Bi annual Action Plan	Bi annual Action Plan	Bi annual Action Plan	Bi annual Action Plan	✖	By exception	✖		✖	✖
NCCR	Bi annual NCCR Update & Action Plan	Bi annual Action Plan	Bi annual Action Plan	Bi annual Action Plan	✖	By exception	✖		✖	✖
Saving Babies Lives and Maternity Care bundle	Quarterly Saving Babies Lives and Maternity Care Bundle Report (Progress against recommendations)	Quarterly Saving Babies Lives and Maternity Care Bundle Report (Progress against recommendations)	Quarterly Saving Babies Lives and Maternity Care Bundle Report (Progress against recommendations)	Quarterly Saving Babies Lives and Maternity Care Bundle Report (Progress against recommendations)	✖	Annual Saving Babies Lives and maternity Care Bundle Report Board sign off	Quarterly Saving Babies Lives and Maternity Care Bundle Report (Progress against recommendations)		✖	✖
Safeguarding	Quarterly Safeguarding Report	Quarterly Safeguarding Report	Quarterly Safeguarding Report	✖	✖	✖	✖		✖	✖
Perinatal Mortality	Quarterly Perinatal Mortality Report (Progress against CNST safety action1)	Quarterly Perinatal Mortality Report (Progress against CNST safety action1)	Quarterly Perinatal Mortality Report (Progress against CNST safety action1)	Quarterly Perinatal Mortality Report (Progress against CNST safety action1)	Quarterly Trust Mortality Group	Quarterly Committee Chair's Highlight Report (Exceptions only)	Quarterly Perinatal Mortality Report (Progress against CNST safety action1)		✓	✖
Dashboard/ Minimum Data set (PQSM)	Quarterly Maternity Dashboard	Quarterly Maternity Dashboard	Quarterly Maternity Dashboard	Quarterly Maternity Dashboard	✖	By exception	Quarterly Maternity Dashboard		✖	✖
Quality Performance Report	Quarterly MNG Quality Performance Report	Quarterly MNG Quality Performance Report	Quarterly MNG Quality Performance Report	Quarterly - Included in Committee Chair's Highlight Report (Exceptions only)	✖	Quarterly Committee Chair's Highlight Report (Exceptions only)	✖		✖	✖

Maternity triage specification benchmarking audit tool

Please enter the name of your **trust** below:
University Hospitals North Midlands

Please enter the **trust site** below:
The Royal Stoke Hospital

Guidance for completion

Purpose
This benchmarking tool has been developed to support maternity services in assessing alignment with the Maternity Triage Specification and identifying opportunities for improvement. The tool should be used as both a self-assessment and quality improvement resource, enabling organisations to evaluate the effectiveness, safety, accessibility, equity and responsiveness of their maternity triage service.

The objective is not solely to determine compliance, but to support continuous service improvement through reflection, evidence review, gap analysis and action planning.

Principles for completion
The Benchmarking Audit Tool must be completed for **each site** within a Trust where maternity triage is operational. This ensures that benchmarking reflects local service delivery arrangements and enables site-specific identification of strengths, gaps and improvement opportunities.

Consider the maternity triage service as a whole, including telephone triage, face-to-face assessment, ongoing care, governance, workforce, environment, equity and measurement.

Base responses on evidence rather than individual opinion.

Dashboard
The Dashboard Tab brings together information from across the benchmarking audit tool into a single, easy-to-view summary. It provides an overview of implementation against each Maternity Triage Specification principle, displaying the number of standards assessed as Fully in Place, Partially in Place, Not in Place, Not Relevant, or where Data is Not Complete. It also includes the estimated cost to progress compliance against the specification standard, enabling organisations to quickly identify areas of strength, prioritise improvement activity, and monitor progress without having to review each individual principle tab separately.

Specification standard
The individual standards within the Maternity Triage Specification have been broken down into specific benchmarking criteria to support a structured assessment of your maternity triage service.

Benchmarking suggestions in line with the specification
This column outlines the minimum standards for benchmarking your maternity triage service against the Maternity Triage Specification. It supports consistent assessment, identification of good practice and improvement opportunities, and consideration of how standards are evidenced, embedded, monitored and continuously improved.

Benchmark rating
This column supports benchmarking against each standard within the Maternity Triage Specification. Each site within the Trust should consider the evidence available to demonstrate implementation, monitoring and continuous improvement, focusing on how standards are embedded in practice and contributing to improved outcomes for women and families.

There is a drop down menu incorporating the following:
Fully in place, evidenced and embedded
Partially in place, but inconsistent or not fully evidenced
Not in place, significant gaps or limited evidence
Not relevant to local pathway/context

Support required from Trust board to progress compliance
This column supports organisations in identifying local improvement needs and the actions, resources and support required to achieve compliance with the Maternity Triage Specification. It should be used to inform prioritisation, action planning and ongoing service development.
What happens if selecting:
Partially in place, but inconsistent or not fully evidenced
Not in place, significant gaps or limited evidence
There is automatic functionality built in that takes you to the Support required from trust board column.

Metrics
This column outlines the metrics for each standard within the Maternity Triage Specification, supporting performance monitoring, assurance and continuous improvement. Where metrics are not currently captured, organisations should identify actions required to enable future data collection.

Data captured per site
This column supports organisations in identifying gaps in data collection and reporting, and the actions required to enable future measurement and monitoring.

There is a drop down menu incorporating the following:
Site captures this data
Site partially captures this data
Site doesn't capture this data

Support required from Trust board to progress the metric
What happens if selecting:
Site partially captures this data
Site doesn't capture this data
There is automatic functionality that takes you to the support required to progress this metric column

Evidence requirements have not been prescribed within this tool to enable each site within the Trust to reflect on local arrangements and identify the most appropriate evidence to demonstrate implementation and compliance. Assessments should be based on documented evidence and demonstrated practice. Benchmarking should be undertaken as a multidisciplinary exercise to support continuous improvement, with actions identified where standards are not fully achieved.

Estimated financial requirements to support compliance
Where assessed as Partially in place, but inconsistent and not fully evidenced or Not in place, significant gaps or limited evidence, each site within the Trust should estimate the financial investment required to achieve compliance, including any workforce, training, digital, infrastructure or operational costs.

Principles Menu
This functionality will enable you to navigate between the principles tabs more easily.

Maternity Triage Specification

Benchmarking Audit Tool Dashboard

Click below to link through to each principle

		Fully in place	Partially in place	Not in place	Not relevant	Data not complete	Estimated cost to progress compliance of specification standard
Principle 1: <u>Access and integration</u>	Clear, local 24/7 pathways so women know where to go and are supported between services.	9%	91%	0%	0%	0%	£1,408,100.00
Principle 2: <u>Recognition as urgent care</u>	Maternity triage is the safety-critical emergency front door for urgent and unscheduled care and must be recognised and treated as such.	10%	80%	10%	0%	0%	£0.00
Principle 3: <u>Assessment and care of women</u>	Every woman receives timely assessment, prioritisation and a clear plan of care.	40%	40%	0%	20%	0%	£0.00
Principle 4: <u>Clear information for women</u>	Information and messaging must be clear, welcoming and unambiguous: contact triage if you are worried.	33%	67%	0%	0%	0%	£0.00
Principle 5: <u>Telephone maternity triage</u>	A dedicated 24/7 maternity helpline must be answered promptly and not diverted to labour ward.	75%	25%	0%	0%	0%	£0.00
Principle 6: <u>Service user voice and experience</u>	Women's feedback must shape service design, improvement and experience.	0%	80%	0%	20%	0%	£0.00
Principle 7: <u>Facilities and estates</u>	Triage needs safe, visible, fit-for-purpose space designed for urgent care.	60%	40%	0%	0%	0%	£0.00
Principle 8: <u>Staffing</u>	Staffing must support timely assessment and prompt midwifery and medical review when escalation is needed.	25%	75%	0%	0%	0%	£0.00
Principle 9: <u>Equity and equality</u>	Services must use data and targeted action to identify and reduce inequalities.	20%	80%	0%	0%	0%	£0.00
Principle 10: <u>Data and measurement</u>	Data must drive oversight, learning from incidents and continuous improvement.	14%	71%	14%	0%	0%	£0.00

Principle 1: Access and integration

Clear, local 24/7 pathways so women know where to go and are supported between services.

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Estimated cost to progress compliance of specification standard

Specification standard	Benchmarking suggestions in line with the specification	Benchmark Rating	Support required from Trust Boards to progress compliance	Estimated cost to progress compliance of specification standard
Work closely with Emergency Departments, Primary Care, Early Pregnancy, Gynaecology and wider maternity services, so women can easily access the right care from early pregnancy to six weeks postnatal.	1. Local guidance agreed by stakeholders is in place ensuring consistent, clearly defined referral pathways for women presenting 24/7 in care areas outside of acute maternity services 2. The pathway defines where women should present based on gestation, symptoms, urgency and clinical need and this is shared with women, healthcare professionals and partner services. 3. The guidance in place covers early pregnancy, antenatal, intrapartum concerns and the postnatal period, up to 6 weeks and includes clearly definition of handover procedures between services.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Review UHNM early pregnancy guidance and pathways across the Trust Collaboration with services outside of maternity Agreement of handover process Development of Gynaecology Assessment Unit (cost of nursing staff to progress to specification) Support from Trust Board: Engagement of key stakeholders to fulfill standard	£535,000.00
Provide clearly defined 24/7 access routes so women always know where to go with urgent concerns.	1. All access routes are clearly described including via telephone, walk-in and professional referral routes and that these are available and monitored 2. All information related to access routes is consistently applied to all areas of your organisation, including the Emergency Dept. 3. Clear information is provided to women identifying appropriate access routes for all gestations of pregnancy and postnatal period	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Local Actions: Review of signage across the trust to ensure clear accessibility to maternity triage Development of wide range of resources to facilitate communication regarding access to women and families Engagement from service users, patient counsel, MNVP to support with co-production of appropriate signage across the Trust Support from Trust Board: Digital creator to support with communications regarding maternity triage Infrastructure for receiving service user feedback by recruitment of Perinatal Advocate (cost to progress compliance) Financial support to recruit perinatal service advocate.	£77,000 B7
Agree the most appropriate place of care for women at different stages of pregnancy and with different clinical needs; share this with women, staff and partner services including primary care, ambulance services and NHS 111, supporting seamless care from early pregnancy to six weeks postnatal.	1. A documented, system-wide agreement exists defining the most appropriate place of care for women with differing clinical needs. 2. The agreed place of care guidance covers the entire maternity journey from early pregnancy to 6 weeks postnatal. 3.Criteria are clearly defined for escalation, transfer, and place of care decisions for different clinical need and pregnancy stages. 4. Pathways have been formally agreed between maternity providers, primary care, ambulance services, NHS111, and other relevant partner organisations	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Local Actions: Development of a 'Place of care guidance' in collaboration with key stakeholders Launch of System wide postnatal care guidance with support joint care with primary care services for women postnatally Review of all system wide agreements for pathways of care. Support from Trust Board: Collaboration with Primary Care Services to achieve standard	
Ensure inclusive access arrangements so all women can use maternity triage safely and equitably, regardless of language, disability, race, ethnicity, socioeconomic status, digital literacy or GP registration; pathways should be clear and accessible to women with no prior system knowledge.	1. A documented policy exists to ensure equitable access to maternity triage for ALL women. 2. Professional interpretation and translation services are available and routinely used within maternity triage services. 3. Information about how to access maternity triage is available in multiple formats, including easy read, large print, audio, digital and translated versions. 4. Reasonable adjustments for women with physical, sensory, learning, cognitive or communication disabilities have been made 5. Triage pathways have been reviewed, and where necessary, amended to identify and reduce barriers related to race, ethnicity, culture, socioeconomic deprivation and inclusion health needs 6. Pathways in place identifying different access routes for women without digital access and literacy and women who have no known GP registration status, immigration status or previous engagement with maternity services. Clear self referral and direct access routes exist without requiring women to navigate complex healthcare systems 7. Information is designed to be understandable for women with no prior knowledge of maternity services.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Local Actions: Review local guidance, SOPs and pathways incorporating impact assessment tool to ensure racial and ethnic equity. Launch of digital poverty strategy to ensure accessibility for all women Robust access, guidance and consistency to interpreter services Focus on pathway and continuity for vulnerable groups including neurodiversity Communication campaign and strategy for service users to promote awareness and access to Maternity triage Development of wide range of resources to facilitate communication regarding access to women and families Digital solution for communicating with service users awaiting assessment in Maternity triage Review of Maternity triage space with service user and MNVP involvement to ensure all needs are met when accessing Maternity triage. Lauch direct access route. Support from Trust Board: Digital Creator to support with maternity specific communications and campaign Financial agreement to support with costs of digital solutions and estates configurations	£99,500.00
Maintain access routes such as telephone, walk-in and community referral, with an open-door policy for anyone attending with concerns or needing urgent care; initial assessment should be equitable regardless of route of access or previous attendance.	1. All access routes are clearly defined through pathway documents including telephone triage, walk- in, community referral, ambulance conveyance and professional referral. 2. A guideline is in place defining an open door policy, ensuring women are not turned away when presenting with concerns 3. A guideline is in place defining how women can access maternity assessment without unnecessary barriers or requiring appointment. 4. A guideline is in place defining initial assessment processes are consistent regardless of route of access.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Local Actions: Guideline and pathways to be updated to achieve standard Communications campaign with service users to raise awareness and encourage attendance to Maternity Triage Support from Trust Board: Digital Creator and communications lead to support with maternity specific communications and	

			Digital creation and communications lead to support with maternity specific communications and campaign		
Provide accessible and consistent guidance and signposting for staff and service users, with onward referral and coordinated handover responsibility resting with healthcare professionals in the presenting service. Providing support for women to navigate between services.	1. The service has clearly defined pathways and guidance to support staff and service users in accessing the appropriate service 2. Information and signposting has been provided to staff and service users 3. Guidance is provided in all accessible formats required for your service. 4. Clear handover procedures are in place for effective handover of care between services.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	£600.00	
Define referral criteria across local maternity services including community midwifery, antenatal clinics and day assessment services.	1. Agreed referral criteria are in place across local maternity services, including community midwifery, antenatal clinics, maternity triage and day assessment services.	Partially in place, but inconsistent or not fully evidenced	Local Actions: Development of Maternity Triage discharge leaflets for specific conditions Standardised handover process between teams / services Collaboration with regional teams to achieve standard Support from Trust Board:	£250,000.00	
Establish communication and referral pathways between triage, primary care, emergency departments, ambulance services, perinatal mental health and safeguarding teams.	1. Documented communication pathways exist between maternity triage and key partner services - including those listed within the specification standard.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below		
Plan ongoing care, including sufficient bed capacity to support timely and safe admission for women requiring inpatient care from maternity triage services.	1. Defined pathways are in place to support the ongoing management and care of women following maternity triage assessment. 2. Clear criteria are established for admission, observation, transfer, discharge and follow up care following triage assessment. 3. The service has a process to assess, monitor and manage maternity bed capacity to support timely admission from triage. 4. The service has provision in place for women requiring admission to be transferred to appropriate inpatient setting without avoidable delay. 5. Formal escalation processes exist when bed capacity is constrained, including operational and clinical escalation arrangements.	Partially in place, but inconsistent or not fully evidenced	Local Actions: Digital consistency between teams and services for handover and management care plans Live Maternity Triage dashboard to ensure oversight of acuity and capacity within Maternity Triage Support from Trust Board:		
Share information and discharge summaries in a timely way with relevant care partners, including primary care and community midwifery, with clear accountability for communicating outcomes, actions and next steps to the woman's usual care provider.	1. A formal process exists for sharing discharge information and outcomes following triage attendance, tailored to the individual need. 2. A formal process exists for sharing discharge summaries/assessments and clinical outcomes to relevant care providers and to the women.	Fully in place, embedded and evidenced	Please outline what support you require from your trust board below		
Provide a postnatal pathway to six weeks postnatal, including guidance on care of the baby where required; where the baby does not need separate neonatal or paediatric care, avoid separating baby from mother wherever possible.	1. A clearly defined pathways exists for women accessing maternity services from birth to 6 weeks postnatal. 2. The pathway describes ongoing assessment, follow-up, escalation and support requirements throughout the postnatal period 3. Guidance is available to support assessment and care of the baby where this is relevant to the reason for attendance. 4. Processes are in place to support the needs of both the woman and baby during postnatal assessment and care. 5. Clear referral process are in place for babies requiring neonatal or paediatric review and ongoing care. 6. Guidance is in place to reflect a family centred approach to minimise separation of mother and baby.	Partially in place, but inconsistent or not fully evidenced	Local Actions: Live Maternity Triage dashboard to ensure oversight of acuity and capacity within Maternity Triage Staff awareness and training to ensure accurate data caption in real time Support from Trust Board: Oversight and escalation support of real time activity and capacity with Maternity Triage	£523,000.00	
Metrics	Data captured per site	Support required from Trust Boards to progress the metric			Total estimated cost to implement this principle
Metric: Rate of triage presentations per 1,000 births. Why: Helps services understand demand and plan capacity.	Site captures this data	Please outline what support you require from your trust board below			£1,408,100.00

Metric: Frequency of unplanned maternity triage service closures per month. Why: Tracks service resilience and identifies risks to 24/7 access, informing contingency planning and capacity improvements.	Site captures this data	Please outline what support you require from your trust board below
Metric: Ethnicity, deprivation and language data for each woman presenting, including English as a first language and need for interpretation services. Why: Identifies groups more likely to face access barriers or worse outcomes, supporting targeted action to reduce inequalities.	Site captures this data	Please outline what support you require from your trust board below
Metric: Proportion of women who attend without prior telephone triage. Why: Helps services understand use of different access routes and confirm open-door policies are working as intended.	Site doesn't capture this data	Please outline what support you require from your trust board below Audit and data analyst support

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	promptly and without assumptions, including latent labour and apparently non-urgent issues.	not turned away when presenting with concerns 3. A guideline is in place defining how women can access maternity assessment without unnecessary barriers or requiring appointment. 4. A guideline is in place defining initial assessment processes are consistent regardless of route of access.	Partially in place, but inconsistent or not fully evidenced	Wide range of communication resources to inform service users or open door policy Staff awareness and training of change in practice Support from Trust Board: Digital Creator / Communications lead		
	Keep maternity triage distinct from scheduled or day assessment activity and, where possible, physically separate.	1. Through operational policy maternity triage operates as a distinct service for unscheduled pregnancy, labour and postnatal concerns. 2. Maternity triage is operationally separate from scheduled outpatient, antenatal clinic and day assessment activity. 3. Maternity triage is provided in a dedicated area that is physically separate from scheduled services, wherever feasible.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Local Actions: Review of pathways for appropriate urgent referrals into Maternity Triage Review of staffing and capacity within day case / planned admission areas to facilitate referral appropriateness Support from Trust Board: Business case for the recruitment of midwifery and medical staffing		
	Define maternity triage through a Standard Operating Procedure that clearly distinguishes it from day assessment, including scope, exclusions and navigation between services; scheduled reviews, tests and treatments should be managed separately by separate staff in a separate location.	1. A documented and approved Standard Operating Procedure (SOP) defines the purpose, scope and function of maternity triage. 2. The SOP describes the presentations, conditions and circumstances appropriate for maternity triage. 3. The SOP describes activities excluded from maternity triage, including scheduled reviews, planned assessments, routine monitoring, tests and treatments.	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below Local Actions: SOP to be developed to meet standard Support from Trust Board: Business case for the recruitment of midwifery and medical staffing Facilities and estates to account for extra capacity in day case/planned admission areas		
	Clearly signpost maternity triage throughout the hospital with information and maps available electronically and/or in paper form.	1. Maternity triage is clearly signposted throughout the hospital from all main entrances, emergency departments, outpatient areas and maternity services. 2. Signage is visible, consistent and easy to understand. 3. Information on how to locate and access maternity triage is available electronically, including hospital websites, apps and digital patient information platforms. The same information also needs to be available for those using paper hand held notes.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below See Principle 1		
	Recognise maternity triage as a core part of the urgent and emergency care system, working with ambulance and emergency services on escalation, conveyance decisions, structured handover and assessment in the safest setting.	1. A documented, system-wide agreement exists defining the most appropriate place of care for women with differing clinical needs. 2. The agreed place of care guidance covers the entire maternity journey from early pregnancy to 6 weeks postnatal. 3.Criteria are clearly defined for escalation, transfer, and place of care decisions for different clinical need and pregnancy stages. 4. Pathways have been formally agreed between maternity providers, primary care, ambulance services, NHS111, and other relevant partner organisations	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below See Principle 1		
	Participate in a system-wide network that supports neighbouring Trusts during periods of high demand to enhance safety across the wider geography.	1. The trust actively participates in system wide maternity networks to support safety across neighbouring trusts. 2. Formal mutual support agreements are in place with neighbouring trusts. 3. Clear triggers are defined for when system wide support should be requested or offered.	Fully in place, embedded and evidenced	No further action required		
Metrics		Data captured per site		Support required from Trust Boards to progress the metric		
Metric: Reason for attendance, categorised by urgency and type of concern, including non-triage-specific concerns. Why: Helps identify common urgent issues and monitor whether triage is being used appropriately as the first point of urgent care.		Site Partially captures this data		Please outline what support you require from your trust board below Sample only collected due to volume of admissions, data inaccuracies and lack of data capture resources Digital Analyst support required		Total estimated cost to implement this principle £0.00

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Principle 3: Assessment and care of women

Every woman receives timely assessment, prioritisation and a clear plan of care.

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Specification standard	Benchmarking suggestions in line with the specification	Benchmark Rating	Support required from Trust Boards to progress compliance	Estimated cost to progress compliance of specification standard
Align the clinical model with RCOG Good Practice guidance and ensure every attending woman is assigned a clinical priority based on physical, mental and social wellbeing.	1.The maternity triage clinical model is aligned with current RCOG Good Practice Guidance and relevant national maternity standards.	Fully in place, embedded and evidenced	No further action required	
Ensure triage assessment and clinical prioritisation are carried out by staff trained in the specific triage method.	1. The service can evidence initial triage assessments and clinical prioritisation are undertaken only by staff who have completed training in the local maternity triage method. 2. A documented competency framework exists for staff undertaking maternity triage assessment and prioritisation. 3. The service can evidence staff complete a structured induction and training programme before independently undertaking triage assessments.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Local Actions: Implementation of competency assessment within BSOTS training programme Compliance trajectory to be monitored for completion of competency assessment for all staff working in Maternity triage	
Aim to adopt the Birmingham Symptom-Specific Obstetric Triage System (BSOTS), as recommended by RCOG Good Practice Paper No. 17.	1. The service had adopted, or has a documented implementation plan to adopt, the Birmingham Symptom Specific Obstetric Triage System or an equivalent evidence based maternity triage methodology.	Fully in place, embedded and evidenced	No further action required	
If not using BSOTS, ensure any adaptation or alternative model is evidence-based, clinically evaluated or piloted, demonstrates equivalent outcomes through audit, and is formally agreed by the Trust Board.	1. Where BSOTS is not used, the Trust has adopted an alternative maternity triage model that is supported by evidence, local evaluation and has undergone testing prior to implementation. 2. The service can demonstrate through audit and performance monitoring that the model achieves outcome equivalent to, or better than, established triage standards 3. The alternative triage model has received formal approval through governance structures and the trust board.	Not relevant to local pathway/context	No further action required	
Ensure triage models and staff training address unconscious bias and support equitable escalation, recognising higher risk and later presentation patterns among Black and Asian women and ensuring timely, appropriate care based on clinical need.	1. The maternity triage model explicitly incorporates principles of equity and supports fair, consistent assessment and prioritisation for all women. 2. Staff undertaking maternity triage roles receive training on unconscious bias, cultural competence and equitable care. 3. Staff training includes awareness of know maternal inequalities and variation in outcome for different population groups.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Local Actions: Review local guidance, SOPs and pathways incorporating impact assessment tool to ensure racial and ethnic equity. Digital solution for communicating with service users awaiting assessment in Maternity triage Education and awareness of unconscious bias to be included in mandatory training Explore hosting Black Maternity Matters training programme locally Process for trianglulation of themselves relating to equality from service user feedback QR code for service user feedback to include ethnicity Support from Trust Board: Funding support for Black Maternity Matters training programme	

Metrics	Data captured per site	Support required from Trust Boards to progress the metric	implement this principle
Metric: Proportion of women triaged in each category of urgency. Why: Shows the spread of urgency levels, helping services understand case mix and plan staffing and escalation capacity.	Site captures this data	Please outline what support you require from your trust board below	£0.00
Metric: Proportion of women for whom expected timeframes are met for initial assessment, waiting time to clinical review, and clinical review, based on their category of urgency. Why: Measure time to initial assessment, waiting	Site captures this data	Please outline what support you require from your trust board below	

Why: Measures time to initial assessment, waiting times and review times, and whether urgent cases are escalated in line with triage standards, reducing the risk of harm.	Site captures this data	
Metric: Proportion of women who experience a delay in assessment, review or onward care, with outcome recorded.	Site captures this data	Please outline what support you require from your trust board below
Why: Monitors the impact of delays on women's care and outcomes, supporting timely review, learning and targeted improvement where harm or increased risk is identified.		
Metric: Proportion of women who leave without further reviews or care following initial triage, despite an identified need for further review or care.	Site captures this data	Please outline what support you require from your trust board below
Why: Helps understand patterns of incomplete assessment and address barriers that cause women to leave early, improving experience and outcomes.		

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Principle 4: Clear information for women

Information and messaging must be clear, welcoming and unambiguous: contact triage if you are worried.

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Estimated cost to progress compliance of specification standard

Specification standard	Benchmarking suggestions in line with the specification	Benchmark Rating	Support required from Trust Boards to progress compliance	specification standard
Provide clear, consistent guidance on how and when to contact maternity services and where to attend with concerns related to their pregnancy or postnatal concerns.	1. Women are provided with clear information on how to contact maternity services throughout pregnancy and up to six weeks postnatal. 2. Information clearly describes when women should seek advice, assessment or urgent care 3. The service has a single point of contact for maternity advice and triage is promoted consistently across the service.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Local Actions: Development of wide range of resources to facilitate communication regarding access to women and families including trust website and My pregnancy notes Review Trust signage Support from Trust Board: Digital creator to support with communications regarding maternity triage	
Offer information and advice in accessible formats, including plain language, easy-read materials, and culturally appropriate messaging. Information should clearly explain how to access care and reassure women of their entitlement to support.	1. Information about maternity triage and access to care is available in accessible formats, including plain language, easy-read and translated materials. 2. Information is designed to meet the needs of women with varying levels of health literacy, communication needs and accessibility requirements. 3. Information is culturally appropriate and reflects the needs of the local population 4. The service ensures women are given clear information on how to access maternity services, including telephone triage, face-to-face triage and urgent care pathways.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Local Actions: Development of Patient information leaflets in accessible formats in collaboration with service users/MNVP Review space to facilitate quiet space for women to go when needed Relaunch of Maternity Triage with publicity Support from Trust Board: Digital creator to support with communications regarding maternity triage	
Provide timely access to effective interpretation services where needed; do not rely on family members or accompanying individuals to interpret; allow adequate time for accurate information exchange and decision-making while reducing communication-related bias and assumptions.	1. The service provides access to professional interpretation services for women who require language support. 2. There is guidance in place enabling access to interpretation services 24/7 with strengthened messaging regarding not relying on family members, friends or accompanying individuals to provide interpretation. 3. Triage assessments and decisions are based on accurate information exchange and not compromised by language barriers. 4. Staff are trained to understand communication related bias, assumptions and risks associated with language barriers.	Fully in place, embedded and evidenced	No further action required	
Provide consistent and personalised discharge information, including asking women if they are happy to be discharged, checking understanding of next steps, and clearly outlining when and how to re-attend or seek further advice if symptoms or concerns change.	1. A standardised discharge process is in place tailored to the woman's individual clinical needs, concerns and circumstances. 2. A standardised discharge process includes actively seeking that the woman is happy to be discharged and that decision making has been informed and in partnership. 3. A standardised discharge process outlining information about follow-up arrangements, investigations, appointments and ongoing care needs.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Local Actions: Development of discharge leaflets for women attending MAU who require relevant information Development of discharge posters to be co produced and displayed for service users in Maternity Triage Update guidance to include personalised discharge information process	
Ensure effective signposting and discharge information through direct referral to the appropriate service, avoiding directing women elsewhere without coordinated handover or support.	1. A guideline exists for women requiring ongoing care from another service are directly referred by the maternity triage staff and not asked to self refer. 2. Clear handover processes are in place when care is transferred between services, and women are supported to understand their care plan and next steps.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Local Actions: Review and update process and guideline to support coordinated handovers in collaboration with key stakeholders Support from Trust Board: Implementation of system wide EPR	
Metrics	Data captured per site	Support required from Trust Boards to progress the metric		Total estimated cost to implement this principle
Metric: Reason for attendance, categorised by urgency and type of concern, including non-triage-specific concerns.	Site Partially captures this data	Please outline what support you require from your trust board below		£0.00
Why: Helps services understand why women seek care and ensure information provided addresses common concerns, improving early help-seeking.		Sample only collected due to volume of admissions, data inaccuracies and lack of data capture resources Digital Analyst support required		

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Principle 5: Telephone maternity triage

A dedicated 24/7 maternity helpline must be answered promptly and not diverted to labour ward.

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Estimated cost to progress compliance of specification standard

Specification standard	Benchmarking suggestions in line with the specification	Benchmark Rating	Support required from Trust Boards to progress compliance	Estimated cost to progress compliance of specification standard
Provide a well-publicised 24/7 single contact number, answered promptly by clinically active midwives trained and experienced in maternity triage; telephone maternity triage should not be diverted to labour wards where prompt response may not be possible.	1. A single, dedicated telephone number is available for maternity triage and advice services. 2. Telephone maternity triage service is available 24 hours a day, 7 days a week. 3. The contact number is well publicised and routinely shared with women, families, primary care, ambulance services, NHS111 and partner organisations. 4. Telephone triage is undertaken by clinically active midwives with responsibility for maternity triage assessment and advice. 5. Guidance is in place to support staffing arrangements to ensure telephone	Fully in place, embedded and evidenced	No further action required	
Encourage telephone triage use where appropriate but never make it the only route to care.	1. All access routes are clearly defined through pathway documents including telephone triage, walk- in, community referral, ambulance conveyance and professional referral. 2. A dedicated telephone triage service is available. 3. Communication is tailored to encourage women to contact telephone triage with clarity that telephone is not the only option available and they can access maternity triage via any route beneficial to them 4. Information provided to women consistently reinforces that telephone triage compliments not replaces direct care.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Local Actions: Development of wide range of resources to facilitate communication regarding access to women and families Support from Trust Board: Digital creator to support with communications regarding maternity triage	
Ensure all women have open access to face-to-face maternity triage; where a woman remains anxious or concerned after telephone triage, invite them to attend for in-person assessment.	1. All women and staff understand there is direct access to face to face maternity triage assessment regardless of previous telephone contact. 2. Women and staff are aware that if the woman remains anxious it is appropriate to encourage face to face attendance.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Local Actions: Review and update guideline to acheive standard Lauch open access policy Support from Trust Board: N/A	
Operate telephone triage from a protected, quiet, confidential space away from the main clinical area and clinical office space; the midwife's sole responsibility during this time should be telephone triage.	1. Telephone triage is delivered from a dedicated space specifically designed to support safe, effective telephone triage. 2. The telephone triage area is sufficiently designed that it is located in a quiet area and in an environment that protects confidentiality. 3. The telephone triage area is located away from busy and noisy clinical areas and in a dedicated space, not a shared office environment.	Fully in place, embedded and evidenced	No further action required	
Do not defer in-person attendance to manage service workload; give women clear information about clinical urgency of attending and operate a low threshold for attendance because telephone assessment is difficult and subjective.	1. Guidance is place to support the decision making around face to face attendance and based on the woman's need not service capacity. 2. The service has processes in place to ensure attendance to face to face is not discouraged or delayed based on awareness of service capacity and/or staffing pressures. 3. Processes are in place to ensure telephone triage promotes a low threshold for face to face review.	Fully in place, embedded and evidenced	No further action required	
Do not allow telephone triage to provide definitive diagnosis, determine clinical priority before in-person assessment, make appointments for in-person triage, or manage or limit the number or timing of women attending.	1. The service has a documented policy in place defining the purpose and limitations of telephone triage. 2. There is a guideline in place acknowledging that telephone triage is used to assess concerns, provide advice and determine next steps, but not provide a diagnosis. 3. There is guidance in place ensuring telephone triage does not replace formal prioritisation of clinical need. 4. Telephone triage is not used to schedule appointments for maternity triage	Fully in place, embedded and evidenced	Guideline No further action required	
Maintain clear pathways so suspected threatened preterm or extreme preterm birth is signposted to in-person maternity triage without delay, where this is the safest and most appropriate setting.	1. The service has a documented pathway for the assessment of suspected preterm labour and extreme preterm birth. 2. The service has a process to ensure all women with suspected preterm or extremely preterm birth are directed to face to face maternity triage without delay. 3. Referral criteria is in place to action this. 4. There are agreed pathways and communication in place with primary care, NHS111, emergency departments and community midwifery services for suspected preterm and extremely preterm birth.	Fully in place, embedded and evidenced	Guideline Directed to DS if appropriate No further action required	
Document all calls in real time using a standardised template within the woman's electronic patient record where available; audio-record calls with	1. All telephone triage contacts are documented contemporaneously during or immediately after contact. 2. A standardised telephone triage template is used for all calls. Including		No further action required	

consent to support accuracy and safety; document requests for hospital attendance including urgency and expected timeframe.	documentation supporting request for attendance and anticipated time frame. 3. Where available, telephone triage assessments are recorded in the woman's Electronic Patient Record.	Fully in place, embedded and evidenced		
Metrics	Data captured per site	Support required from Trust Boards to progress the metric		
Metric: Rate of calls to telephone triage per 1,000 births. Why: Helps services understand demand for telephone triage and plan staffing and resources effectively.	Site captures this data	Please outline what support you require from your trust board below		
Metric: Proportion of women who call telephone triage but do not attend in person. Why: Monitors the effectiveness of telephone triage in identifying urgent care needs and whether barriers may be preventing attendance when needed.	Site doesn't capture this data	Please outline what support you require from your trust board below		
Metric: Proportion of dropped or unanswered calls to telephone triage. Why: Identifies service capacity issues and supports timely access for urgent concerns, reducing risk of harm.	Site captures this data	Please outline what support you require from your trust board below		

implement this principle
£0.00

Principle 6: Service user voice and experience

Women's feedback must shape service design, improvement and experience.

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Estimated cost to progress compliance of specification standard

Specification standard	Benchmarking suggestions in line with the specification	Benchmark Rating	Support required from Trust Boards to progress compliance	Estimated cost to progress compliance of specification standard
Develop a deeper understanding of their local populations, including social, cultural, and geographical contexts. To do this, maternity services should proactively engage and seek feedback from service users on their experiences of triage services and care, including telephone triage.	1.The service has processes in place to understand the social, cultural and geographical characteristics of the local population accessing maternity triage services. 2.The service routinely seeks feedback from women and families regarding their experiences of maternity triage, including telephone triage and face-to-face services.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Local Actions: Implementation of live service user feedback QR code to include ethnicity Listening events in collaboration with MNVP based on local population needs Gather themes from data captured by continuity team for vulnerable groups Support from Trust Board: Digital creator to support with communications regarding maternity triage Infrastructure for receiving service user feedback Recruitment of Perinatal Service Advocate Financial support to acheive standard	
Gather feedback regularly through multiple channels (e.g., surveys, focus groups, real-time tools) and review this regularly to inform continuous service improvement.	1.The service has a documented approach for routinely gathering feedback from women and families who use maternity triage services. 2.Patient experience data are reviewed at regular intervals through local governance and quality meetings. 3.The service routinely analyses data to identify themes, trends, risks and opportunities for improvement.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Local Actions: Introduction of QR code with live feedback Promotion of friends and family test Collation of themes through all sources from service user feedback Creation of you said, we did board Collaboration with MNVP Maternity Triage to be included as separate item within Patient expereince report Introduction of Maternity Triage newsletter	
Present monthly data and quality improvement work in accessible patient-facing and staff-facing formats and use it to improve service quality.	1. The service has a documented approach for routinely gathering, analysing and acting on feedback from women and families using maternity triage services. 2. The service provides opportunity to provide feedback during or immediately following their care experience. 3. Feedback mechanisms are accessible and designed to capture the experiences of diverse population groups.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Local Actions: Introduction of QR code with live feedback Listening events in collaboration with MNVP based on local population needs Gather themes from data captured by continuity team for vulnerable groups Implementation of 'You said, we did' feedback board Support from Trust Board:	
Clearly inform women how to raise concerns or seek further review if dissatisfied with triage review outcomes, including local escalation routes and relevant safety processes, and awareness of Martha's Rule as implemented across maternity services.	1. The service has a documented approach on how women receive clear information on how to raise concerns about their care, assessment or triage outcome. 2. The service has a well documented approach on how women can request further clinical review. 3. There are clear pathways for women to raise concern about ongoing clinical review and care. This should also include progressing implementation of Marthas Rule.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Local Actions: Implementation of Martha's rule Support from Trust Board: Collaboration with regional and national teams to guide implementation Medical staffing for escalation	
Adopt the national maternity and neonatal Patient Reported Experience Measure (PREM) when available.	1. The service has adopted or plans to adopt the national Patient Reported Experience Measure (PREM) when available	Not relevant to local pathway/context	No further action required	
Value qualitative lived experience alongside quantitative data, recognising that small numbers of serious concerns can reveal system issues not visible in aggregated metrics.	1. The service formally recognises qualitative feedback as a key source of intelligence alongside quantitative data. 2. The service regularly gathers and uses intelligence through qualitative data capture.	Partially in place, but inconsistent or not fully evidenced	Local Actions: Review on improve maternity complaints process Introduction of QR code with live feedback Promotion of friends and family test Collation of themes through all sources from service user feedback Creation of 'you said, we did' board Collaboration with MNVP Maternity Triage to be included as separate item within Patient experience report Support from Trust Board: Continued oversight of feedback from service users and requirements to improve experience	

Work with local Maternity and Neonatal Voices Partnership (MNVP) to co-produce improvements and embed service user voice in decision-making and service design; close the feedback loop through "you said, we did" updates.	1. The service has an active and ongoing partnership with local Maternity and Neonatal Voices Partnership (MNVP)	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Local Actions: You said, we did board on Maternity Triage Collaboration with MNVP within Maternity Triage improvement group Support from Trust Board: Infrastructure for receiving service user feedback Recruitment of Perinatal Advocate Financial support to acheive standard	
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Metrics	Data captured per site	Support required from Trust Boards to progress the metric	Total estimated cost to implement this principle
Metric: Qualitative and quantitative data on the experience of women using maternity triage services, collected through existing local feedback methods and transitioning to the national maternity and neonatal Patient Reported Experience Measure when available. Why: Helps services understand women's experience, including whether they feel informed, respected and involved in their care, and target actions to improve experience.	Site Partially captures this data	Please outline what support you require from your trust board below Audit and data analyst support	£0.00
Metric: Frequency and diversity of feedback collected, including review by ethnicity to confirm feedback reflects the service population. Why: Ensures timely, representative feedback is available to support continuous improvement based on service user experience.	Site Partially captures this data	Please outline what support you require from your trust board below Audit and data analyst support	
Metric: Number of improvement actions implemented where issues are identified, including through service user feedback, performance data, incidents, audits, complaints or staff feedback, and the associated impact of these improvements. Why: Monitors whether identified issues lead to timely, measurable improvement actions, supporting continuous service improvement and accountability.	Site Partially captures this data	Please outline what support you require from your trust board below Audit and data analyst support	

Principle 7: Facilities and estates

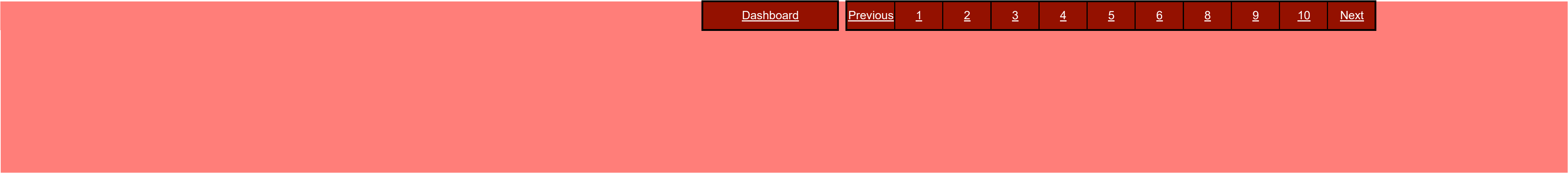
Triage needs safe, visible, fit-for-purpose space designed for urgent care.

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Specification standard	Benchmarking suggestions in line with the specification	Benchmark Rating	Support required from Trust Boards to progress compliance	Estimated cost to progress compliance of specification standard
The triage service, where possible, should be co-located with the central delivery suite or labour ward (or be positioned as close as possible to it), to support timely escalation and care and minimise transfer risks.	1.The maternity triage service is co-located with, or situated in close proximity to, the labour ward/central delivery suite wherever possible. 2.Where co-location is not possible, a formal risk assessment has been undertaken and mitigating actions implemented to ensure that delays in escalation, transfer and treatment for women requiring urgent or emergency care are minimised.	Fully in place, embedded and evidenced	No further action required	
Provide a suitably sized seated waiting area that is easily visible to clinical staff.	1. A designated waiting area is provided for women accessing maternity triage services	Fully in place, embedded and evidenced	No further action required	
Include a reception area where staff are notified of women's arrival and women can access help quickly if they require more urgent attention.	1. Maternity triage includes a clearly identified reception for women attending the service. 2. Processes are in place to ensure clinical staff are promptly notified when a woman arrives at the service. 3. Women have a clear and immediate means of alerting staff if they require more urgent attention.	Fully in place, embedded and evidenced	No further action required	
Maintain dedicated space protected for initial triage so a midwife can assess promptly and safely while maintaining privacy; ensure the space has appropriate equipment.	1. A dedicated space is available and protected for initial maternity triage assessment. 2. The assessment area is equipped with all equipment required to undertake maternity triage assessment.	Fully in place, embedded and evidenced	No further action required	
Ensure appropriate facilities for timely ongoing care, with sufficient space for healthcare staff, women and families while safeguarding privacy and confidentiality.	1. The maternity triage service has sufficient clinical space to support ongoing assessment, treatment, monitoring and observation. 2. The clinical environment facilities are designed to protect privacy during discussions, examinations, investigations and treatment.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Local Actions: Review of clinical space and gain support from estates to meet standard Support from Trust Board: Facilities and estates	
Include a well-equipped office space within the clinical area to support clear confidential handover and centralised oversight of workload.	1. A dedicated office space is located within or immediately adjacent to the maternity triage clinical area. 2. The office space supports confidentiality and oversight of workload.	Fully in place, embedded and evidenced	No further action required	
Ensure access to essential diagnostics including electronic fetal monitoring, blood tests, urine samples and ultrasound.	1. Maternity triage has timely access to diagnostic investigation equipment.	Fully in place, embedded and evidenced	No further action required	
Meet accessibility standards including accessible WCs and clear signage in line with Health Building Note 09-02; provide quiet or private areas where	1. The maternity triage environment meets relevant accessibility standards, including HBN 09-02. 2. Accessible WC arrangements are available and clearly signposted.	Partially in place, but	Please outline what support you require from your trust board below	

possible, clear waiting process explanations, and systems showing women have been seen and are awaiting care.	3. Signposting is clear and consistent 4. Women receive clear information explaining waiting processes and clinical prioritisation	Partially in place, but inconsistent or not fully evidenced	Local Actions: Introduction of longest wait board Digital waiting times board according to priority Staff awareness and training to ensure accurate data caption in real time Review of estates and facilities	
Be physically separate from scheduled or day assessment activity to maintain focus on urgent and unscheduled care.	1. Maternity triage is provided in a dedicated area specifically designed for urgent and unscheduled care. 2. Maternity triage is physically separate from day assessment, antenatal clinic and other scheduled care areas.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Local Actions: Review of pathways for appropriate urgent referrals into Maternity Triage Review of staffing and capacity within day case / planned admission areas to facilitate refarral appropriateness Support from Trust Board: Business case for the recruitment of midwiery and medical staffing	
Design the physical environment to promote women's sense of safety and comfort.	1. The maternity triage area is designed to promote a sense of safety, comfort and reassurance for women and their families.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Local Actions: Purchase of comfortable seeating based on service user feedback Installment of air conditioning Review of estates and facilities Support from Trust Board: Approval for facilities to improve safety and comfort Estates and facilities	
Support maternity triage with modern interoperable digital solutions, including real-time documentation, escalation and timely information sharing across maternity and neonatal services.	1. Maternity triage is supported by a digital system that facilitates assessment, documentation, prioritisation and care coordination. 2. Clinical assessments, triage decisions, escalations and actions are documented in a timely way.	Fully in place, embedded and evidenced	No further action required K2	
Metrics	Data captured per site	Support required from Trust Boards to progress the metric		Total estimated cost to implement this principle
Metric: Clinical area where the woman was admitted following triage, where relevant, for example Antenatal Ward, Labour Ward or Intensive Treatment Unit. Why: Supports estates planning by showing demand for specific areas and informing capacity requirements, inpatient flow and service user	Site captures this data	Please outline what support you require from your trust board below		£0.00
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Principle 8: Staffing

Staffing must support timely assessment and prompt midwifery and medical review when escalation is needed.

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Estimated cost to progress compliance of specification standard

Specification standard	Benchmarking suggestions in line with the specification	Benchmark Rating	Support required from Trust Boards to progress compliance	Estimated cost to progress compliance of specification standard
Use dynamic staffing models informed by local activity data and aligned to the triage system used; consider unit size and activity levels so sufficient trained personnel are available.	1. The maternity triage service uses a staffing model informed by local activity and acuity information. 2. Staffing levels align to the maternity triage system in use.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Local Actions: Review of Maternity and medical staffing for Maternity Triage Support for Trust Board: Approval of business case for Midwifery and Medical staffing	
Ensure appropriate dedicated midwifery, medical and support staffing in line with RCOG Good Practice Paper No. 17 minimum standards, with capacity and escalation pathways at all times including nights and weekends; review staffing models regularly against local attendance data.	1. Dedicated maternity triage midwifery and obstetric staffing is provided in line with the RCOG Good Practice Paper No. 17. 2. Appropriate medical staffing is available to support timely assessment, review and escalation of clinical concerns 3. Staffing arrangements cover 24 hours 7 days a week 4. Staffing models are reviewed regularly utilising data relating to acuity, peak activity periods and service demand.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Local Actions: Review of Maternity and medical staffing for Maternity Triage to meet standard Review data of peak activity periods and ensure rosters reflect planning and service demand Review of process of escalation during times of high acuity Digital dashboard to ensure oversight of acuity within Maternity Triage Support for Trust Board:	
Ensure dedicated triage staffing is structurally independent of labour ward midwifery staffing; treat redeployment from triage to other maternity areas as a formal escalation event and document, review and monitor through governance processes.	1. Maternity triage has dedicated staffing establishment that is separate from labour ward staffing requirements. 2. A formal process defines circumstances in which triage staff may be redeployed and identifies associated escalation requirements and recorded as a formal escalation event. 3. Redeployment events and triage staffing pressures are reviewed regularly through maternity governance processes.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Local Actions: Redeployment of Maternity Triage staff to be added to monthly dashboard Redeployment of staff to be datixed and reviewed through governance processes Internal escalation policy to be reviewed and updated to reflect standard Review of midwifery and medical staffing Support from Trust Board:	
Where possible, have a minimum of one midwife responsible for initial triage assessment and at least one other midwife carrying out subsequent care, informed by local demand, service need and RCOG birth-rate modelling.	1. Staffing arrangements support separation of initial assessment and ongoing care requirements.	Fully in place, embedded and evidenced	No further action required	
Ensure initial triage assessment and telephone triage are undertaken by appropriately trained and experienced staff with clinical judgement to advise, assess urgency, escalate concerns and initiate urgent interventions.	1. Initial maternity triage assessment and telephone triage are undertaken only by staff who have completed training in the locally adopted maternity triage methodology.	Fully in place, embedded and evidenced	No further action required	
Define competency requirements for triage functions so staff are well supported and supervised.	1. A documented competency framework defines the knowledge, skills and behaviours required for all maternity triage roles	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Local Actions: Implementation of competency assessment within BSOTS training programme Compliance trajectory to be monitored for completion of competency assessment for all staff working in Maternity triage Support required from Trust Board: Business case for the recruitment of midwifery and medical staffing	
Ensure staff working in triage receive appropriate training including rapid assessment, with clear competency frameworks and governance, and maintain regular experience in this setting.	1. All staff undertaking maternity triage complete a structured training programme appropriate to their role and responsibilities.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Local Actions: Implementation of competency assessment within BSOTS training programme Compliance trajectory to be monitored for completion of competency assessment for all staff working in Maternity triage Support required from Trust Board: Business case for the recruitment of midwifery and medical staffing	
Define escalation protocols and thresholds for peak activity and escalating midwifery and medical	1. A documented escalation framework exists for maternity triage, defining actions required during periods of increased activity, capacity pressures or		Please outline what support you require from your trust board below Local Actions:	

staffing when capacity is exceeded; base thresholds on attendance numbers and clinical urgency categories, embed in policies/governance and support with real-time activity monitoring.	workforce shortages.	Partially in place, but inconsistent or not fully evidenced	Local Actions: Datix incidents to be submitted during times of peak activity when staffing does not meet demand and reviewed through governance process Internal escalation policy to be reviewed and updated to reflect standard Review of midwifery and medical staffing Support from Trust Board: Approval of business case for Midwifery and Medical staffing Please outline what support you require from your trust board below	
Where staffing is adjusted in response to critical workload and demand, make decisions carefully and promptly, balancing acuity and safety across the wider maternity service to maintain minimum safe staffing levels.	1. A documented policy defines how staffing adjustments are made during periods of critical workload, demand or capacity pressure, including wellbeing of staff needing to have regular breaks.	Partially in place, but inconsistent or not fully evidenced	Local Actions: Review and amendment of escalation policy to meet standard Support from Trust Board: Approval of business case for Midwifery and Medical staffing Oversight and scrutiny of Maternity Triage dashboard Please outline what support you require from your trust board below	
Include locally agreed thresholds for senior or consultant attendance beyond twice-daily ward rounds to ensure timely senior input when required.	1. The maternity triage service has locally agreed criteria defining when senior midwifery, obstetric or consultant review is required in maternity triage. 2. Clear processes are in place for consultant attendance beyond the twice daily ward rounds.	Partially in place, but inconsistent or not fully evidenced	Local Actions: Review of medical staffing and gaps Support from Trust Board: Approval of business case for Medical staffing No further action required	
Ensure the most senior obstetrician on call for labour ward and the midwifery coordinator jointly maintain oversight of triage activity and escalation, with clear communication to neonatal teams where required; review triage activity during consultant-led labour ward rounds twice daily, seven days a week.	1. The maternity service has locally agreed criteria to ensure the most senior obstetrician on call for labour ward and the midwifery coordinator jointly maintain oversight of maternity triage including activity, capacity, acuity and escalation requirements. 2. Processes exist to ensure timely communication with neonatal teams where required. 3. Processes are in place to ensure triage activity is reviewed during consultant led labour ward rounds twice daily, seven days a week.	Fully in place, embedded and evidenced		
Restrict midwifery-led unit triage-type activity to low-risk term labour assessment; promptly transfer women who present with concerns requiring triage care to the appropriate obstetric unit with a designated maternity triage service.	1. Local policy clearly defines the role of Midwifery Led Units (MLUs) in assessing unscheduled attendances. 2. Clear guidance exists defining triage type activity within MLUs including inclusion and exclusion criteria. 3. A clear documented pathway exists to facilitate prompt transfer of women requiring maternity triage assessment to the designated obstetric unit.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Local Actions: Development of Midwifery Birth Centre guideline Support from Trust Board: N/A	
Metrics	Data captured per site	Support required from Trust Boards to progress the metric		Total estimated cost to implement this principle
Metric: Proportion of women assessed, including initial triage and medical clinical review, within expected timeframes based on the category of urgency. Why: Monitors whether triage standards are met and flags delays linked to staffing or capacity, guiding targeted improvements.	Site Partially captures this data	Please outline what support you require from your trust board below		£0.00
Metric: Frequency of staff being redeployed from maternity triage to other maternity care areas within the unit. Why: Monitors how often triage staffing is compromised, supporting improvements to staffing plans.	Site Partially captures this data	Please outline what support you require from your trust board below		

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Principle 9: Equity and equality

Services must use data and targeted action to identify and reduce inequalities.

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Estimated cost to progress compliance of specification standard

Specification standard	Benchmarking suggestions in line with the specification	Benchmark Rating	Support required from Trust Boards to progress compliance	
Acknowledge and understand inequalities experienced by service users as a crucial first step.	1. The service formally recognises health inequalities and their impact on access, experience, safety and outcomes within maternity triage services.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Local Actions: Development of maternity inequalities dashboard to include Maternity triage data Complete PEADP programme and share findings of report Include inequalities data within all assurance reports Support from Trust Board: Oversight and scrutiny of inequalities dashboard and data No further action required	
Understand local population needs and service demand, including social, cultural and geographical factors, and align improvements with wider system work such as ICB-led population mapping and blueprints.	1. The service uses population health intelligence to understand the needs of the local maternity population, including demographic, clinical, cultural and socioeconomical factors.	Fully in place, embedded and evidenced		
Use demographic and outcome data to identify where poor outcomes are concentrated and use this to inform service design and improvements; map inequalities, for example by postcode, to visualise need and guide targeted interventions.	1. The service routinely analyses demographic data to understand variation in access, experience and outcomes across different population groups. 2. Findings from demographic and outcome data analysis informs the design of targeted interventions and improvement strategies to reduce inequalities and improve outcomes.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Local Actions: Review data to support business case for Continuity team for vulnerable groups to be expanded Development of maternity inequalities dashboard to include Maternity triage data Support from Trust Board: Oversight and scrutiny of inequalitites dashboard and data Approval of business case for midwifery staffing to expand continuity team	
Work with local improvement initiatives and community-led organisations so lived experience meaningfully informs service improvements.	1. The service actively participates in local, regional and national improvement initiatives focussed on maternity safety, experience, equity and outcomes.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Local Actions: Completion of Black Maternity matters programme Explore hosting Black Maternity Matters training programme locally Completion of the PEADP programme EDI midwife to collaborate with service users and MNVP to facilitate listening events and triangulate themes Support from Trust Board: To support improvement initiatives based on national and regional guidance and service user feedback Funding for training programme to be delivered locally	
Ensure all staff involved in maternity triage undertake training supporting culturally safe care, including cultural competence, cultural safety, cultural intelligence and unconscious bias.	1. Staff have received training to understand and respond appropriately to diverse cultural beliefs, values, traditions and preferences that may influence care.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Local Actions: Explore external recommended training to meet standard and improve staf awareness Support from Trust Board: Funding for training programme to be delivered locally Approval of midwifery and medical staffing business case to support additional training needs	

Metrics	Data captured per site	Support required from Trust Boards to progress the metric	Total estimated cost to implement this principle
Note: Refer to Principle 1 where these metrics align to Principle 9 of Equity and Equality.	Site captures this data	Please outline what support you require from your trust board below	£0.00
Metric: Equity and equality data should be captured as a defined subset of each primary dependent outcome measure, and reported both overall and stratified by ethnicity, deprivation (IMD) and spoken language.	Site Partially captures this data	Please outline what support you require from your trust board below	

Why: Helps identify variation and potential inequality in access, experience and outcomes.

Data analyst required to support with meeting metric

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gaps or limited evidence

Support from Trust board:
Approval for recruitment of EDI midwife
Digital creator / communications lead

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Total estimated cost to implement this principle

£0.00

Category	Metric	Sample Used	Target	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27	Apr-27	YTD	
Maternity Triage Principle																	
5. Telephone maternity triage	% of women who call telephone triage but do not attend in person		N/A														
	% of dropped or unanswered calls to telephone triage	All	N/A	15	23	28											
6. Service user voice and experience	Qualitative and quantitative data on the experience of women using triage services		N/A														
	Frequency and diversity of feedback collected		N/A														
	Number of improvement actions implemented where issues are identified, including through service user feedback, performance data, incidents, audits, complaints or staff feedback, and the associated impact of these improvements		N/A														
7. Facilities and estates (clinical area where the woman was admitted following triage)	% of women discharged home	All	N/A	83.00%	84.00%	83.00%										83.33%	
	% of women admitted to DS/MBC - intrapartum	All	N/A	6.00%	5.70%	5.30%										5.67%	
	% of women admitted AN Ward	All	N/A	10.00%	9.40%	10.40%										9.93%	
	% of women admitted PN Ward	All	N/A	0.00%	0.20%	0.50%										0.23%	
	% of women admitted to HDU	All	N/A	0.80%	0.70%	0.80%										0.77%	
8. Staffing	See rows 40-47 above		N/A														
	Frequency of staff being redeployed to other maternity care areas within the unit from maternity triage		N/A	0	0	6											
9. Equity and equality	See Principle 1 and 4 above																
		*Snapshot of data where the clock has been started & stopped on K2 i.e. 'care to be given' time etc. Increased capture of this information will form part of the improvement plan. This is already embedded in practice for Triage.															

Executive Summary

Trust Board (Part 1) | 7th October 2026

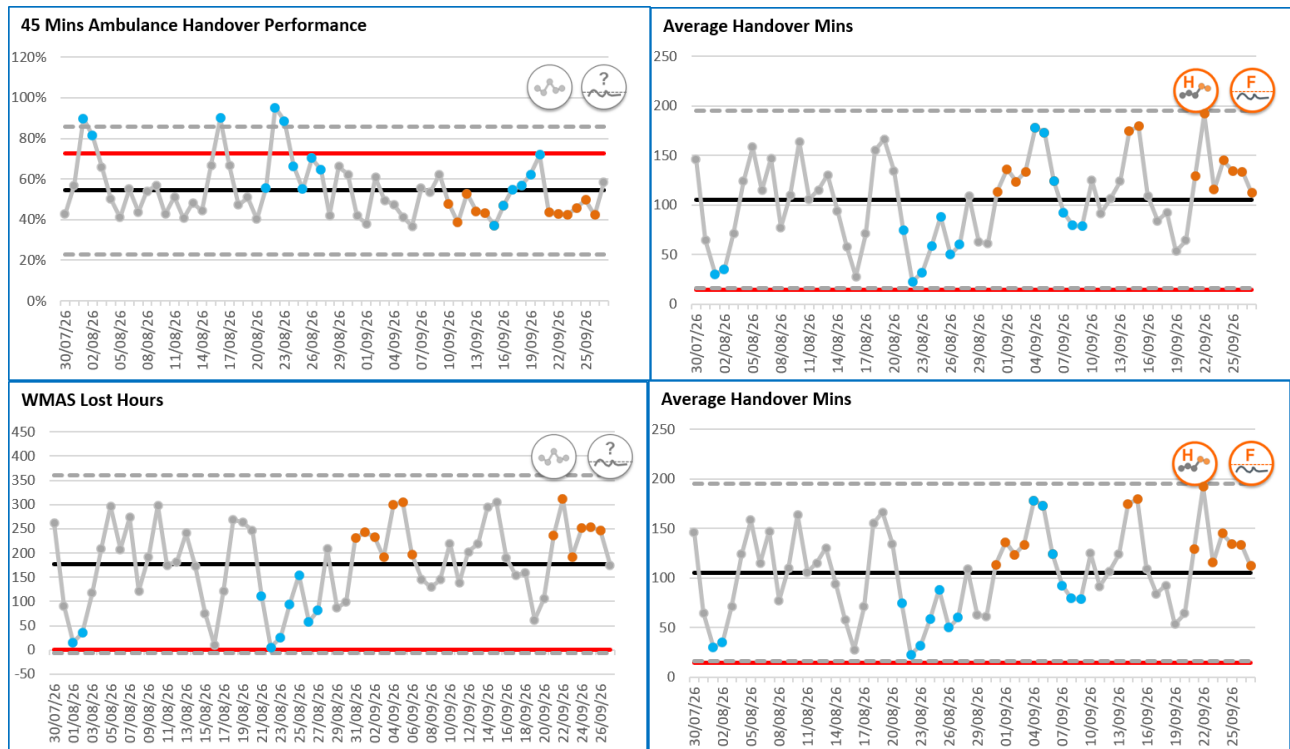
UEC Improvement Journey

Purpose:	Information	Approval	Assurance	✓	Agenda Item:	10.
Author:	Katy Thorpe, Chief Operating Officer					
Executive Lead:	Katy Thorpe, Chief Operating Officer / Ann Marie Riley, Chief Nurse / Diane Adamson, Chief Medical Officer					
Alignment with our Strategic Priorities						
	Our People We will create an inclusive environment where everyone learns, thrives and makes a positive difference					
	Our Patients We will provide timely, innovative and effective services to our patients					✓
	Our Population We will tackle inequality and improve the health of our population					

Risk Register Mapping		
BAF 9	Inability to sustain safe and timely urgent and emergency care performance	Ext 20

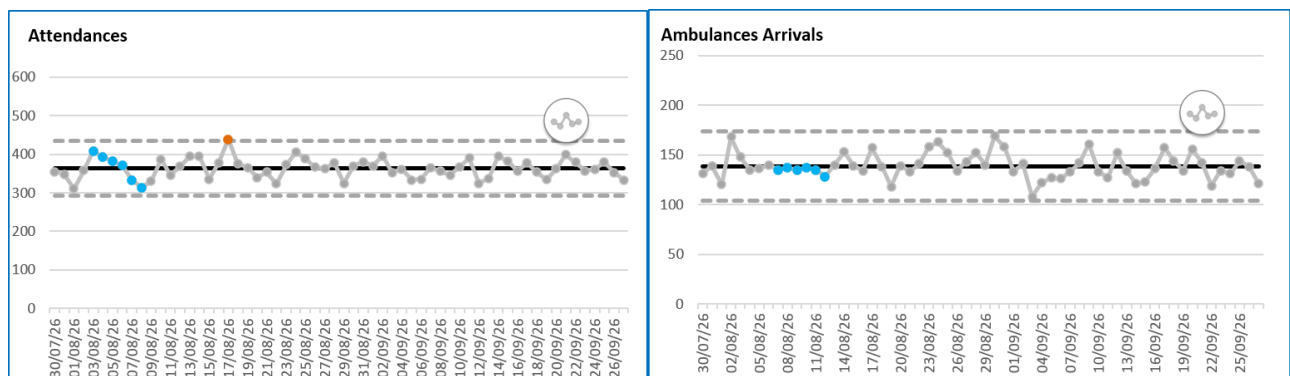
Executive Summary	
Situation The report shows that urgent and emergency care performance remains below the standard required for safe, timely patient care, with particular concern around ambulance handovers and time spent in the Emergency Department. The Trust remains in Tier 1 national oversight. Performance improved steadily up to April, deteriorated following the withdrawal of winter capacity after Easter, recovered towards the previous trajectory in July, and became more variable again in August. The position worsened in September, with consistently poor ambulance handover performance, longer waits within ED and increased numbers of patients awaiting admission. The evidence indicates that the principal constraint is internal hospital flow rather than overall demand. Attendances have remained broadly stable since last winter, although there were intermittent spikes in attendances and ambulance conveyances during August. Even on some of the busiest days, good handover performance was achieved, demonstrating that demand alone does not explain the deterioration. Performance is strongest when capacity is created early in the day. Higher levels of discharge before midday and 4 pm, together with occupancy falling below 93% by early afternoon, are associated with: • faster movement of patients who are clinically ready to proceed; • a reduction in ED length of stay from approximately 8–9 hours to 7–8 hours; and • an improvement of around 12 percentage points in ambulance handovers completed within 45 minutes. These conditions are not being achieved consistently. Discharge numbers—particularly discharges before 4 pm—were lower during September, bed occupancy remains high and variable, and there has been an increase in patients with a decision to admit. Escalation spaces on inpatient wards continue to be used. The unannounced CQC inspection and subsequent closure of 15 corridor spaces in ED have reduced operational flexibility. Mitigating actions include at the time additional community beds support, although this is now back to normal levels ahead of winter capacity coming online; SDEC areas being opened for extended hours; greater use of the discharge lounge; implementation of Criteria Led Discharge; and continued work to reduce long lengths of stay and strengthen ward processes. The Trust is also reviewing admission criteria because benchmarking indicates that its admission rate is higher than comparable organisations.	

Ambulance Handover



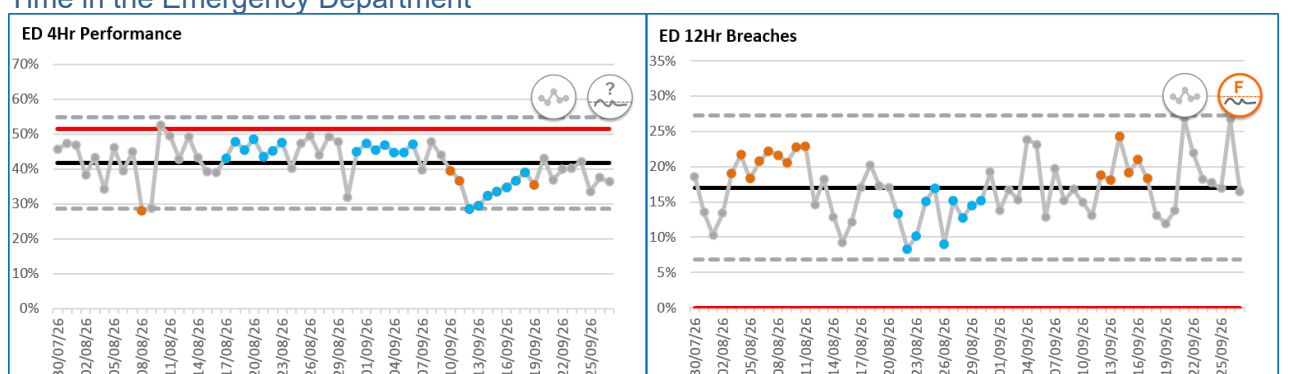
Performance improved month on month up to April, deteriorated during May and June, recovered in July, and became more variable again in August with consistent poor performance in September.

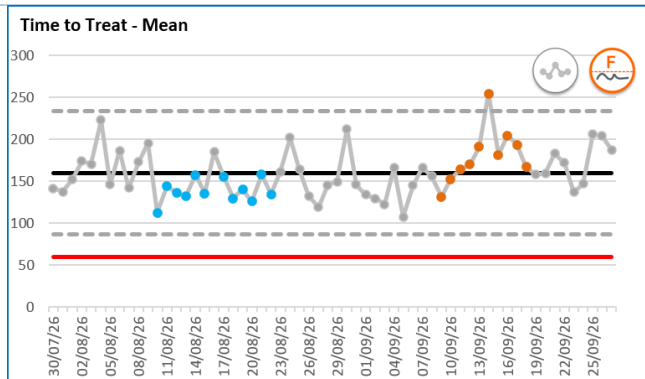
Attendances



Attendances overall remain without variation; This has been consistent since last winter.

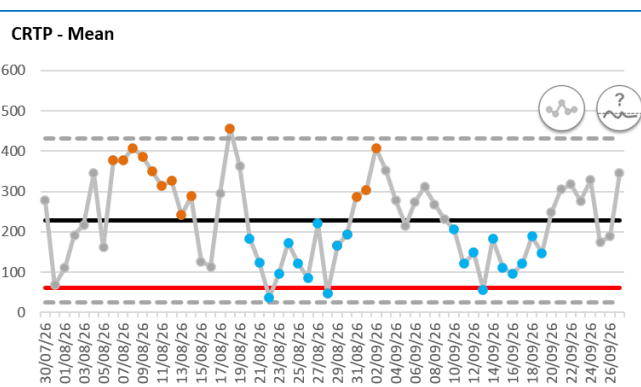
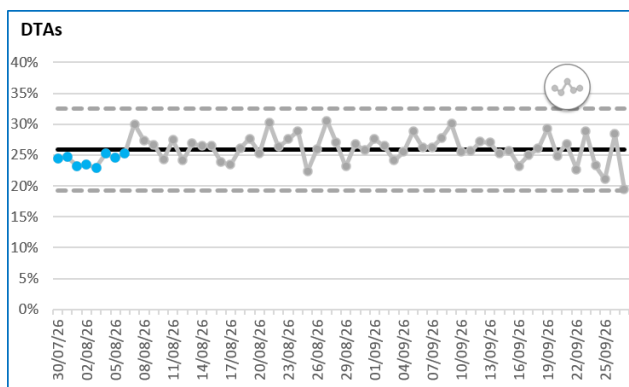
Time in the Emergency Department





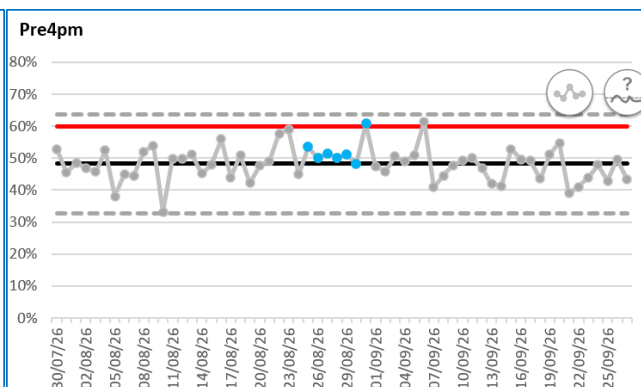
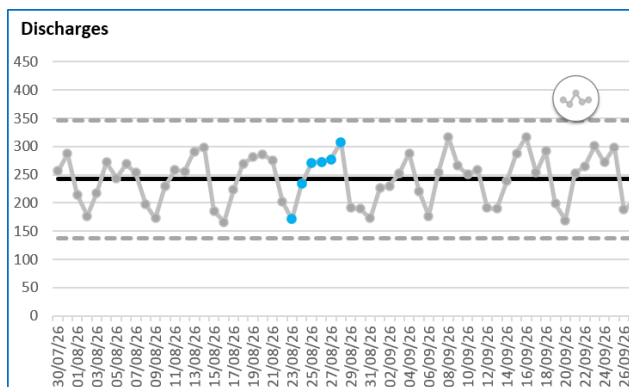
We continue to see variation in time to treatment on a day-to-day basis. September has demonstrated significant challenges.

Decision to Admit and Clinically Ready to Proceed



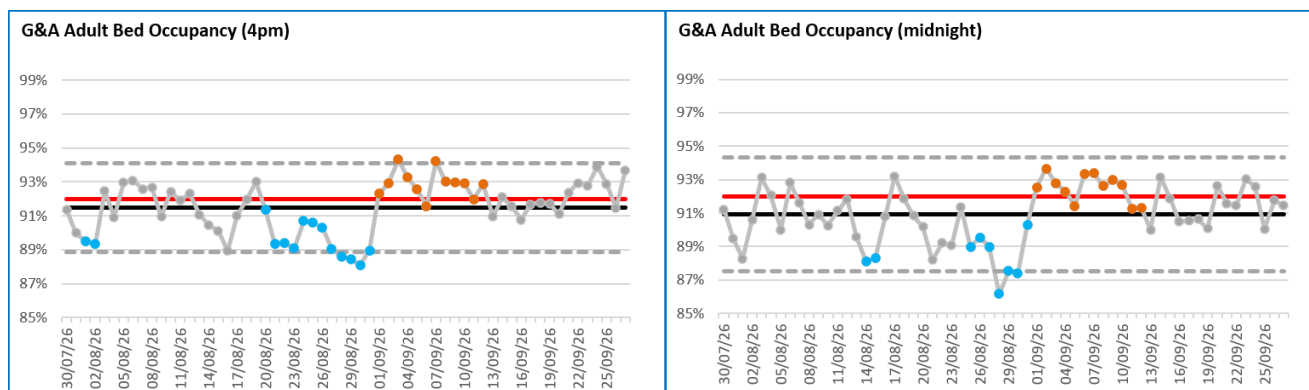
We have seen variation in both patients with a decision to admit and those who are clinically ready to proceed. There has been a consistent variation in September of increased numbers of patients with a decision to admit

Discharges



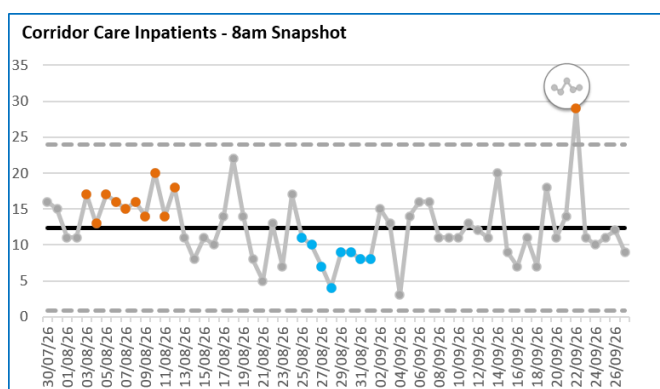
We continue to see variation in discharge on a day to day basis, and variation in discharge numbers pre 4pm. This has been on the lower side during September

Bed Occupancy



Bed occupancy remains variable and high.

Use of Escalation Space (TES)



We continue to use escalation space on ward areas, the corridor in ED remains closed. This graph shows the use of inpatient TES space only.

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.

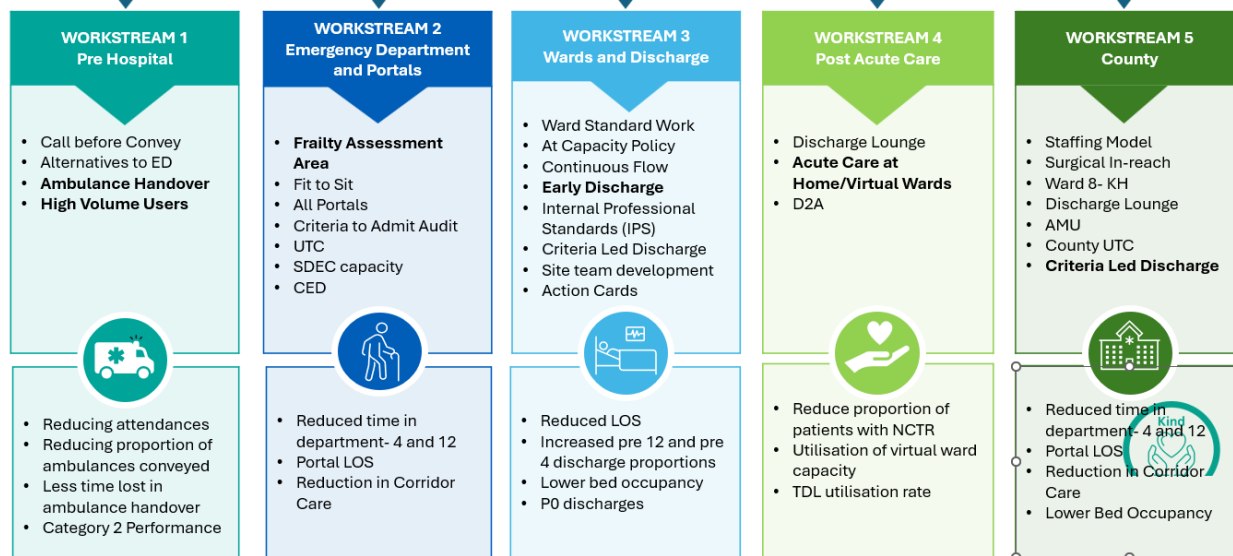
UEC Programme

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



University Hospitals
of North Midlands
NHS Trust

UEC IMPROVEMENT WEEK LESSONS LEARNED / SUSTAINABILITY



The attached quadrant report updates on progress and risk.

Conclusion

Urgent and emergency care performance remains below the standard we expect for our patients, with September proving particularly challenging. The data confirms that demand alone is not driving the deterioration; the principal constraint is the inconsistent flow of patients through the hospital, reflected in high bed occupancy, later discharges and increased numbers awaiting admission.

We understand the operational conditions required to improve performance and have demonstrated that, when capacity is created earlier in the day, ambulance handovers and time spent in the Emergency Department improve. Our immediate priority is therefore to translate this evidence into consistent daily delivery—strengthening ward processes, increasing timely discharge, reducing avoidable admissions and accelerating the movement of patients who are clinically ready to proceed.

The UEC transformation programme provides a clear framework for recovery, supported by robust executive oversight and external challenge from NHS England and GIRFT. While mitigating actions continue to manage immediate risk, sustained improvement will depend on embedding these changes reliably across the organisation. I remain clear that the current position is not acceptable, and our focus must now be on pace, accountability and measurable improvement in outcomes and experience for our patients.

Key Recommendations

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



MATTERS OF CONCERN OR KEY RISKS TO ESCALATE

- Ongoing system pressures continue to impact ambulance handovers, Emergency Department flow, frailty capacity and virtual ward utilisation.
- Delivery of key transformation schemes including Portal Reconfiguration, Discharge Lounge Expansion and Acute Care at Home developments remain dependent upon business case approvals, capital investment, ICT support and operational capacity.
- Workforce recruitment and sustainability remain a risk across several programme areas, including community admission avoidance services and front-door redesign programmes.
- Clinical engagement and operational adoption remain critical risks for successful implementation of Criteria Led Discharge, Portal Reconfiguration and associated pathway changes.
- The Trust maintenance programme and estate dependencies may affect delivery timescales for portal reconfiguration and service mobilisation activities

KEY ACHIEVEMENTS and ESCALATIONS

- Completion of the first system-wide ICC/UHNM admission avoidance data triangulation, providing patient-level insight into admission avoidance outcomes.
- Full business case for Portal Reconfiguration completed and presented to Executive Committee, with key workforce, pathway review and enabling works milestones delivered.
- Successful mobilisation and opening of the RSUH Urgent Treatment Centre, including completion of workforce planning, MOC processes, digital readiness and operational preparations.
- Criteria Led Discharge rollout commenced across Elderly Care, General Medicine and County Hospital wards, supported by development of performance reporting and monitoring arrangements.
- Discharge Lounge Expansion programme progressed significantly with executive approval of the business case, design development and enabling works underway.
- County Hospital strategic programme established, including completion of corridor care gap analysis, pathway reviews and development of frailty and remote follow-up initiatives.
- Acute Care at Home, Respiratory, Palliative Care and Virtual Ward pathway developments continue to progress, with funding secured and recruitment underway for key services.

KEY PERFORMANCE MEASURE(S)



ACTIONS and MILESTONES FOR NEXT PERIOD

- Deliver Portal Reconfiguration go-live and embed new operational pathways
- Implement the ICC Senior Decision Maker model and progress system-wide admission avoidance reporting.
- Complete Acute Care at Home demand and capacity modelling to inform future service expansion requirements.
- Embed Criteria Led Discharge across participating wards and implement associated performance dashboards and success measures.
- Secure final approval and progress mobilisation planning for the Discharge Lounge Expansion programme and staffing model.
- Implement remote follow-up pathways for frail patients and progress County Hospital frailty and admission avoidance initiatives.
- Continue development of programme-wide KPI, benefits realisation and performance reporting frameworks to support delivery oversight.
- Progress recruitment for expanded 7-day palliative care services and further virtual ward pathway developments.

Executive Summary

Trust Board (Part 1) | 7th October 2026

Workforce Race and Workforce Disability Equality Standard Reports 2026

Standard Reports 2020						
Purpose:	Information	Approval	Assurance	✓	Agenda Item:	12
Author:	Charlotte Lees, OD, Culture and Inclusion Business Partner					
Executive Lead:	Jane Haire, Chief People Officer					
Alignment with our Strategic Priorities						
	Our People We will create an inclusive environment where everyone learns, thrives and makes a positive difference					✓
	Our Patients We will provide timely, innovative and effective services to our patients					✓
	Our Population We will tackle inequality and improve the health of our population					✓

Risk Register Mapping

BAF 3	Inability to improve workforce sustainability and organisational culture					Ext 15
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.					

Executive Summary

Situation

UHNM remains committed to advancing race and disability equality through delivery of the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES); which serve as critical tools for measuring progress and driving improvements in equity, diversity, and inclusion across the Trust.

Background

- WRES and WDES are part of the NHS Standard Contract, enabling organisations to benchmark experiences of Black, Asian and Minority Ethnic and Disabled employees, and to monitor progress and address disparities.
- The NHS EDI Improvement Plan outlines six high-impact actions, including measurable EDI objectives for leaders, recruitment overhaul, pay gap elimination, addressing health inequalities, induction for international staff, and eliminating bullying and harassment.
- UHNM's strategy prioritises inclusivity, patient care, and tackling inequality. The People Delivery Plan underpins these priorities with a focus on equality of opportunity and employee experience.
- The UHNM Race Equality Task and Finish Group has been focusing on areas with the most significant inequity – recruitment, career development and experience of harassment, bullying and discrimination.
- In recent months there has been additional focus on anti-racism through the publication of the Mann Review, which highlighted the need for a systematic approach to tackling racism within the NHS and the introduction of new NHS Staff Standards, including a specific standard relating to tackling racism.
- UHNM is a Disability Confident 'Employer'.

Assessment of 2026 Data:

Workforce Race Equality:

- Black, Asian and Minority Ethnic (BAME/Global Majority) representation has increased to 30.9% of the workforce, representing significant growth of almost 17% over the past decade.
- There has been encouraging improvement in ethnic diversity across pay bands, indicating that more global majority colleagues are progressing into higher graded roles than previously.

- Global majority colleagues are not concentrated in lower-paid roles and are well represented in higher pay bands, particularly in medical and dental roles, resulting in a positive ethnicity pay gap position.
- Whilst representation has increased over time, progress across staff experience measures has been limited, suggesting that improvements in diversity have not yet been accompanied by equivalent gains in inclusion and workplace experience, specifically:
- White applicants are 1.9 times more likely to be appointed from shortlisting than global majority applicants, demonstrating a continued disparity within recruitment outcomes.
- White colleagues are nearly 10% more likely to believe that the Trust provides equal opportunities for career progression and promotion than global majority colleagues.
- Reports of harassment, bullying and abuse have increased, both from patients and members of the public and from colleagues, indicating a deterioration in workplace experience for global majority staff.

The data shows significant progress in workforce diversity and demonstrates that the Trust is successful in attracting and retaining a more diverse workforce that is increasingly reflective of the communities it serves. The findings also highlight the need to strengthen inclusion, ensuring that improvements in workforce diversity are matched by equitable experiences, career opportunities and a culture where all colleagues feel valued, respected and able to thrive.

Workforce Disability Equality:

- 6.7% of colleagues have declared a disability, in line with the NHS national average.
- Disability representation has increased across almost all pay bands, although representation in the most senior roles (Bands 8c-VSM) has fallen compared to 2025.
- Most disability workforce metrics continue to improve, reflecting the impact of disability-inclusive policies and support for workplace adjustments.
- There has been a notable increase in the number of disabled colleagues receiving the workplace adjustments they need to carry out their role effectively.
- Some metrics have worsened compared with the previous year, including:
 - Disabled staff engagement scores
 - Disabled staff satisfaction that the organisation values their work
 - Reports of pressure from managers to attend work when not feeling well enough
 However, these declines were also seen among colleagues without a disability.
- Disabled colleagues continue to experience higher levels of discrimination, bullying and harassment than non-disabled colleagues. Encouragingly, reports of bullying, harassment and abuse from colleagues, patients and the public have reduced, although there has been a slight increase from managers.
- Disabled applicants are appointed at a similar rate to non-disabled applicants once shortlisted, indicating no disadvantage at this stage of recruitment.
- The disability pay gap is 13.5%, largely driven by the lower representation of disabled colleagues in higher-paid roles.

Overall, our data demonstrates steady progress in disability inclusion, particularly in representation and access to workplace adjustments. However, further work is needed to improve the experiences of disabled colleagues, reduce harassment, bullying, abuse and discrimination; strengthen engagement, and increase representation in senior positions to help address the disability pay gap.

Recommendations

For Race Equality:

- Establish a formal Anti-Racism Steering Group to provide strategic leadership, governance and accountability for the Trust's anti-racism agenda. Building on the foundations established by the Race Equality Task and Finish Group, the Steering Group will oversee implementation of the Mann Review recommendations and our monitor performance and outcomes, ensure alignment with NHS anti-racism standards, and provide regular assurance on progress and impact to executive and Board-level committees.

For Disability Equality:

- Sustained focus on workplace adjustments and line manager understanding

- Focus on neurodivergence including delivery of a neurodiversity conference in 2026 and advanced awareness training for our Disability Champions to enable them to effectively support neurodivergent colleagues and their line managers.
- The monitoring of disabled progression rates
- Address higher rates of presenteeism by disabled colleagues through line manager awareness

We will track and measure progress through improved metrics in the 2026 National Staff Survey and 2027 WRES and WDES submissions and lived experience feedback from the Ethnic Diversity and Disability and Long Term Conditions Staff Network.

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	x
No Assurance	No confidence in delivery	

Rationale

UHNH has made encouraging progress in increasing workforce diversity and disability inclusion. However, significant inequalities persist in recruitment, career progression, senior leadership representation, and experiences of bullying, harassment and discrimination. While there is evidence of improvement, the findings demonstrate the need for stronger accountability and targeted action to achieve equitable experiences and outcomes for all colleagues, reflected in the report's overall partial assurance rating.

Key Recommendations

- People, Culture and Inclusion Committee has approved this report and the recommendations made, including endorsing a strengthened programme of work to address race inequalities, with the establishment of an Anti-Racism Steering Group, implementation of targeted actions to improve recruitment, progression, leadership representation and staff experience, and the introduction of enhanced governance and accountability arrangements to provide assurance on delivery of the Mann Review recommendations, NHS Anti-Racism Staff Standard and the experiences of colleagues reported by the NHS Staff Survey and other speaking up routes.
- Support the ongoing focus on reasonable adjustments; creating a neuro-inclusive workplace and increasing line manager understanding to address the prevalence of presenteeism amongst disabled colleagues.

Introduction

As part of our commitment to creating a fair and inclusive workplace at UHNM and across the wider NHS, the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) remain critical tools for measuring progress and driving improvement. Mandated annually under the NHS Standard Contract, these frameworks enable organisations to:

- Identify and address disparities in treatment, experience, and opportunity
- Benchmark progress internally and against peers
- Take targeted action to close equity gaps experienced by marginalised groups

The WRES and WDES continue to highlight persistent challenges in career progression, workplace culture, and inclusion. Publishing our data and action plans transparently ensures accountability and reinforces our commitment to meaningful change.

Note on Terminology: The terms Black, Asian and Minority Ethnic (BAME) and global majority will be used throughout this report to describe colleagues from ethnically diverse backgrounds.

NHS EDI Improvement Plan

The NHS EDI Improvement Plan sets out targeted actions to address the prejudice and discrimination – direct and indirect – that exists through behaviour, policies, practices and cultures against certain groups and individuals across the NHS workforce. There are six high impact actions for organisations:

1. Measurable objectives on EDI for Chairs, Chief Executives and Board members
2. Overhaul recruitment processes and embed talent management processes
3. Eliminate total pay gaps with respect to race, disability and gender
4. Address health inequalities within their workforce
5. Comprehensive induction and onboarding programme for international recruited staff
6. Eliminate conditions and environment in which bullying, harassment and physical harassment occurs

Mann Review 2026

The Mann Review examined how the NHS identifies, reports and responds to antisemitism and other forms of racism affecting staff and patients. The review found that racism remains a persistent issue across the NHS, with inconsistent organisational responses, variations in leadership accountability, and weaknesses in reporting and investigation processes. It set out a series of recommendations aimed at strengthening accountability, improving reporting mechanisms, enhancing staff support, embedding anti-racist practice, and using workforce data, including WRES measures, to drive improvement.

The review reinforces the expectation that NHS organisations take a proactive and transparent approach to tackling racism and creating inclusive environments where all staff, patients and communities are treated with dignity, respect and fairness.

NHS Staff Standards

The NHS Staff Standards, also introduced in 2026, establish national minimum expectations for NHS employers across six key areas: line management, health and wellbeing, violence prevention and reduction, sexual safety, flexible working, and tackling racism. The standards are designed to improve staff experience through greater organisational accountability, with performance measured through NHS oversight and assurance processes.

The Tackling Racism Standard requires NHS organisations to take a proactive, anti-racist approach to preventing, identifying and addressing racism in the workplace. The standard emphasises visible leadership accountability, clear reporting and investigation processes, staff support, effective use of workforce data, and action to address racial inequalities. It aligns closely with the recommendations of the Mann Review and reinforces the expectation that all NHS organisations create safe, inclusive environments where racism is challenged, staff are supported to speak up, and progress is transparently monitored through measures such as the WRES.

Status update on last year's WRES and WDES actions

Workforce race equality:

Workstream	Action	Progress
Governance	Launch of a new Equality, Diversity and Inclusion accountability framework, defining the expectations of Care Groups	Complete
Culture of anti-racism	- Hold an anti-racism conference during Black History Month 2025 to raise awareness and understanding of anti-racism and everyone's responsibilities to eliminate racism - Introduce refreshed values and behaviours framework with clear expectations about inclusive and non-discriminatory colleague behaviour - Enhance the remit of WRES Champions to include employee relations support with an anti-racism lens	Complete Complete Not complete – ICS wide project underway
Inclusive leadership	- Introduce new masterclasses into our leadership brochure to include: - Managing inter-cultural teams - Intercultural communication - Active bystander training - Introduction of the NHS Leadership and Management Framework	Launching Q3 2026 'Multi-lingual guidance' complete National delay – launch Sept. 26

Workforce disability equality:

Workstream	Action	Progress	Key performance indicator
Embed the Reasonable Adjustments Policy	High profile campaign to maintain awareness and increase understanding of the Reasonable Adjustments Policy, the Tailored Adjustments Plan and Disability Champions	Complete	Metric 8 (reasonable adjustments) target 73.4% actual 74.01%
Neurodiversity	- Establish a neurodiversity sub-group to the Staff Network to provide dedicated safe space for identifying and improving the workplace experiences of colleagues and carers of individuals with a neurodifference - Enhance line manager and colleague understanding of reasonable adjustments for neurodiversity/introduce a new guide for all colleagues on adjustments for neurodiverse colleagues	Complete Complete	Metric 4a (bullying from manager) target 16.1% actual 15.8% Metric 6 (presenteeism) target 28.5% actual 29.9%
Experience of bullying, harassment and abuse	- Launch of confident conversations support guides - Trained additional Disability Champions	Complete	Metric 9 (staff engagement score) target 6.4 actual 6.29

Workforce Race Equality Standard (WRES) 2026 Data Analysis

Key Findings:

30.9% of our workforce are from Black, Asian or Minority Ethnic backgrounds, an increase of more than 17% over the past 10 years

27.2% of global majority colleagues have experienced abuse from patients and the public in the last 12 months compared to **22.6%** of white colleagues

White colleagues are **10%** more likely than global majority colleagues to report that the trust offers fair opportunities for career progression / promotion.

White applicants are **1.9** times more likely to be appointed from shortlisting compared to global majority applicants

3.4% deterioration in global majority colleagues reporting bullying and abuse from other colleagues in the last 12 months (29.35%)

No difference in the likelihood of global majority employees entering the formal disciplinary process compared to white colleagues

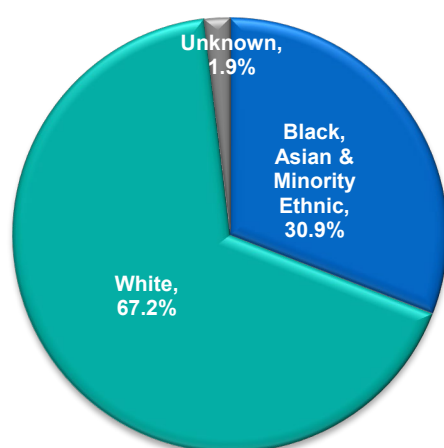
Global majority colleagues more likely to feel discriminated against by a colleague /manager/team leader at **19.6%** compared to **7.7%** of white staff

Global majority colleagues are unequally distributed across professional groups: **11.3%** are in non-clinical roles, **29.6%** in clinical roles and **67.2%** in Medical and Dental roles

18.8% of the UHNM Board are Black, Asian and Minority Ethnic; representing a -13% gap between the board with the composition of the overall workforce

WRES Indicator 1

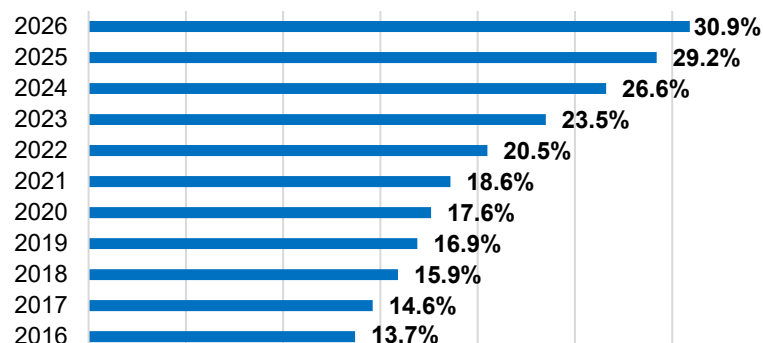
Percentage representation by ethnicity



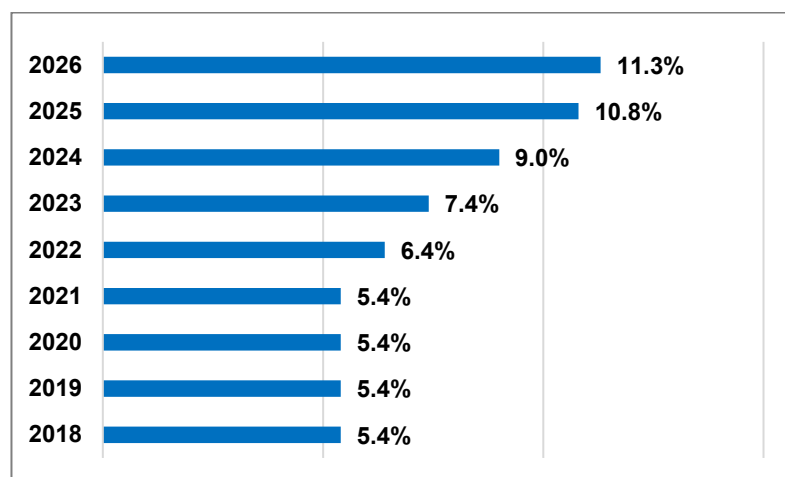
At 31st March 2026, Black, Asian and Minority Ethnic colleagues represented 30.9% of our overall workforce, or 4,162 colleagues (+303 people from 2025)

Across the NHS, 30.7% of the workforce are from global majority heritage (WRES Report 2025).

Black, Asian & Minority Ethnic Representation at UHNM Trend



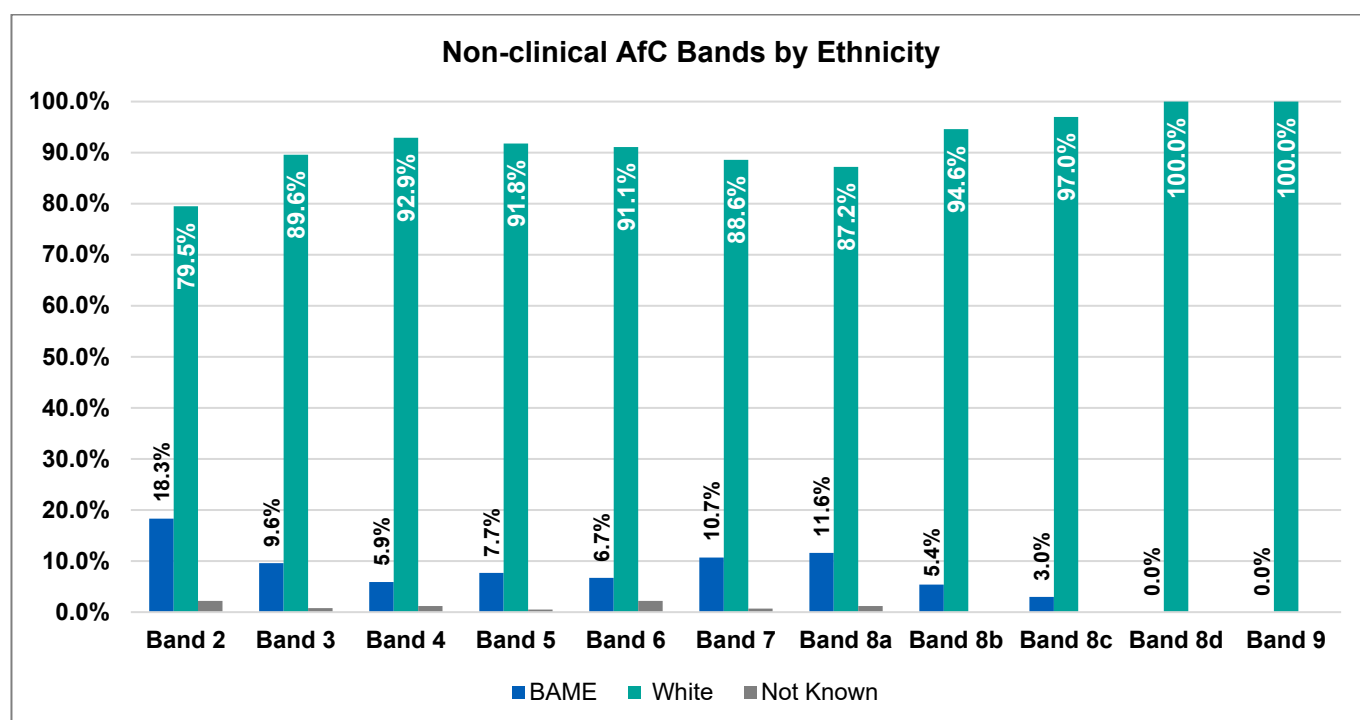
Percentage representation of Black, Asian and Minority Ethnic colleagues in Agenda for Change non-clinical pay bands:



Global majority representation in non-clinical roles has increased year on year since 2021 and is now in line with local community representation within Staffordshire and Stoke on Trent.

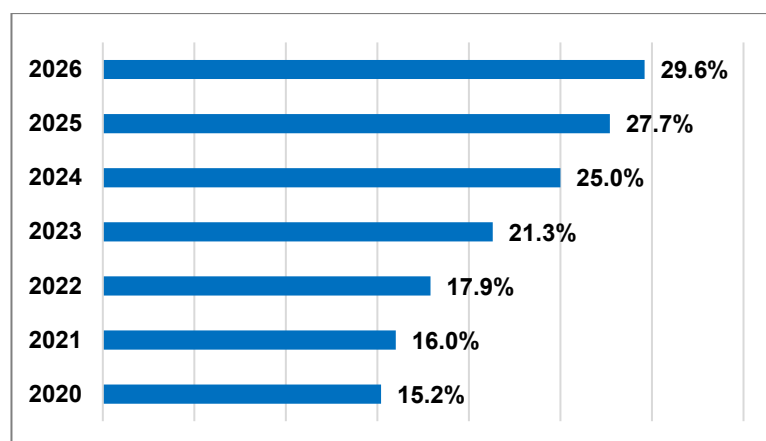
The greatest representation is at Band 2, followed by Band 8A, Band 7 and Band 3.

Across the NHS, 20.7% of non-clinical workforce is from Black, Asian and minority ethnic backgrounds. (2025 WRES Annual Report)



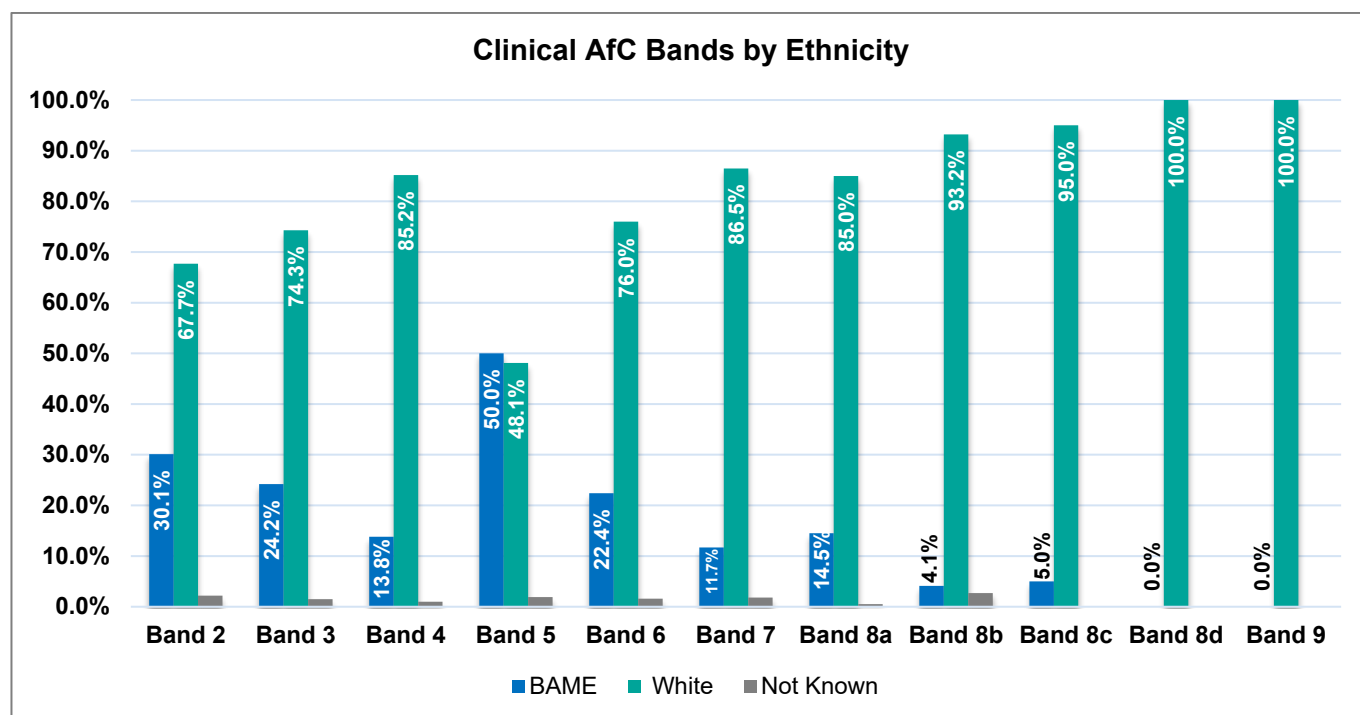
The percentage representation of global majority colleagues in senior non-clinical roles 8C and above, remains an area requiring improvement.

Percentage representation by ethnicity in Agenda for Change clinical pay bands:



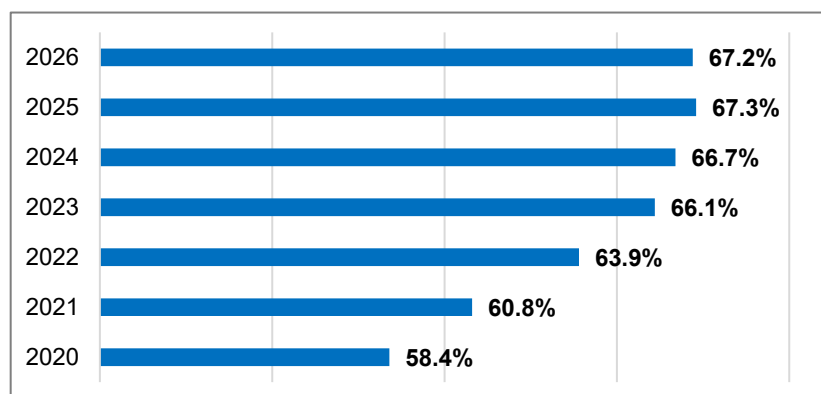
Global majority representation has improved year on year in clinical pay bands, doubling in the last six years. International recruitment has influenced representation, particularly at Band 5.

Representation above AfC Band 5 reduces notably, but there has been positive improvement in Bands 6, 7 and 8a over the past 12 months, which is also evidenced in the improved race disparity ratio for middle to upper and lower to upper representation.



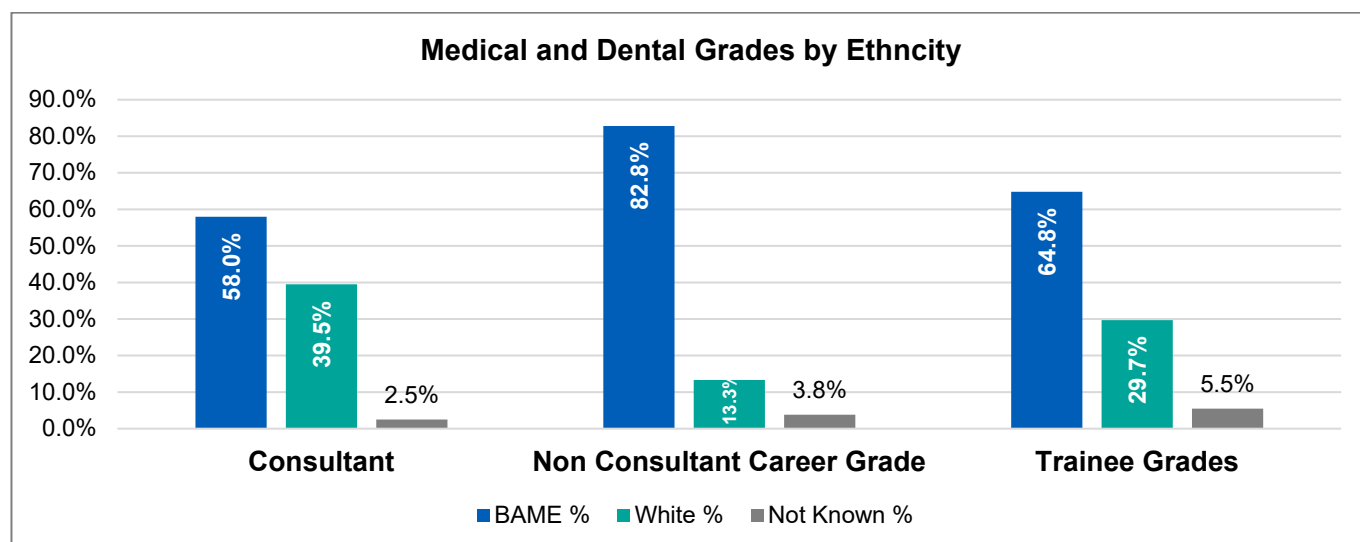
Nationally, representation in clinical Agenda for Change Bands is 31.5%. Representation is greatest in bands up to Band 4 (30.0%) and Bands 5-7 (33.8%), and above Band 5 falls dramatically to 18.3% at Band 8a-b.

Percentage representation by Ethnicity in Medical & Dental Grades:



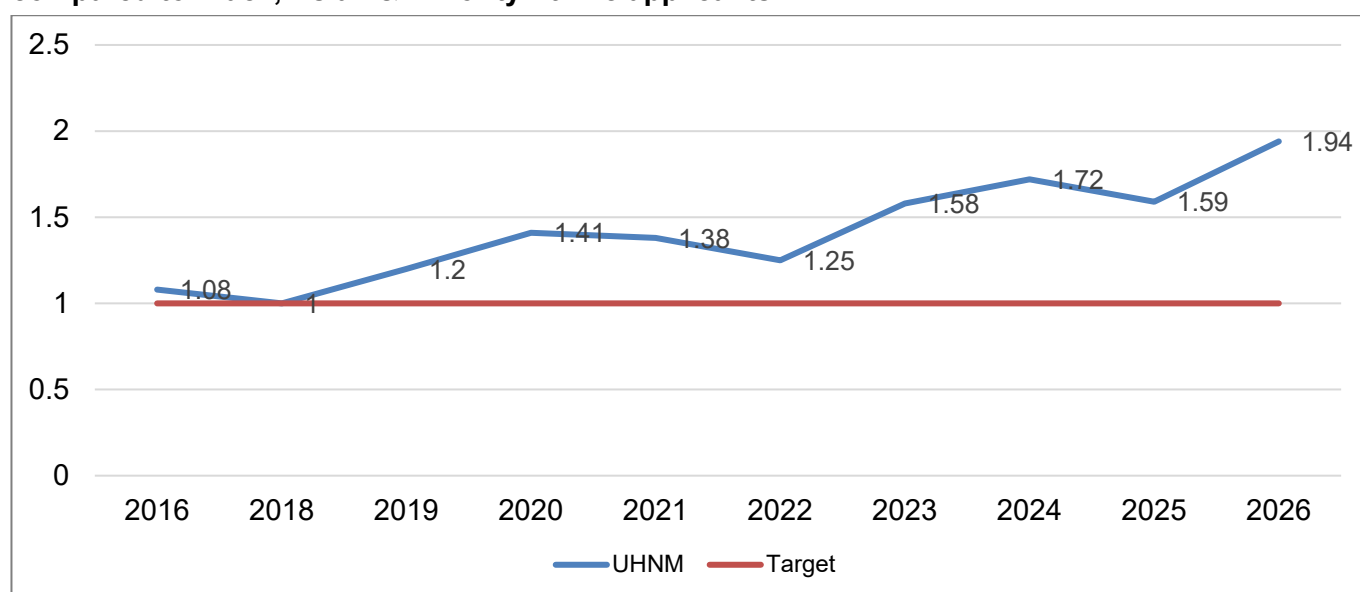
Nationally, at 31st March 2025, 50.0% of NHS doctors/dentists were from Black, Asian and Minority Ethnic backgrounds.

The representation at UHNM is 67%, with the highest representation of global majority colleagues being in non-consultant career grade roles.



WRES Indicator 2

Relative likelihood of white applicants being appointed from shortlisting across all posts compared to Black, Asian & Minority Ethnic applicants



White applicants are almost 1.9 times more likely to be appointed from shortlisting compared to global majority applicants. The National WRES Data Analysis Report (2025) showed that the national likelihood metric was 1.77.

Race Disparity Ratio

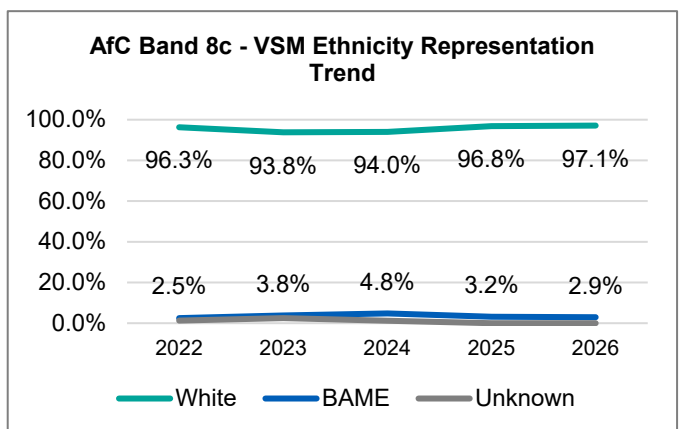
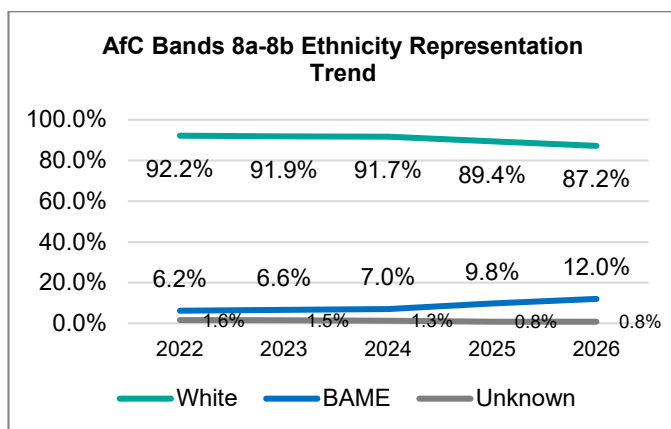
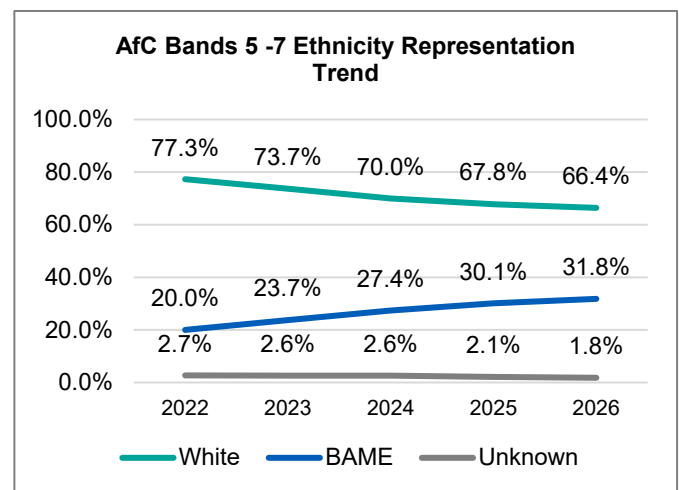
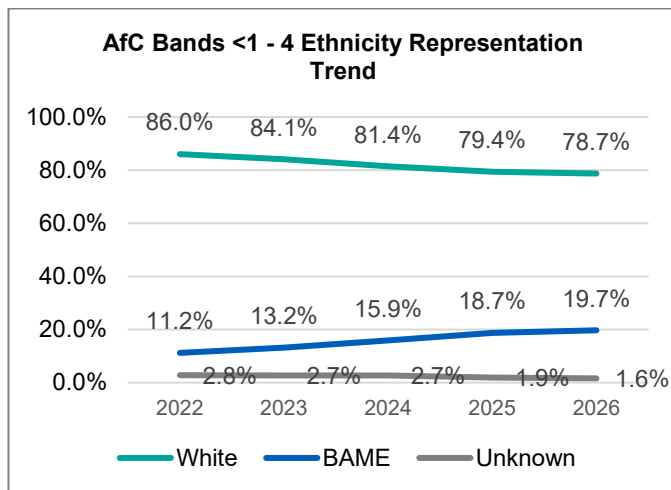
The race disparity ratio is a metric that compares the proportion of global majority employees at different pay levels (lower, middle and upper bands) to that of white employees. A ratio greater than 1.0 indicates inequality, suggesting that white colleagues have a higher likelihood of progression than ethnically diverse staff, while a ratio of 1.0 indicates parity.

Across all stages of career progression, global majority colleagues are less likely than white colleagues to progress. While some variation may be influenced by patterns of international recruitment into specific clinical roles and pay bands, the data nevertheless indicates persistent inequalities in progression opportunities.

Positively the data demonstrates better than the national average likelihood of progression for both clinical and non-clinical global majority colleagues progression from middle tier (bands 6-7) to upper tier (8A+).

Agenda for Change Bands	National 2025	UHNM 2026
Disparity ratio - lower to middle		
Clinical	0.83	2.45
Non Clinical	1.00	1.50
Disparity ratio - middle to upper		
Clinical	2.35	1.72
Non Clinical	1.27	1.23
Disparity ratio - lower to upper		
Clinical	2.54	4.21
Non Clinical	1.71	1.85

The charts below demonstrate the trend in ethnicity representation within Agenda for Change roles at UHNM:



Overall, the organisation has made positive progress in increasing ethnic diversity across Bands 2-8b, particularly within Bands 5-7. However, representation of BAME staff in senior leadership roles (Bands 8c-VSM) remains low, highlighting the need for targeted action to improve progression, talent development and representation at the highest levels of the organisation.

Progress against our Model Employer Aspirational Targets for Black, Asian and Minority Ethnic representation in senior leadership roles (below) also reflects this; with a continued positive trajectory at Band 8a, but below the aspirational targets allocated by NHS England for higher pay bands:

AfC Band	UHNH Headcount 2026	Model Employer Target 2026
8a	68	45
8b	6	12
8c	2	5
8d	0	3
9	0	1
VSM	1	1

Ethnicity Pay Gap

Ethnicity pay gap reporting was introduced as part of the EDI Improvement Plan, and our data shows that there is a positive pay gap in favour of global majority employees:

Ethnicity Pay Gap – White : Black, Asian & Minority Ethnic:

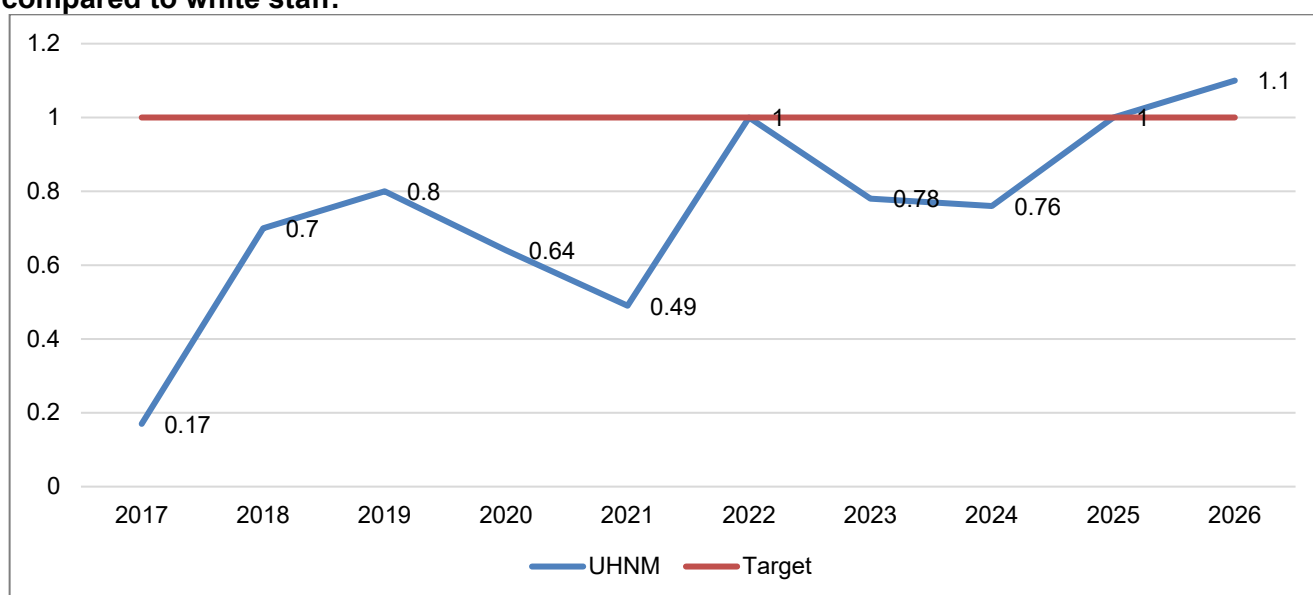
	2026	2025	2024	2023
Mean pay gap	-24.5%	-22.9%	-25.3%	-29.0%
Median pay gap	-14.5%	-14.3%	-18.4%	-20.4%

This is because there is a greater proportion of global majority employees employed in the middle and upper pay quartiles (quartiles 3 and 4), particularly Asian colleagues. Global Majority representation has increased in all quartiles compared to the previous year:

Quartile	Headcount							% Global Majority representation
	Asian	Black	Mixed	Not Stated	Other	White British	White Other	
1	363	108	53	43	25	2,516	109	17.1%
2	678	211	59	51	41	2,062	116	30.7%
3	813	211	52	79	60	1,804	140	36.0%
4	912	182	75	73	94	1,778	162	38.6%

WRES Indicator 3

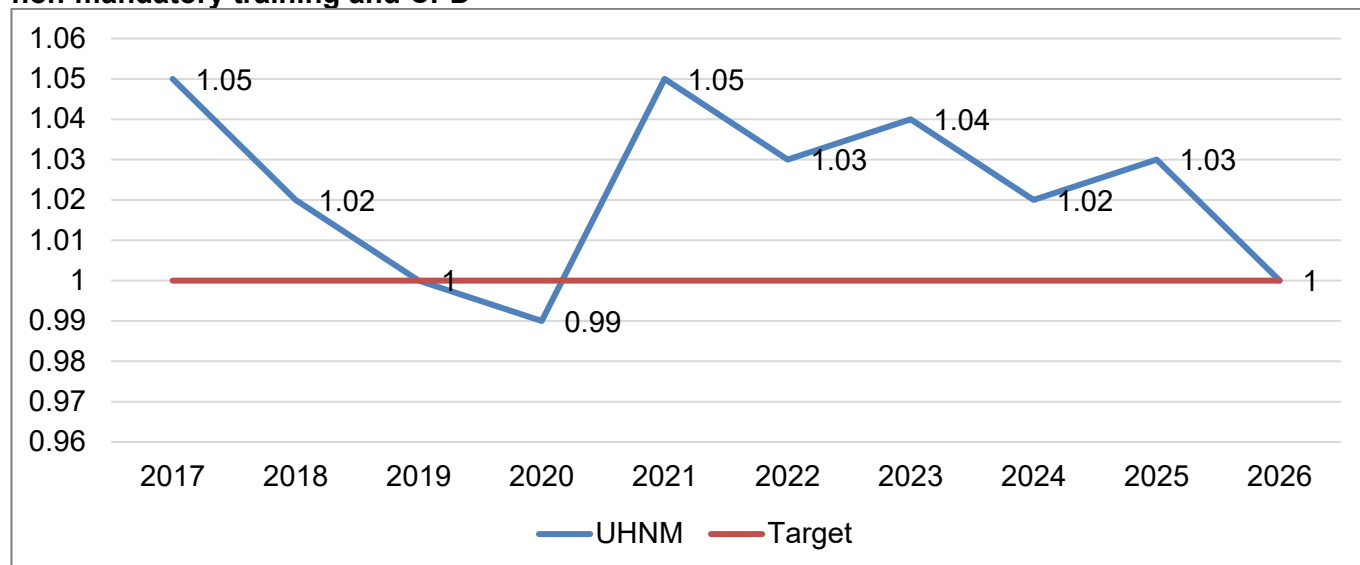
Relative likelihood of Black, Asian & Minority Ethnic staff entering the formal disciplinary process compared to white staff:



Global majority colleagues do not have an increased likelihood of entering formal disciplinary processes at UHNH. Nationally, the 2025 WRES Data Report showed nationally, Black, Asian and Minority Ethnic staff were 1.11 times more likely than white staff to enter the formal disciplinary process.

WRES Indicator 4

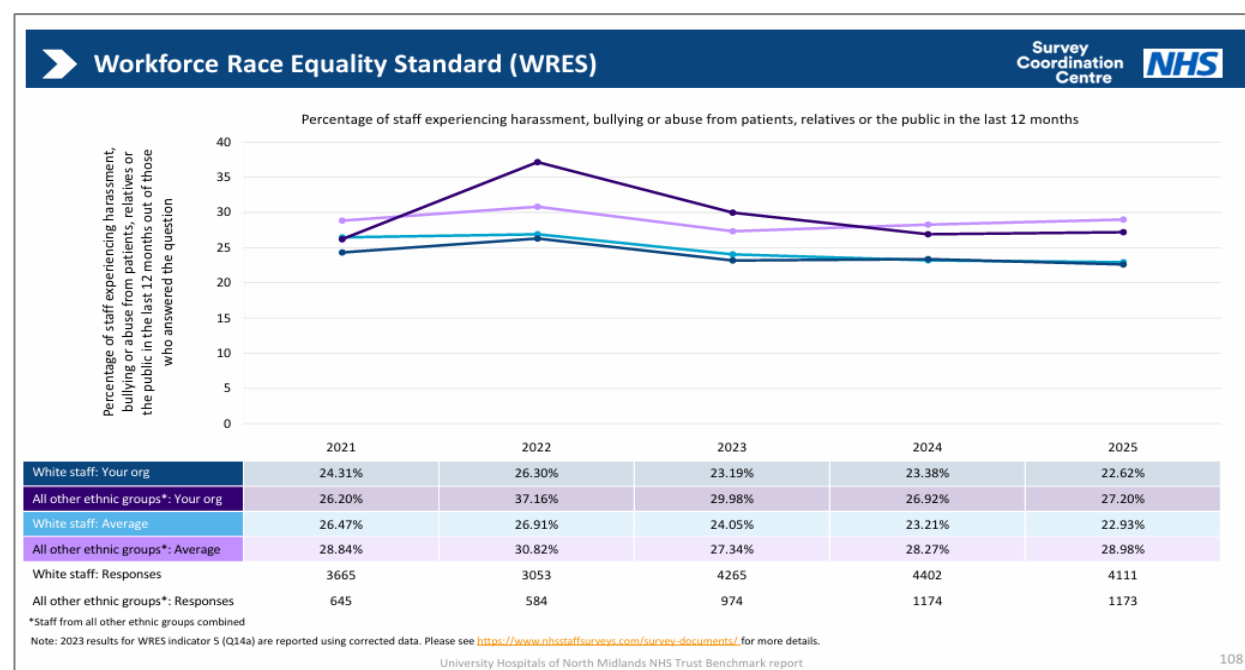
Relative likelihood of white staff compared to Black, Asian and Minority Ethnic staff accessing non-mandatory training and CPD



The acceptable range for this indicator is between 0.80 and 1.25. Our data has consistently been within this. The national figure in 2025 was 1.02.

WRES Indicator 5

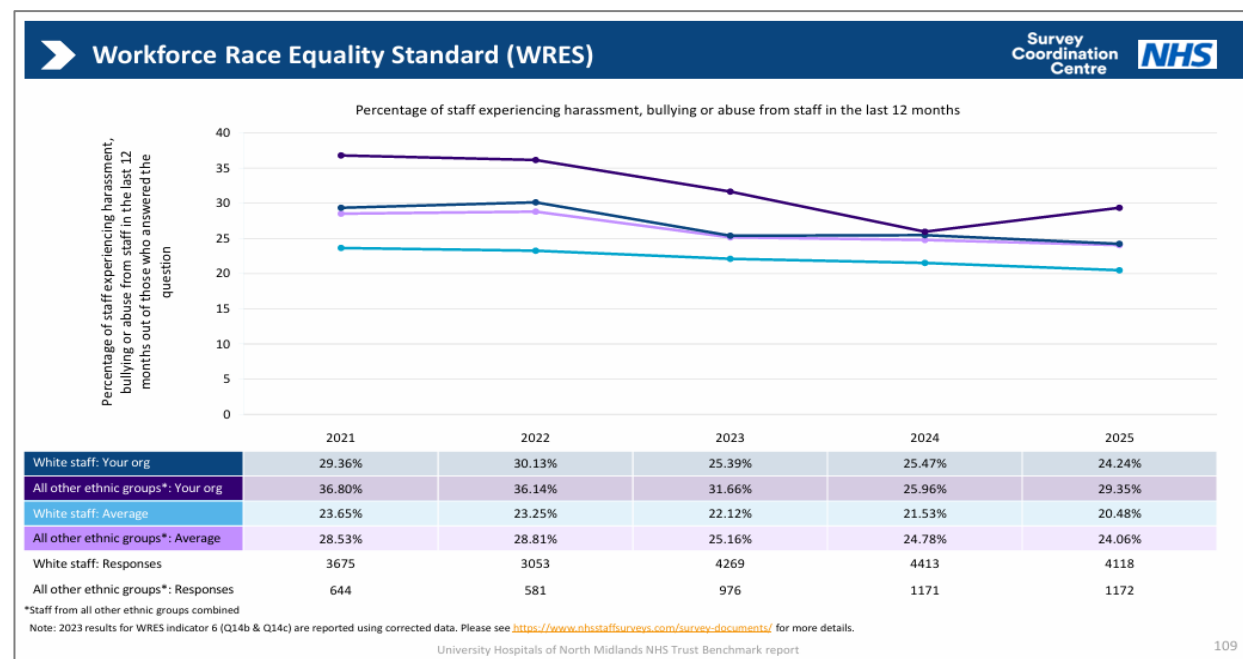
Percentage of staff experiencing harassment, bullying or abuse from patients / service users, their relatives, or the public in the last 12 months (national staff survey q14a):



This indicator has deteriorated by 0.28% for global majority colleagues after two years of significant improvement, however it remains better than the peer average, There has been a small improvement for white colleagues.

WRES Indicator 6

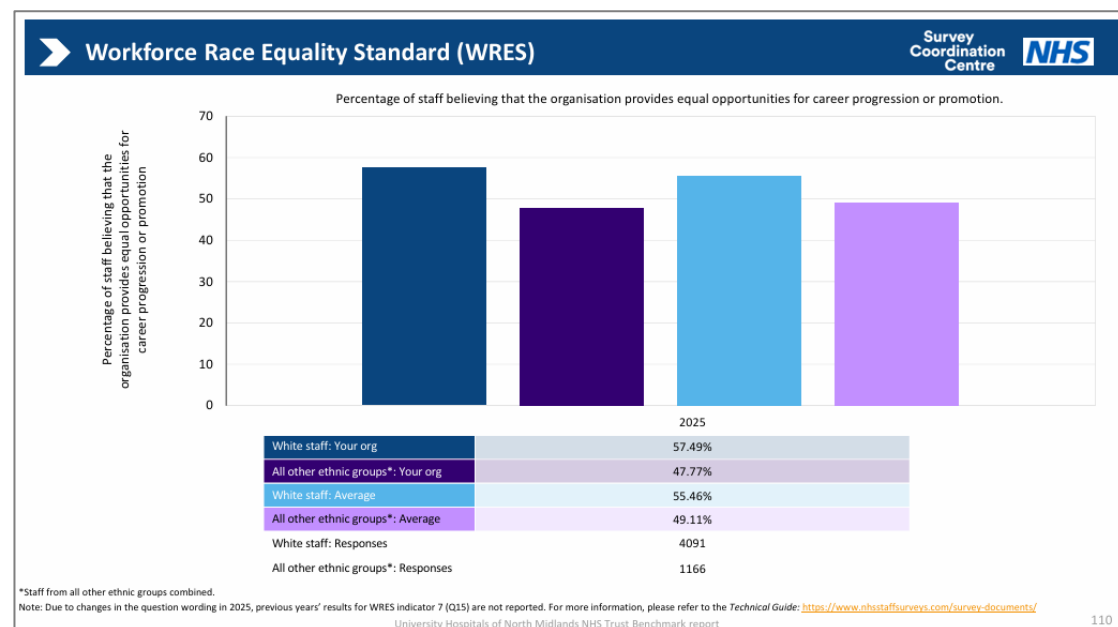
Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months (national staff survey q14c)



This indicator has deteriorated by 3.39% and is notably worse than the peer average for global majority staff. White colleague experience has slightly improved, but is also worse than the peer average.

WRES Indicator 7

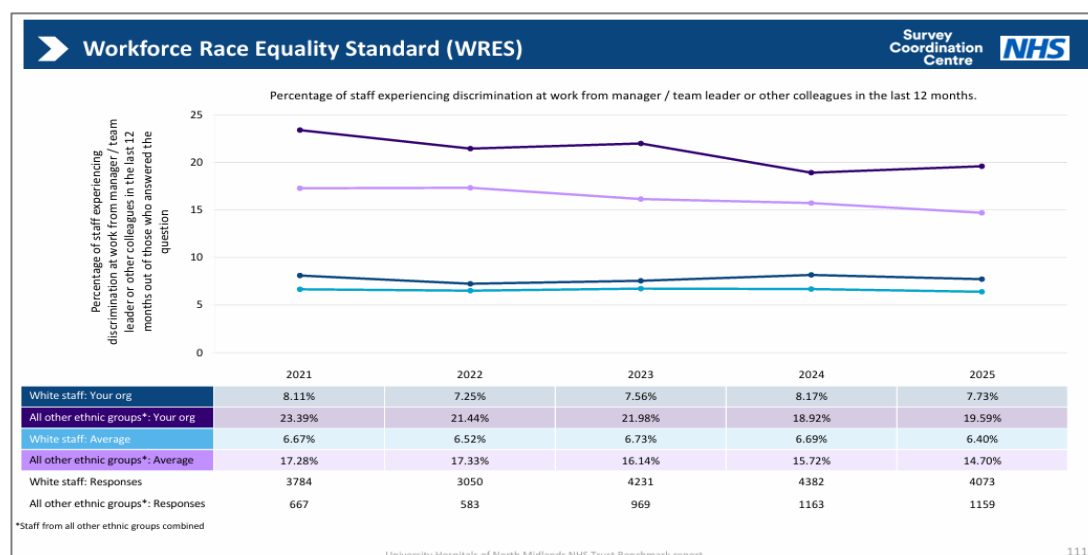
Percentage of staff believing that their trust provides equal opportunities for career progression or promotion (staff survey q15)



The wording of this question was changed for the 2025 national staff survey. The disparity between white colleague and global majority colleagues remains approximately 10%.

WRES Indicator 8

Percentage of staff experiencing discrimination at work from other staff in the last 12 months (staff survey q16b)



This metric has also slightly deteriorated for global majority colleagues. Both white and global majority colleague experiences are worse than our peer average.

WRES Indicator 9

Representation amongst board members by ethnicity compared to the workforce overall

This indicator measures the difference between the ethnicity composition of our Board membership compared to the overall organisation. Boards are expected to be broadly representative of their workforce. At UHNM, 18.8% of the board are from Black, Asian and Minority Ethnic backgrounds, resulting in a difference between the total board membership and the overall organisation of -12.0%.

Nationally, in March 2025, 17.3% of board members recorded their ethnicity as Black, Asian or Minority Ethnic, resulting in a -13.4% difference with the overall NHS workforce.

Summary and Actions

The findings presented within this report demonstrate that racial inequalities continue to affect the experiences and opportunities of our Global Majority colleagues and prospective workforce. The Mann Review, together with the NHS's commitment to advancing anti-racism, has brought renewed focus to the reality that progress to date has not been sufficient to eliminate inequity in our own organisation and across the NHS. These findings reinforce the importance of sustained leadership, robust accountability and targeted action to deliver measurable improvements across the organisation.

Therefore, we will be establishing a formal Anti-Racism Steering Group to provide strategic leadership, governance and accountability for the Trust's anti-racism agenda. Building on the foundations established by the Race Equality Task and Finish Group, the Steering Group will oversee implementation of the Mann Review recommendations and our monitor performance and outcomes, ensure alignment of our task and finish groups with NHS anti-racism standards, and provide regular assurance on progress and impact to executive and Board-level committees.

We will work in partnership with our Ethnic Diversity Network to provide insight, challenge and feedback on the effectiveness of our equality initiatives, helping us understand whether our actions are leading to meaningful improvements in the lived experiences, opportunities and outcomes of ethnic minority colleagues.

Workforce Disability Equality Standard (WDES) 2026 Data Analysis

Key Findings:

6.7% of colleagues have shared a disability or Long Term Condition (LTC) on ESR compared to 27.8% in the anonymised 2025 NHS Staff Survey

51.8% of colleagues with a disability/LTC compared to 58.5% of colleagues without a disability/LTC believe the trust provides equal opportunities for career progression or promotion

Colleagues with a disability/LTC are 9% more likely to feel pressure from their manager to come to work, despite not feeling well enough to perform their duties, compared to colleagues without a disability/LTC

74% of colleagues with a disability/LTC feel they have had the workplace adjustments they need to do their job

28% of colleagues with a disability/LTC reported experiencing harassment, bullying or abuse at work from patients / service users, their relatives or other members of the public and 29% from other colleagues

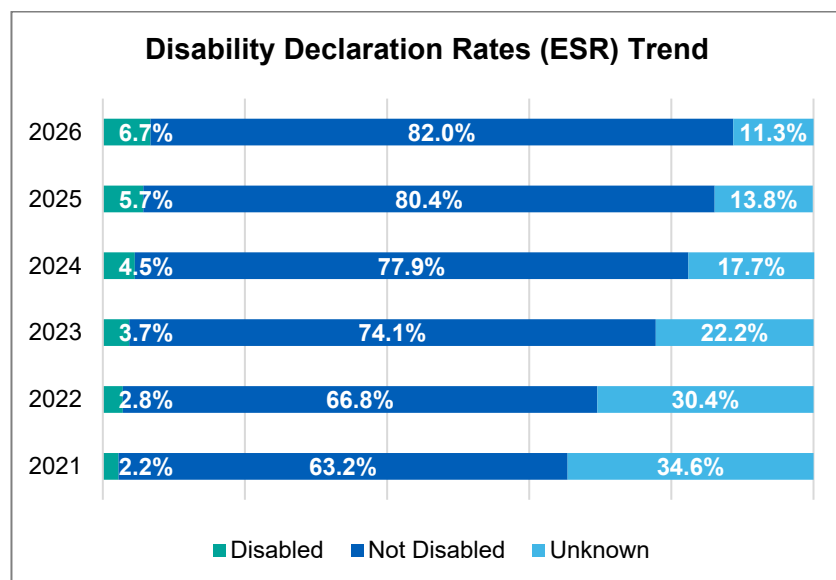
Non disabled applicants are 1.01 times more likely to be appointed from shortlisting than applicants with a disability, demonstrating parity

Introduction

The WDES comprises of 10 indicators. Six of which are drawn from the most recent annual NHS National Staff Survey. The UHNM response rate for the 2025 staff survey was 41% with 28.95% of respondents stating that they had a physical or mental health condition or illness lasting or expected to last 12 months or more. This compares to the peer average of 24.9% and is our highest ever response rate.

WDES Indicator 1

Percentage Representation of Workforce Disability

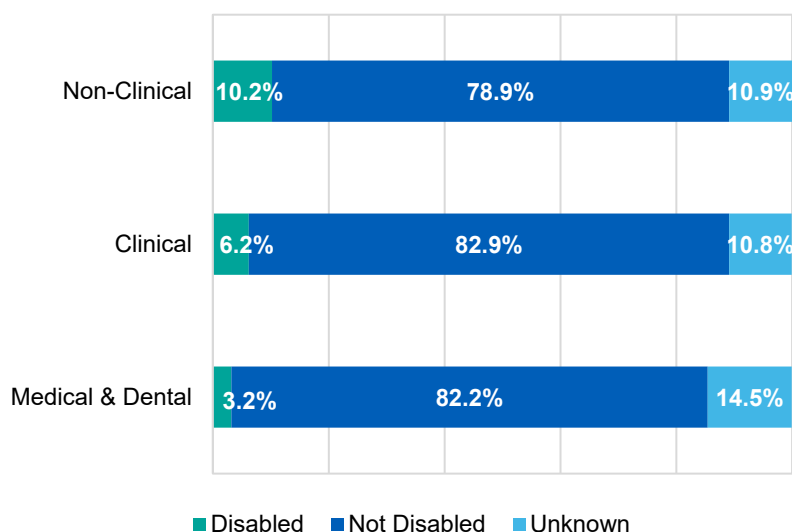


6.7% of UHNM colleagues (898 people) have shared that they have a disability on ESR. Yearly trends show significant improvement in declaration rates on ESR with a 23% reduction in 'unknown' disability status over the last five years.

The percentage of NHS staff in England working with a disability is also 6.7% with 81.4% not disabled and 11.9% unknown status. (source: 2025 WDES Data Report)

Nationally it is recognised that there is a significant under reporting across the country of the numbers of staff who disclose a disability on ESR, compared to those sharing this information when completing the anonymous NHS Staff Survey. We regularly encourage our workforce to update their ESR record and the number of records where colleagues have not disclosed their disability status has improved significantly from 41% in 2020 to 11.3% in 2026.

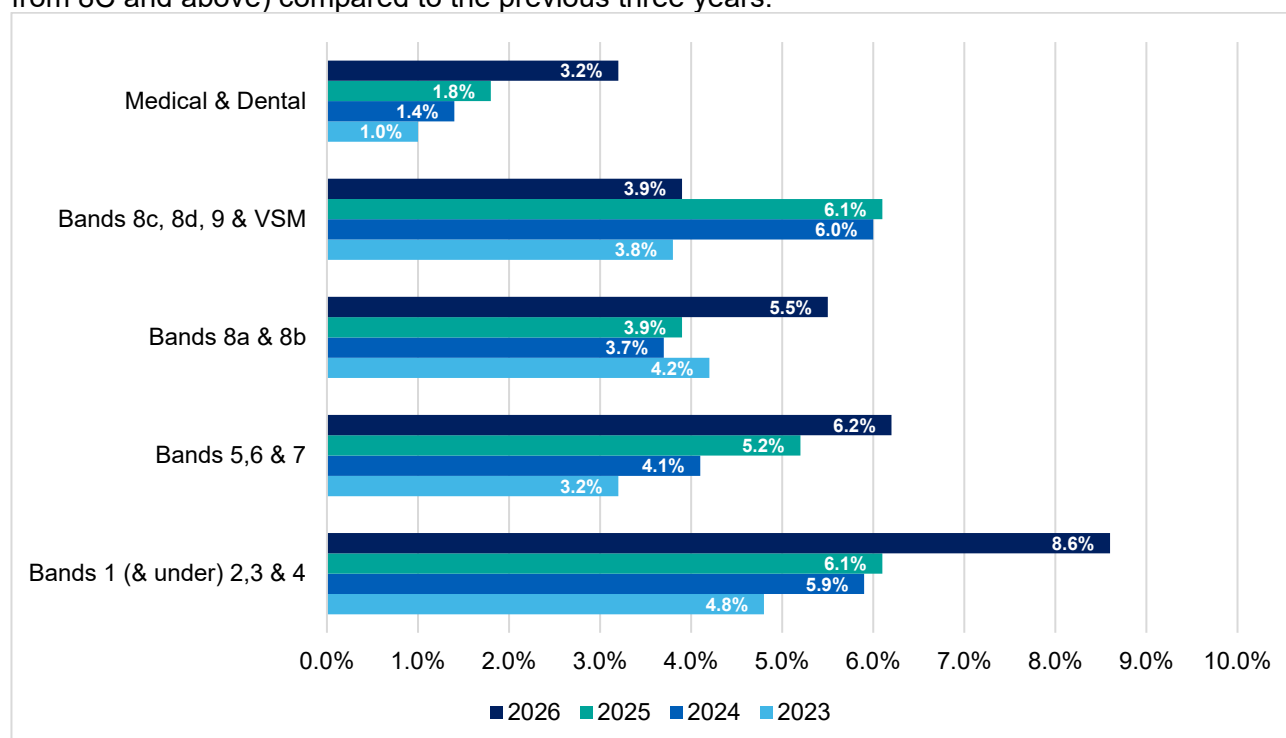
Disability representation across clinical and non-clinical groups:



Disability Category (ESR)	%
Long-standing illness	31.6%
Learning disability/difficulty	20.1%
Other	13.1%
Mental Health Condition	12.0%
Yes (unspecified)	9.6%
Physical Impairment	7.5%
Sensory Impairment	6.1%

'Long standing illness,' 'learning disability/difficulty' and 'mental health conditions' are the most commonly selected categories.

The WDES presents workforce data in four Agenda for Change clusters and a Medical & Dental professional group. The percentage of employees with a disability has increased in all pay clusters (apart from 8C and above) compared to the previous three years:



Disability Pay Gap

Disability pay gap reporting has been introduced as part of the EDI Improvement Plan. Our data shows that there is a 13% pay gap between colleagues with a disability compared to those without. This is because the proportion of disabled people employed decreases as the pay quartiles increase.

Disability Pay Gap – No disability : Employees with disability recorded on ESR:

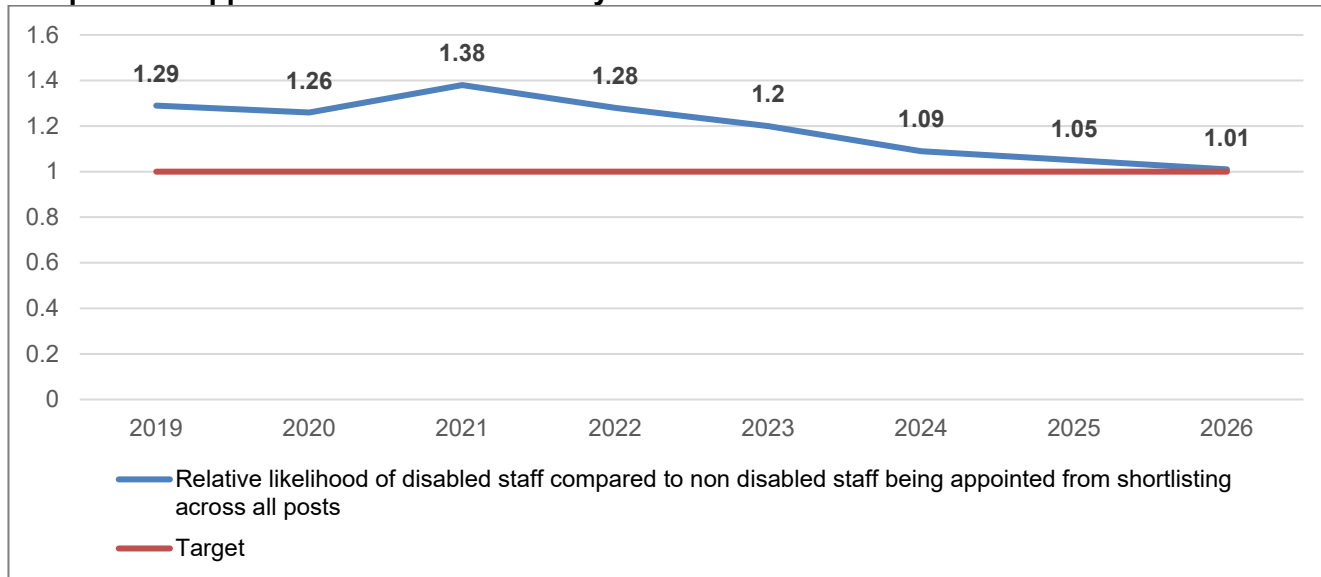
	2026	2025	2024	2023
Mean pay gap	13.5%	13.9%	12.5%	13.0%
Median pay gap	12.8%	13.4%	10.4%	11.3%

Quartile	Not disabled	Status known not	Disabled	% Disability representation
1	2701	202	321	10.0%
2	2787	220	218	6.8%
3	2822	205	199	6.2%
4	2847	234	144	4.5%

Note: the under reporting of disability status on ESR influences the efficacy of disability pay gap reporting.

WDES Indicator 2

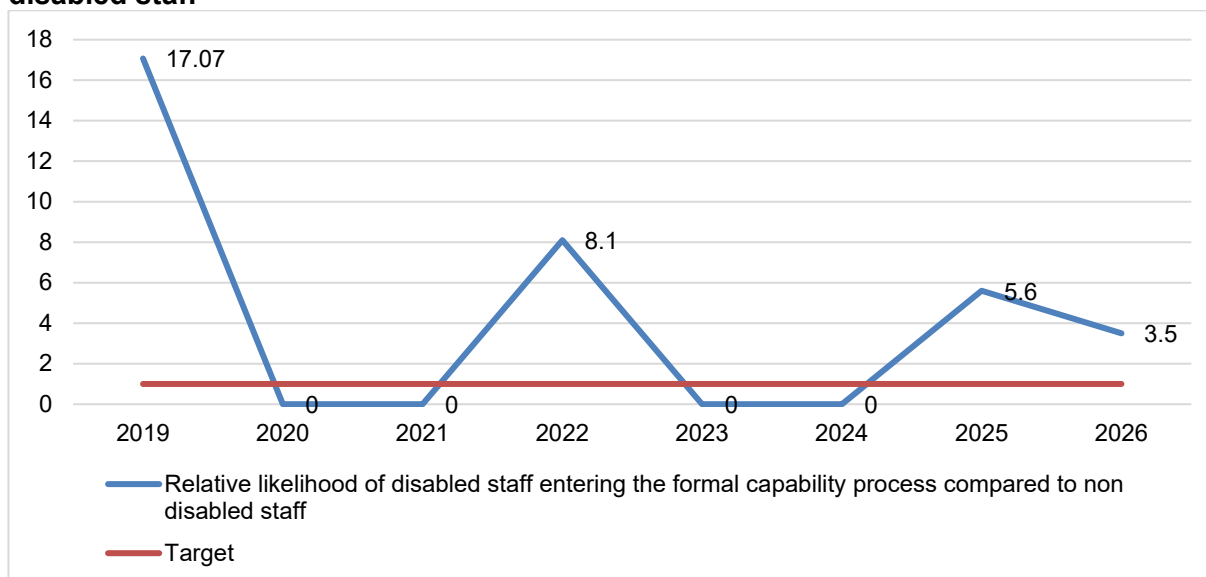
Relative likelihood of Disabled applicants being appointed from shortlisting across all posts compared to applicants without a disability



Analysis of recruitment activity recorded on the TRAC recruitment system shows that non-disabled applicants are 1.01 times more likely to be appointed from shortlisting compared to Disabled applicants (a metric of 1.0 represents equal likelihood of disabled and non-disabled applicants being appointed from shortlisting). A continued downward (positive) trajectory in our recruitment data compares with the most recent national average metric from 2025, which was 0.95.

WDES Indicator 3

Relative likelihood of Disabled staff entering the formal capability process compared to non-disabled staff



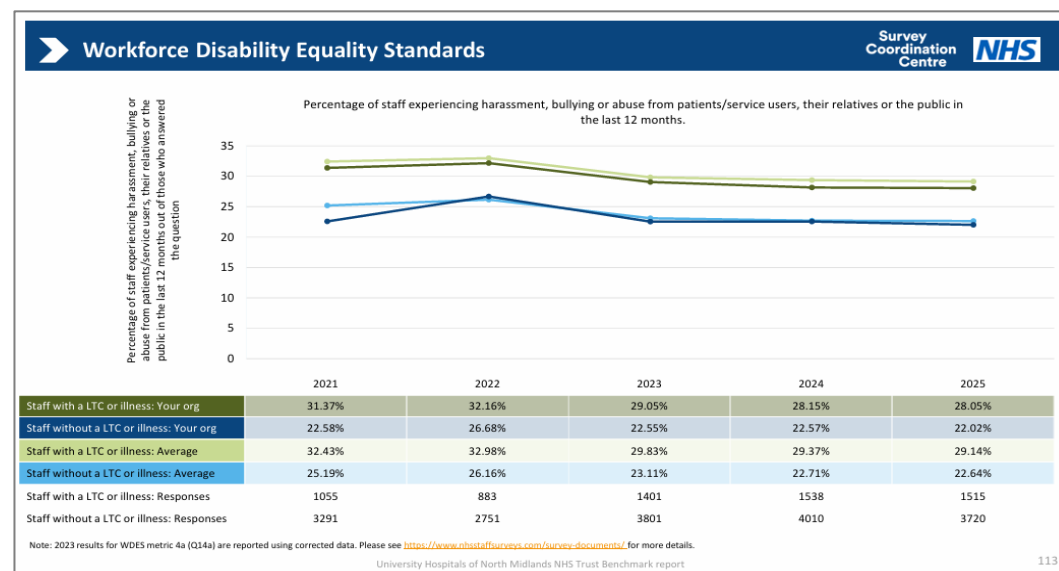
This indicator is based on data from a two-year rolling average of entry into a formal capability process for performance reasons as recorded on the Employee Relations Case Tracker.

Our Capability Policy is designed to be supportive and encouraging to enable colleagues to reach the desired performance level through informal processes and hence relatively small numbers of staff enter the formal stage of the policy.

This year's result gives a relative likelihood of Disabled staff entering the formal capability process compared to non-disabled staff score of 3.5.

WDES Indicator 4a

Percentage of staff experiencing harassment, bullying or abuse from patients/service users, their relatives or the public in the last 12 months

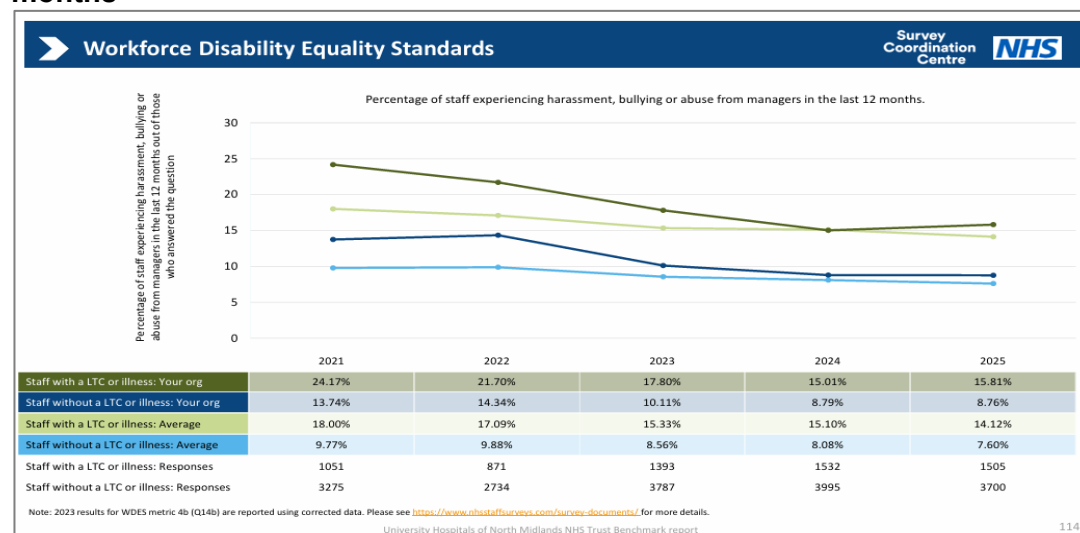


Whilst the levels of abuse experienced by colleagues is unacceptably high, this year's figure is our best performance for colleagues with a disability/LTC since we began reporting the WDES and is better than our peer comparator group for the second consecutive year.

Nationally 29.6% of disabled colleagues and 23.4% of non-disabled colleagues reported experience of harassment, bullying and abuse from patients/service users, their relatives or public in the previous 12 months. (source: WDES Data Report 2025)

WDES Indicator 4a

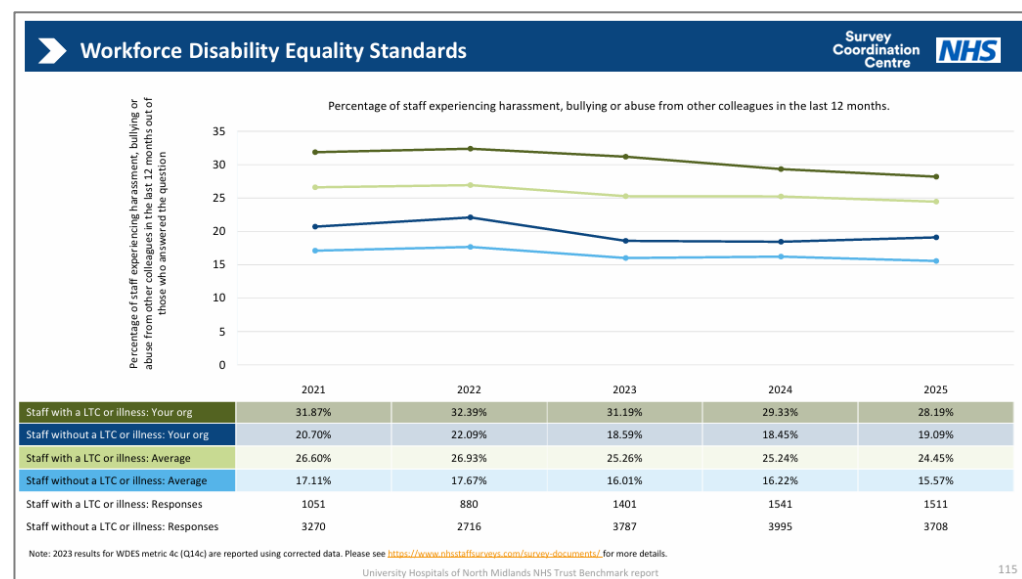
Percentage of staff experiencing harassment, bullying or abuse from managers in the last 12 months



This year's performance has deteriorated by 0.8%. The most recent national data shows that 13.9% of disabled and 7.6% of non-disabled NHS staff reported receiving harassment, bullying or abuse from managers in the previous 12 months.

WDES Indicator 4a

Percentage of staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months

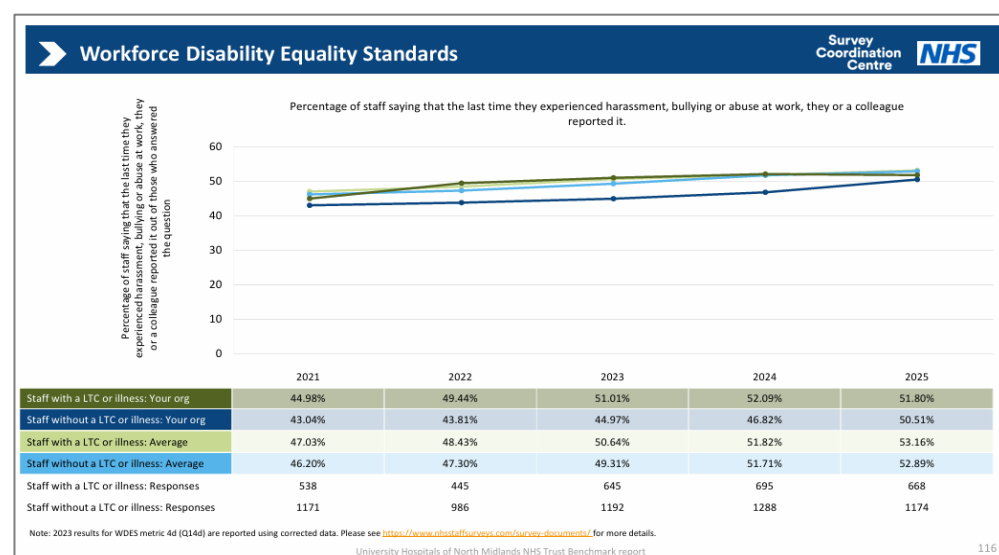


There has been an improvement in this indicator of 1.14%, and the gap between the experiences of colleagues with a disability/LTC and staff without is less than 10 percentage points for the first time. Our performance is worse than the National Staff Survey peer comparator group for all colleagues.

The national data from the most recent WDES Report shows that 23.4% of disabled and 15.1% of non-disabled colleagues report experience of harassment bullying or abuse from colleagues in the last 12 months.

WDES Indicator 4b

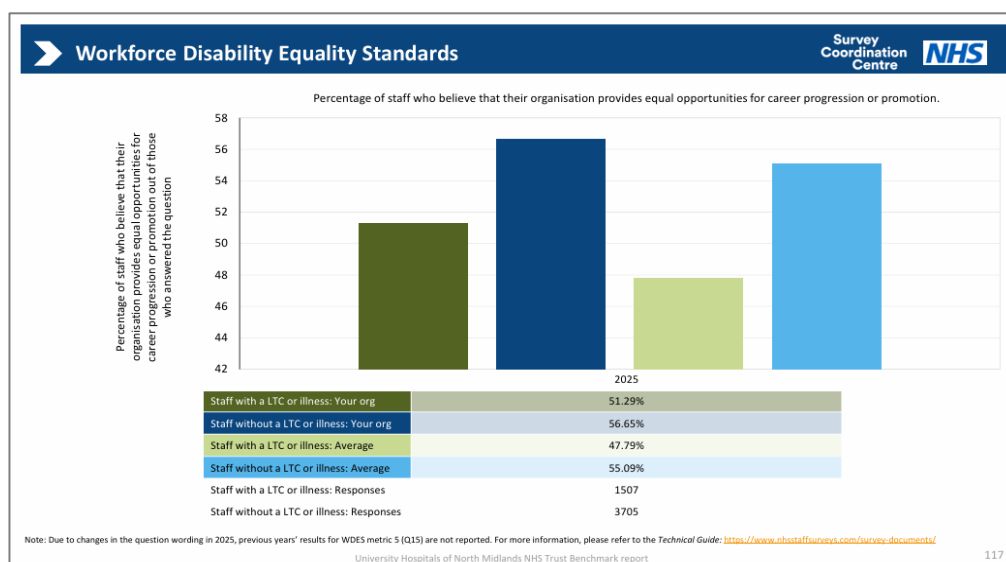
Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it



Whilst the percentage of colleagues with a disability or long term condition saying that they have reported their experience of harassment, bullying or abuse at work has slightly deteriorated, there has been a notable increase in the number of non-disabled colleagues reporting experiences.

WDES Indicator 5

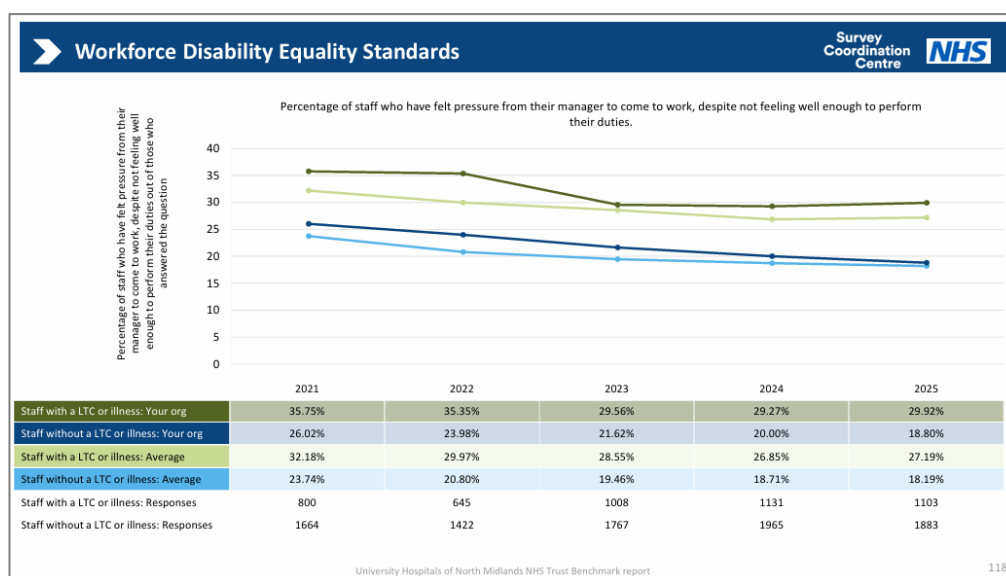
Percentage of staff who believe that the organisation provides equal opportunities for career progression or promotion



The wording of this question was changed for the 2025 national staff survey. Our performance for colleagues with a disability/LTC (and those without) is better than our NSS peer comparator group. The gap between disabled and non-disabled colleagues is also positively narrowing.

WDES Indicator 6

Percentage of staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties

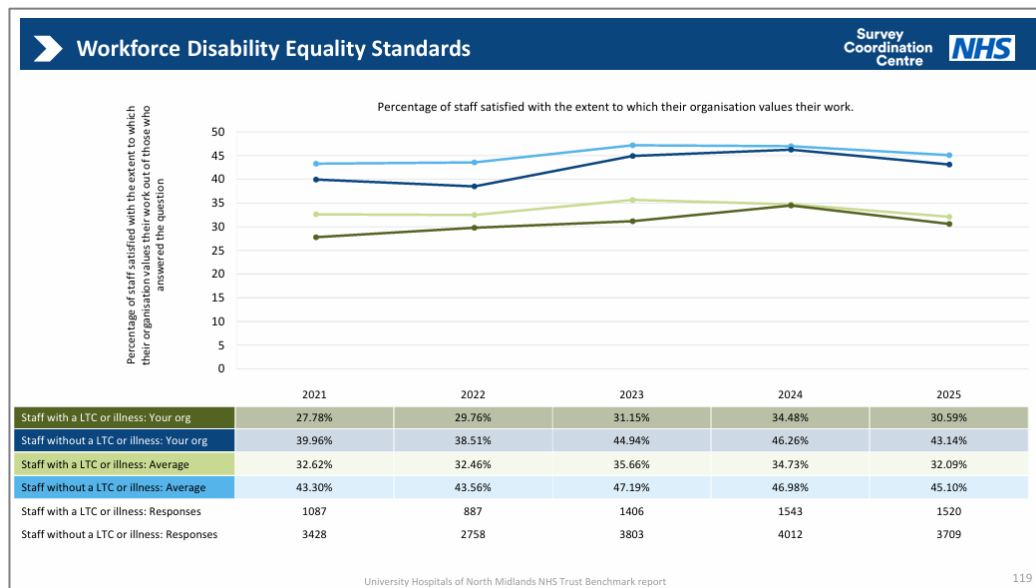


This year's data shows a stable position for disabled colleague experience of feeling pressure from their manager to come to work despite not feeling well enough to perform their duties (known as presenteeism). The difference between the experiences of colleagues with a long term condition compared to those who do not, has deteriorated at 11%.

The performance is worse than the average for our NSS peer comparator group, and the national data from the 2025 WDES Report which shows that 25.3% of disabled colleagues felt presenteeism.

WDES Indicator 7

Percentage of staff satisfied with the extent to which the organisation values their work



This indicator has deteriorated by nearly 4% on the previous year and also fallen for colleagues without a disability or long term condition. Our peer group averages have also deteriorated.

WDES Indicator 8

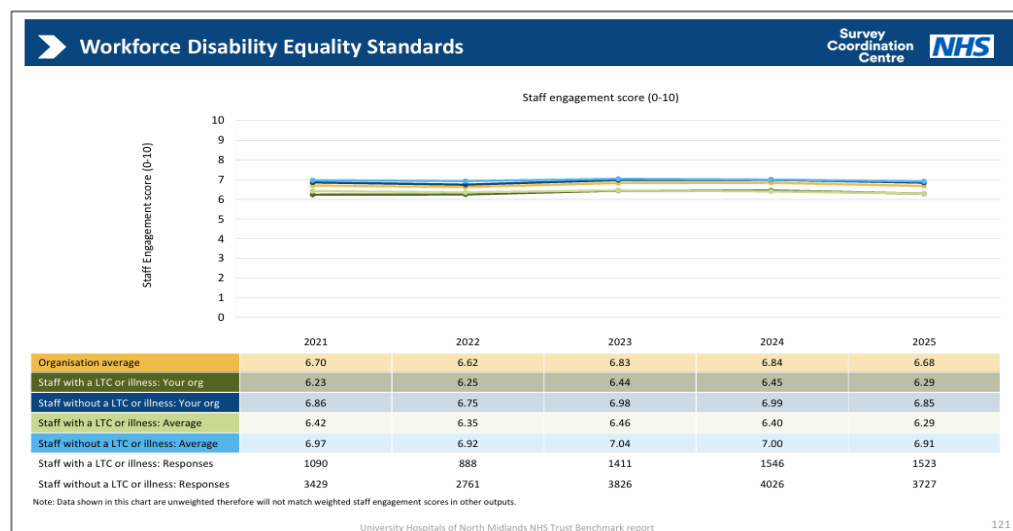
Percentage of staff with a long lasting health condition or illness saying the organisation has made reasonable adjustments to enable them to carry out their work



This metric has improved by 1.8% and for the first time is better than our NSS comparator group (73.65%). The national WDES average was 75.3%.

WDES Indicator 9

Staff Engagement Score



Whilst this indicator has deteriorated for all colleagues, for colleagues with a disability/LTC our score matches our peer average at 6.29

WDES Indicator 10

Percentage difference between the organisations board voting membership and the overall workforce

Boards are expected to be broadly representative of their workforce. 6.25% of the UHNM board have a disability according to ESR, giving a percentage difference between the board and the overall workforce of -0.4%. The national average percentage difference between boards and their overall workforce in 2025 was +0.7.

Summary and Actions

The 2026 WDES demonstrates a mixed picture of progress and persistent inequality for disabled colleagues. There are encouraging signs of improvement in disability disclosure, recruitment outcomes, career progression perceptions and workplace adjustments, with several indicators performing at or above our peer benchmark levels. However, disabled colleagues continue to experience poorer workplace outcomes than non-disabled colleagues, particularly experiences of bullying and harassment, presenteeism, and feeling valued at work. The data suggests that while many of the organisation's systems and processes are improving, disabled colleagues are not yet experiencing equitable outcomes or day-to-day working experiences.

During the next 12 months we will take forward the following actions:

	Reasonable Adjustments	Disability Career Progression	Presenteeism
Action	- Focus on neurodivergence awareness - Targeted action in teams with poorer NSS satisfaction responses regarding workplace adjustments	- Monitor progression rates by disability status - Increase support for disabled colleagues aspiring to senior roles - Promote flexible working in senior roles	Improve manager understanding of: - Recognising signs of presenteeism - Understanding the impact of long-term conditions and fluctuating disabilities. - Having supportive wellbeing conversations - Understanding when a flexible approach to attendance management can be applied as a reasonable adjustment

Executive Summary

Trust Board (Part 1) | 7th October 2026

Equality, Diversity and Inclusion Annual Report 2025-26

Purpose:	Information	Approval	Assurance ✓	Agenda Item:	13.
Author:	Charlotte Lees, OD, Culture and Inclusion Business Partner / Sadaf Butt, OD Consultant				
Executive Lead:	Jane Haire, Chief People Officer / Ann Marie Riley, Chief Nurse				

Alignment with our Strategic Priorities

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

Risk Register Mapping

BAF 3	Inability to improve workforce sustainability and organisational culture	Ext 15
<i>Cause:</i>	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,	
<i>Event:</i>	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,	
<i>Effect:</i>	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.	

Executive Summary

Situation

UHNM has continued to strengthen its commitment to Equality, Diversity and Inclusion (EDI) during 2025/26, embedding EDI across workforce, patient care and community engagement activities. Significant progress has been made in developing inclusive policies, strengthening staff networks, improving accessibility, and increasing engagement with underrepresented communities. Initiatives such as the anti-racism programme, reciprocal mentoring, neurodiversity support, sexual safety framework, accessibility improvements and targeted community outreach demonstrate a sustained organisational focus on reducing inequalities and improving experiences for both colleagues and patients.

At the same time, workforce and patient data show that inequalities remain. Whilst representation of global majority colleagues has improved and positive progress has been seen in disability inclusion, disparities persist in recruitment, career progression, workplace experiences, bullying and harassment, and workforce disclosure rates. Wider health inequalities also continue to affect access, experience and outcomes for some communities.

Background

EDI remains a strategic priority for UHNM and is underpinned by the Equality Act 2010, Public Sector Equality Duty, NHS EDI Improvement Plan and a range of national assurance frameworks including WRES, WDES, and pay gap reporting requirements. UHNM's approach is informed by workforce and patient data, engagement with staff networks, patient groups and community partners, and is aligned to the Trust Strategy 2025-2035.

During 2025/26, the Trust delivered a broad programme of activity to promote inclusion and tackle inequalities. Key achievements included:

- Strengthening anti-racism governance, developing new anti-racism resources, and training.
- Launching a Sexual Safety Support Service and Sexual Misconduct Policy.
- Expanding support for disabled and neurodivergent colleagues through toolkits, disability champions and staff networks.
- Delivering reciprocal mentoring and inclusive leadership initiatives.
- Enhancing accessibility for patients through learning disability services, accessibility improvements, interpretation support and co-production.
- Increasing engagement with diverse communities to address health inequalities and improve access to care.

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	

UHNH has demonstrated strong commitment and visible progress in its obligations under the Public Sector Equality Duty, through embedding EDI across organisational culture, workforce practices and patient care. Governance arrangements, colleague and patient engagement mechanisms and community partnerships have matured, providing a stronger foundation for sustainable improvement. Staff networks continue to play a significant role in influencing policy, supporting colleagues and shaping organisational priorities

Key Recommendations

People, Culture and Inclusion Committee has approved this report, its recommendations below and its acceptable assurance rating. Trust Board is asked to note this annual report and take positive assurance of the ongoing work and commitment to advancing equity and inclusion at UHNH for our workforce, patients and communities. Recommendations for 2026-27:

1. Strengthen anti-racism

- Implement the NHS England Mann Review recommendations.
- Embed the NHS Staff Standard on anti-racism.

2. Disability and neurodivergence inclusion

- Expand reasonable adjustment support and ensure consistent implementation across all services.
- Build manager capability to support disabled and neurodivergent colleagues effectively.

4. Accessible and equitable patient care

- Continue co-production with patients and communities in service redesign.
- Monitor patient experience and outcomes across protected characteristics to identify and address inequalities.

5. Community partnerships to reduce health inequalities

- Use community insight to shape prevention, screening and early intervention programmes.
- Further develop the Patient and Public Engagement Council as a strategic mechanism for community influence.

6. National requirements

- Implement the new NHS Staff Standards.
- Respond to evolving Equality and Human Rights Commission (EHRC) guidance regarding single sex facilities

Equality, Diversity and Inclusion

Annual Report 2025-26



Introduction

At University Hospitals of North Midlands NHS Trust, advancing equality, diversity and inclusion (EDI) is a strategic priority and a core component of delivering high-quality, equitable care for our patients, positive experiences for our colleagues, and meaningful engagement with the communities we serve. This annual report outlines our progress over the past year, providing transparency on where improvements have been made, where inequalities persist, and the actions being taken to address them.

Throughout the year, we have continued to strengthen our governance arrangements, embed inclusive practices, and align our work with national priorities, including the NHS Equality, Diversity and Inclusion Improvement Plan. Through robust analysis of patient and workforce data we have identified areas of inequity, monitored progress and prioritised targeted interventions to improve outcomes for colleagues and patients.

This report highlights how the insights and experiences of our patients, communities, staff networks and colleagues inform our priorities, shape our decision-making and support the delivery of meaningful and sustainable change. While progress has been made, we recognise that further work is required to address longstanding inequalities and ensure equitable opportunities, experiences and outcomes for all.

Legal Requirements The Equality Act 2010:

This places key duties on statutory organisations that provide public services, like the NHS. It protects people from unfavourable treatment and discrimination and refers to people with the following protected characteristics:



How we show due regard to the Public Sector Equality Duty

In addition to the Equality Act, The Public Sector Equality Duty (PSED) requires public bodies to have due regard to the need to:

- eliminate discrimination, harassment and victimisation
- advance equality of opportunity between people who share a protected characteristic and those that do not
- foster good relations between people who share a relevant protected characteristic and those who do not

Assurance is provided to our Trust Board via the following Equality, Diversity and Inclusion (EDI) frameworks:

- Workforce Race and Disability Equality Standards
- Gender, Ethnicity and Disability Pay Gap
- Accessible Information Standard
- Equality Delivery System (EDS)
- Disability Confident Accreditation
- Armed Forces Covenant

You can read these reports, which provides a more in depth update on progress against key metrics and action plans, on our Equality and Diversity page on the [Trust Website](#).

Consultation and engagement

Meaningful engagement with colleagues, patients and communities is fundamental to the development and delivery of our equality, diversity and inclusion priorities. We are committed to ensuring that those with lived experience have opportunities to influence decision-making, shape our improvement plans and hold us accountable for delivering meaningful change.

We achieve this through ongoing consultation and co-production with our employee diversity networks, patient groups and community partners. Their insights help us to identify barriers, understand the impact of our actions, inform service and workforce improvements, and ensure our EDI priorities remain responsive to the needs and experiences of the diverse populations we serve.

Equality Monitoring

Good quality data enables us to identify priorities and measure our effectiveness. Over recent years we have significantly improved the number of employee and patient records where demographic information is not stated. We will continue to actively encourage our workforce and patients to share this information.

The best joined-up care for all

Equality Impact Assessment

All public bodies have a statutory duty to set out arrangements to assess and consult on how their policies and services impact on equality. We have a well-established pathway for the approval of procedures and policies which include the review of Equality Impact Assessments and Action Plans (where applicable). A Quality Impact Assessment similarly reviews impacts of significant changes to services we provide.

UHNM Strategy 2025-2035

Our strategy guides our priorities for the next ten years. Our ambition is to be a leader in health by harnessing innovation to drive transformational change. We are dedicated to investing in our people, improving the health and wellbeing of our community, delivering safe and patient centred care, and advancing services through research, innovation and education.

Every day we will work together to make a positive difference to the lives that we serve.



Our Values

The Trust relaunched its Values Recognition Scheme to celebrate and recognise colleagues who consistently demonstrate UHNM's values through their everyday actions and behaviours. The scheme provides an opportunity for staff to acknowledge individuals and teams who go above and beyond in delivering compassionate care, working collaboratively, and striving for excellence.

This aligns with UHNM's commitment to creating a workplace where everyone is respected, valued, and empowered to contribute their best.



NHS EDI Improvement Plan

The NHS Equality, Diversity and Inclusion (EDI) Improvement Plan provides a national framework for creating a more inclusive, equitable and compassionate NHS. Through six high-impact actions, it aims to address inequalities, reduce discrimination, strengthen inclusive leadership and improve accountability. The plan reinforces the expectation that EDI is embedded within organisational culture, workforce experience and the delivery of high-quality patient care.

Our People



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

In this section we highlight the activities undertaken during the year to meet our strategic priority areas for workforce development, focusing on creating an inclusive, diverse and supportive environment where all staff can thrive and contribute to the delivery of excellent care.

Anti-Racism

The Race Equality Task and Finish Group has continued to drive UHNM's anti-racism agenda through monthly meetings and targeted improvements. During 2025/26, the group co-produced Multilingual Voices guidance with the Ethnic Diversity Network, developed a bespoke anti-racism training programme following specialist training for two clinical colleagues, and commissioned Cultural Ambassadors training to support inclusive recruitment practices.

Progress has also included strengthening EDI oversight within employee relations decision-making processes and preparing the launch of cultural awareness and intercultural communication e-learning to further promote an inclusive workplace culture.

UHNM Anti-Racism Conference

To mark Show Racism the Red Card Day, UHNM hosted an Anti-Racism Conference which brought together colleagues and



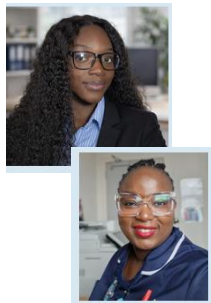
partners to accelerate progress on racial equality. The event showcased expertise and lived experience from UHNM, Staffordshire Police, North Staffordshire Combined Healthcare NHS Trust and Uniting Staffordshire Against Hate (USAH), fostering meaningful dialogue, strengthening partnerships and inspiring action to create more inclusive, equitable and anti-racist workplaces and communities.

Ethnic Diversity Staff Network Leadership

The Ethnic Diversity Staff Network welcomed Chabala Kapoya and Jokotade (Joko) Adeshina as its new Co-Chairs, marking an exciting new chapter for the Network.

As Co-Chairs, Chabala and Joko are committed to increasing the visibility and impact of the Network, encouraging greater staff engagement, and ensuring colleagues from ethnically diverse backgrounds feel seen, heard, and valued.

Joko's own experience of finding support, mentorship, and development opportunities through the Network has strengthened her passion for equity and inclusion, while Chabala is focused on fostering meaningful engagement and amplifying the voices of colleagues across the Trust.



Sexual Safety

This year we launched a new Sexual Safety Support Service, with 18 trained Sexual Safety Liaison Supports now in place across the organisation.

The team will provide vital support across UHNM, offering a compassionate and supportive space for staff to talk and seek guidance. The liaison supports can offer a safe, supportive and informed space where staff can talk through concerns, explore options and receive guidance on possible next steps. Each member of the new liaison support team has completed specialist accredited training equipping them with the skills, knowledge and confidence to provide compassionate, trauma-informed support to colleagues affected by sexual misconduct.

Jenny Birch, sexual safety liaison officer, said: “ We understand that coming forward can feel difficult. People may need time, reassurance and clear information before deciding what, if any, steps they wish to take. Our liaison supports are there to listen without judgement, helping colleagues understand their options and feel empowered to make informed choices.



In addition, we launched the Sexual Misconduct Policy, reinforcing a zero-tolerance approach to sexual misconduct and setting out clear behavioural expectations, reporting routes, and processes for raising concerns. The policy strengthened protections for those who speak up and reaffirmed the Trust's commitment to handling concerns promptly, fairly and with respect.

Disability Staff Network wins Inclusion Award

The Disability and Long Term Conditions Staff Network was proudly recognised at UHNM's annual staff awards, A Night Full of Stars, where it received the Inclusion Award in recognition of its outstanding contribution to disability inclusion across the Trust. This achievement celebrates the Network's leadership in driving meaningful change, including co-producing the Reasonable Adjustments Policy, establishing a team of peer Disability Champions, and championing greater disability awareness. Through its dedication and influence, the Network has helped create a more inclusive, accessible and supportive workplace.



Neurodiversity Toolkit and Support Network



UHNM launched a Neurodiversity Toolkit to support line managers and colleagues in creating more neuro-inclusive workplaces. The toolkit provides practical guidance on reasonable adjustments, inclusive communication, and supporting neurodivergent colleagues, including those with autism, ADHD, dyslexia and other forms of neurodivergence.

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UHNM Reciprocal Mentoring Programme



We successfully launched the third cohort of our Reciprocal Mentoring Programme. Reciprocal Mentoring is a partnership where colleagues learn from one another, sharing experiences, perspectives and insights to promote inclusive leadership and organisational learning.

Building on the success of previous cohorts, the initiative continues to create opportunities for meaningful dialogue, helping leaders better understand the lived experiences of staff and ensuring diverse voices help inform organisational culture and decision-making.

Transgender Inclusion Training

In partnership with Project93 and the UHNM LGBTQ+ Staff Network, UHNM delivered Transgender Inclusion Training for patient-facing colleagues.

The programme combined an online learning module with a half-day face-to-face session, designed to enhance understanding of transgender inclusion and support colleagues in delivering inclusive, respectful, and person-centred care. The training formed part of the Trust's ongoing commitment to improving equality, diversity, and inclusion for both staff and patients.



Chill and Spill: Groundbreaking men's staff health group launches at UHNM

We continued to strengthen our commitment to staff wellbeing through the development of the Men's Health Group, which was established in June 2023.

The group launched the first 'Chill and Spill' session at the Royal Stoke site, attended by over 40 colleagues from the Estates workforce. The initiative provides a supportive space for open conversations about wellbeing, self-care and mental health, contributing to UHNM's commitment to inclusion, psychological safety and staff wellbeing.



NMAHP Inclusion Conference: Every Voice Matters



As part of National Inclusion Week, UHNM hosted the Nursing, Midwifery and Allied Health Professionals (NMAHP) Inclusion Conference: Every Voice Matters.

The event focused on inclusive leadership and creating environments where all colleagues feel heard, valued, and empowered, reinforcing UHNM's commitment to inclusion and belonging across the clinical workforce.

UHNM Cultural and Events Calendar

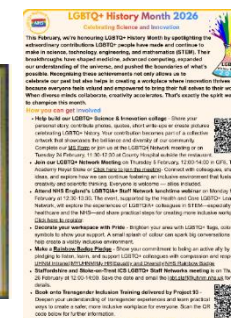


The UHNM annual Cultural and Events Calendar promotes key religious, cultural and awareness events throughout the year. The resource supports colleagues and patients in recognising and celebrating diversity.

Over the following pages we highlight some of the key events we have celebrated over the past year:

LGBTQ+ History Month

We marked LGBTQ+ History Month 2026 by celebrating the contributions of LGBTQ+ individuals to science, technology, engineering, and mathematics (STEM), while promoting the role of diversity and inclusion in driving innovation and progress. Colleagues also contributed to a collaborative collage featuring personal stories, lived experiences, and creative artwork, showcasing the resilience, achievements, and creativity of LGBTQ+ colleagues and allies across the Trust.



National Inclusion Week

UHNM strengthened its commitment to equity, belonging and respect across the Trust. Activities throughout the week encouraged reflection, learning and engagement, while recognising teams nominated for the Inclusion Award for their outstanding commitment to creating inclusive environments where everyone feels valued, heard and empowered to be their authentic selves.



International Women's Day

To mark International Women's Day 2026, UHNM hosted a Purple Power Day event that brought colleagues together to celebrate the achievements of women, promote gender equity, and strengthen networks across the organisation.

A Digital Thank You Wall provided an Opportunity for staff to acknowledge female colleagues who had made a positive impact.



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Staff and partners come together for Iftar event supporting UHNM Charity

UHNM colleagues and community partners came together for an Iftar event at Royal Stoke University Hospital, raising funds for the Children's Oncology Service. The event provided an opportunity for colleagues and partners to break the fast together, strengthen community connections, and increase understanding of local services while celebrating the values of inclusion, partnership and cultural diversity.



Celebrating VE Day 2025

Colleagues across UHNM marked the 80th anniversary of VE Day, recognising the service and sacrifice of Armed Forces personnel, veterans and reservists, and reflecting on their continued contribution to our organisation and communities.

Remembrance Day 2025

Members of UHNM's Armed Forces Community attended Services of Remembrance at both Trust sites on 11 November 2025. Colleagues gathered to observe a two-minute silence and honour those who have served and continue to serve in the Armed



Forces, reinforcing the Trust's commitment to supporting its Armed Forces community.

The Chaplaincy Team led inclusive Remembrance Day services across both hospital sites, bringing together staff, patients, carers, veterans, reservists, local schools, and community representatives. These events provided an opportunity for collective reflection, recognition, and remembrance, promoting community cohesion, mutual respect, and a shared commitment to peace.

Wendy Nicholhson, Non-executive Director reflected on the service. *The service was such a humbling and uplifting experience: I was delighted to be asked to be part of the Trust remembrance service. The service brought together so many staff members, patients, families and our armed forces to remember and to be proud of our loved ones. It was a remarkable experience. Whilst we waited for the service to begin, I was fortunate enough to speak with so many people who shared their experiences and journeys - some with a heavy heart, but all with pride, compassion and hope.*

I heard from those who had suffered loss, and those who were serving or had served. Catching glimpses of people's remarkable contributions was humbling, the camaraderie and kinship was palpable. ...I spoke to so many people - who were generous in sharing their stories and achievements. We were also treated to a further impromptu performance from the Fijian choir members over coffee and cake!

Equality, Diversity and Human Rights Week and National Staff Networks Day

UHNH marked Equality, Diversity and Human Rights Week and National Staff Networks Day, celebrating our commitment to inclusion and the vital role of Staff Networks in driving positive change.

Throughout the week, activities highlighted key topics including neurodiversity, allyship, cultural diversity, emerging legislation and sexual safety, while encouraging colleagues to engage with networks, access support and contribute to creating a more inclusive workplace for all.

Black History Month

During Black History Month 2025, we celebrated the achievements, resilience and contributions of Black communities through activities aligned to the themes "Standing Firm in Power and Pride" and "Building Futures from the Past." The month encouraged learning, reflection and conversation, supporting our ongoing commitment to an inclusive workplace for all.

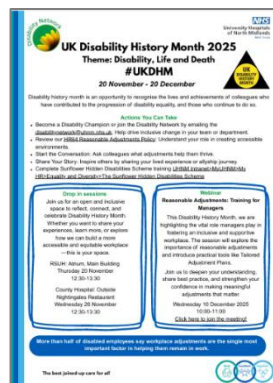


Pride 2025 and Stoke-on-Trent Pride Parade

UHNM celebrated Pride Season 2025 through a range of activities promoting LGBTQ+ inclusion, visibility and belonging. Colleagues participated in Pride-themed events, the NHS Rainbow Badge initiative, and awareness activities, while UHNM's involvement in Stoke-on-Trent Pride demonstrated our commitment to equality, diversity and inclusion within both the Trust and the wider community.



Disability History Month:



UHNM marked Disability History Month by raising awareness of disability inclusion and celebrating the valuable contributions of disabled colleagues. A key focus was the Trust-wide Reasonable Adjustments campaign, which strengthened understanding of inclusive practice and reinforced our commitment to providing an accessible and supportive working environment.

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South Asian Heritage Month Celebration

We celebrated the rich culture, contributions, and lived experiences of colleagues with South Asian heritage. The event recognised the significant contribution of the South Asian community to public service and was delivered in partnership with University of Staffordshire, Staffordshire Police, Staffordshire Fire and Rescue Service, and UHNM.

The celebration provided an opportunity for colleagues and partners to come together, share experiences, and acknowledge the diversity that strengthens both our organisations and the communities we serve.



Windrush Day



Our Ethnic Diversity Staff Network marked Windrush Day by celebrating the contributions of the Windrush Generation and promoting awareness of their lasting impact on the NHS, our workforce and wider society.



Diversity Connections

UHNM launched Diversity Connections, a new staff support group delivered in partnership with PEGiS (Parent Engagement Group in Stoke).

The group was established to provide advice, support, and local expertise for colleagues navigating autism, neurodivergence, learning disabilities, and Special Educational Needs and Disabilities (SEND). Meeting monthly, the initiative created a supportive space for staff to connect, share experiences, and access guidance, further strengthening UHNM's commitment to inclusion and colleague wellbeing.

Maternity colleagues sign the Caring for You Charter

This year our colleagues across Maternity celebrated #InternationalDayOfTheMidwife by signing the Royal College of Midwives 'Caring For You Charter' which aims to improve the wellbeing, health and safety of maternity staff. By signing the charter, UHNM commits to:

- Promoting a positive and inclusive culture at work
- Implement action plans to solve problems
- Provide a safe and healthy working environment
- Nurture new starters
- Listen and act on feedback

Celebrating with nurses and their teams: International Nurses Day Service



To mark International Nurses Day 2025, UHNM hosted a creative wellbeing initiative alongside its annual service at Stoke Minster. Colleagues, patients and family members were invited to decorate wooden tiles, which were brought together to form a heart-shaped display, reflecting the theme: "Caring for yourself enables you to care for others."

Spiritual Care for Colleagues

Chaplaincy services continued to provide valuable support to staff across UHNM, with 261 significant support encounters recorded during 2025/26. Support was provided for spiritual distress, bereavement, work-related challenges, illness and pastoral care, helping colleagues navigate personal and professional challenges while recognising the impact of wider global events on staff wellbeing.

Development of Mosque Facilities

Enhancements to the RSUH Mosque have strengthened the support available for colleagues' spiritual wellbeing. Delivered through a collaborative effort involving staff



donations, UHNM Charities, Estates and the Chaplaincy Team, the project highlights the Trust's commitment to creating inclusive environments that meet the diverse needs of our workforce.

Some feedback: I just wanted to extend a heartfelt thank you for your thoughtful consideration in providing the Islamic bookshelf, notice board, mirror and fan on the women's side of the mosque. These additions were very much needed and truly appreciated. Your efforts and continued support mean a lot to us. I've also spoken with other regular attendees at the mosque who share the same gratitude.

We continued to meet all our statutory and regulatory reporting requirements in relation to EDI - including submitting our Workforce Race Equality Standard (WRES) Workforce Disability Equality Standard (WDES), Gender, Race and Disability Pay Gaps:

Workforce Race Equality Standard

30.9% of our workforce are Black, Asian or Minority Ethnic at 31st March 2026. This year's set of WRES metrics demonstrate mixed progress in the experiences of global majority colleagues. There has been improvements in representation in middle to upper pay bands and in the race disparity ratio (which measures career progression rates). However, experiences of harassment, bullying and abuse from patients, the public and other colleagues has deteriorated, as has the likelihood of ethnically diverse applicants being appointed from shortlisting, compared to white applicants.

Ethnicity Pay Gap: There is a positive pay gap in favour of global majority colleagues, this is because there is a greater proportion of global majority employees employed in the middle and upper pay quartiles

	2026
Mean pay gap	-24.5%
Median pay gap	-14.5%

Our latest Pay Gap Reports are available to read on the UHNM Website

Workforce Disability Equality Standard

The 2026 WDES results show improvement in the experiences of colleagues with disabilities and long-term conditions, particularly positive is the number of colleagues who feel that the organisation has provided the workplace adjustments needed to undertake their work. This reflects UHNM's sustained focus on workplace adjustments and embedding inclusive practices into policy and practice. Whilst 6.7% of colleagues have shared their disability status on the ESR system, nearly 30% of respondents to the 2025 National Staff Survey stated that they were working with a physical or mental health condition expected to last 12 months or longer.

Disability Pay Gap: There is a 13% pay gap, this is because the proportion of disabled people employed decreases as the pay bands increase.

	2026
Mean pay gap	13.5%
Median pay gap	12.8%

Gender Pay Gap

The Gender Pay Gap shows continued improvement.

The main factor in our gender pay gap is that there is a higher proportion of the male workforce working in higher pay roles.

	2026
Mean pay gap	24.5%
Median pay gap	7.1%

Our Patients



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

**In this section we showcase
the actions we have taken to
ensure we deliver accessible
services and person centred
care for our patients and
service users.**

UHNM Learning Disability Training Programme Shortlisted for National Award

A training programme, designed to improve the experiences of patients with learning disabilities and autism has been shortlisted for national award.

The UHNM Oliver McGowan Mandatory Training Programme has been named finalist in the Partnership Award for Co-Produced Training at this year's National Learning Disabilities & Autism Awards.



New Breast Care Unit at County Hospital

Ex-patients and members of the local community with accessibility needs were asked to support with the development of the new Breast Care Unit at County Hospital. They looked at the old unit, the plans for the new unit and the new unit once it was safe to visit and provided their feedback and insights on how the unit will look. Their feedback helped to make sure that the new unit was accessible, inviting and calming.

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Learning Disability Liaison Service

UHNM welcomed a new Learning Disability Liaison Nurse at Royal Stoke University Hospital, strengthening our commitment to improving the experience and outcomes of patients with a learning disability. The role supports the delivery of person-centred care, advocates for the needs of patients and their families, and helps ensure reasonable adjustments are in place to promote equitable access to services.



Lived Experience Input Supports Accessibility at New Community Diagnostic Centre

UHNM engaged Lewis Bunn, a lived experience trainer, to support the accessibility of the new Stoke-on-Trent Community Diagnostic Centre (CDC).

Through an early walkthrough of the facility, practical improvements were identified to help ensure the centre met the needs of wheelchair users and other patients with accessibility requirements. This work reflected the Trust's commitment to involving people with lived experience in the design of new facilities and addressing potential barriers before services opened to the public.



Spiritual, Pastoral and Religious Care Support

UHNM's Spiritual, Pastoral and Religious Care Service continued to provide compassionate, person-centred support to patients, families, carers and partners. During 2025/26, the team helped facilitate five emergency marriage and partnership blessing ceremonies, ensuring patients were able to honour important personal wishes and create meaningful moments with loved ones during challenging times.



Enhancing Inclusive End-of-Life Care

The Chaplaincy Team delivered cultural awareness training to the Medical Examiner Officer team, increasing understanding and confidence in supporting Muslim patients and families at the end of life.

Feedback highlighted the practical value of the session in improving communication with bereaved families and supporting culturally sensitive, person-centred care, contributing to the Trust's commitment to equality, diversity, and inclusion.

Dying Matters Awareness Week

UHNM marked Dying Matters Awareness Week by promoting open conversations about death, dying, and grief, with a focus on the cultural aspects of end-of-life care. The event brought together healthcare professionals, community partners, and support services to raise awareness of bereavement support, palliative care, and the importance of culturally sensitive approaches to caring for patients and families.



Accessibility and Inclusion Improvements

Listening to the experiences of our patients and communities has helped us make meaningful improvements to accessibility and inclusion. During 2025/26, we strengthened support for deaf and hard of hearing patients, improved the experience of prisoners attending outpatient appointments, and partnered with the Thomas Pocklington Trust to enhance accessibility for blind and partially sighted patients. Together, these actions are helping to create more inclusive services and improve equitable access to care for all. Some of the improvements include:

- Revised the Hospital Passport to make it shorter and easier to complete with a key focus on their communication needs and key health information
- Shared the information about how to put an accessibility alert on their patient record
- Created a video about PALS with subtitles and a British Sign Language interpreter
- Working on creating some step-by-step protocols for staff to follow when they have a patient who uses British Sign Language

We have also made improvements to the Friends and Family Test, with surveys now available in the most commonly spoken languages other than English to give those with language barriers the opportunity to give feedback on their experiences at UHNM.

Patient Stories:

“Please could you pass my sincere thanks and gratitude to the staff in A & E at County Hospital for the care and compassion shown to my son Michael on Good Friday. We arrived at the hospital by ambulance and only had to wait 10 minutes until we could go in. My son has learning difficulties and had suffered a grand mal fit whilst in Stone. From the moment we entered the Department he was treated with the utmost care and reassurance. All his tests were carried out very quickly and he was monitored the entire time. Special thanks to Kate who inserted his canula without difficulty but especially to Mark who

spent time with us before discharge and reassuring both Michael and myself. Thank you so much for the care”

“I'm writing to praise the staff members in the fracture clinic at UHNM (Stoke). Last Monday I visited with my mother who had fractured her wrist. My mother has dementia and gets very restless in new environments or when she is around new people. Without prompt or request, the staff in your fracture clinic quickly recognised that my mum was panicking and worked hard to keep her calm, moving us from the busy waiting area into a quieter side room. It was refreshing to see a department quickly identifying a patient's specific needs and working together to address them”

Patient and Public Engagement Council

We have been working on setting up the Patient and Public Engagement Council which will be made up of local patients and members of the public and will act as critical friends for the Trust by ensuring patients, carers, the public and key stakeholders are informed, involved and able to influence the Trust's work and strategic direction.

The group will provide a diverse forum to champion and promote patient and public involvement, shaping Trust strategy from a patient and community perspective while contributing to the planning of effective local health services

Our Population



We will tackle inequality and improve the health of our population

Here we demonstrate how we are tackling inequalities in access, experience and outcomes, whilst empowering our communities to improve their overall health

Community Engagement and Reducing Health Inequalities

The Patient and Public Involvement and Engagement (PPIE) function has strengthened relationships with a wide range of communities across Staffordshire and Stoke-on-Trent, including people with disabilities, faith communities, global majority groups, people experiencing homelessness and the prison population. Working collaboratively with VCSE organisations, NHS partners and Local Authorities, this engagement has helped ensure that the voices of underserved and underrepresented communities inform service improvement and decision-making.



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Outpatient Transformation Programme

Through ongoing engagement with community representatives, we have ensured that the experiences and needs of diverse patient groups help shape service improvements. Feedback has led to practical changes, including better identification of reasonable adjustments, more accessible communication options, and improved information for patients waiting for appointments. Together, these actions support fairer access to care and help reduce barriers for patients with disabilities, communication needs, and other factors that may contribute to health inequalities



Health and Wellbeing Event with the Local Sikh Community

UHNH partnered with local Sikh leaders, VAST, and community organisations to deliver a health and wellbeing event at Guru Nanak Gurdwara and Sikh Cultural Centre. The event promoted cancer screening, healthy lifestyles, and early detection, while providing attendees with access to health information, wellbeing support, and flu vaccinations for eligible individuals.



UHNM maternity bus offers vital early access to antenatal care, screening and vaccines in Stoke-on-Trent

Pregnant women across Stoke-on-Trent are being urged to access vital pregnancy screening, advice and vaccinations through the Trust's maternity bus bringing services directly into local communities.

The drop-in service offers advice and education on pregnancy, screening and vaccinations, with midwives and specialist teams on hand to answer questions and provide support.

The initiative is designed to reach communities who may find it harder to access traditional services, including those who face barriers such as transport, language or awareness of available support.

Rachael Heaven, community midwife, said: "We know that some people in our communities can find it harder to access maternity services, whether that's due to transport, language barriers or simply not knowing what support is available.

"We thought instead of bringing people to us, we would come to them. By being visible in places people already visit; women can hop onto the bus, get advice about pregnancy, have a vaccination, collect vitamins or simply have a friendly chat about their pregnancy and what to expect."



UHNM supports 26 young people from care into NHS careers in pilot partnership project



Through a national pilot programme, UHNM supported 26 young people who have experienced the care system to begin rewarding careers in the

NHS. In partnership with the Integrated Care System (ICS), opportunities were created across domestic services, ward assistant and catering roles at Royal Stoke University Hospital and County Hospital, Stafford, providing valuable employment, skills development and a pathway into long-term careers in healthcare .

UHNM Celebrates Seventh Cohort of Project SEARCH Graduates

A joint initiative between University Hospitals of North Midlands NHS Trust (UHNM), Newfriars College and Sodexo has celebrated student success for the seventh year in a row. Seven of the latest students graduated from the programme in July 2025 after completing a rotation of three placements at UHNM, with a number of the graduates gaining full time paid employment at the Trust.

The Project SEARCH programme at UHNM gives 18 to 24 year-olds with disabilities and learning difficulties the opportunity to work at Royal Stoke University Hospital and County Hospital, Stafford to gain vital experience to help with future employment prospects, independence and confidence.



Lung Cancer Screening in Stafford Prison

UHNM delivered its Lung Cancer Screening programme at Stafford Prison during the prison's Health and Wellbeing Day, offering eligible inmates and staff access to potentially life-saving lung health checks.

The initiative supports NHS England's drive to improve early detection of lung cancer among higher-risk populations. Eligible individuals aged 55 to 74 with a history of smoking were offered free lung health checks, helping to identify potential issues early and improve opportunities for timely treatment.



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Patient and Public Involvement and Engagement (PPIE) Drop-in Sessions

The UHNM Commercial Research Delivery Centre (CRDC) PPIE Team launched a series of PPIE Drop-in Sessions running from January to November 2026 to promote the effective involvement of patients and the public in research and innovation. Delivered via Microsoft Teams, the sessions provided opportunities for colleagues to share examples of PPIE in practice, discuss how PPIE can be embedded throughout the research lifecycle, learn about its role in project development, delivery and dissemination, and exchange experiences and ideas. Each session concluded with an open Q&A, supporting greater understanding and engagement with PPIE across the Trust.

Faith and Community Partnerships

UHNM's Spiritual, Pastoral and Religious Care Team continued to provide support to patients, families, and carers from a wide range of faiths and backgrounds. This included working closely with healthcare teams, prisons, and external faith leaders to ensure care was responsive to individuals' cultural and religious needs. The team supported patients and families with links to HMP Oakwood, HMP Dovegate, and other regional prison services, while also providing specialist support to the local Orthodox Jewish community through partnership working with clinical teams and community representatives.

Feedback highlighted the positive impact of this support during particularly challenging circumstances, with families expressing appreciation for the compassion, cultural understanding, and reassurance provided.



Chaplaincy services also strengthened broader community partnerships, working alongside faith leaders, hospices, community nursing teams, and other NHS organisations to facilitate culturally appropriate care and end-of-life support. Examples included connecting patients and families with faith leaders from diverse communities, ensuring spiritual and cultural needs were respected and supported throughout their care journey. These partnerships reinforced UHNM's commitment to delivering compassionate, inclusive, and person-centred care for all.

Smoke Free

From 1 April 2026, UHNM is completely smoke-free across all sites, meaning smoking is not permitted anywhere on Trust grounds, including car parks and outdoor areas.

Kimberly Perickathara, UHNM Tobacco Dependency Lead Nurse said: "We know quitting smoking is one of the best things you can do for your health. Our smoke-free commitment reflects our dedication to creating a healthier environment for everyone who uses our services. We're here to support patients and staff every step of the way."

Smoking is the leading cause of preventable illness and death in the UK, and by going smoke-free we're creating safer, healthier spaces for everyone—protecting patients, visitors and staff from harmful second-hand smoke while giving people the support they need to quit and enjoy better health and wellbeing.

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UHNM Launches Mobile Lung Cancer Screening CT Scanner to Enhance Accessibility Across the County



More people from Staffordshire are to benefit from early life-saving cancer detection following the launch of a mobile cancer screening CT scanner ensuring that Staffordshire and Stoke-on-Trent communities can access potentially lifesaving screenings close to home.

The mobile unit will provide lung cancer screenings, with a focus on early detection. This service aims to reach individuals who might not otherwise have the opportunity to access these life-saving screenings due to transport or financial reasons.

Dr Hussain, UHNM Clinical Lead for Lung Cancer Screening Programme, said: "We know that early diagnosis is key to improving cancer outcomes. By bringing this screening technology directly to the community, we are ensuring that more people have the chance to detect cancer at its most treatable stage."



Looking forward: Our priorities for the year ahead

This report celebrates the progress UHNM has made in advancing equality, diversity and inclusion, reflecting the commitment and dedication of colleagues, staff networks, leaders and patient and community partners.

At the same time, we recognise that inequalities continue to affect the experiences and outcomes of some colleagues, patients and communities. Against a backdrop of wider social, economic and health inequalities, and increasing diversity within both our workforce and population, there remains more to do to ensure everyone has equitable opportunities and experiences.

As we look ahead, our focus will remain on delivering our strategic priorities. Key equality, diversity and inclusion priorities for the coming year will include embedding the new NHS Staff Standards, implementing the Mann Review recommendations to strengthen our anti-racist approach, responding to evolving EHRC guidance on single-sex spaces and services, improving accessibility and inclusion for disabled people and those with long-term conditions and neurodivergence, and working with communities and partners to tackle health inequalities.

By strengthening accountability, listening to lived experience and working in partnership with our communities, we will continue to tackle inequality, promote inclusion and create a culture where everyone feels valued, respected and able to reach their full potential.

Progress will be tracked against defined KPIs, including patient satisfaction, the National Staff Survey, WRES and WDES and

Equality Delivery System outcomes, and equity metrics such as gender, ethnicity, and disability pay gaps.

Appendices

- Patient and Workforce Demographic Report

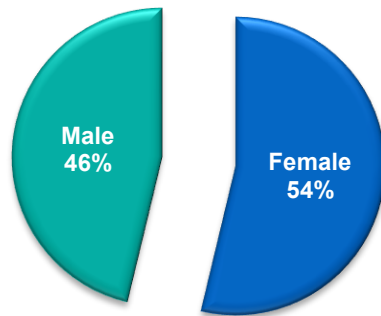
Contact:

For more information about Equality, Diversity and Inclusion please contact our Organisational Development, Culture and Inclusion Team at people.od@uhnm.nhs.uk

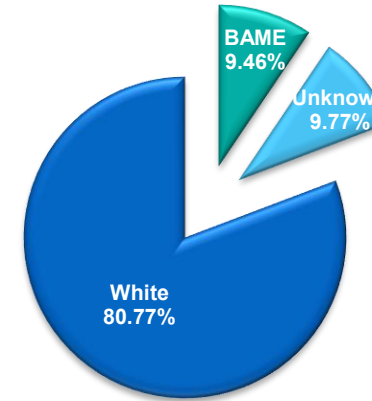


Appendix: Patient Demographic Information

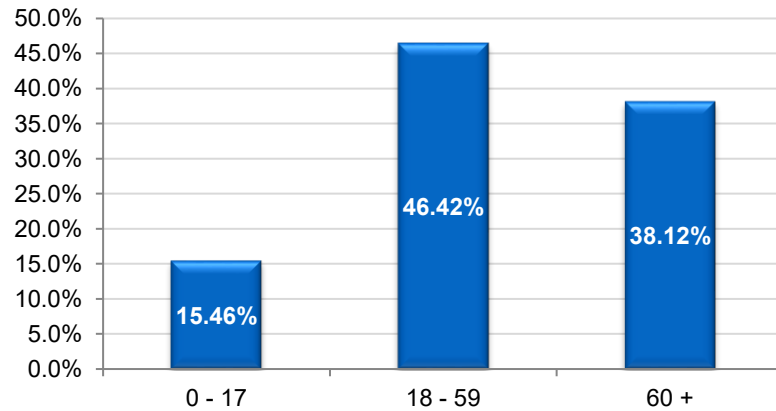
Patients by Gender



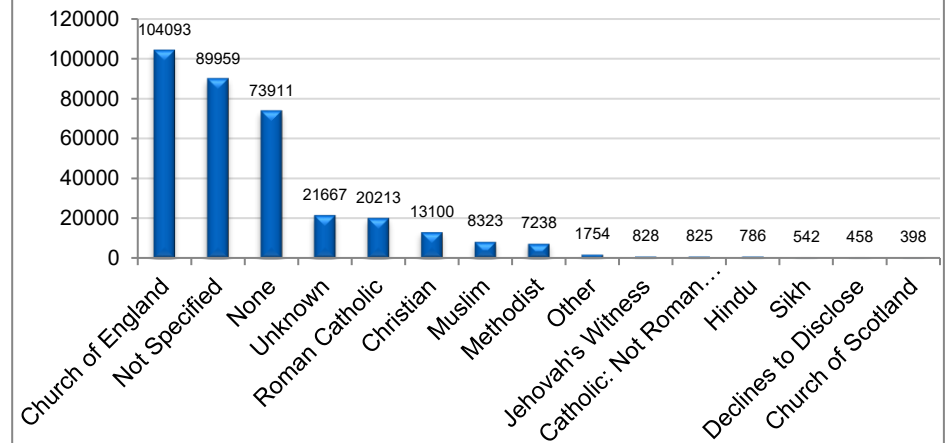
Patients by Ethnic Background



Patients by Age

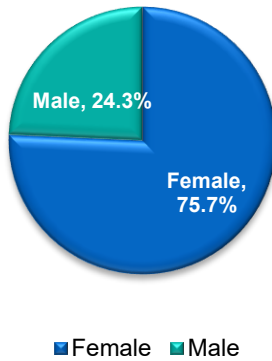


Patients by Religion or Belief (top 15)

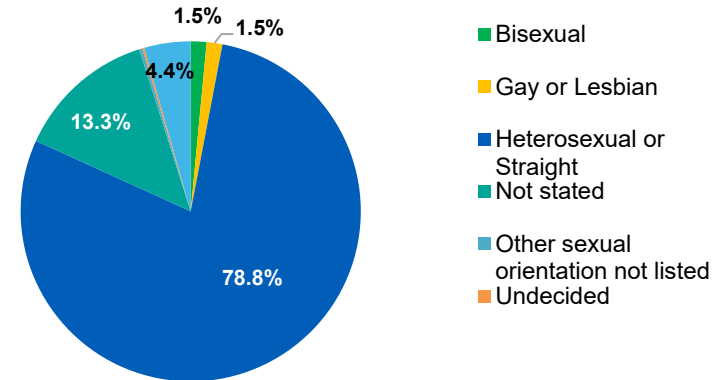


Workforce Demographic Information

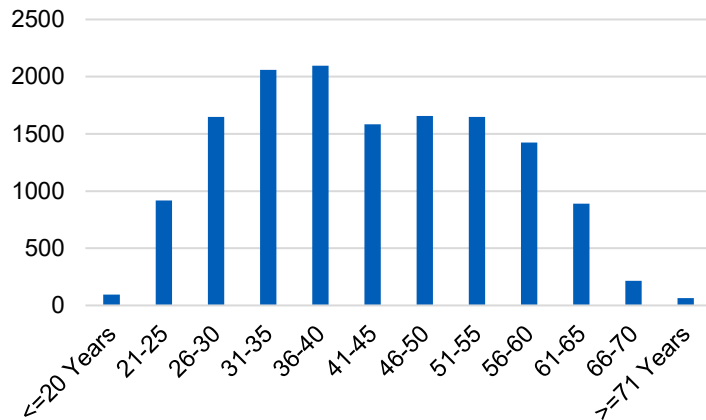
Workforce by Sex



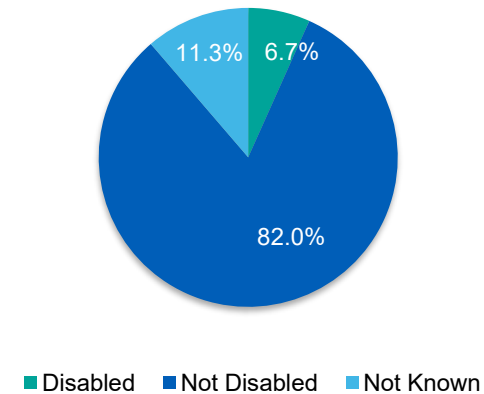
Workforce by Sexual Orientation



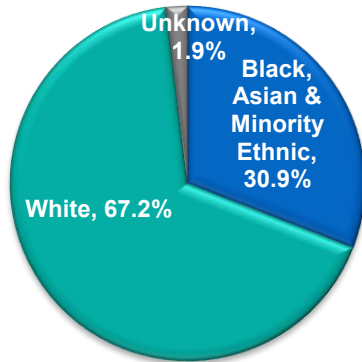
Workforce by Age Band



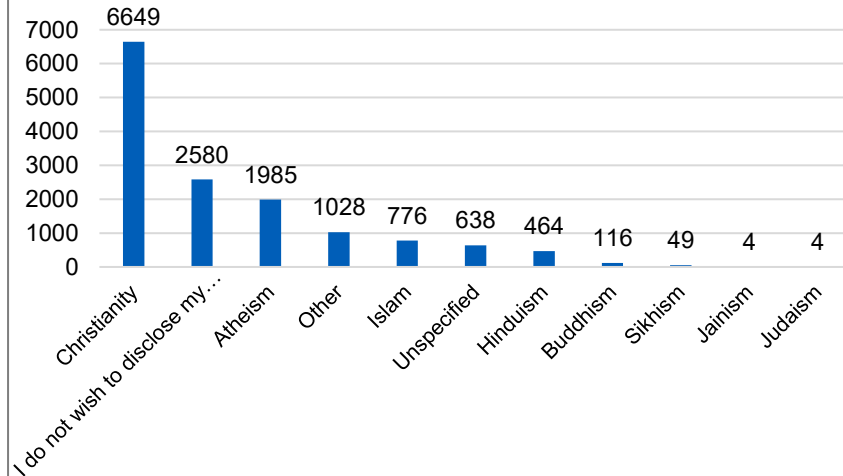
Workforce by Disability Status



Workforce by Ethnic Group



Workforce by Religious Belief



Executive Summary

Trust Board (Part 1) | 7th October 2026

Equality and Human Rights Commission Code of Practice 2026

Purpose:	Information	Approval	Assurance	✓	Agenda Item:	14
Author:	Charlotte Lees, OD, Culture and Inclusion Business Partner					
Executive Lead:	Jane Haire, Chief People Officer / Ann Marie Riley, Chief Nurse					

Alignment with our Strategic Priorities

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

Risk Register Mapping

BAF 3	Inability to improve workforce sustainability and organisational culture	Ext 15
<i>Cause:</i>	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,	
<i>Event:</i>	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,	
<i>Effect:</i>	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.	

Executive Summary

Situation

The Equality and Human Rights Commission (EHRC) introduced an updated [Code of Practice](#) for Services, Public Functions and Associations on 5 August 2026. The Code provides statutory guidance on how organisations delivering public services should comply with the Equality Act 2010. While it does not create new legal duties, it is admissible in legal proceedings and will be considered by courts and tribunals when assessing compliance with equality legislation.

The principal changes reflect the UK Supreme Court judgment in *For Women Scotland Ltd v Scottish Ministers* (2025), which determined that the terms "sex", "woman" and "man" within the Equality Act 2010 refer to biological sex. The Code also reaffirms protections for individuals with the protected characteristic of gender reassignment and provides updated guidance on the operation of single-sex and separate-sex services, ensuring decisions are evidence-based, proportionate and legally justifiable.

Background

As providers of both healthcare services and public functions, NHS organisations are required to consider the implications of the updated Code across clinical services, patient accommodation, intimate care, safeguarding arrangements and the provision of single-sex facilities. NHS providers, like UHNM will need to ensure that local policies align with the revised statutory guidance while continuing to uphold the rights, dignity and safety of all patients, service users and staff. Key implications for NHS organisations include:

- Review of policies relating to single-sex accommodation, changing facilities, toilets, and clinical care environments.
- Assessment of compliance with the Public Sector Equality Duty and wider Equality Act responsibilities.
- Updated guidance and training for managers and frontline staff to support consistent application of policy.

- Robust equality impact assessments and evidence-based decision making to mitigate legal and reputational risk.
- Continued commitment to inclusion, ensuring that all protected groups are treated with dignity, respect and fairness.

Assessment

The Trust's commitment to trans inclusion is reflected in our co-produced policies and established practices, informed by national guidance including the NHS Confederation's Leading for All: Supporting Trans and Non-binary Healthcare Staff and the Health and Care LGBTQ+ Inclusion Framework. These have helped shape our approach to creating an environment where trans colleagues, patients and service users are supported with dignity, respect and fairness, while ensuring the safety, privacy and wellbeing of all.

Partial assurance is our current assurance level reflecting that current policy needs to be reviewed and updated to reflect the revised Code of Practice. In addition, following the 2025 Supreme Court judgment, the NHS Confederation withdrew its Leading for All document and indicated that guidance would be reviewed in light of EHRC guidance.

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	

Key Recommendations

The Board is asked to note the publication of the updated EHRC Code of Practice (August 2026), which provides revised statutory guidance on the application of the Equality Act 2010 to services and public functions. The revised Code has implications for NHS providers, particularly in relation to single-sex services and facilities and requires organisations to review relevant policies and practices to ensure legal compliance while maintaining safe, inclusive and respectful environments for patients, service users and staff.

The Trust is establishing a Single Sex Steering Group, which will provide strategic oversight and assurance regarding the Trust's compliance with the Equality Act 2010, the updated EHRC Code of Practice for Services, Public Functions and Associations, and relevant NHS guidance. The group will oversee the review and implementation of policies relating to single-sex accommodation, facilities and services, ensuring that decisions are lawful, evidence-based and proportionate, while maintaining patient safety, dignity, privacy and inclusion. The Steering Group will support the Trust to balance the rights and needs of all protected groups, identify and mitigate organisational risks, and provide assurance to the Board that arrangements are compliant, consistent and aligned with best practice.

Highlight Report

QUALITY, ACCESS & OUTCOMES COMMITTEE | 2nd September 2026



University Hospitals
of North Midlands
NHS Trust

Matters of Concern / Key Risks to Escalate	Major Actions Commissioned / Work Underway
- The Committee received an update on the findings from the recent Care Quality Commission (CQC) inspection and the Trust's response, noting that CQC had been assured by the immediate actions taken and that no regulatory action was currently proposed. Members requested further assurance on urgent and emergency care sustainability, winter planning, Acute Medical Unit improvement actions and children's services governance. - The Committee received the Month 4 Access Performance report, noting continued pressure across urgent and emergency care, elective and diagnostic services due to sustained demand and reduced capacity during the summer period. Members were assured that recovery plans for RTT, diagnostics and cancer performance had been approved, with improvement trajectories in place and performance expected to recover during the remainder of the year. Partial assurance was agreed. - The Committee received an update on clinical effectiveness, noting progress in implementing actions arising from Get It Right First Time reviews, national audits and NICE guidance. Members welcomed the development of specialty-level clinical effectiveness indicators to strengthen oversight and received assurance that action plans were in place to address identified gaps, including those highlighted through child health audit activity. Partial assurance was agreed. - The Committee received the first standalone annual report from the Controlled Drugs Accountable Officer, which highlighted work to strengthen governance, prescribing oversight and assurance arrangements for controlled drugs. Members noted actions underway to address identified risks, including policy updates, enhanced theatre controls, improved investigation processes and benchmarking of prescribing practices against peer organisations. Partial assurance was agreed. - The Committee received an update on readmissions analysis which provided partial assurance. The improved head and neck readmission performance was noted, with the standardised readmission ratio reducing from 117 to 107 despite increased activity. Members requested further analysis of coding quality, patient demographics, discharge destinations and community support to better understand the remaining causes of readmission and identify opportunities to strengthen discharge planning.	Further analysis commissioned to assess the impact of closing corridor care spaces on patient safety across the wider system and to identify any unintended consequences. The Committee also requested explicit consideration of the risks associated with maintaining corridor closures within winter planning arrangements and the identification of sustainable mitigations.
Positive Assurances to Provide	Decisions Made
- The Committee received the Month 4 Quality Performance report, noting acceptable assurance, stable workforce metrics and continued assurance on patient access. While a number of quality indicators remained below target, members noted gradual improvement in several areas and received assurance regarding ongoing actions to address infection prevention, patient safety and quality performance concerns. - The Committee received a progress update on Paediatric Audiology, noting substantial improvement following the independent review, including completion of patient recalls, workforce training, preparations for IQIPS accreditation, estate improvements and strengthened digital systems. Members received acceptable assurance regarding the service's clinical leadership and governance arrangements and agreed that routine reporting could cease, subject to escalation of any significant findings arising from the final expert review and thematic harm analysis. - The Committee reviewed the Year 8 Learning Disabilities Improvement Standards national benchmarking results, noting areas of good performance and opportunities to strengthen patient involvement and the information provided to patients. Acceptable assurance was provided and members were advised that a detailed action plan will be presented later in the year, supported by the newly established Patient Council to drive improvements and enhance patient engagement. - The Committee received an update on the Maternity Escalation Warning Score (MEWS) action plan, noting progress across four workstreams covering screening, escalation arrangements, education and training, and audit and communication processes. Members were assured that implementation remained on track for March 2027 and requested a further update in December to confirm readiness and address any outstanding issues. - The Committee reviewed the revised Terms of Reference for the Maternity and Neonatal Quality and Outcomes Group and requested further refinement before approval. Members sought clearer arrangements for escalation of urgent issues, assurance reporting to Trust Board, engagement of the Maternity and Neonatal Voice Partnership (MNVP), and oversight of maternity and neonatal safety champion activity to strengthen governance and accountability.	No decisions were made.

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

Summary Agenda

No.	Agenda Item	BAF Mapping			Purpose	No.	Agenda Item	BAF Mapping			Purpose
		BAF No.	Risk	Assurance				BAF No.	Risk	Assurance	
1.	Quality Performance Report – Month 4 • CQC Update	1, 2, 9	Various	Acceptable	Assurance	6.	Paediatric Audiology Update			Acceptable	Assurance
2.	Access Performance Report – Month 4 • UEC Improvement Oversight Group Highlight Report – August 2026	9	Ext 16	Partial	Assurance	7.	Learning Disability Improvement Standards – Findings from Year 8 National Benchmarking Exercise			Acceptable	Assurance
3.	Clinical Effectiveness Update	1, 2, 8, 9	Various	Partial	Assurance	8.	Maternity Escalation Warning Score (MEWS) Action Plan Update			Not applicable	Information
4.	Controlled Drugs Accountable Officer Annual Report			Partial	Assurance	9.	Executive Maternity & Neonatal Quality & Outcomes Group Terms of Reference 2026/27			Not applicable	Approval
5.	UHNM Readmissions Analysis Update	1, 9	Ext 16	Partial	Assurance						

Highlight Report

QUALITY, ACCESS & OUTCOMES COMMITTEE (MATERNITY) | 9th

September 2026



University Hospitals
of North Midlands
NHS Trust

Matters of Concern / Key Risks to Escalate	Major Actions Commissioned / Work Underway
Partial assurance received on maternity and neonatal workforce sustainability. Midwifery vacancies have been recruited to and turnover remains low; however, workforce pressures remain within obstetrics and neonatal services, and further work is underway to strengthen specialist staffing, workforce diversity and targeted continuity of care for vulnerable populations. Partial assurance was received on implementation of the Maternity Care Bundle, with 36% compliance achieved to date. Progress was being made across all workstreams; however, delivery of early VTE assessment and prescribing remains dependent on primary care engagement and wider national solutions. Partial assurance was received on implementation of the national Maternity Triage Specification, with 92.6% of requirements fully or partially implemented. Key delivery risks relate to workforce, infrastructure and transition to a 24/7 open-access model, with full compliance expected by July 2027.	- Development of enhanced maternity assurance reporting, including clearer alignment to Ockenden and national maternity requirements, strengthened outcomes-based reporting, and improved visibility of health inequalities and vulnerable groups. - Escalation of national concerns regarding delivery of early VTE assessment and prescribing requirements, recognising that implementation is dependent upon primary care and wider system arrangements beyond the Trust's direct control. - Development of a maternity workforce inclusion approach to strengthen recruitment, retention and representation of staff reflecting the diverse communities served by UHNM. - Development of a coordinated communications approach to improve engagement with women and families, including communicating learning and improvements arising from maternity reviews and reaching seldom-heard groups. - Review of maternity estate requirements, including consideration of proposals to support future Maternity Assessment Unit (MAU) capacity and patient flow improvements.
Positive Assurances to Provide	Decisions Made
Quarter 1 maternity performance provided acceptable assurance, with all midwifery vacancies recruited, 100% sepsis compliance achieved and ongoing improvement work in relation to maternity care bundle compliance, continuity of care, maternity triage capacity and inequalities reporting. Significant assurance provided by the Perinatal Mortality Review Tool (PMRT) process, including 100% compliance with review requirements and high levels of family engagement. The Committee noted recurring themes relating to communication, interpreter use and domestic abuse enquiry and requested clearer reporting of improvement actions and partnership working. Acceptable assurance was received on delivery of the Infant Mortality Action Plan, with targeted actions in place to address smoking, maternal obesity, safer sleeping, early access and continuity of care. The Committee supported continued multi-agency implementation and wider system engagement to address health inequalities and reduce infant mortality. Acceptable assurance was received on maternity investigation and learning processes, with no new Maternity and Newborn Safety Investigation (MNSI) referrals or local Patient Safety Incident Investigations (PSIIs) reported in Quarter 1. The Committee noted ongoing MNSI investigations, infection prevention learning arising from neonatal case review and the continued use of Patient Safety Incident Response Framework (PSIRF) reviews to identify and monitor themes and improvement actions. Acceptable assurance was received that neonatal intensive care referrals were monitored through the neonatal dashboard and reviewed weekly by the multidisciplinary team, with established escalation processes in place to manage any emerging concerns. Acceptable assurance was received on delivery of the Maternity and Neonatal Ten-Point Plan, with 16 of 26 deliverables assessed as compliant and the remaining 10 partially compliant. The Committee supported the baseline assessment and requested future reporting demonstrate more clearly the impact of actions on outcomes and triangulate assurance with existing maternity performance measures. Significant assurance was received on compliance with the Saving Babies Lives Care Bundle, with 100% compliance maintained and no concerns identified through quarterly monitoring and audit arrangements. Acceptable assurance was received from the first Regional Perinatal Quality Group submission, which provides a consolidated overview of maternity and neonatal performance, workforce and improvement activity. The Committee supported efforts to streamline reporting requirements and emphasised the importance of balancing robust assurance with maximising clinical time for patient care. Acceptable assurance was received on delivery of the Neonatal Intensive Care action plan, with progress continuing against recommendations arising from the 2023 review. Workforce and quality capacity to support advanced neonatal care remain key areas of focus.	The Committee approved the maternity and neonatal 10 point plan and Regional Perinatal Quality Group Submission Q1.

- **Significant assurance** was received regarding **consultant attendance** in maternity services, with sustained improvement demonstrated over recent years and high compliance maintained. A small number of cases did not meet the newly introduced Maternity Early Warning Score (MEWS) immediate-attendance standard, and performance will continue to be monitored as the new process becomes embedded.
- **Acceptable assurance** was received on **patient experience** and co-production arrangements. Feedback from multiple sources continues to inform service improvement, with recent changes to maternity theatre practice implemented in response to patient feedback. The Committee requested stronger visibility of Maternity and Neonatal Voices Partnership (MNVP), Patient Advice and Liaison Service (PALS) and wider community partner contributions within future reporting.
- **Acceptable assurance** was received from the new **thematic learning** report, which triangulates intelligence from incidents, complaints, claims, PMRT, MNSI and other sources. Five recurring themes were identified, providing a stronger focus for improvement activity and demonstrating consistent learning across maternity governance processes.
- **Significant assurance** was received that the **planned home birth service** remains safe and sustainable, with no service suspensions reported and stable activity levels maintained. The Committee noted ongoing workforce pressures associated with service delivery and discussed strengthening consent documentation in light of emerging national guidance.
- The delivery of **CNST** requirements were noted in terms of safety action b, with the first Year 8 training checkpoint successfully achieved and submitted. The Committee noted that delivery remains on track despite increasing national requirements and additional programme workload.

Comments on the Effectiveness of the Meeting

Comments on effectiveness were sought via MS teams.

Cross Committee Considerations

- No cross-committee considerations were identified.

Summary Agenda

No.	Agenda Item	BAF Mapping			Purpose	No.	Agenda Item	BAF Mapping			Purpose
		BAF No.	Risk	Assurance				BAF No.	Risk	Assurance	
1.	Maternity Dashboard Q1	1	Ext 16	Acceptable	Assurance	10.	Regional Perinatal Quality Group Submission Q1			Acceptable	Approval
2.	Maternity & Neonatal Workforce Report Q1			Partial	Assurance	11.	National Maternity Triage Specification Board Assurance Framework			Partial	Assurance
3.	Perinatal Mortality Report Tool Q1	1	Ext 16	Significant	Assurance	12.	Neonatal Intensive Care Unit GIRFT Visit Q1			Acceptable	Assurance
4.	Infant Mortality Action Plan			Acceptable	Assurance	13.	Consultant Attendance at Required Situations Audit Report Q1			Significant	Assurance
5.	Maternity & Neonatal PSIRF Investigation Report Q1 & Neonatal Medication Thematic Review	1	Ext 16	Acceptable	Assurance	14.	Maternity & Neonatal Patient Experience Report Q1	1	Ext 16	Acceptable	Assurance
6.	Neonatal Intensive Care IUT/EUT Referrals			Acceptable	Assurance	15.	Maternity Thematic Learning Report	1	Ext 16	Acceptable	Assurance
7.	Maternity and Neonatal 10 Point Plan Baseline Assessment			Acceptable	Approval	16.	Planned Homebirth Q1			Significant	Assurance
8.	Saving Babies Lives Care Bundle V3 Q1			Significant	Assurance	17.	Maternity Incentive Scheme Year 8 – Safety Action B Training Q1			N/A	Information
9.	Maternity Care Bundle Q1			Partial	Assurance	18.	Executive Maternity & Neonatal Quality & Outcomes Group Highlight Report (03-08-26)			N/A	Information

Highlight Report

QUALITY, ACCESS & OUTCOMES COMMITTEE | 30th September 2026



University Hospitals
of North Midlands
NHS Trust

Matters of Concern / Key Risks to Escalate		Major Actions Commissioned / Work Underway
- The Committee noted continued deterioration in urgent and emergency care, RTT and diagnostic performance, driven by sustained emergency care pressures and diagnostic capacity constraints, particularly MRI. Partial assurance was provided that recovery actions are underway, including the opening of the Urgent Treatment Centre and Enhanced Emergency Medicine Assessment Centre, implementation of discharge improvement initiatives, and installation of an additional MRI scanner. Whilst elective performance remains challenged, early signs of stabilisation are emerging and cancer performance remains on trajectory. - The Committee received an update on progress against actions arising from the August CQC inspection. Immediate actions taken in relation to concerns within the Emergency Department and Acute Medical Unit were highlighted. The Committee was advised that improvement plans continue to be monitored closely, with particular focus on the Acute Medical Unit, and that external assurance processes confirmed the Trust would remain under ICB oversight rather than enter a NHSE improvement programme. - The Committee received assurance that mortality indicators continue to improve, supported by enhanced clinical coding and strengthened mortality governance arrangements. Whilst assurance remains partial due to review backlogs and inconsistent evidence of impact across some specialties, positive improvement was noted across a number of clinical services, with no Prevention of Future Death reports or neglect verdicts received during the quarter. - The Committee received partial assurance regarding delivery of the Continuous Improvement Framework, noting improved collaboration between improvement, patient safety and patient experience teams, alongside increased staff access to improvement training. The Committee supported a pragmatic approach to the use of locally relevant metrics and recognised that future focus should be on demonstrating the sustainability and impact of improvement activities, rather than solely the delivery of action plans.		Further work commissioned to implement NHS England requirements arising from the Thirlwall Inquiry, including assurance regarding safeguarding arrangements, neonatal CCTV coverage, insulin storage controls and incorporation of sudden and unexpected death in childhood learning into the Trust action plan.
Positive Assurances to Provide		Decisions Made
- The Committee noted improving performance in relation to 104-day cancer breaches, with a reduction in the number of patients waiting beyond 104 days. Urology remains the principal area of challenge, with targeted improvement actions in place to address diagnostic, outpatient and surgical capacity constraints. The Committee received acceptable assurance regarding ongoing oversight and agreed that the thematic review could return to routine reporting. - The Committee received acceptable assurance on delivery of the Population Health Strategic Plan, including progress in reducing health inequalities and improving prevention, with a focus on infant mortality and early cancer diagnosis. UHNM has been selected as one of three national Core20PLUS5 accelerator sites, and arrangements are being strengthened to embed population health priorities within care groups. The Committee noted risks relating to organisational capability, population health infrastructure and wider system changes, with mitigating actions in place through partnership working. - The Committee received an update on the Trust's response to the Thirlwall Inquiry and associated NHS England requirements. Immediate actions are underway in relation to neonatal monitoring, insulin storage and access, safeguarding, bereavement care, and staff and family engagement. The Committee was assured that the focus will be on embedding a culture of openness, learning and challenge, with a full report and action plan to be presented directly to Trust Board. - The Committee received acceptable assurance regarding the Trust's patient safety incident investigation arrangements, noting no Never Events during Q1 and continued implementation of learning from patient safety investigations. Ongoing work includes strengthening staff capability through PSIRF training and reducing risks associated with high-risk processes, including the introduction of a revised nasogastric and nasojejunal feeding policy and supporting staff training. - The Committee received an update on the newly established Patient and Public Engagement Council, which brings together patients, carers and local residents to provide feedback and influence service development. The Committee noted the acceptable assurance provided and supported a patient-led approach to the Council's development and emphasised the importance of demonstrating the impact of engagement on service improvement, with an annual progress update to be incorporated within the business cycle.		The Committee approved the Executive Quality and Outcomes Group Terms of Reference.
Comments on the Effectiveness of the Meeting		Cross Committee Considerations

Comments on effectiveness were sought via MS teams.

- The Committee agreed to strengthen linkages between Quality, Access and Outcomes Committee and Finance and Business Performance Committee reporting to ensure both patient impact and financial implications are considered collectively.

Summary Agenda

No.	Agenda Item	BAF Mapping				Purpose	No.	Agenda Item	BAF Mapping				Purpose
		BAF No.	Risk		Assurance				BAF No.	Risk		Assurance	
1.	Access Performance Report Month 5 2026/27 • UEC Improvement Oversight Group Highlight Report – September 2026	1, 9	16	20	Partial	Assurance	7.	PSII Report Q1 2026/27	1, 9	16	20	Acceptable	Assurance
2.	Cancer 104+ Day Breach Analysis Report Q1 26/27 • Thematic Review of 104+ Cancer Treatments in Urology	1	Ext 16		Acceptable	Assurance	8.	Mortality Assurance Report Q1 2026/27	1, 2, 9	Various		Partial	Assurance
3.	Population Health Strategic Plan Update • Anchor Institution Update	2	High 12		Acceptable	Assurance	9.	Improving Together supporting CQC Well-Led (Learning Improvement and Innovation)	1	Ext 16		Partial	Assurance
4.	Thirlwall Report				Not applicable	Information	10.	Patient and Public Engagement Council (PPEC) Update	1	Ext 16		Acceptable	Assurance
5.	EQOG Highlight Report (17-09-26)				Not applicable	Information	11.	Executive Quality & Outcomes Group (EQOG) Terms of Reference 2026/27	1	Ext 16		Not applicable	Approval
6.	CQC Improvement Action Plan	1	Ext 16		Not applicable	Information	12.	Quality Performance Report – Month 5 2026/27	1	Ext 16		Not applicable	Information

Integrated Performance Report

Month 05 Performance
2026/27

Statistical Process Control

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

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

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

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

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

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

NHS
University Hospitals
of North Midlands
NHS Trust



Experience of Care

Experience of care				Data period	Provider value		Chart	
Experience of care domain segment				Q1 2026/27	2	NOF Score		
Experience of care domain score				Q1 2026/27	2.32	NOF Score		
Experience		Data period	Provider value	Peer average ⓘ	National value	National value method	Chart	
CQC inpatient survey satisfaction rate score				Q1 2026/27	2	NOF Score	Provider value	
NHS staff survey advocacy sub-score score				Q1 2026/27	2.65	NOF Score	Provider value	
NHS staff survey advocacy sub-score		2025	6.63	6.26	6.67	Provider median		

Domain change: The former Effectiveness and Experience of Care domain has been divided into Experience of Care, and Effectiveness of Care and Population Health.

Q1 position: Experience of Care is in segment 2. The CQC inpatient survey satisfaction rate remains unchanged from Q4, while the NHS Staff Survey advocacy sub-score is included as a new measure.

Effectiveness of Care and Population Health

Effectiveness of care and population health				Data period	Provider value	Chart
Effectiveness of care and population health domain segment				Q1 2026/27	4	NOF Score
Effectiveness of care and population health domain score				Q1 2026/27	2.57	NOF Score
Preventing ill health				Data period	Provider value	Peer average ⓘ
Percentage of inpatients referred to and seen by an in-house tobacco treatment service who make a supported attempt to stop smoking score				Q1 2026/27	1.59	NOF Score
Percentage of inpatients referred to and seen by an in-house tobacco treatment service who make a supported attempt to stop smoking				To Mar 2026	48.08%	32.28%
						17.65%
Outcomes				Data period	Provider value	Peer average ⓘ
Summary Hospital Mortality Indicator score				Q1 2026/27	2	NOF Score
Delayed inductions rate score				Q1 2026/27	2.68	NOF Score
Delayed inductions rate				Q1 2025/26	35.50	22.80
						31.20
Effective discharge				Data period	Provider value	Peer average ⓘ
Percentage of patients readmitted within 30 days of discharge score				Q1 2026/27	4	NOF Score

Domain change: The former Effectiveness and Experience of Care domain has been divided into Experience of Care, and Effectiveness of Care and Population Health.

Q1 position: Effectiveness of Care and Population Health is in segment 4. The principal driver is the newly introduced 30-day readmission measure, for which UHNM is in segment 4 because its readmission rate is significantly above the national average. SHMI score appeared in the former domain and remains in this domain, this saw an improvement from a score of 3 in Q4 to 2 in Q1.



Patient Safety

Patient safety				Data period	Provider value		Chart		
Patient safety domain segment				Q1 2026/27	4	NOF Score			
Patient safety domain score				Q1 2026/27	3.45	NOF Score			
High Quality Care				Data period	Provider value	Peer average ⓘ	National value	National value method	Chart
Clinical audit outlier score				Q1 2026/27	4	NOF Score	Provider value		
Safe outcomes				Data period	Provider value	Peer average ⓘ	National value	National value method	Chart
Please note that the MRSA, C-Difficile and E-Coli scores each carry a one third weighting									
Number of cases of MRSA in the last 12 months score				Q1 2026/27	3.6	NOF Score	Provider value		
Number of cases of MRSA in the last 12 months				To Jun 2026	8.00	5.50	3.00	Provider median	
Rate of e-coli score				Q1 2026/27	3	NOF Score	Provider value		
Rate of e-coli				To Jun 2026	1.03	1.15	1.18	Provider median	
Blood culture sets per 1,000 bed-days				Q4 2025/26	73.2	76.6	67.0	Provider median	
Rate of c-difficile score				Q1 2026/27	3	NOF Score	Provider value		
Rate of c-difficile				To Jun 2026	1.14	1.03	1.10	Provider median	
Stool specimens examined for diagnosis of c-difficile per 1,000 bed-days				Q4 2025/26	24.7	25.6	22.3	Provider median	
Safe culture				Data period	Provider value	Peer average ⓘ	National value	National value method	Chart
NHS Staff survey - raising concerns sub-score score				Q1 2026/27	3.14	NOF Score	Provider value		
NHS Staff survey - raising concerns sub-score				2025	6.17	6.18	6.32	Provider median	

Q1 position: The Patient Safety score increased from 2.83 in Q4 to 3.45 in Q1, resulting in a move to segment 4.

Key drivers: The deterioration is primarily attributable to the newly introduced Clinical Audit Outlier measure, which scored 4, together with the E. coli measure worsening from a score of 1 to 3.

Quality & Access | Overview

Provide safe, effective and caring services



Overview from the Chief Nurse and Chief Medical Officer

How are we doing against our trajectories and expected standards?

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

We did not meet the required target in August across a number of metrics, DOC, PU developed under UHNM, FFT in ED and maternity, VTE, C-Diff, e-Coli, sepsis maternity, VTE risk assessment and HAT, and mixed sex accommodation breaches. The improvements in timely observations is being sustained - we are 7% off target performance but has plateaued in recent months. Complaints response times also continues to reduce.

There have been 12 Calls for Concern (Martha's Rule) during August 2026: Of the 12 cases referred, 9 qualified for a review, 8 had documented advice only and 1 had a change in management with transfer to a tertiary centre. We recently revised the Call for Concern voicemail message with the aim of reducing non- deteriorating calls. The updated message was implemented on 14 August, and the data suggests that it may already be having a positive impact. The revised voicemail was developed following engaging with colleagues from other trusts, incorporating elements of their approaches alongside adaptations to meet our local requirements.

Trust have received a presumptive positive legionella result for an outlet on Ward 124 (renal) and on Ward 117 (Infectious Diseases) – both are high risk from water safety perspective. Estates have fitted point of use filters. Awaiting final confirmation. Urgent meeting to decide on our engineering strategy with estates colleagues and our external authorising engineer (water). Noted that the fitting of the Point of Use filters has significantly reduced any risk. In addition, we have a second MRSA on Ward 230. However, this patient was positive in County last month as a community sample, been negative and now positive again. This is likely a community case, but it will be included in UHNM figures.

The CQC have been kept briefed on immediate actions relating to the recent inspection the current working action plan is being presented to the Committee.

The Thirwall Inquiry was published 15 September and a briefing summary is being presented to the Board with immediate actions required for all neonatal units.

What is driving this?

There is focused work across Planned and Unplanned Care Groups 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.

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

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

Quality & Access | Overview

Provide safe, effective and caring services



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 for Royal Stoke AMU, the only remaining Bronze CEF area, continues and the adapted support to CEF Silver areas continues. Immediate actions taken to support leadership oversight of AMU and a supportive package is in place to drive improvement. Progress will be monitored weekly and this will be fed back to the CQC. There is focused work to reduce LOS and introduce criteria led discharge across the Trust.

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.

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

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

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

The Thirwall Inquiry actions will be presented to the Committee and Board; alongside the External Review commissioned into the MBACE report. The Neonatal team have now met with the review team and the action plan is in development.

What can we expect in future reports?

We will report progress on delivery of the current CQC actions and will present the final report once received.

We will report a gap analysis and required actions in response to the Thirwall Report

We will provide updates in relation to the Ockenden and Amos Reports

We will provide a report considering if RN and HCA fill rates correlate with incidents of harm (cross committee consideration from PCI Committee)

Quality & Access | Overview

Provide safe, effective and caring services



Care Quality Commission Inspection Update (August 2026)

The CQC conducted an inspection across RSUH and County between 10-12 August 2026. The areas of focus were Urgent and Emergency Care, and Medical Care (including older people's care). The inspection team visited on the evening of the 10th, with two subsequent full day inspections.

On the 12th August 2026 the CQC raised some immediate concerns in relation to practice at RSUH regarding Urgent and Emergency Care and Medical Care, which triggered possible enforcement action. The Trust was required to feedback urgent remedial actions the following day. Following our feedback to the CQC, we were informed that the CQC were assured with actions taken and that enforcement action would not be taken at that time. The CQC conducted an unannounced reinspection of Urgent and Emergency Care and Medical Care at RUSH on Wed 26 August. The CQC confirmed following that visit that no enforcement action would be issued as the remedial actions were seen to be in place.

- Data requests have now been submitted to the CQC
- We have updated the CQC on immediate actions taken to support required improvements to AMU.

The CQC inspection and related concerns have prompted a Rapid Quality Review to be undertaken. This will take place on 29 September and will involve NHSE, ICB, Healthwatch, CQC, and system colleagues.

What can we expect in future reports?

Immediate actions were taken to ensure identified concerns were addressed. Initial feedback is being logged into an action plan whilst we wait for the draft report. We have completed and uploaded the data request to the CQC within the deadline of Friday 4 September. The action plan and progress will be reported to the EQOG and to this committee from September 2026. We will update on the outcome of the Rapid Quality Review

Quality & Access | Dashboard

Provide safe, effective and caring services



University Hospitals
of North Midlands
NHS Trust

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
HSMR (Rolling 12-months)	May 26	111.5	100.0			119.0	111.1	126.8
PSI per 1000 bed days	Aug 26	47.3	50.7			52.3	46.5	58.1
PSI with moderate harm or above per 1000 bed days	Aug 26	0.6	0.6			0.7	0.3	1.0
Patient Falls per 1000 bed days	Aug 26	4.2	-			4.6	3.4	5.7
Patient falls with harm per 1000 bed days	Aug 26	1.5	1.5			1.7	1.1	2.3
Medication incidents per 1000 bed days	Aug 26	5.3	6.0			5.9	4.5	7.2
Medication incidents with moderate harm or above (%)	Aug 26	2%	5%			1%	-1%	4%
Never Events reported	Aug 26	1	0			0	-2	2
PSIs instigated	Aug 26	0	0			2	-4	7
Duty of Candour verbal	Aug 26	87%	100%			91%	70%	112%
Duty of Candour written (letter sent within 10 working days)	Aug 26	74%	100%			82%	49%	115%
Pressure Ulcers developed at uhn per 1000 bed days	Aug 26	1.7	1.6			1.7	0.7	2.7
Pressure ulcers with lapses in care per 1000 bed days	Aug 26	0.3	-			0.5	0.1	0.9
Trust Apportioned Infections	Aug 26	56	38			52	29	75
Trust Apportioned MRSA Bacteraemia	Aug 26	0	0			1	-2	4
HAI and COHA cases of C.Diff toxin	Aug 26	15	12			14	6	22
HAI E.Coli Bacteraemia Cases	Aug 26	19	17			20	7	33
Sepsis Screening - Inpatients	Aug 26	99%	90%			97%	90%	104%
Sepsis IVAB - Inpatients	Aug 26	100%	90%			99%	96%	103%
Sepsis Screening - ED	Aug 26	95%	90%			94%	89%	99%
Sepsis IVAB - ED	Aug 26	94%	90%			85%	67%	103%
Sepsis Screening - Maternity	Aug 26	100%	90%			96%	87%	106%
Sepsis IVAB - Maternity	Aug 26	50%	90%			96%	82%	110%
Sepsis Screening - Childrens	Aug 26	89%	90%			91%	79%	103%
Sepsis IVAB - Childrens	Aug 26	100%	90%			77%	41%	112%

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
VTE Risk assessment Rate (timely) - data from ePMA	Aug 26	84%	95%			83%	#N/A	#N/A
Hospital Associated Thrombosis Rate	Aug 26	1.2	-			1.0	0.2	1.7
Care hours per patient day (safe staffing)	Aug 26	9.2	-			9.2	8.9	9.5
Timely Observations	Aug 26	82%	90%			81%	79%	82%
UHNH Inpatients - Friends & Family Test (% recommended)	Aug 26	95%	95%			96%	94%	97%
UHNH A&E - Friends & Family Test (% recommended)	Aug 26	78%	85%			71%	62%	79%
UHNH Maternity - Friends & Family Test (% recommended)	Aug 26	75%	95%			85%	70%	101%
Complaints - % closed within 25/40/60 working days target	Jun 26	28%	-			26%	0%	52%
Written complaints rate per 10,000 spells	Aug 26	40	-			42	36	48
Mixed Sex Accommodation Breaches Reported	Aug 26	96	-			104	68	141
Maternity Induction of Labour - Breach performance	Jul 26	99%	95%			99%	96%	101%
Maternity Assessment Unit Triage within 15 minutes	Aug 26	89%	85%			84%	76%	93%
3rd/4th degree tears	Aug 26	3	-			8	1	15
Neonatal deaths	Aug 26	4	-			2	-2	6



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 exceeded 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 fail 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)



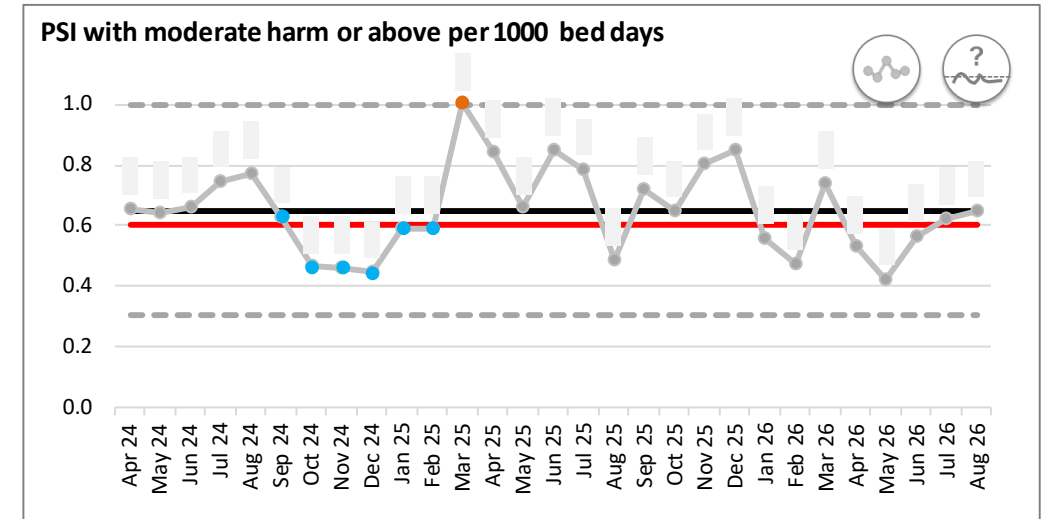
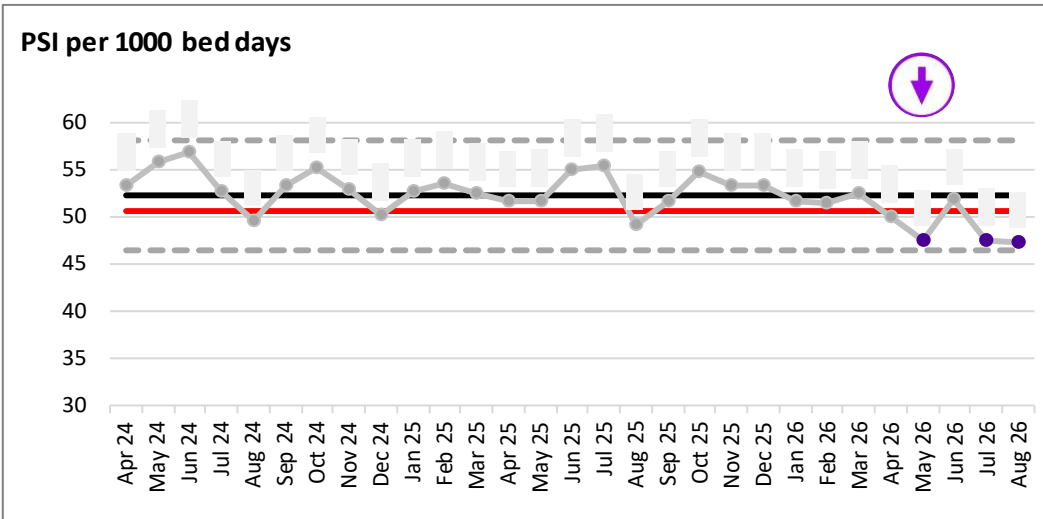
Quality Strategy

The best joined-up care for all

BAF Risk	Q1 (2026/27)		Q2		Q3		Q4	
	Risk	Assurance	Risk	Assurance	Risk	Assurance	Risk	Assurance
BAF 1: Inability to sustain safe & Effective Care Delivery	Ext 20	Partial						

Quality & Access | [PSIs per 1000 bed days]

Provide safe, effective and caring services



What is driving this performance?

The PSI rate for August was again significantly below average. This does not appear to be related to any individual category of incident Trust wide, but the main contributor to the lower numbers is the Planned Care Group, and drilling down to directorate level, T&O, Neurosurgery, Cardio and Thoracic Surgery in particular.

The most common Categories of incidents resulting moderate harm or greater in the past 6 months to Aug-26 were Treatment/procedure and Clinical assessment.

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? (action orientated with timeframes)

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.

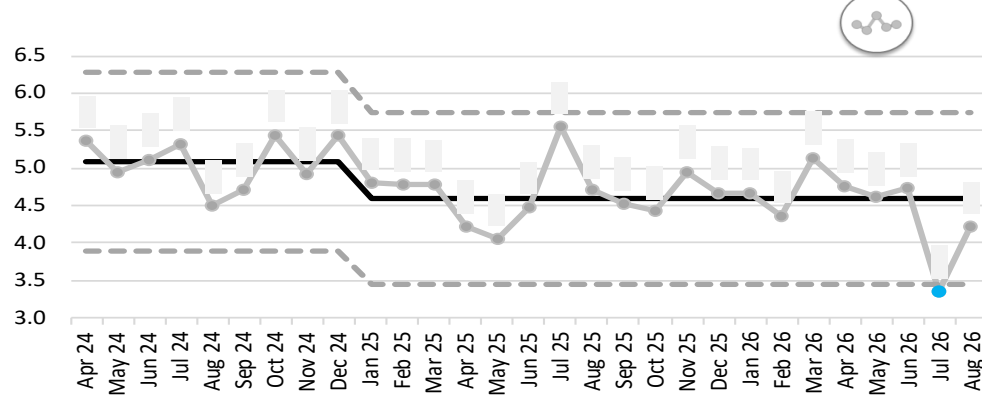
Quality & Access | [Patient Falls]

Provide safe, effective and caring services

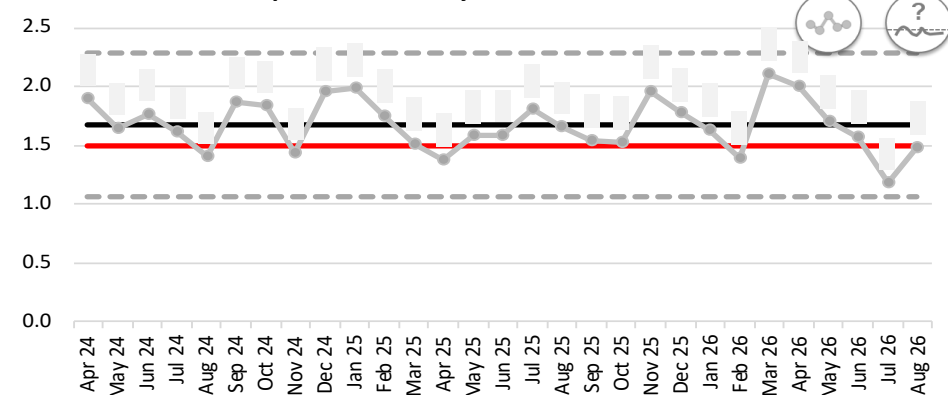


University Hospitals
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NHS Trust

Patient Falls per 1000 bed days



Patient falls with harm per 1000 bed days



What is driving this performance?

The falls rate for August was within the usual range.

Top reporters in August 2026: Stoke AMU – 14 falls, Ward 12 – 11 falls, Ward 124 – 8 falls, Ward 126 – 8 falls. Numbers for these areas are not unusual based on previous months.

6 falls resulting in a serious injury were reported in August, on the following areas: Stoke AMU, Wards 12, 79, 117, 124, 228

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? (action orientated with timeframes)

41 falls occurred on the top four reporting wards; three patients on AMU, ward 12 and 124 had suffered harm. There were 3 other patients that had been harmed following falls in August. All areas have been visited and toolkits, actions and assurances have been completed.

2 patients had not pressed the call bell to ask for assistance. Risk assessments are to confirm that patient has access to a call bell and has the cognition to use this. If the patient does not have cognition, then an alternative arrangement is to be put into place. Confirmation to be acknowledged that a discussion with the patient has highlighted the necessity to use the call bell. Call don't fall posters were in place.

1 patient had pressed the call bell however this was not answered timely and the patient had attempted to stand independently. The ward are completing spot checks and an audit of timely answering of the call bell.

1 patient had slipped on a wet floor. The team will ensure spillages are cleaned.

1 patient had not used their mobility aid. The team will ensure mobility aids are available.

1 patient had required level 4 therapeutic observations however the staff member had left when the patient was asleep. Therapeutic observations were discussed and relayed to the ward team.

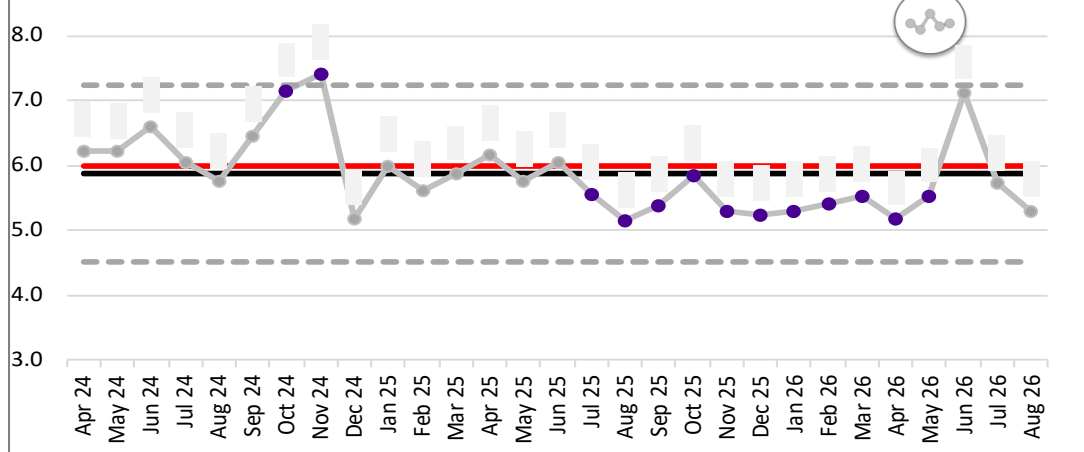
All the above points are highlighted in the risk assessment books. These are audited by the wards, quality team and annual compliance audits.

Go Look Learns continue and feedback is provided.

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

Provide safe, effective and caring services

Medication incidents per 1000 bed days



What is driving this performance?

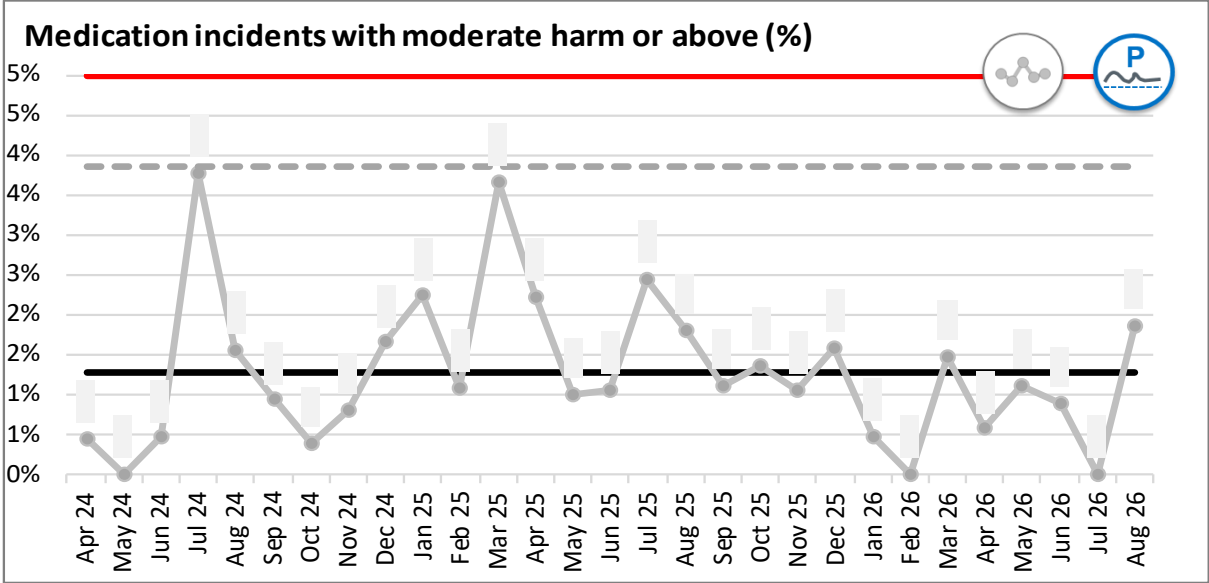
Reducing trend in medication incident reporting is noted as concern as it provides less opportunity to learn from low and no-harm incidents.

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? (action orientated with timeframes)

- Weekly medication incident triage review by the Medicines Safety Team and Patient Safety Team for moderate harm and above medication incidents and for incidents of concern that may require a formal PSIRF learning response.
- Annual Pharmacy-led Safe & Secure Medicines Storage audits underway Sept/Oct '26.
- Wards and Depts encouraged to continue with self-assessment on a Quarterly basis using the mini-CEF tool now on Genome.
- Improved Nurse engagement at Trust Medicines Optimisation & Safety meeting with matron / Head of Nursing representation from all Care Groups.
- MM06 Controlled Drug policy provisional update complete, going through the approval process
- Trust-wide Safety Alerts circulated covering 'Safe use of Suspend function on EPMA', 'High risk of patient harm when clarithromycin is prescribed with other medicines', 'Medication overdose due to typographical error when prescribing a syringe driver'
- Trust Valproate SOP ratified & launched
- Pilot of Self-administration of insulin commenced on Gen Med wards at Royal Stoke in September '26
- EPMA 'Admission' protocols launched Sept '26 to prompt the prescribing of prophylactic LMWH following VTE risk assessment, Oxygen, sodium chloride 0.9% flushes and MRSA decolonisation.

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What is driving this performance?

In August 2026 there were two incidents reported that were categorised as moderate harm or above.

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

What are we doing about it? (action orientated with timeframes)

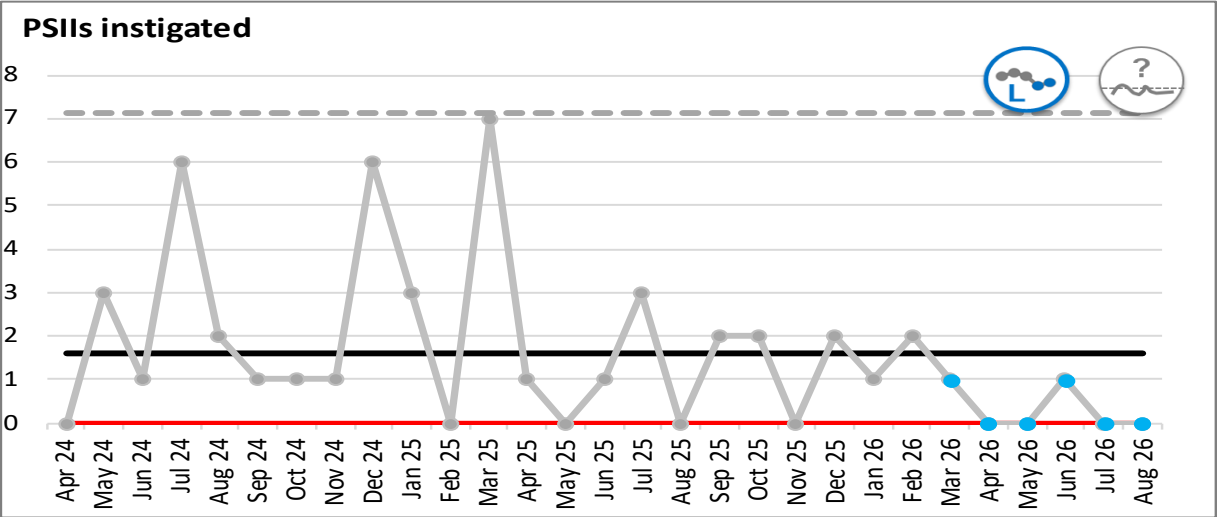
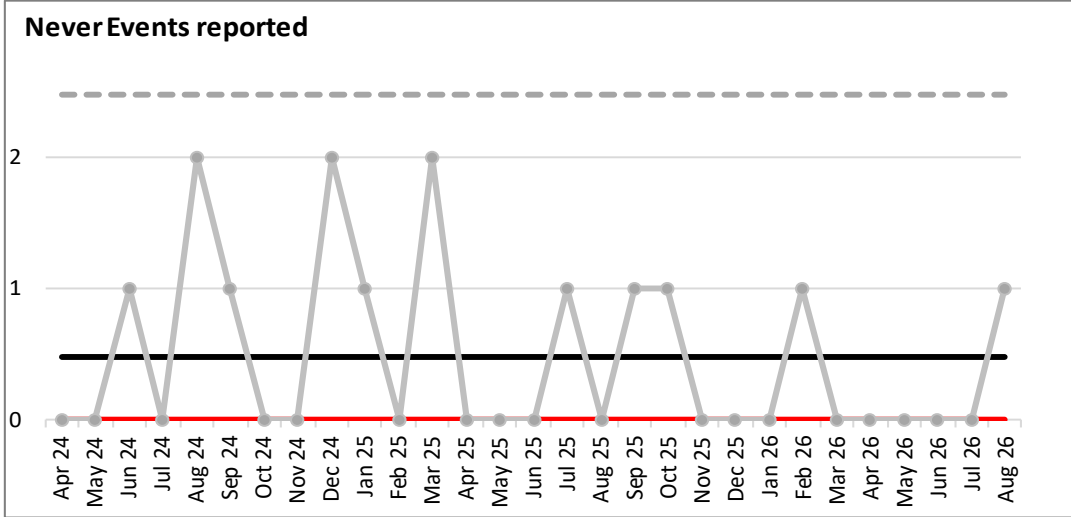
The reported incidents are reviewed and assessed, along with input from the relevant clinical areas to share learning and actions.

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
410291	14/08/2026	External	Medication – Dispensing process / Incorrect medicine	Community Pharmacy dispensed hydroxyzine instead of hydralazine. Patient states has been taking the incorrect medication since the beginning of July. Patient admitted with hypertension into ED at RSUH.	Incorrect medication removed, patient informed, medical team informed.
410859	20/08/2026	202 Onc	Medication – Adverse drug reaction	Cyclophosphamide administered. Patient had tight throat, issues with vision and felt dizzy. Stopped infusion, observations done.	Administered hydrocortisone, chlorphenamine and adrenaline.

Quality & Access | [Never Events & PSII's]

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What is driving this performance?

What are we doing about it? (action orientated with timeframes)

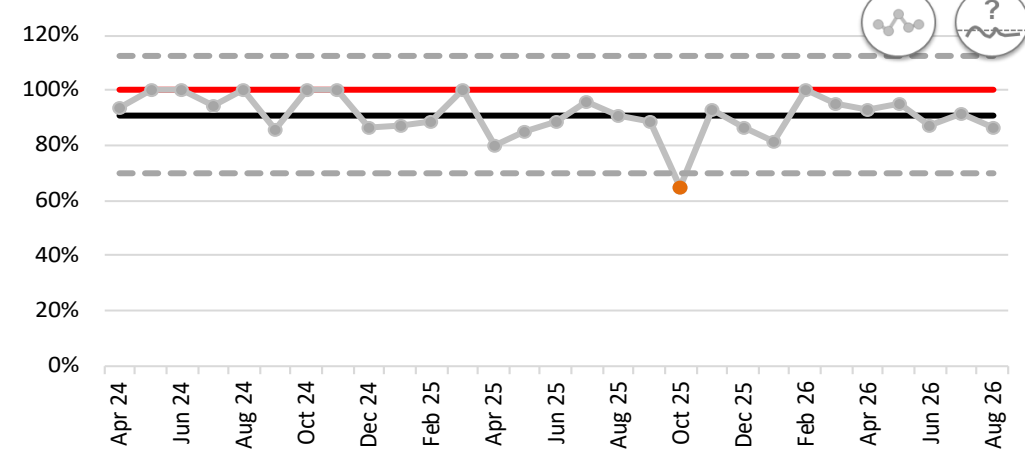
1 never events were identified during August 2026 relating to misplaced NG Tube

No new PSII were commissioned during August 2026.

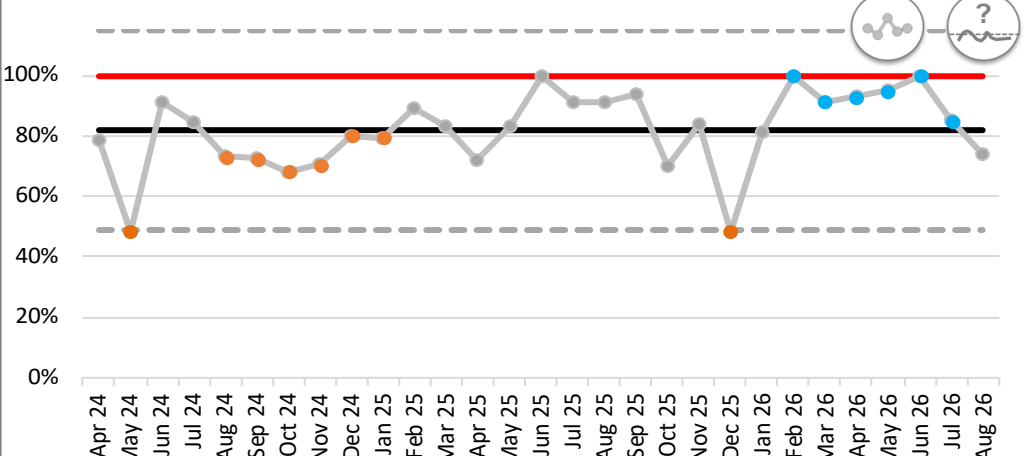
Quality & Access | [Duty of Candour]

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Duty of Candour verbal



Duty of Candour written (letter sent within 10 working days)



What is driving this performance?

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

There were 23 incidents that formally triggered duty of candour in August. Breaches were across all care groups.

What are we doing about it? (action orientated with timeframes)

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

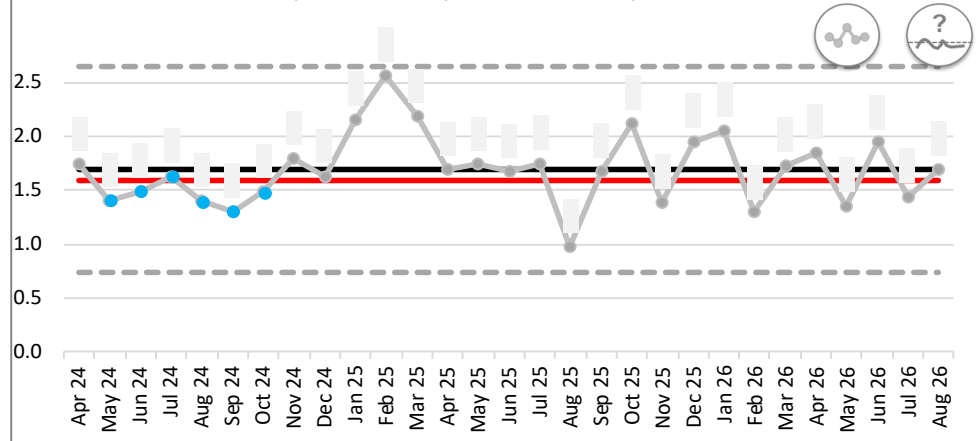
Teams are reminded that evidence of verbal Duty of Candour conversations must be clearly documented within Datix and the clinical record. A new Datix field has been implemented to capture the validation date, which has improved compliance where incidents meet the threshold for Duty of Candour. A supporting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

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

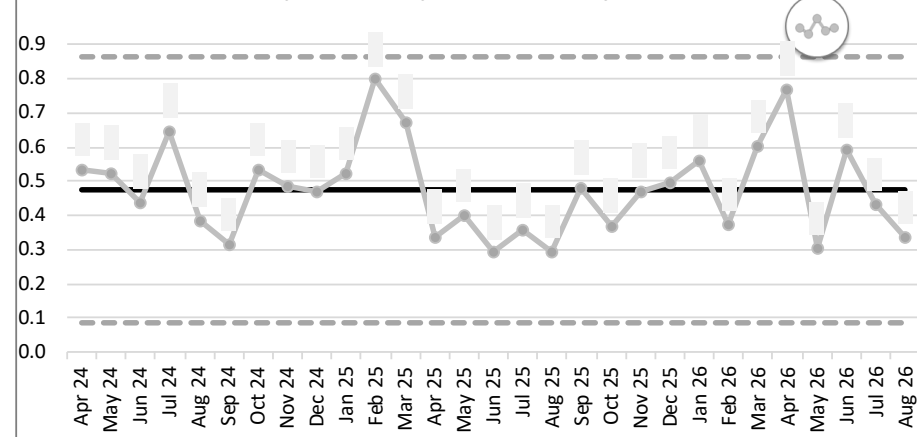
Quality & Access | [Pressure ulcers developed under UHNM care]

Provide safe, effective and caring services

Pressure Ulcers developed at uhnrm per 1000 bed days



Pressure ulcers with lapses in care per 1000 bed days



Type of Lapses Jul 2026	Total
Management of repositioning – position not changed	10
Management of repositioning - timeliness	6
Management of device	4
Management of heel offloading	1

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.

What are we doing about it? (action orientated with timeframes)

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

Quality & Access

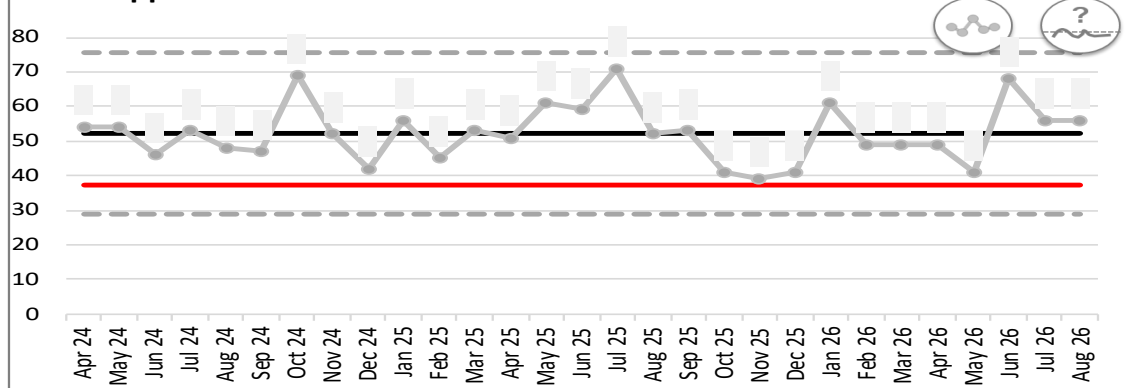
[Trust AppORTioned Infections & MRSA Bacteraemia

Provide safe, effective and caring services

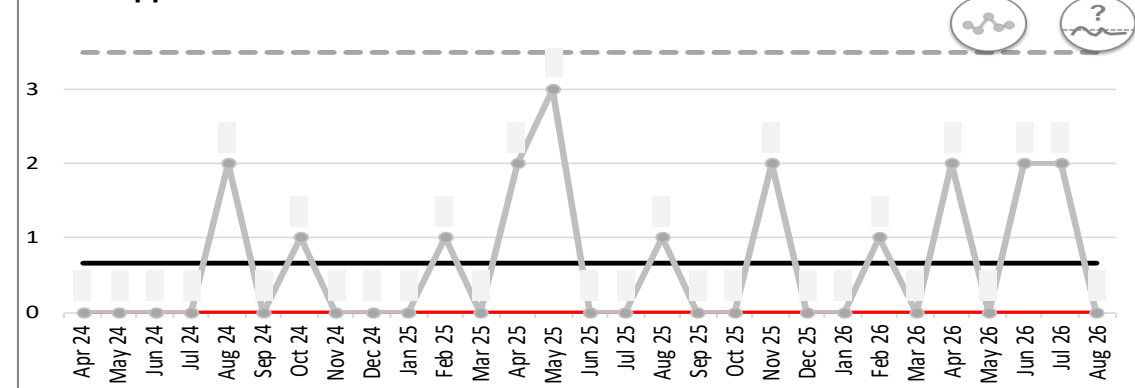


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Trust AppORTioned Infections



Trust AppORTioned MRSA Bacteraemia



What is driving this performance?

Trust AppORTioned Infections - E.coli, C.diff, Klebsiella, Pseudomonas, MSSA & MRSA
Numbers remain within the usual range, with the average a significant distance from the target.

NB The target does not include any allowance for MSSA and this accounted for 16% of TAI in 2025-26. Even excluding MSSA, the target represents a 14% reduction compared to 2025-26.

MRSA-b

The number of Trust appORTioned MRSA Bacteraemia cases identified remains within the usual range.

NB In order to align with the national Oversight Framework the MRSA chart shows Community Onset Hospital Associated (COHA) infections as well as Hospital onset infections as from the July 2026 report.

What are we doing about it? (action orientated with timeframes)

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

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

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

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

Plan to release new trust alert for MRSA Bacteraemia learning to all clinical & medical staff.

Listeria Update:

- No new cases, no international links

- Awaiting Sodexo HQ to confirm what action they want to take on our quarantined L4 Cottage Pie

- Bristol (case 2) also had a positive Listeria cultured from their L4 Cottage Pie – their patient tested positive within a day of ours) – these two were not the outbreak strain

- UHM ice cream, custard and yoghurt all not detected

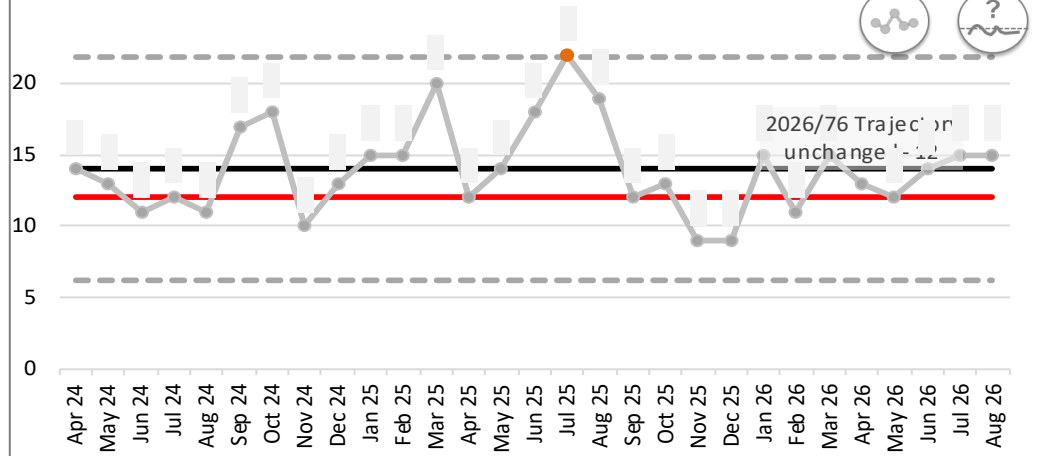
- No source identified yet, although now looking at the potato mashing process but EHO in Tyneside said there were no concerns at the production facility

- Awaiting clarification on what further samples needed from NHS Trusts – Nikki our EHO is co-ordinating with UKHSA and will let us know.

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

Provide safe, effective and caring services

HAI and COHA cases of C.Diff toxin



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. UHNM numbers remain within the usual range however.

There have been 15 reported C diff cases in August 2026 – 13 x HAI and 2 x COHA
There have been two wards with a period of increased incidence reported in August – 2 areas with 1 HAI + 1 COHA at Royal Stoke.

The 2026/27 objective for C-Diff has been issued and UHNM threshold for 2026/27 is 144 (same as 2025/26). As at the end of August there have been 70 HAI+COHA cases versus year to date upper limit of 60 (+17.6% versus the upper limit).

What are we doing about it? (action orientated with timeframes)

- Routine ribotyping of samples continues for samples from areas where we have periods of increased incidence only
- Antimicrobial working group to remind clinical areas to send urine samples when UTI is suspected and ensure appropriate choice of antibiotic for treatment of UTI
- PSIRF process and monthly themes report
- Weekly AMS presence to support antimicrobial prescribing in both sites
- Bi-monthly C diff MDT meeting to discuss cases and share learning
- Ongoing Bed and Commode cleaning day bi-yearly
- C diff training and awareness provided to clinical staff including medics

Quality & Access

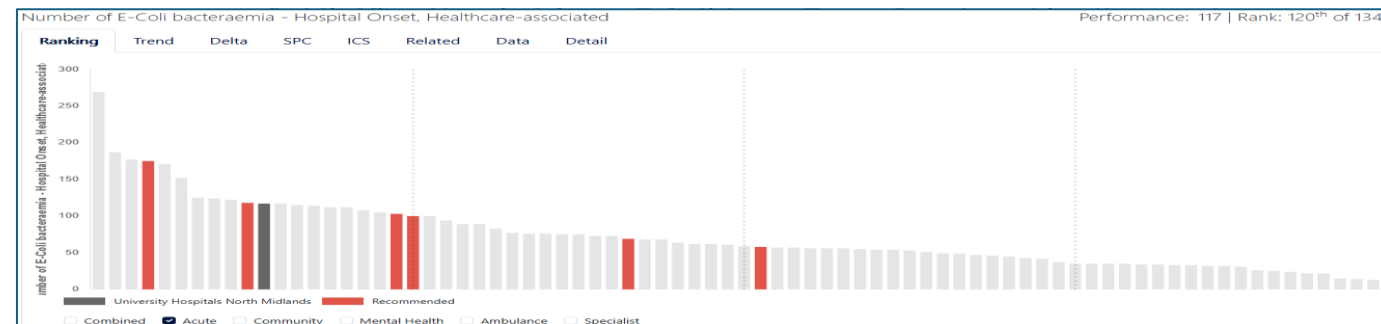
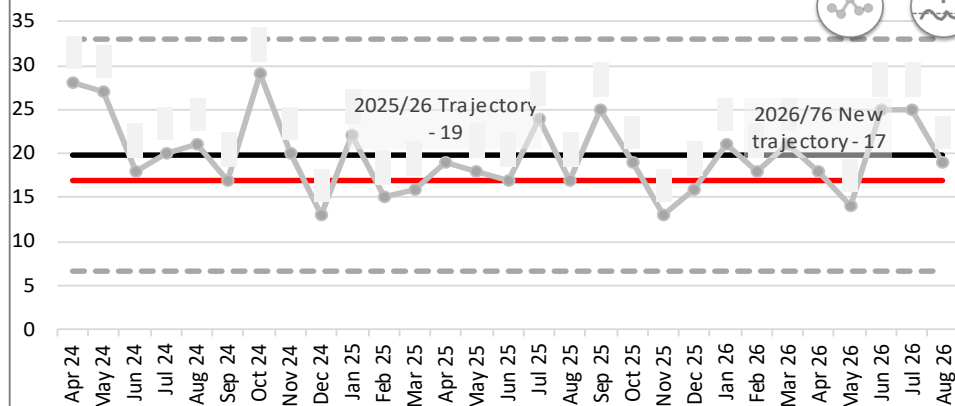
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[HAI E.Coli Bacteraemia cases per month]



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HAI E.Coli Bacteraemia Cases



What is driving this performance?

E.coli-b numbers remain within the usual range.

The target trajectory for 2026/27 has now been issued by NHSE and UHNMM trajectory has been reduced by 24 for 2026/27 to 206 compared to 2025/26 as we reported 229 against trajectory of 230.

As at August 2026 we have had 100 Trust apportioned cases (60 * HAI and 40 * COHA) versus a year to date upper limit of 86 (+16.3% versus the upper limit).

What are we doing about it? (action orientated with timeframes)

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

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

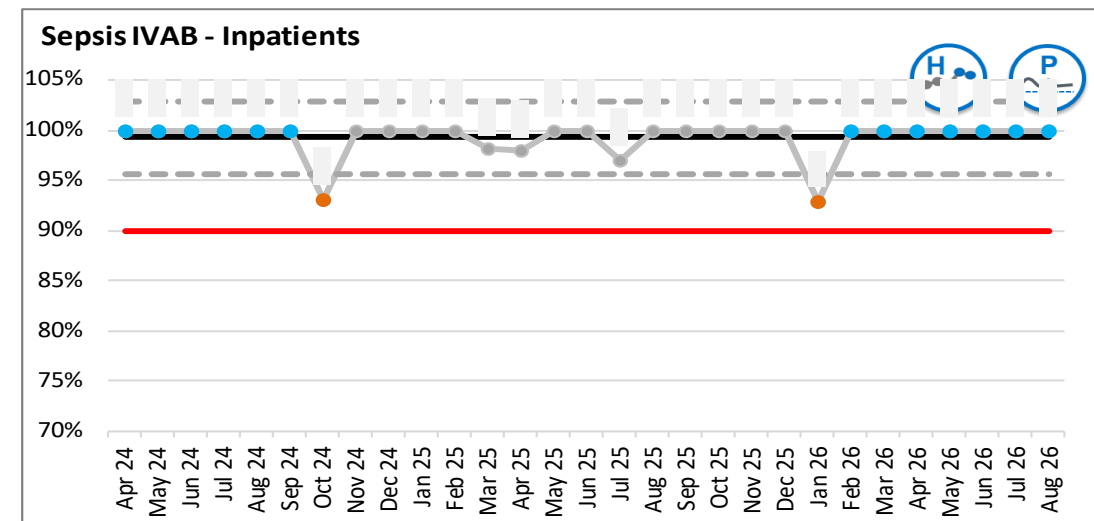
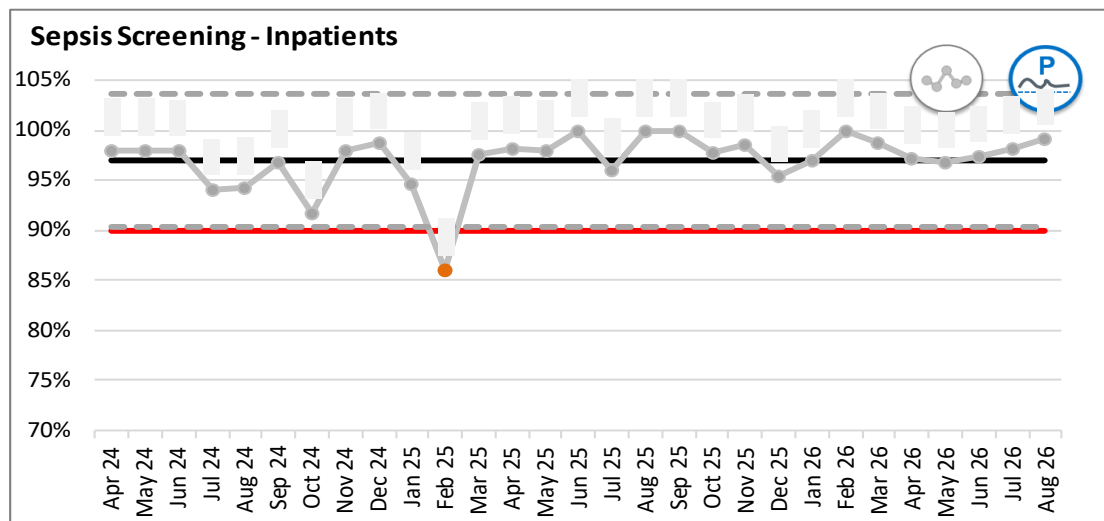
Early identification, appropriate management and treatment prioritised.

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



Quality & Access | [Sepsis – Adult Inpatient]

Provide safe, effective and caring services



What is driving this performance?

Inpatient screening compliance remains within the usual range and has consistently exceeded the target since March 2025.

Compliance for IVAB administration within one hour has also consistently exceeded the target, with 100% compliance across the patients audited since February 2026.

A total of 111 cases were reviewed in August; there were 1 missed screens. 71 cases were identified as red flag sepsis, with 51 receiving an alternative diagnosis. Leaving 20 patients of which all 17 were already on antibiotics. 3 newly identified sepsis patient received IV antibiotics within 1 hour.

What are we doing about it? (action orientated with timeframes)

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.

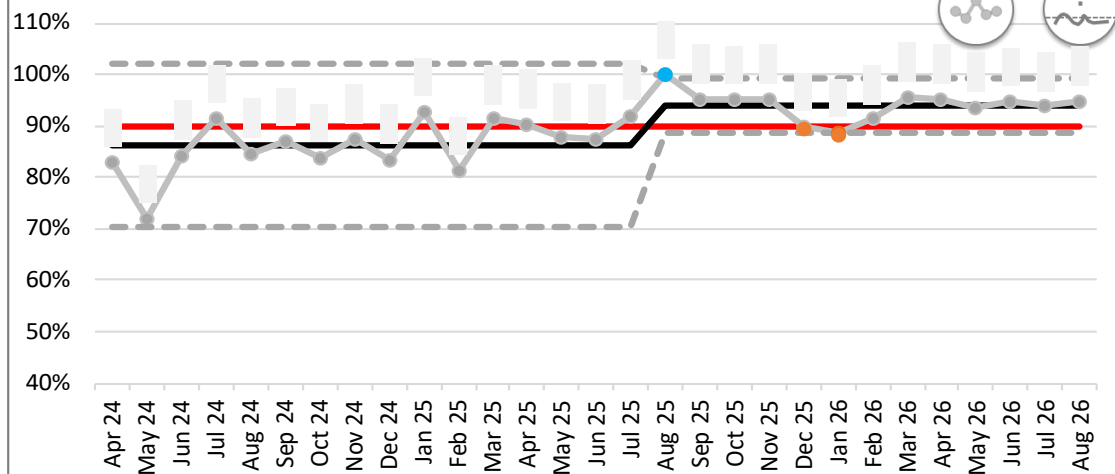
The sepsis team will continue to provide sepsis kiosks/ drop-in sessions to targeted clinical areas.

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

Sepsis Screening - ED



What is driving this performance?

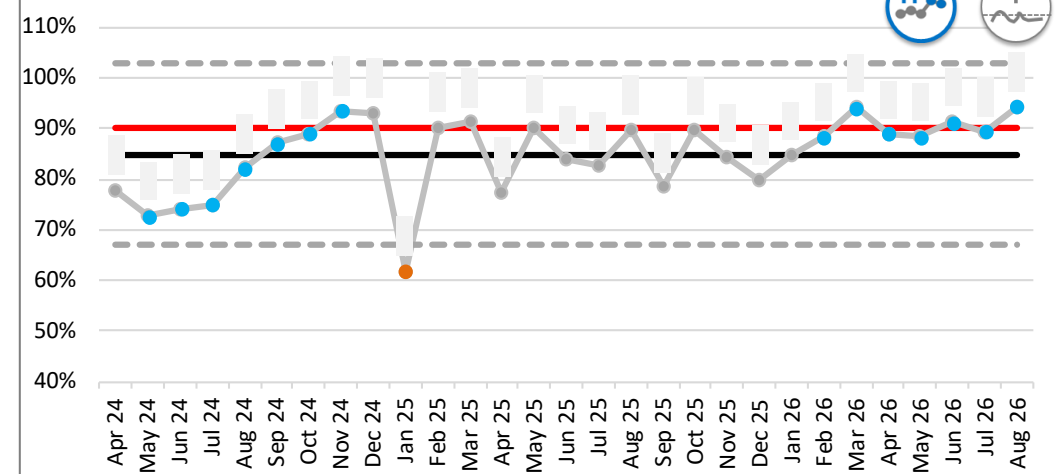
Compliance for adult emergency portals screening has consistently averaged 95% since March 2026.

Compliance with IVAB within 1 Hr has been above the average for 7 consecutive months which may indicate significant change.

In August, 158 cases were reviewed with 8 missed sepsis screens. 112 cases were identified as red flag sepsis – 58 had an alternative diagnosis, 27 were already on IV antibiotics. Leaving 54 newly identified sepsis patients. 3 of these patients received IV antibiotics outside the target 1 hour window.

The best joined-up care for all

Sepsis IVAB - ED



What are we doing about it? (action orientated with timeframes)

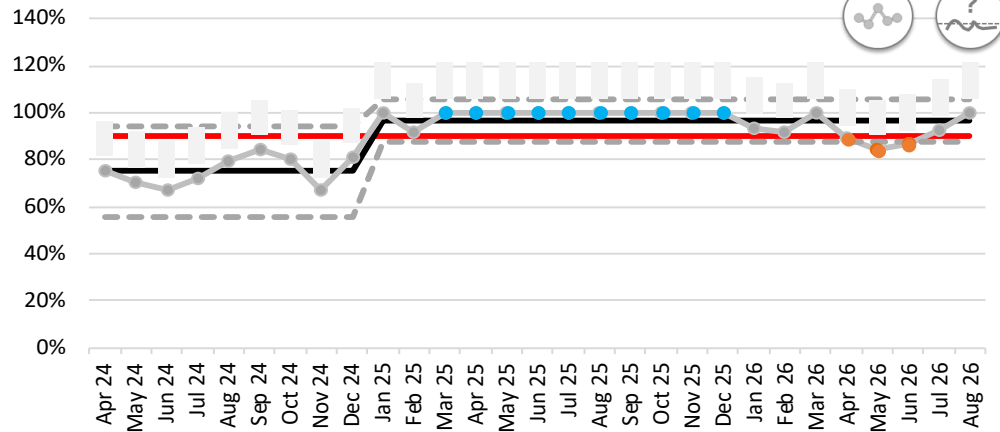
- The sepsis team continue by closely monitor compliance by visiting and auditing ED regularly.
- Regular meetings with ED senior team with robust actions in place.
- Face to face sepsis induction / training for new nursing staff, nursing assistant and medical staff continue.
- ED Pit stop model under review; Improving Together huddles introduced; Tendable checklists introduced pending IT rollout



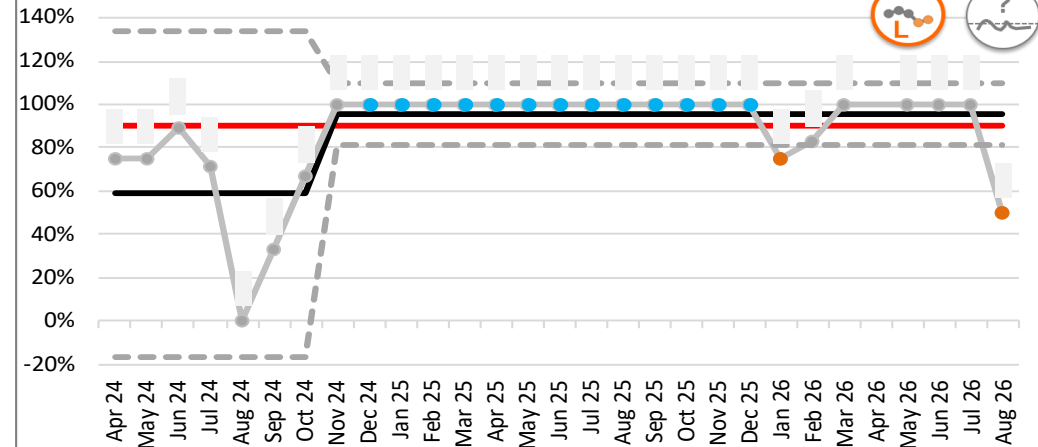
Quality & Access | [Sepsis – Maternity]

Provide safe, effective and caring services

Sepsis Screening - Maternity



Sepsis IVAB - Maternity



What is driving this performance?

Average compliance with screening remains above the 90% target, but rates have been more variable in 2026 than in 2025. Average compliance with IVAB is also above the target but looks highly variable due to small numbers of red flag sepsis cases identified during audits – typically 2-3 per month.

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

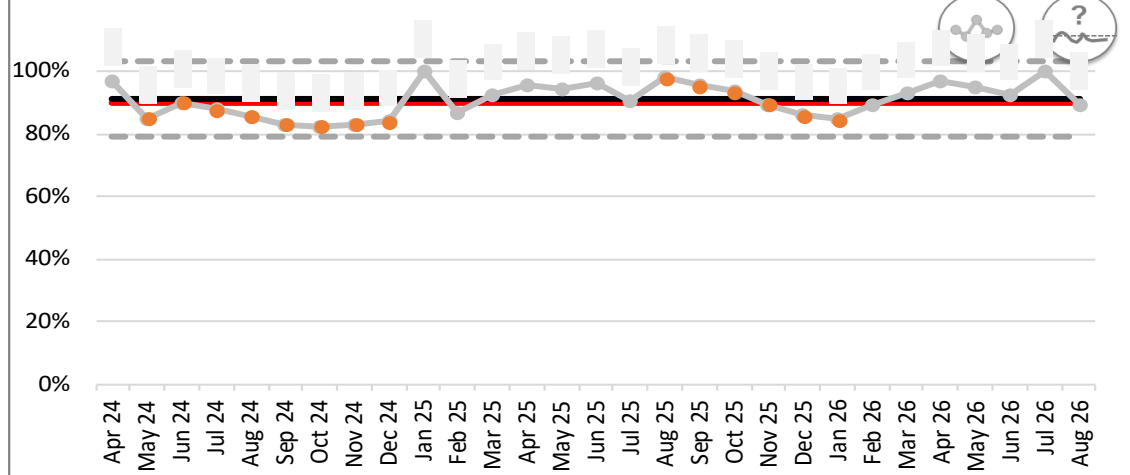
What are we doing about it? (action orientated with timeframes)

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

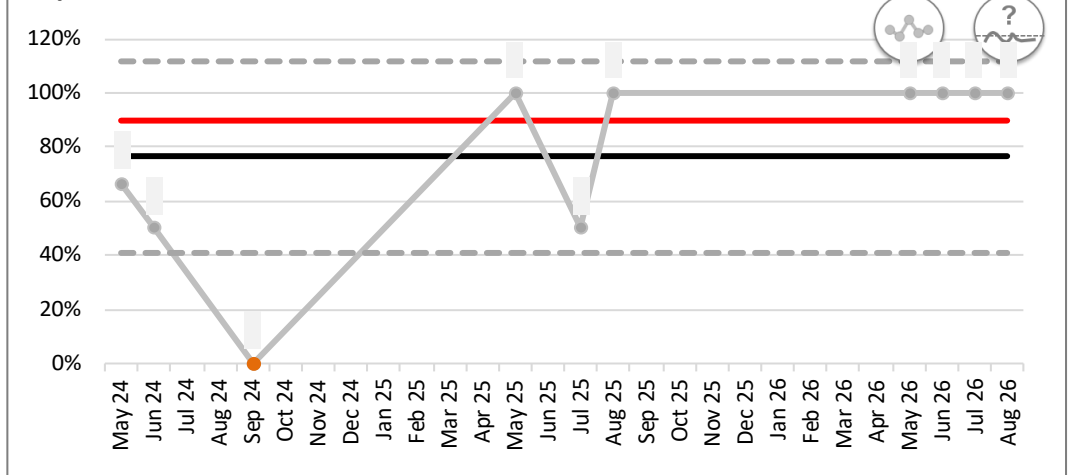
Quality & Access | [Sepsis – Children]

Provide safe, effective and caring services

Sepsis Screening - Childrens



Sepsis IVAB - Childrens



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 18 cases audited for emergency portals with 2 missed screens in August. 8 cases were audited for inpatients also with 1 missed sepsis screens.

What are we doing about it? (action orientated with timeframes)

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

Quality & Access |

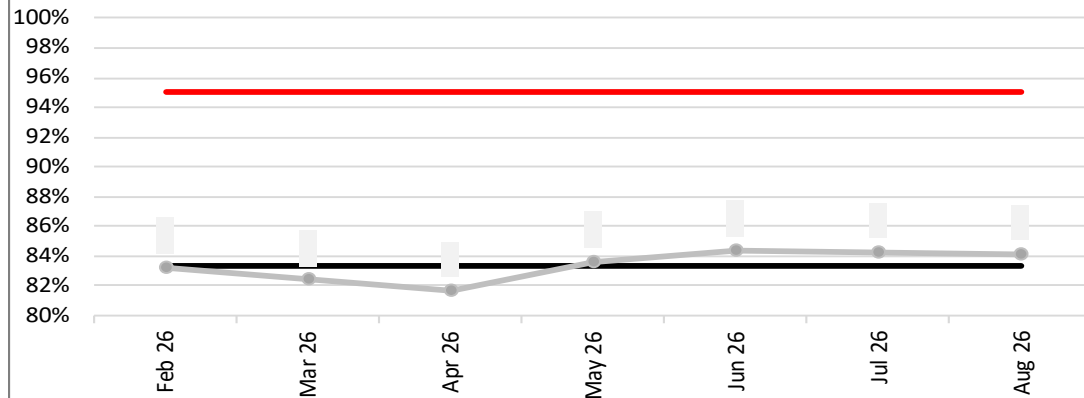
[VTE & Hospital Associated Thrombosis]

Provide safe, effective and caring services

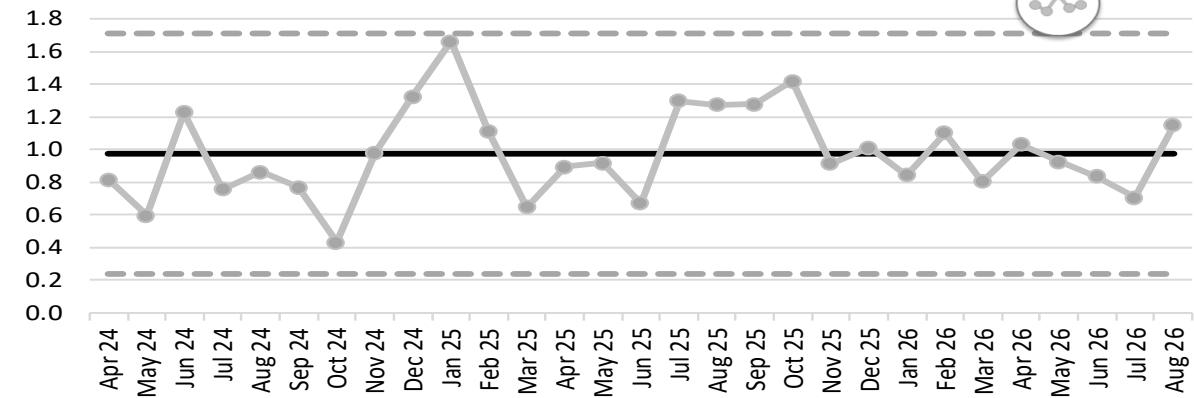


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VTE Risk assessment Rate (timely) - data from ePMA



Hospital Associated Thrombosis Rate



What is driving this performance?

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

Timely VTE risk assessment compliance averages 83% to date. Detailed analysis of early results found very few assessments are missed completely, but a significant proportion are not timely.

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

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

What are we doing about it? (action orientated with timeframes)

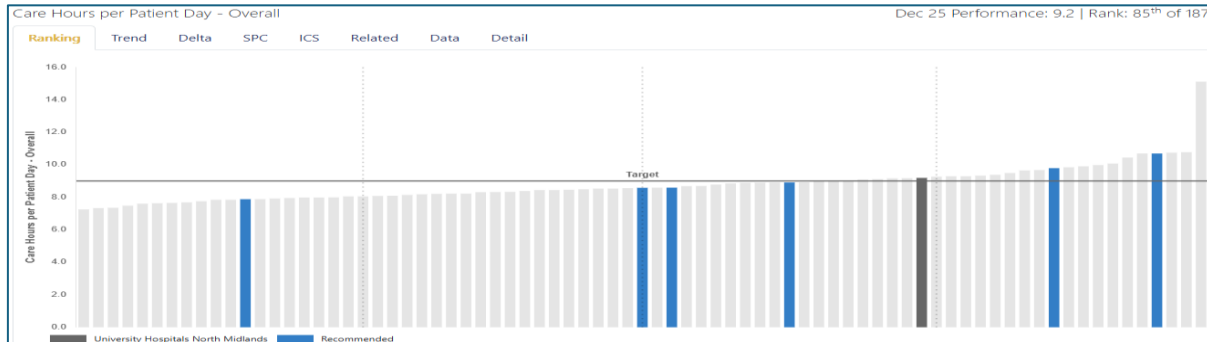
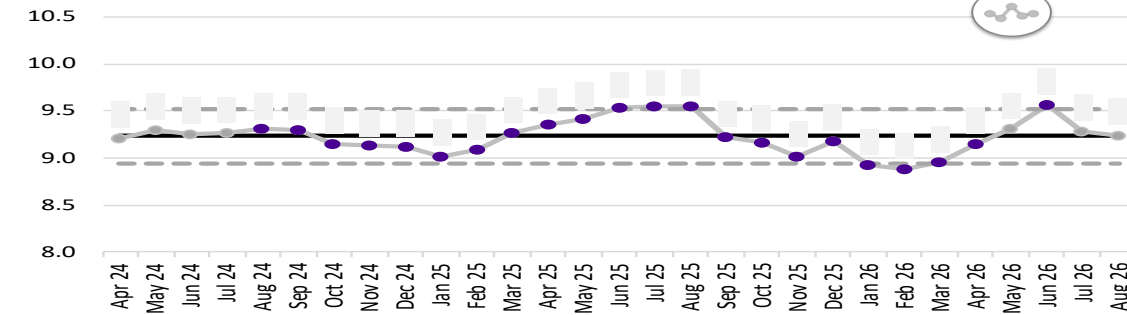
Work has begun with Royal Stoke ED to incorporate VTE Risk assessment, which now appears on the A&E Dashboard, highlighting all patients requiring a VTE risk assessment. Possible digital prompt solutions are being considered to support early completion of VTE Risk assessment and the commencement of VTE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

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

Quality & Access | [Safe staffing & Timely Observations]

Provide safe, effective and caring services

Care hours per patient day (safe staffing)



What is driving this performance?

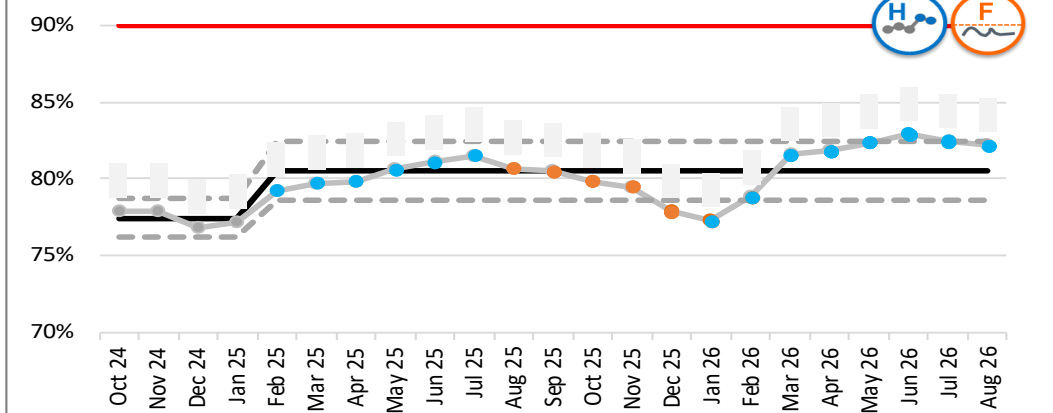
Care hours per patient day (CHPPD)

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

Timely Observations

Compliance appears to have plateaued around 82% since Mar-26. Only 11 wards/departments met the 90% target in August and 7 wards had compliance below 75%: Wards 78, 108, 12, 121, 111, 113, 109 – all from the Medicine & Surgery CBUs.

Timely Observations



What are we doing about it? (action orientated with timeframes)

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.

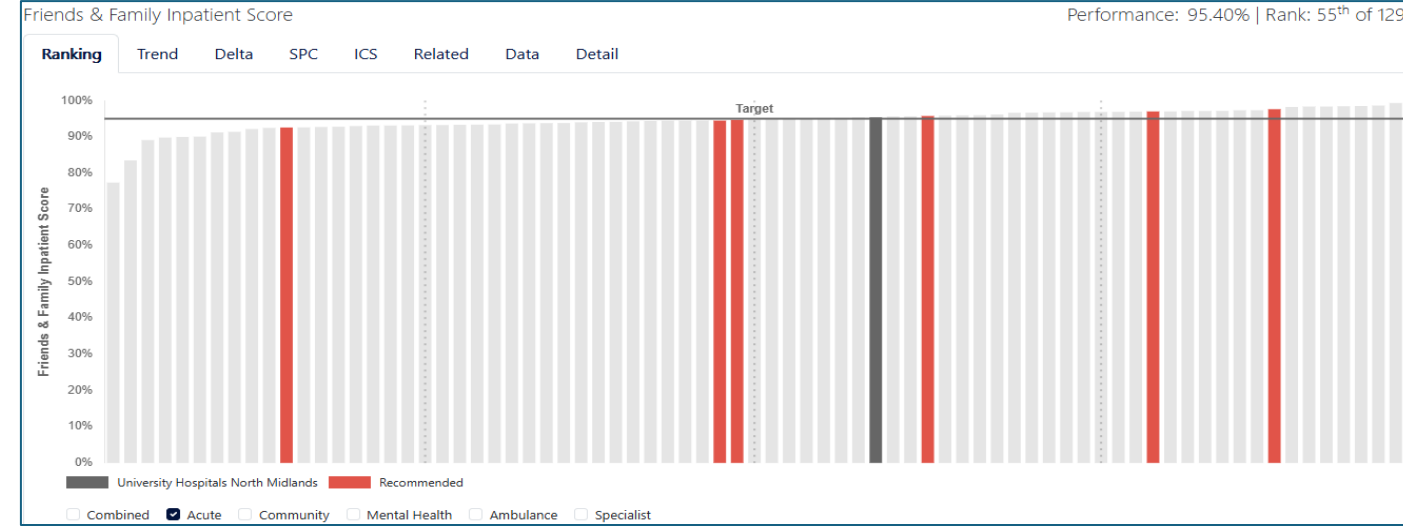
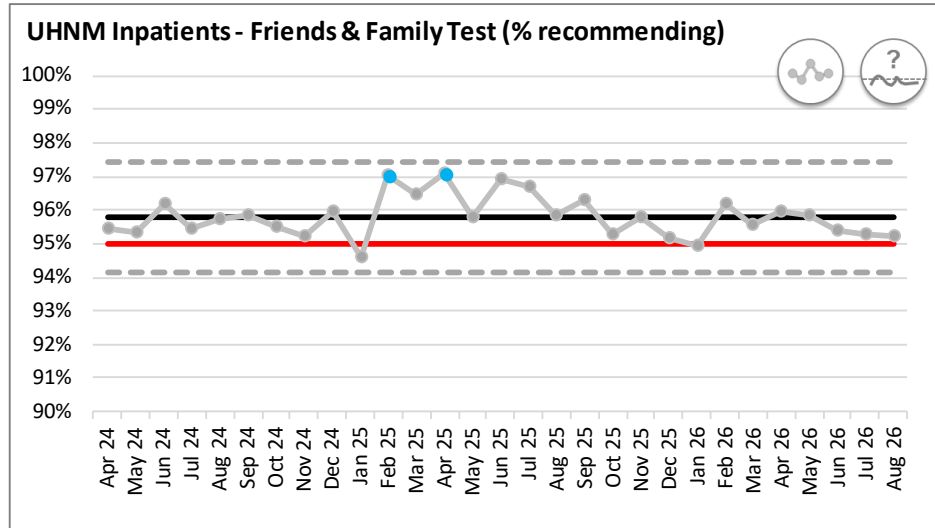
Individual area support and offer to attend the bronze ward review where appropriate.

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

Public View FFT Inpatients Acute Trusts Benchmarking (July 2026)



What is driving this performance?

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

In August 2026, a total of 2919 responses were collected from 68 inpatient and day case areas equating to a 27% return rate, which is within the usual range.

Average Care Group Scores are as follows:

- Unplanned - 19% response rate, 95% satisfaction score
- Planned - 38% response rate, 96% satisfaction (30% response target met since Apr-24)
- CSS (excluding Maternity, see separate slide) - 23 % response rate, 99.4% satisfaction score

What are we doing about it? (action orientated with timeframes)

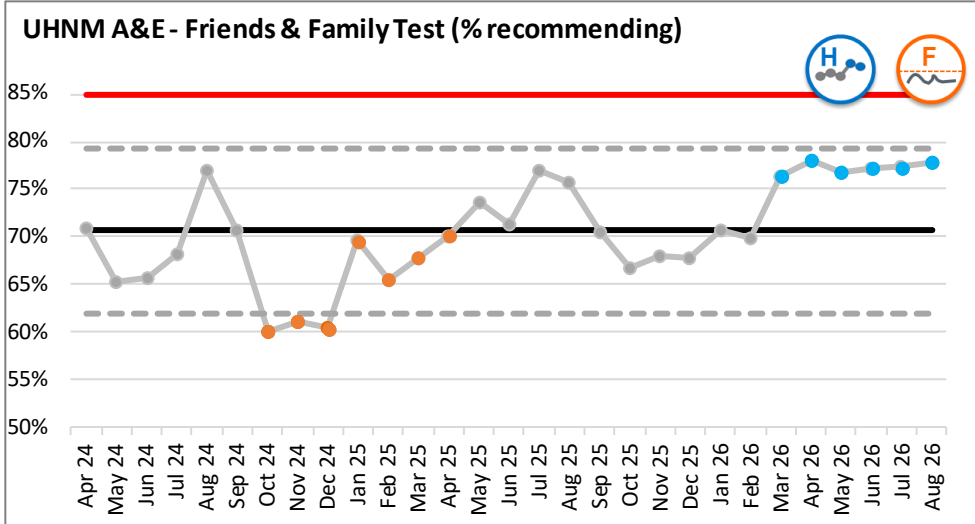
Recommendation Rates are visible on the 'Safe in our Hands' Dashboard.

Review each Clinical Care Group scoring and identify areas for improvement. FFT areas of celebration and areas for improvement to be shared monthly at Patient Experience Group.

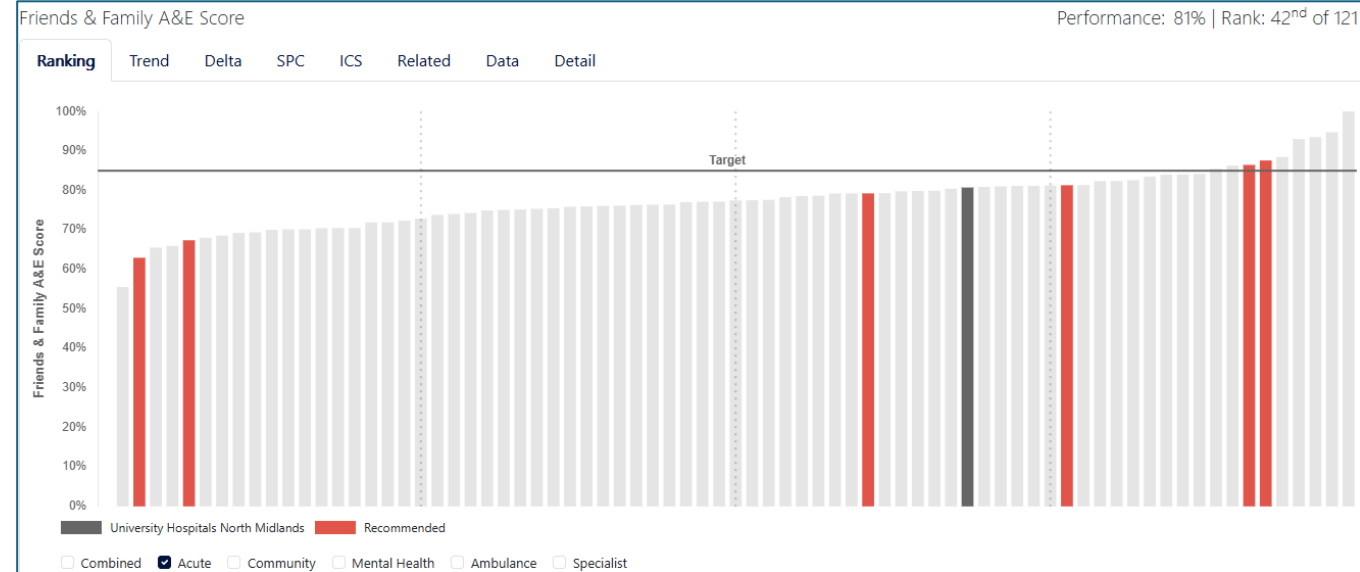
Monthly focus meeting with Heads of Nursing for each Care Group to identify areas they're proud of and areas for improvement based on FFT comments/feedback.

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

Provide safe, effective and caring services



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



What is driving this performance?

The Trust received 1417 responses in August 2026 - a 16% response rate which remains significantly above average since Apr-26. Satisfaction rates remain slightly below the national average of 80% (NHS England April 2026) although rates have been significantly higher than usual since Mar-26. ED County had a higher response and recommend rate at 22% and 86% respectively. ED Royal Stoke have 13% response rate and 72% recommend rate. ED County response and recommend rates both remained significantly above average in August. ED Royal Stoke response rate was again significantly above average in August.

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

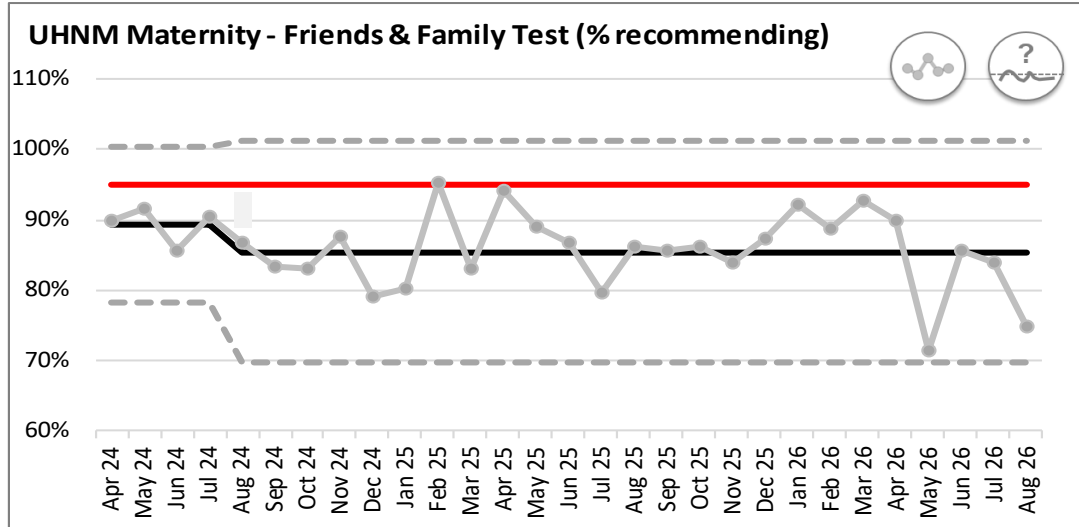
Themes for improvement from April 26 continue to be long waits for both sites. Access to pain relief and not feeling assured by the level of investigations undertaken are also key themes.

What are we doing about it? (action orientated with timeframes)

- Simplified ED survey" now only containing the mandatory "Overall, how was your experience of our service?" with the 6 response options ("very good" through to "very poor" or "don't know" in place.
- Dept Leads to consider how to make improvements with regards to communication in relation to staff attitude and patients feeling dismissed.
- Monthly focus meetings with HoN re continuing to increase response rate.

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

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What is driving this performance?

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

There were a total of 79 surveys received in August 2026 across all 4 touch-points (ante-natal, birth, post-natal ward; post-natal community) with 34 of these being collected for the "Birth" touch-point, making the response rate 7% which is within the usual range. The average satisfaction scores are Ante-natal: 80%, Birth: 87%, Post-natal ward: 88%, Post-natal community: 88%. No significant shifts or trends are currently evident in any of these satisfaction scores.

What are we doing about it? (action orientated with timeframes)

Continue to monitor the efficacy of collecting feedback via text message

Proposal put forward for "business cards" with QR code. Waiting confirmation from Management team.

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

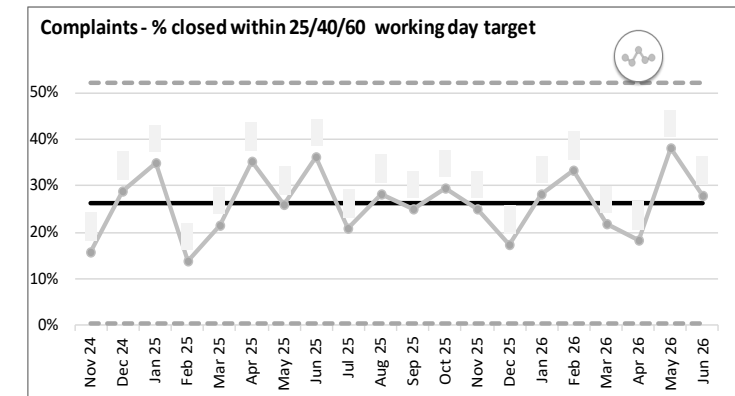
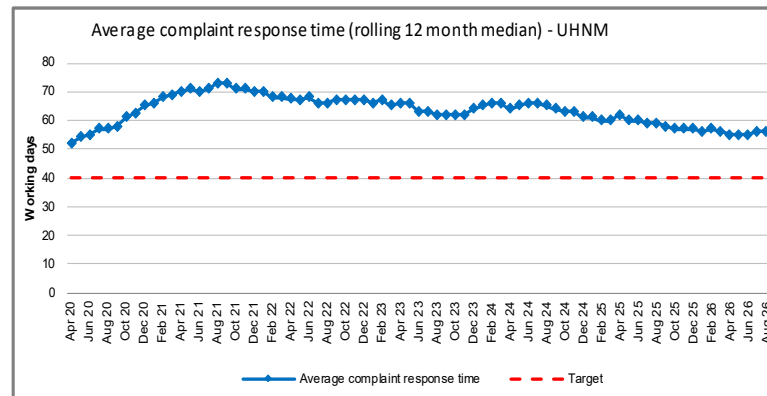
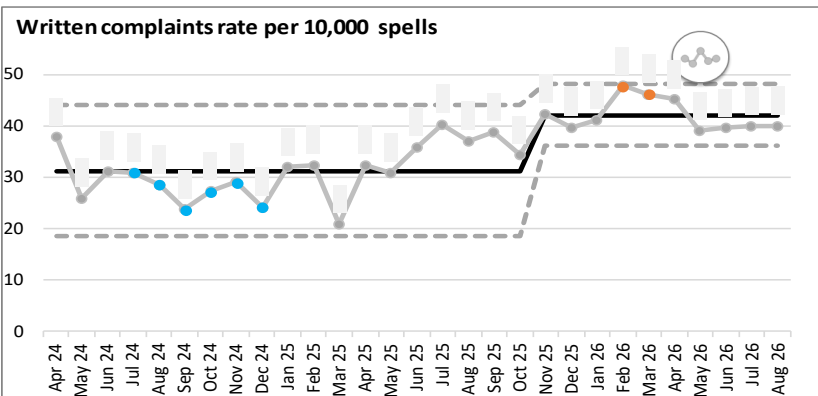
Monthly focus meeting with Heads of Nursing to discuss FFT response rate and results.

Quality & Access | [Formal Complaints]

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What is driving this performance?

The rate of complaints received has been around a third higher than previously since Nov-25. Increases have been noted in relation to clinical treatment, patient care, appointments categories but not in relation to staff values or admissions, discharges & transfers.

80 complaints were closed in August 2026, with a median average response time of 50 working days (chart displays the rolling 12-month average). Although the average response time remains some way above the target, it has come down significantly since the post-pandemic peak in 2021.

260 complaints were open at the end of August 2026, of which:

- 8 had been open longer than 12 months
- 26 had been open 6 – 12 months
- 57 had been open 3 – 6 months

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

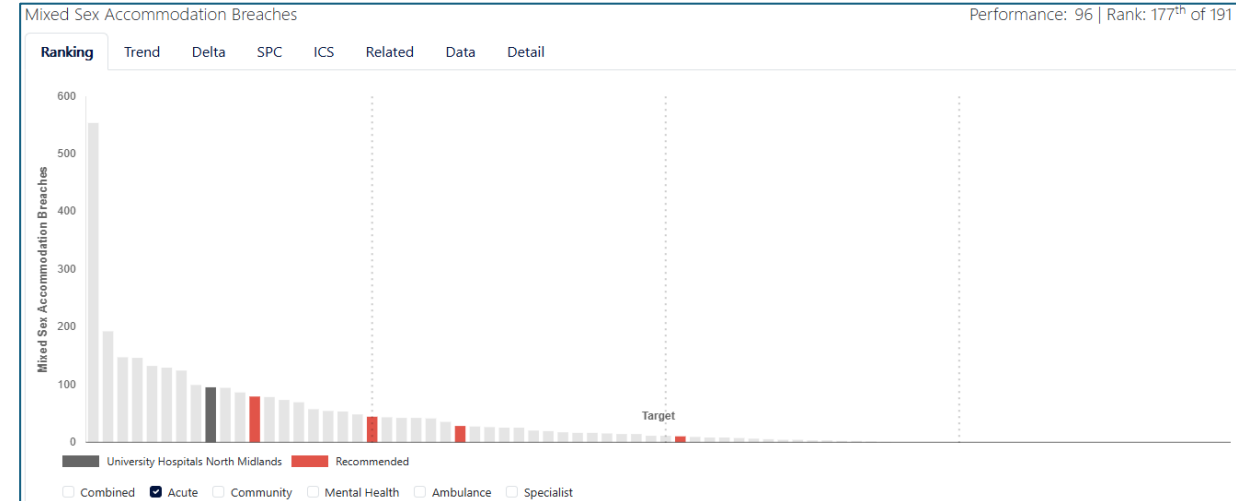
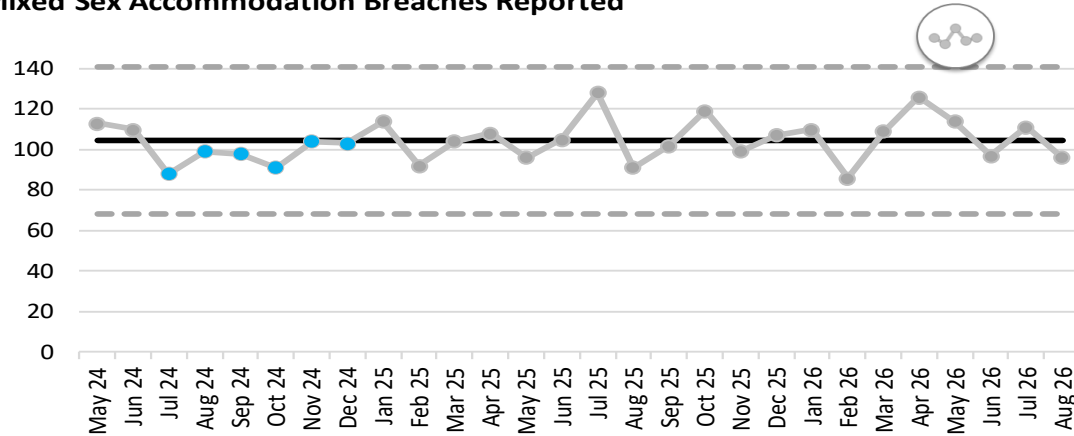
What are we doing about it? (action orientated with timeframes)

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

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

Provide safe, effective and caring services

Mixed Sex Accommodation Breaches Reported



What is driving this performance?

The number of mixed sex accommodation breaches remains within the usual range, with no significant shifts or trends currently evident. 7 of these breaches are Welsh patients and counted as Non-English Commissioner. NHSE will count 89 breaches for August 2026.

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? (action orientated with timeframes)

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 will 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.

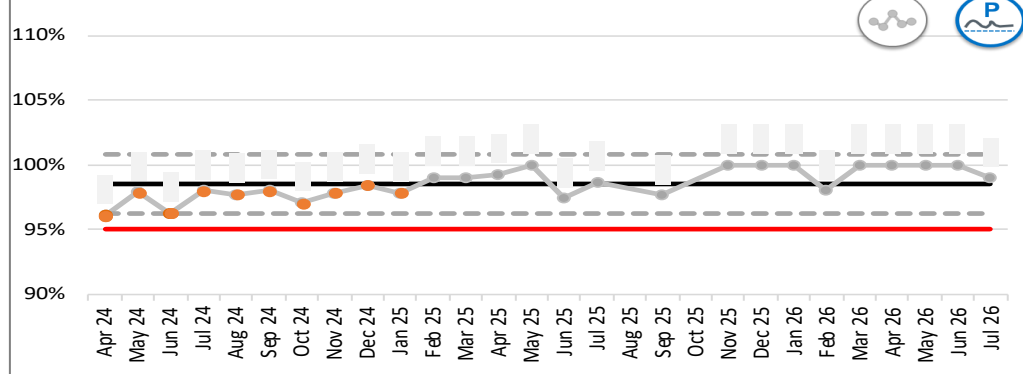
Quality & Access | [Induction of Labour & MAU Triage]

Provide safe, effective and caring services

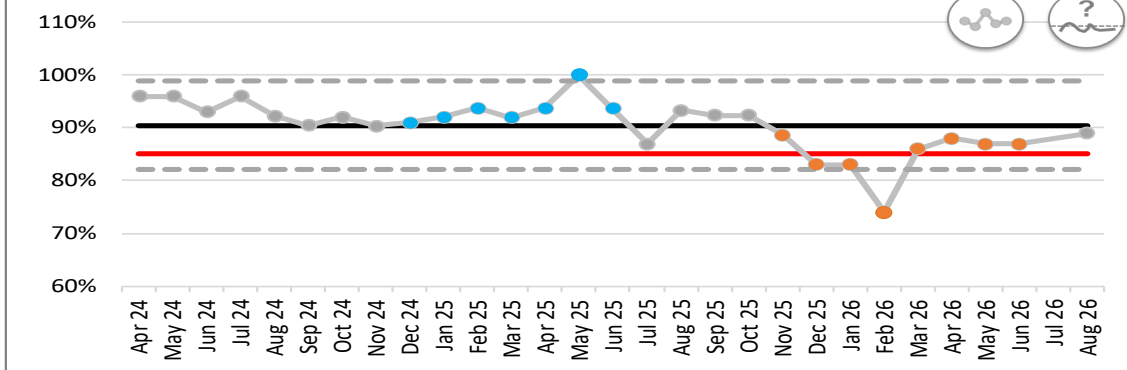


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Maternity Induction of Labour - Breach performance



Maternity Assessment Unit Triage within 15 minutes



What is driving this performance?

Induction of Labour (IOL)

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

Compliance with IOL for July is 99%

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

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

Breach dates challenged when outside of guidance.

MAU triage within 15 minutes

Although current performance remains below the historical levels achieved during 2024 and early 2025, the recent upward trend is encouraging and indicates progress towards returning to the expected standard. Continued monitoring and targeted actions are required to sustain improvement and achieve consistent compliance above the 85% threshold.

What are we doing about it? (action orientated with timeframes)

Induction of Labour (IOL)

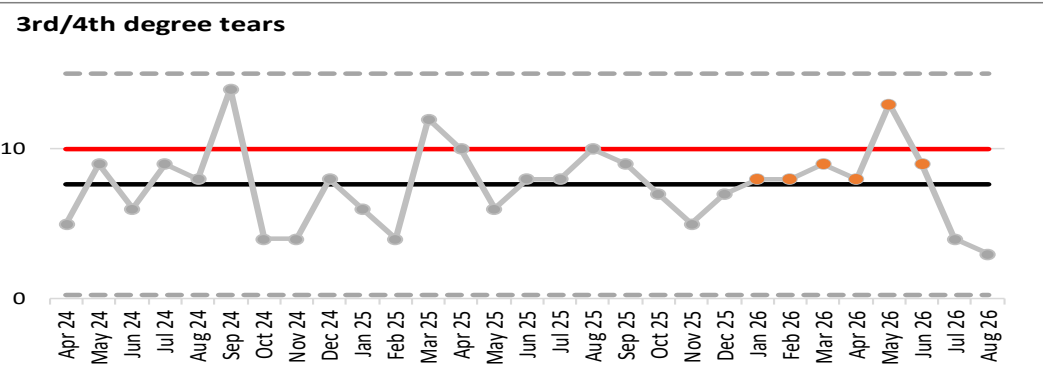
- Any IOL breaches are safety netted and incident reported for full review through the internal governance process.
- Any IOL breaches are discussed daily at the patient safety huddle and escalated and any IOL breaches will have a well-being appointment with a medical review and if necessary, admitted for observation (admission will be offered prior to breaching when this is forecast)
- Prioritisation occurs daily by the on-call Consultant Obstetrician for all IOL's booked for that day
- All midwifery induction core vacancies now recruited.

Maternity Triage

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

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

Provide safe, effective and caring services



What is driving this performance?

3rd/4th degree tears

There were 3 recorded 3rd/4th degree tears in August 2026. August position represents a notable reduction compared with recent months and is below the historical average shown on the chart. While monthly variation is expected, the reduction seen in July and August is encouraging. The service will continue to monitor rates closely and review cases to ensure learning is identified and improvements in maternity care are sustained

Neonatal deaths

4 neonatal death was recorded during August 2026 and although increase remains in normal variation. The chart demonstrates the expected month-to-month variation associated with relatively small numbers, with most months recording between 1 and 3 deaths.

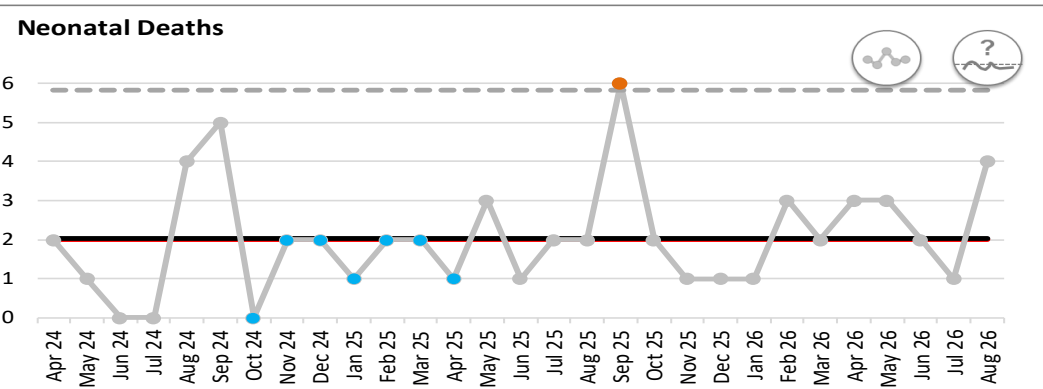
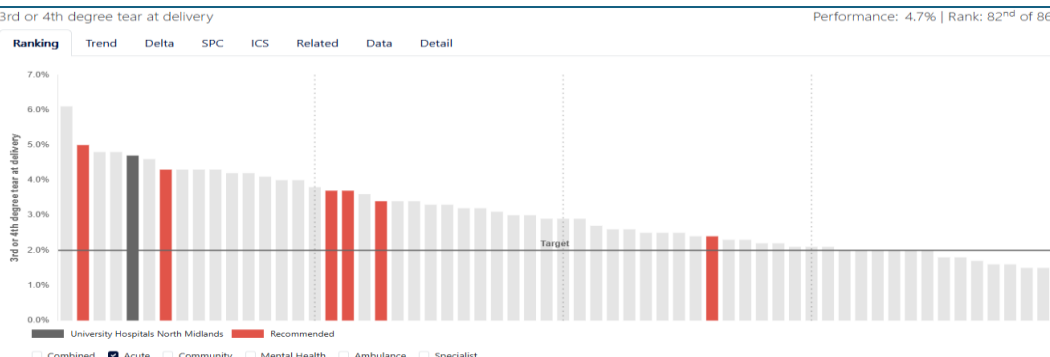
What are we doing about it? (action orientated with timeframes)

3rd & 4th Degree Tears (OASI)

- Clinical Managers have been requested to submit any retrospective data by the end of each completed working week to ensure timely review of incidents and prompt learning to be identified.
- OASI incidents are audited by the Perineal Health Team at UHNM and any themes addressed through training and feedback.
- 2024 NMPA – within mean- UHNM no longer identified as an outlier

Neonatal Deaths

- All Neonatal Deaths receive an Obstetric and Neonatal rapid review of care to identify any concerns or learning to be actioned immediately. Following on from the rapid review all Neonatal Deaths are investigated using the National Perinatal Mortality Review Tool (PMRT). These reviews are reported to the Directorate, Care Group and Trust Board.
- UHNM is part of the WMPN (West Midlands Perinatal Network) and work together to provide external assurance within the PMRT framework. MIS Year 7 has introduced a standard for 50% external assurance of all cases.
- External Neonatal Mortality report received into the Trust from Regional Midwife to be shared to committee. Action plan in progress.
- Response to 2025 themes – thematic review of NEC and maintenance of all Periprem and Saving Babies Lives standards.

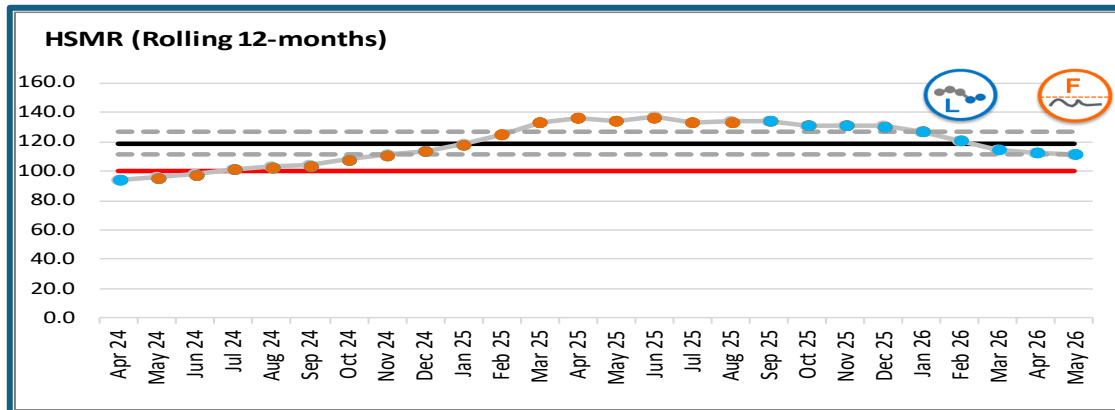
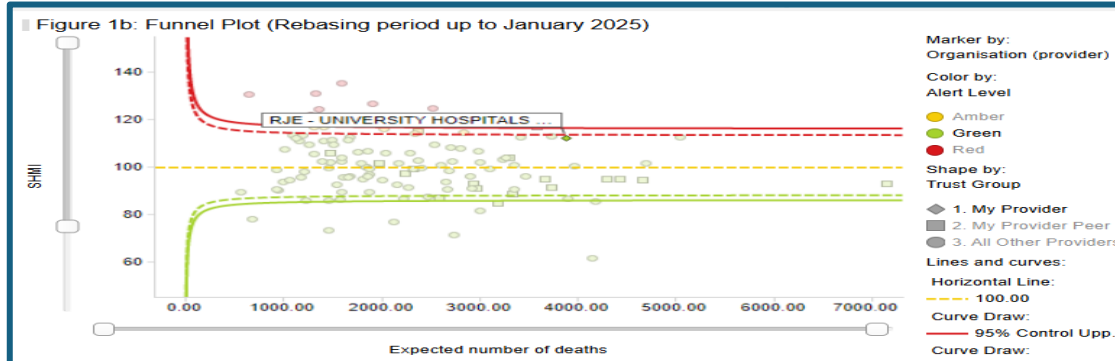
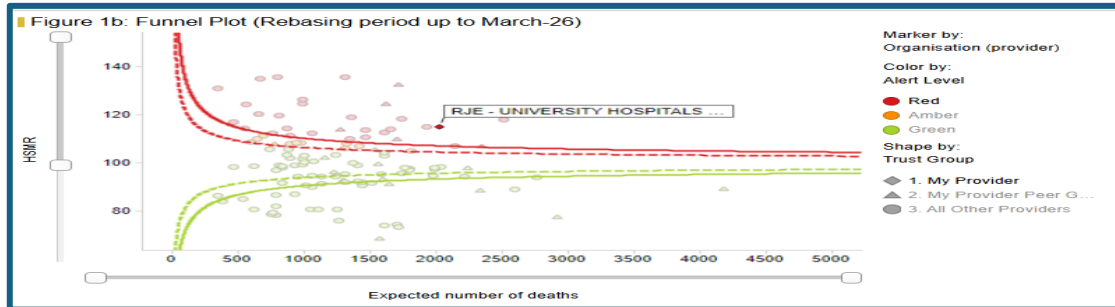


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Quality & Access | [HSMR / SHMI]

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What is driving this performance?

UHNH HSMR remains higher than expected based on case mix and standardisation for current 12-month period (June 2025 – May 2026). The current 12-month HSMR is 111.5.

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

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

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

What are we doing about it? (action orientated with timeframes)

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

Quality & Access | [NPSA Alerts received and overdue]

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Open / Overdue Alerts:

	Year	Alert Type	CAS Status	Alert Reference Number	Alert Title/Device	Date Issued	Deadline Date	Comments	Actions
	2025	Nat/PSA	Open	Nat/PSA/2025/006/NHPS	Harm from Allergic reaction due to misinterpretation of prescription.	20/11/25	20/11/26	There are reports of healthcare staff recording a patients penicillin allergy as penicillamine allergy in the EPMA. This look-a-like sound-a-like error risks a patient with a known penicillin allergy being administered a penicillin base antibiotic and having a potentially fatal reaction.	Work with digital systems to develop/deploy additional built-in mitigations to reduce inadvertent recording of the wrong allergy.
	2026	Nat/PSA	Open	Nat/PSA/2026/004/MHRA	ResMed Astral 100 and 150 Ventilators: Potential for Patient Harm due to Unexpected Interruption of Ventilation Therapy	17/08/2026	17/02/2027	Field Safety Notice (FSN) regarding Astral 100 and 150 ventilators and associated Printed Circuit Board Assembly (PCBA) spare parts manufactured prior to October 2024. An internal supercapacitor may leak electrolyte, causing damage to specific circuitry of the PCBA and unexpected interruption of ventilation therapy. If the issue occurs while the ventilator is delivering therapy, ventilation therapy stops immediately; a high priority audible alarm activates, and the user interface may display therapy alarms and a Safety System Fault red screen. If the issue occurs while the device is in standby, a maximum volume alarm activates, and the user interface message may not be displayed. Once the fault occurs, the ventilator becomes inoperable and cannot be restarted. Alternative ventilation is required immediately.	Alert shared with relevant staff. Field Safety Notice mentioned in alert already shared with Ward 215 Care Co-ordination Team when received from ResMed 01/07/26, actions taken and Clinical Technology dealing with aspects within the FSN. Awaiting completion of Action Plan for assurance.

What is driving this performance?

In August 2026 UHNM received 1 new Patient Safety Alerts that were applicable to the Trust.

There are 2 NHS Patient Safety Alert open, and both are within the nationally set completion deadlines.

What are we doing about it? (action orientated with timeframes)

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



Quality & Access | [Clinical Effectiveness]

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

- Urology – 14 recommendations
 - 3 actions completed
 - 1 actions on track
 - 10 problematic actions – The problematic actions are currently with the Urology clinical and management teams to review. Issues currently being addressed include:
 - Increased access to robotic time – needs to be supported by additional theatre lists
 - Job planning and Consultant availability
 - Review of coding processes
 - Review of the pathway between UHNM and SATH
- Vascular – 22 actions
 - 3 actions completed
 - 10 actions on track
 - 5 delayed actions – The problematic actions are currently with the Vascular clinical and management teams to review. Issues currently being addressed include:
 - Possible business case to support the provision of a Perioperative Care for Older People undergoing Surgery Service
 - Job planning
 - Tracking patients requiring elective aortic aneurysm repair and carotid endarterectomy to determine reasons for delays
 - Provision of service model for Diabetic patients.
- 10 Clinical Audits were published in Q4:
 - 3 Significant Assurance
 - 3 Significant Assurance with Minor Improvements
 - 4 Partial Assurance

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

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

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Access to Services



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Access to services				Data period	Provider value	Chart
• Access to services domain segment				Q1 2026/27	3	NOF Score
• Access to services domain score				Q1 2026/27	2.73	NOF Score
Elective care	Data period	Provider value	Peer average ⓘ	National value	National value method	Chart
• Percentage of cases where a patient is waiting 18 weeks or less for elective treatment score			Q1 2026/27	3.09	NOF Score	Provider value
• Percentage of cases where a patient is waiting 18 weeks or less for elective treatment	Jun 2026	63.05%	65.30%	65.45%	Provider median	
• Percentage of cases where a patient is waiting more than 52 weeks for elective treatment score			Q1 2026/27	3.52	NOF Score	Provider value
• Percentage of cases where a patient is waiting more than 52 weeks for elective treatment	Jun 2026	1.89%	1.50%	1.07%	Provider median	
• Percentage of cases where a patient is waiting more than 52 weeks for community treatment score			Q1 2026/27	1	NOF Score	Provider value
• Percentage of cases where a patient is waiting less than 18 weeks for community treatment score			Q1 2026/27	1	NOF Score	Provider value
Diagnostics	Data period	Provider value	Peer average ⓘ	National value	National value method	Chart
• Percentage of referrals where the patient is waiting six weeks or longer for a test or procedure score			Q1 2026/27	2.92	NOF Score	Provider value
• Percentage of referrals where the patient is waiting six weeks or longer for a test or procedure	Jun 2026	21.62%	39.26%	17.06%	Provider median	
Cancer care	Data period	Provider value	Peer average ⓘ	National value	National value method	Chart
• Percentage of cases meeting the 28 day faster diagnosis standard score			Q1 2026/27	2.48	NOF Score	Provider value
• Percentage of cases meeting the 28 day faster diagnosis standard	Q1 2026/27	78.55%	78.74%	79.51%	Provider median	
• Percentage of cases treated within 62 days of referral score			Q1 2026/27	3.29	NOF Score	Provider value
• Percentage of cases treated within 62 days of referral	Q1 2026/27	65.62%	68.18%	70.39%	Provider median	
Urgent care	Data period	Provider value	Peer average ⓘ	National value	National value method	Chart
• Percentage of A&E patients admitted, transferred or discharged within four hours of arrival score			Q1 2026/27	3.71	NOF Score	Provider value
• Percentage of A&E patients admitted, transferred or discharged within four hours of arrival	Q1 2026/27	67.90%	73.10%	75.60%	Provider median	
• Percentage of patients spending 12 hours or longer in an emergency department without being admitted, discharged or transferred score			Q1 2026/27	3.55	NOF Score	Provider value
• Percentage of patients spending 12 hours or longer in an emergency department without being admitted, discharged or transferred	Q1 2026/27	14.22%	12.12%	10.00%	Provider median	

Overall: UHNM remains in segment 3, although the domain score increased from 2.51 in Q4 to 2.73 in Q1, reflecting deterioration across elective, cancer, and urgent and emergency care.

Elective care: RTT 18-week and 52-week performance declined, with both measures performing less favourably than peer organisations.

Cancer care: 28-day Faster Diagnosis Standard performance was unchanged. However, the score increased from 2.00 to 2.48, indicating that UHNM improved less than comparator trusts. The 62-day position also deteriorated, with performance reducing from 67.02% to 65.62% and the score increasing from 3.00 to 3.29.

Urgent and emergency care: Four-hour performance has improved since Q3, with the score improving from 4.00 to 3.71. In contrast, 12-hour performance deteriorated from 10.69% in Q4 to 14.22% in Q1, and the score increased from 3.00 to 3.55. UHNM compares unfavourably with peers on both measures.

Diagnostics: The six-week diagnostic waiting-time measure has been introduced from Q1.

The best joined-up care for all



Quality & Access | Overview

Overview from the Chief Operating Officer

How are we doing against our trajectories and expected standards?

Non-Elective

Validated 4-hour performance data for August demonstrated a 1.3%pt deterioration in performance compared to July, with performance at 66.8% in month. This remains behind plan by 9.4%pts. County continues to perform better than the RSUH site, and continues to support ambulance divert between the sites.

In month, 2107 patients waited longer than 12 hours in ED (1,023 more than plan, and 2 more than July). 8.4% of patients in ED breached 12 hours, vs 8% in July, and an August target of 4.3%.

August saw 5443 ambulances arrive at UHNM (20 more than July), with an average handover time of 1 hour 19 minutes, 10-minutes worse than performance in July. 64.2% of ambulances were handed over within 45 minutes (2.7%pts worse than performance in July, and 14.5%pts short of plan for July).

August saw a decrease in walk-in attendances, and a minor increase in ambulance attendances. Overall, a reduction in attendances of 1,330. Despite this, attendances still significantly exceeded that of the Winter months (Dec – Feb). Acuity also remains high, with over 60% of ED attendances requiring Majors or Resus.

Corridor Care utilisation remained in July, but subsequent to the CQC visit, ED corridor care has ceased on 12th August. We continue to use corridor care on ward areas as continuous flow.

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

Elective

Cancer:

Combined faster diagnosis standard performance final July position was reported at 80.6% against a trajectory of 81.5%. The provisional August position is currently at 83.4% against a trajectory of 79.87%

31-day final July position was reported at 93.8% against a trajectory of 91.9%. The provisional August position is currently at 92.8% against a trajectory of 93.27%

Combined 62-day performance final July position was reported at 68.8% against a trajectory of 69.6%. The provisional August position is currently at 68.5% against a trajectory of 69.6%

Diagnostics:

August DM01 validated performance was 73.8% against trajectory of 98.4%. Current performance is 80.5 (17/09). 99% being the national standard.

CDC delay to go live for endoscopy has an impact on DM01 performance, alongside challenges for MRI with humidity.

RTT:

18-week performance has deteriorated in August to 59.2% (unvalidated) from 61.4% (validated) in July.

Our 52-week performance is monitored as a % of patients on our total waiting list who are over 52 weeks. For the month of August, 52-week actuals increased from 2.05% to 2.32%. This standard is to achieve by the end of the year is to get to 1%.

RTT % Waiting 1st Contact for August was 72.2%.

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.

Quality & Access | Overview

Overview from the Chief Operating Officer

What is driving this?

Non-Elective

- The maintenance programme has continued to impact on our capacity at RSUH. The creation of the decant ward (122) following the closure of W80, has facilitated the continuation of the maintenance programme and has supported the continued increased utilisation of the TDL when the space allows.
- Attendance volumes continue to be elevated, with circa 25,000 attendances again in August. We normally anticipate a drop in attendances in July and August, but the surge in attendances this year, related to the high temperatures, has bucked the usual summer trend. Along with other NHS providers, we will be completing the Summer Surge planning in coming months.
- Whilst January 26 to April 26 saw a year-on-year reduction in the ambulance handover lost hours of around 7,500 hours, May 26 saw 567 more hours lost to ambulance handovers than the same month last year, and June saw an almost identical handover delay average compared to the same month last year. July and August performance is noticeably worse than the same month last year
- ED conversion rate remains higher than target – with weekly Type 1 performance in August ranging from 40% to 42%, 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 AMU and continuous flow risk assessed spaces. ED corridor has been closed subsequent to the CQC visit in early August.

Elective

Cancer: Challenges remain in access to timely surgery for first definitive treatments on surgical pathways. Imaging appointment and reporting delays contribute to most 62-day breaches, particularly in Lower GI and Gynaecology pathways. The lower GI referral optimisation hub will be stepped down from 1st October 26. New FIT Negative pathway will be implemented alongside this to divert noncancer patients away from the Colorectal cancer team. Skin cancer demand and activity continues to be closely monitored to prevent PTL growth and treatment breaches.

Diagnostics: MRI remains the primary contributor to overall diagnostic underperformance. July MRI performance was 63.8%, with latest reporting indicating 62.9% of patients are receiving diagnostics within six weeks. Recovery has been impacted by delays to the mobile MRI unit. Although the CDC has now opened and activity has commenced, Endoscopy continues to report significant recovery challenges.

RTT: 18-week performance has deteriorated again in August to 59.55% (unvalidated) from 62.61% (validated) in July and is now further behind plan.

Total PTL has increased very significantly again from 74,815 in July to 75,945 (unvalidated) in August. There are several factors contributing to this – lower than average removal rate sustained throughout June and into July, exacerbated by summer holidays. Reduction in activity, validation, and tracking, cancellations in theatres and MRI capacity due to the heat.

Quality & Access | Overview

Overview from the Chief Operating Officer

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

Non-Elective

- We have been chosen as one of seven Trusts in the Midlands for a Discharge Rapid Improvement Offer. This will enhance the existing work of WS3 and WS4 of the UEC Improvement Plan and will lead into the Discharge Marathon work that will run up until Christmas.
- Our UEC improvement plan is developing at pace, with each workstream established and working on high impact deliverables
- Each workstream now has a clear Executive SRO, Corporate sponsor, Care Group SROs, Clinical lead and Improvement support, complemented by the work of the GIRFT UEC team
- Governance of the workstreams has been simplified and strengthened, with a focus on continuous improvement
- We continue to meet weekly with the national GIRFT leads, focusing on rapid improvement actions to improve ambulance handover performance, reduce 12 hour in dept volumes and reduce corridor care
- We are planning a portal reconfiguration for early October, following the completion of the essential maintenance work in ED
- UTC opened on 7th September and the volume of patients seen in the first 2 weeks has been broadly in line with prediction.

Elective

Cancer: The development and implementation of a Cancer Waiting Times (CWT) Dashboard has been completed, providing site-level and target-level performance reporting. The overall cancer PTL position remains stable despite high referrals experienced over summer weeks. Small reduction in the 62+ day backlog. Challenges remain in access to timely surgery for first definitive treatments on surgical pathways. Imaging appointment and reporting delays contribute to most 62-day breaches, particularly in Lower GI and Gynaecology pathways. The lower GI referral optimisation hub will be stepped down from 1st October 26. New FIT Negative pathway will be implemented alongside this to divert noncancer patients away from the Colorectal cancer team.

Neurophysiology insourcing created 1,732 slots for 450 patients. Cardiology planned 1,000 insourced echoes, subject to executive agreement. CDC mitigation of TI / WLI to offset endoscopy activity loss. This is expected to significantly reduce the long wait position during the coming months.

Elective Recovery Plan on a Page have been drafted and will combine activity, with performance, including any incentives and agreed recovery bids already currently live. There are 17 Elective Recovery bids that are live or are still being mobilised. Expected activity for New / FUP / Elective / Daycase that supports on PTL size / RTT 18-week performance to be tracked weekly, with executive oversight given against the phasing of schemes going live. MBI ROVA license extended a further 12 months, with all approved recovery bids requiring all admin / operational teams to be trained and using MBI ROVA going forward. This will embed better focus on validation of next steps / to shut pathways of patients. Manual validation also commissioned through Patient Not Present funded allocation; further work being completed for the opportunity to send full pathways to IS pending confirmation of ICB allocation; specific focus on gynae and pain.

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

Overview from the Chief Operating Officer

What can we expect in future reports?

Non-Elective

We remain below trajectory and performance in August worsened compared to due, mainly due to the specific challenges of high attendances, acuity, our statutory maintenance programme, heatwaves and the removal of the corridor capacity in ED.

- Our performance remains below the standard we aspire to deliver
- 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. The decision to remove the ED corridor will further reduce the utilisation of corridor space in August.
- The opening of the UTC, the Portal Reconfiguration, EEMAC opening, the Emergency Medicine Workforce case and the Discharge Marathon RIO will all help to deliver improved performance in the coming months.
- 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

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

Cancer: Formalise the Cancer Transformation Programme, establishing robust governance arrangements, delivery oversight and clear programme objectives. Recruitment to project support roles is underway. Implement the Endometrial One-Stop Clinic model, supported by the introduction of Pentrox, to improve patient experience and pathway efficiency. Progress recruitment to a fifth Gynaecology-Oncology Consultant post to increase clinical capacity and support sustainable performance recovery. Roll out the GALEAS pathway within the Bladder Cancer service to reduce reliance on flexible cystoscopy procedures and streamline diagnostics. Strengthen governance arrangements for the Bladder Cancer Planning Meeting to support more efficient management of patients awaiting surgical intervention.

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

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

Quality & Access | Dashboard

KPI	Latest month	Measure	Target	Variation	Assurance
UEC 4 Hour Performance	Aug 26	66.8%	77.1%		
UEC 4 Hour Performance (Aged <18)	Aug 26	87.6%	77.1%		
Over 12 hours in ED	Aug 26	2096	-		
Over 12 hours in ED (Aged <18)	Aug 26	23	-		
Ambulance Handover Average Time	Aug 26	01:17:30	00:49:12		
Corridor Care ED	Aug 26	1780	-		
Corridor Care Inpatient (8am)	Aug 26	480	-		
Cancer 28 Day FDS	Aug 26	83.1%	82.7%		
Cancer 31 Day Combined	Aug 26	92.4%	94.8%		
Cancer 62 Day Combined	Aug 26	67.6%	80.5%		
Diagnostics DM01 Performance	Aug 26	73.8%	99.0%		
RTT Performance - <18 Weeks	Aug 26	59.2%	70.3%		
RTT Performance - % 52+ Weeks	Aug 26	2.3%	1.0%		
RTT Performance - % Waiting 1st Contact	Aug 26	72.2%	78.1%		
RTT Performance - <18 Weeks (Aged <18)	Aug 26	65.3%	70.3%		
RTT Performance - % 52+ Weeks (Aged <18)	Aug 26	2.5%	1.0%		
RTT Performance - % Waiting 1st Contact (Aged <18)	Aug 26	81.0%	78.1%		



Related Strategy and Board Assurance Framework (BAF)

BAF Risk	Q1		Q2		Q3		Q4	
	Risk	Assurance	Risk	Assurance	Risk	Assurance	Risk	Assurance
BAF 9: Inability to sustain safe and timely urgent and emergency care performance	Ext 20	Partial						

The best join

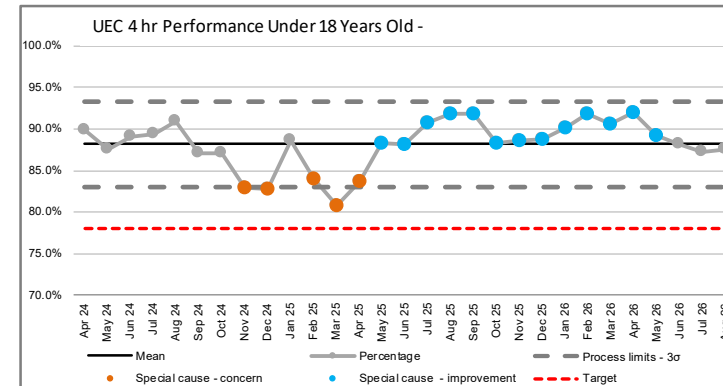
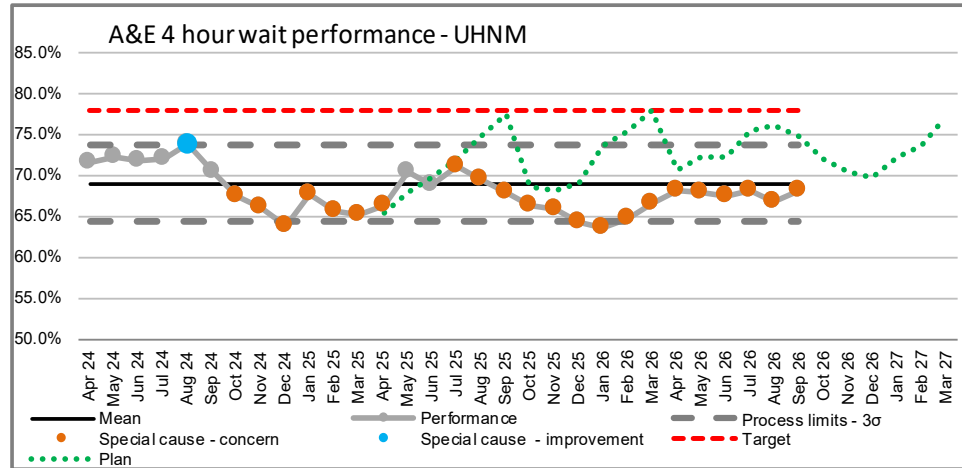


Assurance Grid

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

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

Quality & Access | UEC 4-hour Target



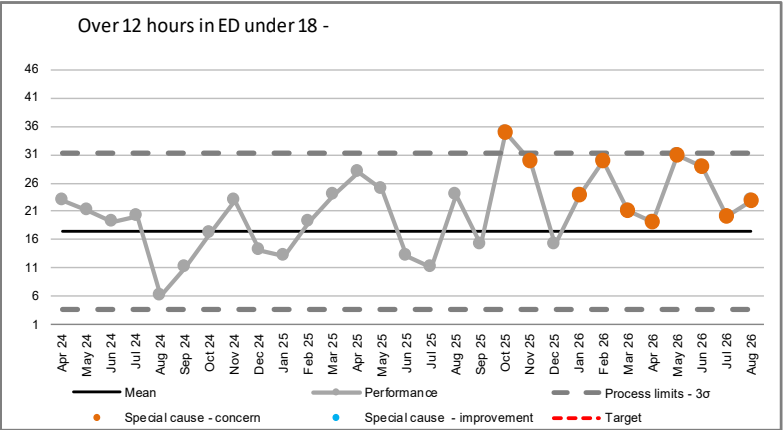
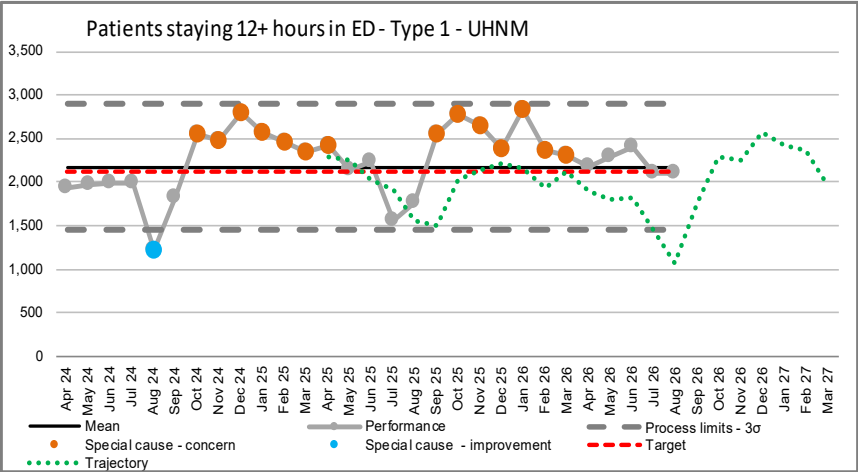
Variation	Assurance	Monitoring against plan				
			Jun 26	Jul 26	Aug 26	Sep 26
	Target 78%	Actual	67.6%	68.1%	66.8%	68.1%
Background		Plan	72.4%	75.4%	76.2%	74.8%
The percentage of patients admitted, transferred or discharged within 4 hours of arrival at A&E		Variance	-4.8%	-7.3%	-9.4%	-6.7%

ED - Attendances managed within 4 hours

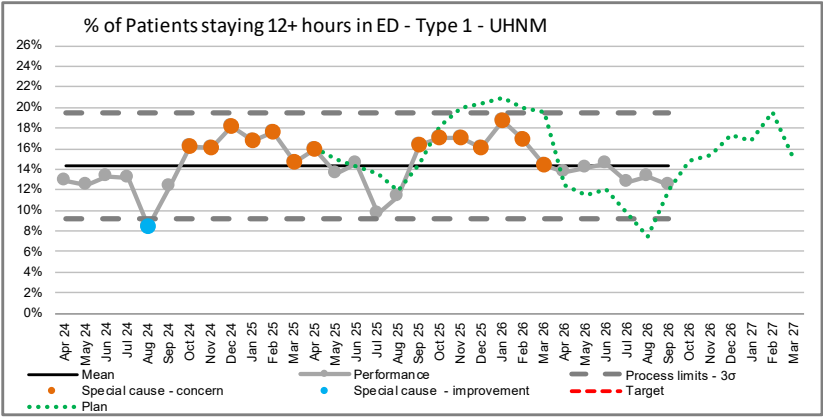
Performance: 68.08% | Rank: 110th of 148



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



Variation	Assurance		Monitoring against plan				
				May 26	Jun 26	Jul 26	Aug 26
		Target	2128	Actual	2,297	2,393	2,092
Background			Plan	1,800	1,825	1,450	1,077
The number of patients admitted,transferred or discharged over 12 hours after arrival at A&E			Variance	497	568	642	1019

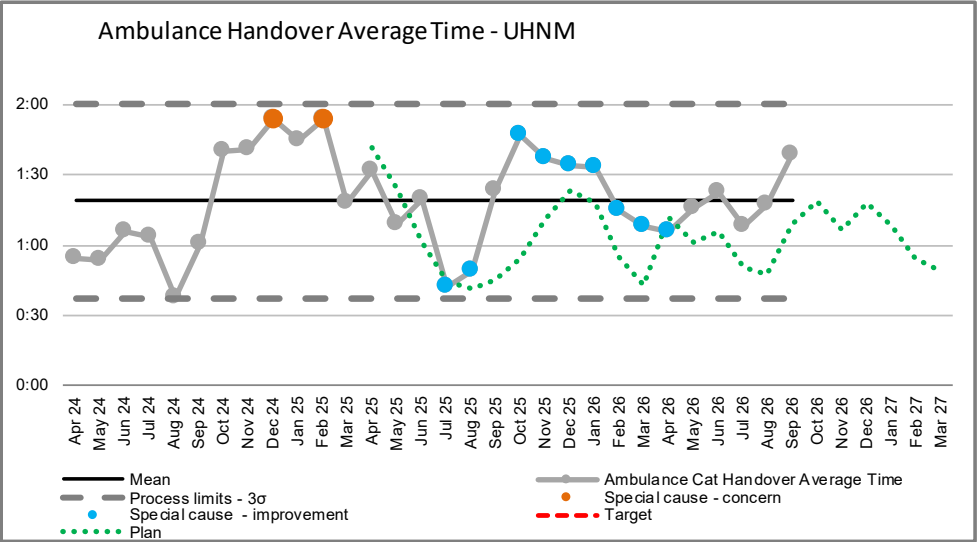


ED - Attendances over 12 hours in department

Performance: 13.8% | Rank: 99th of 125



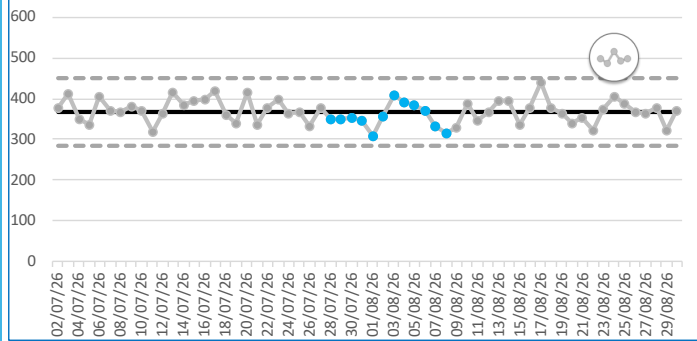
Quality & Access | Ambulance Handover Average Time



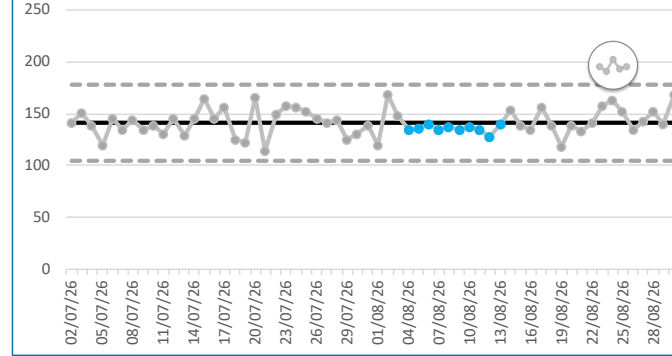
Variation	Assurance		Monitoring against plan				
				Jun 26	Jul 26	Aug 26	Sep 26
	Target	0:00:00	Actual	1:22:45	1:08:16	1:17:30	1:38:15
Background			Plan	1:05:21	0:50:16	0:47:23	1:08:48
The average time taken for patients to be handed over from Ambulances arriving at UHNM.			Variance	0:17:24	0:18:00	0:30:07	0:29:27

Quality & Access | Non Elective – Royal Stoke

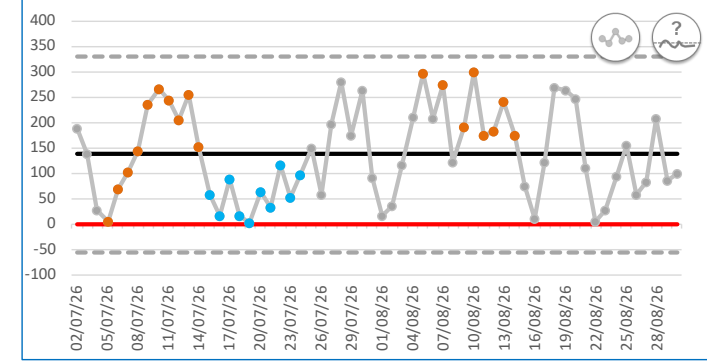
Attendances



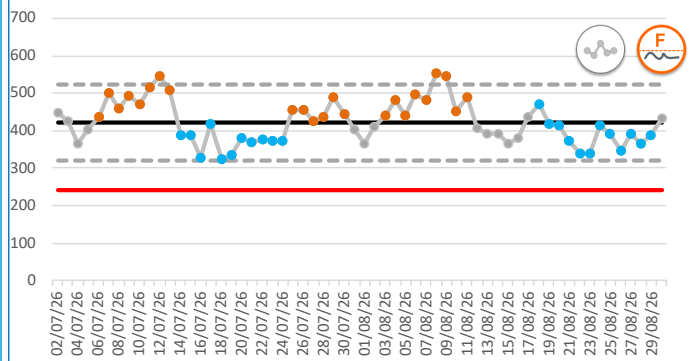
Ambulances Arrivals



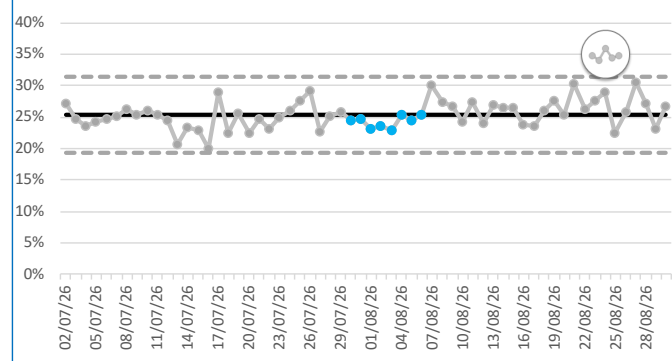
WMAS Lost Hours



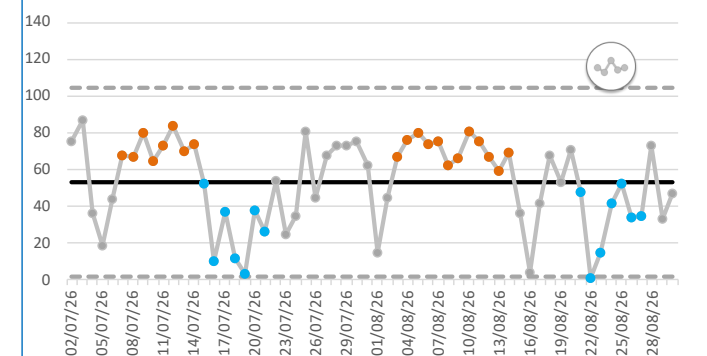
Time in ED - Mean



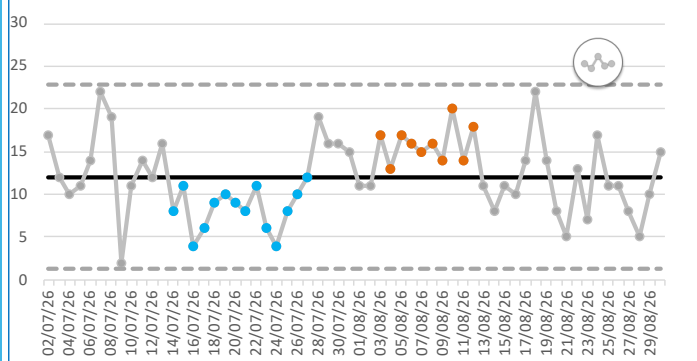
DTAs



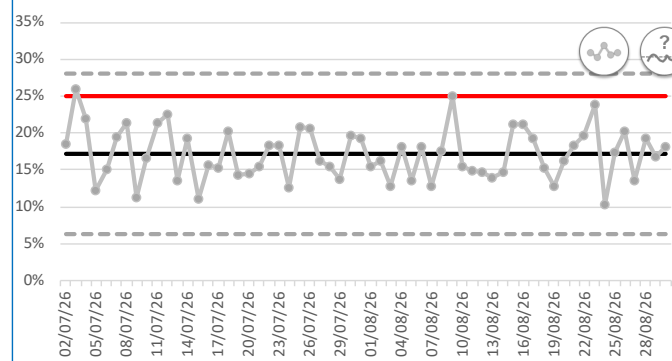
Corridor Care ED



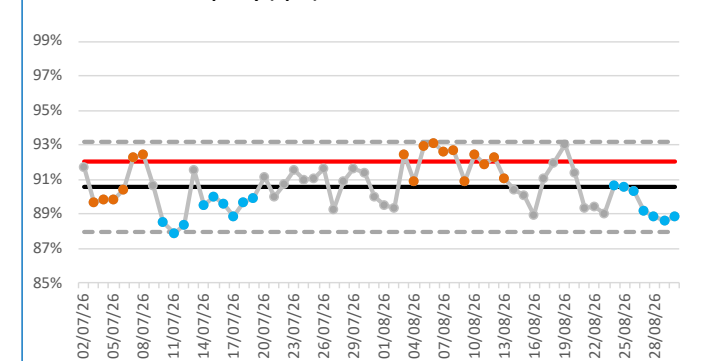
Corridor Care Inpatients - 8am Snapshot



Pre12pm

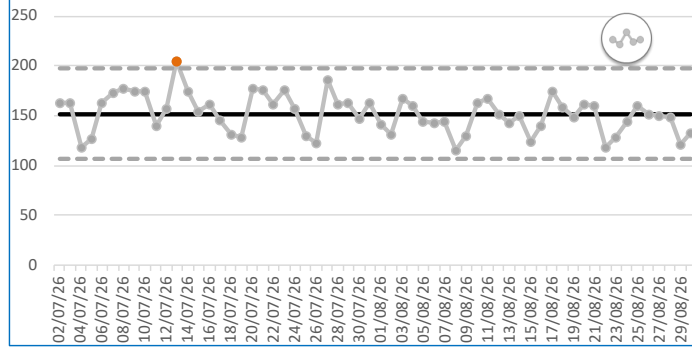


G&A Adult Bed Occupancy (4pm)

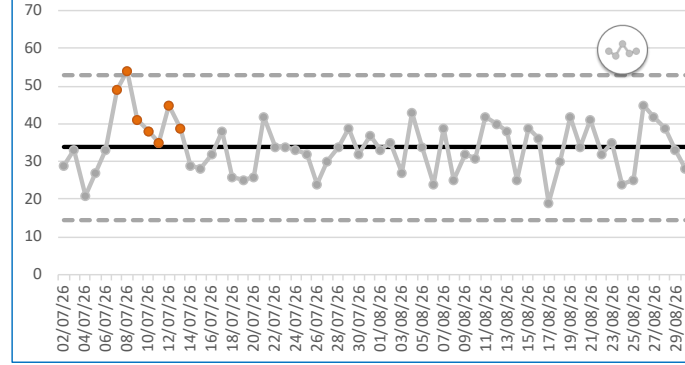


Quality & Access | Non Elective – County

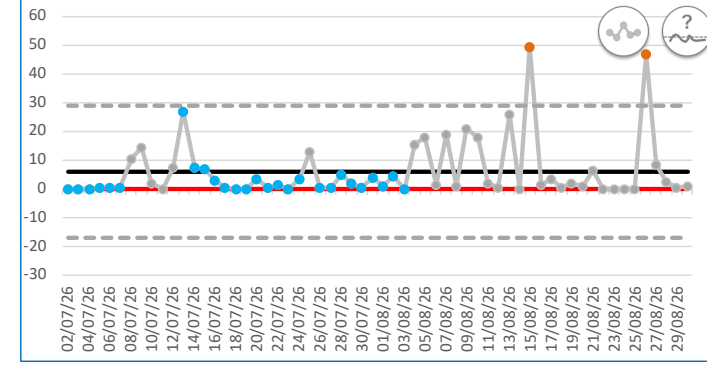
Attendances



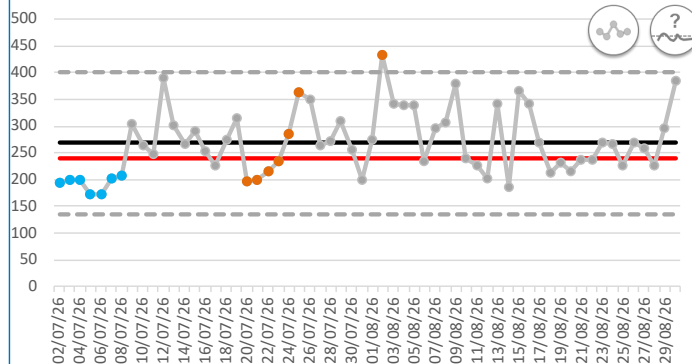
Ambulances Arrivals



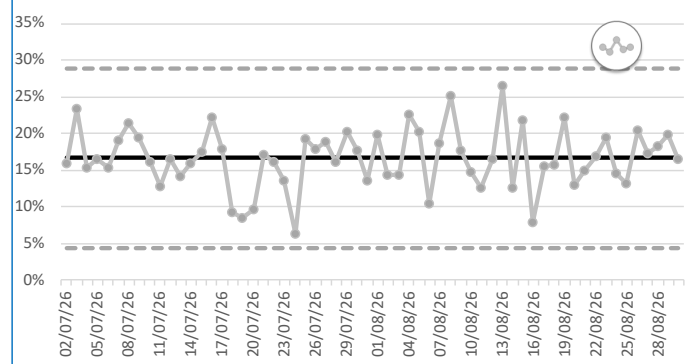
WMAS Lost Hours



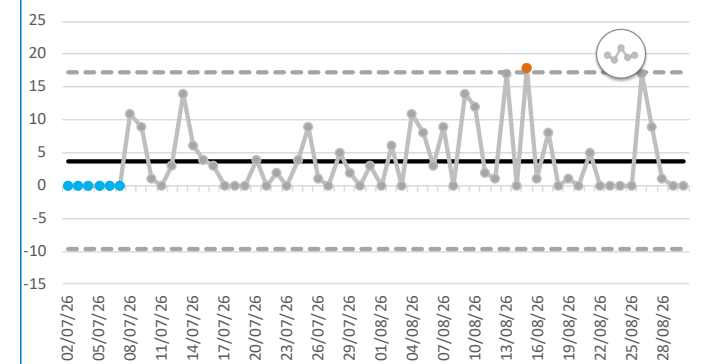
Time in ED - Mean



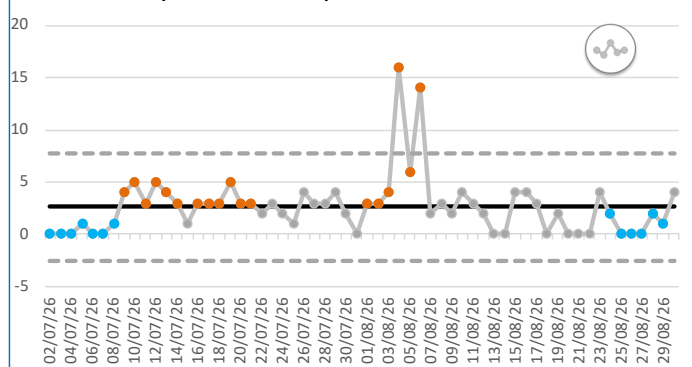
DTAs



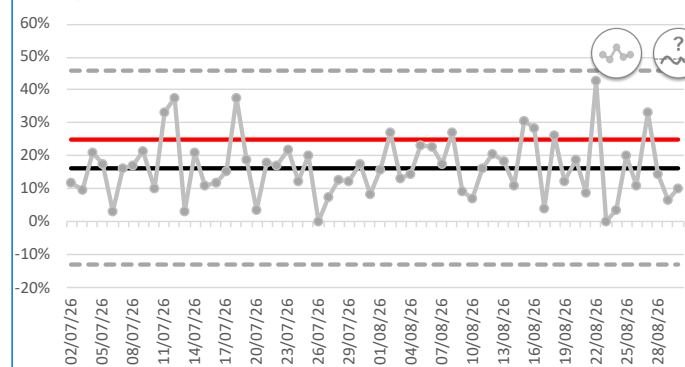
Corridor Care ED



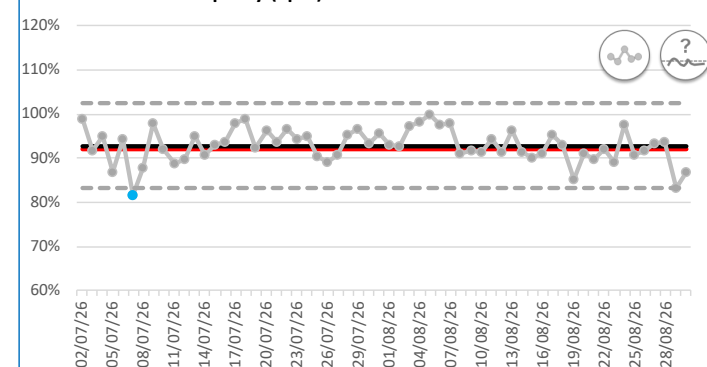
Corridor Care Inpatients - 8am Snapshot



Pre12pm



G&A Adult Bed Occupancy (4pm)



What is the data telling us?

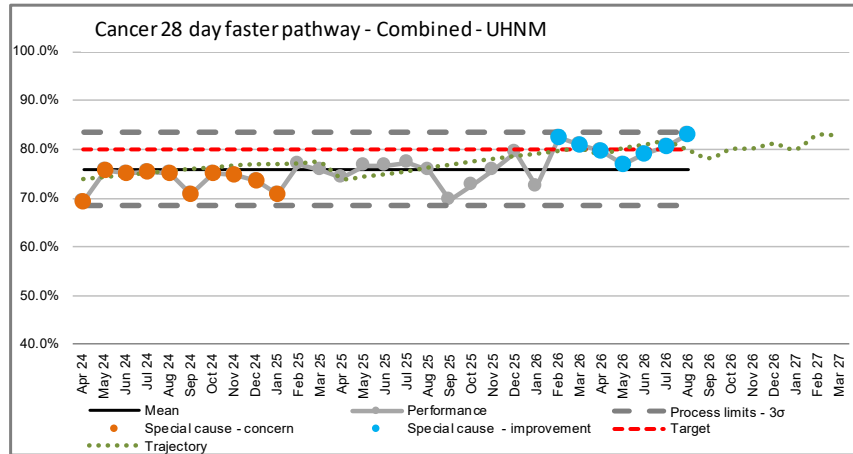
- The data for August is showing a minor reduction in 4-hour performance vs July, and 9.4% short of plan.
- There has also been a minor reduction in 12-hour performance in month. 8.4% of patients in ED breached 12 hours, vs 8% in July, and an August target of 4.3%.
- In month, 2107 patients waited longer than 12 hours in ED (1,023 more than plan, and 2 more than July).
- August saw 5443 ambulances arrive at UHNM (20 more than July), with an average handover time of 1 hour 19 minutes.
- This handover time is a 10-minute increase when compared with July.
- 64.19% of ambulances were handed over within 45 minutes (a 2.7% worsening in position since July and 14.5% short of plan in month).
- August saw a decrease in walk-in attendances, and a minor increase in ambulance attendances. Overall, a reduction in attendances of 1,330. Despite this, attendances still significantly exceeded that of the Winter months (Dec – Feb).
- County attendances were down slightly, but still the third highest recorded in the last 12 months.
- Continued high acuity with over 60% of ED attendances requiring Majors or Resus.
- Corridor utilisation remained very high in early August, but corridor care ceased on 12th August following CQC visit, which has led to some of the worsening in performance, particularly in relation to ambulance holds.

What are we doing about it?

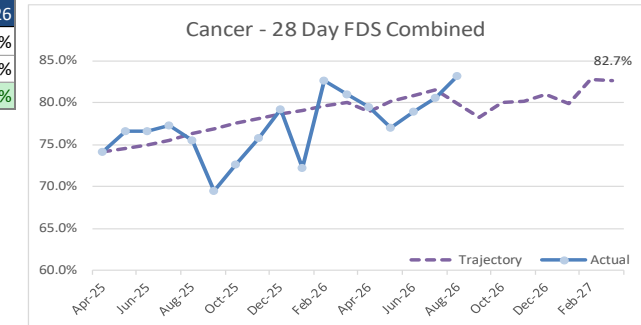
- Working with ICB around improving engagement regards call before convey, and utilisation of Silver Phone – reduced conveyances will help decompress department and improve performance.
- Working with WMAS to improve number of patients arriving with clinical frailty score to support improved FSDEC streaming.
- Decant ward created to support with maintenance programme – lessen net bed impact when wards shut due to maintenance works.
- AMRA opened to 24/7 to help mitigate / offset some of the lost corridor capacity
- UTC opens 07/09 to support with improved streaming of minor injury and minor illness out of ED.
- Work ongoing around portal reconfiguration following GIRFT visit. Derive efficiencies around timeliness of patient moves out of ED, with enhanced opening hours for Medical SDEC (24/7) for more consistent pull from ED all hours. Case went
- Simpler pathways for movement out of ED – Frailty SDEC, Medical SDEC, Surgical SDEC or inpatient bed.
- EEMAC to be opened on 21/09 which will operate similarly to CDU but significantly increased capacity with ringfenced nursing workforce to ensure it remains open and is not stood up / stood down



Quality & Access | Cancer 28 Day FDS



Variation	Assurance		Monitoring against plan					
				May 26	Jun 26	Jul 26	Aug 26	
Target			80%	Actual	77.0%	79.0%	80.6%	83.1%
Plan			80.2%	80.9%	81.5%	79.9%		
Variance			-3.2%	-1.9%	-0.9%	3.3%		
Background				Performance of confirmation or exclusion of cancer communicated with patients within the 28 day timeframe.				



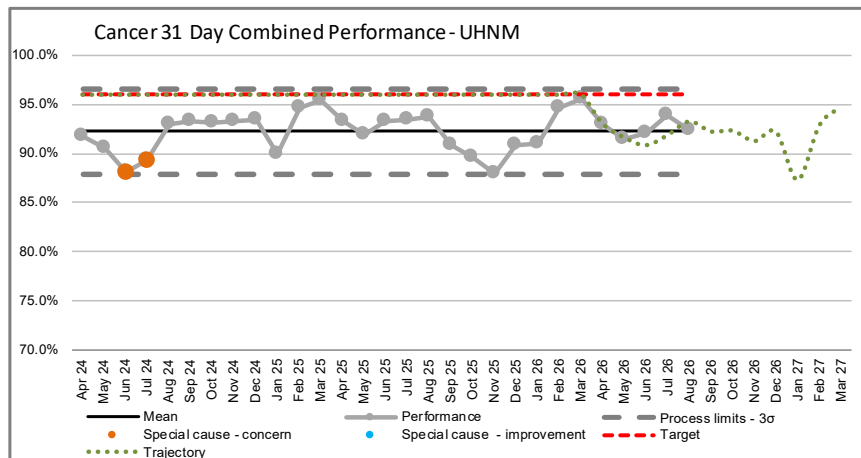
What is the data telling us?

- The **final** July position was reported at 80.6% against a trajectory of 81.5%
- The **provisional** August position is currently at 83.4% against a trajectory of 79.87%
- There is good performance among most specialties.
- Specialties performing particularly well include Skin, Breast, Upper GI & Paeds.
- Specialties falling below standard include H&N, Lung, Colorectal & Urology.
- Specialties falling way below standard but with low volumes include Haematology, Brain and Sarcoma.

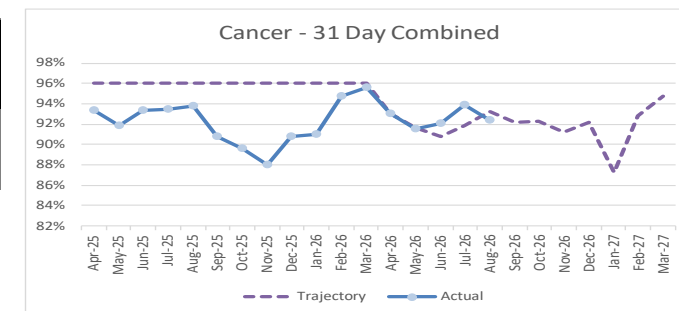
What are we doing about it?

- The standard was missed in May and June with a recovery demonstrated in July. The provisional August position is also strong, indicating that the standard will be achieved again for a second month.
- Imaging reporting delays are impacting timely diagnosis and rule out of cancer.
- Maintaining oversight through the Cancer Delivery Group meetings to bring focus on operational delivery for improvement plans and adherence to agreed trajectories for 26/27.
- A breakdown of cancer diagnosed versus excluded performance is provided to all specialties 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



Variation	Assurance	Monitoring against plan			
	Target	96%			
Background					
% patients beginning their treatment for cancer within 31 days following an urgent GP referral for suspected cancer					
		Actual	May 26	Jun 26	Jul 26
		Plan	91.5%	92.0%	93.8%
		Variance	-0.1%	1.2%	2.0%
			92.4%	93.3%	



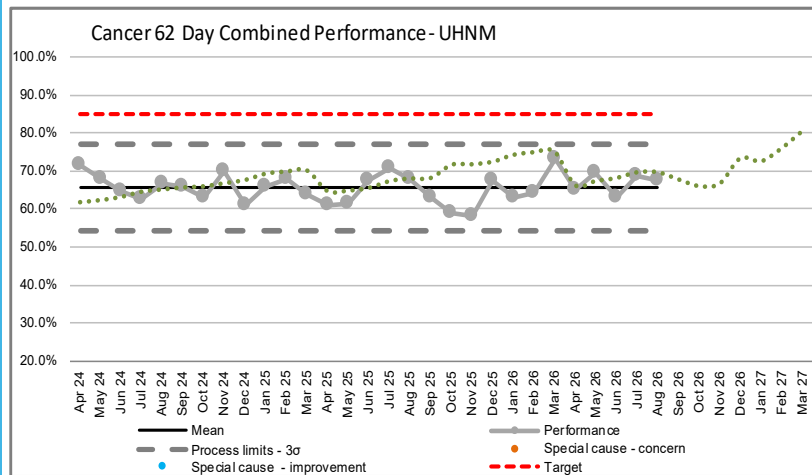
What is the data telling us?

- The **final** July position was reported at 93.8% against a trajectory of 91.9%
- The **provisional** August position is currently at 92.8% against a trajectory of 93.27%
- Strong performance reported across most specialties, particularly Breast, Gynae.
- However, underperformance across specialties in areas where access to surgical capacity remains challenged; Upper GI, Lung, Skin, Gynae, Colorectal, and Urology.
- Within the 31-day cohort of patients breaching surgery, the main delay reason is attributable to lack of capacity.

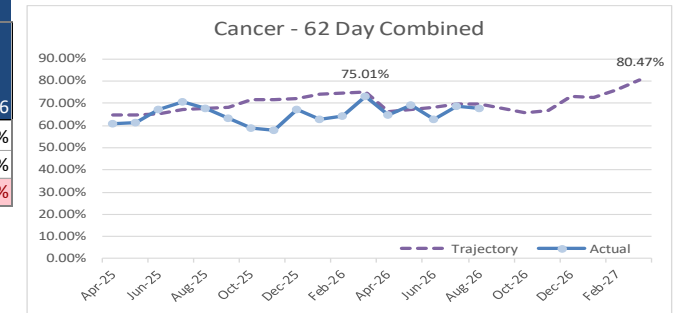
What are we doing about it?

- 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. With input from Theatres where necessary to unblock challenges.
- 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



Variation	Assurance	Monitoring against plan			
			May 26	Jun 26	Jul 26
	Target	85%	Actual	69.4%	63.0%
Background		Plan	67.2%	68.0%	69.6%
% patients beginning their treatment for cancer within 62 days following an urgent GP referral for suspected cancer		Variance	2.2%	-5.1%	-0.7%



Cancer - Patients treated within 62 of referral

Performance: 62.98% | Rank: 107th of 133



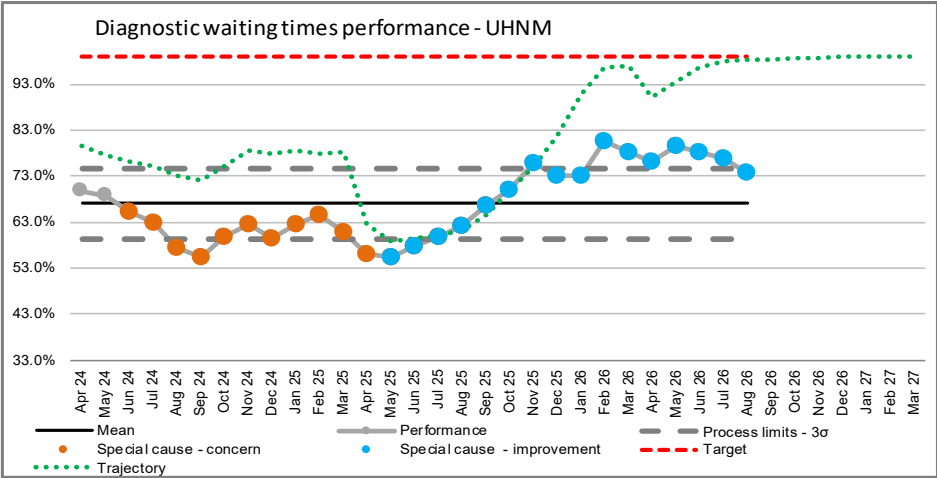
What is the data telling us?

- The **final** July position was reported at 68.8% against a trajectory of 69.6%
- The **provisional** August position is currently at 68.5% against a trajectory of 69.6%
- Although June performance missed the trajectory, July and provisionally August is tracking closer to forecasts.
- 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



Variation	Assurance		Monitoring against plan				
							
	Target	99.0%		May 26	Jun 26	Jul 26	Aug 26
Background The percentage of patients waiting less than 6 weeks for the diagnostic test.			Actual	79.6%	78.4%	77.0%	73.8%
			Plan	93.6%	96.6%	98.2%	98.4%
			Variance	-14.0%	-18.2%	-21.2%	-24.6%



What is the data telling us?

DM01 validated performance was 73.8%; 24.6% off plan. Plan set for August is for 98.4%. 99% being the national standard.

MRI DM01 performance

MRI is now showing as the majority contributor for UHNMs overall DM01 performance. MRI performance is 61.2% with 3.3% 13-week breaches

Echocardiography DM01 performance is recovering, with performance at 61.2%; an improvement of 30% since last month. Diagnostic Cell will track the recovery action plan

NOUS

Unvalidated performance is 90.1% - 1.2% increase since last month

Neurophysiology

Unvalidated performance is 65.8% - 19.4% decrease since last month

What are we doing about it?

MRI

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

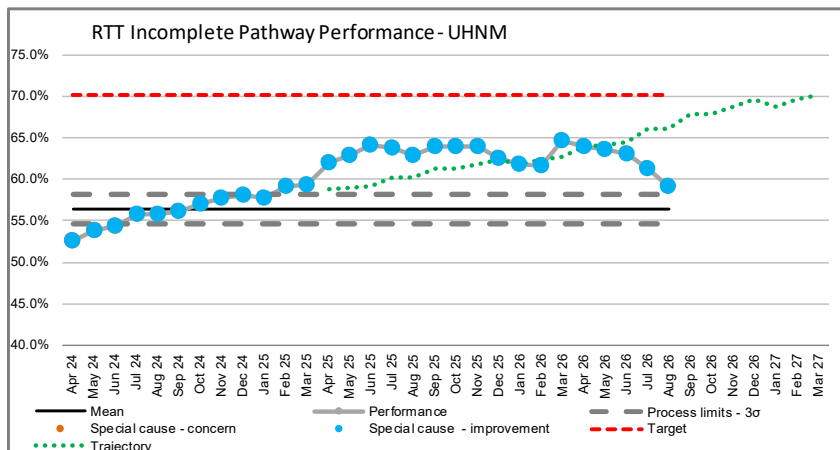
Echocardiography

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

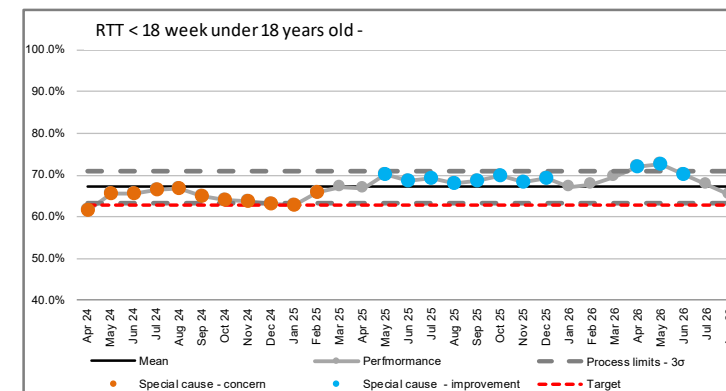
Cystoscopy

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

Quality & Access | RTT Performance

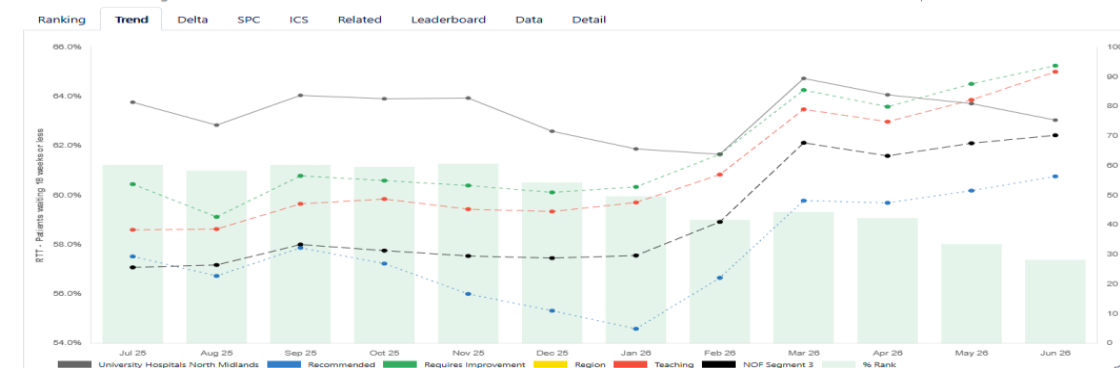


Variation	Assurance		Monitoring against plan				
				May 26	Jun 26	Jul 26	Aug 26
	Target	70%	Actual	63.7%	63.0%	61.4%	59.2%
Background			Plan	64.2%	64.5%	66.1%	66.2%
The percentage of patients waiting less than 18 weeks for treatment.			Variance	-0.5%	-1.4%	-4.8%	-7.0%



RTT - Patients waiting 18 weeks or less

Performance: 63.05% | Rank: 108th of 150



What is the data telling us?

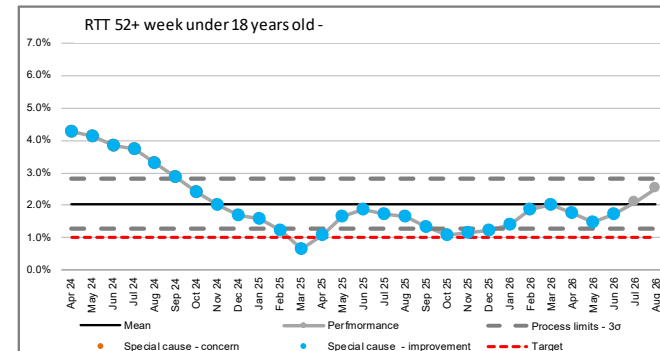
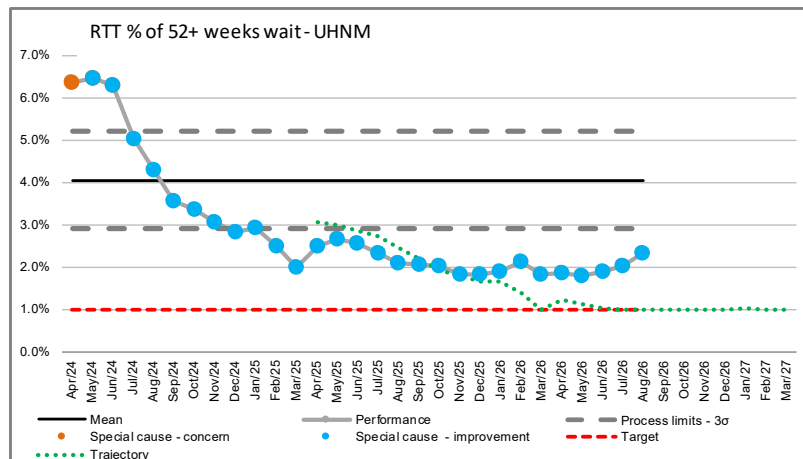
- Performance has deteriorated again in August to 59.55% (unvalidated) from 62.61% (validated) in July, and is now further behind plan.
- Total PTL has increased very significantly again from 74,815 in July to 75,945 (unvalidated) in August. There are several factors contributing to this – lower than average removal rate sustained throughout April and into May, exacerbated by Easter and school holidays; higher than average addition rate throughout April and May barring second week of school holidays), reduction in activity, validation, and tracking following Sprints ending, cancellations in theatres and MRI capacity due to the heat.
- From April onwards, sustained reduction in removals from the waiting list despite activity being stable.

The best joined-up care for all

What are we doing about it?

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

Quality & Access | RTT Performance – % 52+ Weeks



Variation	Assurance	Monitoring against plan				
			May 26	Jun 26	Jul 26	Aug 26
	Target 1.00%	Actual	1.81%	1.89%	2.05%	2.32%
Background		Plan	1.12%	1.03%	1.00%	1.00%
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	0.7%	0.9%	1.0%	1.3%

RTT - Patients waiting over 52 weeks

Performance: 1.89% | Rank: 115th of 148



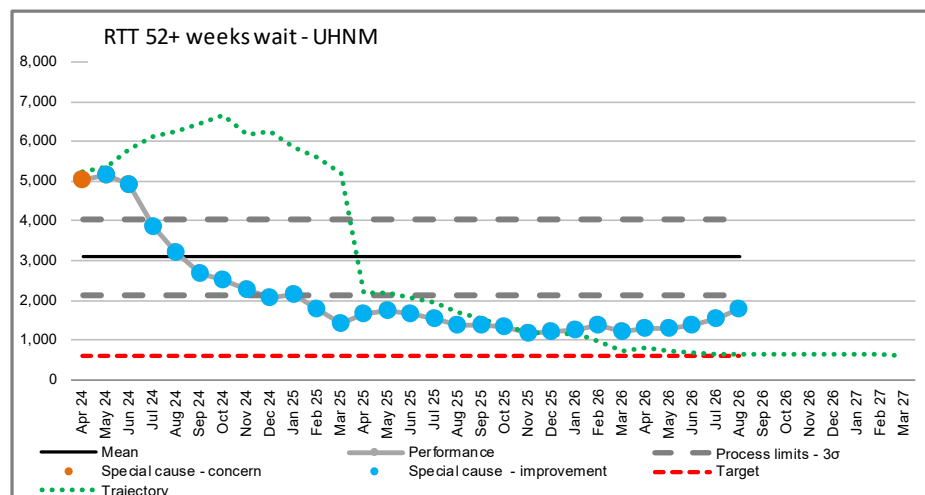
What is the data telling us?

- Percentage of total PTL above 52 weeks has seen an increase again in August.
- 52 week actuals has increased, from 1,531 to 1,750 (unvalidated)
- This cohort is extensively validated, so there's not much scope for improvement through validation alone

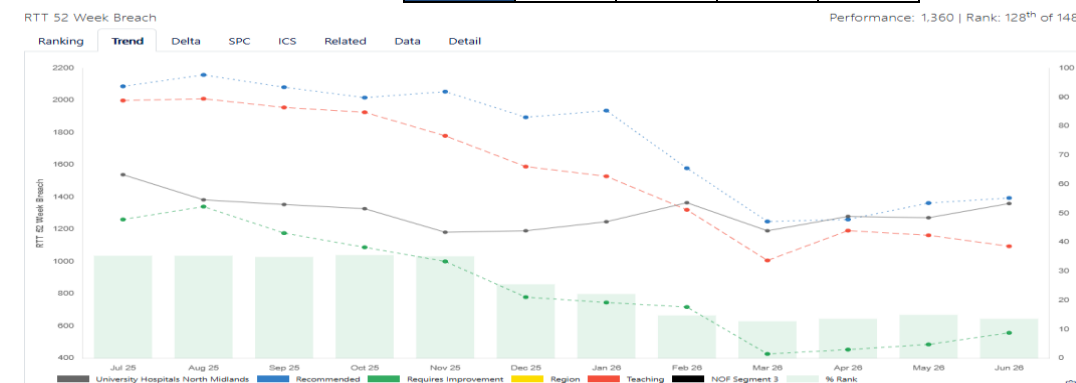
What are we doing about it?

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

Quality & Access | RTT No. of Long Waiting Patients



Variation	Assurance		Monitoring against plan				
							
				May 26	Jun 26	Jul 26	Aug 26
Target		612	Actual	1,277	1,366	1,521	1,759
Background			Plan	734	678	656	658
The number of patients on a RTT pathway who have waited longer than 52 weeks for treatment.			Variance	543	688	865	1,101
			65+	87	60	63	81
			78+	3	4	4	4
			104+	0	0	0	0



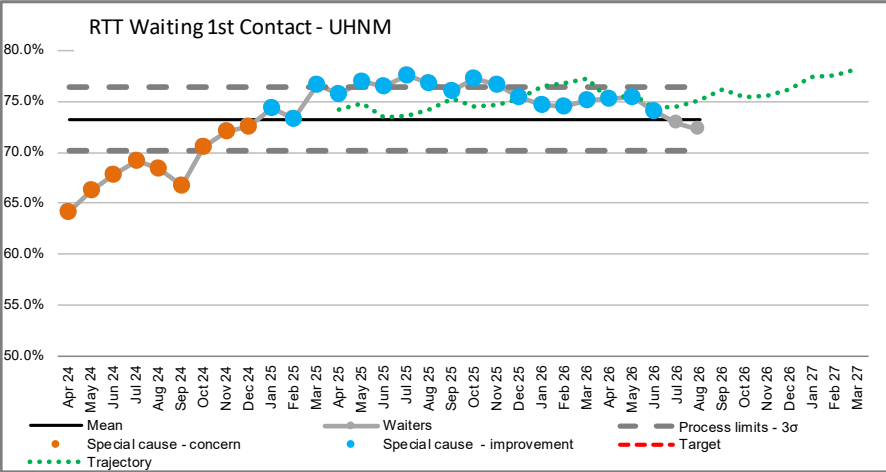
What is the data telling us?

- 4 patients breaches 78 weeks in July – an Endocrinology patient requiring complex thyroidectomy, 2 orthopaedic patients requiring custom implants, and a gynae patient requiring Endometriosis surgery.
- 65 week waits have increased significantly from 63 in July to 80 in August.
- 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.

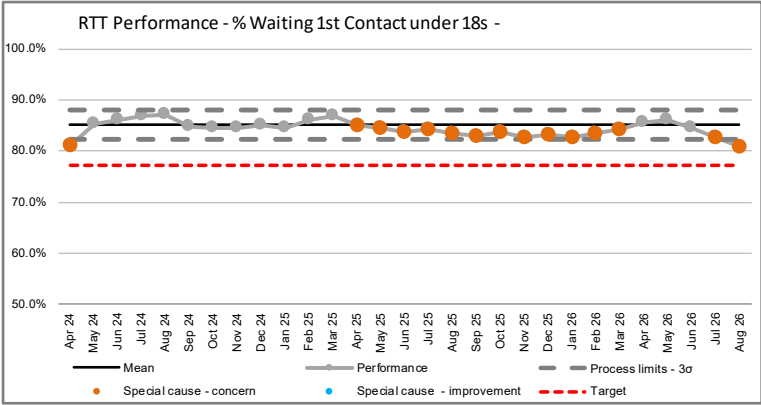
What are we doing about it?

- 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.

Quality & Access | RTT % Waiting 1st Contact



Variation	Assurance		Monitoring against plan				
							
				May 26	Jun 26	Jul 26	Aug 26
	Target	0.0%	Actual	75.4%	74.1%	72.8%	72.2%
Background			Plan	75.7%	74.4%	74.5%	75.1%
Of all patients waiting for first event after referral - the percentage that are waiting under 18 weeks			Variance	-0.3%	-0.2%	-1.7%	-2.9%



What is the data telling us?

- Time to first contact has reduced and is now off plan, at 72.17%
- Of the October 52 week cohort, 195 patients have yet to have their 1st appointment booked, compared with 158 of September cohort last month.

What are we doing about it?

- Reviewing clinic templates to release more capacity
- Developing use of ambient voice technology to decrease clinic admin and increase clinical capacity during OP attendances.

Highlight Report

PEOPLE, CULTURE AND INCLUSION COMMITTEE | 24th September 2026



University Hospitals
of North Midlands
NHS Trust

Matters of Concern / Key Risks to Escalate		Major Actions Commissioned / Work Underway	
- The Committee received the annual WRES and WDES reports, noting improvements in workforce representation, workplace adjustments and support for disabled colleagues, together with increased ethnic diversity at senior levels. Members also noted ongoing disparities in recruitment outcomes, career progression, senior disability representation and workforce data quality. The Committee agreed with partial assurance, supported continued action to improve inclusive recruitment, reduce inequalities and strengthen workforce experience for global majority and disabled colleagues. - The Committee noted that there were no new significant health and safety risks requiring escalation. However, members discussed ongoing variation in statutory and mandatory training compliance, limited Care Group attendance and engagement, and pressures relating to radiation protection arrangements. The Committee requested further assurance regarding mitigating actions and agreed to strengthen Care Group accountability and engagement. - The Committee received partial assurance regarding the Chief People Officer report, noting low turnover and continued controls on agency expenditure alongside ongoing challenges relating to sickness absence, appraisal compliance and workforce capacity. Members discussed the effectiveness of interventions to support staff wellbeing and return to work and requested further assurance regarding the impact of sickness-management arrangements and the relationship between workforce indicators and organisational performance. The Committee also emphasised the importance of strengthening accountability for core management practices, including appraisals, team engagement and wellbeing conversations.		- The Committee requested further analysis and recommendations to better understand the impact on resident doctor experience and identify any actions required within future guardian of safe working reports. - Further assurance requested on the impact of staff redeployment, skill mix and the relationship between staffing levels and patient safety outcomes, with additional analysis to be presented to a future meeting. - The Committee requested a future update on the workforce sickness assurance programme, including assessment of the effectiveness of interventions to support staff wellbeing and return to work.	
Positive Assurances to Provide			Decisions Made
- The Committee received the Quarter 1 Guardian of Safe Working report and noted a significant increase in exception reporting following changes to reporting arrangements and the inclusion of locally employed doctors. Concerns were highlighted regarding missed breaks, late finishes, supervision, workplace facilities and out-of-hours workload. Acceptable assurance was agreed. - The Committee received the annual Equality, Diversity and Inclusion report, noting acceptable assurance and progress across anti-racism, sexual safety, disability inclusion, staff networks and community engagement. Members discussed outcomes measurement, health inequalities, support for carers and young people, and how Freedom to Speak Up themes are informing improvement activity. The Committee welcomed the continued focus on reducing inequalities for both patients and colleagues and strengthening co-production and community involvement. - The Committee received significant assurance regarding the continued strong performance of the medical school, including high levels of student satisfaction, successful mitigation of cancelled teaching opportunities and maintenance of training quality despite operational pressures. Members discussed future teaching capacity, the retention of graduates within UHNM and the forthcoming university quality review with GMC involvement. - The Committee received an update from the Medical Workforce Group, noting progress in reviewing rota arrangements, improving recruitment and reducing reliance on bank and agency staffing. Positive progress was reported in traditionally hard-to-recruit specialties, including pathology, alongside development opportunities for locally employed doctors. The Committee also noted the group's increased focus on workforce planning and reducing medical agency expenditure. - The Committee received acceptable assurance regarding nurse staffing levels and mitigating actions where fill rates fall below planned levels, including staff redeployment and adjustments to capacity where required. Positive progress was noted in neonatal recruitment. - The Committee received an update on the 2026 National Staff Survey campaign, which runs from 22 September to 27 November. Members discussed actions to maximise participation, reinforce confidentiality, and demonstrate how colleague feedback leads to improvement. The Committee emphasised the importance of Care Group accountability for participation and action planning and welcomed the focus on strengthening staff voice and organisational learning. Acceptable assurance was agreed. - The Committee received an update on implementation of the NHS Staff Standards and Leadership and Management Framework, noting that arrangements are being established to embed the framework across the Trust. Members discussed leadership expectations, management capability, governance arrangements and the importance of ensuring the framework drives meaningful behavioural and leadership improvement rather than compliance alone.			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.

The Committee discussed the need to strengthen triangulation between **safe staffing metrics**, skill mix and patient safety incidents to provide greater assurance regarding any relationship between staffing levels and adverse events. Analysis is being undertaken and will be reported through both the People, Culture & Inclusion Committee and Quality Committee.

Summary Agenda

No.	Agenda Item	BAF Mapping			Purpose	No.	Agenda Item	BAF Mapping			Purpose
		BAF No.	Risk	Assurance				BAF No.	Risk	Assurance	
1.	Guardian of Safe Working Report Q1			Acceptable	Assurance	7.	Medical Workforce Group Highlight Report (01-09-26)			Not applicable	Information
2.	Equality, Diversity & Inclusion Annual Report 2025/26	3	Ext 15	Acceptable	Assurance	8.	Safe Staffing Report – August 2026	3	Ext 15	Acceptable	Assurance
3.	Workforce Race and Workforce Disability Equality Standard Reports 2026	3	Ext 15	Partial	Assurance	9.	Chief People Officer Report - Spotlight on agile and flexible organisation - People strategic plan progress update	3	Ext 15	Partial	Assurance
4.	Health & Safety Group Highlight Report (15-09-26)			Not applicable	Information	10.	NHS Staff Survey 2026 Campaign	3	Ext 15	Acceptable	Assurance
5.	Medical School Annual Report 24 th /26	8		Significant	Assurance	11.	NHS Staff Standards			Not applicable	Information

Integrated Performance Report

Month 05 Performance
2026/27

Contents

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4	People	59-68
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Statistical Process Control

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.

People

People	Data period	Provider value	Chart
People domain segment	Q1 2026/27	3	NOF Score
People domain score	Q1 2026/27	2.72	NOF Score

People and Culture	Data period	Provider value	Peer average ⓘ	National value	National value method	Chart
Sickness absence rate score	Q1 2026/27		2.7	NOF Score	Provider value	
Sickness absence rate	To Mar 2026	5.70%	5.23%	5.54%	Provider median	
NHS staff survey engagement theme sub-score score	Q1 2026/27		2.92	NOF Score	Provider value	
NHS staff survey engagement theme sub-score	2025	6.67	6.54	6.80	Provider median	
National Education and Training Survey overall experience sub-score score	Q1 2026/27		3.49	NOF Score	Provider value	
National Education and Training Survey overall experience sub-score	2025	73.54%	73.95%	78.16%	Provider median	
NHS staff standards sub-score score	Q1 2026/27		3.44	NOF Score	Provider value	
NHS staff standards sub-score	Q3 2025/26	7.38	7.40	7.52	Provider median	
Percentage of frontline healthcare workers to receive a flu vaccination score	Q1 2026/27		1.79	NOF Score	Provider value	
Percentage of frontline healthcare workers to receive a flu vaccination	Q1 2025/26	53.70%	49.90%	49.35%	Provider median	

Workforce	Data period	Provider value	Peer average ⓘ	National value	National value method	Chart
Please note that at Trust level only the overall temporary staffing score contributes to the domain score						
Temporary staffing cost relative band score	Q1 2026/27		2	NOF Score	Provider value	
Temporary staffing bank score	Q1 2026/27	2	2	2	Provider median	
Temporary staffing agency score	Q1 2026/27	2	2	2	Provider median	

Q1 position: The People score and segment remain unchanged despite the introduction of new measures.

Key drivers: An improvement in the sickness absence score, from 3.00 to 2.70, was offset by scores of 3.49 for the National Education and Training Survey overall experience measure and 3.44 for the NHS Staff Survey standards sub-score. Flu vaccination uptake among frontline healthcare workers compares favourably with peers and the national average.

Overview from the Chief People Officer

How are we doing against our trajectories and expected standards?

Our most recent **Staff Engagement** score was 6.3 for July 2026, (6.4 for April 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 being paused until January 2027, to allow for the annual National Staff Survey, which starts in September 2026.

Sickness absence remains above our expected standard of 4.1%. In-month sickness increased to 5.65% while the rolling 12-month cumulative sickness rates increased slightly to 5.50%. 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 July, 385 episodes of Cold, Cough, Flu, and Chest & Respiratory conditions were reported, compared to 234 episodes in June — representing a 59.6% month-on-month increase.

Turnover and **vacancy** metrics continue to perform well against our expected standards. The turnover rate in August 2026 remains low, at 7.8%, which is consistently below our 11% target, for the last 3 years. Vacancies also remain low, at 6.8%, which is reflective of the reintegration of 567 WTE, offset by the planned cumulative CIP of 165 WTE by [current] year-end, delivered progressively from Month 1, and the additional growth in the workforce since the start of the financial year (+127 WTE). Any remaining variance in the vacancy rate is reflective of the combined bank and agency utilisation, and any approved business case funding, which ultimately affects the overall vacancy rate.

Agency costs remained static at 1.7%, in August 2026. In real-terms, overall agency usage increased to 130.29 WTE in August from 124.29 WTE in July 2026, which is 55.9 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. August saw a slight increase in the in-month sickness absence rate, potentially influenced by the exceptionally hot weather.

Agency expenditure was 55.9 WTE above plan, across all staff groups. Medical & Dental were 28.5 WTE above plan due to less-than-full-time vacancies in Neurosciences, and hard to fill vacancies Neurology, and broader vacancies in General Medicine. Registered Nursing was 13.6 WTE above plan due to increased demand for specialist skills in Cardiothoracic Surgery and Ophthalmology Theatres. Infrastructure was 1.3 WTE above plan due to specialised skills required in engineering services. Agency use is influenced by the additional scrutiny at executive and care group level which is having the desired effect in reducing overall agency spend, with some agency activity being converted to bank expenditure, as well.

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 into the Autumn months, episodes of sickness absence associated with gastrointestinal, cold & flu, and Covid-19 related symptoms may start to increase, as we start to head into the colder months. September 2025 saw a marked increase in cold & fu related cases, which may repeat this year.

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.

Metric	Target	Previous	Latest	Variation	Assurance	R12M Trend
Staff Turnover (R12M)	11.0%	7.7%	7.8%			
Staff Vacancy Rate	8.0%	6.7%	6.8%			
Sickness Absence (In Month)	3.4%	5.7%	5.8%			
Appraisal (PDR)	95.0%	81.7%	82.2%			
Agency Utilisation	3.2%	1.7%	1.7%			
Employee Engagement	7.2	6.3	6.3			

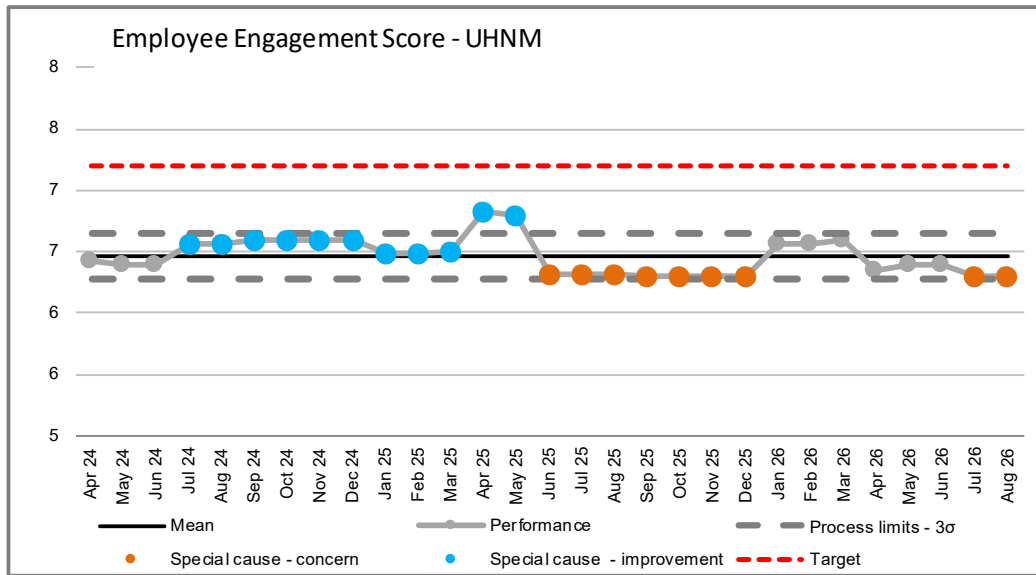
Related Strategy and Board Assurance Framework (BAF)

People Strategy

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

People | Employee Engagement

Creating a great place to work for everyone



Variation		Assurance		
				
Target	Jun 26	Jul 26	Aug 26	
7.2	6.4	6.3	6.3	
Background				

What is the data telling us?

The Staff Engagement score reduced slightly to 6.3 in July 2026, (6.4 in June 2026) against a target of 7.2.

The Staff Engagement Score is now measured quarterly through the NHS People Pulse Survey. Collection will pause during the annual Staff Survey period, beginning in mid-September 2026, meaning the NHS People Pulse will resume in January 2027.

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 will be January 2027.

Sustained operational pressures continue to impact on overall employee engagement.

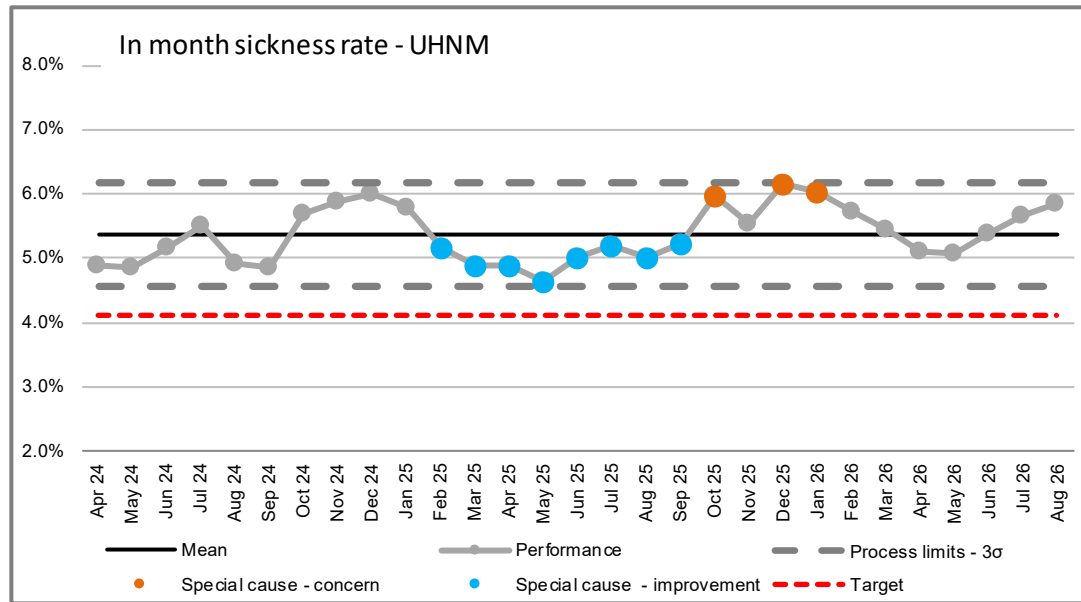
All Divisions and Care Groups will develop their staff survey response plans and have a driver metric for staff engagement, now that the 2025/26 data is available.

People | Sickness Absence in Month

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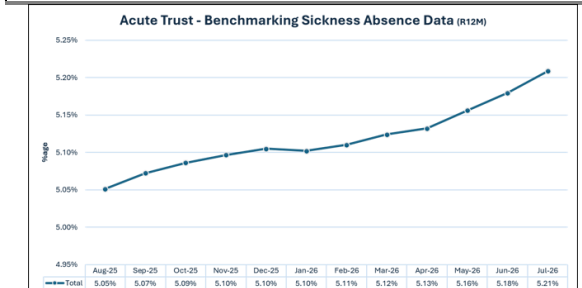


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Our sickness absence rates are very similar to other Acute Trust's when examining the available benchmarking data.
(Benchmarking data effective July-26 - 5.2%)

Variation		Assurance		
				
Target	Jun 26	Jul 26	Aug 26	
4.1%	5.4%	5.7%	5.8%	
Background				
Percentage of days lost to staff sickness				



What is the data telling us?

The rolling 12-month average sickness absence rate increased to 5.57% (5.50% in July 2026) against the target of 4.1%, resulting from the higher sickness absence rates seen over this specific 12-month period.

The in-month sickness absence rate increased to 5.84% in August (5.65% in July 2026) with other stress and anxiety seeing the largest increase of 0.6%, while other musculoskeletal problems increased by 0.4% and gastrointestinal problems reduced by 1.5%.

In rank order (highest first), the top 3 reasons for absences during August were: (1) Anxiety/stress/depression/other psychiatric illnesses, (2) Other musculoskeletal problems, (3) Gastrointestinal problems, which has been consistent for the last three months.

What are we doing about it?

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

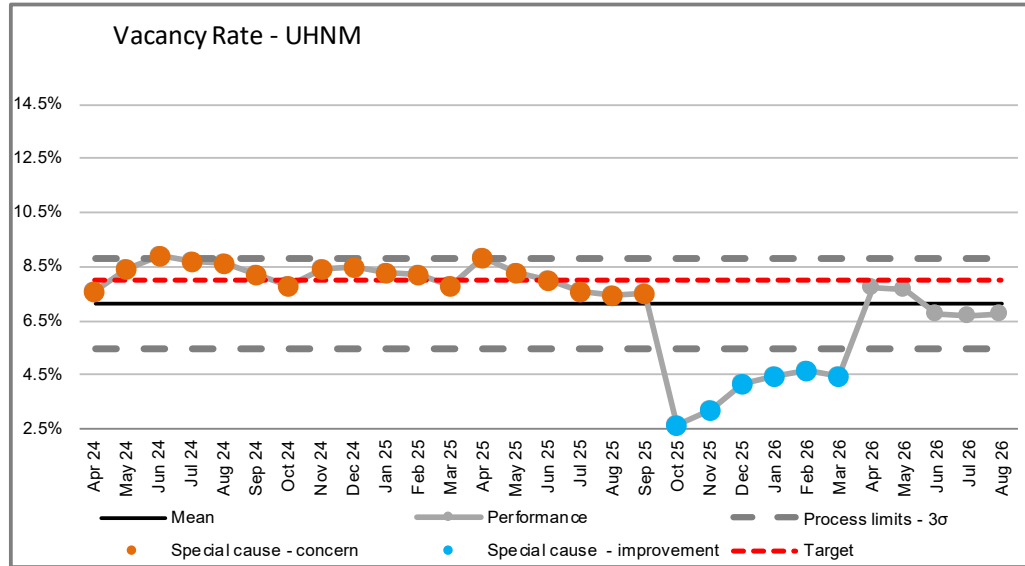
Unplanned Care - assessment of hotspot areas for long and short term absences to provide targeted support including re-training.

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



People | Vacancy Rate

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What is the data telling us?

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

August's vacancy rate increased to 6.8%, from 6.7% in July-26. (The 2026/27 establishment reflects the reintegration of 567 WTE, offset by a planned cumulative CIP of 165 WTE by year-end, delivered progressively from Month 1. Any remaining variance is reflective of the combined bank and agency utilisation and any approved business case funding, which will ultimately affect the overall vacancy rate.)

Colleagues in post increased in August 2026 by 16.63 fte, budgeted establishment increased by 29.7 fte, which increased the vacancy fte by 13.07 fte.

[*Note: the Staff in Post fte is a snapshot at a point in time, so may not be the final figure for 31/08/26]

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.)

Variation		Assurance		
Target		Jun 26	Jul 26	Aug 26
8%		6.8%	6.7%	6.8%
Background				

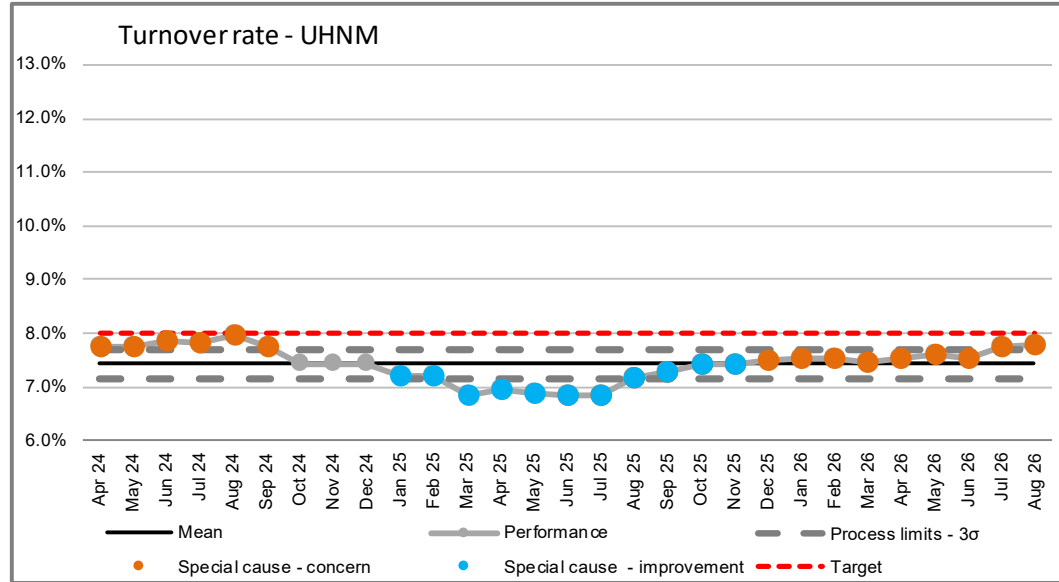
Based on Full Establishment (Substantive, Bank & Agency)

Vacancies at 31-08-26	Budgeted Establishment	Staff In Post fte	Vacancies	Vacancy %	Previous Month
Medical and Dental	1,883.41	1,651.39	232.02	12.32%	11.99%
Registered Nursing	3946.00	3855.34	90.66	2.30%	2.38%
All other Staff Groups	7142.98	6588.57	554.41	7.76%	7.66%
Total	12,972.39	12,095.29	877.10	6.76%	6.68%



People | Turnover Rate

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What is the data telling us?

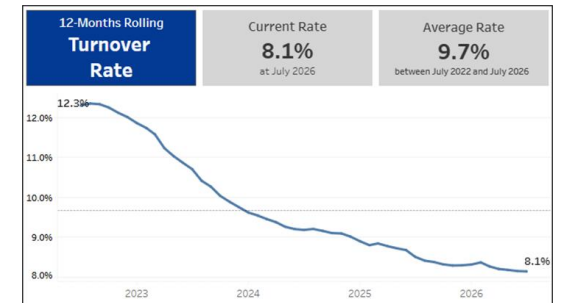
August 2026's turnover rate increased slightly to 7.8% (7.7% in July 2026), which is consistently below the Trust's 11% target, for the last three years.

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

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

(Benchmarking data effective July 2026)

Variation		Assurance	
			
Target	Jun 26	Jul 26	Aug 26
8.0%	7.5%	7.7%	7.8%
Background			
Turnover rate.			



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 :

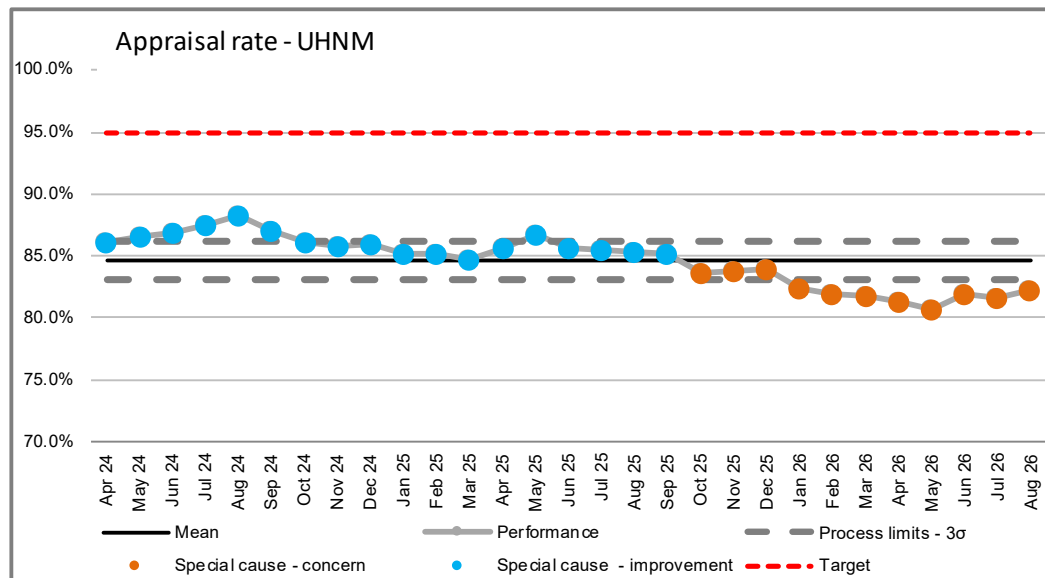
- Medical Staffing finishing school.
- Employment of a People Promise (Retention) Manager who currently continues in a fixed term post.
- Monthly targeted campaigns aligned to our Trust Values. For example, August included our Trust Values week which involved a dedicated week of recognition for colleagues who consistently demonstrate our Trust values.

People | Appraisal Rate

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Variation		Assurance		
				
Target	Jun 26	Jul 26	Aug 26	
95%	81.9%	81.7%	82.2%	
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.

August's appraisal rates recovered, increasing to 82.2% from 81.7% in July 2026, despite an on-going ESR issue, in legacy code, which has been causing some issues for some Managers when attempting to enter their appraisal data. Infosys (who support ESR) are currently working on a solution, which should become available in ESR version 70, which should be installed in the coming months.

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.

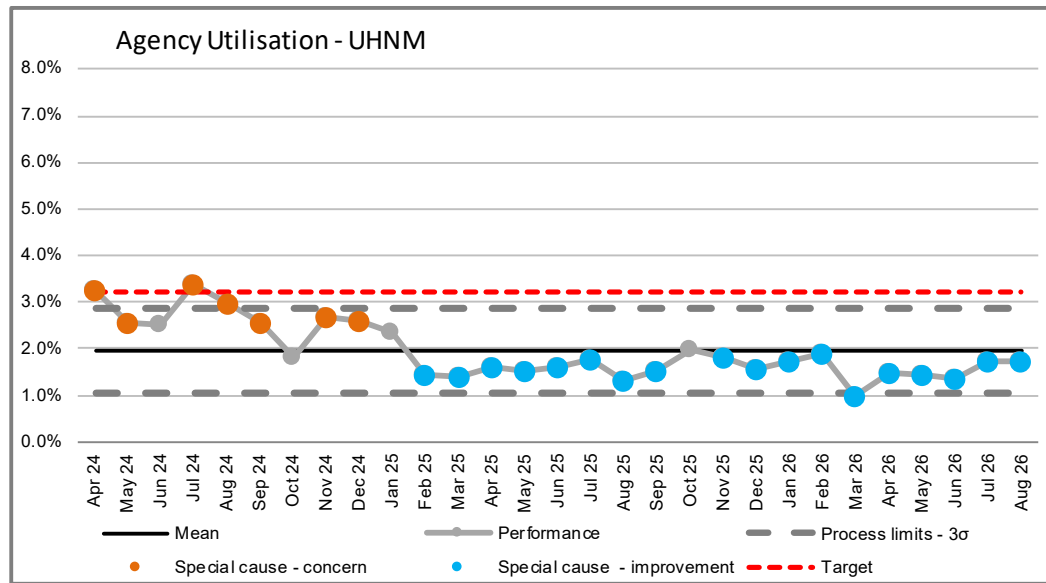
Clinical & Scientific Services Care Group – Weekly performance reports and assurance meetings.

User guides demonstrating the workarounds such as using the Chrome web browser and alternate PC's have been circulated to Managers, and with appropriate support from the ESR Team, the workarounds have been very successful at mitigating the risk, until ESR version 70 is installed.



People | Agency Utilisation

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Variation		Assurance		
				
Target	Jun 26	Jul 26	Aug 26	
3.2%	1.4%	1.7%	1.7%	
Background				
Agency cost as a percentage of total pay cost				

What is the data telling us?

Agency cost is calculated as a percentage of the total Pay Costs, which remained static at 1.7% in August 2026, (1.7% in July 2026).

In real terms, overall agency usage increased from 124.29 WTE in July to 130.29 WTE in August 2026 which is 55.9 WTE above plan. For Medical & Dental staff, this was driven by less-than-full-time vacancies in Neurosciences, hard-to-fill vacancies in Neurology, and broader vacancies in General Medicine. Registered Nursing usage also increased, reflecting demand for specialist skills in Cardiothoracic Surgery and Ophthalmology in Theatres

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 18 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.
- The CFO has approved the use of off-framework clinical coders for the next 3 months. This is the first instance of off-framework use in well over 18 months.
- 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.

Highlight Report

Finance & Business Performance Committee | 3rd September 2026



University Hospitals
of North Midlands
NHS Trust

Matters of Concern / Key Risks to Escalate		Major Actions Commissioned / Work Underway
- The Committee received an initial progress update on delivery of the Digital Strategic Plan. Members noted that implementation was slightly behind the original timetable due to delays in confirmation of national frontline productivity funding and were advised that future reports will provide clearer tracking of planned versus actual delivery milestones through the new strategic programme governance arrangements. - The Committee considered arrangements to support delivery of special projects and noted the requirement for additional specialist capacity and expertise. Members agreed that the wider strategic business case should be considered by Trust Board, including engagement with NHS England and national stakeholders regarding roles, responsibilities and funding requirements, while supporting the use of previously approved funding to provide immediate operational support where required. - The Committee reviewed the Month 4 Cost Improvement Programme (CIP) position, noting delivery remained £5 million adverse to the original plan monitored by NHS England, largely due to a gap between approved schemes and planned savings rather than in-year delivery performance. Members received partial assurance and noted that the agreed recovery trajectory with NHS England had been achieved but that delivery had been supported by non-recurrent measures and that further work through the financial recovery programme would be required to deliver sustainable recurrent savings in the remainder of the year. - The Committee received the findings of the Financial Recovery Assessment and noted the requirement for both short-term financial stabilisation and longer-term transformational change to deliver sustainable improvement. Members were advised that a comprehensive recovery plan was being developed for Board approval and submission to NHS England, with strengthened governance, capacity and delivery oversight forming key components of the proposed approach.		Review the committee's terms of reference in light of financial recovery and strategic-transformation oversight, incorporating feedback from NHS England.
Positive Assurances to Provide		Decisions Made
- The Committee reviewed the 2025/26 NHS Premises Assurance Model (PAM) assessment, noting compliance levels of 84–91% across the principal domains and receiving acceptable assurance that no significant patient safety, statutory compliance or operational risks required escalation. Members supported submission of the Trust return and noted that improvement activity is focused on strengthening evidence management and assurance processes under the revised assessment methodology. - The Committee received a mid-point review of the Trust's Artificial Intelligence business case, noting that delivery was progressing broadly as planned and that a number of key milestones and performance indicators had already been achieved. Acceptable assurance was agreed and members requested a greater focus on evidencing impact and benefits realisation in future reports, sought consideration of the contribution AI initiatives can make to financial recovery, and noted the development of a business case to address the backlog of clinical digital safety assessments. - The Committee received acceptable assurance regarding medicines governance, financial management and supply arrangements, noting increasing demand for NICE-approved medicines and emerging capacity pressures in a number of specialist services. Members highlighted the need to ensure medicines supply and delivery models were fully considered within future outpatient and Community Diagnostic Centre developments and noted ongoing work to manage cost pressures, optimise prescribing and strengthen assurance around future service sustainability.		- The Committee approved progression of the Royal Stoke discharge lounge expansion business case to the next stage of development. Members requested further assurance regarding benefits realisation, operational dependencies, funding arrangements and financial assumptions before consideration of the final business case. - The Committee considered proposals to expand the Stoke-on-Trent Community Diagnostic Centre and approved progression of the design and assurance phase. Further assurance on demand forecasts, current service performance, funding arrangements, revenue sustainability and risk was requested, before any decision on full scheme implementation. - The Committee approved the recruitment of specific posts for Special Projects at a total value of £286,000 for 2026/27. - The Committee approved the following e-REAFs 18791, 18688, 18658, 18532 and 18865. - The Committee supported the next steps in relation to the Electronic Patient Record as previously approved by the Trust Board
Comments on the Effectiveness of the Meeting		Cross Committee Considerations
Comments on effectiveness were sought via Microsoft Forms		No cross-committee considerations were identified.

Summary Agenda

No.	Agenda Item	BAF Mapping			Purpose	No.	Agenda Item	BAF Mapping			Purpose	
		BAF No.	Risk	Assurance				BAF No.	Risk	Assurance		
1.	NHS Premises Assurance Model (PAM) Assessment	5	High 12	Acceptable	Assurance	8.	BC-0647 CMO Special Projects Business Case			Not applicable	Approval	
2.	Digital Strategic Plan Progress Update	4	Ext 16	Not assessed	Assurance	9.	Financial Recovery Assessment – Key Findings & Recommendations	6, 7	Ext 20	Ext 25	Not applicable	Information
3.	BC-0594 Digital Services AI Team Review	4	Ext 16	Acceptable	Assurance	10.	Cost Improvement Programme 2026/27 Update	6, 7	Ext 20	Ext 25	Partial	Assurance
4.	Executive Digital Data & Governance Group Highlight Report (27-08-26)	4	Ext 16	Not applicable	Information	11.	Finance Report Month 4	6, 7	Ext 20	Ext 25	Partial	Assurance
5.	BC-0652 Royal Stoke Discharge Lounge			Not applicable	Approval	12.	Authorisation of New contract Awards, Contract Extensions and Non-Purchase Order (NPO) Expenditure	6, 7	Ext 20	Ext 25	Not applicable	Approval
6.	Stoke on Trent Community Diagnostic Centre (CDC) Expansion and Neighbourhood Health Hub Development			Not applicable	Approval	13.	Frontline Productivity Investment: CareFlow Optimisation and Reduction of Dependence on iPortal and WIS	4	Ext 16		Not applicable	Information
7.	Pharmacy Directorate Medicines Finance, Procurement & Supplies Report Q4 & Q1	6	Ext 20	Acceptable	Assurance							

Highlight Report

Finance & Business Performance Committee | 28th September 2026



University Hospitals
of North Midlands
NHS Trust

Matters of Concern / Key Risks to Escalate		Major Actions Commissioned / Work Underway
- The Committee noted the Trust's month 5 deficit, deterioration to NHS Oversight Framework Segment 4 and ongoing challenges in recovering key performance trajectories. Further work was agreed to strengthen the integration of workforce, finance and performance oversight and inform the forthcoming three-year plan refresh, as a result partial assurance was agreed for the medium term plan update. - The Committee reviewed the Month 5 financial position, noting a £24.7m deficit, with performance driven by elective income under-delivery, cost improvement programme (CIP) slippage, workforce pressures and industrial action costs. Members noted that while cash remains sustainable in-year, significant risks remain for 2027/28. Key areas of focus include elective recovery, sickness absence reduction, delivery of the financial recovery programme and management of system-wide dependencies affecting urgent and emergency care performance. Partial assurance was agreed. - The Committee reviewed delivery of the Cost Improvement Programme, which provided partial assurance, noting £12.7m of savings had been achieved at Month 5, supported by a significant element of non-recurrent benefit. While procurement, pharmacy and medical workforce schemes remained broadly on track, further recovery action was required in relation to nursing, corporate savings, theatres and activity-related income. Members noted the importance of delivering the financial recovery plan trajectory and reducing reliance on non-recurrent savings in the second half of the year. - The Committee reviewed the Trust's Financial Recovery Plan ahead of submission to NHS England, noting a proposed mitigation package against a forecast deficit. Members sought assurance regarding deliverability, workforce reduction proposals, associated risks and governance arrangements, and emphasised the importance of clear accountability, risk management and quality impact assessment to support implementation. Concerns were also noted regarding system dependencies, bed capacity and elective recovery, which remain critical to delivery of the plan. - The Committee reviewed progress against the Estates and Facilities Strategic Plan, noting continued delivery across estate compliance, resilience and strategic development programmes. Members requested clearer reporting on amber-rated areas, including the underlying constraints, mitigating actions and requirements for achieving delivery, and deferred the assurance rating pending receipt of enhanced information at the next meeting. - The Committee noted strengthened arrangements for business case approval, monitoring and benefits realisation. However, concerns remained regarding delivery of the Endoscopy business case and achievement of the anticipated benefits, and the Committee agreed a rating of partial assurance pending the outcome of this work.		- An executive review was commissioned to provide further assurance on implementation, ownership and recovery actions for the endoscopy business case. - Revision of Estates and Facilities strategic plan assurance reporting, to provide clearer information regarding constraints, mitigating actions and delivery trajectories before a revised assurance assessment is considered.
Positive Assurances to Provide		Decisions Made
- The Committee received assurance regarding the annual costing submission. Members supported greater operational and clinical engagement to ensure costing data informs decision-making, identifies opportunities within loss-making services and supports more meaningful discussions on clinical variation and service sustainability. - The Committee received assurance that the PFI contract continues to perform well, with no contractual or KPI threshold breaches, a stable financial position and effective management of key risks. In light of the positive performance reported, the Committee agreed a rating of significant assurance.		- The Committee approved the costing engagement and assurance framework, to strengthen the use of costing information in service planning, productivity improvement and financial recovery. - The Committee approved e-REAFs 18842 and 18832. - The Committee approved UHNM's role as host organisation for the West Midlands Imaging Network and the submission of a £1.42m NHS England funding bid to support procurement and development of a full business case for a regional digital imaging platform.
Comments on the Effectiveness of the Meeting		Cross Committee Considerations
Comments on effectiveness were sought via Microsoft Forms		Cross-committee review of operational performance governance, to strengthen oversight of access, performance and recovery across Finance and Business Performance Committee and Quality, Access and Outcomes Committee.

Summary Agenda

No.	Agenda Item	BAF Mapping				Purpose	No.	Agenda Item	BAF Mapping				Purpose
		BAF No.	Risk		Assurance				BAF No.	Risk		Assurance	
1.	Medium Term Plan Update	6, 7	20	25	Partial	Assurance	6.	Authorisation of New Contract Awards, Contract Extensions and Non-Purchase Order Expenditure				Not applicable	Approval
2.	Finance Report – Month 5 2026/27	6, 7	20	25	Partial	Assurance	7.	West Midlands Imaging Network Converged Digital Imaging Platform				Not applicable	Approval
3.	CIP 2026/27 Update	6, 7	20	25	Partial	Assurance	8.	Estates & Facilities Strategic Plan Update	5	High 12		Not assessed	Assurance
4.	Financial Recovery Plan	6, 7	20	25	Not applicable	Discussion	9.	PFI 6 Monthly Exception Report	5	High 12		Significant	Assurance
5.	Costing Engagement and Assurance Framework	6, 7	20	25	Not applicable	Approval	10.	Business Case Review Update September 2026	6, 7	20	25	Partial	Assurance

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

- NOM4369, supplied by DAY WEBSTER (CARE PROVIDERS, for the period 01/02/2027-31/01/2029 plus 2 x 12-month options to extend, at a total cost of £7,000,000.00, providing In-Year Negated Inflation Value of £34,510.00, approved 13th August 2026.
- MED6203/MED6124, supplied by NHSSC, for the period 17/09/2026 - 16/09/2030, at a total cost of £12,852,865.39, approved 13th August 2026.
- MED3185, supplied by Medica Reporting Ltd, for the period 1st April 2025 - 31st January 2027, at a cost of £3,900,000.00, approved 13th August 2026.

Integrated Performance Report

Month 05 Performance
2026/27

Statistical Process Control

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

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

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

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

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

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

NHS
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- Access to Services increased from 2.51 to 2.73 and remains in segment 3
- Experience of Care is a new domain, scoring 2.32 and placed in segment 2
- Effectiveness of Care and Population Health is a new domain, scoring 2.57 and placed in segment 4
- Patient Safety increased from 2.83 to 3.45 and moved to segment 4
- Finance and Productivity increased from 2.20 to 2.96 and moved to segment 4
- People remains unchanged at 2.72 and in segment 3



Finance, Productivity and Innovation

Finance, productivity and innovation							Data period	Provider value	Chart				
Finance, productivity and innovation domain segment							Q1 2026/27	4	NOF Score				
Finance, productivity and innovation domain score							Q1 2026/27	2.96	NOF Score				
Finance							Data period	Provider value	Peer average ⓘ	National value	National value method	Chart	
Please note that only the combined finance score contributes to the domain score													
Combined finance score							Q1 2026/27	3	NOF Score	Provider value			
Planned surplus/deficit score							Q1 2026/27	1	NOF Score	Provider value			
Planned surplus/deficit							Q1 2026/27	0.00%	-0.17%	0.00%	Provider median		
Variance to plan year-to-date score							Q1 2026/27	4	NOF Score	Provider value			
Variance to plan year-to-date							Q1 2026/27	-1.85	-0.14	0.00	Provider median		
Productivity							Data period	Provider value	Peer average ⓘ	National value	National value method	Chart	
Relative cost difference (National Cost Collection Index) score							Q1 2026/27	2.47	NOF Score	Provider value			
Relative cost difference (National Cost Collection Index)							Dec 2025	102.89	100.17	100.71	Provider median		
Innovation							Data period	Provider value	Peer average ⓘ	National value	National value method	Chart	
Percentage of clinical trials set up within 90 days score							Q1 2026/27	4	NOF Score	Provider value			
Percentage of clinical trials set up within 90 days							Q1 2026/27	25.00%	45.56%	50.00%	Provider median		
Overall Data Quality Maturity Index score							Q1 2026/27	2.39	NOF Score	Provider value			
Overall Data Quality Maturity Index							Apr 2026	93.20%	93.00%	93.00%	Provider median		

Q1 position: Finance, Productivity & Innovation moved from segment 3 to segment 4, with the overall score increasing from 2.20 in Q4 to 2.96 in Q1.

Key drivers: The combined finance score worsened from 1 to 3, while the variance-to-plan score moved from 2 to 4. The newly introduced measures for clinical trials established within 90 days and the Data Quality Maturity Index also contributed to the Q1 position.

Finance | Financial Summary

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

This report presents the financial performance of the Trust for August 2026 (Month 5).

The Trust reported a deficit of £24.7m at Month 5, which is a £12.9m overspend against plan.

Income: The income at month 5 is below plan by £4.2m, which relates to patient income £4.7m (£0.3m pass through drugs and devices) below plan and operating income £0.5m above plan.

Expenditure: Total operating expenditure is overspent by £9.5m. Pay expenditure was £355.2m to Month 5, generating an overspend of £8.7m year to date. The year-to-date position includes £1.6m of cost relating to industrial action. Non pay expenditure to Month 5 is £208.7m against a plan of £207.7m, resulting in a £0.9m overspend year to date.

CIP: The Trust had a £73.1m CIP target for 2026/27. At Month 5, it has delivered £12.7m of in-year savings, an under performance of £4.6m against the £17.3m target. The CIP was reforecast and against the forecast the CIP was delivered.

Capital: At Month 5 capital expenditure of £20.7m is £1.2m lower than plan. This underspend is mainly due to expenditure on the Stoke UTC scheme and the computer hardware refresh and IM&T sub-group schemes being lower than plan. There are no risks being identified for the year end forecast in these areas and expenditure is expected to increase in the coming months.

Statement of Financial Position: The Month 5 Statement of Financial Position shows total assets employed of £266.3m. The cash balance is £62.7m against a plan of £51.5m.

Financial Outlook and Risk: Following the Month 5 financial close, the Care Groups and Divisions completed a detailed bottom-up forecast based on current run rates. This indicates an unmitigated year-end deficit of **£60.4m**. The regional NHSE team has requested that the Trust submit a Financial Recovery Plan by 30 September, including monthly activity, workforce, CIP and financial projections.

The recovery plan with the mitigations is being worked up and will be tabled on the day of the committee meeting.

Related Strategy and Board Assurance Framework (BAF)

BAF Risk	Q1		Q2		Q3		Q4	
	Risk	Assurance	Risk	Assurance	Risk	Assurance	Risk	Assurance
BAF 9: Inability to sustain safe and timely urgent and emergency care performance	Ext 20	Partial						

The best join



Finance | Income and Expenditure

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

The Trust has reported a £24.7m deficit at Month 5, which is a £12.9m overspend to the planned £11.7m deficit. The below table summarises the Income and Expenditure position at Month 5.

Income & Expenditure Summary Month 05 2026/27	Annual Budget £m	In Month			Year to Date		
		Budget £m	Actual £m	Variance £m	Budget £m	Actual £m	Variance £m
Income From Patient Activities	1,235.6	103.5	102.1	(1.3)	513.9	509.2	(4.7)
Other Operating Income	101.3	8.6	8.6	0.0	42.3	42.9	0.5
Total Income	1,336.9	112.0	110.7	(1.3)	556.2	552.0	(4.2)
Pay Expenditure	(829.8)	(69.0)	(72.1)	(3.1)	(346.4)	(355.1)	(8.7)
Non Pay Expenditure	(473.8)	(41.8)	(41.2)	0.6	(207.7)	(208.6)	(0.9)
Total Operational Costs	(1,303.5)	(110.8)	(113.3)	(2.5)	(554.1)	(563.6)	(9.5)
EBITDA	33.3	1.2	(2.6)	(3.8)	2.1	(11.6)	(13.7)
Interest Receivable	2.9	0.2	0.4	0.1	1.2	2.0	0.8
PDC	(4.8)	(0.4)	(0.4)	(0.0)	(2.0)	(2.0)	(0.0)
Finance Cost	(31.4)	(2.6)	(2.6)	(0.0)	(13.1)	(13.1)	(0.0)
Other Gains or Losses	0.0	0.0	0.0	0.0	0.0	0.1	0.1
Surplus / (Deficit)	0.0	(1.6)	(5.3)	(3.7)	(11.7)	(24.7)	(12.9)

The Trust overspend of £12.9m is mainly driven by the

- Reprofile of CIP £4.6m,
- £1.6m net costs incurred for industrial action that took place during April
- Patient income being below plan £5.9
- Service pressures linked to ED support and In-Reach £1.1m



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 5, it has delivered £12.7m of in-year savings, which is £4.6 below the month 5 original plan of £17.3m. The CIP was reforecast and against the forecast the CIP was delivered. The month 5 position includes £5.4m of non-recurrent saving which is £4.4m higher than the planned value at month 5. Earlier delivery of non-recurrent CIP has partly mitigated the under-delivery of recurrent schemes. The table below summaries the month 5 position.

CIP Summary Month 5 2026/27 £m	Annual	In Month			Year to date		
	Plan	Plan	Actual	Variance	Plan	Actual	Variance
Recurrent							
Income	13.4	1.0	0.4	(0.6)	4.9	1.5	(3.4)
Pay	21.7	1.6	2.1	0.4	6.8	4.1	(2.7)
Non Pay	12.1	1.0	0.4	(0.6)	4.7	1.8	(2.9)
Total Recurrent	47.2	3.7	2.8	(0.8)	16.4	7.4	(9.0)
Non Recurrent							
Income	-	-	0.0	0.0	-	0.0	0.0
Pay	-	-	0.2	0.2	-	2.0	2.0
Non Pay	25.9	0.3	1.6	1.3	0.9	3.3	2.4
Total Non Recurrent	25.9	0.3	1.8	1.5	0.9	5.4	4.4
Total CIP	73.1	4.0	4.7	0.7	17.3	12.7	(4.6)



Finance | Capital

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

The below tables set out the July capital plan agreed at the last Committee and the updated capital plan for August. Capital funding and expenditure have decreased by £0.3m in August.

A funding shortfall of £0.2m remains, £0.3m lower than last month. This will be monitored and managed throughout the year, with progress updates provided to the Committee.

UHNH Capital Expenditure Plan	July Capital Plan 2026/27 £m	August revised Capital Plan 2026/27 £m	Variance	Month 5 YTD Plan £m	Month 5 YTD Actual £m	Variance £m
Pre-committed items - PFI and Loans						
PFI re-payment of liability	23.738	23.738	0.000	9.891	9.891	0.000
PFI lifecycle commitments	3.237	3.237	0.000	1.350	1.350	0.000
PFI Managed Equipment Scheme	1.518	1.518	0.000	1.049	1.049	0.000
Repayment of IFRS16 leases	4.608	4.608	0.000	1.920	1.920	0.000
Total PFI and IFRS16 lease repayments commitments	33.101	33.101	0.000	14.210	14.210	0.000
Pre-committed schemes						
Finance salaries	0.074	0.074	0.000	0.031	0.032	0.001
Estates salaries	0.754	0.754	0.000	0.314	0.303	(0.011)
PFI enabling costs	0.200	0.200	0.000	0.015	0.016	0.001
Network & Comms BC525	1.250	1.250	0.000	0.350	0.261	(0.089)
LED lighting BC546	0.462	0.462	0.000	0.000	0.002	0.002
IM&T computer hardware refresh BC569	3.308	3.308	0.000	0.500	0.132	(0.368)
ED ambulance off - enabling ward moves	0.305	0.042	(0.263)	0.000	0.000	0.000
Endoscopy works 7th room - PDC allocation prior yrs	0.097	0.097	0.000	0.000	0.000	0.000
Completion of estates safety funding LTHW and chiller	0.975	1.030	0.055	0.190	0.174	(0.016)
Completion of CDC enabling	1.300	1.300	0.000	0.825	0.881	0.056
Completion of County Breast Unit	0.218	0.218	0.000	0.218	0.247	0.029
Completion of CDC IM&T	0.046	0.046	0.000	0.046	0.037	(0.009)
CDC pathways - 25/26 medical equipment	0.393	0.293	(0.100)	0.072	0.040	(0.032)
CDC pathways - 25/26 IM&T (Pathology/ICE)	0.000	0.100	0.100	0.000	0.000	0.000
CDC Endoscopy 4th room - 25/26 brokerage	1.000	1.000	0.000	0.000	0.000	0.000
Frontline digitalisation EPR 2025/26	0.602	0.602	0.000	0.216	0.214	(0.002)
Endoscopy decontamination air handling unit	0.035	0.035	0.000	0.000	0.000	0.000
EPMA - outpatients	0.291	0.291	0.000	0.160	0.091	(0.069)
PDC physiological science brought forward	0.235	0.200	(0.035)	0.000	0.000	0.000
Maternity - improvement to bereavement services/estate	0.129	0.129	0.000	0.000	0.000	0.000
Project Star - RI remedial work	0.010	0.010	0.000	0.000	0.000	0.000
Managing H&S risk register - BC562	0.043	0.000	(0.043)	0.000	0.000	0.000
Elective Hub - TBC	0.195	0.050	(0.145)	0.042	0.042	0.000
Pathology LIMS slippage	0.305	0.305	0.000	0.000	0.000	0.000
Royal Stoke ED healthcare planning feasibility	0.047	0.047	0.000	0.047	0.007	(0.040)
Central Contingency & risk	0.500	0.500	0.000	0.000	0.000	0.000
Total pre-committed schemes	12.774	12.343	(0.431)	3.026	2.479	(0.547)

UHNH Capital Expenditure Plan	July Capital Plan 2026/27 £m	August revised Capital Plan 2026/27 £m	Variance	Month 5 YTD Plan £m	Month 5 YTD Actual £m	Variance £m
Capital Planning Prioritised Schemes						
Stryker Power tools RemB	0.220	0.220	0.000	0.220	0.220	0.000
Operating tables x 4 for County Theatres	0.183	0.183	0.000	0.000	0.000	0.000
Windows 11 Upgrades for Diagnostic Equipment in Neurophysiology	0.117	0.117	0.000	0.005	0.005	0.000
Screening Room - CH room 4	0.631	0.631	0.000	0.000	0.000	0.000
Micro Plastic sets	0.057	0.057	0.000	0.057	0.004	(0.053)
UPS Replacements	0.080	0.080	0.000	0.000	0.000	0.000
MAU Wall removal	0.014	0.014	0.000	0.014	0.005	(0.009)
Replacement of Echo Blood Grouping analyser	0.031	0.031	0.000	0.000	0.000	0.000
Medical Gas Equipment	0.150	0.150	0.000	0.000	0.000	0.000
Replacement of RO plant	0.275	0.275	0.000	0.010	0.009	(0.001)
Cardiac Cath Lan - Cardiology PACS replacement	0.044	0.044	0.000	0.044	0.044	0.000
Audiology - County soundproofing	0.630	0.630	0.000	0.000	0.000	0.000
Refurbishment of RSUH Cancer Centre Pharmacy including Cold Store	0.728	0.728	0.000	0.000	0.000	0.000
PET-CT Autoinjector	0.069	0.069	0.000	0.000	0.000	0.000
Royal Stoke road enhancements	0.300	0.300	0.000	0.050	0.056	0.006
Sedation Equipment - Capnography	0.156	0.156	0.000	0.000	0.000	0.000
Heidi ambient voice technology AI solution BC	0.400	0.400	0.000	0.023	0.009	(0.014)
Endoscopy Medilogic	0.059	0.059	0.000	0.030	0.029	(0.001)
County High-Definition Procedural Screens - X4 Rooms	0.087	0.087	0.000	0.086	0.086	0.000
ED electrical supply to support glucometer	0.011	0.011	0.000	0.000	0.000	0.000
Bone Freezer replacement - SoN	0.009	0.009	0.000	0.000	0.000	0.000
Microaire theatre 6-10	0.027	0.027	0.000	0.000	0.000	0.000
Safety Works to Royal Stoke Helipad - BC	0.776	0.776	0.000	0.000	0.000	0.000
Total Capital Planning Prioritised Schemes	5.054	5.054	0.000	0.539	0.467	(0.072)
Other corporate schemes						
IFRS16 Lease liability re-measurement	(0.800)	(0.800)	0.000	(0.219)	(0.219)	0.000
Vehicles lease renewals	0.415	0.415	0.000	0.149	0.149	0.000
Heart Lung by-pass equipment replacement	1.306	1.306	0.000	0.000	0.000	0.000
Urology robot (lease)	0.305	0.366	0.061	0.000	0.000	0.000
Roache sakura equipment (IFRS16)	0.225	0.225	0.000	0.000	0.000	0.000
Heat Network Efficiency Scheme	0.729	0.769	0.040	0.000	0.000	0.000
Business Cases expected to progress						
Endoscopy scopes County Hospital	2.720	2.720	0.000	0.000	0.000	0.000
Royal Stoke endoscopy lease buy-out	0.180	0.180	0.000	0.000	0.000	0.000
Total Other corporate schemes	5.080	5.181	0.101	(0.070)	(0.070)	0.000
Capital sub-group (ICB allocation)						
IMT Sub Group Total Funding	2.448	2.448	0.000	0.300	0.207	(0.093)
Medical Devices Sub Group	2.500	2.535	0.035	0.745	0.694	(0.051)
Estates Sub Group Total Funding	2.000	1.945	(0.055)	0.300	0.360	0.060
Estates safety - additional allocation	1.694	1.694	0.000	0.000	0.000	0.000
Health & Safety compliance	0.150	0.150	0.000	0.007	0.008	0.001
Total Capital Sub-Groups	8.792	8.772	(0.020)	1.352	1.269	(0.083)
Total Internal Capital Expenditure	31.700	31.350	(0.350)	4.847	4.145	(0.702)
Funding to allocate/(shortfall)	(0.519)	(0.220)	0.299	0.000	0.000	0.000
Total Operational Capital/Internally funded expenditure	64.282	64.231	(0.051)	19.057	18.355	(0.702)

UHNH Capital Expenditure Plan	July Capital Plan 2026/27 £m	August revised Capital Plan 2026/27 £m	Variance	Month 5 YTD Plan £m	Month 5 YTD Actual £m	Variance £m
Additional CRL / Externally Funded PDC (multi-year schemes)						
Charitable funded expenditure	1.633	1.633	0.000	0.370	0.370	0.000
NIHR funded CEC works	0.571	0.054	(0.517)	0.000	0.000	0.000
West Midlands Ambulance - Helipad donation	0.814	0.814	0.000	0.000	0.000	0.000
Externally Funded PDC						
PDC Constitutional standards Royal Stoke UTC Estates	2.694	2.694	0.000	1.655	1.372	(0.283)
PDC Constitutional standards Royal Stoke UTC Digital	0.616	0.616	0.000	0.000	0.000	0.000
PDC Constitutional Standards Stoke Discharge Lounge	1.100	1.100	0.000	0.055	0.016	(0.039)
PDC Constitutional Standards UTC County	2.100	2.100	0.000	0.070	0.000	(0.070)
PDC Constitutional standards Urgent Emergency Care	0.800	0.800	0.000	0.000	0.000	0.000
PDC Constitutional Standards Diagnostics CDC Expansion	1.000	1.000	0.000	0.000	0.000	0.000
PDC UHNH Barcoding at source pilot extension	0.000	0.270	0.270	0.000	0.000	0.000
PDC Pathology LIMS	1.270	1.270	0.000	0.722	0.633	(0.089)
Total Additional CRL / PDC Funded expenditure	12.598	12.351	(0.247)	2.872	2.391	(0.481)
Total Capital Expenditure	76.880	76.582	(0.298)	21.929	20.746	(1.183)

UHNH Capital Funding Plan - 2026/27 to 2029/30	July Capital Plan 2026/27 £m	August revised Capital Plan 2026/27 £m	Variance	Month 5 YTD Plan £m	Month 5 YTD Actual £m	Variance £m
Total PFI and IFRS16 lease repayments commitments	33.101	33.101	0.000	14.210	14.210	0.000
Total ICB capital allocation	26.051	26.051	0.000	7.349	6.196	(1.183)
Elective Care Capital Incentive Scheme - RTIS	2.000	2.000	0.000	0.000	0.000	0.000
PDC Estates Safety	1.694	1.694	0.000	0.000	0.000	0.000
PDC Constitutional standards Urgent Treatment Centre	3.310	3.310	0.000	0.000	0.000	0.000
PDC Constitutional Standards Stoke Discharge Lounge	1.100	1.100	0.000	0.000	0.000	0.000
PDC Constitutional Standards UTC County & discharge	2.100	2.100	0.000	0.000	0.000	0.000
PDC Constitutional standards Urgent Emergency Care	0.800	0.800	0.000	0.000	0.000	0.000
PDC Constitutional Standards Diagnostics	1.000	1.000	0.000	0.000	0.000	0.000
PDC Digital Diagnostics Capability (DDC) Barcoding at source	0.000	0.270	0.270	0.000	0.000	0.000
PDC Pathology LIMS	1.270	1.270	0.000	0.000	0.000	0.000
Other disposals	0.789	0.789	0.000	0.000	0.000	0.000
Charitable funded expenditure	1.633	1.633	0.000	0.370	0.370	0.000
NIHR funded CEC works	0.571	0.054	(0.517)	0.000	0.000	0.000
West Midlands Ambulance - Helipad donation	0.814	0.814	0.000	0.000	0.000	0.000
Internal resources capital to revenue	0.150	0.099	(0.051)	0.000	0.000	0.000
Internal resources - VAT and accruals release	0.497	0.497	0.000	0.000	0.000	0.000
Total capital funding	76.880	76.582	(0.298)	21.929	20.746	(1.183)
Funding to be allocated/(shortfall)	0.000	0.000	0.000	0.000	0.000	0.000



Finance | Balance Sheet

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

Statement of Financial Position	31/03/2026	31/08/2026		
	Actual £m	Plan £m	Actual £m	Variance £m
Property, Plant & Equipment	732.3	730.3	728.5	(1.8)
Right of Use Assets	21.8	20.2	20.4	0.2
Intangible Assets	12.1	12.8	12.7	(0.1)
Trade and other Receivables	1.0	1.1	1.0	(0.1)
Total Non-Current Assets	767.3	764.4	762.5	(1.8)
Inventories	21.4	21.0	21.4	0.4
Trade and other Receivables	51.2	53.0	59.3	6.4
Asset held for sale	7.7	7.7	7.7	-
Cash and Cash Equivalents	88.1	51.5	62.7	11.2
Total Current Assets	168.4	133.1	151.1	18.0
Trade and other payables	(136.9)	(106.1)	(136.9)	(30.7)
Borrowings	(28.8)	(28.8)	(28.5)	0.2
Provisions	(1.1)	(1.1)	(0.7)	0.3
Total Current Liabilities	(166.7)	(136.0)	(166.1)	(30.1)
Borrowings	(482.2)	(477.9)	(477.8)	0.1
Provisions	(3.4)	(3.4)	(3.4)	0.1
Total Non-Current Liabilities	(485.7)	(481.4)	(481.2)	0.2
Total Assets Employed	283.3	280.2	266.3	(13.8)
Financed By:				-
Public Dividend Capital	775.6	775.6	775.6	-
Retained Earnings	(692.0)	(699.7)	(713.6)	(13.8)
Revaluation Reserve	199.7	204.3	204.3	-
Total Taxpayers Equity	283.3	280.2	266.3	(13.8)



Quarterly Productivity Report

Trust Board

September 2026

Implied Productivity Headline Measures

Strengthening governance and increasing visibility

NHS England recently published its trust-level productivity methodology. Every NHS trust in England now has a productivity score that will be published monthly. The Spending Review target is 2% productivity growth, year on year, until the NHS returns to pre-pandemic levels. Understanding what the productivity metric measures, and what it doesn't, has never been more important.

What the framework does

At its core, the methodology asks a simple question: *“for every pound spent (in real terms), is the NHS delivering more care than it did in the same period the year before?”* It does this by comparing two things:

- How much activity a trust has delivered
- And how much it has spent delivering it across equivalent time periods

If activity grows faster than spend, productivity improves. If spend outpaces activity, it falls. The calculation divides the two growth rates rather than subtracting them, which means a trust growing activity by 10% whilst costs rise by 5% sees productivity grow by 4.8%, because that output growth is being expressed relative to a cost base that has itself expanded. i.e. $(100+0.1)/(100+0.05)=1.048$

Cost weighting: activity is not just counted; it is value adjusted. For example, a complex surgical episode counts for more than a routine outpatient appointment, weighted by national average unit costs. This means a trust shifting toward higher-acuity work will see the change in complexity mix reflected in its productivity metric.

Equalisation: This is the important design choice in the methodology. Moving patients from elective overnight stays to day surgery is clinically right and financially sound. Without equalisation, it would make a trust look less productive, because day cases carry a lower unit cost. The methodology corrects for this, assigning equivalent cost weights to equivalent outcomes. It is designed to reward the shift to lower-cost, same-outcome care, not penalise it.

Inflation adjustment: Pay costs are deflated using national pay award uplifts; non-pay costs using CPI, RPI and GDP deflator. A trust that spent more because of a national pay settlement is not penalised for it. High-cost drugs, private patient income and redundancy costs are excluded.

Difference from ONS: The ONS also publishes NHS productivity figures, but it is a different measure. ONS quality-adjusts for waiting times, survival rates and patient outcomes, is published with a two-year lag, and covers UK-wide healthcare rather than acute trusts in England only. The two measures will give different answers for the same period, and that is expected. The 2% Spending Review target is tracked against this NHSE methodology, not ONS.

Implied Productivity Headline Measures

Why this matters right now

The first estimates were published publicly February 2026 but have been available for trust review since April 2025. For every board and executive team, the immediate task is understanding what their number means in context, how their activity mix, care model and cost reporting combine to produce it, and whether it reflects genuine improvement, deterioration or data artefacts.

The methodology is explicit that SDEC reporting changes, EPR implementations and unaudited monthly finance returns all create distortions at trust level. Estimates are provisional. Trusts can raise data notifications. The number is meant to be a starting point for a conversation, not a final verdict.

What it doesn't measure

This is not an outcomes measure. A hip replacement is counted the same regardless of the quality-of-life improvement it delivered. It does not capture prevention, population health, or the value of keeping people out of hospital, the very things the 10 Year Plan is built around. The methodology is transparent about these limitations.

Further Limitations

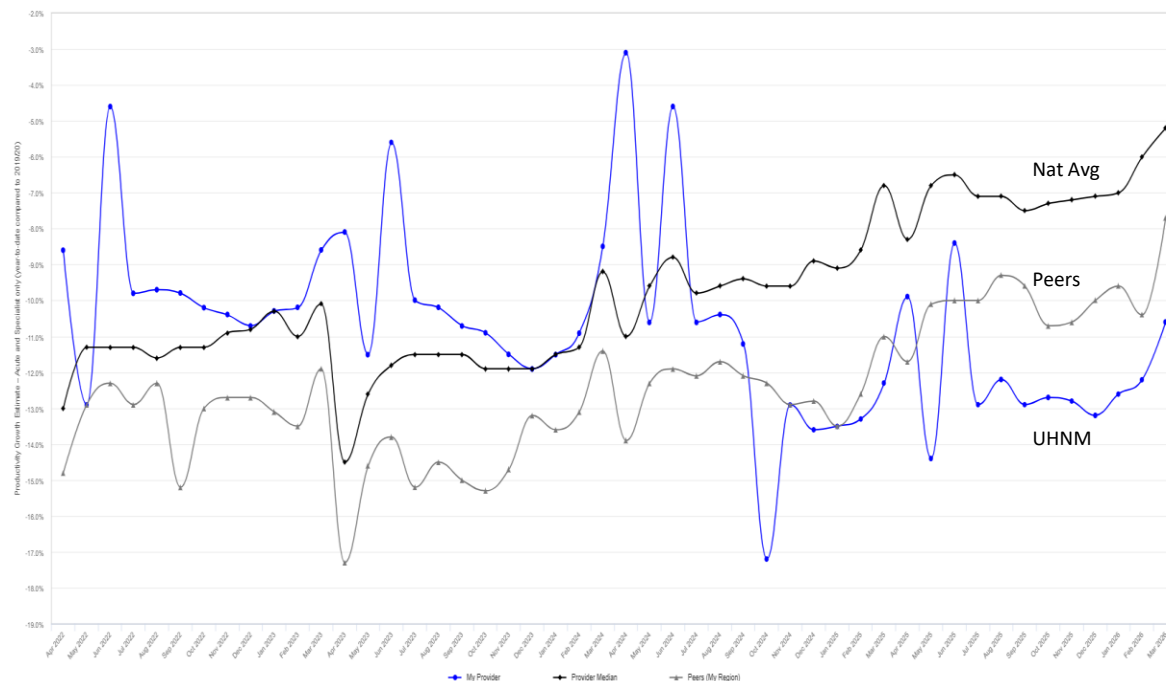
- The measurement is always against a year-to-date position against a base year, i.e. 2019/20 and previous year. This means it's always a relative position that resets each April. Fluctuations in the base year and relative performance between trusts therefore means it should be read alongside other finance/productivity measures.
- To make the most use of the measure, the calculation attempts to balance accuracy, speed and simplicity. Each of these three elements has a trade off against the others. Over time, to improve the accuracy of reporting the cost weighting more adjustments have been made at the centre including, inflation, lower-level cost weighting, weightings between points of delivery, treatment of high-cost drugs. To ensure these are reported in a timely manner there is limited local validation and drill down. This means trusts have limited ability to produce detail analysis of the measure at point of delivery or service level. It's therefore important that the measure is read in conjunction with productivity drivers where further appraisal is possible. The productivity driver metrics can be influenced through the trusts transformation programme which should then lead to changes in the productivity measures.
- It's therefore recommended that attention is also paid in the charts set out after the measure in this report and in conjunction with information provided in other papers



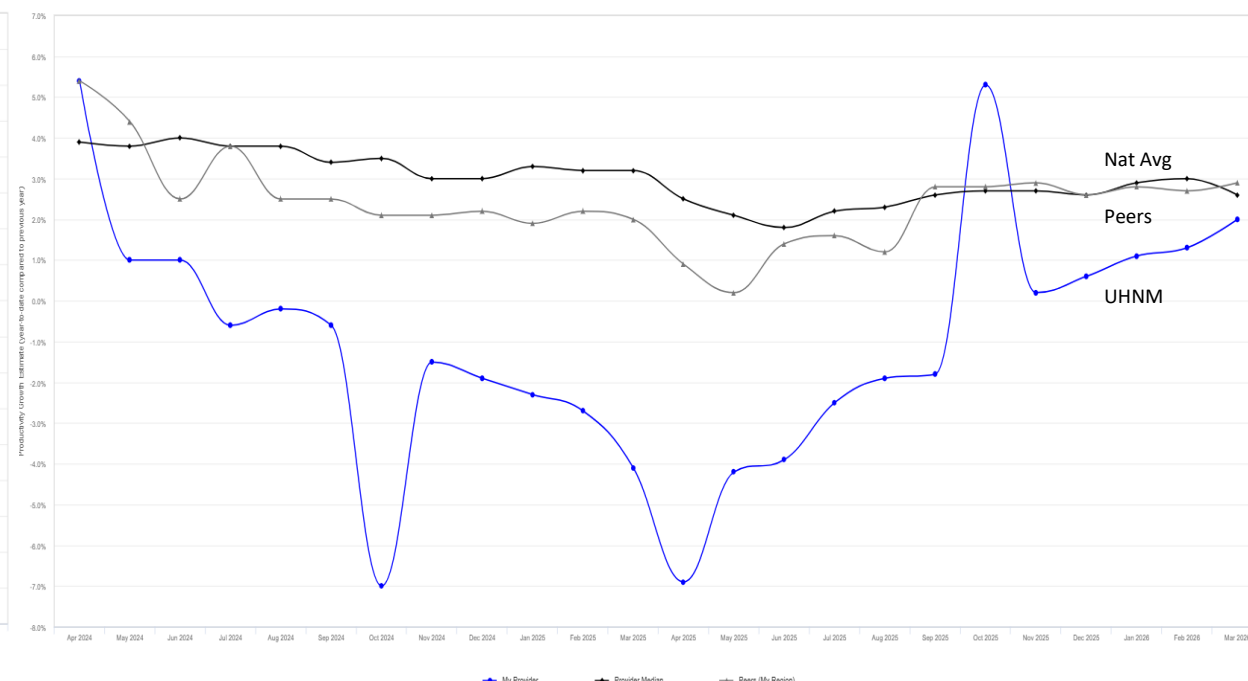
Productivity/Efficiency | Headline Measures

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

Productivity growth estimate compared to 2019/20



Productivity growth estimate compared to 2024/25



What is the data telling us?

- The chart above measures the change in outputs v's the change in inputs compared to 2019/20 (i.e. a pre-COVID baseline)
- At March 2025, the Trust shows as 10.6% less productive (peers are 7.7% less productive)
- Largely UHNM has experienced a similar rise in input costs to peers since 19/20, (26%) but has delivered 2.7% less additional activity for that similar rise (12.5% v 15.2%)
- The top right-hand chart compares the change in outputs v's inputs to the previous year
- This is the measure that features in the NHSE report and the Operating Framework position
- The Trust is 2% more productive over that period and therefore achieves the national target of 2% - the national average was 2.6%
- Compared to last year resources have grown 0.4% more than peers but delivered 0.3% less additional activity - this is consistent with the longitudinal pattern from 2019/20

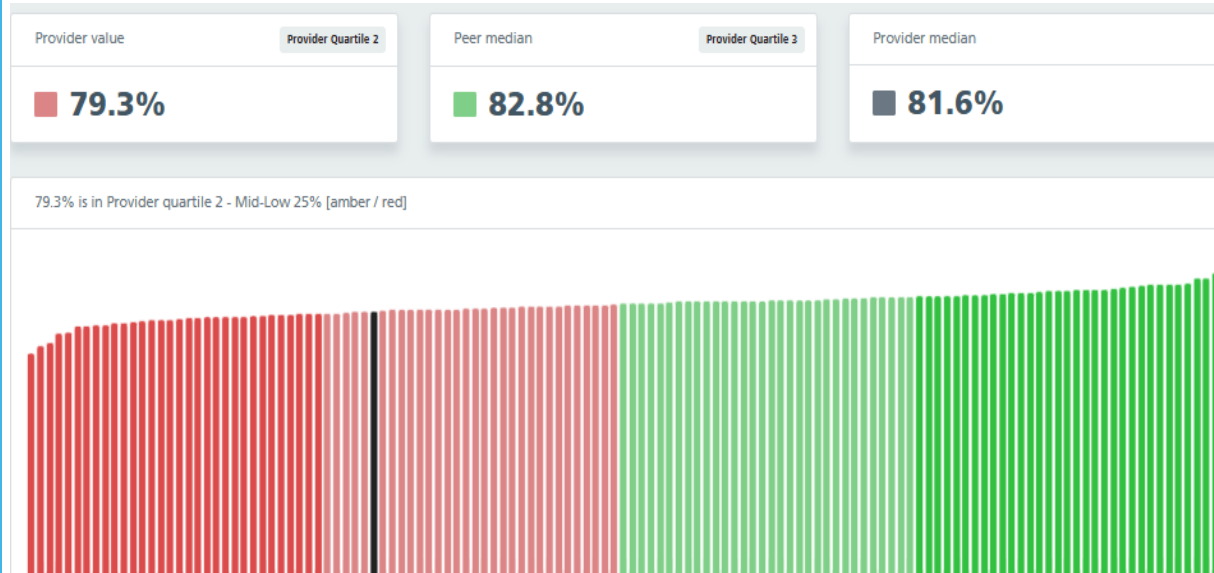
What are we doing about it?

- The Trust continues to develop its capacity and capability to interrogate and use national comparative data to support strategy and planning
- The national productivity & efficiency data set has been used to support the design and development of the 2026/27 CIP programme - including transformation programmes which apply organisation wide and more tailored interventions at individual speciality level
- The following slides draw out the pathways this is targeting.
- The trust has engaged with the national programme to understand the technical elements and has feedback on its use in the national benchmarking productivity packs that support construction of the medium-term plan.

Productivity/Efficiency | Theatre – utilisation & DC rates

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

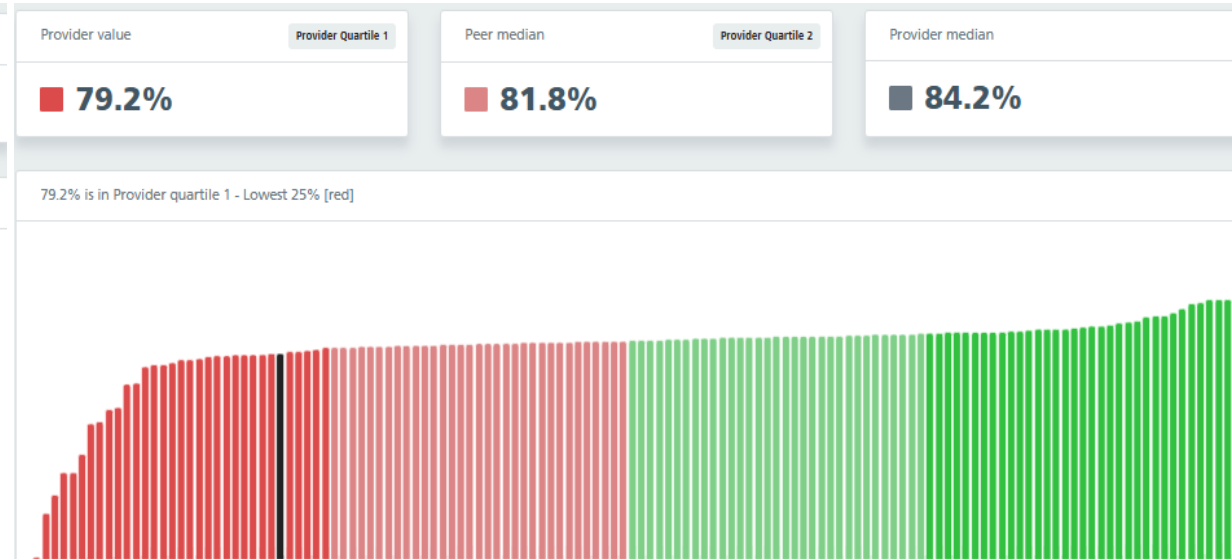
Theatre Utilisation



What is the data telling us?

- Theatre utilisation are viewed as a key operational productivity drivers within both the NHSE insightful board recommendations and on Model Health System
- The national target for theatre utilisation is 85% - UHNM are currently reporting a rate of 79.3% with a national average of 81.6%.
- Day case rates are viewed as a key operational productivity drivers within both the NHSE insightful board recommendations, Model Hospital System and the GIRFT programme.
- The bar chart above is very sensitive to the case mix of the provider. i.e. specialist providers tend to be at the extremes e.g. Moorfields eye hospital is at the very right

Day Case Rates



What are we doing about it?

- New theatres board is now in place chaired by COO and supported by Deloitte with clear governance framework established between incorporating 6-4-2 process, scheduling, theatre productivity group and theatre program board
- Pre-AMS review commenced to streamline patient optimisation in preparation for theatre. This will aim to facilitate the growth of a standby list of patients for theatres to reduce the impact of on-the-day cancellations
- Cancellations SOP approved and introduced.
- About to commence a full theatre staffing review to include structure, skill mix and different ways of working.
- DC rates influenced by specialities with high proportion of DC/OPPROC work, including Ophthalmology and specialities included in the SLR programme

Trust Board
2026/27 BUSINESS CYCLE

KEY TO RAG STATUS	
Paper rescheduled for future meeting	
Paper rescheduled for next meeting	
Paper taken to meeting as scheduled	

Title of Paper	Executive Lead	Apr	Jun	Aug	Oct	Dec	Feb
		8	10	12	7	9	10
PROCEDURAL ITEMS							
Patient / Staff Story	Chief Nurse / Chief People Officer	Staff	Pt	Staff	Pt	Staff	Pt
Chairs Update	Chair				N/A		
Chief Executives Report	Chief Executive						
Board Assurance Framework	Director of Governance		Q4	Q1		Q2	Q3
OUR PATIENTS: QUALITY, ACCESS & OUTCOMES							
Quality, Access & Outcomes Committee Assurance Report	Director of Governance						
Mortality Assurance Annual Report	Chief Medical Officer						
Maternity Serious Incident Report	Chief Nurse	Q3	Q4	Q1			
Maternity Triage Specification	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				N/A		
NHS Resolution Maternity Incentive Scheme	Chief Nurse						
Quality, Access & Performance Strategic Plan Update	Chief Nurse / Chief Medical Officer / Chief Operating Officer						
Integrated Performance Report	Various						
OUR PEOPLE							
People, Culture & Inclusion Committee Assurance Report	Director of Governance						
Staff Survey Report	Chief People Officer						
Gender, Ethnicity and Disability Pay Gap Report	Chief People Officer						
Speaking Up Report	Director of Governance						
Revalidation	Chief Medical Officer						
Workforce Disability Equality and Workforce Race Equality Reports	Chief People Officer						
Equality, Diversity and Inclusion Annual Report	Chief People Officer						
People Strategic Plan Update	Chief People Officer						
OUR POPULATION							
Population Health Strategic Plan Update	Director of Strategy						
FINANCE AND BUSINESS PERFORMANCE							
Finance & Business Performance Committee Assurance Report	Director of Governance						
Annual Report and Accounts including Going Concern	Chief Finance Officer						
Annual Plan	Director of Strategy						
Financial Plan including Capital Programme	Chief Finance Officer						
Standing Financial Instructions	Chief Finance Officer						
Scheme of Reservation and Delegation of Powers	Chief Finance Officer						
OUR STRATEGIC PLANS							
Digital Strategic Plan Update	Chief Digital Information Officer						
Research Strategic Plan Update	Chief Medical Officer						
Innovation Strategic Plan Update	Director of Strategy						
Estates & Facilities Strategic Plan Update	Director of Estates, Facilities & PFI						
GOVERNANCE							
Audit Committee Assurance Report	Director of Governance						
Fit and Proper Persons Annual Assurance Report	Director of Governance						
Anchor Institution Update	Director of Strategy & Communications						
Emergency Preparedness Annual Assurance Statement and Annual Report	Chief Operating Officer						
Annual Evaluation of the Board Committees	Director of Governance						
Annual Review of the Rules of Procedure	Director of Governance						
Well-Led / Provider Capability Integrated Action Plan	Director of Governance						
Risk Management Policy	Director of Governance						
Complaints Policy	Chief Nurse						
Annual Organ Donation Report	Chief Medical Officer						