University Hospitals of North Midlands NHS Trust

AGENDA | Trust Board - Part 1 (in Public)

Meeting held on Wednesday 8th April 2026 at 9.30 am to 12.35 pm

Trust Boardroom, Third Floor, Springfield, RSUH

Time	No.	Agenda Item	Purpose	Lead	Format	BAF Link
9:30	**PROCEDURAL ITEMS**					
20 mins	01	Staff Story	Information	Mrs J Haire	Verbal	
5 mins	02	Chair's Welcome, Apologies and Confirmation of Quoracy	Information	Ms J Small	Verbal	
	03	Declarations of Interest	Information	Ms J Small	Verbal	
	04	Minutes of the Meeting held 11th February 2026	Approval	Ms J Small	Enclosure	
	05	Matters Arising via the Post Meeting Action Log	Assurance	Ms J Small	Enclosure	
10 mins	06	Questions from Members of the Public in relation to matters on the agenda	Information	Ms J Small	Verbal	
10:05	**CHAIR AND CHIEF EXECUTIVE UPDATES**					
10 mins	07	Chair's Update	Information	Ms J Small	Verbal	
10 mins	08	Chief Executive's Report – April 2026	Information	Dr S Constable	Enclosure	
10:25	**OUR PATIENTS: QUALITY, ACCESS & OUTCOMES**					
10 mins	09	UHNM PLACE Results 2025	Assurance	Mrs L Whitehead	Enclosure	5
10 mins	10	Maternity & Neonatal PSIRF Investigation Report Q3	Assurance	Mrs D Brayford	Enclosure	1
15 mins	11	UEC Improvement Journey	Assurance	Mrs K Thorpe	Enclosure	1
11:00 – 11:15 COMFORT BREAK						
11:15	**OUR PEOPLE**					
10 mins	12	NHS Staff Survey 2025 Results	Assurance	Mrs J Haire	Enclosure	3
10 mins	13	Gender, Ethnicity and Disability Pay Gap Report 2025	Assurance	Mrs J Haire	Enclosure	3
11:35	**PERFORMANCE**					
	14	Integrated Performance Report – Month 11 and Committee Assurance Reports:				
20 mins	14a	• Quality, Access & Outcomes Committee Assurance Report (05-03-26 & 02-04-26) • Quality & Access Dashboard	Assurance	Prof K Maddock Mrs AM Riley/ Mrs K Thorpe	Enclosure	1
15 mins	14b	• People, Culture & Inclusion Committee Assurance Report (01-04-26) • People Dashboard	Assurance	Prof S Toor Mrs J Haire	Enclosure	3
20 mins	14c	• Finance & Business Performance Committee Assurance Report (02-03-26 & 30-03-26) • Finance Dashboard	Assurance	Ms T Bowen Mrs S Proffitt	Enclosure	6, 7
12:30	**CLOSING MATTERS**					
5 mins	15	Review of Meeting Effectiveness Link to feedback form: https://forms.office.com/e/tydNkMB2Mj	Information	Ms J Small	Verbal	
	16	Review of Business Cycle	Information	Ms J Small	Enclosure	
12:35	**DATE AND TIME OF NEXT MEETING**					
	17	**Wednesday 10th June 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 6th April to nicola.hassall@uhnm.nhs.uk

Minutes of Meeting

Trust Board – Part 1 | 11th February 2026, 9.30 am to 11.35 am

Trust Boardroom, Third Floor, Springfield

University Hospitals of North Midlands NHS Trust

Members Present:			
Name	**Initials**	**Title**	
Ms J Small	JS	Chair (Chair)	Voting
Mrs L Bainbridge	LB	Non-Executive Director	Voting
Ms T Bowen	TBo	Non-Executive Director	Voting
Prof K Maddock	KM	Non-Executive Director	Voting
Miss W Nicholson MBE	WN	Non-Executive Director	Voting
Dr S Constable	SC	Chief Executive	Voting
Dr D Adamson	DA	Chief Medical Officer	Voting
Ms H Ashley	HA	Director of Strategy	Non-Voting
Mrs C Cotton	CC	Director of Governance & Communications	Non-Voting
Mr M Oldham	MO	Chief Finance Officer (virtual)	Voting
Mrs J Haire	JH	Chief People Officer	Non-Voting
Mrs AM Riley OBE	AR	Chief Nurse	Voting
Mrs K Thorpe	KT	Interim Chief Operating Officer	Voting
Mrs L Whitehead	LW	Director of Estates, Facilities & PFI	Non-Voting

Apologies Received:			
Name	**Initials**	**Title**	
Mrs A Freeman	AF	Chief Digital Information Officer	Non-Voting
Mrs M Monckton	MM	Non-Executive Director	Voting
Prof S Toor	ST	Non-Executive Director	Voting

In Attendance:		
Name	**Initials**	**Title**
Mrs D Brayford	DB	Interim Director of Midwifery (item 10)
Mrs J Dickson	JD	Deputy Director of Communications
Mrs N Hassall	NH	Deputy Director of Governance (minutes)
Miss H Poole	HP	Deputy Chief Digital Information Officer (representing Mrs Freeman)

Members of Staff and Public: 3

No.	Agenda Item	Action
PROCEDURAL ITEMS		
1.	**Patient Story**	
001/2026	A video was played to Board members https://vimeo.com/1163655941/0e4b6bf4e5?share=copy&fl=sv&fe=ci which highlighted Mr Frearson's personal account following his wife's diagnosis and treatment at the Trust. The video demonstrated the support he received and the way in which clear information was provided to help alleviate anxieties throughout their experience. Miss Nicholson asked whether there had been any specific learning identified from Mr Frearson's experience. Mrs Riley advised that any learning would be taken forward through co-production approaches. Mrs Thorpe added that cancer waiting time data showed that, for the majority of pathways, patients experienced similar levels of care, although it was recognised that this was not always consistent across all pathways, such as skin and lung cancer. Overall, however, most patients received a comparable experience.	

	Mrs Haire commented that the story provided a strong example of the Trust's people also being its patients and population. Ms Small described the story as inspirational and welcomed the positive outcome and the support Mr Frearson had received. She queried how such messages could be shared more widely to highlight good practice and the support available. Mrs Riley noted that there was an existing workstream focused on what it is like to work at the Trust and that this would include engagement with people, using similar examples as the work developed. Mrs Cotton added that she would be undertaking focused work on the communications required for the Trust's people, patients and population. Ms Small further reflected that the account was very emotive and clearly captured the impact of the Trust's care and communication. She noted that if this could be conveyed more widely, communications would be stronger and more meaningful for people. Mrs Huntley left the meeting.	
2.	**Chair's Welcome, Apologies and Confirmation of Quoracy**	
002/2026	Ms Small welcomed members to the meeting. Apologies were received as noted above and the meeting was confirmed as quorate. Ms Small noted that Professor Hassell had left the Trust at the end of January 2026 and she formally thanked him for the contribution he had made to the Board during his 8 years. She highlighted that following his departure a number of roles had been reassigned; Ms Bowen had become the Senior Independent Director, Miss Nicholson the Freedom to Speak Up Guardian Non-Executive Director Lead, and Professor Maddock was to chair Quality, Access and Outcomes Committee (QAOC).	
3.	**Declarations of Interest**	
003/2026	There were no declarations of interest raised.	
4.	**Minutes of the Meeting held 10th December 2025**	
004/2026	The minutes of the meeting held on 10th December were approved as a true and accurate record.	
5.	**Matters Arising via the Post Meeting Action Log**	
005/2026	PTB/622 – Mrs Riley highlighted that an update had been provided to Professor Hassell. PTB/623 – It was noted that a meeting had been scheduled regarding the use of persona analysis and as such it was agreed to change the due date to March.	
6.	**Questions from Members of the Public in relation to matters on the agenda**	
006/2026	Mr Syme raised the following questions: 1. Sepsis	

Mr Syme referred to the Staffordshire area Coroner Prevention of Future Deaths Report (PFD) issued to UHNM and NHS England at the conclusion of a coroner's inquest on 20th January 2026, which emphasised concerns regarding 'sepsis screening' of a pregnant lady which resulted in the lady's death. He also referred to the specific National Early Warning Score Matrix (NEWS) for Prenatal women that must be used in all hospital departments, although noted that this matrix was not used in the Trust's Emergency Department portal, only the maternity unit.

Mr Syme referred to the reference to sepsis in the board pack which indicated the sepsis team monitor for compliance. He questioned whether the Trust had reviewed its implementation of the matrix and whether it was being implemented in all hospital departments when required. If no, he queried what inhibited the implementation of the matrix.

Mrs Riley explained that the original intention had been to implement a digital system for recording observations; however, the system could not be updated in a timely way and it was anticipated that implementation would be delayed for a prolonged period. She advised that a working group had been established to consider the available options, including whether to proceed with a digital system or revert to paper-based records, and to assess the risks associated with each approach. Mrs Riley confirmed that progress updates would be provided as work continued and noted that a conclusion was anticipated shortly.

Mr Syme referred to the West Midlands Ambulance Service emergency ambulances which have a screening tool for sepsis in addition to completing 'pre alert for sepsis' when conveying to Emergency Departments. He referred to the board pack which stipulated that intravenous antibiotics within 60 minutes 'remained a little below standard'. He queried how, given emergency ambulances do "pre alert for sepsis' when conveying to Emergency Department, the pre alerts for sepsis were managed on arrival, given the ambulance handover delays.

Dr Adamson explained that practice had changed following the case, with an increase in patients being flagged for sepsis. She confirmed that it was correct that any patient about whom the ambulance service had concerns would be pre-alerted via the resuscitation phone.

Previously, a Consultant or Registrar would have been based with the triage nurse at the ambulance handover to assess whether sepsis treatment was required. It had since been agreed that any patient who was pre-alerted would be brought directly into the resuscitation area and reviewed by either a Consultant or Registrar at that point, before being triaged to the most appropriate clinical area.

Dr Adamson noted that, when reviewing inpatient screening and timeliness, there was a difference between Emergency Department (ED) performance and inpatient areas. She advised that work was ongoing through a number of workstreams to improve care within the ED, particularly in the context of departmental overcrowding, and that this work contributed to overall performance against key indicators of good quality care.

2. Radiology Reporting

Mr Syme referred to the risks associated with radiology reporting which were highlighted within the Board Assurance Framework (BAF). He referred to the

	significant sums invested over the years in an attempt to improve radiology reporting including the use of external providers. He stated that he had been told that the Trust was telling patients that there was a 12 week backlog for radiology reporting and he queried what was the present backlog for radiology reporting and what further mitigations were required to ensure that radiology reporting was timely and not protracted. Mrs Thorpe provided an update on radiology reporting backlogs. She advised that the current number of patients waiting for radiology reports was 12,683, of whom 1,266 had been waiting longer than six weeks. At the time of the previous report, the total number waiting had been over 5,000, indicating a significant reduction to date. Mrs Thorpe reported that the average turnaround time for body imaging was 12.4 days. Musculoskeletal (MSK) and neurological imaging remained the main areas of concern, with an average reporting time of 36 days. A small number of patients had experienced the longest waits, up to 87 days, although this was on a reducing trend. She confirmed that work was ongoing with the radiology team to improve reporting performance, including prioritising reporting across different settings. External workforce support had also been utilised to report cases in chronological order, with more complex cases taking longer to report, thereby helping to reduce overall risk. 3. Ambulance Handovers and UEC Plan 2025/26 Mr Syme referred to ambulance handover delays in the West Midlands and reference to handover delays within the Chief Executive report. He referred to the Release to Respond initiative which had reduced ambulance handover delays throughout England which was being used at the Trust. He referred to handover delays in December 2025 and queried what, if any, improvement the Trust was experiencing by implementing both the 'continuous flow model' and 'Release to Respond initiative". He queried given the 95 minutes ambulance handovers position, how the Trust was going to attain and sustain the Urgent and Emergency Care (UEC) plan of a maximum ambulance handover of 45 minutes, and reducing corridor care given the short period of time before year end. Mrs Thorpe provided an update on the Trust's release to respond performance. She advised that work to reduce handover times had commenced with an initial target of 90 minutes, with the aim of progressing towards 45 minutes. During the first few weeks, a reduction in handover times had been observed, although performance had fluctuated. Times had reduced and been sustained at around 95 minutes, subsequently increased to approximately one hour and ten minutes, and then reduced again. Mrs Thorpe explained that early analysis indicated that the position was not driven solely by Emergency Department attendances or increased ambulance arrivals. Instead, the primary factors were internal capacity constraints and bed occupancy. She confirmed that work was ongoing to improve discharge processes and to bring discharges forward earlier in the day, in order to support improvements in release to respond performance.	
CHAIR AND CHIEF EXECUTIVE UPDATES		
7.	**Chair's Update**	

007/2026	Ms Small provided an update highlighting several key areas of focus. She emphasised the importance of values and behaviours as integral to the organisation, and the need to understand what it feels like to work at the Trust. She reported that she had been meeting monthly with Mr Irving to discuss organisational culture, including themes emerging from Freedom to Speak Up (FTSU). These discussions had included examples relating to patient safety, staff morale, wellbeing, workload and team behaviours. Ms Small noted that she had been meeting regularly with Dr Constable to understand challenges and to triangulate information. Ms Small also stressed the importance of developing and sustaining collaborative relationships with partners across the wider system. In light of recent system changes, she advised that she had met with other Chairs, and that a positive outcome had been the opportunity to engage with the new ICB Chair, Mr Ian Green, who was keen to understand organisations across the system. She confirmed that he would be invited to visit the Trust's services, see both sites and undertake walkabouts. She further highlighted the importance of maintaining strong relationships and advised that she had met with Mr Dale Bywater and was meeting regularly with Mrs Rebecca Farmer to discuss key policies and strategies that the Trust needed to take into account. Ms Small noted that she was part of a national network of Chairs and that meeting with peers from other organisations provided valuable opportunities for shared learning and reciprocal working. She also reported that she had attended the Oliver McGowan mandatory training at Midlands Partnership Foundation Trust (MPFT), which set important context around ensuring equitable care for all people who use services. Ms Small confirmed that further meetings were planned with the national network and other local Chairs. **The Trust Board noted the update.**	
8.	**Chief Executive's Report – February 2026**	
008/2026	Dr Constable provided an update and highlighted that the main challenge at the time related to urgent and emergency care (UEC) pathways and ambulance handovers, noting that given their importance it would be remiss not to raise these as key issues. He reported that the Getting It Right First Time (GIRFT) team continued to work with the Trust and that their support had been helpful in working alongside clinical teams. He noted that performance over the previous six to eight weeks had shown week-on-week improvement when compared to the same period last year, indicating that the actions being taken were having a positive impact. Ms Bowen referred to a recent critical incident and issues relating to System C and requested an update on progress with the electronic patient record (EPR). Dr Constable explained that the system issues had caused difficulties in the period leading up to Christmas, particularly in managing patient flow, and that this remained a risk due to the fragility of the current system. He advised that the long-term solution would be the implementation of a Trust-wide EPR.	

	Mrs Thorpe added that when the system was unavailable, the entire site reverted to paper-based processes, requiring significant additional support from site teams. She noted that this created delays for patients and presented operational challenges, including difficulties in avoiding duplication of activity, and that these issues extended beyond the digital challenges themselves. Ms Bowen also referred to developments in robotic surgery and noted that the Trust's charity had successfully secured additional funding, providing an excellent opportunity to access this technology. She formally thanked the Denise Coates Foundation for their support. Ms Small reflected on the work of the GIRFT team and emphasised the importance of ensuring that the learning and improvements achieved were embedded and sustained over the longer term. Dr Constable advised that work was ongoing with the GIRFT team on developing a long-term model, including the continuous transfer of skills. Mrs Thorpe added that the GIRFT work was supporting the development of appropriate patient pathways and was focused on working with clinical teams to drive bottom-up change, rather than solely altering day-to-day processes. Dr Constable concluded that this provided assurance that the Board was focusing on the right priorities and that further work would offer additional assurance regarding the sustainability of the improvements. **The Trust Board received and noted the update.**	
9.	**Board Assurance Framework – Quarter 3**	
009/2026	Mrs Cotton presented the Quarter 3 Board Assurance Framework (BAF) and highlighted that it had been scrutinised through the Trust's Committees. She advised that the Audit Committee had been assured regarding the robustness of the process undertaken, as referenced within the individual committee highlight reports. Mrs Cotton noted that the BAF continued to evolve and develop, including the incorporation of additional analysis drawn from the Executive Summary. Ms Bowen commented that, at the Finance and Business Performance (FBP) Committee, the quality of the paper had been considered exceptional, particularly in terms of the assurance it provided. She noted that the identification of gaps and associated actions had shown significant improvement. Dr Constable observed that considerable progress had been made over the past 12 months and that the BAF was now driving the right conversations at Board level. Mrs Cotton added that the document felt like a real and accurate reflection of the Trust's current position. Ms Small noted that the BAF effectively drove the agendas of both the Board and its Committees and welcomed the fact that it was treated as a live document. **The Trust Board received and approved the Board Assurance Framework for Quarter 3.**	
OUR PATIENTS: QUALITY, ACCESS & OUTCOMES		
10.	**Maternity Incentive Scheme – Year 7 Declaration**	
010/2026	Mrs Brayford and Mrs Whittaker joined the meeting.	

	Mrs Brayford provided an operational update and reported that the Trust had declared compliance with Maternity Incentive Scheme (MIS) Year 7, achieving all ten safety actions. She noted that this had not been easy to achieve and that a number of challenges had been encountered along the way. Mrs Brayford thanked the Board for listening to the service and for investing in the team to support delivery. She advised that an external review had been undertaken for the Perinatal Mortality Review Tool (PMRT), with 95% achievement. This had been delivered through close working between consultants and regional teams. Mrs Brayford also highlighted the investment made in the workforce, which aligned with the Birthrate Plus (BR+) methodology, and confirmed that an additional 23 whole-time equivalent (WTE) staff had been recruited. Miss Nicholson congratulated the team on the achievement, noting that it was no mean feat to reach full compliance. She commented that feedback from staff suggested a strong ambition to go further, which she felt should be acknowledged. Ms Bowen referred to Safety Action 4 and noted that changes to British Association of Perinatal Medicine (BAPM) guidance on transitional care, alongside a deficit of nurses, raised the question of whether a business case would be required. Mrs Brayford advised that an action plan had already been developed and that this formed part of a service development proposal for 2026/27. She explained that delivery had been supported through the conversion of other workforce roles to maintain quality and that an additional requirement for five WTE neonatal nurses had been identified. This had been shared with the Care Group and Mrs Riley, and all available options were being evaluated to ensure delivery. Miss Nicholson noted that this was not an issue unique to the Trust and confirmed that it had been raised at the regional Non-Executive Director Safety Champions meeting. She advised that the matter would continue to be escalated to the regional team to highlight the implications for local delivery. Dr Constable reflected that the Birthrate Plus numbers had presented a significant dilemma for the Board during the year, with a need to balance financial delivery against quality considerations. He noted that a number of discussions had taken place and that, despite financial pressures, the decision had been taken to proceed in the right way to maintain quality and safety. Ms Small referred to smoking in pregnancy and fetal growth surveillance, noting that partial compliance had previously been reported. Mrs Brayford confirmed that compliance was now nearing 100% and that full compliance for both measures had been achieved from 5 February. Mrs Riley thanked Mrs Brayford and the team for their work in meeting the standards, noting that doing so required significant resources and that not all Trusts were able to deliver all ten safety actions. Mr Cunningham joined the meeting. Ms Small welcomed the progress made over the last year. Mrs Brayford explained that, once submitted, NHS Resolution would review the declaration to confirm that there were no conflicts, before confirming the funding to be returned through the scheme. Mrs Riley added that the submission had already been reviewed by the Local Maternity and Neonatal System (LMNS) prior to being presented to the Board.	

	The Trust Board approved the Chief Executive Officer signing the declaration and its submission to NHS Resolution. Mrs Brayford, Mrs Whittaker and Mr Cunningham left the meeting.	
11.	**Urgent and Emergency Care (UEC) Pressure and Ambulance Handover Update**	
011/2026	Mrs Thorpe provided an update on urgent and emergency care and ambulance pressures. She advised that the actions being taken in relation to release to respond required a whole-hospital response to ambulance demand. She reported that internal professional standards had been reintroduced, particularly in relation to how colleagues responded to pressures at the front door. This work was being undertaken alongside the site management team, which was now fully staffed and played a pivotal role in ensuring early patient movement and continuous flow throughout the hospital. Mrs Thorpe noted that clinical teams were operating an in-reach service on a trial basis, with the aim of moving clinical decision-making closer to the front door to support patient flow, including bringing frailty decision-making earlier in the pathway. Dr Adamson referred to work underway to strengthen Consultant engagement and ownership of pathways, emphasising that this was everyone's responsibility. She reported that leadership posts had been successfully recruited to and that engagement levels were high. A representative and highly engaged team was now in place, supported by internal professional standards. Mrs Thorpe confirmed that she would consider how more detailed information on the workstreams could be brought to a future Board meeting. Mrs Cotton added that discussions had taken place regarding a dedicated Board session on assurance versus reassurance, using urgent and emergency care as a practical example, and drawing on the insight of Board members. She advised that work would be progressed to develop such a session. Ms Small asked whether patients within the urgent and emergency care system were experiencing improvements in support and care where delays had previously been identified. Dr Adamson confirmed that work was ongoing, with multiple tangible initiatives in place and further ideas being actively progressed. Dr Constable referred to the use of live data, noting that at the time of the meeting there were two ambulances waiting for more than 45 minutes, which was two too many. He reflected that the position was not good enough but noted that actions being taken were having the right impact, and that performance compared favourably to the position 12 months earlier. Dr Adamson also reported improvements in how quickly the organisation was recovering following critical incidents and advised that actions taken in response to such incidents were being actively reviewed. Ms Bowen commented that it would be helpful to understand the impact of the various interventions and how data would be reported back to Committees. She also requested visibility of the collective impact of the interventions, supported by robust data, at Board level. Ms Bowen further noted that while demand could only be influenced to a certain extent, it would be helpful to understand forecast demand, the sources	**CC/KT**

	of that demand, and which interventions were contributing to any changes. Mrs Thorpe acknowledged that demand originated from multiple sources and advised that work was underway on demand management solutions and wraparound services. She highlighted that additional senior clinicians had been introduced to support call before convey, recognising that this required a cultural shift. She also noted that work was being undertaken to better understand why patients were being conveyed, including escalation routes into frailty services, with a focus on small changes that could have a wider system impact. Dr Adamson emphasised the importance of collaboration across the system and advised that discussions had taken place with system partners, with resources committed to support joint working. Mrs Thorpe added that the GIRFT team was assisting with data analysis and reviewing the impact of each intervention, and that work was underway to establish a clear method of providing assurance to the Board. Mrs Cotton noted a welcome increase in applications from clinicians for leadership roles, indicating improved engagement and interest in leadership positions. Ms Small commented positively on the progress being made and welcomed the collaborative work with partners to raise awareness and support education aimed at reducing demand. **The Trust Board received and noted the update.**	
PERFORMANCE		
12.	**Integrated Performance Report – Month 9 and Committee Assurance Reports:**	
012/2026	<u>Quality, Access & Outcomes Committee Assurance Report (23-12-25 & 05-02-26)</u> Professor Maddock highlighted a number of key matters. She referred to performance in mortality data, which had been a concern for some time, and advised that assurance had now been received regarding the coding issues that had affected the data. She noted that the data was beginning to correct itself and thanked Mr Oldham and the team for their work in resolving the issue. It was agreed that flags would be included within reporting for the next 12 months to clearly indicate the period during which the coding issues had occurred. Professor Maddock also provided an update on the Patient Council and patient voice arrangements. She reported that the Chair and Vice Chair had been appointed and expressed her anticipation that the group would play a key role in informing co-production going forward. She commended the collective work of Mrs Riley, Mrs Thorpe and Dr Adamson, describing their efforts to address urgent and emergency care challenges as an excellent example of collegiate working. Professor Maddock noted that the Infection Prevention (IP) Board Assurance Framework currently provided partial assurance, due to ongoing work relating to blood cultures at County Hospital, although she advised that a solution was close. She also highlighted that a marker relating to surgical site infections remained under active monitoring.	

	An update was provided on the chaperoning policy, which Professor Maddock described as nationally leading. She noted that while the policy was being audited, there was an opportunity to take this work further and to publish it at a national level. Professor Maddock commended the Trust's flu vaccination performance, noting the strong results achieved this year and the positive impact this had had on staff sickness rates. She also referred to timely observations, noting that while there had previously been an upward trajectory in data accuracy, performance had recently dropped off that trajectory. Work was underway to understand the underlying reasons for this change. Ms Bowen raised the action highlighted regarding the need for additional assurance on the Trust's population strategic plan. She queried whether the plan had continued to be presented to the Committee. It was noted that there had been challenges in managing the transition, although significant work had been undertaken and this did not represent a gap in assurance. Professor Maddock expressed interest in the underlying metrics rather than identifying a specific assurance gap. Mrs Cotton highlighted that, now the strategic plans had been approved, they would be presented to the Committees at least on a six-monthly basis. <u>Quality & Access Dashboard</u> Mrs Riley provided an update and advised that the roll-out of the Electronic Prescribing and Medicines Administration (EPMA) system had now been completed. She noted that there were some remaining technical issues to be resolved, which were being overseen by the relevant steering group. Mrs Riley also highlighted improvements in ward accreditation scores and advised that work was underway to refresh the process into a broader excellence framework, which would incorporate allied health professionals (AHPs) and medical staff going forward. Mrs Thorpe provided a performance update and reported that cancer performance had dipped over the summer period but was now returning to the expected trajectory. She advised that Referral to Treatment (RTT) performance was tracking in line with the 18-week standard, including time to first appointment, although a cohort of patients with longer waits remained. She confirmed that plans were in place to transfer activity back into surgery and to rebalance activity levels going forward. Ms Small asked about the process in place for harm reviews and the management of avoidable harm. Mrs Thorpe explained that patients were reviewed by clinicians and although the ability to complete these competed with providing clinical care. **The Trust Board received and noted the assurance report and dashboard.**	
013/2026	<u>People, Culture and Inclusion Committee Assurance Report (04-02-26)</u> Mrs Bainbridge provided an overview of the People, Culture and Inclusion Committee's (PCIC) recent discussions. She reported that the Board Assurance Framework (BAF) risk within the Committee's remit remained rated as extreme; however, the Committee had received assurance that good progress was being made. She highlighted the health and safety capacity risk and outlined the mitigations currently in place.	

	Mrs Bainbridge also referred to a presentation and discussion on the ten-point plan. She noted that while good progress had been made, an action plan had been received, and the Committee had agreed that the item would return for further assurance. <u>People Dashboard</u> Mrs Haire presented the latest People Dashboard and provided an update on key themes. She reported that vacancy and turnover rates remained low and that agency utilisation was well managed. She advised that sickness absence rates had increased in December, reflecting expected seasonal trends, and that this had created additional pressures for services. Mrs Haire noted that work was underway to consider the interdependencies between the drivers of temporary staffing and sickness absence, recognising that improved management of sickness absence could have a positive impact on staffing pressures. She highlighted a focus on the cultural aspects of sickness absence, with a number of high-impact interventions already in place. She confirmed that temporary staffing expenditure remained a focus with already low agency expenditure. She advised that, as outlined within the medium-term plan, more stretching bank and agency targets were anticipated and that this would be discussed further as plans for 2026/27 were progressed. Mrs Haire also noted that a continued focus for leaders and line managers would remain a priority in 2026/27. Ms Small asked whether there were identified hotspot areas for sickness absence and how these were being addressed. Mrs Haire explained that analysis was undertaken at Care Group level through People Business Partners to identify hotspots and understand root causes. Ms Small further queried whether sickness absence data was cross-tabulated with other metrics. Mrs Haire advised that this work had begun and that efforts were being made to bring together unstructured datasets to provide a clearer view of trends. She noted that additional data sources had been requested to support a more structured approach and to help identify any underlying cultural factors. Mrs Riley added that the Trust's excellence framework was also being considered and that tools were being scoped to support staff engagement and improve understanding of the causes of sickness absence. **The Trust Board received and noted the assurance report and the People Dashboard.**	
014/2026	<u>Finance & Business Performance Committee Assurance Report (22-12-25 & 02-02-26)</u> Ms Bowen presented the Finance and Business Performance Committee's assurance report and highlighted a number of key points. She advised that an income risk had been identified in relation to the expansion of Community Diagnostic Centre (CDC) activity, alongside concerns regarding equipment lead times. As a result, two decisions had been taken to commence procurement and to approve, in principle, the associated proposal. Ms Bowen reported that theatres and endoscopy performance had been considered by the Committee, with additional assurance requested. She noted that all six NHS diagnostic pathway bids relating to the CDC had been	

	successful. She also highlighted that the annual audit of private patients and overseas visitors had provided substantial assurance. Ms Bowen advised that the Committee had queried the Trust's capacity and capability to deliver all strategic plans and transformation programmes and had requested an overarching paper to provide assurance on the initiatives and investments required. She confirmed that additional outpatient capacity had been approved, along with support from Deloitte to assist in delivering the financial plan. She noted that the Committee had discussed the Cost Improvement Programme (CIP) focus for 2026/27 and that the strategic plans would demonstrate how CIP delivery would be driven through transformational change. Additional assurance had been provided in relation to Shadow IT risks, with further assurance requested regarding Care Group capacity and capability to address these risks. An update paper on the Electronic Patient Record (EPR) had also been requested. Ms Bowen advised that an update on the medium-term plan had been received, which highlighted the significant underlying financial deficit. She further noted that the Committee had requested assurance on the monitoring metrics relating to people, patients and population, and had queried when data and metrics underpinning the strategic plans would be presented. <u>Finance Dashboard</u> Mr Oldham provided an update on the Trust's financial performance. He reported that, at month nine, the Trust was forecasting a £6.1 million deficit, representing an improvement on the previously reported position. This improvement had been driven by the receipt of additional funding and further financial support negotiated with the Integrated Care Board (ICB). Mr Oldham advised that ongoing discussions with the ICB were expected to result in a further improvement, potentially reducing the year-end forecast deficit to approximately £1.8 million, subject to further work. He noted that a significant proportion of the improvement had been delivered through non-recurrent actions, with a shortfall remaining in the underlying position going into 2026/27. He also reported that the Trust's capital allocation had increased by £5 million and that a further £4 million of regional slippage had been secured. This had enabled some schemes to be brought forward and had improved the Trust's financial position for 2026/27. Mr Oldham noted that cash performance remained behind plan at £55.6 million compared to £60 million, with £10 million of this variance relating to capital expenditure, which would be covered by Public Dividend Capital (PDC). Dr Constable reflected on the way the system had worked collaboratively to support delivery during the current year and in planning for the year ahead. He described the approach as constructive and positive and noted that this had been welcomed. **The Trust Board received and noted the assurance report and dashboard.**	
GOVERNANCE		
13.	**Audit Committee Assurance Report (05-02-26)**	

015/2026	The report was taken as read. Mrs Cotton highlighted that work had commenced on determining the internal audit plan for 2026/27 which was to be considered by the Committee in April. **The Trust Board received and noted the assurance report.**	
CLOSING MATTERS		
14.	**Review of Meeting Effectiveness**	
016/2026	Members were asked to provide feedback via MS forms.	
15.	**Review of Business Cycle**	
017/2026	No further comments were provided.	
DATE AND TIME OF NEXT MEETING		
16.	**Wednesday 8th April 2026, 9.30 am, Trust Boardroom, Third Floor, Springfield, Royal Stoke**	

Post Meeting Action Log

Trust Board Part 1 - Open

As at **27 March 2026**

Ref	Meeting Date	Agenda Item	Action	Assigned to	Due Date	Done Date	Progress Report	RAG Status
PTB/620	10/12/2025	Speaking Up Report Quarter 1 & Quarter 2 2025/26	To obtain information from Mr Irving on the reasons and themes 22% of respondents indicated they would not speak up again.	Nicola Hassall	28/05/2026		To be provided within the Q3/Q4 Speaking Up Report, which is due to be presented to the PCIC in May	GB
PTB/621	10/12/2025	Speaking Up Report Quarter 1 & Quarter 2 2025/26	People, Culture and Inclusion Committee (PCIC) to review the representativeness and diversity breakdown of FTSU Champions.	Nicola Hassall	28/05/2026		To be provided within the Q3/Q4 Speaking Up Report, which is due to be presented to the PCIC in May	GB
PTB/622	10/12/2025	Integrated Performance Report - Month 7	To check and clarify the difference in measurement approaches between NHS Oversight Framework (NOF) data showing nine MRSA cases and internal data indicating three cases.	Ann-Marie Riley	11/02/2026	11/02/2026	Complete. Information provided to Professor Hassell.	B
PTB/623	10/12/2025	Integrated Performance Report - Month 7	To liaise with Ms Bowen regarding the use of complaints data for persona analysis to better understand patient experience.	Ann-Marie Riley	~~11/02/2026~~ 31/03/2026	09/03/2026	Meeting has taken place with Ms Bowen, Mrs Riley & Mrs Freeman.	B
PTB/624	11/02/2026	Urgent & Emergency Care (UEC) Pressure and Ambulance Handover update	To consider a session for the Trust Board on assurance versus reassurance in particular considering the additional assurance which could be provided in terms of the UEC actions being taken.	Claire Cotton / Katy Thorpe	31/03/2026	11/03/2026	Complete - provided to March's Board.	B

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

Chief Executive's Report
Trust Board | 8th April 2026

University Hospitals of North Midlands NHS Trust

Part 1: Highlight Report

This report provides the Trust Board with an overview of a range of strategic and operational issues since the last public meeting on 11th February 2026, some of which are not covered elsewhere on the agenda for this meeting.

1. Regional and National Leadership Context

Russell Hardy has been appointed as NHS England Midlands Regional Chair.

As set out in the Model Region Blueprint, as Regional Chair Russell will provide visible, independent non-executive leadership across the region, working with Regional Directors to develop a coherent strategy to deliver against the 10 Year Health Plan, ensuring improved life expectancy and quality of life, consistently high quality and efficient services and reduced inequalities in health outcomes. The Regional Chair will work with Provider and ICB Chairs to deliver against that strategy and ensure high performing Boards and work with the regional executive team to support improvement and intervention.

Russell brings extensive experience of board level leadership, most recently as Chair of four NHS Trusts in the Foundation Group - South Warwickshire University FT, George Eliot, Worcestershire Acute and Wye Valley.

The Regional Chair role is central to strengthening leadership across the NHS at a time of significant change, supporting the delivery of the NHS's long-term priorities including improving health and reducing health inequalities. shifting care out of hospitals and improving productivity for example through digital transformation.

Russell will take up post on 1st April 2026 for an initial 3 year term, working part-time in line with the non-executive nature of the role.

A number of changes to the leadership team across the Department of Health and Social Care and NHS England have also been confirmed since my last Board report. These are:

- David Probert will return to his full-time role at University College London Hospitals from 1st April 2026. A permanent Performance and Delivery Director General, who will also serve as Deputy NHS Chief Executive will be appointed in due course.
- In the interim:
    - Glen Burley and Meghana Pandit will act as Deputy Chief Executives in a part time capacity alongside their trust roles.
    - Mark Cubbon, National Programme Director for Planned Care, will continue in his role part-time, before returning to his trust full time in the summer.
    - Sarah-Jane Marsh, will take on the role of Chief Operating Officer for NHS England, with a focus on the organisation's internal operations, retaining responsibility for urgent and emergency care, operations, emergency preparedness, resilience and response (EPRR) and improvement until the new Performance and Delivery function is in place, which we expect ahead of winter 2026.
- Elizabeth O'Mahony has been appointed as Director General for Finance, having carried out the role on an interim basis.
- The recruitment for the National Medical Director role has been completed and an announcement will be made shortly, once approvals are complete.
- Rob Checketts will continue as Director of Corporate Affairs and Communications.

- Matthew Style will take on the role of interim Second Permanent Secretary at the DHSC with immediate effect.
- In line with the 10 Year Health Plan's commitment to keeping the experience of people using NHS services at the centre of everything we do, a new role as Director of Patient Experience will be established. This role will sit within the Chief Nursing Officer's directorate and will have a direct reporting line to the NHS Chief Executive.
- Matthew Coats, Chief Executive of West Herts Teaching NHS Trust, will be joining NHS England as CEO Advisor to the New Hospitals Programme for a six-month period from 1st April. A permanent leadership team will be recruited over the coming months.

2. Neighbourhood Health

In March, there has been the publication of the *Neighbourhood Health Framework* and *Fit for the future: towards population health delivery models.*

Neighbourhood health sits at the heart of the 10 Year Health Plan with the ambition to build an integrated, multi-disciplinary service that delivers more personalised care closer to where people live; empowers people to lead healthier, more independent lives; and offers genuine choice in how people access support.

There are already many strong examples of neighbourhood working across the country, where local partners collaborate to improve outcomes and make better use of collective resources.

The aim of these publications is to create the conditions for local leaders to systematise those examples in a way that best suits their local communities – setting clear expectations on what services should aim to achieve and articulating the different commissioning and delivery models which may be employed in pursuit of these aims.

The framework sets out the foundational steps local areas will need to take in 2026/27 to develop local neighbourhood health plans for 2027/28, delivered through joint working. Local government and ICBs are encouraged to consider how services can be reconfigured to focus more on prevention and early intervention, an approach that should be increasingly prominent within local neighbourhood health plans over time.

The framework also sets out a minimum set of interventions for all ICBs to deliver over the next three years to establish the foundational building blocks of an effective, joined-up neighbourhood health service.

Local systems will be supported by the National Neighbourhood Health Implementation Programme, which will build capability, develop infrastructure and identify success criteria for the scaling of new models.

Working in partnership through health and wellbeing boards, in 2026/2027, ICBs and local government will be asked to:
i) agree neighbourhood footprints around natural communities for the future development of integrated neighbourhood teams (INTs)
ii) agree plans to establish INTs focussed on high priority cohorts, including how devolving care budgets could work in their area
iii) confirm intentions to use pooled funding under the Better Care Fund (BCF) in line with BCF guidance
iv) confirm organisational ownership of planned deliverables
v) confirm plans for having the appropriate data-sharing arrangements in place to do robust patient identification and evaluation

From 2027/28, ICBs and local government, working through health and wellbeing boards, will be asked to develop a local neighbourhood health plan. The plan will need to:
i) provide a broad overview of how the national NHS objectives will begin to be delivered through the 3 reform agendas outlined in the framework
ii) set out how neighbourhood health will support wider local goals for improving health outcomes and reducing health inequalities
iii) set out how local objectives are informed by the Joint Strategic Needs Assessment, and any other assessments by ICBs or local authorities, as deemed necessary by the health and wellbeing board
iv) confirm final geographies that partners will then work within

v) confirm which organisations are responsible for different elements of delivery
vi) confirm the arrangements which will be in place to deliver this
vii) confirm how other relevant local services or initiatives will align with the strategy over time, such as Best Start Family Hubs, housing, mental health hubs, Pride in Place, and employment support

UHNM will continue to contribute to this development through existing structures within the ICS and Provider Collaborative.

3. Senior Leadership Changes

Mark Oldham, Chief Finance Officer, has announced his retirement later this year, bringing to a close an exceptional 36 year career in the NHS. He has been an extraordinary member of our Executive Team, and his positive impact on this organisation cannot be overstated.

From the moment he joined us, Mark has provided outstanding leadership, assurance and calm direction, particularly through some of the most challenging financial periods UHNM has faced. His stewardship was instrumental in guiding the Trust out of financial special measures in 2022, securing major investments that strengthened our services, and navigating the complex financial environment we all continue to work within.

Under Mark's leadership, UHNM has consistently delivered against its financial objectives while keeping a relentless focus on what matters most - our patients and the communities we serve. He will be able to have the great satisfaction of leaving the Trust in better financial shape than that inherited upon appointment, despite all the previous and ongoing challenges. His expertise, experience and values, both as a financial officer and corporate director, will be hard to replace. He will be much missed.

Mark's professionalism, steady guidance and commitment have been invaluable to me personally and to the organisation as a whole. I am deeply grateful for everything he has contributed during his time with us.

Following the most recent Nominations and Remuneration Committee in March, the recruitment process for our next Chief Finance Officer has begun and will likely conclude next month. Mark has kindly agreed to facilitate the smoothest handover possible.

4. UEC Intensive Support Week

As reported previously we have seen some modest improvements in the overall performance in the urgent and emergency care pathway with 10 out the last 13 weeks showing an improvement of the position compared to the same weeks last year. However, what we are delivering is still not good enough and we have much more to do.

We had our UEC Intensive Support Week from 23rd March 2026 in order to further focus on flow, earlier decisions, better discharge planning, and improving the patient journey through our Emergency Departments, wards, portals and SDEC. The heart of this week is also about the culture (the way we work) that we choose to create together.

The week was about making a shared commitment to work in a way where problems are surfaced early rather than hidden and where we use data constructively to drive improvement, not to assign blame. This shift from reactive firefighting to proactive, well-coordinated flow, enables safer, more reliable hospital operations. It is the environment we want to create for the longer term.

We have made some improvements already over the last few months and our figures this winter are better than this time last year. It does feel different already and the numbers support that assertion. However, we still have a way to go to reach the same standard as other trusts with the exact same challenges we face. Consistency, rigour and the discipline of doing things to a certain standard is key.

Our approach to the week was built around the five core pillars that define the culture of a traditional "Perfect Week":

- **Safe** – making sure we reduce avoidable harm, strengthen reliability, and create clinical environments where risks are addressed early rather than accumulated.

- **Flowing** – ensuring patients move smoothly and predictably through our UEC pathway and beyond, with teams working together to remove delays before they become barriers to care.
- **Timely** – giving every patient the assessment, treatment and discharge they need without unnecessary wait, because timeliness *is* a fundamental part of high-quality care.
- **Compassionate** – committing to dignity and kindness in every interaction, even during the busiest moments, because how people are treated matters as much as the outcome of their care.
- **Sustainable** – building ways of working that protect staff wellbeing, reduce burnout, strengthen operational resilience, and create improvements that last beyond this week.

5. Corridor Care at UHNM

In February, UHNM sent a multiprofessional delegation to London to an NHSE summit to discuss corridor care.

Jackie Small, our Chair, attended, alongside Katy Thorpe (Chief Operating Officer), Dr Di Adamson, (Chief Medical Officer), Dr Fiona Hobberts (Deputy Chief Nurse) and Jessie Dickson (Deputy Director of Communications). The day discussed how we tackle corridor care in our ED (without holding ambulances) and on our wards with a chance to learn from others who have successfully eliminated corridor care.

Senior leaders from NHS Trusts were invited alongside NHSE colleagues and members of the Corridor Coalition – a group of agencies and colleges established to help eliminate corridor care. Different organisations shared their own experiences reflecting the impact of corridor care on staff and patients. There was impactful insight from patient experience and staff (staff feel helpless with losing hope; patients praise staff for a great job in difficult circumstances) and trusts who have eliminated corridor care spoke about the importance of leadership and visibility. There was the opportunity to share views on the NHSE draft 10-point corridor care plan.

The points that most resonated and discussed were:

- Defining corridor care once nationally to support consistency of measurement and improvement actions.
- Increasing transparency through publishing trust-level corridor care data monthly (needing to ensure all trusts are reporting the same data against same definition).
- Supporting operational and clinical improvement including experts on the ground to support the most challenged organisations.
- Clarifying escalation and incident reporting for providing patient care in corridors.
- Develop further actions local leaders can take to reduce corridor care and improve support for patients and staff - working initially with the 30 trusts facing the biggest challenges to inform guidance for all Trusts.

The afternoon session gave the UHNM team the opportunity to consider what additional actions we will commit to in response to the proposals in the 10-point plan.

6. Becoming Smoke Free

From 1st April 2026, we take our first step to becoming a smoke free organisation across all of our buildings including County Hospital, Royal Stoke, the Stoke on Trent Community Diagnostic Centre and the Thornburrow building.

This change is something that is, on the face of it, apparently very simple but very important. It marks our commitment to creating a healthier environment for the people who work here, the patients we care for and the communities we serve. As an NHS organisation, supporting health and wellbeing has to start with us. Going smoke free is a clear signal of our commitment to that responsibility, not just in words, but in action.

For our colleagues, this is about making our workplaces healthier and more pleasant places to be. Smoke free sites mean cleaner air, safer surroundings and hospital grounds that reflect the care and pride we all have in where we work. For our patients and visitors, it reinforces the messages we give every day about prevention, healthier choices and reducing harm, particularly for people living with long term conditions, respiratory illness or those trying to quit smoking themselves.

There is also a very visible impact on our environment. Each year, an estimated 328,500 cigarette butts are discarded across the grounds of our hospitals. That is a significant level of litter. Going smoke free helps us tackle that problem directly, improving the look and feel of our sites and reducing the environmental damage caused by cigarette waste.

So from 1st April 2026, smoking is no longer permitted on UHNM premises. Help to stop smoking is available. Access to free, confidential support is through our Tobacco Dependency Team and managers have guidance to help them support their teams through this transition.

Vaping will continue to be allowed on site, and I would ask colleagues who vape to use the designated vaping shelters (formerly the smoking shelters). I know that for some people this change will feel challenging, but support is available.

I want to thank everyone in advance for the understanding and kindness I know will be shown to one another, to patients and to visitors as we embed this change. By working together, we can make this a positive step forward and create a healthier, cleaner and more welcoming environment for everyone who comes onto our sites.

This is an important moment for UHNM and I am grateful for your support as we take it.

7. Annual NHS Staff Survey

This year's NHS Staff Survey results were published last month. The survey is one of the most meaningful reflections of how colleagues feel about working here, and its publication gives us the opportunity to look honestly at the progress we have made as well as the areas where we still need to go further. As always, feedback genuinely shapes who we are as an organisation and how we continue improving the experience of working at UHNM.

I want to thank every one of the 5,883 colleagues who completed the survey and for taking the time to share their views. The insight provided is invaluable in guiding our work. What we have been told through the survey, as well as through daily conversations with leadership teams, gives us a real sense of how it feels to work at UHNM today.

Despite the challenges we face, it is encouraging to see that 'morale' remains a relative strength, performing above the benchmarking group average, and to know that so many colleagues continue to feel proud of the difference their work makes. Eighty seven percent said that the work done has a positive impact on patients – again, a powerful reminder of the purpose that unites us. It is also positive to see signs of improvement in work-life balance, with fewer hours being worked beyond contracted time and colleagues feeling more able to talk openly about flexible working with their managers.

Many of the improvements made in 2024 have been sustained into 2025, particularly around flexible working, teamwork and morale, where small but important gains continue. Over the past year, we have seen our "You Said, We Did" commitments translated into practical changes across the organisation from the growing Men's and Women's Health Groups and wellbeing initiatives to smoke free support, on site health checks and a series of health focused podcasts and events. Our investment in learning and development has also strengthened, with greater access to leadership programmes, apprenticeships, the A&C Academy and co designed engagement workshops that colleagues have helped shape.

This year has also brought significant progress in our equality outcomes. All Workforce Race Equality Standard and Workforce Disability Equality Standards indicators improved, including a notable seven per cent increase in confidence among ethnically diverse colleagues in fair opportunities for career progression, and better experiences reported by colleagues with disabilities or long-term conditions. These improvements show that the steps we are taking are starting to have real impact, even as we recognise there is more work ahead.

However, at the same time, the survey tells us clearly where we need to improve. Some colleagues still do not feel sufficiently involved in decisions that affect their everyday work or recognised for the contribution they make. Others describe ongoing frustration and burnout linked to workload and pressures.

Many colleagues continue to report that PDRs are inconsistent and not always meaningful, and some still feel uncertain about raising concerns or whether they will be heard when they do.

These issues matter deeply, and addressing them will require steady, focused effort across teams and leadership at all levels.

As we look ahead to the coming year, feedback and our new Trust strategy points us in a clear direction. We need to strengthen the foundations of colleague wellbeing, addressing burnout, supporting morale and ensuring people can access help promptly when they need it. We must make learning and development genuinely meaningful, with clearer career pathways, better-quality PDR conversations and greater support for leaders and managers. And we need to embed flexibility in a way that works for both colleagues and services, building on the experience and stories already coming from teams across UHNM. Throughout this work, engagement and inclusion will run through everything we do. Your voice will continue to shape decisions, culture and priorities, because the best solutions always come from the people closest to the work.

But, whilst words are important, actions speak volumes louder than words.

8. Sexual Misconduct Policy

In March we launched our new Sexual Misconduct Policy. This sets out clear expectations for behaviour, transparent processes for raising concerns, and firm commitments about how we will act when those expectations are not met.

Sexual misconduct has no place at UHNM. It can cause lasting harm, undermine trust, and damage the culture we all depend on to deliver safe, compassionate and effective care. We take a zero-tolerance approach to any unwanted, inappropriate or harmful sexual behaviour, whether verbal, physical, online or visual.

This policy is an important step forward in strengthening “how we work around here”. It clearly defines what sexual misconduct is and the standards of behaviour expected of everyone working at UHNM. It sets out straightforward and accessible reporting routes for staff and patients, explains what happens when a concern is raised, and reinforces our commitment that all concerns will be taken seriously, investigated promptly, and handled with fairness, dignity and respect for everyone involved. It also strengthens protections for anyone who speaks up.

We recognise that raising concerns about sexual misconduct can feel difficult. Impact matters more than intent and everyone’s experience deserves to be heard. That is why we are continuing to build an approach that ensures that people are supported throughout the process, whether they are seeking confidential advice or making a formal report.

We all share responsibility for creating an environment where people feel able to raise concerns without fear of retaliation or judgement. Support is available through our Sexual Safety Liaison Officer, our Freedom to Speak Up Guardians, our People colleagues and our safeguarding teams, all of whom can provide confidential advice and guidance.

Over the coming weeks, managers will receive briefing materials and guidance to help them lead open and supportive conversations within their teams.

In October 2023, UHNM signed the NHS Sexual Safety Charter. This policy reflects that commitment, but this is not now intended to simply be a policy launch. It is a clear statement of our intent to act.

We will monitor how the policy is working, listen carefully to feedback from colleagues and staff networks, and continue to strengthen our approach. Creating a safer culture requires visible leadership, continuous learning and shared accountability at every level of the organisation.

A safe workplace is fundamental to staff wellbeing, psychological safety and the quality of care we provide to our patients. When our people feel safe and respected, they are better able to provide the compassionate, high-quality care our communities rely on.

9. Our Armed Forces Community

The current conflict in the Middle East once again serves us a reminder of the importance of our Armed Forces. March is Military March and it gives me a chance to recognise and say thank you to the many colleagues across UHNM who are part of or closely connected to the Armed Forces community.

Across UHNM, I am incredibly proud that more than 240 of our colleagues are part of our Armed Forces Staff Network. That includes serving personnel, reservists, veterans, military spouses and family members, cadet force adult volunteers, and colleagues who have chosen to train as Veteran Aware Champions.

Some have worn uniform themselves, others support those who do and many advocate passionately for Armed Forces patients alongside their day jobs. Together, they form a strong, committed community that adds real depth to our workforce and to the care we provide.

The values that members of the Armed Forces bring – teamwork, resilience, leadership, compassion and a strong sense of service – align closely with what we stand for as an NHS organisation. These skills and experiences enrich our teams and make a tangible difference to patients, colleagues and the wider communities we serve.

Our commitment to the Armed Forces community is not symbolic. Since signing the Armed Forces Covenant in 2017, we have continued to strengthen our approach to being a forces friendly employer. I am delighted that UHNM has recently been reaccredited with the Defence Employer Recognition Scheme Gold Award, the highest level of recognition in the scheme. This reflects sustained effort across the organisation to go beyond words and put practical support in place.

We know that some colleagues can face real challenges when transitioning from military life into civilian employment. That is why we offer a guaranteed interview scheme for members of the Armed Forces community who meet the essential criteria for a role, ensuring their skills and potential are properly recognised. We also actively support the Step into Health programme, which opens doors into NHS careers through training, placements, insight days and tailored application support. These initiatives matter, and they make a difference.

Most importantly, I want colleagues from the Armed Forces community to know that they are valued, supported and respected here. Whether you are currently serving, have served in the past, support someone who does, or advocate for Armed Forces patients, you are an important part of UHNM.

As part of Military March, and well beyond it, I want to personally thank all for their service to our country and for everything they continue to bring to our Trust. We remain absolutely committed to standing with them, and ensuring UHNM is a place where the Armed Forces community can flourish.

10. Healthcare Science Week

Healthcare Science Week was recognised from 9th to 15th March 2026. This brings together over 50 scientific specialisms and professional groups to celebrate and raise awareness of this diverse NHS workforce. Healthcare science plays a vital role in the diagnosis, prevention and treatment of disease and the health of our population. The week was an opportunity to showcase this work and inspire the scientific workforce of the future. On Monday 9th March I visited Nabila Kauser and the team in the Pathology Department at Macclesfield General Hospital, part of the North Midlands and Cheshire Pathology Service. During our Trust Board on Wednesday11th March we visited Audiology, Neurophysiology and Nuclear Physics.

11. AI at UHNM

Across our hospitals, we continue to show what's possible when we combine expertise, compassion, and a shared ambition to improve the care we deliver, consistently with discipline and rigour.

There is an area of work that is becoming increasingly important to our future: how we use artificial intelligence (AI) to support our staff and strengthen the services we provide to our patients.

You may have already seen early examples of this through projects that reduce administrative burden, improve efficiency, and give teams back valuable time. Building on this, I am pleased to introduce our UHNM AI Team dedicated to supporting AI transformation across the organisation.

Their focus is to help our clinical, operational and administrative colleagues use AI confidently and safely. This includes automation of routine tasks, operational intelligence to support decision making, clinical AI projects, Microsoft Copilot adoption, and tools that improve productivity across departments. Their aim is to ensure that every member of staff, clinical or non-clinical feels equipped to benefit from these technologies and not overwhelmed by them.

To support this, the team have developed a growing training offer, including:

- Introduction to AI and Machine Learning
- Security and Governance in AI
- Drop-in sessions
- Practical demonstrations
- Support identifying AI opportunities in your own service

12. Paediatric and Neonatal Team Recognition

In February we have celebrated UHNM's Neonatal and Paediatric success at the West Midlands PAFTAs. The West Midlands Paediatric Training Committee awarded the PAFTAs (Paediatric Awards for Training Achievement) for 2025. I am delighted to recognise the fact that UHNM neonatal and paediatric teams and team members won awards across a wide range of categories.

- **Best Training Unit**
  UHNM Neonatal Unit is very proud to have won 'Best Training Unit', having also won this in the 2023 awards. A special mention should go to Dr Asha Shenvi, College Tutor for Neonates, for her excellent educational leadership on NICU during this time. UHNM Community Paediatrics was also nominated in this category.
- **Best ANP/ANNP**
  UHNM Neonatal Nurse Practitioner Kathleen Crutchley won 'Training Hero – Best ANP/ANNP. Ann-Marie Wherton-Whitehurst (ANP on PICU) was also nominated in this category.
- **Training Hero (medical)**
  Dr Tania van Westering, who is currently an ST7 doctor on NICU and was previously working in General Paediatrics, won the 'Training Hero Vishna Rasiah (medical) award. Dr Voula Mikou, Consultant Paediatrician and General Paediatric College Tutor was also nominated in this category.
- **Best Educational Supervisor**
  UHNM had six nominations for the Annie Callaghan award for Best Educational Supervisor. Dr Alison Ventress (Consultant Neonatologist) and Dr Rebecca Dack (Consultant Community Paediatrician) were both Highly Commended in this category. Nominations were received for Dr Oluwaseyi Olatimilehin (Consultant Neonatologist), Dr Sean Monaghan (Consultant Paediatrician), Dr Voula Mikrou (Consultant Paediatrician) and Dr Ayaz Vantra (Consultant Community Paediatrician).
- **Best Senior trainee**
  Dr Marius Ungureanu, previous General and Community Paediatric doctor at UHNM, won this award. Dr Katherine Hill (Community Paediatrics) was Highly Commended in this category. Four other senior resident doctors were nominated – Dr Olaniyi Fayemi (NICU), Dr Joanne Stock (General Paediatrics), Dr Ambika Samsundar (General Paediatrics and PICU) and Dr Ayat Mohamed (General Paediatrics)
- **Best Junior Trainee**
  Dr Ibrahim Afolabi is a current ST4 doctor on NICU and was Highly Commended as 'Best Junior trainee'. In addition, Dr Sai Gopalakrishnan, previous General Paediatric and Neonatal ST1 doctor was nominated.
- **Best Non-training grade resident doctor**
  Dr Aaya Seedahmed (NICU) and Dr Rebecca Clifford (General Paediatrics) were nominated).
- **Training Hero – Best nurse or midwife**
  Harriet MacKintosh (UHNM Paediatric HDU) was nominated for this award.

13. BMA Industrial Action

The 15th period of industrial action from resident doctors since March 2023 will begin at 7am on Tuesday 7th April and run until Monday 13th April, following on from the Easter Bank Holiday weekend.

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

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

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

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

14. Employee and Team Recognition

Team of the Month (February 2026) – Breast Imaging Administration, County Hospital

In February, I had the pleasure of presenting February's award to the Breast Imaging Administration team at County Hospital. They may be tucked away in an office at the back of the site, but their impact is anything but hidden. The culture they have created speaks volumes about who we are as a Trust.

They were nominated by a neurodivergent colleague. In a fast-paced scheduling role, the team's support helps them thrive. They guide, encourage and have even created practical tools, like digital spreadsheets, to make complex tasks easier. Their inclusive approach ensured the whole team feel valued, supported and able to shine, even during the busiest moments. This is inclusion in action.

Employee of the Month (February 2026) – Natalie Robinson, Practice Development Nurse in Royal Stoke Theatres

Natalie was nominated by her team and recognised for her outstanding commitment to staff development, patient safety and staff wellbeing across our theatre services. Natalie supports large, multidisciplinary teams, develops innovative training approaches, delivers life-saving education, provides restorative supervision as a professional nurse advocate and leads on important safety initiatives that directly improve care for our patients. Her work epitomises how investing in people, skills and wellbeing leads to safer environments and better outcomes for those we care for.

Chief Executive Award (February 2026) - Joseph Orosun, Organisational Development Consultant

This award was made in recognition of his exceptional contribution towards race equality and inclusion at UHNM. During his time as Chair of the Ethnic Diversity Staff Network, Joe has shown outstanding leadership, compassion and determination. He has helped ensure the voices and experiences of ethnically diverse colleagues are heard, supported colleagues during challenging times, and has worked with senior leaders to keep fairness, equity and belonging at the heart of what we do. His impact will be lasting, and this recognition was particularly fitting during Race Equality Week.

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

I have personally recognised the contribution of the following colleagues:

- Simon Wilmore - Senior Project Manager, Estates Capital Developments Team
- Janet Kelly - Manager, Early Pregnancy Unit
- Mr Philip Varghese - Consultant Colorectal Surgeon
- Dr Aftab Malik - Speciality Doctor, Anaesthetics
- Nabila Kauser and Team, NMCPS - Macclesfield

- Rebecca Law and Team, Neurophysiology
- Mr Akshay Malhotra - Consultant Orthopaedic Surgeon

Part 2: Consultant Appointments

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

Post Title	Reason for advertising	Appointed (Yes/No)	Start Date
Consultant in Renal Medicine	Newly created	Yes	2 posts – both TBC
Consultant Medical Oncologist	Vacant post	No	N/A
Pre Ams & Oral & Max Anaesthetics Consultant	Newly created	Yes	23.3.2026
Consultant Oncoplastic Breast Surgery	Newly created	Yes	TBC

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

Post Title	Reason for advertising	Start Date
Consultant Plastic Surgeon (Interest in Breast & Skin)	Vacancy	9.2.2026
Consultant Intensivist	Vacancy	5.3.2026
General Paediatrician Speciality Interest Epilepsy and Neurology	Vacancy	18.2.2026
Consultant Anaesthetist with interest in Pre-Ams & Max Fax	Newly created	23.3.2026

There were no medical vacancies that closed without applications / candidates during February and March 2026

Medical Management Appointments

The following table provides a summary of medical management interviews which have taken place during February and March 2026

Post Title	Reason for advertising	Appointed (Yes/No)	Start Date
Foundation Training Programme Director (2 posts)	Vacancy	Yes	1.4.2026 7.4.2026

The following table provides a summary of medical management who have taken up positions in the Trust during February and March 2026

Post Title	Reason for advertising	Start Date
Clinical Director – Cardiology, Stroke & Neurology Directorate	Vacancy	1.3.2026
Clinical Director – Head, Neck & Skin Directorate	Vacancy	1.2.2026

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

Executive Summary

Trust Board (Public) | 8th April 2026

UHNM PLACE Results 2025

University Hospitals of North Midlands NHS Trust

Purpose:	**Information**		**Approval**		**Assurance**	✓	**Agenda Item:**	9.
Author:	Teresa Platt, Deputy Head of Governance and Compliance							
Executive Lead:	Lorraine Whitehead, Director of Estates, Facilities & PFI							

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 5	Inability to Deliver Investment in Estate Infrastructure and Workforce	High 12

Executive Summary

Situation

- The purpose of this paper is to inform the Trust Board of the 2025 Patient-Led Assessment of the Care Environment (PLACE) results achieved at UHNM Royal Stoke and County Hospitals.
- The results of the PLACE inspections were published on 26th February 2026, and this report provides a summary of findings from the inspections.

Background

- PLACE assessments are an annual appraisal of the non-clinical aspects of NHS and independent/private healthcare settings, undertaken by teams made up of staff and members of the public (known as patient assessors).
- Our patient assessors were welcomed back to our County and Royal Stoke sites over a series of inspection dates during September and October 2025 to visually inspect our hospital environment. The inspection team assessed how the environment supports the provision of clinical care, inspecting things such as cleanliness, food, general building maintenance, privacy and dignity and the specific needs of our patients with dementia or a disability.
- The results are from data published by NHSE on 26th February 2026.

Assessment

- UHNM achieved above the national average across all the Domains for the third consecutive year.
- Overall position when compared to our peers (Model Health), UHNM performs strongly and ranks within the top three in several domains and is above the peer average in all domains.
- UHNM leads the entire peer group for cleanliness.

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	
No Assurance	No confidence in delivery	

Rationale

PLACE assessments provide a framework for assessing quality against common guidelines and standards to quantify the facility's cleanliness, food and hydration provision, the extent to which the provision of care with privacy and dignity is supported, and whether the premises are equipped to meet the needs of people with dementia or with a disability. Estates, Facilities and PFI Division ensure that areas that need attention are addressed where possible at the time of the inspection and an action plan is produced to highlight and monitor areas of concern post inspection by EFP Board, and this information is communicated to the wards and departments concerned.

Key Recommendations

The Trust Board is asked to receive and note the contents of this report and its findings and to support the implementation of actions identified to improve the patient environment and experience.

UHNM PLACE Results 2025

March 2026

1. Introduction

April 2013 saw the introduction of Patient Led Assessments of the Care Environment (PLACE), which is the system for assessing the quality of the patient environment, replacing the old Patient Environment Action Team (PEAT) inspections. The assessments primarily apply to hospitals and hospices providing NHS-funded care in both the NHS and private/independent sectors, but others are also encouraged and helped to participate in the programme.

Good environments matter and every NHS patient should be cared for with compassion and dignity in a clean, safe environment. Where standards fall short, they should be drawn to the attention of managers and hold the service to account. PLACE assessments provide motivation for improvement by providing a clear message, directly from patients, about how the environment or services might be enhanced.

The assessments involve local people who use the services or have had experiences of it (known as patient assessors) going into hospitals as part of teams to assess how the environment supports the provision of clinical care, assessing such things as privacy and dignity, food, cleanliness, and general building maintenance and, more recently, the extent to which the environment can support the care of those with dementia or with a disability.

The assessments take place every year, and results are published to help drive improvements in the care environment. The results show how hospitals are performing both nationally and in relation to other hospitals providing similar services. Note that PLACE assessments focus exclusively on the environment in which care is delivered and do not cover clinical care provision or how well staff are doing their job.

This report provides a description of the process and summarises the scores achieved for the full UHNM PLACE inspection undertaken in 2025.

2. PLACE Process

PLACE assessments are a voluntary annual appraisal of the non-clinical aspects of NHS and Independent/private healthcare settings, undertaken by teams made up of staff and members of the public (known as patient assessors). The team must include a minimum of 2 patient assessors, making up at least 50% of the group. In 2022, the criteria for staff to patient assessor ratio was enforced and assessments not meeting this standard are excluded from the national results.

PLACE assessments provide a framework for assessing quality against common guidelines and standards to quantify the facilities cleanliness, food and hydration provision, the extent to which the provision of care with privacy and dignity is supported, and whether the premises are equipped to meet the needs of people with dementia or a disability. Questions score towards one or more of the following non-clinical domains:

- Cleanliness.
- Food/Hydration.
- Privacy, Dignity and Wellbeing.
- Condition, Appearance and Maintenance.
- Dementia.
- Disability.

3. PLACE Scores and Patient Assessors Comments

PLACE scores were published nationally on 26th February 2026 and are recorded in the table below. Scores are generated by the national database system based on the information submitted from the inspections. Scores are not generated by Trusts and are in the public domain at the following link: https://digital.nhs.uk/data-and-information/publications/statistical/patient-led-assessments-of-the-care-environment-place/england---2025

Nationally a total 1,080 of assessments were undertaken in 2025 compared to 1,107 in 2024. There were 9 sites that were excluded as they did not fully meet the required patient-to-staff ration and a further 3 sites were excluded as they did not fully complete their assessments. The findings were based on the 1,068 remaining assessments.

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

UHNM achieved above the national average for all domains.

PLACE Scores 2025:

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

Patient Representative Comments

In addition to completing score sheets on a pass, fail or qualified pass basis, patient assessors are encouraged to provide any supporting comments that the Trust may take on board. Below is a summary of some of the comments received for each site: -

County Hospital: - "*A great feel from the areas visited and patients seemed very comfortable."*
Royal Stoke Hospital: - *"Confident first and last impressions overall, clean and tidy and an overall calm feeling despite being very busy."*

4. Conclusions

The PLACE scores achieved in 2025 for UHNM and its sites Royal Stoke and County Hospitals demonstrate that the hospital environment for patients from a non-clinical perspective at UHNM continues to provide a positive experience for our patients. Trusts are encouraged not to compare scores with previous year's inspections due to different areas being inspected and different patient assessors undertaking the inspections, inspections are based on what is seen on that day. Changes to questions made each year to improve upon feedback regarding the inspections also makes comparing previous year's data difficult.

Good environments and services that respond to the needs of our patients really do matter and thanks go to all staff for their continued hard work and commitment in this area. Special recognition goes to our Estates, Facilities and PFI Division for the vital part they play every day in continuing to maintain an excellent care environment and impacting positively on our patient and staff experience.

Appendix 1 highlights the schedule of areas inspected and an action plan has been developed which has been provided to the Quality, Access and Outcomes Committee, providing more detail on the comments received and areas where action is necessary to make improvements.

5. Recommendations

To receive and note the contents of this paper and the scores achieved for PLACE 2025 and to support in delivering the actions outlined across the organisation.

Appendix 1 – Inspection Schedule

RSUH Schedule - Inspection Requirements: 14 Wards, 14 Outpatients, 14 Public Areas, 5 Meal Services, Emergency Dept, External Area

PFI Wards	Lyme Building Wards	Outpatient Departments	Outpatient Department Cont
210 + food	~~100~~	Outpatients 1	~~202 Day Case~~
215	~~101~~	~~Outpatients 2~~	Early Pregnancy Unit
216	102	Outpatients 3	~~Maternity Assessment Unit~~
~~217~~	103	~~Eye Clinic~~	Radiotherapy
~~218~~	104	Transitional Discharge Lounge	Chemotherapy Suite
~~220~~	105	Poswillo	Haemodyalisis
221	~~106~~	PreAms	Fracture Clinic
222	~~107~~	REHAB	Kidney Unit
223 + Food	108 + food	Cath Labs	~~Ambulatory Emergency Centre (AEC)~~
~~225~~	109	~~Childrens Outpatients Clinic~~	**West Building Wards**
~~226~~	110	Cardiac Clinic	~~76A~~
227	111	~~Endoscopy~~	~~76B~~
228	112	~~Neurophysiology Clinic~~	78
230	113	~~Heart and Lung Clinic~~	79
231	117	~~Ear Nose Throat~~	80
232	ITU POD 6	~~Oral Orthodontic Clinic~~	81
233 + Food	SSCU	~~Nuclear Medicine~~	**Maternity Wards**
Cardiac Care Unit	**Trent Building**	Shine Clinic	205
Critical Care Unit	~~122~~	Breast Clinic	206 + food
~~AMRAU~~	123	~~Hearing and Balance~~	~~Maternity Birthing Centre~~
Compulsory Areas	~~124~~	Gastro Liver Unit	Delivery Suite
External Area	126	EHPC Emergancy GP	**Cancer Centre Ward**
Emergency Department	127		~~201~~
	128		

Team 1 - 2 PFI Wards including public areas, 3 outpatient areas	**Team 2 -** 2 PFI Wards including public areas, 3 Outpatient areas, 1 meal service
Team 3 - ED, 1 External area, 2 Trent Wards including public areas and 1 meal service	**Team 4 -** 2 Lyme Wards including public areas, 3 outpatient areas, 1 meal service
Team 5 - 2 West Building Wards, 1 Maternity Ward, 1 Cancer Centre Ward including public areas, 2 outpatient areas and 1 meal service	**Team 6 -** 2 PFI Wards including public areas, 3 outpatient areas, 1 meal service

Areas inspected on 09/09/2025	Areas inspected on 23/9/2025	**Areas inspected during PLACE 2024**	

County Schedule

Wards	Outpatients	Compulsory Areas	Communal
12	CT Unit	External - Entrance	Chemotherapy Garden
AMU	Breast Care	A&E	Nightingales
15	STS (new)		
EOU	MRU		
1	Neurological Unit		
14	Womens Health		
Day Case	Outpatient Main		
	Endoscopy		
	Renal		
	Physio		
	X-Ray		

Team 1 - Ward 12 (plus food tasting) including communal area, CT Unit, Breast Care, STS (new), AMU, External - Entrance, A&E

Team 2 - Food tasting?, MRU, Neurological Unit, Womens Health, Ward 15, EOU, Ward 1 including communal areas, Outpatient Main

Team 3 - Ward 14 including communal area, Endoscopy, Renal, Physio, Day Case, X-Ray, Chemotherapy Garden, Nightingale

Executive Summary

Trust Board (Public) | 8th April 2026

Maternity & Neonatal PSIRF Investigation Report – Quarter 3

University Hospitals of North Midlands NHS Trust

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

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

Risk Register Mapping		

Executive Summary

Situation

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

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

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

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

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

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

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

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

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

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

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

MBRRACE-uk confidential enquiry reports (2025) continue to recognise inequalities as a theme in maternal and perinatal mortality particularly relating to ethnicity and social deprivation. These inequalities have been considered within the cases detailed within this report.

No of open maternity and neonatal PSIRF reviews:	
PMRT (Not reportable as PSII) PMRT (Reportable as PSII)	44 7 (inc MNSI cases)
MNSI: In progress Final report received Actions plans developed and for approval through governance process	8 4 3 1
PSII (Local Priority)	2
AAR	6
Thematic Review	2
Case Record Review	2

Assessment

In Quarter 3 there was 1 new incident reported that met the criteria for PSII's

- October 2025 0
- November 2025 0
- December 2025 1

Category of Incidents:

- 0 PMRT (Potentially score C or above)
- 1 MNSI
- 0 PSII (local priority)

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

Three final reports from MNSI have been received in Quarter 3 and action plans are in development to meet safety recommendations.

Assessment

Assurance Assessment		
Significant	High level of confidence in delivery of existing mechanisms / objectives	
Acceptable	General confidence in delivery of existing mechanisms / objectives	*X*
Partial	Some confidence in delivery of existing mechanisms / objectives, some areas of concern	
No Assurance	No confidence in delivery	
Rationale		
All incidents are reviewed weekly at the Obstetric and Neonatal risk meeting to identify any immediate learning or themes. A rapid review of care is completed for incidents that meet the national reporting criteria or are considered of moderate harm or above. *Incidents that meet the criteria for PMRT or MNSI will follow a robust review process and any immediate actions or local reviews will be implemented as a result of a rapid review or a PSIRF response review.*		

Key Recommendations

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

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

Executive Summary

Trust Board (Public) | 8th April 2026

UEC Improvement Journey

University Hospitals of North Midlands NHS Trust

Purpose:	**Information**		**Approval**		**Assurance**	✓	**Agenda Item:**	11
Author:	Katy Thorpe, Chief Operating Officer							
Executive Lead:	Katy Thorpe, Chief Operating Officer Ann Marie Riley, Chief Nurse Diane Adamson, Chief Medical Officer							

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

Risk Register Mapping		
BAF1	Delivering responsive patient care	Ext 20

Executive Summary

Situation

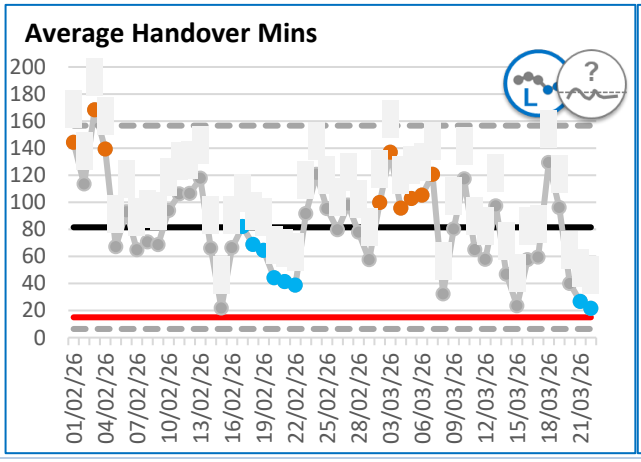
This paper ais to update board member on the situation with regard to UEC pressure and ambulance handover; and cover the Trusts improvement programme. This covers data up to the latest reported week which was 21/3/26. We remain in tier 1 for national oversight for our UEC position. Industrial action took place during the reporting period 17/12 – 22/12

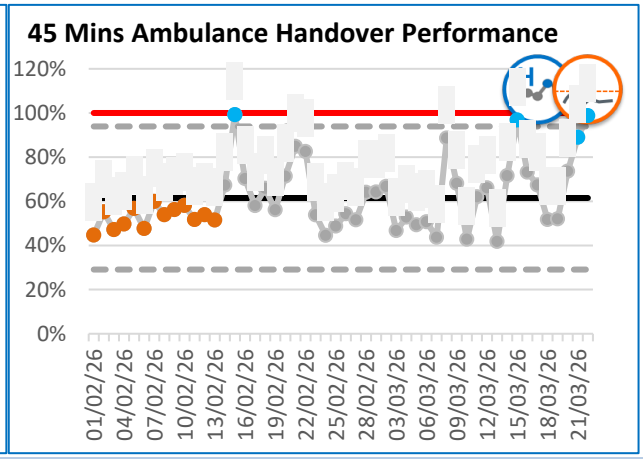
The report has been amended this month to demonstrate the patients full pathway across urgent and emergency care. Royal Stoke's UEC improvement data shows that ambulance handover delays are driven far more by internal flow than attendances. We see minimal correlation between overall ED attendances and handover performance – some of our busiest days have delivered strong handover compliance. The most consistent improvement occurs when we create early bed capacity. On days when we see a higher percentage of discharges before midday and 4pm, and occupancy falls below 93% by early afternoon, we achieve:

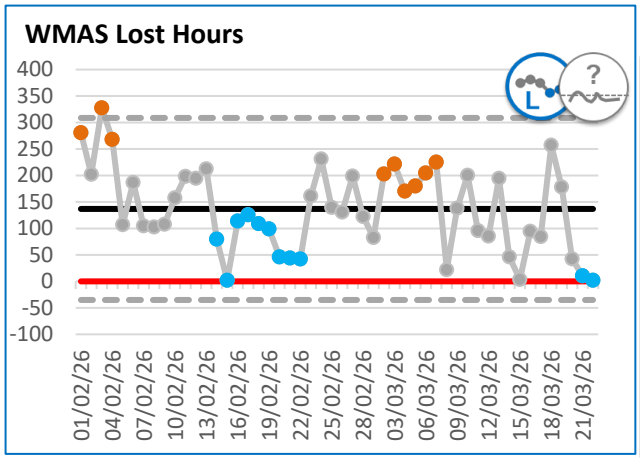
- faster CRTP (patients who a Clinically Ready To Proceed) movement
- ED time reduces from 8-9 hours to around 7-8 hours, and
- c.12 percentage-point improvement in <45 minute handovers.

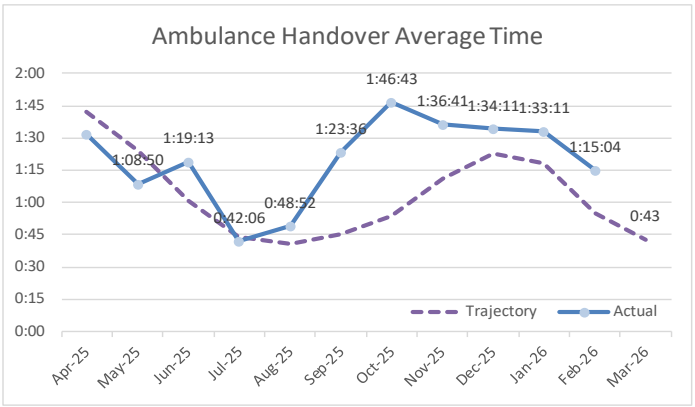
The evidence is clear: when we get flow right early in the day, performance improves across the whole UEC pathway – ambulance handovers, ED 4-hour performance, and patient experience. Our programme focuses on making these flow-enabling behaviours routine every day.

Ambulance Handover



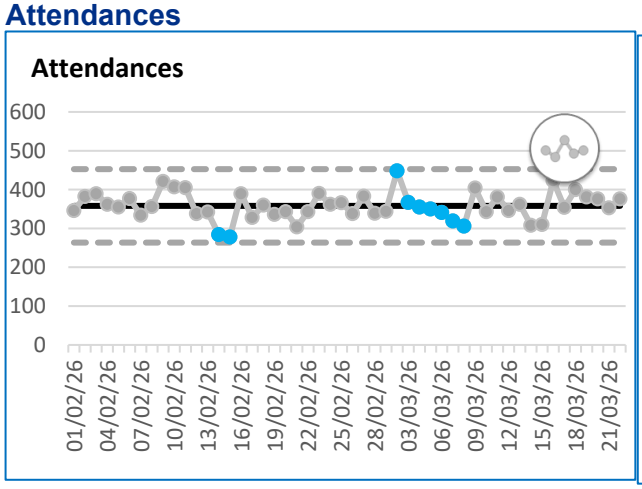


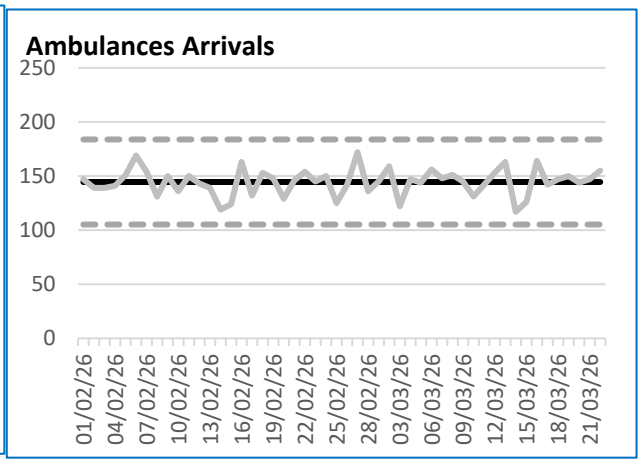




We continue to see variation in ambulance handover on a day to day basis, however when viewed with the monthly figures we are seeing month on month improvement.

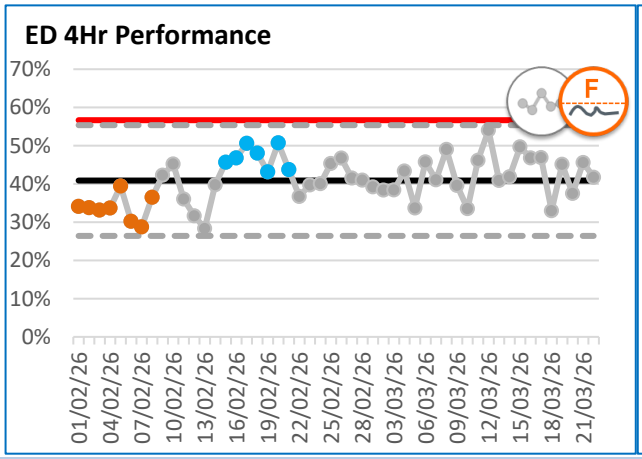
Attendances

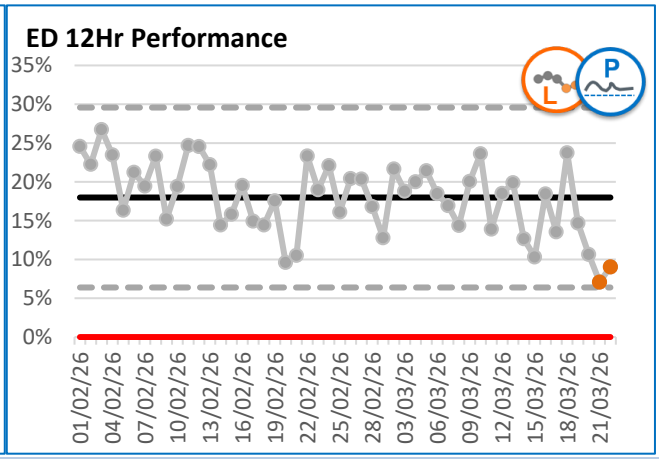


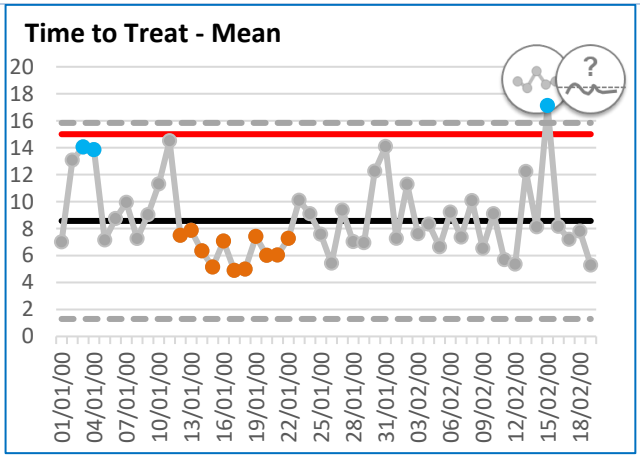


Attendances remain without variation

Time in the Emergency Department

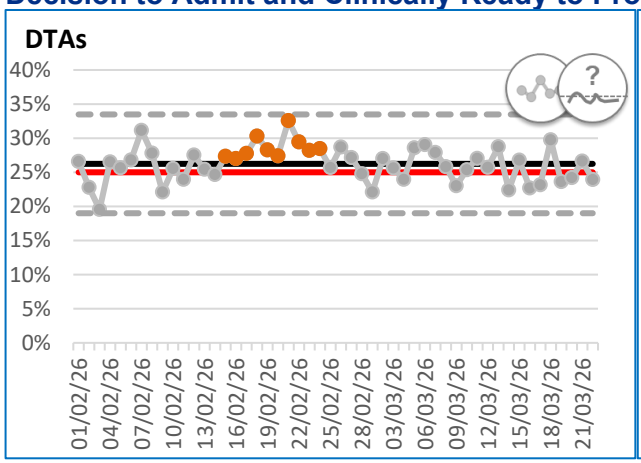


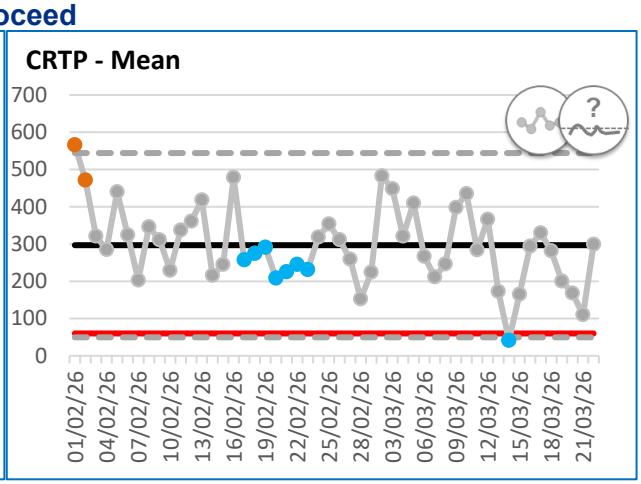




We continue to see variation in time to treatment on a day to day basis.

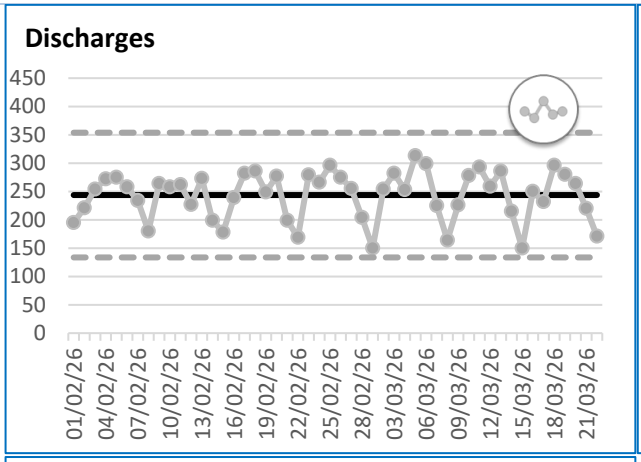
Decision to Admit and Clinically Ready to Proceed

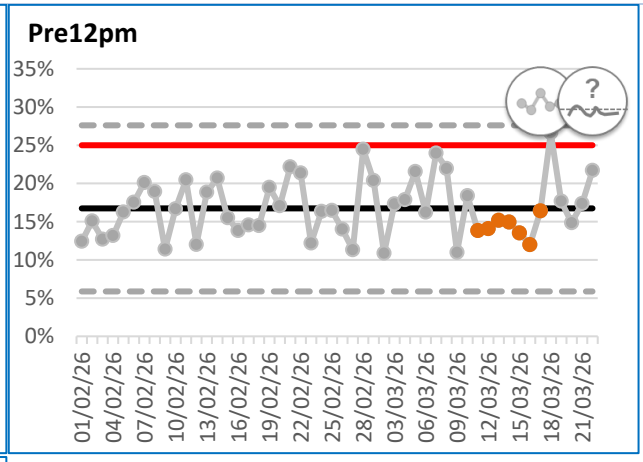


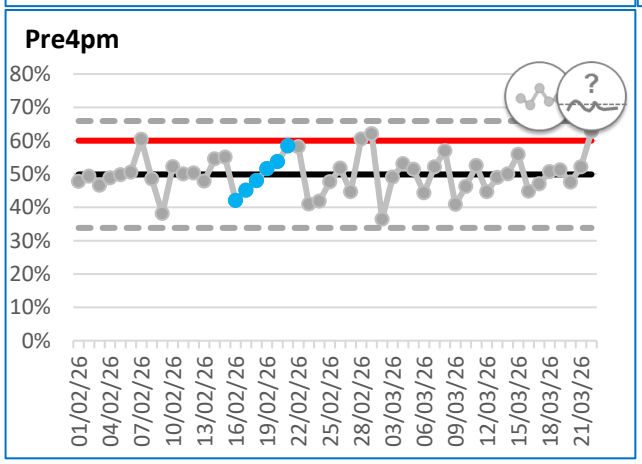


While patients with a DTA remains static, we are seeing improvement in the time by which patients are clinically ready to proceed.

Discharges

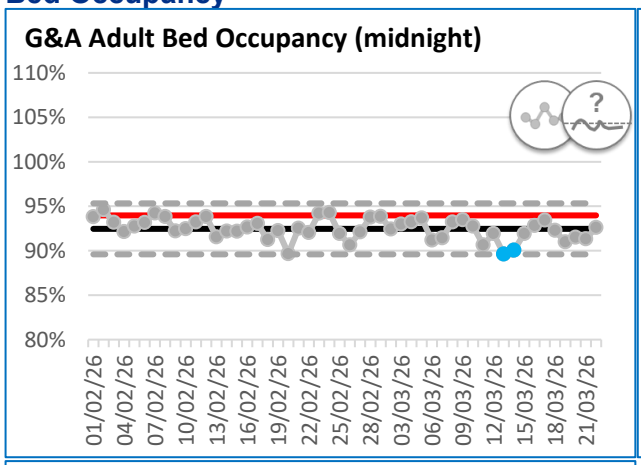


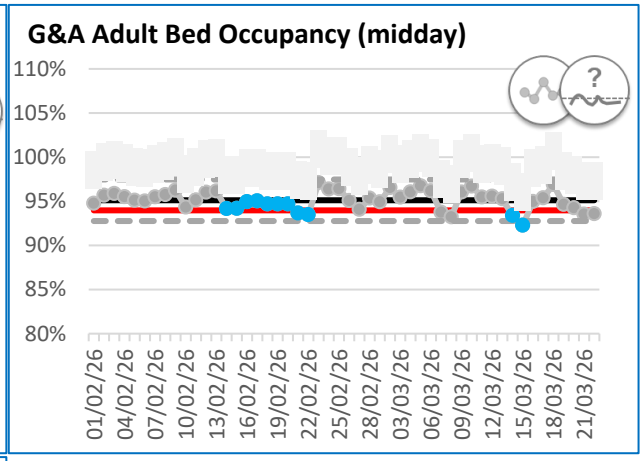


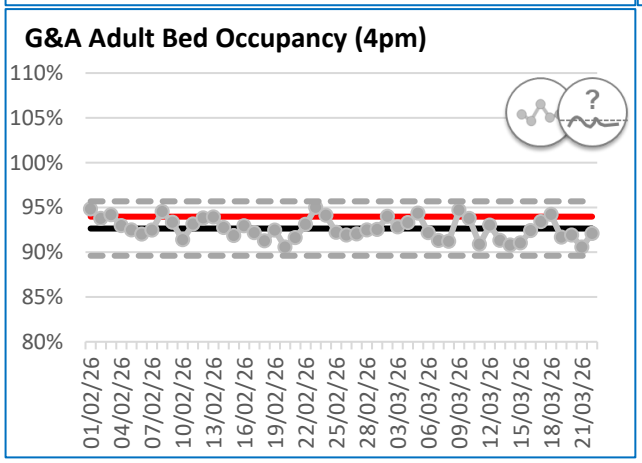


We continue to see variation in discharge on a day to day basis, however when viewed with the monthly figures we are seeing signs of improvement in bringing discharge earlier in the day.

Bed Occupancy







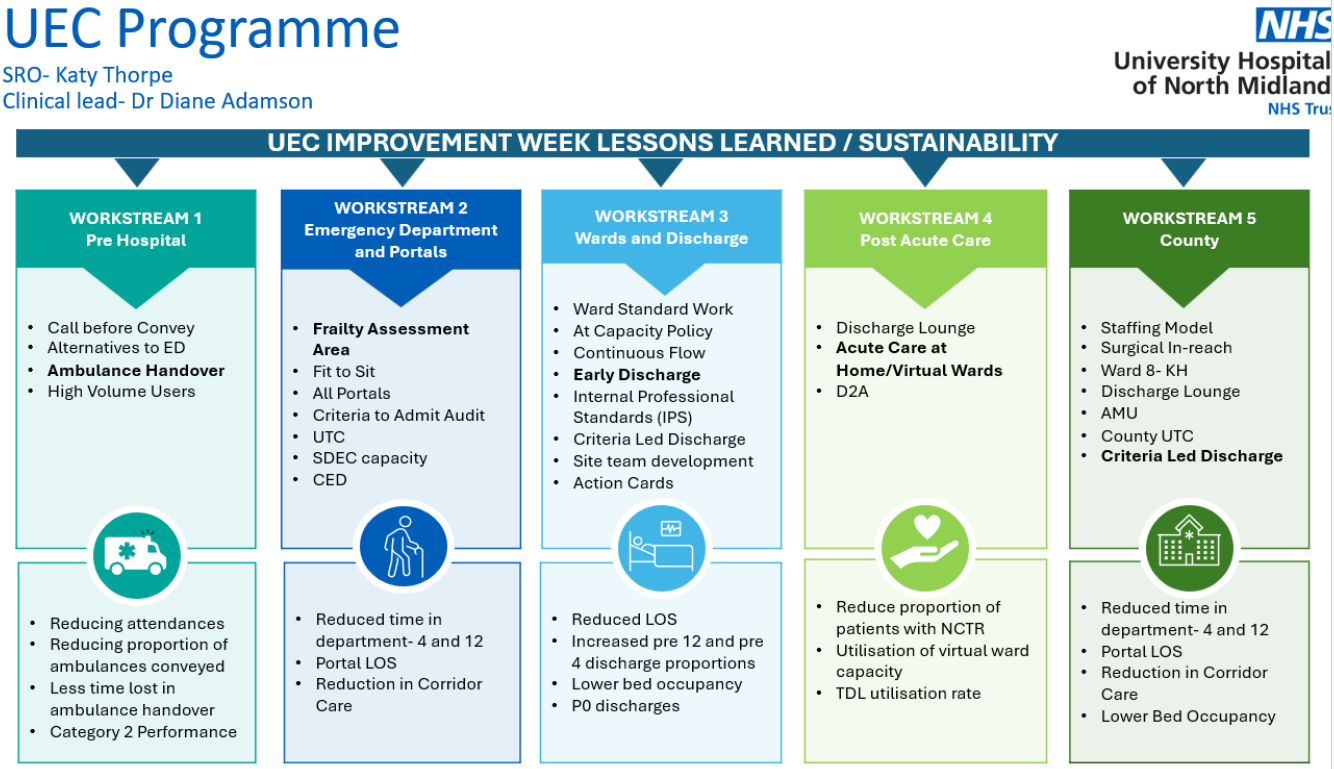
Bed occupancy remains static

Use of Escalation Space (TES)

New reporting is due for this report on use of escalation space. We are working with teams on improving corridor care with the use of the GIRFT guidance 'Corridor Care Improvement Guide'. We continue to use escalation space on both ward and ED areas. This is audited on a daily basis and reported through Quality Committee.

UEC Transformation Programme

Our UEC improvement plan is now in place following the visits in January 2025 where we invited in the NHSE national team to support with a review of our UEC pathways. The oversight of this is being monitored through our 'UEC Recovery and Oversight Meeting'. This is being supported now by the UEC GIRFT team.
The programme is outlined below and has a weekly cadence in order to be agile and focused in its improvement work. The workstreams are outlined below and in bold the areas of intense work which are highest priority for immediate change.



March Change

During March we have built on to the 'release to respond' programme of work to a change week which took place during the week of the 23rd of March. During the week all teams across the UEC pathway took their highest impact actions and shifted to new ways of working in order to embed change sustainably. This was delivered alongside our colleagues at GIRFT and focused on changing pathways, ways of working, changing habits and a focus on culture of bringing the right care to the patients as early in their pathway as possible. During the week itself there have been teething problems as teams work through together their new ways of working and embed ownership at different points of pathways.
This is now in a continuous improvement cycle as the new ways of working are embedded. The results of this will be fed back in the next report.

Conclusion

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

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

Key Recommendations

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

Executive Summary
Trust Board | 8 April 2026
NHS Staff Survey 2025 Results

NHS University Hospitals of North Midlands NHS Trust

Purpose:	**Information**	✓	**Approval**		**Assurance**	✓	**Agenda Item:**	12
Author:	Laura Smoult, Senior OD Consultant							
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	**Improving our Workforce Sustainability and Organisational Culture**		**Ext 15**
	Cause:	**If** we are unable to achieve workforce (people) sustainability through an effective long term workforce strategy and plan which is underpinned by a positive, inclusive organisational culture …	
	Event:	**Then,** we may face significant challenges in ensuring we have colleagues with the right skills, values and behaviours in the right place at the right time …	
	Effect:	**Resulting in** an adverse impact on colleague experience, voice, wellbeing, recruitment, development and retention, with the potential to compromise quality of care for our patients, inability to deliver operational targets and increased premium costs negatively affecting the financial position.	

Executive Summary

Situation

The NHS Staff Survey is one of the most significant sources of colleague insight across the health service, providing a consistent, national measure of colleague experience and engagement. It gives colleagues a direct voice on what is working well and where improvement is needed, making it a vital tool for understanding culture, wellbeing, and organisational performance.

This paper sets out the Trust's NHS Staff Survey 2025 results and what they mean for colleague experience, culture and organisational performance. It provides the Trust Board with an overview on progress against the People, Culture and Inclusion agenda by summarising headline findings, benchmarking position and key themes, and by highlighting priority areas for improvement and the actions planned for 2026/27.

The report supports effective Board oversight, ensuring colleague voice informs strategic decisions and that improvement activity remains focused, measurable and aligned to the Trust's strategic priorities.

Background

The survey ran from 25 September 2025 to 28 November 2025 and achieved a 41% response rate, with 5,388 colleagues participating. Although this represents a reduction from 2024 and remains below the benchmarking group average for 121 Acute and Acute & Community Trusts, the response reflects sustained local effort to encourage participation during a particularly challenging period for the organisation.

The NHS Staff Survey results have been presented to Executive Management Team, Trust Leadership Forum, Trust Joint Negotiating and Consultative Committee, and People, Culture and Inclusion Committee, as well as two Trust-wide briefing sessions which have been held for all colleagues to attend.

Assessment

Nationally, the 2025 NHS Staff Survey shows a continued downward trend across staff engagement, morale and wellbeing for Acute and Acute & Community Trusts. UHNM reflects this national pattern, with overall stability and slight negative drift across the People Promises and themes.

Overall, colleague experience has remained stable in a challenging national context, demonstrating organisational resilience. However, the negative drift highlights the need for focused improvement, with actions for 2026/27 prioritising learning and development, line management capability, and targeted organisational development support.

UHNM is positioned in the lower half of its benchmarking group, sitting slightly below average across the People Promise elements and engagement themes, while being slightly above average for morale. This profile suggests organisational resilience during a year of significant financial pressure, organisational redesign and sustained operational challenge, but also indicates limited traction from prior improvement activity.

The Trust's 2025 results present a consistent, coherent picture across participation, national benchmarking and year-on-year movement. First, the reduced response rate (41%, down 4 percentage points from 2024 and below the 47% benchmarking average) is a material consideration. While 5,388 responses still provide a robust evidence base, lower participation can reduce representativeness and suggests a need to strengthen survey promotion, local encouragement and confidence that feedback leads to visible change.

The report notes that differences are small, but the overall pattern matters: it indicates that UHNM is not experiencing unique or isolated deterioration; rather, colleague experience is tracking the same downward pressures seen nationally. This "middle-to-lower" positioning creates both a risk and an opportunity, without focused improvement activity the Trust is likely to continue to drift with national trends, whereas targeted action in a small number of high-leverage areas could realistically move UHNM above the group average over time.

Staff Engagement stands at 6.67. The sub-score profile is important: UHNM matches the benchmarking average for advocacy but remains below average for motivation and involvement. This suggests colleagues are broadly willing to recommend the Trust as a place to work (or feel positively about the organisation in principle) but are less likely to report feeling energised by their work or meaningfully involved in decisions that affect them. Addressing involvement (how decisions are communicated, how change is implemented, and how staff voice is acted on) is therefore likely to be a key mechanism for improving engagement.

"We are always learning" remains the Trust's lowest-scoring People Promise element, and the survey reinforces the central role of consistent line management and team-based culture in shaping colleague experience, particularly in relation to involvement, communication and how change is implemented.

Morale is a relative strength, with UHNM slightly above the benchmarking average. Taken alongside the report's conclusion that overall results are broadly stable (with only a slight negative drift), this points to organisational and individual resilience during a year of sustained challenge. However, stability should not be over-interpreted as improvement: the Trust's own reflection notes that prior-year improvement activity has not yet translated into measurable uplift at scale. " "**We are a team**" is identified as a high-impact opportunity because it is linked to belonging, psychological safety and day-to-day working relationships. In practice, these two areas often act as 'multipliers': strengthening learning and development (through consistent appraisal, access to development, and clear pathways) and improving team-based culture can generate positive movement across multiple staff experience indicators simultaneously.

The report consistently points to the **critical influence of line managers** on local colleague experience, alongside the need for **targeted organisational development, culture and inclusion support** in areas of greatest need rather than broad, uniform interventions. This is reinforced by the mixed picture

indicated in workforce race equality/workforce disability equality scheme measures, which will be reviewed in depth through the People, Culture and Inclusion Committee.

Together, these findings imply that the next phase of improvement should focus on strengthening core people-management practices (communication, support, fairness and follow-through) and using granular care-group/service insights to prioritise where resource and attention will have the greatest impact.

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	
No Assurance	No confidence in delivery	

Rationale

The rationale for this rating is that there is **acceptable assurance** in the delivery of the relevant actions and interventions relating to the NHS Staff Survey, including listening to colleague feedback, understanding the results and ensuring action plans and priorities are in place.

Key Recommendations

It is recommended that the Trust Board notes the report and endorses a focused 2026/27 improvement approach that:

1. Prioritises improvements in “We are always learning” through clearer development pathways, higher-quality appraisal and development conversations, and better access to learning opportunities
2. Strengthens line management fundamentals (communication, regular support, and consistent people management practice) given the evidenced influence on engagement and wellbeing; and
3. Targets organisational development, culture and inclusion support to services and teams with the greatest need, maintaining colleague engagement and equality, diversity and inclusion as golden threads and strengthening ongoing listening through the transition to NHS People Pulse.

NHS Staff Survey 2025 Results

April 2026

1. Introduction

1.1 The NHS Staff Survey is one of the most significant sources of colleague insight across the health service, providing a consistent, national measure of colleague experience and engagement. It gives colleagues a direct voice on what is working well and where improvement is needed, making it a vital tool for understanding culture, wellbeing, and organisational performance.

1.2 The NHS Staff Survey ran from 25 September to 28 November 2025 and achieved a 41% response rate, down from 45% in 2024. In total, 5,388 colleagues completed the survey, compared with 5,680 the previous year. This response rate is below our benchmarking group average of 47% for the 121 Acute and Acute & Community Trusts.

1.3 Nationally, the 2025 NHS Staff Survey results for Acute and Acute & Community Trusts show a continued downward trend in staff engagement, morale and wellbeing indicators. UHNM's results show a similar pattern of overall stability with slight negative drift across the People Promises and Themes, indicating that the Trust broadly mirrors the national benchmarking group rather than representing an outlier position. When benchmarked against 121 peer Trusts, UHNM is positioned in the lower half of the group, with performance trends aligned to those seen nationally.

1.4 While this is not the direction of travel the Trust would aspire to, the results indicate that UHNM's overall position has remained stable during a period characterised by significant financial pressure, organisational redesign and sustained operational challenge. This suggests a degree of organisational resilience, with colleague experience broadly holding steady in line with national movement rather than declining disproportionately.

1.5 The actions planned for 2026/27 will build on the positive elements of the results, acknowledge the Trust's progress over the past year, and set out targeted actions in response to colleague feedback. These will focus on improving the

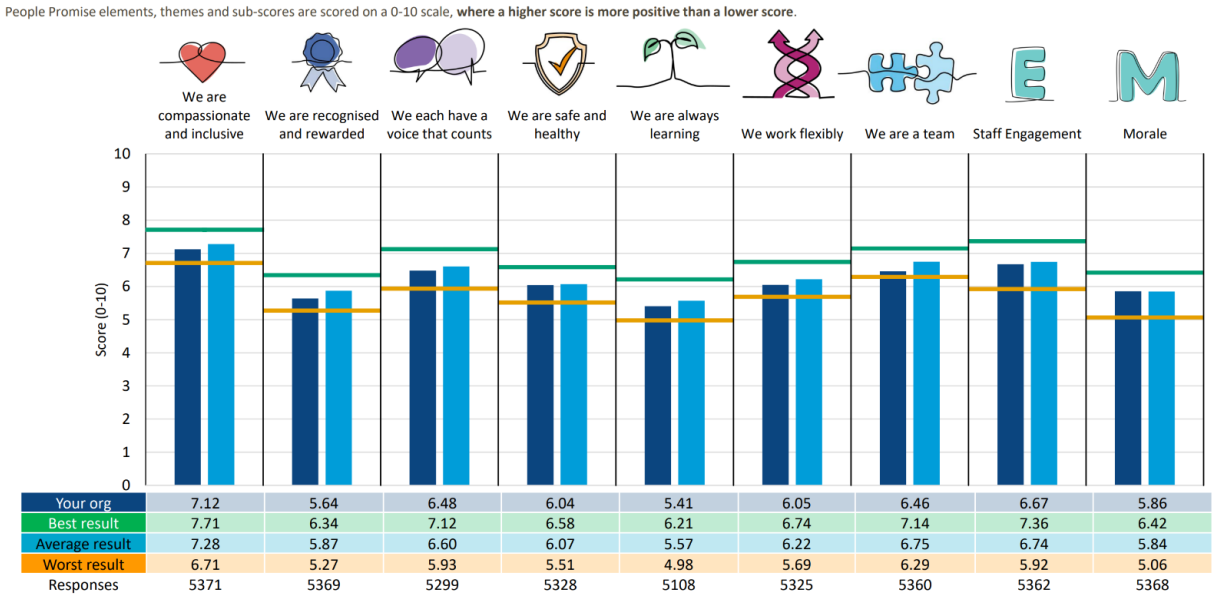
- **'We are always learning'** score
- **Strengthening the critical role of line managers** in shaping local colleague experience, and
- Ensuring the **flexible, tailored support** to the services and teams with the greatest need.

1.6 Detailed Care Group and service-level analysis have been reviewed through People, Culture and Inclusion Committee (PCIC).

2. Key Survey Findings – National Benchmarking with Comparable Acute and Acute & Community Trusts

2.1 The full benchmark report can be found online here where the results of the NHS Staff Survey 2025 are measured against the seven People Promise elements and against the two themes of Staff Engagement and Morale. The reporting also includes sub-scores, which feed into the People Promise elements / themes. **Figure One** below shows the Trust's overall People Promise elements / theme scores when compared to our benchmarking group average

Figure One: Trust's People Promise elements / themes scores compared to our benchmarking group average



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

2.2 It should be noted that these are small differences, however this does demonstrate that the Trust is sitting slightly below the benchmarking group average. It is positive to see that the Trust is slightly above the benchmarking group average for Morale and this evidences the increased focus the Trust has given to support colleagues and their wellbeing throughout difficult operational pressures and organisation redesign over the last 12 months.

3. Key Survey Findings – Trust position compared to NHS Staff Survey 2024 results

3.1 Whilst the Trust benchmarked in the lower half of the benchmarking group, it is positive to see that the Trust's overall position remains stable, with many questions changing only slightly. Nonetheless, there has been a slight negative drift across several People Promise elements and themes. This can be seen in **Figure Two** below.

Figure Two: People Promise elements / themes – Trust's 2024 scores compared with Trust's 2025 scores

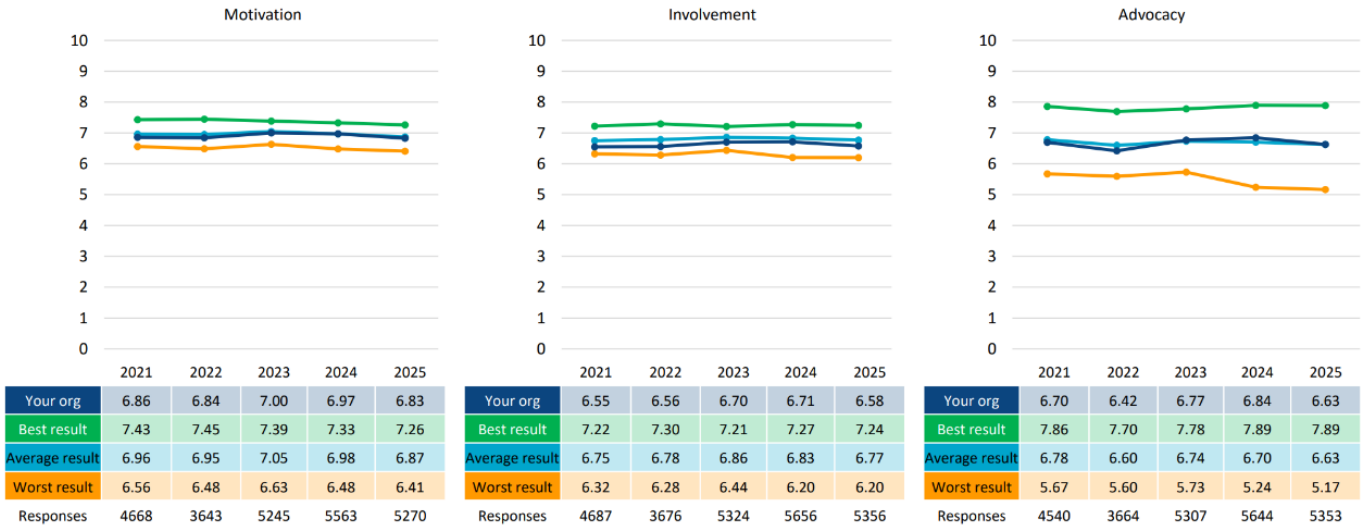
People Promise elements	2024 score	2024 respondents	2025 score	2025 respondents	Statistically significant change?
We are compassionate and inclusive	7.22	5660	7.12	5371	Significantly lower
We are recognised and rewarded	5.77	5657	5.64	5369	Significantly lower
We each have a voice that counts	6.63	5592	6.48	5299	Significantly lower
We are safe and healthy	6.11	5618	6.04	5328	Significantly lower
We are always learning	5.54	5423	5.41	5108	Significantly lower
We work flexibly	6.09	5607	6.05	5325	Not significant
We are a team	6.56	5647	6.46	5360	Significantly lower
Themes					
Staff Engagement	6.84	5658	6.67	5362	Significantly lower
Morale	5.97	5666	5.86	5368	Significantly lower

3.2 The Trust's overall Staff Engagement score stands at 6.67, marginally below the benchmarking group average last year's score. Among the sub-scores (see **Figure Three** below), the Trust matches the benchmarking group average for Advocacy but falls below average for Motivation and Involvement. Notably, within Advocacy, fewer colleagues now believe that care is the organisation's top priority.

Figure Three: Staff Engagement sub-scores

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score.**

Theme: Staff Engagement



	2021	2022	2023	2024	2025
Your org	6.86	6.84	7.00	6.97	6.83
Best result	7.43	7.45	7.39	7.33	7.26
Average result	6.96	6.95	7.05	6.98	6.87
Worst result	6.56	6.48	6.63	6.48	6.41
Responses	4668	3643	5245	5563	5270

	2021	2022	2023	2024	2025
Your org	6.55	6.56	6.70	6.71	6.58
Best result	7.22	7.30	7.21	7.27	7.24
Average result	6.75	6.78	6.86	6.83	6.77
Worst result	6.32	6.28	6.44	6.20	6.20
Responses	4687	3676	5324	5656	5356

	2021	2022	2023	2024	2025
Your org	6.70	6.42	6.77	6.84	6.63
Best result	7.86	7.70	7.78	7.89	7.89
Average result	6.78	6.60	6.74	6.70	6.63
Worst result	5.67	5.60	5.73	5.24	5.17
Responses	4540	3664	5307	5644	5353

3.3 Workforce Race Equality Standards (WRES) and Workforce Disability Equality Standards (WDES) results show a mixed picture. WRES findings indicate a widening gap in experience, with outcomes worsening for ethnically diverse colleagues while improving for white colleagues, particularly in relation to discrimination and bullying from managers and colleagues. This represents a clear priority for leadership and cultural focus. WDES results show some positive movement, including improved access to workplace adjustments; however, colleagues with a long-term condition or disability continue to report feeling significantly less valued. These findings, and the actions arising from them, will be considered in depth through the People, Culture and Inclusion Committee and in continued engagement with Staff Networks.

4. Reflecting on the past 12 months

4.1 Following the NHS Staff Survey 2024 results, the Trust committed to focusing improvement activity on four People Promise areas: **We are safe and healthy (PP4); We are always learning (PP5)**; **We work flexibly (PP6)**; and **We are a team (PP7)**. These areas were identified as priorities based on colleague feedback and national benchmarking.

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

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

4.4 The results reinforce that, although the Trust has remained resilient during a period of sustained pressure, further focus is required to strengthen colleague experience. In particular, the findings highlight the continued importance of learning and development, consistent line management, and team-based culture in driving improvement.

4.5 Detailed Care Group and service-level actions relating to these areas have been reviewed through the People, Culture and Inclusion Committee.

5. Areas of focus for the next 12 months

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

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

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

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

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

5.2 Detailed Care Group and Service-level actions will continue to be overseen through the People, Culture and Inclusion Committee.

6. Next Steps

7.1 Care Groups and Services have been asked to identify and communicate the three actions that matter most for their teams, informed by survey findings and wider people metrics. These high-level action plans will be presented at performance reviews and other reporting forums. The OD, Culture and Inclusion team will continue to support senior leaders in closing the feedback loop and communicating key messages across the Trust. Detailed analysis and ongoing oversight of actions will be managed through the People, Culture and Inclusion Committee.

7. Conclusion

7.1 Although the NHS Staff Survey 2025 results show a slight downward shift, colleagues have been clear and consistent about the areas where they expect to see improvement, providing a clear direction for action. Encouragingly, sentiment relating to personal resilience, optimism, and motivation remains comparatively strong. This provides the Trust with a solid psychological foundation on which to build; strengthening culture is significantly more achievable when underlying morale is stable and positive.

7.2 Another aspect of the survey results is that, alongside the corporate areas of focus, 'We are a team' presents a high-impact opportunity for improvement. Although it is currently the lowest-scoring People Promise theme when benchmarked nationally, this also means we can demonstrate visible progress at pace. The theme is connected to belonging, working relationships, line management behaviours, and psychological safety; improvements here typically generate uplift across multiple People Promise areas at once, offering a strong return on investment.

7.3 It is acknowledged overall that we have still further to go in comparison to our benchmarking group. Through our collective work at a corporate and local level we aim to continue to build on our successes, learn where things can be even better and most importantly act as a result of colleague feedback to ensure that the Trust is a great place to work and we continue to improve patient outcomes.

8. Recommendations

It is recommended that the Trust Board consider and note the information contained within this report.

Executive Summary

Trust Board (Public) | 8th April 2026

Gender, Ethnicity and Disability Pay Gap Report 2025

University Hospitals of North Midlands NHS Trust

Purpose:	**Information**		**Approval**		**Assurance**	✓	**Agenda Item:**	13
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	*Cause*	**If** we are unable to achieve workforce (people) sustainability through an effective long term workforce strategy and plan which is underpinned by a positive, inclusive organisational culture….	Ext 15
	Event	**Then,** we may face significant challenges in ensuring we have colleagues with the right skills, values and behaviours in the right place at the right time….	
	Effect	**Resulting** in an adverse impact on colleague experience, voice, wellbeing, recruitment, development and retention, with the potential to compromise quality of care for our patients, inability to deliver operational targets and increased premium costs negatively affecting the financial position.	

Executive Summary

Situation

UK organisations employing 250 or more employees are required to publicly report on their gender pay gap, and following the introduction of the NHS EDI Improvement Plan in 2024 this extends to voluntary ethnicity and disability pay gap reporting.

Background

The issues that surround pay gaps are complex and the causes are a mix of work, family and societal influences. Our UHNM People Delivery Plan sets out our ambition to be the employer of choice by prioritising the health and wellbeing of our people, ensuring equity of opportunity and where flexible working, career mobility and a respectful, safe environment will be the norm.

Assessment

The 2025 pay gaps show:

Gender Pay Gap

- UHNM has a 75.9% female workforce, broadly aligned with NHS-wide representation.
- Despite men making up only 24.1% of the workforce, 37.1% of male staff work in the upper pay quartiles, creating our gender pay gap.
- Women are over-represented in all quartiles except quartile 4 (highest paid roles).
- The medical workforce is the main driver of the gender pay gap: women represent 41.5% of medical staff, dropping to 30.7% at Consultant level, though representation is improving year on year.

Ethnicity Pay Gap

- There is an overall pay advantage for global majority colleagues, due to strong representation in middle-upper and upper pay bands.
- All individual global majority groups show a pay advantage compared to White British colleagues.
- Ethnic diversity increases with each pay quartile, driven primarily by Asian representation.
- However, in most professional groups, senior roles remain disproportionately held by White colleagues, generating pay gaps within professional categories.

- Most notable gap: Medical & Dental shows a 29.1% negative pay gap (improved from 33%), linked to over-representation of global majority colleagues in non-consultant roles (84%).

Disability Pay Gap

- Only 5.7% of staff are recorded as having a disability, limiting the usefulness of the data.
- Disability representation is lowest at the upper pay quartile, creating a pay gap favouring non-disabled employees.
- Low declaration rates—particularly in medical and dental roles—impact the ability to present bonus gap calculations.

On the basis of the above, our proposed assurance assessment is:

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	

Key Recommendations

The Trust Board is asked to note the pay gap metrics and the workstreams identified for the coming year to continue reducing pay inequity at UHNM amongst marginalised groups.

Pay Gap Report 2025

University Hospitals of North Midlands NHS Trust

1. Introduction

All organisations with 250 or more employees are mandated by the government to report annually on their gender pay gap. In addition, the NHS Equality, Diversity and Inclusion (EDI) Improvement Plan High Impact Action 3 is to 'eliminate total pay gaps with respect to race, disability and gender' with the success metric for NHS organisations being improvement in their gender, race and disability pay gap data. Ethnicity and disability pay gap reporting are currently voluntary.

Pay gap reporting is essential for identifying, measuring, and reducing disparities in earnings between different demographic groups, fostering transparency, and driving actionable change to build more equitable workplaces. It promotes accountability, helping to track progress on equality, diversity, and inclusion goals, particularly when considered against other frameworks, such as the workforce race equality standard (WRES), the workforce disability equality standard (WDES) and national staff survey people promise metrics.

Methodology

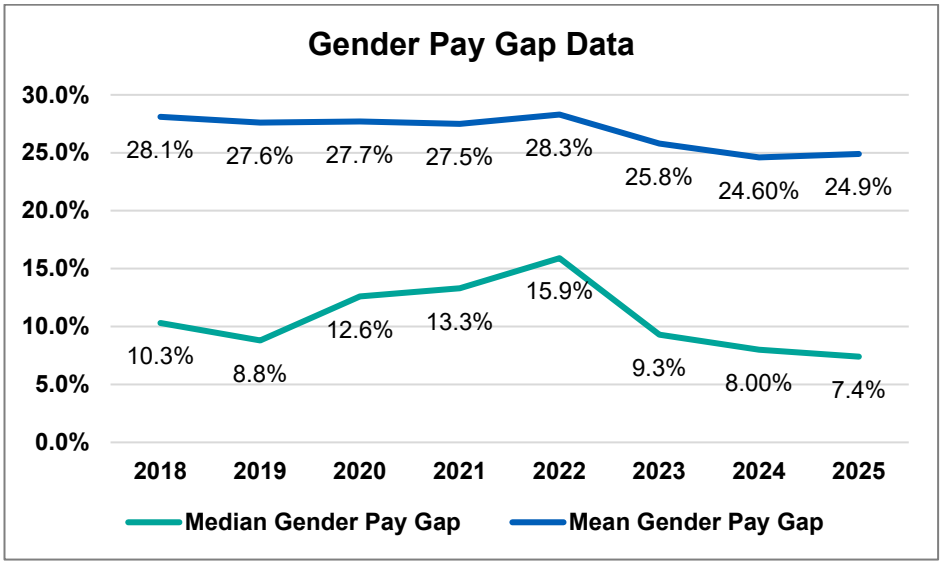
A pay gap is calculated as the percentage difference between average hourly earnings for men and women; for white and global majority employees and disabled and non-disabled employees. This report fulfils the Trust's reporting requirements to publish information relating to six pay gap measures. The six measures are:

- Median pay gap (median is the middle number of a range of numbers in order from smallest to biggest)
- Mean pay gap (mean is the average number obtained by the total divided by the number of values)
- Median bonus pay gap (note: the only payments classed as bonus pay relate to Clinical Excellence Awards payable to eligible medical and dental consultants)
- Mean bonus pay gap
- Proportion receiving a bonus
- Proportion in each pay quartile

All NHS organisations use standard pay gap reporting methodology available on the ESR business intelligence platform. Gender pay gap data is a legal requirement and should be reported on a designated government website at www.gov.uk/genderpaygap by 30th March 2026.

Gender Pay Gap 2025

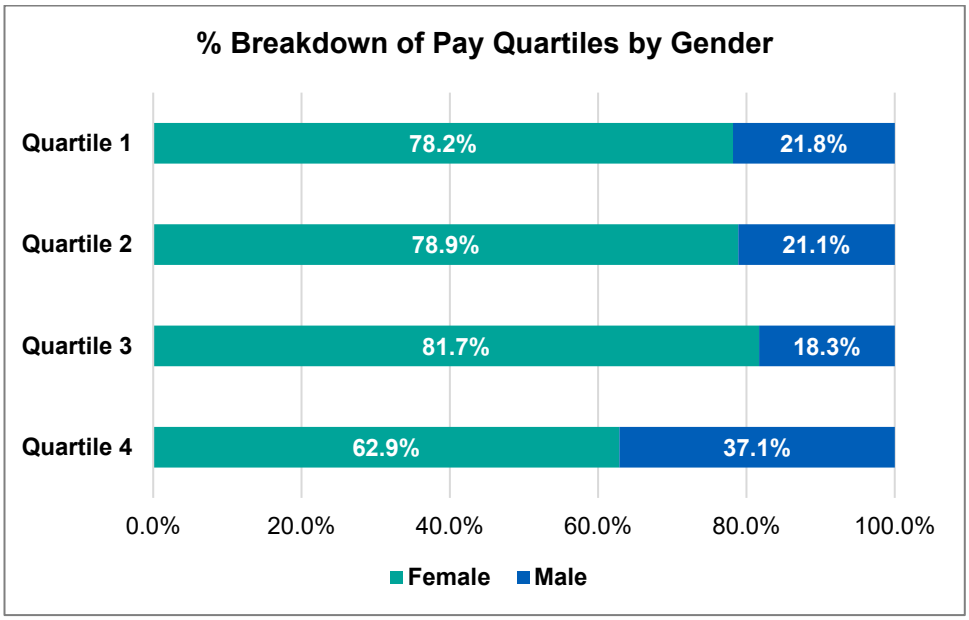
The gender pay data is a snapshot of pay taken on 31st March each year:



This year's data shows continued downward trajectory of the median pay gap and minimal change in the mean pay gap. Our gender pay gap is influenced by the make-up of our workforce which has a larger proportion of males working in the upper pay quartile and a greater proportion of females employed in the lower and middle pay quartiles.

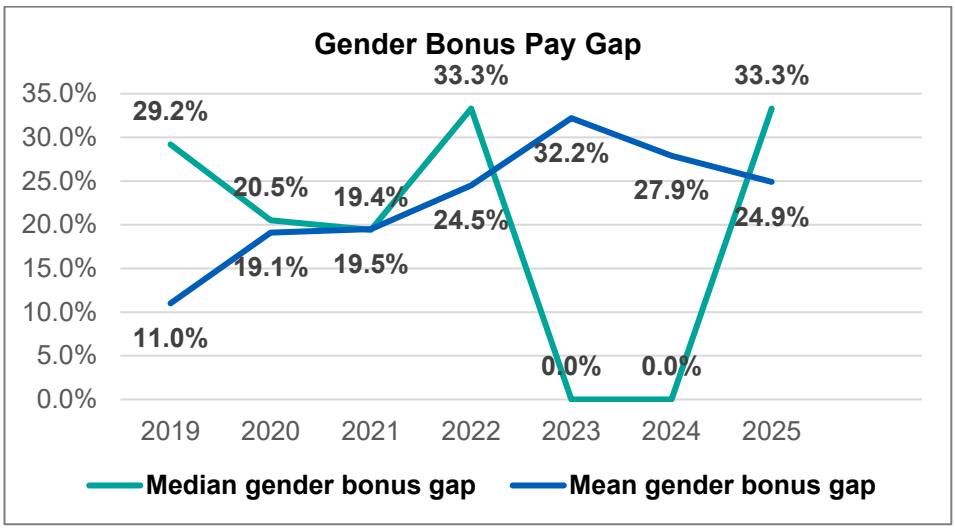
The proportion of male and female workforce in each pay quartile at 31st March 2025:

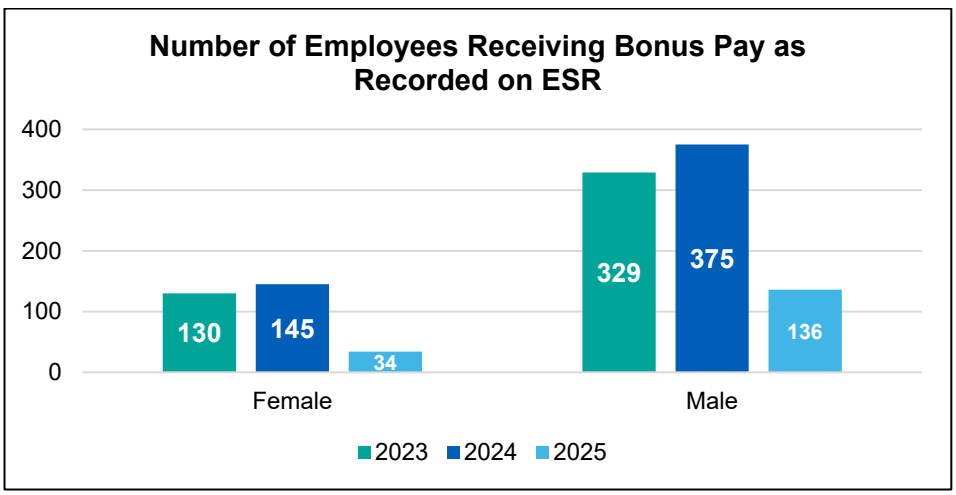
Quartile 1: Percentage of employees in the lower pay quartile
Quartile 2: Percentage of employees in the lower middle pay quartile
Quartile 3: Percentage of employees in the upper middle pay quartile
Quartile 4: Percentage of employees in the upper pay quartile



Women make up 75.9% of the UHNM workforce, and ideally this representation should be evenly distributed across the pay quartiles, however it is evident that women are under-represented in quartile 4 – the most highly paid roles including senior clinical and management roles and medical and dental consultants

Bonus Pay

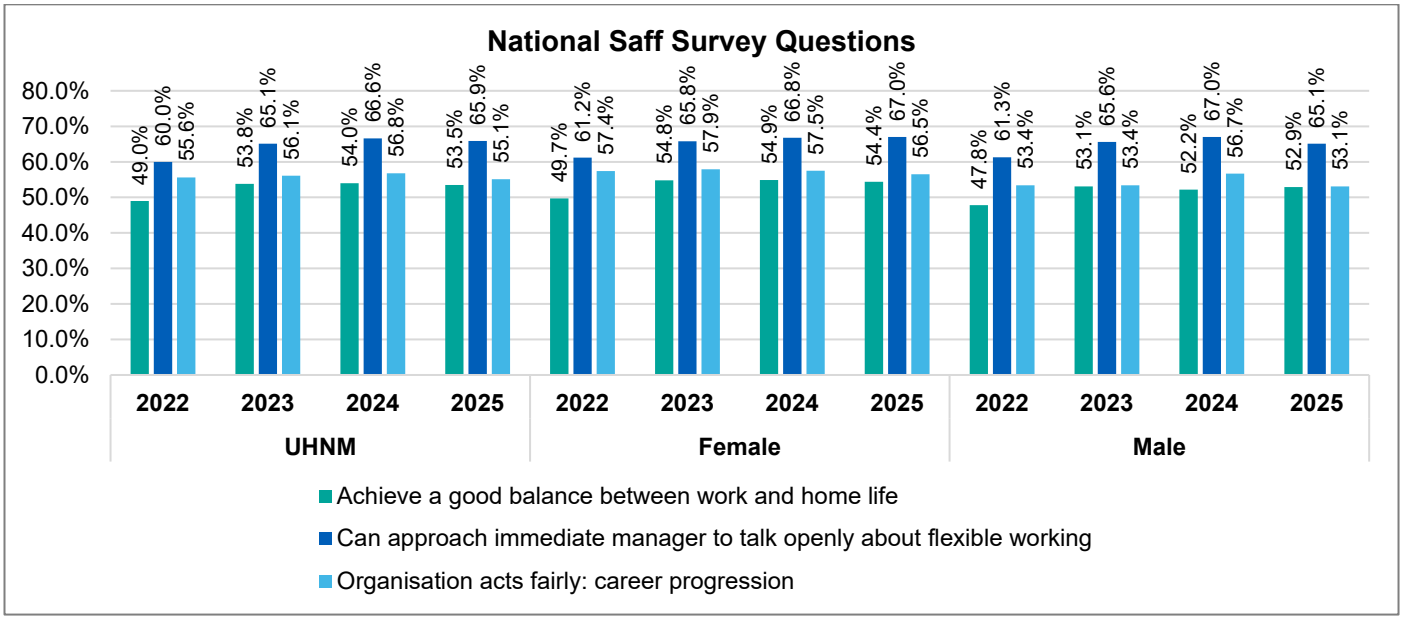




The only bonus pay within UHNM relates to awards available to eligible medical and dental consultants. This data reflects the 2024-25 awards cycle. The organisation's local Clinical Excellence Awards (CEA) scheme has now concluded, and no further awards are made under this arrangement. Consultants seeking recognition for their achievements can instead apply for the national Clinical Impact Awards. These awards are overseen by ACCIA, with applications submitted via the national portal during the yearly application round, following nationally defined criteria and guidance.

Flexible Working

The following information demonstrates UHNM responses to the People Promise element – we work flexibly and the work-life balance questions in the NHS National Staff Survey 2025. Flexible working is a key factor in attracting and retaining women, who remain primary care givers in society. The data tells us that there is sustained improvement for colleagues achieving a good balance between work and home life and that there is no significant difference between the responses of women and men in our organisation.



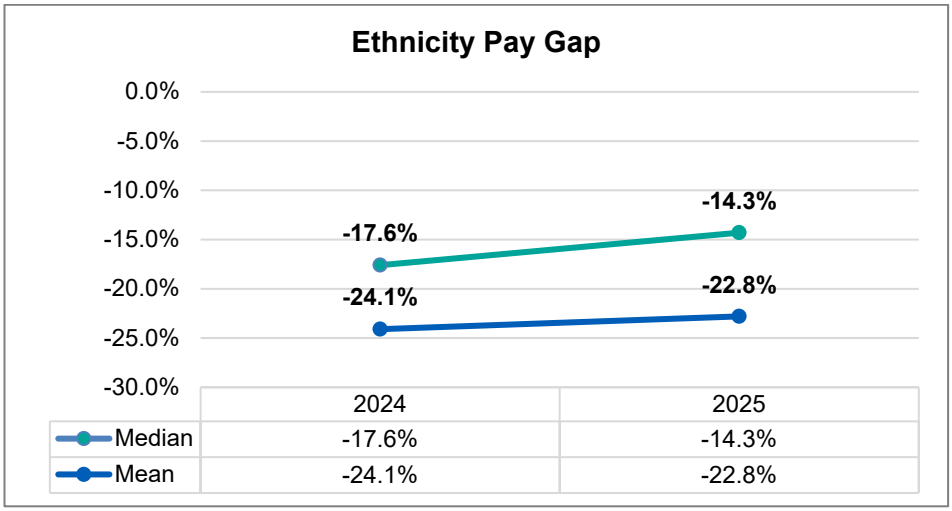
Summary of the 2025 Gender Pay Gap

- UHNM has a 75.9% female workforce (a reduction from 77.0% in 2024). This is reflective of the gender representation across the NHS as a whole (76% female – NHS Providers, 2024)
- This data shows that whilst men represent 24.1% of the workforce a greater proportion of the male workforce (37.1%) are employed in the upper pay quartiles, which drives our gender pay gap.
- Women are over-represented in all pay quartiles, except quartile 4 (highest paid roles)
- The main driver of our pay gap is the gender inequity in the medical profession; women represent 41.5% and this falls further to 30.7% at Consultant level. However, female representation is steadily increasing each year.

Ethnicity Pay Gap

The Ethnicity Pay Gap has been introduced because of the inequalities between colleagues of global majority heritage and white colleagues which have been demonstrated through the NHS Workforce Race Equality Standard (WRES). This is the second year of reporting our ethnicity pay gap.

The ethnicity pay data is a snapshot of pay taken on 31st March each year:



	2024	2025
Median	-17.6%	-14.3%
Mean	-24.1%	-22.8%

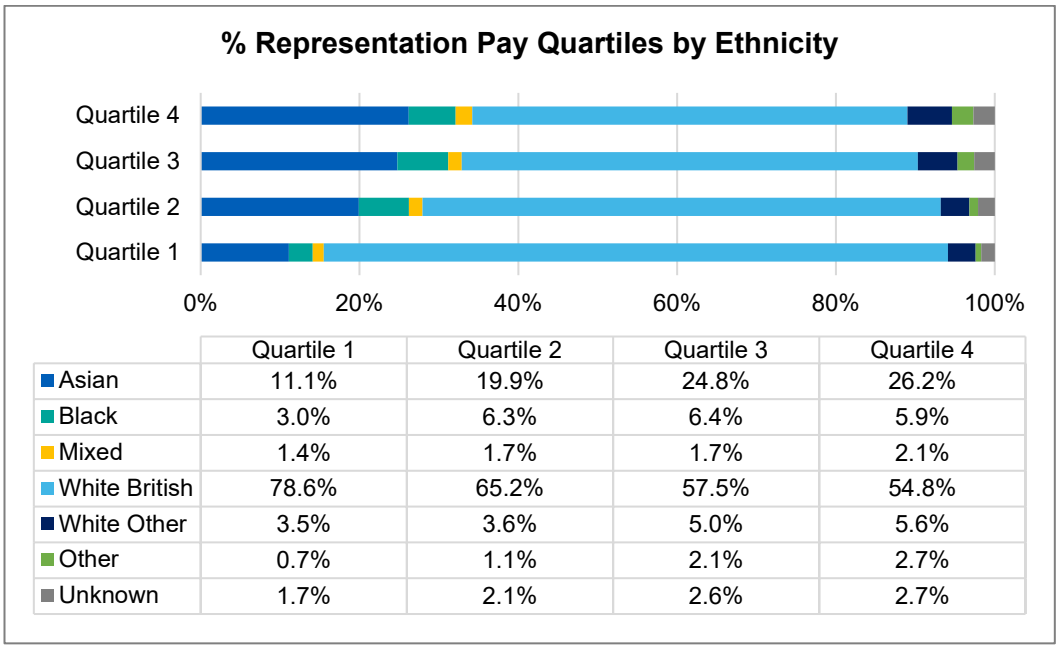
A negative value indicates a positive pay gap – a 'pay advantage' in favour of colleagues from global majority heritage.

Ethnic Origin Summary	Mean Hourly Rate		Median Hourly Rate	
	2024	2025	2024	2025
% Diff White British - Black	-10.8%	-12.2%	-13.7%	-12.7%
% Diff White British - Asian	-29.2%	-27.1%	-22.0%	-16.5%
% Diff White British - Mixed	-19.4%	-17.2%	-15.8%	-10.0%
% Diff White British - Other	-35.9%	-41.3%	-30.9%	-28.8%
% Diff White British - White Other	-20.6%	-22.2%	-17.7%	-14.8%

There is a pay advantage for all ethnicity groups.

The proportion of white and ethnically diverse employees in each pay quartile at 31st March 2025:

Quartile 1: Percentage of employees in the lower pay quartile
Quartile 2: Percentage of employees in the lower middle pay quartile
Quartile 3: Percentage of employees in the upper middle pay quartile
Quartile 4: Percentage of employees in the upper pay quartile



	Quartile 1	Quartile 2	Quartile 3	Quartile 4
Asian	11.1%	19.9%	24.8%	26.2%
Black	3.0%	6.3%	6.4%	5.9%
Mixed	1.4%	1.7%	1.7%	2.1%
White British	78.6%	65.2%	57.5%	54.8%
White Other	3.5%	3.6%	5.0%	5.6%
Other	0.7%	1.1%	2.1%	2.7%
Unknown	1.7%	2.1%	2.6%	2.7%

Global majority representation increases as pay quartiles increase, driven primarily by Asian representation.

UHNM global majority representation is 29.2%, but this is unevenly distributed across professional groups and pay bands.

Ethnicity Pay Gap by Professional Group (% difference White : Black, Asian & Minority Ethnic):

Professional Group	Mean Ethnicity Pay Gap	Median Ethnicity Pay Gap
Medical & Dental	14.2%	29.1%
Nursing & Midwifery Registered	9.7%	10.2%
Allied Health Professionals	8.0%	14.2%
Administrative & Clerical	5.9%	0.0%
Healthcare Scientists	17.6%	19.0%
Additional Clinical Services	-6.1%	-8.6%
Additional Professional & Scientific	-1.1%	-6.6%
Estates & Facilities	-4.2%	-6.0%

Bonus Ethnicity Pay Gap

The following demonstrates ethnicity representation in clinical excellence/impact awards allocated in 2024-2025, and the mean and median pay value.

Ethnic Group	Ethnicity Representation	Mean pay value	Median pay value
Asian	48.2%	£10,382.17	£6,032.04
Black	0.0%		
Mixed	2.4%	£12,332.91	£13,572
White British	36.5%	£11,692.40	£9,048
White Other	8.2%	£13,384.52	£11,218.92
Other	2.4%	£14,910.93	£4,524
Not Stated	2.4%	£10,297.82	£7,023.64

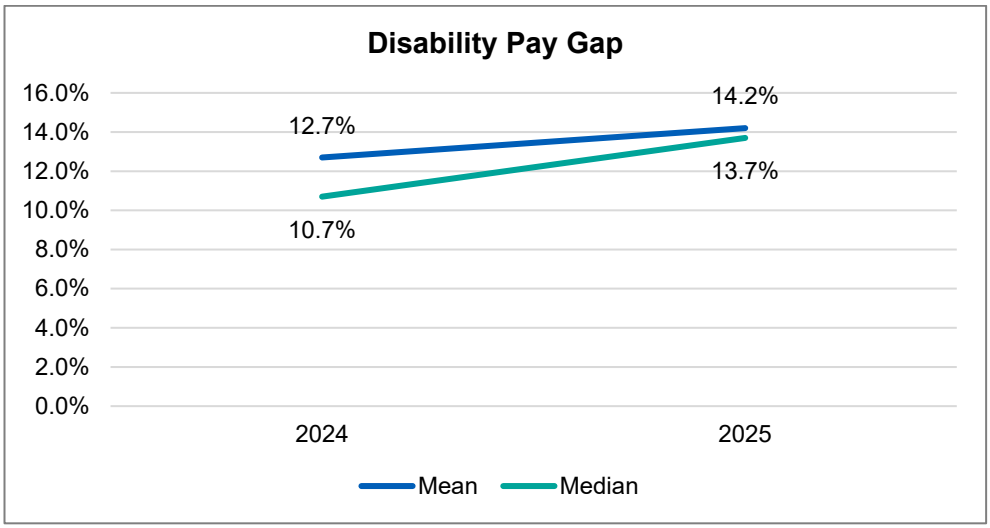
Summary of Ethnicity Pay Gap 2025

- Overall, there is a pay advantage for global majority colleagues at UHNM. This is because a greater proportion of Black, Asian and minority ethnic colleagues are employed in the middle-upper and upper pay bands.
- There is a pay advantage for all disaggregated ethnicity groups compared to White British.
- Ethnically diverse representation increases as the pay quartiles increase. This is primarily due to Asian employee representation in quartiles 3 and 4. Conversely, White representation decreases as the pay quartiles increase.
- A high proportion of global majority representation is within the medical and dental workforce (upper pay quartile 4)
- However, White colleagues have a favourable pay gap in all professional groups except for Additional Clinical Services, Professional & Scientific and Estates and Facilities.
- The most notable negative pay gap is in the Medical & Dental professional group at 29.1% (a reduction from 33% in 2024). Although over 67% of this group are from global majority backgrounds, they are over-represented in non-consultant career grade levels at 84%.
- Our data demonstrates that whilst UHNM has significant global majority representation, in most professional groups the more senior higher paid roles are disproportionally held by white colleagues, resulting in the pay gaps.

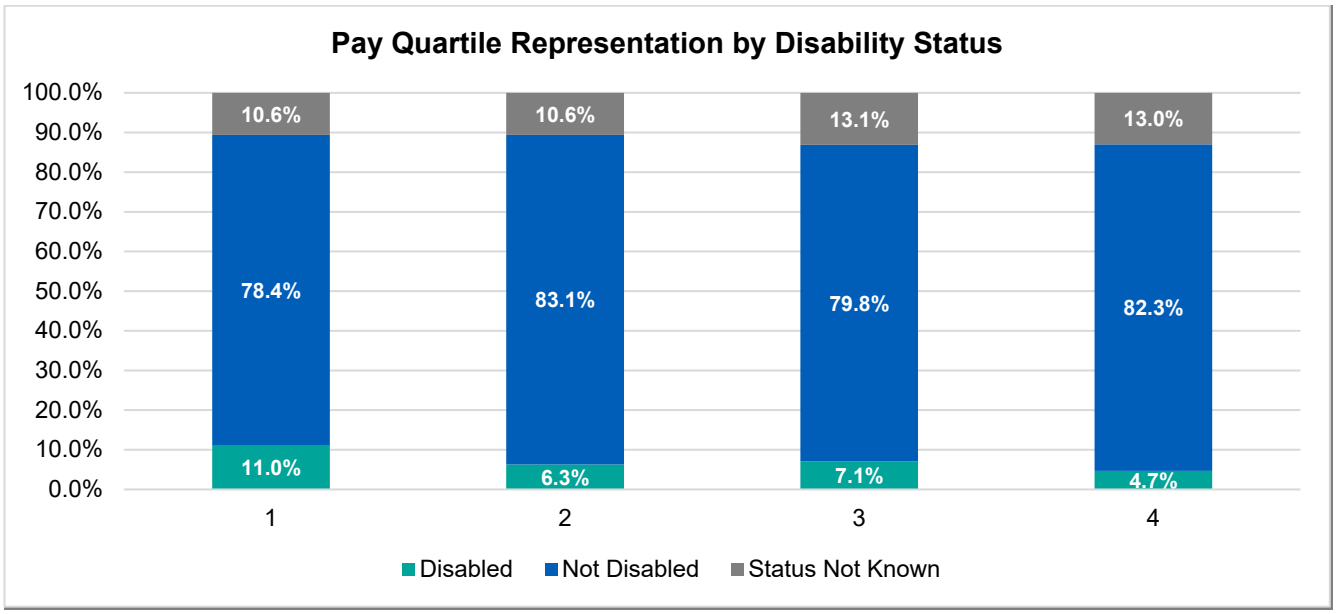
Disability Pay Gap

Disability pay gap voluntary reporting was introduced as part of the NHS EDI Improvement Plan in 2024 and is a recognition of the lower proportion of disabled people in employment in England. The disability pay data is a snapshot of pay taken on 31st March each year:

Unlike gender and ethnicity, disability status reported on ESR is less than six percent, which limits the usefulness of the data. This is the second year of disability pay gap reporting.



The mean and median pay gaps have increased compared to last year. Because so few employees have recorded a disability status, even small changes in the workforce can significantly affect these figures.



Insufficient data means that the bonus pay calculation is unavailable.

Summary of Disability Pay Gap 20225

- 5.7% of UHNM colleagues are recorded as having a disability on ESR. This limits the usefulness of the disability pay gap data.
- Disability representation is lowest in the upper pay quartile, which drives the pay gap in favour of non-disabled employees.
- Disability declaration rates are lowest in the medical and dental professional group, which impacts the ability to calculate the bonus pay gap (which only applies to Clinical Excellence Awards).
- In recent years, we have significantly reduced the number of unknown disability status records on ESR and our disability declaration rates are in line with the wider NHS.

Conclusion

Our pay gaps are not about unequal pay for equal work—which is unlawful—but reflect structural, cultural, social and systemic factors leading to inequalities in recruitment, career progression and employee experience. Key issues remain:

- Access to flexible or adjusted roles
- Structural and societal bias, values and norms
- Systemic discrimination

As an inclusive employer, NHS organisations should take steps to address gender, ethnicity and disability pay gaps. By identifying and addressing disparities, we can create a fairer, more inclusive workplace where all colleagues can thrive.

Our pay gap data highlights how gender, ethnicity and disability inequality do not operate in isolation. Instead, they intersect—meaning that individuals who belong to more than one disadvantaged group often experience greater and compounding disparities. When these factors overlap, for example a disabled global majority woman, the likelihood of being represented in higher pay quartiles reduces further.

Actions

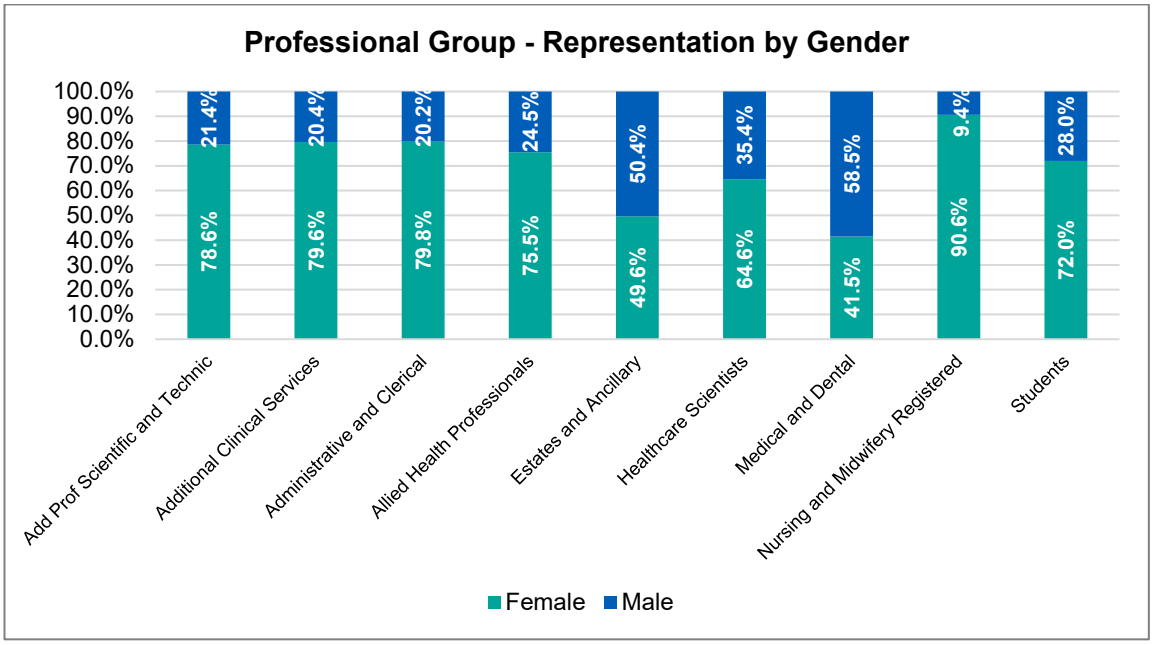
Several coordinated programmes are in progress to address the structural inequalities that influence recruitment, progression and retention outcomes for women, global majority colleagues and disabled people - factors that directly contribute to our pay gaps. These programmes include:

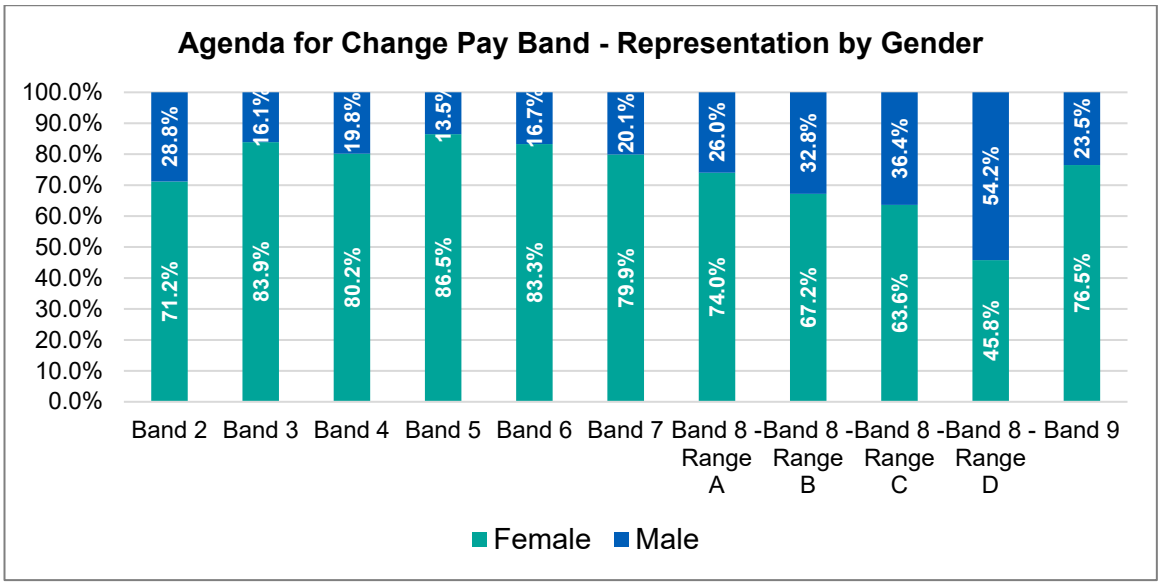
- Race Equality Task and Finish Group — driving actions to improve representation, experience and progression for global majority colleagues
- Disability (WDES) Priorities for 2026 — strengthening accessibility, workplace adjustments and neurodiverse inclusion
- Flexible Working Steering Group — expanding equitable access to flexible working to support retention, wellbeing and work–life balance
- Sexual Safety Steering Group — ensuring a sexually safe, respectful working environment
- Wellbeing Delivery Plan — improving the day-to-day employee experience through targeted wellbeing interventions and support

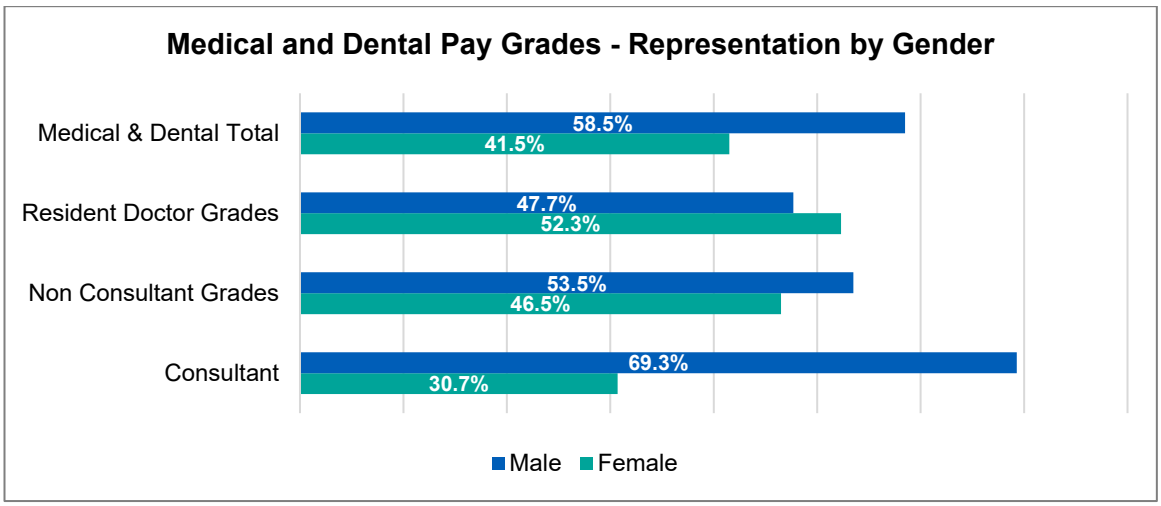
Our accountability for progress will be demonstrated through measurable improvements in employee experience and workforce outcomes. We will track the impact of these programmes through annual WRES and WDES submissions, Public Sector Equality Duty reporting, national staff survey indicators and annual pay gap analysis.

Appendix 1 Workforce Profile: Gender

UHNM is typical of any NHS Trust in that it has a higher number of females than males in its workforce. 75.9% of our workforce are female compared to 24.1% men. This is a reduction from 77% the previous year.





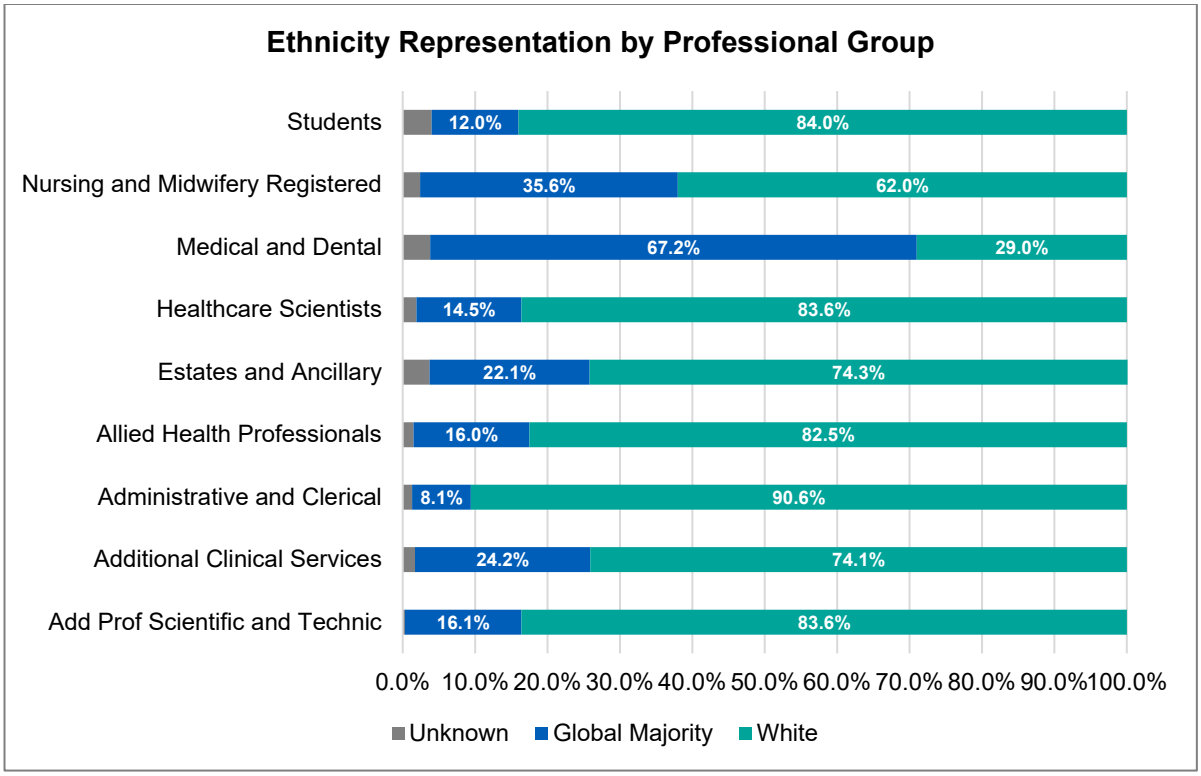


The following data table is from Model Hospital, and is UHNM Gender Pay Gap data (from 2024-25) in comparison with our peer average:

Pay Gap Metrics	Data period	Provider value	Peer average	National value	National value method	Chart
Average gender hourly pay gap	2024/25	24.6%	19.9%	18.0%	Provider median	
Median gender hourly pay gap	2024/25	8.0%	7.8%	7.0%	Provider median	
Proportion of males in lower quartile of hourly pay	2024/25	20.7%	18.0%	20.5%	Provider median	
Proportion of females in lower quartile of hourly pay	2024/25	79.3%	82.0%	79.5%	Provider median	
Proportion of males in top quartile of hourly pay	2024/25	35.6%	31.2%	32.0%	Provider median	
Proportion of females in top quartile of hourly pay	2024/25	64.4%	68.8%	68.0%	Provider median	

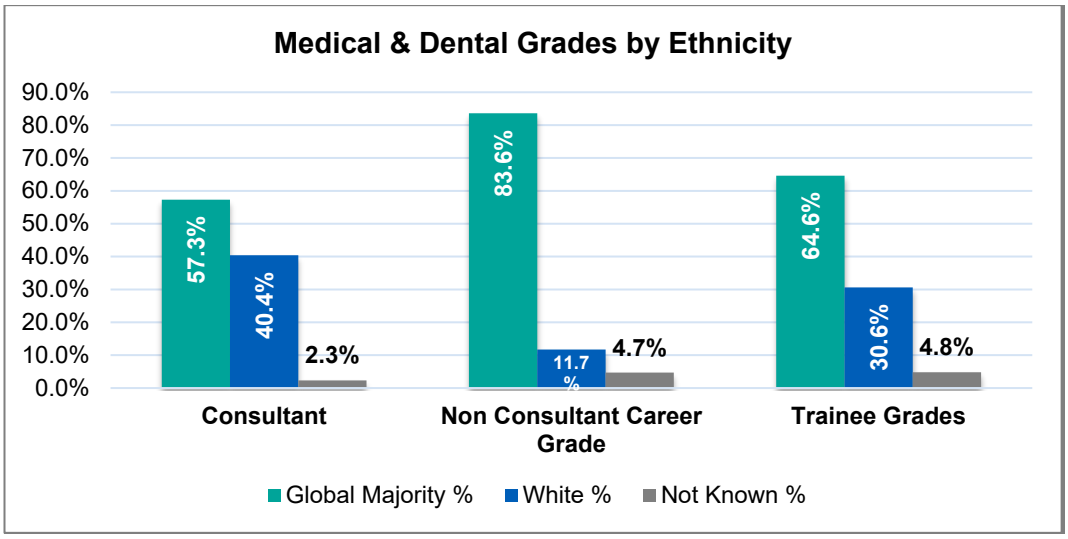
Rate of Change Metrics	Data period	Provider value	Peer average	National value	National value method	Chart
Average gender hourly pay gap - change from previous year (in percentage points)	2024/25	-1.2	-1.1	-0.8	Provider median	
Median gender hourly pay gap - change from previous year (in percentage points)	2024/25	-1.3	-0.9	-0.7	Provider median	
Proportion of males in lower quartile of hourly pay - change from previous year (in percentage points)	2024/25	0.3	0.4	0.6	Provider median	
Proportion of females in lower quartile of hourly pay - change from previous year (in percentage points)	2024/25	-0.3	-0.4	-0.6	Provider median	
Proportion of males in top quartile of hourly pay - change from previous year (in percentage points)	2024/25	0.1	0.0	0.0	Provider median	
Proportion of females in top quartile of hourly pay - change from previous year (in percentage points)	2024/25	-0.1	0.0	0.0	Provider median	

Workforce Profile: Ethnicity



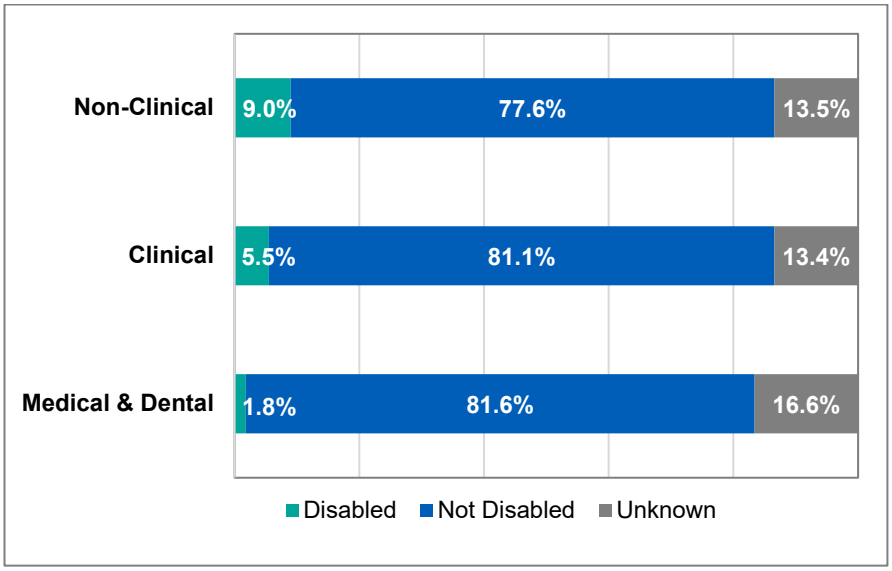
Ethnicity representation in Agenda for Change roles 2022-2025:

AfC Bandings	White %				Black, Asian & Minority Ethnic %				Unknown %			
	2025	2024	2023	2022	2025	2024	2023	2022	2025	2024	2023	2022
<1 to 4	79.4%	81.4%	84.1%	86.0%	18.7%	15.9%	13.2%	11.2%	1.9%	2.7%	2.7%	2.8%
5 to 7	67.8%	70.0%	73.7%	77.3%	30.1%	27.4%	23.7%	20.0%	2.1%	2.6%	2.6%	2.7%
8a and 8b	89.4%	91.7%	91.9%	92.2%	9.8%	7.0%	6.6%	6.2%	0.8%	1.3%	1.5%	1.6%
8c to VSM	96.8%	94.0%	93.8%	96.3%	3.2%	4.8%	3.8%	2.5%	0.0%	1.2%	2.5%	1.3%

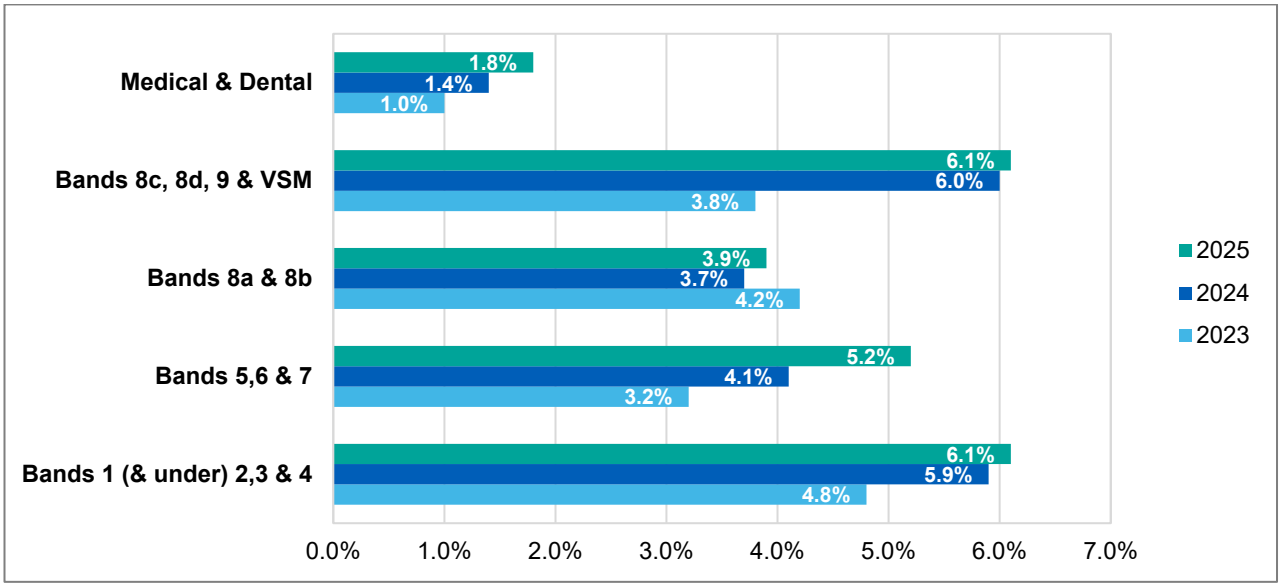


Workforce Profile: Disability

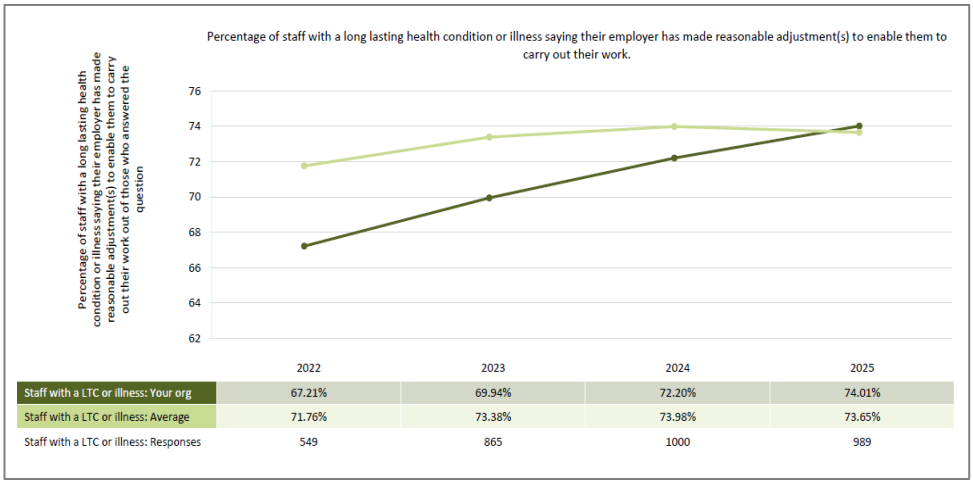
Disability representation across non-clinical, clinical and medical and dental sub groups:



Disability representation across 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 8A and 8B) over recent years.



6.0% of women employed at UHNM have a disability according to ESR, and 4.9% of men.



	2022	2023	2024	2025
Staff with a LTC or illness: Your org	67.21%	69.94%	72.20%	74.01%
Staff with a LTC or illness: Average	71.76%	73.38%	73.98%	73.65%
Staff with a LTC or illness: Responses	549	865	1000	989

Workplace adjustments are recognised as the most significant factor in supporting disabled colleagues. The 2025 national staff survey indicates that, for the first time, UHNM is performing above the national average on this metric.

Appendix 2: Update on actions from 2024-5 Gender Pay Gap

Action / Recommendation	Owner	Time scale	Desired Outcome/ success criteria	Status
Corporate areas of focus arising from the 2024 National Staff Survey data as defined within the People Domain of the UHNM Strategy. These People Promises are: **We are safe and healthy** Corporate actions to include going back to basics, addressing colleague burnout, morale and ensuring the Trust wellbeing offer supports mental, physical and financial wellbeing.	Chief People Officer	2025-26	Target of 6.3 for the People Promise 'we are safe and healthy' by 2027	2025 NSS: 6.0
We work flexibly Corporate actions to include consistent and continued roll out of our FlexFocus Campaign, sharing of staff stories and manager training programmes. We will support teams to be flexible and agile by improving how they work together to manage service demands and navigate change.	Chief People Officer	May 2026	Target of 6.9 for the People Promise 'we work flexibly'	2025 NSS: 6.05
We are always learning Corporate actions to include increasing the effectiveness of PDRs and developing and increase awareness and understanding of inclusive Career Roadmaps per staff group and functions).	Chief People Officer	March 2026	Target of 5.8 for the People Promise 'we are always learning' by 2027	2025 NSS: 5.42
Creating a sexually safe environment We will Implement the recommendations from the independent review of sexual safety by Lime Culture	Deputy CPO	2025-26	Yearly reduction in % reporting experience of inappropriate conduct of a sexual nature	Reporting to PCIC committee
Governance We will develop and embed an improved EDI governance framework, using EDI dashboards to monitor progress and the influence of our staff networks, staff stories and survey feedback to better inform actions.	EDI Lead	June 2025	EDI framework and dashboard	Complete
Focus on intersectionality Extend our pay gap reporting by ethnicity and disability to gain a better understanding of the difference in pay and impact of intersectionality	EDI Lead	Sept. 2025	Produce baseline ethnicity and disability pay gap reports	Complete

Highlight Report

QUALITY, ACCESS & OUTCOMES COMMITTEE | 5th March 2026

University Hospitals of North Midlands NHS Trust

Matters of Concern / Key Risks to Escalate	Major Actions Commissioned / Work Underway
• January **Urgent and Emergency Care performance** reflected winter pressures, including deterioration in four-hour performance, though paediatric performance improved. Encouragingly, ambulance handover performance remained stable relative to regional deterioration, and post-January data showed improving trends. The Committee received strong assurance regarding cultural and operational improvements, including faster recovery from pressure events and improved whole-hospital engagement. • **Cancer performance** showed improvement, with February provisional 62-day performance expected to be the strongest of the year. Diagnostic capacity was to be further supported by the Community Diagnostic Centre opening in April. RTT performance dipped during winter pressures, but recovery actions were underway, including targeted elective "sprints" in March and restored elective theatre capacity. The Committee was assured that recovery plans were credible and aligned to national requirements. • The Committee received assurance that **clinical effectiveness** governance continued to be strengthened following investment in senior clinical leadership and improved engagement. Key areas of work included endoscopy governance, peer reviews, and preparation for expanded audit models within medicine, aligned with established surgical approaches. • The Committee reviewed the **Quality Performance** report, providing an overview of harm metrics, infection control, medicines safety, VTE, sepsis and duty of candour compliance. While some deterioration was noted in timely observations and duty of candour timescales, trends were generally stable or improving year-on-year, with targeted improvement actions in place. The Committee was assured that strengthened accountability, ward-level focus and EPMA implementation were supporting sustained quality improvement. • The Committee received assurance on **maternity** quality and safety oversight arrangements. Benchmarking data on third and fourth degree tears has been strengthened to include national comparators, with further work underway to validate local performance. The Committee supported continued visibility of this metric until full assurance was achieved. Emerging risks, including neonatal staffing and women declining recommended care, were appropriately escalated.	• The Committee agreed to receive the full paper regarding **clinical coding**, for information. • To receive a further update on **52 week wait harm reviews** in May / June 2026. • Neonatal and **maternity** medication incidents were discussed, including the impact of EPMA implementation on reporting rates. A detailed thematic review was in progress, and it was agreed to bring a dedicated paper on the outcome of this to a future meeting. • It was agreed to provide the outcome of the thematic analysis for urology **cancer** breach cases to the Committee once complete.

Positive Assurances to Provide	Decisions Made
• An update was provided on progress against the **clinical coding** backlog. A five to six week backlog remained but this was reducing, supported by earlier commencement of monthly coding, recruitment of five trainee coders, streamlined documentation processes, and weekly monitoring of coder throughput. Automation was being piloted for high-volume, low-complexity activity, with assurance that coding depth and quality was being maintained. • Progress was reported on implementing a digital solution for **52-week wait harm reviews**. The clinical alert and documentation functionality were complete, with remaining work focused on business intelligence reporting capability. Implementation was expected to support real-time harm review completion with minimal additional clinical burden. The Committee welcomed progress following a prolonged delivery timeline. • The Committee welcomed the confirmation of **JAG** re-accreditation and agreed to receive the full report at the meeting in April. • The Committee received a comprehensive update on **Maternity Patient Safety Incident Response Framework** (PSIRF) investigations, including one maternity case meeting national referral criteria and several neonatal medication incidents. Although national investigation was declined for the case referred to MNSI, significant internal learning was being progressed. The Committee noted extensive thematic reviews underway (CTG interpretation, medication safety, escalation and MEWS) and welcomed strengthened staff debrief and psychological support arrangements. • Significant discussion focused on women declining recommended **maternity** care, with recognition of complex cultural, linguistic and inequality factors. The Birth Choices Clinic was highlighted as regional best practice, offering MDT-led, extended consultations. Further thematic analysis was underway to better understand population drivers, with national learning, equality, diversity and inclusion leadership and trauma-informed approaches embedded. • The Committee received the **Maternity Dashboard**, providing an overview of maternity quality, safety, workforce and performance metrics. Improvements were noted in several areas, including achievement of CNST Year 7 and sustained one-to-one care in labour, with no Maternity Outcome Signals System alerts reported for the quarter. Areas requiring continued focus included maternity acuity reporting, early booking access and workforce capacity, with actions underway to strengthen data accuracy, improve early access through Careflow, and address vacancies. • The Committee reviewed the **Perinatal Mortality Review Tool** (PMRT) Quarter 3 report, covering 14 cases, with one case identified where learning was likely to have contributed to the outcome, relating to hypertension management and referral pathways. The Committee noted strong compliance with external reviews (95%), ongoing thematic learning (including escalation, hypertension, interpreter use and neonatal emergency equipment standardisation), and positive parental engagement arrangements. Significant assurance was agreed, reflecting robust governance and learning arrangements.	• No decisions were required to be made.

- The outcome of a review of **foetal growth surveillance systems** following national concerns regarding electronic recording risks was provided. The Trust had been assessed against national recommendations, and no significant concerns had been identified. While transcription risk remained due to non-integrated systems, no themes or harm were identified through incident reporting.
- An update was provided on the emerging requirements for **Maternity Incentive Scheme** (MIS) Year 8, noting changes to the number of safety actions, training compliance milestones and neonatal workforce standards. The Committee noted that MNVP infrastructure requirements had been removed as this sat outside the Trust's control, and further assurance would be brought to the Committee once full national guidance was released. No immediate risks were identified, with preparatory work underway.
- The Committee considered the **Cancer 104-Day Breach Analysis** for Quarter 2, noting an increase in breaches compared with Quarter 1 but improved harm review completion through risk-stratified approaches. Capacity pressures, particularly within urology, were identified as the primary driver. The Committee welcomed the introduction of thematic deep dives to inform targeted improvement actions and agreed significant assurance.
- The Committee received an update on the revised national **Learning from Deaths – People with Learning Disability and Autism** (LeDeR) report and local implications. Assurance was provided on UHNM arrangements, including attendance at all LeDeR reviews, strengthened liaison nurse capacity, development of learning disability pathways and policy, and triangulation with safeguarding and mortality intelligence. Further work was underway to baseline UHNM performance and it was agreed that the organisational response would be considered in due course.

Comments on the Effectiveness of the Meeting	Cross Committee Considerations
• Comments on effectiveness were sought via MS forms	• The challenges associated **with clinical leadership** were noted to continue to remain until the corporate capacity business case had been approved by Finance and Business Performance Committee • A bi-monthly **safe staffing** report has been introduced, triangulating staffing levels with quality indicators. Concerns had since been identified in two areas, linked to acuity and medication-related issues. Care group reviews were underway, and the Committee emphasised the importance of escalating quality-related staffing risks for appropriate assurance.

Summary Agenda

No.	Agenda Item	BAF Mapping			Purpose	No.	Agenda Item	BAF Mapping			Purpose
		BAF No.	Risk	Assurance				BAF No.	Risk	Assurance	
1.	Maternity Quality & Safety Oversight Group Assurance Report (16-02-26)	1	Ext 20	Not applicable	Assurance	7.	Executive Quality & Outcomes Group Highlight Report (12-02-26)	1	Ext 20	Not applicable	Assurance
2.	Maternity & Neonatal PSIRF Investigation Report Q3 25/26	1	Ext 20	Acceptable	Assurance	8.	Access Performance Report Month 10 25/26	1	Ext 20	Partial	Assurance
3.	Maternity Dashboard Q3 25/26	1	Ext 20	Acceptable	Assurance	9.	Cancer 104+ Day Breach Analysis	1	Ext 20	Significant	Assurance
4.	Perinatal Mortality Report Tool Q3 25/26	1	Ext 20	Significant	Assurance	10.	Patient Waiting List Backlog	1	Ext 20	Not applicable	Information
5.	Review of Fetal Growth Surveillance Systems and Associated Safety Risks	1	Ext 20	Significant	Assurance	11.	Quality Performance Report – Month 10 2025/26	1	Ext 20	Partial	Assurance
6.	Maternity (Perinatal) Incentive Scheme year 8 summary	1	Ext 20	Not applicable	Information	12.	Learning from Lives and Deaths – People with Learning Disability and Autistic People (LeDeR) Report 2023			Not applicable	Information

Highlight Report

QUALITY, ACCESS & OUTCOMES COMMITTEE | 2nd April 2026

University Hospitals of North Midlands NHS Trust

Matters of Concern / Key Risks to Escalate	Major Actions Commissioned / Work Underway
• Partial Assurance: **Mortality Assurance Report Q3 2025/26** due to ongoing identified issues with clinical coding and the impact this is having on the Trust's mortality indices; some concern identified around the length of time in 'backlog' and the impact on trends / triggers being reported. • Partial Assurance: **UHNM Readmissions Analysis** due to the higher-than-expected readmission rate and the need for further review of specific specialities and pathways • Partial Assurance: **Access Performance Report** due to the improvements being seen, particularly through the UEC Improvement Programme – although recognised there is still significant work to be undertaken to achieve sustained improvement across all areas. • Partial Assurance: **Population Health Board Assurance Framework** as while progress is positive, full assurance cannot yet be provided given the scale of need in the local population, persistent health inequalities and the need to develop consistent infrastructure. • **Major Trauma Peer Review** identified one serious concern regarding Orthoplastics provision which remains in progress. • **Mental Health Report** identified some concerns regarding absconding patients in high-risk areas, activity relating to dementia / flow and under 18's requiring admission to adult wards – all were being worked through with actions in place.	• Mortality Report to reflect the assurance available through the processes including Medical Examiners service. A deep dive was requested in relation to the coding challenges and the impact this has on other indicators, i.e. readmission. • Future Access Reports will include oversight against the national ambition to eliminate corridor care, as external reporting will also be required – Board oversight will be provided through highlight reports. • Targeted work underway in relation to category 4 pressure ulcer causes, along with increased oversight through the Quality, Access and Outcomes Executive Group. • Clarification of oversight of the Fuller gap analysis through the Pathology Network; to ensure that the governance route is clear and unambiguous. • A review is being undertaken in response to the recent Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE) report. • Progress with implementation of the Modified Early Warning Score will be overseen through regular quality governance arrangements as opposed to maternity governance.

Positive Assurances to Provide	Decisions Made
• Acceptable Assurance: **Endoscopy JAG Accreditation** which demonstrated that the service meets all accreditation standards, with one infrastructure related item pending completion but with strong evidence of progress • Acceptable Assurance: **Major Trauma Peer Review Update** where there has been substantial progress in addressing the findings of the review in 2024 • Acceptable Assurance: **Mortuary Board Assurance (Fuller Report)** as evidence was provided that many of the recommendations were being met, including governance structures, workforce controls and comprehensive review processes. However there remained some actions in progress. • Acceptable Assurance: **Mental Health Report Q3 2025/2026** as strong performance improvements were demonstrated in particular around VP notifications, reduced self-harm incidents, lower detentions and stabilising liaison activity. • Significant Assurance: for **Sepsis in Children's Services Q3/Q4** given the positive utilisation of early warning scoring, low volumes of patients, no evidence sepsis development in acute care, appropriate escalation and documentation. • Significant Assurance: for **PLACE assessment** as the latest findings demonstrated achievement above the national average across all domains for the third consecutive year. • **Duty of Candour** compliance has increased to 100%, and good progress is also being made with previous areas of concern through the Care Excellence Framework.	There we no items requiring decision.

Comments on the Effectiveness of the Meeting	Cross Committee Considerations
• A survey was circulated through the agenda for comments on meeting effectiveness.	• Audit Committee to consider a Clinical Audit of readmissions as part of the Clinical Audit Programme

Summary Agenda

No.	Agenda Item	BAF Mapping			Purpose	No.	Agenda Item	BAF Mapping			Purpose
		BAF No.	Risk	Assurance				BAF No.	Risk	Assurance	
1.	Mortality Assurance Report Q3 25/26	1	Ext 20	Partial	Assurance	7.	Major Trauma Peer Review Update	1	Ext 20	Acceptable	Assurance
2.	UHNM Readmissions Analysis	1	Ext 20	Partial	Assurance	8.	Mortuary - Board Assurance (Fuller Report Phase 2)	1	-	Acceptable	Assurance
3.	Endoscopy JAG Accreditation Report	1	Ext 20	Acceptable	Assurance	9.	Mental Health Report Q3 25/26	1	Ext 20	Acceptable	Assurance
4.	Access Performance Report Month 11 25/26	1	-	Partial	Assurance	10.	Sepsis in Children's Services Q3/Q4 2025/26	1	Ext 20	Significant	Assurance
5.	Population Health Programme Board Assurance Framework	2	High 10	Partial Acceptable	Assurance	11.	UHNM PLACE Results 2025	1/5	High 12	Significant	Assurance
6.	Executive Quality & Outcomes Group Highlight Report (26-03-26)	1	-	Not Applicable	Information	12.	Quality Performance Report – Month 11 2025/26	-	-	-	Information

University Hospitals of North Midlands NHS Trust

Integrated Performance Report

Month 11 Performance

2025/26

Kind Excellent Together

University Hospitals of North Midlands NHS Trust

Contents

Statistical Process Control

University Hospitals of North Midlands NHS Trust

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

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

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

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

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

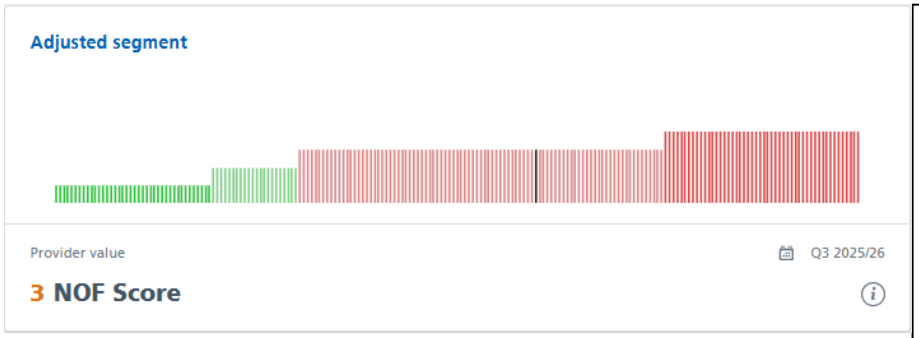
Where icons indicate an area needs attention, you could give more detail by attaching the full SPC chart and narrative describing the context, issues and actions in an appendix.

Oversight Framework Summary

University Hospitals of North Midlands NHS Trust

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

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



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

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

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

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Effectiveness and Experience

University Hospitals of North Midlands NHS Trust

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

Patient experience	Data period	Provider value	Peer average	National value	National value method	Chart
CQC inpatient survey satisfaction rate score	Q3 2025/26	2	NOF Score	Provider value	
Summary Hospital-level Mortality Indicator score	Q3 2025/26	3	NOF Score	Provider value	

Effective flow and discharge	Data period	Provider value	Peer average	National value	National value method	Chart
Average number of days from discharge ready date to actual discharge date (including zero days) score	Q3 2025/26	1.48	NOF Score	Provider value	
Average number of days from discharge ready date to actual discharge date (including zero days)	Dec 2025	0.31	0.80	0.83	Provider median	

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

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

Patient Safety

University Hospitals of North Midlands NHS Trust

Patient Safety Domain Score	Data period	Provider value		Chart
Patient safety domain segment	Q3 2025/26	3	NOF Score	
Patient safety domain score	Q3 2025/26	2.67	NOF Score	

Patient safety Please note that the MRSA, C-Difficile and E-Coli scores each carry a one third weighting	Data period	Provider value	Peer average	National value	National value method	Chart
NHS Staff Survey - raising concerns sub-score score			Q3 2025/26 2.71	NOF Score	Provider value	
NHS Staff survey - raising concerns sub-score	2024	6.37	6.32	6.42	Provider median	
Number of MRSA bacteraemia cases score			Q3 2025/26 3.79	NOF Score	Provider value	
Number of MRSA bacteraemia cases (12 months)	To Dec 2025	9.00	7.00	3.00	Provider median	
Proportion of C. difficile infections score			Q3 2025/26 3.06	NOF Score	Provider value	
Proportion of C. difficile infections versus threshold (12 months)	To Dec 2025	1.24	1.10	1.12	Provider median	
Proportion of E. coli bacteraemia score			Q3 2025/26 1	NOF Score	Provider value	
Proportion of E. coli bacteraemia versus threshold (12 months)	To Dec 2025	0.97	1.17	1.17	Provider median	

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

Quality & Access | Overview

Provide safe, effective and caring services

University Hospitals of North Midlands NHS Trust

Overview from the Chief Nurse and Chief Medical Officer

How are we doing against our trajectories and expected standards?

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

We have performed above target across a range of metrics including medication incidents % with moderate harm, patient falls with harm per 1000 bed days, pressure ulcers developed under UHNM, pressure ulcer with lapses in care (although we will focus on reducing this as part of the work to reduce avoidable harm), e-coli, induction of labour and midwifery triage within 15 mins.

There have been 17 Calls for Concern (Martha's Rule) during February 2026: Of the 17 cases referred in February: 9 qualified for a review, all with documented advice only.

February 2026 reported 86 Mixed sex accommodation breaches which is the lowest value since reporting started in May 2024.

We have received the MBRRACE- UK mortality report for 2024 which highlights that the stabilised and adjusted neonatal rate has been an outlier of more than 5% for the last 3 years. Data is currently being considered and an update will be provided to the Quality, Access and Outcomes Committee in due course.

We have achieved 100% for both verbal and written Duty of Candour during February 2026 following introduction of refined reporting and escalation processes across the Care Groups supported by the Care Group Patient Safety Managers.

What is driving this?

We failed to meet the required target for a number of metrics including VTE assessments (although this is improving), C-Diff (16.7% over the ytd upper limit), complaint response time (however this is continually improving), timely observations, single sex accommodation breaches, Sepsis IVAB across ED and maternity (relates to one patient), FFT in ED and maternity, duty of candour verbal and written, and HSMR/SHMI.

We have seen a number of Category 4 pressures ulcers and focused work is underway to ensure root causes of these are clear and action plans prevent reoccurrence of these factors.

VTE reporting is still via Tendable but work is still underway to report via ePMA.

The current performance is at the level of limited assurance.

Quality& Access | Overview

Provide safe, effective and caring services

University Hospitals of North Midlands NHS Trust

Overview from the Chief Nurse and Chief Medical Officer

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

Intensive and specific corporate support to the two Bronze CEF areas continues and the adapted support to CEF Silver areas has now commenced. Both of these initiatives are supporting our ambition to achieve Gold CEF as a minimum across all areas. There is already evidence of improvements in these areas and we now only have one area rated Bronze (AMU RSUH) as AMU County has now achieved Silver. Working group now set up to improve CEF to Platinum and CQC rating across County, Childrens, West Building – Maternity will join this work Q1/2.

Working group now set up to ensure focus on reducing avoidable harm due to HAI, falls, pressure damage, malnutrition and patient deterioration (timely observations). Timely observations had been on a downward trajectory since July 25 and has now seen its first increase in performance

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

Our Patient Council has developed their TOR and are currently recruiting to their membership

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

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. Care Groups focused on remedial actions where appropriate

HSMR Continues to be higher than expected but is showing improvements since the commencement of 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 have been provided at Executive level and Quality, Access & Outcomes Committee on uncoded activity and the different submission deadlines (Flex, Freeze and Post Reconciliation). A more detailed report is now being produced to review and monitor submission figures and progress with improvement plans for recruitment of trainees and contract coders.

What can we expect in future reports?

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

The IP review across UEC and wards will be reported to the next Committee

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

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

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)	Dec 25	134.4	100.0			111.2	105.8	116.6
PSI per 1000 bed days	Feb 26	48	51			53	45	61
PSI with moderate harm or above per 1000 bed da	Feb 26	0.5	0.6			0.7	0.3	1.0
Patient Falls per 1000 bed days	Feb 26	4.3	-			4.6	3.7	5.6
Patient falls with harm per 1000 bed days	Feb 26	1.4	1.5			1.7	1.1	2.2
Medication incidents per 1000 bed days	Feb 26	4.6	6.0			6.2	4.4	7.9
Medication incidents with moderate harm or above	Feb 26	1%	5%			2%	-1%	4%
Never Events reported	Feb 26	1	0			1	-2	3
PSIIs instigated	Feb 26	2	0			2	-4	8
Duty of Candour verbal	Feb 26	100%	100%			93%	74%	111%
Duty of Candour written (letter sent within 10 worki	Feb 26	100%	100%			80%	44%	115%
Pressure Ulcers developed at uhnm per 1000 bed	Feb 26	1.4	1.6			1.7	0.8	2.6
Pressure ulcers with lapses in care per 1000 bed c	Feb 26	0.3	-			0.5	0.1	0.9
Trust Apportioned Infections	Feb 26	45	-			50	29	71
Avoidable cases of MRSA Bacteraemia	Feb 26	0	0			0	-1	1
HAI and COHA cases of C.Diff toxin	Feb 26	11	12			14	6	22
HAI E.Coli Bacteraemia Cases	Feb 26	18	19			20	8	32
Sepsis Screening - Inpatients	Feb 26	100%	90%			96%	87%	105%
Sepsis IVAB - Inpatients	Feb 26	100%	90%			99%	96%	102%
Sepsis Screening - ED	Feb 26	91%	90%			92%	85%	99%
Sepsis IVAB - ED	Feb 26	88%	90%			84%	63%	105%
Sepsis Screening - Maternity	Feb 26	92%	90%			98%	93%	103%
Sepsis IVAB - Maternity	Feb 26	83%	90%			97%	91%	103%
Sepsis Screening - Childrens	Feb 26	89%	90%			90%	73%	107%
Sepsis IVAB - Childrens	Aug 25	100%	90%			79%	34%	123%

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
VTE Risk assessment Rate (timely) - data from Tenda	Feb 26	93%	95%			87%	83%	92%
Hospital Associated Thrombosis Rate	Feb 26	1.1	-			1.0	0.2	1.7
Care hours per patient day (safe staffing)	Feb 26	8.9	-			9.2	9.0	9.5
Timely Observations	Feb 26	79%	90%			80%	78%	82%
UHNM Inpatients - Friends & Family Test (% recomm	Feb 26	96%	95%			96%	94%	98%
UHNM A&E - Friends & Family Test (% recommendir	Feb 26	70%	85%			69%	59%	80%
UHNM Maternity - Friends & Family Test (% recomme	Feb 26	89%	95%			86%	72%	100%
Complaints - % closed within 25/40/60 working day tar	Dec 25	19%	-			26%	1%	50%
Written complaints rate per 10,000 spells	Feb 26	50	-			33	19	47
Mixed Sex Accommodation Breaches Reported	Feb 26	86	-			103	69	137
Maternity Induction of Labour - Breach performance	Feb 26	98%	95%			98%	96%	101%
Maternity Assessment Unit Triage within 15 minutes	Feb 26	74%	85%			91%	83%	99%
3rd/4th degree tears	Feb 26	7	-			9	0	17
Neonatal deaths	Feb 26	2	-			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 exceed the target and the variability icon is

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

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

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

Related Strategy and Board Assurance Framework (BAF)

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

Quality & Access | [PSIs per 1000 bed days]

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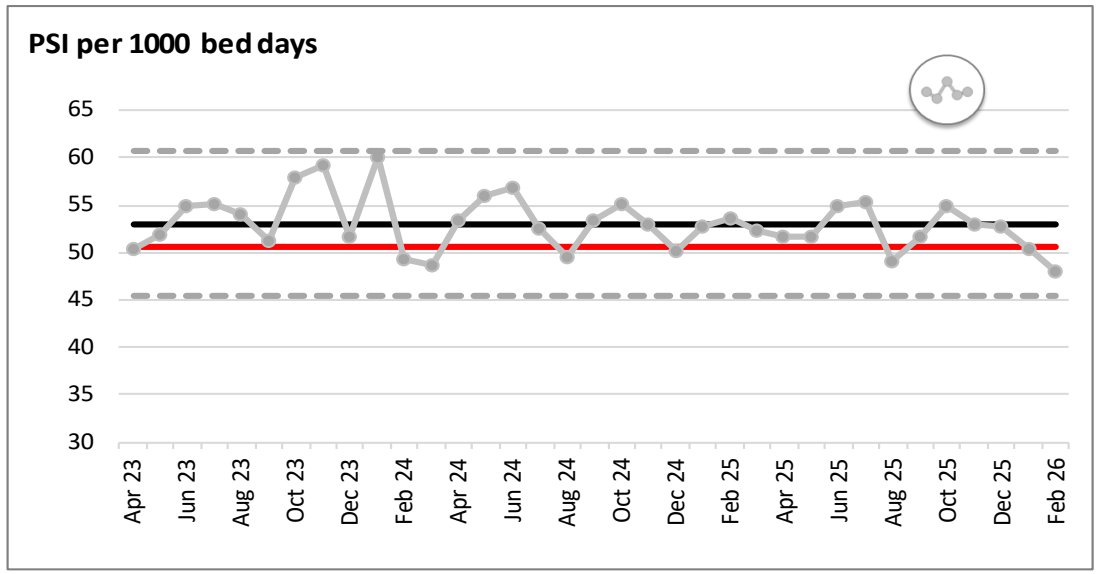
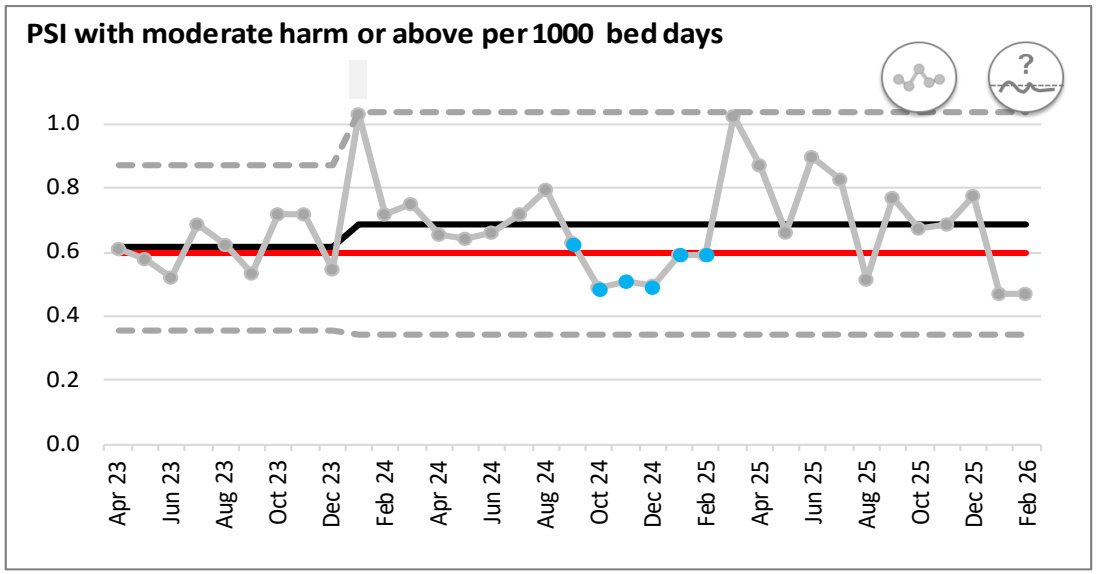
University Hospitals of North Midlands NHS Trust





What is driving this performance?

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

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

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

What are we doing about it?

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

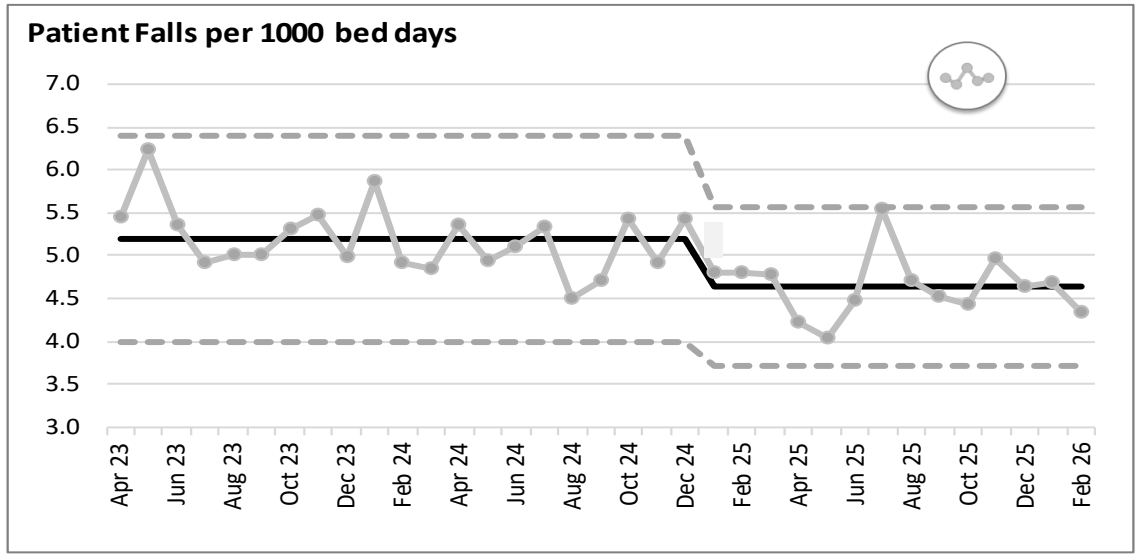
We are continuing to complete thematic reviews to ensure wider learning is captured and actions to improve the quality and safety of care delivered are in place. These are Trust's Patient Safety Group and Quality, Access & Outcomes Group.

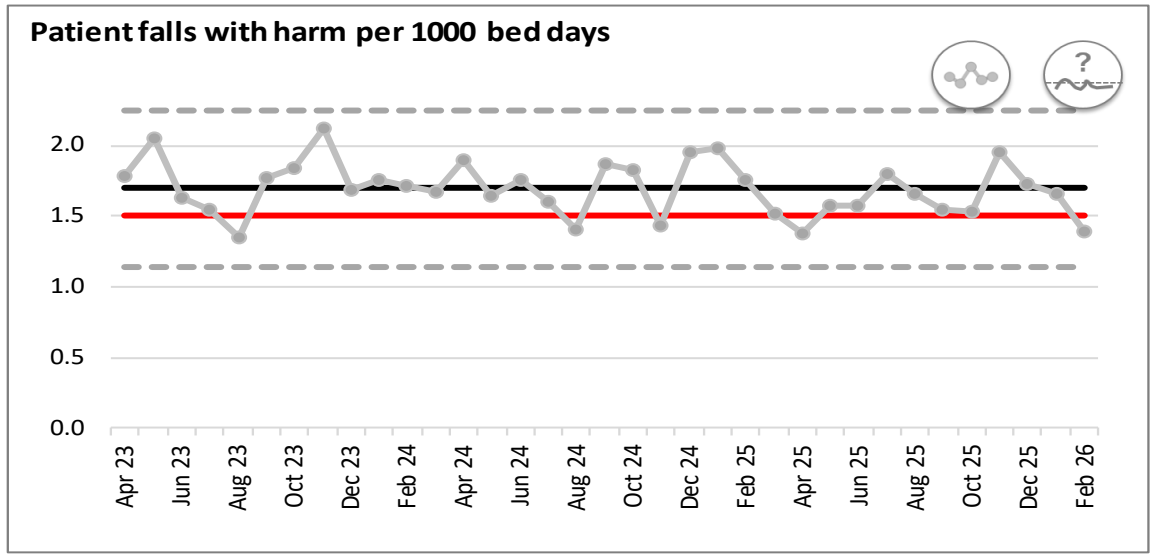
To utilise LFPSE data published to assess/benchmark our reporting and outcomes as soon as this is available. Noted that 99% of all NHS providers are now utilising LFPSE.

Quality & Access | [Patient Falls]

Provide safe, effective and caring services

University Hospitals of North Midlands NHS Trust





What is driving this performance?

The average rate of reported patient falls was within the usual range in February 2026. The rate of patient falls resulting in harm has remained consistent since June 2023. Top reporters in January 2026: Stoke AMU – 17 falls, Stoke ED – 15 falls, AMRA – 8 falls, Ward 113 – 7 falls, FEAU – 7 falls. None of these numbers is significantly higher than usual.

1 fall resulting in a serious injury was reported in February, on the following ward: ARTU (further L4# and L1, L3).

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?

54 falls occurred on the top reporting wards, no patient suffered harm.

AMU, AMRA and FEAU all had patients that were multiple fallers. These patients were reviewed to identify if everything was in place to prevent further falls.

Pharmacy have commenced reviewing medication (Falls Risk Increasing Drug) on those patients that have suffered multiple falls.

4 out of the 5 areas are admission portals. Guidance recommends that initial risk assessments are to be completed within 6 hours of admission. Patients that are deemed suitable to be treated in alternative areas to maintain admission avoidance will be directed from the admission portals. The patients admitted to the portals may have high NEWS scores, delirium and therefore the patient's mobility may have declined. Action to discuss this at the next falls steering group to identify initial recommendations if the falls risk assessments cannot be completed immediately.

Ward visits, discussions and audits continue.

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

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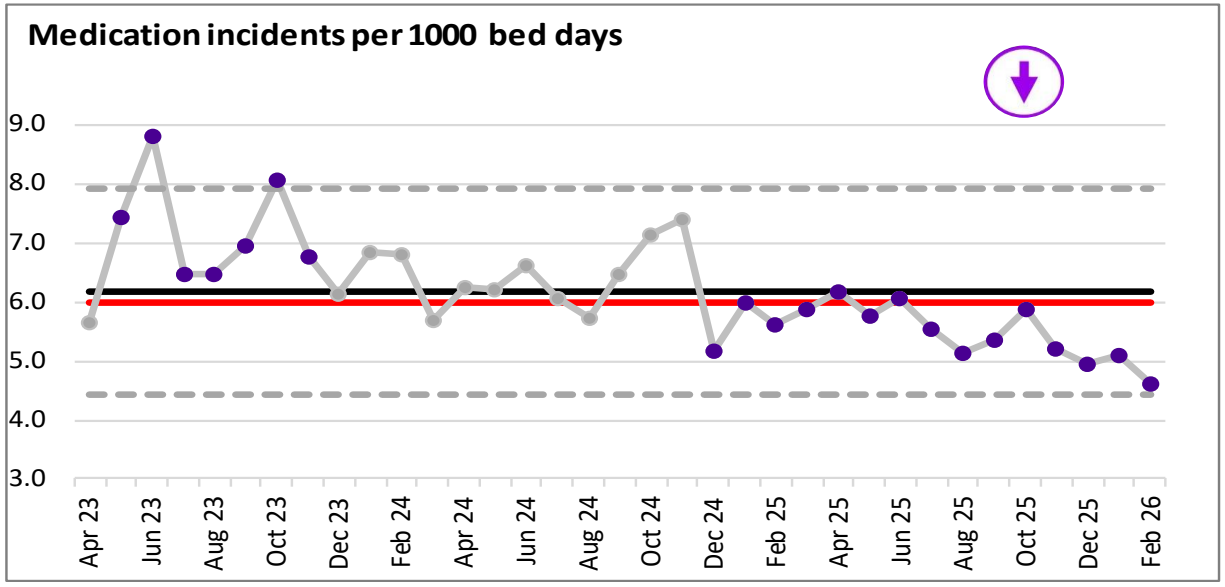
University Hospitals of North Midlands NHS Trust



What is driving this performance?

The rate of reported medication-related incidents appears to have been on a downward trajectory since 2023.

NB: The rate was significantly lower before 2023 – average 5.0 incidents per 1000 bed days, so the latest rates are just nearing the previous normal range.

However, this is of concern as it provides less opportunity to learn from low and no-harm incidents.

What are we doing about it?

1. Bi-annual Ward Controlled Drug audit report (data collection period May-Aug '25) presented at Trust MOSG Dec '25. Theatres/Endoscopy/Imaging Controlled Drug audit report in production. Q3 Controlled Drugs report produced for the Local Intelligence Network (LIN).
2. Annual Ward Storage Audits completed Sept '25, report produced, to go to Trust MOSG.
3. Significant effort being given to the update of Trust Policies MM03 (Storage, Prescription, Supply & Administration of Medicines) & MM06 (Prescribing, Storage, Supply and Administration of Controlled Drugs)
4. Review underway around the trust wide governance of FP10s (MM03 SOP to be updated)
5. MHRA Safety Alerts circulated trust wide e.g. risks of GLP-1/GIP agonists, and Gabapentinoids/benzodiazepines/Z drugs.
6. UHNM Safety Alerts & Learning Alerts produced & circulated in response to specific incidents e.g. risk of dosing errors due to misinterpretation of EPMA, reminder with EPMA to cross-check digital prescription with patient details at the bedside.
7. Now EPMA is embedded at ward level, data is being explored to provide future assurance around supply vs administration of controlled drugs, in particular schedule 4 & 5.
8. Compared to other Trusts in the West Midlands, UHNM submit a high volume of Yellow Card reports (positive).

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

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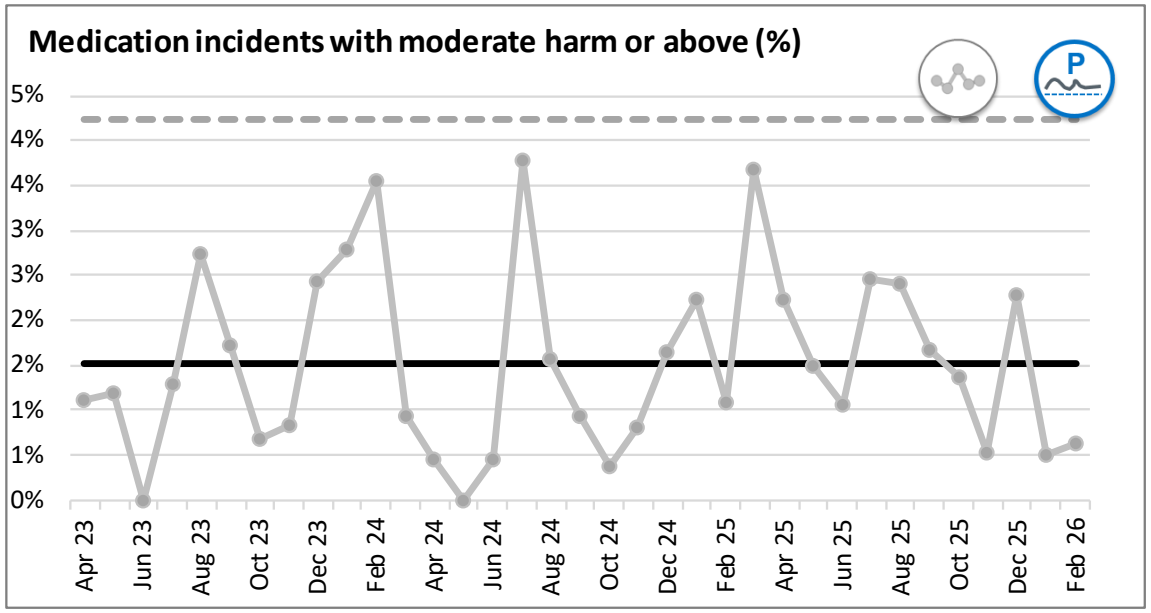


What is driving this performance?

In February 2026 there was 1 incident reported categorised as moderate harm – await PSIRF investigation for ID 394112; the table also reflects a moderate harm incident from January, but reported in February: a sepsis thematic review is underway in the for ID 393405.

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

What are we doing about it?

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

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

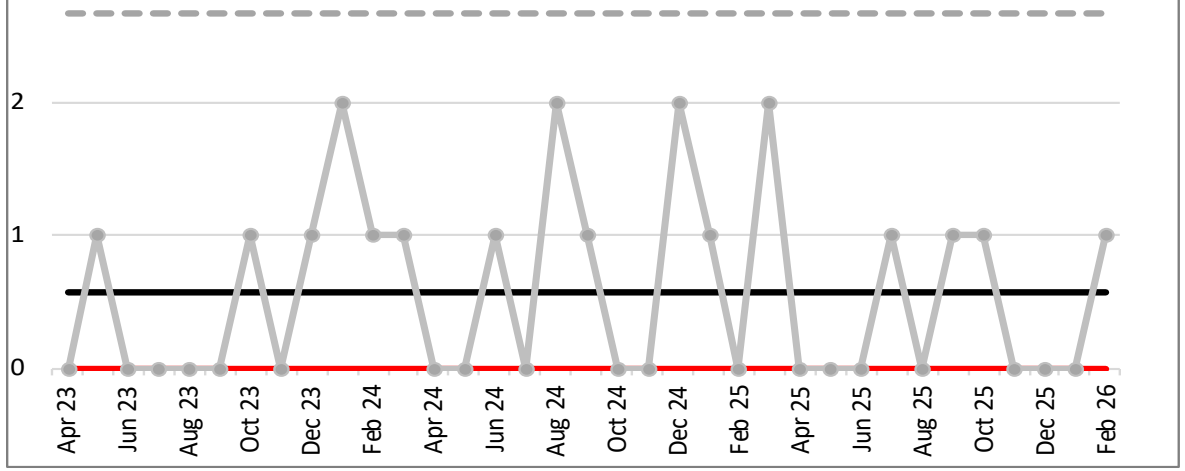
ID	Incident Date	Location	Subcategory	Description	Actions
394112	12/02/2026	Specialised Medicine CBU	Delay in supplying medication.	Patient had not been started on adjuvant chemotherapy; due of the delay they were unable to progress with treatment as more than 3 months had passed and the benefits of adjuvant chemotherapy was significantly reduced.	.
393405	08/01/2026 (reported Feb)	Urgent & Acute Care CBU	Failure/delay to treat	Written in retrospect following audit. Patient triggered for sepsis on 08/01/26 at 12:41. NEWS2 score of 5. Red flag present. Patient died 2 days later (full details on datix)	

Quality & Access | [Never Events & PSIIs]

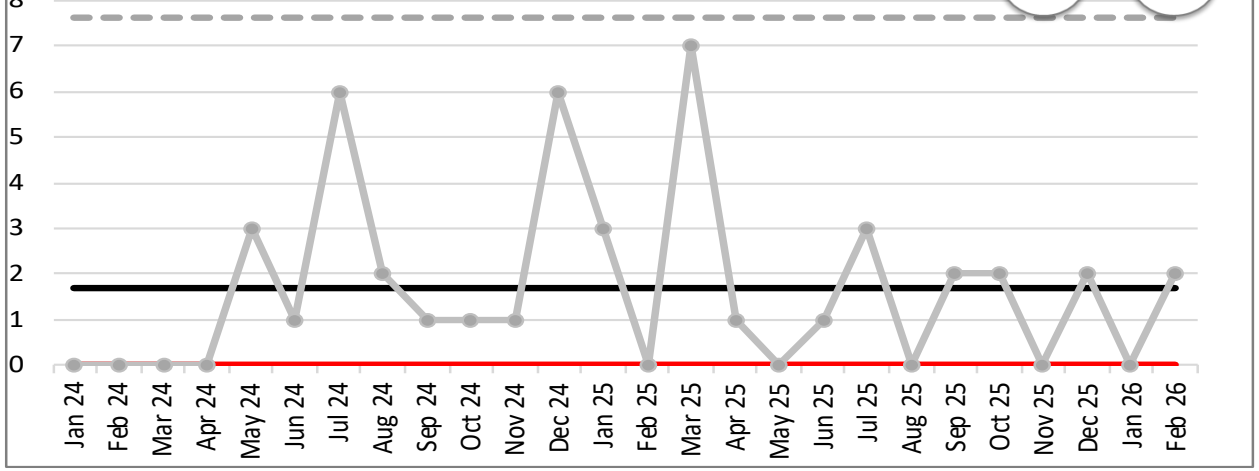
Provide safe, effective and caring services

University Hospitals of North Midlands NHS Trust

Never Events reported



PSIIs instigated



What is driving this performance?

1 never event was identified during February 2026..

2 new PSII were commissioned during February 2026.

What are we doing about it?

Never Event: Misplaced NG Tube: NG added to the risk register and a working group commenced to progress policy and training competency framework.

Case 1: Limited skill on site at County when patients are deteriorating and presenting with airway compromise and needing front of neck access. Added to the risk register and deteriorating patient working group commenced to review themes, escalation processes, policy and any additional workforce requirements.
Case 2: Neonatal – tachycardia detected via ultrasound, CAT 1 EMCS called and infant delivered within 25 minutes of detection. Case Referred to MNSI as Infant cooled

Quality & Access | [Duty of Candour]

Provide safe, effective and caring services

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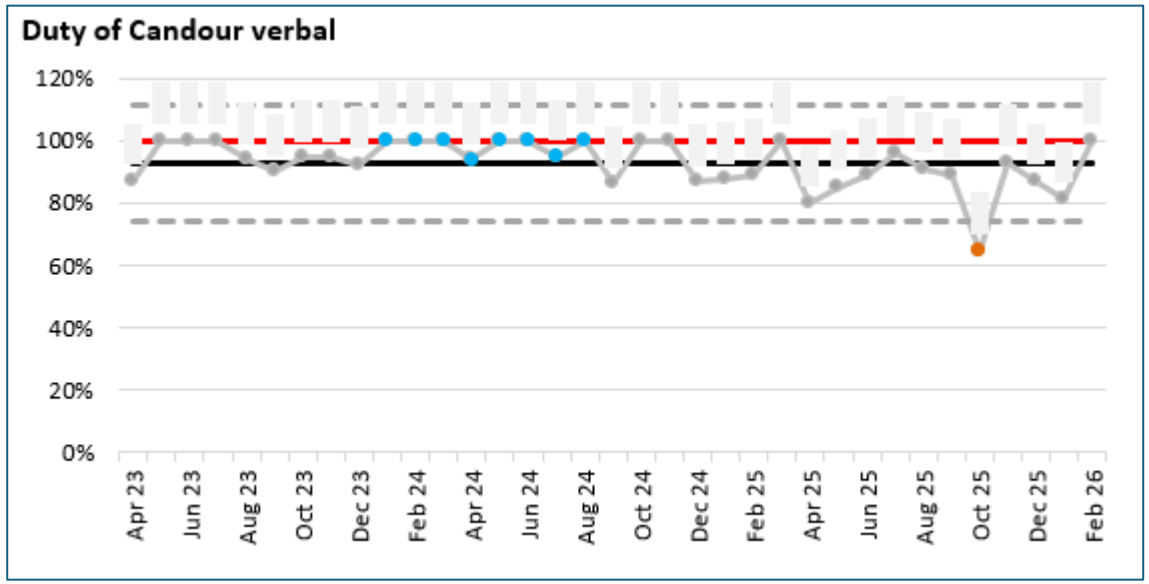
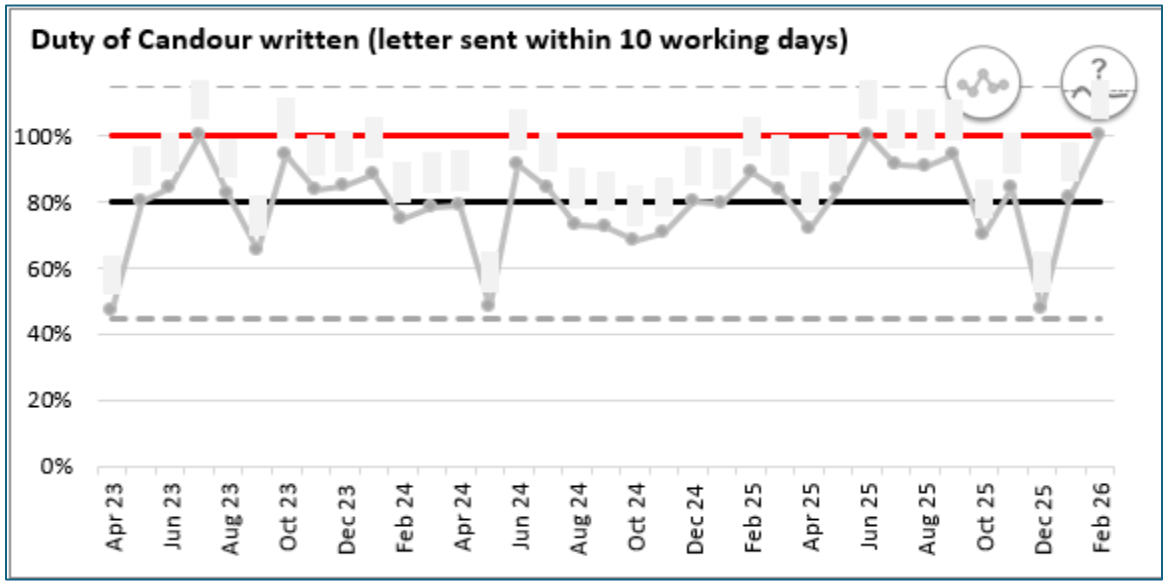




What is driving this performance?

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

15 out of 15 incidents that formally triggered duty of candour in February met compliance for both verbal and written (100).

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

What are we doing about it?

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

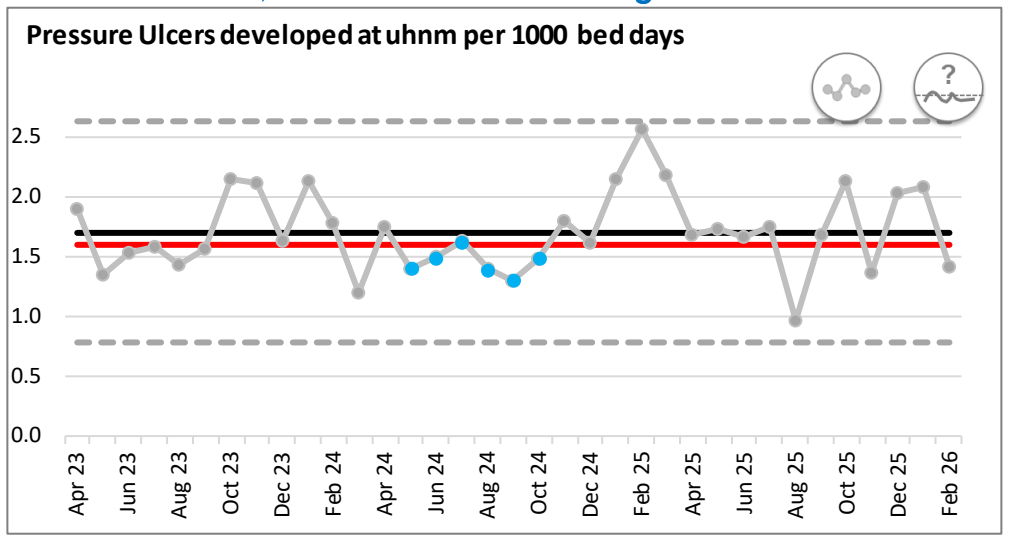
Teams are reminded that evidence of verbal Duty of Candour must be recorded in Datix and notes to show that conversations have been completed. A new tab has been implemented for use within datix to capture validation date, which has improved compliance when harm is identified as meeting the need to start Duty of Candour. In addition, a SOP has been developed to support monitoring and escalation of compliance.

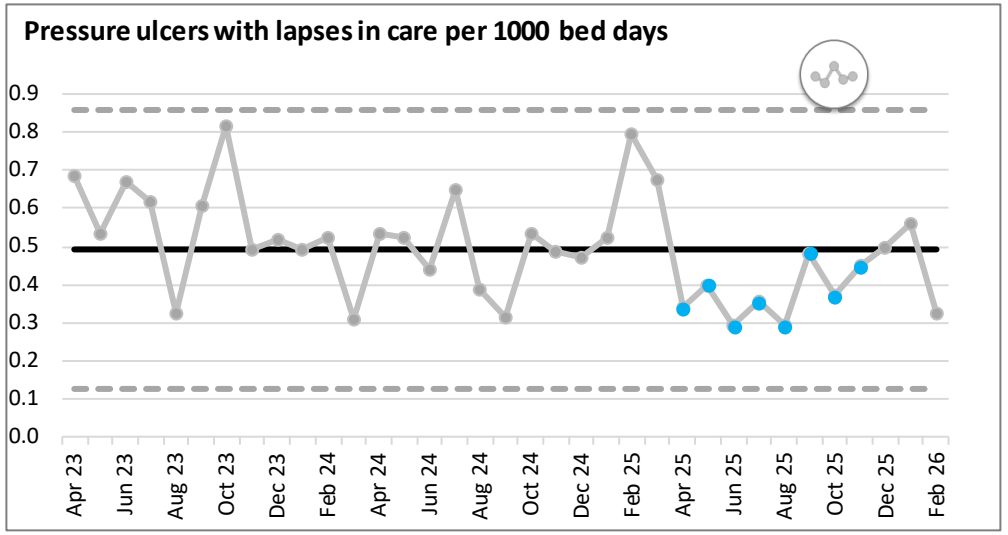
A structured note on iPortal has been agreed to further support this workstream. Audits are now being undertaken quarterly.

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

Provide safe, effective and caring services

University Hospitals of North Midlands NHS Trust





Type of Lapses Feb 2026	Total
Management of repositioning	14
Management of heel offloading	1
Management of device	1

What is driving this performance?

The rate of pressure ulcers reported as developing under UHNM care was within the usual range in February 2026. Numbers within each category of damage were within their usual ranges.

The rate of pressure ulcers with lapses in care identified was within the usual range in February 2026, based on cases reviewed as of the 3rd of the month. The winter peaks appear to be related to UEC and especially RSUH ED especially in relation to repositioning and heel offloading.

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

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

6 urethral splits were reported in February, 3 of which were noted to have lapses in care (1 TBC).

What are we doing about it?

Decisions made steering group in January 2026 (No steering group in February)
An update to discuss the ESR package with OD and Training
To discuss with nursebank team options available for bank staff regarding learning and education
Further pressure prevention and categorisation training dates have been released
Areas who have reported multiple HAPU within a singular month are invited to steering group to provide assurance for improvements
Prompt cards being printed for staff to include categorisation, pressure ulcer prevention and pathways
Champions programme to re-commence March 2026
The Quality and Safety team are to commence 'Ward for the week' from February, providing auditing and education
Industry are support with on-site education for products used
Thematic reviews to be completed for hospital acquired pressure ulcers following approval of SOP. This will include gaining staff feedback.
ED Stoke have had further Trezzo mattresses ordered, with the aim to have the entire department with Treo mattresses by the end of February. Data being review now that the mattresses have been in place for 6 months
The catheter summit aims to reduce unnecessary catheterisation in the Trust through agreed actions.

Quality & Access | [Trust Apportioned Infections & MRSA Bacteraemia

Provide safe, effective and caring services

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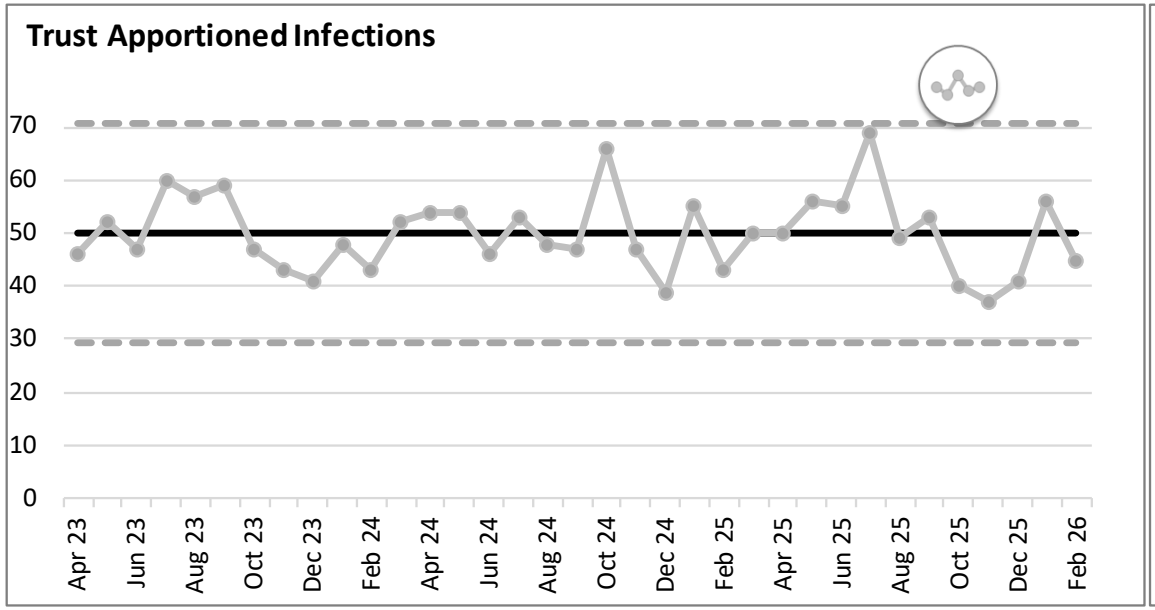

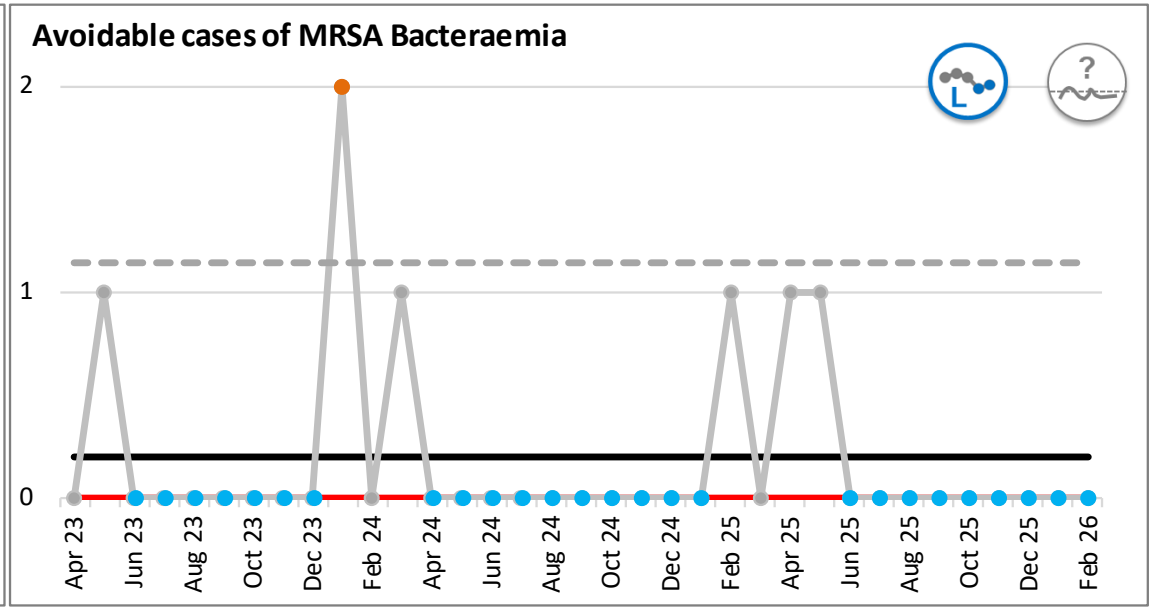

What is driving this performance?

Trust Apportioned Infections
Numbers remain within the usual range.

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

What are we doing about it?

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

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

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

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

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

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

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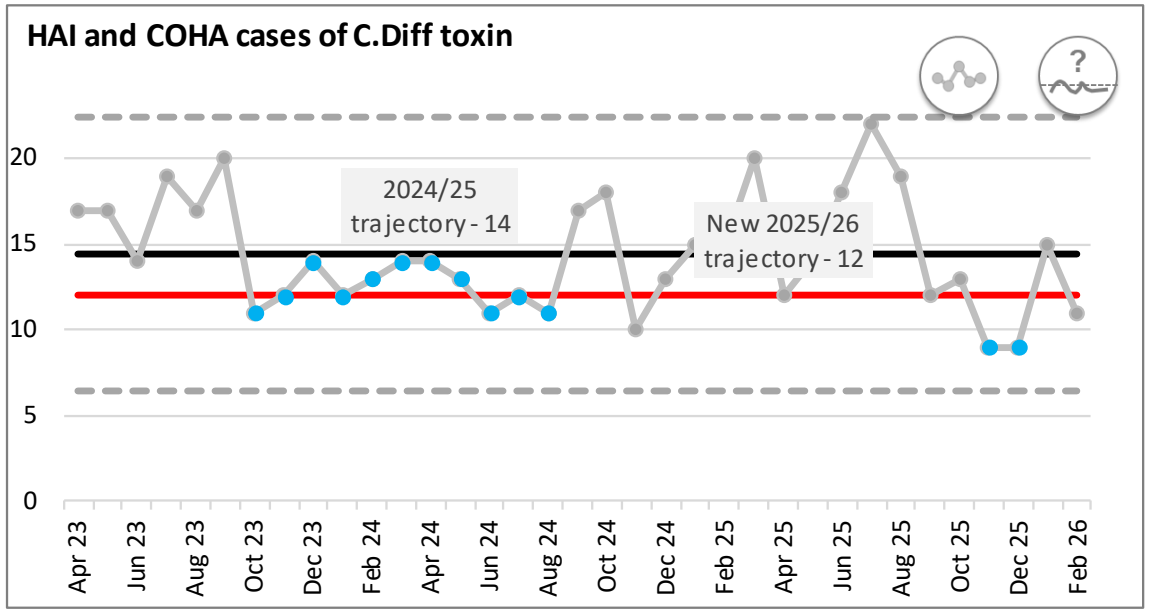

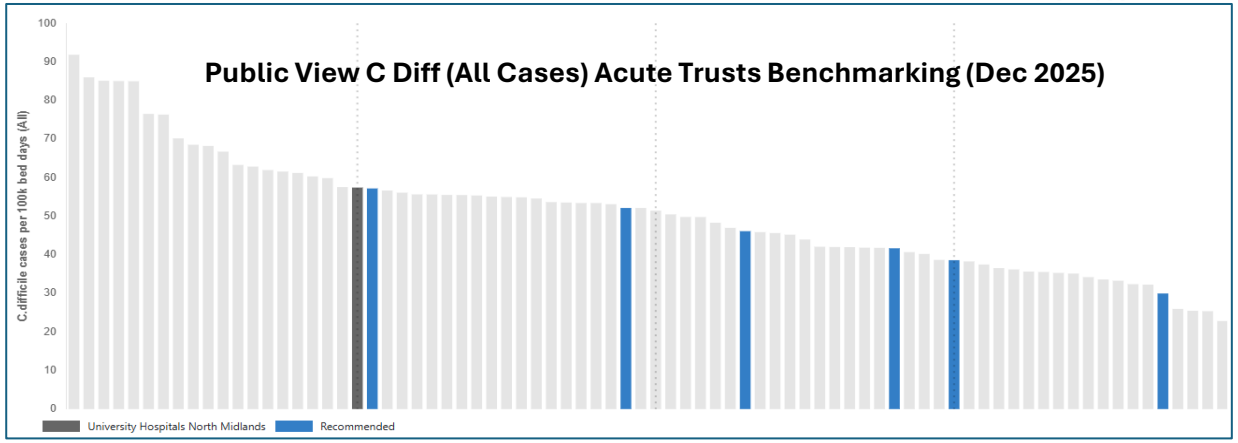

What is driving this performance?

The monthly number of C-Diff cases was within the usual range in February 2026. C diff has been declared a National Incident by the UKHSA due to the increased number of cases throughout England; work is ongoing to try to understand the reasons behind this.

There have been 11 reported C diff cases in February 2026 - 9 x HAI and 2 x COHA
There has been one ward with a period of increased incidence reported in February with 2 HAI cases at Royal Stoke.

The 25/26 objective for C-Diff is 144 cases or less. This was released in June 2025.
As at February 26 we have had 154 Trust apportioned cases (99 * HAI and 55 * COHA) versus a year to date upper limit of 132 (16.7% over the ytd upper limit).

What are we doing about it?

- Routine ribotyping of samples continues for samples from areas where we have periods of increased incidence only
- CURB -95 score added to CAP antimicrobial Microguide (Eolas)
- Antimicrobial working group to remind clinical areas to send urine samples when UTI is suspected and ensure appropriate choice of antibiotic for treatment of UTI
- Additional oversight of C-Diff cases is being implemented where there is potential learning in terms of antibiotic use. ePMA will further support for antibiotic auditing.
- Big bed clean commenced from 9th July 2025 & repeated in Oct 2025 IP week
- PSIRF process and monthly themes report
- Weekly AMS presence at County to support antimicrobial prescribing

Commode cleaning day completed January 2025 and October 2025. Aim for twice yearly.

- The existing Pneumonia guidelines were reviewed, revised and ratified through ASG and launched to prescribers in early January 2025. Key changes involve the reduction in the use of Co-Amoxiclav in CAP, with a focus on using the narrower spectrum oral antimicrobials where possible or a prompt IV to oral switch
- There has been a deterioration in the number of late sampling for patients admitted with diarrhoea resulting in classification as hospital onset.
- There has been several repeat sampling of known C diff cases outside the 28-day period resulting in a patient being included multiple times, education is provided by IP

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

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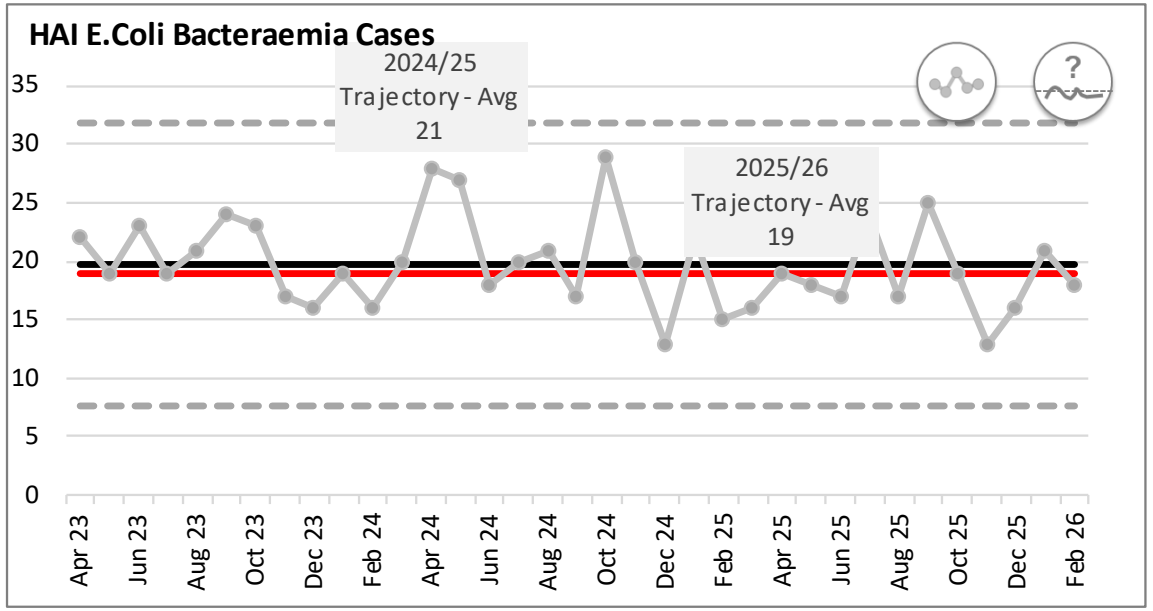

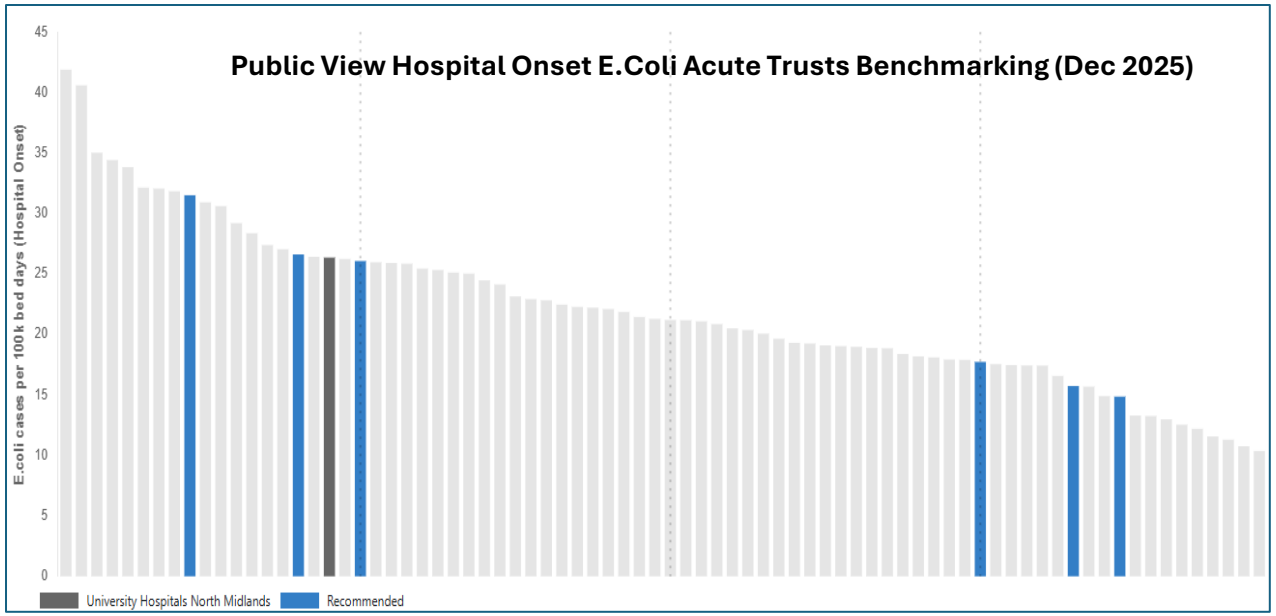

What is driving this performance?

The average monthly number of E.coli cases has stood at 20 since 2022, just outside the 2025-6 target, and the number of cases identified in February 2026 was within the usual range.

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

As at February 2026 we have had 208 Trust apportioned cases (106 * HAI and 102 * COHA) versus a year to date upper limit of 211 (1.4% under the upper limit).

What are we doing about it?

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

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

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

Quality & Access | [Sepsis – Adult Inpatient]

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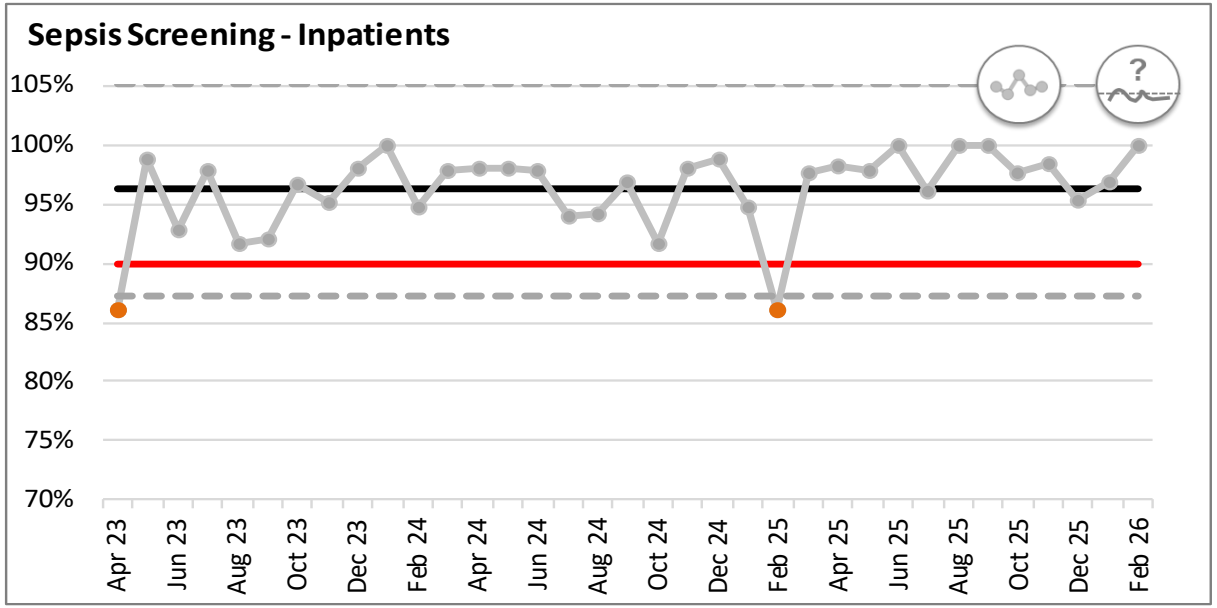

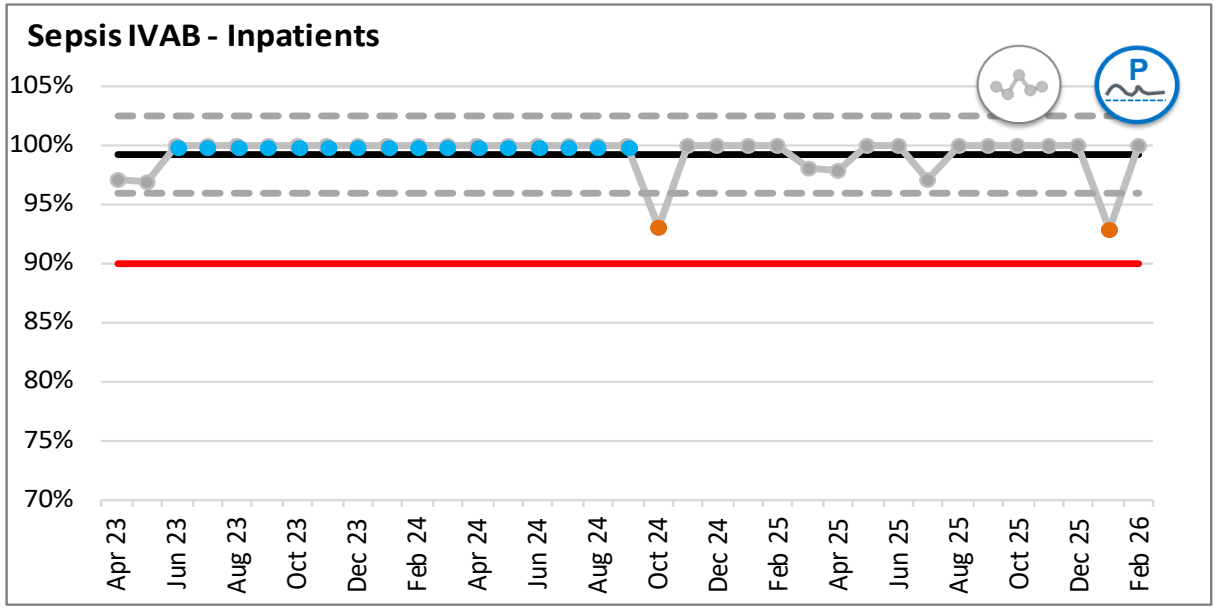

What is driving this performance?

Inpatient screening compliance was within the usual range in February 2026.
Average compliance for IVAB administration within one hour appears to far exceed the target, though the uncertainty in these rates is likely to be significant due to the difficulty in finding the small number of patients requiring new antibiotics due to sepsis.

A total of 141 cases were reviewed in February; there were 0 missed screens. 96 cases were identified as red flag sepsis, with 52 receiving an alternative diagnosis. Leaving 44 patients of which 39 were already on antibiotics and 5 were identified as new sepsis. - all these patients received IVAB within the hour.

What are we doing about it?

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

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

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

Quality & Access | [Sepsis – Emergency Portals]

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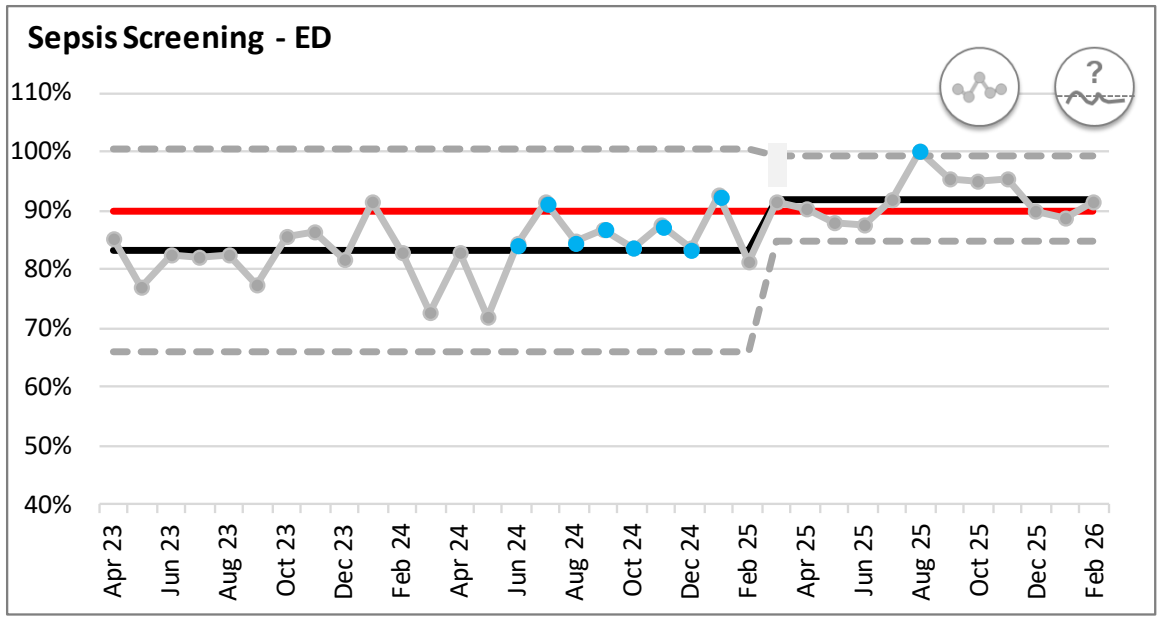

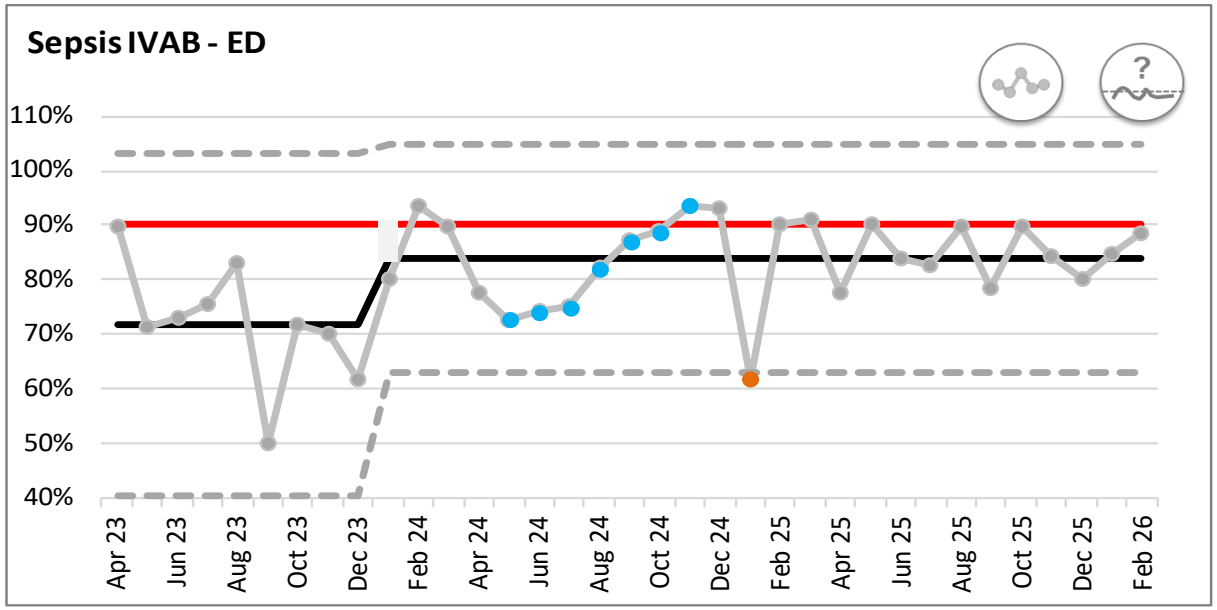

What is driving this performance?

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

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

In February, 162 cases were reviewed with 14 missed sepsis screens. 130 cases were identified as red flag sepsis - 78 had an alternative diagnosis, 23 were already on IV antibiotics. Leaving 29 newly identified sepsis patients. 5 of these patients received IV antibiotics outside the target 1 hour window.

What are we doing about it?

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

Quality & Access | [Sepsis – Maternity]

Provide safe, effective and caring services

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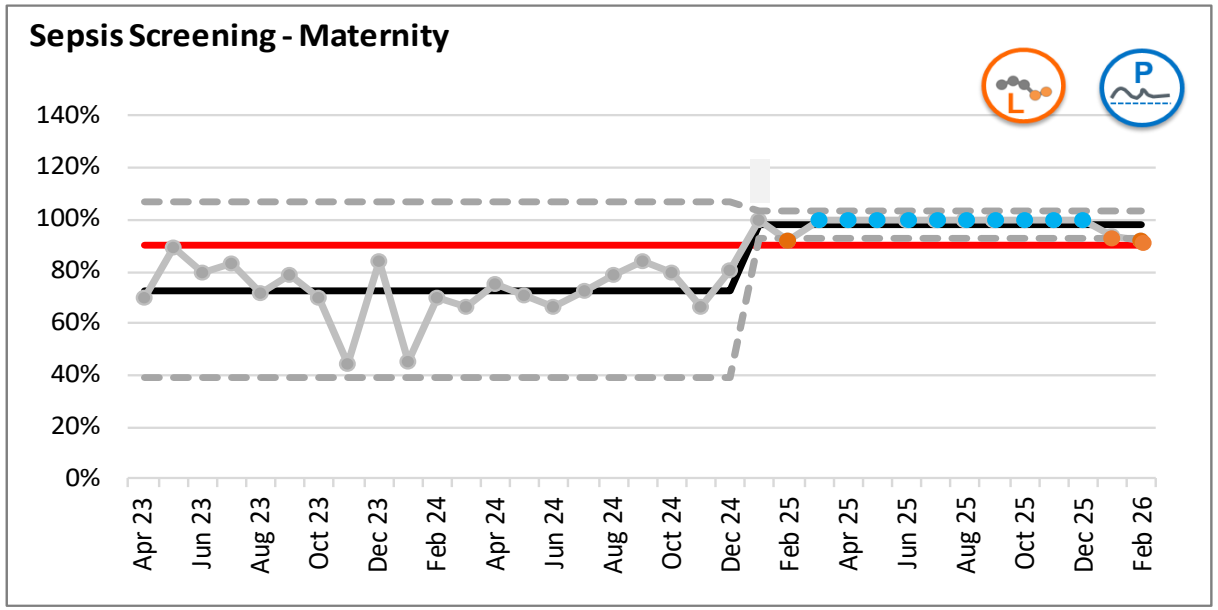

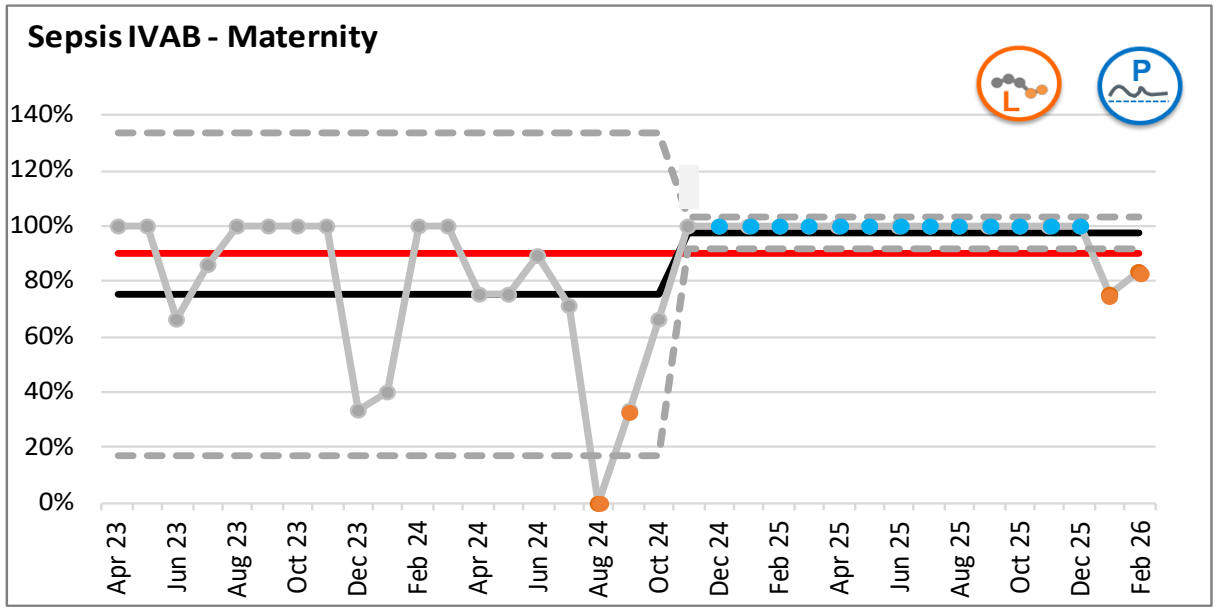

What is driving this performance?

Audits show screening compliance in Maternity meeting the target since Jan-25. Average compliance with administering IVAB within one hour also exceeds the target however, IVAB compliance is assessed using a limited number of cases. Screening and IVAB compliance for January & February appear significantly lower but in each instance this is due to just one non compliant case.

A total of 6 cases were audited from the emergency portal MAU in February and there was 1 missed screen. 6 cases were reviewed for inpatients, and there were no missed sepsis screens. For emergency portals, there was 2 newly identified sepsis patients and one patient received IVAB outside the one-hour window.

What are we doing about it?

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

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

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

Quality & Access | [Sepsis – Children]

Provide safe, effective and caring services

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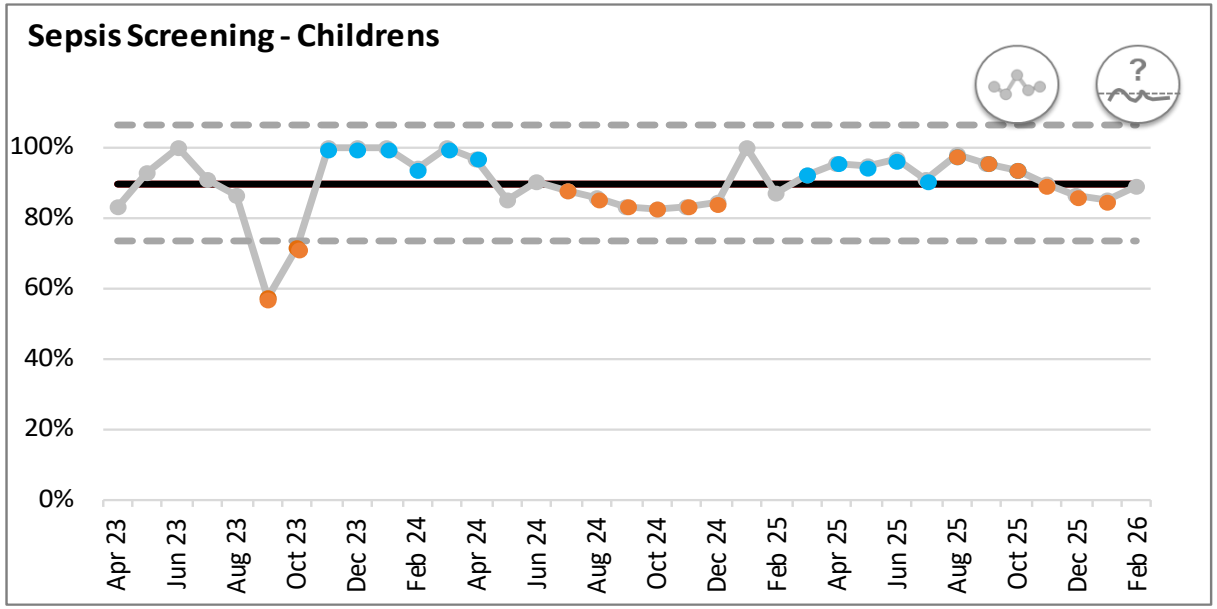

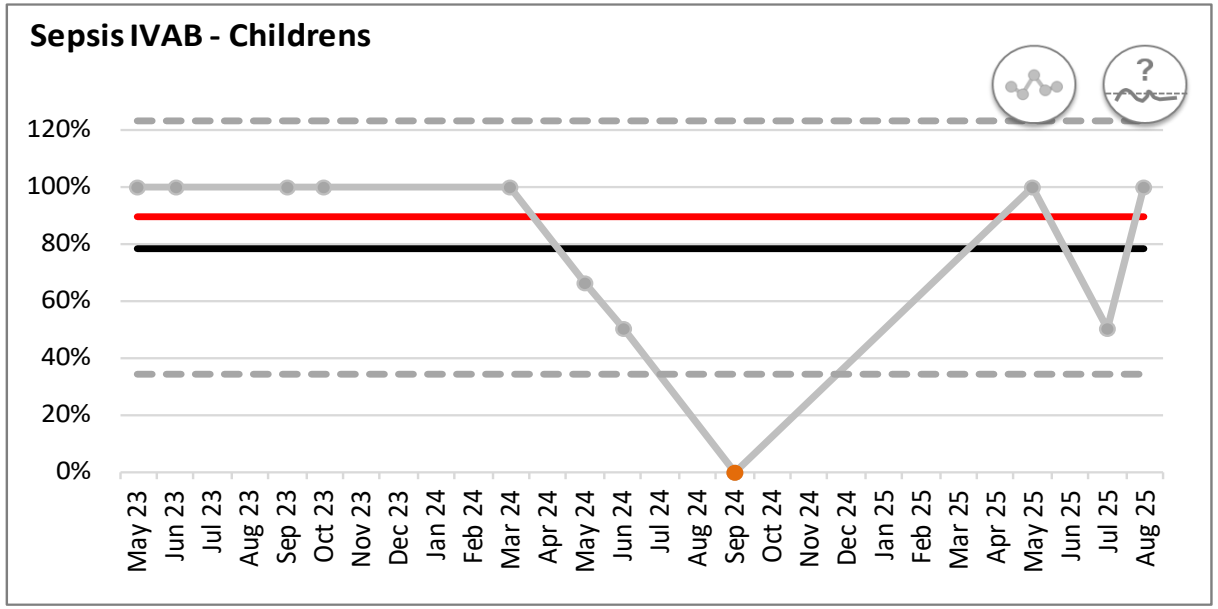

What is driving this performance?

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

There were 32 cases audited for emergency portals with one missed screens in February. 14 cases were audited for inpatients with 5 missed sepsis screens.

No true red flag sepsis have been identified from the randomised audits in the emergency portals or inpatients since August 2025.

What are we doing about it?

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

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

Quality & Access | [VTE & Hospital Associated Thrombosis]

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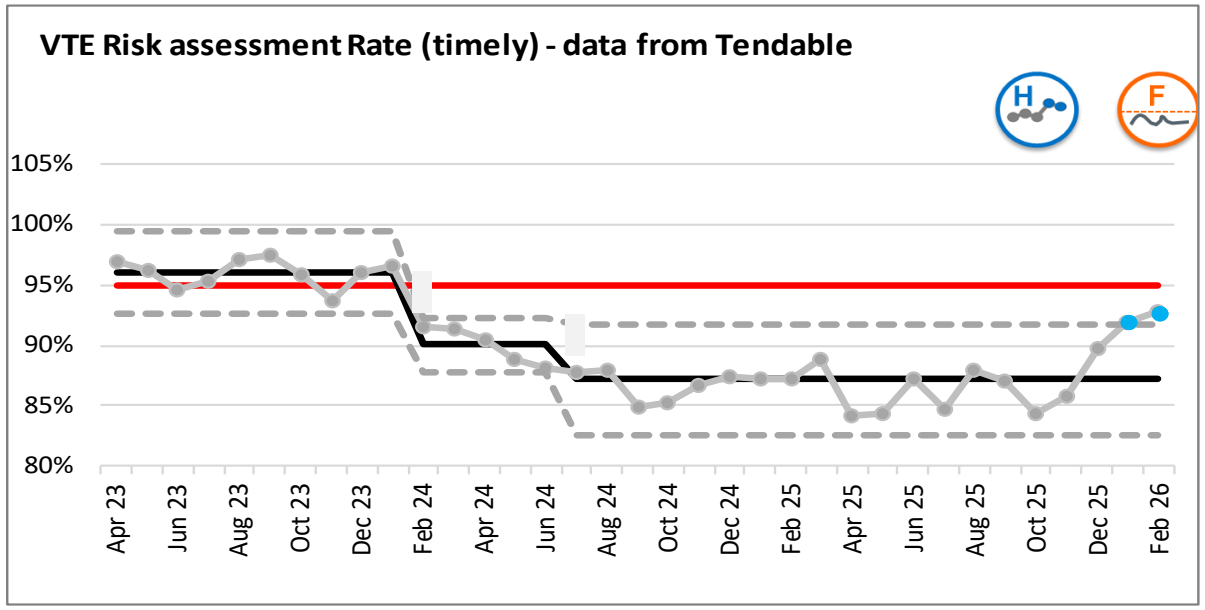

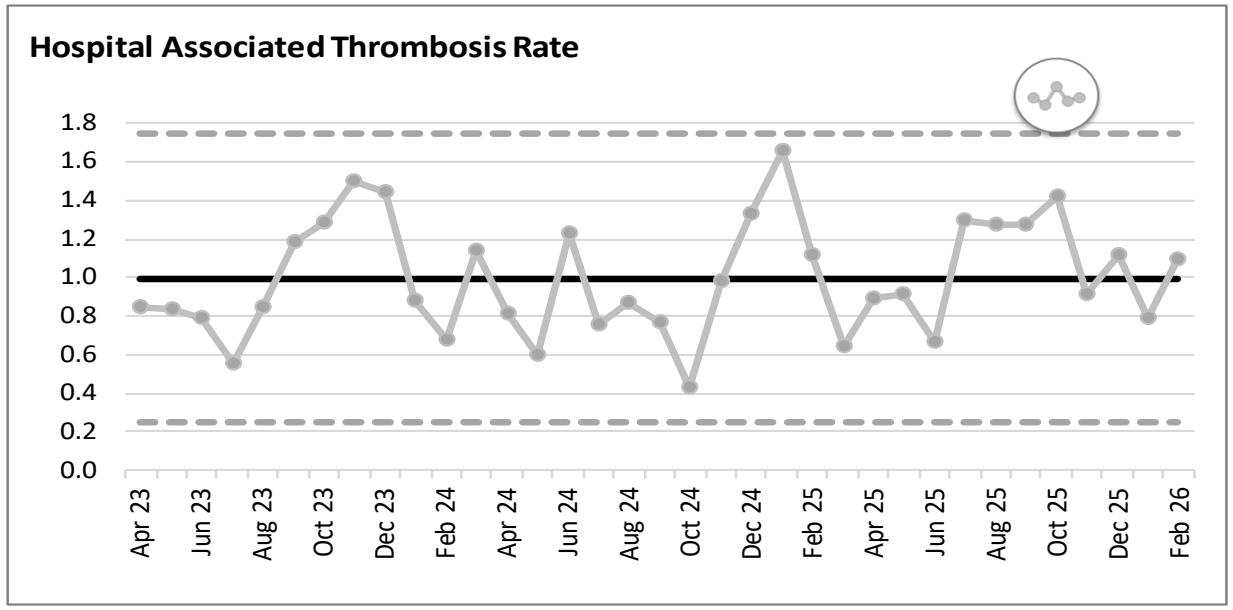

What is driving this performance?

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

Low performance has historically been largely due to the failure to document the date and time of the assessments and in February 2026 5% of assessments audited were recorded as missing date or time and 2% were recorded as late. Only 1% of assessments had not been completed at all. On average 98% of prophylaxis doses are given, or reasons documented if withheld. Reported compliance in February 2026 was significantly higher, possibly due to ePMA.

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

The apparent lower rates of compliance with timely VTE Risk assessments since 2024 do not seem to correlate with any notable rise in the HAT rate.

What are we doing about it?

EPMA rollout now complete and early data is being examined and report setup worked on.

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

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

Quality & Access | [Safe staffing & Timely Observations]

Provide safe, effective and caring services

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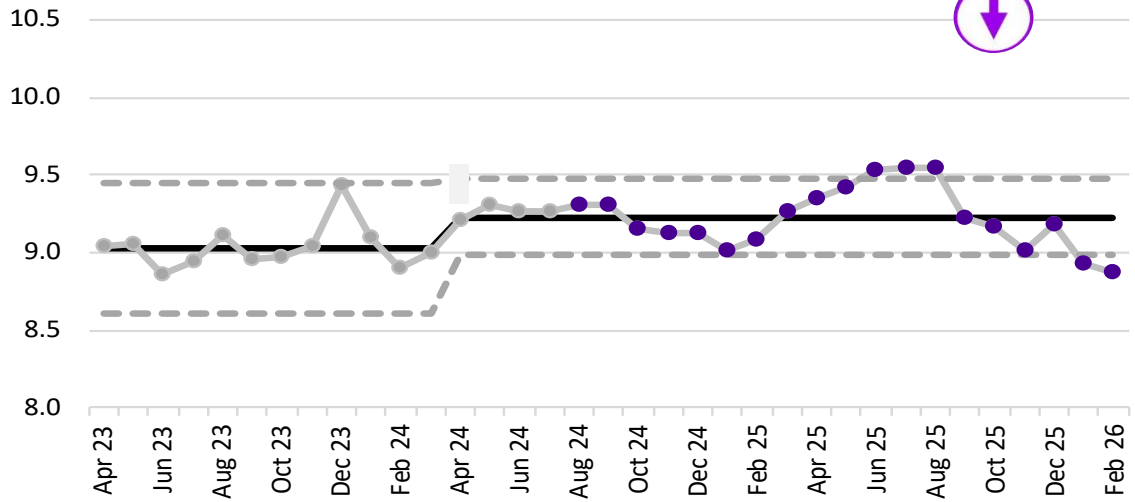
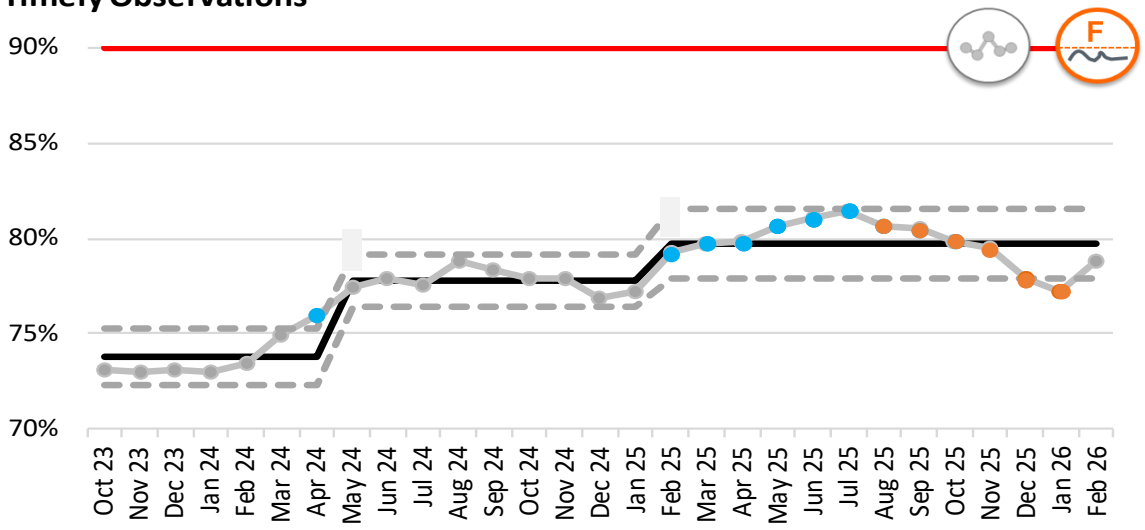
Care hours per patient day (safe staffing)



Timely Observations



What is driving this performance?

Care hours per patient day (CHPPD)

- CHPPD appears to have been on a downward trajectory since the summer.

Timely Observations

The proportion of observations recorded as timely in February 2026 was 79%, ending the period of declining compliance. This is due to efforts on a number of wards within the Unplanned Care Group. Planned Care Group compliance for February was almost identical to January's.

- Only 8 wards/departments met the 90% target in February.
- 8 wards had compliance below 70%, 6 of which are under Medicine CBU: Wards 113, 78, 12, 112, 76a, FEAU, 108, 76b.

What are we doing about it?

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

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

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

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

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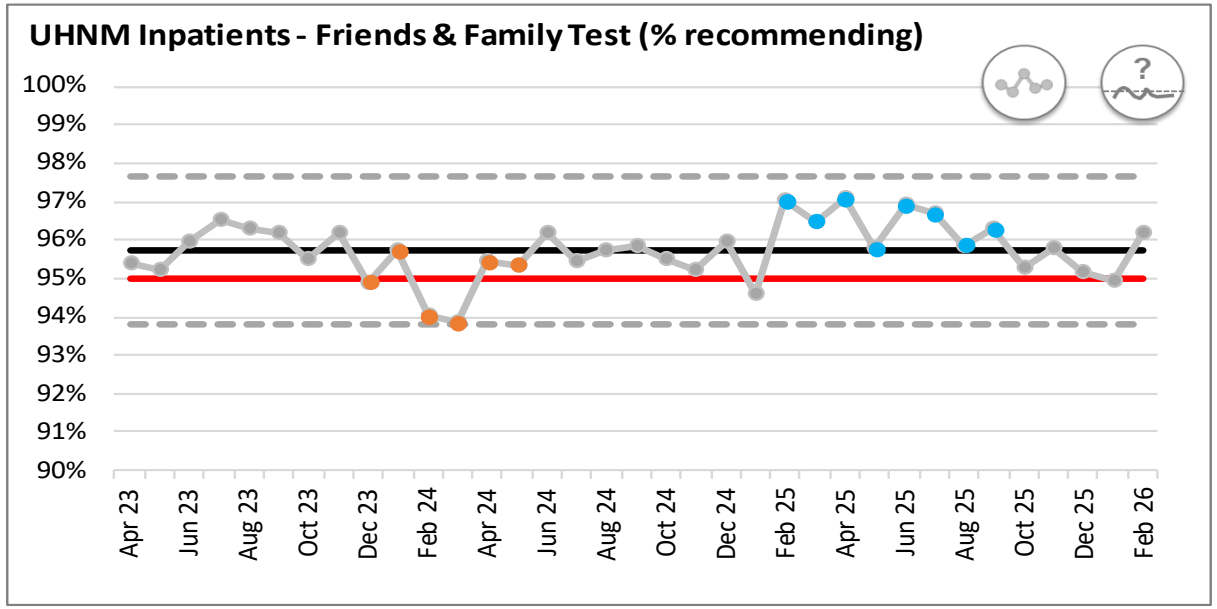

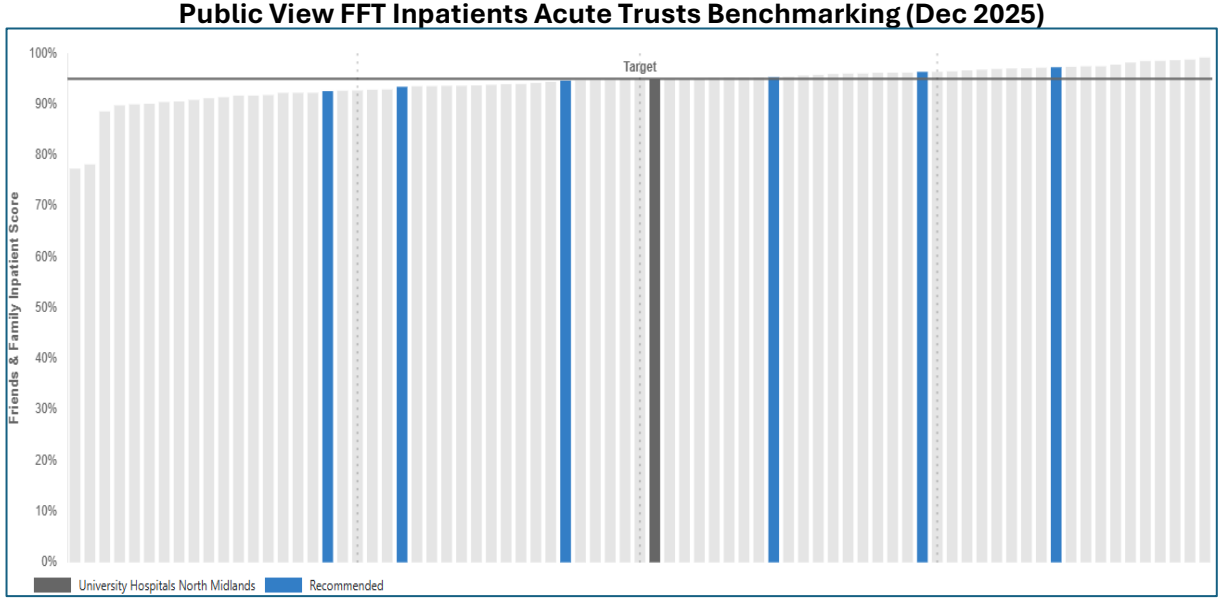

What is driving this performance?

The monthly satisfaction rate for inpatient areas was within the usual range in February 2026. The average rate remains above the national average of 95% (Oct 2025 NHS England- last data).

In February 2026, a total of 2678 responses were collected from 65 inpatient and day case areas equating to a 25% return rate, which is within the usual range.
Average Care Group Scores are as follows:

- Unplanned - 18% response rate, 95% satisfaction score
- Planned - 37% response rate, 96% satisfaction (30% response target met since Nov-23)
- CSS (excluding Maternity, see separate slide) - 22 % response rate since Apr-25, 99.6% satisfaction score

No significant changes are currently evident in any of these figures.

What are we doing about it?

Following the trial period, a simplified survey will now be used in all inpatient, Emergency Portal and Daycase areas containing the mandatory "Overall, how was your experience of our service?" with the 6 response options ("very good" through to "very poor" or "don't know".)
We have included Recommendation Rates on our Quality Dial of The Day Dashboard.
RAG rating is simplified to show just response rate and recommendation rate.
Review each Clinical Care Group scoring and identify areas for improvement.
FFT areas of celebration and areas for improvement to be shared monthly at Patient Experience Group.

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

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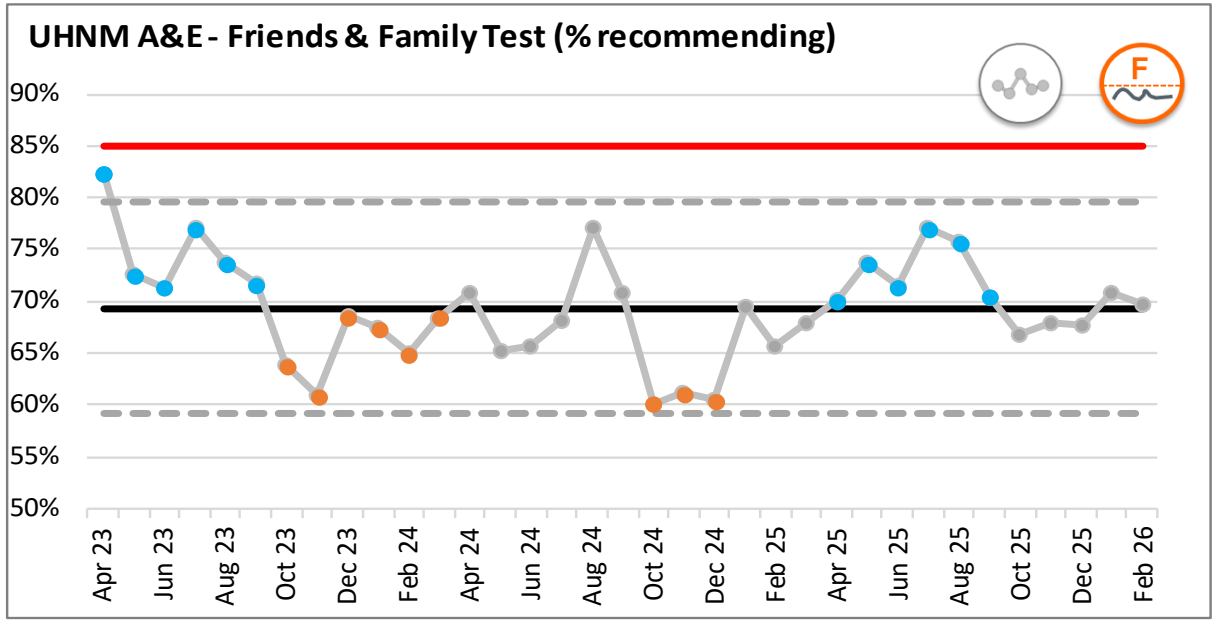

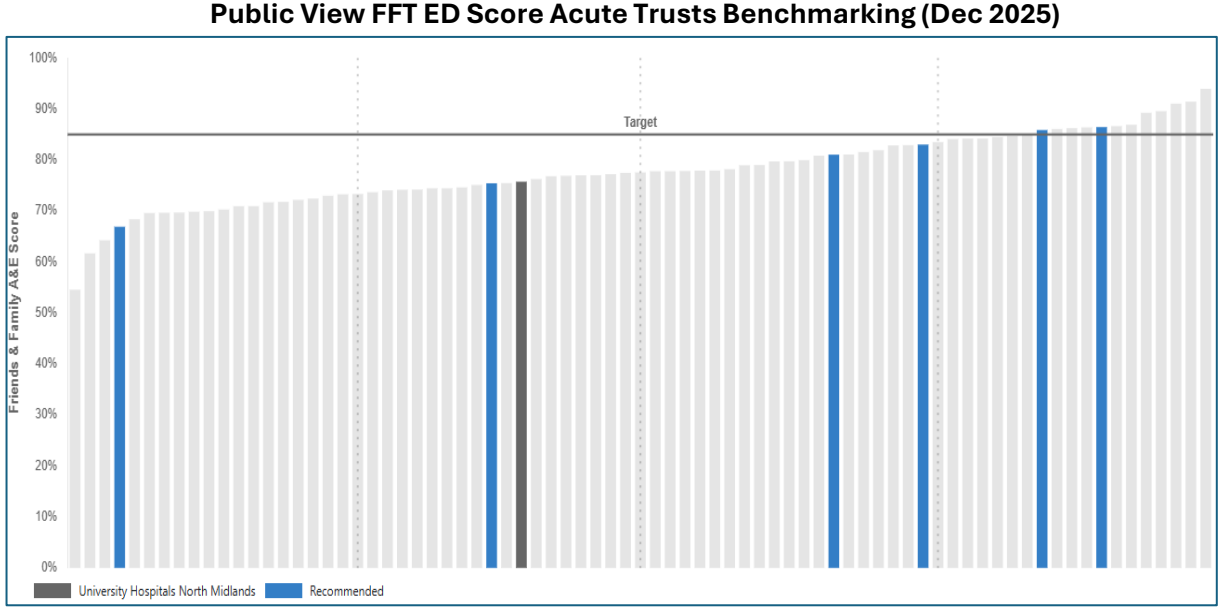

What is driving this performance?

The Trust received 824 responses in February 2026 – a 10% response rate which is within the usual range. Satisfaction rates remains somewhat below the national average of 77% (NHS England Oct 2025) and have varied considerably over the past couple of years.

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

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

What are we doing about it?

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

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

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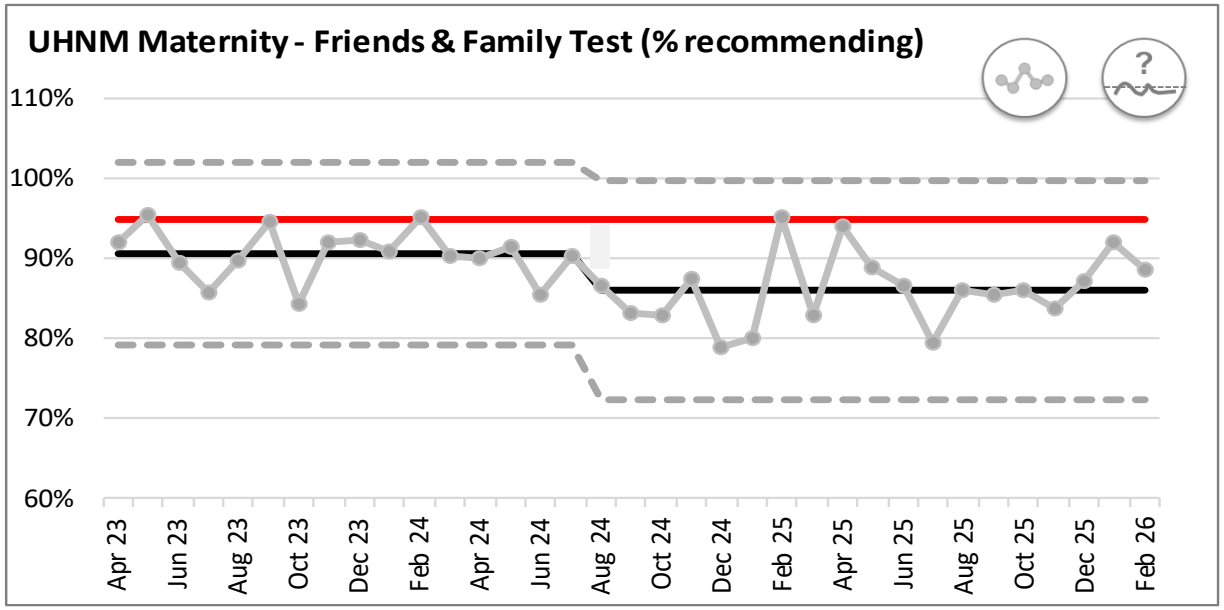

What is driving this performance?

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

There were a total of 106 surveys received in February 2026 across all 4 touch-points (ante-natal, birth, post-natal ward; post-natal community) with 30 of these being collected for the "Birth" touch-point, making the response rate 6% which is within the usual range. The average satisfaction scores are Ante-natal: 80%, Birth: 90%, Post-natal ward: 90%, Post-natal community: 90%. No significant shifts or trends are currently evident in any of these satisfaction scores.

What are we doing about it?

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

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

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

Quality & Access | [Formal Complaints]

Provide safe, effective and caring services

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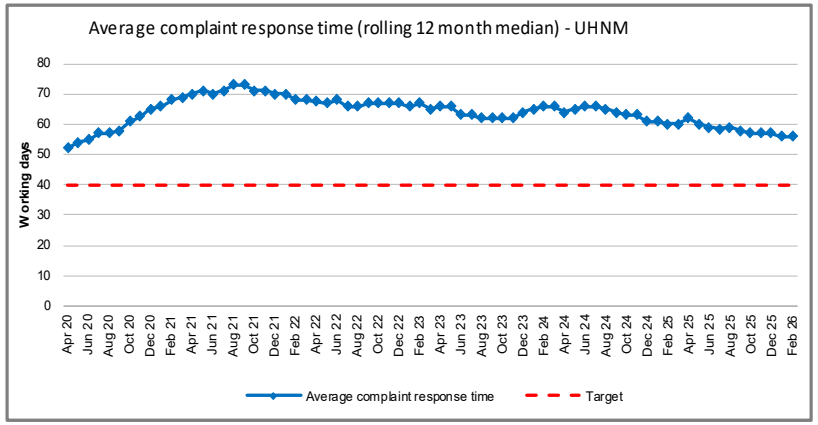
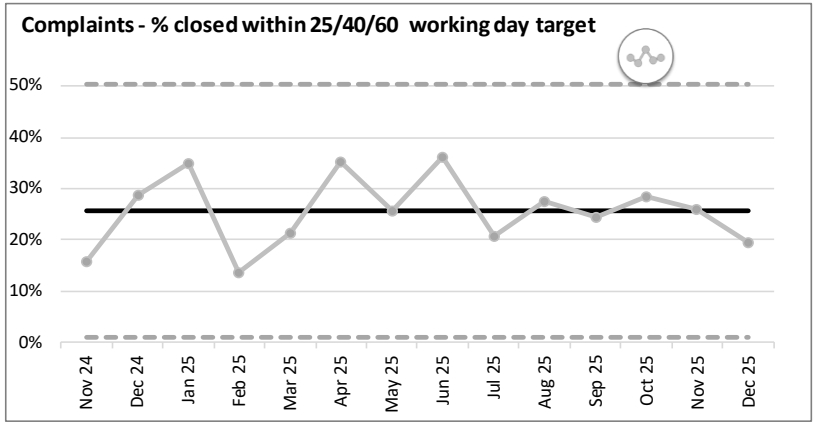
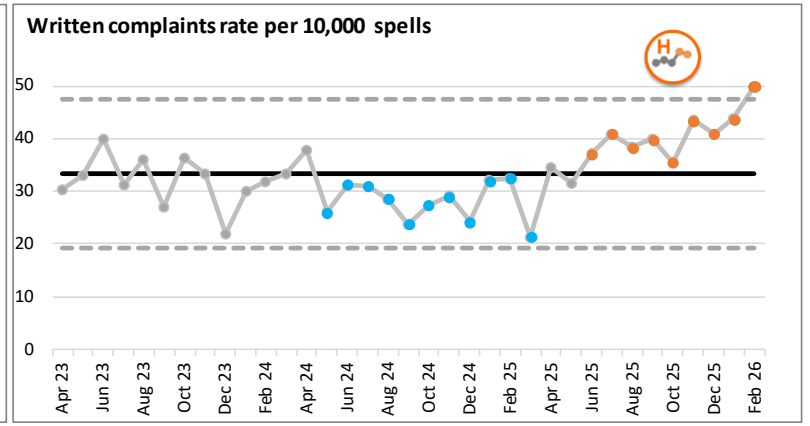






What is driving this performance?

61 complaints were closed in February 2026, with a median average response time of 61 working days.
The chart shows the average complaint response time peaked in 2021 but has been on a downward trajectory since mid 2021, though it remains some way above the 40 working day target.

313 complaints were open at the end of February 2026, of which:

- 8 had been open longer than 12 months
- 35 had been open 6 – 12 months
- 62 had been open 3 – 6 months

Since November 2024 complaints received have been assigned a target resolution time of 25/40/60 working days, and as of the first week of March 2026, 26% of complaints opened between November 2024 and December 2025 were closed within target.

The rate of formal complaints opened has been above average since June 2025 and was significantly above average in February 2026.

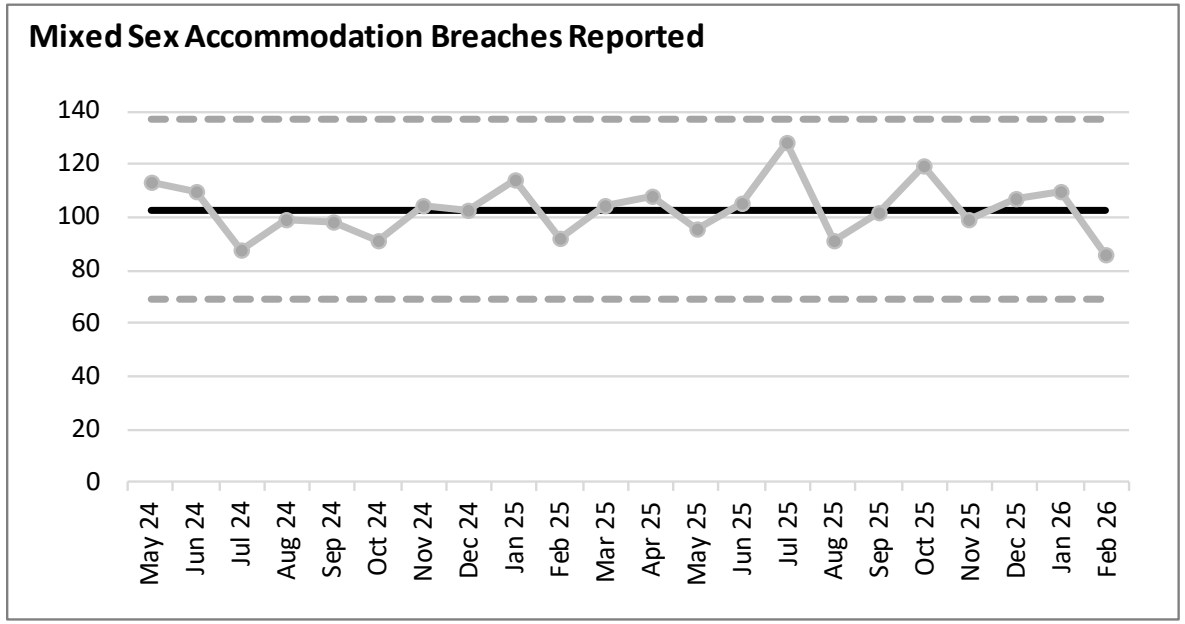
What are we doing about it?

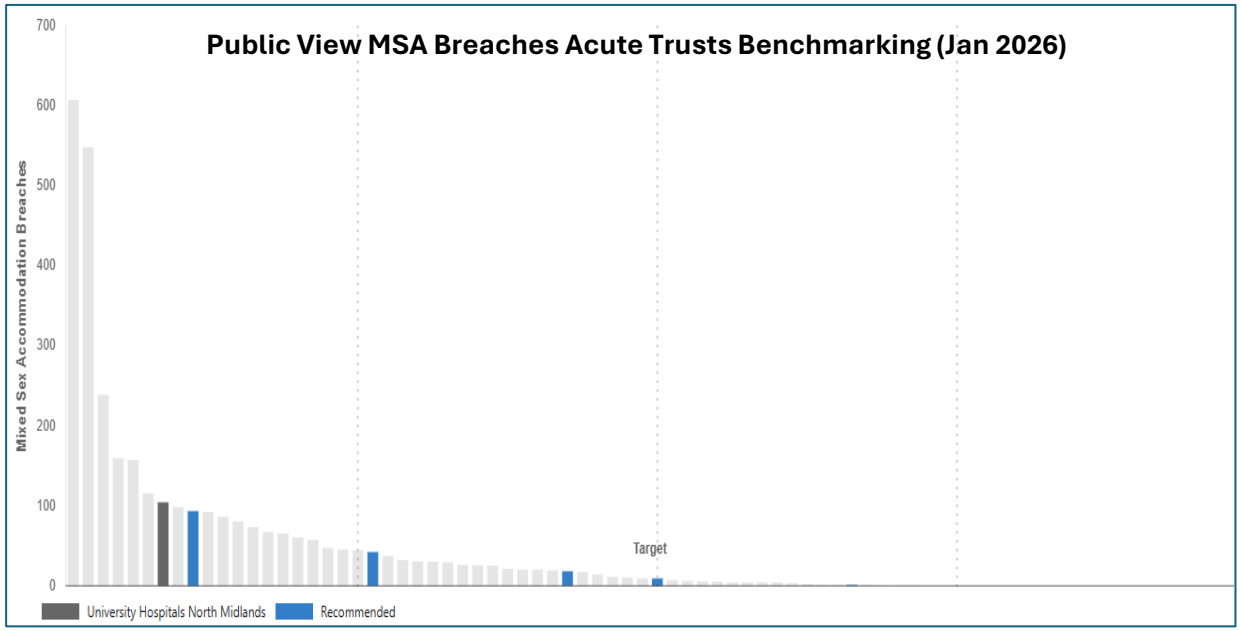
*An updated reporting structure has been implemented to more accurately capture at what stage open complaints are within the formal process.
*New Complaints Policy includes complaint response times triage.
*Formal Escalation process enacted to support with response times.
*Following receipt of Weightman's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

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

Provide safe, effective and caring services

University Hospitals of North Midlands NHS Trust





What is driving this performance?

February 2026 reported 86 Mixed sex accommodation breaches which is the lowest value since reporting started in May 2024.

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

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

What are we doing about it?

An improvement plan has been created to ensure a planned approach to the reduction of breaches. On going pressure on the Trust continues to impact on bed availability and the ability to timely step-down patients from ITU. The site operations team and working closely with the planned care group to find more robust solutions to addressing the high number of breaches. We continue to wait for allocated time from the digital team to progress work within iPortal The site time and critical care have set up a communication forum to support this and other issues and we hope that working closer in this way will lead to clear communication and a reducing in breaches,= going forward.

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

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

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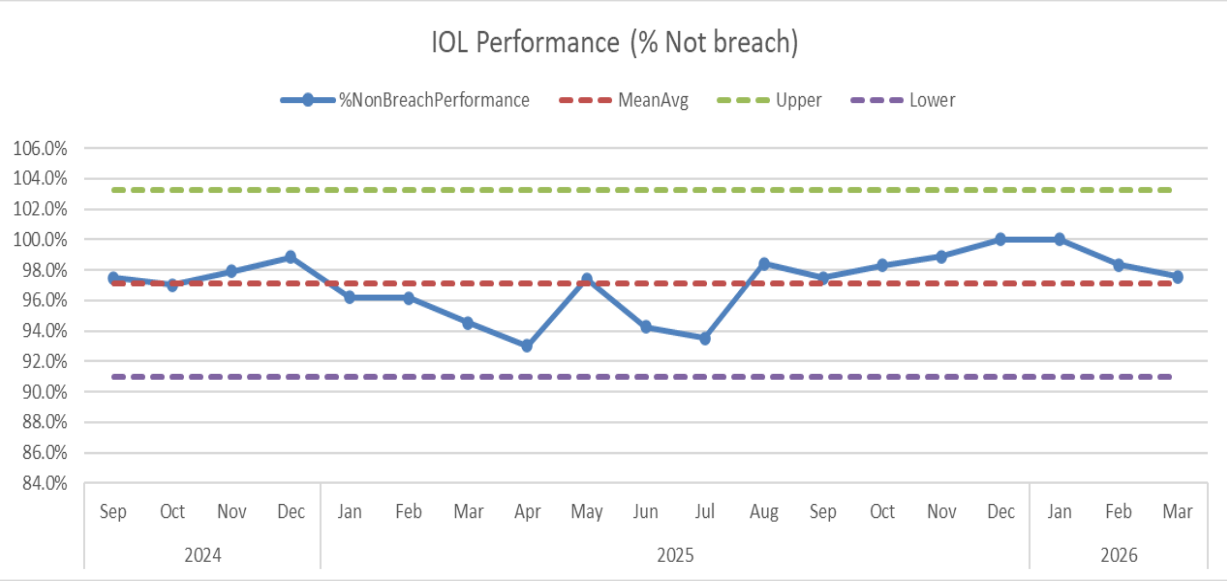

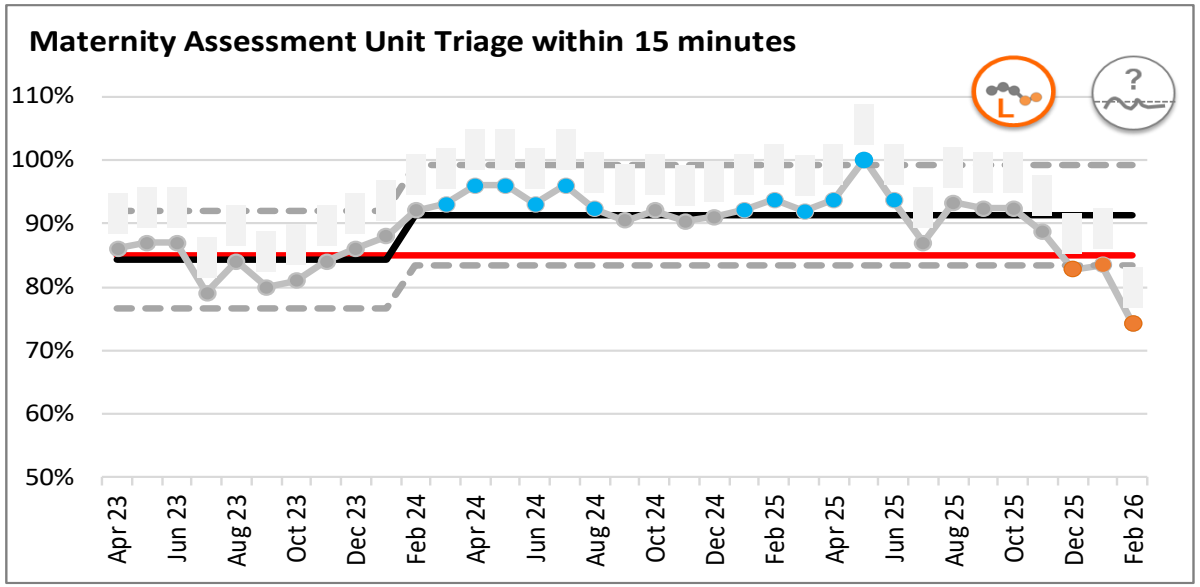

What is driving this performance?

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

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

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

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

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

What are we doing about it?

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

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

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

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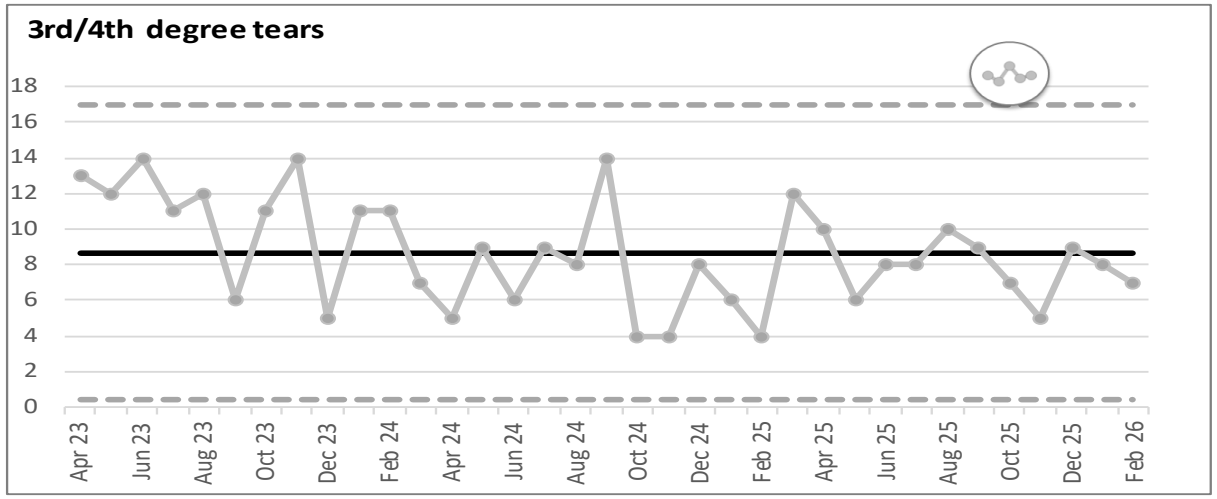

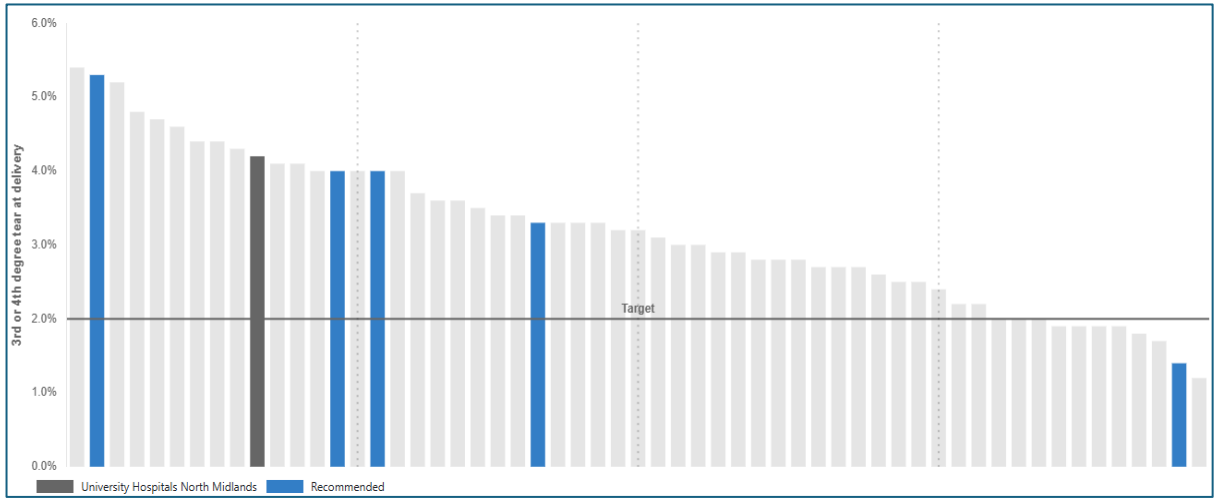

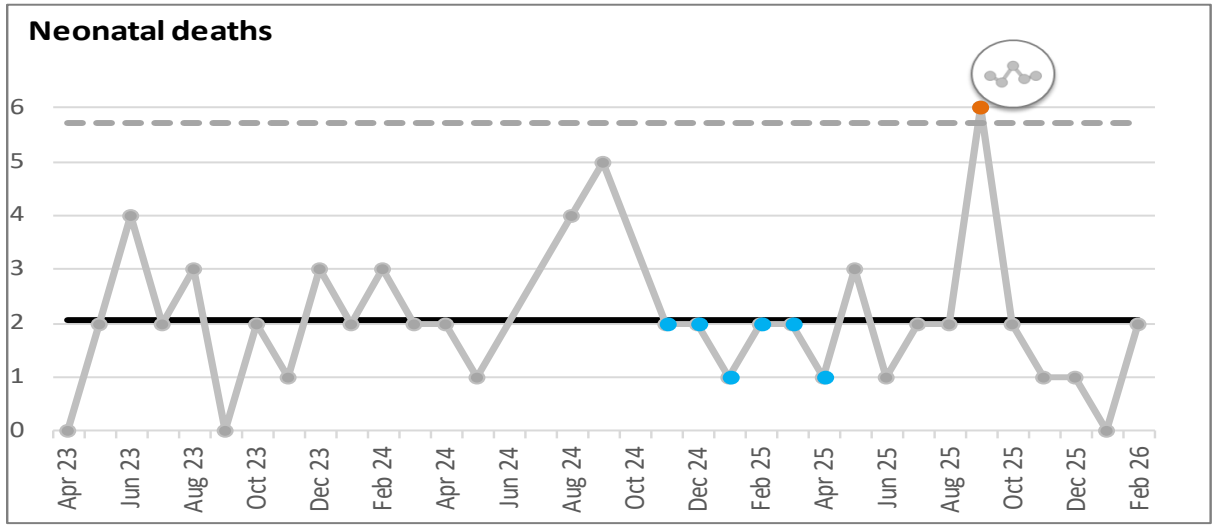

What is driving this performance?

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

Neonatal deaths
2 recorded deaths during February 2026.

What are we doing about it?

Quality & Access | [HSMR / SHMI]

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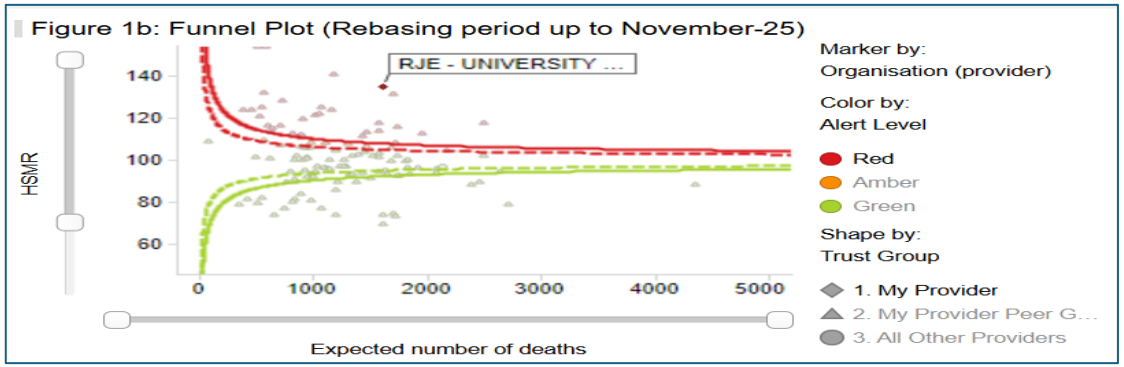

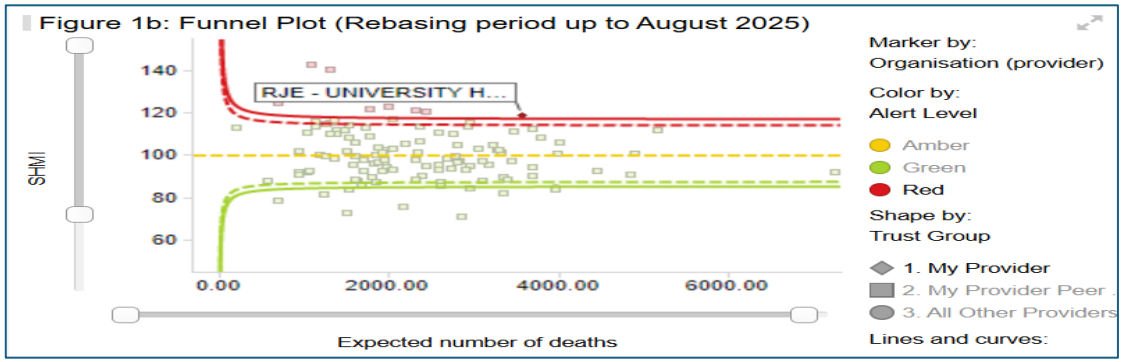

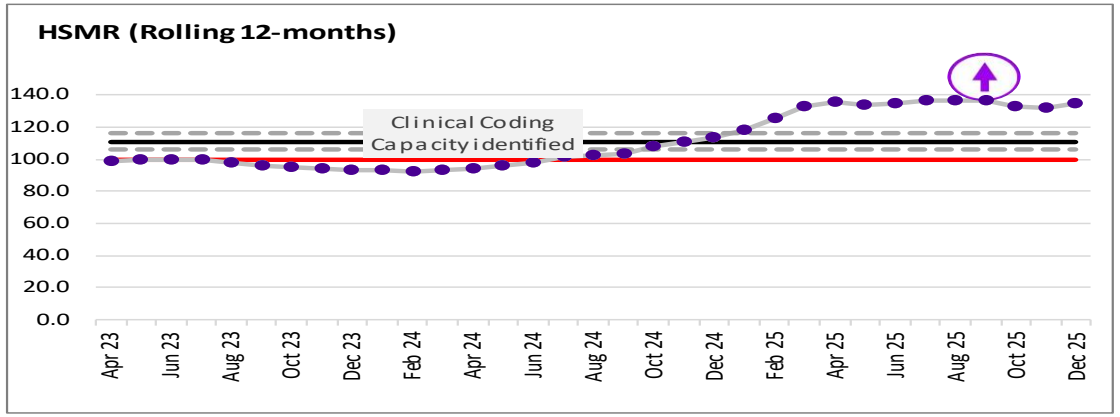

What is driving this performance?

UHNM HSMR remains significantly higher than expected based on case mix and standardisation for current 12-month period (January – December 2025). The current 12-month HSMR is 134.4. There have been in-month reductions in monthly HSMR for Augst, September, October and November 2025 following full data refresh and submission. Since the last report the HSMR figure was updated and refreshed and reduced from the initial 134.7 to 131.96. The December 2025 HSMR will be updated further following final submission of the validated coding submission.

UHNM SHMI also remains higher than expected at 118.06 for current 12-month period (December 2024 – November 2025) but has decreased from previous 12-month period 118.70.

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

What are we doing about it?

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

Quality & Access | [NPSA Alerts received and overdue]

Provide safe, effective and caring services

University Hospitals of North Midlands NHS Trust

New Alerts received:

No new alerts received applicable to UHNM

Open / Overdue Alerts:

Year	Alert Type	CAS Status	Alert Reference Number	Alert Title/Device	Date Issued	Deadline Date	Comments	Actions
2023	Nat/PSA	Open	NatPSA/2025/008 /NHSPS	Risk associated with adult breathing circuits lacking a patent exhalation route	11/12/25	12/06/26	The National Patient Safety Team are aware of patients who have come to harm or been exposed to potential harm because the breathing circuit to which they were connected was incorrectly assembled	Organisations should identify a clinical lead and form a working group to develop local guidance and visual aids for the assembly, connection and reconnection of breathing circuits.
2025	Nat/PSA	Open	Nat/PSA/2025/00 5/NHSPS	Harm from delayed administration of rasburicase for tumour lysis syndrome	09/09/25	09/03/26	Pharmacy liaising with various areas within the trust. i.e. emergency care, Haematology/Oncology, Critical Care. **Alert completed, deadline met awaiting final sign off.**	
2025	Nat/PSA	Open	Nat/PSA/2025/00 6/NHPS	Harm from Allergic reaction due to misinterpretation of prescription.	20/11/25	20/11/25	There are reports of healthcare staff recording a patients penicillin allergy as penicillamine allergy in the EPMA. This look-a-like sound-a-like error risks a patient with a known penicillin allergy being administered a penicillin base antibiotic and having a potentially fatal reaction.	Work with digital systems to develop/deploy additional built in mitigations to reduce inadvertent recording of the wrong allergy.

What is driving this performance?

In February 2026 UHNM received o new Patient Safety alerts.

There are 3 NHS Patient Safety Alerts that remain open and actions are ongoing to ensure that the necessary requirements of the alerts are being effectively implemented.

What are we doing about it?

Quality & Access | [Clinical Effectiveness]

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NHS University Hospitals of North Midlands NHS Trust

2 External Accreditations undertaken during Q4

- JAG Accreditation – Accreditation status has been reinstated. A meeting has been arranged for June 2026 for the Clinical Team to meet with the inspection team to discuss progress.

Key actions –

- Gap analysis currently being undertaken against the new standards
- Sedation SOP

- Peer Review of Children's and Teenage and Young Adult Cancer Services – Paediatric Oncology Shared Care Unit and TYA Designated Hospital:
  - 13 noticeable achievements identified
  - 22 gaps identified

Key actions –

- The recommendations have been incorporated into the Child Health Delivery Plan. Actions will be prioritised / triangulated with other actions currently being considered as part of the Child Health Clinical Effectiveness programme

- During Q4 UHNM continued to review guidance published by NICE. There are currently 21 pieces of NICE guidance awaiting final implementation. There is good engagement from the Clinical Teams and delays vary from the provision of bespoke clinics, ratification of new polices and the introduction of new patient pathways.
- 4 National Audit published during Q4:
  - Fracture Liaison Database
  - Lung Cancer
  - National Paediatric Diabetes
  - National Maternity & Perinatal Audit
- Work is ongoing around 4 NCEPOD projects during Q4:
  - Emergency Procedures in Children and Young People – National Report has been published. Action plan currently being developed
  - Pleural Procedures – Case Note data collection complete. Organisation Questionnaire currently being completed.
  - Stabilisation of the critically ill child - Case Note data collection complete. Organisation Questionnaire currently being completed.
  - Rib Fractures – Case Note data collection complete. Awaiting publication of the Organisational Questionnaire

- 5 GIRFT visits were undertaken during Q2 / Q3 and the Trust is continuing work around the action plan development for the following clinical specialties:
  - Breast Surgery
  - General Surgery
  - Vascular
  - Urology
  - Interventional Radiology
- 4 LocSSIP audits were published during Q4:
  - 3 Significant Assurance
  - 1 Significant Assurance with Minor Improvements
- 19 Clinical Audits were published in Q4:
  - 10 Significant Assurance
  - 8 Significant Assurance with Minor Improvements
  - 1 No Assurance

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

What are we doing about it?

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

Access to Services

University Hospitals of North Midlands NHS Trust

Access to Services	Data period	Provider value		Chart
Access to services domain segment	Q3 2025/26	3	NOF Score	
Access to services domain score	Q3 2025/26	2.57	NOF Score	

Elective Care	Data period	Provider value	Peer average	National value	National value method	Chart
Percentage of cases where a patient is waiting 18 weeks or less for elective treatment score	Q3 2025/26	2.11	NOF Score		Provider value	
Percentage of cases where a patient is waiting 18 weeks or less for elective treatment	Dec 2025	62.60%	55.70%	60.90%	Provider median	
Difference between planned and actual 18 week performance score	Q3 2025/26	1	NOF Score		Provider value	
Difference between planned and actual 18 week performance	Dec 2025	0.20%	-3.05%	-1.82%	Provider median	
Percentage of patients waiting over 52 weeks for elective treatment score	Q3 2025/26	2.84	NOF Score		Provider value	
Percentage of patients waiting over 52 weeks for elective treatment	Dec 2025	1.84%	2.52%	1.56%	Provider median	
Percentage of patients waiting over 52 weeks for community services score	Q3 2025/26	1	NOF Score		Provider value	
Percentage of patients waiting over 52 weeks for community services	Dec 2025	0.00%	1.05%	0.42%	Provider median	

Cancer Care	Data period	Provider value	Peer average	National value	National value method	Chart
Percentage of patients with cancer diagnosed or ruled out within 28 days of an urgent referral score	Q3 2025/26	2.99	NOF Score		Provider value	
Percentage of patients with cancer diagnosed or ruled out within 28 days of an urgent referral (quarter)	To Dec 2025	75.76%	73.60%	77.61%	Provider median	
Percentage of patients treated for cancer within 62 days of referral score	Q3 2025/26	3.64	NOF Score		Provider value	
Percentage of patients treated for cancer within 62 days of referral (quarter)	To Dec 2025	61.61%	64.30%	71.48%	Provider median	

Urgent and Emergency Care	Data period	Provider value	Peer average	National value	National value method	Chart
Percentage of emergency department attendances admitted, transferred or discharged within four hours score	Q3 2025/26	3.78	NOF Score		Provider value	
Percentage of emergency department attendances admitted, transferred or discharged within four hours (quarter)	To Dec 2025	65.37%	72.27%	73.05%	Provider median	
Percentage of emergency department attendances spending over 12 hours in the department score	Q3 2025/26	3.21	NOF Score		Provider value	
Percentage of emergency department attendances spending over 12 hours in the department (quarter)	To Dec 2025	10.47%	9.27%	8.17%	Provider median	

UHNM's access metrics show mixed performance with small variation between Q2 and Q3.

Elective Care – each metric either seeing a deterioration in the score or score remains the same as Q2. All metrics are better than peer average.

Cancer Care – 62 day cancer seeing a deterioration since Q2 from 2.84 in Q2 to 3.64 in Q3 and behind both peer and national averages.

Urgent and Emergency Care – 4 hour performance has seen a deterioration since Q2, however 12 hour performance has improved from 12.51% in Q2 to 10.47% in Q3.

Quality & Access | Overview

University Hospitals of North Midlands NHS Trust

Overview from the Chief Operating Officer

How are we doing against our trajectories and expected standards?

Non-Elective

For the 4-hour standard in UEC our validated performance improved from to 63.6% in January to 64.8% in January. This is 10.7%pts behind our trajectory of 75.5% but it is the first month of improvement following a seven consecutive months of performance deterioration. The national target for this standard is 78%.

In February 2372 patients waited longer than 12 hours in ED against a plan of 1930 (variance of -442). This is 454 less than January and the lowest recorded for 6 months. Overall performance was 10.7% against a target of 13.2%. Important to note that County continues to support RSUH with ambulance diverts.

5019 ambulances arrived at UHNM in January – 63.39% of these were handed over within 45 minutes. This is an improvement since January where performance was 56.32%, and February's performance is the best recorded since August 2025.

This has meant that during February 1806 patient waited in an ambulance for longer than 45 minutes before being handed over, compared to 2180 in January.
Average handover time in February was 1 hour and 15 minutes, an 18 minute improvement from January, but still 20 minutes off-plan. February performance was 40 minutes faster than the same month last year and was the fifth consecutive monthly improvement.

The Trust remains in tier 1 for our UEC performance.

Elective

Cancer:
The combined faster diagnosis standard performance final January position was reported at 72.30% against a trajectory of 79.09%. The provisional February position is currently at 82.47% against a trajectory of 79.63%.
31-day final January position is currently at 90.99%. Provisional February position is currently at 93.42%.
Combined 62-day performance final January position was 62.84% against a trajectory of 74.18%. Provisional February position is currently at 61.4% against a trajectory of 74.87%; this position is expected to improve through validation.

Diagnostics:
Februarys DM01 validated performance was 79.3% against trajectory of 96.8%. Current performance is 82.1% (18/03).

RTT:
Februarys overall RTT performance was 60.3%; behind plan of 62.4%. Current performance is 62.15% (18/03).
Our 52-week performance is monitored as a % of patients on our total waiting list who are over 52 weeks. For the month of February, 52-week plan increased from 1.95% to 2.16%. This standard is to achieve by the end of the year is to get to 1%.
RTT % Waiting 1st Contact dipped in February, with performance being 74.5%; 2.2% off plan. However, UHNM are still a regional leader on this metric.

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

The Trust continues to be in Tier 2 for Planned Care and Cancer, however UHNM are no longer in Tier 2 for our Diagnostic performance.

Quality & Access | Overview

University Hospitals of North Midlands NHS Trust

Overview from the Chief Operating Officer

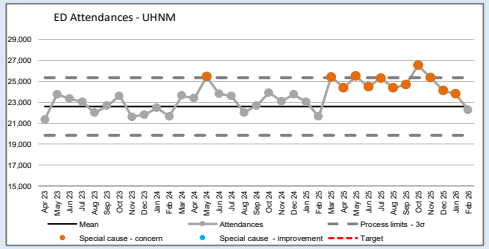
What is driving this?

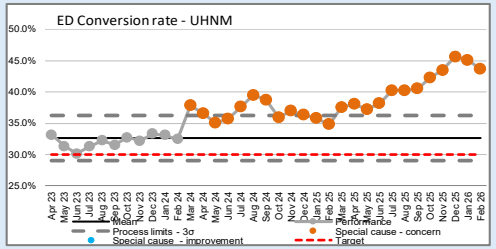
Non-Elective

4-hour performance is 10.7%pts behind our revised improvement trajectory. Seasonal activity and increased Conversion rates have resulted in higher site occupancy and reduced UEC flow. There were 22,289 attendances in February, a reduction of 1,523 compared to January, but with 3 fewer days in February than in January, the average volume of patients per day increased from 768 in Jan to 796 in Feb.

In response to the increased Demand, our Winter Plan has been enacted, with ward 102 continuing to support cohorted outliers, and Ward 8 (County) being mobilised. The planning for decant from the additional space is in progress, balanced against the operational risks to both UEC and Elective care. Ward 8 will be emptied and cleaned by the end of March and Ward 102 will hand back to Planned Care following the Easter break.

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





Elective

Cancer performance is recovering and UHNM have modelled a sustainable backlog trajectory, that will enable achievement of submitted 62-day treatment performance trajectories, by reducing the disproportionate backlog of patient waiting to be treated. For FDS, after falling below trajectory for 4 months out of the year so far, provisional February position shows performance ahead of plan. Most 31-day breaches are attributable to patients receiving surgery as either a first or a subsequent cancer treatment above the 31-day breach range. Particularly first Skin treatments account for a high number of 31-day breaches. For 62-day performance Breast, Colorectal, Gynae, Head & Neck, Skin & Upper GI are below their trajectories. Skin performance has been particularly challenged owing to capacity for diagnostics and treatment which is significantly impacting on overall Trust performance from September onwards.

Non-Obstetric Ultrasound is the majority contributor for UHNMs overall DM01 performance variance against the national standard, NOUS unvalidated performance is now 75.1%. An increase in performance of 5.2% in the last 4 weeks. Neurophysiology is emerging as a diagnostic specialty of concern due to locum and short-term workforce cover (ERF).

RTT Performance has deteriorated slightly during February with a provisional position of 61.7%, due again to the combination of UEC pressures, half term, and reduced administrative capacity. Performance is now behind plan. Rank against acute trusts slipped in January to 77th from 70th. Total PTL has reduced from 65,506 in January to 64,814 in February.

The increase in patients waiting >65weeks to be treated is due to UEC pressures and Christmas downtime. 65-week waits have increased from 85 in January to 109 in February. There is some risk with the extensive validation work underway of pop-up long waiters – these will be managed through the trust's "uncorrected breaches" process. Specialties which impact are Orthopaedics, ENT, Ophthalmology, OMFS and Gynaecology. The rate of reduction of patients waiting over 65 week shows that most of these patients are on admitted pathways who require an RSUH bed for a complex procedure requiring some combination of specific surgeons, surgical robots and extended theatre time.

Quality & Access | Overview

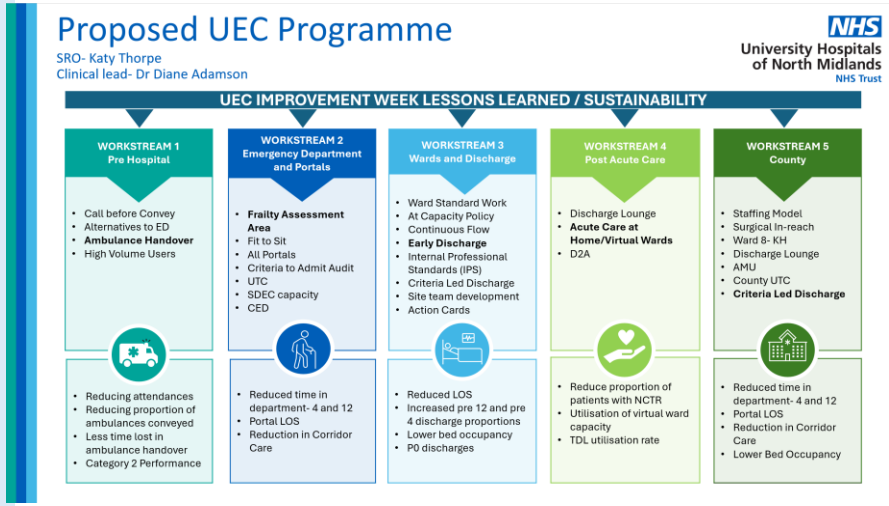
University Hospitals of North Midlands NHS Trust

Overview from the Chief Operating Officer

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

Non-Elective

- Our UEC improvement plan has been in place since April 2025 but has been refreshed and relaunched in March 26, with a Change Week planned from 23/3
- The focus of the workstreams has been prioritised, with High Impact Task and Finish Groups being established to deliver Rapid Improvement in key areas
- Each workstream now has a clear Executive SRO, Corporate sponsor, Care Group SROs, Clinical lead and Improvement support, complemented by the work of the GIRFT UEC team
- Governance of the workstreams will be simplified and strengthened, with a focus on continuous improvement
- Command and Control of site meetings, with senior accountable officer engagement from each Care Group continues
- Winter plans continue to create additional capacity and to support flow
- UTC Phase 1 is now complete, with phase 2 expected to deliver in July
- The Site Team leadership structure is now at establishment, with the second Head of Nursing, James Woods having started in February
- Test of Change for Release to respond demonstrated some positive initial results, alongside some challenges with sustainability, due to site occupancy levels
- 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



Elective

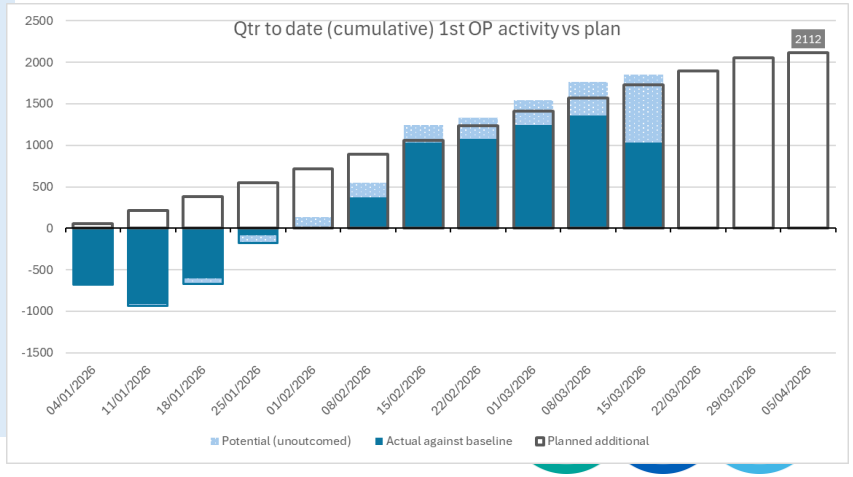
Improvement plans in cancer with associated trajectories by tumour site to reduce the diagnosed and undiagnosed backlog of patient 62 days will continue to be monitored and developed. Delays due to histopathology (in line with other centres regionally) will need to be offset by further improvements in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

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

The 1st new Outpatient Sprint has now been in place for 2 months, with additional activity to be delivered for patients waiting 1st appointment. UHNM are expected to deliver at, or above the additional patients to be seen, which was set at 2112 patients.

Independent Sector full pathway transfers have been agreed through Q4, with 200 pain patients to be sent (175 sent to time). Although Gynae was identified to send 200 patients, only 9 patients have been sent to time.

The digital and operational teams have worked with external partners to develop a process to validate the majority of our c700,000 patients on our waiting lists. Validation work will continue at pace to deliver the asks of the National validation sprint. The ROVA validation tool has been carrying out automated validation for 5 months, which will continue to extend to the entire waiting list.



Quality & Access | Overview

University Hospitals of North Midlands NHS Trust

Overview from the Chief Operating Officer

What can we expect in future reports?

Non-Elective

Whilst we are tracking 10.7% percentage points below the revised trajectory in February, we remain optimistic that the work of GIRFT UEC, our relaunch of the UEC Improvement plan and the Change Week focus will all support a return to the trajectory over 26/27.

Going forward, improvements in 4-hour performance, 12-hour performance, ambulance handover delays and the utilisation of corridor care will be tracked and monitored in both real-time and in retrospect within our governance framework. We have seen the correlation between improvements in flow and these indicators. The current 26/27 improvement trajectory does not return us to the national standard, but would represent a significant and ambitious improvement compared to our current and historic performance.

Elective

For RTT position, UHNM expect to improve in line with our planning trajectories and an ongoing reduction in our longest waiting patients. MBI have returned to bolster validation capacity during the final sprint, having commenced 9th February. 2 directorates are now utilising Rova, with plans for the rest of the relevant directorates to be onboard by mid-April. For 1st new contact, work has started to understand the Ophthalmology increase; a reduction in independent sector cataract capacity within the ICS in 2024/25 has likely had an impact.

For cancer, an established collaborative working group between Histopathology, Directorates and Cancer Services to identify specimens for reporting on appropriate triage pathway. iPortal shared pathology escalation currently live for lung and gynae, next sites LGI and HPB. A refocus on daily and weekly oversight of 28 Day PTL with escalations to specialties to ensure data completeness and avoid tip-overs. WMCA funding has been received to support performance improvements, 4 additional bids have been approved.

County Elective Hub is live, with extended Weekend and evening sessions now in place. Notably procedure numbers will significantly increase across County Theatres with activity to be tracked against delivery, specifically for Orthopaedics / General Surgery / Gynaecology. However, there has been difficulties with consultant's job plans, for anaesthetic cover and surgical cover.

1st Outpatient Q4 sprint outcome, ISP send of pain patients and end of year RTT position to be reflected.

Quality & Access | Dashboard

University Hospitals of North Midlands NHS Trust

Metric	Target	Previous	Latest	Variation	Assurance	R12M Trend
UEC 4 Hour Performance	78%	63.6%	64.8%			
UEC 4 Hour Performance (Aged <18)	78%	90.2%	91.8%			
Over 12 hours in ED	2,128	2,827	2,372			
Over 12 hours in ED (Aged <18)	0	24	30			
Ambulance Handover Average Time	00:43:00	01:33:11	01:15:04			
Cancer 28 Day FDS	80%	72.4%				
Cancer 31 Day Combined	96%	88.4%				
Cancer 62 Day Combined	75%	59.5%				
Diagnostics DM01 Performance	97%	73.3%	79.3%			
RTT Performance - <18 Weeks	63%	61.9%	60.3%			
RTT Performance - % 52+ Weeks	1%	1.9%				
RTT Performance - % Waiting 1st Contact	77%	74.7%	74.5%			
RTT Performance - <18 Weeks (Aged <18)	63%	67.1%	67.7%			
RTT Performance - % 52+ Weeks (Aged <18)	1%	1.4%	1.9%			
RTT Performance - % Waiting 1st Contact (Aged <18)	77%	82.6%				

Related Strategy and Board Assurance Framework (BAF)

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

Assurance Grid

University Hospitals of North Midlands NHS Trust

Assurance / Variation Key

Assurance

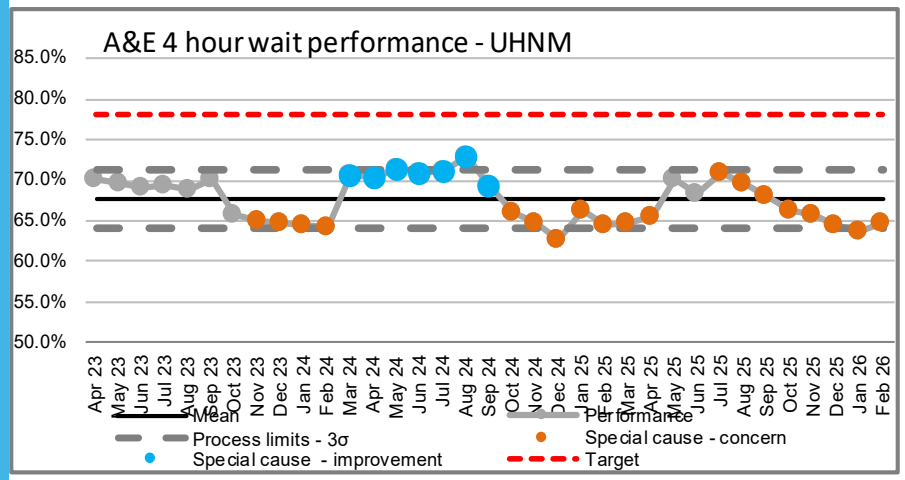
?	P	F
Variation indicates inconsistently hitting passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target

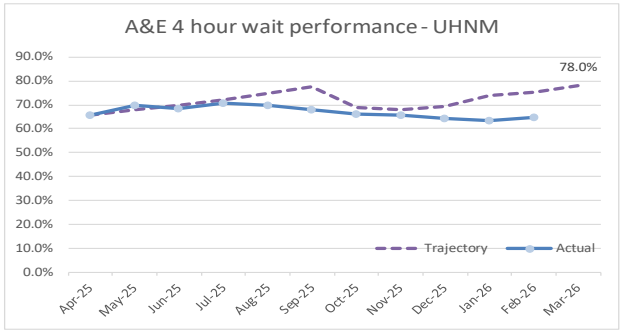
Variation

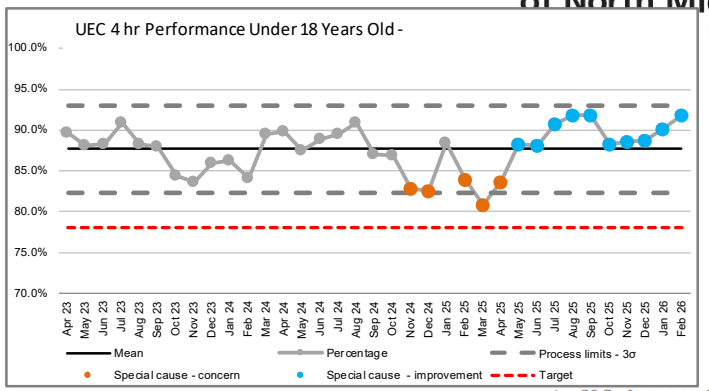
	H / L	H / L
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values

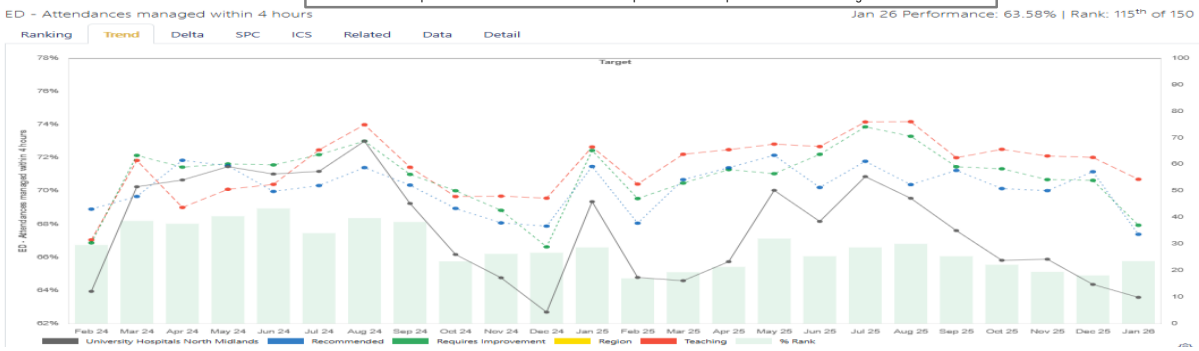
VARIATION \ ASSURANCE	P	?	F	No Target
H / L	UEC 4 Hour Performance (Aged <18) RTT Performance - % Waiting 1st Contact (Aged <18)	RTT Performance - <18 Weeks (Aged <18)	Diagnostics DM01 Performance RTT Performance - <18 Weeks RTT Performance - % 52+ Weeks RTT Performance - % Waiting 1st Contact RTT Performance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

Quality & Access | UEC 4-hour Target









Variation	Assurance		Monitoring against plan				
				Nov 25	Dec 25	Jan 26	Feb 26
	Target	78%	Actual	65.9%	64.4%	63.6%	64.8%
Background			Plan	68.1%	69.2%	73.8%	75.5%
The percentage of patients admitted, transferred or discharged within 4 hours of arrival at A&E			Variance	-2.2%	-4.8%	-10.2%	-10.7%

What is the data telling us?

Validated 4-hour performance was 64.8% for February, a marginal improvement from 63.6% in January.

We came off original trajectory in September and as such, plan was adjusted. For February, plan was 75.5%, which we fell short by 10.7%. By site, RSUH performance was 39.7% vs a target of 45.7%, and County 55.9% vs a target of 63.4%.

Overall admitted performance was 36.6% vs a target of 32.4%. By site, RSUH 34.7%, above target of 30.1%, County 43.3% vs a target of 40.8%.

Overall Non-admitted performance was 50.3% vs a target of 64.9%. By site, RSUH 44.2% vs a target of 59.8%, County 62.4% vs a target of 75.1%.

What are we doing about it?

The UTC project for Royal Stoke continues to progress. Anticipate opening date of July 2026

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

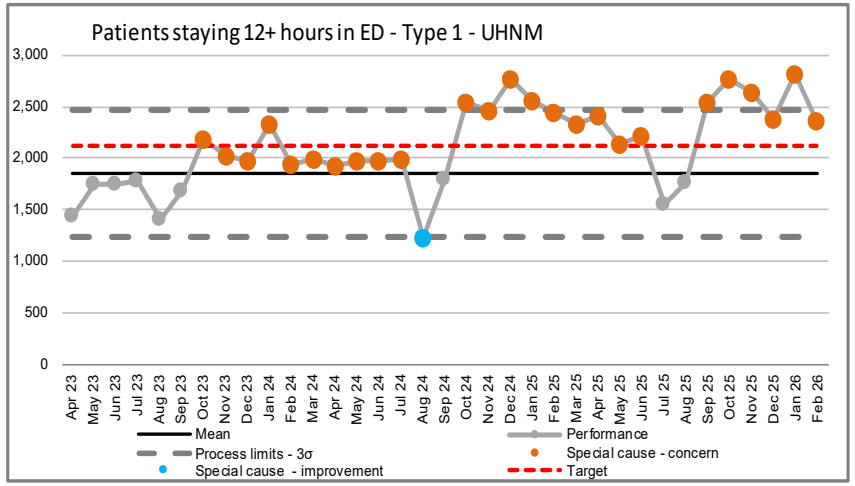
ED in-reach ToC live to improve the timeliness of specialty input in ED – will run until end of March 26

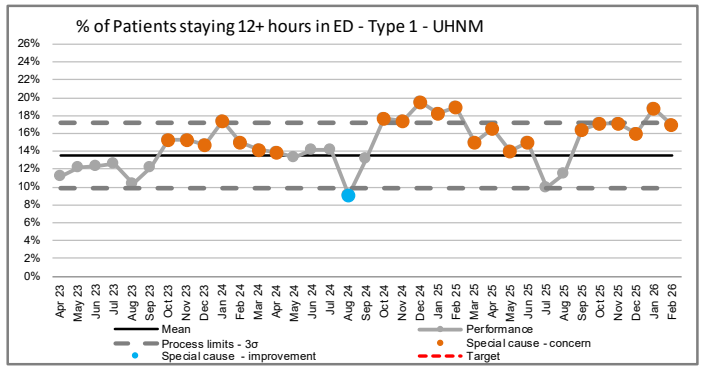
Renewed focus to expand Frailty SDEC back to 2 bays to improve timeliness of pulling this patient cohort – with minor positive impact re 4-hour performance

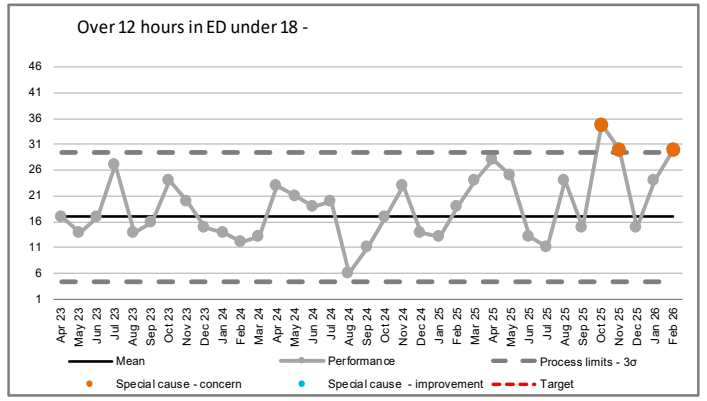
Planning commenced for the GIRFT led rapid improvement week 23/03

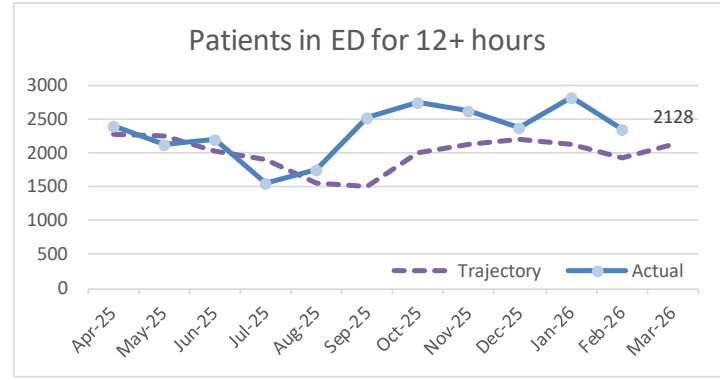
Quality & Access | Over 12-hours in ED From Arrival

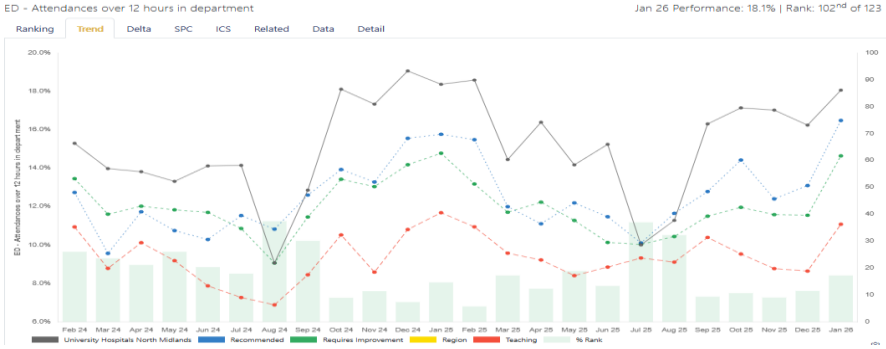
University Hospitals of North Midlands NHS Trust











Variation	Assurance		Monitoring against plan				
				Nov 25	Dec 25	Jan 26	Feb 26
	Target	2128	Actual	2,644	2,383	2,827	2,372
Background			Plan	2,133	2,213	2,149	1,930
The number of patients admitted,transferred or discharged over 12 hours after arrival at A&E			Variance	511	170	678	442

What is the data telling us?

In February 2372 patients waited longer than 12 hours in ED against a plan of 1930 (variance of -442). This is 454 less than January and the lowest recorded for 6 months. By site, 2193 at RSUH and just 185 at County.

Overall performance was 10.7% against a target of 13.2%. Important to note that County continues to support RSUH with ambulance diverts.

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

What are we doing about it?

Work is ongoing around UTC as per previous slide to support with maximising streaming.

'Release to respond' showing signs of benefit, some of which are being sustained.

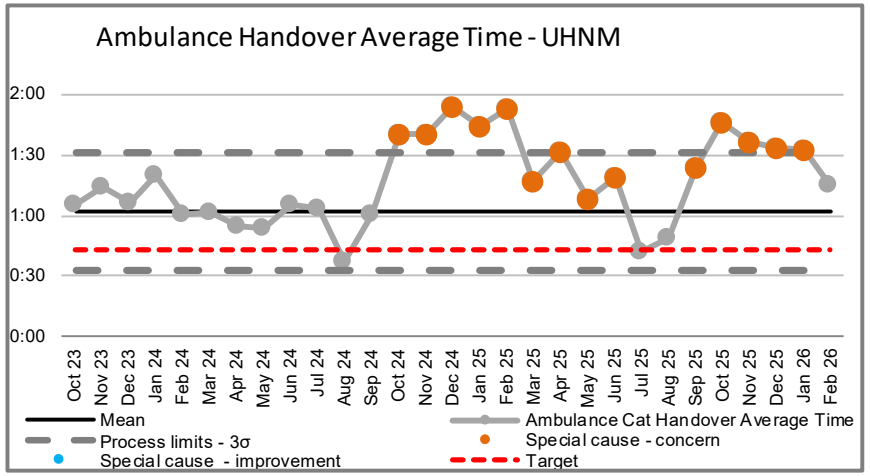
Specialty in-reach in ED is speeding up time to be seen, and this ToC will continue at least until the end of March 2026.

GIRFT led rapid improvement week planned for wc 23/03. ED will look to improve local processes such as escalation timeliness, huddle efficiency and proactive push re IPS.

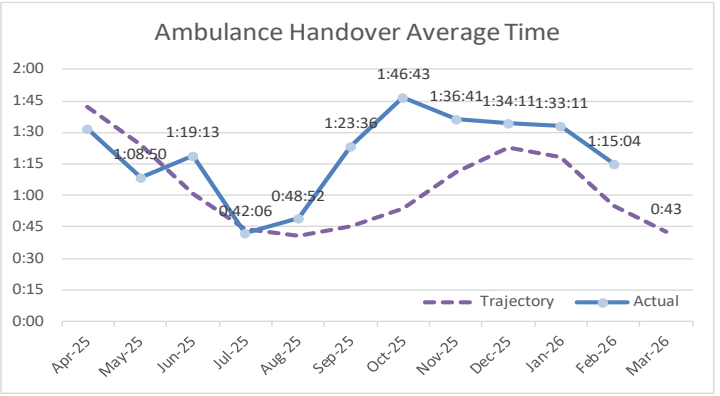
Continue to work on improving flow with GIRFT colleagues.

Quality & Access | Ambulance Handover Average Time

University Hospitals of North Midlands NHS Trust



Variation	Assurance		Monitoring against plan				
				Nov 25	Dec 25	Jan 26	Feb 26
	Target	0:43:00	Actual	1:36:41	1:34:11	1:33:11	1:15:04
Background			Plan	1:11:00	1:23:00	1:18:00	0:55:00
The average time taken for patients to be handed over from Ambulances arriving at UHNM.			Variance	0:25:41	0:11:11	0:15:11	0:20:04



What is the data telling us?

5019 ambulances arrived at UHNM in January – 63.39% of these were handed over within 45 minutes. This is an improvement since January, and the best performance recorded since August 2025.

This has meant that during February 1806 patient waited in an ambulance for longer than 45 minutes before being handed over, compared to 2180 in January.

By site: RSUH was 59.02%, up from 51.18%, and County 81.06% up from 76.40% in January. County was impacted by a number of diverts within the month and still performed better than the previous 6 months.

Average handover time in February was 1 hour and 15 minutes, an 18 minute improvement from January, but still 20 minutes off-plan.

Important to note, February performance was 40 minutes faster than the same month last year.

What are we doing about it?

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

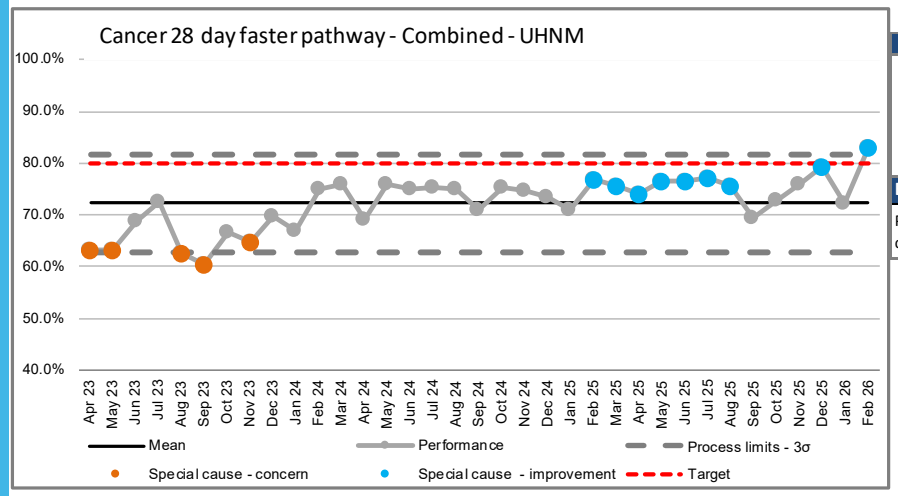
On the 14/01 the 'release to respond' initiative went live, with a focus on offloading ambulances over 90 mins. Through a re-launch of IPS and a system wide focus on shared responsibly (including earlier discharge), some of these benefits have been sustained.

Re-focus on establishing and maintaining BOTH Frailty SDEC bays will allow for quicker pull / offload for this cohort of patients, which is significant proportion of ambulance conveyances.

Planning commenced for the GIRFT led rapid improvement week 23/03 across all care groups to support with flow

Quality & Access | Cancer 28 Day FDS

University Hospitals of North Midlands NHS Trust

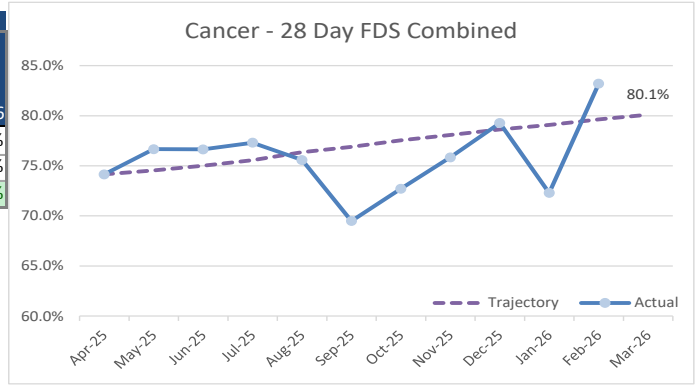


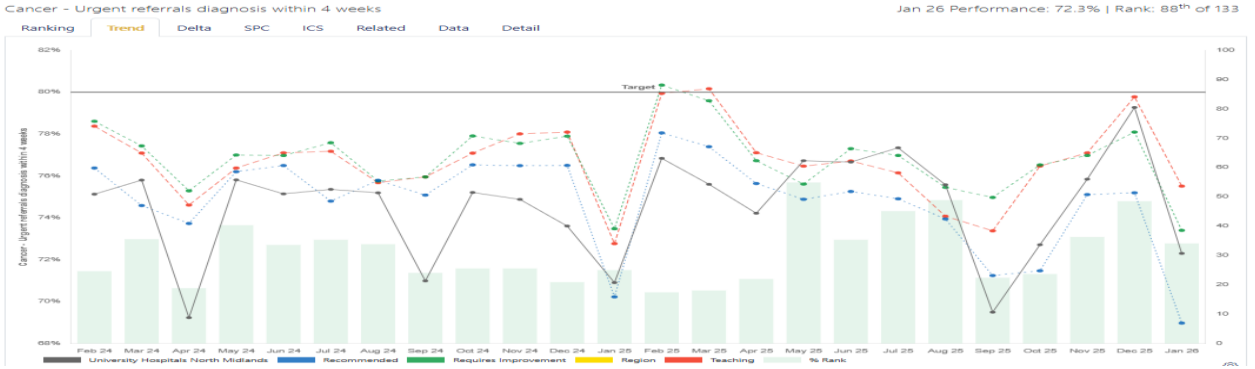
Variation	Assurance
H	?
	Target 80%

Background

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

Monitoring against plan	Nov 25	Dec 25	Jan 26	Feb 26
Actual	75.8%	79.3%	72.3%	83.2%
Plan	78.1%	78.6%	79.1%	79.6%
Variance	-2.2%	0.6%	-6.8%	3.6%





What is the data telling us?

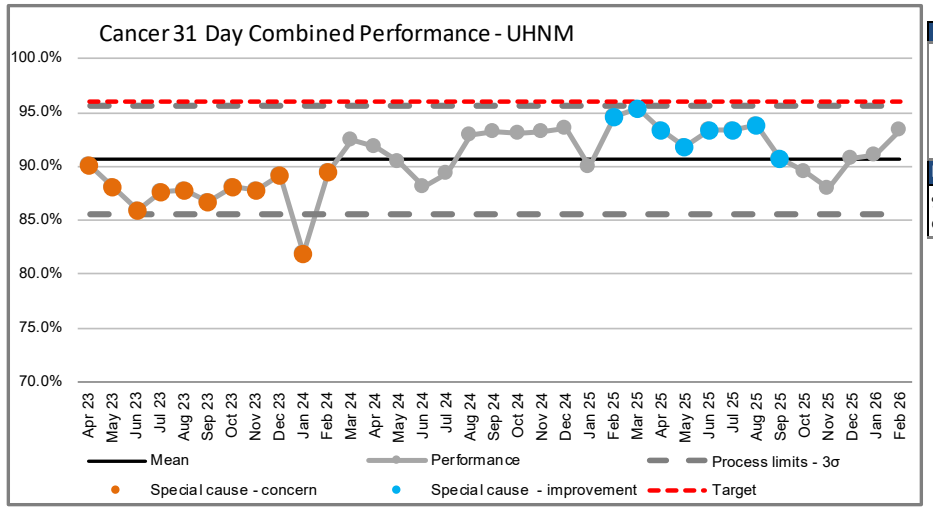
- The final December position is currently at 79.27% against a trajectory of 78.63%
- The final January position was reported at 72.30% against a trajectory of 79.09%
- The provisional February position is currently at 82.44% against a trajectory of 79.63%
- The provisional March position is currently at 81.17% against a trajectory of 80.09%
- There is good performance among most specialties.
- Specialties performing particularly well include Breast and Gynae. Skin have also improved the position in December.
- Specialties falling below standard include H&N – improvement plans in place.

What are we doing about it?

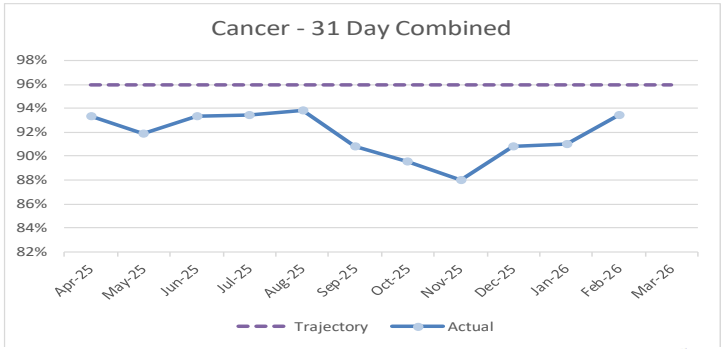
- Maintaining the Cancer Delivery Group meetings to bring focus on operational delivery for improvement plans and adherence to agreed trajectories for 25/26.
- High level escalations sent weekly as part of all cancer PTL escalations for senior oversight and daily oversight by the Cancer Team, escalating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

Quality & Access | Cancer 31 Day Combined

University Hospitals of North Midlands NHS Trust



Variation	Assurance		Monitoring against plan				
				Nov 25	Dec 25	Jan 26	Feb 26
	Target	96%	Actual	88.0%	90.8%	91.0%	93.4%
Background			Plan	96.0%	96.0%	96.0%	96.0%
% patients beginning their treatment for cancer within 31 days following an urgent GP referral for suspected cancer			Variance	-8.0%	-5.2%	-5.0%	-2.6%



What is the data telling us?

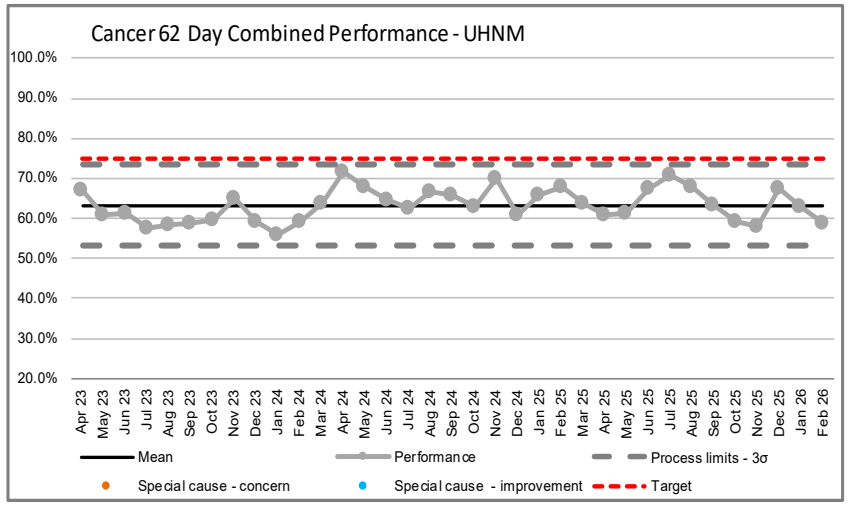
- The final December position is currently at 90.81%
- The **final** January position was reported at 90.99%
- The **provisional** February position is currently at 93.88%
- The **provisional** March position is currently at 87.60%
- Specialties performing well include Breast, H&N, Lung and Upper GI, however challenges in access to surgical capacity remain within Gynae, Colorectal, and Skin.
- The majority of 31-day breaches are attributable to patients receiving surgery as either a first or a subsequent cancer treatment above the 31-day breach range. Particularly first Skin treatments account for a high number of 31 day breaches.
- Within the 31-day cohort of patients breaching surgery, the main delay reason is attributable to lack of capacity in skin, colorectal, gynae and urology tumour sites.
- Radiotherapy and Systemic Anti Cancer Treatments have also seen a slight deterioration of performance. Current waits for Skin Oncology first appointments are at 4 weeks.

What are we doing about it?

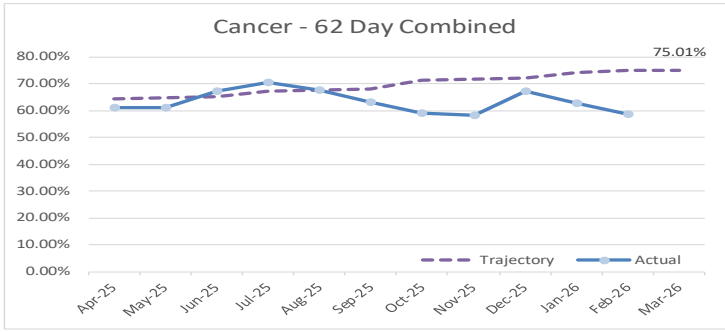
- The Trust and specialties are actively reviewing theatre capacity to ensure utilisation of all capacity available.
- Escalation of surgical capacity constraints at all appropriate forums such as Cancer Delivery Group, Specialty Improvement Groups, Cancer Services Strategy Group & Elective Oversight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

Quality & Access | Cancer 62 Day Combined

University Hospitals of North Midlands NHS Trust



Variation	Assurance		Monitoring against plan				
				Nov 25	Dec 25	Jan 26	Feb 26
	Target	75%	Actual	58.1%	67.5%	62.8%	58.7%
Background			Plan	71.7%	72.4%	74.2%	74.9%
% patients beginning their treatment for cancer within 62 days following an urgent GP referral for suspected cancer			Variance	-13.6%	-4.9%	-11.3%	-16.1%



What is the data telling us?

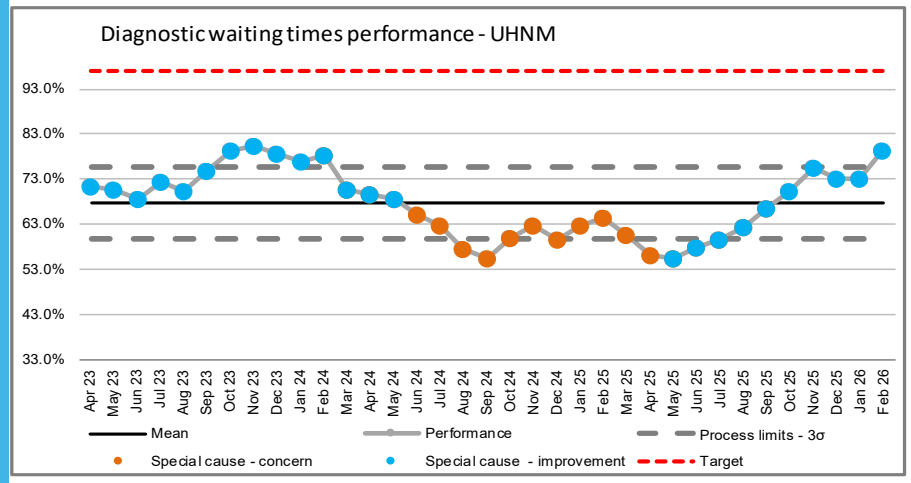
- The final December position was reported at 67.47% against a trajectory of 72.37%
- The final January position was reported at 62.84% against a trajectory of 74.18%
- The provisional February position is currently at 60.96% against a trajectory of 74.87%
- February is expected to improve as the position nears completeness and is validated.
- Higher number of breaches in Skin has contributed to the declining position, with additional activity secured with an outsourced provider.
- Breast, Colorectal, Gynae, Head & Neck, Skin & Upper GI are below their trajectories.
- Skin performance is particularly challenged owing to capacity for diagnostics and treatment which is significantly impacting on overall Trust performance from September onwards.
- Surgical capacity constraints (including robotics) affecting Gynae, Colorectal and Skin.
- Complex pathways (i.e. multiple investigations, second look biopsies, molecular and genetics testing).

What are we doing about it?

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

Quality & Access | Diagnostics DM01 Performance

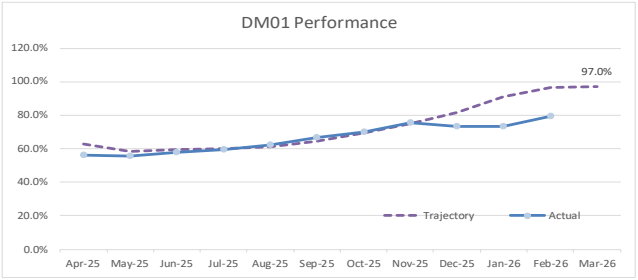
University Hospitals of North Midlands NHS Trust

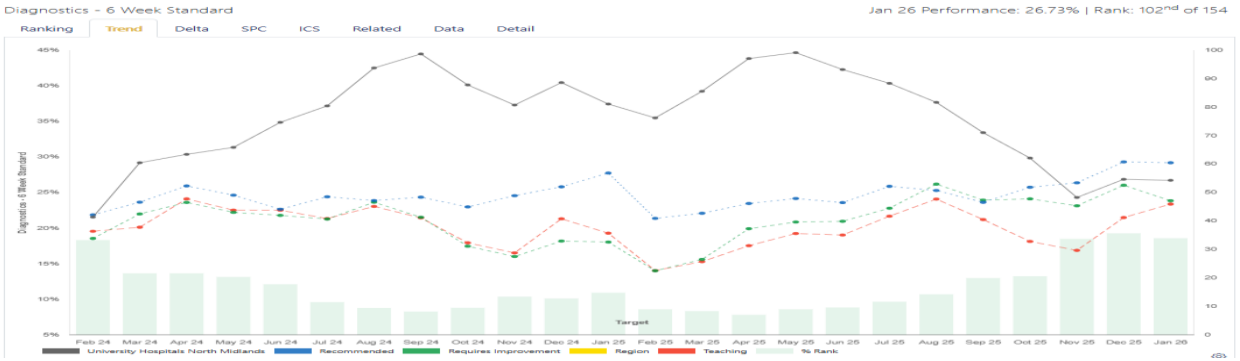


Variation	Assurance		Monitoring against plan				
				Nov 25	Dec 25	Jan 26	Feb 26
	Target	97.0%	Actual	75.7%	73.1%	73.3%	79.3%
			Plan	75.2%	81.8%	90.8%	96.8%
			Variance	0.5%	-8.7%	-17.5%	-17.4%

Background

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





What is the data telling us?

Februarys DM01 validated performance was 79.3% against trajectory of 96.8%. 95% being the national standard. Current performance is 82.1% (13/03)

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

- NOUS unvalidated performance is now 75.1%. An increase in performance of 5.2% in the last 4 weeks

Urodynamics has previously been highlighted as a concern, however processes have been updated and performance is expected to quickly improve by end of March (currently 52.8%)

Cystoscopies have also been highlighted as a concern. This is due to a data quality issue which is also being resolved in the month of March, and performance is also expected to improve by the of March (currently 62.6%)

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

What are we doing about it?

Non obstetric Ultrasound

- NOUS backlog position continues to improve (previous fortnightly position in brackets) current breakdown as follows:
  - Total waiting for an appointment = 3189 (4,492)
  - Total under 6 weeks = 2,838 (3,305)
  - Total between 6 and 13 weeks = 109 (775)
  - Total over 13 weeks = 54 (318)

Endoscopy

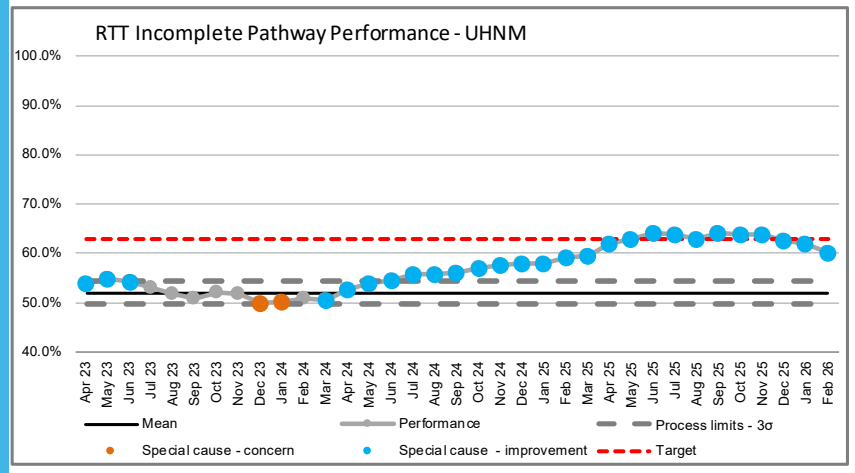
- Full business case approved by execs for Nov to March to bridge CDC gap until April 26.
- Consultant only slots will need WLI support from Gastro Consultants; Gastro aware and looking to support

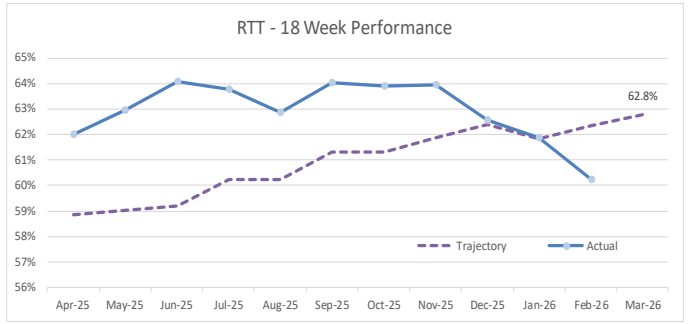
Neurophysiology

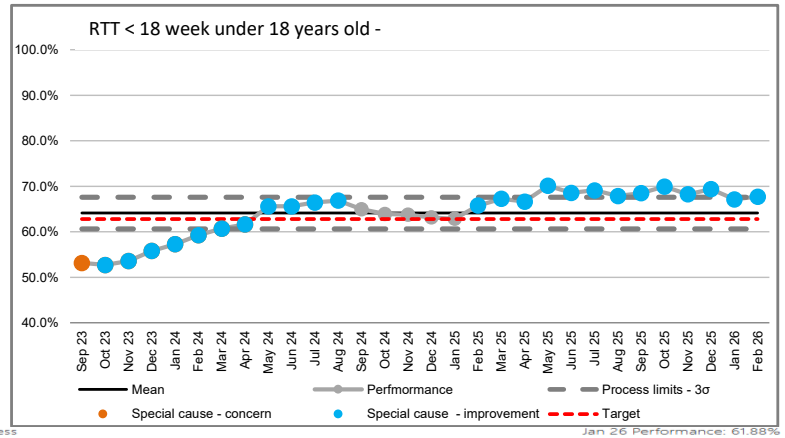
- Revenue for diagnostics for 26/27 available to cover 12-month workforce gap whilst BC written

Quality & Access | RTT Performance

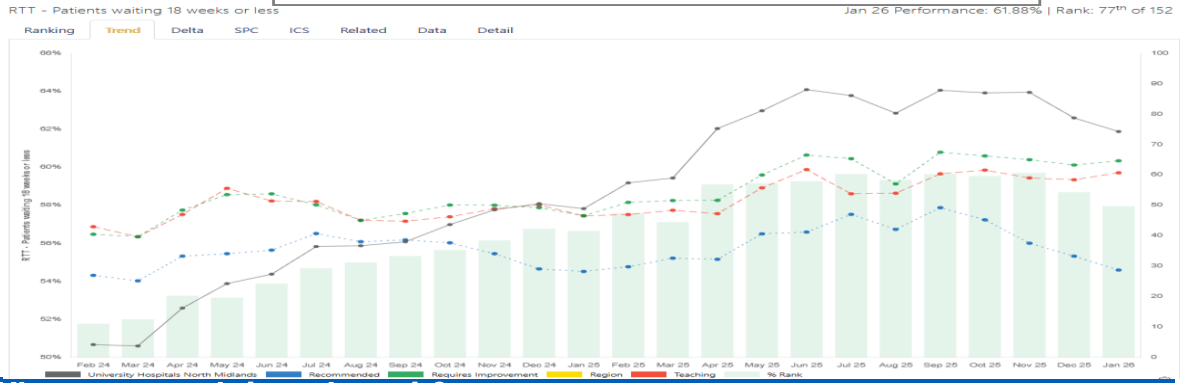
University Hospitals of North Midlands NHS Trust







Variation	Assurance		Monitoring against plan				
				Nov 25	Dec 25	Jan 26	Feb 26
	Target	63%	Actual	63.9%	62.6%	61.9%	60.3%
Background			Plan	61.9%	62.4%	61.8%	62.4%
The percentage of patients waiting less than 18 weeks for treatment.			Variance	2.1%	0.2%	0.0%	-2.1%



What is the data telling us?

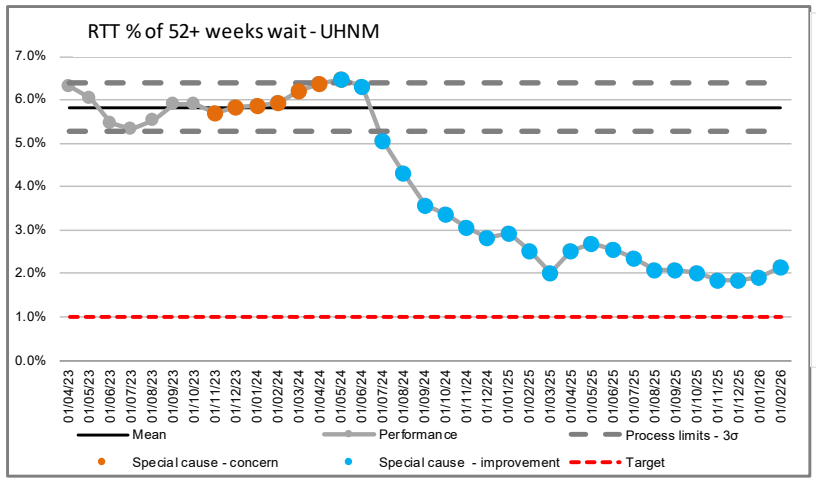
- Performance has deteriorated slightly during February with a provisional position of 61.7%, due again to the combination of UEC pressures, half term, and reduced administrative capacity. Performance is now behind plan.
- Rank against acute trusts slipped in January to 77th from 70th.
- Total PTL has reduced from 65,506 in January to 64,814 in February.

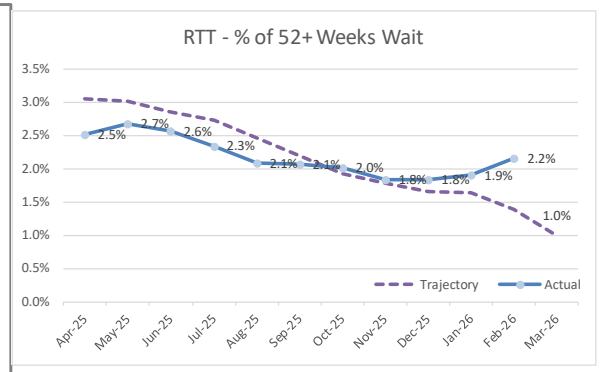
What are we doing about it?

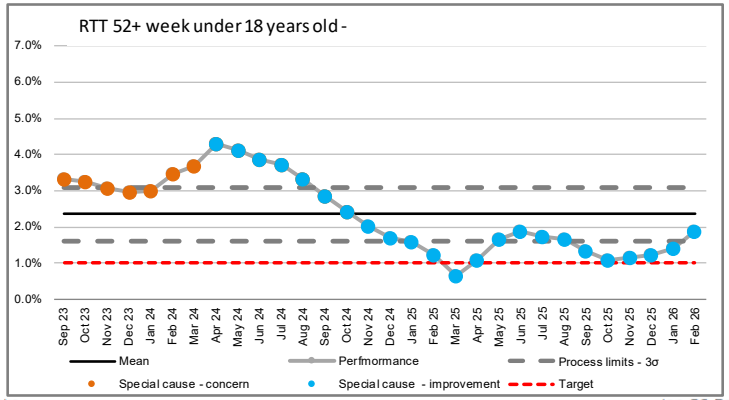
- MBI have returned to bolster validation capacity during the final sprint, having commenced 9th February.
- 2 directorates are now utilising Rova, with plans for the rest of the relevant directorates to be onboard by mid-April.
- 2 corporate validator posts recruited to and are now in post.

Quality & Access | RTT Performance – % 52+ Weeks

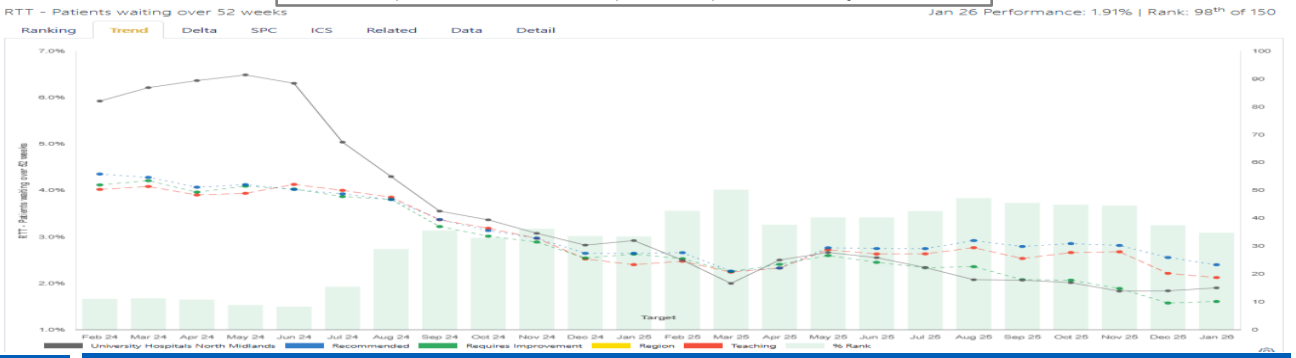
University Hospitals of North Midlands NHS Trust







Variation	Assurance		Monitoring against plan				
				Nov 25	Dec 25	Jan 26	Feb 26
	Target	1.00%	Actual	1.83%	1.84%	1.91%	2.16%
Background			Plan	1.79%	1.65%	1.65%	1.39%
The percentage of patients on a RTT pathway who have			Variance	0.0%	0.2%	0.3%	0.8%



What is the data telling us?

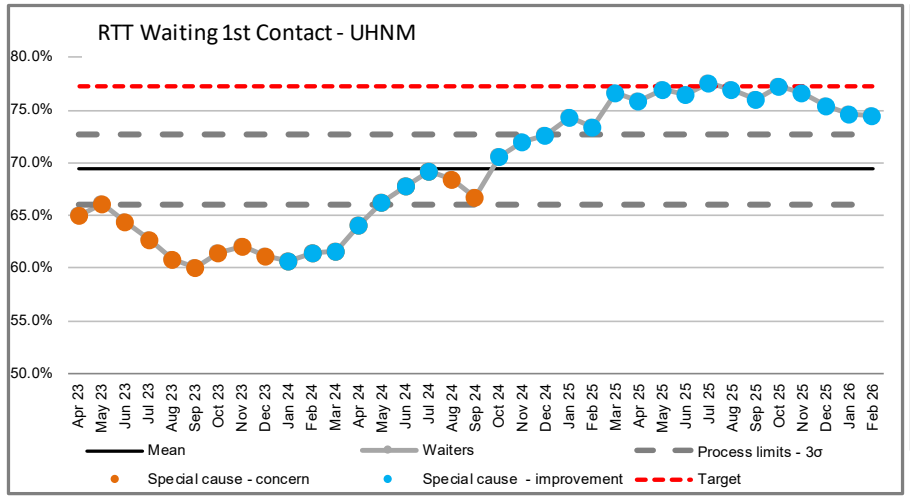
- Percentage of total PTL above 52 weeks has seen an increase again during February –from 1.91% to 2.11% - further behind plan.
- 52 week actuals has seen another increase in February from 1,250 to 1,370.
- This cohort is extensively validated, so there's not much scope for improvement through validation alone
- Another factor influencing this is the reduction in total waiting list size, so the unavoidable side effect of the validation programme is an increase in the percentage of the waiting list over 52 weeks

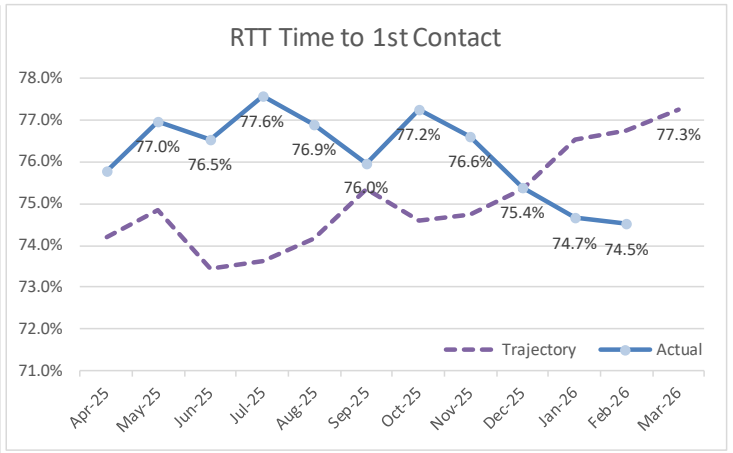
What are we doing about it?

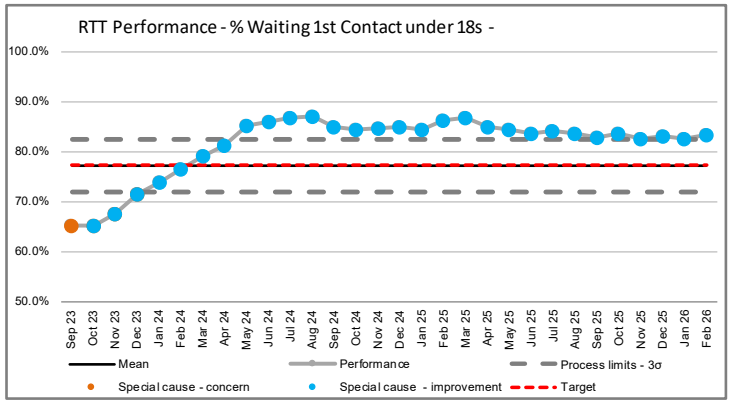
- Gynae Recovery funding approved at execs to deliver substantial additional activity through weekend and STS working; activity against recovery to be tracked separately on a week-by-week basis
- The ROVA validation tool also highlights pathways where actions have not been taken, and groups pathways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

Quality & Access | RTT % Waiting 1st Contact

University Hospitals of North Midlands NHS Trust







Variation	Assurance		Monitoring against plan				
				Nov 25	Dec 25	Jan 26	Feb 26
	Target	77.3%	Actual	76.6%	75.4%	74.7%	74.5%
Background			Plan	74.7%	75.3%	76.6%	76.7%
Of all patients waiting for first event after referral - the percentage that are waiting under 18 weeks			Variance	1.9%	0.1%	-1.9%	-2.2%

What is the data telling us?

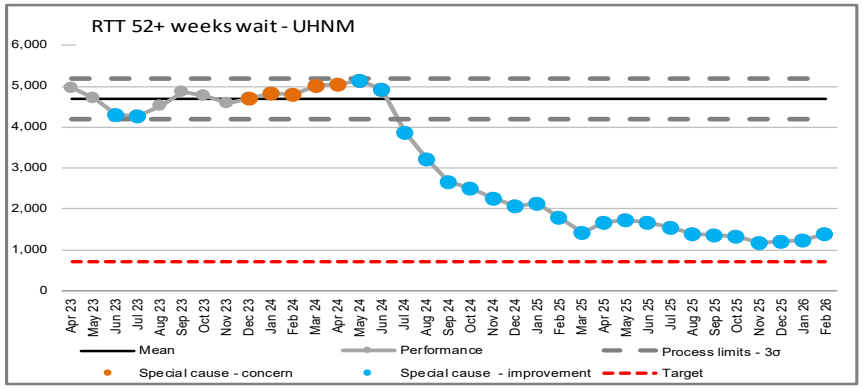
- UHNM is a regional leader on this metric and has been continually ahead of plan
- Time to first contact has reduced and is now off plan, at 74.7%
- The Elective sprint increasing the volume of Outpatient 1st New Activity in Q4 should bring the trust back on plan, and current data indicates this is achievable.

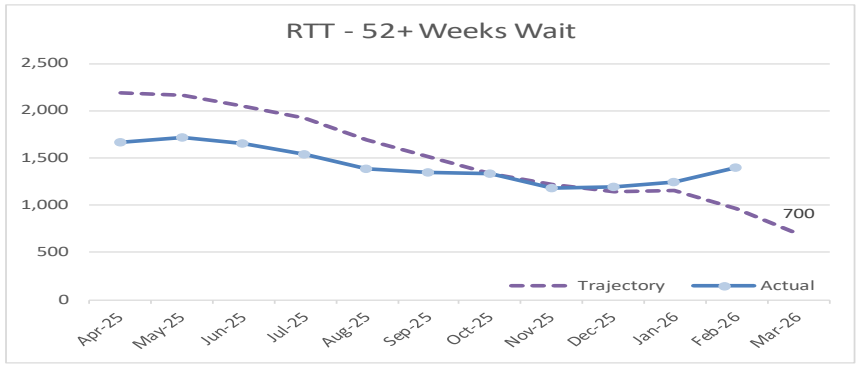
What are we doing about it?

- 52-week 1st contact for patients by March '26 are required to be seen by January '26. Performance being tracked weekly through EOMG
- Increased validation of pathways in target specialties for patients awaiting 1st contact, as not all should be on an RTT pathway
- Work to understand the Ophthalmology increase is underway; a reduction in independent sector cataract capacity within the ICS in 2024/25 has likely had an impact
- Focus on outcoming of 1st new appointments on an RTT pathway.

Quality & Access | RTT No. of Long Waiting Patients

University Hospitals of North Midlands NHS Trust





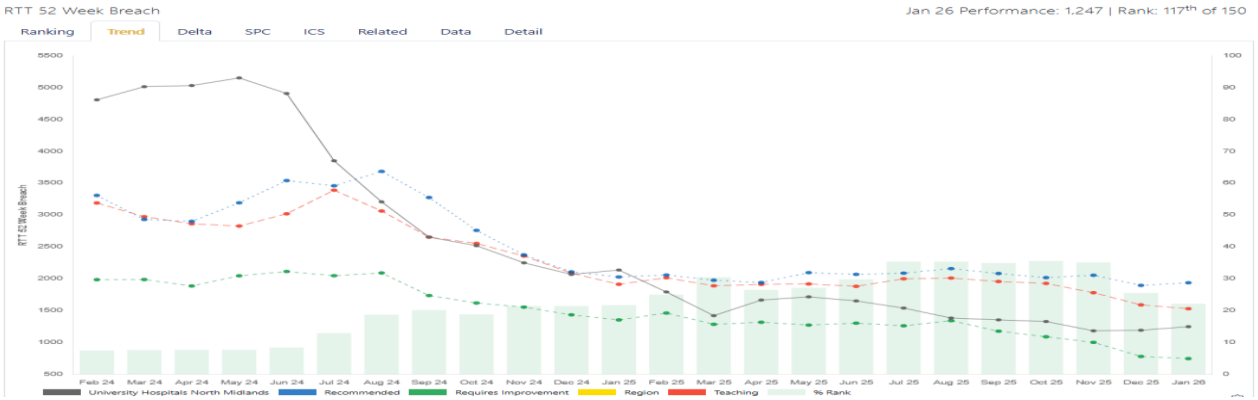
Variation	Assurance

Target	700

Background

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

Monitoring against plan	Nov 25	Dec 25	Jan 26	Feb 26
Actual	1,183	1,192	1,248	1,403
Plan	1,224	1,138	1,151	969
Variance	-41	54	97	434
65+	46	66	84	111
78+	1	3	6	6
104+	0	0	0	1



What is the data telling us?

- The number of 78 week stayed stable in February -6 patients. All of these patients are booked to be treated in April.
- 65 week waits have increased in January, up to 83 from 66. Although an increase, this was an improvement on forecasts earlier in the month.
- There is some risk with the extensive validation work underway of pop-up long waiters – these will be managed through the trust's "uncorrected breaches" process
- Particular specialties which impact are Orthopaedics, ENT, Ophthalmology, Oral MaxFacs and Gynaecology.

What are we doing about it?

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

Highlight Report

PEOPLE CULTURE & INCLUSION COMMITTEE | 1st April 2026

University Hospitals of North Midlands NHS Trust

Matters of Concern / Key Risks to Escalate	Major Actions Commissioned / Work Underway
• Partial Assurance for **Guardian of Safe Working** Q3 report; high number of hours related exception reports were noted, with a number of key areas identified as requiring focused action. • **Medical Workforce Group** highlighted ongoing workforce risk from persistent consultant vacancies across key specialties, services remaining safe but stretched through heavy reliance on locum and locally employed doctor cover, creating fragility, cost pressure and oversight challenges. • There remain gaps and variation to be addressed in relation to **Talent Management and Succession Planning**, along with some capacity challenges to release leaders for development. • Partial Assurance for the **Chief People Officer Report** as whilst tangible progress has been made against the People Plan, key risks continue to limit assurance – including capacity constraints and ability to respond to increasingly complex Subject Access Requests and Freedom of Information Requests. • Slightly below average against the benchmarking group for all areas of the **Staff Survey** with the exception of morale. • Partial Assurance for the **Health & Safety Report** due to some gaps in compliance which will be prioritised through the annual work plan; ongoing risk remains in relation to the notice of contravention. • Partial Assurance for the **Gender, Ethnicity and Pay Gap** report, with a mixed and complex picture being presented. Workstreams and metrics have been identified to continue to reduce pay inequity amongst marginalised group although UHNM is not an outlier at a national level.	• Further reports from the **Medical Workforce Group** will include the wider scope of work being undertaken to ensure sustainability. • **Nurse Staffing Report** identified a corporate workstream commenced to consider a different approach to managing enhanced observations of care. • Plans in place to address the key challenges identified within the **Talent Management and Succession Planning** for 2026 / 2027, which were shared with the Committee through a Driver Diagram. • Focused improvement attention on sickness absence management, capacity and resilience within the People Directorate, strengthening compliance with Subject Access Requests and accelerating progress on apprenticeships, appraisal and leadership development. • Enhanced oversight of the **sexual safety programme**, including training, case management and cultural interventions. • **Health and Safety** Annual Plan focus on ensuring all toolkits and training are implemented, along with audit processes to determine local level compliance and inform targeted actions. • Engagement in national networks remains underway and will be strengthened through learning from successful organisations in relation to the national **Staff Survey.** • Update to the **Health and Safety** workplan to be undertaken to provide clear timescales for completion of delayed actions.

Positive Assurances to Provide	Decisions Made
• Improved engagement through the **Resident Doctor Forum** was noted in the report from the Guardian of Safe Working. • Improved engagement and representation at the **Medical Workforce Group**. • Acceptable Assurance noted for the **Nurse Staffing Report** process, which identifies to Care Groups for risks / concerns to be identified and actions to improve quality and safety. Overall fill rate for registered nurses for February was 92% and 91% for unregistered. • Acceptable Assurance for **Talent Management and Succession Planning** reflecting the general confidence in actions / interventions in place, including those as a result of the complex organisation wide change process. • Acceptable Assurance for the approach to ensuring Committee oversight aligned with the Insightful Board metrics. • Acceptable Assurance for the Staff Survey as there is general confidence in the delivery of key action and interventions, and findings reflect national trend.	• There were no items requiring decision.

Comments on the Effectiveness of the Meeting	Cross Committee Considerations
A questionnaire was circulated to Committee members for completion.	• Current Job Planning Policy is out of date and will be noted by the **Audit Committee** as such; however, a review is underway although it is not yet ready to be taken to the Local Negotiating Committee. • Use of timely observations data for further consideration by the **Quality, Access and Outcomes Committee**. • **Finance and Performance Committee** in relation to balancing the risk associated with corporate capacity and capability / compliance and where investment is targeted.

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 Q3 25/26	1/3	-	**Partial**	Assurance	7.	Strategic Workforce Group Highlight Report (19-03-26)	3	-	**Not Applicable**	Information
2.	Medical Workforce Group Highlight Report (03-03-26)	3	-	**Not Applicable**	Information	8.	NHS Staff Survey 2025 Results	3	**Ext 15**	**Acceptable**	Assurance
3.	Staffing Report - Unify Report (Bi-Monthly)	1/3	**Ext 15**	**Acceptable**	Assurance	9.	Health & Safety Report Q3 25/26	-	**18673 - Ext** **25412 - Ext** **22876 - High**	**Partial**	Assurance
4.	Talent and Succession Planning Update	3	**Ext 15**	**Acceptable**	Assurance	10.	Executive Health & Safety Group Highlight Report (17-02-26 & 17-03-26)	-	-	**Not Applicable**	Information
5.	Chief People Officer Report	3	**Ext 15**	**Partial**	Assurance	11.	Gender, Ethnicity and Disability Pay Gap Report 2025	3	**Ext 15**	**Partial**	Assurance
6.	Insightful Provider Board	3	**Ext 15**	**Acceptable**	Assurance	12.					

University Hospitals of North Midlands NHS Trust

Integrated Performance Report

Month 11 Performance

2025/26

Kind Excellent Together

University Hospitals of North Midlands NHS Trust

Contents

Statistical Process Control

University Hospitals of North Midlands NHS Trust

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

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

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

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

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

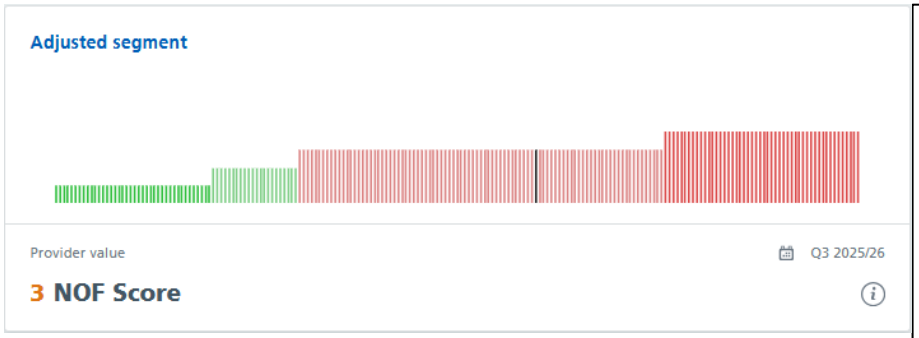
Where icons indicate an area needs attention, you could give more detail by attaching the full SPC chart and narrative describing the context, issues and actions in an appendix.

Oversight Framework Summary

University Hospitals of North Midlands NHS Trust

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

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



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

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

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

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University Hospitals of North Midlands NHS Trust

People and Workforce

People and workforce	Data period	Provider value		Chart
People and workforce domain segment	Q3 2025/26	2	NOF Score	
People and workforce domain score	Q3 2025/26	2.49	NOF Score	

Retention and Culture	Data period	Provider value	Peer average	National value	National value method	Chart
Sickness absence rate score	Q3 2025/26	2.35	NOF Score	Provider value	
Sickness absence rate (quarter)	To Sep 2025	5.13%	5.23%	5.24%	Provider median	
NHS staff survey engagement theme sub-score score	Q3 2025/26	2.62	NOF Score	Provider value	
NHS staff survey engagement theme sub-score	Dec 2024	6.84	6.78	6.88	Provider median	

UHNM remain in segment 2 in this domain, with an improved score of 2.49 in quarter three, compared to 2.53 in quarter two.
Although a deterioration in the sickness absence rate in quarter three to 5.13% from 4.83% in quarter two, it suggests that other providers performed worse than UHNM as the overall domain score improved. UHNM performed better than peers and the national average.

Staff survey scores remain unchanged.

People | Overview

Creating a great place to work for everyone

Overview from the Chief People Officer

How are we doing against our trajectories and expected standards?

Our most recent ***Staff Engagement*** score was 6.6 for January 2026, up from the score of 6.3 for July 2025, against a target of 7.2. The Staff Voice Survey is now collected quarterly and recommenced in January 2026, following a pause during the 2025 National Staff Survey period, with the next data collection scheduled for April 2026.

Sickness absence remains above our expected standard of 3.39%. In-month sickness decreased to 5.73% while the rolling 12-month cumulative sickness rates increased slightly to 5.34%. Overall, sickness absences continue to be driven by stress and anxiety, followed by cold, cough, flu and then other musculoskeletal problems, as the second and third most common reasons. In February, 558 episodes of Cold, Cough, Flu, and Chest & Respiratory conditions were reported, compared to 835 episodes in January — representing a 33.17% decrease.

Turnover and ***vacancy*** metrics continue to perform well against our expected standards. The turnover rate in February 2025 remains low, at 7.5%, which is consistently below our 11% target, for the last 3 years. Vacancies remain low at 4.7%, which is linked to the cost improvement profile and changes to the budgeted establishment. Colleagues in post increased in Registered Nursing (+13), Registered ST & T (+8.5), Support to Clinical (+4.0), Infrastructure (+1.0), with Medical & Dental reducing by -3.0 fte.

Agency costs increased to 1.91%, in February 2026, from 1.71% in January 2026, which is below the threshold set by NHS England. In real-terms, overall agency usage increased to 120.75 WTE in February from 96.05 WTE in January 2026, which is 25 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. February saw a slight decrease in the in-month sickness absence percentage, influenced by seasonal fluctuations associated with a reduction in the episodes of cold, cough & flu, and Covid-19.

Agency expenditure was 25 WTE above plan, with all staff groups performing below plan, except for Medical & Dental who are 38 WTE above plan due to vacancies, maternity leave and sickness absence. Agency use is also influenced by the additional scrutiny at executive and care group level which is having the desired effect in reducing overall agency spend, with some agency activity being converted to bank expenditure, as well.

People | Overview

Creating a great place to work for everyone

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.

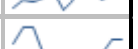
What can we expect in future reports?

As we move towards the end of Winter, we may see a continued stabilisation in sickness absence reasons associated with gastrointestinal, cold & flu, and Covid-19 related symptoms, but any deterioration in the weather may impact on short term sickness absences.

Without further Industrial Action, agency usage may track slightly above plan in March 2026, resulting from the usual end-of-year financial accruals. Despite this, and the additional scrutiny, of agency expenditure, the on-going elective recovery programme activity, and the continued need for escalation capacity and the additional demand in theatres and endoscopy services, and in the emergency portals, there are still many influences demanding the need for agency.

People | Dashboard

Creating a great place to work for everyone

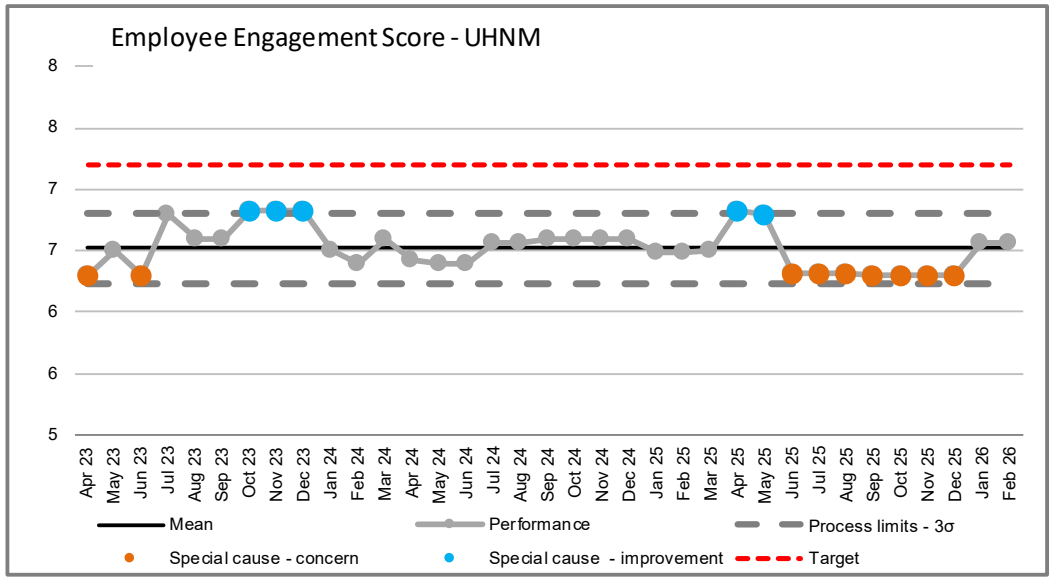
Metric	Target	Previous	Latest	Variation	Assurance	R12M Trend
Staff Turnover (R12M)	11.0%	7.5%	7.5%	L	P	
Staff Vacancy Rate	8.0%	4.4%	4.7%	L	?	
Sickness Absence (In Month)	3.4%	6.0%	5.7%		F	
Appraisal (PDR)	95.0%	82.4%	82.0%	L	F	
Agency Utilisation	3.2%	1.7%	1.9%	L	?	
Employee Engagement	7.2	6.6	6.6		F	

Related Strategy and Board Assurance Framework (BAF)

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

People | Employee Engagement

Creating a great place to work for everyone



Variation	Assurance
	F

Target	Dec 25	Jan 26	Feb 26
7.2	6.3	6.6	6.6

Background

What is the data telling us?

Our most recent Staff Engagement score was 6.6, for January 2026, up from the score of 6.3 for July 2025, against a target of 7.2.

The Staff Voice Survey is now collected quarterly and recommenced in January 2026, following a pause during the 2025 National Staff Survey period, with the next data collection scheduled for April 2026, via the National Quarterly Pulse Survey.

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

What are we doing about it?

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

Sustained operational pressures continue to impact on overall employee engagement.

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

People | Sickness Absence in Month

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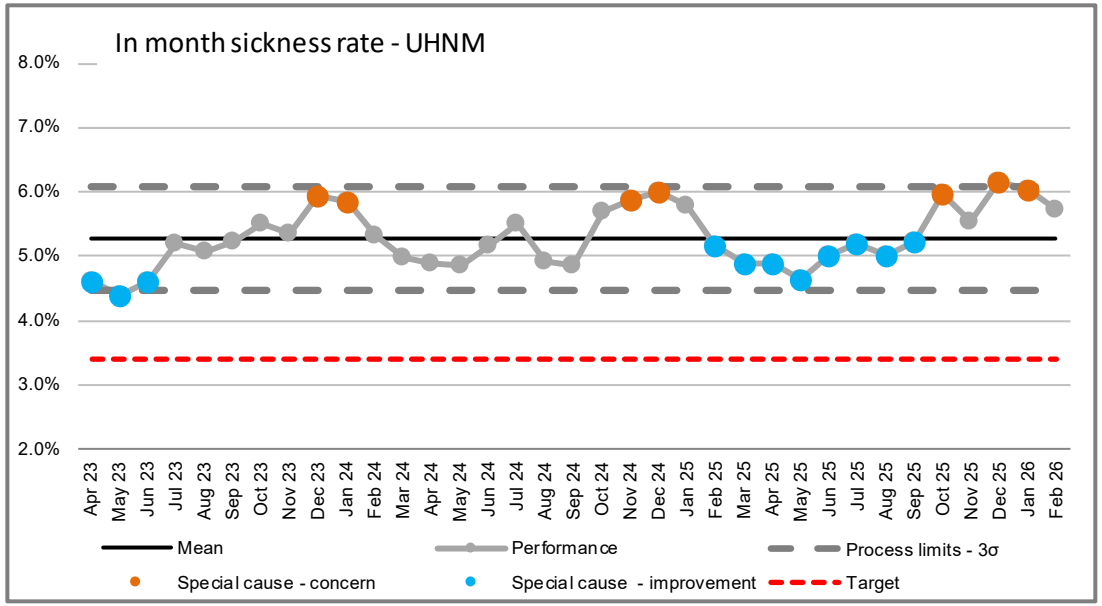


Variation	Assurance
	

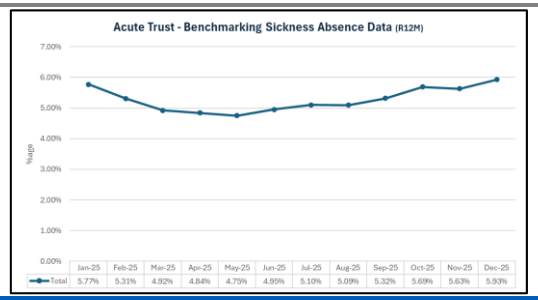
Target	Dec 25	Jan 26	Feb 26
3.4%	6.2%	6.0%	5.7%

Background

Percentage of days lost to staff sickness

Our sickness absence rates are very similar to other Acute Trust's when examining the available benchmarking data.

(Benchmarking data effective Dec 2025- 5.93%)



What is the data telling us?

The rolling 12-month average sickness absence rate increased to 5.34% (5.30% in January 2026) against the target of 3.4%.

The in-month sickness absence decreased to 5.73% in February (6.04% in January 2026) with stress and anxiety seeing the largest increase of 1.6%, while Cold, Cough, Flu – influenza and other musculoskeletal problems decreasing by -2.5% and -0.8% respectively.

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

What are we doing about it?

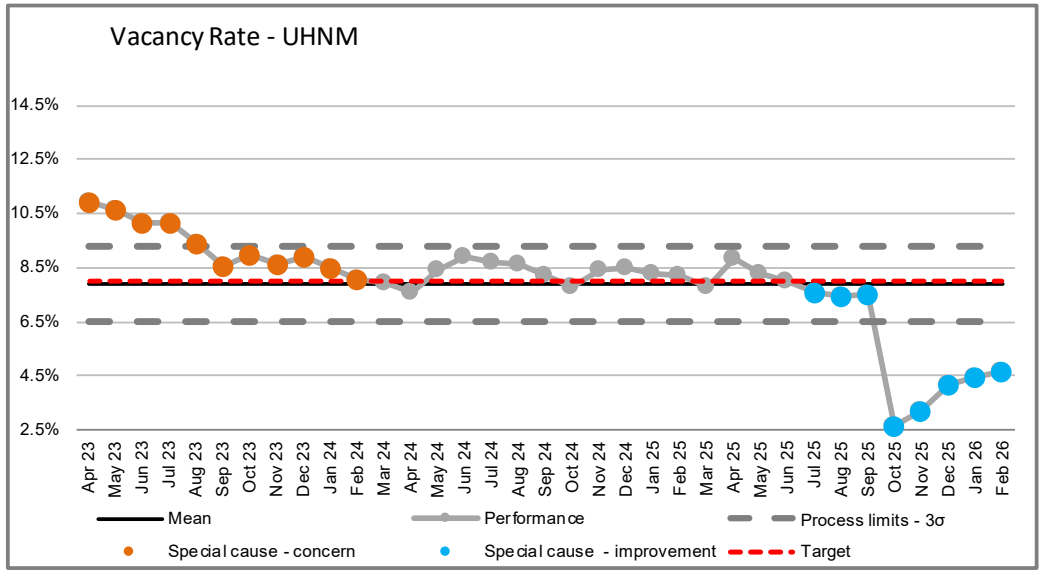
Unplanned Care - sickness absence continues to be monitored at CBU performance reviews. Areas with over 8% or of concern are supported by the People Advisor focusing on long term sickness cases.

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

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

People | Vacancy Rate

Creating a great place to work for everyone



Variation	Assurance
	

Target	Dec 25	Jan 26	Feb 26
8%	4.2%	4.4%	4.7%

Background

Based on Full Establishment (Substantive, Bank & Agency)

Vacancies at 28-02-26	Budgeted Establishment	Staff In Post fte	Vacancies	Vacancy %	Previous Month
Medical and Dental	1,805.02	1,642.83	162.19	8.99%	8.97%
Registered Nursing	3774.01	3830.84	-56.83	-1.51%	-1.59%
All other Staff Groups	6897.44	6423.13	474.31	6.88%	6.52%
Total	12,476.47	11,896.80	579.67	4.65%	4.43%

What is the data telling us?

February's low vacancy rate of 4.7% (4.4% in January) links to the cost improvement profile and changes to the budgeted establishment, which came into effect from October 2025.

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

Colleagues in post increased in February 2025 by 25.22 fte, budgeted establishment increased by 55.18 fte, which increased the vacancy fte by 29.96 fte.

[*Note: the Staff in Post fte is a snapshot at a point in time, so may not be the final figure for 28/02/26]

What are we doing about it?

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

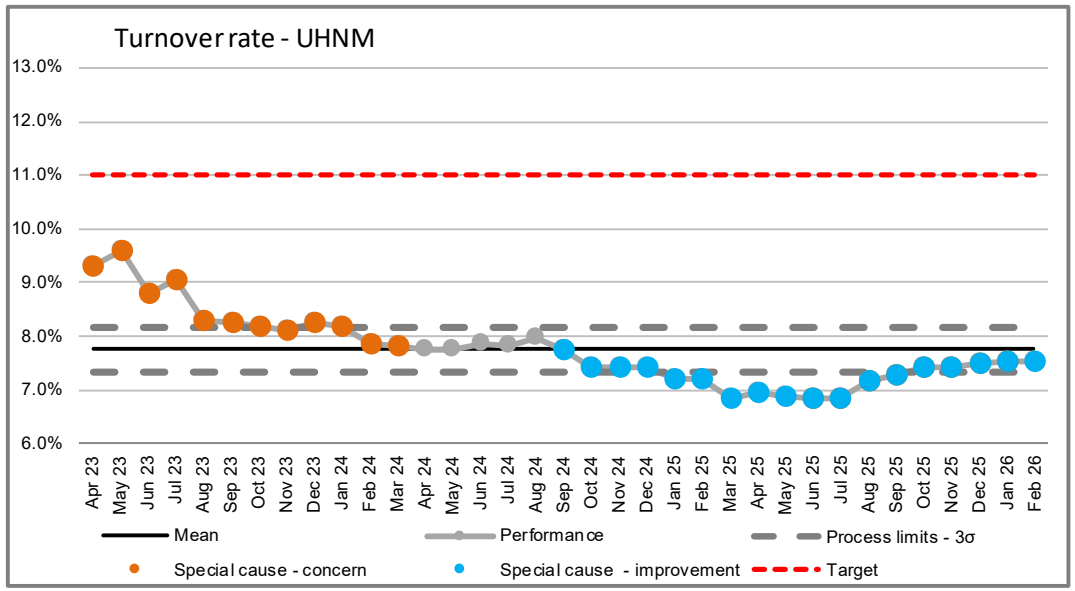
Targeted social media campaigns continue, advertising that our organisation is a great place to work.

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

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

People | Turnover Rate

Creating a great place to work for everyone



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

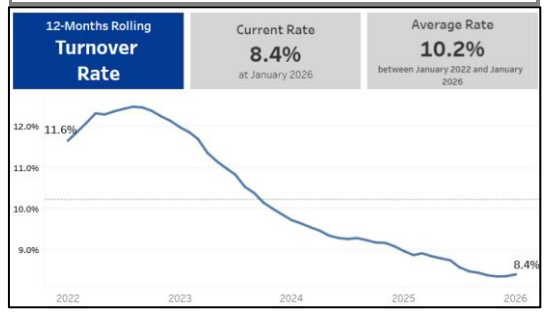
(Benchmarking data effective January 2026)

Variation	Assurance
	

Target	Dec 25	Jan 26	Feb 26
11.0%	7.5%	7.5%	7.5%

Background

Turnover rate.



What is the data telling us?

February 2026's turnover rate remained static at 7.5% for the third consecutive month, which is consistently below the Trust's 11% target, for almost three years.

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

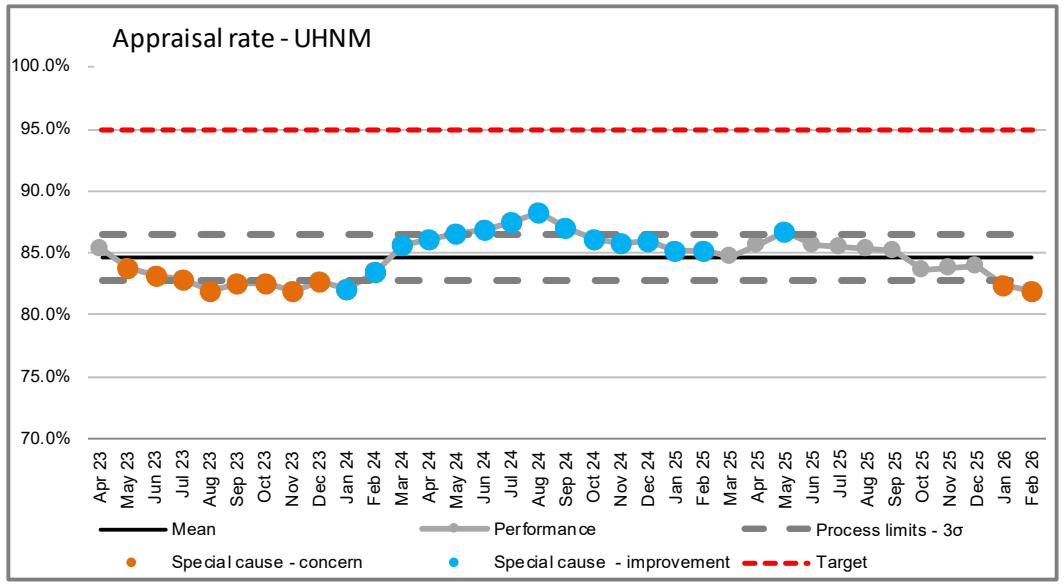
What are we doing about it?

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

- Medical Staffing finishing school.
- Employment of a People Promise (Retention) Manager who currently continues in a fixed term post.
- Monthly targeted campaigns aligned to our Trust Values. For example, February included the Race Equality Week, with this year's theme being "*Change Needs All of Us"* which offers us all the chance to reflect together as colleagues who share a common purpose and responsibility.

People | Appraisal Rate

Creating a great place to work for everyone



Variation	Assurance
L	F

Target	Dec 25	Jan 26	Feb 26
95%	83.9%	82.4%	82.0%

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.

February's appraisal rates decreased to 82.0% from 82.4% in January 2026, although Estates, Facilities and PFI Division consistently achieving above the target, at 98.11% for February 2026.

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

What are we doing about it?

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

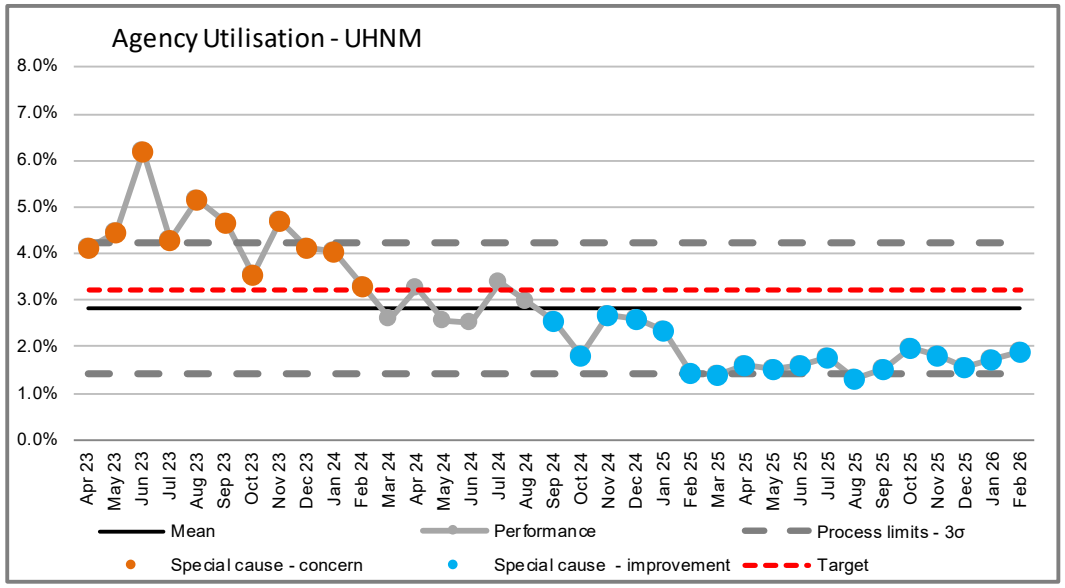
Planned Care– Monthly compliance report, with a focus on hotspots.

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

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

People | Agency Utilisation

Creating a great place to work for everyone



Variation	Assurance
	

Target	Dec 25	Jan 26	Feb 26
3.2%	1.6%	1.7%	1.9%

Background

Agency cost as a percentage of total pay cost

What is the data telling us?

Agency cost is calculated as a percentage of the total Pay Costs, which increased to 1.91% in February 2026, (1.71% in January 2026).

In real-terms, overall agency usage increased to 120.75 WTE in February from 96.05 WTE in January 2026, which is 25 WTE above plan, driven by vacancies, maternity leave and sickness, in Medical & Dental, and vacancies in cardiac perfusionists and healthcare scientists, with all other staff groups below plan.

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

What are we doing about it?

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

Highlight Report

Finance & Business Performance Committee | 2nd March 2026

University Hospitals of North Midlands NHS Trust

Matters of Concern / Key Risks to Escalate	Major Actions Commissioned / Work Underway
• **Demand and activity** (Month 10) demonstrated Emergency Department (ED) demand returning to a normalised level; however, higher ED conversion rates and increased patient complexity remain, resulting in partial assurance. The Committee requested further assurance on the outcomes and impact of the Frail Elderly Assessment Unit (FEAU) test of change, including evidence of system and flow benefits. • An update on the **Cost Improvement Programme** (CIP) 2026/27 confirmed that £48.1m of the £62.2m target has been identified and the position had been discussed with NHS England. Due to the incomplete nature of the programme and reliance on further scheme development, the Committee concluded partial assurance. • Month 10 **financial performance** reported a £6.8m adverse variance to plan, which was anticipated. The underlying position of a £34m deficit was confirmed as consistent with the planned start position for 2026/27. The capital programme remained on track to achieve forecast, despite some slippage, which was expected to recover. Partial assurance was agreed. • A verbal update was provided on initial feedback from NHS England following submission of the **Medium-Term Plan**, noting that further clarification and engagement will be required as national feedback was formalised.	• Following consideration of the **Shadow IT internal audit**, the Committee requested a comprehensive, trust-wide overview of Shadow IT systems, including confirmation of DPIA, DTAC compliance, and clinical safety assessments, to identify systems at higher risk and determine where further deep-dive assurance may be required. • The Committee requested additional assurance on the balance of pay and non-pay savings within the 2026/27 **CIP**, to strengthen understanding of deliverability and sustainability.
Positive Assurances to Provide	**Decisions Made**
• The Committee received and noted the follow-up **internal audit on transformational and major change project management**, which concluded that good progress has been made, providing positive assurance.	• The Committee agreed to delegate authority to the Executive Team to deploy £1.5m for **additional corporate capacity**, with the proviso that further assurance and clarity on funded areas was provided at the next Committee meeting. • The Committee approved continued substantive funding for the **frailty service at County Hospital**, subject to final confirmation of costs and submission of updated benefits realisation metrics. • The Committee approved the following **e-REAFs** 17589, 17639, 17737, 17729, 17730, 17646, 17644, 17228 and 17766.
Comments on the Effectiveness of the Meeting	**Cross Committee Considerations**
• Members were asked to provide comments on the effectiveness of the meeting via MS Forms.	• It was agreed to provide an update to the Audit Committee on the actions being taken in respect of Shadow IT

Summary Agenda

No.	Agenda Item	BAF Mapping			Purpose	No.	Agenda Item	BAF Mapping			Purpose
		BAF No.	Risk	Assurance				BAF No.	Risk	Assurance	
1.	Additional Corporate Capacity	ALL	-	N/A	Approval	5.	CIP 2026/27 Update	6, 7	12 25	Partial	Assurance
2.	County Hospital Frailty Service	1		N/A	Approval	6.	Finance Report – Month 10 2025/26	6, 7	12 25	Partial	Assurance
3.	Internal Audit Reports: • Follow up: IT Systems Managed by Operational Areas • Follow up: Transformational and Major Change Project Management	4	Various	Some Progress Good Progress	Assurance	7.	Authorisation of New Contract Awards, Contract Extensions and Non-Purchase Order (NPO) Expenditure	-	-	N/A	Approval
4.	Demand and Activity Performance Report – Month 10 2025/26	6, 7	12 25	Partial	Assurance						

Highlight Report

Finance & Business Performance Committee | 30th March 2026

University Hospitals of North Midlands NHS Trust

Matters of Concern / Key Risks to Escalate

- **Building Safety Act** 'client role' remains the subject of joint legal and technical work in order to fully understand the requirements; this is currently impacting our ability to conclude the latent defect works, with four areas remaining outstanding
- **No Assurance** for the **Digital Services** report, with shadow IT within Care Groups being the primary area for improvement
- **Partial Assurance** in relation to the **Electronic Patient Record (EPR)** procurement although this is in a holding position pending Treasury approval
- **Partial Assurance** for **business case performance** based on Care Group ability to implement in accordance with plan, with two reviews outstanding; concerns expressed around the need to strengthen grip and control (to be reflected within the BAF)
- **Partial Assurance** for **Demand and Activity Performance** Report with some further refinements needed in the next report, including children versus adults
- **Partial Assurance** for the **CIP 2026 / 2027** which has increased to circa £81m; there remain gaps in programme identification and readiness with a significant proportion rated as 'red' or 'amber', £4.2m recurrent gap and £10.9 non-recurrent gap confirmed
- **Partial Assurance** for the Month 11 finance report, as several risks have been recognised including unfunded escalation capacity, shortfall in CIP plans and winter planning

Major Actions Commissioned / Work Underway

- To achieve Significant Assurance, further information to be included within the PFI performance report including contract performance management arrangements, findings from review of recently published Model Health PFI data, changes around Hard and Soft FM and visibility of any further opportunities to stretch the partnership along with references to where assurance reports have been presented to other Committees
- Digital governance is being strengthened through improved oversight, tighter system controls, enhanced Care Group reporting, and added capacity
- Quarterly updates will be provided on progress with the EPR procurement
- Further consideration to be given to implementation costs being factored into business to support effective project management capability, as well as learning
- Future demand and activity reports will ensure a split between adults and children
- Future CIP reports will focus more so on delivery although it was noted that the position was evolving on a daily basis
- Capital business case pipeline and capital bids for national funding, i.e. digital, which were not include in the programme will be shared in the next report for completeness and visibility, was well as the reporting being longer term aligned with the medium term plan
- Analysis to be provided in relation to postal charges, given the focus on digitalisation and the approval of a new contract award
- Feedback to the Committee the reasons behind delayed payment for the work undertaken in outpatients and separately, around the utilisation of virtual wards
- Paper on coding backlog to be provided to the Committee

Positive Assurances to Provide

- **Acceptable Assurance** relating to PFI performance which remains stable, contractual compliance is robust, unitary payment movements are understood with active management around emerging national and commercial risks
- **CIP programme** assurance is expected to improve due to strengthened governance and clearer role definition, accelerated project initiation development and increased oversight through new reporting mechanisms

Decisions Made

- Approval of the Capital Plan for 2026 / 2027

Approval of new contract awards, extension and non-purchase order expenditure:

- Franking Machine Postage Charges (e-REAF 17826)
- Provision of Insourced ENT Support (e-REAF 17997)
- Enhanced Primary Care Services - Medical Service Provision (e-REAF 17940)
- Supply of Distal Elbow and Pelvic Sets (e-REAF 17938)
- Non-Emergency and High Dependency Patient Transport Service UHNM Extension (e-REAF 17909)
- Non-Emergency and High Dependency Patient Transport Service UHNM (e-REAF 17912)
- Optimising Capacity & Productivity in Outpatients – Phase 2 (e-REAF 18067)

Comments on the Effectiveness of the Meeting

- A questionnaire was made available to participants through the agenda, which will be used to inform ongoing evaluation of Committee Effectiveness

Cross Committee Considerations

- Audit Committee to consider the Digital Services report in view of the risks presented
- Quality, Access & Outcomes Committee to ensure that reporting on children's services is sufficient to recognise any potential inequalities in care provision / access

Summary Agenda

No.	Agenda Item	BAF Mapping			Purpose	No.	Agenda Item	BAF Mapping			Purpose
		BAF No.	Risk	Assurance				BAF No.	Risk	Assurance	
1.	PFI 6 Monthly Exception Report	5	High 12	Significant	Assurance	6.	CIP 2026/27 Update	6, 7	Ext 25	Partial	Assurance
2.	Digital Services - IT Standards Update	4	34619 - 20 34869 - 15	Partial	Assurance	7.	Finance Report – Month 11 2025/26	6, 7	BAF 6 – High 12 BAF 7 – Ext 25	Partial	Assurance
3.	Digital Services – Electronic Patient Record (EPR) Update	4	Various	Partial	Assurance	8.	Capital Plan 2026/27	6, 7	BAF 6 – High 12 BAF 7 – Ext 25	N/A	Approval
4.	Business Case Review Update	-	-	Partial	Assurance	9.	Authorisation of New Contract Awards, Contract Extensions and Non-Purchase Order (NPO) Expenditure	-	-	N/A	Approval
5.	Demand and Activity Performance Report – Month 11 2025/26	6, 7	-	Not Assessed	Assurance	10.					

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

- **Rowlands - Outpatient Service for Royal Stoke Hospital - Drug Costs,** supplied by Rowlands Pharmacy, for the period 01/04/2025 – 31/03/2026, at a total cost of £3,600,000, approved on 11th February 2026
- **Supply Chain Coordination Limited (SCCL) - Trust wide Annual Expenditure including High Cost Tariff devices (HCTED) 2026/27,** supplied by SCCL, for the period 01/04/2026 – 31/03/2027, at a total cost of £95,412,605, approved on 11th February 2026
- **Salary Sacrifice Vehicle Leasing - NHS Fleet Solutions (NORTHUMBRIA HEALTHCARE NHS FT),** supplied by NHS Fleet Solutions (Northumbria Healthcare NHS FT), for the period June 2025 – June 2029, at a total cost of £40,344,314, providing savings through pension and NI savings, approved on 11th February 2026
- **MED3271 National Blood Services Contract,** supplied by NHS Blood and Transplant, for the period 01/04/2026 – 31/03/2027, at a total cost of £6,121,500, , approved on 11th March 2026
- **MED2061 Staff Rostering Software for Medics and Nursing Staff,** supplied by Softcat (to sub-contract to Allocate), for the period 01/04/2026 – 31/03/2031, at a total cost of £4,961,221.20, providing cost avoidance savings of £150,000, approved on 11th March 2026
- **NOM6899 Rowlands – Outpatient Service for Royal Stoke Hospital – Drug Costs (MPSU Pass-Through),** supplied by Rowlands Pharmacy, for the period 01/04/2026 – 31/03/2027, at a total cost of £30,000,000, approved on 11th March 2026
- **Supply Chain Coordination Limited (SCCL) – Trust-Wide Annual Expenditure Including HCTED – Increase to 2025/26 Value (15321),** supplied by SCCL, for the period 01/04/2025 – 31/03/2026, at a total cost of £12,000,000, approved on 11th March 2026
- **NOM6820 Services of Junior Doctors via Health Education England Contract with Mersey and West Lancashire NHS Trust,** supplied by Mersey and West Lancashire NHS Trust, for the period 01/04/2026 – 31/03/2027, at a total cost of £4,200,000, approved on 11th March 2026
- **RS/1897/CAP UTC,** supplied by Graham Asset Management, at a total cost of £2,623,148.19, approved on 11th March 2026

University Hospitals of North Midlands NHS Trust

Integrated Performance Report

Month 11 Performance

2025/26

Kind Excellent Together

University Hospitals of North Midlands NHS Trust

Contents

Statistical Process Control

University Hospitals of North Midlands NHS Trust

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

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

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

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

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

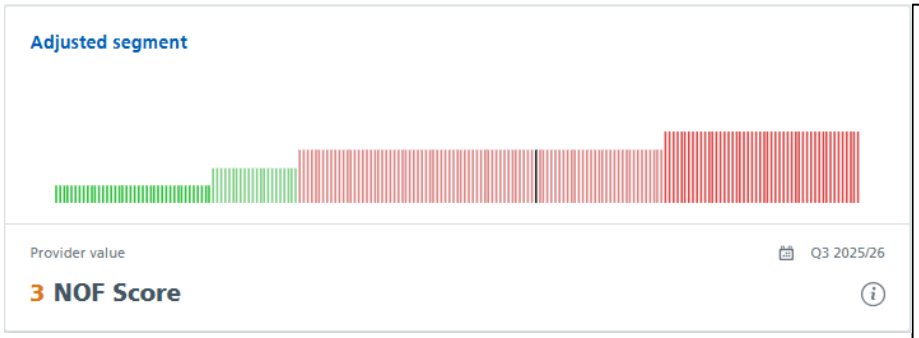
Where icons indicate an area needs attention, you could give more detail by attaching the full SPC chart and narrative describing the context, issues and actions in an appendix.

Oversight Framework Summary

University Hospitals of North Midlands NHS Trust

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

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



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

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

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

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Finance and Productivity

University Hospitals of North Midlands NHS Trust

Finance and productivity	Data period	Provider value		Chart
Finance and productivity domain segment	Q3 2025/26	3	NOF Score	
Finance and productivity domain score	Q3 2025/26	2.35	NOF Score	

Finance Please note that only the combined finance score contributes to the domain score	Data period	Provider value	Peer average	National value	National value method	Chart
Combined finance score			Q3 2025/26 1	NOF Score	Provider value	
Planned surplus/deficit score			Q3 2025/26 1	NOF Score	Provider value	
Planned surplus/deficit	Apr 2025	0.00%	-2.03%	0.00%	Provider median	
Variance year-to-date to financial plan score			Q3 2025/26 1	NOF Score	Provider value	
Variance year-to-date to financial plan	Dec 2025	0.00	-1.34	0.00	Provider median	

Productivity Please note: In Q1 2025/26, the implied productivity metric for ICBs applied only to acute trusts. This was later expanded to all trust types, so Q1 figures are not directly comparable with later quarters.	Data period	Provider value	Peer average	National value	National value method	Chart
Implied productivity level score			Q3 2025/26 3.71	NOF Score	Provider value	
Implied productivity level	Sep 2025	-1.80%	4.10%	2.60%	Provider median	

UHNM score for this domain saw a slight improvement from 2.36 in quarter two to 2.35 in quarter three.
Variance YTD to financial plan saw a marginal improvement from 0.01 to 0.00 in quarter three.
Implied Productivity level saw an improvement from -3.91% in quarter two to -1.80% in quarter three, but remains below peer and national averages.

Finance | Financial Summary

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

The Trust reported a deficit of £2.0m at Month 11, which is a £0.5m underspend against plan. After accounting for non-recurring support and adjusting for industrial action, the underlying deficit stands at £38.1m.

The Month 11 deficit of £2.0m is in line with the trajectory to deliver the Trust's year end forecast of a £4.8m deficit.

Income: The income is underperforming by £6.9m, mainly due to lower-than-expected income from pass-through devices and drugs (which are offset by reduction in non-pay spend), and a delay in Community Diagnostic Centre income.

Activity: The month 11 Elective Inpatients and Outpatient activity is £10.1m below the plan. For 2025/26, it has been agreed with the ICB that any under performance against the ERF target will be re-invested as non-recurrent deficit support funding. Therefore, for Staffordshire and Stoke ICB the income level for the ERF funding reflects the agreed plan.

Expenditure: There is a year to date pay overspend of £9.2m, which includes cumulative industrial action costs totalling £3.3m and under delivery of CIP. Non-pay is underspent by £9.0m, mainly due to lower expenditure for pass through devices and drugs (offset by an under recovery of income).

Financial Outlook 2025/26: The Trust's updated forecast indicates an improved year end deficit of £4.8m, representing a £2.1m improvement since Month 10. This improvement reflects the confirmation of additional ICB funding. At system level, a breakeven position is now forecast, with surpluses expected from MPFT and Combined Healthcare.

CIP: The Trust has a £74.8m CIP target for 2025/26. At Month 11, it has delivered £44.9m of in year savings against a planned £66.0m, with £6.9m delivered non recurrently above the original £22.0m non recurrent plan. The Trust is forecasting £32.2m of recurrent savings, which will roll forward into 2026/27 this is a shortfall of £40.2m.

Capital: The capital income and expenditure forecast for 2025/26 is £99.33m, a small reduction of £0.455m from Month 10. The year-to-date position shows spend of £75.6m against a plan of £80.8m, with the underspend mainly relating to CDC enabling works.

Statement of Financial Position: The Month 11 Statement of Financial Position shows total assets employed of £303.3m. The cash balance is £87.2m against a plan of £72.7m. Payroll payments are higher than plan due to impact of pay awards however the Trust has also received higher than plan income from Commissioners to offset the overall impact. Cash increased by £34.3m from Month 10 and is currently £14.5m above plan, which is due to the receipt of £35.7m of PDC in month 11.

System Position: The system Month 11 position has a favourable variance of £1.8m from the planned deficit of £6.7m.

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

Related Strategy and Board Assurance Framework (BAF)

BAF Risk	Q1		Q2		Q3		Q4	
	Risk	Assurance	Risk	Assurance	Risk	Assurance	Risk	Assurance
BAF 6: Inability to Deliver In-Year Financial Position	Ext 20	Partial	Ext 20	Partial	High 12	Acceptable		
BAF 7: Inability to Deliver Financial Sustainability	Ext 20	Partial	Ext 20	Partial	Ext 25	Partial		

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Finance | Income and Expenditure

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

The Trust has delivered a £2.0m deficit at Month 11, which is a £0.5m underspend to the planned deficit of £2.4m. The £2.0m deficit at month 11 is in line with the year-end forecast trajectory to deliver a £4.8m year end deficit.

Income & Expenditure Summary Month 11 2025/26	Annual Budget £m	In Month			Year to Date		
		Budget £m	Actual £m	Variance £m	Budget £m	Actual £m	Variance £m
Income From Patient Activities	1,220.6	101.1	105.7	4.6	1,117.5	1,114.7	(2.8)
Other Operating Income	99.6	8.7	8.8	0.1	91.2	92.5	1.3
Total Income	**1,320.2**	**109.8**	**114.4**	**4.7**	**1,208.7**	**1,207.2**	**(1.4)**
Pay Expenditure	(785.1)	(64.0)	(67.4)	(3.5)	(721.2)	(730.4)	(9.2)
Non Pay Expenditure	(502.9)	(41.1)	(39.6)	1.5	(460.4)	(451.4)	9.0
Total Operational Costs	**(1,288.0)**	**(105.1)**	**(107.0)**	**(1.9)**	**(1,181.6)**	**(1,181.8)**	**(0.2)**
EBITDA	**32.2**	**4.7**	**7.4**	**2.7**	**27.1**	**25.4**	**(1.6)**
Interest Receivable	2.6	0.2	0.3	0.1	2.4	4.8	2.4
PDC	(4.8)	(0.4)	(0.4)	(0.0)	(4.4)	(4.7)	(0.3)
Finance Cost	(30.0)	(2.5)	(2.5)	(0.0)	(27.5)	(27.6)	(0.1)
Other Gains or Losses	0.0	0.0	0.0	0.0	0.0	0.1	0.1
Surplus / (Deficit)	**(0.0)**	**2.0**	**4.8**	**2.8**	**(2.4)**	**(2.0)**	**0.5**
Industrial action costs less funding						(1.2)	
Non recurrent CIPs & mitigation						(34.9)	
Underlying Surplus/(Deficit)	**(39.6)**				**(36.3)**	**(38.1)**	**(1.8)**

Kind Excellent Together

Finance | CIP

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

The Trust has a £74.8m CIP target for 2025/26. At Month 11, it has delivered £44.9m of in-year savings against a planned £66.0m, with £6.9m delivered non-recurrently above the original £22.0m non-recurrent plan. The Trust is forecasting £32.2m of recurrent savings, which will roll forward into 2026/27 this is a shortfall of £40.2m.

Efficiency Savings	31PLANYTD	31ACTYTD	31VARYTD
	Plan Plan 28/02/2026 YTD £'000	Actual Actual 28/02/2026 YTD £'000	Variance Variance 28/02/2026 YTD £'000
Recurrent			
Pay - Recurrent	31,016	8,943	(22,073)
Non-pay - Recurrent	9,754	6,105	(3,649)
Income - Recurrent	3,212	976	(2,236)
Total recurrent efficiencies	**43,982**	**16,024**	**(27,958)**
Non recurrent			
Pay - Non-recurrent	9,878	12,024	2,146
Non-pay - Non-recurrent	8,541	15,463	6,922
Income - Non-recurrent	3,555	1,380	(2,175)
Total non-recurrent efficiencies	**21,974**	**28,867**	**6,893**
Total Efficiencies	**65,956**	**44,891**	**(21,065)**

Kind Excellent Together

Finance | Capital

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

The tables below set out the capital expenditure forecast for 2025/26 of £99.3m, a small decrease of £0.5m compared to month 10.

At month 11 capital expenditure is £75.6m against a plan of £80.8m, an underspend of £5.2m. The main areas of underspend are in relation to the significant PDC funded scheme for the CDC enabling works (£2.2m) however it should be noted that these have reduced from previous months as schemes near completion. Pre-committed schemes are showing an underspend of £1.2m relating to a number of schemes including network and comms, IM&T hardware replacement and the high voltage network updates. There is an underspend of £0.7m in relation to capital sub-group expenditure to month 11 of which IM&T (£0.7m) and estates (£0.8m) are most significant.

UHNM Capital Expenditure Plan 2025/26	Revised Capital Plan £m	Forecast outturn £m	Variance £m	YTD plan M11 £m	YTD actual M11 £m	M11 Variance £m	Planned M12 to spend	RAG bid status
Pre-committed items - PFI and Loans								
PFI re-payment of liability	14.900	14.900	0.000	13.658	13.658	0.000	1.242	
PFI lifecycle commitments	2.268	2.268	0.000	2.266	2.266	0.000	0.002	
PFI PACS refresh - increase to PFI liability	0.200	0.200	0.000	0.000	0.000	0.000	0.200	
PFI MES - increase to PFI liability TBC	7.131	7.131	0.000	3.330	3.330	0.000	3.801	
Repayment of IFRS16 leases	4.272	4.272	0.000	3.916	3.916	0.000	0.356	
Total PFI and IFRS16 lease repayments commitments	**28.771**	**28.771**	**0.000**	**23.170**	**23.170**	**0.000**	**5.601**	
Investment items								
PFI enabling costs	0.181	0.065	0.116	0.065	0.040	0.025	0.025	
Network & Comms BC525	0.748	0.462	0.286	0.462	0.162	0.300	0.300	
LED lighting BC546	0.427	0.432	(0.005)	0.275	0.275	0.000	0.157	
IM&T computer hardware refresh BC569	2.142	1.455	0.687	1.000	0.682	0.318	0.773	
Investment funding for new business cases 25/26	0.250	0.306	(0.056)	0.306	0.296	0.010	0.010	
Project Star - RI remedial work	0.010	0.010	0.000	0.010	0.000	0.010	0.010	
ED ambulance off - enabling ward moves	0.006	0.006	0.000	0.006	0.006	0.000	0.000	
Endoscopy works 7th room - PDC ICB allocation TBC	0.009	0.009	0.000	0.009	0.012	(0.003)	(0.003)	
Completion of County Holding Bay	0.074	0.074	0.000	0.074	0.055	0.019	0.019	
Managing H&S risk register - BC562 (from £500k)	0.043	0.000	0.043	0.000	0.000	0.000	0.000	
Endoscopy BC GI PHYS BC583	0.130	0.130	0.000	0.130	0.130	0.000	0.000	
Royal Stoke high voltage upgrade BC required	0.752	0.752	0.000	0.752	0.425	0.327	0.327	
Printer lease refresh BC591	0.593	0.593	0.000	0.593	0.593	0.000	0.000	
Elective hub 24/25 BC brought forward spend	0.632	0.932	(0.300)	0.606	0.606	0.000	0.326	
County CT replacement	1.200	0.000	1.200	0.000	0.000	0.000	0.000	
SoN CIG	0.100	0.161	(0.061)	0.161	0.161	0.000	0.000	
Day Case completion costs	0.000	0.097	(0.097)	0.097	0.094	0.003	0.003	
SoN Fortinet licences	0.000	0.399	(0.399)	0.399	0.333	0.066	0.066	
PSDS - completion of business case	0.000	0.286	(0.286)	0.286	0.286	0.000	0.000	
Sustainability Heat Network - Busness Case design fees	0.000	0.110	(0.110)	0.110	0.068	0.042	0.042	
SoN - Shine ambulatory unit	0.000	0.061	(0.061)	0.061	0.054	0.007	0.007	
Removal of Covid staff wellbeing cabins	0.000	0.075	(0.075)	0.075	0.026	0.049	0.049	
SoN Stryker trollies	0.000	0.111	(0.111)	0.111	0.040	0.071	0.071	
Central Contingency & risk	0.000	0.000	0.000	0.000	0.000	0.000	0.000	
Funding to allocate/(shortfall)	(0.373)	0.000	(0.373)	0.000	0.000	0.000	0.000	
Total Pre committed Investment items	**6.924**	**6.526**	**0.398**	**5.588**	**4.344**	**1.244**	**2.182**	
Capital sub-group (ICB allocation)								
IMT Sub Group Total Funding	2.535	1.774	0.761	1.980	1.237	0.743	0.537	
Medical Devices Sub Group	3.600	3.600	0.000	2.167	2.982	(0.815)	0.618	
Estates Sub Group Total Funding	5.462	6.019	(0.557)	4.526	3.737	0.789	2.282	
Health & Safety compliance	0.156	0.156	0.000	0.083	0.034	0.049	0.122	
Net zero carbon (sustainability) initiatives	0.100	0.024	0.076	0.000	0.035	(0.035)	(0.011)	
Total Capital Sub-Groups	**11.853**	**11.573**	**0.280**	**8.756**	**8.025**	**0.731**	**3.548**	

UHNM Capital Expenditure Plan 2025/26	Revised Capital Plan £m	Forecast outturn £m	Variance £m	YTD plan M11 £m	YTD actual M11 £m	M11 Variance £m	Planned M12 to spend	RAG bid status
IFRS16 leases								
Lease liability re-measurement	0.200	0.200	0.000	0.200	0.006	0.194	0.194	
IFRS16 Guy Hilton	0.010	0.010	0.000	0.010	0.010	0.000	0.000	
IFRS 16 New Vehicles lease	0.188	0.188	0.000	0.084	0.084	0.000	0.104	
IFRS16 Leighton and Macclesfield Path Beckman	1.036	1.036	0.000	0.644	0.644	0.000	0.392	
IFRS16 Endoscopic Equipment renewal/expansion	1.511	0.254	1.257	0.113	0.094	0.019	0.160	
IFRS16 Stoke and County Pathology (Siemens lease ext Sep 26)	0.301	0.301	0.000	0.000	0.000	0.000	0.301	
IFRS16 Bridge Centre	0.143	0.143	0.000	0.147	0.147	0.000	(0.004)	
IFRS16 Replacement meters gluclose keytone testing BC	0.000	0.433	(0.433)	0.000	0.000	0.000	0.433	
IFRS16 Sharman Close lease extension to 2030	0.000	0.758	(0.758)	0.758	0.755	0.003	0.003	
IFRS16 Medtronic Nitron	0.000	0.073	(0.073)	0.073	0.073	0.000	0.000	
IFRS16 Payroll offices lease renewal (2 yrs)	0.066	0.066	0.000	0.066	0.066	0.000	0.000	
Total IFRS 16 leases	**3.455**	**3.462**	**(0.007)**	**2.095**	**1.879**	**0.216**	**1.583**	
Total Internal Capital Expenditure programme	**51.003**	**50.332**	**0.671**	**39.609**	**37.418**	**2.191**	**12.914**	
Additional CRL / Externally Funded PDC (multi-year schemes)								
CDC phase 1 medical equipment	1.879	2.020	(0.141)	1.852	1.656	0.196	0.364	
CDC IM&T	0.223	0.063	0.160	0.000	0.000	0.000	0.063	
CDC phase 1 estates enabling	22.555	22.455	0.100	21.448	19.195	2.253	3.260	
CDC phase 1 cost pressure	0.595	0.595	0.000	0.000	0.000	0.000	0.595	
CDC endoscopy expansion	3.100	0.000	3.100	0.000	0.000	0.000	0.000	
TIF 2 PDC (Breast Unit)	9.086	8.936	0.150	8.936	8.936	0.000	0.000	
TIF 2 PDC (Breast Unit) cost pressure	0.430	0.530	(0.100)	0.530	0.319	0.211	0.211	
Frontline Digitalisation - PDC funded 2024/25	1.120	1.120	0.000	1.120	1.120	0.000	0.000	
Frontline Digitalisation EPR - PDC funded 2024/25	0.680	0.280	0.400	0.280	0.160	0.120	0.120	
Charitable funded expenditure	3.834	4.848	(1.014)	3.319	3.319	0.000	1.529	
Extemally Funded PDC (2025/26 schemes)								
PDC Constitutional Standards Urgent Treatment Centre - enabling	7.775	2.140	5.635	1.036	1.036	0.000	1.104	
PDC Urgent Treatment Centres - programme costs	0.000	0.075	(0.075)	0.000	0.000	0.000	0.075	
PDC Constitutional Standards Imaging and MRI	2.583	2.150	0.433	1.200	0.920	0.280	1.230	
PDC Constitutional Standards Equipment for Physiological Science	0.590	0.460	0.130	0.060	0.060	0.000	0.400	
PDC County Discharge Lounge	2.375	0.000	2.375	0.000	0.000	0.000	0.000	
PDC Elective equipment	0.839	0.539	0.300	0.470	0.470	0.000	0.069	
PDC - Cyber security funding	0.000	0.072	(0.072)	0.000	0.000	0.000	0.072	
PDC Digital Pathology Scanners	0.827	0.694	0.133	0.000	0.000	0.000	0.694	
PDC - Histopathology Modernisation BC	0.000	0.179	(0.179)	0.000	0.000	0.000	0.179	
PDC - additional imaging equipment	0.000	0.133	(0.133)	0.000	0.000	0.000	0.133	
PDC - home reporting work stations	0.000	0.110	(0.110)	0.000	0.000	0.000	0.110	
PDC - additional funding for ultrasounds	0.000	0.240	(0.240)	0.000	0.000	0.000	0.240	
PDC Pathology LIMS	1.628	1.358	0.270	0.986	0.986	0.000	0.372	
Total Additional CRL / PDC Funded expenditure	**60.119**	**48.997**	**11.122**	**41.237**	**38.177**	**3.060**	**10.820**	
Total Capital Expenditure	**111.122**	**99.329**	**11.793**	**80.846**	**75.595**	**5.251**	**23.734**	

UHNM Capital Funding Plan -2025/26	Revised Capital Plan £m	Forecast outturn £m	Variance £m	YTD plan M11 £m	YTD actual M11 £m	Variance £m	RAG bid status
Total PFI and IFRS16 lease repayments commitments	28.771	28.771	0.000	23.170	23.170	0.000	
Total ICB capital allocation	22.456	23.211	0.755	21.085	21.822	0.737	
PDC - cash backed ICB funding	0.000	4.000	4.000	0.000	0.000	0.000	
PDC CDC (including expansion)	18.100	18.100	0.000	15.000	15.000	0.000	
PDC County Breast Unit completion	3.000	3.000	0.000	3.000	3.000	0.000	
PDC Estates Safety	3.593	4.767	1.174	4.767	4.767	0.000	
PDC Constiutional standards Urgent Treatment Centre	7.775	2.340	(5.435)	2.340	2.340	0.000	
PDC Constitutional Standards Equipment for Physiological Science	0.590	0.590	0.000	0.590	0.590	0.000	
PDC Constitutional Standards Imaging and Diagnostic	2.583	2.583	0.000	2.583	2.583	0.000	
PDC Constitutional Standards Elective	0.839	0.839	0.000	0.839	0.839	0.000	
PDC Constituional Standards Discharge Lounge	2.375	0.000	(2.375)	0.000	0.000	0.000	
PDC Pathology LIMS	1.628	1.628	0.000	1.628	1.628	0.000	
PDC Digital Pathology	0.828	0.828	0.000	0.828	0.828	0.000	
PDC Pathways and Urology funding	0.000	0.720	0.720	0.000	0.000	0.000	
PDC - Cyber security funding	0.000	0.072	0.072	0.000	0.000	0.000	
PDC - Decarbonisation	0.000	0.005	0.005	0.000	0.000	0.000	
PDC - Histopathology Modernisation BC	0.000	0.179	0.179	0.000	0.000	0.000	
PDC - additonal imaging & diagnostic equipment replacement	0.000	0.245	0.245	0.000	0.000	0.000	
PDC - maternity improvement works	0.000	0.129	0.129	0.000	0.000	0.000	
PDC - home working stations	0.000	0.110	0.110	0.000	0.000	0.000	
PDC - additional funding for ultrasounds	0.000	0.500	0.500	0.000	0.000	0.000	
Disposal of RI/COPD	10.900	0.000	(10.900)	0.000	0.000	0.000	
Other disposals	0.789	0.789	0.000	0.000	0.000	0.000	
Charitable funds	3.834	4.848	1.014	3.319	3.319	0.000	
Internal resources (including capital to revenue transfer)	3.061	1.075	(1.986)	0.000	0.000	0.000	
Total capital funding	**111.122**	**99.329**	**(11.793)**	**79.149**	**79.886**	**0.737**	
Funding to be allocated/(shortfall)	**0.000**	**0.000**	**(0.000)**				

Kind Excellent Together

Finance | Balance Sheet

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

Statement of Financial Position as at Month 11	31/03/2025	28/02/2026		
	Actual £m	Plan £m	Actual £m	Variance £m
Property, Plant & Equipment	715.7	742.7	741.9	(0.8)
Right of Use Assets	23.1	19.6	20.8	1.1
Intangible Assets	16.0	12.1	12.1	0.0
Trade and other Receivables	1.1	1.1	1.1	0.0
Total Non Current Assets	**755.9**	**775.5**	**775.8**	**0.3**
Inventories	19.2	18.7	21.3	2.6
Trade and other Receivables	43.5	54.4	57.2	2.9
Asset held for sale	10.9	10.9	10.9	-
Cash and Cash Equivalents	84.2	72.7	87.2	14.5
Total Current Assets	**157.8**	**156.7**	**176.6**	**19.9**
Trade and other payables	(129.4)	(117.3)	(135.2)	(17.9)
Borrowings	(20.3)	(25.7)	(19.7)	5.9
Provisions	(8.5)	(9.3)	(1.2)	8.1
Total Current Liabilities	**(158.2)**	**(152.3)**	**(156.1)**	**(3.8)**
Borrowings	(490.3)	(483.7)	(490.7)	(7.0)
Provisions	(2.8)	(2.3)	(2.3)	(0.0)
Total Non Current Liabilities	**(493.0)**	**(485.9)**	**(493.0)**	**(7.0)**
Total Assets Employed	**262.5**	**293.9**	**303.3**	**9.4**
Financed By:				-
Public Dividend Capital	734.9	762.5	770.6	8.0
Retained Earnings	(680.7)	(677.0)	(673.7)	3.3
Revaluation Reserve	208.3	208.3	206.3	(1.9)
Total Taxpayers Equity	**262.5**	**293.9**	**303.3**	**9.4**

Trust Board

2026/27 BUSINESS CYCLE

KEY TO RAG STATUS	
Paper rescheduled for future meeting	
Paper rescheduled for next meeting	
Paper taken to meeting as scheduled	

Title of Paper	Executive Lead	Apr	Jun	Aug	Oct	Dec	Feb	Notes
		8	10	12	7	9	10	
PROCEDURAL ITEMS								
Patient / Staff Story	Chief Nurse / Chief People Officer	Staff	Pt	Staff	Pt	Staff	Pt	
Chairs Update	Chair							
Chief Executives Report	Chief Executive							
Board Assurance Framework	Director of Governance		Q4	Q1		Q2	Q3	
OUR PATIENTS: QUALITY, ACCESS & OUTCOMES								
Quality, Access & Outcomes Committee Assurance Report	Director of Governance							
Mortality Assurance Annual Report	Chief Medical Officer							
Maternity Serious Incident Report	Chief Nurse	Q3						
PLACE Inspection Findings and Action Plan	Director of Estates, Facilities & PFI							
Bi Annual Nurse Staffing Assurance Report	Chief Nurse							
Quality Account	Chief Nurse							
Winter Plan	Chief Operating Officer							
NHS Resolution Maternity Incentive Scheme	Chief Nurse							
Quality, Access & Performance Strategic Plan Update	Chief Nurse / Chief Medical Officer / Chief Operating Officer							TBC
Integrated Performance Report	Various							
OUR PEOPLE								
People, Culture & Inclusion Committee Assurance Report	Director of Governance							
Staff Survey Report	Chief People Officer							
Gender, Ethnicity and Disability Pay Gap Report	Chief People Officer							
Raising Concerns Report	Director of Governance							
Revalidation	Chief Medical Officer							
Workforce Disability Equality and Workforce Race Equality Reports	Chief People Officer							
Equality, Diversity and Inclusion Annual Report	Chief People Officer							
People Strategic Plan Update	Chief People Officer							TBC
OUR POPULATION								
Population Health Strategic Plan Update	Director of Strategy							TBC
FINANCE AND BUSINESS PERFORMANCE								
Finance & Business Performance Committee Assurance Report	Director of Governance							
Annual Report and Accounts including Going Concern	Chief Finance Officer							To be considered by Extraordinary Trust Board in June
Annual Plan	Director of Strategy							
Financial Plan including Capital Programme	Chief Finance Officer							

Standing Financial Instructions	Chief Finance Officer							
Scheme of Reservation and Delegation of Powers	Chief Finance Officer							
OUR STRATEGIC PLANS								
Digital Strategic Plan Update	Chief Digital Information Officer							TBC
Research Strategic Plan Update	Chief Medical Officer							TBC
Innovation Strategic Plan Update	Director of Strategy							TBC
Estates & Facilities Strategic Plan Update	Director of Estates, Facilities & PFI							TBC
GOVERNANCE								
Audit Committee Assurance Report	Director of Governance							
Fit and Proper Persons Annual Assurance Report	Director of Governance							
Anchor Institution Update	Director of Strategy & Communications							TBC
Emergency Preparedness Annual Assurance Statement and Annual Report	Chief Operating Officer							
Annual Evaluation of the Board Committees	Director of Governance							
Annual Review of the Rules of Procedure	Director of Governance							
Board Development Programme	Director of Governance							
Well-Led Self Assessment	Director of Governance							
Risk Management Policy	Director of Governance							Next due for review February 2027
Complaints Policy	Chief Nurse							Next due for review November 2027