NHS
University Hospitals of North Midlands
NHS Trust

AGENDA | Trust Board - Part 1 (in Public)

Meeting held on Wednesday 8th October 2025 at 9.30 am to 1.00 pm

Trust Boardroom, Third Floor, Springfield, RSUH

Time	No.	Agenda Item	Purpose	Lead	Format	BAF Link
9:30	**PROCEDURAL ITEMS**					
20 mins	01	Patient Story	Information	Mrs J Holmes	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 9th July 2025	Approval	Ms J Small	Enclosure	
	05	Matters Arising via the Post Meeting Action Log	Assurance	Ms J Small	Enclosure	
5 mins	06	Questions from Members of the Public in relation to matters on the agenda	Information	Ms J Small	Verbal	
10:00	**CHAIR AND CHIEF EXECUTIVE UPDATES**					
5 mins	07	Chair's Update	Information	Ms J Small	Verbal	
10 mins	08	Chief Executive's Report – October 2025	Information	Dr S Constable	Enclosure	
10 mins	09	Provider Collaborative Update	Assurance	Ms H Ashley	Enclosure	
10 mins	10	Board Assurance Framework – Q1	Assurance	Mrs C Cotton	Enclosure	All
10:35	**OUR PATIENTS: QUALITY, ACCESS & OUTCOMES**					
10 mins	11	Maternity & Neonatal PSIRF Investigation Report Q1	Assurance	Mrs S Jamieson	Enclosure	1
10 mins	12	Mortality Assurance Annual Report (2024/25)	Assurance	Dr D Adamson	Enclosure	1
15 mins	13	Urgent and Emergency Care Pressures, Ambulance Handovers & Winter Plan	Assurance	Mrs K Thorpe	Enclosure	1, 4
10 mins	14	Undertakings - Urgent & Emergency Care / Elective Care Recovery Programmes	Approval	Mrs K Thorpe	Enclosure	1
11:20 – 11:30 COMFORT BREAK						
11:30	**OUR PEOPLE**					
10 mins	15	Appraisal and Revalidation Annual Report	Assurance	Dr M Poulson	Enclosure	
10 mins	16	Speaking Up Report Q3/Q4 2024/25	Assurance	Mrs C Cotton	Enclosure	3
10 mins	17	Workforce Race and Workforce Disability Equality Standard Reports 2025	Assurance	Mrs J Haire	Enclosure	3
10 mins	18	Equality, Diversity and Inclusion Annual Report 2024- 2025	Assurance	Mrs J Haire	Enclosure	3
12:10	**PERFORMANCE**					
	19	Integrated Performance Report – Month 5 and Committee Assurance Reports:				
10 mins	19a	• Quality, Access & Outcomes Committee Assurance Report (31-07-25, 28-08-25 & 01-10-25) • Quality & Access Dashboard	Assurance	Prof A Hassell Mrs J Holmes / Mrs K Thorpe	Enclosure	1
10 mins	19b	• Finance & Efficiency Committee Assurance Report (28-07-25, 01-09-25 & 29-09-25) • Finance Dashboard	Assurance	Ms T Bowen Mr M Oldham	Enclosure	6, 7
10 mins	19c	• People, Culture and Inclusion Committee Assurance Report (30-07-25 & 30-09-25) • People Dashboard	Assurance	Prof S Toor Mrs J Haire	Enclosure	3
12:40	**GOVERNANCE**					
5 mins	20	Audit Committee Assurance Report (31-07-25)	Assurance	Mrs M Monckton	Enclosure	
10 mins	21	Provider Capability Assessment	Information	Mrs C Cotton	Verbal	
12:55	**CLOSING MATTERS**					
5 mins	22	Review of Meeting Effectiveness Link to feedback form: https://forms.office.com/e/tydNkMB2Mj	Information	Ms J Small	Verbal	
	23	Review of Business Cycle	Information	Ms J Small	Enclosure	
13:00	**DATE AND TIME OF NEXT MEETING**					
	24	**Wednesday 10th December 2025, 9.30 am, Trust Boardroom, Third Floor, Springfield, Royal Stoke**				

Questions from the Public - Please submit questions in relation to the agenda, by 9.00 am 6th October to nicola.hassall@uhnm.nhs.uk

Minutes of Meeting

Trust Board – Part 1 | 9th July 2025 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 (virtual)	Voting
Prof G Crowe	GC	Non-Executive Director	Voting
Prof A Hassell	AH	Associate Non-Executive Director	Non-Voting
Prof K Maddock	KM	Non-Executive Director	Voting
Mrs M Monckton	MM	Non-Executive Director (virtual)	Voting
Miss W Nicholson MBE	WN	Associate Non-Executive Director	Non-Voting
Prof S Toor	ST	Non-Executive Director	Voting
Dr D Adamson	DA	Interim Chief Medical Officer	Voting
Ms H Ashley	HA	Director of Strategy	Non-Voting
Mrs C Cotton	CC	Director of Governance	Non-Voting
Mr M Oldham	MO	Chief Finance Officer	Voting
Mrs A Freeman	AF	Chief Digital Information Officer	Non-Voting
Mrs J Haire	JH	Chief People Officer	Non-Voting
Mrs AM Riley	AR	Chief Nurse	Voting
Mrs K Thorpe	KT	Interim Chief Operating Officer	Voting

Apologies Received:			
Name	**Initials**	**Title**	
Dr S Constable	SC	Chief Executive	Voting
Mrs L Thomson	LT	Director of Communications	Non-Voting
Mrs L Whitehead	LW	Director of Estates, Facilities & PFI	Non-Voting

In Attendance:		
Name	**Initials**	**Title**
Mrs J Dickson	JD	Deputy Director of Communications (representing Mrs Thomson)
Mrs N Hassall	NH	Deputy Director of Governance (minutes)
Mr D Ruscoe	DR	Deputy Director of Estates, Facilities & PFI (representing Mrs Whitehead)

Members of Staff and Public: 6

No.	Agenda Item	Action
PROCEDURAL ITEMS		
1.	**Colleague Story**	
078/2025	A colleague story was shared with members of the Trust Board via the following link: https://vimeo.com/1099300106/b551478af6?share=copy whereby Mrs Ferneyhough provided an update on the work she had undertaken in collaboration with Johns Hopkins. Mrs Haire highlighted the project's contribution to supporting people, patients, and the wider population and Mrs Riley emphasised the significance of tracking patient mobility within the context of the Johns Hopkins initiative. Professor Toor inquired about opportunities to disseminate the learning more broadly and to publish the associated data. Mrs Riley confirmed that efforts were underway to establish robust evidence base and anticipated that sufficient data would be available within a year to demonstrate meaningful impact. She also outlined the international research connections and the	

	collaboration with NHS England (NHSE). Professor Maddock encouraged early publication of preliminary findings rather than delaying progress. Ms Bowen referenced a recent walkabout at County Hospital, which included a visit to the library where boards had displayed data and findings. She suggested that further communication of these developments would be beneficial. Miss Nicholson proposed submitting the work as a case study to the World Health Organization (WHO) network as an initial step prior to formal publication. Professor Crowe supported the previous comments and suggested exploring partnerships with charitable organisations to enhance storytelling of the initiative and outreach. Ms Small expressed gratitude to Mrs Ferneyhough for sharing the story and commended the holistic approach to promoting mobility, health, and wellbeing. She noted the importance of embedding such practices more widely to maximise their impact. Mrs Dickson provided an overview of the internal communication campaigns that had been undertaken to support the initiative. **The Trust Board noted the colleague story.**	
2.	**Chair's Welcome, Apologies and Confirmation of Quoracy**	
079/2025	Ms Small welcomed members to the meeting. Apologies were received as noted above and the meeting was confirmed as quorate.	
3.	**Declarations of Interest**	
080/2025	There were no declarations of interest raised.	
4.	**Minutes of the Meeting held 7th May 2025 and of the Extraordinary Meeting held 25th June 2025**	
081/2025	Ms Bowen requested an amendment to page 6 in relation to the Charitable contribution made which had helped to improve Patient Led Assessment of the Care Environment (PLACE) Scores. With the exception of this amendment, the minutes of the meetings held on 7th May and 25th June were approved as a true and accurate record.	**NH**
5.	**Matters Arising via the Post Meeting Action Log**	
082/2025	PTB/614 – Mrs Thorpe highlighted that comparator data for ambulance handovers was not published publicly and as such it would be included within the private session. PTB/615 - Mrs Haire highlighted that the head of workforce information was considering the changes required which would be reported to the People, Culture and Inclusion Committee (PCIC) in July.	
6.	**Chief Executive's Report – July 2025**	
083/2025		

Ms Ashley provided the following updates:

- The NHS 10-Year Plan had been published. A short paper was to be discussed in the private session to compare the Trust's current strategy against the new plan. No immediate actions were required at this stage.
- The Stoke-on-Trent Centenary Celebrations took place in June, during which the Trust actively participated in a number of community events.
- The County Day Case Unit had officially opened. This development formed part of the broader strategic plan to establish County Hospital as an elective centre. The Trust aimed to build on this initiative to offer patients an alternative to Royal Stoke for elective procedures.

Ms Bowen welcomed the recognition of the work undertaken by the Trust's volunteers. She also raised a query regarding the perioperative optimisation programme, specifically when measurable benefits would be observed and what data would be available to support this.

In response, Ms Ashley confirmed that the programme had gone live in a small number of specialties. The team had begun identifying patients who required more intensive support prior to planned procedures. This approach enabled the identification of specific patient needs, allowing for more targeted and meaningful pre-operative conversations. Although the pilot was in its early stages, it was anticipated that the programme would be expanded across all specialties, including both adult and paediatric services.

Professor Hassell asked whether the outcomes of the programme would be visible. Ms Ashley responded that the initiative was expected to report to Quality, Access and Outcomes (QAOC) Committee, with a particular focus on addressing health inequalities.

Professor Crowe formally acknowledged the retirement of Mrs Thompson, Chief Pharmacist. He commended her outstanding dedication to the role, her embrace of innovation and research, and her leadership in modernising pharmacy services. He also praised the quality of her handover to incoming colleagues.

On the topic of consultant recruitment, Professor Crowe noted the encouraging level of interest in new roles and asked whether this reflected a broader trend. Mrs Haire responded that while some roles remained difficult to fill, with limited or no applicants, the Trust was generally seeing an increase in the number of candidates being interviewed. Dr Adamson added that the Trust's positive reputation for workplace culture was becoming more widely recognised, particularly among those in training programmes, and this was contributing to improved retention of trained staff.

Ms Small referred to the perioperative optimisation programme in the context of the NHS 10-Year Plan. Ms Ashley acknowledged that progress had taken longer than anticipated, which had been a source of frustration. However, she emphasised the importance of ensuring that patients were not referred until their issues had been addressed, allowing for better monitoring over time.

Mrs Thorpe noted that as the scope of the programme widened, the data collected would provide valuable insights into conditions that delayed timely care and led to patients returning to the community without treatment. This would support more proactive interventions prior to referral.

Ms Small highlighted the importance of triangulating this data with broader health and wellbeing indicators. Mrs Freeman added that collaboration with

	GP practices had improved visibility of patient information, enabling earlier identification of individuals who were not yet fit for surgery and potentially preventing unnecessary hospital admissions. **The Trust Board received and noted the update.**	
7.	**Annual Plan 2025/26**	
084/2025	Ms Ashley presented the Annual Plan and highlighted the following key points: • The plan had been developed in the context of the Trust's new strategy, launched in April 2025, and incorporated elements of the broader strategic framework and Year 1 priorities. • Financial references within the plan were framed in terms of cost improvement initiatives. • The plan aimed to establish a comprehensive suite of measures to monitor progress, with regular updates to be provided to the Board throughout the year. Mrs Cotton noted that the plan formed part of the wider Well-Led Framework for the organisation, supporting governance and accountability. Professor Hassell welcomed the clarity of the document, particularly the structured outline of the programmes and the specificity of its content. He raised a query regarding the time to first appointment metric, noting that only one area appeared not to be planned to not meet its target. In response, Mrs Thorpe explained that during the initial planning phase, this metric had been identified as off-trajectory. However, following further discussions related to elective recovery funding, it had since been brought back on track and would be amended accordingly in the plan. Professor Hassell also queried where the combined hospital score would be reported. Ms Ashley acknowledged that it was not yet clear whether the three explicit priorities would be reported to a committee or directly to the Board. Mrs Cotton added that the Trust had received its National Oversight Framework (NOF) segmentation rating and ranking, and further consideration was needed to determine how the associated metrics and measures would be aligned and reported. Mrs Monckton welcomed the document as a clear record of the Trust's planned activities over the next 12 months. She suggested that, at year-end, it would be valuable to overlay actual achievements against the plan to support ongoing reference and accountability. Professor Crowe raised several points regarding the 2025/26 performance measures, particularly those related to workforce. He noted that references to "premium staffing" at PCIC included both agency and bank staff and queried whether patient experience was adequately reflected in the targets. He also sought clarification on the meaning of the activity target figures. Mr Oldham confirmed that the activity targets were broadly in line with those delivered in 2024/25. In response to a further query from Professor Crowe about whether the "community first" approach was reflected in the activity plan, Mr Oldham noted that the figures were based on the previous year's data and demographic growth, and did not necessarily capture that shift. Mrs Haire clarified that not all bank staffing incurred premium costs and committed to providing further detail on what was included under "premium	**JH**

	spend." She also confirmed that reporting on bank and agency staffing would be aligned with national targets and brought to the PCIC. It was agreed that the Annual Plan document would be added to the Business Intelligence (BI) bookshelf and published on the Trust's website. The Board acknowledged that a key challenge would be ensuring robust reporting at year-end and identifying areas where performance had not met expectations. Ms Ashley concluded by expressing her thanks to Mr Chris Bird for his work in compiling the document. **The Trust Board approved the Annual Plan.**	
OUR PATIENTS: QUALITY, ACCESS & OUTCOMES		
8.	**Urgent and Emergency Care Pressures, Ambulance Handover and Winter Update**	
085/2025	Mrs Thorpe provided an update on urgent and emergency care (UEC) performance, noting that handover times had been improving in line with the planned trajectory. However, June had presented particular challenges. She outlined the tactical responses implemented and highlighted significant changes at the front door, including efforts to move towards a maximum handover time of 45 minutes. While early indications suggested progress in the right direction, it remained too early to confirm whether improvements would be sustained. She referenced the Recovery Highlight Report, which indicated that the 45-minute handover target had not yet been fully embedded and remained a key objective for July. She also noted ongoing issues with the co-location of the Urgent Treatment Centre (UTC) at the Royal Stoke front entrance, citing planning regulations and the need for further medical engagement as barriers. Professor Crowe welcomed the inclusion of trajectory data and raised concerns regarding the Trust's vulnerability in achieving its objectives, particularly in relation to capital investment in the discharge lounge and UTC. Mrs Thorpe confirmed that capital allocations had been received from the centre, but these were ringfenced for specific purposes. While the facilities existed, they were not currently functioning as intended and were insufficient in size. Mr Oldham added that access to the capital funding was contingent upon a business case with no associated revenue impact, which presented a challenge—particularly for the UTC, where timing was a critical issue. Ms Ashley emphasised that the Trust was not in a position to create new costs and that teams were exploring how to utilise the existing workforce more efficiently. Professor Hassell raised a query regarding the reliability of ambulance handover data. Mrs Thorpe responded that there were no concerns with the data provided by the ambulance service itself. However, she explained that national mapping of provider sites had caused discrepancies, with County Hospital previously being mapped to Midlands Partnership NHS Foundation Trust (MPFT) rather than UHNM. This issue was being addressed and was believed to be resolved, although further testing was required. Ms Small asked when the data mapping issue would be fully resolved. Mrs Thorpe responded that while it had been expected to be corrected two weeks prior, further testing was scheduled for the current week to confirm resolution.	

	The Trust Board received and noted the update.	
9.	**Maternity Serious Incident Report**	
086/2025	The high-level summary was taken as read. Ms Bainbridge referred to recommendations in terms of the processes in place to review themes and queried whether QAOC had received that information as the level of detail was not available for the Trust Board. Professor Hassell confirmed that this level of detail was considered by the Committee. **The Trust Board received and noted the update.**	
PERFORMANCE		
10.	**Integrated Performance Report – Month 2 and Committee Assurance Reports:**	
087/2025	<u>Quality, Access & Outcomes Committee Assurance Report (05-06-25 & 04-07-25)</u> Professor Hassell reported that the Committee continued to focus on access metrics and the Trust's progress against recovery trajectories. He highlighted the following key points: • Ongoing challenges remained in specific areas of cancer performance and diagnostics, as well as in managing long-wait patients. Some assurance had been received in relation to gynaecology and ear, nose and throat services, although orthopaedics continued to present greater difficulties. • Partial assurance was noted for infection prevention, with 4 out of 10 Board Assurance Framework (BAF) standards still outstanding. • The Committee reviewed the analysis of 104-day cancer breaches and discussed the tension between conducting harm reviews and progressing treatment for patients still awaiting care. • Several issues had been identified in relation to medicines optimisation. However, assurance had since been received that the relevant posts had been filled and the issues addressed. • The implementation of the Electronic Prescribing and Medicines Administration (EPMA) system had been delayed. The system was expected to address a number of patient safety concerns, including medication storage and venous thromboembolism prophylaxis. An update on the project had been requested. • Significant assurance was provided by the Medical Examiner update, which confirmed that the service continued to meet or exceed national guidance. The Trust's approach had also attracted interest from other organisations seeking to learn from its practices. Ms Ashley confirmed that an update on EPMA would be provided at the private Board session. Professor Crowe welcomed the assurance provided by the Medical Examiner service and noted that transplant performance, although strong, may not be receiving sufficient visibility. He suggested that the Trust should consider how to better communicate these positive outcomes to stakeholders. Professor Hassell further noted:	

	• Several themes discussed at the July meeting had also been raised in June, including urgent and emergency care (UEC), long-wait patients, harm reviews, and the adoption of electronic systems. • The Quarter 4 Mortality Assurance Report had been discussed in detail. The Committee agreed to downgrade the assurance rating to "no assurance" due to concerns regarding the reliability of Hospital Standardised Mortality Ratio (HSMR) data, which was believed to be affected by a coding backlog. Although raw mortality rates had not increased and the assurance of the Medical Examiner service and Structured Judgement Reviews (SJRs) remained positive, the lack of reliable HSMR data represented a serious concern. Ms Ashley advised that the issue had been discussed at Executive level. No further actions had been commissioned by the Committee due to the financial implications, which were beyond its remit. Ms Small noted that the Committee was not in receipt of sufficient assurance and requested that the Executive Team consider appropriate mitigation. Mr Oldham confirmed that a paper was being prepared to explore alternative sources of assurance, and he explained that even with additional investment, resolving the coding backlog would take four to five months. He stated that April and May data had been fully coded, and it was anticipated that the dataset would be clean within 12 months. However, further assurance was needed in the interim. He also noted that evolving data definitions would continue to impact HSMR, making it a national issue. Ms Ashley acknowledged that the HSMR gap could not be closed in the short term. She proposed providing alternative data to demonstrate that there were no concerns regarding the quality of care or mortality, even if HSMR could not be relied upon. Professor Hassell stated that he had reviewed a paper from Mrs Carter and Dr Morris but remained unassured, as the additional data did not address whether mortality rates were outliers. He suggested exploring the use of HED monthly data to provide more timely assurance, rather than relying solely on 12-month rolling data. Ms Small emphasised the need to determine how the Board could gain appropriate assurance. Mr Oldham noted that while indicators of pressure and potential negative impacts were being monitored, they did not provide absolute assurance. It was agreed that the actions taken would be reported to the QAOC and reported to the Trust Board via the highlight report. Professor Crowe suggested that, if internal assurance remained insufficient, the Trust could consider seeking third-party or peer review to validate its approach. Ms Small agreed that this should be considered by the Executive Team and fed into QAOC. Professor Hassell also reported: • A review of hospital-acquired thrombosis had identified 21 cases with incomplete risk assessments. However, all patients had received appropriate thromboprophylaxis, and none of the cases were deemed avoidable. • The latest Quality Performance Report (QPR) had received an "acceptable assurance" rating. This was attributed to improvements across a range of metrics and a positive Care Quality Commission (CQC) evaluation of maternity services. This marked the first time the QPR had achieved this level of assurance, despite ongoing challenges. <u>Quality & Access Dashboard</u>	**MO**

	Mrs Riley referred to the timely observations' metric and pace of improvement. She stated that the Care Excellence Framework (CEF) approach had been refreshed and one of the predominant reasons for bronze ratings was in relation to timely observations, and currently the Trust did not have any bronze wards, therefore the Trust was meeting minimum requirements, as such while overall improvements were slow, at ward level this had improved. Mrs Riley added that deep dives into cohorts of the population were to be undertaken and reported to the Committee, to provide further assurance. **The Trust Board received and noted the assurance report and dashboard.**	
088/2025	<u>Finance & Efficiency Committee Assurance Report (02-06-25 & 30-06-25)</u> Ms Bowen presented the Committee's assurance report and highlighted the following key points: • Significant assurance had been received in relation to the Trust's sustainability report • Further assurance was required regarding the revenue budget implications of the Laboratory Information Management System (LIMS). • Opportunities for future savings through robotic technologies were being explored. • Additional clarity was needed on the Endoscopy Elective Recovery Fund (ERF) bid and associated activities. • Partial assurance was provided for the County Elective Hub due to delays in implementation. • Partial assurance was also noted in relation to overall financial performance, with risks identified that could potentially worsen the Trust's financial position. • The Cost Improvement Programme (CIP) remained partially assured, with a significant proportion of savings still at risk. • The process for reviewing business cases required updating. • A further paper was expected to outline the capital programme and its implications for long-term financial sustainability. • A positive update was received on Project STAR. • The Committee approved the Operation Anzu business case and referred it to the Risk Management Oversight Committee for further consideration • An increase to the capital programme for the discharge lounge was approved. <u>Finance Dashboard</u> Mr Oldham presented the Month 2 financial report which indicated that the Trust remained on plan, with a reported deficit of £6.9 million. The breakeven plan relied heavily on Cost Improvement (CIP) delivery, with a significant proportion of savings backloaded to the final six months of the financial year. He highlighted the following: • The revenue position, particularly pay, remained on plan with no exceptional variances. • Indicative Month 3 figures suggested continued alignment with the plan, with no significant increase in expenditure or deviation in pay run rate. • CIP delivery to date totalled £4.1 million, primarily through non-recurrent measures such as workforce controls, rather than sustainable recurrent schemes.	

	• Activity levels were estimated to be £1 million below plan, representing a financial risk. • Capital expenditure was slightly under plan, and a full capital review was underway, with findings to be reported back to the Committee. • A financial forecast was scheduled for completion at Month 3. • An unmitigated risk of £30 million had been reported to the centre, primarily linked to CIP delivery. The Trust continued to work with NHS England to refine and implement its CIP plans. • Cash levels were slightly below plan but remained within a reasonable range. Professor Crowe noted emerging vulnerabilities, particularly the lack of recurrent savings schemes. He emphasised the need for a reforecast and a deeper review at Committee level to assess risks and identify mitigating actions. Mr Oldham confirmed that the Trust was still forecasting a breakeven position but acknowledged the scale of the risks, particularly the reliance on CIP delivery in the latter half of the year. Ms Bowen suggested that early identification of CIP themes would be beneficial. Mr Oldham responded that all CIP programmes had identified schemes or thematic areas and that Project Initiation Documents (PIDs) were being developed. He noted that while opportunities had been identified through the NHS England opportunity tracker and incorporated into the plan, actual delivery would present a separate challenge. Ms Small stressed the importance of receiving assurance before year-end that the PIDs were in development and that actions were actively being implemented. Mr Oldham agreed, highlighting that the key priority was to ensure robust tracking and safe delivery of the programme. **The Trust Board received and noted the assurance report and dashboard.**	
089/2025	<u>People, Culture and Inclusion Committee Assurance Report (05-06-25)</u> Professor Crowe provided an overview of the Committee's discussions and highlighted the following key points: • Significant assurance had been received following a review of the Trust's equity and inclusion work, conducted through NHS England. The outcome was positive and provided further endorsement of the Trust's plans and approaches, despite some outstanding actions remaining. • Areas of concern were primarily linked to partial assurance ratings. While actions were underway to address these issues, the Committee acknowledged the considerable amount of work still required. It also recognised the ongoing capacity challenges and the pressure on resources due to competing priorities across the people agenda. The need to prioritise and, where necessary, re-prioritise workstreams was emphasised. • Additional actions included a deeper level of assurance on staff survey responses, with a focus on how care groups were responding to feedback. The Committee also stressed the importance of strong and impactful support for staff wellbeing and engagement. Ms Ashley noted that while the possibility of re-prioritising the people agenda had been considered, the current workstreams represented essential activities that could not be deprioritised. She acknowledged that the Trust remained	

	under-resourced in relation to the scale of delivery required. Professor Crowe agreed, stating that some initiatives were fundamental and must continue. Mrs Haire explained that partial assurance in several areas reflected the fact that many actions were only just beginning to be implemented. She confirmed that the focus for the year ahead would be on delivering impact and ensuring that actions were aligned with value. She also noted that some colleagues' work had been re-prioritised, particularly in relation to the urgent and emergency care (UEC) pathway, to ensure attention was directed toward the most pressing organisational issues while maintaining business-as-usual operations. Ms Small raised concerns about the current support available for staff experiencing stress and anxiety and asked what more could be done to make a meaningful difference. Mrs Haire responded that the Trust already offered a range of internal support services for stress, anxiety, and depression. The current focus was on improving job design, addressing burnout, and alleviating workplace pressures. She emphasised the need to invest further in line manager support and committed to reviewing the existing staff support and counselling offers to ensure they remained effective and accessible. <u>People Dashboard</u> Mrs Haire reported on the latest People Dashboard, noting the following: • The staff engagement score, measured through the quarterly "Staff Voice" survey, would be reviewed for the final time in July before commencement of the Staff Survey. Care groups had delivered detailed presentations to the Strategic Workforce Group outlining their responses to staff survey results and shared ideas for improvement. • Sickness absence had decreased during the reporting period, as expected for the time of year. The Trust continued to focus on targeted interventions and support for colleagues. • Staff turnover remained low. While there were challenges in managing the run rate, the Trust had some ability to reduce it naturally. Agency utilisation was also trending positively and was expected to fall below the established ceiling, and Mrs Haire agreed to provide an overview for the People, Culture and Inclusion Committee (PCIC) on premium staffing and associated definitions. Mrs Riley clarified that the reported figure of 200 nursing vacancies was a result of the calculation method used and did not reflect the actual number of unfilled posts. Ms Small requested that a narrative explanation be included in future reports to provide clarity. Professor Hassell noted that the People Dashboard showed staff turnover as amber despite its low level and suggested that this may warrant reclassification to reflect the improvement. **The Trust Board received and noted the assurance report and dashboard.**	**AMR/JH**
GOVERNANCE		
11.	**Rules of Procedure & Output of Committee Effectiveness 2024/24**	
090/2025	Mrs Cotton presented the updated governance documents and highlighted the following key points:	

	• The documents reflected recent changes to the committee governance structure. • The Rules of Procedure formed a key component of the Trust's Well-Led Framework, with explicit reference made to the strategic plan on a page. • The revised documents placed slightly greater emphasis on the Board's role as a unitary body, achieved through updated language and terminology. • While the Terms of Reference (ToR) for the Finance and Business Performance (FBP) Committee were nearing completion, further work was required to reflect the Committee's evolving role. The intention was to finalise these and present them to the Committee in July for formal approval. This would include a new cycle of business to ensure continued focus on financial performance and other key areas of oversight. • Once finalised, the updated documents would be published on the Trust's website. Mr Oldham noted that the FBP Committee's Terms of Reference should also include a mechanism for tracking the activity plan, which was currently missing. **The Board approved the documents, subject to the inclusion of the updated FBP Committee Terms of Reference.** Ms Small welcomed the revised documentation and thanked those involved in its preparation.	**NH**
12.	**Board Seminar Plan 2025/26**	
091/2025	Mrs Cotton presented the proposed Board Seminar Plan for 2025/26, outlining the topics scheduled for developmental and strategic sessions. She noted that the plan was designed to be flexible and would be updated as necessary to reflect emerging priorities. The intention was to ensure alignment with the Well-Led Framework and to provide structured time for Board development. She expressed a particular interest in including an Organisational Development (OD) session focused on Board maturity and the evolving information needs of the Board. She also highlighted ongoing work with care groups to adopt a similar approach at the care group level, which was viewed as a positive step in supporting leadership development across the organisation. Ms Bowen queried whether the winter plan debrief would be included in the seminar schedule. It was confirmed that the winter plan would be discussed in full at a future Board meeting rather than within the seminar programme. Professor Hassell welcomed the structure of the plan and commended the categorisation of topics under strategic programme themes. **The Trust Board received and noted the programme.**	
CLOSING MATTERS		
13.	**Review of Meeting Effectiveness**	
092/2025	Mrs Cotton highlighted that a digital feedback form would be circulated for completion.	
14.	**Review of Business Cycle**	

093/2025	No further comments were provided.	
15.	**Questions from Members of the Public**	
094/2025	Mr Syme raised a number of questions in relation to the Urgent and Emergency Care (UEC) Pressures, Ambulance Handover, and Winter Update item. He referred to an ongoing investigation by NHS England (NHSE) and West Midlands Ambulance Service (WMAS) concerning erroneous data reporting of ambulance handovers. Mrs Thorpe clarified that the issue related specifically to County Hospital, which had been incorrectly mapped to the Haywood site in national datasets. While the baseline data itself was accurate, the national mapping had been incorrect. She confirmed that this had now been addressed and that the Trust would assume full ownership of the data going forward. Mr Syme reiterated concerns regarding ambulance handover delays at Royal Stoke Emergency Department (ED), referencing the Urgent and Emergency Care Plan 2025/26. He noted that these delays had previously been acknowledged as unacceptable and that improving UEC performance remained the Trust's top priority. He highlighted that the national UEC plan stipulated a maximum ambulance handover time of 45 minutes. He observed that the current average handover time stood at 64 minutes, and in order to meet the 45-minute maximum, the average would need to be reduced to approximately 18–19 minutes. Mr Syme further noted that ambulance lost hours at Royal Stoke had exceeded 17,000 in the first three months of the year. Although there had been a reduction of over 500 hours—bringing the total to around 1,000 lost hours—he emphasised that this remained insufficient to meet the national standard. He queried how the Trust intended to publicly report ambulance handover delays, expressing concern that reporting average figures did not reflect compliance with the 45-minute maximum or demonstrate a clear trajectory toward achieving it. In response, Mrs Thorpe explained that the Trust had adopted the 45-minute maximum handover time as part of its improvement trajectory. However, the requirement to report average handover times had been set during national planning rounds for 2025/26, and the Trust was therefore obligated to report against that metric. Ms Ashley confirmed that there had been no request to re-submit data using alternative metrics, and the Trust was required to comply with the existing reporting framework. Mrs Thorpe acknowledged the challenge of aligning internal improvement standards with national reporting requirements. Mr Syme also referred to the national 'Release to Rescue' standard, which mandates that once a handover reaches 30 minutes, all ambulances should complete their handover and leave the hospital within 45 minutes. He asked whether UHNM had implemented this standard, and if not, when it would be adopted and how performance would be publicly reported. Mrs Thorpe clarified that the Trust had not yet implemented the 'Release to Rescue' standard. She explained that while the 45-minute handover target was in place, the 'Release to Rescue' model required further collaboration with ambulance service colleagues to ensure safe and timely implementation. She	

	noted that the Trust still had significant work to do before the standard could be fully adopted. In the meantime, immediate and rapid offload procedures were in place, prioritised by patient category (e.g., Category 1 and 2) and community needs, rather than national policy.	
DATE AND TIME OF NEXT MEETING		
16.	**Wednesday 8th October 2025, 9.30 am, Trust Boardroom, Third Floor, Springfield, Royal Stoke**	

Post Meeting Action Log

Trust Board Part 1 - Open

As at **02 October 2025**

Ref	Meeting Date	Agenda Item	Action	Assigned to	Due Date	Done Date	Progress Report	RAG Status
PTB/614	07/05/2025	Urgent and Emergency Care (UEC) Pressures, Ambulance Handover and Winter Update	To consider the additional information which could be provided as national / comparator context within future reports	Katy Thorpe	~~09/07/2025~~ 06/08/2025	06/08/2025	Information included within reports to Part 2 due to this not being readily available in the Public domain.	B
PTB/615	07/05/2025	People Dashboard	To take the point regarding increase in agency usage from February to March to PCI in addition to providing an update on the actions being taken to review rostering practices to avoid such increases in the future.	Jane Haire / Kay Myatt	30/07/2025	24/09/2025	Complete. Information included within the workforce planning update to PCIC In September.	B
PTB/616	09/07/2025	Annual Plan	To provide further detail in terms of definitions associated with premium spending and bank and agency staff, to PCIC.	Jane Haire	30/07/2025	15/07/2025	Slide included in the Chief People Officer report to July's PCIC to explain the categories of premium rates	B
PTB/617	09/07/2025	Quality Access and Outcomes Committee Highlight Report	To provide further assurance to QAOC on the actions being taken to address the HSMR and provision of alternative assurance, including consideration of using monthly HED data.	Mark Oldham	07/11/2025		Action not yet due.	GB
PTB/618	09/07/2025	People Dashboard	To include additional narrative within the dashboard to explain the reason for the differences in reporting nursing vacancies.	Jane Haire	07/11/2025		Action not yet due.	GB
PTB/619	09/07/2025	Rules of Procedure	to consider the revised terms of reference for Finance and Business Performance to the Committee in July prior to including within the Rules of Procedure and publishing on the website.	Nicola Hassall	09/08/2025	09/08/2025	Revised ToR considered and agreed with FBP.	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 October 2025

University Hospitals of North Midlands NHS Trust

Part 1: Highlight Report

This report provides the Trust Board with an overview of a range of strategic and operational issues since the last public meeting on 9 July 2025, some of which are not covered elsewhere on the agenda for this meeting. This may be a somewhat longer report than usual because of the timing of this year's Annual General Meeting and our Board cycle of business.

1. NHS 10-Year Plan

The publication of the *NHS 10-Year Plan: Fit for the Future* over the summer marked a milestone for our national health and care system. It is a vision for the future – one that is more preventative, digitally enabled, and rooted in joined-up care across communities.

This national direction aligns closely with our own strategy at UHNM: the best joined-up care for *all*.

There are three key elements to this: i) the 'best' because it is the right thing to do to be ambitious and pursue excellence in everything we do; ii) 'joined-up' because we need to work together as teams across traditional silos, both inside and outside our hospitals (a frequent complaint of patients is that nothing ever seems 'joined-up' in the NHS; and iii) 'all' because we have to look after everyone fairly, equally and inclusively, both our local population as well as the wider population for which we provide more specialist services.

Our focus remains firmly on delivering for Our People, Our Patients, and Our Population – and our plan gives us renewed momentum to do so.

The exciting opportunities ahead are also of course in the context of the reality we face. Like many NHS organisations, UHNM is operating in an extremely challenging financial and operational environment. Pressures on our budgets are significant, and we are working hard to manage rising demand, workforce costs, and inflationary pressures while maintaining safe, high-quality care.

This context makes the ambitions of the national plan even more important. We must find smarter, more sustainable ways of working – reducing duplication, improving flow, and embracing innovation that delivers better outcomes and better value.

Aligning with our own plan, the NHS plan outlines three key shifts:
- From hospital to community care
- From analogue to digital systems
- From sickness to prevention

These shifts are already reflected in our local priorities:
- Digital transformation is underway, with virtual wards, AI-assisted diagnostics, and improved patient access to information. We will talk even more about a new EPR as that comes closer.
- Integrated care is growing through our partnerships across Staffordshire and Stoke-on-Trent.
- Prevention and population health are central to our work with the Integrated Care System (ICS), helping us address inequalities and improve long-term outcomes.

As a Trust we will continue to:
- Put patients first, ensuring care is safe and effective, kind, and compassionate, and joined-up across settings.
- Support and invest in our people, even in difficult times, with a focus on wellbeing, development, and flexible career pathways.
- Work with our communities, using data and insight to target interventions where they are needed most.

2. Reflections upon the past year

This Board report sees my one-year anniversary as chief executive of UHNM. In the context of the above forward-looking NHS 10-Year Plan, it inevitably gives rise to some pause for reflection. Whilst we have made some progress with performance, including waiting times, it is clear we have more to do.

I hope that we have concentrated on developing solutions, not problems, with a strong emphasis on engagement, transparency, and the genuine transformation of our services to adapt to the current environment in which we find ourselves. The changes are designed to ensure UHNM delivers the best possible outcomes for patients, staff, and the wider population, with a clear structure to support ongoing cultural and operational improvement.

Key to this has been the development and launch of a new mission, vision, and values statement, with a brand new 10-year strategy and strategic framework, aligned with the Darzi report and the new NHS 10-year plan. We have had high levels of engagement through this process which lasted over six months. We have emphasised the importance of leadership, especially clinical leadership, and a high-performing multi-professional leadership team at all levels, as critical to cultural change.

Our strategic priorities now have very clear unambiguous metrics, including a focus on wider population health beyond the traditional acute provider remit.

We have revised our organisational structure and accountability framework to reflect the new strategy in line with the National NHS Performance Assessment Framework. Our new strategic programmes are focused on delivering fundamental performance standards across all quality domains, linking quality of care with access and performance standards, ensuring a holistic approach to improvement. We have acknowledged operational performance issues, particularly in urgent and emergency care, accepting external support and establishing a targeted recovery programme to address the issues proactively. We now have a Balanced Scorecard for newly formatted Performance and Risk Reviews, and these have thus far been well received by all concerned.

The last year has also seen us highlight and escalate issues with our inadequate digital infrastructure, especially our electronic patient record/patient administration system, emphasising the impact of digital shortcomings on clinical care and overall performance. We look forward to further development of our unifying approach to change management through the new virtual Strategy Delivery Unit (SDU), enhancing change-management capacity and capability by bringing together transformation, organisational development, quality improvement, research, innovation, and digital services under one virtual roof.

3. National NHS League Tables

In September NHS England has published its first national tables showing how trusts are performing across a range of measures. The publication of the NHS league tables marks a new era of transparency and accountability and is part of the commitment to give patients a clearer view of local healthcare services.

It is the first time that members of the public and NHS leaders can explore league tables that show how trusts, like ours, compare with others across England on both individual services and at an overall level. Based on their performance against targets such as waiting times for electives and A&E and improving ambulances waiting time, each trust has been placed into one of four core segments. Segment one represents those with the least range of challenges while segment four contains those with the most.

Providers facing the most significant performance or governance challenges will be placed into an additional segment (segment 5) and may receive intensive, tailored support through a recovery support programme.

Reflecting the need for the NHS nationally to recover financially, any trust in deficit is limited to segment three, regardless of wider performance, and this is where we have been placed. Within this group, we are ranked 83 out of 134 acute/specialist trusts. It is fair to say that this shows we have a long way to go, and there are areas where we must improve to deliver the care our patients deserve.

At the same time, it is important to be clear that our hospitals are safe places to receive care. Over the past year, we've made real progress – reducing waiting times for planned operations and improving flow through our hospitals, so people who need urgent care get it as quickly as possible.

But if we are to deliver high quality care fairly, we need to further improve access to that care.

Looking ahead, we will continue to focus on improving our urgent and emergency care performance while also prioritising our longest waits, with clear actions in place to make real change. We are working to strengthen our services and support patients more effectively. We will also continue to work with our partners across Staffordshire and Stoke-on-Trent Integrated Care System to remove duplication and streamline processes to deliver high quality care so that every organisation can meet its obligation to meet their financial challenges.

4. NHS Provider Capability Framework

NHS England has also published its approach to assessing provider capability.

As set out in the recently published NHS Oversight Framework (NOF), NHS England will consider not only an organisation's delivery, as evidenced by its NOF segment, but also its capability. The rating of provider capability will help inform our response to NOF segmentation and may also inform any decisions about entry into the National Provider Improvement Program (NPIP), as well as trusts being considered for new FT status.

The aim is to ensure that NHS England has a holistic view of providers, not just focussed on delivery of national programmes but also capturing wider information relevant to grip and governance. It is also intended to be a development tool, helping Boards to reflect on their competencies, develop robust approaches to internal assurance, and encourage continuous improvement.

The capability rating will be based on:

- an annual self-assessment by provider Boards and submission to NHS England, with supporting evidence. The assessment will be based on themes from last year's publication of 'The Insightful Board.'
- a review of the self-assessment, triangulated with the provider's track record to date and any third-party information (including CQC), to provide an overall view on the Board's capability. Whilst ICBs remain jointly responsible and involved in provider oversight we would also seek their views on the provider capability self-assessments for the providers in their systems.
- across the year, NHS England will use the capability rating and self-assessment to inform the relationship with the provider, revising the capability rating should events merit it e.g. if an issue emerges that was not foreseen in the self-assessment.

It is currently intended that the capability rating will be published alongside the NOF segmentation.

5. Leadership development

Leadership, and the development of our collective leadership capability, is front and centre of the delivery of all of the above. In July, I was inspired and enthused in equal measure to attend the Gold & Platinum Connects Awards in Leadership Development & Improvement. On 16 July there was the Gold Cohort and on 17 July the Platinum Cohort, a total of 62 leaders who started their journey at the launch events in September 2024.

Ten months later (attending one day per month) with their cohort colleagues saw them at the celebration event this week, reflecting on their learning. There have been eight masterclass titles including: Creating a well-led environment, Strategic Thinking, Navigating Change, Continuous Improvement, Looking after our people, Political Awareness & Influencing, Personal Impact & Coaching, as well as Inclusive Leadership. As well as the masterclasses, their journey of self-discovery started with participating in the NHS Healthcare Leadership 360 tool and they all received their feedback on their leadership impact.

It is clear to me that all participants have taken full advantage of the networking, peer to peer coaching and the power of the cohort experience, coming together as a group of diverse individuals across all of our professions. People working together who would not ordinarily find themselves working together. They have reflected on their practice – before, during and after their programme, and taken their teams on the journey with them.

There were so many impactful statements made, including the sheer power of looking within, self-awareness and continuous learning, especially in the context of what I would call the sweet spot between "top-down" and "bottom-up" initiatives. The groups had obviously bonded to create a shared space of psychological safety where it was ok to display vulnerability and be open with colleagues.

Thank you to the ODCI team that host our Connects programme, especially to Carrie Lippitt and Joseph Orosun (OD Consultants) who have guided and supported our leaders, not only in the classroom but also in a coaching capacity. Thank you also to all that have contributed to the masterclass delivery, which means that the programme continues to have a positive impact on those who participate.

6. UHNM Chaperone Policy

Healthcare is built upon trust. Patients and visitors rightly expect that their privacy will be respected, and that they will feel safe and supported during every examination, procedure, or consultation. Equally, staff deserve to work in an environment where they are protected from misunderstanding or harm.

This is why it is important to be able to announce in September the launch of our new chaperone policy which is a key milestone in our ongoing commitment to patient safety, dignity, and respect.

Our new policy clearly sets out when a chaperone must be offered or be present, how to record consent, and the standards we expect of everyone involved. Chaperoning is not just a formality – it is a vital safeguard that:

- Protects patients from inappropriate behaviour or harm.
- Reassures patients during potentially sensitive or uncomfortable procedures.
- Protects staff against unfounded allegations.
- Promotes a culture of openness, professionalism, and respect.

The updated policy has been shaped by feedback from staff, safeguarding leads, and national recommendations. Key elements include:

- Role-specific eLearning training which will be mandatory every three years.
- A structured clinical note in iPortal to document when a chaperone is offered or present.
- Updated posters for adults, children, and young people, with QR codes linking to the information on our website and the full policy.
- Clear guidance for special circumstances such as examinations under anaesthetic, virtual consultations and working with children or people who may be vulnerable.
- There is also a new section on supporting patients with additional needs, including communication, or learning difficulties.

This matters because we have signed the NHS Sexual Safety Charter and because we believe everyone should be safe from harm, abuse, or unwanted behaviour in all healthcare settings. Recent letters and guidance from NHS England remind us that safeguarding patients and staff is a collective responsibility – and it is one we take very seriously.

The revised policy reflects national learning from high-profile inquiries and reinforces our zero-tolerance approach to sexual misconduct or breaches of professional boundaries. It also empowers staff to raise concerns if they see anything that could compromise safety or dignity.

Launching this policy is not just about compliance; it's about strengthening the culture we want for UHNM: one where safety, respect, and compassion are at the heart of everything we do.

7. Tessa Jowell Brain Cancer Centre of Excellence

UHNM has been designated as a regional centre of excellence for neuro-oncology by the Tessa Jowell Brain Cancer Mission (TJBCM).

UHNM was named as part of the newly awarded West Midlands Centre of Excellence for Neuro-Oncology, recognising the Trust's leading role in the treatment, care, and research of brain tumours in partnership with University Hospitals Birmingham NHS Foundation Trust and the University of Birmingham.

Tessa Jowell, Baroness Jowell, was a Labour Party MP and then life peer, who sadly died from brain cancer in 2018. The West Midlands Centre of Excellence for Neuro-Oncology was announced as one of 14 new national centres of excellence at an event at the Francis Crick Institute in London in May. The Centre of Excellence initiative aims to ensure all UK patients with a brain tumour can access the best standard of treatment, care, and research.

The award follows a joint application from UHNM and its West Midlands partners as well as an extensive peer-led review of services and patient feedback. The West Midlands application met and, in several areas, exceeded the rigorous, expert-led criteria to ensure the highest standards of patient treatment, innovation, and research.

As part of the review, psychological support for brain tumour patients at UHNM was cited as "exemplary".

Brain tumours affect over 12,000 adults in the UK every year and kill more people under the age of 40 than any other cancer.

8. CT Colonography Centre of Excellence

Our Imaging and Training Academy has been recognised as a Centre of Excellence for CT Colonography. This is a proud and important milestone and one that highlights the power of innovation, collaboration, and teamwork in transforming patient care.

The pioneering National CT Colonography Training and Accreditation Programme has been developed here, led by Dr Ingrid Britton, UHNM Consultant Gastrointestinal Radiologist, alongside St Mark's Hospital in London and is already helping to save lives through earlier and improved cancer diagnosis.

The first of its kind nationally, the programme will have trained up to 500 radiographers and radiologists between 2022 and the end of this year.

We were the first trust in the country to deliver accredited CT Colonography training, starting back in 2012 and that pioneering spirit continues today, with our academy now established as one of five centres nationally leading this vital work, an important step in the earlier detection of bowel cancer.

I want to pay tribute to the dedication of the multi-professional team who have made this achievement possible. CT colonography performance varies widely across the UK and we hope this programme will help to narrow these gaps and improve patient outcomes.

As a Centre of Excellence radiographers will be given the opportunity to network and every six months there will be a faculty meeting where the team present how many people have been trained, ensuring all radiographers keep to the same standards.

9. Organ Donation

Every day across the UK, lives are saved and transformed thanks to organ and tissue donation. Yet sadly every day someone also dies waiting for a transplant that never came. Most of us would accept an organ if we needed one but fewer have registered to give.

Here at UHNM we are proud to be one of the country's larger donor-generating centres, supported by our status as a major trauma centre. In 2024/25, thanks to the generosity of patients and families and the hard work and dedication of our organ donation team:

- 36 patients donated their organs (up from 24 the previous year)
- On average just over three organs were donated per donor

- Donations included 61 kidneys, 24 livers, eight lungs, six hearts and five pancreases
- 116 corneas were also donated to NHS Blood and Transplant eye banks
- In total 95 patients received a lifesaving or life-changing transplant

Behind each of these donations is our team of four specialist nurses in organ donation (SNODs). They work in critical care, emergency departments and our neonatal and children's intensive care units to support patients and families through the most difficult of times. Their role is both clinical and compassionate, from identifying potential donors and having the important yet often difficult conversations with patients and family members to co-ordinating national surgical teams. They also teach and support our UHNM staff to ensure colleagues are aware of processes.

We know that one person can save up to nine lives through organ donation and many more through tissue donation. Age is not a barrier, and we especially want to encourage those aged 50 to 69 to confirm their decision on the NHS Organ Donor Register.

Across the UK last year 2,394 people donated the gift of life to 4,583 recipients, but sadly, more than 400 people still died waiting, including 64 in the Midlands alone. Only 36 per-cent of people in our region are currently registered as organ donors compared to 42 per-cent nationally.

If more people joined the NHS Organ Donor Register, we could save even more lives and prevent the heartache of families losing loved ones while waiting for a transplant.

10. Launch of National NHS Staff Survey

On 25 September the NHS Staff Survey opened here at UHNM.

The experiences quantified and described will help shape how we move forward together. The survey gives us insight into what's working, what needs to change, and how we can make UHNM a better place for everyone.

The national staff survey provides a vital opportunity to hear directly from all staff, and feedback helps us as a team and as an organisation understand what support is needed, what is working well, and where we can do better. Those experiences guide our decisions, improvements and support.

Last year, your feedback led to real action on areas including the below:
- New appraisal paperwork focused on wellbeing and development
- Our flexible working campaign launch
- Strengthened commitments to anti-racism and sexual safety

This year, we want to keep that momentum going and continue delivering on the NHS People Promise and our UHNM values of being Kind, Excellent, and Together.

Most people will receive the survey via email from IQVIA, the research company running the survey. Some colleagues will receive a paper version instead; this has been carefully determined through workforce checks based on job roles.

We know confidentiality is key. As the survey is run independently by IQVIA, all responses are completely confidential. While we can see how many responses have been received across care groups, departments, and staff groups, we do not have access to the content of individual responses. Unique links and barcodes are assigned and managed solely by IQVIA, and we do not have visibility of this. It's genuine candour, the good and the bad, from thousands of responses that really helps us shape what we do and how we do it.

11. Digital Developments

There are a number of digital developments upon which to report.

The transition from the CRIS-led to a SECTRA PACS-based reporting went live on 25 September 2025. The benefits of the new SECTRA PACS-based reporting (PBR) system are:
- Improved reporting efficiency: The new system will streamline the reporting process, making it more efficient and reducing the time required for reporting.

- Enhanced accuracy: By ensuring that all patient events are registered and post-processed accurately, the system aims to improve the accuracy of data input and reporting.
- Better coordination: The system will facilitate better coordination among imaging operators, reporters, and the PACS team, ensuring that any urgent technical issues are promptly addressed.
- Seamless transition: The transition to the new system is designed to be smooth, with clear guidelines for handling downtime and ensuring that all necessary steps are followed.
- Support for urgent cases: During the transition period, the system ensures that urgent and emergency examinations are still reported promptly, maintaining the quality of patient care.

EPMA (Electronic Prescribing and Medicines Administration): The EPMA project continues to progress, with Ward 15 at County already live. The project is critical for reducing clinical safety risks, improving digital information availability, and reducing paper medication charts.

The trial of Ambient Voice Technology (AVT) from the "Heidi" started in ED on 29 September 2025. The expected benefits are:

- Improved clinical documentation. AVT uses AI-enabled ambient scribing to unobtrusively record clinician-patient conversations and convert them into structured clinical notes
- Enhanced patient care by automating notetaking, AVT allows clinicians to focus more fully on patient interaction.
- Staff wellbeing and efficiency: AVT is designed to reduce burnout by cutting down on administrative burden.

October is Cyber Security Awareness Month and UHNM will be promoting awareness.

3. Low Carbon Care Framework

The Low Carbon Care Framework (LCCF) employee development and recognition scheme was launched in September, with strong engagement seen at the launch events. The LCCF aims to empower teams to embed sustainability in their everyday working lives and support the delivery of low carbon care for our patients. Teams work together to achieve small, easy wins and gain recognition through Bronze, Silver and Gold accreditation and awards.

The NHS is responsible for approximately 5% of England's carbon footprint, therefore it is vital that the NHS acts to reduce its impact on the environment. Sustainability is a key issue for many of our colleagues who are concerned about the effects of climate change on their patients and their community. The LCCF is key to delivering the refreshed Trust Green Plan for 2025/26 – 2028/29 and it links with existing programmes such as Improving Together and the Care Excellence Framework. At the time of writing nine teams have signed up to join the online toolkit.

12. Clinical Technology

Our Clinical Technology Team has successfully passed their BSI 13485:2016 surveillance audit with zero non-conformities.

This is an exceptional achievement, particularly given the stringent requirements of ISO 13485, which is the internationally recognised standard for quality management systems in the design, development, and maintenance of medical devices. Certification to this standard demonstrates that an organisation consistently meets regulatory requirements and maintains the highest levels of safety, reliability, and performance.

Key highlights from the audit include:

- Robust governance and assurance embedded in daily operations.
- Proactive risk management and process-driven practices.
- Exemplary cross-departmental collaboration and professionalism.

Achieving a zero non-conformity outcome under such a demanding framework is a testament to the dedication, expertise, and integrity of the Clinical Technology team. It not only enhances our external reputation but also provides strong internal assurance that our systems and practices are of the highest calibre. This milestone reflects our collective commitment to delivering safe, high-quality care through effective medical device governance, and it reinforces UHNM's position as a leader in clinical technology management.

13. Employee and Team Recognition

i) UHNM Awards

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

- ***Team of the Month Award to the Nuclear Medicine and PET CT Appointments Team (July 2025).*** Although they are tucked away on the lower floors of the Royal Stoke, their impact on patients and colleagues is felt far and wide. They were nominated for their "*unwavering dedication, resilience, and exceptional teamwork during a challenging period*". You cannot help but be genuinely impressed by their positive attitude and the way they pull together as a team to deliver the highest-quality support for clinical care.

- ***UHNM Heroes Award: Paediatric Oncology Team at Staffordshire Children's Hospital at Royal Stoke (August 2025)***. The team was nominated by a member of staff following the heartbreaking loss of their child who bravely battled refractory acute myeloid leukaemia (AML). In the nomination, it was described how the team delivered "exceptional care," going above and beyond to help, creating the best possible memories for the family in the limited time they had left together. Special thanks were given to Dr Sarah Thompson, consultant paediatrician, and Julie Eaton, children's oncology nurse specialist, in the hardest of circumstances. Words from me cannot do any of this justice.

- ***UHNM Heroes Award: Ward 123, RSUH (August 2025).*** The team was nominated by a member of staff whose mother sadly passed away earlier this year. The nomination spoke of the immense pride about the "*exemplary care, kindness and compassion*" shown by sister Sandra Hughes and her team. She described how the whole ward worked together to support her family, often anticipating their needs before they even knew what to ask for - "*NHS at its very best*", a reflection of strong, compassionate leadership and a team who live our values every day.

- ***Chief Executive Award: Ward 205 and Delivery Suite, RSUH (September 2025).*** I presented a chief executive award to colleagues from maternity services at the Royal Stoke. This award recognised the remarkable compassion shown by staff on Ward 205 and the Central Delivery Suite in the early hours of one summer morning, when a lady was admitted in difficult and distressing circumstances. Her baby was born unexpectedly at 20 weeks gestation with signs of life but sadly passed away shortly afterwards. At a time of deep shock and sadness for the family, our midwives, student midwives and maternity support workers responded with extraordinary tenderness. Recognising that the parents were unable to cope with the situation, our teams ensured that the baby was never left alone. They took turns nursing her, surrounding her with affection and dignity during her very short life.

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

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

- Phil Windsor - Head of Operations, Surgery
- Kate Dono - Staff Nurse, Emergency Department, RSUH
- Emily Hulme - Student Nurse, Staffordshire University
- North Midlands Hand Centre, County - Whole Team
- Fiona Green - Patient Experience Advisor
- Laura Pitt - Staff Nurse, Nurse Bank
- Charlotte Grimes - JOSM, Urology
- Helen Chapman - PALS Officer, PALS Team
- Mr Rakhul Raveendran - Consultant Urologist
- Russell Goodfellow - Volunteer
- Deborah Hughes - Clinical Nurse Specialist, Immunology & Allergy
- Nathan Joy-Johnson and Team, Supplies and Procurement
- Dr Caroline Groves and Team, Community Paediatrics
- Dr Adam Fullagar - Consultant Clinical Oncologist
- Dr Melissa Hubbard - Consultant Paediatrician
- Ellie Hancock - Orthodontics Secretary

Part 2: Consultant Appointments

The following table provides a summary of consultant medical staff interviews which have taken place during July, August, and September 2025:

Post Title	Reason for advertising	Appointed (Yes/No)	Start Date
Consultant Orthopaedic Soft Tissue Knee	Newly created	Yes	1 to commence 20.10.25. 1 start date TBC
Respiratory Consultant with Specialist interest	Vacant post	Yes	2 start date TBC
Consultant in Neonates	Vacant post	Yes	TBC
Consultant Intensivist	Vacant post	Yes	TBC

The following table provides a summary of medical staff who have taken up positions in the Trust during July, August, and September 2025:

Post Title	Reason for advertising	Start Date
Consultant Interventional Cardiologist with interest in TAVI	Vacant post	1.8.2025
Consultant Obstetrician and Gynaecologist	Newly created	1.9.2025
Acute Medicine Consultant	Vacant post	1.9.2025

No medical vacancies closed without applications / candidates during July, August, and September 2025.

Medical Management Appointments

The following table provides a summary of medical management interviews which have taken place during July, August, and September 2025:

Post Title	Reason for advertising	Appointed (Yes/No)	Start Date
Clinical Director for Acute Medicine	Vacant post	Yes	TBC

The following table provides a summary of medical management who have taken up positions in the Trust during July, August, and September 2025:

Post Title	Reason for advertising	Start Date
Deputy Clinical Director - Gynaecology	Vacant post	10.8.2025

No medical management vacancies closed without applications/candidates during July, August, and September 2025.

Executive Summary

Trust Board | 8th October 2025

Provider Collaborative Update

NHS
University Hospitals of North Midlands
NHS Trust

Purpose:	**Information**		**Approval**		**Assurance**	✓	**Agenda Item:**	9.
Author:	Helen Ashley, Director of Strategy and Transformation							
Lead:	Helen Ashley, Director of Strategy and Transformation							

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:

The Provider Collaborative Board met on 18th September 2025. There are currently four programmes which make up the associated work programme in 2025/26 and their current status is as follows:

- **Integrated Neighbourhood Teams** – Phase 1 is underway with pilots running in North Stoke, East Staffordshire and Cannock. Work continues to clarify the role of the Strategic Commissioner in this space versus the Provider Collaborative to prevent duplication of activities, eliminate confusion for clinical and operational teams and confirm where co-production needs to take place. Accelerator application bid was unsuccessful.

- **Urgent and Emergency Care (UEC) / Community Transformation** – Action Groups have been established for each workstream and project briefs and supporting delivery plans are currently being developed. Highlight report updates were shared with the newly established Provider Collaborative Operational Forum on 5th September, which is chaired by the Chief Operating Officers. This forum is key to making sure we can successfully operationalise the delivery plans, ahead of Winter. Additionally, work has now commenced on the scoping of a broader / more strategic Community Transformation Programme, including the NHS 10 Year Plan priorities, which will be complimentary to the integrated neighbourhood working.

- **Corporate Services** – Benchmarking information for 2024/25 has been requested from all NHS Providers and is being analysed to explore the opportunities for collaboration using the most up to date and valid data. This will be presented by the CSO and validated by lead execs prior to discussion at the October Board. Staffordshire and Stoke on Trent (SSOT) continue to build relationships and explore opportunities to collaborate at scale across and Shropshire Telford and Wrekin (STW). No further action has taken place on 'delegated functions'. The ICB are currently exploring with the regional team the possibilities for 26/27.

- **Tough Choices Programme** - a review of the 'ideas' aligned to the Provider Collaborative has been completed and an update will be provided at the Provider Collaborative Board once these have been socialised within the provider organisations themselves.

INTEGRATED NEIGHBOURHOOD TEAMS CEO LEAD: JOHN ROUSE SRO: ADAM MCKEOWN	UEC / COMMUNITY TRANSFORMATION TO SUPPORT WINTER PLAN CEO LEAD: NEIL CARR SRO: JENNIE COLLIER		CORPORATE SERVICES CEO LEAD: BUKI ADEYEMO SRO: LIZ MELLOR			TOUGH CHOICES PROGRAMME CEO LEAD: TBC if applicable
THREE EARLY IMPLEMENTOR SITES AGREED	**NEED TO REDUCE ADMISSIONS AT UHNM EQUIVALENT TO 24 BEDS**	**NEED TO REDUCE AMBULANCE CONVEYANCES TO ED**	**STW SHARED SERVICES PROGRAMME**	**SSOT SPECIFIC OPPORTUNITIES**	**CREATING SPACE FOR DELEGATED ICB FUNCTIONS TO TRANSFER / DELIVER FURTHER ECONOMIES OF SCALE**	**SCOPE TBC**
East Staffordshire	Respiratory pathway redesign – Stoke and Cannock	UHNM Access	Phase 1 – HR, Finance & Digital	Estates**	MoU under development. Functions in scope still being determined by NHSE.	The 'ideas' given to the Provider Collaborative for review have been aligned to 3 themes: • Estates** • Organisational Restructure • Stopping / charging for clinical services
North Stoke		Physiologically Normal Mental Health	Phase 2 – Facilities & Estates			
Cannock		Minor Injury Fallers	Phase 3 – Communications, IG, Legal, EPRR, Health & Safety			

Key priorities for October 2025 are as follows:

- Continue to develop the Memorandum of Understanding (MoU) between the ICB and the Provider Collaborative in terms of roles and responsibilities.
- Ensure there is no double counting of beds across the Respiratory workstream and the wider bed modelling for Winter. Potential areas of duplication include Virtual Wards, which has its own target.
- Progress the delivery plans for the emergency department conveyance projects.
- Validate the 2024/25 corporate services data within the Model Health System database. Determine whether there are any remaining opportunities when taking into account existing CIP Plans for 25/26.
- Continue to develop a longer-term plan for Community Transformation in line with the requirements set out in the NHS 10 Year Plan.

Key Recommendations:

The Trust Board is asked to note the update.

Executive Summary

Trust Board | 8th October 2025

Board Assurance Framework – Quarter 1

NHS
University Hospitals of North Midlands
NHS Trust

Purpose:	**Information**		**Approval**	✓	**Assurance**	**Agenda Item:**	10
Author:	Nicola Hassall, Deputy Director of Governance						
Executive Lead:	Claire Cotton, Director of Governance						

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

Executive Summary

Situation

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

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

This latest update reflects the position at Quarter 1 of 2025/26, as provided by Executive Leads. It was presented to the relevant Board Committees for assurance and approval in July, ahead of final submission to the Trust Board.

Background

The strategic risks within the 2024/25 Board Assurance Framework (BAF) were reviewed and refreshed by the Executive Team and subsequently approved by the Board in April 2025, in line with the annual review process. For 2025/26, the BAF format has been streamlined to focus on the key elements of the summary BAF, eliminating the need for two separate documents.

The revised risk appetite statement—also approved by the Board in April 2025—has informed the setting of tolerable risk scores. All risks have been aligned with the updated Strategic Priorities: Our People, Our Patients, and Our Population and, as discussed during the April Board session, the primary issues identified by the Executive Team have been mapped to each strategic risk to enhance clarity and accountability.

Assessment

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

The ‘most threatened’ of our Strategic Priorities is ‘Our Patients, with all 8 Strategic Risks posing a threat to its achievement. Our People and Our Population is threatened by 7 of our Strategic Risks.
The most significant strategic risks relate to our inability to deliver the required in-year financial position and financial sustainability (BAF 6 & BAF 7), with a score of Extreme 20, significantly above the risk tolerance. There remain 3 other strategic risks which have extreme scores (BAF 1, BAF 3 and BAF 4).
The risk in relation to our inability to sustain safe and effective care delivery (BAF 1) has been revised to incorporate the previous responsive patient care risk (No. 4 in the 2024/25 BAF)
BAF 5 – inability to deliver investment in estate infrastructure and workforce is the only risk within the risk tolerance, with a score of High 12. All other remaining risks are above the tolerated risk appetite score.
The number of linked risks for the quarter have been refreshed and the most linked risks continue to be in relation to BAF 1. Summaries of key themes relating to the linked risks are included within the document, and actual linked risks are listed in Appendix 2.
The majority of actions from 2024/25 have been carried forward to the 2025/26 BAF, therefore the number of delayed and problematic actions identified have increased (reflecting the additional movement in target dates). 3 / 8 have identified problematic actions and 5 / 8 risks have identified actions which are problematic.

There are a number of sources of assurance which have not been seen in line with business cycles and where possible, these are or have been rescheduled.

Following discussion at Committees in July, the format of the BAF is being further enhanced for Quarter 2 and an initial draft has been provided to Non-Executive Directors for comment. In addition, Committees specifically requested that future versions ensure that the actions identified are clearly linked to the ability to reduce the risk towards its target as well as ensuring actions had been identified to address any gaps in control and assurance.

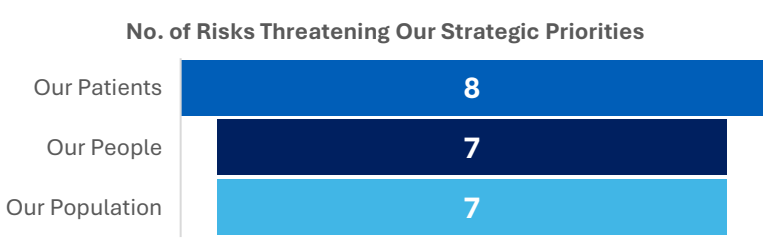
Key Recommendations

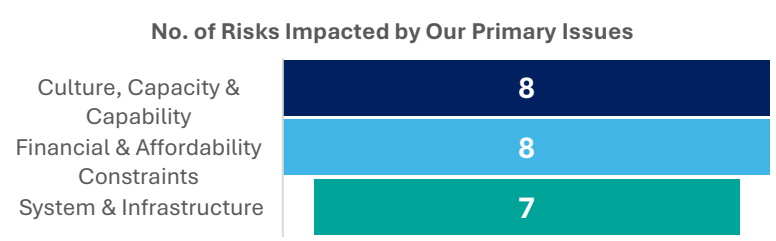
The Trust Board is asked to approve or amend the BAF, considering whether risk scores, assurance assessments and actions are an accurate reflection of the current position.

Board Assurance Framework

Quarter 1 | 2025 - 2026

Strategic Framework and Threat to Strategic Priorities





OUR PRIMARY ISSUES

Culture, Capacity and Capability
i.e. Staff fatigue & burnout / workforce affordability & skills / digital and technological capacity

System and Infrastructure
i.e. fragmented systems & silo working / infrastructure and capital limitations / research & innovation constraints

Financial and Affordability Constraints
i.e. financial issues / affordability of services / sustainability & demand management

Our Priorities

Our People

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

Key Metric:
Staff Engagement Score

Our Patients

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

Key Metric:
Combined Hospital Score

Our Population

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

Key Metric:
Number of Years in Good Health

Our Programmes

Brilliant Basics: Standards & Performance
Addressing the immediate concerns facing our patients

Digitally Enabled Care Transformation
Standardising and redesigning pathways – enabled by a new EPR

Our Future Hospital Services
Designing services so they reflect the latest developments in medical knowledge and provide care closer to home

Collaborations & Networks
Working with others to ensure sustainable and joined-up care

Our Strategic Plans

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

Our Values

Summary

BAF No.	Risk Title	Risk Score & Assurance Assessment Q1	Q2	Q3	Q4	Target	Risk Appetite	Strategic Priorities			Primary Issues			No. of Linked Risks	Committee Assurance Assessment: Significant	Acceptable	Partial	None	NR	Gaps in Control	Gaps in Assurance	Action Plan Progress: Complete	On Track	Delayed	Problematic
BAF 1	Inability to Sustain Safe and Effective Care Delivery	Ext 16 / Partial				High 8 / 31/03/2026	Minimal (1 - 4) / Score has exceeded the tolerable score (5-9) since 2022/23	•	•	•	•	•	•	391	3	11	12	1	7	5	4	1	4	1	3
BAF 2	Inability to Design and Deliver Services that Address Local Population Needs	High 10 / Acceptable				High 8 / 31/03/2026	Minimal (1 - 4) / Score has exceeded the tolerable score (5-9) since 2023/24		•	•	•	•	•	1	0	0	0	0	0	1	1	0	4	0	0
BAF 3	Inability to Improve Workforce Sustainability & Organisational Culture	Ext 15 / Partial				High 10 / 31/03/2027	Cautious (1 - 9) / Score has exceeded the tolerable score (10-12) since 2024/25	•	•		•		•	139	1	1	2	0	0	4	5	0	3	0	0
BAF 4	Inability to Deliver Digitally Enabled Care Transformation	Ext 16 / Partial				High 8 / 31/03/2026	Minimal (1 - 4) / Score has exceeded the tolerable score (5-9) since 2022/23	•	•	•	•	•	•	106	0	0	1	0	0	7	5	1	0	0	1
BAF 5	Inability to Deliver Investment in Estate Infrastructure & Workforce	High 12 / Acceptable				High 12 / Achieved Q1 2025	Cautious (1 - 9) / Score has remained within the tolerable score (10-12) since 2022/23	•	•	•	•	•	•	80	2	1	0	0	0	14	0	0	1	2	4
BAF 6	Inability to Deliver In-Year Financial Position	Ext 20 / Partial				High 12 / 31/03/2026	Cautious (1 - 9) / Score has returned to exceeding the tolerable score (10-12) in Q1 2025/26	•	•	•	•	•	•	17	3	5	8	1	4	3	3	2	2	0	0
BAF 7	Inability to Deliver Financial Sustainability	Ext 20 / Partial				High 12 / 31/03/2027	Cautious (1 - 9) / Score has exceeded the tolerable score (10-12) since	•	•	•	•	•	•	3	2	2	8	1	4	3	1	1	0	0	3
BAF 8	Inability to Sustain Research and Innovation Excellence	High 12 / Partial				High 8 / 31/03/2026	Minimal (1 - 4) / Score has exceeded the tolerable score (5-9) since 2024/25	•	•	•	•	•	•	2	0	0	0	0	0	4	1	0	0	1	3

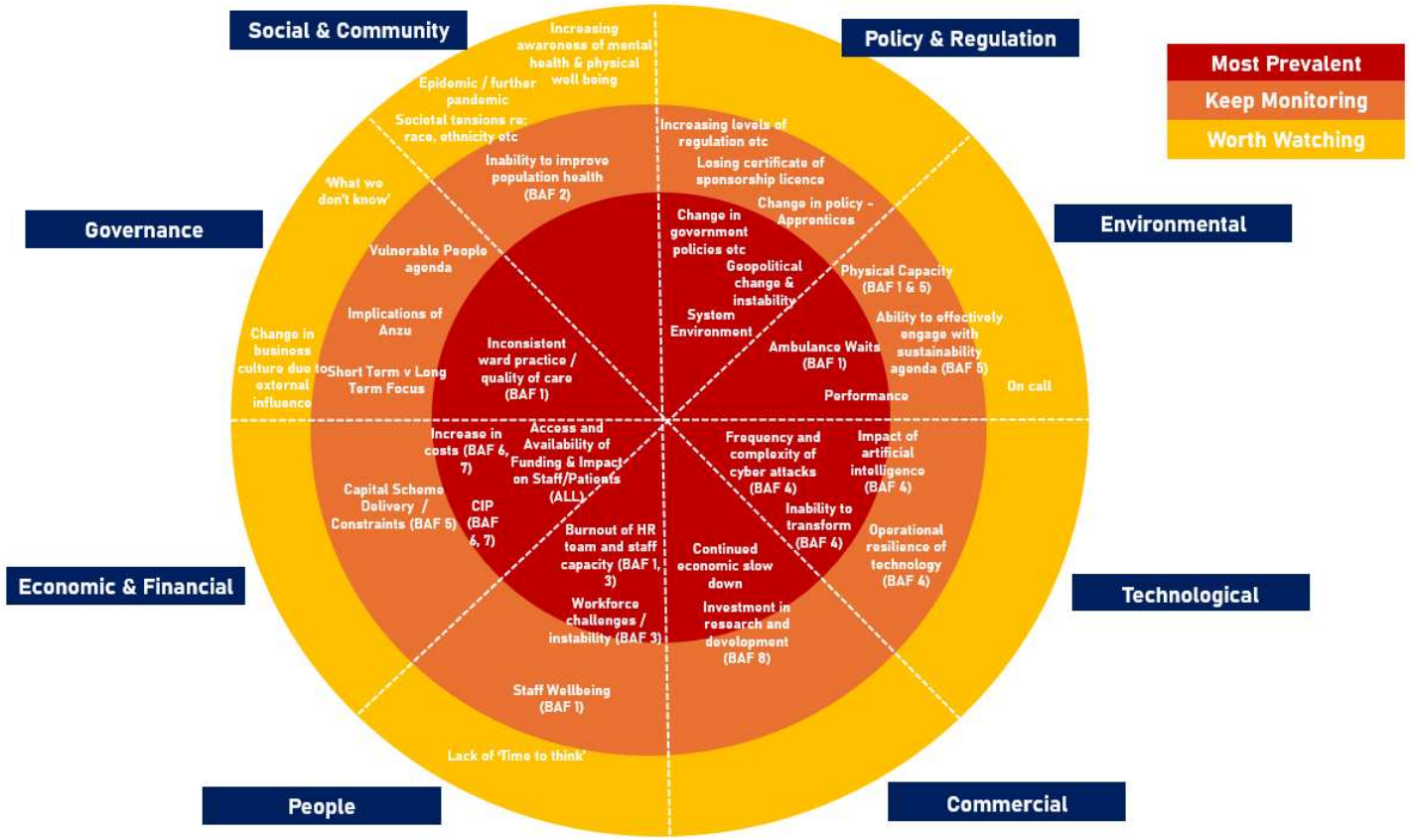
Positive Assurance

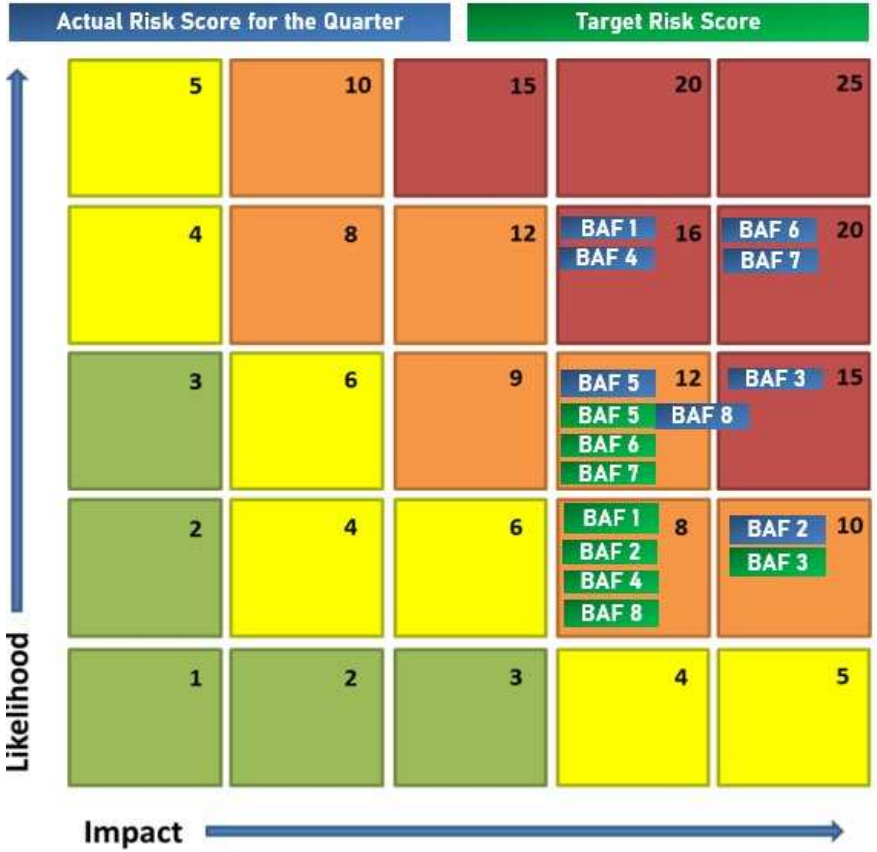
- 2 / 8 risks identified as providing acceptable assurance
- 17% assurances were rated as significant assurance and 31% as acceptable assurance
- 14% of actions have been completed with 37.5% on track
- 1 / 8 risks in line with risk tolerance and target risk score

Matters of Concern

- 6 / 8 risks identified as providing partial assurance
- 7% of assurance were not seen during Q1
- 48% assurances were rated as partial assurance and 4% identified as having no assurance
- 11% of actions are delayed and 37.5% problematic
- 7 / 8 risk scores are above the tolerance

Risk Radar & Heat Map





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

BAF 1: Inability to Sustain Safe and Effective Care Delivery

Quality, Access & Outcomes Committee / People, Culture & Inclusion Committee

Chief Nurse, Chief Medical Officer & Chief Operating Officer

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

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

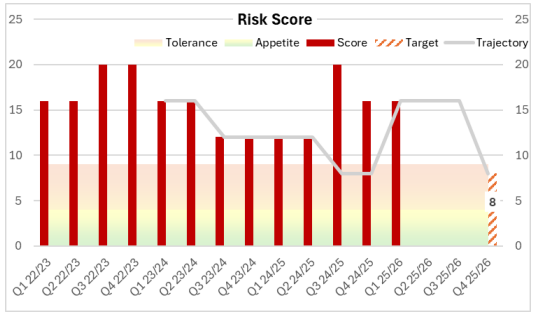
Impact on Our Strategic Priorities

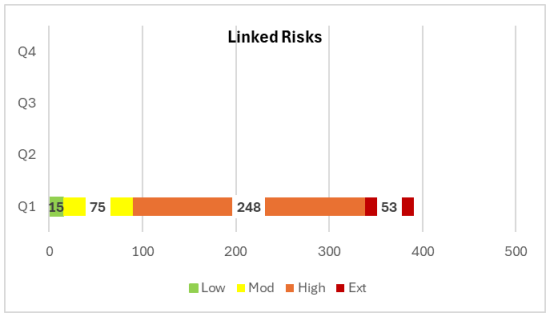
Impacted by Our Primary Issues

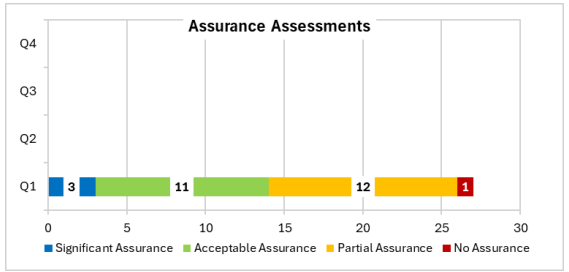
Executive Overview

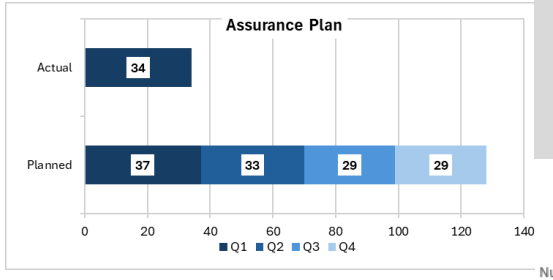
This risk has been refreshed for 2025/26 and incorporates the previous BAF 1 - risk of delivering positive patient outcomes (Ext 16 at Q4 2024/25) and BAF 4 – delivering responsive patient care (Ext 20 at Q4 2024/25). The risk score for this risk at Q1 2025/26 reflects the new ways of working being trialled across the urgent and emergency care pathway, which is showing early improvements across a number of metrics. We also now have a definite date for the start of the ePMA rollout, and the communication and training plans have been enacted. In addition, the governance associated with clinical effectiveness has been strengthened by including this within the Quality, Safety and Outcomes Group as well as more robust governance and oversight being put in place for acute care at home and virtual wards.

Risk and Assurance Dashboard





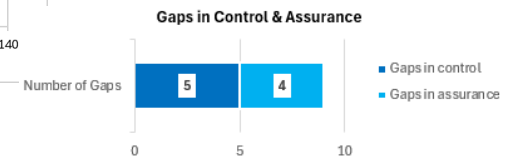




What is the data telling us?

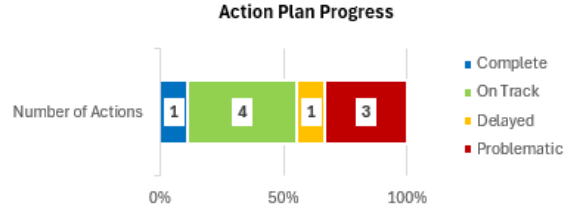
The target risk score for 2025/26 has been reset in line with the revised risk appetite statement, while the target date remains March 2026. The number of linked risks has increased since Q4 due to the inclusion of the former BAF 4 risk, with this strategic risk continuing to have the highest number of operational links. Key themes include workforce pressures, digital infrastructure, and capacity and performance constraints.

Over half of the Q1 assurances were positive; three were delayed but have been rescheduled. Two new actions have been identified for 2025/26, with the remainder carried over from 2024/25.



What are we doing about it?

No	Summary Action	Due	2024/2025 Q1	2024/2025 Q2	2024/2025 Q3	2024/2025 Q4	2025/2026 Q1	2025/2026 Q2	2025/2026 Q3	2025/2026 Q4
1	Enhance harm review process	~~31/12/2024~~ ~~31/03/2025~~ 01/10/2025								
2	Embed clinical effectiveness processes	~~31/12/2024~~ ~~31/03/2025~~ 01/02/2026								
3	Deliver ePMA programme	31/12/2025								
4	Review national patient safety recommendations re: patient experience	31/12/2025	N/A	N/A	N/A	N/A				
5	Assess impact of iPortal downtime	31/03/2025	N/A	N/A						
6	Winter bed modelling to be reviewed and assessed	~~31/03/2025~~ ~~30/05/2025~~ 31/08/2025	N/A	N/A						
7	Large language data validation of waiting lists via MBI	~~31/03/2025~~ 31/07/2025	N/A	N/A						
8	Build additional capacity via different pathways i.e. acute care at home / virtual wards	31/03/2026	N/A	N/A	N/A	N/A				
9	Identify actions to resolve the coding backlog and identify interim assurance for HSMR/SHMI	31/08/2025	N/A	N/A	N/A	N/A				



BAF 1: Inability to Sustain Safe and Effective Care Delivery

Control and Assurance Framework

Key Controls

Care Group (n=14)	• Monthly Directorate Mortality and Morbidity meetings to review deaths and discuss cases including input from Medical Examiner and use of Structured Judgement Reviews • Clinical staff recruitment, induction, mandatory training, registration and revalidation • Defined safe medical, nursing, midwifery and Allied Health Professional (AHP) staffing levels for all areas • Ward assurance / metrics and accreditation programme • 4x daily capacity calls in place including Executive Director and Care Group attendance • Urgent and Emergency Care Improvement Programme • Non-Elective Improvement Programme • Weekly weekend planning meetings • Weekly tumour site cancer patient tracking list (PTL) meetings • Twice weekly care group referral to treatment (RTT) meetings taking place • Diagnostic Cell in place • Weekly elective oversight management group • Validation plan to ensure all patients >52 weeks are validated • Twice monthly County Elective Hub Group
Corporate (n=18)	• Mortality Review Group • Executive Quality, Access and Outcomes Group (Clinical Effectiveness incorporated into the Group and to be held bi-monthly) • Medical Workforce Group • Monthly Performance and Risk Reviews • Executive Recovery Oversight Group • Strategic Delivery Unit in place • 6 monthly nurse staffing establishment reviews • Birth Rate Plus staffing assessment for midwifery services • Care Excellence Framework refreshed with enhanced patient-led monitoring for bronze review panel meetings • Clinical policies, procedures, guidelines, pathways, supporting documentation and IT systems in place • Corporate escalation process in place regarding current operational status and action required • Comprehensive capacity, demand, organisational and system bed model completed • Internal rapid handover process within Emergency Department • County Hospital Daycase Unit in place • County Frailty business case approved • Robotic Assisted Surgery Expansion business case approved • Additional capital business cases approved – Urgent Treatment Centre, Community Diagnostic Centre, CT and MRI Scanner, Cardiology and Respiratory and Elective Hub • Strategic Delivery Unit in place with responsibility for delivery of strategic plans
System (n=11)	• Registered and regulated by Care Quality Commission (CQC) • Integrated Care Board (ICB) quality, safety and compliance meetings • Healthwatch and Maternity and Neonatal Voices Partnership (MNVP) Meetings • Screening Quality Assurance Services (SQAS) Assessments • Daily calls during winter with System Partners regarding urgent and emergency care • Weekly meetings with system partners including West Midlands Ambulance Service • Regular tiering calls chaired by Regional NHSE with regards to urgent and planned care performance • System Planned Care Board in place • System Urgent Emergency Care Board in place • Weekly System Executive ambulance improvement Task and Finish Group • Provider Collaborative in place

Gaps in Control	• Introduction of ePMA system • Maintain future workforce requirements and pipelines • Schemes to be identified to create additional capacity for challenged specialties • IT systems have not allowed for consistent management of RTT pathways • Challenged specialties for elective delivery where additional capacity cannot be found in a timely manner.

Key Assurances Received in Quarter 1

Assurance Source	April	May	June
Access Performance Report & Executive Recovery Oversight Group Highlight Report	M12	M1	M2
Allied Health Professional Workforce Establishment Review			
Cancer 104+ Day Breach Analysis	☒		
Care Quality Commission Inspection Update	☒		
CDC Business Case Update			
CeNREE Update			
Chief Healthcare Scientist Update		☒	
Chief People Officer Report			
Chief Pharmacist Workforce Report			
Clinical Effectiveness Update	NR		
Executive Recovery Oversight Group Terms of Reference			NR
Hospital Associated Thrombosis Increase November 2024 - February 2025			
ICB Quality Assurance Visit Reports		NR	
Internal Audit: Maternity and Neonatal Action Plans: Single Delivery Plan (SDP) Framework			
Major Trauma Peer Review		☒	
Maternity and Neonatal Action Plans: Single Delivery Plan (SDP) Framework			
Maternity and Neonatal PSIRF Investigation Report			
Maternity and Neonatal Single Delivery Plan			
Maternity and Neonatal Voices Partnership Feedback Report		☒	
Maternity Dashboard			
Maternity Quality & Safety Oversight Group Assurance Report		NR	
Medical Examiner Service Update			
Medicines Optimisation & Safety Report		Q4	
Mortality Assurance Report			
Nurse Staffing Establishment Review		☒	
Patient Safety Incident Investigation & Serious Incident Highlight Report	Q4		
Patient Waiting List Backlog			
Perinatal Mortality Report			
Quality & Safety Report	M12	M1 | NR	M2
Quality, Access & Outcomes Group Assurance Report	NR	NR	☒
Saving Babies Lives Care Bundle			
Strategic Development Unit Project Management			
Winter Close Down Report			☒

Gaps in Assurance	• Robust system is required for evaluating harm in patients waiting for elective procedures • Assurance regarding non-clinical workforce staffing to be determined • Coding issues identified in relation to SHMI and HSMR • Robust assurance not yet available from outpatients and other elective care delivery groups

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

Quality, Access & Outcomes Committee | Director of Strategy

Cause:	If we are unable to effectively design and deliver services that are responsive to the specific needs of our local population,
Event:	Then our ability to improve population health and reduce health inequalities may be significantly limited,
Effect:	Resulting in increased and unsustainable demand on local health and care services, organisational capacity being exceeded, impacting service delivery and deterioration in patient outcomes and widening health disparities.

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

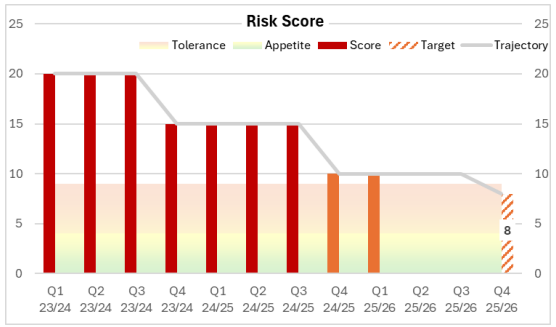
Impact on Our Strategic Priorities

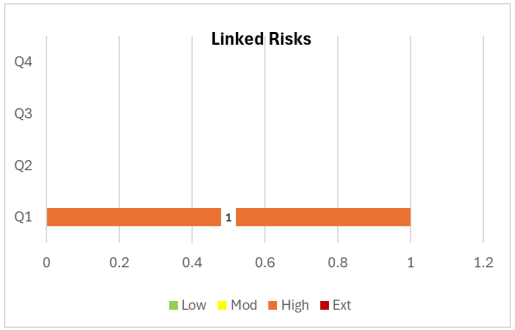
Impacted by Our Primary Issues

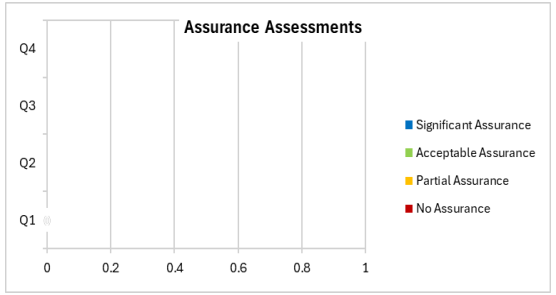
Executive Overview

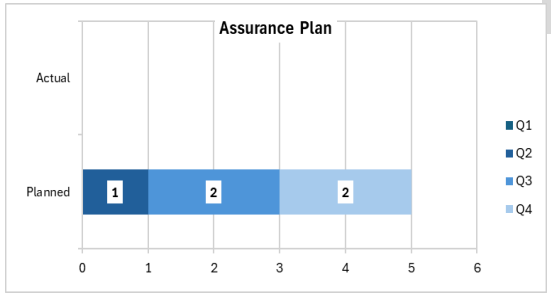
The new Trust Strategy sets a clear ambition to tackle inequalities, prevent ill-health, and leverage our role as a major employer to improve population health. A strategic programme has been defined to deliver these aims over the life of the strategy, with a clear annual plan for 2025/26 which is currently on track. Executive approval has been secured to expand our winter 2025/26 vaccination programme for patients and staff, piloting its impact on reducing emergency admissions. This work is gaining regional and national recognition. At system level, we've been asked to lead on alcohol treatment, recovery, and targeted prevention as part of the Staffordshire and Stoke on Trent alcohol strategy. The risk score reduced from 15 to 10 in Q4 2024/25 and has been maintained this quarter, with further reduction expected as programme impact is evidenced.

Risk and Assurance Dashboard





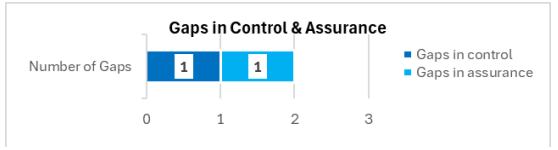




What is the data telling us?

The target risk score for 2025/26 has been lowered in line with the revised risk appetite statement, while the target date remains March 2026. One additional linked risk was added in Q1, though this remains the lowest number across all strategic risks.

Assurance levels continue to be lower than for other strategic risks, with five sources planned for the year. Four new actions have been identified for 2025/26, all currently on track.



What are we doing about it?

No	Summary Action	Due	2025/26 Q1	Q2	Q3	Q4
1	Evidence base to confirm impact of interventions, to reduce health inequalities and prevent ill-health	31/03/2026				
2	Interventions to target workforce access and health	31/12/2025				
3	Improve use of population health management tools	30/09/2025				
4	Raise regional and national profile of the programme	31/03/2026				

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

Control and Assurance Framework

Key Controls	
Care Group (n=4)	• Health inequality, making every contact count and anchor leads identified across trust services. • Use of health equity assessment tool (HEAT) and continuous improvement techniques • Estates and Sustainability Programme, Workforce, Community Engagement, Elective Recovery • Patient Engagement leads identified as part of the Health Inequalities and Prevention Group
Corporate (n=5)	• Population Health strategic plan approved as part of 2035 Trust Strategy (key focus on population throughout), supported by programmes of work • Deputy Director of Strategy and Transformation given specific responsibilities for Health and Wellbeing / Reducing Health Inequalities • Established groups to focus on health inequalities, anchor and prevention actions. Targeted interventions in place • Office for health improvement and disparities (OHID) funded intelligence and public health practitioner posts • Population Health plan in place with associated outcomes framework
System (n=8)	• ICP Strategy approved with a focus on '5P's' across the life course which all centre on reducing health inequalities across Staffordshire and Stoke-on-Trent • Public Health consultant appointed jointly with the ICB • Improving Population Health Board established at ICB level with representation from UHNM. UHNM is now starting to lead on system work (e.g. Alcohol, weight management) • Health protection links in place to support national/regional/system public health needs, i.e. measles • Infant mortality programme established by ICB • National CORE20PLUS5 priorities • Regional Health Inequalities Network • Population Health Management linked datasets
Gaps in Control	• The population health steering group and is being reconfigured to align with the revised Trust Governance.

Key Assurances Received in Quarter 1	
Whilst no specific assurances have been received by the Quality, Access and Outcomes Committee in Quarter 1, an update on the Population Health Strategic Plan has been included on the business cycle to be received in Quarter 2.	
Gaps in Assurance	• The committee reporting requirements are being reconfigured to align with the revised Trust Governance

BAF 3: Inability to Improve Workforce Sustainability & Organisational Culture

People, Culture and Inclusion Committee | Chief People Officer

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

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

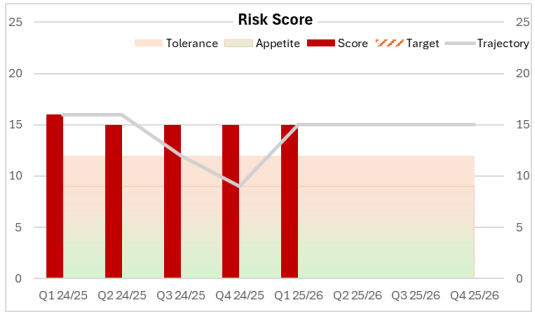
Impact on Our Strategic Priorities

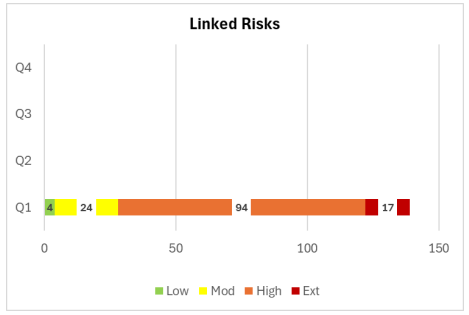
Impacted by Our Primary Issues

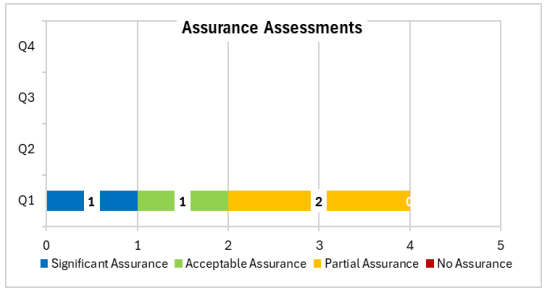
Executive Overview

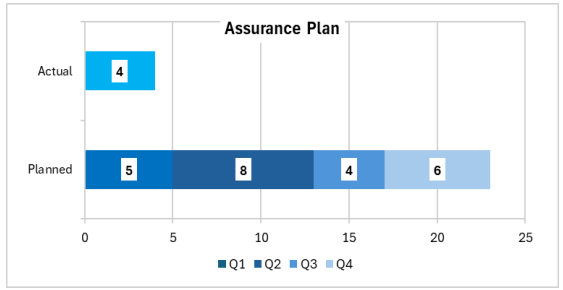
Target risk score identified and aligned with risk tolerance; however, the target date is 2027 due to the anticipated pressures and the actions being taken focussing on keeping this position stable in 2025/26 as opposed to reducing the risk score. Following the launch of our refreshed strategy in April 2025, the vision for our people is that 'we will create an inclusive workplace where everyone learns, thrives, and makes a positive difference'. As of the end of quarter 1, partial assurance ratings have been proposed for the three priority domains in 'our strategic delivery plan for our people 2025-35' (Health and wellbeing, Learning and Development and Flexibility and Adaptability).

Risk and Assurance Dashboard





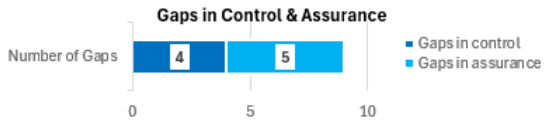




What is the data telling us?

The target risk score for 2025/26 remains unchanged and aligned with the revised risk appetite statement; however, the target date has been extended from March 2026 to March 2027. The number of linked risks is unchanged from Q4, though there is a slight increase in high and extreme risks. This strategic risk continues to have the second highest number of linked risks.

The top three themes among linked risks are workforce capacity and staffing shortages, service delivery and performance pressures, and challenges related to governance, quality, and compliance. Of the four assurances presented this quarter, two were positive and one was delayed but has been rescheduled. Actions for 2025/26 remain aligned with the three priority domains.

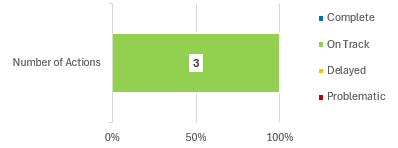


What are we doing about it?

No	Summary Action	Due	2025/26 Q1	Q2	Q3	Q4
1	Priority 1: Health & Wellbeing - Improve work environments and wellbeing offers, champion diversity and support health & wellbeing of our people	31/03/2026				
2	Priority 2: Learning & Development - Offer learning and development opportunities and establish clear, inclusive career pathways	31/03/2026				
3	Priority 3: Flexibility & Adaptability - Be a place where our offers and practices continue to improve the flexibility, adaptability and sustainability of our workforce	31/03/2026				

Assurance Assessment

Action Plan Progress



BAF 3: Inability to Improve Workforce Sustainability & Organisational Culture

Control and Assurance Framework

Key Controls

Care Group (n=15)

GENERAL/OVERARCHING
- Monthly Divisional Workforce Assurance Groups in place subject to clinical divisions transition to care groups
- Medical Staffing Workforce Assurance Group
- Divisionally led bi-monthly Directorate Performance Review Meetings
- Appropriate governance in place for formal Partnership Agreements where UHNM is the lead provider/ employer, e.g. North Midlands and Cheshire Pathology Service and the North Midlands and Black Country Procurement Group

WORKFORCE SUSTAINABILITY
- Workforce plans in place and budgets transacted accordingly, including Cost Improvement Plans (CIP) delivery
- Directorate and divisional management teams monitor staffing levels. Divisional vacancy controls in place. Internal deployment and redeployment of staff to support safer staffing levels
- Experienced medical rota coordinators aligned to Divisions to support operational planning
- Divisional targets for Apprenticeships and uptake against plan monitored
- Insourcing contracts in place in key areas to support the operational recovery plan
- Divisional workforce organisational change / re-design / TUPE processes delivered in accordance with agreed governance and employment legislation

ORGANISATIONAL CULTURE
- Work on initiatives focussing on the retention of our workforce; including key focus on the NHS People Promise areas
- Directorate and divisional staff engagement / NHS National Staff Survey metrics and associated action plans are reviewed at directorate and divisional Performance Review Meetings
- Culture improvement programme and plans in place
- Senior leadership development programme launched in July 2025
- Divisional operational escalation plans; including for periods of Industrial Action

Corporate (n=21)

GENERAL/OVERARCHING
- 2025-35 strategy and delivery plan for 'Our People' priorities
- 2025-35 Strategic Delivery Plan for our People highlights key strategic areas of focus and programmes of activity for our workforce for 2025/26
- Quarterly Strategic Workforce Executive Group meetings
- Bi-monthly Divisional (Care Group) Performance Review meetings
- Regular, local negotiation consultative committee meetings with our Trade Union colleagues (e.g. TJNCC and LNC)
- People (HR) policies and procedures in place and reviewed in accordance with policy review governance.

WORKFORCE SUSTAINABILITY
- 2025/26 (establishment) Workforce Plan in place
- Business Intelligence and Workforce Information tracking and analysis of workforce demographics
- Oversight and scrutiny of vacancy controls, including bank and agency usage
- Tracking of turnover rates, vacancy metrics and agency costs. Work-flow recruitment management system to track and optimise on-boarding processes. General recruitment drives are on-going
- Pipeline of approved business cases in key areas profiled into the workforce establishment to enable tracking of vacancies and workforce supply
- Additional workforce requirements for corporately led transformation programmes identified
- Nurse Establishment Reviews reported twice yearly
- Chief Allied Health Professional (AHP) and Chief Healthcare Scientist roles in place with annual reporting
- Established Banks (workforce) are in place – including Nursing, Medics, Admin & Clerical, and other groups.
- Weekly meetings with Medical Staffing to review rotas, gaps and progress against recruitment
- Education leads and teams working with providers across the System to enhance opportunities for learning and the education experience for our trainees.
- Daily tracking (through the Empactis system) of unplanned absences to support local planning
- Operational Escalation / Winter Planning Group stood up at the appropriate time in the year.

ORGANISATIONAL CULTURE
- Improvement plans for organisational culture and staff engagement are in place (for 2nd year)
- Established Staff Networks with task and finish groups as appropriate for specific in year priorities.

System (n=3)
- Member of ICS People, Culture and Inclusion workstreams
- NHSE regional and national oversight; including review meetings. NHS Employers support to workforce leaders.
- National target for agency reduction with associated national and system controls for non-clinical agency expenditure

Gaps in Control
- Divisional / Care Group capacity to effectively manage and drive their People Plans. This has particularly been exacerbated in Q1 due to the first 2 phases of the organisational structure redesign programme.
- Demand for the People Directorate's services has continued to outstrip the available resource. This has continued to be particularly in respect to our People Operations department and our Workforce Information department and service delivery. Risk ratings are 'extreme' and worsening. Still awaiting approval to proceed with business cases in respect to these resource issues.
- Corporate risk in respect of the programme for up banding of Healthcare Support Workers from Agenda for Change Band 2 to 3; particularly in respect to the cost of (a) forward pay and (b) back pay.
- Future renewal of the Empactis system contract is under review due to cost.

Key Assurances Received in Quarter 1

Assurance Source	April	May	June
Appraisal and Revalidation Annual Report			
Employee Relations Casework Trends (formerly Formal Case Activity Report)			
Equality, Diversity & Inclusion Annual Report			
Equity and Inclusion Assurance Tool			
Freedom to Speak Up			
Gender Pay Gap Report			
Guardian of Safe Working Report		Q3	
Learning and Education Annual Report			
Results of Annual Staff Survey Report			
Statutory & Mandatory Training Review			
Strategic Workforce Group Assurance Report			
Talent and Succession Planning Update		☒	
Wellbeing Report			
Workforce Race and Workforce Disability Equality Standard			

Gaps in Assurance
- Impact of financial pressures (Trust and System), including CIP targets on the workforce
- Workforce Plan for 2025/26 is challenging to deliver against – including the very large target for workforce reduction (which is naturally dependent on demand management strategies too).
- Anticipated disruption for leaders across the Trust during 2025/26 due to the organisation structure redesign programme (re the clinical divisions) and other big CIP and transformation programmes will potentially detrimentally impact focus on delivery of business as usual, business continuity and unsettle the wider workforce.
- Manager and People Operations Directorate capacity to manage absence and ER cases does not meet the sustained high demand.
- Workforce related Freedom of Information [FOI] requests and workforce Subject Access Requests [SAR] continue to be a challenge with an increasing number and complexity of requests received and inadequate resources to handle them.

BAF 4: Inability to Deliver Digitally Enabled Care Transformation

Finance and Business Performance Committee | Chief Digital Information Officer

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

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

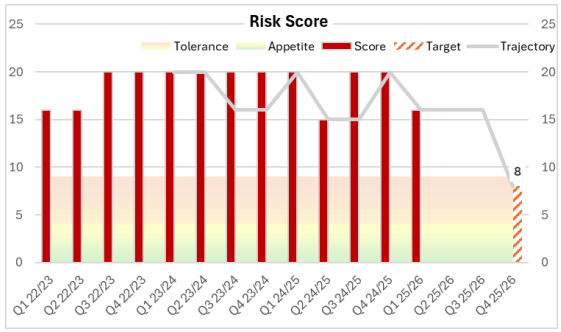
Impact on Our Strategic Priorities

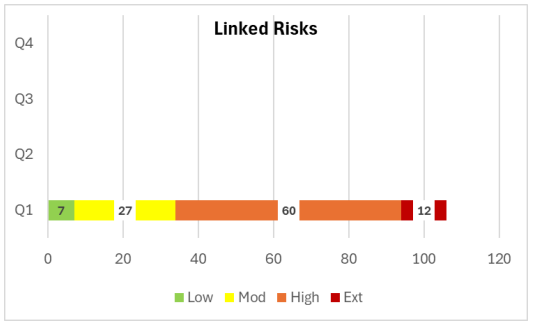
Impacted by Our Primary Issues

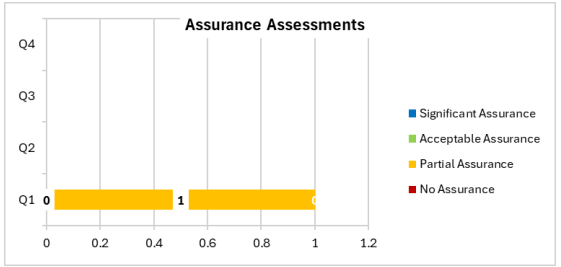
Executive Overview

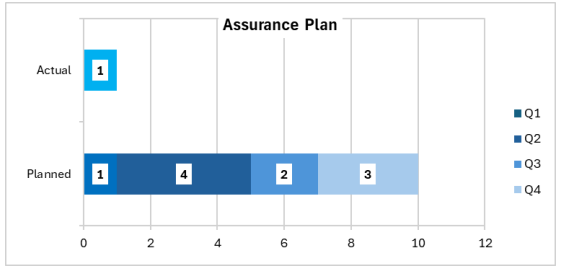
During this quarter, the risk score has been adjusted due to the issuance and subsequent review of the outline Electronic Patient Record (EPR) business case by the region. The region's feedback has led to some advised changes that are currently being implemented. Additionally, there has been a delay in the Electronic Prescribing and Medicines Administration (EPMA) project due to the supplier not meeting contractual deliverables. This delay has impacted the overall timeline and has been factored into the risk assessment. Key actions undertaken include addressing the feedback from the region and working closely with the supplier to ensure that the contractual obligations are met promptly to mitigate further delays.

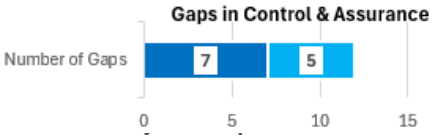
Risk and Assurance Dashboard

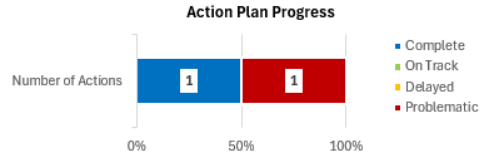












What is the data telling us?

The target risk score for 2025/26 remains unchanged and aligned with the revised risk appetite statement, with the target date still set for March 2026. The number of linked risks has increased since Q4, making this the third highest among all strategic risks.

Key themes include digital infrastructure and system reliability, cybersecurity and data protection, and information governance/data quality. The single assurance presented this quarter received a partial positive rating, with no delays. Both actions identified have been carried over from 2024/25, one of which is now complete.

What are we doing about it?

No	Summary Action	Due	2024/25 Q1	2024/25 Q2	2024/25 Q3	2024/25 Q4	2025/26 Q1	2025/26 Q2	2025/26 Q3	2025/26 Q4
1	ePMA pilot	~~31/10/2024~~ ~~30/11/2024~~ ~~30/03/2025~~ 30/10/2025								
2	Deploy digital accountability framework	~~01/01/2025~~ 01/03/2025	N/A							

Assurance Assessment

BAF 4: Inability to Deliver Digitally Enabled Care Transformation

Control and Assurance Framework

Key Controls

Care Group (n=14)	• Digital operational groups meet bi-monthly to ensure digital initiatives align with national mandates and strategic goals • Approved business case for end user device lifecycle management allowing kit older than 5 years old to be replaced • Information Asset Register with assigned information asset owners • Regular review and update of the risk register • Rolling review of national guidelines to identify any gaps in compliance • Annual testing of IT service continuity plans • Clinical engagement through Chief Medical Information Officer (CMIO) and Chief Nurse Information Officer (CNIO) along with digital nurses, midwives, pharmacists and divisional CMIOs • Trained clinical safety officers • Membership of the Digital Health Clinical Information Officer (CIO) Network • Participation in regional and national innovation networks • Expansion of Digitial Pathology Scanning Capacity BC-0601 • LIMS and Order Communications Results and Reporting System Implementations BC-0602 • Engagement in the capital programme to secure funds of replacement of out of support hardware and software and for additional investment to support clinical transformation • Ongoing training programmes tied to the rollout of new technologies and systems
Corporate (n=7)	• Executive Digital and Data Security Protection Group monitors active management of IM&T risks via monthly Risk Register Reports • Digital maturity assessments to enable the prioritisation of core capabilities • Freedom of Information improvement plan developed • Frontline digitalisation investment approved • Digital services management print lease contract approved • Suite of key IM&T policies • Regional Cyber Security Operations Centre live with over 450 servers reporting to the Security Information and Event Management System (SIEM)
System (n=1)	• NHS England EPR Business Case approved and submitted to region.

Gaps in Control	• Not all nationally mandated standards met • Use of obsolete technology • Shadow IT not operated in line with NHS standards. • Limited funding and significantly less than the suggested 4%. • Digital solutions are not consistently integrated. • No formal process is in place for reviewing and upgrading all 405 solutions in use. • Insufficient digital skills training available to the wider workforce.

Key Assurances Received in Quarter 1

Assurance Source	April	May	June
Cyber Assessment Framework Follow Up			
Cyber Security Assurance Report			
Digital Strategic Plan			
DSP Toolkit			
Transformation & Major Change Project Management & IT Systems Managed by Operational Areas (Shadow IT) Follow Up			

Gaps in Assurance	• Data Protection Impact Assessment (DPIAs) not in place for all systems • Digital Technology Assessment Criteria (DTAC) not in place for all systems • Clinical Safety Assurance Reports not in place for all systems • Configuration management processes not in place for all systems. • Governance arrangements for artificial intelligence

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

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

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

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

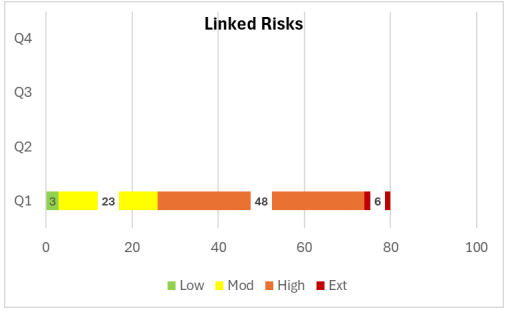
Impact on Our Strategic Priorities

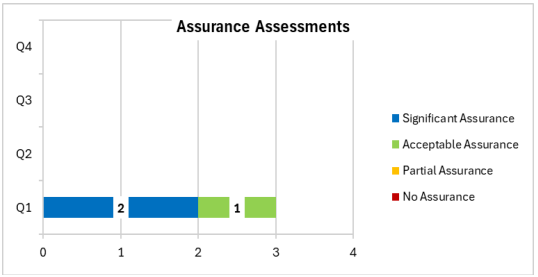
Impacted by Our Primary Issues

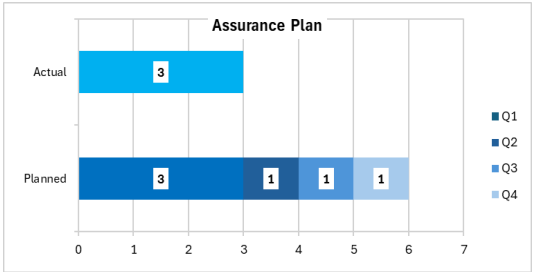
Executive Overview

Whilst the current risk score continues to be in line with the risk tolerance target, this is due to the additional capital funding which became available in Quarter 1 and as such has provided the additional headroom to invest in the estate. There remain challenges in terms of insufficient capital funding to address backlog risks and decarbonisation, a reduction in the number of supply chain partners and risks in terms of energy security, supply and costs. In addition, there remain challenges in terms of the ability to agree formal variations to the PFI and address the requirements from the Building Safety Act 2022.

Risk and Assurance Dashboard







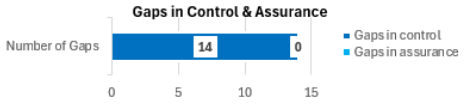
What is the data telling us?

The target risk score for 2025/26 remains unchanged and within tolerance. The number of linked risks has slightly increased since Q4. Key themes include fire safety, infrastructure and estate condition, and limitations in capacity, space, and equipment.

All three planned sources of assurance were presented this quarter and received positive ratings. One new action has been identified for 2025/26, with the remainder carried over from 2024/25.

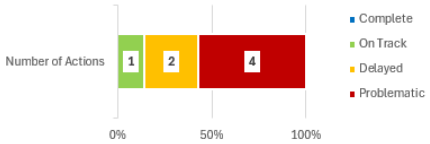
What are we doing about it?

No	Summary Action	Due	2024/25 Q1	2024/25 Q2	2024/25 Q3	2024/25 Q4	2025/26 Q1	2025/26 Q2	2025/26 Q3	2025/26 Q4
1	Capital funding	~~28/06/2024~~ ~~31/12/2024~~ ~~31/03/2025~~ ~~30/06/2025~~ 30/06/2029								
2	Estates strategic plan	~~30/06/2025~~ 30/12/2025								
3	Supply chain partners	~~31/03/2025~~ 30/06/2026								
4	Sustainability/net zero carbon	~~31/03/2025~~ ~~31/07/2025~~ 30/01/2026								
5	Workforce	~~27/12/2024~~ ~~31/01/2025~~ ~~30/07/2025~~ 30/03/2026								
6	PFI partners / lender issues	~~30/08/2024~~ ~~31/03/2025~~ ~~31/07/2025~~ 30/03/2026								
7	Building safety act	31/10/2025	N/A	N/A	N/A	N/A				



Assurance Assessment

Action Plan Progress



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

Control and Assurance Framework

Key Controls

Care Group (n=3)	• Estate condition: Planned Preventative Maintenance programme; competent Estates staff / Authorised persons; KPI's monitored through CEF / Environmental Audits, Maintenance Operational Board; Operational Policies, Service Specifications PFI, 6 Facet Survey • Fire Safety / Security Policies; Protocols, Guidelines; patrolling, CCTV, Risk Assessments in place • Sustainability / Net Zero Carbon (NZC): Sustainable Development Steering Group (biannual), Sustainability Working Groups (monthly), Nitrous Oxide Waste Reduction Group (to meet NHSE funding T&C's), Public Sector Decarbonisation Scheme (PSDS) Group (to meet DESNZ funding T&Cs) Sustainability and NZC capital investment subgroup, NZC Trust Board Lead (Director EFP), Clinical NZC lead
Corporate (n=7)	• Estate Condition - Capital bids against prioritised list of Estate 6 Facet Findings with subsequent approval via CIG • Estate Strategy – Clinical & System Strategy and independent review used to inform content • Fire/Security: 'On the spot' fire improvement notices, Fire Safety KPIs & ad-hoc audits/inspections • Head of Fire Safety and Security close working with local Police and visibility on site • Sustainability / NZC: Biannual Sustainability performance report to Finance and Business Performance • Capital team / Capital programme external Audit / internal procedure audit annually • Targeted capital refurbishment where appropriate to address significant risk backlog.
System (n=6)	• Statutory maintenance programme – Maintenance Operational Board. • Participation in National Programme Strategic Supplier Relationship Management (SSRM) hosted by Cabinet Office & HM Treasury • Collaborative working with system partners on Estate Infrastructure and Sustainability agenda, members of key working groups to drive transformation and efficiency in these areas • Close liaison NHSE and Department of Health PFU on PFI material issues • Sustainability / NZC: Work with external partners regarding zero-capital solutions and grant funding applications, attendance at ICS and Midlands Greener Delivery Groups and system-wide projects • Jointly agreed interpretation of Building Safety Act between Trust and PFI partners

Gaps in Control

- Maintenance backlog programme underfunded; this will see a continued rise in backlog figures over next 5 year plan (Retained Estates)
- Gap in confirmed clinical strategies, and lack of completed feasibilities to deliver agreed clinical plans and Royal Institute of British Architects (RIBA) stage 2 designs and budget costs to match emergency funding as this becomes available to bid for.
- No further expansion space for modulars at Royal Stoke, rightsizing to drive development and refurbishment in the right place to ensure sustainable development control plan (DCP), with a phase delivery approach, 5-10 year DCP.
- Limited number of national NHS framework supplies bidding for large amounts of NHS funded work, national procurement means one supplier can win multiple schemes and therefore drive resource issues, which can impact programme and cost.
- Limited number of worked up sustainability feasibilities to enable quick utilisation of available capital when becomes available.
- Existing NHS estate is designed to current NHS and Chartered Institute of Building Services Engineers (CIBSE) guidance which currently does not account for the constantly increasing summer hotter prolonged periods, and colder winter snaps. Real risk to operational availability.
- Lack of capital & revenue funding to deliver identified carbon reduction schemes, required to meet nationally mandated targets.
- Challenges with pay and the ability to recruit and retain our skilled workforce with private sector pay comparison to agenda for change (AFC)
- Ageing workforce with a risk of losing site knowledge onto future apprentices which can only be funded via current establishment budget.
- Lack of ability to over recruit in areas of high turnover, resulting in bank and overtime whilst we recruit replacement substantive posts.
- Lack of training budget within current funding to upskill workforce for evolving and more digital and technical infrastructure. Becoming more reliant of external contractors at premium costs.
- Remedial works for PFI Latent Defects to be concluded
- Rightsizing work to inform Estate Strategy and Development Control Plan to be concluded
- Supply Chain Partners – small number of suppliers operating across many hospital Trusts impacting on supplier resilience, flexibility and confidence in programme and cost model delivery. Significant schemes underway in year include CDC, Elective Hub, UTCs and Breast Care.

Key Assurances Received in Quarter 1

Assurance Source	April	May	June
Estates & Facilities Strategic Plan			
Fire Safety Annual Report			
PLACE Inspection Findings and Action Plan			
Project STAR – Planning, Marketing and Land Disposal			

Gaps in Assurance

- None identified

BAF 6: Inability to Deliver In-Year Financial Position

Finance and Business Performance Committee | Chief Finance Officer

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

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

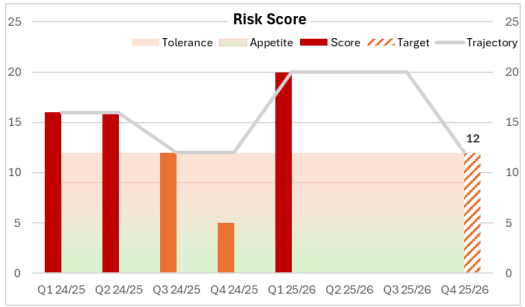
Impact on Our Strategic Priorities

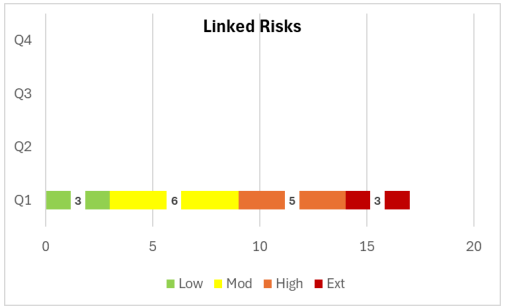
Impacted by Our Primary Issues

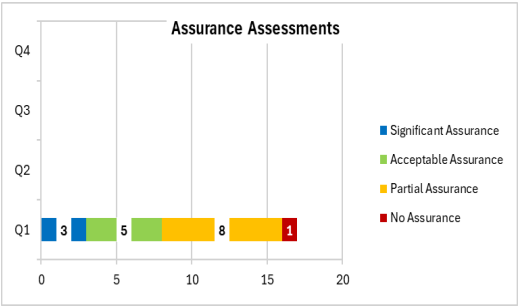
Executive Overview

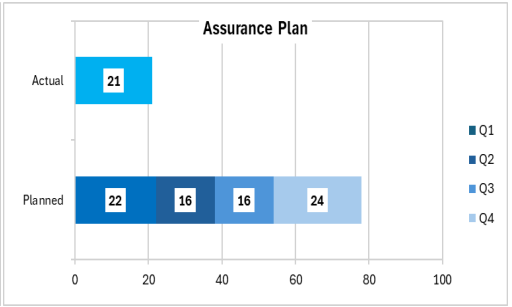
Although the Trust has remained on plan to month 3, the system the position is not meeting the plan. The forecast for the year will be prepared for month 4, and it is expected that the Trust will be forecasting a deficit from the plan. There are several risks within the CIP plan and further mitigations will need to be worked up.

Risk and Assurance Dashboard





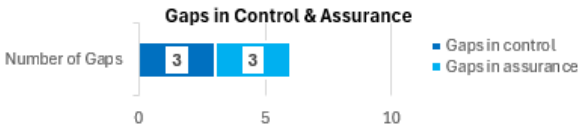




What is the data telling us?

The target risk score for 2025/26 remains unchanged, with the target date revised to March 2026 to reflect the focus on in-year delivery. The number of linked risks has slightly decreased since Q4.

All but one planned assurance was presented this quarter, with eight receiving positive ratings and four not rated. While the actions remain broadly consistent with 2024/25, updated target dates reflect the emphasis on achieving outcomes within 2025/26.



What are we doing about it?

No	Summary Action	Due	2025/26 Q1	Q2	Q3	Q4
1	Identification of recurrent CIP	31/03/2026				
2	Ensure delivery of elective targets	31/03/2026				
3	Establish FRCGs to improve financial control	25/04/2025				
4	Complete external audit to get to unqualified position	30/06/2025				

BAF 6: Inability to Deliver In-Year Financial Position

Control and Assurance Framework

Key Controls	
Care Group (n=3)	• Performance Management meetings in place with the Care Groups with financial performance included as a driver metric. Additional executive focus through Finance, Activity and Performance Group • Standing Financial Instructions (SFIs), scheme of delegation and approval structure for any additional expenditure in place • Executive Team approving and monitoring spend against Elective Recovery Fund
Corporate (n=9)	• Finance report to Finance and Business Performance Committee (FBP) with associated scrutiny; enhanced to include run rate performance and impact of activity levels of income recovery • Monthly forecast in place to identify best, likely and worst case ranges reported through FBP • The level of non-recurrent mitigations well understood but constantly assessed and quantified • Future investments guidance issued to the Care Groups in that only investment requests where significant patient safety risks are involved will be considered and any additional investments will now need to go through the double lock • Reset of the bed model and final allocation of system capacity funding undertaken • Audit Committee oversight of system of internal control such as SFI breaches, write offs etc • Executive Recovery Oversight Group in place • Strategy Delivery Unit in place • Enhanced vacancy and workforce controls
System (n=5)	• Internal audit programme to be utilised depending on changing risks in financial plan • Varying the pace of investment to provide additional mitigation • External auditor review of reported financial position • System Recovery Programme • PWC assessment of Grip and Control measures
Gaps in Control	• Recurrent CIP versus non-recurrent • Under delivery of elective work • Understanding of increased bank staffing spend

Key Assurances Received in Quarter 1

Assurance Source	April	May	June
Accounting Policies Update			
Activity Performance Report		NR	☒
Annual Accounts			
Annual Accounts Timetable			
Audit Findings Report and Letter of Representation			
Audited Accounts and Financial Statements and Analytical Review			NR
Budget Setting Framework 2026/2027			
Business Case Review Schedule			
Capital Plan			
Cost Improvement Report			
Draft Financial Outlook			
Executive Recovery Oversight Group Terms of Reference			NR
Finance Report	M12	M1	M2
Financial Plan 2025/26	NR		
Going Concern			
Grip and Control: Medical Staff and Nursing Bank and Agency Controls			
Internal Audit into Overseas Visitors Policy			
Key Financial Controls			
Losses and Special Payments and Stock Write Offs			
Medicines Finance, Procurement and Supplies Report			
Medicines Write Off Report			
Productivity / Efficiency Performance Report			
SFI Breaches relating to Procurement processes and Single Tender Waivers			
SFI Breaches relating to Salary Overpayments			
Supplies and Procurement Report			
Overseas Patients Activity			

Gaps in Assurance	
	• Forecast is required • Some CIP schemes to be worked up in detail • Contract to be agreed and monitored

BAF 7: Inability to Deliver Financial Sustainability

Finance and Business Performance Committee | Chief Finance Officer

Cause:	If we, or system partners, are unable to manage within the assumptions made within the financial plan for 2025/26,
Event:	Then our underlying financial position will deteriorate further,
Effect:	resulting in reduced availability of funding for essential investments, an increased level of external scrutiny (level 5) and potential regulatory intervention, loss of autonomy over financial and strategic investment decision making within the Trust, breach of statutory financial duties, adverse impact on the Trust's ability to deliver sustainable and high-quality care.

	Q1	Q2	Q3	Q4	Target		Appetite
L	4	4	4	3	3	31/03/2027	Cautious 1 – 9
C	5	5	5	5	4		Tolerance
Score	20	20	20	15	12		High 10 - 12

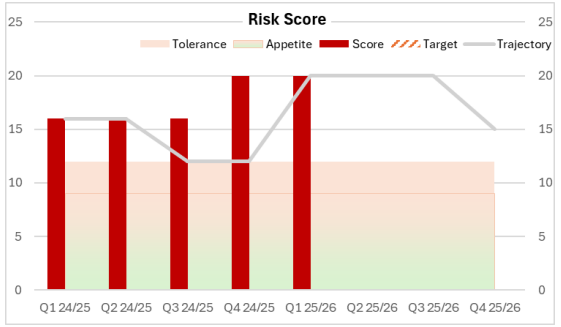
Impact on Our Strategic Priorities

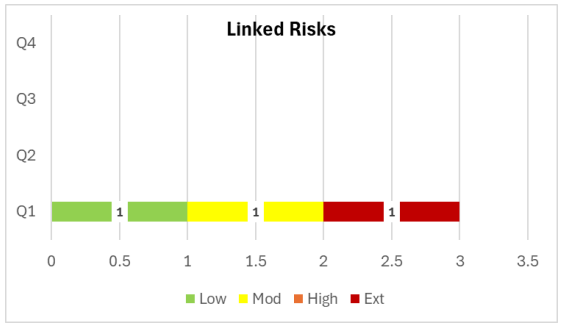
Impacted by Our Primary Issues

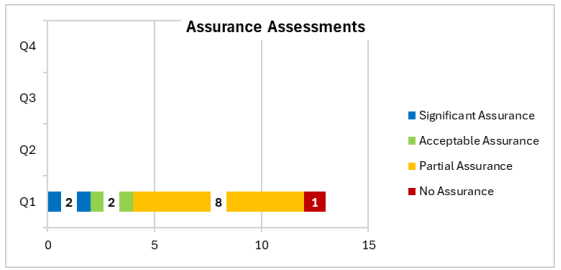
Executive Overview

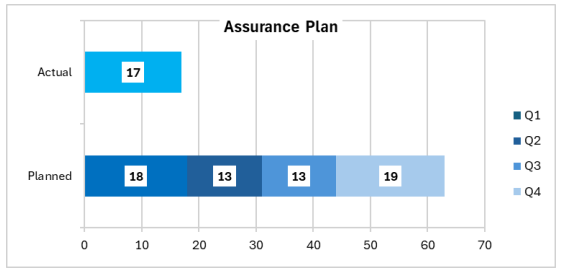
Although the Trust has remained on plan to month 3, the system the position is not meeting the plan. The forecast for the year will be prepared for month 4, and it is expected that the Trust will be forecasting a deficit from the plan. There are several risks within the CIP plan and further mitigations will need to be worked up. The target score has been set at 2026/27 due to the deficit support failing out at the end of 2025/26 resulting in an inability to meet the target in year.

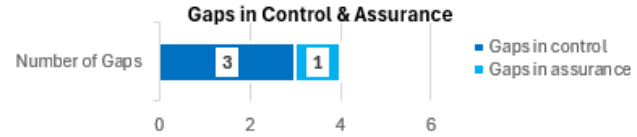
Risk and Assurance Dashboard

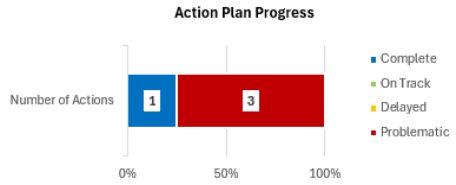












What is the data telling us?

The target risk score has been reduced for 2025/26 in line with the revised risk appetite statement, with delivery expected by March 2027. This strategic risk has the third lowest number of linked risks.

All but one planned assurance was presented this quarter, with four receiving positive ratings and four not rated. All actions have been carried over from 2024/25, with one completed during the quarter.

What are we doing about it?

No	Summary Action	Due	2024/25 Q1	2024/25 Q2	2024/25 Q3	2024/25 Q4	2025/26 Q1	2025/26 Q2	2025/26 Q3	2025/26 Q4
1	Identification of recurrent CIP	~~31/07/2025~~ ~~31/05/2025~~ 31/03/2026								
2	Ensure delivery of elective targets	~~30/09/2025~~ ~~30/04/2025~~ 31/03/2026								
3	Establish FRCGs to improve financial control	25/04/2025	N/A	N/A						
4	Tough decisions	~~31/01/2025~~ ~~31/05/2025~~ 31/12/2025	N/A	N/A						

BAF 7: Inability to Deliver Financial Sustainability

Control and Assurance Framework

Key Controls	
Care Group (n=4)	• Performance Management meetings in place with the Care Groups with financial performance included as a driver metric. • Standing Financial Instructions and scheme of delegation • Exec Team approval of additional investment up to £250k • Monthly Care Group attendance a Financial Recovery Group.
Corporate (n=4)	• New Financial Recovery Group established to give oversight of CIP delivery both corporate schemes and Care Group targets. • Finance report in place to performance and Finance Committee with associated scrutiny; enhanced to include run rate performance and impact of activity levels of income recovery. • Future investments guidance issued to the Care Groups in that only investment requests where significant patient safety risks are involved will be considered and any additional investments will now need to go through the double lock • Reset of the bed model and final allocation of system capacity funding undertaken
System (n=3)	• Internal audit programme adjusted to reflect changing risks in financial plan • External audit programme in place • System Recovery Programme
Gaps in Control	• Fully signed off CIP Plan • Recurrent CIP versus non-recurrent • Contractual position requires finalising, and agreement not yet reached. Unclear on Trusts ability to access support for costs of potential redundancy may undermine CIP delivery in year

Key Assurances Received in Quarter 1

Assurance Source	April	May	June
Accounting Policies Update			
Activity Performance Report		NR	☒
Annual Accounts			
Annual Accounts Timetable			
Audit Findings Report and Letter of Representation			
Audited Accounts and Financial Statements and Analytical Review			NR
Budget Setting Framework 2026/2027			
Business Case Review Schedule			
Cost Improvement Report			
Draft Financial Outlook			
Executive Recovery Oversight Group Terms of Reference			NR
Finance Report	M12	M1	M2
Financial Plan 2025/26	NR		
Going Concern			
Grip and Control: Medical Staff and Nursing Bank and Agency Controls			
Internal Audit into Overseas Visitors Policy			
Key Financial Controls			
Medicines Finance, Procurement and Supplies Report			
Productivity / Efficiency Performance Report			
Supplies and Procurement Report			
Overseas Patients Activity			

Gaps in Assurance	• Triangulation of Care Group activity plan versus income assumptions.

BAF 8: Inability to Sustain Research and Innovation Excellence

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

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

	Q1	Q2	Q3	Q4	Target		Appetite
L	3	3	3	2	2	31/03/2026	Minimal 1 – 4
C	4	4	4	4	4		Tolerance
Score	12	12	12	8	8		Mod 5 – High 9

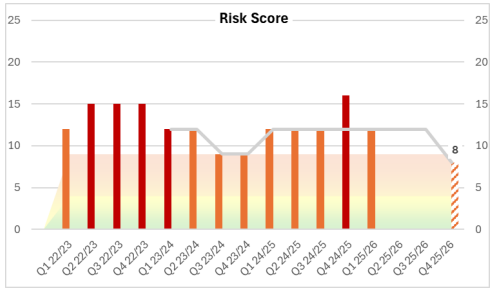
Impact on Our Strategic Priorities

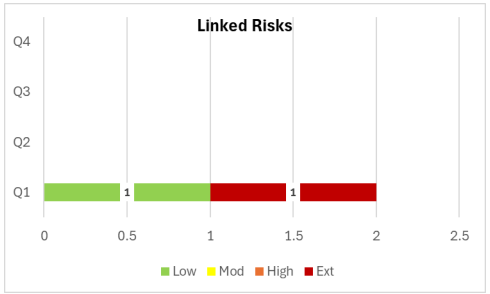
Impacted by Our Primary Issues

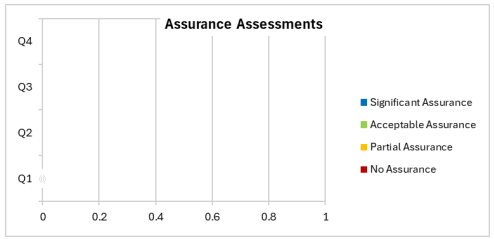
Executive Overview

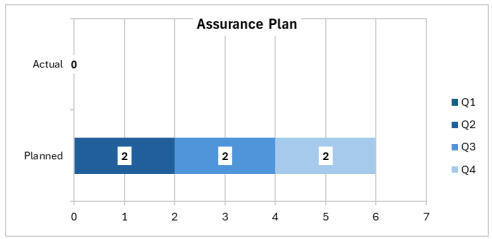
The launch of the new Trust Strategy 2025-2035 identifies Research and Innovation as two of only seven strategic plans. This reflects the importance of these two areas in enabling the Trust to achieve its strategic objectives. Strategic Delivery Plans have been codesigned via the Research Strategy Delivery Oversight Forum and will be presented to Finance & Business Performance Committee in July 2025. In this context, the current arrangements for governance of research and innovation is being updated to ensure there is appropriate focus on delivery of these plans.

Risk and Assurance Dashboard

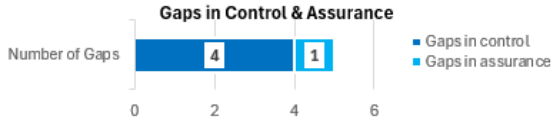


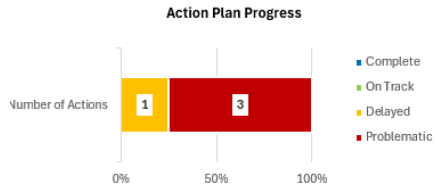






Assurance Assessment





What is the data telling us?

The target risk score remains unchanged from Q4, though the target date has been extended to March 2026. This strategic risk has the second lowest number of linked risks.

No assurances were presented this quarter, but six are scheduled for the remainder of the year. All actions have been carried over from 2024/25, with revised due dates now in place.

What are we doing about it?

No	Summary Action	Due	2024/25 Q1	2024/25 Q2	2024/25 Q3	2024/25 Q4	2025/26 Q1	2025/26 Q2	2025/26 Q3	2025/26 Q4
1	Research to form part of Care Group Board Agendas	~~30/09/2024~~ ~~31/03/2025~~ 30/09/2025								
2	Commissioning an external specialist to review QMS prior to MHRA inspection	~~30/09/2024~~ ~~31/12/2024~~ 30/06/2025								
3	Increasing patient and public involvement in developing research strategy	~~31/03/2025~~ 30/09/2025								
4	Action plan for international commercial opportunities	~~31/03/2025~~ ~~30/06/2025~~ 31/12/2025	N/A	N/A						

BAF 8: Inability to Sustain Research and Innovation Excellence

Control and Assurance Framework

Key Controls	
Care Group (n=8)	• Research Operations and Leadership Meeting to coordinate and support operational activities • Review of research and innovation directorate structure undertaken • Recruitment monitoring and forecasting are being utilised to align with growth-oriented strategic objectives, with forecasts contributing to feasibility assessments. • Academic Development Officer for CeNREE appointed • Chief Allied Health Professional hosted by CeNREE in post aimed at empowering and promoting research. • Research Governance Manager in post • CRDC manager in post • Clinical Research Matron in post
Corporate (n=5)	• Strategic Delivery Plans for Research and Innovation codesigned through Research Strategy Delivery Oversight Forum • Research Strategy Delivery Oversight Forum terms of reference being updated to reflect Strategic Delivery Plans and ensure appropriate arrangements in place to provide oversight of delivery • Widening out the R&I Directorate staff recruitment for delivery beyond nursing to include midwives, AHP's and other research active professions (e.g. recent appointment of Physician Associate as Band 7 lead research practitioner) • Increasing investment in Patient and Public Involvement and Engagement (PPIE), with plans to establish a PPIE lead position. • Executive Team support for proposal to explore repurposing space within Clinical Education Centre to provide a dedicated base for a range of research, education, learning and development teams to come together
System (n=7)	• Active programme to improve relationships with both Keele University and University of Staffordshire at organisational level – this will include research agenda • Keele and UHNM have agreed revised process for joint medical appointments between the two organisations • UHNM is a part of SSHERPa, contributing to the ICS research agenda – SSHERPa expanding remit to include Innovation • Closer working with MPFT – Work force training & recruitment • UHNM is a member of the West Midlands R&D Research Forum. • Active participation in the Communities of Practice for the National Contract Value Review • National strategies from the Chief Nurse Office for England, the Chief Midwifery Office for England and the Chief Allied Health Professional Office for England, which will support implementation of CeNREE priorities.
Gaps in Control	• Clarification being sought on criteria for further joint appointments and research active staff (wider than medics) • Inability for further substantive appointments / investment into CeNREE • Mandatory GCP training for Principal/Chief Investigators • No dedicated Research Facility as seen within comparator regional Trusts

Key Assurances Received in Quarter 1			
Assurance Source	**April**	**May**	**June**
Innovation Strategic Plan			
Research Strategic Plan			
Gaps in Assurance	• Strengthening of reporting from research and innovation into Committees required		

Risk Appetite Framework

Appendix 1

Risk Types

Clinical Risk

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

Operational Risk

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

Workforce Risk

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

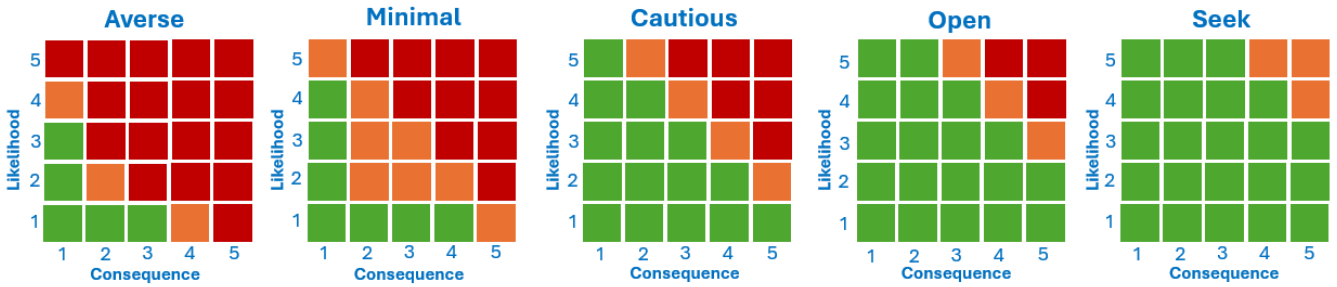
Financial Risk

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

External Risk

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

Risk Appetite and Tolerance Levels



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

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

ID	Opened	Title	Rating (Q1)	Rating (Target)	Division	BAF Link
32463	16/05/2024	Risk of not achieving £8.5 million contribution to County Elective Hub	25	9	Network Services	1
34791	16/11/2024	Careflow Product Reliability and Availability	25	10	Central Functions Division	1, 4
34423	19/11/2024	Non-Compliance with BLS Face to Face Training	20	5	Central Functions Division	0
36050	14/04/2025	Challenges with Trust PGD sign off procedures	20	2	Children's, Women's and Clinical Support Services	1
33427	19/08/2024	Non Medical Referring - Protocols	20	6	Children's, Women's and Clinical Support Services	1
32545	30/05/2024	Demand on our People Operations services is greater than our resource capacity.	20	9	Central Functions Division	1, 3
35614	06/03/2025	patient pathways affected by lack of non medical referrer oversight and governance	20	4	Children's, Women's and Clinical Support Services	1, 3
34608	01/12/2024	Network Service's divisional unfunded 1:1 nursing assistant cost pressure	20	3	Network Services	1, 3
34619	02/12/2024	Shadow IT and lack of system maintenance	20	5	Central Functions Division	1, 4
33424	19/08/2024	Non Medical Referring - Ownership and Maintenance of the Database	20	6	Children's, Women's and Clinical Support Services	1, 4
21697	07/07/2021	Shortfall against 25/26 CIP Plans - high risk £49.2 and medium risk £7.1m	20	8	Central Functions Division	6, 7
18673	02/12/2019	Lack of Compliance with Health and Safety Regulations	16	6	Central Functions Division	0
24178	26/04/2022	Pharmacy IT hardware out of warranty	16	2	Children's, Women's and Clinical Support Services	0
34789	02/12/2024	Corporate RTT (Referral to Treatment) Validation at UHNM	16	8	Central Functions Division	1
32464	20/05/2024	Incorrect use of bedrails	16	6	Central Functions Division	1
26887	18/01/2023	Ineffective Clinical Effectiveness Provision	16	6	Central Functions Division	1
29812	27/09/2023	Replacement Medical Devices - Capital and Revenue Funding Risk	16	4	Estates, Facilities and PFI	1
24028	06/04/2022	Emergency Department Performance Standards not being achieved	16	6	Medical Division	1
17873	16/07/2020	Inability to Off-load Patients from Ambulances (both sites)	16	4	Medical Division	1
20448	17/03/2021	Patient LOS above 48 hrs on AMU - against Internal Standards	16	4	Medical Division	1
14958	29/10/2024	Triage Times (Royal) In Adults and Children's ED	16	6	Medical Division	1
26832	12/01/2023	Your Next Patient (Holding Areas Queues) Acute Medicine	16	4	Medical Division	1
31958	08/04/2024	MCHT Beckman Track & Stock yard (storage module)	16	6	North Midlands and Cheshire Pathology Service	1
30149	23/10/2023	AAA Time to Surgery	16	4	Surgical Division	1
33959	07/10/2024	Colorectal Cancer Position	16	2	Surgical Division	1
35527	27/02/2025	County Elective Hub Theatres Equipment	16	4	Surgical Division	1
25469	04/08/2022	Delivery of constitutional cancer quality standards	16	4	Surgical Division	1
27156	07/02/2023	EMR/ESD Service - Lack of Operational Policy	16	6	Surgical Division	1
25471	04/08/2022	Follow Up Delays	16	4	Surgical Division	1

ID	Opened	Title	Rating (Q1)	Rating (Target)	Division	BAF Link
32807	19/06/2024	Head and Neck Cancer Delivery	16	4	Surgical Division	1
34158	18/10/2024	Admin Account Authorisation	16	4	Central Functions Division	4
34277	06/11/2024	Need viable solution for redaction software for SARs and suitable available resource to act as data handlers	16	6	Central Functions Division	4
35798	25/03/2025	Doors at STS	16	4	Surgical Division	5
22641	15/11/2021	Blood Sciences Managed Service Contract tender	16	4	North Midlands and Cheshire Pathology Service	6
30986	11/01/2024	Centre for Research and Education Excellence (CeNREE) sustainability	16	6	Central Functions Division	8
34138	24/10/2024	Workforce Information team's resource / capacity is significantly less than the current and growing demands on the service	16	8	Central Functions Division	1, 3
34826	13/12/2024	Child Health Rota remains a 1:7- The Tier 2 resident doctor cover does not meet service need.	16	4	Children's, Women's and Clinical Support Services	1, 3
18842	05/10/2020	Gaps within the Junior Medical Rota	16	6	Children's, Women's and Clinical Support Services	1, 3
32149	24/04/2024	MNG Consultant workforce recruitment	16	8	Children's, Women's and Clinical Support Services	1, 3
33426	19/08/2024	Non Medical Referring - Management Resource	16	6	Children's, Women's and Clinical Support Services	1, 3
33539	29/08/2024	Non Obstetric Ultrasound (NOUS) Performance - DM01 compliance	16	4	Children's, Women's and Clinical Support Services	1, 3
21481	28/06/2021	Reduced Breast service (Imaging), due to vacancy within Breast Radiologist workforce.	16	4	Children's, Women's and Clinical Support Services	1, 3
33720	16/09/2024	AEC Nursing Workforce	16	4	Medical Division	1, 3
35962	26/03/2025	Fragility of ILD service - nursing	16	4	Medical Division	1, 3
35094	21/01/2025	Medical Staffing in ED Overnight & at Weekends	16	8	Medical Division	1, 3
10381	27/04/2018	Medical Staffing - Haematology	16	9	Network Services	1, 3
34960	09/01/2025	AAA Screening Workforce - CST and Technicians	16	4	Surgical Division	1, 3
25893	29/09/2022	Delay in EPMA roll out	16	4	Central Functions Division	1, 4
25454	02/08/2022	EPMA and/or Clinical Narrative System not fit for purpose	16	4	Central Functions Division	1, 4
26427	16/11/2022	Use of Q-pulse as electronic quality management system	16	6	North Midlands and Cheshire Pathology Service	1, 4
32544	30/05/2024	UHNM negotiations underway to upband & backpay all AfC B2 Healthcare Support Workers who have been delivering work at B3.	16	12	Central Functions Division	3, 6
35342	10/02/2025	Process re: Non-Medical Prescribing	15	5	Central Functions Division	0
27411	24/01/2023	ReSPECT	15	5	Central Functions Division	0
31987	09/04/2024	UK Visas and Immigration rules (legal migration rules)	15	12	Central Functions Division	0

ID	Opened	Title	Rating (Q1)	Rating (Target)	Division	BAF Link
30881	18/12/2023	Non compliance with RCR 2022 guidelines for Notification of Imaging Results	15	2	Children's, Women's and Clinical Support Services	0
36198	25/04/2025	Out of date Gynaecology Guidelines, Standard Operating Procedures and Patient information leaflet	15	2	Children's, Women's and Clinical Support Services	0
34159	28/10/2024	Prescription of opiods for children within UHNM	15	2	Children's, Women's and Clinical Support Services	0
36839	23/06/2025	Noise level in pod 6, Critical Care	15	6	Surgical Division	0
36848	23/06/2025	Purchase of Non EEA Country Human Tissue	15	3	Surgical Division	0
28733	21/06/2023	Tracheostomy care	15	10	Surgical Division	0
35517	26/02/2025	Urogynae Backlog and Long Wait	15	4	Children's, Women's and Clinical Support Services	1
35516	26/02/2025	Endometriosis Backlog and Long Waits	15	4	Children's, Women's and Clinical Support Services	1
18664	28/09/2020	Gynaecology 52 Week Long Waits	15	6	Children's, Women's and Clinical Support Services	1
32023	11/04/2024	Maternity Early Warning Scores not used for Maternity Patients outside of Maternity Dept	15	2	Children's, Women's and Clinical Support Services	1
31322	05/02/2024	Long WTBS by the RS medics	15	5	Medical Division	1
33109	16/07/2024	Audiology Waiting List Backlog	15	5	Surgical Division	1
30476	20/11/2023	NHS Financial position and procurement of System Wide EPR	15	5	Central Functions Division	4
34869	24/12/2024	Technical Debt	15	5	Central Functions Division	4
34491	18/11/2024	Pharmacy Isolators - Performance and downtime	15	4	Children's, Women's and Clinical Support Services	5
23331	02/02/2022	MCHT Ceiling RAAC planks	15	4	North Midlands and Cheshire Pathology Service	5
32486	22/05/2024	Long Wait Patients in the Trauma Directorate	15	6	Network Services	1, 3
31724	11/03/2024	Non clinical users able to order on behalf of clinician for IRMER requests	15	5	Central Functions Division	1, 4
9036	25/10/2017	Vulnerability to Cyber Attack	15	12	Central Functions Division	1, 4
34369	13/11/2024	ECC Patient toilet facilities safety and prevention	15	8	Medical Division	1, 5
20926	30/04/2021	Emergency Department (Royal) majors & children's cubicle doors	15	4	Medical Division	1, 5
25917	30/09/2022	Suitability of Cohort Area (Known as Ambulance Assessment 7 - 10)	15	2	Medical Division	1, 5
25537	15/08/2022	Breach of Freedom of Information FOI Act 2000 in responding to requests within 20 working days (95%)	12	4	Central Functions Division	0
22518	29/10/2021	Cleanliness	12	3	Central Functions Division	0
8877	21/05/2012	Hospital Acquired Infections	12	8	Central Functions Division	0
22876	10/12/2021	Lack of compliance and risk of injury with medical sharps	12	6	Central Functions Division	0

ID	Opened	Title	Rating (Q1)	Rating (Target)	Division	BAF Link
25457	02/08/2022	Lack of regular audit of IT assets	12	4	Central Functions Division	0
26815	10/01/2023	Resuscitation Training	12	6	Central Functions Division	0
29364	15/08/2023	Extremity radiation doses to nuclear medicine/PET staff	12	3	Children's, Women's and Clinical Support Services	0
33819	23/09/2024	Insufficient radiopharmacy releasing officers	12	3	Children's, Women's and Clinical Support Services	0
28461	01/06/2023	non compliance of basic life support (BLS) training in Radiology SPR's	12	4	Children's, Women's and Clinical Support Services	0
29196	27/07/2023	Immunisation gap	12	4	Estates, Facilities and PFI	0
33444	21/08/2024	Potential loss of franking machine due to a lack of supplier support	12	3	Estates, Facilities and PFI	0
34148	25/10/2024	Lack of full completion of the ED Mental Health Proforma and Capacity Assessments	12	4	Medical Division	0
31146	23/01/2024	Risk Assessment of MH Patients Overnight at County ED	12	2	Medical Division	0
34950	07/01/2025	Risk to ED Staff from Ambulance Holds	12	2	Medical Division	0
30496	22/11/2023	Business Continuity Plans - Network Services Division	12	4	Network Services	0
36457	19/05/2025	Critical Care Side Rooms	12	4	Surgical Division	0
36828	20/06/2025	Ophthalmology Referral Inbox	12	4	Surgical Division	0
31836	20/03/2024	Violence & Aggression towards staff	12	4	Surgical Division	0
32652	05/06/2024	Clinical Harm Review Process	12	6	Central Functions Division	1
11415	20/08/2018	End of Life - Portable battery powered syringe pumps.	12	9	Central Functions Division	1
8901	05/12/2013	Ensure correct blood sample management	12	6	Central Functions Division	1
33311	07/08/2024	Antenatal consultant clinic capacity	12	6	Children's, Women's and Clinical Support Services	1
33223	19/07/2024	Ante-natal prescriptions in the community	12	4	Children's, Women's and Clinical Support Services	1
28881	30/06/2023	Breast Screening community locations	12	2	Children's, Women's and Clinical Support Services	1
35351	11/02/2025	Clinic over runs	12	4	Children's, Women's and Clinical Support Services	1
34519	22/11/2024	Delivery of Gestational Diabetes GTT Clinics	12	4	Children's, Women's and Clinical Support Services	1
29165	20/07/2023	Diabetic Pump Contracts	12	4	Children's, Women's and Clinical Support Services	1
33821	23/09/2024	essential maintenance to the radiopharmaceutical isolators	12	2	Children's, Women's and Clinical Support Services	1

ID	Opened	Title	Rating (Q1)	Rating (Target)	Division	BAF Link
30573	30/11/2023	Inability to support patient pathway turnaround times in MRI due to not being able to secure sufficient GA slots to meet demand	12	4	Children's, Women's and Clinical Support Services	1
32013	10/04/2024	Insufficient number of maternity theatre slots for Category 4 caesarean section	12	6	Children's, Women's and Clinical Support Services	1
33928	02/10/2024	Noncompliance with requirements of the Fetal anomaly screening programme (FASP) & saving babies lives pathways	12	4	Children's, Women's and Clinical Support Services	1
33630	05/09/2024	Out of date gynae stack	12	2	Children's, Women's and Clinical Support Services	1
20435	16/03/2021	Paediatric Follow up Backlog	12	6	Children's, Women's and Clinical Support Services	1
32124	22/04/2024	Service Level Agreement between SaTH & Leighton for IR Referrals	12	6	Children's, Women's and Clinical Support Services	1
32954	29/06/2024	Siemens software error	12	2	Children's, Women's and Clinical Support Services	1
15788	13/01/2020	(CQC) Delivery of RTT Performance - Diagnostic Capacity	12	8	Medical Division	1
9738	05/02/2018	(CQC) Nursing training (both sites)	12	6	Medical Division	1
35166	27/01/2025	Central access for Specialised Medicine	12	4	Medical Division	1
17470	12/06/2020	Compliance with NEWS and escalation (Royal)	12	4	Medical Division	1
20180	29/10/2021	Controlled drugs management	12	6	Medical Division	1
34083	18/10/2024	County ED boarding patients overnight	12	1	Medical Division	1
24213	29/04/2022	Enhanced Primary Care (EhPC) Service Staffing and Demand	12	3	Medical Division	1
8660	20/09/2017	Follow up back log (outpatient appointments)	12	6	Medical Division	1
12699	15/02/2019	High Acuity Emergency Patients	12	4	Medical Division	1
26808	09/01/2023	Holding Patients on the ED Corridor	12	4	Medical Division	1
24025	06/04/2022	ILD Service - increased demand as a result of prescribing changes	12	4	Medical Division	1
24216	29/04/2022	Inability to refer primary care patients to OOH service when EhPC closes	12	3	Medical Division	1
32423	15/05/2024	Interruption to Plasma Service due to Machine Failure	12	4	Medical Division	1
35530	27/02/2025	Lack of Pathway Compliance for Children Presenting to ED, County with an Illness/Injury	12	5	Medical Division	1
31806	18/03/2024	No Psychological provision for renal patients	12	2	Medical Division	1
35708	03/03/2025	RTT Delivery - outpatient capacity/wait times to achieve 52wks	12	6	Medical Division	1
24340	10/05/2022	Severe Asthma Service - impact once external funding ceases	12	3	Medical Division	1
35931	04/04/2025	Availability of Savane - Antidote to anti-cancer medicines called Anthracyclines	12	4	Network Services	1
26529	28/11/2022	Leighton Hospital Hyper-Acute Stroke Pathway	12	4	Network Services	1
33893	27/09/2024	Major Trauma Peer Review	12	1	Network Services	1

ID	Opened	Title	Rating (Q1)	Rating (Target)	Division	BAF Link
34050	14/10/2024	Neurology Toxic Non MS Drug Monitoring	12	6	Network Services	1
34270	05/11/2024	Utilisation of Holistic Cancer Centre	12	6	Network Services	1
35466	21/02/2025	RSUH/CH Haematology Advia 2120 reliability	12	4	North Midlands and Cheshire Pathology Service	1
32034	12/04/2024	AAA Age of mobile Ultrasound machines	12	6	Surgical Division	1
35615	07/03/2025	Adherence to Trust Policy MM06: Prescribing, Storage, Supply and Administration of Controlled Drugs	12	2	Surgical Division	1
30749	13/12/2023	Contact Lens/Low Visual Acuity (CL/LVA) Service Delivery	12	8	Surgical Division	1
17637	30/06/2020	Decline in cancer performance	12	8	Surgical Division	1
35797	25/03/2025	ENT On Call Crosscover	12	4	Surgical Division	1
25470	04/08/2022	Increasing waiting list size and patients waiting greater than 18 weeks for treatment	12	4	Surgical Division	1
27953	12/04/2023	Lack of provision for patients requiring DIEP surgery	12	6	Surgical Division	1
36829	20/06/2025	Referral process for WET AMD patients	12	4	Surgical Division	1
36225	29/04/2025	SDEC/SAU Model Template	12	3	Surgical Division	1
32683	07/06/2024	Timely Reporting of Emergency MRI Results	12	4	Surgical Division	1
36830	20/06/2025	Ward 111 Band 3 staff members are unable to provide basic tracheostomy care	12	4	Surgical Division	1
33184	24/07/2024	Inability to provide timely management of Freedom to Speak Up Cases	12	4	Central Functions Division	3
32500	22/05/2024	TI Rates	12	6	Central Functions Division	3
34115	23/10/2024	Inability to comply with compensatory rest due to on call requirements	12	6	Children's, Women's and Clinical Support Services	3
21784	06/08/2021	(CQC) Confidentiality, Integrity and Availability of Trust Information	12	4	Central Functions Division	4
28595	01/06/2023	COIN Network	12	4	Central Functions Division	4
34157	17/10/2024	DC1-SQLDB19 _ DC2-SQLDB20	12	6	Central Functions Division	4
8849	13/10/2017	Inappropriate use of mobile devices for work purposes	12	4	Central Functions Division	4
33518	29/08/2024	Proactive audit & monitoring of patient record systems	12	4	Central Functions Division	4
33770	18/09/2024	RPA Sophos AV False Positive Beaconing Threats	12	3	Central Functions Division	4
33097	01/03/2024	Reduced Security Support - (Sophos exemptions) for the Omnicell Automated Dispensing Cabinets	12	4	Children's, Women's and Clinical Support Services	4
35090	21/01/2025	Rapid AI Linux OS Out of support	12	4	Children's, Women's and Clinical Support Services	4
12595	01/02/2019	(1) Image Vault Storage (2) security update patches	12	4	Network Services	4
25353	21/07/2022	Sale of RI and COPD Land later than NHSE funding requirement of 24/25	12	6	Central Functions Division	5
32133	23/04/2024	Ambient temperatures in pharmacy hubs	12	4	Children's, Women's and Clinical Support Services	5

ID	Opened	Title	Rating (Q1)	Rating (Target)	Division	BAF Link
28802	23/06/2023	Insufficient hub space and clinical room capacity for community midwifery teams	12	4	Children's, Women's and Clinical Support Services	5
30237	04/09/2023	PFI latent defects	12	4	Estates, Facilities and PFI	5
35143	24/01/2025	Royal Stoke Primary Distribution heating and hot water pipework leaks	12	4	Estates, Facilities and PFI	5
29213	28/07/2023	ECT Cooper Building roof leaks	12	4	North Midlands and Cheshire Pathology Service	5
22717	23/11/2021	Space in Pathology Directorate RSUH - Cellular Pathology	12	4	North Midlands and Cheshire Pathology Service	5
32237	01/05/2024	Fire Risk on Corridors	12	4	Surgical Division	5
34188	29/10/2024	Non pay overspend - Histology send away activity	12	6	North Midlands and Cheshire Pathology Service	6
27153	07/02/2023	QI Academy Staffing under-resourced to deliver sustainable change	12	12	Central Functions Division	1, 3
36230	29/04/2025	Clinical Photography Workforce shortfall	12	4	Children's, Women's and Clinical Support Services	1, 3
28944	03/07/2023	Deficit in appropriate numbers in Skilled Neonatal Specialist Nurses.	12	4	Children's, Women's and Clinical Support Services	1, 3
28820	25/06/2023	Delivery of Transitional Care -Preparing for Adults	12	4	Children's, Women's and Clinical Support Services	1, 3
35057	17/01/2025	Inadequate Pharmacy Staffing to Emergency Departments	12	6	Children's, Women's and Clinical Support Services	1, 3
32490	22/05/2024	Insufficient Epilepsy CNS cover.	12	4	Children's, Women's and Clinical Support Services	1, 3
25152	06/07/2022	Insufficient trained staff in Pharmacy Technical Services to deliver aseptic products including chemotherapy to the Trust	12	4	Children's, Women's and Clinical Support Services	1, 3
21719	29/07/2021	Medicine Safety Officer Vacancy	12	4	Children's, Women's and Clinical Support Services	1, 3
34113	23/10/2024	Quality, Safety and Compliance Resource - Imaging	12	4	Children's, Women's and Clinical Support Services	1, 3
26995	20/01/2023	Radiology Reporting Backlog - Body Radiology	12	4	Children's, Women's and Clinical Support Services	1, 3
26997	20/01/2023	Radiology Reporting Backlog - Neuro Radiology	12	4	Children's, Women's and Clinical Support Services	1, 3
33514	29/08/2024	Ultrasound Imaging Workforce	12	4	Children's, Women's and Clinical Support Services	1, 3
8523	01/09/2017	AMU Workforce (both sites)	12	4	Medical Division	1, 3
10356	25/04/2018	Bowel prep prescription pre-assessment capacity	12	3	Medical Division	1, 3

ID	Opened	Title	Rating (Q1)	Rating (Target)	Division	BAF Link
35330	10/02/2025	County AMU nursing budget/establishment	12	4	Medical Division	1, 3
24837	14/06/2022	Cystic Fibrosis workforce/service delivery	12	4	Medical Division	1, 3
35063	11/12/2024	Fragile Service - GI Physiology	12	4	Medical Division	1, 3
25467	04/08/2022	Funding for HD capacity and workforce	12	8	Medical Division	1, 3
29508	01/09/2023	Inability to deliver hybrid closed loop pumps to type 1 diabetes patients	12	9	Medical Division	1, 3
35847	31/03/2025	Lack of Pharmacy for ED departments	12	4	Medical Division	1, 3
15664	13/01/2020	Liver Mortality - CQC actions	12	4	Medical Division	1, 3
27071	26/01/2023	NIV Service Workforce - Domicilary service	12	4	Medical Division	1, 3
31807	18/03/2024	No nursing Clinical Educator in post in Renal	12	2	Medical Division	1, 3
34700	04/12/2024	Physiotherapy respiratory Outpatient clinic waiting list	12	2	Medical Division	1, 3
32408	14/05/2024	Clinical Perfusion- Inadequate Establishment & Staff Shortages	12	6	Network Services	1, 3
29712	14/09/2023	Consultant and Scientist Shortages in Neurophysiology	12	4	Network Services	1, 3
29480	30/08/2023	County and Ward 202 SACT Unit Staffing	12	2	Network Services	1, 3
32891	25/06/2024	Epilepsy Specialist Nursing Resource Availability	12	12	Network Services	1, 3
17967	23/07/2020	Medical Cover Cardiothoracic ICU	12	3	Network Services	1, 3
32977	02/07/2024	Palliative Care staffing	12	6	Network Services	1, 3
29141	19/07/2023	Temporarily funded posts	12	6	Network Services	1, 3
33912	01/10/2024	Anticoagulation Management Service staffing	12	4	North Midlands and Cheshire Pathology Service	1, 3
34408	18/11/2024	Haematology Advanced Practitioner Biomedical Scientist - fragility of service	12	4	North Midlands and Cheshire Pathology Service	1, 3
19397	21/12/2020	Impact of increased workload on service and Quality management system in Immunology	12	6	North Midlands and Cheshire Pathology Service	1, 3
20616	01/08/2017	Insufficient Biomedical Scientific Staff Resource to Provide a Quality Haematology & Blood Transfusion Service at Macclesfield H	12	4	North Midlands and Cheshire Pathology Service	1, 3
25120	05/07/2022	Insufficient Biomedical Scientific Staff Resource to Provide a Quality Haematology & Blood Transfusion Service at MCHFT	12	8	North Midlands and Cheshire Pathology Service	1, 3
21591	08/07/2021	Insufficient Clinical Staff to Support the NMCPS Microbiology Service	12	6	North Midlands and Cheshire Pathology Service	1, 3
20626	05/11/2020	Low staffing levels for Phlebotomy at Cheshire Sites	12	6	North Midlands and Cheshire Pathology Service	1, 3
11294	31/07/2018	NMCPS Pathology Histology Medical Capacity - dissection & reporting(achieving TAT)	12	6	North Midlands and Cheshire Pathology Service	1, 3
31723	11/03/2024	Specimen reception staffing and workload - RSUH, MCHT, ECT	12	4	North Midlands and Cheshire Pathology Service	1, 3
31429	14/02/2024	Audiology Staffing	12	4	Surgical Division	1, 3

ID	Opened	Title	Rating (Q1)	Rating (Target)	Division	BAF Link
25628	01/09/2022	Ophthalmology Service Delivery	12	8	Surgical Division	1, 3
25682	05/09/2022	(CQC) Unstructured records Management	12	4	Central Functions Division	1, 4
23759	14/03/2022	Inappropriate clinical decisions due to large number of digital systems in place	12	4	Central Functions Division	1, 4
30477	20/11/2023	Lack of records retention in line with Code of Practice	12	4	Central Functions Division	1, 4
29744	18/09/2023	Cardiac Imaging Storage	12	2	Children's, Women's and Clinical Support Services	1, 4
29217	28/07/2023	Egrow digital plotting for height and weight	12	2	Children's, Women's and Clinical Support Services	1, 4
30129	24/10/2023	Inpatient E-notification initial report not enabled	12	2	Children's, Women's and Clinical Support Services	1, 4
34116	23/10/2024	Lack of audit ability for reporting in the CRIS System	12	6	Children's, Women's and Clinical Support Services	1, 4
32551	31/05/2024	Operational risk associated with the Pharmacy robot replacement	12	6	Children's, Women's and Clinical Support Services	1, 4
33674	23/07/2024	Sectra PACS Imaging - No Security Endpoint protection	12	12	Children's, Women's and Clinical Support Services	1, 4
30811	14/12/2023	Security Patches for Sectra Servers	12	4	Children's, Women's and Clinical Support Services	1, 4
33292	06/08/2024	Security Patches for Syngo.Via	12	4	Children's, Women's and Clinical Support Services	1, 4
34402	18/11/2024	Syngo Via unsupported security posture	12	4	Children's, Women's and Clinical Support Services	1, 4
35532	27/02/2025	Delay in Ambulance PRFs being Uploaded to iPortal	12	4	Medical Division	1, 4
29645	10/09/2023	Endoscopy Booking Process	12	4	Medical Division	1, 4
31527	26/02/2024	Auto-Contoring	12	6	Network Services	1, 4
28354	23/05/2023	Blood Analyser Lantronix UDS box	12	4	North Midlands and Cheshire Pathology Service	1, 4
34582	27/11/2024	CIM Failovers	12	6	North Midlands and Cheshire Pathology Service	1, 4
34580	27/11/2024	CIM Hold and Error Queue Management	12	4	North Midlands and Cheshire Pathology Service	1, 4
34594	28/11/2024	Illegal Characters in SampleNet	12	6	North Midlands and Cheshire Pathology Service	1, 4
31946	08/04/2024	MCHT Remisol performance and vulnerability	12	4	North Midlands and Cheshire Pathology Service	1, 4

ID	Opened	Title	Rating (Q1)	Rating (Target)	Division	BAF Link
21332	16/06/2021	NMCPS Management of Incidents across all network sites	**12**	4	North Midlands and Cheshire Pathology Service	1, 4
34965	10/01/2025	No MFA for Winpath Enterprise (LIMS)	**12**	2	North Midlands and Cheshire Pathology Service	1, 4
34595	28/11/2024	SampleNet Is Unable to Handle Time Changes	**12**	6	North Midlands and Cheshire Pathology Service	1, 4
32033	12/04/2024	AAA Screening operational charges and access	**12**	4	Surgical Division	1, 4
28684	14/06/2023	Lack of Clean Utility Room - Children's High Dependency	**12**	6	Children's, Women's and Clinical Support Services	1, 5
25309	19/07/2022	Medicines Storage Area Temperatures Exceeding 25 degrees C	**12**	1	Children's, Women's and Clinical Support Services	1, 5
35039	17/01/2025	Pharmacy Cancer walk-in cold store Ward 202 performance and capacity	**12**	2	Children's, Women's and Clinical Support Services	1, 5
35126	14/01/2025	Electrical High Voltage infrastructure capacity on Royal Stoke site	**12**	4	Estates, Facilities and PFI	1, 5
10277	03/07/2024	Reduction in Estates Capital backlog 3-5 year funding	**12**	6	Estates, Facilities and PFI	1, 5
34189	29/10/2024	Clinical Haematology specialist referral service (HODS/MHIRO)	**12**	6	North Midlands and Cheshire Pathology Service	1, 6
26168	26/10/2022	Pathology IT System Expertise	**12**	6	North Midlands and Cheshire Pathology Service	3, 4
31185	29/01/2024	DataCentre Air Conditioning EOL - Unfit for Purpose	**12**	4	Central Functions Division	4, 5

Executive Summary

Trust Board | 8th October 2025

Maternity & Neonatal PSIRF Investigation Report Quarter 1

University Hospitals of North Midlands NHS Trust

Purpose:	**Information**		**Approval**		**Assurance**	✓	**Agenda Item:** 11
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		
BAF 1	Inability to Sustain Safe and Effective Care Delivery	**Extreme 16**

Executive Summary

Situation

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

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

PMRT:

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

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

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

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

MNSI (formerly HSIB):

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

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

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

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

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

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

Background

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

Assessment

In Quarter 1 there were 4 new incidents reported that met the criteria for PSII:

- April 2025 1
- May 2025 0
- June 2025 3

Category of Incidents:

- 0 PMRT (Potentially score C or above)
- 3 MNSI (2 also referred to ENS)
- 1 local priority

No of open maternity and neonatal Serious Incidents (under the former SI framework):	0
Investigation in progress:	0
Investigations completed/awaiting to be presented and closed by Risk Management Panel and ICB SI Group:	3
No of open maternity and neonatal PSIRF reviews:	
PMRT (Not reportable as PSII) PMRT (Reportable as PSII)	36 2
MNSI: In progress Final report received Actions plans developed and for approval through governance process	7 4 2 1
AAR	8
Thematic Review	1
Case Record Review	4

Duty of candour is performed with families for all eligible incidents and information given in an accessible format. Two final reports from MNSI have been received in Quarter 1 and action plans have been developed to meet safety recommendations.

Key Recommendations

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

- All actions from PMRT and PSIRF investigations are monitored through the directorate outcomes meeting
- 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.
- Further embed the PSIRF review process through staff engagement and PMA support

Executive Summary

Trust Board | 8th October 2025

Mortality Assurance Annual Report (2024/25)

NHS
University Hospitals of North Midlands
NHS Trust

Purpose:	**Information**		**Approval**		**Assurance**	✓	**Agenda Item:**	12
Author:	Jamie Maxwell, Head of Quality, Safety and Compliance								
Executive Lead:	Di 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		
36869	Reduced Clinical Coding Capacity	**Ext 20**

Executive Summary

Situation

The purpose of this paper is to provide an update from the Mortality Review Group (MRG) on its function and associated workstreams and current mortality indicators.

Background

The Trust's Learning from Deaths and Mortality Indices are governed through the monthly Mortality Review Group (MRG), where individual Directorates present updates on their Mortality and Morbidity (M&M) Meetings. The Mortality Review Group assures that deaths are being reviewed, with wide clinical participation in the reviews, and that learning is being identified and actioned.

Assessment

Good presentations from specialties, as part of the M&M assurance processes, indicate that progress has been made against key areas of the Learning from Deaths programme with increased attendance and presentation from Directorates during 2024/2025 with 31 compared to 17 in previous year. The report also provides a summary of the key actions agreed at the MRG in relation to specialties providing updates and outcomes of reviews undertaken. There are good practices and improvements noted.

The specialties that have presented during 2024/2025 at the Mortality review Group have, provided assurances that there are M&M review processes with effective representation and demonstration that there are actions being taken following reviews to improve practices/processes. There are continued improvements needed in the completion of outstanding mortality reviews and assurances that actions are being taken following identification of learning and/or issues.

Mortality Indices:

- SHMI and HSMR have increased, and this is due to rises in observed deaths greater than rises in expected deaths.
- HSMR significantly higher than expected.
- Crude mortality position remains in line with the national rate.
- Noted the increase in mortality indices and identification of shortages in clinical coding resources and the impact this has had on being unable to code all activity which has resulted in non-elective activity not all being coded so deaths are at present higher proportion of coded activity and the surviving patients not all being coded as previously. There has been increases in number of patients being recorded under U-codes or R codes (diagnosis and comorbidities not fully coded) and this impact the standardisation as not reflect full mortality risks.

The report provides update on the SJRs being completed to assess the care and impact on patients' outcomes with 12 hours or more in the Emergency Department as part of their final admission. None of the completed reviews have identified that the long time spent in the Emergency Department contributed to the patients' outcomes but there have been some themes / learning identified. The requirement to undertake additional SJRs has now been agreed with the ICB to stop and have been used to inform the UEC Improvement programme.

Neonatal Mortality and Perinatal Mortality review Tool updates were provided to the Mortality Review Group and noted that there are actions and ongoing monitoring of mortality and outcomes within these areas. These are reported quarterly to Mortality Review Group and Quality, Access & Outcomes Group (formerly QSOG).
The Trust received 4 Prevention of Future Deaths Notifications received during 2024/2025. All of these PFDs have had the Trust responses submitted to HM Coroner which are publicly available via the HM Judiciary website where all PFDs are published.

The Mortality Review Group have continued to meet their requirements and responsibilities in reviewing mortality and seeking assurances from local M&M leads that there are local processes and reviews being undertaken. The focus for future work will be the ongoing improvement in mortality review completion and working with individual leads to support this improvement. This will allow greater assurance that deaths are reviewed promptly and allow sharing of learning across the Trust and with Medical Examiner Team, relatives, LeDeR (Learning Disability) reviewers and HM Coroner.

During 2024/2025 the Mortality Review have highlighted the following key recommendations / focusses for 2025/2026:

1. Clinical Coding and Mortality Indices

- Continue to prioritise the resolution of the clinical coding backlog, with executive oversight and support from the Integrated Care Board (ICB).
- Implement and monitor the impact of newly recruited clinical coders and improved discharge documentation processes.
- Develop and report on internal mortality indicators to provide assurance while national datasets remain affected by coding delays.

2. Structured Judgement Reviews (SJRs)

- Maintain and improve SJR completion rates across all specialties, with targeted support for areas with persistent backlogs.
- Ensure timely dissemination of learning from SJRs, particularly those rated as poor or very poor care, through M&M meetings and governance forums.
- Standardise documentation and storage of SJR outputs to improve accessibility and auditability.

3. Directorate M&M Processes

- Sustain improvements in M&M meeting attendance, documentation, and action tracking.
- Encourage wider multidisciplinary participation, including nursing and pharmacy staff, in M&M reviews.
- Promote the use of iPortal and CareFlow for real-time mortality review tracking and learning dissemination.

4. Learning Disability and Perinatal Mortality Reviews

- Ensure all Learning Disability and Autism deaths are reviewed through the LeDeR process and reported to the ICB.
- Maintain 100% compliance with the Perinatal Mortality Review Tool (PMRT) and CNST standards.
- Embed learning from perinatal reviews into clinical practice, particularly around communication, triage, and interpreter use.

5. Prevention of Future Deaths (PFDs) and Neglect Verdicts

- Implement and audit actions in response to PFDs, including staffing models, documentation standards, and escalation protocols.
- Monitor the impact of EPMA implementation on medication omission documentation and audit trails

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	✓
No Assurance	No confidence in delivery	
Rationale		
Assessed as Partial Assurance due to identified issues with clinical coding and the impact this is having on the Trust's mortality indices		

Key Recommendations

The Trust Board is asked to approve the latest annual report and to note that the Quality, Access and Outcomes Committee will receive regular updates on the following:

- The identified diagnosis group reviews and CuSum alerts
- Actions identified within the report as part of the Quarterly Reports in relation to clinical coding support and further actions to reduce the coding backlog
- The options being developed to address the clinical coding backlog and mitigations/assurances to be provided whilst HSMR and SHMI continue to be affected
- Further MBRRACE, PMRT and neonatal mortality reports

NHS
University Hospitals of North Midlands
NHS Trust

UHNM Mortality Assurance Annual Report 2024/2025

July 2025

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1. Introduction

The purpose of this paper is to:

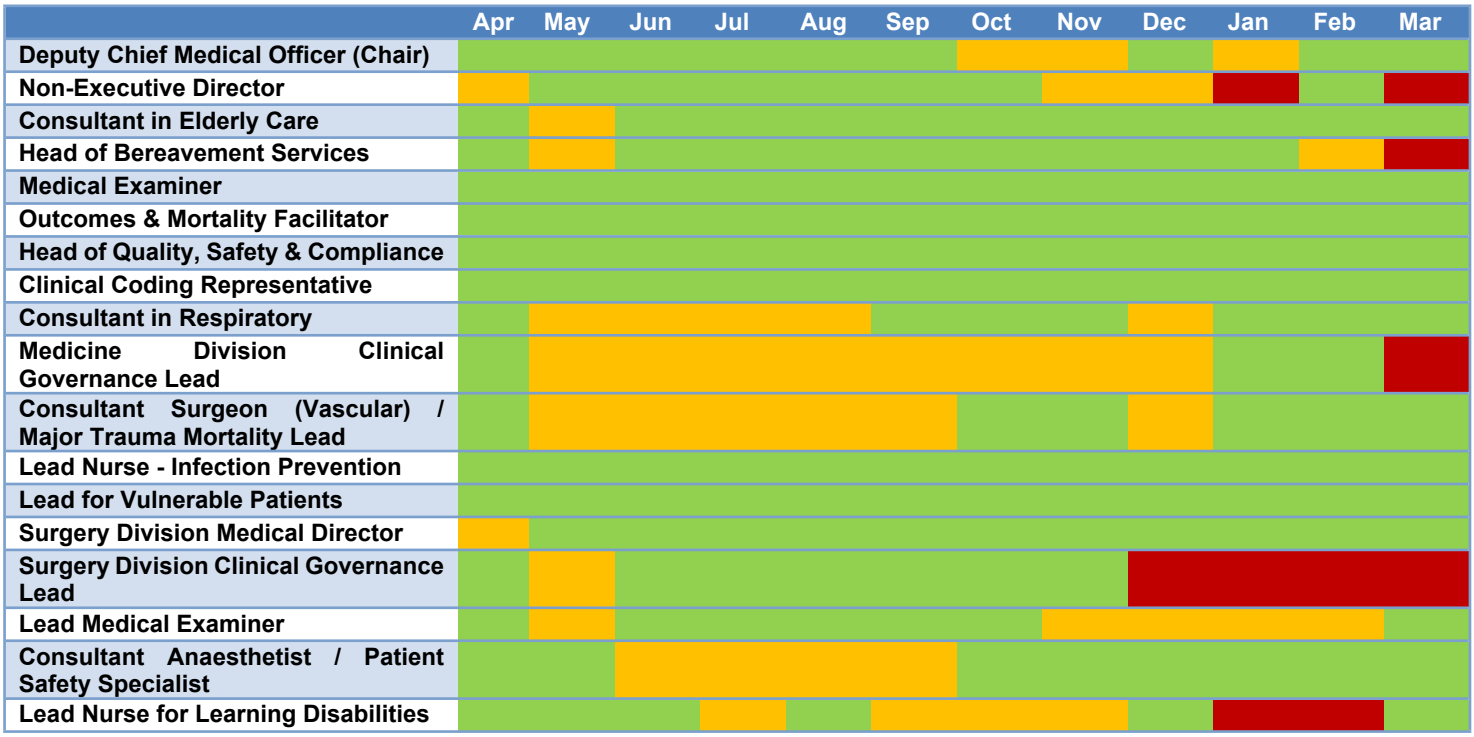
- Provide a summary of the work undertaken by the Mortality Review Group (MRG)
- Report against the Learning from Deaths (LFD) agenda
- Provide an update on University Hospitals of North Midlands Hospitals (UHNM) mortality indices.

2. Summary from the Mortality Review Group

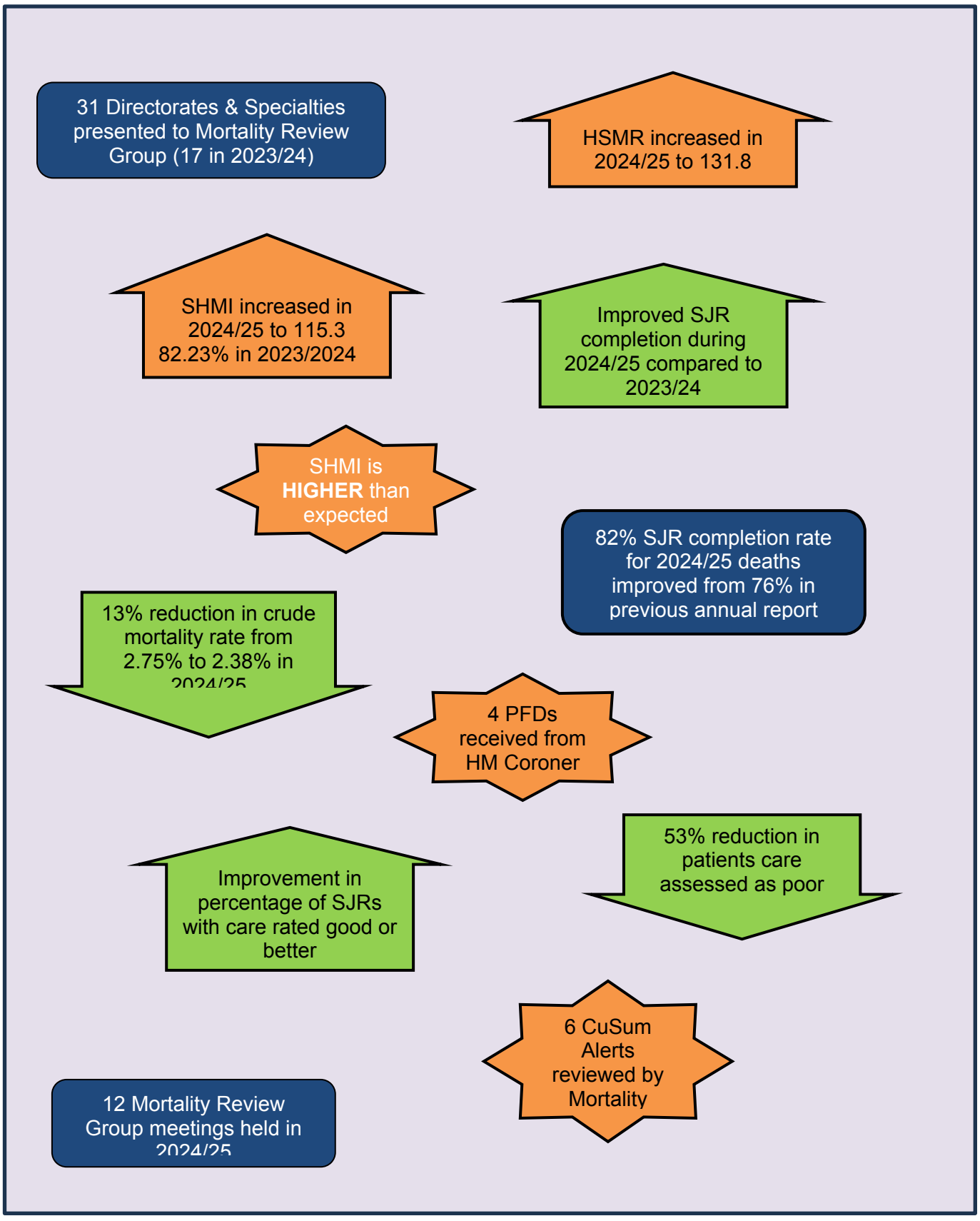
The Mortality Review Group (MRG) is chaired by the Deputy Chief Medical Officer (Quality and Safety) meets monthly and has a number of aims, outlined below:

- Be responsible for the identification and prioritisation of mortality and morbidity related work streams and associated projects. These will be informed by local and national intelligence.
- Oversee the implementation, monitoring and support of the trusts learning from deaths and mortality indices programmes of work.
- Ensure alignment between work streams to optimise learning and patient outcomes across UHNM including engagement with external stakeholders.
- Track risks relevant to mortality and escalate issues where projects and or clinical outcomes are off track.
- Enable sharing of information and lessons learned across the Trust and amongst external stakeholders.

The MRG maintains an action log which is reviewed at each meeting. The MRG has met as planned on monthly basis during 2024/2025. These meetings have been quorate and have included Non-Executive Director representation. Following from last year's report and identified action, the Trust Learning Disability Team are now included in required membership of the Mortality Review Group and have attended over 80% of the meetings during 2024/2025.



2024/2025 Mortality activity on a page



2.1 Directorate M&M Presentations & Assurance

During 2024/25 the following 31 Directorates have presented at the Mortality Review Group to provide updates on the 12 months of M&M meetings, outcomes of the meetings, issues identified, and actions taken. This is improvement in specialty/directorate presentation compared to 2023/2024 when there were 17 presentations. The improvement in the attendance by the M&M leads is noted for sharing key themes and learning:

- Oncology
- End of Life / Palliative Care
- Renal
- ENT
- Breast / Plastics
- Diabetes/Endocrinology
- Anaesthetics
- Child Health
- Emergency Medicine
- Haematology
- Stroke
- Orthodontics Plastic Surgery
- Gastroenterology / Liver
- Upper GI
- Cardiothoracic Surgery
- Urology
- Anaesthetics
- Breast Surgery
- Perinatal / Obstetrics & Gynaecology
- Interventional Radiology / Vascular Surgery
- Neurology
- Cardiology
- Elderly Medicine
- Femoral Fracture Patients (Fracture NOF)
- Intensive Care Unit
- Acute Medicine
- Major Trauma
- T&O / Spine
- Ophthalmology
- Stroke
- Oral and Maxillo-Facial

Positive Assurance

- Oncology M&M Process noted as robust with well-structured meetings, utilising benchmark data for SACT. Provided good evidence and assurance on follow up for any cases rated as poor care or issues identified.
- End of Life / Palliative Care noted as excellent overall mortality review compliance at 98% and SJR compliance for requested / triggered reviews at 100%.
- Renal and ENT Directorates noted good processes, mortality review activity and learning
- Clinical Coding noted that there have been improvements in Discharge Summaries a section re completion of Discharge summary to be included in the Discharge Checklist.
- UHNM Thrombolysis and Mechanical thrombectomy positive and higher than national average and target. Better outcomes post thrombectomy for return to independent living (UHNM 49.4% v 34.7% National). Post thrombectomy mortality better than national average (14.8% UHNM v 18% National)
- Good completion of mortality Reviews in Stroke Directorate and good attendance including Stroke School and wider participation and sharing of learning. 100% SJR completion
- NICU activity reduced during Q1 2024/25 compared to Q4 2023/24 and no serious incidents reported
- Noted positive completion of PMRTs in set timeframes and targets against CNST Safety action 1 for Quarter 1 2024/25 and maintained positive involvement of families involved in process.

- External reviewers included in PMRT review process and anonymized reports and learning shared at Regional Neonatal Network for learning sharing. Plus, national MBBRACE reports.
- Good outcomes for completed reviews in Haematology with 44 'A' Outcome and only 1 'C' outcome where ward staff unaware from Paramedics that DNAPR was in place at time of handover.
- Plastic Surgery noted that M&M meetings discuss complications and not just deaths along with excellent Consultant attendance.
- Cardiothoracic Surgery mortality is benchmarked nationally against peers utilising national database. Noted that UHNM Cardiothoracic surgery mortality outcomes are positive against peers
- Excellent PMRT processes in place and Maternity services are meeting all the CNST standards and timeframes for commencing and completing reviews.
- Neurology reported improvements in the M&M meetings but with aim to continue to widen participation.
- Urology demonstrated excellent completion rates for SJRs along with excellent outcomes of the reviewed cases.
- Interventional Radiology have good national benchmarking comparison for outcomes and treatment
- Anaesthetics reported excellent participation and engagement with all subspecialty leads, Clinical Director, Deputy Clinical Director, Pharmacy team, acute Pain Team and Governance Lead present at the meetings. In addition, there was good attendance from Consultants and Doctors in training.
- Anaesthetic M&M noted that there have been increasingly complex cases being undertaken at County Hospital due to patients suffering from significant co-morbidities. 2 cases reviewed and noted that outcome would have been the same at RSUH. The cases both demonstrated excellent engagement and explanation of procedures and risks/benefits with the patients and families.
- Upper GI service noted good attendance at the M&M meetings with regular attendance from senior nursing and senior pharmacist representatives. Noted good independence of reviews as all cases were allocated to consultants not involved in the care of the patients.
- Very good completion rates for Mortality reviews and SJRs. The learning from the SJRs and reviews are also shared at the Upper GI SAGE meeting to allow greater sharing of issues and learning.
- Upper GI service is engaged with national benchmarking of Oesophago-Gastric Cancers and the Trust's 30-day mortality was recorded at 1% compared to national average on 1.5%
- Obstetrics & Gynaecology participate in MBRRACE.
- Robust review processes in place for review of stillbirths which multidisciplinary and include external representatives from the Local Maternity & Neonatal System (LMNS).
- Neonatal deaths have joint multi-disciplinary meeting which also include LMNS representatives. Noted that the latest available UHNM standardised and adjusted still
- UHNM reported 100% compliance for data reporting and PMRT completion
- Noted that the stillbirth rate was around average for similar Trusts and Health Boards at 3.59 per 1000 total births
- Vascular Surgery / Interventional Radiology noted that via national benchmarking for Vascular Surgery (VSQIP) UHNM was not outlier compared to peers
- All cases utilise the standardised review process using CIRSE (Cardiovascular and Interventional Radiological Society of Europe) classification
- Good attendance at M&M meetings and different medical staff grades attend along with Clinical Nurse specialists with excellent 100% completion rate for requested SJRs in Vascular Surgery.
- Urology noted to have good process in place and attendance at M&M meetings with 100% requested SJRs completed with positive classifications of Excellent or Good overall care.
- Urology undertook audit (as part of action from last year) and identified that most mortalities related to frail elderly advanced cancer patients with terminal illness.
- Acute Medicine noted that there was a good review process in place and high numbers being completed. The completion of SJRs is being included in the job planning process within acute Medicine
- Oral & Maxillo-Facial Directorate have achieved 100% completion rate for mortality reviews and SJRs
- Perinatal Mortality Review Tool process has maintained 100% compliance with the CNST standards
- Cardiology noted improvement in M&M process and reducing backlog of outstanding mortality reviews and SJRs with very good multi-disciplinary team involvement at M&M meetings
- Excellent participation and completion of mortality reviews and SJRS within Elderly Medicine
- Elderly Medicine noted that there has been reduction in resuscitation attempts with improved Do Not Attempt CPR discussion being held and documented
- Ophthalmology noted as having M&M meetings in place and focus on morbidity with no deaths attributed to specialty during the past 12 months.

- Obstetrics & Gynaecology participate in MBRRACE.
- Robust review processes in place for review of stillbirths which multidisciplinary and include external representatives from the Local Maternity & Neonatal System (LMNS).
- Neonatal deaths continue to have joint multi-disciplinary meeting which also include LMNS representatives. Noted that the latest available UHNM standardised and adjusted still
- UHNM reported 100% compliance for data reporting and PMRT completion

2.2 Actions identified during 2024/2025:

- Oncology & Haematology are reviewing how can increase the participation and attendance of nursing staff at the Directorate M&M Meetings
- Oncology & Haematology are reviewing the use of using iPortal to record morbidity case for review (as per Urology)
- Critical Care are assessing pilot project for nurses to undertake/complete SJRs which will support the increased involvement and participation of nursing staff in the M&M processes.
- M&M Process A3 continued to progress and Medical Examiner process to be included as part of the review.
- Escalated the need to appoint new T&O clinical lead with T&O Clinical Director.
- To review feasibility with the Medical Examiner Service of uploading the QAP (plus other ME documents) to iPortal for access when completing mortality reviews and SJRs
- Child Health working with Medical Examiner and interface with Designated Doctors for Child Death
- Local & Regional thematic suicide deep dive underway with Child Health and Learning from Modifiable Factors training
- Support for Stroke Team with increased capacity when multiple emergency cases are being reviewed including 2nd Interventional Radiology Theatre – awaiting response from NHSE
- Plan to involve neuro anaesthetist and Interventional Radiologist in Stroke M&M Meeting
- Joint SOP for Mechanical Thrombectomy with Stroke and IR
- Stroke M&M Meeting to review comparison between UHNM Stroke mortality and 11 other Comprehensive Stroke Centres along with timeframes from transferring between referrer and Stroke Centres.
- Neurology is working towards improved engagement and participation with medical colleagues and having wider junior medical staff attendance. Neurology M&M Lead has requested support from the Clinical Director for support in engaging with all medical colleagues across Neurology Directorate.
- Urology noted that they had made improvements, following reviews of SJRs and mortality cases in the M&M meetings, in relation to improving the quality of life and earlier engagement with the Palliative Care team and discussions/engagement of the families.
- Interventional Radiology are undertaking new plans to have dedicated / protected time for their M&M Meetings and are undertaking an audit of outcomes for Interventional Radiology procedures which have been included in their local clinical audit / clinical effectiveness programme. These audits will be reported and actioned at the Directorate and Divisional Clinical Effectiveness Meetings
- Liver M&M taking forward the British Association for the Study of the Liver (BASL) Care Bundle which supports timely sepsis screening and antibiotics, timely and careful use of Terlipressin and management and scoping of GI bleed out of hours and variceal banding. The BASL Care Bundle to be shared with Emergency Portals to support management of patients.
- Planning to combine the Liver and Gastroenterology M&M meetings to share learning and promote closer working relationships.
- Liver & Gastroenterology to improve the completion of mortality reviews and SJRs now that the new M&M processes had been implemented with regular meetings, good MDT involvement and recording of activity and outcomes utilising iPortal and CareFlow
- Obstetrics & gynaecology to embed the AID (Advice, Informing, Do) escalation tool
- Urology aim now is to focus on the quality of life; for example, avoiding treatment which had more risks than benefits (like replacing nephrostomies), early involvement of the Palliative Care Team, early documentation of the ReSPECT (Recommended Summary Plan for Emergency Care and Treatment)/DNAR (Do not attempt resuscitation) form and early discussion with the family regarding decisions and indications for active treatment.
- Reviewing the national guidance regarding the management of pneumothorax and pulmonary embolism within Acute Medicine
- Acute Medicine are to undertake audit regarding consideration of anticoagulation in new onset atrial fibrillation at the point of contact. To be presented and Divisional Governance and RMP

- Cause of death discussions to be included in junior doctors' information.
- Establishing 24/7 Major Trauma Coordination with system of major trauma coordinators to provide seamless patient care
- Cardiology new Mortality & Governance Lead to develop formal tracker for outstanding mortality reviews and SJRs
- Electronic ReSPECT (Recommended Summary Plan for Emergency Care and Treatment)/DNAR (Do not attempt resuscitation) documentation to be rolled out and reduce the risk of omissions of information and discussions with patients and families.

2.3 Actions taken, changes made and implemented during 2024/2025

- Renal Services developed a Standard Operating Procedure (SOP)/Pathway for patients with large intradialytic weight gain and further education was to be given to Haemodialysis Nurses
- Following review of a case where a patient was prescribed the wrong dose of Daltepartin as worsening renal function was not taken into consideration, has led to a Trust Learning Alert regarding the need to adjust the dose of Dalteparin in patient with reduced renal function, especially when re-reviewing the dose if a patient is developing an acute Kidney injury (AKI), was developed.
- Following the identification of issues with dislodgement or accidental decannulation of adjustable portex tubes with ENT, new fixed tubes are being used to avoid this.
- Adjustable flange tracheostomy tube nursing checklists have been introduced during the past 12 months to reduce the risk of dislodged tubes. Since the introduction, it was noted that there have been no safety issues reported
- The use of iPortal and death verification prompt has been implemented via Bereavement Services and is now in use. This will support clinicians in completing M&M reviews
- Learning from deaths themes being shared with Junor Doctor Training lead to help promote learning and raise awareness of issues identified via the M&M reviews.
- Where cases/reviews note poor care, agreed that the relevant M&M leads are to be invited to attend the Mortality review Group to present the case, and the learning / actions identified to provide assurance that actions are taken.
- Emergency Medicine introduced changes to PACMAN worklist to allow prompt monitoring and facilitate case selection for M&M Meetings
- Emergency Medicine have provided further training and awareness for staff when patients present with cellulitis and sepsis features that necrotising fasciitis is considered
- Confusion in the elderly patients are often normalised, and that new confusion is to be considered and treated/assessed with same urgency as for young patients and treat appropriately with CT and/or sepsis screening.
- Patients presenting with knee dislocation / limb threatening injury are now undergoing immediate assessment and reduction ASAP within ED.
- Following previously raised action the QAP is available has been agreed and introduced on iPortal via Bereavement Services.
- Learning from deaths themes are shared with Junor Doctor Training lead to help promote learning and raise awareness of issues identified via the M&M reviews.
- Clinical Coding have recruited 4 new clinical coders and are undertaking training programme. The recruitment will improve the coding position, and this has been escalated and noted with Executives.
- There are now fewer missing discharge letters available to Clinical Coding following new processes introduced that allow sharing of discharge letters with clinical coding at the time of coding the admission/activity.
- Plastic Surgery now include the presentation of national audits at M&M meetings and had presented latest national audit results relating to open fractures compared to the British Orthopaedic Association for Trauma and Orthopaedics (BOASts). This highlighted learning points and as result a new Group Job Planning Meeting has been established to take forward the learning and improvements.
- Following previous Liver M&M presentation at Mortality Review Group, the iPortal Mortality list and chronic liver database on CareFlow have been implemented. The Clinical Nurse Specialists are now leading the Non-alcoholic fatty liver disease (NAFLD) service set up
- 2 new Liver Clinical Nurse Specialists have been appointed to support Hepatocellular carcinoma (HCC) screening
- Endocrinology/Diabetes introduced new review management process with administrative support for the collation of notes as noted in previous annual report.
- Establishment of new interventional case review meeting to advise on mortality and morbidity cases

- Inter-Hospital Transfer (IHT) Standard Operating Procedure for Transcatheter Aortic Valve Implantation (TAVI) patients has been updated and implemented
- There has been roll out of use of intravenous bisphosphonate in line with National Hip Fracture Database requirement.
- A second hip Surgeon commenced in role during October 2024, while a fourth Ortho-Geriatrician started in September and a fifth during Jan 2025

3. Mortality Indicators

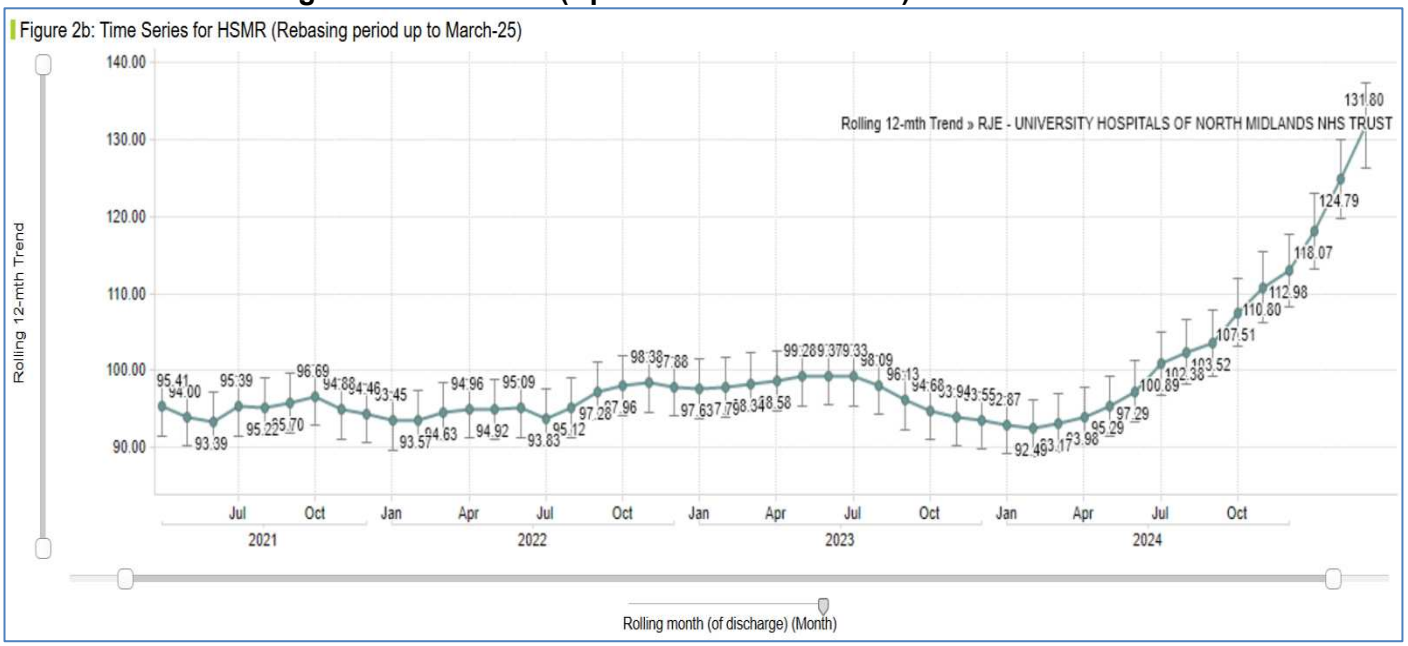
The Trust uses two national benchmarks as primary indicators for mortality, Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Index (SHMI). The table below shows the Trust's current HSMR and SHMI along with national and peer group comparison.

Indicator	Current	Previous	Change	Peer	National
Crude mortality rate (12 mth rolling) - HES Inpatients and HES-ONS Linked Mortality Datasets (May 2025)	2.38% (Apr 2024 - Mar 2025)	2.75% (Apr 2023 - Mar 2025)	-0.37	2.29%	2.26%
HSMR (12 mth rolling) - HES Inpatients (May 2025)	131.80 (Apr 2024 - Mar 2025)	92.79 (Apr 2023 – Mar 2024)	39.01	99.51	99.98

Indicator	Current	Previous	Change	Peer	National
SHMI (12 mth rolling) - HES Inpatients, HES-ONS Linked Mortality Datasets (May 2025)	115.30 (Mar 2024 - Feb 2025)	98.93 (Mar 2023 – Feb 2024)	16.37	101.02	101.03

The most current available 12-month HSMR (April 2024 – March 2025) is 131.80 and is higher than the expected range.

Chart 1: UHNM Rolling 12-month HSMR (April 2021 – March 2025)



The above chart shows the longer-term trend for HSMR. Our HSMR has remained within expected limits until the August 2024 data point. Values since then have been in the higher-than-expected range.

The current HSMR value is now higher than the SHMI value with both on increasing trend. The 12-month rolling HSMR is higher than expected and 12-month rolling SHMI is on the upper limit of expected range. *There is a one-month lag between SHMI and HSMR values.*

The Trust has observed an increase in mortality rates (HSMR and SHMI), which upon review, is likely attributed to issues with clinical coding and the impact these appear to be having on the mortality indices. Specifically, not all patient records were fully coded, leading to a backlog. Consequently, while all in hospital deaths were fully coded, the coding for other patient activities was not consistently accurate. Thus, while all patients dying from a given diagnosis were coded, all patients admitted with the same diagnosis were not necessarily coded, meaning the percentage deaths from a given cause may not be accurate. Additionally, there was an increase in episodes categorised under "U codes," impacting the accuracy of mortality risk and standardization calculations. To address these issues, efforts are underway to enhance coding accuracy with the assistance of Executive Directors and colleagues from the Integrated Care Board (ICB).

The Mortality Review Group has noted that currently there is no assurance in the HSMR / SHMI due to the issues with backlog of clinical coding and it was acknowledged that this will continue to number of months until the clinical coding team can start to update the coding activity and these updates are then refreshed in the national dataset utilised by HED and SHMI.

- Have not seen changes in outcomes of the completed mortality reviews / SJRs highlighting ant concerns in practice linked to the period of increased HSMR
- This increase in unknown/unspecified causes of mortality in HED coincided with Clinical Coding staff absences which resulted in increases of U codes (uncoded episodes). These U codes at UHNM are likely pulled into R69 code within HED system
- Clinical Coding are developing a proposal for options in addressing the risk and potential improvements in reducing the uncoded episodes are expected to be seen in coming months.
- Additional internal mortality reporting is being developed to allow for further assurances to be provided regarding UHNM mortality reporting whilst there remain issues with HSMR and SHMI values. These new reporting indicators will be available from June 2025.

Chart 2: HSMR (All Acute Trusts) Funnel Plot (April 2024 – March 2025)

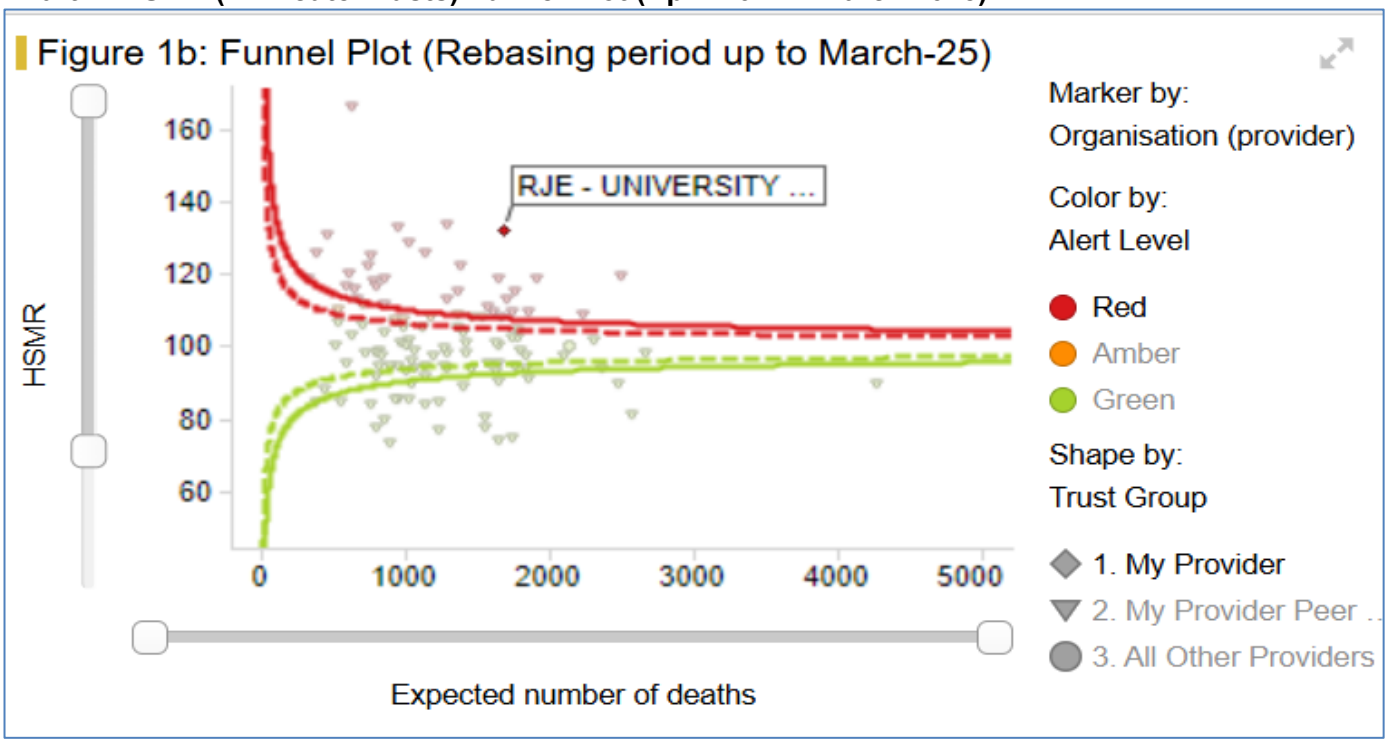


Chart 2 illustrates where UHNM is for current 12-month HSMR in comparison to all other Acute Trusts in England as well as Peer Group. UHNM is currently statistically significantly higher than the expected range.

Chart 3: SHMI Rolling 12-month trend (December 2022 – February 2025)

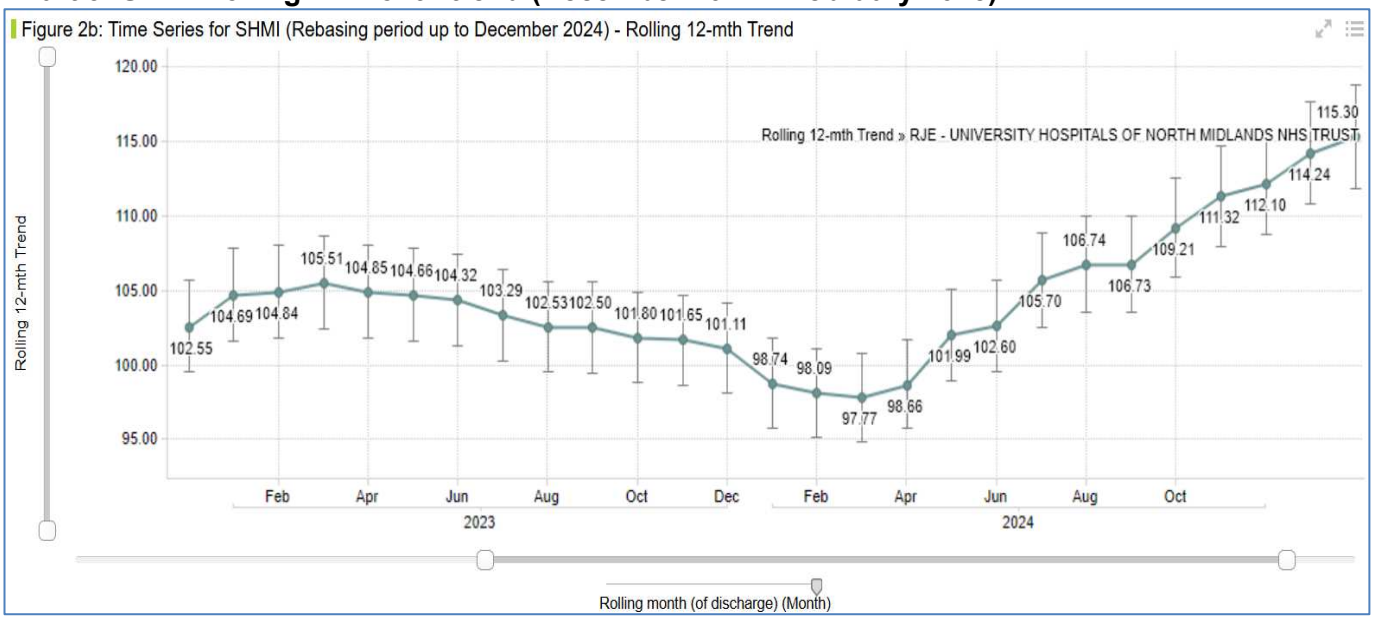


Chart 3 illustrates the monthly SHMI figures calculated using HED system (HES Data).

The Trust's 12-month rolling SHMI has shown improvements throughout the past 12 months and is just within the expected range with a current 12-month rolling SHMI of 115.30.

Chart 4: SHMI Funnel Plot (March 2024 to February 2025) (over dispersed model)

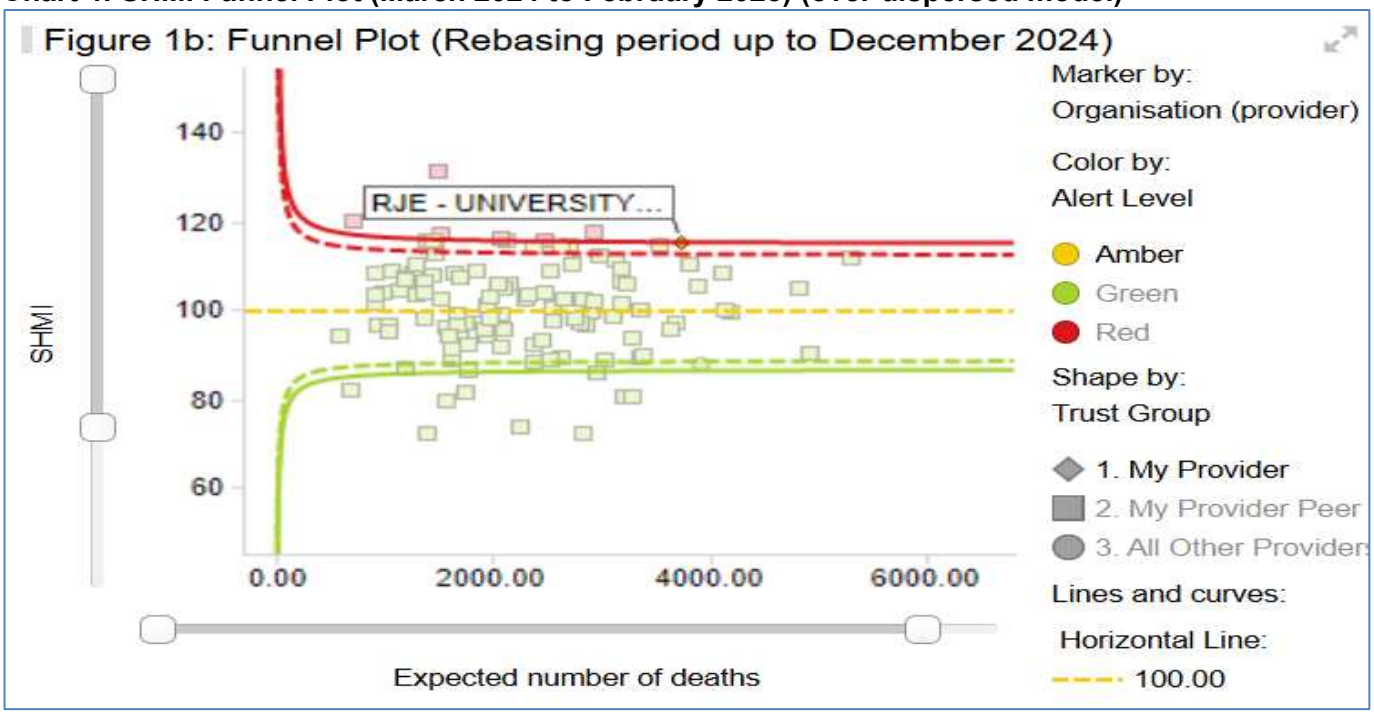
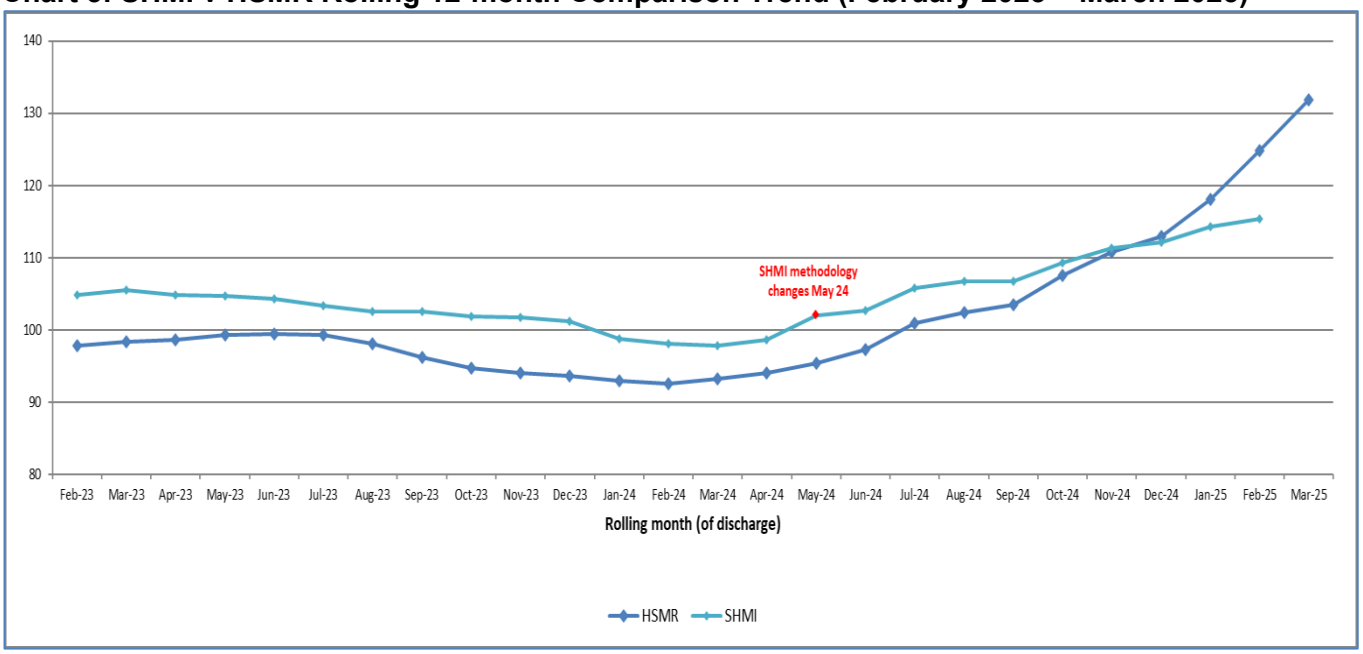


Chart 4 shows that UHNM is on the 95% upper control limit for expected mortality.

When using HES data within HED system to review the SHMI figures there continues to be an increase in the rolling 12-month trend (Chart 3).

Chart 5: SHMI v HSMR Rolling 12-month Comparison Trend (February 2023 – March 2025)



Both values generally correlate, though they have been converging since June 2024. The latest figures have seen SHMI now below HSMR and this is following the reported issues with clinical coding for hospital admissions since May 2024.

The national SHMI figures that are published by NHS show UHNM to on the upper limit of the expected range (see Chart 4 Funnel Plot).

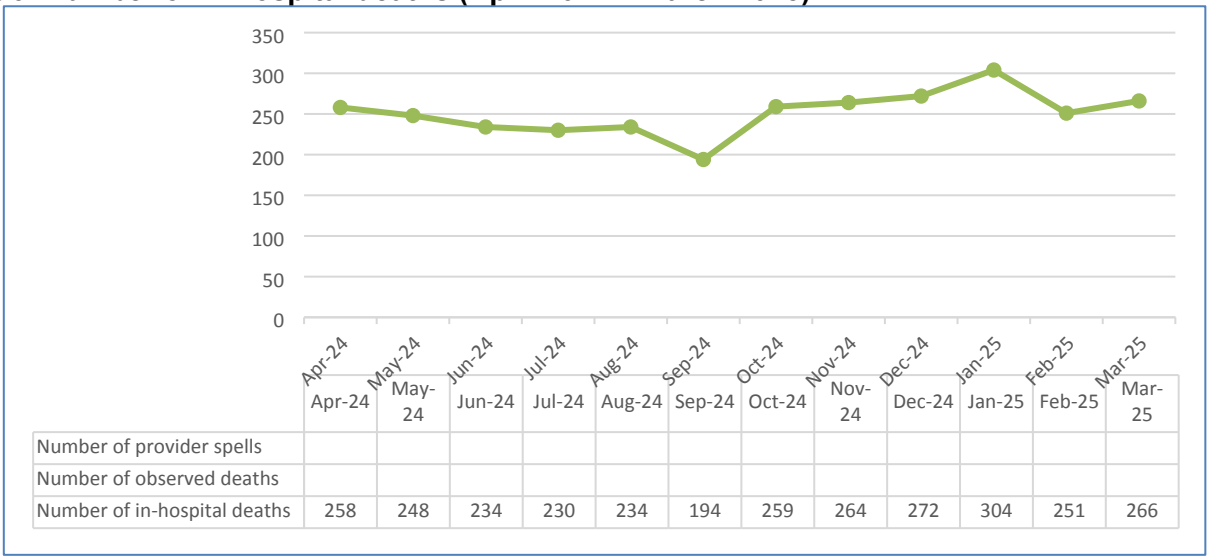
Chart 5 shows the latest monthly data reported that SHMI and HSMR moved closer together up to July 23. The two then began to converge from July 2024 with HSMR overlapping SHMI for the first time in November 2024 following the identification of the issue re clinical coding activity and not all patients being fully coded. This will continue to be monitored and evaluated at Mortality review Group using HED analysis of different diagnostic groups.

4. Crude Mortality

Indicator	Current	Previous	Change	Peer	National
Crude mortality rate (12 mth rolling) - HES Inpatients and HES-ONS Linked Mortality Datasets (May 2025)	2.38% (Apr 2024 - Mar 2025)	2.75% (Apr 2023 - Mar 2025)	-0.37	2.29%	2.26%

Overall, there has been 13.4% reduction in the crude mortality rates from last year to this year. The reducing crude mortality rates noted provide some assurance that there are not increases in actual raw numbers of deaths within UHNM.

Chart 6: Number of in-hospital deaths (April 2024 – March 2025)



	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Number of provider spells												
Number of observed deaths												
Number of in-hospital deaths	258	248	234	230	234	194	259	264	272	304	251	266

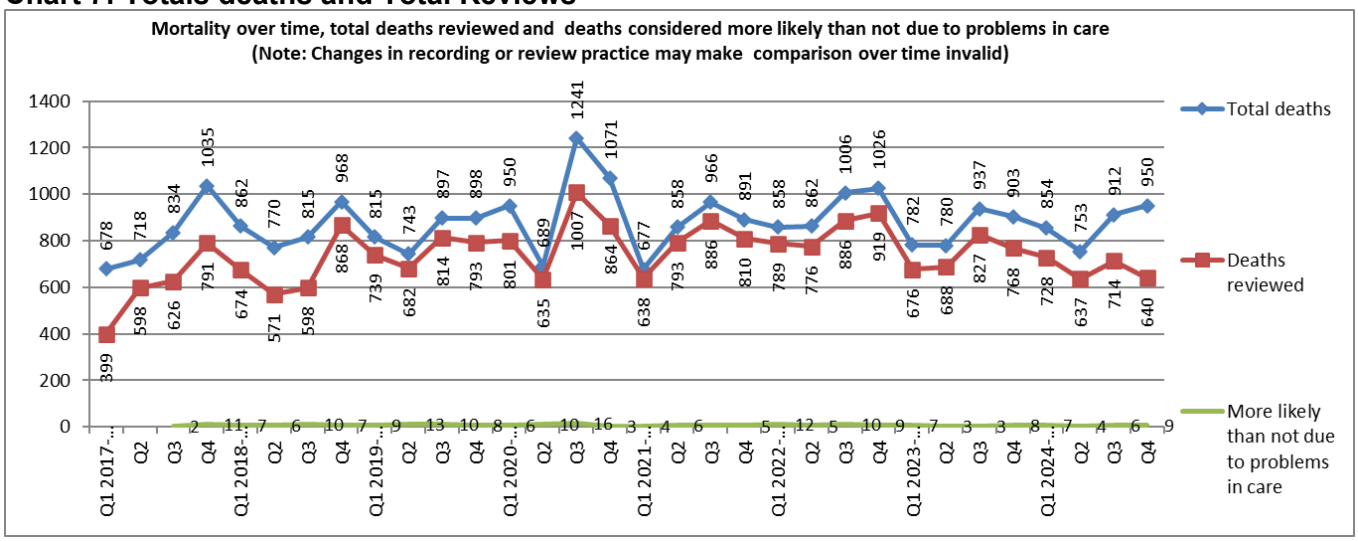
5. Total number of Deaths and Mortality Reviews

In 2024/2025 there have been 3469 (3402) inpatient deaths identified compared to 3402 during 2023/2024

Currently 2719 (78% compared to previous year report 67%) of these deaths have been reviewed and 26 have been assessed with a classification of poor or very poor care in subsequent SJR, compared to 14 in previous reporting years.

Total Number of Deaths, Deaths Reviewed and Deaths Deemed more likely than not due to problems in care (does not include patients with identified learning disabilities)					
Total Number of Deaths in Scope		Total Deaths Reviewed		Total Number of deaths considered more likely than not due to problems in care SJR Classification of 1 & 2	
This Month	Last Month	This Month	Last Month	This Month	Last Month
303	285	154	210	2	3
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
950	912	640	714	9	6
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
3469	3402	2719	2959	26	21

Chart 7: Totals deaths and Total Reviews



There is a built-in time lag for completion of the mortality reviews and SJRs as the deaths from a month are not circulated to the M&M Leads until c.12th of the following month i.e. May 2025 deaths are not circulated to the relevant Directorate until June 2025. There is then further time required to complete the review and discuss at M&M meetings.

6. Learning Disability Patient Deaths and Reviews

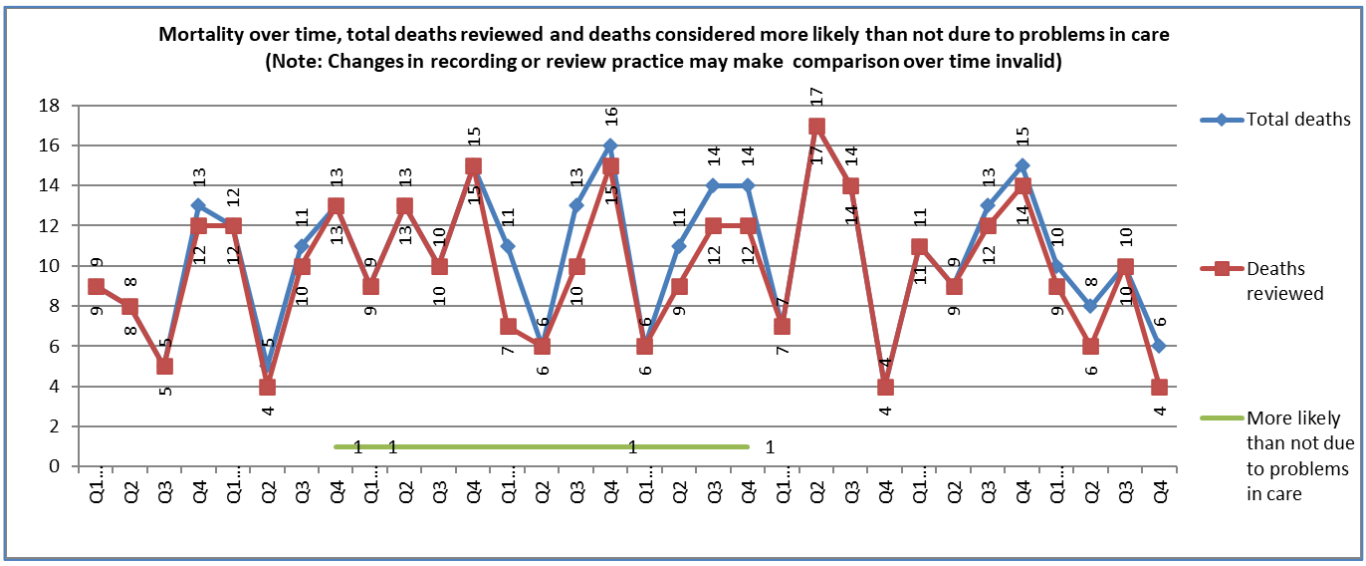
One of the main drivers nationally for the introduction of changes in the way deaths are identified and reviewed, including the Structured Judgement Casenote Review (SJCR) process was as a result of concerns of a patient who died with a LD under Southern Health FT in 2013. Research has shown that, on average, people with a learning disability die earlier than the general public and do not receive the same quality of care as people without a learning disability.

All Learning Disability (including autism) deaths are reviewed through the National Learning Disabilities Mortality (LeDeR) review process. All UHNM LD deaths are reported to the LeDeR Programme by the Adult LD Nurse Specialists. The oversight regionally of the LeDeR reviews has been through the Clinical Commissioning Group [CCG] but this is now under the Integrated Care Board.

Total Number of Deaths, Deaths Reviewed and Deaths Deemed more likely than not due to problems in care for patients with identified learning disabilities

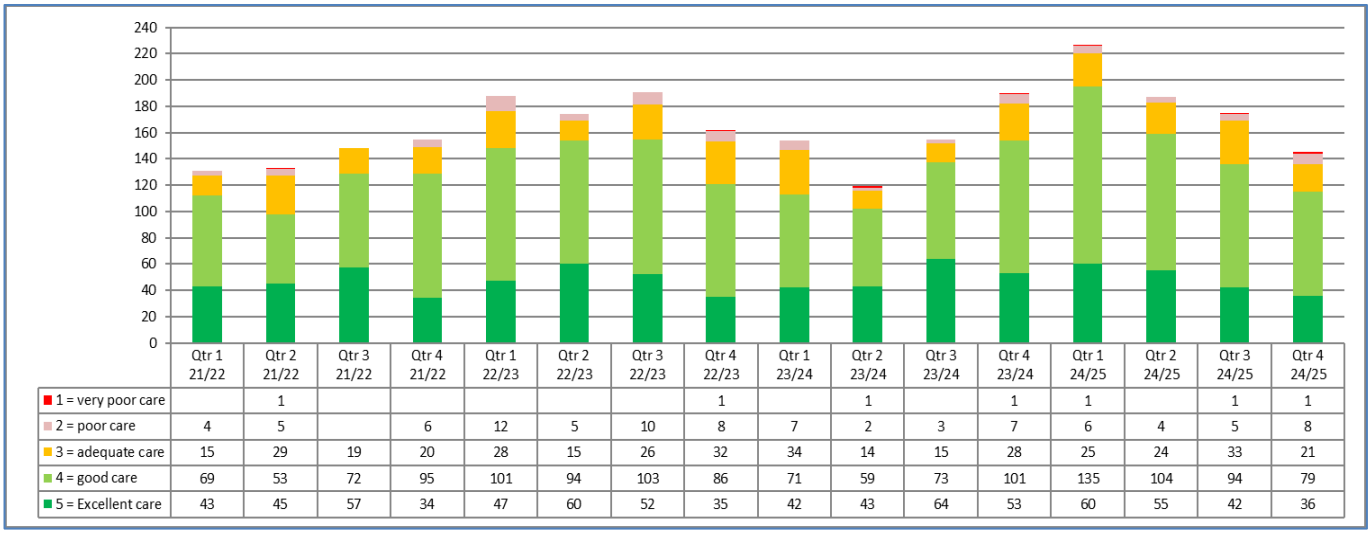
Total Number of Deaths in scope		Total Deaths Reviewed Through the LeDeR Methodology (or equivalent)		Total Number of deaths considered more likely than not due to problems in care	
This Month	Last Month	This Month	Last Month	This Month	Last Month
3	1	2	1	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
6	10	4	10	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
34	48	29	46	0	0

In this year we have seen 34 inpatients identified within the scope of Learning Disability & Autism reviews (compared to 48 in previous year). Twenty-nine of these have been reviewed. There have been 0 cases identifying poor or very poor care in a subsequent SJR during 2024/2025.

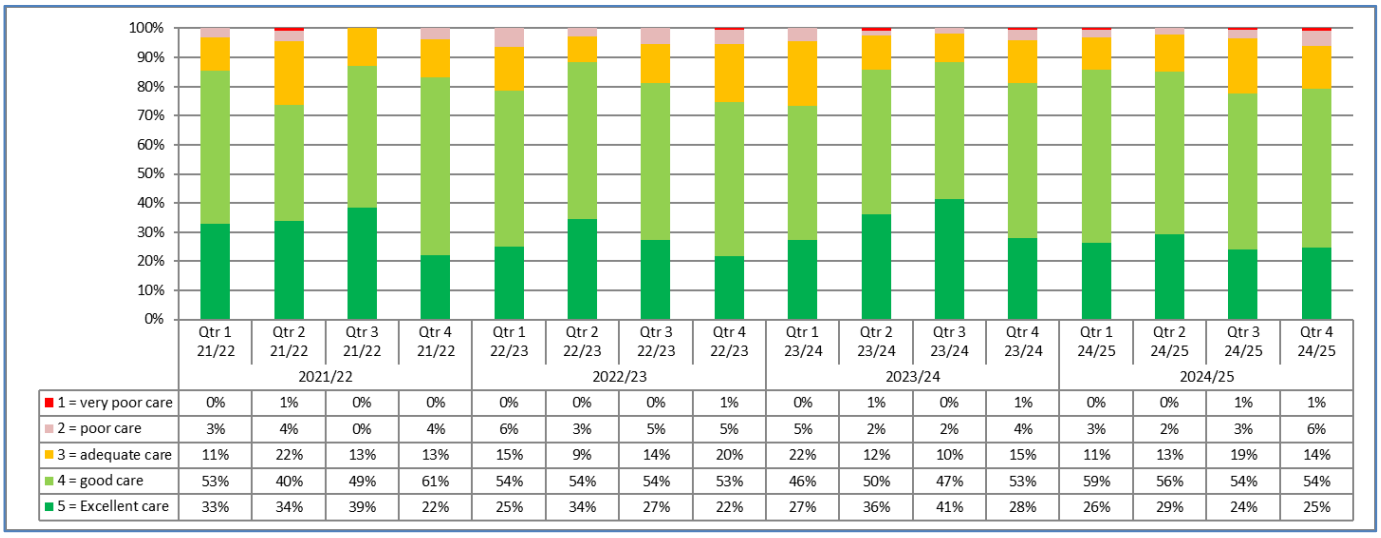


7. SJR ratings / outcomes

There were 734 SJRs completed relating to deaths occurring during 2024/25 (as at 12/06/2025) compared to 618 in previous year. The outcomes from these SJRs show that there are 82.4% rated as good care or better and there are 3.5% rated as poor or very poor care. This compares with 81.8% rated as good care or better and 3.4% rated as poor or very poor care during 2023/2024.



	Qtr 1 21/22	Qtr 2 21/22	Qtr 3 21/22	Qtr 4 21/22	Qtr 1 22/23	Qtr 2 22/23	Qtr 3 22/23	Qtr 4 22/23	Qtr 1 23/24	Qtr 2 23/24	Qtr 3 23/24	Qtr 4 23/24	Qtr 1 24/25	Qtr 2 24/25	Qtr 3 24/25	Qtr 4 24/25
1 = very poor care		1						1		1		1	1		1	1
2 = poor care	4	5		6	12	5	10	8	7	2	3	7	6	4	5	8
3 = adequate care	15	29	19	20	28	15	26	32	34	14	15	28	25	24	33	21
4 = good care	69	53	72	95	101	94	103	86	71	59	73	101	135	104	94	79
5 = Excellent care	43	45	57	34	47	60	52	35	42	43	64	53	60	55	42	36



	Qtr 1 21/22	Qtr 2 21/22	Qtr 3 21/22	Qtr 4 21/22	Qtr 1 22/23	Qtr 2 22/23	Qtr 3 22/23	Qtr 4 22/23	Qtr 1 23/24	Qtr 2 23/24	Qtr 3 23/24	Qtr 4 23/24	Qtr 1 24/25	Qtr 2 24/25	Qtr 3 24/25	Qtr 4 24/25
	2021/22				2022/23				2023/24				2024/25			
1 = very poor care	0%	1%	0%	0%	0%	0%	0%	1%	0%	1%	0%	1%	0%	0%	1%	1%
2 = poor care	3%	4%	0%	4%	6%	3%	5%	5%	5%	2%	2%	4%	3%	2%	3%	6%
3 = adequate care	11%	22%	13%	13%	15%	9%	14%	20%	22%	12%	10%	15%	11%	13%	19%	14%
4 = good care	53%	40%	49%	61%	54%	54%	54%	53%	46%	50%	47%	53%	59%	56%	54%	54%
5 = Excellent care	33%	34%	39%	22%	25%	34%	27%	22%	27%	36%	41%	28%	26%	29%	24%	25%

Overall Score	#	%
5 = Excellent care	193	26.4%
4 = good care	412	56.1%
3 = adequate care	103	14.0%
2 = poor care	23	3.1%
1 = very poor care	3	0.4%
Grand Total	**734**	

8. Themes, issues and learning from SJRs

The following themes/issues have been identified during the completion of SJRs in 2024/25:

- Importance of timeliness and regularity of clinical reviews
- Importance of following established screening protocols e.g. for sepsis
- Importance of ordering and following up on appropriate investigative tests in timely way
- Importance of reviewing test results in timely way to facilitate diagnosis/decision making and to consider alternative causes of patient's illness
- Patients should be cared for on appropriate wards based on their clinical needs e.g. stroke patients
- Appropriateness of transfers should be considered
- Importance of timely referrals to other specialties where indicated
- Medications should prescribed and administered in timely fashion (especially antibiotics/anticoags/IV fluids) and adhere to guidelines on dosage and suitability, especially as part of Sepsis pathway
- Need to ensure key documentation is completed in timely, legible and accurate way and stored correctly to facilitate access
- There should be good communication as required between specialties e.g. when patients deteriorate, or specialist advice would be beneficial to inform care
- Ensure discussion re DNAR and ceilings of care are held with patients and family members at early opportunity
- Ensure patient wishes regarding communication with relatives are adhered to
- Ensure to keep patients and relatives informed of transfer processes e.g. Your Next Patient and make sure contact numbers for relatives are up to date
- Ensure escalation processes are adhered to when patient observations/NEWS scores indicate this is required
- Ensure relevant pathways are referred to and implemented in timely way e.g. Palliative Care/End of Life
- Ensure requested treatments are carried out when indicated and are within recommended guidelines e.g. administration of fluids
- Consideration of comorbidities and number of recent admissions when deciding upon appropriateness of treatment options and ceilings of care

Issues identified from the SJRs rated as poor care are:

- Importance of timely clinical reviews
- Importance of accurate patient assessments
- Importance of following screening protocols i.e. for Sepsis
- Importance of timely administration of medications, especially antibiotics
- Importance of timely and legible documentation of care
- Importance of keeping relatives informed of transfer processes

9. Perinatal Mortality Review Tool Updates

Mortality Review Group received quarterly updates on perinatal mortality under the CNST Maternity Incentive Scheme Framework (year 6).

The update during Quarter 4 noted that following on from the MBRRACE-UK conference presenting the Perinatal Reports 2024, it was highlighted how language and interpreting services are key within their recommendations in supporting vulnerabilities in non-English speaking and migrant women. Identifying where multiple barriers to accessing care can be highlighted. UHNM reports now highlights all ethnicities, first language spoken and social deprivation score.

The Mortality Review Group also received update report on the Trust's process and reported outcomes for completed Perinatal Mortality Review Tool and that UHNM recorded compliance with all 6 elements of the Saving Babies Lives Care Bundle (SBLCB) and 100% compliance against the CNST Safety actions regarding Trust processes:

- Notifying all deaths
- Seek parents views of care
- Review the death and complete the review
- Report to the Trust Executive

The report provided updates on learning and actions taken from the completed reviews. There was also assurance provided on the actions taken following the receipt of recommendations by MNSI reviews.

Learning Identified	Action taken in response
The preterm birth labour risk assessment was not completed appropriately	• Raise awareness of history of cervical treatment • and indicators for referral to pre term birth clinic
There is an indication to offer face to face assessment when a mother contacts MAU with any concerns and there is a language barrier as there can be an uncertainty of the history and understanding of the advice given	• Practice change since December 2023 that all non-English speaking women should be invited to attend the hospital if they contact the helpline with any concerns or suspected labour. • Memo recirculated regarding the change of practice for all non-English speaking women to invited to attend the hospital if any concerns or suspected labour. • Change of practice re-iterated at MAU and MBC safety huddles.
This mother's risk status was not formally assessed at the start of her care in labour to ensure that her intended place of care in labour was appropriate	• Prompt aid devised for use within the multidisciplinary office. • Ongoing audit into compliance of completing the risk assessment at the start of labour. • Review findings to be shared through skills drills • training. • Review findings to be shared through PMRT learning on skills drills training. • Review findings to be shared with all midwifery staff via ward managers and safety huddles. • An enlarged version of RAG Table - Risk Factors Influencing Place of Birth and Method of Surveillance within the Delivery Suite for easier reading and reminder to staff.
Breach in triage times of midwifery and medical reviews MAU Triage process must be completed in its entirety following the ASQUAM Guideline BSOTS Telephone Triage and Maternity Assessment Unit	• Escalation needs to be considered during times of high activity and breaching in medical review. • Implementation of BSOTS training. • Quarterly audit of MAU triage breaches.
The mother had poor/no English and family members were used as interpreters on occasions during her antenatal care, labour and birth	• An interpreter on wheels via Language Line Solutions has been recently purchased and available within maternity and neonatal services. • Email to all managers to share information with teams via safety huddles and handovers to raise awareness of availability to facilitate either video or telephone interpretation services. • Audit to highlight areas within maternity services that require improvement in the use of recognised translating services. • Explore options to enable improved access to interpreter services within the antenatal clinic department.

- Following PMRT reviews of all cases, themes have been identified that relate directly to the Saving Babies Lives Care Bundle (SBLCB) version 3.
- Compliance with all six elements of SBLCB are monitored and presented separately in the Saving Babies Lives Care Bundle, (SBLCB) report.
- Compliance with the implementation of PERIprem at UHNM in July 2024 will be monitored within our reviews and will be reported in future reports.

10. Quarterly Neonatal Mortality Report Updates

The Quarterly Neonatal Mortality Reports were presented. Key comparisons were made with other Level 3 Neonatal Intensive Care Units (NICUs) in the West Midlands, revealing that although admissions at lower gestations were slightly fewer, the mortality rate remained lower.

Mortality Statistics:

The reports highlighted the overall mortality indicators for Neonatal mortality and also outlined the case reviews undertaken and any learning/outcomes.

It was noted that UHNM had fewer deaths by gestation and birth weight in comparison to other Level 3 NICU in the network, however at the start of 2024/2025 there was also lower activity. During the year the neonatal mortality rate per 1000 births has reduced whilst the average ITU Days activity has increased.

	No. of live births <24 weeks	No. of deaths	Neonatal mortality rate	Average ITU Days
Quarter 1	1512	2	2.0	93
Quarter 2		3	2.6	113
Quarter 3	1476	3	1.36	155

- Overall, a lower death rate was maintained despite extended ITU stays.

Key actions noted:

- Maternal Health: ongoing review concerning maternal diabetes following a neonatal death.
- Admissions Fluctuation: attributed the fluctuation in admissions to demographic factors and cot capacity availability at the Trust.
- Trust to continue to complete the Perinatal Mortality Review Tool (PMRT) for thorough analysis.
- Monitor ITU admission rates to ensure alignment with recommended intensive care practices.
- Present findings and further discussions to LMNS Quality & Safety Oversight Group for continued learning and improvement.

11. Emergency Department 12 hours+ Mortality Reviews

During 2024/2025 the Mortality Review Group received summary reports regarding completion of SJRs for patients that died following 12 hours or longer in the Emergency Department during their final hospital admission. The report related to deaths from 1st February 2024 to 28th February 2025. At the culmination of 2024/2025, there had been 455 SJRs completed for patients who had spent >12 hours in ED. 300 SJRs had been completed which had been requested specifically for that reason.

The report provided information against different phases of care, problems in care and learning identified. The phases of care are classified as:

- Admission and Initial Management
- Ongoing Care
- Care during a procedure (if applicable)
- Perioperative care (if applicable)
- End of Life Care
- Overall Assessment

The majority of cases with regards to Admissions and Initial Management were rated as good or excellent care (77%). Two cases since the previous report were rated as very poor care and nine rated as poor care. These related to issues such as delays in administration of antibiotics, lack of sepsis screening, issues with clinical reviews e.g. timeliness and coordination, failure to recognise patient symptoms and delay in realising a patient's DNAR was in place.

With regards to Ongoing Care the majority of cases were rated as good or excellent care (86%). No cases were rated as poor or very poor care in the 'Care During a Procedure' section since the previous report.

No cases were rated as poor or very poor care in the 'Perioperative Care' or 'End of Life Care' since the previous report. 89% of the SJRs completed rated End of Life Care as good or excellent. Three cases rated as poor care since the previous report relating to delayed referrals to Palliative Care team.

Seven cases rated 'Overall Care' as poor since the previous report. This relates to issues identified in phases of care above. 85% of the SJRs completed rated Overall Care as good care or above.

No SJRs stated that the long stay/delay in ED contributed to the outcome for the patient.

Learning identified from SJRs completed since the previous report was as follows:

- Need prompt recognition of patient being end of life and timely referrals to palliative care
- Importance of recognition of Sepsis and completion of Sepsis pathway where indicated
- Importance of prompt completion of Respect forms
- Importance of good communication with relatives around end-of-life care, treatment options and ensuring bad news is delivered in sensitive manner
- Ensure patient confidentiality is respected e.g. checking wishes around speaking with relatives
- Medications should be administered in timely manner especially antibiotics and pain medication and prescribed according to guidelines
- Implementation of Covid care plans for patients where indicated
- Accurate completion of food charts
- Importance of liaising with LD nurses where patient has LD
- Implementation of ceilings of care and recognition of where treatment will offer little or no benefit to the patient
- Ensure decision making evolves if clinical condition of patient deteriorates

Subsequently agreed, with the ICB, that the requirement to undertake these additional SJRs has been stopped. The learning and assurance provided from the reviews has allowed the review of the cases to be undertaken as part of 'Business as Usual' and included as part of the standard SJR process.

12. CuSum Alerts during 2024/25

The purpose of this section is to collate the various mortality performance indicators within the HED system for particular diagnosis groups (where a CCS diagnosis group has been identified as having a CuSum score>=3), together with the Mortality Review/SJR results for the relevant cohort of patients in that group. Analysis is done on groups where the number of observed deaths is >=10. The value for CQC CuSum alert triggers is 5.48.

A Red/Amber/Green rating is then applied based on the scoring algorithm previously agreed by the Mortality Review Group. The analysis allows any areas of concern to be highlighted and assists the Mortality Review Group to determine if any further review is required. Information is collated from the following (*see attached Glossary for a description of the HED indicators*):

- Hospital Standardised Mortality Ratio (HSMR) – HED system
- Summary Hospital-level Mortality Indicator (SHMI) – HED system
- VLAD (Visually Life Adjusted Display) – HED system
- CuSum(Cumulative Sum) – HED system
- Mortality Review Scores for the relevant date range of deceased patients – Datix system records matched to list of inpatient deaths
- SJR Scores for the relevant date range of deceased patients – Datix system records matched to list of inpatient deaths

The CCS groups considered during 24/25:

	CuSum	VLAD	HSMR	SHMI	Mortality Revs	SJRs	Total Overall	(Average)
122 - Pneumonia (except that caused by tuberculosis or sexually transmitted disease)	3	3	3	3	1	3	**16**	**2.7**
2 - Septicemia (except in labor)	3	3	3	3	1	3	**16**	**2.7**
129 - Aspiration pneumonitis; food/vomitus	3	3	3	2	1	3	**15**	**2.5**
261 - COVID-19	3	3	3	3	1	2	**15**	**2.5**
152 - Pancreatic disorders (not diabetes)	3	3	3	3	1	1	**14**	**2.3**
109 - Acute cerebrovascular disease	3	3	2	1	1	3	**13**	**2.2**
130 - Pleurisy; pneumothorax; pulmonary collapse	2	3	2	2	1	1	**11**	**1.8**
127 - Chronic obstructive pulmonary disease and bronchiectasis	3	2	1	1	1	2	**10**	**1.7**
100 - Acute myocardial infarction	2	3	1	1	1	1	**9**	**1.5**
159 - Urinary tract infections	1	3	1	1	1	2	**9**	**1.5**
145 - Intestinal obstruction without hernia	2	2	1	1	1	2	**9**	**1.5**
135 - Intestinal infection	1	2	1	2	1	2	**9**	**1.5**
115 - Aortic; peripheral; and visceral artery aneurysms	1	2	1	1	1	3	**9**	**1.5**
157 - Acute and unspecified renal failure	2	1	1	1	1	3	**9**	**1.5**
237 - Complication of device; implant or graft	2	2	1	1	1	2	**9**	**1.5**
233 - Intracranial injury	2	2	1	1	1	1	**8**	**1.3**
231 - Other fractures	1	2	1	1	1	2	**8**	**1.3**
39 – Leukemias	2	2	1	1	1	1	**8**	**1.3**
125 - Acute bronchitis	1	1	1	1	1	3	**8**	**1.3**
226 - Fracture of neck of femur (hip)	1	2	1	1	1	2	**8**	**1.3**
96 - Heart valve disorders	1	2	1	1	1	2	**8**	**1.3**
81 - Other hereditary and degenerative nervous system conditions	2	2	1	1	1	1	**8**	**1.3**
103 - Pulmonary heart disease	1	2	1	1	1	2	**8**	**1.3**
146 - Diverticulosis and diverticulitis	1	3	1	1	1	1	**8**	**1.3**
150 - Liver disease; alcohol-related	1	2	1	1	1	1	**7**	**1.2**
151 - Other liver diseases	1	1	1	1	1	2	**7**	**1.2**

CuSum Alerts Responses and Reviews during 2024/2025

Noted that the diagnostic groups listed above were agreed that no further action was required. The green rated groups were closed and the amber rated groups were agreed to keep on watch and wait pending any further alerts.

The groups identified as Red overall are under review. However, as previously noted the impact of clinical coding will have affected the ‘accuracy’ of these alerts.

The Pneumonia and septicaemia alerts were already under review. Pneumonia Task & Finish Group are undertaking data collection of 100 consecutive patients to able to undertake audit of the processes and assessment of treatment in line with Pneumonia Care Bundle / CURB-65 scoring. The outcome of the audit, which is being led by Respiratory Consultant, will be presented at Mortality review Group during 2025.

13. Prevention of Future Death (PFD) Notifications

The Coroners and Justice Act 2009 sets out a statutory duty for coroners in England or Wales to issue a PFD report, also known as a Regulation 28 report, if they believe that action should be taken to prevent a future death. These reports are publicly available.

UHNM has been issued with four PFD reports from HM Coroner during 2024/25. Two were received in both Quarter 3 and Quarter 4. UHNM also received 4 PFDs during 2023/2024

All responses have been submitted to HM Coroner in line with reporting requirements and both the initial PFD notification and the Trust responses are available on HM Judiciary website.

Case 1 (received 18th October 2024): HM Coroner raised concern that there is no Vascular team on hand at County Hospital where urgent Vascular opinion is required.

UHNM Response:
UHNM's vascular lead reviewed the concern raised and confirmed that UHNM provides a 24/7 vascular on-call service which is based at the Royal Stoke Hospital site. There are also vascular surgeons present at County Hospital every weekday (excluding the weekend). Normally, review of the in-patients is led 2 of our Consultant Vascular Surgeons at County Hospital. In addition to this, a further 2 senior Consultant Vascular Surgeons also visit County Hospital on a regular basis.

In this case the patient was referred to the Vascular service via the 'careflow' system which is usually a slower pathway of referral (i.e. rather than someone calling the Consultant on-call / on-site). Requests via 'careflow' emerge on a list on iPortal called "vascular inpatient specialty referrals". The on-call surgeon based at Stoke then triages these referrals and try to ensure expeditious review at County Hospital by a colleague, or instead, arrange to transfer the patient to Stoke.

Whilst the team endeavour to provide prompt reviews for patients in County Hospital, we also rely on accurate information from referrers and prefer, in emergency situations, to receive direct contact rather than electronic.

We will ensure that this information is further conveyed to the wards and clinicians at County Hospital so that they understand that there is always someone from the vascular team to contact, should the need arise.

Case 2 (received 16th December 2024): There were 3 specific concerns raised by HM Coroner in the PFD notification related to different electronic systems not being linked together for clinicians from different specialties being able to access the different systems.
1. Noted that patient received treatment from three hospital teams: cardiology, cardiothoracic surgery and coronary intensive care. Each team used their own ward-based medical notes which are not accessible by the other teams. Whilst each team has access to the iPortal system on which patient's MDT decision was stored, it was apparent that this was not accessed and acted upon. As a result, the MDT decision regarding patient's ICD was overlooked.
2. Plans to introduce electronic patient records to which all medical teams have access are still at an early stage and no date has been identified for moving over to a single electronic notes system.
3. The steps which the Trust has taken as a result of patient's death to address the risk of MDT decisions being missed in the future still rely upon the manual transcription of decisions from one set of medical notes to another, with the continuing potential for human error and important decisions about treatment being overlooked.

UHNM Response:
In response to HM Coroner the Trust have accepted that that a Trust wide electronic patient record (EPR) to provide a single source of patient information is likely to have ensured that the MDT decision regarding the need for Mrs Leake's ICD was known to all the teams providing her care. Such a system would ideally, in addition, include alerts to ensure that she was discharged safely.

As an immediate action, the development of a new alert within iportal will be implemented – this will be populated by the multidisciplinary team to inform clinicians that an ICD is required prior to discharge. The team are going to introduce teaching into the resident doctor induction to ensure this is checked prior to discharge.

Trust noted that at present the Trust uses many digital systems whilst still reliant on paper records. The clinical systems used are bespoke to the needs of specific clinical teams and their patients and these cannot always share information with or be accessed by other teams and specialties.

A single Electronic Patient record cannot be achieved by consolidating current systems and this remains a significant risk for the organisation and there remains risk of transcription and /or human error in relation to sharing clinical information.

The Trust is aspiring to acquire a new, highly sophisticated purpose built EPR system but that this will require significant capital investment, development and time to ensure safe deployment. UHNM Digital team, along with ICS, are drafting business case to apply for NHS funding for an EPR that will meet the growing needs and provide the functionality and interoperability required to prevent the events that contributed to this case.

Case 3 (received 19th February 2025): HM Coroner raised concern that although the death was natural causes there was concern that there was failure of medical teams to respond to concerns that patient was deteriorating whilst awaiting assessment and that there were recommendations in PSII completed that there was not compliance with the guidance from the Royal College of Emergency Medicine for Nursing Workforce standards.

UHNM Response:
It is correct that the Royal College of Emergency Medicine (RCEM) Nursing Workforce Standards for Type 1 Emergency Departments states that "there will be a minimum of a Registered Nurse to each patient in the resuscitation area. The recommendation also provides that there should be a named nurse allocated to each patient, as per National Guidance.

Royal Stoke Hospital has a Type 1 Emergency Department and has a total of 8 cubicles in the resuscitation (resus) area, however the team try to keep resus at a maximum of 6 patients leaving 1 space for paediatric emergencies (and when in use paediatric nursing staff from Children's Emergency Department attend), and 1 cubicle space for any trauma patients. There are always 4 Nurses who are allocated to the department for each shift in resus and then the department flexes our nurses to cover all Emergency Department Areas, flexing into the area with the most need at the time.

Additionally, there is a Operation Department Practitioner (ODP) in the department who supports resus during the day, and we also have the 'outreach team' who will attend resus whenever there is a trauma call. When acuity or resus capacity is high, the Nurse in Charge (NIC) both supports and makes appropriate staff moves from across the whole of the department, increasing both trained and untrained presence in resus on a continual prioritisation of need.

The overall nurse staffing numbers for the whole of the Emergency Department allow for a degree of flexibility across the department to wherever the greatest need is at any one time. Professional clinical judgement allows for this decision making, and the NIC remains non-clinical to flex staff as required.

RCEM guidance is not mandatory and the given the size of the ED at Royal Stoke, our ability to flex our nursing team during times of surge, escalation and need is preferred by our ED team on the ground and the leadership Triumvirate. This means we continually prioritise through the non-clinical Nurse in Charge so as to understand need, and then flex according to skill and priority across our ED.

We previously trialled a ‘named nurse’ approach within resus and the team felt this lacked flexibility as they used an ‘allocated nurse’ based on patient need and skill set per shift but, following further review, we have decided to structure this and reinstate this model to include a ‘named nurse’ within our resus from early April 2025. The named nurse model will then be audited/monitored via our internal review processes and as part of the Integrated Care Board (ICB) reviews of our Emergency Department.

Case 4 (received 11th March 2025): There were 3 specific concerns raised by HM Coroner in the PFD notification related to:

1 national awareness and guidelines for severe invasive soft tissue infections.
2 training provided previously for treatment of severe invasive soft tissue infections had failed to make significant in roads, and also;
3 in relation to the not having a requirement for a signature when staff are recording an ‘omitted dose’ which means there is no audit trail if patient is not given their medication because its unavailable or omitted for another reason.

UHNM Response:

1. We recognise and share the HM Coroner’s concern regarding the national lack of awareness and guidance relating specifically to Severe Invasive Soft Tissue Infections (SISTIs) that are not necrotising fasciitis but have similar aggressive and life-threatening characteristics.

   As an individual NHS organisation, we are not directly responsible for developing national clinical guidelines, however, we would fully support any national work to raise awareness of these rare but serious infections, and the development of clear diagnostic and management guidance. We also accept the challenge presented in ensuring wide clinical awareness of rare conditions, particularly in environments where staff rotate frequently, and experience may be limited. This challenge is compounded further by the relative rarity of such presentations, meaning that many clinicians may never have encountered a case during their training or practice. Nevertheless, Mr McFadyen will continue with the important work he is undertaking in this area.

2. Within our Trust, we continue to take the issue of training very seriously. We have already undertaken a significant programme of training and learning following this case, ensuring key themes and learning have been widely shared across our clinical teams.

   We are committed to continuing this education, both through formal teaching and case-based discussions. However, again, we do recognise that due to the rarity and complexity of these presentations, training alone will not always ensure early recognition. To that end, we will continue to emphasise the importance of early escalation and senior clinical review where there is any concern about deteriorating soft tissue infections. We believe that early involvement of senior decision-makers, particularly consultants who may have greater experience with rare or atypical presentations, is imperative to supporting early diagnosis and appropriate intervention.

3. With regard to the concern raised about medication omissions and the lack of an auditable trail when a dose is not administered, I can confirm that currently we do not have an Electronic Prescribing and Medicines Administration (EPMA) system in place at our Trust.
   However, the Trust is in the process of implementing EPMA across both our sites. Once implemented, EPMA will provide a robust and transparent record of all medication activity, including when a dose is omitted, the reason for omission and the identity of the person making that decision. When we have our EPMA system, the electronic chart will capture everything in one place. In the interim, we have developed a Patient Safety Learning Alert requiring staff to document reasons for drug omissions. These omissions are to be documented within the relevant patient record. This alert has been circulated to all staff and is enclosed for your review.

   The implementation of our EPMA will significantly improve the governance and auditability of our medicines management across the Trust and directly addresses the concern raised in the Regulation 28 report.

In addition to local PFD notifications, the Mortality Review Group received information in relation to PFD received by the Royal College of Anaesthetists in August 2024 relating to the Administration of Excessive Local Anaesthetic during surgery following patient death at Addenbrooke's Hospital in July 2022. The PFD related to concerns in checking and administering local anaesthetic and inconsistency around whether the anaesthetic was recorded in millilitres or milligrams.

The Report had been presented at the Medicines Optimisation and Safety Meeting and shared with the Anaesthetics Department and Theatres for awareness. The Royal College of Anaesthetists response to the Report would be published in due course.

It was noted at Mortality Review Group that there was understandable anxiety surrounding this and Surgery Division Medical Director agreed that non-Anaesthetists should not be routinely exceeding the recommended dose for any local anaesthetic, and that if a non-expert in the administration of these drugs was directed to do so by an Anaesthetist, then it was reasonable to challenge them.

The UHNM guidelines which mention local anaesthetic pre-procedure are under review in line with Royal College response.

14. Neglect Verdicts

During 2024/2025, UHNM received two Neglect verdicts from HM Coroner. Both were received during Quarter 3. One of these relates to Case 2 under the above the Prevention of Future Deaths notifications section.

The second Neglect Verdict was issued due to hospital acquired pressure damage leading to complications following and infected pressure sore.

15. Medical Examiner Service

As previously noted during 2023/2024 the Medical Examiner service continued to provide summary reports on the plaudits received and these are shared with relevant Divisions and Directorates for feedback to the staff and promote the good practice. These plaudits have been received across the different divisions at UHNM. To support the sharing of themes and learning, during Quarter 4, the Medical Examiner Service refined the reporting format submitted to Mortality Review Group to provide updates on all ME Service activity and themes from the reviews completed.

A summary from Quarter 4 2024/25 is provided below:

Quarter 4 Operational Overview
• Number of hospital deaths (both sites) scrutinised: 880 • Number of community deaths scrutinised: 815 • Number of deaths notified to the Coroner *after* scrutiny by a Medical Examiner: 91

Recommendations for Structured Judgement Review	Other Feedback and Potential Learning
• Medical Examiner concerns:- - Serious lack of documentation to evidence consultations and handover - Medication prescribing dosage concerns - Acute diagnosing delay - Delay in treatment/missed opportunity to treat deteriorating patient • Learning disability x3 • Severe mental illness x1	• Delay in referring to appropriate speciality x3 • Inappropriate treatment x8 • Inappropriate CPR (ReSPECT form in place) • Poor quality/lack of documentation x5 • Possible historic diagnosing delay
Plaudits	**Signposting to other governance processes**
• A&E (RSUH) • AMU (County) x2 • NICU • Ward 12 (County) • Ward 76a, 81, 210 FEAU • Ward 101, 102, 105, 110 • Ward 127 • Ward 128, 222 (x2) • Ward 201 x2 • Ward 220, 221, Coronary Care Unit and SHINE Clinic	• 57 families signposted to PALS

Feedback/Comments – Plaudits

RSUH Plaudits

- NOK said that Mandy (Bereavement) was very helpful and knowledgeable, she was lovely in her tone, and he was happy to get her on the other end of the phone, he didn't expect anybody to answer because of the snow. He also said he couldn't believe how quickly we sorted everything out; he didn't expect to have a phone call for a couple of days. A big thankyou to us, very professional and helpful service.
- Staff on ward 81 treated mum with respect and care. Specifically mentioned Louise Knowlan
- The family would like to thank the staff on Ward 232, they all went above and beyond to look after the patient and the family. But in particular a nurse called Ann (who was on the night shift on the Saturday) she is an absolute credit to the ward.
- Plaudit for Ward 220: This patient's son would like to extend his thanks to everyone who cared for his father on Coronary Care/Ward 220. He said that the staff kept in touch with updates and were always asking if he was OK and if there was anything he needed. He was grateful that his dad was so well looked after and that he was kept comfortable at the end of his life. He went on to say that although he doesn't live in Stoke-on-Trent, he was so impressed with the care that he would ask to come to the Royal Stoke if he was ever ill himself
- Plaudit the care on Ward 101, 105 and 102 was exemplary. In particular Emma and Dawn on Ward 105. Also Lydia on Ward 102. So empathetic, kind and caring.
- The family say that the staff were wonderful on Ward 201 Haem, to the patient and the family. His wife says that when he passed away and she was leaving the ward, staff arrived from other areas of the oncology building to hug her and show respect. She says that she felt like the Queen, it showed how much all of the staff cared for the patient
- PLAUDIT - In for a month, last few weeks/days care was out of this world Ward 201- They will be going into the ward personally to take a thankyou card & chocolates but would like to mention the following names - SN - Mohammed, Sr - Zoe & Ethel, NA - Jane, Skin care nurse Evangeline, Sn Dawn, Georgia, Palliative care team Becky & Ellie. They all offered care not only to the patient but extended their care to the family making sure they had a bed and food etc.
- Plaudit for Ward 222. This patient's daughter would like to thank the staff who cared for her father on Ward 222. She felt that the staff never gave up on the possibility of treatment and recovery for her dad, despite his advanced age, and she was very grateful for this. She described the quality of care as 10 out of 10!
- Plaudit for A&E Resus and Ward 127. This patient's son would like to thank all the staff who cared for his father at RSUH. He particularly felt that the staff in A&E stood out for their ability to remain calm and dedicate time to caring for his father when the department was so busy. He said that as a family, they never felt 'in the way' and that the staff gave the impression that they had all the time in the world, despite family understanding that this would not have been the case. Throughout his stay in A&E and Ward 127, family felt well looked after, and they said that staff communicated well - always keeping them up to date, and explaining the medical processes to them. He said that every member of staff was superb!
- Plaudit - Very happy with care on Ward 122, especially from a nurse called Anu. Found end quite traumatic as husband went into respiratory arrest through his breathing issues but felt supported by the team on the ward.
- PLAUDIT - The management especially communication and documentation by one of the junior doctors Dr Manmohan has been of exemplary quality. There was a constant update to the family, and I am pretty sure they will be appreciative of this. Please feed this back to the junior doctor who I am sure will be motivated to continue with the excellent work.
- Plaudit - care was perfect and particularly staff nurse Charlotte, who didn't leave patient's bedside
- Plaudit - Staff on 128 were excellent, gave the best care possible to the patient especially the SN names Jessie.

Feedback/Comments – Plaudits
• Plaudit for the bereavement & medical examiner service. This patient's brother remarked on how impressed he was about the service he received from the bereavement service. He said that bereavement officer, Mandy had a lovely telephone manner and was very kind, and that MEO, Alex had reassured him by explained the cause of death, and answering all his questions very well. He said that the bereavement service had been very informative and very supportive to him • Plaudit – Patients wife said that the care that her husband received in the Shine Clinic, CCU and Ward 221 was very good, she could not fault the care from the nurses and doctors. In particular a nurse in the SHINE clinic called Liju, she was exceptional • Plaudit for the medical examiner service: This patient's daughter thanked the MEO for the call. She said that it had been very useful to talk through the circumstances around her dad's death (how anticoagulation can exacerbate bleeding and make surgery risky). She said that it was good to 'put the pieces together'
County Hospital
• Plaudit – Patients wife was full of brace for the care that she received from the entire hospital trust and hospitals she was especially touched by the care that a nurse who went to fetch fizzy drink for the patient and ensured that she gave it to him as he had asked for it before he passed away. She is full of praise for all the care, and she says that she cannot thank them all enough she especially mentioned that when they talk about Stafford hospital, she does not recognise that from the care that she received I promised to pass that on. • Plaudit - The family appreciate the staff on the ward for doing everything in their power to help the patient. In particular the chest physios were superb. Also, the on-call doctor working Sunday 02/02/2025, who came from A&E to try and help the patient, he was outstanding.
Medical Examiner Service
• Plaudit for the ME service: NOK thanked the MEO for the call, and for everything we are doing to support bereaved relatives. He appreciated that it can't be an easy job to do, but said that the MEO 'presented herself very well' and that he was grateful for our input • PLAUDIT for the Medical Examiner Service: • This patient's daughter wanted to thank everyone is the Medical Examiner Service who had worked to resolve her mum's case so quickly. She was quite upset at the amount of time take it had taken the GP to send the referral (8 days) and was daunted by the prospect of waiting for a further three days due to AP unavailability. The MEO team worked hard across sites to avoid this delay, and the MCCD was eventually issued within 1 working day of referral. The daughter said that she couldn't thank the team enough for their help. Team involved: AC, JK, KST

16. Conclusions

The Trust's Learning from Deaths and Mortality indices work continues to be governed through the Mortality Review Group which meets on a monthly basis with good attendance and clinical engagement. During 2024/25 the membership of the group has remained consistent following previous enhancements with the inclusion of the Lead Medical Examiner, Medical Examiner Service Manager and Mental Health & Learning Disability Lead Nurse included as members.

The Mortality review Group, when reviewing the effectiveness of the meetings, have noted that there have been improved discussions regarding the M&M meetings and review of cases and learning with the M&M leads during presentations. This has been noted as a positive change and to be supported moving forward.

Trust mortality indices, both HSMR and SHMI, have seen increases during 2024/2025 and are higher than expected.

HSMR and SHMI are higher than expected and linked to the noted issues with shortages in clinical coding resources and ability to code all admissions/ discharges.

Crude HSMR position remains in line with the national rate and has not shown increases at same period of HSMR and SHMI increases.

Noted shortages of clinical coding resources and coding of all activity has impacted on increased HSMR and SHMI figures. It has been noted that these increases will continue until the backlog in outstanding activity is reduced. The issue has been escalated to executives and is included on the Risk Register. This is also impacting the number of CuSum alerts that have been received during Quarter 4 as this will contribute to higher SMR for different diagnostic and procedural codes.

The completed SJRs and mortality Reviews are still showing consistent completion rates and positive outcomes on the assessment of care provided.

Previously reported CuSum alerts have been further reviewed and these are within expected ranges and triangulated utilising agreed indicators and no further concerns or issues identified in these alerts. The outcomes of the reviews and indicator data did not raise the need for further review or analysis. Any changes or further alerts will then be analysed further and reported via the Mortality Review Group with identified leads.

The completed SJRs and mortality Reviews are still showing consistent completion rates and positive outcomes on the assessment of care provided.

The completed SJRs for patients with 12+ hours ED attendance has not identified any cases where, in the opinion of the reviewers, the long has contributed to the patient's outcome. The long waits in ED have impacted on patient experience but not clinically contributed to the patients' outcomes for those that have been reviewed. Learning from these completed SJRs are shared with UEC Board and ICB as well as local teams. It has also been agreed with the ICS, that the specific request for SJRs for these patients are to cease and the remedial/improvement work to continue. Key themes and issues have been gathered from the completed SJRs and used to inform the UEC work programme with the ICB.

The focus for future work will be the ongoing improvement in mortality review completion and working with individual leads to support this improvement. This will allow greater assurance that deaths are reviewed promptly and allow sharing of learning across the Trust and with Medical Examiner Team, relatives, LeDeR (Learning Disability) reviewers and HM Coroner.

The Mortality Review Group have continued to meet their requirements and responsibilities in reviewing mortality and seeking assurances from local M&M leads that there are local processes and reviews being undertaken. The focus for future work will be the ongoing improvement in mortality review completion and working with individual leads to support this improvement. This will allow greater assurance that deaths are reviewed promptly and allow sharing of learning across the Trust and with Medical Examiner Team, relatives, LeDeR (Learning Disability) reviewers and HM Coroner.

17. Recommendations for 2025/2026

1. Clinical Coding and Mortality Indices

- Continue to prioritise the resolution of the clinical coding backlog, with executive oversight and support from the Integrated Care Board (ICB).
- Implement and monitor the impact of newly recruited clinical coders and improved discharge documentation processes.
- Develop and report on internal mortality indicators to provide assurance while national datasets remain affected by coding delays.

2. Structured Judgement Reviews (SJRs)

- Maintain and improve SJR completion rates across all specialties, with targeted support for areas with persistent backlogs.
- Ensure timely dissemination of learning from SJRs, particularly those rated as poor or very poor care, through M&M meetings and governance forums.
- Standardise documentation and storage of SJR outputs to improve accessibility and auditability.

3. Directorate M&M Processes

- Sustain improvements in M&M meeting attendance, documentation, and action tracking.
- Encourage wider multidisciplinary participation, including nursing and pharmacy staff, in M&M reviews.
- Promote the use of iPortal and CareFlow for real-time mortality review tracking and learning dissemination.

4. Learning Disability and Perinatal Mortality Reviews

- Ensure all Learning Disability and Autism deaths are reviewed through the LeDeR process and reported to the ICB.
- Maintain 100% compliance with the Perinatal Mortality Review Tool (PMRT) and CNST standards.
- Embed learning from perinatal reviews into clinical practice, particularly around communication, triage, and interpreter use.

5. Prevention of Future Deaths (PFDs) and Neglect Verdicts

- Implement and audit actions in response to PFDs, including staffing models, documentation standards, and escalation protocols.
- Monitor the impact of EPMA implementation on medication omission documentation and audit trails.

Glossary

Hospital Standardised Mortality Ratio (HSMR)

The HSMR is a ratio of the observed number of in-hospital deaths at the end of a continuous inpatient spell to the expected number of in-hospital deaths (multiplied by 100) for all diagnostic (CCS) groups in a specified patient group. The expected deaths are calculated from logistic regression models with a case-mix of: age band, sex, deprivation, interaction between age band and co-morbidities, month of admission, admission method, source of admission, the presence of palliative care, number of previous emergency admissions and financial year of discharge.

HED HSMR Module

HED HSMR module is designed to provide national, regional and bespoke peer benchmarking of HSMR performances within all NHS acute and specialist hospitals. The module allows you to review the overall performance, time series and a further breakdown by age band, sex, admission method, specialties, hospital sites, diagnosis groups, operation groups and weekday/weekend admission etc.

Standardised Mortality Ratio (SMR)

Ratio of the observed number of in-hospital deaths at the end of a continuous inpatient spell to the expected number of in-hospital deaths (multiplied by 100) for diagnostic (CCS) groups. The expected deaths are calculated from logistic regression models with a case-mix of: age band, sex, deprivation, interaction between age band and co-morbidities, month of admission, admission method, source of admission, the presence of palliative care, number of previous emergency admissions and financial year of discharge.

Summary Hospital-level Mortality Index (SHMI)

SHMI is a hospital-level indicator which reports mortality at trust level across the NHS (acute care trusts only) in England using a standard and transparent methodology. This indicator is being produced and published officially by NHS Digital. HED team replicated the methodology by using our subscribed Hospital Episode Statistics (HES) and HES-ONS Linked Mortality Dataset from NHS Digital.

HED HES-based SHMI

HES-based SHMI module is designed to provide a national, regional and bespoke peer benchmarking of overall SHMI and contextual indicators (released by NHS Digital) within all NHS acute hospitals in a more **timely and detailed** manner. The module will be refreshed every month after we receive monthly subscribed HES and HES-ONS datasets. The module allows users to review overall performance, time series and further breakdowns by age band, sex, admission method, specialties, hospital sites, diagnosis groups and weekday/weekend admission etc.

NHS D SHMI vs. HES-based SHMI

NHS D SHMI is built on the data with the same time period as that for monthly official national SHMI release (by NHS Digital); The HES-based SHMI module is refreshed on a monthly basis using the latest data available to HED team through subscriptions to HES and ONS extracts. Therefore, monthly SHMI scores after the modelling data period are provisional and will be updated after the next SHMI model rebasing period. Numbers differ slightly because NHS D SHMI includes patients who have chosen to 'opt out' whereas HES-based SHMI excludes them.

HES-based SHMI utilises the same model built for NHS D SHMI to make predictions on new data. It enables the trust to see a timely update of (provisional) SHMI figures prior to national monthly release. It also allows the trust to drill down to patient level details (which is why it excludes patients who have 'opted out'.

Why has SHMI score changed when this report has been updated?

There are a number of reasons that SHMI scores will change with time. If the difference between your current overall SHMI score and a previous SHMI for the same period is more than 1 point (SHMI average score is 100), please check the following:

1. Model Re-basing – NHS Digital re-bases the SHMI modelling period, on a monthly basis, by using the latest 36 months data available at the time of production to calculate expected deaths. If the underlying data used for models are different, the model coefficients will be changed accordingly.
2. More death data being captured – HED updates the Monthly SHMI using the latest data (both HES episodes and HES-ONS linked death records) provided monthly by NHS Digital. It is possible that a

number of post-discharge mortality records may not have been completed in the previous report, in particular for the last couple of months, as some deaths can take a while to be registered.

3. Data resubmission – if your organisation has resubmitted SUS data for previous months, it will cause changes to the SHMI score.

Crude mortality rates (HES ONS Linked mortality datasets)

This indicator shows the percentage of spells that end in mortality for deaths that occurred post-discharge. In this dashboard, changes in crude rates over time may warrant further investigation. For further investigation and comparison across trusts, consider using the case-mix adjusted SHMI and HSMR indicators.
The numerator is the number of post-discharge mortalities.
The denominator is the total number of discharges.
The data is sourced from the HES Inpatient dataset and the HES-ONS linked mortality dataset.
The value shown is calculated from data across a rolling 12-month period.

Cumulative Sum (CuSum)

CuSum statistical process control techniques are commonly applied to mortality monitoring to detect changes in mortality rates over time. The CuSum value increases when patients die and decreases when they survive. They are calibrated with a 'trigger' value, and if a CuSum exceeds its trigger, it should be investigated. A CuSum chart is 'reset' after each trigger and continues monitoring.

In this module two CuSum techniques are applied to the Hospital Standardised Mortality Ratio (HSMR) (Jar man et al. 1999):

- Aggregated CuSum - uses monthly data aggregated by trust and diagnosis group. This technique is based on Spiegelhalter et al. (2012) and developed for use by the CQC (CQC 2014). A trigger value of 5.48 is used, and has been confirmed by CQC, with the chart resetting to zero after a trigger

- Patient-level CuSum - plots patients arranged by discharge data. This method is based on techniques published by Steiner et al (2001) and Bottle & Aylin (2008). Trigger values are set using an approximation based on simulation experiments (Bottle & Aylin, 2011), and charts are reset to half the trigger value after a breach (similar to elements of Lucas & Crozier (1982), 'Fast-initial response' CuSum).

SHMI VLAD Model (Visually Life Adjusted Display)

VLAD charts are used to show long-term trends in treatment outcomes (Sherlaw et. al., 2007). Here, we show the ‘number of lives saved’ against case number, where ‘lives saved’ is calculated as a running total of (expected number of deaths) – (observed number of deaths). For each case the risk of death is calculated using the same methodology as used in calculating the SHMI (HES-based) value.

CuSum statistical process control techniques are commonly applied to mortality monitoring to detect changes in mortality rates over time. The CuSum value increases when patients die and decreases when they survive. They are calibrated with a 'trigger' value, and if a CuSum exceeds its trigger, it should be investigated. A Cu Sum chart is 'reset' after each trigger and continues monitoring.

VLAD charts are not as responsive as CuSum charts when used to detect short-term changes in outcome trends. For this reason, these VLAD charts have been modified to include the CuSum trigger levels for both improvement (odds of death halved) and deterioration (odds of death doubled). These are shown on the VLAD charts as control limits above and below the number of lives saved.

Executive Summary

Trust Board | 8th October 2025

UEC Pressure and Ambulance Handover Update

University Hospitals of North Midlands NHS Trust

Purpose:	**Information**		**Approval**		**Assurance**	✓	**Agenda Item:**	13.
Author:	Katy Thorpe, Chief Operating Officer							
Executive Lead:	Katy Thorpe, Chief Operating Officer / Ann Marie Riley, Chief Nurse / Diane Adamson, Chief Medical Officer							

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

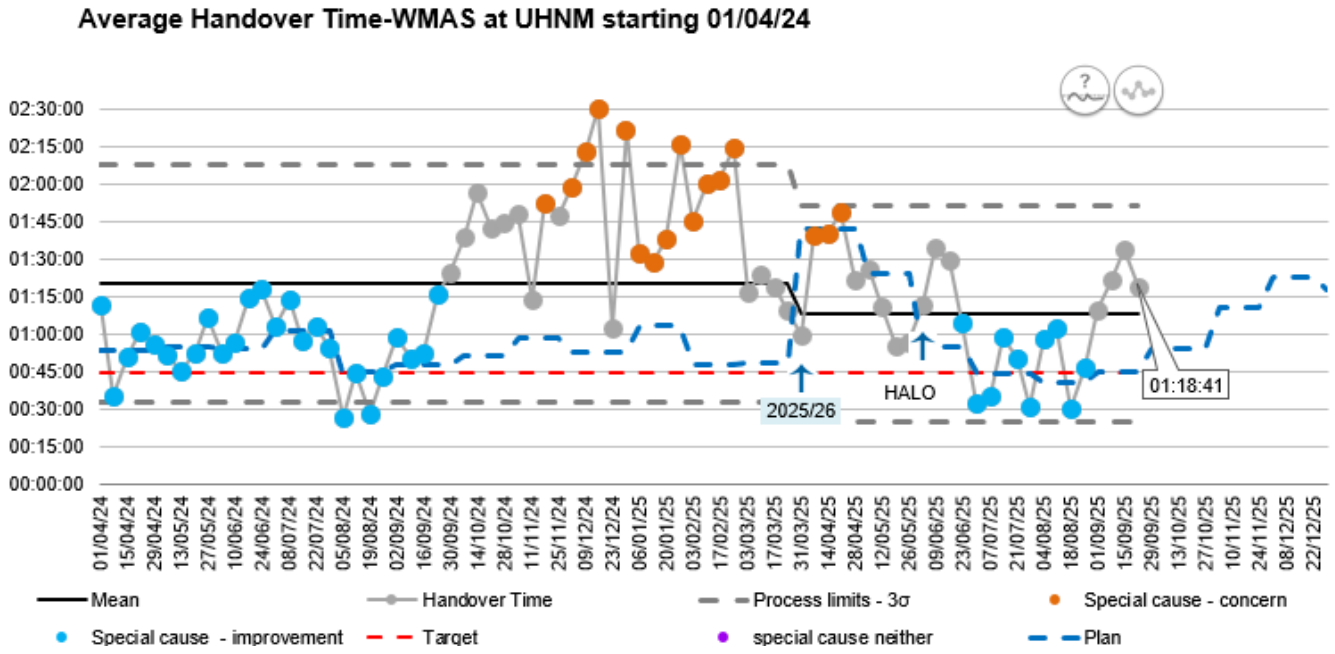
Risk Register Mapping		
BAF4	Delivering responsive patient care	15 (extreme)

Executive Summary

Situation

- This paper ais to update board member on the situation with regard to UEC pressure and ambulance handover delays.
- This covers data up to the latest reported week which was 30th September 2025
- We have been escalated to tier 1 for national oversight for our UEC position.

Ambulance Handover



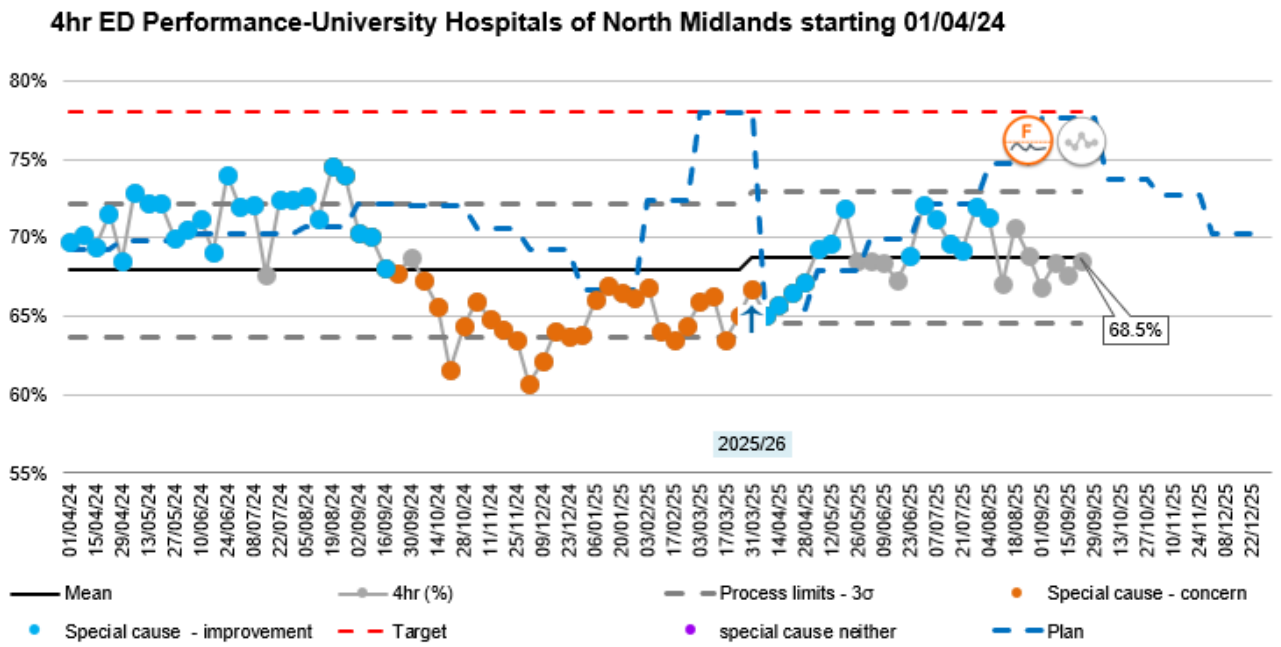
Average Handover Time

- Average Handover Time last week improved by over 15 minutes to 1hr 18mins, with September reporting as worse than plan at 1hr 21mins 45secs.
- Handover Trajectory for latest week was 59.0%, up almost 4% on the previous week. September is reporting as 57.8%.
- Time Lost (> 15mins) due to handover fell almost 334 hours to 1245 hours from 1,579 hours.

Category 2 Response Time

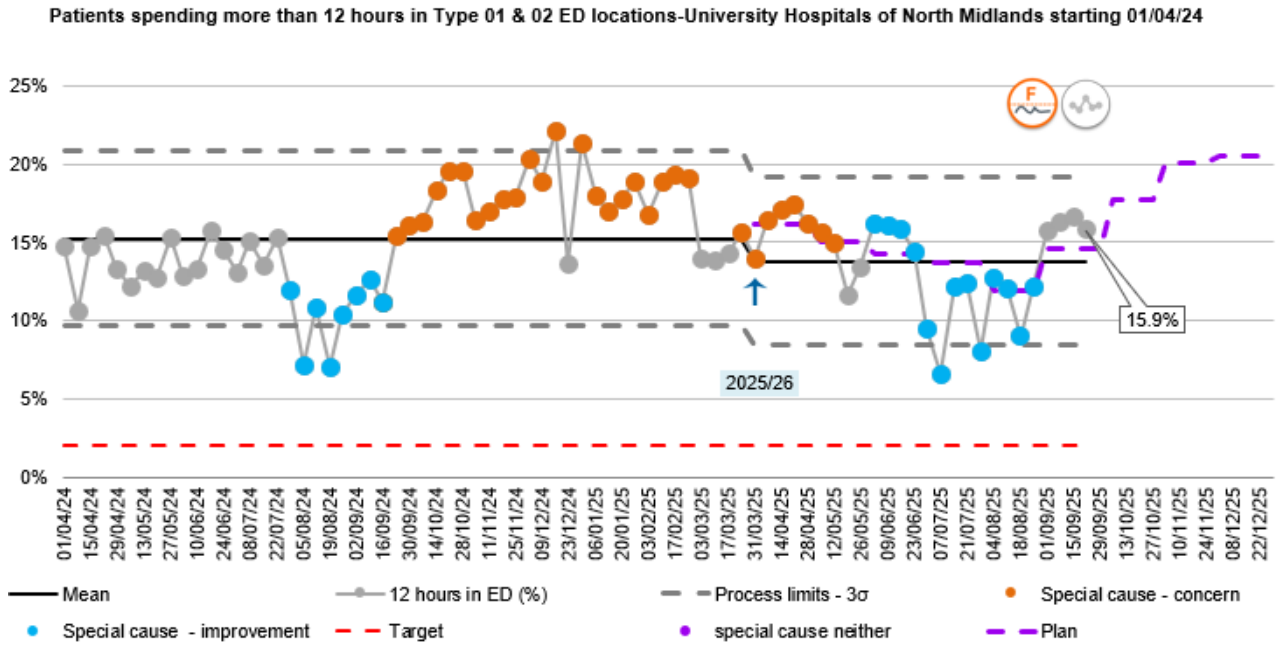
- Category 2 Response Times for the latest week (w/e 21st September) were 34min 25 secs, up almost 4.5 minutes on the previous week. This placed the system 6th regionally and 25th nationally.
- August 2025 reported as 21mins 31secs, 3 minutes worse than plan.

Four Hour Performance



- Last week saw an improvement in performance of 0.9% against the previous week, rising to 68.5%.
- September's position of 68.1% is 9.5% worse than plan.
- UHNM reported an increase in attendances with Types 01 (1.6%) and Type 3 reporting a decrease (-3.4%).
- Last week Type 1 Paediatrics saw an increase in performance of almost 6% against the previous week, rising to 83.1%.
- September is currently reporting as 80.6%, up 0.9% on August.

12 Hour Performance



- Provisional 12hr performance for last week was 15.9%, down 0.8% on the previous week of 16.7%.
- August reported as 11.31%, better than plan by 0.6%, whilst September is currently reporting as 16.18% against a plan of 14.6%.

Tactical Mitigating Actions

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

HALO Model
- Initial review commenced with a system agreement that a further period with the role being in place is required to full assess impact,
- Feedback from partners positive regarding
- Pinning compliance remains around 99% for the month to time,
- This role working with ICC to support ED referrals and challenging call before you covey
- Avg. handover time for September reduced, however, is impacted by operational pressures.

Reducing Ambulance Handover
- Continuation of system workstream and monitoring in place with a daily tracker monitored via SCC, escalations via System calls as required.
- AOO model fully mobilised, updates as per HALO/AOO Review,
- Focus remains on sustaining performance in line with system plan however, operational challenges continue to remain prevalent including walk-in demand and acuity challenges.

Ward Process & Discharge
- Continuing to strengthen positive risk management across the Integrated Discharge Team and the newly formed Therapy Collaborative.
- Initial discussions are underway around potential tests of change in discharge pathways, alongside the development of meaningful outcome metrics.
- D2A productivity and efficiency recommendations have been shared with all partners and are now being reviewed for prioritisation and implementation.
- The Virtual Ward is exploring opportunities to maximise IV antibiotic capacity in the community, using insights from the HRD tool.
- The HRD tool is now fully mobilised, enabling tracking patients from admission and to support increased care reinstatement volumes within 7 days of arrival.
- Winter funded discharge schemes are being mobilised.
- ECIST support on site at UHNM from 1 October, focus on ward-based discharge processes.

Front Door
- Alternative Pathways working group progressing next steps, regular meetings in place to take forward.
- Ambulance triage process review underway; changes being scoped prior to implementation.
- FEAU changes commenced from 29 September.
- UTC – Approach to in year plan agreed, currently navigating appropriate Governance processes. Capital & revenue agreed.
- UTC partial opening during January, fully operational May-26 (x-ray online).
- ECIST support for acute medicine pathways from 1 October.

Bed & Site Management
- Amended daily flow model now in place focusing specifically on the 12-hour target & ambulance handovers/offloads.
- Ongoing monitoring in place via BAU model.

Infection Prevention

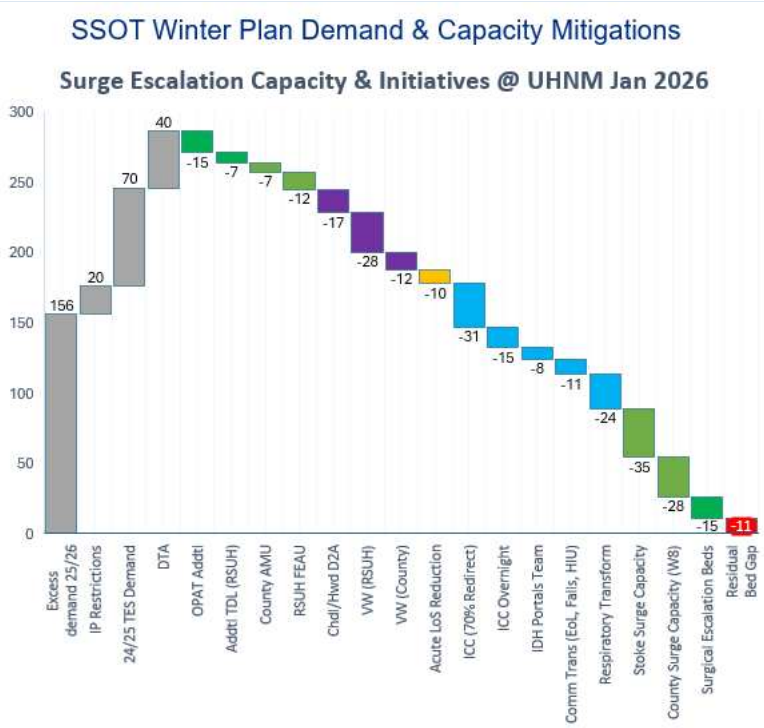
- Winter vaccination programme commenced 1 October for staff & patients; a new ordercomm available for staff to request vaccination team to visit clinical areas to vaccinate inpatients if they fit the criteria. (those going to care homes, those in for more than 21 days for flu and covid).
- Outpatients: vaccination team targeting under 65 with chronic conditions & those patients less likely to take up community vaccination offers.
- Staff vaccination campaign live; uptake is good – execs taking lead with CEO daily message sharing photos of exec team receiving their vaccines.
- Bi-annual Big Bed Clean in October will be used to share outbreak information with teams. IP supporting with outbreak refresher training for ward staff.
- Twice daily IP review of inpatient areas, & restrictions with 7-day service cover.

ICC

- Call Before Convey redirection rate for W/C 15.09.25 was 79.7%. Total number of CBC referrals was 69 (previous week was 69).
- NHS111 referrals in - Total number of NHS111 referrals w/c 15.09.25 was 40 (previous week was 38).
- Agreement with NHS111 to use GP escalation via 111 with dedicated phone line (weekends only). This may be only a clinical conversation between ICC triage nurse and 111 GP or if appropriate transfer of patient to 111 (e.g. for prescriptions). Go live 4th October.
- Link to GP alliance and lead Dr regarding senior clinical decision-making support and leads regarding SDEC pathways
- ICC FAQs document finalised and communicated to stakeholders. Short video for referrers-in is in development. ICC flyers being distributed in care homes by MPFT High Intensity team when working in the homes to support awareness and referrals-in.
- Comms issued in GP Bulletin and requested targeted comms for Care Homes via SOTCC. Case studies being prepared to communicated to referrers.
- Additional recruitment into ICC underway (4x triage vacancies recruited to) and exploring new roles to support team further
- Plans for base move to Haywood Hospital continue to be progressed which will support senior clinical decision-making by co-locating team with wider MPFT urgent care team including ANPs, GP with specialist interest, senior therapy roles, nurse consultant etc.
- Out of Hours redirection rate for telephony remains high at 84%,

System Surge Planning/Winter Review

- System Winter Plan review undertaken at ICB Board on 18 September.
- Board Assurance statements & Winter Plan Checklist completed, signed off by CEO & Chair & returned to NHSE.
- Review at provider partner Board meetings undertaken with assurance statements reviewed and completed accordingly.
- Winter plan Below is a reminder of the waterfall for the winter plan.



- Mobilisation of surge/winter schemes progressing. Below is the initial overview of the proposed phasing of the winter capacity. This is provisional currently but gives an initial overview of how schemes will be enacted. This will be recalibrated as we move through the winter period through the System Winter Oversight Meeting

Initial winter plan position	Lead provider	Position	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26
Bed gap (Inc IP impact)		**-286**	**-74**	**-155**	**-211**	**-286**	**-238**	**-213**	**-147**
Mitigated by									
OPAT	UHNM	-15	-7	-15	-15	-15	-15	-15	
Addtl TDL (RSUH)	UHNM	-7	-7	-7	-7	-7	-7	-7	-7
County AMU	UHNM	-7	-7	-7	-7	-7	-7	-7	-7
RSUH FEAU	UHNM	-12	-12	-12	-12	-12	-12	-12	-12
Chdl/Hwd D2A	MPFT	-17			-17	-17	-17	-17	-17
VW (RSUH)	UHNM	-30	-24	-24	-28	-28	-28	-28	-28
VW (County)	UHNM	-8	-8	-8	-8	-12	-12	-12	-12
Acute LoS Reduction	UHNM	-10	-5	-5	-10	-10	-10	-10	
ICC (70% Deflect)	MPFT	-31		-5	-8	-31	-20	-15	-12
ICC Overnight	PHL	-15			-3	-15	-10	-5	-5
IDH Portals Team	UHNM	-8		-8	-8	-8	-8	-8	
Comm Trans (EoL, Falls, HIU)	ICB	-24		-8	-11	-16	-11		
Respiratory Transform	Provider Collab	-24				-24	-5		
Stoke Surge Capacity	UHNM	-35	-4	-15	-35	-35	-35	-35	-20
County Surge Capacity	UHNM	-28		-28	-28	-28	-28	-28	-12
Surgical Escalation Beds	UHNM	-15	-5	-10	-15	-15	-15	-15	-15

Balance		0	5	-3	1	-6	2	1	0

UEC Transformation Programme

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

ED and Acute Medicine are now reviewing their pathways with our Unplanned Care Group with a view to support a test of change to improve ambulance offload. The detail of this is being worked on in the next week.

Expected Impact

The trajectory has been set for the year through the annual planning. These trajectories are included in the integrated performance report and are taken through Quality, Access and Outcomes Committee. These are also shown on the SPC chart included in this pack. This trajectory is currently being adjusted given the delay to the UTC.

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 as we see the start of Winter impacting earlier than expected. We acknowledge is not the performance we want for our patients or population.

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

Key Recommendations

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

Highlight Report

EXECUTIVE RECOVERY OVERSIGHT GROUP | 22nd September 2025

University Hospitals of North Midlands NHS Trust

Matters of Concern / Key Risks to Escalate	Major Actions Commissioned / Work Underway
• **UTC Delays:** Due to the issues in approvals for the UTC this delivery is off track – but for the Royal Stoke site now progressing with delay. • **Discharge Lounge & Capital Funding:** The feasibility for the discharge lounge is ongoing, but lack of a business case and uncertainty over capital funding means progress is stalled. There is a risk of not meeting performance trajectories due to this delay. • **Ambulance Delays:** Ambulance service time lost reached 1,100 hours last week, the worst for several months, indicating the current recovery plan is not delivering as intended. • **Bed Capacity & Flow:** Persistent gaps in bed capacity and alternatives are not being addressed upfront in the programme, impacting patient flow and performance. This is being picked up through a different work programme • **Site Team Resilience:** Challenges with staff resilience though new staff have been appointed, with more joining soon, which should help improve resilience and consistency.	• **Discharge Lounge Feasibility**: Capital team and steering group are working on revision 4 of the brief, with ongoing feasibility studies for the Trent Building and fire safety works. • **Performance Improvement:** Focus on embedding the continuous flow model and corridor care, with mitigations being put in place while deeper bed based changes are developed. • **Ambulance Offload Solutions:** Consideration of more radical options, such as an ambulance receiving centre and reformatting existing capacity, to address persistent ambulance delays. • **AI and Digital Transformation:** Exploring opportunities to accelerate transformation through AI and digital-first approaches, despite resource constraints. • **Visibility of Programmes:** Efforts to improve oversight and coordination of all recovery and transformation programmes, including virtual wards.
Positive Assurances to Provide	**Decisions Made**
• **Engagement & Support:** There is strong leadership support for the site team, with a commitment to a team approach and mitigation of risks. • **Collaboration:** Good engagement from Care Groups in recalibration work, and care groups are being brought together to improve visibility and coordination of programmes.	• **Deferral of Discharge Lounge Funding:** Decision to defer drawing down capital for the discharge lounge, with a need to re-pitch next year. • **Focus for Q3/Q4:** Agreement that the group's focus for the remainder of the year will be on the five key workstreams identified, with further reflection on opportunities for 2026/27. • **Rapid Improvement Initiatives:** Commitment to trial more radical solutions for ambulance offload and bed capacity, with engagement of clinical teams and rapid improvement cycles.
Comments on the Effectiveness of the Meeting	
• No further comments were made.	

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	Month 5 Operational Performance	Assurance	4.	2025/26 CIP Update	Assurance
2.	UEC Recovery Workstream Updates • Workstream 1 (WS1) Front Door Processes • Workstream 2 (WS2) Frailty • Workstream 3 (WS3) Clinical Pathways • Workstream 4 (WS4) Bed & Site Management • Workstream 5 (WS5) Ward Process & Discharge	Assurance	5.	Delivering 25/26, developing 26/27	Information
3.	Month 5 Finance Performance	Assurance			

Executive Summary

Public Trust Board | 8 October 2025

Urgent & Emergency Care / Elective Care Recovery Programmes

University Hospitals of North Midlands NHS Trust

Purpose:	**Information**		**Approval**	✓	**Assurance**		**Agenda Item:**	14.
Author:	Various							
Executive Lead:	Katy Thorpe, Chief Operating 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 1	Inability to Sustain Safe and Effective Care Delivery	**Ext 16**

Executive Summary

Situation

We are required to submit updated Urgent and Emergency Care (UEC) and Elective Recovery Programmes to NHS England as part of our regulatory undertakings (appendix 1). These submissions are essential to demonstrate compliance with national expectations and our commitment to service improvement under the NHS Oversight Framework.

Background

We continue to face significant challenges in both urgent care performance and elective recovery, which have led to increased regulatory oversight. In response, we have developed comprehensive programmes that align with national and system priorities and address specific areas of concern.

The UEC programme has been specifically designed to respond to the recommendations made by the national clinical advisor, following a review earlier this year. These recommendations have been incorporated into the programme's design and delivery plan.

The elective recovery programme supports the national ambition to restore elective activity, reduce waiting times, and improve patient outcomes. Both programmes have been developed in collaboration with system partners and reflect the priorities set out by NHS England.

Assessment

The programmes have undergone detailed internal review and reflect our planned trajectories for improvement. They are underpinned by clinical leadership, operational planning and system wide engagement. They reflect the broader work being undertaken in relation organisational redesign and cultural improvement.

Key features include:

- **UEC programme** addresses the national clinical advisor recommendations, including improvement to front door triage, same day emergency care and discharge processes.
- **Elective recovery programme** focusses on increasing elective throughput, prioritising long waiters, optimising theatre utilisation, and leveraging independent sector capacity.

Both programmes are aligned with the Integrated Care Board priorities and are supported by enabling strategies in workforce, digital transformation and financial planning. It is envisaged that these programmes will continue to evolve, as their effectiveness is evaluated and where appropriate actions are refreshed.

Key Recommendations

The Board is asked to:

- Approve the UEC and elective recovery programmes as presented
- Endorse their submission to NHS England in fulfilment of regulatory undertakings
- Support continued oversight and delivery through our governance and performance management structures

ENFORCEMENT UNDERTAKINGS

University Hospital of North Midlands NHS Trust ("the Licensee")
Royal Stoke University Hospital
Newcastle Road
Stoke on Trent
ST4 6QG

DECISION

NHS England, based on the grounds set out below, and having regard to its Enforcement Guidance, has decided to accept from the Licensee the enforcement undertakings specified below pursuant to its powers under section 106 of the Health and Social Care Act 2012 ("the Act").

These undertakings supersede the previous undertakings agreed with NHS England in October 2023. NHS England is satisfied that the Licensee has met the requirements related to Maternity, the Staff Survey, Cancer services, and specific Governance requirements as set out in the 2023 undertakings. NHS England has issued compliance certificates for those undertakings.

GROUNDS

1. Licence

   The Licensee is the holder of a licence granted under Section 87 of the Act.

2. Breaches

2.1. NHS England has grounds that the Licensee has provided and is providing health care services for the purposes of the NHS in breach of the following conditions of its licence: NHS 2 (5) (a) (b) (c) (f) (g) NHS 2: (6) (b)

3. Issues:

3.1. The Licensee has been non-compliant with the standards for A&E waiting times (4 hour and 12 hours) and ambulance handover delays ("the standards") set by NHS England Operational Planning Guidance since 2018 and has not delivered a sustained improvement in other aspects of its urgent and emergency care performance, including most notably in relation to ambulance handover delays and the number of days spent in critical incident escalation.

3.2. The Licensee did not deliver the Operating Plan targets it agreed with NHS England for elective care in 2024/25 and has a significant number of patients experiencing long waits from referral to treatment. The Licensee accounted for

approximately half of all 78 week waits in the Midlands region in May 2025 and a quarter of all 65 week waits.

UNDERTAKINGS

Operational Performance – Urgent and Emergency Care (UEC)

3.3. The Licensee will, by 10th October 2025, ensure that there is a robust UEC improvement plan ("the UEC Plan") in place to improve A&E waiting times (4 and 12 hour waits) and reduce ambulance handover delays in accordance with the commitments made in the Staffordshire and Stoke on Trent system's Operational Plan for 2025/26. The UEC Plan should also describe how and when the Licensee will implement the recommendations arising from the NHS England National Clinical Advisor's review of the Licensee's UEC services which was carried out in January 2025.

3.4. The UEC Plan will include actions to:

3.4.1. monitor the impact on quality and mitigate potential harm;
3.4.2. address any issues relating to the effectiveness of the leadership and management within the Emergency Department or wider organisation;
3.4.3. address any cultural or behavioural issues which may be acting as a barrier to improved performance;
3.4.4. include trajectories to show how the Licensee will meet the targets for UEC contained in the Staffordshire and Stoke-on-Trent Operational Plan (2025/26), which has been agreed with NHS England;
3.4.5. describe the key risks and the mitigating actions that will be taken to support the UEC Plan's implementation;
3.4.6. be jointly developed with SSOT ICB, WMAS and other system partners as required;
3.4.7. describe the key milestones associated with the implementation of the UEC Plan, including the deadline for completion and senior accountable officers for each milestone; and
3.4.8. confirm the key performance indicators which the Licensee will use to measure progress against each action, and the expected impact on overall UEC performance.

3.5. The Licensee will incorporate any comments or amendments regarding the UEC Plan made by NHS England, or a third party if such assurance is requested by NHS England, and will send a revised copy of the UEC Plan to NHS England within 5 working days of amendments being agreed.

3.6. The Licensee will deliver the UEC Plan and will provide NHS England with a monthly report on the delivery of each of the improvement priorities identified within the UEC Plan. Reports will be submitted in writing and reviewed as part of the System Delivery Meetings and Quarterly System Review Meetings between the Licensee and NHS England. The Licensee will also provide more regular and / or ad hoc updates on the UEC Plan's delivery if requested by NHS England.

3.7. The Licensee will notify NHS England as soon as practicable when it becomes aware of matters which materially affect the Licensee's ability to deliver the UEC Plan, and the Licensee shall promptly update the UEC Plan to address those matters. The Licensee shall submit an updated UEC Plan within five working days of notifying NHS England of the proposed change. Any changes will be subject to approval by NHS England before they can be actioned by the Licensee.

3.8. The Licensee will ensure that the implementation of the UEC Plan does not compromise its overall financial position. The Licensee will keep the financial cost of its improvements under close review and will notify NHS England and Staffordshire and Stoke-on-Trent ICB as soon as practicable of any matters which are identified as potentially having a material impact on the Licensee's overall financial position.

Operational Performance – Elective Care

3.9. The Licensee will, by 10th October 2025, ensure that there is a robust Elective Improvement Plan ("the Elective Plan") in place to deliver its 2025/26 Operational Plan commitments to improve elective care, as agreed with NHS England.

3.10. The Elective Plan will in particular:

3.10.1. state how the Licensee will deliver its 2025/26 Operational Plan commitments for elective care (including diagnostics, theatres, outpatients and patient access) and provide trajectories that demonstrate the route to delivery of the Elective Plan;

3.10.2. set out a future vision for elective care services (including diagnostics, theatres, outpatients and patient access) at the Licensee and the milestones that will lead to the implementation of that vision over the next ten years. This should be aligned with the defined health needs of the population, as well as the Ten Year Plan (once published), national Reforming Elective Care for Patients strategy and Staffordshire and Stoke on Trent ICB's strategy for transforming elective care;

3.10.3. describe the key risks and the mitigating actions that will be taken to support the Elective Plan's implementation;
3.10.4. demonstrate that the Licensee has collaborated with Staffordshire and Stoke on Trent ICB and other partner organisations as appropriate;
3.10.5. describe the governance arrangements that the Licensee will put in place to oversee the delivery of the Elective Plan, how these will relate to the Licensee's existing governance arrangements (including those overseeing operational performance, clinical quality and finance) and how they will integrate with the governance arrangements that Staffordshire and Stoke on Trent ICB has established to lead the delivery and development of elective care.
3.10.6. describe the key milestones associated with the implementation of the Elective Plan, including the deadline for completion and senior responsible officers for each milestone;
3.10.7. confirm the key performance indicators which the Licensee will use to measure progress against each action, and the expected impact on overall elective performance.

3.11. The Licensee will incorporate any comments or amendments regarding the Elective Plan made by NHS England, or a third party if such assurance is requested by NHS England, and will send a revised copy of the Elective Plan to NHS England within five working days of amendments being agreed.

3.12. The Licensee will deliver the Elective Plan and will provide NHS England with a monthly report on the delivery of the each of the improvement priorities identified within the Elective Plan. Reports will be submitted in writing and reviewed as part of the System Delivery Meetings and Quarterly System Review Meetings between the Licensee and NHS England. The Licensee will also provide more regular and / or ad hoc updates on the Elective Plan's delivery if requested by NHS England.

3.13. The Licensee will notify NHS England as soon as practicable when it becomes aware of matters which materially affect the Licensee's ability to deliver the Elective Plan, and the Licensee shall promptly update the Elective Plan to address those matters. The Licensee shall submit an updated Elective Plan within five working days of notifying NHS England of the proposed change. Any changes will be subject to approval by NHS England before they can be actioned by the Licensee.

3.14. The Licensee will ensure that the implementation of the Elective Plan does not compromise its overall financial position. The Licensee will keep the financial cost of its improvements under close review and will notify NHS England and Staffordshire and Stoke-on-Trent ICB as soon as practicable of any matters

which are identified as potentially having a material impact on the Licensee's overall financial position.

4. Programme Management

4.1. The Licensee will implement sufficient programme management and governance arrangements to enable delivery of these undertakings.

4.2. Such programme management and governance arrangements must enable the Board to:

4.2.1. obtain clear oversight over the process in delivering these undertakings;
4.2.2. obtain an understanding of the risks to the successful achievement of the undertakings and ensure appropriate mitigation;
4.2.3. hold individuals to account for the delivery of the undertakings; and
4.2.4. ensure that appropriate quality impact assessments are undertaken and monitored

5. Meetings and Reports

5.1. The Licensee will provide NHS England with final draft copies of its UEC and Elective Plan ("Plan/s") (as indicated in paragraphs 3.3. and 3.9) to review before they are approved by the Licensee's Board. The final version of both plans will then be shared with NHS England within five working days.

5.2. The Licensee will attend meetings or, if NHS England stipulates, conference calls, at such times and places, and with such attendees, as may be required by NHS England.

5.3. The Licensee will provide such reports in relation to the matters covered by these undertakings as NHS England may require.

5.4. The Licensee will report to NHS England on the delivery of its Plans on a monthly basis and more frequently if required.

The undertakings set out above are without prejudice to the requirement on the Licensee to ensure that it is compliant with all the conditions of its licence and those conditions relating to:

5.4.1. compliance with the health care standards binding on the Licensee;

5.4.2. and compliance with all requirements concerning quality of care.

Any failure to comply with the above undertakings will render the Licensee liable to further formal action by NHS England. This could include the imposition of discretionary requirements under Section 105 of the Act in respect of the breach

which the undertakings were given, and/or revocation of the licence pursuant to Section 89 of the Act.

Where NHS England is satisfied that the Licensee has given inaccurate, misleading or incomplete information in relation to the undertakings: (i) NHS England may treat the Licensee as having failed to comply with the undertakings; and (ii) if NHS England decides so to treat the Licensee, NHS England must by notice revoke any compliance certificate given to the Licensee in respect of compliance with the relevant undertakings.

SIGNED

LICENSEE

Signed

Dr Simon Constable
Chief Executive of Licensee

Dated: 10.09.2025

NHS ENGLAND

Rebecca Farmer
Director of System Co-ordination and Oversight (West Midlands) and member of the Regional Support Group
NHS England – Midlands

Dated: 12.09.2025

Urgent & Emergency Care (UEC)

Improvement Plan

Overview

The purpose of this plan is to improve Emergency Department waiting times (4 and 12 hours) and reduce ambulance handover delays in accordance with the Staffordshire and Stoke-on-Trent system's Operational Plan for 2025 / 26 and in response to the recommendations arising from the NHS England National Clinical Advisor's review of UEC services in January 2025.

UEC Improvement Programme

Programme Objective
To ensure that our non-elective patients receive the best healthcare and outcomes by ensuring that patients have the right access to the right care, in the right place and in a timely way.

Workstream 1 **Front Door Processes**	• Urgent Treatment Centre (UTC) • Standard Work • ED Staffing • Layout review of ED floor
Workstream 2 **Frailty**	• New Clinical Model
Workstream 3 **Clinical Pathways**	• Acute Medicine standardised pathways • Portals
Workstream 4 **Bed and Site Management**	• Continuous Flow • OPEL escalation / Policy Review
Workstream 5 **Ward Processes and Discharge**	• Discharge Lounge • Criteria Led Discharge • Safety Stop • Ward processes • Discharge Planning

The Programme will be measured via national targets and in line with the Staffordshire and Stoke-on-Trent Operational Plan 2025/26

Measure	Target	Deadline	Plan (Aug 25)	Actual (Aug 25)
% patients leaving A&E within 4 hours	78%	March 26	78%	69.5%
Number of patients in A&E for over 12 hours	2,128	March 26	1,565	1,757
Average Handover Time for Ambulances	0:43:00	March 26	0:41:00	0:48:52

The table above shows full year target for 25/26 and August 2025 Plan versus August 2025 Actuals

National Clinical Advisor's Review of UEC

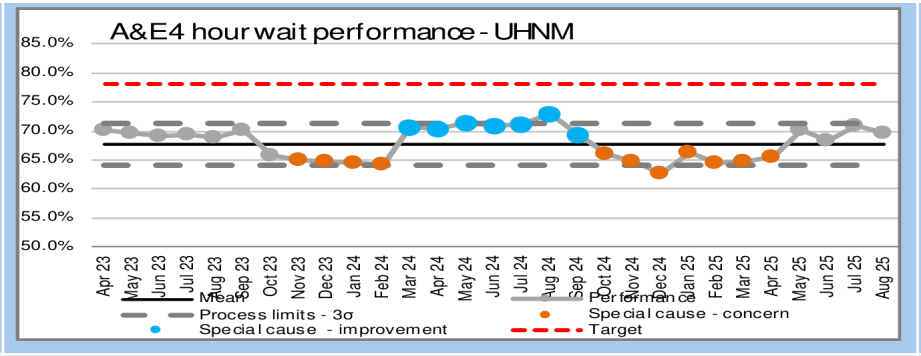
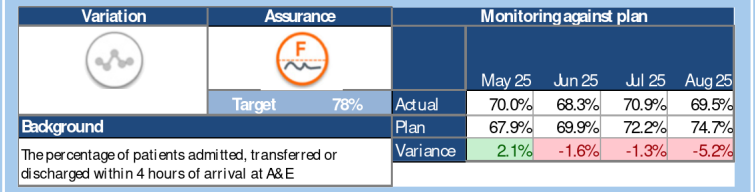
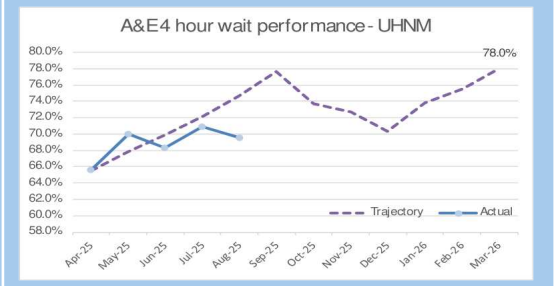
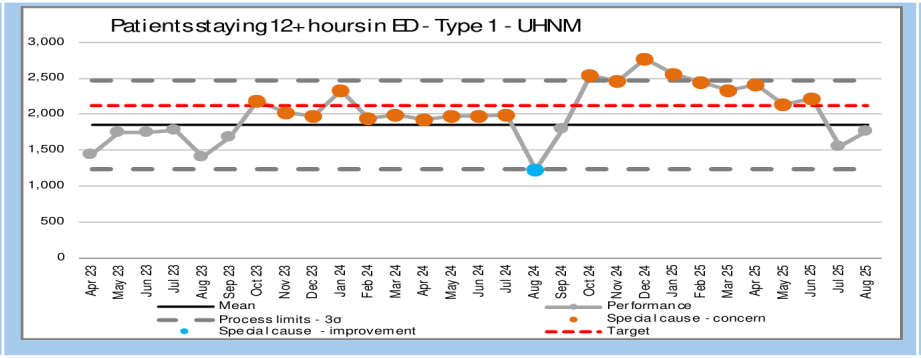
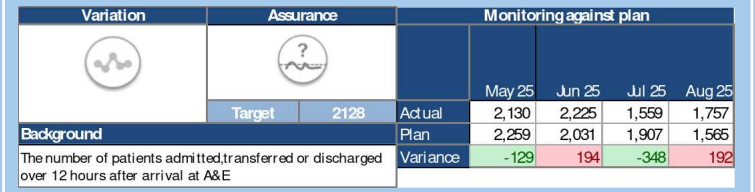
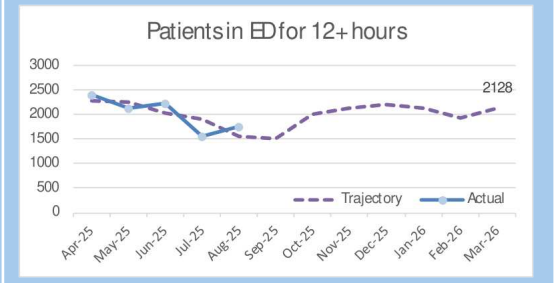
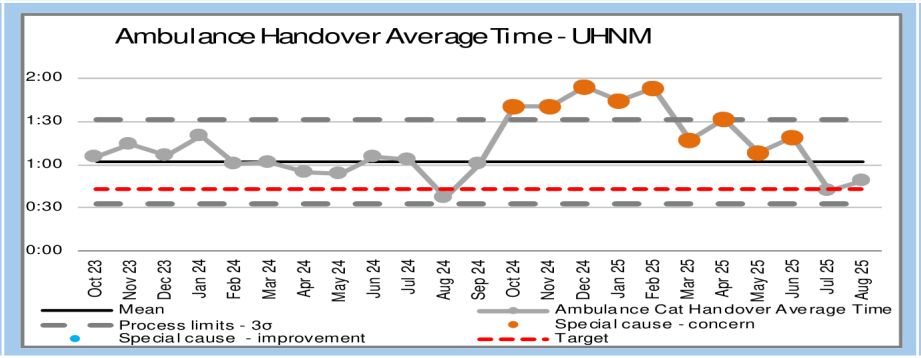
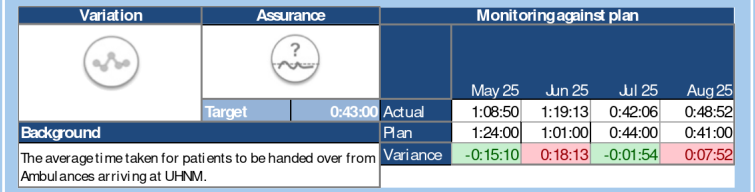
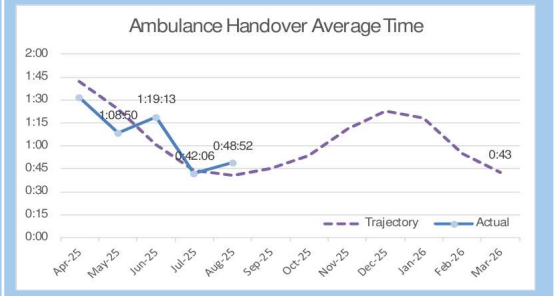
- Review focussed on ED, system, hospital operations, specialities, frailty, corporate, wards, acute medicine and SSDEC / SAU
- 54 recommendations made focussed on service, processes and leadership
- All recommendations consolidated into our Urgent and Emergency Care (UEC) Recovery Programme and/or reflected in the Organisation Redesign Programme

UEC Milestone Plan on a Page

	2025								2026		
Workstream	**May**	**June**	**July**	**August**	**September**	**October**	**November**	**December**	**January**	**February**	**March**
1. Front Door Processes **SRO Dr Liz Gunning**			Navigation & Triage ToC and Final model		Ambulance Assessment Area ToC and Final model						
					ED Staffing Review	ED Physical Layout post UTC					
					RSUH UTC Partial Go-live						RSUH UTC Full Go live
2. Frailty Clinical Model **SRO Dr Liz Gunning**					Assessment Area in FEAU ToC						
3. Clinical Pathways **SRO Dr Liz Gunning**		Acute Medicine pathway review		Acute Medicine standardised pathways implemented				HMU into Enhanced Care Unit			
		Clinical pathway development and Portal model and pathway review									
4. Bed and Site Management **SRO Dr Fiona Hibberts**			Continuous Flow process review		OPEL escalation and Flow Operational Policy approval						Site infrastructure Business Case
5. Ward Processes and Discharge **SRO Dr Fiona Hibberts**			Expanded Discharge Lounge Business Case and mobilisation (ON HOLD)				Discharge Facilitators Standardisation	Maximise use of current discharge lounge		Criteria Led Discharge Pilot (respiratory)	Therapies Test of Change
					Standardised Safety Stop	Long LOS review process	Standard Work Patient Information Leaflet and Transportation	Directory of Services for Social Prescribing			
						Standard 24hrs on ward	Education & Training Plan				
						Discharge Planning Acute Care at Home	Transfer of Care form review				
						Standard work Pharmacy PEG tubes					

Key Performance Metrics

A comprehensive suite of dashboards have been developed to support oversight of the programme. Metrics are available against each workstream, although all underpin three core metrics. (Appendix 1 shows workstream level metrics).

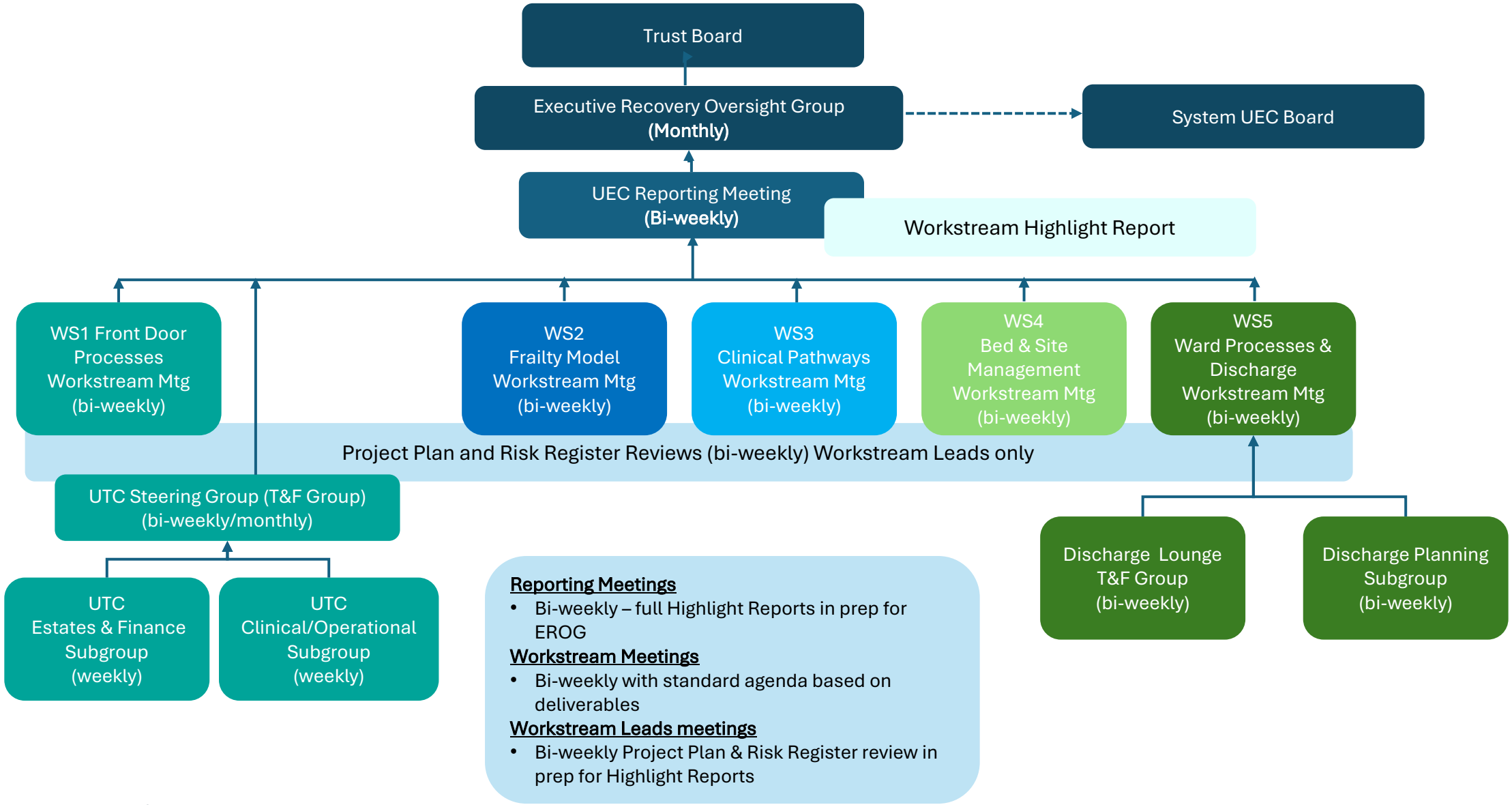
	Strategic Objective	Target	Trajectory
A&E 4 hour wait performance			
Patients staying 12+ hours in ED (Type 1)			
Ambulance Handover Average Time			

Variation	Assurance	Monitoring against plan				
	F		May 25	Jun 25	Jul 25	Aug 25
	Target 78%	Actual	70.0%	68.3%	70.9%	69.5%
Background		Plan	67.9%	69.9%	72.2%	74.7%
The percentage of patients admitted, transferred or discharged within 4 hours of arrival at A&E		Variance	2.1%	-1.6%	-1.3%	-5.2%

Variation	Assurance	Monitoring against plan				
	?		May 25	Jun 25	Jul 25	Aug 25
	Target 2128	Actual	2,130	2,225	1,559	1,757
Background		Plan	2,259	2,031	1,907	1,565
The number of patients admitted,transferred or discharged over 12 hours after arrival at A&E		Variance	-129	194	-348	192

Variation	Assurance	Monitoring against plan				
	?		May 25	Jun 25	Jul 25	Aug 25
	Target 0:43:00	Actual	1:08:50	1:19:13	0:42:06	0:48:52
Background		Plan	1:24:00	1:01:00	0:44:00	0:41:00
The average time taken for patients to be handed over from Ambulances arriving at UHNM.		Variance	-0:15:10	0:18:13	-0:01:54	0:07:52

UEC Programme Governance / Reporting



Reporting Meetings

- Bi-weekly – full Highlight Reports in prep for EROG

Workstream Meetings

- Bi-weekly with standard agenda based on deliverables

Workstream Leads meetings

- Bi-weekly Project Plan & Risk Register review in prep for Highlight Reports

National Clinical Advisor Review of UEC

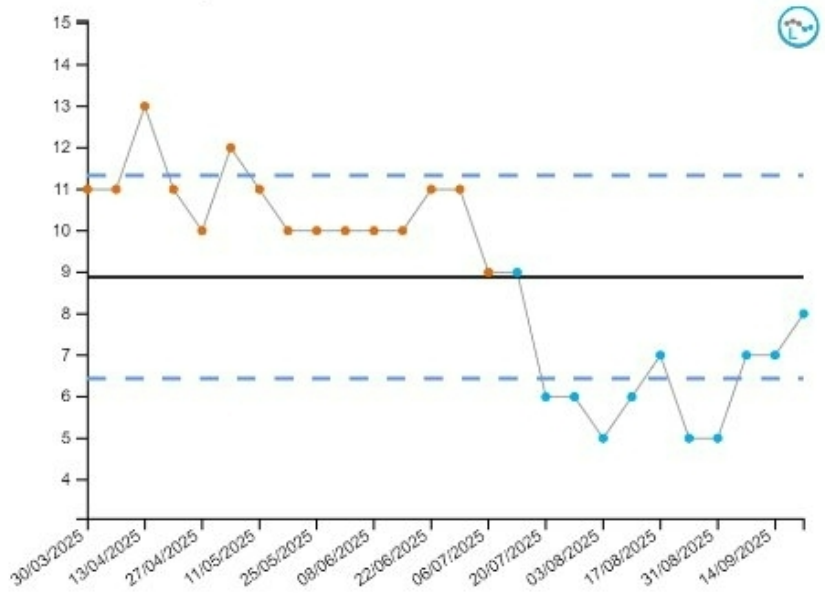
Service	Theme	PROGRAMME WORKSTREAM ALIGNMENT				
		WS1 Front	WS2 Frailty	WS3 Clinical Pathways	WS4 Bed & Site Management	WS5 Ward Processes & Discharge
Emergency Department	Safety	■				
	Process	■	■		■	
	Leadership	■				
System	Service	■	■		■	■
	Leadership				■	■
Hospital Operations	Process				■	■
	Leadership				■	
Specialties	Process	■		■		
	Leadership					■
Frailty	Process	■			■	■
	Leadership					
Corporate	Leadership				■	
Wards	Leadership				■	■
	Service				■	■
	Process				■	■
Acute Medicine	Process			■	■	■
	Leadership			■		
	Service			■	■	
SSDEC/SAU	Leadership			■	■	
	Services			■	■	■

Appendix 1 – UEC Workstream Level Metrics and Performance

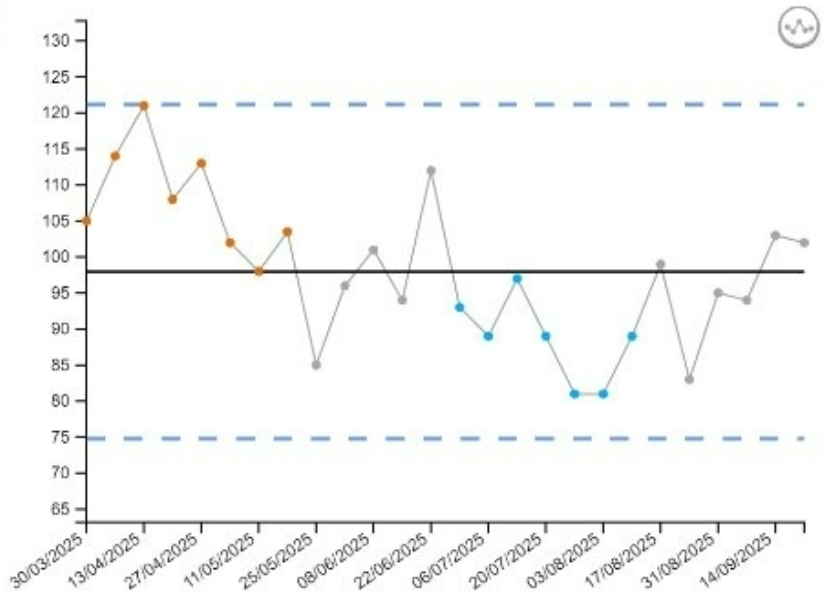
Urgent & Emergency Care Workstream 1: Acute Front Door

Selected Date Range: 24/03/2025 - 21/09/2025

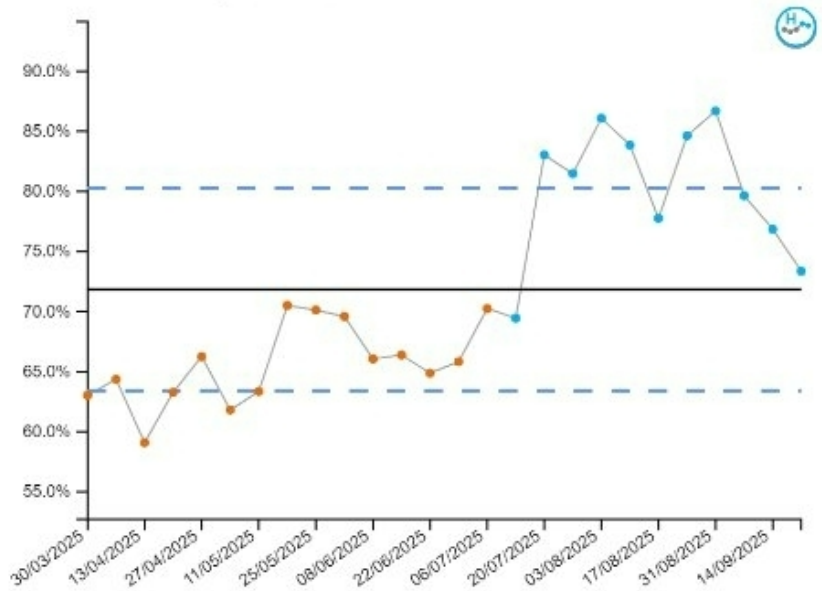
Median mins to Triage



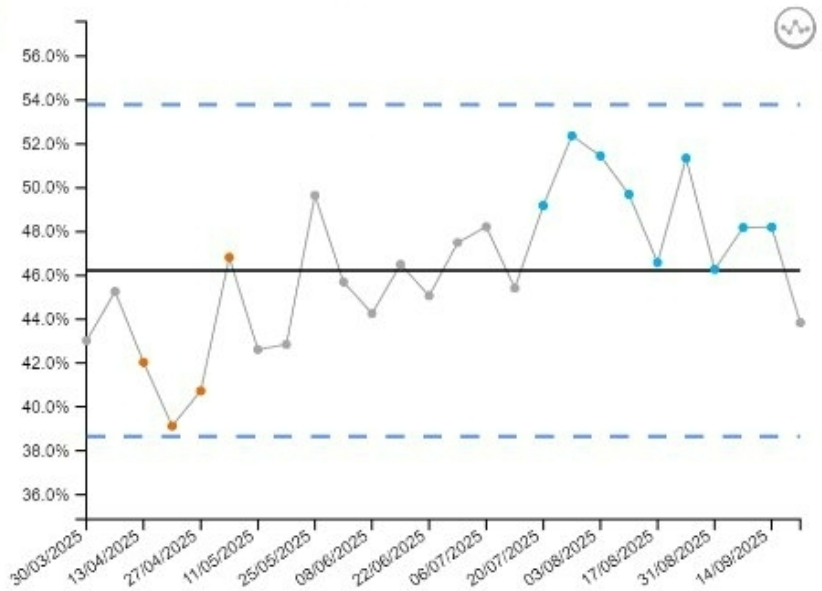
Median mins to First Seen



% of Attendances Triaged within 15 mins



% of Attendances Treated within 60 mins



Last 30 Days | Last 26 Weeks | Custom Date Range

Metrics

Median mins to Triage
Median mins between arrival in ED and triage time

Median mins to First Seen
Median mins between arrival in ED and first doctor seen time

% of Attendances Triaged within 15 mins
Number of ED attendances triaged within 15 mins of arrival / Total number of ED attendances

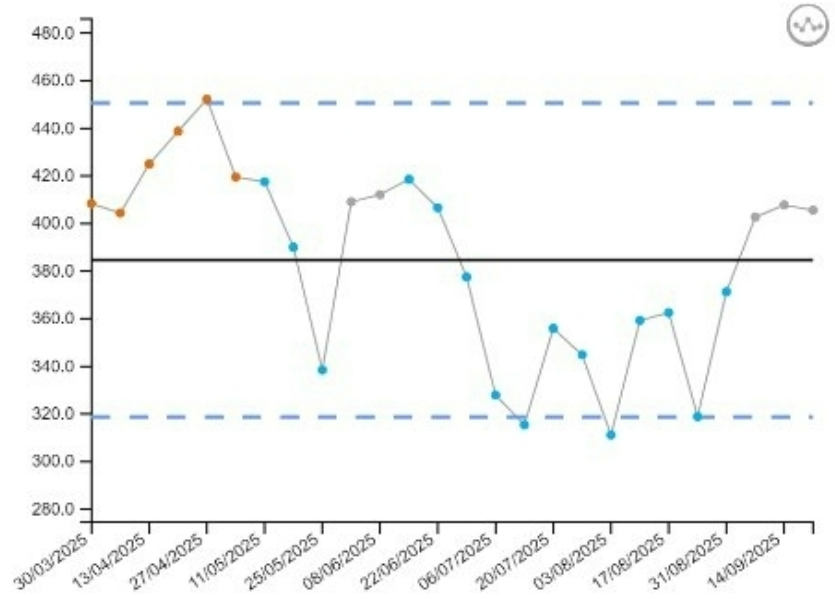
% of Attendances Treated within 60 mins
Number of ED attendances seen by doctor within 60 mins / Total number of ED attendances

Strategic Objectives: 4-hour performance & ambulance handover delays

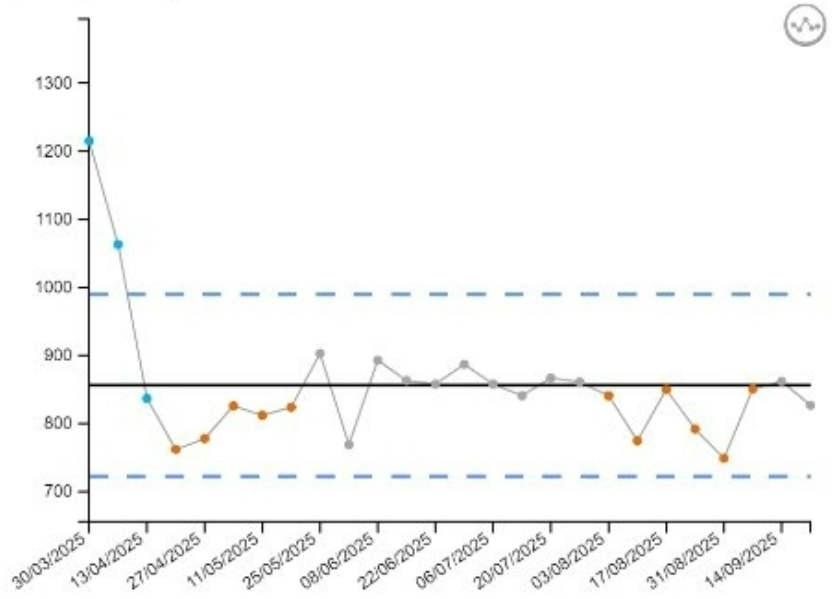
Urgent & Emergency Care Workstream 2: Frailty

Selected Date Range: 24/03/2025 - 21/09/2025

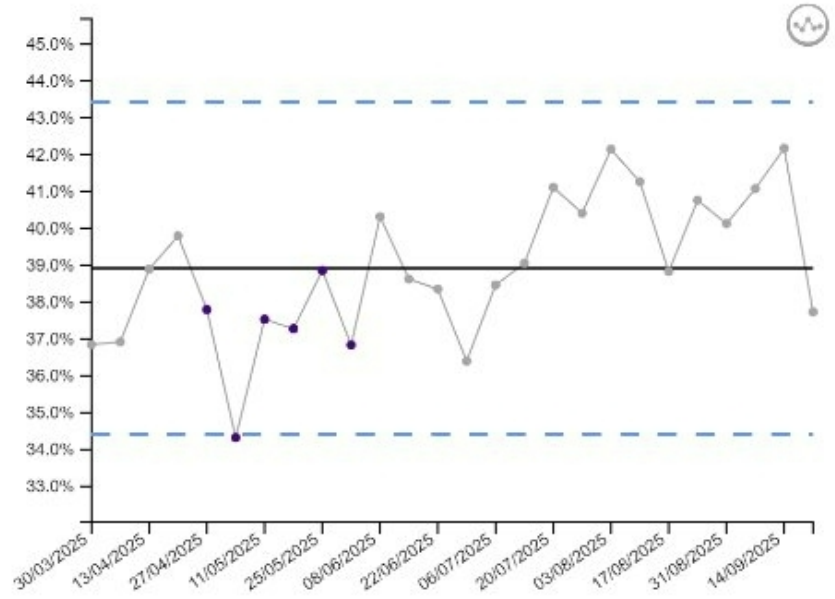
Mean mins in ED



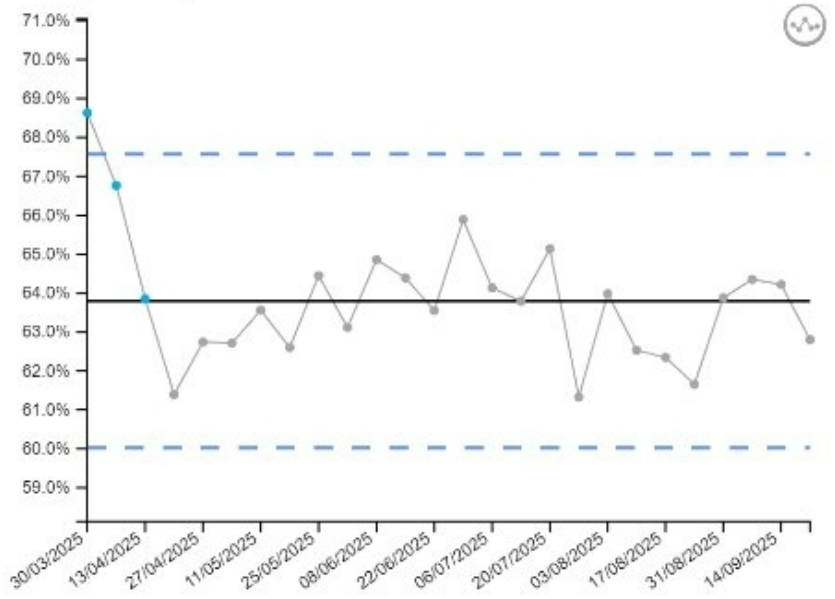
Discharges 0 Day LoS



Conversion %



Discharges <3 Days LoS



Last 30 Days | Last 26 Weeks | Custom Date Range

Age Filter

☐ Age over 75

Metrics

Note: all metrics on this page relate to patients who are either:

- *aged 65 and over and resident of a care home, or*
- *aged over 75*

Use the age filter above to view only patients aged over 75.

Discharging Ward filter relates to the ward prior to the discharge lounge (if the patient was discharged via the lounge).

Mean mins in ED
Mean mins between arrival in ED and departure/conclusion

Discharges 0 Day LoS
Number of inpatient spells discharged on the same day as admission (excl. Daycase)

Conversion %
Number of ED attendances that were admitted (based on disposal method) / Total number of ED attendances

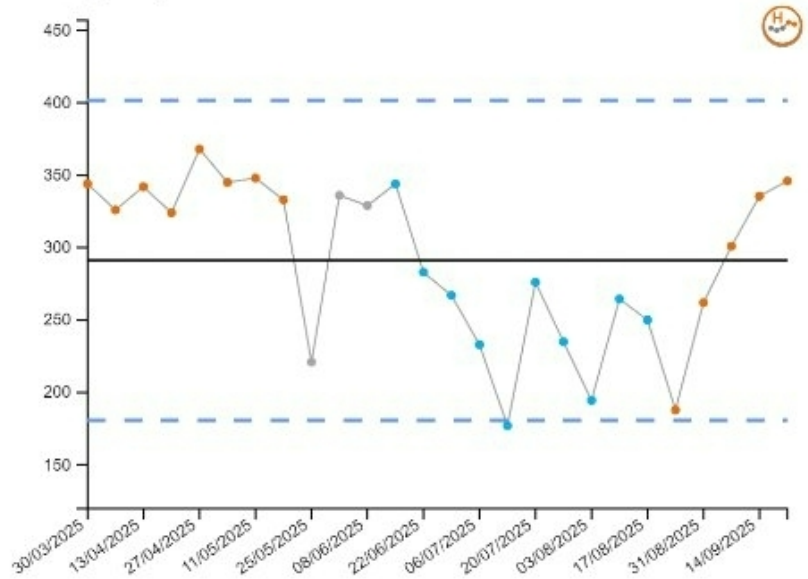
Discharges <3 Days LoS
Number of inpatient spells discharged within 3 days of admission (excl. Daycase) / Number of discharges (excl. Daycase)

Strategic Objectives: 12-hour breaches & ambulance handover delays

Urgent & Emergency Care Workstream 3: Clinical Pathways

Selected Date Range: 24/03/2025 - 21/09/2025

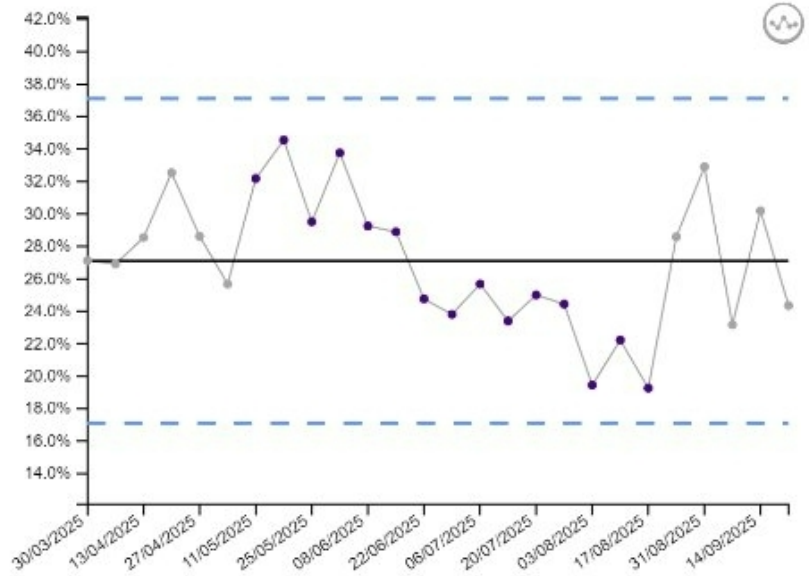
Median Specialty Referral to Conclusion mins



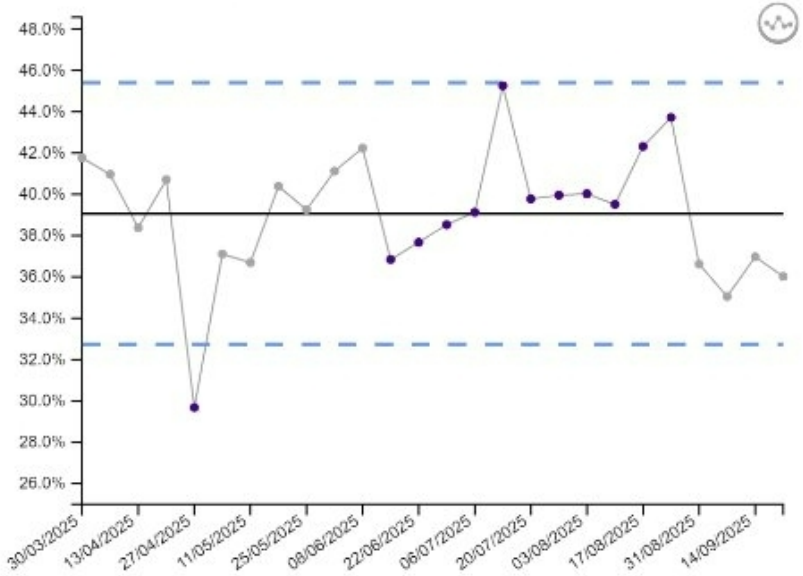
Total & Median Specialty Request to Conclusion mins by Specialty

Specialty	Total Spec Req-Conc mins	Median Spec Req-Conc mins
Acute Medical Unit (AMU)	8,459,750	465
Social Care	629,573	654
T&O	591,726	237
Surgical	558,800	177
Physio/OT	517,179	367
Cardiology	271,333	145
Liaison Psychiatry	246,207	229
Neurology	207,764	170
Stroke	153,172	143
Urology	151,435	114
Spinal	144,802	305
Total	**13,239,145**	**281**

% of SDEC activity via ED



% of SDEC activity via GP



Last 30 Days | Last 26 Weeks | Custom Date Range

Metrics

Note: SDEC metrics include ED and inpatient areas

Median Specialty Referral to Conclusion mins
Median mins between ED referral to specialty and ED departure/conclusion

% of SDEC activity via ED
Number of SDEC admissions and attendances with admission method "Emergency A&E or Dental Casualty Dept" or referral source "Emergency Services" / Total SDEC admissions and attendances

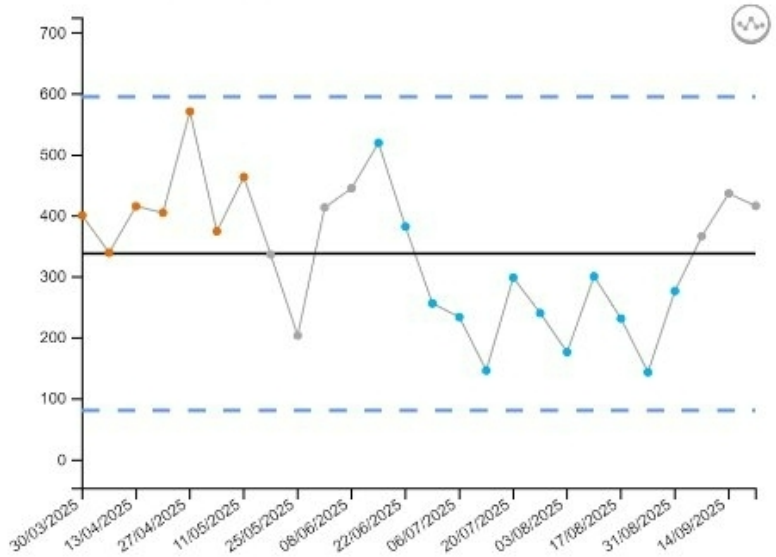
% of SDEC activity via ED
Number of SDEC admissions and attendances with admission method "Emergency GP" or referral source "General Medical Practitioner" / Total SDEC admissions and attendances

Strategic Objective: ambulance handover delays

Urgent & Emergency Care Workstream 4: Bed & Site Management

Selected Date Range: 24/03/2025 - 21/09/2025

Median DTA to Conclusion mins



Last 30 Days | Last 26 Weeks | Custom Date Range

Metrics

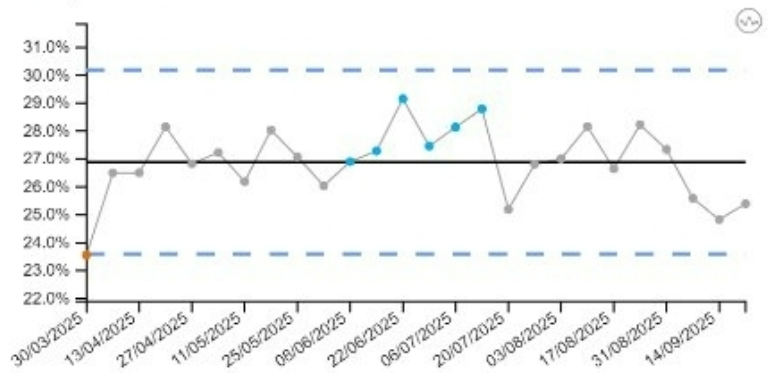
Median DTA to Conclusion mins
Median mins between ED decision to admit and ED departure/conclusion

Strategic Objectives: 12-hour breaches & ambulance handover delays

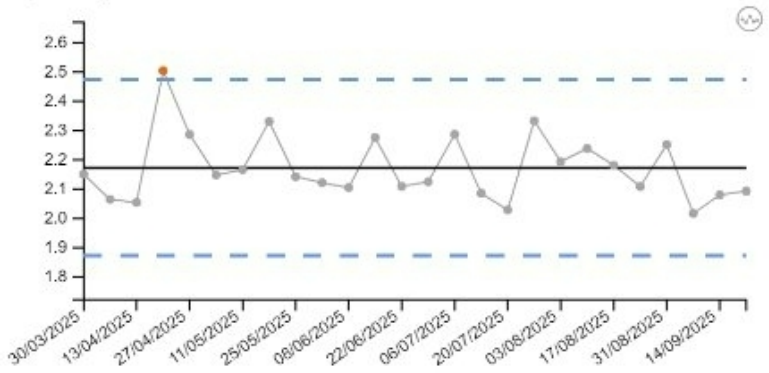
Urgent & Emergency Care Workstream 5: Ward Process & Discharge

Selected Date Range: 24/03/2025 - 21/09/2025

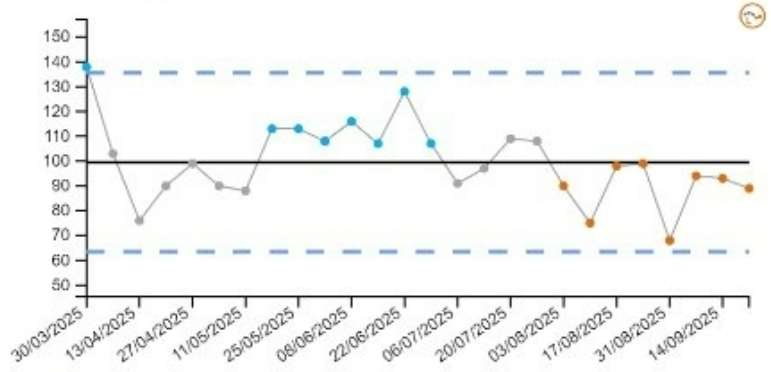
RtR Populated %



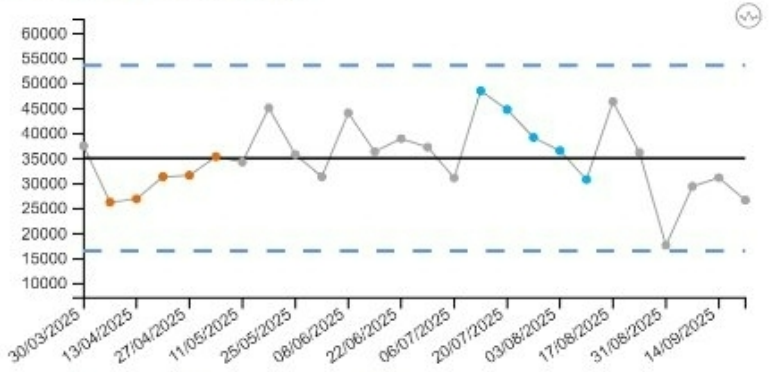
Avg LoS (Spell)



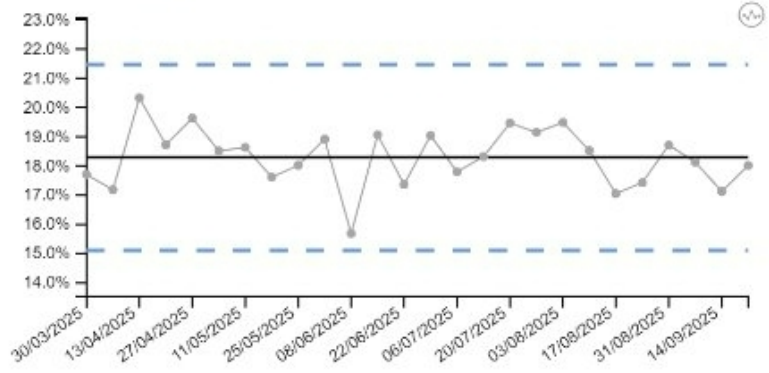
Discharge Lounge Usage



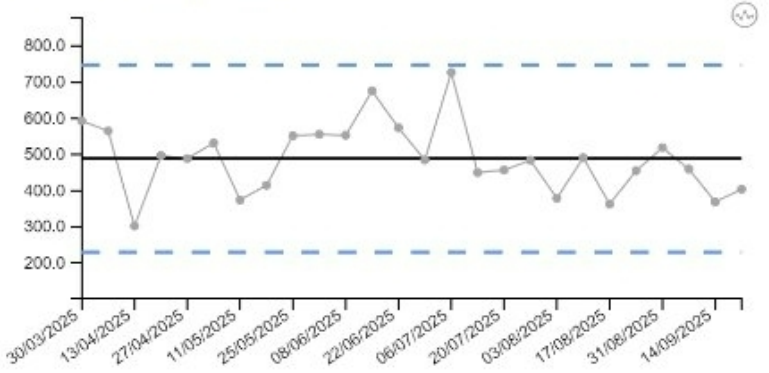
Mean mins in Discharge Lounge



Pre-noon Discharges %



Avg MFFD Days (Home First & Assessment Bed)



Last 30 Days | Last 26 Weeks | Custom Date Range

Metrics

Discharging Ward filter relates to the ward prior to the discharge lounge (if the patient was discharged via the lounge).

RtR Populated
Discharged inpatient spells (excl. Daycase) with reason to reside populated during the spell / all inpatient discharges (excl. Daycase)

Avg LoS (Spell)
Total LoS for discharged inpatient spells (excl. Daycase) / all inpatient discharges (excl. Daycase)

Discharge Lounge Usage
Inpatient ward stays in discharge lounge (where patient was discharged from the lounge)

Mean mins in Discharge Lounge
Mean mins between arrival in and departure from discharge lounge (where patient was discharged from the lounge)

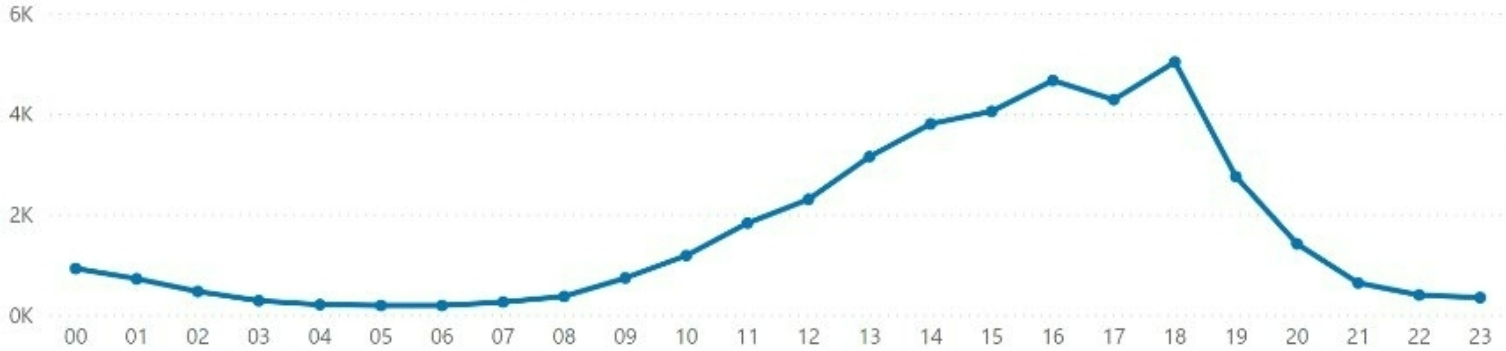
Pre-noon Discharges %
Inpatient spells (excl. Daycase and 0 day LoS) discharged from hospital or moved to discharge lounge before 12:00pm / all inpatient discharges (excl. Daycase and 0 day LoS)

Avg MFFD Days (Home First & Assessment Bed)
Number of days patients spent classed as medically fit before discharge / total number of spells with MFFD populated during spell ("Pathway 1 - Home First" & Pathway 2 - Assessment Bed" only)

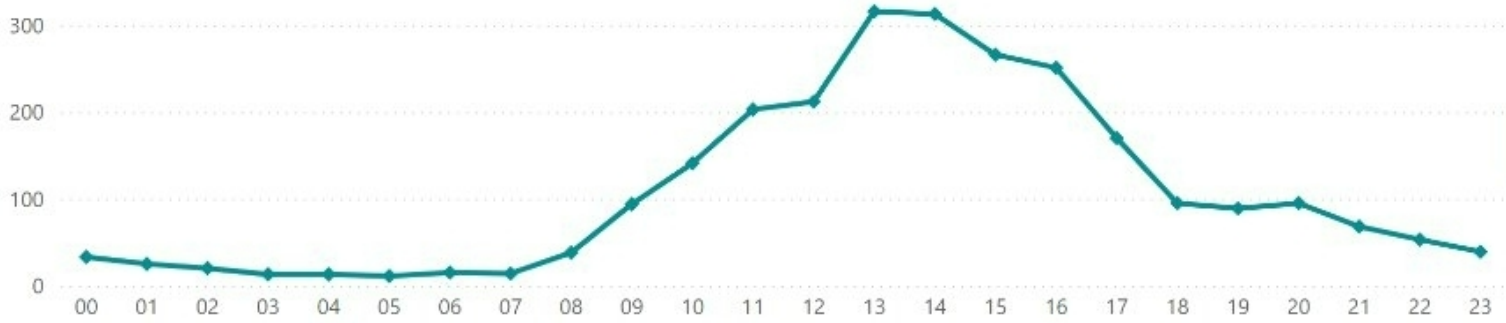
Strategic Objectives: 12-hour breaches & ambulance handover delays

Urgent & Emergency Care Workstream 5: Discharges — **Selected Date Range: 24/03/2025 - 21/09/2025**

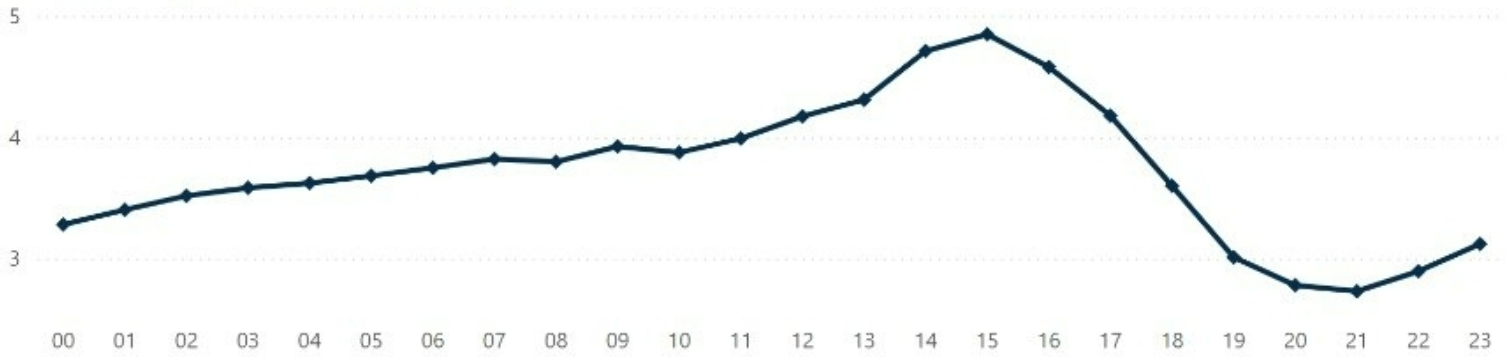
Discharges (excl Daycase and 0 Day LoS) by Hour



Discharge Lounge Usage by Hour



Discharge Lounge Tally by Hour (daily average)



Metrics

Charts | Discharge Lounge Tally

Discharges by Hour
No. of discharges (excl. Daycase and 0 day LoS) by hour of discharge or move to discharge lounge.

Discharge Lounge Usage by Hour
Ward stays in discharge lounge by starting hour

Discharge Lounge Tally by Hour (daily average)
Avg. number of inpatients in lounge by hour for selected date range

Discharges by Ward
Number of discharges by discharging ward (if patient was discharged via the discharge lounge then the previous ward is reported)

Discharge Lounge Usage by Previous Ward
For spells discharged via the discharge lounge, the ward prior to transfer to the lounge

Discharging Ward filter relates to the ward prior to the discharge lounge (if the patient was discharged via the lounge).

Disch. by Ward | Prev. Ward | Disch. Destination

Discharges by Ward

Ward	Discharges
Ward 202	13,823
MAT - Maternity Assessment Unit	8,935
Chemotherapy and Treatment Unit	6,949
Endoscopy Department	6,574
Endoscopy Unit SGH	4,673
Ward 105	4,081
CH - CAU (Childrens Assessment Unit)	3,491
SDU (Specialised Decisions Unit)	2,434
MAT - Ward 206	2,220
Urology Ambulatory Care Unit	1,962
Central Treatment Suite (CTS)	1,768
AMRAU	1,755
Short Stay Unit	1,618
Total	**115,421**

Appendix 2
UEC Executive Recovery Oversight Group
UEC Highlight Reports

Monday 22nd September 2025

UEC Programme Overview

Period	SRO	Overall Status		
Aug/Sept	Katy Thorpe	On Track	At Risk	Off Track

Objectives

The main strategic objectives of the UHNM UEC Programme is to ensure that our non-elective patients receive the best healthcare and outcomes by ensuring that patients have access to the right care, in the right place and in a timely way.

The programme will be measured via national targets of:

- 4-hour standard
- Aggregated time of arrival greater than 12 hour in the ED
- Reduced ambulance handover delays (45 min -as per recent national conversations)

Programme Summary

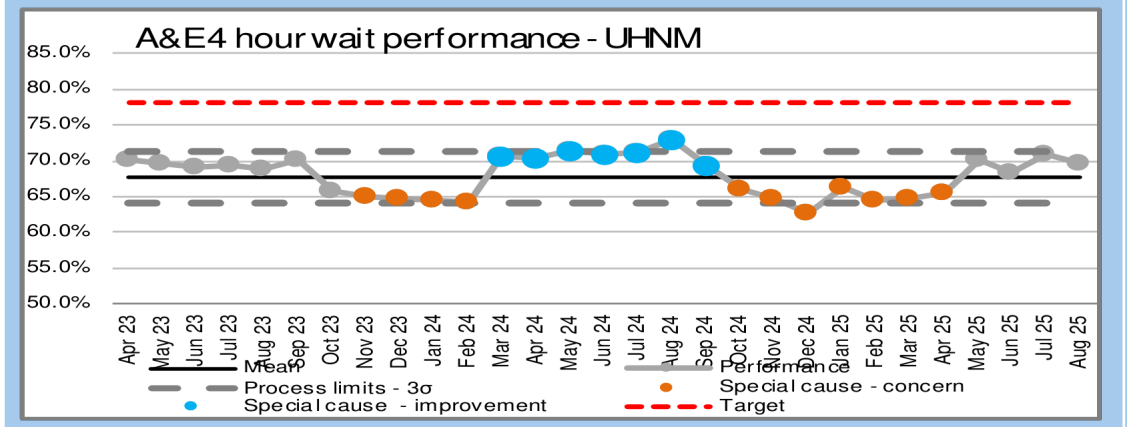
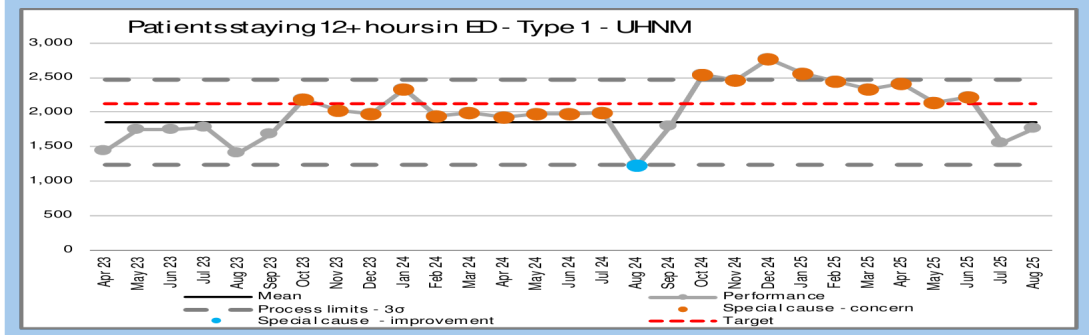
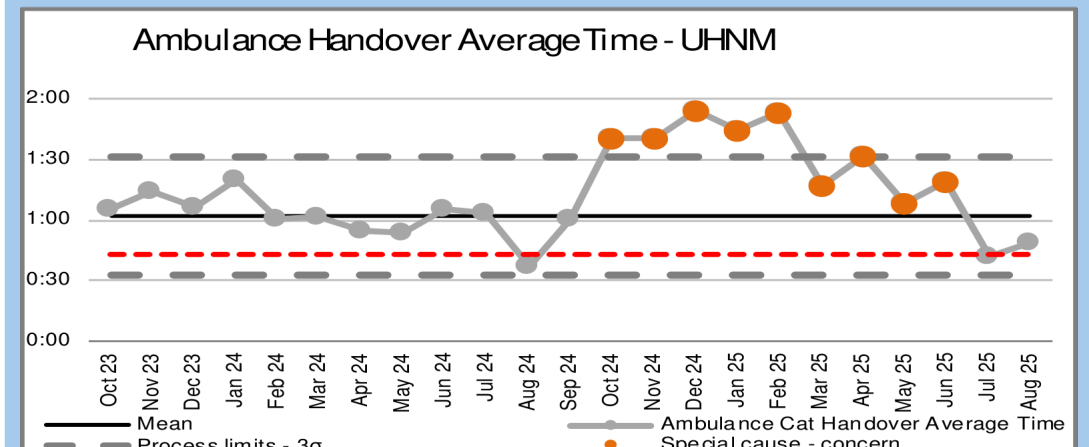
- Roles and responsibilities (overall programme and in the Care Group Structure) are starting to embed, Clinical SRO supporting arrangements within some workstreams require further clarification. Programme Management and Project Support Management is now embedded across the programme.
- A two week period to enable stocktake and refresh of workstream plans, leadership, governance and delivery structures has been undertaken to support transition to the Care Group structure with a switch to alternating bi-weekly full workstream meetings and Project Plan and Risk Register review meeting.
- A number of Tests of Change have taken place or are scheduled to run over the coming weeks e.g. Navigation & Triage, Ambulance Assessment and Frailty Assessment model.
- UTC has recommenced following both capital and revenue funding approvals.

Key Programme Issues that need resolution		Escalation /Decision required
Impact of NHSE capital approval process on UTC.		Capital and revenue approval process escalated to NHSE 18th July
Revenue gap remains unresolved for UTC.		Approval given and workstream remobilised 9/9/25. Risk reduced
Clinical and operational leadership and programme management is in transition		Roles and responsibilities, workstream plans, governance and delivery structure refreshed. Requires further work to completely embed in to workstreams

Workstreams at a glance

Workstream		Project	RAG	Comments
1	Front door processes	UTC		UTC Revenue and capital now approved and workstream remobilised 9/9/25 and new timelines established. Remains off track (RED) this month pending confirmation of planning permission timelines.
		Standard work		Navigation and Triage test of change completed with final model agreed to inform future business case. Initial feedback is positive. Further test of change for ambulance assessment area delayed slightly until beginning of October 2025.
		ED staffing		Process and roster review complete. Alignment to demand for T3 and T4 underway. Locum Consultant post out to advert until 8th October 2025.
		Layout review of ED floor		Health planner commissioned and initial workshop held with follow up meetings scheduled. ARCHUS report anticipated.
2	Frailty	New clinical model		Frailty Test of Change slightly delayed, will now commence w/c 29th September 2025
3	Clinical Pathways	Portals		Clinical Pathways and portals work is off track due to changes in leadership. Initial meeting to review SOPs and commence scoping is scheduled with PMO and Transformation Team support aligned. Phase 1 focus on medical portals (AEC, AMRAU, AMU) to recover. Acute Medicine work well underway. Handed over to Unplanned Care Group.
4	Bed & Site	Continuous Flow Review		Review of Continuous Flow process underway, delayed due to leadership changes and capacity.
		OPEL escalation/ Policy review		The OPEL escalation cards and policy out for further review and comments from Unplanned Care and Planned Care Groups.
5	Ward Process Discharge	Discharge Lounge		Review of current model and SOPs against current footprint underway
		Criteria Led Discharge		Pilot under development
		Safety Stop		Review of current utilisation underway. Digital support required to access WIS Board
		Ward processes		Rapid Improvement workshop and Confirm and Commit session undertaken with three priority areas of focus agreed
		Discharge planning		Work on positive risk taking continues with focus on home care pathways. Maximisation of virtual ward capacity continues. Patient Discharge Information Leaflet is with the printers ahead of October launch. ToC for pharmacy discharge escalation scheduled.
Enabling HRD		Front door deflections		HRD workstream have continued to reduce LoS. Approval received to recruit to the x2 IDH staff to support tracking from the HRD tool. The team have been focusing on Virtual ward pathways to support deflection. Palliative audit underway to inform opportunities and changes in current process. The team have been focusing on ensuring MDT involvement in the daily huddles.
		HRD into new model		
		Clinical pathways		
		Site escalation		
		Embed HRD		

UEC Strategic Objectives

Strategic Objective	Target	What is the data telling us (June)
	**Monitoring against plan** May 25 / Jun 25 / Jul 25 / Aug 25 Actual: 70.0% / 68.3% / 70.9% / 69.5% Plan: 67.9% / 69.9% / 72.2% / 74.7% Variance: 2.1% / -1.6% / -1.3% / -5.2%	Validated performance is 69.5% for August, which is a marginal drop from 70.9% in July. Performance has stabilised well over summer with just 2.6% variation over a 4 month period (May – August) The submitted improvement trajectory against the 4hr standard set for August was slightly short of Plan (Plan 74.7% vs Actual 69.5%), and also short of Target (Target 78% vs Actual 69.5%) The teams ongoing work to improve this performance metric has sustained improvement since April '25 Type 1 4hr performance for Royal Stoke was 46.0% which marginally dropped since last month at 46.4%. Type 1 4hr performance for County was 68.8% which has dropped by 3.3% since last month from 72.1%. We are ranked as 106th out of 142 trusts which is a negative move down 13 Ranking places since April 2025 (119th).
	**Monitoring against plan** May 25 / Jun 25 / Jul 25 / Aug 25 Actual: 2,130 / 2,225 / 1,559 / 1,757 Plan: 2,259 / 2,031 / 1,907 / 1,565 Variance: -129 / 194 / -348 / 192	In August, 1757 patients waited longer than 12 hours in ED compared to 1559 in July – demonstrating a 12% increase The performance trajectory for August was 1565,wo we have underperformed against plan by 192. Note, there has been a decreasing trend since January in the number of patients waiting over 10 hours albeit fluctuations against plan month on month.
	**Monitoring against plan** May 25 / Jun 25 / Jul 25 / Aug 25 Actual: 1:08:50 / 1:19:13 / 0:42:06 / 0:48:52 Plan: 1:24:00 / 1:01:00 / 0:44:00 / 0:41:00 Variance: -0:15:10 / 0:18:13 / -0:01:54 / 0:07:52	Total number of ambulances in August was 5543, of which 1532 had a delay of over 45 mins (72.36% within 45 mins). This compares negatively to July, which had a total of 5692, of which 1342 were over 45 mins (76.42% within 45 mins) Average handover time in August was 48 minutes, a marginal 6 minute increase since July. The target for August was 43 minutes, meaning we underperformed against this by 5 minutes per ambulance (around 10% off target), and also fell short of plan which was 41 minutes, slightly less time than target. We continue to work with colleagues at WMAS on overall ambulance handover reduction. We continue to push the internal 'test of change' which involves pushing YNP's to free up space in ED, and subsequently into Ambulance assessment providing the space to

Workstream 1 Front Door Process Highlight Report

Period	SRO	Overall Status		
18.08.2025 – 16.09.2025	Liz Gunning	On Track	At Risk	Off Track

Overview (this period)
Full review of work plan undertaken and meeting schedule refreshed to alternate bi-weekly workstream meeting and leads only meeting to review progress and provide assurance for reporting purposes
Navigation and Triage (N&T) Test of Change (ToC) completed and final model agreed
Ambulance Assessment (AA) ToC development progressing and expected to commence 8th October 2025.
Support required to ensure flow does not block ToC process
Initial meeting with Health Planners r.e. ED Layout undertaken with follow up meetings scheduled to look at activity/demand

Objectives

To ensure that our patients receive the best healthcare and outcomes by ensuring that:

- We develop services that enables patients to have access to the right care, in the right place and in a timely way.
- We do the best that we can do collaboratively to ensure that each person receives the best possible care as there is only one of every person.
- A 7-Day service which meets the needs of all patients and ensures safe and equitable care

Agreed Metrics
Aligns to strategic objectives:
4 hour and Ambulance Handover delays

- 4 hour admitted and non-admitted
- Time to initial assessment
- Time to treatment

Key Tasks for completion by 16.09.2025	Comp Yes/No	Comment
Review and refresh of current project plan and delivery/governance structure	Yes	
N&T: Review ToC model	Yes	
N&T: Agree final model	Yes	Consultant discussions – Clinical model
N&T: Review data to inform the gap for UTC criteria	No	In progress
AA: Define SOP, roles & responsibilities, staffing requirements and engagement	Yes	
AA: Walk around to review equipment/tch required and area flow	Yes	
AA: Meeting with WMAS	Yes	
AA: MDT engagement r.e. ToC model	No	To next consultant meeting
AA: Baseline data and metrics approved	Yes	
AA: Approval for additional consultant and progress chaser via bank	No	Senior meeting 22/9/25
AA: Clarification required around closing cohort	No	Senior meeting 22/9/25
AA: Sessions with tactical on call managers to discuss changes	No	Delayed until Frailty ToC
AA: Review of County ED and CED rotas	Yes	
AA: Review and agree ambulance offload area	Yes	
ED Staffing: Recruit to locum consultant post	No	Applications due to close 08/10/25
ED Layout: Initial workshop with Health Planners	Yes	
ED Layout: Define true activity	Yes	

Key Tasks for completion before 22.10.2025	WHO	WHEN
AA: Include escalation policy in final model	Georgia/Vicki/Laura	23/09/2025
AA: Add baseline data in to SOP	Laura/Vicki	23/09/2025
AA: ToC Go live	Georgia/Dani/Vicki	30/09/2025
ED Staffing: Review and agree County ED additionality to align rota with demand	Georgia/Vicki	10/10/2025
ED Layout: Confirm ED activity by area	Steve	30/09/2025
ED Layout: Confirm actions post review		07/10/2025

Milestones	Due Date
SW N&T: Navigation & Triage Standard Work	25/07/2025
SW N&T TOC: Development of ToC for new Navigation & Triage tool	10/07/2025
N&T TOCGL: Navigation and Triage ToC Go Live	07/07/2025
N&T FM: Navigation and Triage Final Model agreed	22/08/2025
SW AA: Develop Priority Matrix of ambulance dashboard	12/05/2025
AA ToC: Ambulance Assessment Area TOC development	30/08/2025
AA ATOC: Ambulance Assessment TOC approved	13/09/2025
AA TOCGL: Ambulance Assessment TOC Go live	30/09/2025
AA FM: Ambulance Assessment Final Model	30/10/2025
EDS: ED Staffing – Review	29/09/2025
EDS: ED Staffing – Recruitment to posts	29/08/2025
ED Layout: Physical ED layout post UTC implementation	07/10/2025

Risk/Issue	Description	Mitigations	Risk Score (Mitigated)	Escalation /Decision required
Risk	Risk to ambulance holds if unable to complete back door ToC and impact if flow risk isn't addressed	Process mapping sessions and redesign. Model being prioritised following W45 update. Request to care group for additional funding and cohort decision Stakeholders agreed to go ahead 08/10/2025	8	Support and communications across Trust to ensure flow does not impact on the ability of the ToC to achieve expected outcomes

UTC

Period	SRO	Overall Status		
18.08.25 – 15.09.25	Michelle Harris	On Track	At Risk	Off Track

Objectives
To secure, implement and operationalise co-located UTCs at the Royal Stoke and County Hospitals that meet the necessary constitutional standards against the national directives. The urgent treatment centres will provide an alternative location to the emergency department whereby the appropriate and relevant care will be afforded and secured in a timely manner to ensure safe treatment to our patients.
The development of the co-located UTCs will allow a secondary streaming to support ambulance offloads.

Overview (this period)
Confirmation received from the ICB for revenue funding for RSUH UTC of £684k for 25/26 through winter plan and commissioning intentions for recurrent funding to support a co-located UTC at RSUH from 26/27 onwards.
A revised capital business case for £5.7m (RSUH only) has been approved by the Finance Committee 1st September 2025
Revised Capital Funding requirements and Heads of Terms issued to PHL r.e. County site, to be reviewed by PHL during September 2025. (PHL exited EHPC as planned on 31st August 2025).
Absolute maximum timelines have been revised to reflect planning permission and build requirement timescales now that the workstream has been re-mobilised. 1st June 2026 (without risk), 15th May (with risk).
Internal build to be completed 19th December 2025 with handover scheduled for 31st December 2025, pushback provided to occupy by 19th December 2025 (ambition).
County UTC is on hold, which will require the case to be developed as part of the wider County medical model and 2026/7 planning. (However a request has been made to explore, prior to the new build, what 'could' be converted, from an activity perspective – workshops are now being arranged to explore further).
Both the build and clinical pathways/operational process elements have transitioned to the same SRO for accountability

Key Tasks for completion by 16.09.2025	Completed Yes/No	Comment
Exec approval to remobilisation of RSUH UTC workstream	Yes	Recommenced 9/9/25
Project Plan and Risk Register refresh	Yes	
Approval of Capital Business Case	Yes	
Approval of Revenue Business Case	Yes	
PHL vacation of space at RSUH	Yes	Vacated 31/8/2025
Consideration of options and risk appetite r.e. planning permission	TBC	
Paper to execs to support preferred option	TBC	To be informed after 18/9 mtg
Revised Estates timeline to be shared and built into project plan	Yes	

Key Tasks for completion before 22.10.2025	Who	When
Agreement on how to progress County UTC	Michelle Harris	TBC
Revise A&E performance trajectory	Mat Hadfield	TBC
Consideration of options to allow UTC activity to be undertaken prior to estates reconfiguration work	Michelle Harris	TBC
Re-mobilisation of Clinical Pathways/Operational Processes work to set and work plan	Michelle Harris	19/09/2025

Milestones	Due Date	Revised due date NO RISK	Revised due date AT RISK
UTC Business Case – Capital	30/06/2025	02/09/2025	02/09/2025
UTC Estate: Stage 3 Design	18/07/2025	18/07/2025	18/07/2025
UTC Estate: Stage 3 Developed Design	18/07/2025	18/07/2025	18/07/2025
Planning Approval Received	N/A	15/12/2025	15/12/2025
UTC Stage 4: RIBA S4 technical design	13/10/2025	28/11/2025	28/11/2025
UTC Stage 5: Internal alterations (RSUH)	19/09/2025	19/12/2025	19/12/2025
UTC Stage 6: Partial handover & close out	30/09/2025	30/12/2025	30/12/2025
UTC Stage 7: Partial operational activity line	01/10/2025	31/12/2025	31/12/2025
UTC Business Case – Revenue	30/06/2025	02/09/2025	02/09/2025
UTC Model: Clinical/Staffing Model development	01/09/2025	TBC	TBC
UTC Implementation	01/10/2025	TBC	TBC
UTC Mobilisation Plan	01/10/2025	TBC	TBC
UTC Stage 5: Extension	12/02/2026	01/05/2026	16/04/2026
UTC Stage 6: Handover and Closeout	12/03/2026	29/05/2026	14/05/2026
UTC Stage 7: Go Live	13/03/2026	01/06/2026	15/05/2026
UTC Post UTC Review	01/10/2025	TBC	TBC
UTC County	PAUSED	TBC	TBC

Risk/Issue	Description	Mitigations	Risk Score (Mitigated)	Escalation /Decision required
Risk	Prior inability to agree revenue funding conditions as part of 2025/26 planning	Joint agreement with UHNM and ICB for 25/26 funding	3	
Risk	Conversations in respect of County UTC remain live but nothing currently confirmed.	A request has been made to explore prior to the new build, what 'could' be from an activity perspective converted – workshops are now being arranged to explore further	16	

Workstream 2 - Frailty

Period	SRO	Overall Status		
18.08.2025 – 16.09.2025	Liz Gunning	On Track	At Risk	Off Track

Overview (this period)
Workstream refresh undertaken with leads assigned and fully owned, aligned project plan, meeting and governance structure established
Team are working towards **Phase 1 (P1)** Assessment Area within FEAU **Test of Change (ToC)** now scheduled to commence week commencing 29th September 2025.
IT support has been prioritised to this workstream to achieve thsupport e revised go live date

Key Tasks for completion by 16.09.2025	Completed Yes/No	Comment
Full review of work programme, project plan, risk register, meeting structure and governance	Yes	IT support prioritised to support this ToC
Phase 1 Test of Change		
Remapping of Vitalpak		SDEC module in Careflow required completed pro-forma, received by team 4/9/25, complete and returned by 11/9/25. Developers due to complete 22/9/25 with training that week, pushing go live date back to w/c 29/9/2025.
Creation of portal on Careflow (Frailty SDEC)		
Development of operational policy		
Sign off and approval of operational policy (sharing final draft 19/9)		
Review of HRD tool to scope opportunities within Frailty SDEC		
Staff training (Nursing and Admin) on SDEC system		
Review of patient EDDs		
Closure of 8 beds within FEAU to make physical space		
Ensure patients beds are not backfilled when the patients are discharged		
Pharmacy and use of FP10s		Other actions being undertaken to align with this new go live date
Essential equipment is in place		
IT processes are in place and finalised	Yes	
Staffing model developed	Yes	
Catering, portering, radiology, domestic services briefed and in place	Partial	Furniture expected w/c 29/9/25
Monitoring meeting established		
KPIs identified and agreed	Yes	
Communications and flow processes between FEAU and ED		

Key Tasks for completion before 22.10.2025	WHO	WHEN
All above actions to support Go live date of 29.09.2025, plus		

Objectives
To ensure that our patients receive the best healthcare and outcomes ensuring that patients have access to the right care in the right place and in a timely way through:
- Safe and timely assessment of frail patients that present through our emergency portals
- Providing care in the most appropriate setting for the patients' needs ensuring that the service is a collaborative approach across the community

Agreed Metrics (following joint leads meeting to agree metrics on 2nd July)
Aligns to strategic objectives:
12 hours and Ambulance Handover delays

- Mean time in ED for +75
- 0 day LoS
- < 3 day Los (%)
- Conversion rate

Milestones	Due Date
Alignment of project plans, workstream delivery and reporting structure	28/08/2025
Options Paper approved to determine the assessment area within FEAU	15/07/2025
Development of an assessment area within FEAU	12/09/2025
Closure of 8 beds within FEAU (previously ward 210) in order to create the physical location	12/09/2025
Mobilisation to support the development and commence ToC	12/09/2025
ToC Go live	15/09/2025
Post ToC evaluation	24/10/2025
Develop comm's strategy in line with the ToC	12/09/2025
Development of Phase 2 ToC (date determined by evaluation of P1 ToC)	TBC

Risk/Issue	Description	Mitigations	Risk Score (Mitigated)	Escalation /Decision required
	All risks have been reviewed 17/9/2025 and are either being managed within the workstream, or a risk identified post Test of Change which the ToC will identify further and will be captured in the evaluation			

Workstream 3 – Clinical Pathways

Period	SRO	Overall Status		
18.08.2025 – 16.09.2025	Liz Gunning	On Track	At Risk	Off Track

Objectives

Develop pathways that supports patients access to the right care, in the right place and in a timely way with a particular focus on Acute Medicine pathways.

Overview (this period)

Note: SRO change since the last period.
Focus remains on Acute Med portals with meeting scheduled with SRO/PMO to commence scoping of all portals SOPs, prioritisation and develop full work programme for the workstream
Implementation of Acute Medicine standardised pathways now completed although there is a risk that the impact may be skewed due to the bedding of patients in AMRAU resulting in patients being held in ED

Agreed Metrics

Aligns to strategic objectives: Ambulance Handover delays

- % patients going to SDEC's via ED (include breakdown by specialty)
- % GP referrals direct to portals (not entered via ED0
- ED Referral to discharge time

Key tasks for completion by 16.09.2025	Comp (Yes/No)	Comment
Review and refresh of current project plan and delivery/governance structure	Partial	Focus remains on Acute Med Meeting 22/9 r.e. wider portals
Progress against Non-Acute Med portals		
AM LOS: Trust-wide comm's/understanding of acute med and its purpose	No	
AM LOS: IPS reinforcement to support flow	No	
AM AMPCS: Collate feedback from cross-shadowing for suggestions/improvements	Yes	
AM AMPSOP: Approval of County Transfer SOP	Yes	
AM Process: Request to separate discharge data from medicine dashboard	Yes	
AM Process: Dedicated Acute Med progress chaser & Phlebotomist	**No**	**On hold – include in w/f business case**
AM Process: Electronic nursing documentation	**No**	**IT timescales April 2026 post EPMA**
AM SCR: Clarify DVT pathway to avoid continual returners	Yes	
AM SCR: Support requirement to remove iron infusions/ascitic taps	No	
HMU ECU: Request to proceed to 2 additional monitors presented at CIG	Yes	
HMU ECU: Manual Audit of data to confirm demand	Yes	
Key Tasks for completion before 22.10.2025	**WHO**	**WHEN**
SRO meeting with PMO to support scoping of all portal SOPs and development of full work programme for the workstream	Liz	22/09/2025

Milestones	Due Date
AM AAR: Acute Medicine development of Vision/Proposal (VP)	30/06/2025
AM AMP: Full review of Acute Medicine Pathways (AMP)	31/07/2025
AM CR: Clinical Activity Review (AEC & AMRA)	25/06/2025
AM AMPEDD: EDD visibility	11/06/2025
CPD: Clinical Pathway Development – **TO BE REFRESHED**	01/06/2025
CPD PM: Define Portal Model – **TO BE REFRESHED**	20/06/2025
CPD PMR: Portal Pathway Review – **TO BE REFRESHED**	15/07/2025
RAC: Reduce Ambulance Conveyances – **TO BE REFRESHED**	25/06/2025
AM LOS: IPS Reinforcement – **TO BE REFRESHED**	31/07/2025
Implementation of Acute Med standardised Pathways (IP)	15/08/2025
Develop efficient AMU processes (to support LoS 24 hours)	01/08/2025
AM SCR: Streamline SDEC Clinic Activity (AEC & AMRA)	31/10/2025
HMU ECU: Development of HMU into Enhanced Care Unit	31/12/2025

Risk/Issue	Description	Mitigations	Risk Score (Mitigated)	Escalation /Decision required
Risk	Inappropriate utilisation of AMRAU (SDEC) with bedded patients will result in patients appropriate for AMRAU being held in ED and inability to monitor impact of improvement work	Escalated to care group Meeting requested with Becky Ferneyhough and Site Team to discuss issues	16	Escalated to care group 15/09/2025 requires support and commitment to mitigate risk further
Risk	EPMA priority and implementation timeline resulting in lack of IT capacity to support the development of electronic nursing documentation will impact on the ability to develop efficient AMU processes and reduce LoS 24 hours metric		16	IT timescales quoted as April 2026. Support required to prioritise this initiative or accept delay

Workstream 4 – Bed & Site Management

Period	SRO	Overall Status		
18.08.2025 – 16.09.2025	Fiona Hibberts	On Track	At Risk	Off Track

Overview (this period)
Due to significant changes in site leadership a review of the project plan was undertaken and meetings paused.
Following approval of the Business Case, posts recruited to will commence in Sept/Oct/Nov.
Recruitment commenced for Heads of Nursing posts (both external and internal interest).
Formal thanks to be given to Becky Ferneyhough as new Clinical Head of Site.

Objectives
To ensure that our patients receive the best healthcare and outcomes through:
- All patients are cared for in an appropriate and safe environment, with processes in place to minimise the risk of infection or other avoidable complications
- A 7-Day service which meets the needs of all patients and ensures safe and equitable care
- Robust, clear and effective processes are in place to manage flow across the hospital
- A responsive service enacting OPEL actions and proactive management to de-escalate levels
- There are fit for purpose discharge areas that meets the demand of each site and that these are managed effectively and timely to support patient flow

Key Tasks for completion by 16.09.2025	Completed Yes/No	Comment
Revise Project Plan to align with site leadership changes	Yes	
Reshape project delivery and governance infrastructure	Yes	
SSR comms: Increase awareness of site team and function	On hold	Delay to staff arriving (Oct/Nov)
SSR AD: Action staff wellbeing output from staff away day	No – in progress	OD support obtained. KO meeting w/c 22/9/25
Escalation: Review OP15 Hospital At Capacity Policy	No – in progress	Feedback from UP/P Groups pending
Escalation: Update of Policy/OPEL escalation post comments	No – in progress	Policy sign off delayed. CF Policy Out of Date due to restructure
Escalation: Process rollout	No	
HRD S: Recruit to 2 x HRD posts	Yes	Start in post w/c 8/9/25
HRD S: HRD site team awareness	Yes	

Key Tasks for completion before 22.10.2025	WHO	WHEN
SSR AD: Outputs of away day to be incorporated in to project plan	Becky/Taylor/OD	w/c 22/09/2025
CF: Continuous Flow process review	Becky, Faye, Nik	TBC
CF: Confirm timescales for additional actions following review	Becky, Clare	TBC
Escalation: Final approval of Policy/OPEL escalation	Fiona, Becky, Ellishia	15/10/2025

Agreed Metrics (following joint leads meeting to agree metrics on 2nd July)
Aligns to strategic objectives:
12 hours
Ambulance Handover delays
DTA to discharge/admit from ED
SHREWD measures

Milestones	Due Dates
BSM PD: Data Requirements and essential metrics	30/06/2025
SFR BC: Site Infrastructure Business Case Development (SI)	31/03/2026 (amended)
SSR: Site support requirements – site wellbeing	30/07/2025
CF: Continuous Flow Process Review	31/07/2025
OPEL escalation and Clinical Operational Flow Policy review (OPEL)	01/09/2025 (amended)
EPR C: Redesign of capacity meetings	31/10/2025 (amended)
HRD S: HRD site team awareness	31/10/2025
HRD Tool Huddle Effectiveness	31/10/2025 (amended)

Risk/Issue	Description	Mitigations	Risk Score (Mitigated)	Escalation /Decision required
Risk	Lack of medical engagement resulting in lack of buy in from front line staff to have robust discharge plans to enable earlier discharge	Unplanned Care Medical Director is engaged	12	Support from Clinical Directors to encourage wider engagement
Risk	Lack of engagement from planned care will mean programme will lack clinical input, leadership and support	Ongoing requests made for support	12	Support from Clinical Directors to encourage wider engagement
Risk	The enactment of continuous flow across the Trust is inconsistent and variable	Continuous flow process and OP15 Policy under review, good engagement from unplanned and planned care and collegiate. Leadership agreed to take forward	25	Request support from QI and Transformation team to prioritise this to mitigate the biggest risk

Workstream 5 – Ward Processes & Discharge

Period	SRO	Overall Status		
18.08.2025 – 16.09.2025	Fiona Hibberts	On Track	At Risk	Off Track

Overview (this period)
Head of Operations and Head of Nursing within Unplanned Care now agreed and assigned to workstream. Review of current discharge lounge model, SOP and current processes to re-commence now HOO/HON in post.
P2 Discharge Lounge expansion on hold. Can no longer have bedded patients in TDL, awaiting fire officer to undertake risk assessment, then SOP to be reviewed.
QI team led Rapid Improvement week and Confirm and Commit session undertaken with three priority areas of focus identified:

- Nursing Handover
- Board Rounds
- Discharge letters and TTOs

Objectives

To ensure that our patients receive the best healthcare and outcomes through:

- No-one is admitted to the base wards of our hospitals unnecessarily and avoids excessive waits in ED when the decision to admit has been made.
- All patients are cared for in an appropriate and safe environment, with processes in place to minimise the risk of infection or other avoidable complications.
- Ensure effective monitoring of patient journeys, prevent delayed discharges and unnecessary readmissions
- Deliver a service which meets the needs of all patients and ensures safe and equitable care

Agreed Metrics (following joint leads meeting to agree metrics on 2nd July)
Aligns to strategic objectives: 12 hours and Ambulance Handover delays

- Lost hours in ED
- Overall LoS
- Right to Reside
- Discharges (by time of day)
- Discharge usage
- Discharge lounge LoS
- Discharge lounge occupancy
- Pre-noon Discharges (including moves to the discharge lounge

Key Tasks for completion by 16.09.2025	Completed Yes/No	Comment
Full review of project plan, risk register, delivery and governance structure	Partial	Requires re-work
CLD: Approval of Criteria Led Discharge project proposal	Yes	
CLD: Establish T&F Group	No	
WR SS: Review areas currently undertaking safety stop (huddle)	No	
WR SS: Test of Change for safety stop roll out	No	Ward manager WIS access
Development of workstream comm's strategy	No	Waiting for IT (above)
Discharge Lounge ToC Proposal drafted	Yes	

Key Tasks for completion before 22.10.2025	WHO	WHEN
Discharge Lounge usage: agree plan with HOO/HON	Becky, Nik, Pip	15/09/2025
P2 Expanded Discharge Lounge: Fire Risk Assessment	TBC	TBC
P2 Expanded Discharge Lounge: Develop plan following fire assessment (on hold	TBC	TBC
SLOS: Feedback from ToC and amendments to model	Nik, Pip,	30/09/2025
CLD: Confirm timeline Criteria Led Discharge Pilot	Lewis Taylor	Post Clinical Governance
CLD CP: Care Group approval for CLD Childrens processes	Janet Hagan	15/10/2025
CLD CP: Review and agree the new Iportal note	Lewis	15/10/2025
WR SS: Evaluation of the safety stop roll out	Fiona	30/09/2025
Comm's: Launch comm's campaign	Abi/Jessie	30/09/2025

Milestones	Due Dates
DL U: Review/maximise current usage and practice	31/12/2025
DL WF: Workforce requirements for expanded discharge lounge	31/07/2025 **ON HOLD**
DL CR: Capacity requirements for expanded discharge lounge	14/07/2025 **ON HOLD**
DL BC FS: P2 Capital Business Case and Feasibility Study	29/07/2025 **ON HOLD**
DL C: P2 Complete Capital works	31/10/2025 **ON HOLD**
DL M: P2 mobilisation plan	31/10/2025 **ON HOLD**
SLOS: Establish a streamlined long LOS review process	31/10/2025
CLD: Criteria led Discharge Development & Pilot (Respiratory)	01/02/2026
CLD: Criteria Led Discharge Post pilot review to enable rollout	01/06/2026
CLD: Criteria Led Discharge – Children's Pathway	TBC
WLD: Development of Ward Manager Training Programme	22/12/2025
WR SS: Develop standardised Safety Stop	30/09/2025
Comms: Develop a robust comms strategy for the workstream	01/08/2025
WSW 24/7: Standard 24 hours on a ward	31/10/2025

Risk /Issue	Mitigations	Risk Score (Mitigated)	Escalation
Delay to reviewing the discharge lounge SOP means that the Business Case cannot be developed, impacting on ability to access funding to support discharge lounge expansion to support winter pressures	Care Group leads identified to progress work which as commenced. Outputs of the SOP review will inform improvements for current discharge lounge to increase utilisation	12	Discussion around impact of not accessing capital and revenue funding to support any expansion
Lack of capacity within digital team to support the development of the	Risk has been raised previously without resolution	15	Prioritisation of IT to this initiative is

Workstream 5 – Ward Processes & Discharge

Period	Project Lead	Overall Status		
18.08.2025 – 16.09.2025	Hayley Bishop	On Track	At Risk	Off Track

Overview (this period)
Focussed work on Positive Risk taking continues - focus on Home care pathways as BAU not bed based assessment provision – linked to 'home care best care' why not today winter strategy.
Work is continuing to maximise utilisation of Virtual Wards capacity.
Patient Discharge Information Leaflet ii now on order with Harlow – delivery date pending but will be ready to launch in October.
Standard work r.e. pharmacy PEG tubes pilot is now completed and handed over as Business as Usual
Test of change for pharmacy discharge escalation agreed to commence 22.09 for 2 weeks

Objectives
To ensure that our patients receive the best healthcare and outcomes through:
- Ensure safe and timely patient discharge
- Ensure effective monitoring of patient journeys, prevent delayed discharges and unnecessary readmissions
- Deliver a service which meets the needs of all patients and ensures safe and equitable care
- To provide a person-centred care approach to supportive, safe and effective discharge

Key Tasks for completion by 16.09.2025	Completed Yes/No	Comment
DP DFC: DF mobilisation (HRD workstream)	Yes	Started w/c 15/9
DP SW: Develop clarity roles & responsibilities linked to DF activities	Yes	
DP SW: Re-launch of therapies and transport challenges to access	Yes	
DP SW: Therapy and Transport combined training sessions	Yes	
DP SWPPT: Standard Work Pharmacy PEG tubes pilot complete (ward 222)	Yes	Now BAU
DP SWT: Pathway 1 education/awareness session to UHNM Therapy Teams		Due for completion Oct – Dec but work commencing 1st September 2025
Commence a number of key actions for Therapies to: • Scope outcome measures e.g. Bartell scoring • Map demand and capacity • Review duplication in assessments and assessment times • Scope therapy role inside the Integrated Discharge Hub (IDH) • Co-design test projects to improve therapies contribution for early discharge		
DP TOC: Review and develop best practice /training guide	No	In progress but delayed
VCSE SP: Review Bio hazard cleans process	Yes	

Key Tasks for completion before 22.10.2025	WHO	WHEN
Dedicated comm's support to develop materials and roll out plan for the Patient Discharge Information Leaflet	Jessie/Taylor	By 30/09/2025 (now end Oct 25)
DP ACAH: Increase the step down to VW/ACAH	Becky, Hayley, Steve	01/10/2025
DP ACAH: Monitor compliance of the WIS Dashboard Standard Work	Sarah P/Steve	01/10/2025
DP ACAH: Education for ward staff on use of ACAH/VW	Trevour	01/10/2025
DP ACAH: SW Discharge for HRD for Virtual Ward	Kelli	15/10/2025
DP ACAH: ACAH County Plan	Sarah P/Steve	01/10/2025
DP DFC: DF Development programme (skills/education)	Hayley, Lisa	01/10/2025
DP SW: Roll out and mobilisation of Patient Discharge Leaflets	Hayley, Jessie	30/09/2025
VCSE SP: Develop education for OTTs to better understanding of service provision	Katie	30/09/2025
VCSE SP: Chaplaincy visit to site	Katie, Hayley	01/10/2025

Agreed Metrics
IDH - Assessment notification to service listing - Target 80% of patients 'same day' - New Data pending baseline (Bed days lost in IDH processing)
Reduction in Failed Discharges - % target to be agreed - data under development (Focus on transport in phase 1)
Virtual Ward utilisation

Milestones	Due Dates
DP Audits: Discharge Audits to support workstream direction	31/07/2025
DP ACAH: Discharge Planning - Acute Care at Home (ACAH)	31/10/2025
DP DFC: Discharge Facilitator Standardisation	29/11/2025
DP SW: Standard Work – Patient Information Leaflet	01/11/2025
DP SW: Standard Work – Transportation	01/11/2025
DP SWPPT: Standard Work Pharmacy PEG tubes	31/10/2025
Therapies: Scope, map, model and test therapy input and resource	31/03/2026
DP SWDE: Standard Work Develop Education & Training Plan	01/11/2025
DP TOC: TOC Form review	01/12/2025
VCSE SP: Develop Directory of Services for social prescribing	31/12/2025

Risk /Issue	Mitigations	Risk Score (Mitigated)	Escalation
Discharge Facilitation integration mobilisation remains on hold	Executive teams considering HR/OD workforce opportunities (ICB tasked to consider what support they could offer the process to facilitate the process of mobiles change ahead of 31st October 2025	20	

Workstream – HRD (Enabling workstream)

Period	Project Lead	Overall Status		
September 2025	Dr Andrew Davy	On Track	At Risk	Off Track

Overview (this period)

- Focus on Virtual ward pathways to support deflection
- Palliative audit underway
- Focus on ensuring MDT involvement in the daily huddles
- Team continue to capture 'golden patients' of what has gone well
- Approval of IDH staff to support HRD tracking

Objectives

To support the 5 UEC workstreams to improve safety by increasing flow. By identifying those with a long LOS, and at risk of delayed discharge and pairing those patients with a defined clinical response tailored to their needs the aim is to improve their outcomes. Reduction in longest LOS provides the biggest improvement in terms of deconditioning/ ongoing care needs and risk of infection for the individual but is also important to release capacity/flow in the system.

Agreed Metrics:

Aligns to strategic objectives:

4 hour, 12 hours and Ambulance Handover delays

- Reduction of LOS compared with previous LOS in last 12 months.
- 25% Reduction in Care packages requiring brokerage by 6 months 50% at 12 months.

Key Tasks for completion September 2025	Completed Yes/No	Comment
COPD and Spirometry 72 hr review pathway completion	Yes	On track
Team metrics available (number seen/discharge/readmissions)	Yes	On track Tom Hill actioning
Charities funding for ongoing I.T/clinical resource release.	Yes	On Track
Homeless pathway update.		
Review of TOC virtual ward pathways screening	Yes	Scope for increase
Bronchiectasis Pathway scoping (OPAT/respiratory)	On track	Meeting in place

Key Tasks for completion October 2025	WHO	WHEN
Armed forces/HIU and Heart failure team teams page creation.	Thomas Hill	31/10/2025
Palliative Scoping of alternative pathways	Charmaine Butcher	31/10/2025
Trial of care package patient notifications to council.	Andrew Davy	31/10/2025
Embedded IDH staff to support HRD tracking	Jane McFarlane	31/10/2025

Milestones	Due Dates
WS1 : Deflections at front door i.e. criteria suitable for FEAU	31/10/2025
WS2 : Incorporate HRD into the new Frailty Model	31/10/2025
WS3 Develop clinical pathways • Armed forces-veterans • HIU • Heart Failure	31/10/2025
WS4 Develop site awareness and use of HRD in escalation	31/10/2025

WS5
• Embed HRD on the Ward/Board Rounds
• Discharge Planning Subgroup
  • Acute Care at Home pathways
  • IDH input to support earlier discharge
	31/10/2025

Risk /Issue	Mitigations	Risk Score (Mitigated)	Escalation
Ward engagement	• Clinical and nursing meetings held with frailty wards.	12	Ongoing engagement/shared learning planned.
Pull of FOH staff to FEAU	• Possible to enable cross cover of both functions if extra resource released to do this.	12	

Elective Improvement Plan

Contents

Operational Performance – Elective Care

Annex ref	Detail	Response
3.10.1	The Elective Plan will in particular state how the Licensee will deliver its 2025/26 Operational Plan commitments for elective care (including diagnostics, theatres, outpatients and patient access) and provide trajectories that demonstrate the route to delivery of the Elective Plan	Please see Section 1
3.10.2	Set out a future vision for elective care services (including diagnostics, theatres, outpatients and patient access) at the Licensee and the milestones that will lead to the implementation of that vision over the next ten years This should be aligned with the defined health needs of the population, as well as the Ten-Year Plan (once published), national Reforming Elective Care for Patients strategy and Staffordshire and Stoke on Trent ICB's strategy for transforming elective care	Please see Section 2 for Outpatients, Diagnostic, Patient Access and Theatres milestones and vision For Diagnostics and Elective care, UHNM has worked in collaboration with system colleagues to implement both strategies. These documents are available through SSOT ICB
3.10.3	Describe the key risks and the mitigating actions that will be taken to support the Elective Plan's implementation	Please see Section 1 (slide 8) detailing the risks to elective long wait recovery Please refer to appendix 2 for specialities of concern trajectories for long wait recovery Please refer to appendix 3 for specialities of concern trajectories for diagnostic wait recovery
3.10.4	Demonstrate that the Licensee has collaborated with Staffordshire and Stoke on Trent ICB and other partner organisations as appropriate	UHNM and the ICB collaborate weekly to provide trajectories to NHS-E / attend Tier 2 calls in partnership For Diagnostics and Elective care, UHNM has worked in collaboration with system colleagues to implement both strategies In addition, the ICS has developed (UHNM, ICB, UHDB) strategies as per response to 3.10.2 are available through SSOT ICB
3.10.5	Describe the governance arrangements that the Licensee will put in place to oversee the delivery of the Elective Plan, how these will relate to the Licensee's existing governance arrangements (including those overseeing operational performance, clinical quality and finance) and how they will integrate with the governance arrangements that Staffordshire and Stoke on Trent ICB has established to lead the delivery and development of elective care	Please see Section 3
3.10.6	Describe the key milestones associated with the implementation of the Elective Plan, including the deadline for completion and senior responsible officers for each milestone	Please see Section 2 and associated trajectories in Section 1
3.10.7	Confirm the key performance indicators which the Licensee will use to measure progress against each action, and the expected impact on overall elective performance	Please see Section 1

RTT Performance on a page *Latest week Ending* 21 September 2025

University Hospitals of North Midlands NHS Trust

Total PTL	<18 Weeks	52+ Weeks	65+ Weeks	Time to 1st	Yet to be seen; 35+ weeks
65,838	**62.38%**	**2.21%**	**128**	**76.52%**	**1,452**
-861	0.29% | -519	0.04% | 7	-4	-0.31% | -215	-48
Change from last week	Change from last week	Change from last week	Change from last week	% Waiting 1st Activity <...	Change from last week
The total number of open pathways yet to receive first definitive treatment	The proportion of open pathways that are under 18 weeks since referral	The proportion of open pathways that are over 52 weeks since referral	The number of open pathways that are 65 weeks or more	Out of all open pathways that are yet to be seen, the proportion that are under 18 weeks	The number of open pathways that are yet to be seen and have waited 35+ weeks

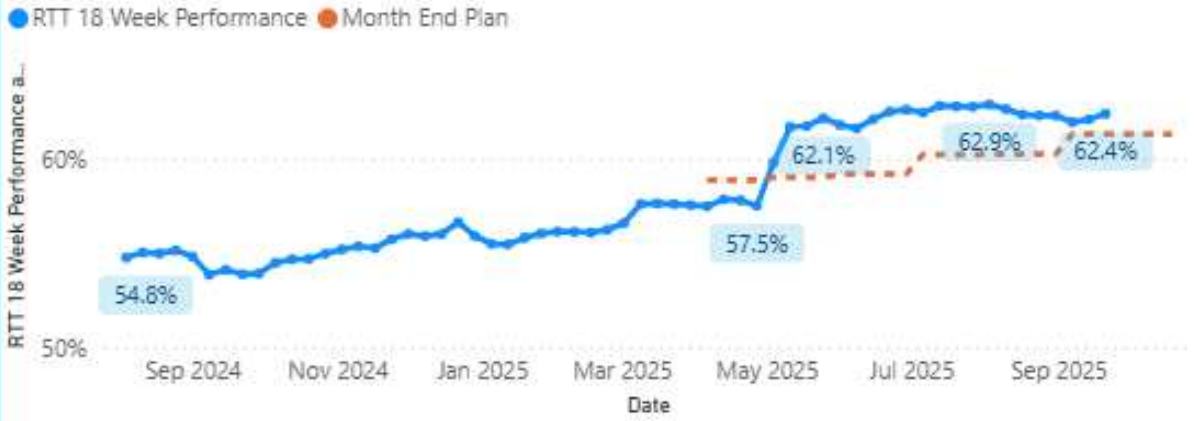
RTT 18 Weeks - Actual Vs Plan

Specialty (TFC)	Latest %	Plan	Breach Variance
320 Cardiology	60.8%	67.3%	456
330 Dermatology	67.6%	77.2%	298
191 Pain Management	33.7%	38.4%	252
108 SPINAL SURGERY SERVICE	46.7%	55.0%	249
101 Urology	63.0%	68.1%	233
104 Colorectal Surgery	66.7%	70.6%	188
140 Oral Surgery	44.9%	53.3%	175
110 Trauma & Orthopaedics	55.4%	57.7%	173
303 Clinical Haematology	79.9%	84.3%	89
Total	**62.4%**	**61.3%**	**-1143**

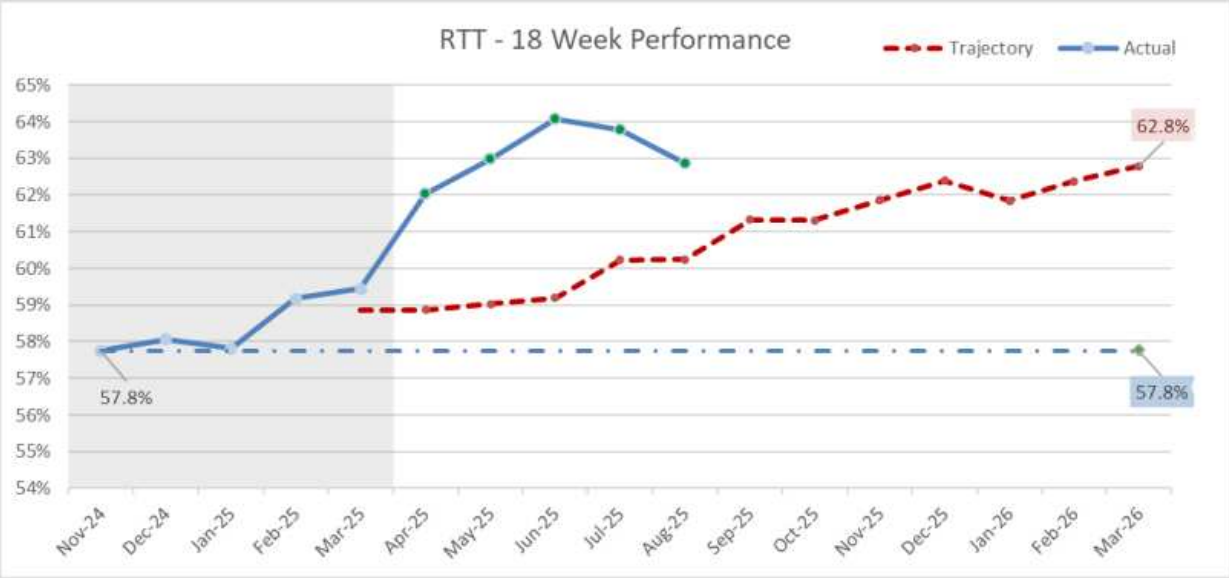
Update

- UHNM continue to see good performance across 18 week and 52-week performance
- Latest snapshot shows UHNM 18-week performance now at 62.4% (better than plan of 61.3%)
- 52+ Weeks has been seeing steady reduction consistently ahead of plan. Last week saw a slight increase of 7
- 65+ Week actuals remain around 130
- Time to first contact performance remains strong at 76.5% against a plan of 75.4%

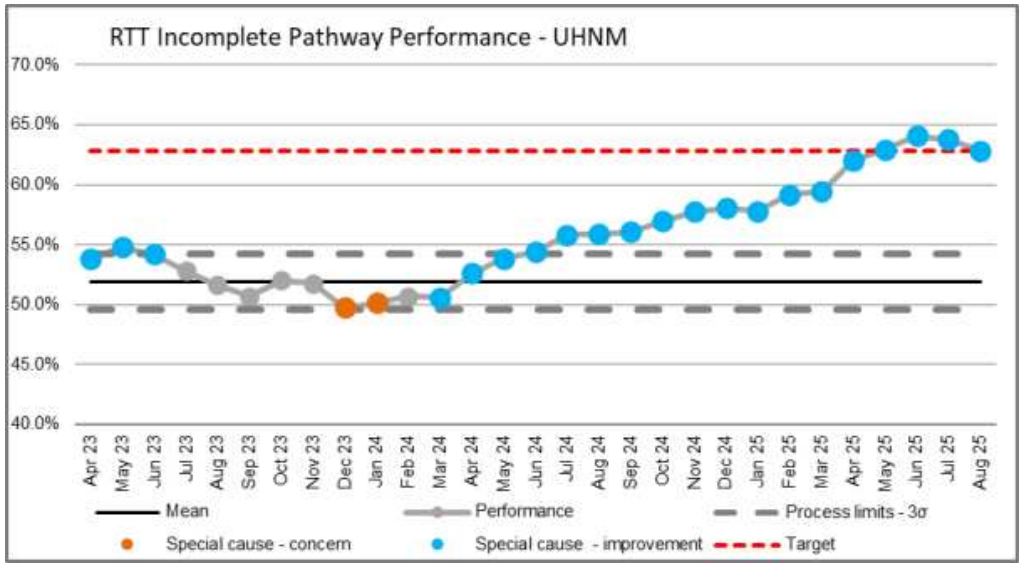
RTT 18 Week Performance



RTT Performance



A 5% improvement from the Trusts November 2024 RTT position was planned for in 2025/26

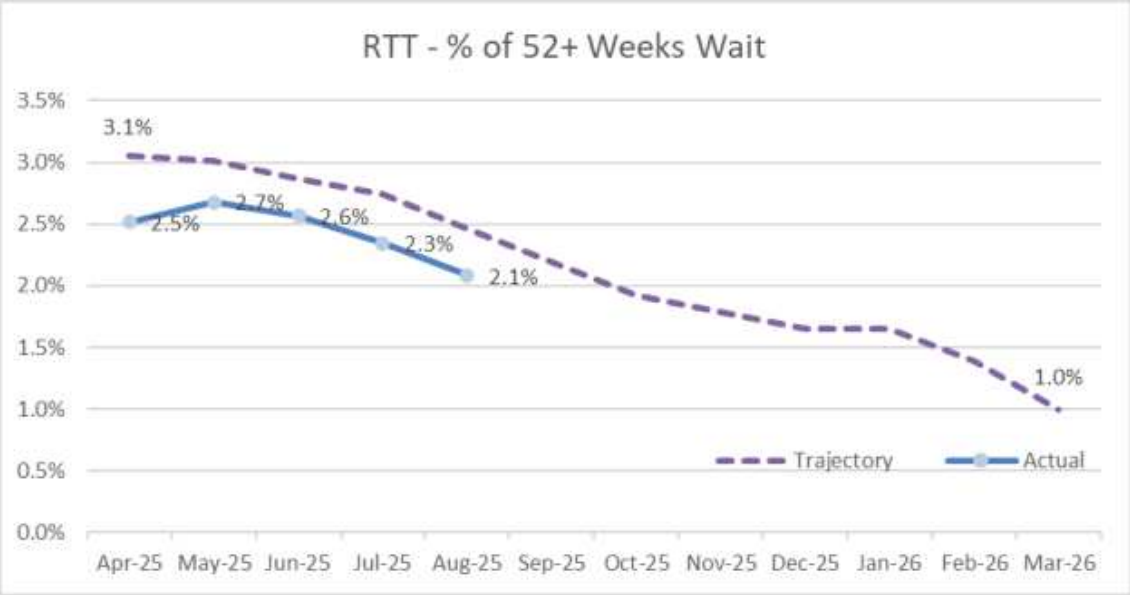


Monitoring against plan				
	May 25	Jun 25	Jul 25	Aug 25
Actual	63.0%	64.1%	63.8%	62.9%
Plan	59.0%	59.2%	60.2%	60.2%
Variance	3.9%	4.9%	3.5%	2.6%

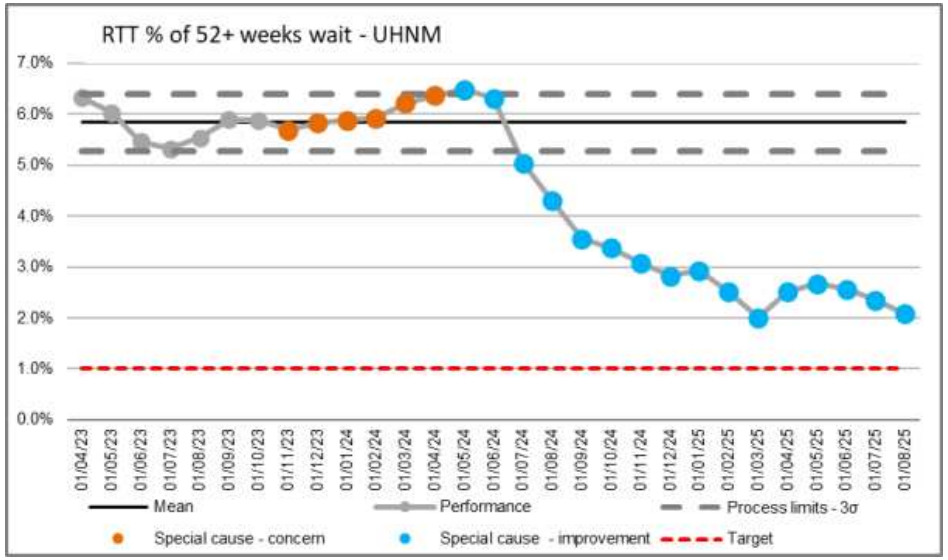
UHNM have seen an 18-month period of steady improvement in RTT performance

When monitoring against plan, UHNM have been performing over 2.5% better than plan for the first 5 months of the year

RTT 52+ week wait Performance



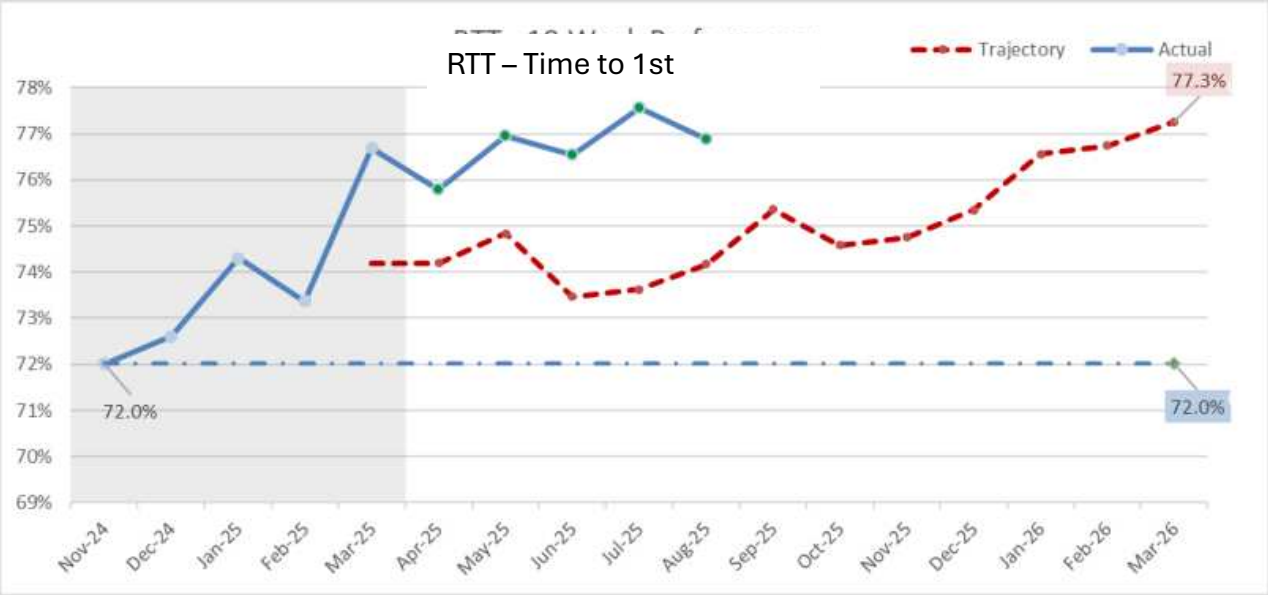
An improvement from the Trusts November 2024 position of 3.1% down to 1% was planned for in 2025/26



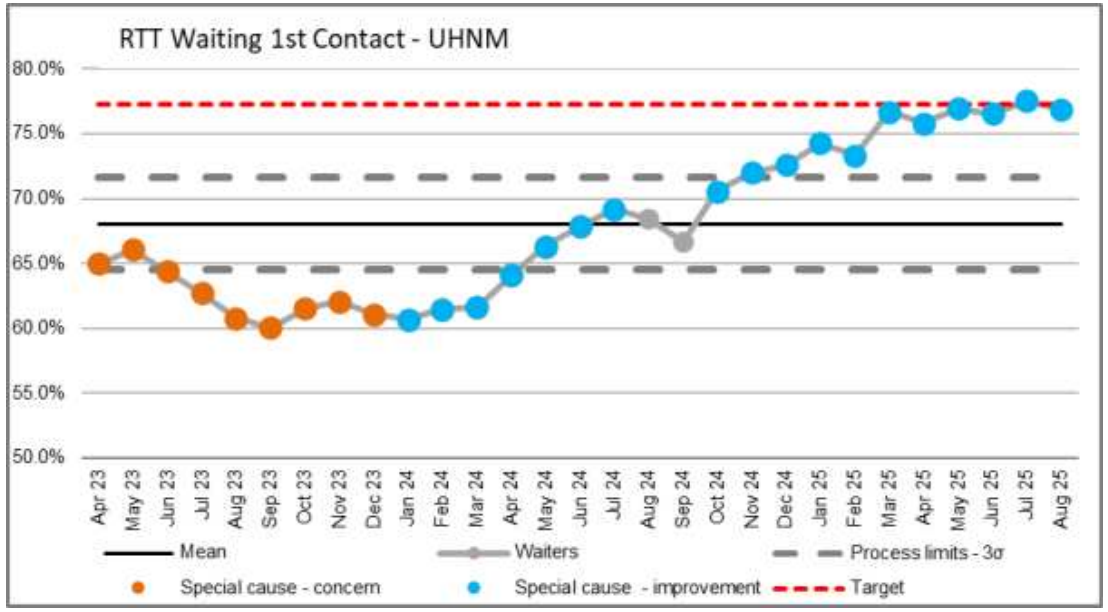
Monitoring against plan				
	May 25	Jun 25	Jul 25	Aug 25
Actual	2.68%	2.57%	2.35%	2.08%
Plan	3.01%	2.87%	2.74%	2.46%
Variance	-0.3%	-0.3%	-0.4%	-0.4%

Over the last 15 months UHNM have seen a significant improvement from 6.5% down to 2.1% of incomplete pathways being over 52 weeks
More recently, when monitoring against plan, UHNM have been performing ahead of plan for the first 5 months of the year

RTT time to first performance



Despite UHNM already performing at the national ambition, a 5% improvement from the Trusts November 2024 position was planned for in 2025/26

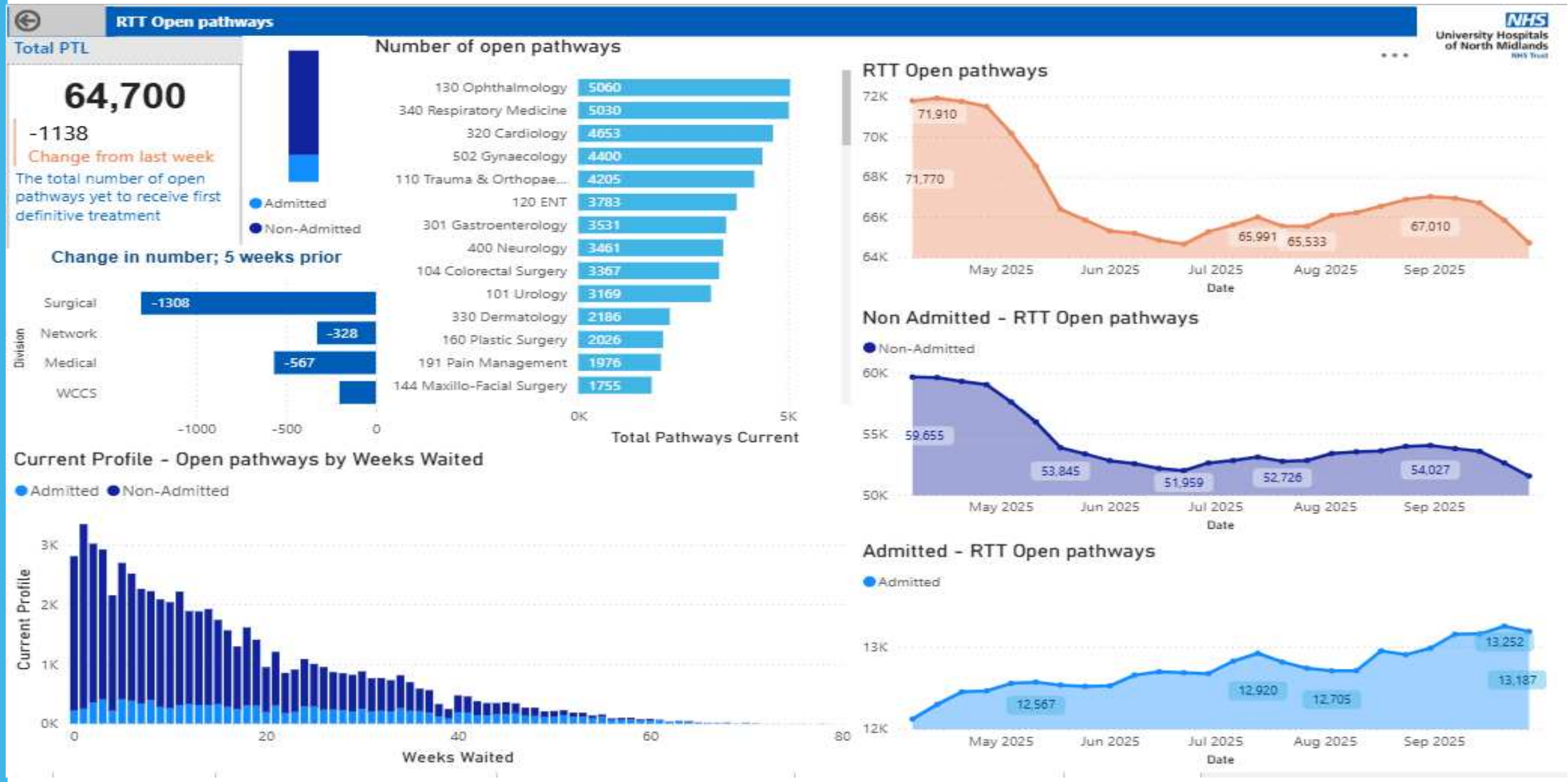


Monitoring against plan				
	May 25	Jun 25	Jul 25	Aug 25
Actual	77.0%	76.5%	77.6%	76.9%
Plan	74.8%	73.5%	73.6%	74.2%
Variance	2.1%	3.1%	3.9%	2.7%

UHNM have seen a 19-month period of steady improvement in RTT performance

When monitoring against plan, UHNM have been performing over 2% better than plan for the first 5 months of the year

RTT Open Pathways



RTT 65 WEEK RECOVERY - COHORT OVERVIEW

SSOT ICB Planning ambition

No Patients waiting 65 weeks or more for elective care by the end of September 2024 – with continuous reduction in those waiting at month end from July

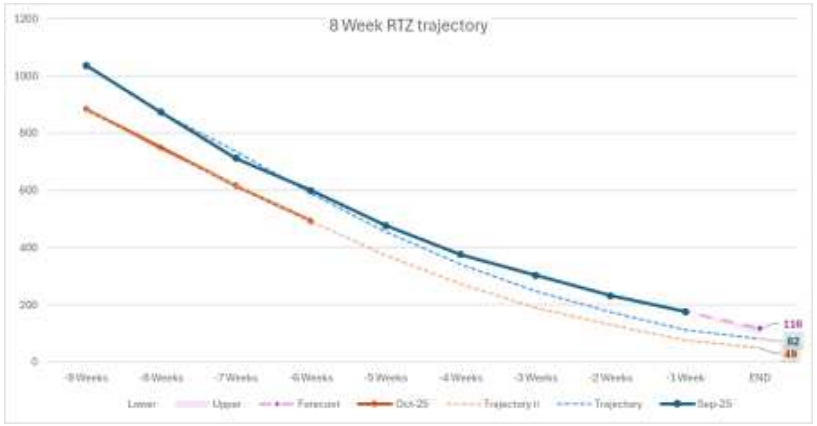
Cohort	Current Week	Previous Week	Reduction		8 week RTZ	distance from RTZ	change from previous week
Sep-25	176	232	-56	-24%	113	63	6
Oct-25	493	616	-123	-20%	490	3	4

65+ week cohort reduction tracking

Update;

- September cohort saw a reduction of 56 patients this week, 6 fewer than expected.
- September has been tracking slightly above where the August cohort was now 1 week out.
- Now tracking 63 behind trajectory of 82 but expected to recover some of this forecast now at 109
- October cohort start point is 137 better off than September cohort was

8-week Route to Zero Trajectory



65+ week Current Month Specialty breakdown

This section shows booking of current month cohort by specialty

Non-Admitted At September 2025 End

Potential breaches by TFC

TFC	Potential Breach	No TCI/Appt Date	Has TCI/Appt	% Dated
105 Hepatobiliary & Pancreatic Surgery	1	1		
106 Upper Gastrointestinal Surgery	1	1		
108 SPINAL SURGERY SERVICE	4	4		
110 Trauma & Orthopaedics	5	3	2	40.0%
120 ENT	24	13	11	45.8%
130 Ophthalmology	5	2	3	60.0%
144 Maxillo-Facial Surgery	4	4		
150 Neurosurgery	1		1	100.0%
320 Cardiology	5	2	3	60.0%
400 Neurology	3	2	1	33.3%
502 Gynaecology	8	6	2	25.0%
812 Diagnostic Imaging	1	1		
Total	62	39	23	37.1%

Admitted At September 2025 End

Potential breaches by TFC

TFC	Potential Breach	No TCI/Appt Date	Has TCI/Appt	% Dated
100 General Surgery	3	1	2	66.7%
101 Urology	1	1		
104 Colorectal Surgery	3	3		
106 Upper Gastrointestinal Surgery	1		1	100.0%
108 SPINAL SURGERY SERVICE	6	4	2	33.3%
110 Trauma & Orthopaedics	14	6	8	57.1%
120 ENT	26	13	13	50.0%
130 Ophthalmology	19	16	3	15.8%
140 Oral Surgery	2	1	1	50.0%
143 Orthodontics	1		1	100.0%
144 Maxillo-Facial Surgery	3	2	1	33.3%
160 Plastic Surgery	5	4	1	20.0%
191 Pain Management	3	1	2	66.7%
214 Paediatric Trauma And Orthopaedics	1	1		
502 Gynaecology	25	3	22	88.0%
812 Diagnostic Imaging	1	1		
Total	114	57	57	50.0%

65-week breakdown:

Ophthalmology

- 17 patient definite breaches for September; mix of patient choice and corneal grafts. Theatre allocation for confirmation to cover 3 further patients for TCI over weekend
- GIRFT visit will support with throughput and productivity for Ophthalmology patients. Concern of growing PTL and receiving increased referrals from the community provider (CHEC) due to clinical complications, primarily linked to Glaucoma

ENT

- 17 patient's definite breaches for September; 9 TCIs dated in October; 4 pt choice / 8 appointments; 6 pt choice. Breakdown on ENT slide
- 17 likely patients, with 11 booked with outpatients in month, and at risk to flip to admitted / needing further treatment (23)

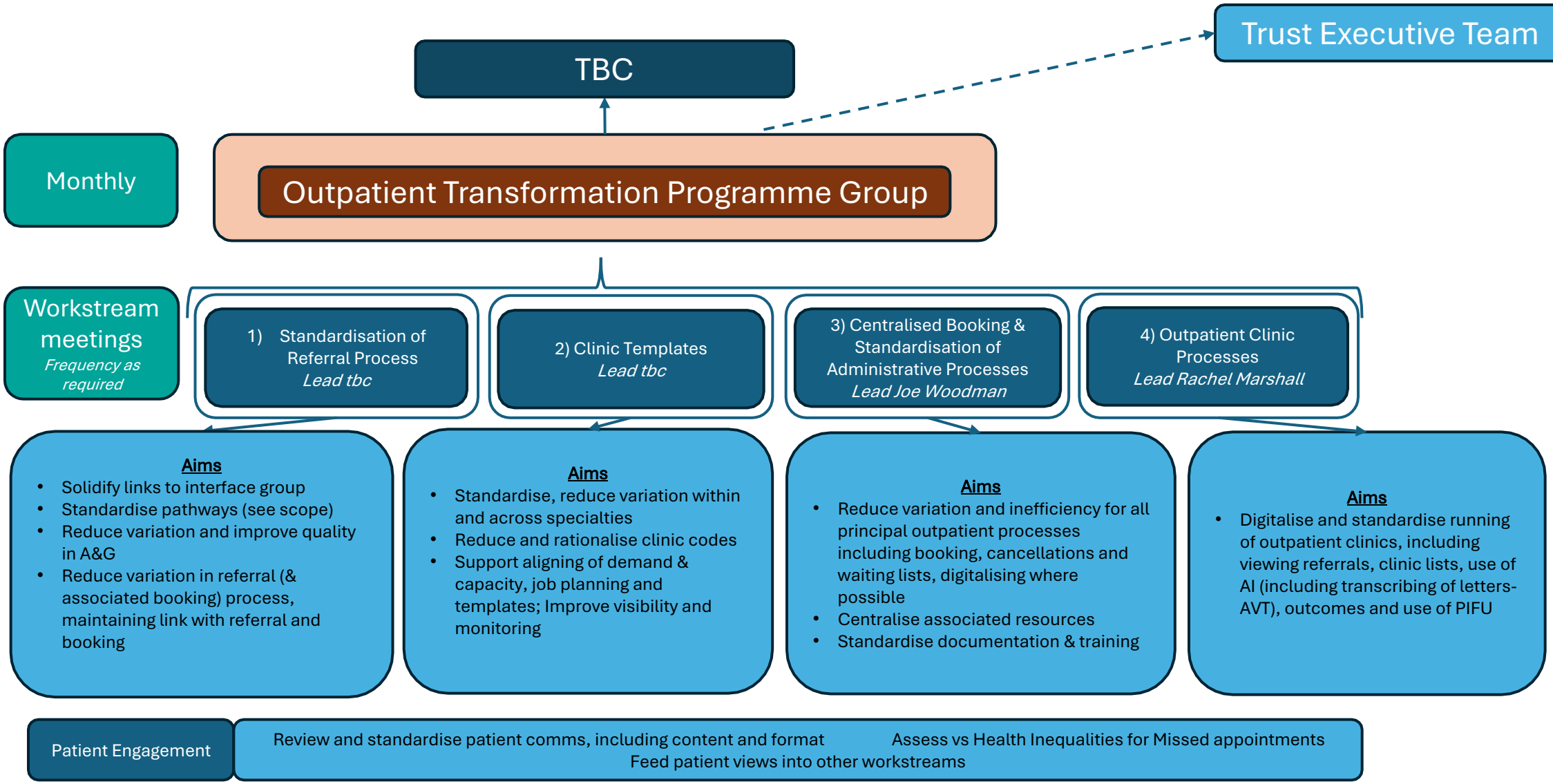
65+ weeks Potential end of Month breaches

Ortho: End of month prediction is 15 likely breaches
Gynae: Patients tracked to currently 5; reduction of 8 since last week. Ops team managing daily and touchpoints supporting validation / next steps
ENT: September currently 29 off trajectory. Concern of likely cohort of non-admitted and risk to flip to admitted / needing further treatment (23)
Ophthalmology: 17 patient definite breaches for September; mix of patient choice and corneal grafts. Theatre allocation for confirmation to cover 3 further patients for TCI over weekend

Week commencing 22/09/25

	65+ week wait patients			*Change from last week* 65+ week wait patients		
	September	October	November	September	October	November
UHNM	109	76	49	27	27	49
which Corneal	12	17	18	-1	2	18
PFT	0	0	0	0	0	0
Nuffield NS	0	0	0	0	0	0
Ramsay	0	0	0	0	0	0
Medefer	0	0	0	0	0	0
SSOT System Total	**109**	**76**	**49**	**27**	**27**	**49**

Outpatient Transformation Programme Governance



Outpatient Workstreams & Milestones

Workstreams	Sub Workstreams	Qtr 3 25/26	Qtr 4 25/26	Qtr 1 26/27	Qtr 2 26/27	Y2
1) Standardisation of Referral Processes	1A) Clinical Review and Redesign of Specialty Pathways	• Confirm approach and scope to outlining which specialties will explore specific transformation options– ranging from enhancements to basic Advice & Guidance (A&G) through to full scale pathway re-design (system wide)	• *Future milestones dependent on identified option*			
	1B) Reconfiguration of Trust Systems & Processes	• Benchmark current processes across trust/ identify variation • Scope digital requirements • Identify 'good' and 'challenged' specialties to work with	• Develop standard trust process in collaboration with care groups • Roll out plan agreed by speciality	*Future milestones dependent on identified option (1A)*		
2) Clinic Templates	2A) Standardisation of Templates	• Develop local checklist to provide framework for review • Launch initial specialty Clinical Lead & Ops Manager sessions (variation & benchmarking)	• Develop Monitoring Dashboard & visibility • Continue specialty sessions, implement changes as identified	• Improve alignment of templates with capacity & demand and job planning • Continue specialty sessions, implement changes as identified	• Establish robust process for changes to templates, and ongoing BAU review process	• Any further actions relating to readiness for new EPR, including design criteria
	2B) Review of Clinic Codes	• Clinic code cleanse of DQ & obsolete • Start review and consolidation of codes – initial specialties	• Develop robust process for signoff of additional codes • Continue specialty review and consolidation of codes	• Continue specialty review and consolidation of codes	• Move monitoring and governance to BAU (OP Cell)	
3) Centralised Booking & Standardisation of Administrative Processes	3A) Centralisation of Booking	• Stock take of all specialty booking arrangements & associated resources • Prioritise specialties • Evaluate 642 • Comms approach to be informed by benefits assessment to drive engagement	• Develop standardised admin procedures for bookings • Review job descriptions, start phased approach moving to book centrally (informed by current provision analysis, demand) • Start of formal MOC	• Develop standardised procedures for related admin processes • Extend scope of 642 • MOC process	• Continue phased approach, confirm exceptions • MOC process	• Review progress & confirm milestones
	3B) Standardisation of OP Processes - Cancellations	• Launch Cancellations Task & Finish Group • Identify key constraints / factors	• Scope options to improve automation & oversight of cancellations & approval process	Develop standardised admin procedures for clinic reductions & cancellations and begin targeted training	• Formalise training on cancellations as part of BAU (OP Cell)	• Scope any outpatient process not yet standardised
	3C) Standardisation of OP Processes – Waiting List Management	• Scope workstream	• Launch Waiting List Mgt Task & Finish Group	*Dependent on scope*	• Formalise training on waiting list mgt processes as part of BAU (OP Cell)	
4) Outpatient Clinic Processes		• Confirm work already underway (eg AVT) relating to this workstream and establish links				• Plan for launch in Y2
Patient Engagement		• Pt baseline and establishing links for feeding to other workstreams	• Confirm scope for reviewing communication methods & formats			

Diagnostics Community Diagnostic Centre

Opens April 2026

CDC - Planned Activity / Year

Diagnostic	Planned Activity (Exams) / Year
Imaging - CT	31500
Imaging - MRI	18900
Imaging - NOUS	21065
Imaging X-ray	30150
Physiology Sciences Cardiology	20250
Physiology Sciences Respiratory	34500
Endoscopy	10640
Phlebotomy	20000
TOTAL	187005

Further Developments	Planned Activity (Exams) / Year
Fibroscanning - Liver Pathway	3000
GI Physiology / Cytosponge	Additional plans currently in development - activity plan TBC
Urology Urodynamics	
Gynae Pathway - Hysteroscopy	
Head and Neck Pathway - TN scope	

- CDC planned activity will ramp up throughout April '26, with full activity profiles for all services delivering through full month of May '26 onwards
- 165, 615 activity will be new diagnostic activity at CDC
- NOUS will transfer 14,730 activity to release estate (rooms) at Royal Stoke
- Future potential to fill vacant 1,800 Sq. Ft of CDC estate

PET-CT

Current Contract with AML extended to March 2027. Plan to support bid in upcoming National contract tender to continue to provide PET-CT from UHNM.

Forecast Activity Requirement

	Forecast Current Year	Forecast - Next 10 years									
Year	25/26	26-27	27-28	28-29	29-30	30-31	31-32	32-33	33-34	34-35	35-36
Activity (Exams)	4940	5683	6346	7085	7899	8825	9852	11008	12290	13734	15349

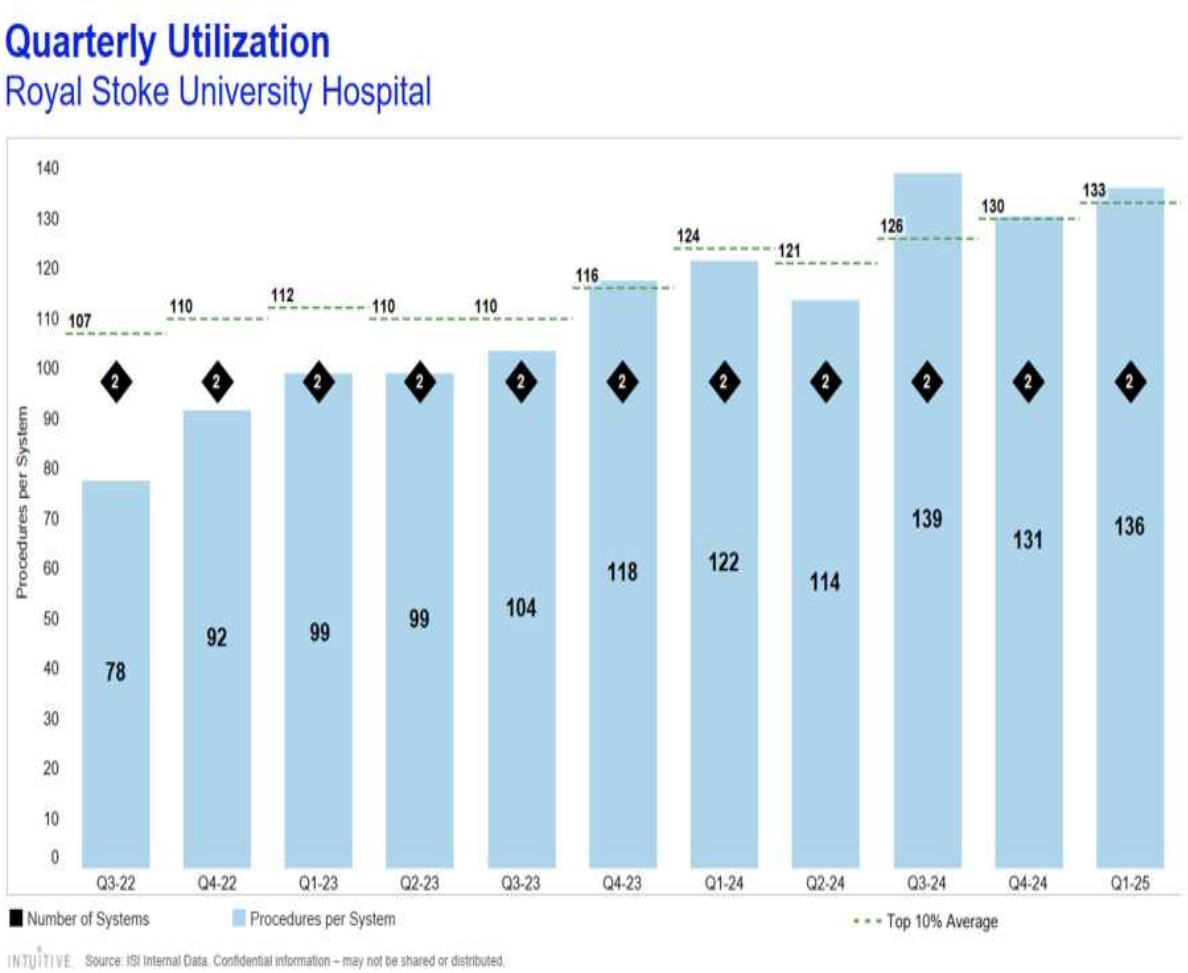
Theatre Workstreams & Milestones

Workstreams	Sub Workstreams	Qtr 3 25/26	Qtr 4 25/26	Qtr 1 26/27
1) UHNM Anaesthetic Consultant Rota Review	1A) Roles and responsibilities of sub-specialty Leads need to be clearly defined along with lines of accountability	Task and finish group established. Scope sub specialty demands and requirements.	Develop and implement clear lines of responsibility and accountability and extend to rota coordination and other cross speciality leadership roles.	Ensure that job plans for 26/27 reflect the sub specialty lead roles.
	1B) Alignment of Consultant Job Plans to model output. (This will include a SPA/APA/External Duties review within the existing allocations)	Recruitment to bridge known subspecialty capacity gaps. Maintaining a small vacancy factor may provide some additional flexibility	Undertake a Team Job Planning exercise using the model output. This to include a comprehensive review of SPA/APA/External Duties to ensure consistency across sub-specialties	Ensure that job plans for 26/27 reflect the output demand.
	1C) Operationalisation, including the building of rosters and establishing clear rules around annual leave and lines of communication between subspecialities need to be prescribed	Task and finish group established. Link with BMA to ensure proposal is in line with job plan requirements. Communicate proposed change and present at Anaesthetic Consultant Meeting.	Develop rosters in CLW system, linking with Medicial Staffing Department.	Use model output, sensitive to sub-speciality demand, to build rosters that ensure consistent delivery, meeting service demand without the need for premium spend
2) Development of Theatres Dashboard		Scope and agree requirements of dashboard. Build code and dashboard testing environment.	Dashboard signed off and live.	
3) Elective Orthopaedics Utilisation & Productivity Work Group	3A) Increase Theatre Session Utilisation to 85% from 69-76%	Task and finish group to be established. Benchmark current process, including Trauma lists.	Evaluate 642 scheduling process	
	3B) Relocate Block Injectios from Main Theatres to OP Suite/Treatment Room	Working with clinical teams agree suitability and scope of opportunity.	Develop standardised admin procedures in terms of listing and 642 scheduling process.	Review benefits and patient experience.
	3C) Hand Centre Capacity and Demand	Launch Task and Finish Group Review current demand and acitvity levels running through the Hand Unit	Review opportunity to support repatriation of activity from IS - working with ICS to publish sub-specialty waiting times.	*Future Milestones dependant on identifed option.*
	3D) Average Case Per List Improvement	Task and finish group to be established, working with clinical teams agree scope of opportunity.	Utilise dashboard to improve session uptake visibility. Evaluate 642 scheduling.	
4) Opthalmology GIRFT - HVLC Cataracts Lists	4A) Patient flow pre- and post-operation	Task and finish group established. Nurses checklist to be streamlined. Patient packs to be prepped correctly. Post op fit patients directed to Eye Clinic	Investigate the possibility of additional space - explore discharge lounge.	Submit case, in line with Service Developments, to increase staffing levels to support increase throughput.
	4B) Clear identication of suitable patients for HVLC lists	To clearly highlight 'Suitable for HVLC' on relevant documentation. HVLC Surgeons to triage and complete the Direct Access clinic and to list their own patients.	Update to Surgical Booking Forms within iPortal.	
	4C) Theatre Equipment	Work with HSDU to ensure that set distribution to Poswillo Theatres is happening in a timely manner with correct equipment.		
	4D) Theatre Staffing	Implement huddle pre-surgery to ensure all staff members have clear expectations. Request for volunteer support.	Review Opthalmology Theatre Staffing Models from other Trusts.	Increased skillmix within theatres staffing team to enable more cover within Opthalmology Theatres.

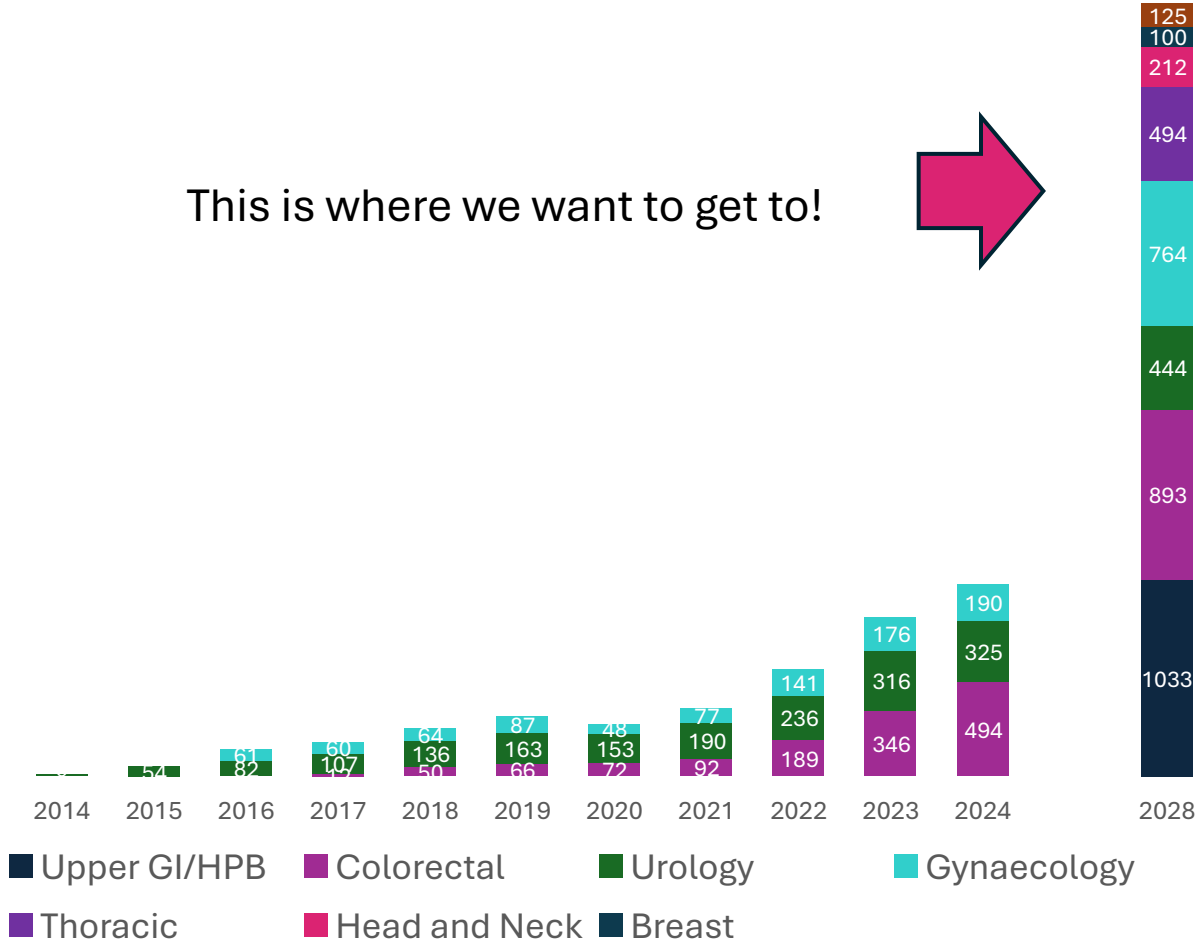
Workstreams	Sub Workstreams	Qtr 3 25/26	Qtr 4 25/26	Qtr 1 26/27	Qtr 2 26/27
5) CEPOD Utilisation		Task and finish group commenced. Golden patients to be identifed. 8:30 huddles established to review and discuss patients.	Review CEPOD utilisation and productivity and impact to Elective lists.		
6) Review and Relaunch Performance Data & Review		Stocktake of all internal meetings and reports provided. Comms sent out to speciality teams to drive engagement. Clinician ownership encouraged of additional list availability.	Relaunch of Theatres Productivity Group and robust 642 processes established.		
7) Perioperative Programme	Digitalisation Medical Optimisation Booking & Scheduling PreAMS Prehabilitation	Stress test the digital solution to support early health screening and patient optimisation Introduce the new process for booking and scheduling surgeries that optimises timing based on patient readiness Develop a better understanding of the opportunities for early prehabilitation within the pathway to improve patient strength, fitness, and mental readiness for surgery Improve communication between multidisciplinary teams (surgical, anaesthetic, nursing, rehabilitation) to ensure coordinated patient care from the preoperative phase through to discharge	Conduct evaluation, incorporating feedback and lessons learned to provide actionable reccomendations Review and update the programme plan with revised timelines and next steps, informed by insights gained from the pilot, to ensure successful full implementation and rollout of the pathway across additional specialties within UHNM. Finalise the rollout strategy for all current specialties Develop a comprehensive roadmap for engaging and onboarding new specialties	*Future Milestones dependant on pilot updates.*	
8) County Elective Hub	8A) Full establishment of Main Theatres and STS operating into evenings and Saturdays	50% of all sessions to be running into evening / Saturday (23 sessions of 46)	75% of all sessions to be running into evening / Saturday (34 sessions of 46)	100% of all sessions to be running into evening / Saturday (46 sessions of 46)	
	8B) Performance & Activity Dashboard	Final draft of Theatre Dashboard. Ability to split County Hub performance from UHNM / Royal Stoke overview	Live Theatre Dashboard, with performance and activity tracked daily		
	8C) Accreditation	75% of evidence compiled within the 5 domains as per NHS-E guidelines First Accreditation visit to take place, with feedback given by NHS-E	100% evidence compiled and full governance structure in place for full Hub oversight		Fully accredited County Hub

UHNM robotic journey

UHNM can demonstrate the highest levels of productivity in the UK and have a strategic aim to complete over 30% of activity robotically within the next 3 years.



This is where we want to get to!



Patient Access Workstreams & Milestones

Workstream	Sub Workstreams	Qtr 3 25/26	Qtr 4 25/26	Qtr 1 26/27
Artificial Intelligence waiting list validation	1A) Rolling programme to validate Incomplete PTL in line with Validation Sprints	Increased efficiency; completing 3 months work of validation in 5 days, with a projected 1.3% RTT improvement through validation alone	Further validation work to be undertaken with NON-RTT outpatient waiting lists; focusing not only on removals but also on stratifying clinical risks in patient's overdue follow-up	• Validation of all clock stops and new pathways as they are added to the PTL, ensuring PTL is completely cleansed, and all errors are captured as they happen • Adding new data streams into AI solution such as CRIS and EPR to highlight where next steps have been missed
	1B) Training and Business Processes	RTT & Planned Care Training now delivered digitally and made mandatory. By January 2026, all will be tracked through ESR giving managers easily accessible data to ensure all relevant staff attend annual refresher training	January 2026 will see the launch of joined-up waiting list training encompassing all aspects of RTT and NON-RTT waiting list management, delivered jointly by Planned Care, Data Quality & Information Teams	Clinician RTT & Clinic Outcome Form training to be re-launched in 2026, in conjunction with Outpatient Transformation Programme

Elective Delivery Programme

Quality, Access and Outcomes Committee

Planned Care Board

- 18+ week waits; 63%
- 52+ week waits; 1%
- Time to 1st Appt; 77%
- 62 day wait; 75%
- 28-day diagnosis; 80%

DQ / Validation / Admin

- Elective Care Improvement Plan
- Planned Care Validation (& AI)
- Validation Training
- Data Quality
- Performance & Reporting
- Digital
- Planned Care System Working

Outpatients

Brilliant Basics:

1. Missed appointments rate <5.5%
2. 90% RTT validation <12 weeks
3. Slot utilisation 90%
4. Utilisation of specialist advice requests (A&G) >10%
5. Response to A&G <48hrs
6. Minimum of 25% Non-face to face consultations
7. >49% of OP appointments are new or attract a tariff
8. Clinic letter to pt. / GP <5 days
9. PIFU >6%
10. Reduction of Clinic cancellations <6weeks by 50%
11. Clinic outcomes <72hrs
12. Actioned rebooking / cancellation requests >95%

Diagnostics

- DM01 99%
- Diagnostic Surveillance / Planned Patient UHNM process
- 99% of patients receive DM01 test results within 3 weeks
- 95% of patients receive diagnostic test results within 6 weeks
- CDC Delivery & Activity
- Missed appointments rate <5.5%
- Diagnostic Strategy SSOT Delivery

Theatres

- 85% theatre in-session (capped) utilisation
- 95% theatre session uptake
- 4% reduction for on the day cancellations against specialty
- Theatre starts on time >80%
- **Elective**: Achieve 85% DC for BADs procedures
- **Elective**: EL Readmission rate >0 day (metric needed)

Cancer

- 80% FDS performance
- 96% 31 Day Combined Standard
- 75% 62 Day Combined Standard
- Reduce cancer 62+ day backlog
- Reduce cancer 104+ day backlog
- 80% Cancer Outcomes Service Dataset (COSD) for stage completeness

Elective Oversight Management Group

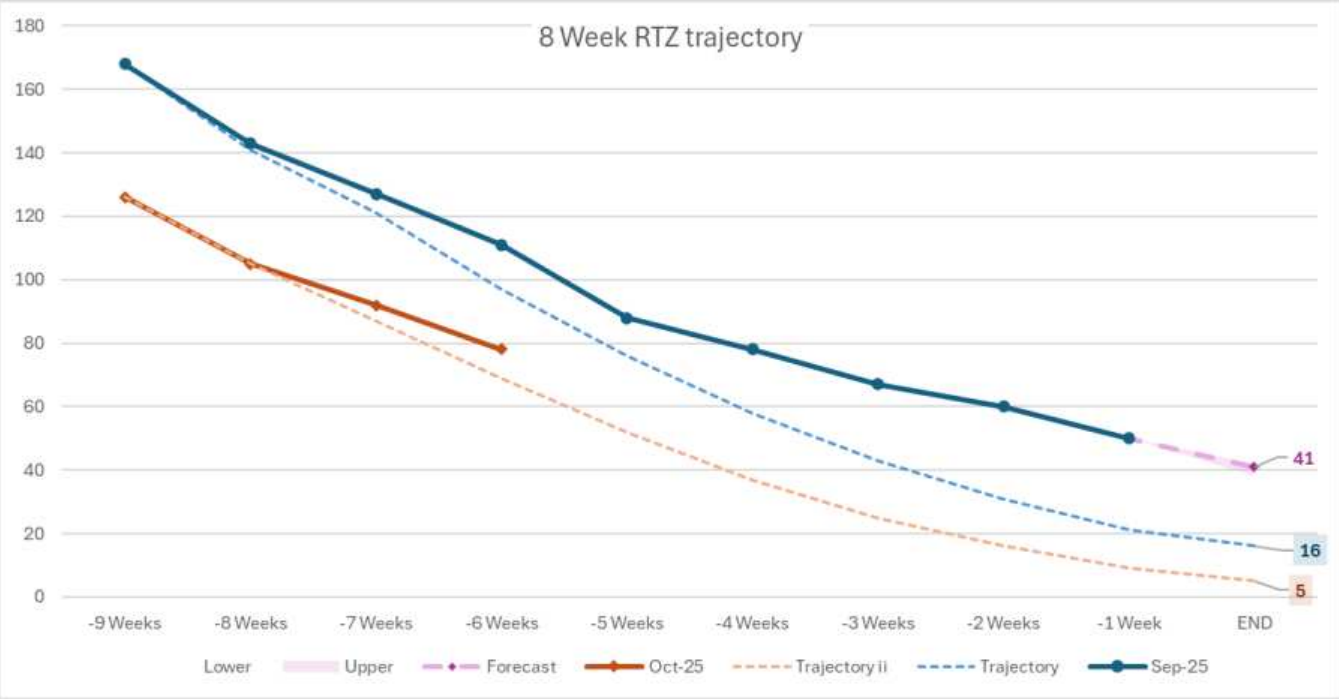
- Eliminate 52ww by Sept 2025
- Eliminate 26ww for CYP by Sept 2025
- 100% of patients waiting over 12w are validated

RTT 65 WEEK RECOVERY – Specialty of concern

ENT – Performance against trajectory

Cohort	Current Week	Previous Week	Reduction		8 week RTZ	distance from RTZ	change from previous week
Sep-25	50	60	-10	-17%	21	29	0
Oct-25	78	92	-14	-15%	69	9	4

ENT – Performance against trajectory



Update

- August outturn performance for 65wks was 24 breaches

- September currently 29 off month end trajectory of 16
- Additional capacity coming online but improvement not expected to impact in September (over the next week) meaning expected end of month position 34 – 42
- October cohort is tracking below September position and November cohort also tracking below October – Thus showing recovery is starting to be seen in the data

- September tracking 17 definites:
  - 9 TCIs in October
    - 4 capacity; 2 Rhinology / 1 thyroid / 1 complex otology
    - 4 pt choice
    - 1 GP intervention for High BP
  - 8 appointments
    - 6 patient choice
    - 1 01/10 - MRI report needed; dated in prep
    - 1 pt to consider surgery; 08/10 for decision
- September tracking 17 likely:
  - 11 with appointment in month
  - 1 TCI for October; capacity for thyroids - 2 a month lists
  - 1 MRI reporting needed
  - 1 referred to Birmingham; need decision - was sent last week
  - 1 repeat pre-ams; haematology issue ?WW - 08/10
  - 1 TCI for Rhinology - flipped to admitted
  - 1 24/09 - TCI required; likely breach if flip

- Short term 'workforce bridge' created by insourcing, whilst recruitment to posts within the approved ENT business case are appointed. PMO support being established to expedite business case.

- Business Case funding requested for admin support to book / progress patient's journeys

- Current locum extended until September 25

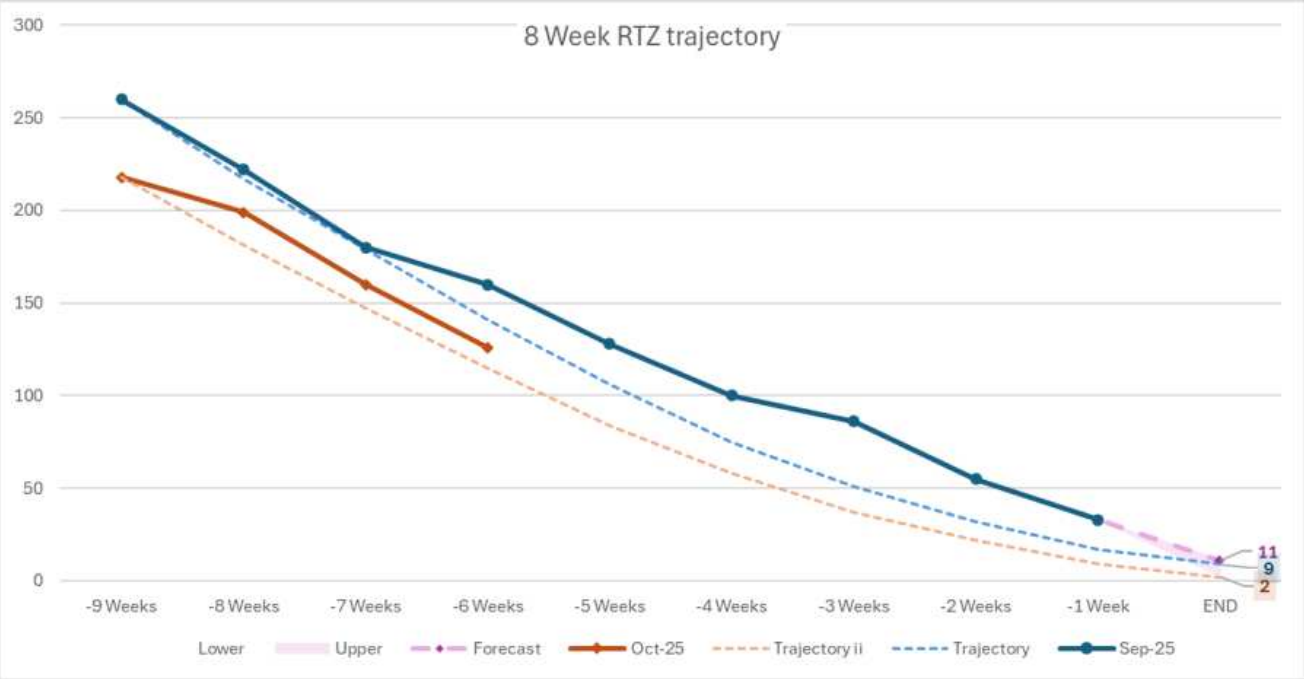
- Consultants offering to undertake additional capacity, Ops Team working on plans with Theatres – limitations is consultant availability

RTT 65 WEEK RECOVERY – Specialty of concern

Gynae – Performance against trajectory

Cohort	Current Week	Previous Week	Reduction		8 week RTZ	distance from RTZ	change from previous week
Sep-25	33	55	-22	-40%	17	16	-7
Oct-25	126	160	-34	-21%	115	11	-2

Gynae – Performance against trajectory



Data Update

- Positive week saw September cohort see a reduction of 22.
- This was 7 more than expected bringing the cohort much closer to trajectory
- Gynae remains slightly off trajectory this month however - Patient level tracking gives an expected end of month position of 6.
- October cohort has a reduced starting point 218 vs 260 in September

Update

September
65 ww
32 tracked
24 unlikely - with plan
4 definite

- Urodynamics; pt choice holiday
- JW - multiple consultants; 01/10 TCI - capacity
- IR Case - canx on day consultant not happy with interpreter machine; f2f interpreter. Rebooked for 03/10 - mandarin
- Inhaler patient; needs RS only - 60 min gap - 15/10; to place patient

4 likely

- 2 IR cases; pts. Canx prior to October; booked to 03/10 now. Asked to b/f
- Fertility patient; bloods needed back?? DX?
- Clinic 23/09 - marina coil treatment required - dated for Thursday 25/09 - if accepts - safe

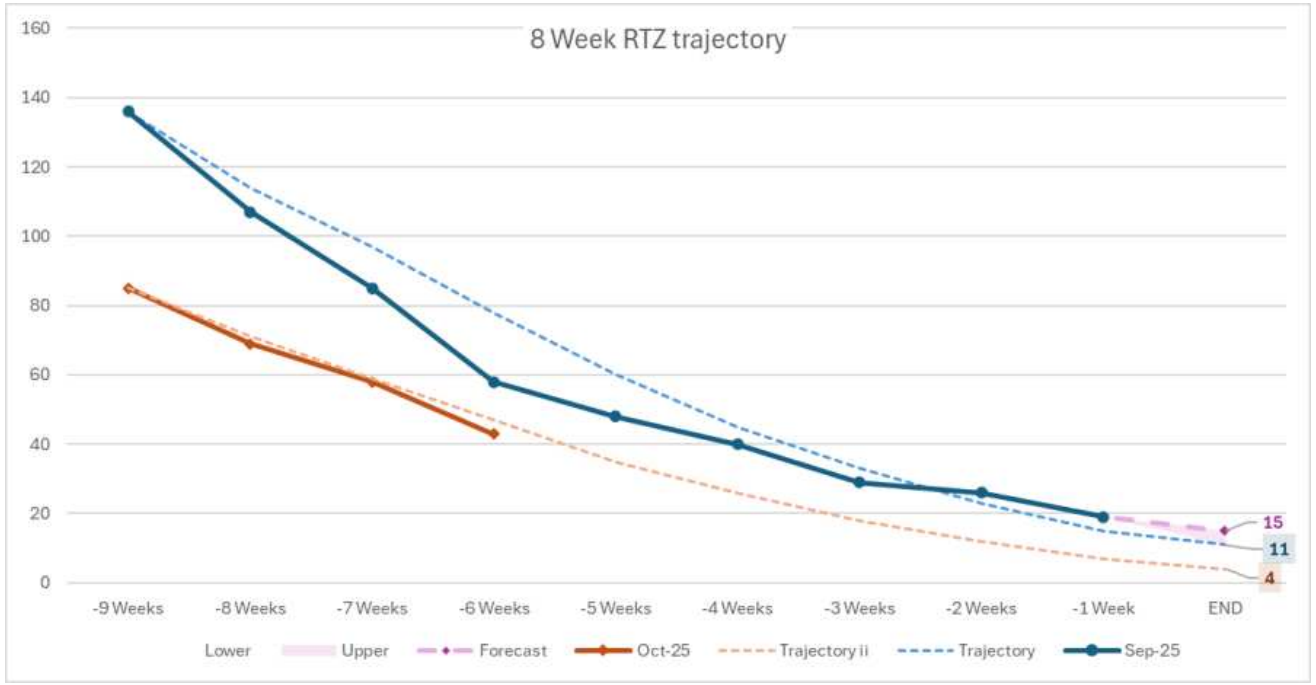
The Elective Hub will commence beginning of September, with additional theatre sessions also being pursued.
The STS Saturday session for outpatient procedures has now been job planned. One session has been picked up on a temporary basis for the next two months, after which it will be formally job planned.
Insourcing has been delayed for a few weeks due to changes in activity.

RTT 65 WEEK RECOVERY – Specialty of concern

T&O – Performance against trajectory

Cohort	Current Week	Previous Week	Reduction		8 week RTZ	distance from RTZ	change from previous week
Sep-25	19	26	-7	-27%	15	4	1
Oct-25	43	58	-15	-26%	47	-4	-3

T&O – Performance against trajectory



- September cohort expected end of month position on track and in line with trajectory. expected 9-15, with plans in place to improve.
- October cohort remains ahead of where September cohort was 6 weeks out. And expected to deliver single figure end of month position
- Continued improvements in cohort size show sustained improvements (right side chart).
- >52 weeks end of March 2026 71% reduction compared to the starting position taken on 4th April

Update

September
65 ww

- 31
- Ortho - 26 now was 29 last week
- Spines - 10 this week
- 5 definite - scoliosis with booked for October - capacity constraints / CT&MR needed for date for October
- 4 likely- 3 are imaging injection
- RISK - trauma / infection control
- Could reduce by half if 3 imaging booked
- Paeds T&O - 1

October
65 ww

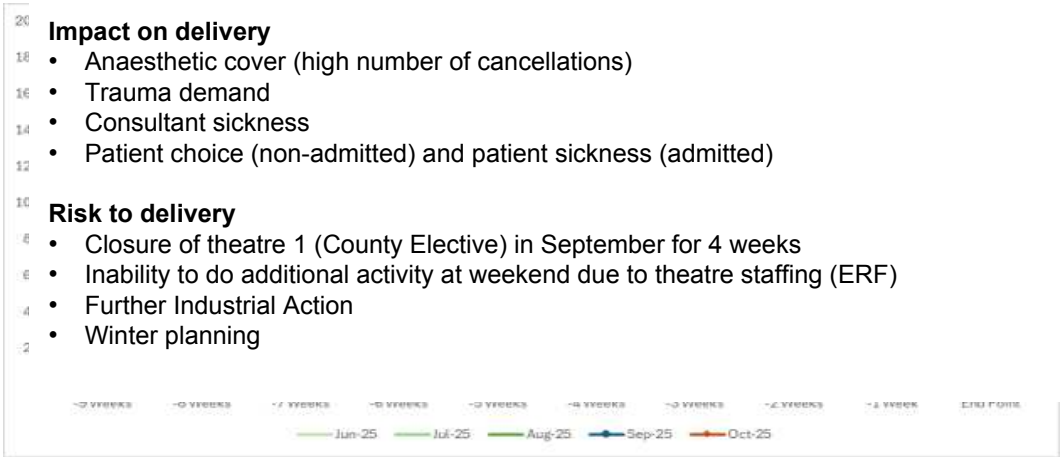
- 83 total - including Sept
- 41 likely
- 17 Ortho
- 18 spines
- Will improve as the month continues
- Risk for Spines – unstaffed Saturday lists
- 4/5 for imaging injections for spines
- Paeds T&O route to 0; subject to consultant cover - should be OK

Impact on delivery

- Anaesthetic cover (high number of cancellations)
- Trauma demand
- Consultant sickness
- Patient choice (non-admitted) and patient sickness (admitted)

Risk to delivery

- Closure of theatre 1 (County Elective) in September for 4 weeks
- Inability to do additional activity at weekend due to theatre staffing (ERF)
- Further Industrial Action
- Winter planning

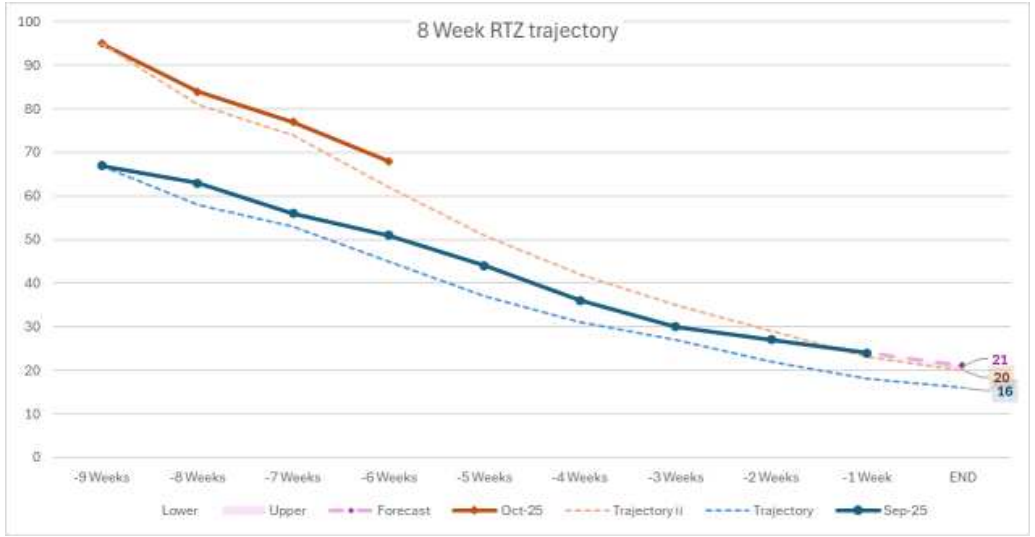


RTT 65 WEEK RECOVERY – Specialty of concern

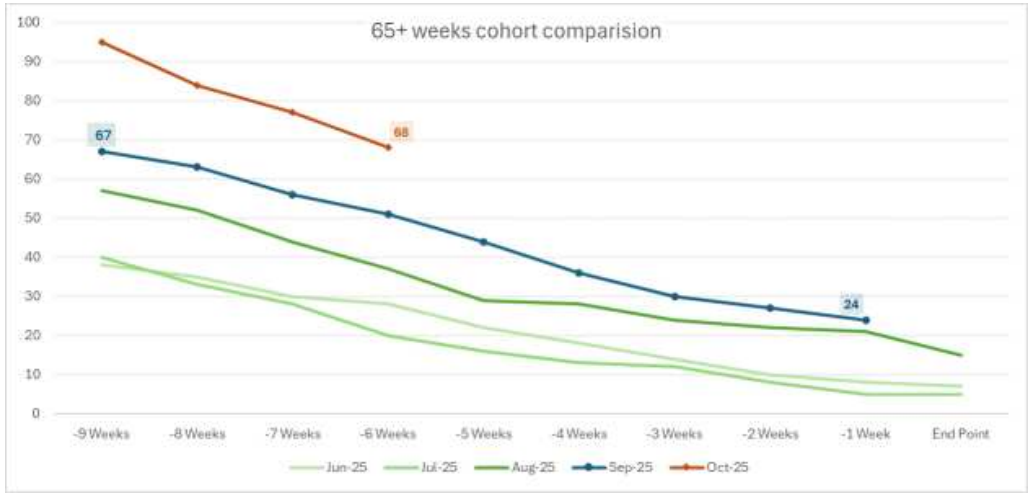
Ophthalmology – Performance against trajectory

Cohort	Current Week	Previous Week	Reduction		8 week RTZ	distance from RTZ	change from previous week
Sep-25	24	27	-3	-11%	18	6	1
Oct-25	68	77	-9	-12%	62	6	3

Ophthalmology – Performance against trajectory



- September cohort currently off trajectory
- Expected end of month position 21

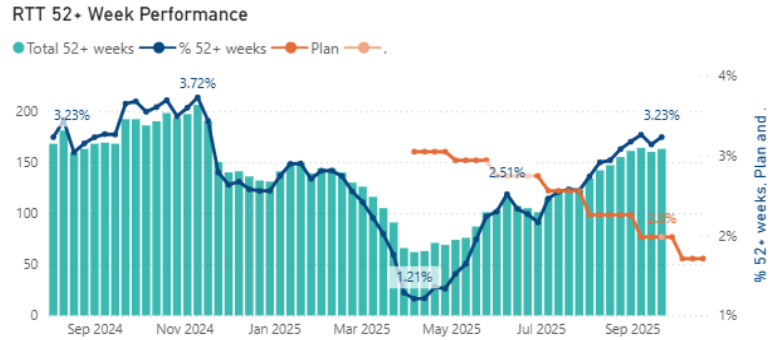


- 4 months of rising cohort starting position – indicates an unsustainable level of RTT closures
- October cohort 18 higher than September was 6 weeks out

25/26 priorities

- Total PTL seeing growth over the last 4 months

- 18 Week % although above plan, is deteriorating
- Last week saw improvement



- 52+ week waits are growing.

Diagnostic DM01 13+ Week Breaches

Current DM01 waiters over 13 weeks (Un-validated)

Weekly DM01 - Elective Recovery Board

>> Unvalidated Waiting List

Area	DM01 Modality	<6 weeks	6-9 Weeks	10-12 Weeks	13+	Total	% 13+	13 Week Cohort		
								No TCI	TCI <= Month End	TCI > Month End
Imaging	Magnetic Resonance Imaging	3,268	174	22	4	**3,468**	0.1%	3	1	
	Computed Tomography	3,561	12	4	23	**3,600**	0.6%	23		
	Non-obstetric ultrasound	3,992	2,014	1,550	3,471	**11,027**	31.5%	2,112	622	737
	Barium Enema	0	0	0	0	**0**				
	DEXA Scan		0	0						
Physiological Measurement	Audiology - Audiology Assessments	401	174	22	45	**642**	7.0%	30	7	8
	Cardiology - echocardiography	1,164	33	4	5	**1,206**	0.4%	3	2	0
	Cardiology - electrophysiology	1	0	0	0	**1**	0.0%	0	0	0
	Neurophysiology - peripheral neurophysiology	278	125	2	1	**406**	0.2%	0	0	1
	Respiratory physiology - sleep studies	621	95	6	3	**725**	0.4%	1	1	1
	Urodynamics - pressures & flows	9	10	6	41	**66**	62.1%	9	13	19
Endoscopy	Colonoscopy	201	12	5	0	**218**	0.0%	0	0	0
	Flexi sigmoidoscopy	124	8	1	0	**133**	0.0%	0	0	0
	Cystoscopy	119	33	20	78	**250**	31.2%	36	24	18
	Gastroscopy	364	50	11	1	**426**	0.2%	0	1	0
	Total	**14,103**	**2,740**	**1,653**	**3,672**	**22,168**	**16.6%**	**2,217**	**671**	**784**

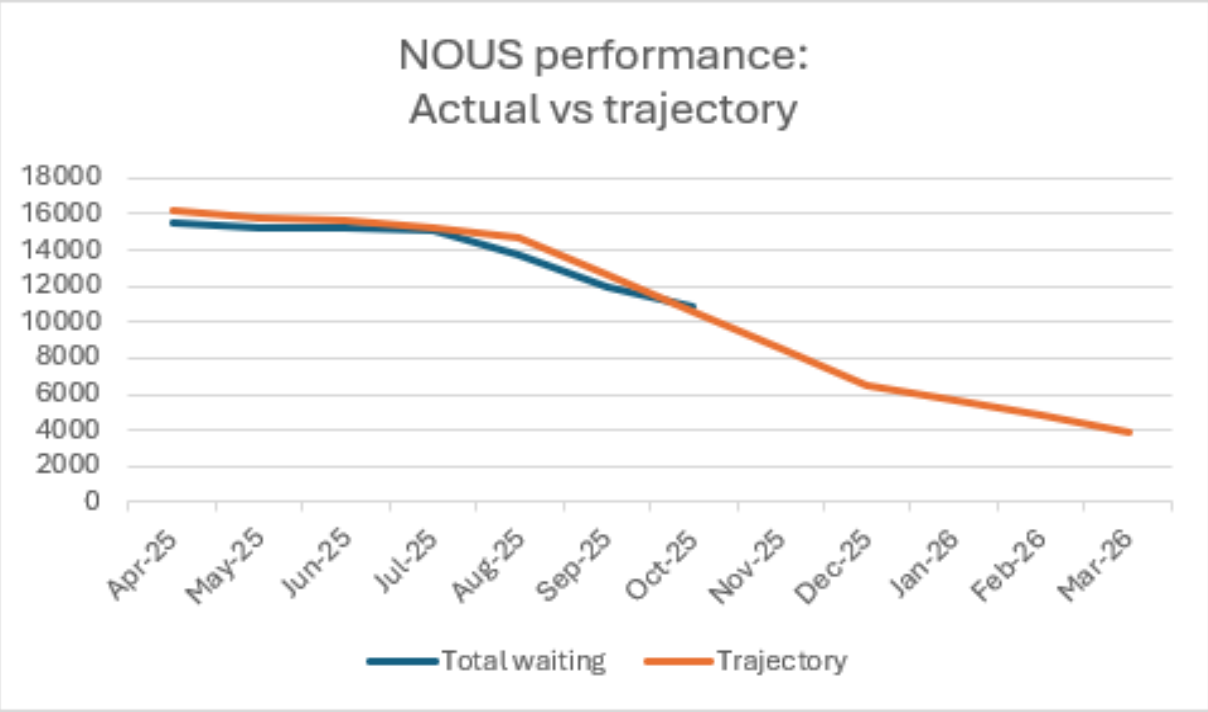
Overview of Diagnostics

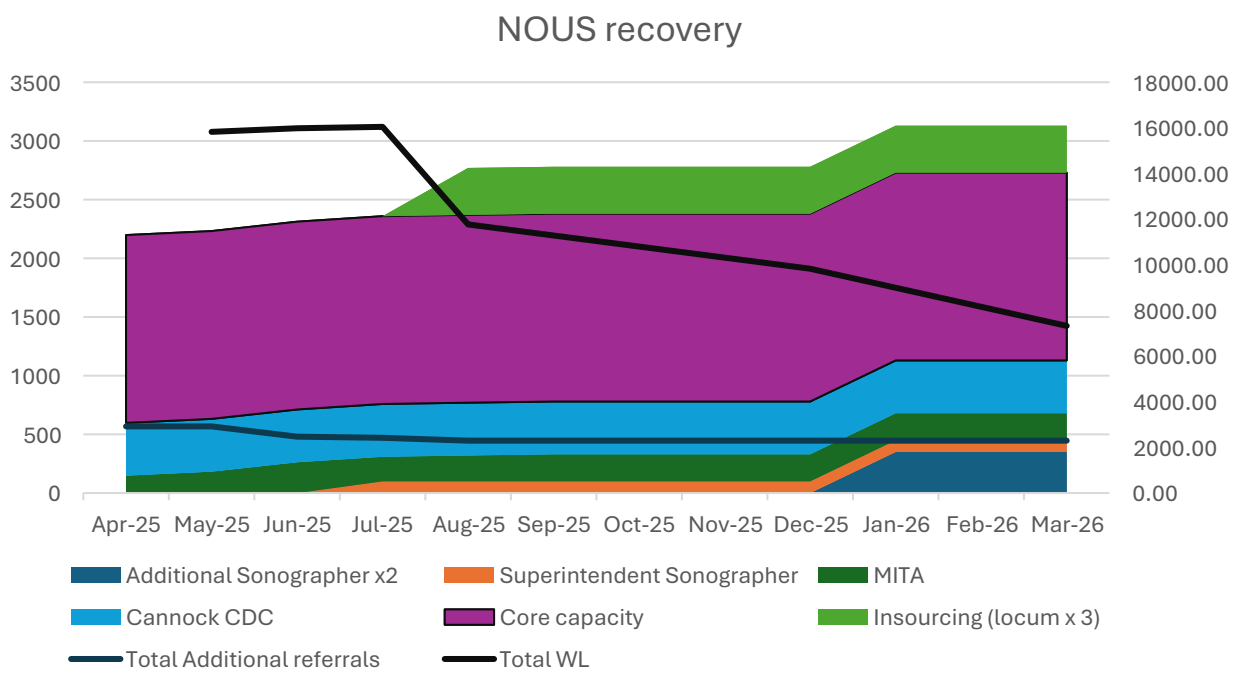
- 65.3% of patients receive their diagnostic test within 6 weeks (1% improvement from 2 weeks ago)
- Performance driven by backlog in NOUS
- NOUS weekly recovery group identified Partial Booking Waiting List to support with recovery
- Endoscopy DM01 performance August performance dip to 78.3% as predicted due to loss of CDC capacity
- All diagnostic performance monitored via the Trust Diagnostics Cell

NOUS:

- DM01 position has improved by 1% due to NOUS recovery. Backlog position is starting to recover which will support an improvement in DM01 position in the coming months; now under 11,000 patients waiting for appointment
- 1000 patients have been discharged from NOUS backlog following clinical revalidation. LLC authorisation agreed
- Unvalidated performance is now 36.8% (2.7% improvement)
- **Endoscopy:**
- WMCA bid not supported. 18weeks carrying out c.1000 slots across Sept as per approval paper. Further paper drafted to support for Oct to allow recovery whilst rest of FY bus case developed – waiting exec approval.

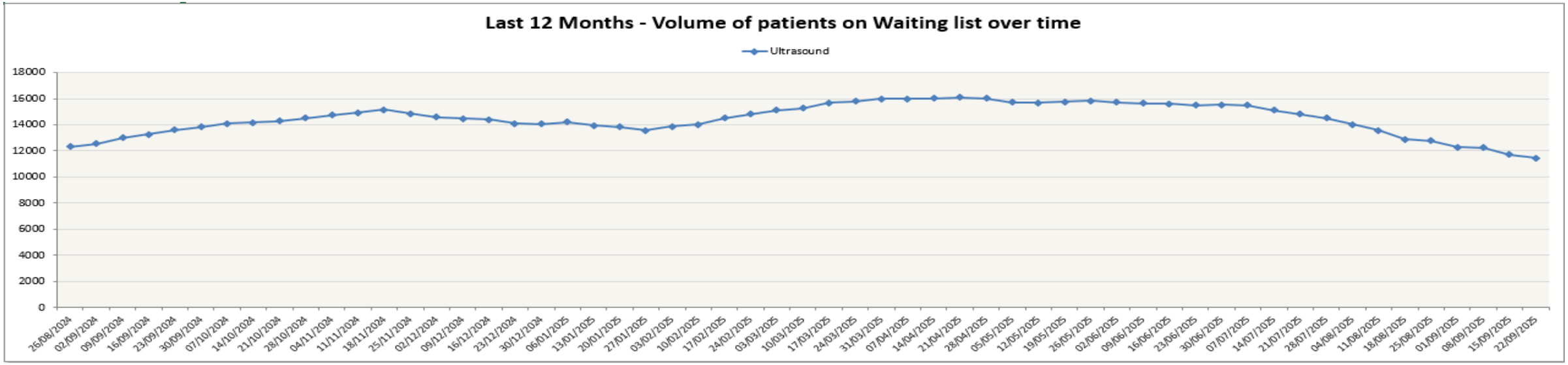
Non-Obstetric USS



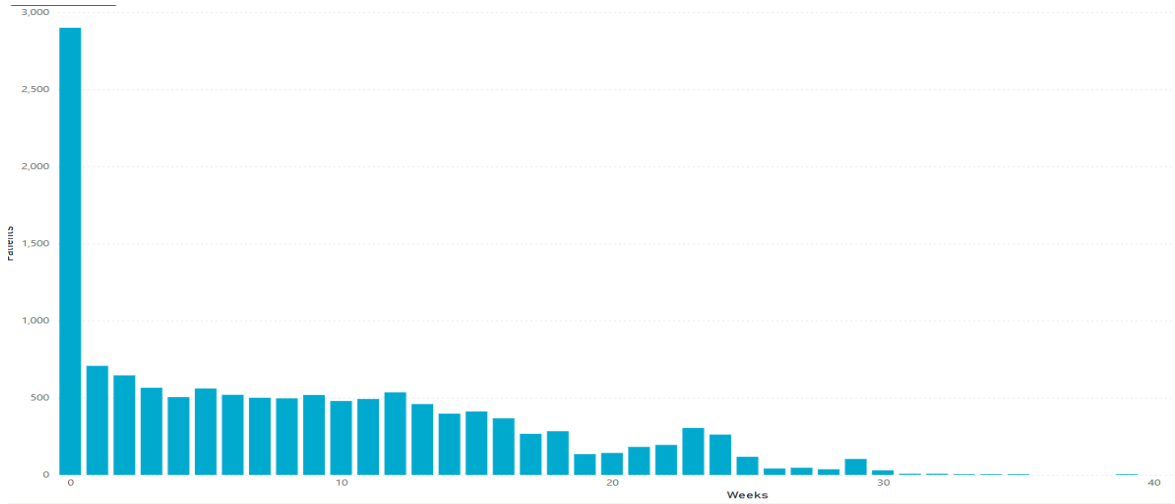


- Current recovery plan and projection for NOUS detailing all capacity streams. This position does not include a potentially positive impact from alignment to gynae referral pathway or MSK pathway as indicated overleaf
- New agency activity now on-line to support the position too so further improvement anticipated

Non-Obstetric USS



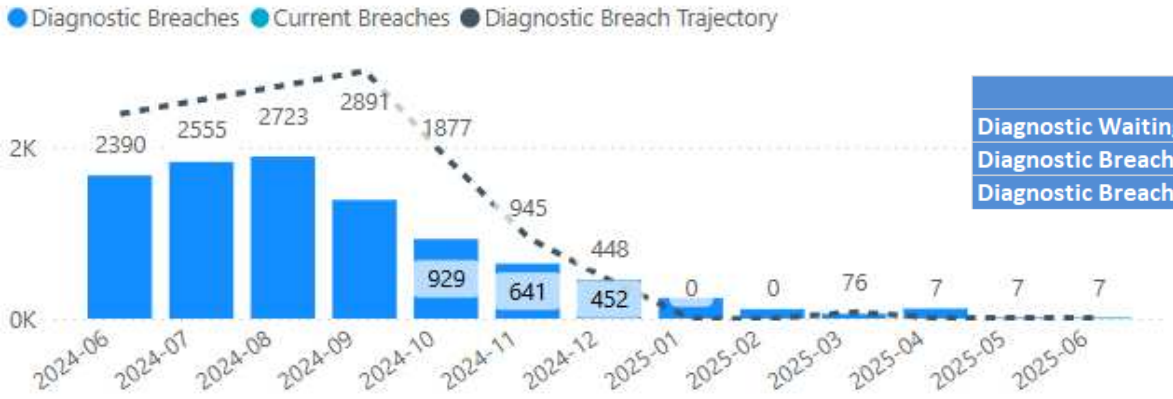
- The majority of long waits are either Gynae or Abdo patient creating a distorted view of the backlog. Discussions on-going with ICB colleagues to redefine the gynae pathway to ensure that patients are being treated in line with the pathway – and also to ensure that the pathway aligns with contracts for external providers.



- The backlog position continues to improve – with a predicted end-of-week position of approximately 10,500 patients. Current backlog position is the best since June 2024 and is continuing to improve.
- Interviews planned for wc 22.9.25 for sonographers with a positive applicant pool. 3 vacancies are being advertised and there is confidence that recruitment will be successful for these posts, thus significantly improving the position.
- All long waits on the chart (right) currently assigned to Royal Wolverhampton Trust via mutual aid. Those patients are being tracked individually to ensure that they are cleared rapidly. WC 22.9.25 has seen excessive long waits reduce and currently no patients are waiting longer than 40 weeks – with patients over 30 weeks delayed due to patient choice with appointment dates.
- DM01 position continues to lag due to focus on clearing longest waits first – therefore even though the backlog position is improving, DM01 will continue to be slow to recover in the short term.

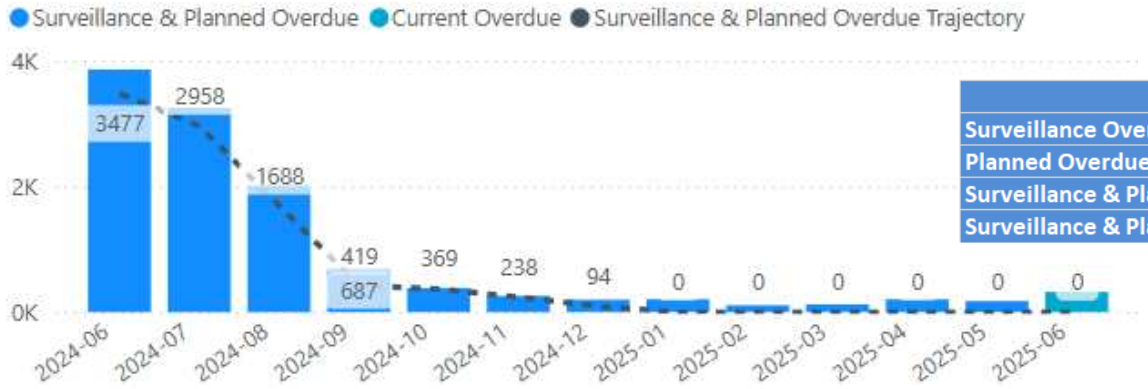
Endoscopy Waiting List Actual Size v Trajectory

Diagnostic Waiting List V Trajectory



Diagnostic Waiting List Size	484
Diagnostic Breaches	0
Diagnostic Breach Trajectory	0

Surveillance & Planned Overdue V Trajectory



Surveillance Overdue	37
Planned Overdue	30
Surveillance & Planned Overdue	67
Surveillance & Planned Overdue Trajectory	0

	Total Waiting List Size		
	Actual @ 01/07	Trajectory @ 31/07	Difference
Surveillance & Planned	67	0	-67
Diagnostic 6+ Week	0	7	7
Total	67	7	-60

	Dated	Undated
Surveillance & Planned	62	5
Diagnostic 6+ Week	0	0
Total	62	5

To Note:

Those patients not accommodated in August/Sept from a planned/surveillance wait list are being booked and now on the live wait list as per rules.

DM01 performance dipped to 78% in August as per updated warning trajectory. Execs supported Sept insourcing and c.1000 slots in month to catch up as much as possible. Will be asking for same level of support in October to mitigate DM01 drop – paper awaiting exec approval this week

Tracking all 52+ week RTT patients daily. Focus on capacity given to cancer pathway pts taking priority given capacity gap to allow cancer perf not to dip.

WMCA did not support endoscopy bid, FBC needed now to take to execs to provide capacity until April 2027 when CDC in and full sustainable capacity in place. All cancer pts being rippled forward where able to minimise wait times across the 2 pathways for Upper & Lowers.

5 consultant vacancies in Gastro (in differing stages of recruitment) affecting consultant level cover for procedures.

MPFT Paediatric Audiology

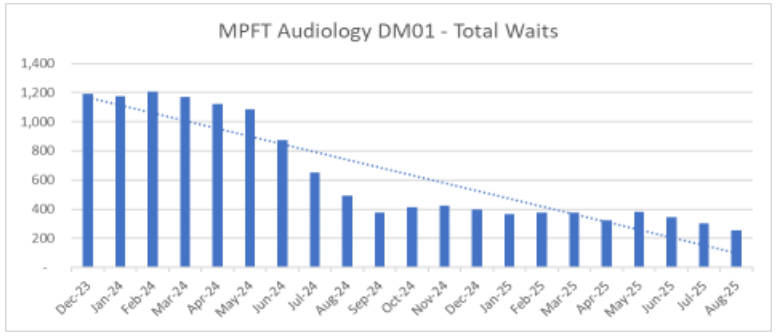
DM01 REPORTING

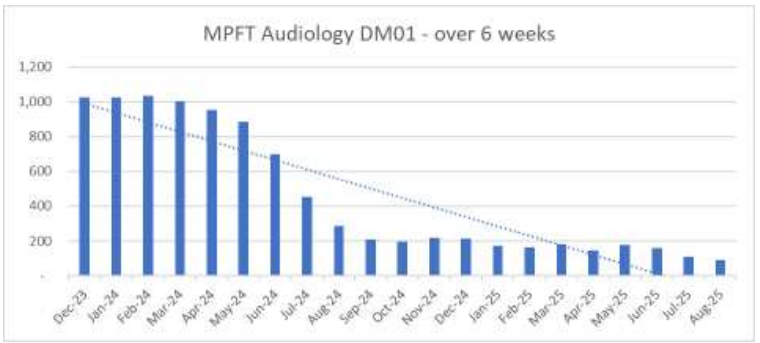
Month	Total	>6 wks	%>6w	>13 wks	%>13w
Sep-24	**378**	211	56%	152	40%
Oct-24	**412**	194	47%	136	33%
Nov-24	**426**	216	51%	132	31%
Dec-24	**396**	212	54%	117	30%
Jan-25	**366**	171	47%	89	24%
Feb-25	**375**	162	43%	83	22%
Mar-25	**378**	183	48%	91	24%
Apr-25	**324**	145	45%	70	22%
May-25	**379**	177	47%	89	23%
Jun-25	**343**	158	46%	66	19%
Jul-25	**301**	108	36%	38	13%
Aug-25	**255**	90	35%	21	8%

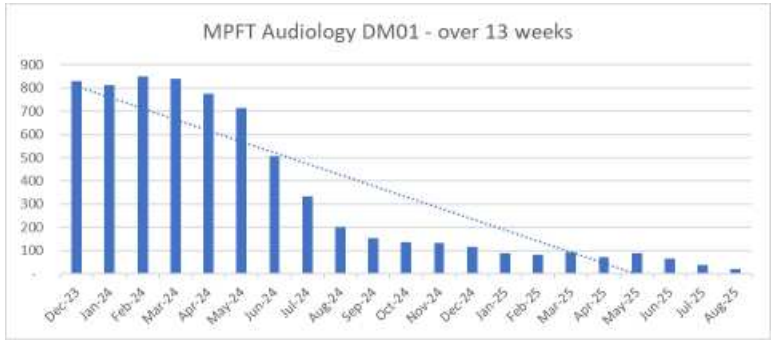
SUMMARY

ACTIVITY & PERFORMANCE

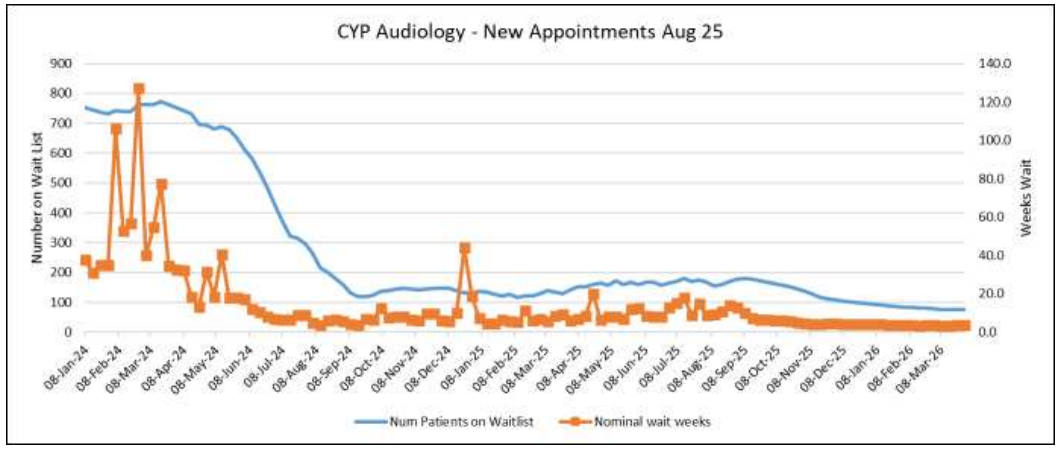
- All triage timescales remain in timescale with all D1 and D2 appointed within 2 weeks.
- An internal SITREP is used to monitor all children waiting over 6 weeks, currently a focussed effort on reducing the follow up backlog for D1 & D2 waiting over 6wks.
- The number waiting >6weeks and >13 weeks continues on a downward trajectory.
- Additional scrutiny taking place over the coming week to further understand that standards are correctly applied to all waits.
- The demand and capacity trajectory continues to be monitored.

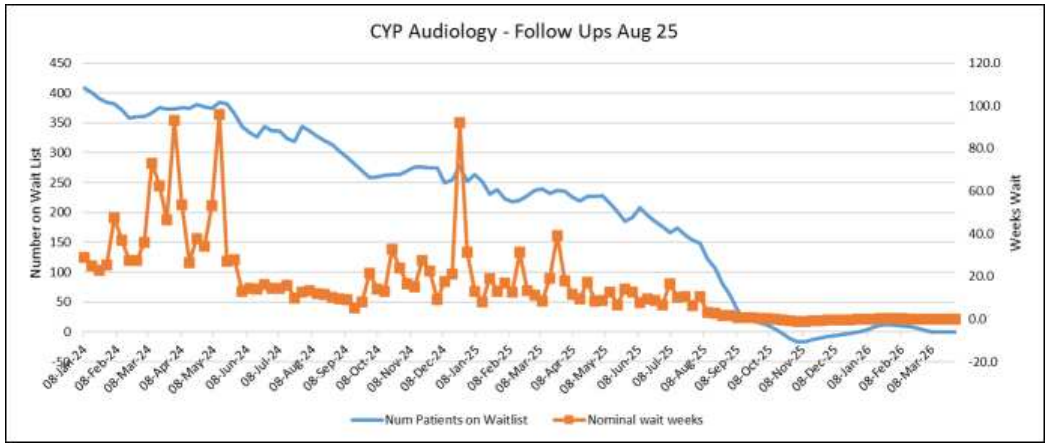






RECOVERY TRAJECTORY – NEW & FOLLOW UP





UEC Recovery Programme

Mapping to NHSE National Clinical Advisor Recommendations

University Hospitals of North Midlands NHS Trust

Service	Theme	Recommendations	KPI Measurement (s) to Improve	UEC Programme Workstream Mapping					
				Front Door Processes	Frailty	Clinical Pathways	Bed & Site Management	Ward Processes & Discharge	Organisational Restructure
Emergency Department	Safety	• Review registration process so no one waits longer than 1-2 mins to register • Ensure all staff are performing IA only (1-2 mins per patient) • Review process for recognition, action and mitigation to achieve IA in under 15 mins of arrival for ALL patients' 24/7	Initial assessment in under 15 minutes	●					
		• Review the current Consultant rota in order to have Consultant on site cover at night • Review processes at night which cause dysfunction • Trial an afternoon huddle which identifies then mitigates ED safety issues going into the night	4hr wait | Time to be seen within 60 mins | Out of hours vs in hours waits	●					
	Process	• IPC to be based in operations • IPC and operations to jointly review a SOP that phases IPC standards versus OPEL and risk • IPC to standardise a daily review of all side rooms and RAG rate (or equivalent) clinical requirements for side rooms • IPC and operations to create an FCP for IPC	Reduction in 12hr DTAs in ED | Reduction in cubicle requests				●		
		• ED to design a corridor care process that prioritises safety and is standardised across all leaders • The ED should design a process that proactively creates ED cubicles before ambulance waits occur (NB however, corridor care is a strong indication of wider organisation failure and as such process and risk mitigation proactivity needs to be focused in-hospital)	Ambulance HHOs	●			●		

Service	Theme	Recommendations	KPI Measurement (s) to Improve	UEC Programme Workstream Mapping					
				Front Door Processes	Frailty	Clinical Pathways	Bed & Site Management	Ward Processes & Discharge	Organisational Restructure
		• All patients are fit to sit unless they have a clinical reason to lay down (consider clinical only decision trolley usage)	Ambulance HHOs | Admissions in frailty reduction	●	●				
		Front door diagnostics: • Audit for unwarranted variation • Conduct clinical supervision • Trial a clinically led diagnostics proforma particularly for patients allocated to the majors stream and for older patients • Host departmental teaching sessions on the consequences of inappropriate diagnostics	Diagnostic volume reduction | 4hr times for Type 1 | 4hr times in older patients	●					
	Leadership	• Each NIC and CIC should receive on shift peer review and feedback on their leadership skills and ability to run the service as it has been agreed. Constructive peer review promotes a supportive environment and creates better leaders. • ED huddles should identify the risks that are in ED's control and should serve to describe mitigation to that risk (e.g. reducing initial assessment waiting times).	360 feedback | ED clinical standard times (15 min, 60 mins, 4hrs)	●					
		• The ED triumvirate should meet at least once a fortnight formally reviewing their dashboard • This should feed a report that can be used across a range of other meetings so as to avoid duplication.	The presence of a robust formal report which all 3 parts of the triumvirate know	●					
System	**Service**	Conveyance: • Gap analysis of services required vs missing for the demand • Review of HRG codes being brought to hospital that an alternative service should be taking	Call before convey increase | Reduction in conveyance from care/res/nursi	●	●				

Service	Theme	Recommendations	KPI Measurement (s) to Improve	UEC Programme Workstream Mapping					
				Front Door Processes	Frailty	Clinical Pathways	Bed & Site Management	Ward Processes & Discharge	Organisational Restructure
		• System review of ambulance personnel behaviour reasoning • Trial a hospital based advisory service to support HCPs in the community • System review of UCR • System review of care home non conveyance strategy	ng homes | improved HHO times						
		• Pilot an immediate co-located UTC • Ensure the access criteria meets best practice • Review and mitigate all reasons why UCC staff may be hesitant to accept pt groups • Ensure staff are available at times of actual demand • Mitigate unmet demand with an open service	Increased Type 3 activity | Improved 4-hour performance	●					
		• System to urgently create and trial services capable of delivering IV fluids, IV medications and community-based monitoring • The hospital and system to map actual demand (in conjunction with the sustained HIT process) so as to identify the capacity required	LOS reduction | Increased use of VW, SDEC and community services | Improved 12hr	●			●		
	Leadership	• The system to review its own OPEL actions to see if they meet the SMART criteria • System and UHNM leaders should meet to collaborate via an honest appraisal of action required • System leaders should regularly work within the acute provider and shadow services. The UHNM exec team should use this as an opportunity to improve relations to create system first solutions.	OPEL escalation and de-escalation frequency / time	●			●		

Service	Theme	Recommendations	KPI Measurement (s) to Improve	UEC Programme Workstream Mapping					
				Front Door Processes	Frailty	Clinical Pathways	Bed & Site Management	Ward Processes & Discharge	Organisational Restructure
Hospital Operations	Process	• Digital management of beds: Diagnose system issues • Create a plan to mitigate it and hold to account on behavioural dependencies • Aim to go to a digital only bed management model	Reduction in 12hr DTAs in ED				●	●	
		• A full review of the site operations function, form, roles and responsibilities • A re-write and launch of OPEL actions • Site coaching which includes empowering staff and rigor around SMART actions rather than outcomes • Introduction of clinical divisional decision makers at OPEL 3 and above	Reduction in 12hr DTAs in ED | Improved 4hr | Improved HHOs delays | Improved LoS				●	●	
		• With external support review the OPEL cards to make them SMART and meaningful rather than outcome focussed • Involve clinicians and Executive Directors at OPEL 3 and above • With external support review site meetings with very clear emphasis on action by whom to accomplish what • Ask the National Ops team to support ensuring the OPEL / SHREWD system is reporting properly and being used effectively • Each Directorate to have clear FCPs written and attendance to site meetings with plans for the next 24hrs to mitigate risk and demand successfully (no team leaves the next team without a plan)	OPEL escalation and de-escalation frequency / time				●	●	

Service	Theme	Recommendations	KPI Measurement (s) to Improve	UEC Programme Workstream Mapping					
				Front Door Processes	Frailty	Clinical Pathways	Bed & Site Management	Ward Processes & Discharge	Organisational Restructure
	Leadership	• With external support define the role of the site team, the rhythm of the day, and the roles / responsibilities of those attending ops meetings • Include clinician and executive attendance to ops meetings at OPEL 3 or above • Design a SMART action proforma for daily use • Use a predictor for G&A each day and where mitigation is not working, have a meaningful FCP escalation process • Initiate peer supervision for all ops team members • Initiate competency / capability assessments per directorate and role • Site are given full autonomy to make any bed management decision in the absence of a directorate plan that mitigates flow - the executive triumvirate empower this	Staff feedback | Audit of Site meetings | Audit of action tracker usage | Reduction of 12hrs				●	●	
		• Trial IPC being present in all site meetings at OPEL 3 and above • All services should have a plan which describes measures site can take in extremis which will help mitigate risk in ED • IPC to identify on a daily basis the order of patients in side rooms who can be moved out under what circumstances / IPC to support operationally in defining when barrier nursing and cohorting can be used in challenged circumstances	Reduced 12hr DTAs | Audit site meetings				●		
Specialties	Process	• A clinical summit to agree the clinical model for how patients enter and move through the UEC pathway • Patients should be streamed to the most appropriate specialty for their presenting complaint	Improved 4hr | Improved streaming numbers | Reduced HHO delays |	●		●			

Service	Theme	Recommendations	KPI Measurement (s) to Improve	UEC Programme Workstream Mapping					
				Front Door Processes	Frailty	Clinical Pathways	Bed & Site Management	Ward Processes & Discharge	Organisational Restructure
		• Streaming empowerment, decision making and refusals should be monitored daily and acted upon formally by division • Any patient reattending regardless of time or referral route should be given to the appropriate specialty on arrival • Ambulance staff should be granted direct access rights • No specialty should advise any pt to attend or ED unless they are an emergency • No speciality should transfer patients back to ED • All divisions should create a plan which enables patient assessment in their receiving areas • At times of increased demand, patients should wait in all assessment areas rather than just in ED • An FCP should clearly state how each Directorate manages increased demand and does not resort to sending their patients to ED	Increased direct access						
		• Relaunch IPS around specialty response rates with an appropriate monitoring and escalation process which is clinically led	Spec response times within 1 hour of request within ED and AM and same day for ward areas			●			

Service	Theme	Recommendations	KPI Measurement (s) to Improve	UEC Programme Workstream Mapping					
				Front Door Processes	Frailty	Clinical Pathways	Bed & Site Management	Ward Processes & Discharge	Organisational Restructure
		• Process map the portals and access criteria within the hospital so that national guidance is being followed	Improved 4hr Increased activity to alt to ED | Improved times and outcomes on targeted HRG coded patient types			●			
	Leadership	• Review of the current IPS in the trust with the senior medical leaders with a view to relaunching it and a maintaining a strict adherence through robust oversight at Directorate and Executive levels • At each new staff orientation, a senior leader will present the IPS as a must do - 'this is how we work here' • Senior leaders create an assurance process that escalations around non-adherence to IPS is robust AND all episodes of non-compliance are understood and supported and / or managed	Audit IPS adherence - time stamps | Audit IPS escalations			●			
		• All specialties should adopt a trusted assessor model that doctors can support thus freeing up all clinicians' time unless there is a need for their specific advice • All medical referrals should go through one single point of access empowered to give to any medical directorate service • All surgical and W&C services should do the same. • Streaming, ambulance and HCPs should have direct access to a trusted assessor who is able to accept and signpost patients to any service in the	Reduction of spec type attendances to ED | Improved 4hr | Improved 12hr | Increase in direct referrals to specs					●	

Service	Theme	Recommendations	KPI Measurement (s) to Improve	UEC Programme Workstream Mapping					
				Front Door Processes	Frailty	Clinical Pathways	Bed & Site Management	Ward Processes & Discharge	Organisational Restructure
		hospital UNLESS it is an emergency and should consequently go to ED.							
Frailty	**Process**	• The system should pull together an urgent frailty strategy action plan (including a detailed demand and capacity plan) with immediate (and longer term) actions that map all older patient conveyances with a view to reducing them. This plan should include a DoS review, UCR provision, care/resi/nursing home interventions, HRG code audit and mitigations and support to immediately trial a frailty advice line for healthcare partners. • The hospital should trial an older patient / frailty advice service Mobilisation of an extensive frailty assessment service (perhaps in an SDEC environment) which aims to pull	Older patient conveyance reduction | Care/resi/nurse home conveyance reduction | Older patient time to be seen by ED and frailty improvement | Older patient LoS reduction		●				
		• Reinstate and audit intentional rounding • Peer review live rounding • Trial a pj paralysis initiative • Introduce grand round initiative (like HIT) across targeted / trial wards (nurse and dr leaders) to challenge aspects like: 1. can only be managed in hospital 2. only PT OT can mobilise / sit out 3. IV hydration etc	LoS reduction | Successful results on audit		●			●	
		• An executive led discussion with Divisional teams to establish an agreed outlier management process which prioritises outlier care via a huddle / board round / ward round process. This SOP will be audited and managed by divisional clinical SROs who will enact peer review and manage unwarranted variation. • This process should be embedded as part of the winter planning exercises.	Outliers LoS reduction				●	●	

Service	Theme	Recommendations	KPI Measurement (s) to Improve	UEC Programme Workstream Mapping					
				Front Door Processes	Frailty	Clinical Pathways	Bed & Site Management	Ward Processes & Discharge	Organisational Restructure
		• Review the functionality of FEAU with a view to redesigning a functional frailty service on arrival. • Trial a 'silver line' to support non conveyance.	LoS in older patients | TTBS within 2 hours of arrival		●				
		• Empower front door services to be trusted assessors for all portals. This should be open access criteria rather than inclusion / exclusion lists - they should be trusted.	Time to be seen by frailty from arrival | 12hr waits | LoS in frailty patient journeys		●				
		• Prioritise a chaired and trolleyed frailty assessment area for the front door to use. This could be co-located to the ED, in FEAU, or be embedded in an SDEC / AM estate already in existence.	Time to be seen by frailty from arrival | 12hr waits | LoS in frailty patient journeys		●				
		• Frailty to lead a small clinical group to evaluate the use and understanding of the tools with a view to creating an action plan that improves understanding, compliance and consequently outcomes for frailty patients	LoS for all Frailty patients across the UEC pathway		●				
Leadership	**Leadership**	• Trust wide review of structures, roles and responsibilities • Governance review to include scale of meetings, content, format and attendances including ensuring they are efficient in action, time and outcome	Leaders feedback on time and capacity | Meeting reduction | Attendee reduction | Clear action and outcome plans				●		

Service	Theme	Recommendations	KPI Measurement (s) to Improve	UEC Programme Workstream Mapping					
				Front Door Processes	Frailty	Clinical Pathways	Bed & Site Management	Ward Processes & Discharge	Organisational Restructure
		• A senior review / big room exercise on triumvirate capacity / competency / capability - is it working? How can we make it work? What do you need? • Peer reviewing • 360 appraisals • Leadership team objectives	Staff feedback | Triumvirate governance						●
		• Introduce Schwartz rounds which are well communicated, initially exec led, which staff are freed to join that evidence real patient journeys which came to avoidable harm which align with this action plan.	Attendance and feedback at Schwartz rounds			●			
		• Consider a robust meaningful cultural / OD plan around engagement, improvement and cultural positivity. This must be meaningful to succeed. • Consider visibility days where all leaders rota at least half a day into a service, working within in then feeding back to their leadership peers on findings. • Consider RAG rated department welfare boxes (each shift anonymously votes with tokens on how they feel - this is then enacted upon within 24hrs) • Consider using big room / large scale QI methods to empower staff. • Consider daily improvement huddles with exec and staff updating on improvement projects and what they need to be unblocked. • Consider peer working / leadership feedback. • Consider 360 appraisals. • Consider employing a grand round methodology (akin to HIT) • Consider allocating leadership objectives and/or ratings from teams. • Consider a values relaunch aligned with any restructure or consultation	Staff feedback survey results | Anonymous surveys						●

Service	Theme	Recommendations	KPI Measurement (s) to Improve	UEC Programme Workstream Mapping					
				Front Door Processes	Frailty	Clinical Pathways	Bed & Site Management	Ward Processes & Discharge	Organisational Restructure
Wards	Leadership	• Introduce Medical Director and Nurse Director led weekly review of patients (grand round equivalent) that copies the HIT methodology but makes it business as usual. This should be role modelled by execs but quickly disseminated to Directorate clinical and nursing leads to conduct as peer assessors. A list of actions and learning should be recorded for wards, services and individuals in order to support sustainable consistent service delivery.	Length of stay reduction | Earlier in day discharges Increased use of VW, SDEC and community services				●	●	
		• Review actions at ward levels during critical incident with a focus as to whether the actions are SMART and will produce a desired outcome (e.g. Consultants raised complaints that they receive a text asking for more discharges which is an outcome not an action) • Review each ward's and service's FCP with a view to the triumvirate articulating what and when additional measures take place (e.g. selection of patients to put in boarding spaces, process around discharging at risk, extending the use of alternative services like SDEC, outpatients, VW etc)	Discharges and LoS during Opel 4 and critical incident				●	●	
	Service	• Launch a PJ Paralysis initiative or equivalent	Length of stay reduction particularly in older patients				●	●	

Service	Theme	Recommendations	KPI Measurement (s) to Improve	UEC Programme Workstream Mapping					
				Front Door Processes	Frailty	Clinical Pathways	Bed & Site Management	Ward Processes & Discharge	Organisational Restructure
	Process	• Embed a sustained consistent HIT equivalent process across the trust which is CMO and CNO led in order to identify robust clinical decision making, good use of out of hospital / SDEC services, and to be assured that escalation processes are reactive and effective	Diagnostic times | Length of stay reduction | Improved use of SDEC VW etc				●	●	
		• Relaunch of the value of intentional rounding • Audit of intentional rounding efficacy - checking if the outcomes of rounding are working (less deconditioning, less IV fluids, good patient experience etc)	Audit rounding occurrence | Audit rounding outcomes | Patient experience spot checks					●	
		• Relaunch of board and ward round processes • Relaunch of Red2Green or equivalent • Audit by clinical leaders that the right process is being followed with unwarranted variation being recorded and managed. • Peer review of huddles	LoS reduction | Staff feedback					●	
		• Review the scale and cause of delays to identify the specific issue to resolve.	Needle to result time reduction				●	●	
		• Set a ward IPS for DSUMs and TTOs to be written in conjunction with juniors and ward staff. • Audit IPS compliance with a view to identify and resolve causes of delays	Time of day discharge | LoS				●	●	
		• Contact all medical staff and nurses to ask for volunteers for a small test of change CLD group. • Lead a pilot which phases in the use of CLD	Reduced LoS | Earlier in day discharges				●	●	

Service	Theme	Recommendations	KPI Measurement (s) to Improve	UEC Programme Workstream Mapping					
				Front Door Processes	Frailty	Clinical Pathways	Bed & Site Management	Ward Processes & Discharge	Organisational Restructure
Acute Medicine	Process	• Acute Med should collaboratively design a clear process with ED that ensures patients in ED are regularly reviewed throughout the day, seen at least once per 24 hours by a Consultant, are seen by medicine in time order within 2 hours of referral and have a clear escalation process that mitigates at time of challenge • Acute Med needs to be given referral rights equitable to ED so that care is transferred to specialties early. • Acute Med post take needs to ensure there is a robust digital solution that lists and manages the take / post take	TTBS by AM reduction | LoS in Acute Medicine reduction | Reduction in discharges from AM areas within a few hours of arrival			●	●	●	
	Leadership	The Acute Med best practice: • Introduce huddles, and full MDT board / ward rounds - this needs to be clinically led with external support. • Introduce peer supervision around leadership and adherence to agreed processes	AM LoS | AM TTBS | 4hr | 12hr | 0-day LoS reduction | Reduced over 72hr stays under AM			●			
	Service	• Perform a demand and capacity for Acute Med	AM LoS | AM TTBS | 4hr | 12hr | 0 day Los reduction | Reduced over 72hr stays under AM	***Workstream outside UEC programme, rightsizing the bed base***					
		• Acute Med should design a standardised digital process whereby no patient is missed, and all patients are reviewed by AM and then a SDM in a timely manner (which has a trigger and action SOP) • AM should use a digital take tool • AM will likely require supporting in rolling out specialty one-way referrals that ED had permission to do	Time to be seen by medics | Number of patients under AM in ED reduces			●			

Service	Theme	Recommendations	KPI Measurement (s) to Improve	UEC Programme Workstream Mapping					
				Front Door Processes	Frailty	Clinical Pathways	Bed & Site Management	Ward Processes & Discharge	Organisational Restructure
		• Review all AM portals, their access criteria and on day declines in order to ensure services are consistently taking appropriate patients • As part of the AM estate review, ensure that the AECU and AMRA portals are delivering the service they aspire	AM LoS | AM TTBS | 4hr | 12hr | 0-day Los reduction | Reduced over 72hr stays under AM			●			
SSDEC SAU	Leadership	• A facilitated leadership conversation to put in place true collaborative working • Trial of a full trusted assessor model • An externally supported review of SAU SSDEC function versus actual demand against good practice	Surg LoS & TTBS | LoS | Increased SDEC activity and reduced 0 - 1 Los			●		●	●
	Service	• Review how SSDEC and SAU can be co-located to ED and other assessment units	4hr wait | TTBS from surgical referral			●			
		• All access criteria should be open • Adopt a trusted assessor model across all 9 specs feeding the services • The triumvirate team to meet with facilitated support to review current SOPs versus known good practice and alignment with the Patient First ideology • Clinical lead to conduct a peer review around process adherence Operations to agree an IPS for any patient in the wrong area to be moved by	Activity to SSDEC / SAU increase | 4hr | 12hr			●			
		• Ask surgical nursing to design and or lift a CLD proforma from another organisation, gain CD sign off and employs a trial	Earlier in day discharges			●			

Service	Theme	Recommendations	KPI Measurement (s) to Improve	UEC Programme Workstream Mapping					
				Front Door Processes	Frailty	Clinical Pathways	Bed & Site Management	Ward Processes & Discharge	Organisational Restructure
		• The Directorate should write a phased FCP which plans triggers and actions at increased demand that does not result in ED usage	Reduced surgical / urological etc patients going to and staying within ED over 30 minutes				●	●	
		• A facilitated conversation with the area triumvirate team given the action to increase VW usage. Part of this will be to establish causes for concern (with mitigation) and potentially peer review in the management of unwarranted variation.	Earlier in day discharges reduced LoS					●	
		• IPS on diagnostics to be reviewed, agreed and relaunched with SRO oversight, management and assurance • Surgical clinical lead to enact board and ward rounds which capture diagnostic usage via SSDEC, VW and community rather than maintaining admission • Surgical leadership team to enact a staff development plan for the use of the USS	Reduction in LoS | Time to diagnostic from request					●	

Executive Summary
Trust Board | 8th October 2025
Appraisal and Revalidation Annual Report

University Hospitals of North Midlands NHS Trust

Purpose:	**Information**		**Approval**	✓	**Assurance**		**Agenda Item:**	15
Author:	Dr Mark Poulson, Deputy CMO and Responsible Officer							
Executive Lead:	Dr Di Adamson, CMO							

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

The Responsible Officer (RO) is obliged, according to the RO regulations, to submit an annual board report and statement of compliance and then forward this to NHS England. This contains details of revalidation information, appraisal compliance, and any issues relating to RO responsibilities within the organisation. The key messages in this year's report are summarised as follows:

- Arrangements for appraisal and revalidation are of high quality and in line with the Responsible Officer regulations.
- Appraisals are conducted in accordance with national standards.
- The Trust needs to recruit additional appraisers to provide resilience to an increase in medical recruitment and losing appraisers to retirement - a recruitment drive is ongoing.
- A project of work is underway focussing on improving educational supervision and mentorship of locally employed doctors and international medical graduates.
- Effective systems are in place for monitoring the conduct and performance of all doctors and, where escalation is required, an appropriate consensus is reached to ensure that action is timely appropriate, and free from bias.
- A Responsible Officer Advisory Group (ROAG) aligned with NHSE and GMC guidance has been established to replace the current Professional Standards and Clinical Conduct Committee (PSCCC).
- A new Lead Appraiser has been appointed – Dr Andrew Brown.

Key Recommendations

The Trust Board is asked to note the report and approve the findings.

Designated Body Annual Board Report and Statement of Compliance

Section 1 Qualitative/narrative

1A – General
The board/executive management team of University Hospitals of North Midlands, can confirm that:

1A(i) An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year:	Deputy CMO took over as RO on 1st November 2024.
Comments:	Interim RO arrangement in place May 2025 to present.
Action for next year:	No change

1A(ii) Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Action from last year:	Nil
Comments:	Sufficient resources are in place to carry out the responsibilities of the role.
Action for next year:	Business case for Case manager and investigator raining being brought for approval.

1A(iii)An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

Action from last year:	Nil
Comments:	The list of licensed medical practitioners is regularly reviewed on the GMC Connect application and updated to ensure it is accurate.
Action for next year:	No change

1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year:	Nil
Comments:	All relevant policies are updated as part of the Trust business cycle.
Action for next year:	No changes planned

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

Action from last year:	Previous RO was organising an external peer review.
Comments:	No recent peer review has been undertaken.
Action for next year:	An external peer review will be arranged for the coming year.

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

Action from last year:	See below
Comments:	All the Trust's doctors are supported with their appraisal and revalidation processes by the RO the Lead Appraiser, four Senior Appraisers and Medical Staffing colleagues. The Trust has recently appointed two Consultant Physicians as leads for Locally Employed Doctors (LED) and International Medical Graduates (IMG). Their remit includes developing a dedicated framework and systems for induction, continuing professional development, appraisal and revalidation for these groups of doctors.
Action for next year	To implement a dedicated framework and systems for induction, continuing professional development, appraisal and revalidation for LED and IMG doctors.

1B – Appraisal

1B(i) Doctors in our organisation have an annual appraisal that covers a doctor's whole practice for which they require a GMC licence to practise, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Action from last year:	New lead Appraiser has been appointed – Dr Andrew Brown.
Comments:	Appraisers are allocated to all new appointments and rotated every 3 years for existing colleagues. The appraisal format is consistent with the current GMC guidance and is a streamlined process that puts focus on wellbeing. There has been a reduction in pre-appraisal paperwork requirements leading to a reduction in the burden on doctors. The RO expects the information presented to be limited to that which directly supports the doctor's clinical practice and should concentrate on clinical effectiveness, complaints and adverse events. There is a strong emphasis on personal development and the doctor's wellbeing.
Action for next year:	Ongoing training and development in place – delivered by new lead appraiser

1B(ii) Where in Question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year	Nil
Comments:	There are regular electronic reminders regarding appraisal and additional contact if deadlines are missed. All doctors non-compliant with the appraisal process are approached by the Lead Appraiser for him to understand the reason for non-compliance. The Lead Appraiser regularly updates the RO on cases of concern.
Action for next year:	No change

1B(iii) There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year:	Nil
Comments:	There is an agreed and approved medical appraisal policy in place.
Action for next year:	No change

1B(iv) Our organisation has the necessary number of trained appraisers[1] to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year:	The Deputy CMO (People) will work with the new Lead Appraiser on a recruitment drive aimed at correcting the shortage.
Comments:	There is currently a modest shortage of appraisers, but this has not led to any appraisals being missed. Ongoing recruitment drive for new appraisers.
Action for next year:	The RO will work with the new Lead Appraiser to continue a recruitment drive aimed at correcting the shortage.

1B(v) Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent).

Action from last year:	Nil
Comments:	The Lead Appraiser takes responsibility for ongoing training of the appraiser team, organises training events for them and supports review of their performance.
Action for next year:	Timetable for appraiser updates and training for new appraisers to be published.

1B(vi) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year:	The Deputy CMO (People) will work with the new Lead Appraiser on enhancing the quality assurance process to include an analysis of feedback from appraisees.
Comments:	The Lead Appraiser regularly audits the appraisers' performance. Each of the appraisers has one, randomly selected appraisal scored by the Lead Appraiser using a quality assurance tool. The last audit showed 87 out of 114 appraisals scored 75% or more.
Action for next year:	Repeat of quality audit by Lead Appraiser to be undertaken.

1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

Action from last year:	Compliant
Comments:	The Trust is fully complaint with this standard. Recommendations are made promptly and in accordance with the GMC requirements. Each recommendation, including any information relevant to it, is recorded on the electronic appraisal system (Allocate eAppraisal) by the RO or his delegate.
Action for next year:	No change

[1] While there is no regulatory stipulation on appraiser/doctor ratios, a useful working benchmark is that an appraiser will undertake between 5 and 20 appraisals per year. This strikes a sensible balance between doing sufficient to maintain proficiency and not doing so many as to unbalance the appraiser's scope of work.

1C(ii) Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood.

Action from last year:	Nil
Comments:	Positive recommendations are not routinely communicated to the doctor in advance. Deferral recommendations (or very rarely declarations of non-engagement) are always preceded by written communication with the doctor in advance by the Deputy CMO (People). This communication contains a detailed explanation of the reasons for the proposed recommendation. It is supportive in tone and offers detailed advice, guidance and signposting to additional assistance.
Action for next year:	Confirmation of positive recommendations will be emailed to doctor when made to GMC.

1D – Medical governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year:	Deputy CMO for Clinical Effectiveness and Governance in place and discusses with RO.
Comments:	UHNM has a strong framework for clinical governance with a tightly organised reporting infrastructure and effective implementation of agreed actions.
Action for next year:	No Change

1D(ii) Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation.

Action from last year:	Reform of current arrangements and establishment of a Responsible Officer Advisory Group (ROAG) aligned with NHSE and GMC guidance to replace the current Professional Standards and Clinical Conduct Committee (PSCCC).
Comments:	ROAG established – ToR agreed and implemented. Working well. There are multiple sources of information used by the RO and CMO. These include participation in national and local audit, data from the Risk Management Panel, clinical governance forums, data from mortality reviews, structured judgement reviews and never events etc. Concerns about medical practitioners come from a variety of sources including local concerns, grievances, complaints, and the Freedom to Speak Up Guardian. These are systematically triaged, considered by a decision-making group and acted upon appropriately.
Action for next year:	Final ratification of ROAG terms of reference to complete.

1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

Action from last year:	Nil
Comments:	All relevant information is provided for doctors in electronic document format which can be uploaded to the appraisal portfolio software provided by the Trust.
Action for next year:	No change

1D(iv) There is a process established for responding to concerns about a medical practitioner's fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year:	Nil
Comments:	All concerns reaching the RO/CMO and Deputy CMOs are considered by a decision-making group (DMG) which uses a locally agreed decision-making algorithm to guide next steps. This algorithm was developed based on NHSE and GMC guidance on responding to concerns about medical practice. Using it, the DMG triages concerns according to seriousness, co-ordinates fact finding, considers evidence from fact finding and decides on appropriate responses including liaison with other agencies such as the GMC, PPA, Safeguarding Team, Police etc.
Action for next year:	No change

1D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

Action from last year:	The PSCCC will be replaced by a Responsible Officer Advisory Group (ROAG)
Comments:	All concerns regarding medical practice and practitioners are referred to the ROAG where they are discussed in detail and appropriate actions agreed. This group has wide representation to ensure that the RO can establish a broad consensus on action. A highlight report is prepared and escalated to the Trust's People, Culture and Inclusion Committee.
Action for next year:	ROAG established and working effectively

1D(vi) There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Action from last year:	Nil
Comments:	Requests for information from other organisations are reviewed by the revalidation admin team and information regarding complaints or concerns are sought from the clinical governance team and from the R.O. directly. These are processed quickly and efficiently.
Action for next year:	No change

1D(vii) Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year:	The PSCCC will be replaced by a ROAG.
Comments:	Any concerns raised from a variety of sources are initially discussed by a decision-making group with the RO/CMO or Deputy CMO (People) always present. Where further action is taken this is managed according to our local disciplinary policy for Medical and Dental Staff which is consistent with the national MHPS process. We now have sufficient trained case investigators to ensure formal processes are not unnecessarily prolonged and all concerns are discussed in detail at meetings of the Trust's ROAG where there is appropriate representation to ensure freedom from bias and discrimination. Referrals to the GMC are routine checked for impartiality, taking diversity into consideration. This is done in accordance with GMC RO referral guidance and guidance published by NHSE.
Action for next year:	ROAG established and effective

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, e.g. from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture. (Give example(s) where possible.)

Action from last year:	The PSCCC will be replaced by a ROAG.
Comments:	These requirement and opportunities, when identified, are discussed in the meetings of the ROAG which co-ordinates the appropriate cascading of any learning / improvement opportunities.
Action for next year:	ROAG established and ToR will be reviewed.

1D(ix) Systems are in place to review professional standards arrangements for all healthcare professionals with actions to make these as consistent as possible (Ref Messenger review).

Action from last year:	Nil
Comments:	Professional standards arrangements were regularly reviewed in meetings of the Professional Standards and Clinical Conduct Committee. The will be discussed at the ROAG.
Action for next year:	Review through ROAG

1E – Employment Checks

1E(i) A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year:	Nil
Comments:	All doctors employed by UHNM are subject to the mandatory NHS pre-employment checks. In addition, a medical practitioner information template form (MPIT) is used for all doctors who have had prior NHS employment.
Action for next year:	No change

1F – Organisational Culture

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

Action from last year:	Nil
Comments:	ROAG reports to the People, Culture and Inclusion Committee (PCIC). The latter functions as a barometer for the culture of our processes for responding to concerns about medical practitioners and act as a mirror for the ROAG. In this way openness and fairness are promoted as vehicles to protect patients, support professionalism, and improve quality of care.
Action for next year:	No change

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

Action from last year:	Nil
Comments:	The Trust is committed to building an inclusive workforce which is valued and whose diversity reflects the community it serves, enabling us to deliver the best possible healthcare service to our patients, service users and communities. The Trust's Equality, Diversity and Inclusion Policy provides a framework from which strategy, policy and procedures are developed. It sets the standards to enable the Trust to meet its duties in line with the Equality Act (2010), Public Sector Equality Duty (PSED) and the Human Rights Act (1998), as both an employer and health service provider. Based on this policy there are numerous, successful initiatives which focus on promoting compassion, fairness, respect, diversity and inclusivity.
Action for next year:	Ongoing EDI activity

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

Action from last year:	Nil
Comments:	The Trust's Analysing and Learning Policy (RM09) promotes openness, transparency and a non-blaming learning culture. This is backed up by the Trust's Risk Management Strategy (RM01), Complaints Policy (RM02), Claims Policy (RM06) and Adverse Incident Reporting and Investigation Policy (RM07). The Trust's policy for encouraging and supporting speaking up is based on the national 'Freedom to Speak Up Policy for the NHS'. We welcome speaking up and we listen. The Trust's message to workforce members is that by speaking up at work they will be playing a vital role in the continuous improvement of our services in the interest of all patients and staff. We want to hear about any concerns our staff have, whichever part of the organisation they work in. We know some groups in our workforce can feel they are not heard or can be reluctant to speak up. They could be an agency worker, bank worker, locum or student. We also know that staff with disabilities or those from a Black, Asian or minority ethnic background or from the LGBTQ+ community can face barriers to speaking up. The policy is for all our staff, and we want to hear all their concerns.

	An appropriate structural framework is in place to facilitate the proper implementation of the above policies e.g. A Restorative Just & Learning Culture (RJLC) Model which is a 4-step process for managing and improving our people practices. This model applies to all Trust investigations and encourages learning from adverse events and incidents in a way which is supportive and compassionate towards the people we work with. Healthy attitudes and behaviours around patient safety are strongly incentivised and monitored whilst the Trust foster's strong leadership behaviour to this end e.g. Formal training for clinical leaders on the impact of organisational culture on quality of care, access to care and service sustainability.
Action for next year:	No change

1F(iv) Mechanisms exist that support feedback about the organisation' professional standards processes by its connected doctors (including the existence of a formal complaint procedure).

Action from last year:	Nil
Comments:	Mechanisms to allow such feedback include a BMA Local Negotiating Committee, Staff Surveys, Medical Workforce Group, Freedom to Speak Up Guardian, twice weekly meetings between care group medical directors, RO, CMO and deputy CMOs, and a formal complaints procedure. In addition, the CMO, RO and Chief People Officer have an 'open door policy' and welcome direct feedback from any member of the workforce.
Action for next year:	No change

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the Equality Act.

Action from last year:	Nil
Comments:	The ROAG evidences to its oversight committee that its processes are transparent and fair and that they do not discriminate against individuals with protected characteristics. This includes measuring the potential for unfair impact of this nature and mitigating against it if identified.
Action for next year:	External reviewed planned for this year

1G – Calibration and networking

1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to, attending network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes.

Action from last year:	Nil
Comments:	The CMO and RO attend RO network events. The RO regularly engages with the higher-level RO quality review processes.
Action for next year:	No change

Section 2 – metrics
Year covered by this report and statement: 2024/245 .
All data points are in reference to this period unless stated otherwise.

2A General
The number of doctors with a prescribed connection to the designated body on the last day of the year under review. This figure provides the denominator for the subsequent data points in this report.

Total number of doctors with a prescribed connection on 12 September 2025	1074

2B – Appraisal (01 Apr 2024 – 31 Mar 2025)
The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions is as recorded in the table below.

Total number of appraisals completed	807
Total number of appraisals approved missed	1
Total number of unapproved missed	266

2C – Recommendations
Number of recommendations and deferrals in the reporting period.

Total number of recommendations made	164
Total number of late recommendations	35
Total number of positive recommendations	116
Total number of deferrals made	48
Total number of non-engagement referrals	0
Total number of doctors who did not revalidate	48

2D – Governance

Total number of trained case investigators	20
Total number of trained case managers	8
Total number of new concerns registered	14
Total number of concerns processes completed	4
Longest duration of concerns process of those open on 31 March	1425 days
Median duration of concerns processes closed	110.5 days
Total number of doctors excluded/suspended	6
Total number of doctors referred to GMC	2

2E – Employment checks
Number of new doctors employed by the organisation and the number whose employment checks are completed before commencement of employment.

Total number of new doctors joining the organisation	564
Number of new employment checks completed before commencement of employment	564

2F Organisational culture

Total number claims made to employment tribunals by doctors	1
Number of these claims upheld	1
Total number of appeals against the designated body's professional standards processes made by doctors	0
Number of these appeals upheld	0

Section 3 – Summary and overall commentary

This comments box can be used to provide detail on the headings listed and/or any other detail not included elsewhere in this report.

General review of actions since last Board report
Actions still outstanding
Current issues
Insufficient number of trained case managers and investigators for the workload at present. Looking to train more and using external investigators to assist at present.
Actions for next year (replicate list of 'Actions for next year' identified in Section 1):
Overall concluding comments (consider setting these out in the context of the organisation's achievements, challenges and aspirations for the coming year):

Section 4 – Statement of Compliance

The Board/executive management team have reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body
[(Chief executive or chairman (or executive if no board exists)]

Official name of the designated body:	University Hospitals of North Midlands

Name:	
Role:	
Signed:	
Date:	

Executive Summary

Trust Board | 8th October 2025

Speaking Up, Biannual Report, Quarters 3 and 4

University Hospitals of North Midlands NHS Trust

Purpose:	**Information**		**Approval**		**Assurance**	✓	**Agenda Item:**	16
Author:	Rob Irving, Freedom to Speak Up Guardian							
Executive Lead:	Claire Cotton, Director of Governance							

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

Risk Register Mapping		
	See appendix 1 for full Risk Summary.	High 9

Executive Summary

Situation

The Speaking Up Report is a biannual report designed to provide assurance to the People, Culture and Inclusion Committee on the work of the Freedom to Speak Up Guardian. The report covers quarters 3 and quarter 4 of 2025 /2026. The report is presented in a different format to reports presented previously although this will continue to evolve, ensuring alignment with the metrics set out within the Insightful Board.

Background

The National Guardians Office, Care Quality Commission and NHS England all have a role in setting the national expectations for the NHS in relation to speaking up.

The National Guardian's Office (NGO) plays a crucial role in fostering a positive speaking up culture. It leads, trains and supports a network of Freedom to Speak Up Guardian's, conducts speaking up reviews and provides guidance and challenge to the healthcare system.

The Care Quality Commission Well Led Framework has specific quality statements in relation to speaking up, and expects leaders to:

- Ensure that all colleagues and leaders act with openness, honesty and transparency.
- Ensure that all colleagues and leaders actively promote staff empowerment to drive improvement.
- Encourage colleagues to raise concerns and promote the value of doing so, in order that all colleagues are confident that their voices will be heard.
- Ensure that there is a culture of speaking up where colleagues actively raise concerns and those who do (including external whistleblowers) are supported, without fear of detriment.
- Ensure that when concerns are raised, leaders investigate sensitively and confidentially, and lessons are shared and acted on.
- Ensure that when something goes wrong, people receive a sincere and timely apology and are told about any actions being taken to prevent the same happening again.

Finally, NHS England aim to ensure that everyone working in the NHS feels safe and confident to speak up. They seek to improve the quality of speaking up arrangements in a number of ways including evaluation of concerns, organisational culture and the quality of care provided, provision of a support scheme for those who have spoken up and the development of policy, guidance and resources.

Assessment

Activity and Engagement

- **120 concerns** raised (62 in Q3, 58 in Q4), a **13% decrease** from the previous period.

- **Policy and procedure** emerged as the top concern category (30%), overtaking behavioural concerns for the first time.
- Behaviour-related concerns (bullying, harassment, inappropriate behaviour) still account for **51%** of all cases.
- **3 cases (4%)** involved reported detriment, a decrease from the previous period.

Service Development
- **Deputy Guardian and Support Secretary** appointed, expanding capacity and visibility.
- Office relocated to a more accessible location within Royal Stoke.
- Expansion of the **FTSU Champions network** underway, with integration of Employee Support Advisors planned.

National and Regional Context
- Launch of the **Guardian Enquiry Management System (GEMS)** by the National Guardian's Office (NGO).
- National reviews highlight challenges for **overseas-trained workers** and the need for **cultural competence**.
- New **Detriment Guidance** and **Recruitment Framework** issued by the NGO to support local implementation.

Local Initiatives
- Development of a **Detriment Framework** and independent executive panel for case review.
- Strong performance in **FTSU-related NHS Staff Survey metrics**.
- Plans to embed **Civility Saves Lives** training into the organisational culture strategy.

Thematic Insights
- Concerns about **policy adherence** and **managerial accountability** are increasing.
- Some managers show **limited engagement** with the Speaking Up Policy (G26).
- Need for **greater independence and transparency** in investigations.

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

An accountability framework has been developed as part of the revised governance arrangements, which sets out explicitly their responsibilities in relation to Speaking Up. This will form part of a Leadership Board Development Programme with a view to making improvements in this aspect of assurance.

Key Recommendations

- The Committee is asked to consider the assurance provided through this report, and the priorities plan to continue to strengthen our speaking up culture / arrangements.

Speaking Up

Biannual Report, Quarters 3 and 4
2025 - 2026

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Introduction

Overview from the Freedom to Speak Up Guardian

This biannual report provides and overview of activities and developments, along with an analysis of Speaking Up during quarters 3 and 4, 2024 / 2025.

During this period, our Freedom to Speak Up (FTSU) Guardian has continued to build relationships and networks with senior leaders and colleagues from across the organisation, Integrated Care System (ICS) and the region, as well as progressing the ongoing development of the service and work through some of the challenges that have been highlighted through previous reports.

Quarters 3 (Q3) and 4 (Q4) 2024 / 2025 saw a number of developments and opportunities both locally, regionally and nationally. Following the approval of a business case highlighted in the last report, the reporting period saw the expansion of speaking up provision locally with the recruitment to a Deputy Freedom to Speak Up Guardian position, as well as part time administrative support.

The period saw 120 concerns, with 62 during Q1 and 58 during Q2. Numbers were slightly down on the unprecedented levels of concern raised in the previous reporting period, which saw our highest numbers of concerns ever received during a single quarter. This can possibly be explained by the Lead Guardian being primarily focussed on the process of recruiting to the vacancies within the team, with less proactive work and engaged as he would usually undertake.

We have continued to work on improving our data collection and reporting efficiency and have implemented some new measures to improve our processes. However, the reporting mechanism remains far from ideal, and the Lead Guardian and Deputy will be meeting with IT colleagues to explore the available options. Accurate and effective data is key in improving the service we can deliver, as well as making it as easy as possible for our staff to raise concerns. We will continue our focus on this, as well as our ability to triangulate with other sources of information.

We continue to work on the self-reflection tool, which is an ongoing process and will allow us to review leadership and governance arrangements and identify further areas to develop and improve.

Our highest category of concern for the period has been ‘policy and procedure’, accounting for 30% of concerns raised. This is the first time that this has been the highest reporting category, and as such the first time for a non-behaviour related category. Issues relating to ‘inappropriate attitudes and behaviours’ accounted for 27% of concerns, ‘bullying and harassment‘ was 24% and ‘quality and safety’ was 14%.

Once again, and consistent with past reporting periods is that concerns in the two behavioural categories continue to account for appropriately 50% of all concerns raised (51% in quarters 3 and 4), which highlights the need to continue to utilise our newly refreshed values to focus on the impact of poor behaviours not only for our staff but for our patients. We hope that this will continue to have an impact on the way that our staff interact with one another.

The increase in concerns involving policy and procedure continues a trend which began in the previous six months, is also worrying as it might indicate that staff feel that our policies and processes are not being respected or adhered to by line managers. We will continue to monitor this trend as we move into 2025 / 2026.

National and Regional Developments

Developments During the Quarters

New Guardian Enquiry Management System

The National Guardian's Office has launched a new Guardian and Enquiries Management System (GEMS). This new solution, using Microsoft 365 Dynamics, will improve the internal processes of answering enquiries, and provide a new portal for guardians to register, manage their training record and profile, and submit quarterly data. This new portal will eventually completely replace the existing portal, with Q1 2025 / 2026 being submitted in July 2025.

Independent Commission into Adult Social Care

In response to the announcement by the Secretary of State for Health and Social Care, Wes Streeting, that the Baroness Casey of Blackstock DEB CB will chair an independent commission into adult social care, National Guardian Dr Jayne Chidgey-Clark said: '….as we know from the NHS, working in organisations under extreme pressure can be very challenging, especially if a worker wants to raise a concern. We hope that when the Commission reports, it will include support for introducing Freedom to Speak Up Guardians in social care."

Overseas Trained Workers in the NHS Fear Speaking Up

The NGO has published its latest Speak Up Review, 'Listening and Learning: Amplifying the voices of overseas trained workers, a review of the speaking up experiences of overseas trained workers in England'. The review highlights the unique challenges faced and sheds light on their experience, as well as highlighting examples of innovative practice.

To make it easier for overseas trained workers to speak up, the NGO is call for action to:

- Make recruitment and retention guidance support speaking up
- Design speaking up arrangements that work for everyone
- Use better data to understand and improve experiences
- Build cultural competence and awareness to remove barriers to speaking up

2025 Speaking Up Support Scheme

NHS England's Speaking Up Support Scheme provides a range of support for past and present NHS workers who have experienced a significant adverse impact on both their professional and personal lives following the completion of a formal speaking up process. The scheme offers a structured online support programme including a health and wellbeing session, psychological support, career coaching and personal development workshops.

We have identified suitable staff members who have raised concerns in the previous 12 months and felt that they have suffered detrimental treatment as a direct result of doing so and offered them the option to apply for the scheme.

NGO Detriment Guidance for Guardians

Nationally, Freedom to Speak Up Guardians report that 4% of cases are from workers who have experienced some for disadvantageous and / or demeaning treatment as a result of speaking up. In response to these findings, the NGO have just published detriment guidance for organisations. This guidance is being used to develop our own approach to detriment cases during early 2025/2026.

New Framework Launched to Support Recruitment of Freedom to Speak Up Guardians

A new framework has been launched by the NGO, to support healthcare organisations recruiting and embedding guardians more effectively. It includes guidance on recruitment, appointment and support, plus practical tools such as sample role specifications, banding advice, and job descriptions. The framework also outlines how guardians can be best supported and makes recommendations for leadership responsibilities. Development of the framework has been a critical piece of work for the NGO, and it has been sent to all Chief Executives and Human Resources directors.

National and Regional Developments

NGO Spotlight on the NHS Staff Survey – national level

In response to the latest national NHS Staff Survey findings, the NGO has made a number of observations and recommendations. These are summarised as follows:

Overall Trends

- Freedom to Speak Up score remains nearly unchanged (6.45 in 2024 versus 6.46 in 2023) indicating stagnation
- Confidence to speak up is stable but not improving, risking disengagement and silence

Group Specific Highlights

- Ambulance trusts show slight improvement due to targeted interventions
- Minority ethnic staff confidence in organisational action rose slightly (54.5% to 55.2%)
- International recruits report higher trust than UK recruits
- Wider Healthcare Team trust has declined significantly (59.9% in 2021 to 53.5% in 2024)
- Longer-serving and White staff show declining trust in organisational response

Action Gap

- 61.8% feel safe raising concerns (down from 62.3% in 2023)
- Only 49.5% trust their organisation to act on concerns
- National action gap: 12.3%; UHNM improved slightly (13% to 11.5%)

Key Challenges

- A persistent gap between raising concerns and seeing action
- Risk of further decline without renewed focus
- Cultural memory of the Freedom to Speak Up initiative is fading

Key Recommendations

1. Embedding a culture of listening and action

Creating more avenues for workers to speak up is essential but insufficient – a stronger focus on listening and responding. A consistent, structured approach to ensure concerns are taken seriously and lead to action. This includes clear, standardised processes so that leaders at all levels understand and fulfil their responsibility to act. Training that goes beyond awareness – equipping leaders with the skills and accountability to respond effectively. System-wide bodies must ensure that concerns are handled effectively including concerns raised with them.

2. Greater accountability for leaders and organisations

Stronger accountability for both individual leaders and organisations, ensuring concerns are taken seriously, and workers are protected from victimisation. This means leaders must be held responsible for fostering a culture where staff feel safe to speak up and see their concerns addressed. Organisations must be accountable for how they handle concerns – not just encouraging speaking up but demonstrating that concerns lead to meaningful action. System-wide oversight must be strengthened, ensuring that when concerns are raised, there is clear follow-through and consequences for inaction

3. Strengthening and standardising the guardian role

Greater consistency in how the Freedom to Speak Up guardian role is implemented across organisations. This includes ensuring guardians have sufficient time and resources to carry out their duties effectively. Safeguarding their impartiality, recognising that whichever model organisations use to appoint a guardian – whether directly employed or contracted – presents potential challenges in maintaining impartiality and trust. The NGO welcomes the opportunity to work with government, regulators, healthcare leaders, and other stakeholders to ensure that speaking up remains a priority and leads to meaningful change.

Local Developments

Developments During the Quarters

Rob Irving, Lead Freedom to Speak Up Guardian has continued to identify and work on key areas for development of our service. Below provides a brief outline of some of the work he has undertaken during the quarters.

Appointment of Deputy Guardian and Support Secretary

A business case seeking additional resource into the FTSU service was approved in the early part of Q1 and as such a rigorous recruitment process was undertaken in line with NGO guidance to appoint a full time Deputy Freedom to Speak Up Guardian. The application, shortlisting and interview process was both fair and objective. The post attracted over 60 candidates and after two shortlisting elements, six candidates were interviewed. John Beckett was appointed and commenced in March 2025. John is a registered nurse by profession and brings a wealth of experience from his career in the armed forces. His most recent role in education has seen him involved with speaking up processes, and he is well versed in improving culture within a large public body.

John has knowledge and experience of UHNM having undertaken clinical placements within our Emergency Department, as such he is already a familiar face to many staff which has been evident by the number of people who have warmly greeted him during his induction period.

Kay Turner has been appointed to a part time support secretary role. Kay has been employed at UHNM for over 20 years in similar roles and working for directorate managers, heads of service and consultant surgeons amongst others and is another welcome addition to the team. Kay has also undergone her guardian training from the NGO in order to improve her understanding of the FTSU role as well as her responsibilities for maintaining confidentiality of those using the service.

Office Move

Expansion of the team led to alternative office accommodation being identified through our Space Utilisation Panel. The team are now based in a prime location within the main building at Royal Stoke, making them easily accessible to colleagues wanting to use the service.

Freedom to Speak Up Champions

Following the appointment to the Deputy Guardian role and increased resource into the service, a key priority has been to expand the current network of five FTSU Champions. It is recognised and understood that a network of champions across large organisations has a positive impact on the ability to adequality signpost staff into the various options for raising concerns. It improves the confidence of staff that the organisation takes speaking up and improving culture seriously and prioritises it accordingly.

The Lead and Deputy Guardian have worked together to produce a role description, advert and expressions of interest process to which is being launched through our Communications Team.

There will be no limit on numbers, instead it is a priority to ensure that the correct calibre of candidates are considered, in line with our refreshed values. It is hoped that this recruitment process will commence early June 2025.

There are also moves, in conjunction with our Organisational Development Team to integrate our current team of Employee Support Advisors (ESA) into the champion role as it is recognised that their roles are similar in nature and have significant crossover. The ESA role will be phased out in favour of the FTSU Champions role.

Local Developments

Developments During the Quarters

Detriment Framework / Policy

Following a number of difficult cases and in response to publication of the NGO guidance, it was agreed that the Lead Guardian would undertake a review of the current arrangements for dealing with cases of detriment.

A paper was taken to the Executive Team with proposals on how the process could be improved and a follow up discussion was then held with the Deputy Chief Executive, Director of Governance, Chief People Officer and Chief Medical Officer to agree next steps. The outcome was that an independent, Executive panel would be convened to consider each case and agree the appropriate course of action.

The Speaking Up Policy is being reviewed in line with the proposals and whilst it is expected to continue to evolve, the panel will be convened by the Lead Guardian as appropriate.

Staff Survey Results 2024

The headline figures for our 2024 NHS Staff Survey results have once again been encouraging across all four FTSU metrics:

		2022	2023	2024
20a	I would feel secure raising concerns about unsafe clinical practice (agree / strongly agree)	65.1%	67.4%	69.3%
20b	I am confident that my organisation would address my concern (agree / strongly agree)	50.0%	53.7%	55.4%
25e	I feel safe to speak up about anything that concerns me in this organisation	55.7%	59.6%	60.7%
25f	If I spoke up about something that concerned me, I am confident my organisation would address the concern (agree / strongly agree)	42.2%	47.0%	48.6%

These results are indicative of the effort that has been made across the organisation to encourage staff to raise concerns and to feed back on outcomes as a result.

If staff see that the organisation takes their concerns seriously and investigates in a fair and objective manner and outcomes are commensurate with the evidence produced, they will have confidence and faith that the organisation is committed to the safety and wellbeing of our workforce and of our patients.

A further breakdown of the results by division and directorate is being analysed so that it can be used to gain a better understanding of where targeted support and engagement is required and this will form part of the future work programme for the team.

Training Needs Analysis / Compliance

The current FTSU training offer consists of a module within the statutory and mandatory training for Equality, Diversity and Inclusion (EDI), and a further 3 modules on Speak Up, Listen Up and Follow Up which are not currently mandated. Latest compliance is as follows:

	%	No.
EDI and Speak Up combined	93.3%	-
Speak Up	4.9%	635
Listen Up	3.0%	382
Follow Up	0.1%	9

This tells us that our core training uptake is above 90% however uptake of our developmental modules for the three elements is particularly poor. However, there is considerable overlap between the 'Speak Up' module and what is provided in mandatory training. The challenge is to establish how we can increase attendance at the Listen Up and Follow Up offer in an environment where there is significant pressure on time resource of staff to complete training and an ever-increasing volume of training required. A review of the Training Needs Analysis will be undertaken with consideration of CPD accreditation as an incentive, particularly for revalidation of our registered workforce.

Local Developments

Developments During the Quarters

Civility Saves Lives

Aligned with the potential for an accredited teaching package, the Lead Guardian will also explore options for incorporating the Civility Saves Lives training into our offer. The Guardians recognise the huge importance of the message around Civility Saves Lives, in reframing of simple conversations and how that can make a huge impact, not only on the wellbeing of staff, sickness and absence rates and general teamwork in the work environment, but also on productivity, service delivery and patient outcomes. There has been initial support for this within the Executive Team.

Other Activity

Other activities undertaken by the Lead Guardian and Deputy Guardian include:

- Bronze **Care Excellent Framework (CEF)** panellist, monitoring wards identified as in need of improvement, with many having a culture element that goes hand in hand with their performance. Support is offered to improve relationships and communication, and an Away Day has been convened to support reframing conversations.
- Members of **Sexual Safety Working Group,** providing input from a FTSU perspective.
- Provision of education and training to new starters through induction, as well as regular sessions to F1 and F2 doctors in training.
- **Wednesday Walkabouts** to wards and departments, to meet and engage with managers and their teams.
- Regular **engagement with other key stakeholders** such as Professional Nurse Advocates, Organisational Development Team, Staff Networks and Trade Unions.

Thematic Review

Developing Themes

Following on from the last FTSU report where it was reported that the Lead Guardian had taken a paper to Executive Directors on developing themes, there remain a number of challenges to overcome.

Observations regarding Implementation of the Speaking Up Policy (G26)

- There appears to be a limited awareness or understanding of the Speaking Up Policy (G26), along with occasional reluctance or resistance to fully engage with its processes.
- Engagement with Freedom to Speak Up (FTSU) Guardians is sometimes limited. In certain instances, concerns raised are not thoroughly explored or investigated, and the role of the Guardians may be perceived as adding to existing workloads.
- Some managers have expressed frustration when their assurances are not accepted at face value, indicating a preference for their perspective to be taken as conclusive without further inquiry.
- There are instances where the principles of fair and objective investigation are not fully understood or consistently applied. In some cases, investigations may not be conducted with the necessary independence or impartiality.
- Feedback to FTSU Guardians regarding the handling and outcomes of investigations is sometimes insufficient. Guardians have expressed concern that this may be due to a desire to protect existing relationships or reputations, particularly when the subject of a concern is a long-standing or high-performing colleague.
- When further clarification or escalation is required, some managers may not respond promptly, necessitating intervention from the People Directorate to ensure appropriate engagement.
- There remains a general hesitancy to address complex or sensitive issues directly.
- There is a tendency in some cases to focus on the individual raising a concern rather than the concern itself.

Commitment to Improvement

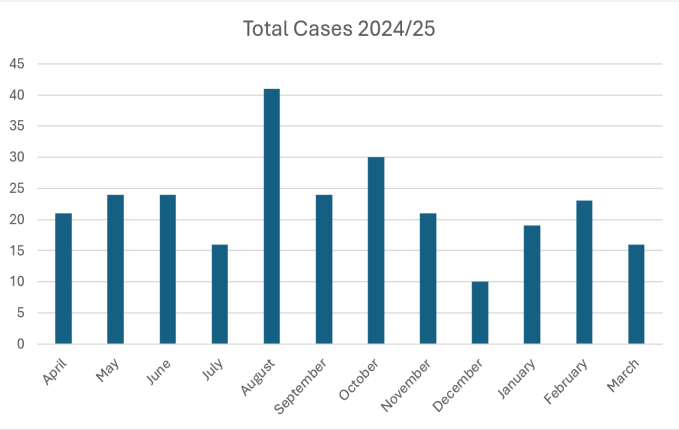
The Lead Guardian and Deputy Guardian remain committed to working collaboratively with Executive and Non-Executive leaders to address these challenges. Several proposals are currently under discussion, including:

- Enhancing the Speaking Up Policy to include clear expectations and potential consequences for non-engagement or failure to meet procedural timelines.
- Assigning investigations of concerns raised within a specific division to individuals or teams from outside that division to ensure independence.
- Establishing mechanisms to provide assurance that investigations are conducted fairly and independently, and that outcomes are evidence-based and proportionate.

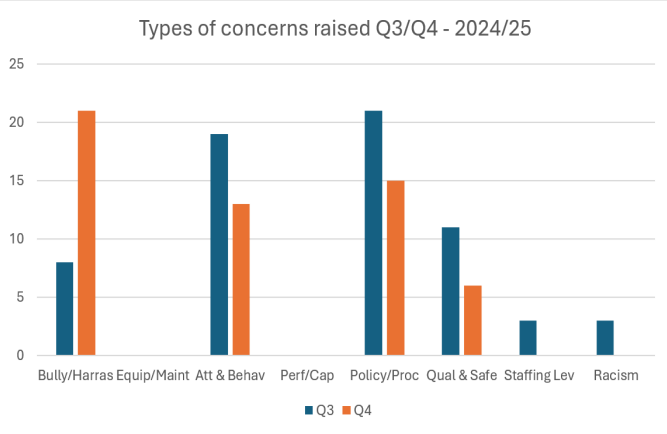
Concerns Raised During the Quarters

Number and Types

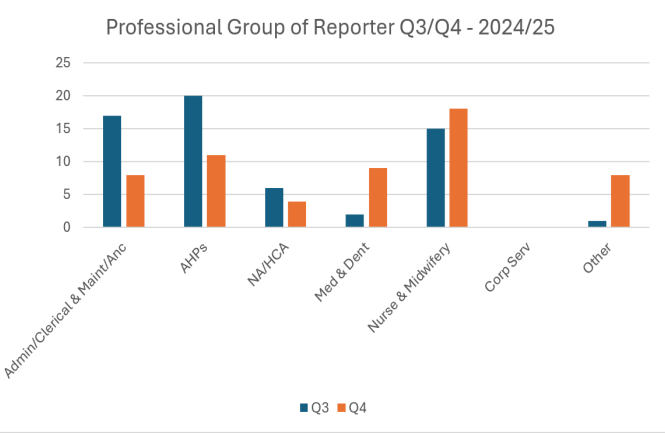
Number of Concerns Raised



Types of Concerns Raised



Types of Staff Raising Concerns



What is the data telling us?

There were 62 concerns raised during Q3 and 58 in Q4. This is a decrease of 13% on the same periods the previous year. The decline may be attributed to several factors:

- A natural correction following two years of steadily increasing concern volumes, culminating in an exceptionally high previous reporting period
- An IT issue that prevented some anonymously submitted concerns from reaching the Guardian, resulting in underreporting
- Limited capacity of the Lead Guardian to engage in proactive work due to previously high volumes of concerns and a lack of sufficient resourcing at the time

Types of concern:

- Policy and Procedure was the most reported category for the first time, accounting for 30% of concerns, inappropriate attitudes and behaviours made up 27%, and bullying and harassment accounted for 24% Quality and safety concerns represented 14%
- 50% of all concerns were behaviour related, a consistent trend across recent quarters.
- There does not appear to be any particular trend emerging around the types of staff raising concerns.

What are we doing about it?

- Continue proactive promotion of the Speaking Up service across the organisation, aligned with the People Plan.
- Build and maintain strong networks with leaders to foster a positive speaking up culture.
- Monitor trends in concern categories, particularly behaviour-related concerns
- Support cultural change by reinforcing the Trust's Being Kind agenda, Trust Values, and NHS People Promise.
- Promote recognition initiatives such as Enable, Platinum, Gold, and Silver Connects awards to encourage positive behaviours.
- Investigate the rise in policy and procedure concerns to understand underlying causes and inform targeted interventions.
- Track reporting patterns by staff group, specifically monitoring low reporting from Nursing Assistants and the increase in reports from Medical and Dental staff, especially following a Q4 spike.

Concerns Raised During the Quarters

Ethnicity and Divisional

Ethnicity of Staff Raising Concerns

Ethnicity	Quarter 1 + 2 (2024/25)	Quarter 3+ 4 (2024/25)	Change
White British	92 (61%)	80 (66%)	↑
Other White Background	3 (2%)	6 (5%)	↑
BAME	43 (29%)	21 (18%)	↓
Did Not State	11 (7%)	13 (11%)	↑

Concerns by Division / Quarter

	Surgery				WCCSS				Network				Medicine				EF PFI				Central Functions				Pathology			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
2022/2023	1	2	2	4	31	19	12	3	4	3	8	2	6	10	10	9	1	2	4	0	3	7	15	3	2	0	2	1
2023/2024	6	9	16	16	4	12	13		8	5	12	11	10	10	19	16	0	2	1	0	3	3	15	7	1	1	1	0
2024/2025	20	12	23	15	8	14	5	9	6	14	9	10	14	16	8	10	4	0	3	2	9	16	10	10	0	1	1	1

What is the data telling us?

The ethnicity data compares the ethnicity of individuals raising concerns over the first half Q1 and Q2 of the year and the second half (Q2 and Q3) of 2025.

- White British has accounted for the majority of concerns in both periods, increasing from 61% to 66%. This suggests a growing proportion of concerns are being raised by this group.
- Other white background representation also increased from 2% to 5%, indicating a small but notable rise in engagement with the speaking up process.
- BAME decreased significantly, from 29% to 18%. This drop may warrant further exploration to understand whether it reflects a reduction in concerns or a potential barrier to speaking up.
- The proportion of staff who did not state their ethnicity rose slightly from 7% to 11%, which could indicate a preference for anonymity or discomfort in disclosing demographic information.

What are we doing about it?

The shift in reporting patterns may reflect changes in awareness, confidence or accessibility of the speaking up service among different ethnic groups. Further analysis and engagement may help ensure equitable access and trust in the process across all demographics.

Speaking Up efforts should focus on maintaining strong engagement in high-reporting areas like Surgery and Medicine, while exploring the reasons behind consistently low reporting in areas such as Pathology, Network, and EF PFI. While low numbers may indicate fewer issues or higher staff satisfaction, it is important to ensure that all staff feel equally safe, informed, and empowered to raise concerns if needed. Continued attention is also needed in WCCSS, where a recent decline in reporting warrants further understanding.

The FTSU Guardians will continue to be part of the Data, Culture, Learning and Understanding Group. This has been set up to gather data and information from relevant sources to triangulate, improve understanding and learning lessons. Recent improvements in speaking up data collection has mean better data being made available to this Group in relation to developing themes and hotspots.

Concerns Raised During the Quarters

Detriment and Case Management

Detriment as a Result of Raising Concerns

Q3 / Q4	3

Status of Concerns Raised

	Q1 24/25			Q2 24/25			Q3 24/25			Q4 24/25		
	Raised	Closed	Open	Raised	Closed	Open	Raised	Closed	Open	Raised	Closed	Open
Quarterly Totals	66	54	12	83	43	40	62	54	8	58	40	18

What is the data telling us?

Of the 120 cases reported, 3 individuals reported detriment as a result of raising their concern. This represents 4% of cases and whilst this remains unacceptable, is positive to see a reduction following the spike in the previous reporting period. On occasions, reporters have difficulty differentiating between a general feeling that they are being detrimentally treated and suffering detrimental treatment as a direct result of raising a concern.

Once again in Q3 and Q4 the majority of cases have been closed (78%) which is an increase on the 65% closed in the previous reporting period and the 60% closed in Q4 of 2023/2024. This reflects the firmer approach being taken to chasing cases and less tolerance where actions have not been completed or reporters have failed to reply to correspondence. Some of the cases that remain open can be attributed to them being received in the final two months of the quarter and are therefore less likely to be resolved by the end of the quarter.

What are we doing about it?

The work being undertaken in relation to detriment is described earlier in this report. It includes an executive panel, revisions to policy and process and ensuring alignment with the recently published NGO guidance on detriment.

Some of the cases that remain open are as a result of investigations not being completed within a timely manner, despite regular follow up. This goes beyond the speaking up service and has been escalated previously by the People Directorate through their reporting on employee relations cases.

Benchmarking

NGO Data

We use benchmarking from the National Guardian's Office to compare our speaking up data with similar organisations, helping us to better understand volumes and effectiveness of our speaking up arrangements. The data used here is Q2 and Q3 2024 / 2025 which is the latest available.

Total Number of Speaking Up Reports by NHS / NHS Foundation Trust

We ranked 9th out of 44 organisations for total number of concerns raised during Q2 2024/2025 and 19th out of 46 in Q3 2024/2025. We reported 87 concerns in Q2 and 62 in Q3, which was above average of 58 and 61 concerns for each reporting period respectively. Further analysis is shown here:

UHNM Ranking within this Benchmarking Group Q2 2024/25				
Category of Concern	UHNM Ranking* (high to low)	No. Cases**	Average	Above ↑ / Below ↓ Average
Anonymous cases	Joint 9/15	6	4.7	↑
Element of patient safety / quality	2/23	41	11.1	↑
Element of worker safety	9/30	33	22.7	↑
Element of bullying / harassment	Joint 16/25	10	12.8	↓
Element of inappropriate attitudes / behaviour	6/32	41	23.9	↑
Detriment as a result of speaking up	Joint 7/8	1	1..2	↓

UHNM Ranking within this Benchmarking Group Q3 2024/25				
Category of Concern	UHNM Ranking* (high to low)	No. Cases**	Average	Above ↑ / Below ↓ Average
Anonymous cases	Joint 12 /15	3	5.3	↓
Element of patient safety / quality	Joint 7/19	15	9.0	↑
Element of worker safety	Joint 16/30	15	21.1	↓
Element of bullying / harassment	4/22	35	12.3	↑
Element of inappropriate attitudes / behaviour	Joint 20/31	19	25.1	↓
Detriment as a result of speaking up	3/10	7	1.9	↑

*whilst the total number of trusts within the benchmarking group is 46, many ranked in joint places, which is why the denominator is variable
**cases can be assigned to multiple categories which is why the total exceeds the cases submitted
*** cases with an element of detriment as a result of speaking up in Q3 (7 reported) may be incorrect. This may be due to the data being submitted prior to a review of cases which established that in 6 cases general detriment had been listed as opposed to detriment as a direct result of raising a concern.

Benchmarking

NGO Full Dataset Q2 and Q3 2024/2025

Organisation Name	Type of Organisation	Quarter	Size of organisation	Region	Number of cases brought to Freedom to Speak Up Guardians	Number of cases raised anonymously	Number of cases with an element of patient safety/quality	Number of cases with an element of worker safety or wellbeing	Number of cases with an element of bullying or harassment	Number of cases with an element of other inappropriate attitudes or behaviours	Number of cases where people indicate that they are suffering disadvantageous and/or demeaning treatment (detriment) as a result of speaking
Nottinghamshire Healthcare NHS Foundation Tru	NHS Trust/Found	Q2 2024/20	Large (mor	Midlands	168	1	16	48	20	50	0
University Hospitals Plymouth NHS Trust	NHS Trust/Found	Q2 2024/20	Large (mor	South West	160	17	68	132	64	120	0
Somerset NHS Foundation Trust	NHS Trust/Found	Q2 2024/20	Large (mor	South West	117	11	32	66	21	32	1
Mid and South Essex NHS Foundation Trust	NHS Trust/Found	Q2 2024/20	Large (mor	East of England	116	0	13	31	15	78	0
The United Lincolnshire Hospitals NHS Trust	NHS Trust/Found	Q2 2024/20	Large (mor	Midlands	109	2	14	18	10	0	0
University Hospitals of Derby and Burton NHS F	NHS Trust/Found	Q2 2024/20	Large (mor	Midlands	103	11	17	54	37	30	4
University Hospitals of Leicester NHS Trust	NHS Trust/Found	Q2 2024/20	Large (mor	Midlands	94	6	10	28	14	64	1
Nottingham University Hospitals NHS Trust	NHS Trust/Found	Q2 2024/20	Large (mor	Midlands	89	0	8	3	10	21	0
University Hospitals of North Midlands NHS Trus	NHS Trust/Found	Q2 2024/20	Large (mor	Midlands	87	6	41	33	10	41	1
Manchester University NHS Foundation Trust	NHS Trust/Found	Q2 2024/20	Large (mor	North West	82	4	28	47	29	29	8
King's College Hospital NHS Foundation Trust	NHS Trust/Found	Q2 2024/20	Large (mor	London	81	10	15	2	25	12	2
University Hospitals Birmingham NHS Foundation	NHS Trust/Found	Q2 2024/20	Large (mor	Midlands	79	2	9	17	33	6	2
Mersey Care NHS Foundation Trust	NHS Trust/Found	Q2 2024/20	Large (mor	North West	71	9	7	9	3	29	1
Leeds Teaching Hospitals NHS Trust	NHS Trust/Found	Q2 2024/20	Large (mor	North East & Yorkshi	68	0	21	27	1	17	2
Cambridge University Hospitals NHS Foundation	NHS Trust/Found	Q2 2024/20	Large (mor	East of England	67	0	7	43	13	30	0
Gloucestershire Hospitals NHS Foundation Trust	NHS Trust/Found	Q2 2024/20	Large (mor	South West	67	9	20	34	6	28	1
Bedfordshire Hospitals NHS Foundation Trust	NHS Trust/Found	Q2 2024/20	Large (mor	East of England	64	0	38	58	24	26	0
Guy's and St Thomas' NHS Foundation Trust	NHS Trust/Found	Q2 2024/20	Large (mor	London	64	1	5	5	10	20	0
The Royal Wolverhampton NHS Trust	NHS Trust/Found	Q2 2024/20	Large (mor	Midlands	62	29	12	13	35	32	0
East Lancashire Hospitals NHS Trust	NHS Trust/Found	Q2 2024/20	Large (mor	North West	61	5	0	34	16	35	0
Hull University Teaching Hospitals NHS Trust	NHS Trust/Found	Q2 2024/20	Large (mor	North East & Yorkshi	54	0	4	10	5	14	1
Liverpool University Hospitals NHS Foundation T	NHS Trust/Found	Q2 2024/20	Large (mor	North West	52	3	13	23	11	36	3
Frimley Health NHS Foundation Trust	NHS Trust/Found	Q2 2024/20	Large (mor	South East	51	8	14	31	2	33	3
Barts Health NHS Trust	NHS Trust/Found	Q2 2024/20	Large (mor	London	49	3	1	1	8	25	0
Royal Devon University Healthcare NHS Founda	NHS Trust/Found	Q2 2024/20	Large (mor	South West	49	0	5	32	25	42	1
The Newcastle upon Tyne Hospitals NHS Found	NHS Trust/Found	Q2 2024/20	Large (mor	North East & Yorkshi	47	4	2	12	8	9	0
University Hospitals Sussex NHS Foundation Tru	NHS Trust/Found	Q2 2024/20	Large (mor	South East	47	0	2	4	6	34	0
South Tees Hospitals NHS Foundation Trust	NHS Trust/Found	Q2 2024/20	Large (mor	North East & Yorkshi	39	22	4	10	5	25	1
St George's University Hospitals NHS Foundatio	NHS Trust/Found	Q2 2024/20	Large (mor	London	34	0	12	19	17	18	2
Oxford University Hospitals NHS Foundation Tru	NHS Trust/Found	Q2 2024/20	Large (mor	South East	31	4	1	21	7	2	2
Sheffield Teaching Hospitals NHS Foundation Tr	NHS Trust/Found	Q2 2024/20	Large (mor	North East & Yorkshi	29	2	5	18	5	3	5
University Hospitals Bristol and Weston NHS Fou	NHS Trust/Found	Q2 2024/20	Large (mor	South West	27	0	0	10	2	11	0
East Kent Hospitals University NHS Foundation T	NHS Trust/Found	Q2 2024/20	Large (mor	South East	26	2	7	21	11	9	11
Lancashire Teaching Hospitals NHS Foundation	NHS Trust/Found	Q2 2024/20	Large (mor	North West	25	7	3	12	5	10	0
University College London Hospitals NHS Founda	NHS Trust/Found	Q2 2024/20	Large (mor	London	25	4	1	0	8	18	0
East Suffolk and North Essex NHS Foundation T	NHS Trust/Found	Q2 2024/20	Large (mor	East of England	24	3	8	13	9	0	0
Mersey and West Lancashire Teaching Hospital	NHS Trust/Found	Q2 2024/20	Large (mor	North West	21	3	3	11	3	13	0
Royal Free London NHS Foundation Trust	NHS Trust/Found	Q2 2024/20	Large (mor	London	21	3	0	2	7	10	0
University Hospitals Coventry and Warwickshire	NHS Trust/Found	Q2 2024/20	Large (mor	Midlands	20	4	3	6	4	6	0
Northumbria Healthcare NHS Foundation Trust	NHS Trust/Found	Q2 2024/20	Large (mor	North East & Yorkshi	18	0	7	12	5	13	0
University Hospital Southampton NHS Foundatio	NHS Trust/Found	Q2 2024/20	Large (mor	South East	18	2	2	1	2	2	1
Imperial College Healthcare NHS Trust	NHS Trust/Found	Q2 2024/20	Large (mor	London	16	1	3	2	6	4	0
Cumbria, Northumberland, Tyne and Wear NHS F	NHS Trust/Found	Q2 2024/20	Large (mor	North East & Yorkshi	15	0	4	13	3	5	1
Northern Care Alliance NHS Foundation Trust	NHS Trust/Found	Q2 2024/20	Large (mor	North West	15	10	3	13	5	12	0

Organisation Name	Type of Organisation	Quarter	Size of organisation	Region	Number of cases brought to Freedom to Speak Up Guardians	Number of cases raised anonymously	Number of cases with an element of patient safety/quality	Number of cases with an element of worker safety or wellbeing	Number of cases with an element of bullying or harassment	Number of cases with an element of other inappropriate attitudes or behaviours	Number of cases where people indicate that they are suffering disadvantageous and/or demeaning treatment (detriment) as a result of speaking up
University Hospitals Plymouth NHS Trust	NHS Trust/Fou	Q3 2024/2025	Large (more	South West	151	7	43	119	60	120	1
Nottinghamshire Healthcare NHS Founda	NHS Trust/Fou	Q3 2024/2025	Large (more	Midlands	138	1	16	30	14	44	1
University Hospitals of Leicester NHS T	NHS Trust/Fou	Q3 2024/2025	Large (more	Midlands	133	12	21	34	11	79	1
Nottingham University Hospitals NHS Tru	NHS Trust/Fou	Q3 2024/2025	Large (more	Midlands	122	0	3	5	5	32	0
The United Lincolnshire Hospitals NHS T	NHS Trust/Fou	Q3 2024/2025	Large (more	Midlands	118	4	17	21	10	36	5
East Lancashire Hospitals NHS Trust	NHS Trust/Fou	Q3 2024/2025	Large (more	North West	115	2	4	22	7	29	1
Guy's and St Thomas' NHS Foundation T	NHS Trust/Fou	Q3 2024/2025	Large (more	London	113	2	3	4	10	29	0
Mersey Care NHS Foundation Trust	NHS Trust/Fou	Q3 2024/2025	Large (more	North West	99	21	10	43	14	32	0
Hampshire and Isle of Wight Healthcare	NHS Trust/Fou	Q3 2024/2025	Large (more	South East	96	5	14	23	17	33	0
Somerset NHS Foundation Trust	NHS Trust/Fou	Q3 2024/2025	Large (more	South West	89	6	22	61	12	27	3
King's College Hospital NHS Foundation	NHS Trust/Fou	Q3 2024/2025	Large (more	London	88	10	12	2	5	8	3
University Hospitals of Derby and Burto	NHS Trust/Fou	Q3 2024/2025	Large (more	Midlands	84	17	15	43	19	37	0
University Hospitals Birmingham NHS Fo	NHS Trust/Fou	Q3 2024/2025	Large (more	Midlands	83	0	10	9	36	34	3
Cambridge University Hospitals NHS Fou	NHS Trust/Fou	Q3 2024/2025	Large (more	East of Engla	79	1	10	50	12	27	0
Hull University Teaching Hospitals NHS T	NHS Trust/Fou	Q3 2024/2025	Large (more	North East &	79	1	5	6	7	26	0
University Hospitals Sussex NHS Found	NHS Trust/Fou	Q3 2024/2025	Large (more	South East	73	2	7	20	11	47	0
Manchester University NHS Foundation	NHS Trust/Fou	Q3 2024/2025	Large (more	North West	70	7	14	39	24	36	13
The Royal Wolverhampton NHS Trust	NHS Trust/Fou	Q3 2024/2025	Large (more	Midlands	62	33	4	0	8	35	1
University Hospitals of North Midlands N	NHS Trust/Fou	Q3 2024/2025	Large (more	Midlands	62	3	15	15	35	19	7
Barts Health NHS Trust	NHS Trust/Fou	Q3 2024/2025	Large (more	London	56	6	3	1	11	38	0
Bedfordshire Hospitals NHS Foundation	NHS Trust/Fou	Q3 2024/2025	Large (more	East of Engla	56	7	12	47	39	39	0
Mid Yorkshire Teaching NHS Trust	NHS Trust/Fou	Q3 2024/2025	Large (more	North East &	56	2	1	0	1	0	0
Leeds Teaching Hospitals NHS Trust	NHS Trust/Fou	Q3 2024/2025	Large (more	North East &	55	1	3	27	7	17	0
Frimley Health NHS Foundation Trust	NHS Trust/Fou	Q3 2024/2025	Large (more	South East	54	5	22	42	4	30	4
The Newcastle upon Tyne Hospitals NH	NHS Trust/Fou	Q3 2024/2025	Large (more	North East &	48	9	5	15	15	31	3
East Kent Hospitals University NHS Fou	NHS Trust/Fou	Q3 2024/2025	Large (more	South East	46	0	25	37	28	3	6
London Ambulance Service NHS Trust	NHS Trust/Fou	Q3 2024/2025	Large (more	London	44	1	0	39	12	36	1
Royal Devon University Healthcare NHS	NHS Trust/Fou	Q3 2024/2025	Large (more	South West	44	0	8	21	28	31	1
St George's University Hospitals NHS Fo	NHS Trust/Fou	Q3 2024/2025	Large (more	London	42	0	7	10	12	29	4
Oxford University Hospitals NHS Found	NHS Trust/Fou	Q3 2024/2025	Large (more	South East	41	21	9	30	6	10	1
East Suffolk and North Essex NHS Four	NHS Trust/Fou	Q3 2024/2025	Large (more	East of Engla	38	4	15	13	12	2	6
Sheffield Teaching Hospitals NHS Found	NHS Trust/Fou	Q3 2024/2025	Large (more	North East &	38	6	4	11	8	7	7
University College London Hospitals NH	NHS Trust/Fou	Q3 2024/2025	Large (more	London	36	3	2	3	3	29	0
South Tees Hospitals NHS Foundation T	NHS Trust/Fou	Q3 2024/2025	Large (more	North East &	35	10	6	14	7	25	2
Midlands Partnership University NHS Fo	NHS Trust/Fou	Q3 2024/2025	Large (more	Midlands	34	5	15	30	16	22	11
Lincolnshire Partnership NHS Foundatio	NHS Trust/Fou	Q3 2024/2025	Large (more	Midlands	29	0	7	21	1	0	0
Liverpool University Hospitals NHS Four	NHS Trust/Fou	Q3 2024/2025	Large (more	North West	29	0	9	20	1	19	0
University Hospitals Bristol and Weston	NHS Trust/Fou	Q3 2024/2025	Large (more	South West	28	1	0	9	3	6	2
University Hospitals Coventry and Warv	NHS Trust/Fou	Q3 2024/2025	Large (more	Midlands	28	4	0	6	3	19	0
Royal Free London NHS Foundation Tru	NHS Trust/Fou	Q3 2024/2025	Large (more	London	23	2	3	2	11	5	0
Chelsea and Westminster Hospital NHS	NHS Trust/Fou	Q3 2024/2025	Large (more	London	20	3	1	1	4	8	0
Imperial College Healthcare NHS Trust	NHS Trust/Fou	Q3 2024/2025	Large (more	London	20	1	4	4	7	4	1
University Hospital Southampton NHS Fo	NHS Trust/Fou	Q3 2024/2025	Large (more	South East	19	8	1	1	6	2	1
Northumbria Healthcare NHS Foundation	NHS Trust/Fou	Q3 2024/2025	Large (more	North East &	17	1	1	12	3	9	1
Northern Care Alliance NHS Foundation	NHS Trust/Fou	Q3 2024/2025	Large (more	North West	14	10	7	8	2	5	0
Coventry and Warwickshire Partnership	NHS Trust/Fou	Q3 2024/2025	Large (more	Midlands	2	2	1	0	1	0	0

Looking Ahead

Priorities for the Next Quarter

As we continue to develop our services, we have identified a number of key priorities that will be our focus for the coming quarter. These are described below.

- Review policy and establish a new procedure to effectively deal with cases of alleged detriment as a direct result of raising a concern
- Establish a system whereby the FTSU Guardians can ensure that reporters concerns have been fairly and objectively investigated, and outcomes are commensurate with evidence produced
- Review the current data collection, reporting and triangulation system to establish if there is a more efficient method that can be utilised. Possibilities include internal development of a web based secure reporting system, purchase of an “off the shelf” third party application
- Embedding Civility Saves Lives into our FTSU/Culture strategy
- Continue to increase visibility of the service via ward/dept visits, social media presence, comms, presentations etc.
- Produce action plan to address themes developing around Speaking Up Culture within the organisation
- Implement recruitment process for expansion of the FTSU Champions network
- Refresh communications and social media strategies.
- Perform training needs analysis to inform and improve the FTSU education reach within the organisation

Executive Summary

Trust Board | 8th October 2025

Workforce Race and Workforce Disability Equality Standard Reports 2025

University Hospitals of North Midlands NHS Trust

Purpose:	**Information**		**Approval**	✓	**Assurance**	**Agenda Item:**	17.
Author:	Charlotte Lees, OD, Culture and Inclusion Business Partner						
Lead:	Jane Haire, Chief People Officer						

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

Risk Register Mapping		
BAF 3	**Inability to improve workforce sustainability and organisational culture**	**Ext 15**

Executive Summary

Situation

University Hospitals of North Midlands (UHNM) continues its commitment to workforce equality, focusing on the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES). Both standards are mandated annually and serve as critical tools for measuring progress and driving improvements in equity, diversity, and inclusion across the Trust. Recent data shows encouraging improvements in representation, workplace experience, and fair opportunities, but persistent challenges remain in career progression, workplace culture, and inclusion for global majority and disabled colleagues.

Background

- WRES and WDES are part of the NHS Standard Contract, enabling organisations to benchmark progress and address disparities.
- The NHS EDI Improvement Plan outlines six high-impact actions, including measurable EDI objectives for leaders, recruitment overhaul, pay gap elimination, addressing health inequalities, induction for international staff, and eliminating bullying and harassment.
- UHNM's refreshed strategy (April 2025) prioritises inclusivity, patient care, and tackling inequality. The People Delivery Plan underpins these priorities with a focus on equality of opportunity and employee experience.
- In 2024, UHNM established a Race Equality Task and Finish Group to address areas where WRES metrics had not improved sufficiently, generating 47 recommendations.

Assessment

Workforce Race Equality:

- Representation of Black, Asian, and Minority Ethnic colleagues has increased to 29.2% of the workforce, up nearly 12% over five years.
- Middle-upper level diversity and confidence in fair promotion opportunities have improved.
- Reports of bullying, harassment, and abuse have decreased, but global majority colleagues still experience higher rates than white colleagues.
- White applicants are 1.6 times more likely to be appointed from shortlisting compared to global majority applicants.
- Disparity in senior leadership roles persists, with global majority representation below aspirational targets.
- Ethnicity pay gap favours global majority employees due to higher representation in middle and upper pay quartiles.

Workforce Disability Equality:

- 5.7% of colleagues have declared a disability, matching the national NHS average.

- Nine out of ten WDES indicators have improved year-on-year, reflecting progress in disability positive attitudes and workplace adjustments embedded in policy.
- Disabled colleagues report higher rates of discrimination, bullying, and harassment than non-disabled peers.
- Non-disabled applicants are 1.05 times more likely to be appointed from shortlisting than disabled applicants.
- Disability pay gap stands at 13.9%, attributed to lower representation of disabled colleagues in higher pay quartiles.

Recommendations

For Race Equality:

- Implement the short, medium and long term recommendations from the Race Equality Task and Finish Group, focusing on debiasing recruitment, improving equity in career development, and tackling harassment.
- Hold an anti-racism conference during Black History Month 2025.
- Refresh values and behaviours framework to set clear expectations for inclusive conduct.
- Enhance WRES Champions' remit to include employee relations support with an anti-racism lens.
- Introduce leadership masterclasses on managing intercultural teams and active bystander training.
- Launch a new EDI accountability framework for Care Groups.

For Disability Equality:

- Maintain awareness and understanding of the Reasonable Adjustments Policy and Tailored Adjustments Plan.
- Review management training effectiveness for supporting colleagues with long-term conditions.
- Streamline procurement processes for workplace adjustments.
- Establish a neurodiversity sub-group to improve experiences for neurodiverse colleagues.
- Launch new values and behaviours framework and practical learning sessions for managers.

We will track and measure progress through improved metrics in the 2025 National Staff Survey and 2026 WRES and WDES submissions and lived experience feedback from the Ethnic Diversity and Disability and Long Term Conditions Staff Network.

Key Recommendations:

This paper has been presented to the People, Culture and Inclusion Committee. The Trust Board is asked to approve this report and the recommended actions, co-created with our Staff Networks to continue the improvement in colleague experience and equity.

University Hospitals of North Midlands NHS Trust

Introduction

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

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

Representation and workplace experiences of global majority and disabled colleagues are continuing to improve, encouragingly, year-on-year data demonstrates:

- Increased middle-upper level diversity
- Greater confidence in fair promotion opportunities
- Fewer reports of bullying, harassment, and abuse
- More colleagues getting the adjustments they need at work

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

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

NHS EDI Improvement Plan

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

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

In April 2025, our assessment against the EDI Improvement Plan was reviewed by NHS England Midlands and we received a rating against all six high impact actions of 'good progress.' Two recommendations were identified and are underway as part of our EDI programme of work, these include the expansion of pay gap reporting to ethnicity and disability, and to focus on eliminating conditions for bullying and harassment to occur.

UHNM Strategy and People Delivery Plan

In April 2025, we launched the refreshed UHNM Strategy, with its three strategic priorities of:

The People Delivery Plan outlines how we will achieve our people priorities, and is underpinned by our commitment to equality of opportunity and employee experience:

Workforce race equality:

In 2024 we recognised the pressing need for systemic change to dismantle structural barriers that hinder equity in workplace experiences for global majority colleagues. We established a Race Equality Task and Finish Group, chaired by our Chief Nurse to focus on three areas where WRES metrics have not seen meaningful improvement. The Group, which meets monthly, has identified 47 recommendations and the group is currently working through the short, medium and long term actions to meet the ambitions and progress will be monitored through the trusts people, culture and inclusion committee.

A summary of the recommendations and the key performance indicators is below:

Workstream	Action	Progress	Key performance indicator
Debiasing recruitment & selection	25 actions identified that impact on advertising, shortlisting and interview, and onboarding	In progress	**Metric 2** (recruitment ratio) Target: year on year improvement aspiring to target of 1.0. Actual: 1.6
Improving equity in career development	14 actions that impact on communication, inclusive development processes (including career pathways) and line manager approval	In progress	**Metric 7** (belief in fair opportunities for career progression) Target: match national average of 47% by 2025. Actual: 48.3%
Tackling harassment,	8 recommendations that cover anti-racism, an anti-abuse campaign and training, guidance and use of data.	In progress	**Metrics 5 and 6** (bullying, harassment and abuse) Target: achieve long term sustained reduction. Actual: 3.06%

Workstream	Action	Progress	Key performance indicator
bullying and abuse	The We're People Too campaign launched in December 2024		reduction in experience of bullying, harassment or abuse from patients / public and 5.7% reduction from other staff

Workforce disability equality:
We identified three key workstreams to focus on during 2024-25:

Workstream	Action	Progress	Key performance indicator
Embed the Reasonable Adjustments Policy	• Review the effectiveness of our Reasonable Adjustments Policy • Refresh people management training to increase capability on compassionate management of colleagues with long term conditions • Introduce guidance on adjustments in the recruitment process	Complete Complete Complete	**Metric 8** (reasonable adjustments) target 73.4% actual 72.2% **Metric 4a** (bullying from manager) target 16.1% actual 15.0% **Metric 6** (presenteeism) target 28.5% actual 29.3% **Metric 9** (staff engagement score) target 6.4 actual 6.45
Supporting colleagues to have confident conversations	• Introduce the Purple Space Confident Conversations approach at the 2024 Workforce Disability Inclusion Conference • Continue to increase the number of Disability Champions buddy programme	Complete Complete	
Supporting colleagues with neuro-differences	• Introduce guidance about the adjustments available in the recruitment process for neurodifferent applicants • Raise awareness of neurodifference through a range of resources and sessions (including a specialist session from Diverse Learners) • Increase neurodifferent Disability Champion representation	Complete Complete Complete	

Workforce Race Equality Standard (WRES) 2025 Data Analysis

Key Findings:

29.2% of our workforce are from Black, Asian or Minority Ethnic backgrounds, an increase of nearly 12% over the past 5 years

26.9% of global majority colleagues have experienced abuse from patients and the public in the last 12 months compared to **23.4%** of white colleagues

7% improvement in global majority colleague belief the trust offers fair opportunities for career progression / promotion. This is **11%** less than white colleague belief

White applicants are **1.6** times more likely to be appointed from shortlisting compared to global majority applicants

5% improvement in global majority colleagues reporting bullying and abuse from other colleagues in the last 12 months

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

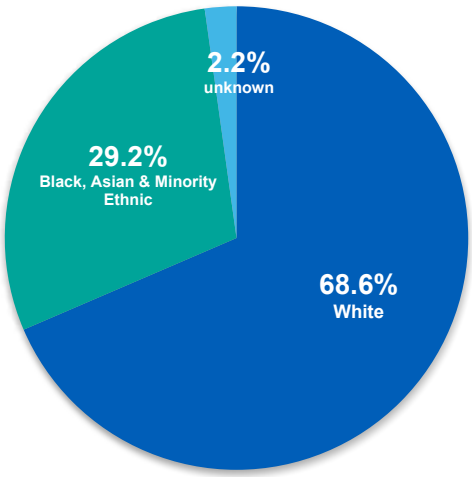
Global majority colleagues more likely to feel discriminated against by a colleague /manager/team leader at **18.9%** compared to **8.2%** of white staff

Global majority colleagues are unequally distributed across professional groups: **10.8%** are in non-clinical roles, **27.7%** in clinical roles and **67.3%** in Medical and Dental roles

There is a gap of **-19%** between the representation of Black, Asian & Minority Ethnic board members and the composition of the overall workforce

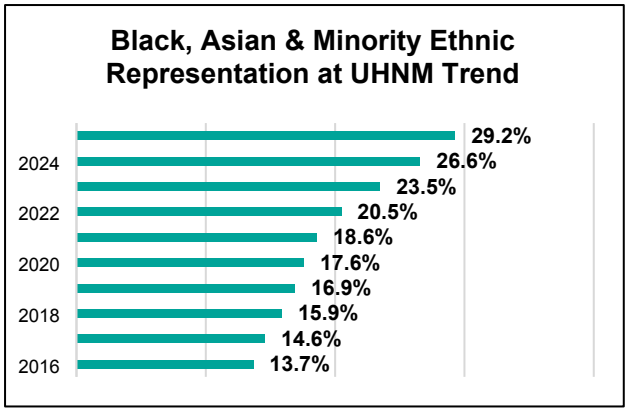
WRES Indicator 1

Percentage representation by ethnicity

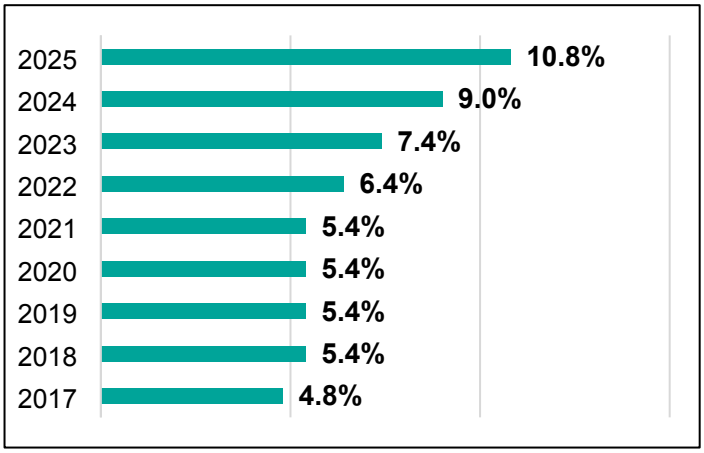


At 31st March 2025, Black, Asian and Minority Ethnic colleagues represented 29.2% of our overall workforce (3,859 people).

Across the NHS 28.6% of the workforce are from global majority, across the Midlands it is 28.2% (as at March 2024).



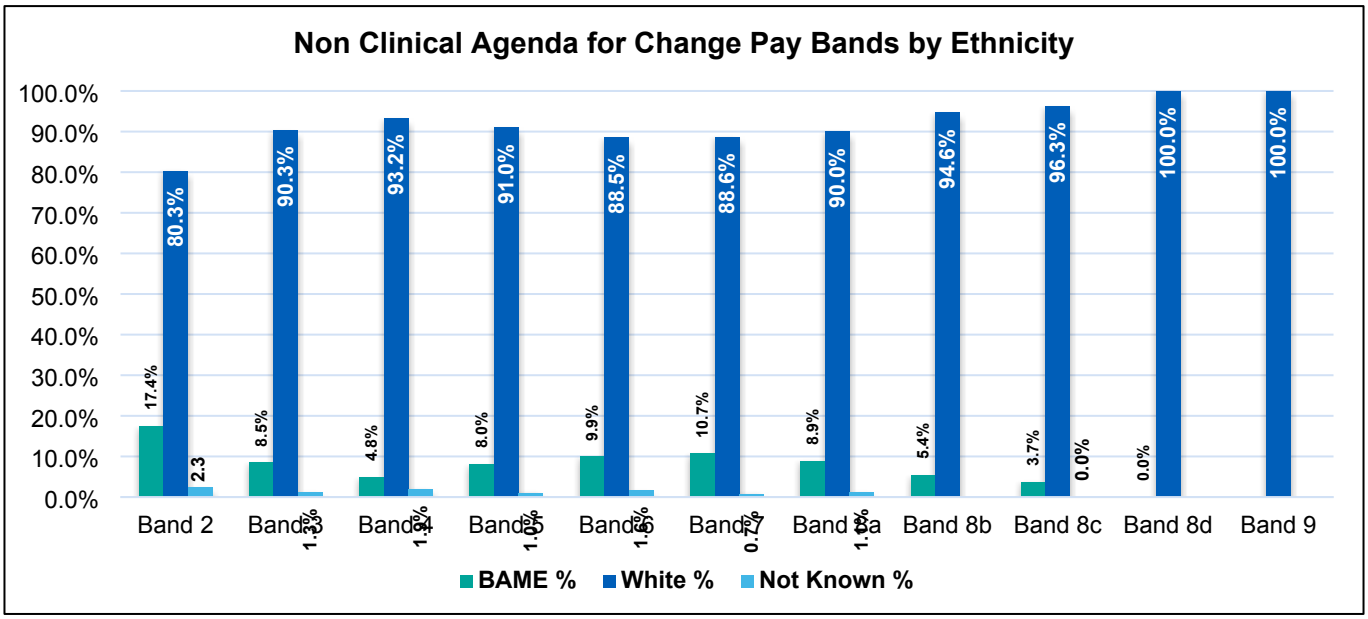
Percentage representation of Black, Asian and Minority Ethnic colleagues in Agenda for Change non-clinical pay bands:



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

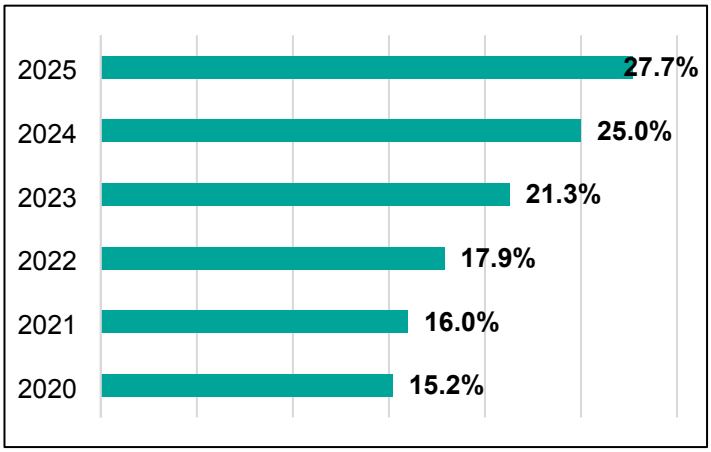
The greatest representation is at Band 2.

In the NHS, 18.8% of non-clinical workforce is from Black, Asian and minority ethnic backgrounds.



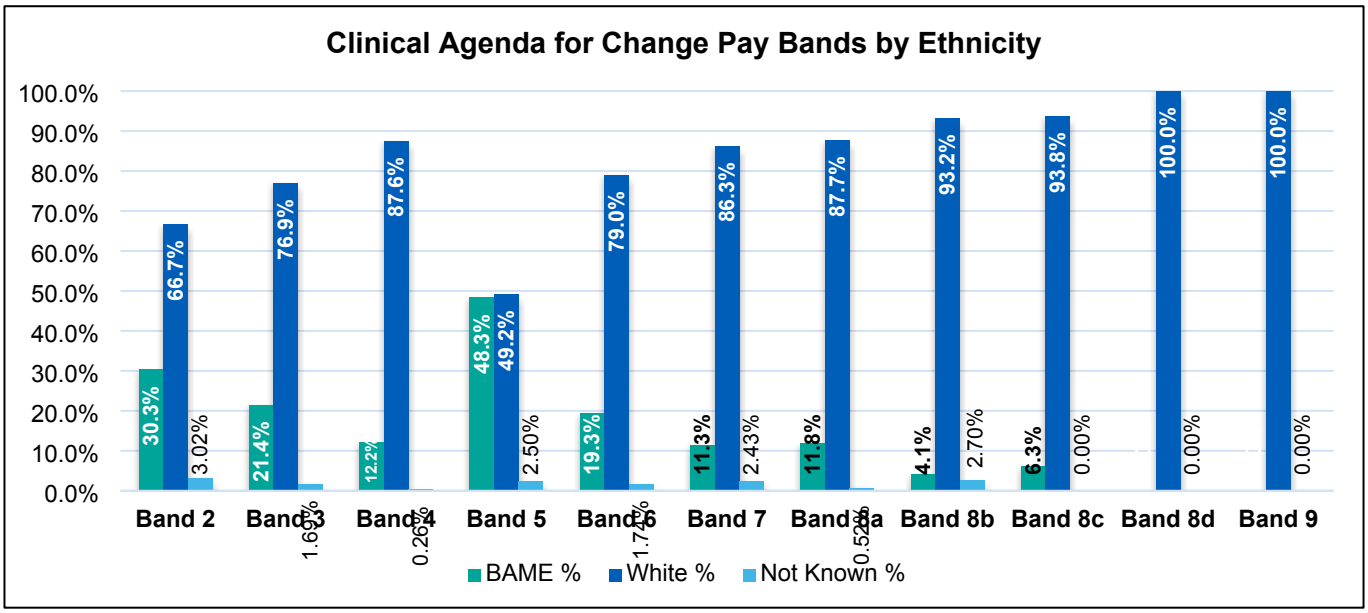
The percentage representation of global majority colleagues in senior non-clinical roles 8c and above, remains an area requiring improvement.

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



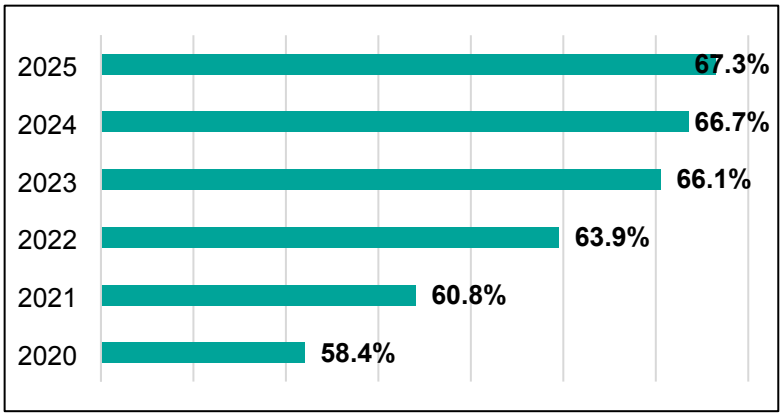
Global majority representation has improved year on year in clinical pay bands, with a 12.5% increase over 5 years. International recruitment has influenced representation, particularly at Band 5.

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



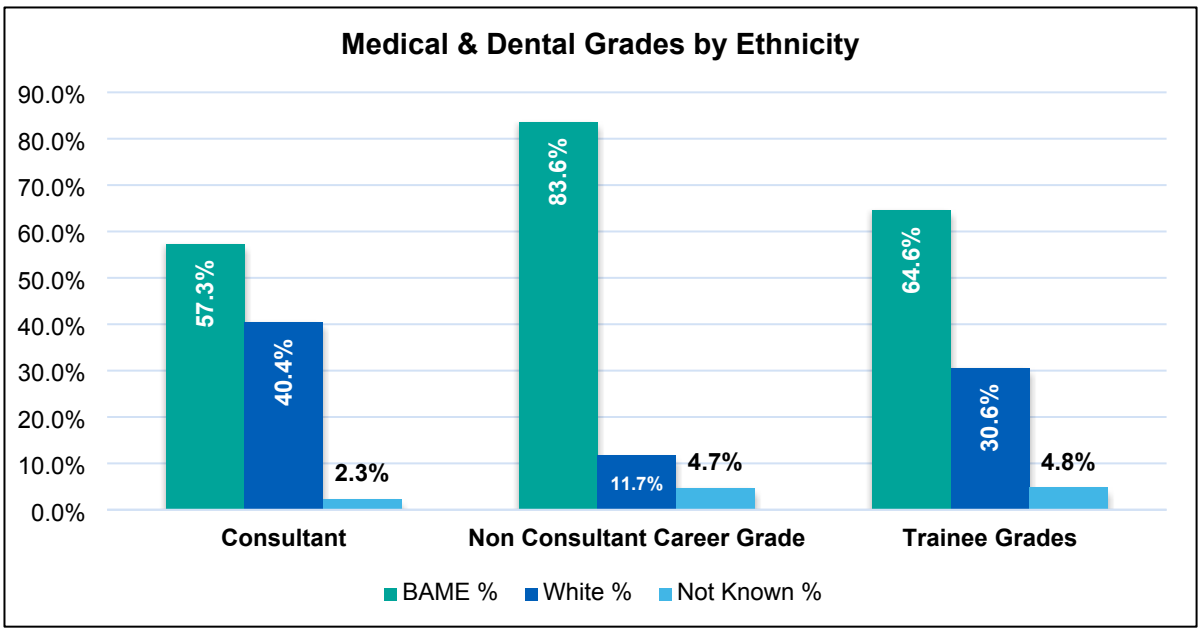
Nationally, representation is also highest at Agenda for Change Band 5 (45.7%), and above Band 5 falls dramatically to 25.2% at Band 6 and 18.8% at Band 7.

Percentage representation by Ethnicity in Medical & Dental Grades:



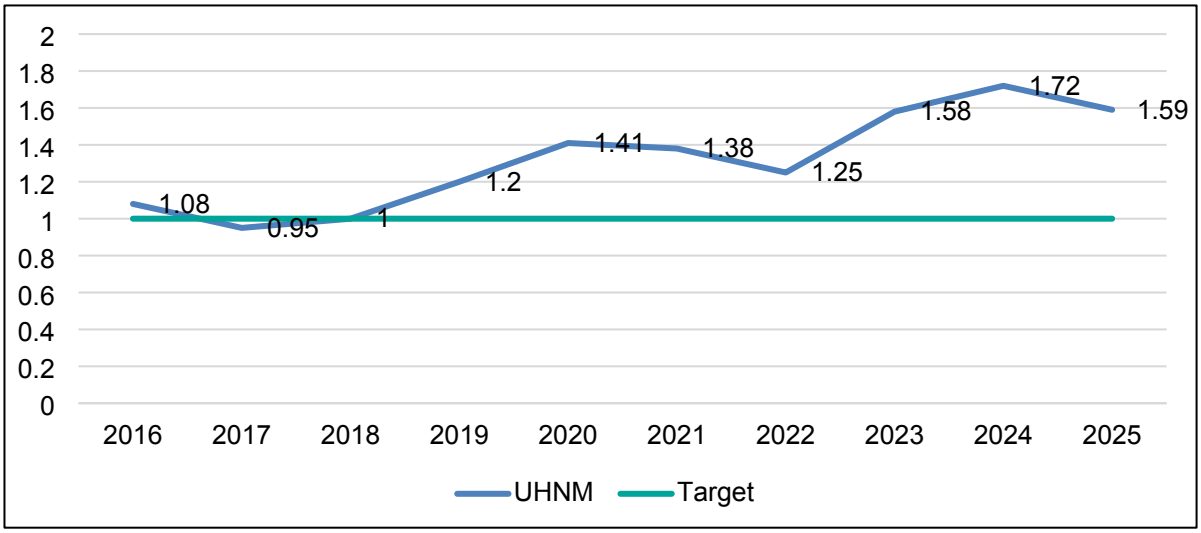
Representation of global majority colleagues continues to rise each year. Nationally, in March 2024 48.7% of NHS doctors/dentists were from Black, Asian and Minority Ethnic backgrounds.

UHNM reflects the national situation, with the highest representation of global majority colleagues being in non-consultant specialist roles.



WRES Indicator 2

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



White applicants are almost 1.6 times more likely to be appointed from shortlisting compared to global majority applicants. The National WRES Data Analysis Report (2024) showed that at 80% of NHS trusts, white applicants were significantly more likely to be appointed from shortlisting, and this is a worsening position. The national likelihood metric in 2024 was 1.63 and the midlands likelihood metric 1.71.

Race Disparity Ratio

The race disparity ratio is a metric that compares the proportion of global majority employees at different pay levels (lower, middle and upper bands) to that of white employees. A ratio greater than 1.0 indicates inequality, suggesting that white colleagues have a higher likelihood of progression than ethnically diverse staff, while a ratio of 1.0 indicates parity. There has been improvement compared to last year in the middle to upper and lower to upper RDR, but there is a significantly better progression rates for white colleagues into senior roles.

Agenda for Change Bands	2025	2024
Disparity ratio - lower to middle	2.03	1.98
Disparity ratio - middle to upper	2.00	2.37
Disparity ratio - lower to upper	4.06	4.68

The chart below demonstrates ethnicity representation in Agenda for Change roles at UHNM and the shifting ethnicity representation over the years.

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%

Whist global majority representation has increased, particularly in pay bands <1 to 7, there has been no improvement in senior pay bands 8C and above. Progress against our Model Employer Aspirational Targets for Black, Asian and Minority Ethnic representation in senior leadership roles reflects this, with a continued positive trajectory at Band 8a, but below the aspirational target allocated by NHS England for higher pay bands:

AfC Band	UHNM Headcount 2025	Model Employer Target 2025
8a	53	42
8b	6	11
8c	2	4
8d	0	2
9	0	1
VSM	1	1

Ethnicity Pay Gap

Ethnicity pay gap reporting was introduced as part of the EDI Improvement Plan, and our data shows that at 31st March 2025 there is a positive pay gap in favour of global majority employees:

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

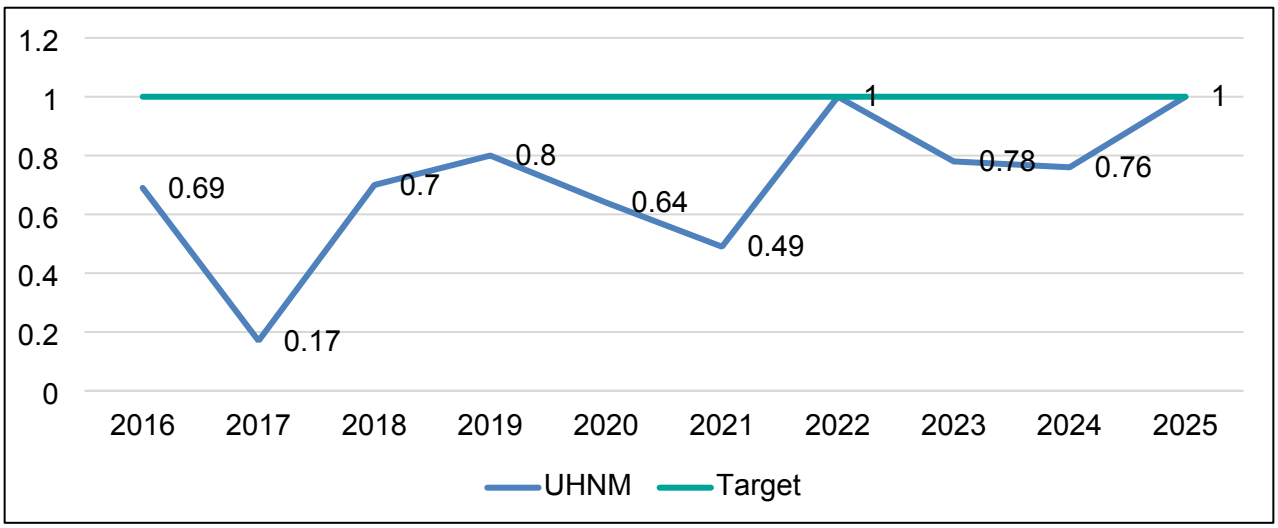
	2025	2024	2023
Mean pay gap	-22.9%	-25.3%	-29.0%
Median pay gap	-14.3%	-18.4%	-20.4%

This is because there is a greater proportion of global majority employees employed in the middle and upper pay quartiles, particularly Asian colleagues:

	Headcount							% Global Majority representation
Quartile	Asian	Black	Mixed	Not Stated	Other	White British	White Other	
1	371	101	47	53	24	2,628	116	**16.3%**
2	666	211	58	77	36	2,182	123	**29.0%**
3	831	213	57	118	69	1,922	166	**33.2%**
4	878	197	68	145	92	1,837	186	**36.2%**

WRES Indicator 3

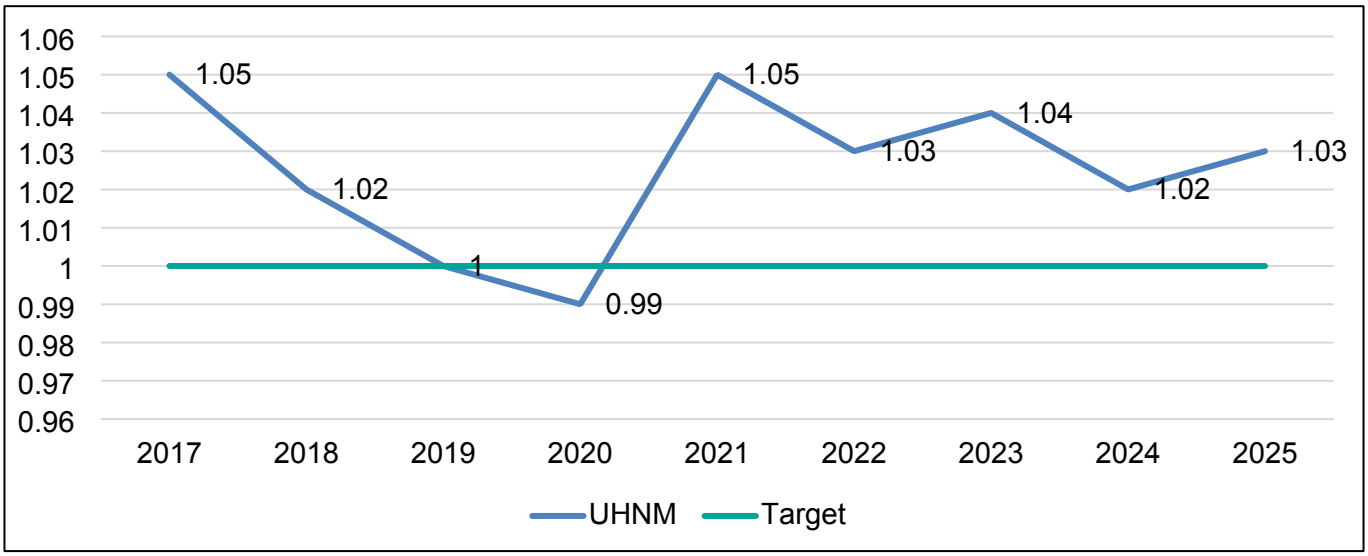
Relative likelihood of Black, Asian & Minority Ethnic staff entering the formal disciplinary process compared to white staff:



Global majority colleagues do not have an increased likelihood of entering formal disciplinary processes at UHNM. Nationally, the 2024 WRES Data Report showed that in 51% of NHS trusts, Black, Asian and Minority Ethnic staff were over 1.25 times more likely than white staff to enter the formal disciplinary process. The Midlands figure was 1.17.

WRES Indicator 4

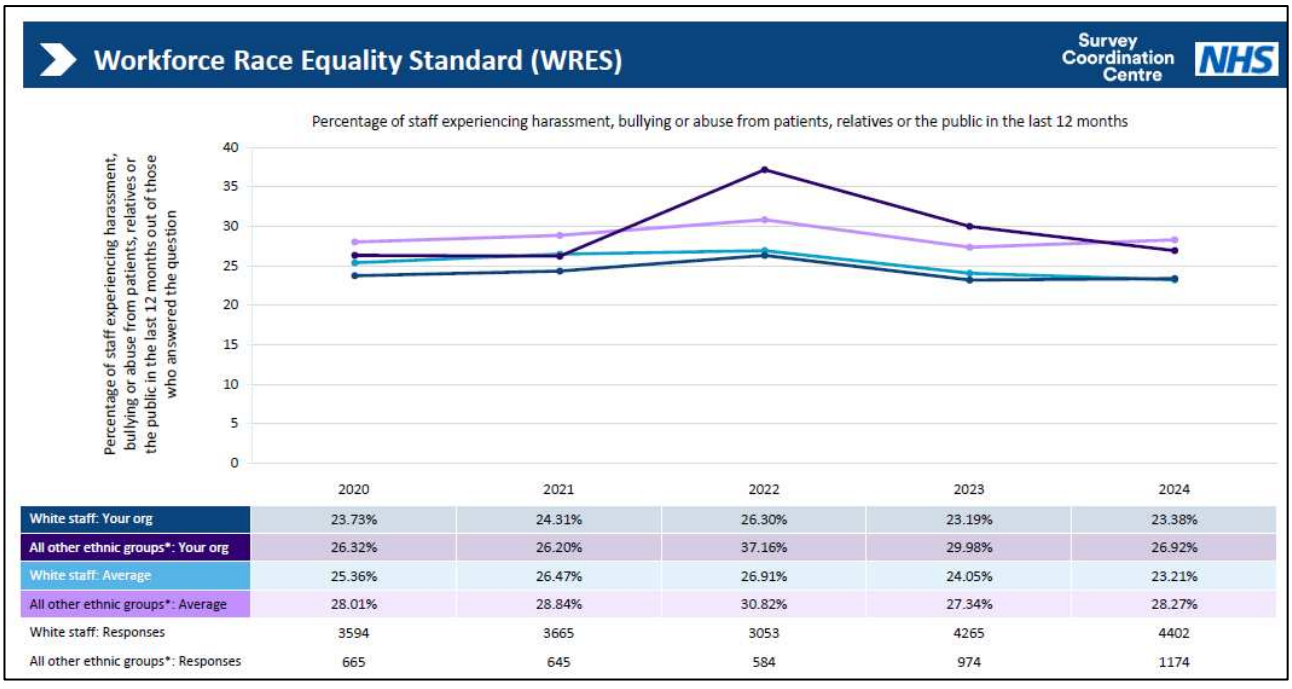
Relative likelihood of white staff compared to Black, Asian and Minority Ethnic staff accessing non-mandatory training and CPD



The acceptable range for this indicator is between 0.80 and 1.25. Our data has consistently been within this.

WRES Indicator 5

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



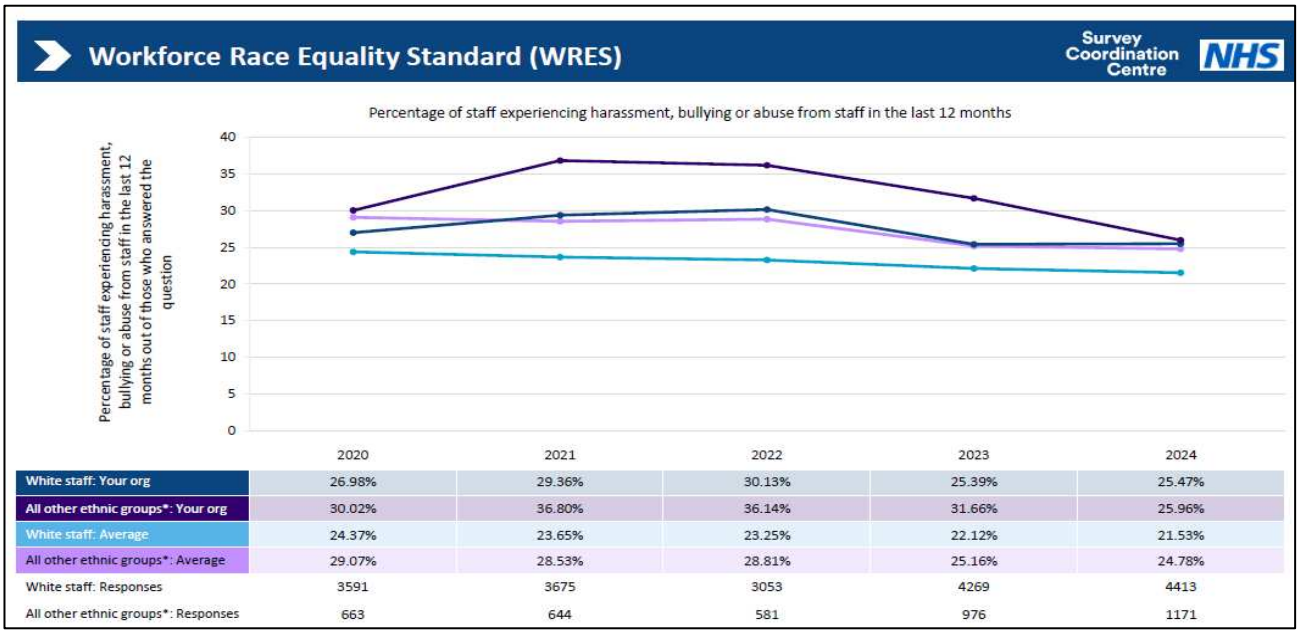
	2020	2021	2022	2023	2024
White staff: Your org	23.73%	24.31%	26.30%	23.19%	23.38%
All other ethnic groups*: Your org	26.32%	26.20%	37.16%	29.98%	26.92%
White staff: Average	25.36%	26.47%	26.91%	24.05%	23.21%
All other ethnic groups*: Average	28.01%	28.84%	30.82%	27.34%	28.27%
White staff: Responses	3594	3665	3053	4265	4402
All other ethnic groups*: Responses	665	645	584	974	1174

This indicator has improved by 3.06% for global majority colleagues and is better than the peer average, but it has slightly risen for white colleagues. During the year we launched a new anti-abuse public campaign “we’re people too” to tackle racist and discriminatory abuse from patients and visitors.

The most recent national data from the 2024 WRES Report showed that in 82% of trusts, a higher proportion of global majority staff compared to white staff experienced harassment, bullying or abuse from patients, relatives or the public in the last 12 months.

WRES Indicator 6

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

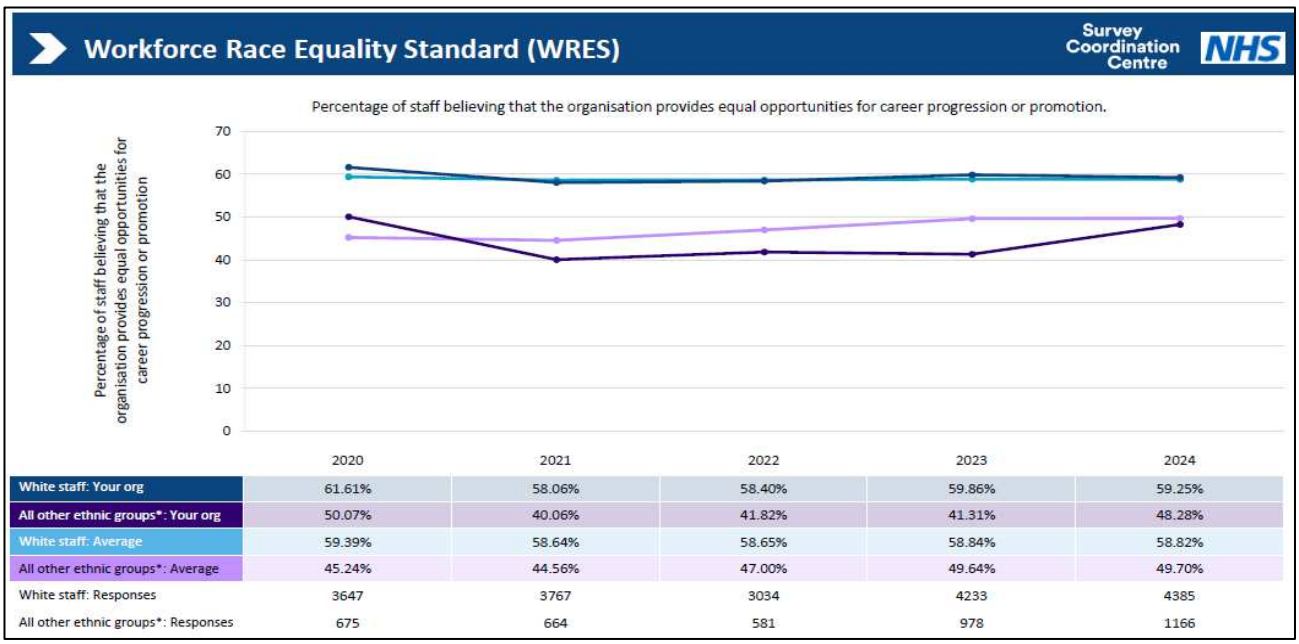


	2020	2021	2022	2023	2024
White staff: Your org	26.98%	29.36%	30.13%	25.39%	25.47%
All other ethnic groups*: Your org	30.02%	36.80%	36.14%	31.66%	25.96%
White staff: Average	24.37%	23.65%	23.25%	22.12%	21.53%
All other ethnic groups*: Average	29.07%	28.53%	28.81%	25.16%	24.78%
White staff: Responses	3591	3675	3053	4269	4413
All other ethnic groups*: Responses	663	644	581	976	1171

This indicator continues in a positive trajectory, and the latest figure of 25.96% is the best performance over the past five years and an improvement of 5.7%. It remains worse than the peer average for global majority staff but the gap has closed significantly. White colleague experience has slightly deteriorated, and is also worse than the peer average. Nationally, 89% of trusts reported a higher proportion of global majority employees compared to white employees experiencing harassment, bullying or abuse from other staff in last 12 months (WRES 2024 data report).

WRES Indicator 7

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



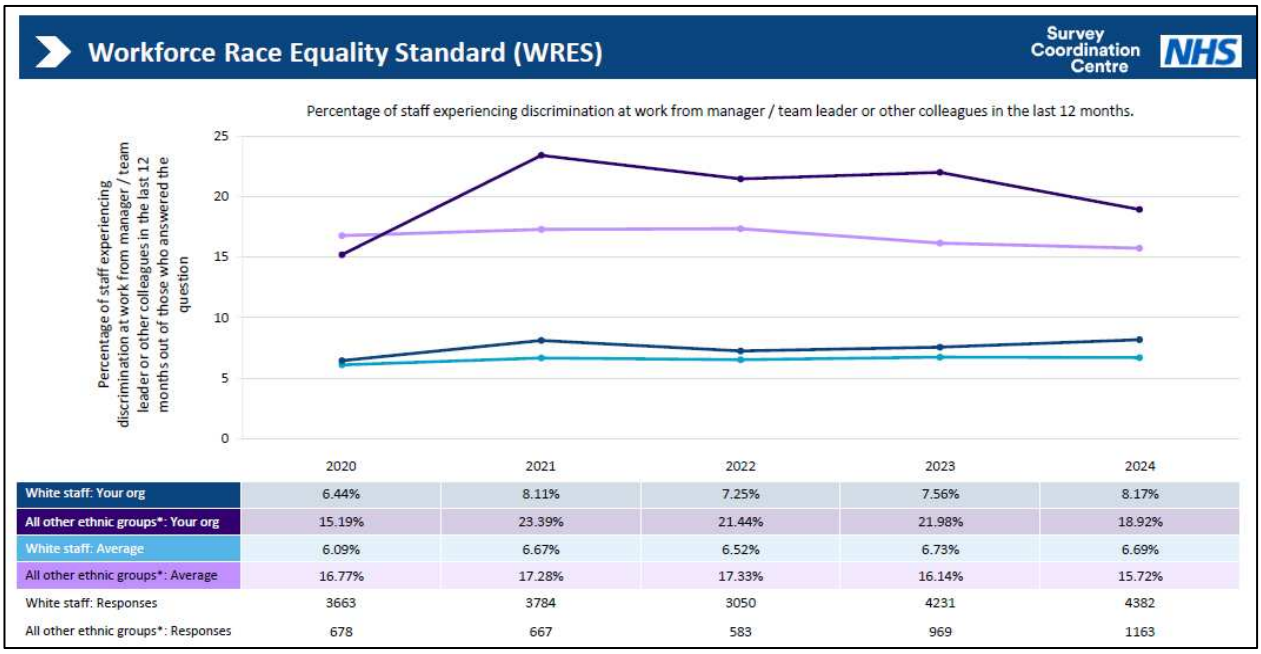
	2020	2021	2022	2023	2024
White staff: Your org	61.61%	58.06%	58.40%	59.86%	59.25%
All other ethnic groups*: Your org	50.07%	40.06%	41.82%	41.31%	48.28%
White staff: Average	59.39%	58.64%	58.65%	58.84%	58.82%
All other ethnic groups*: Average	45.24%	44.56%	47.00%	49.64%	49.70%
White staff: Responses	3647	3767	3034	4233	4385
All other ethnic groups*: Responses	675	664	581	978	1166

This indicator has improved by 6.97% for global majority colleagues and the gap has reduced significantly between global majority and white colleague experience (reducing from 18.6% in 2023 to 10% in the 2024 NSS). The gap in relation to the peer average has also significantly closed.

The most recent WRES Data report from 2024 showed that at 97.6% of NHS trusts, a lower percentage of global majority employees than white colleagues felt that their trust provides equal opportunities for career progression or promotion.

WRES Indicator 8

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



	2020	2021	2022	2023	2024
White staff: Your org	6.44%	8.11%	7.25%	7.56%	8.17%
All other ethnic groups*: Your org	15.19%	23.39%	21.44%	21.98%	18.92%
White staff: Average	6.09%	6.67%	6.52%	6.73%	6.69%
All other ethnic groups*: Average	16.77%	17.28%	17.33%	16.14%	15.72%
White staff: Responses	3663	3784	3050	4231	4382
All other ethnic groups*: Responses	678	667	583	969	1163

This indicator has improved by 3.06% for global majority colleagues and the gap has improved between global majority and white colleagues (reducing from 14.4% in 2023 to 10.75%). The gap in relation to the peer average has also significantly closed. In 99% of trusts in England, global majority colleagues report greater experience of discrimination than white staff.

WRES Indicator 9

Representation amongst board members by ethnicity compared to the workforce overall

This indicator measures the difference between the ethnicity composition of our Board membership compared to the overall organisation. Boards are expected to be broadly representative of their workforce. At UHNM, 11.8% of the board are from Black, Asian and Minority Ethnic backgrounds.

Board Representation	2025
Difference Total Board: Overall Organisation	-19%
Difference Voting Board Membership: overall organisation	-13%
Difference Executive Board Membership: overall organisation	-20%

Nationally, in March 2024, 16.5% of board members recorded their ethnicity as Black, Asian or Minority Ethnic, compared to 28.6% of staff in NHS trusts. In every region, there was a lower percentage of global majority board members compared to the overall percentage of global majority workforce.

Summary and Action Plan for 2025-26

This report highlights the progress we have made in advancing racial equality within our workforce, while also emphasising the areas where further work is still required. The reductions in the levels of harassment, bullying and abuse from the public and by other colleagues, coupled with the increasing confidence of global majority employees in their belief of fair opportunities for career progression, are positive improvements that should only get better with the focus brought by the implementation phase of the recommendations made by the UHNM Race Equality Task and Finish Group.

However, the findings continue to remind us that our journey towards becoming an anti-racist organisation and achieving racial equality remains some way off. Whilst there has been improvement in 6 indicators, 2 indicators within acceptable range and 1 indicator that has slightly deteriorated, our metrics, despite being on a positive trajectory remain worse than peer comparator averages in all but three.

Our actions for 2025-26, which we will be working with our Ethnic Diversity Network to ensure they are effectively implemented, and in addition to implementing the recommendations of the Race Equality Task & Finish Group are:

	Culture of anti-racism	Inclusive leadership	Governance
Actions	• Hold an anti-racism conference during Black History Month 2025 to raise awareness and understanding of anti-racism and everyone's responsibilities to eliminate racism • Introduce refreshed values and behaviours framework with clear expectations about inclusive and non-discriminatory colleague behaviour • Enhance the remit of WRES Champions to include employee relations support with an anti-racism lens	• Introduce new masterclasses into our leadership brochure to include: - Managing inter-cultural teams - Intercultural communication - Active bystander training • Introduction of the NHS Leadership and Management Framework	• Launch of a new Equality, Diversity and Inclusion accountability framework, defining the expectations of Care Groups

Progress will be measured by improved metric results in the 2025 National Staff Survey, 2026 WRES submission, and the monitoring of other relevant metrics and the lived experiences of our Ethnic Diversity Staff Network membership

Workforce Disability Equality Standard (WDES) 2025 Data Analysis

Key Findings from the 2025 WDES:

5.7% of colleagues have shared a disability or Long Term Condition (LTC) on ESR compared to **27.8%** in the NHS Staff Survey

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

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

28% of colleagues with a disability/LTC do not feel they have had all the workplace adjustments they need to do their job

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

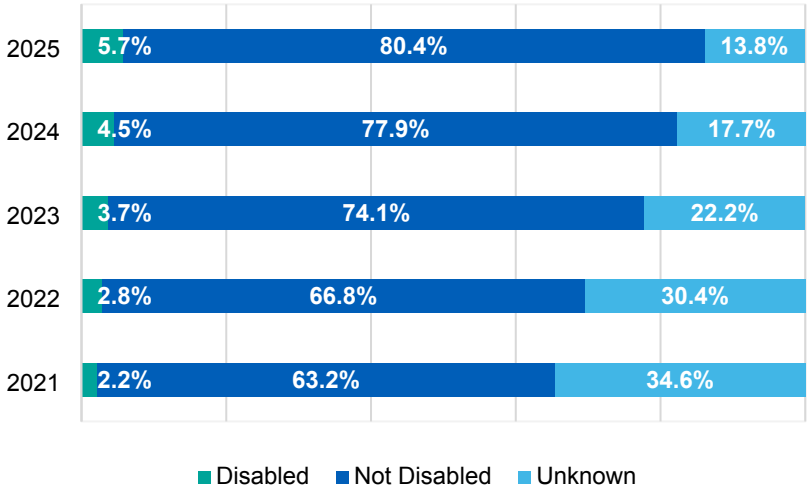
Non disabled applicants are **1.05 times** more likely to be appointed from shortlisting than applicants with a disability

Introduction

The WDES comprises of 10 indicators. Six of which are drawn from the most recent annual NHS National Staff Survey. The UHNM response rate for the 2024 staff survey was 45% (the same as 2023) with 27.75% of respondents (1,554 people) stating that they had a physical or mental health condition or illness lasting or expected to last 12 months or more. This compares to the peer average of 24.45% and is our highest ever response rate.

WDES Indicator 1

Percentage Representation of Workforce Disability

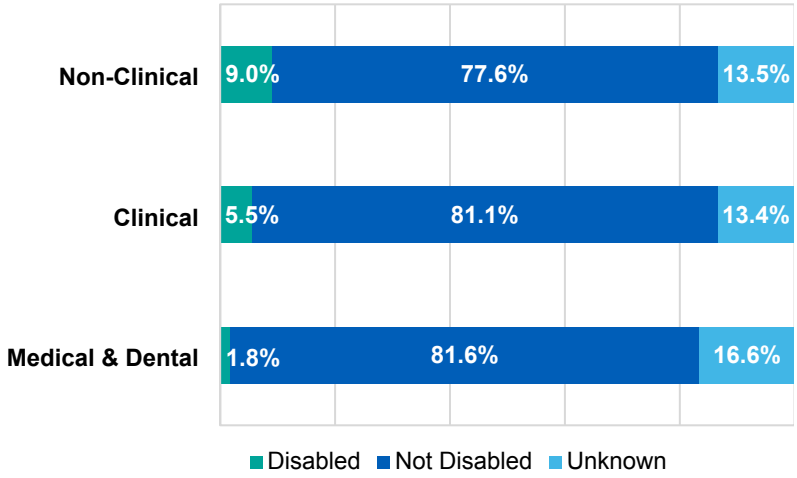


5.7% of UHNM colleagues have shared that they have a disability on ESR. Yearly trends show significant improvement in declaration rates on ESR with a 20% reduction in 'unknown' disability status over the last 4 years.

The percentage of NHS staff in England working with a disability is also 5.7% with 80.0% not disabled and 14.3% unknown status. (source: 2024 WDES Data Report)

Nationally it is recognised that there is a significant under reporting across the country of the numbers of staff who disclose a disability on ESR, compared to those sharing this information when completing the anonymous NHS Staff Survey. We regularly encourage our workforce to update their ESR record and the number of records where colleagues have not disclosed their disability status has improved significantly from 41% in 2020 to 13.8% in 2025.

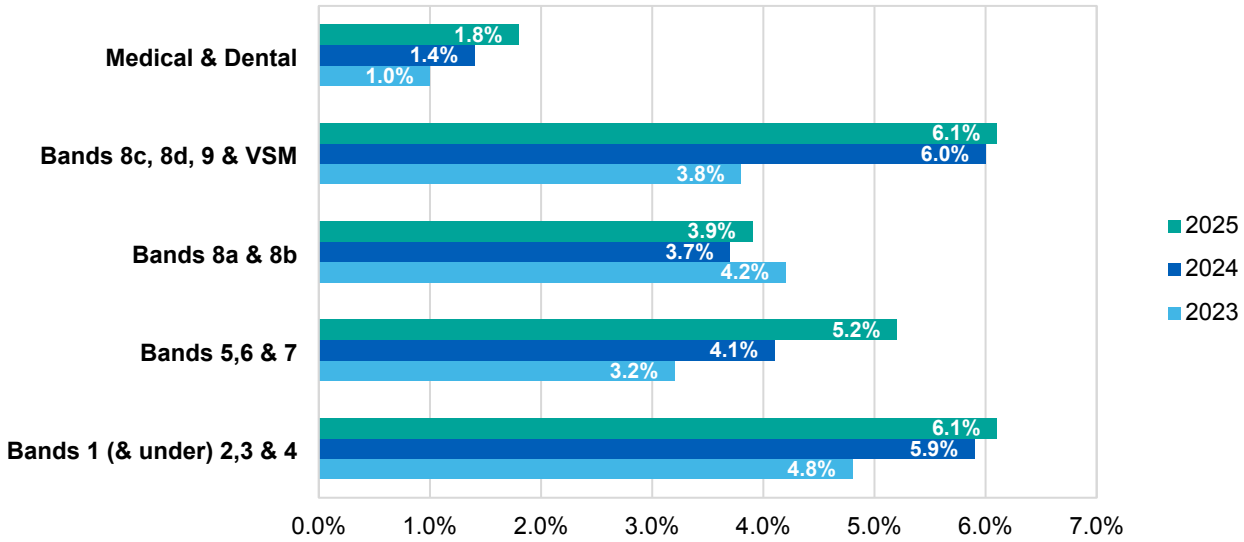
Disability representation across clinical and non-clinical groups:



Disability Category (ESR)	%
Long-standing illness	32.4%
Learning disability/difficulty	19.8%
Other	12.9%
Mental Health Condition	11.6%
Yes (unspecified)	9.0%
Sensory Impairment	7.4%
Physical Impairment	6.8%

758 colleagues have shared that they have a disability on ESR. 'Long standing illness,' 'learning disability/difficulty' and 'mental health conditions' are the most commonly selected categories.

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



Disability Pay Gap

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

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

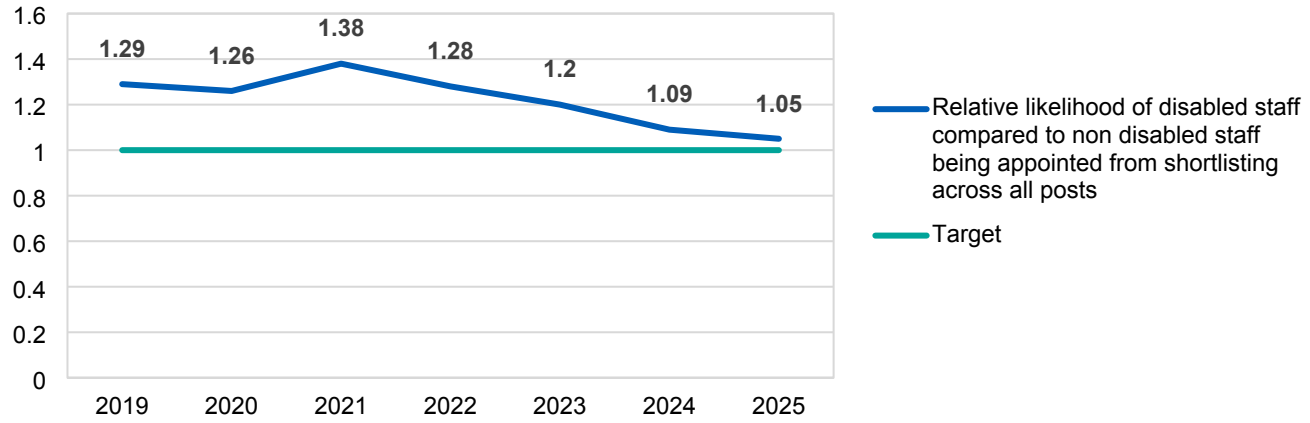
	2025	2024	2023
Mean pay gap	13.9%	12.5%	13.0%
Median pay gap	13.4%	10.4%	11.3%

Quartile	Not disabled	Status not known	Disabled	% Disability representation
1	2668	387	289	8.6%
2	2724	449	173	5.2%
3	2701	459	186	5.6%
4	2643	590	113	3.4%

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

WDES Indicator 2

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

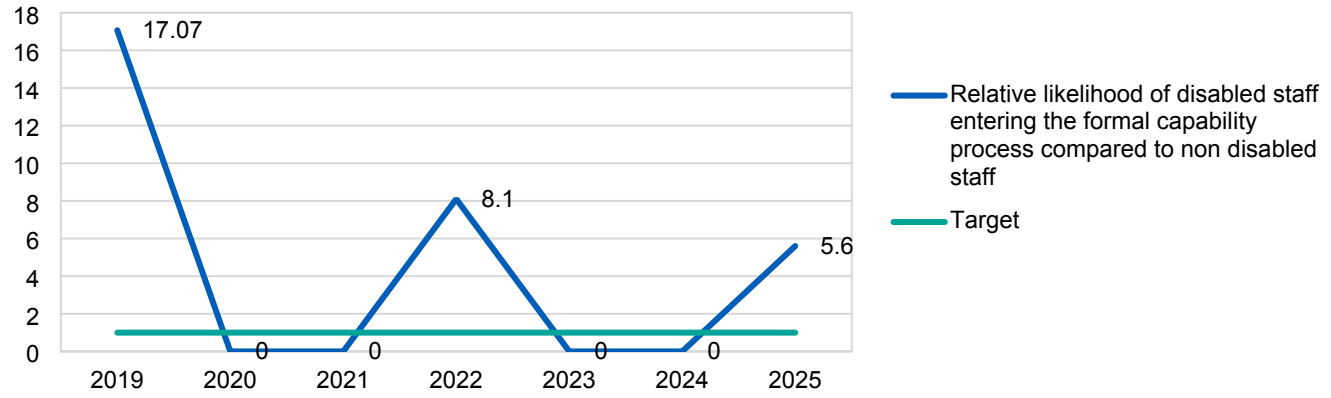


Analysis of recruitment activity recorded on the TRAC recruitment system shows that non-disabled applicants are 1.05 times more likely to be appointed from shortlisting compared to Disabled applicants (a metric of 1.0 represents equal likelihood of disabled and non-disabled applicants being appointed from shortlisting).

A continued downward (positive) trajectory in our recruitment data compares with the most recent national average metric from 2024, which was 0.98.

WDES Indicator 3

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



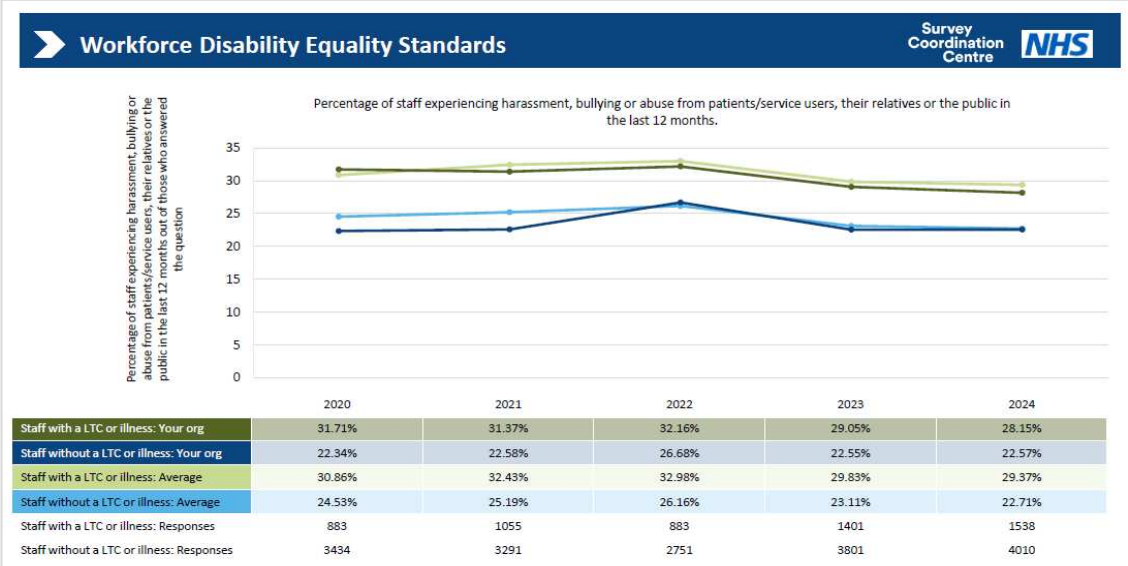
This indicator is based on data from a two-year rolling average of entry into a formal capability process as recorded on the Employee Relations Case Tracker. From 2022 this metric is related to entry into the formal capability process for all reasons (previously the metric measured entry into the capability process due to performance issues only).

Our Capability Policy is designed to be supportive and encouraging to enable colleagues to reach the desired performance level through informal processes and hence only very small numbers of staff enter the formal stage of the policy. The policy was reviewed as an action from the 2023/24 WDES Action Plan and has been updated reflecting feedback from the Disability & LTC Staff Network.

This year's result gives a relative likelihood of Disabled staff entering the formal capability process compared to non-disabled staff score of 5.6, compared to the most recent national result of 2.04. Trend analysis for this metric would suggest that the increase in 2025 is due to case mix, but this will be monitored.

WDES Indicator 4a

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



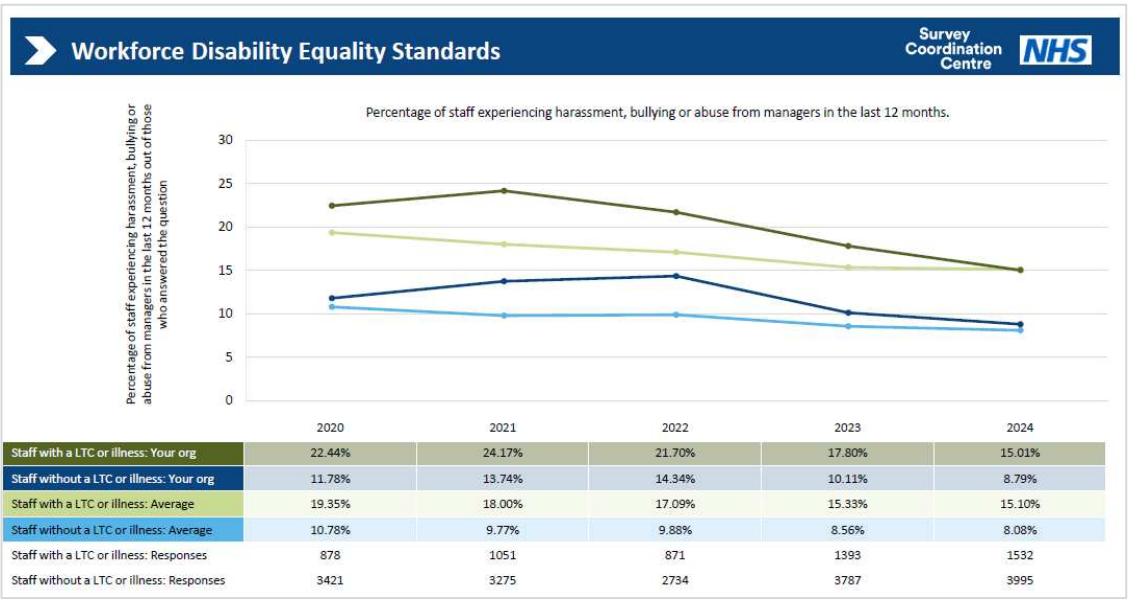
	2020	2021	2022	2023	2024
Staff with a LTC or illness: Your org	31.71%	31.37%	32.16%	29.05%	28.15%
Staff without a LTC or illness: Your org	22.34%	22.58%	26.68%	22.55%	22.57%
Staff with a LTC or illness: Average	30.86%	32.43%	32.98%	29.83%	29.37%
Staff without a LTC or illness: Average	24.53%	25.19%	26.16%	23.11%	22.71%
Staff with a LTC or illness: Responses	883	1055	883	1401	1538
Staff without a LTC or illness: Responses	3434	3291	2751	3801	4010

Whilst the levels of abuse experienced by colleagues is unacceptably high, this year's figure is our best performance for colleagues with a disability/LTC since we began reporting the WDES and is better than our peer comparator group. The difference with non-disabled colleagues has also narrowed.

Nationally 30% of disabled colleagues and 23.3% of non-disabled colleagues reported experience of harassment, bullying and abuse from patients/service users, their relatives or public in the previous 12 months. (source: WDES Data Report 2024)

WDES Indicator 4a

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

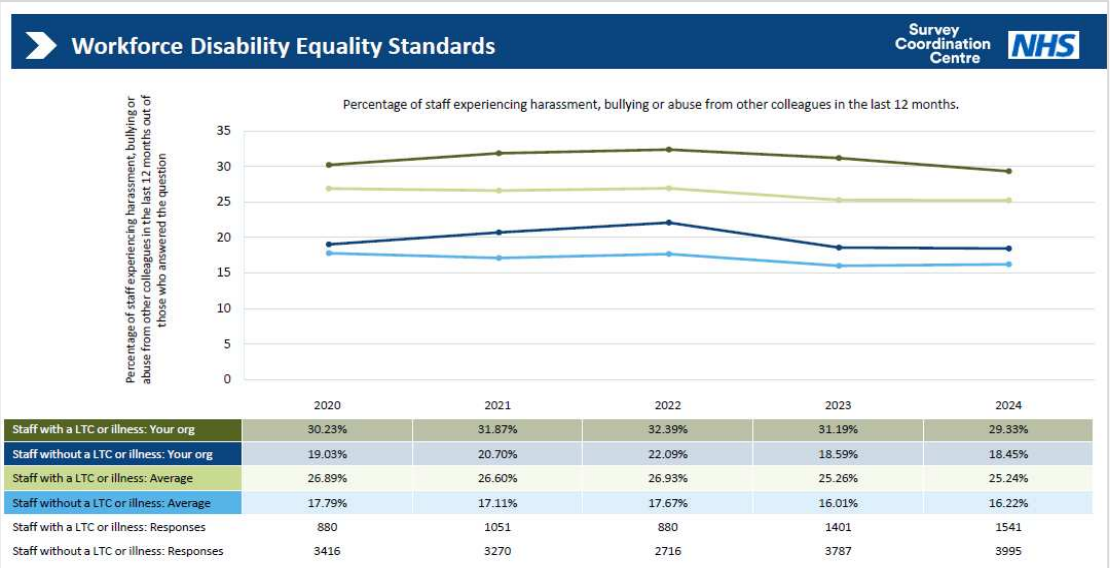


	2020	2021	2022	2023	2024
Staff with a LTC or illness: Your org	22.44%	24.17%	21.70%	17.80%	15.01%
Staff without a LTC or illness: Your org	11.78%	13.74%	14.34%	10.11%	8.79%
Staff with a LTC or illness: Average	19.35%	18.00%	17.09%	15.33%	15.10%
Staff without a LTC or illness: Average	10.78%	9.77%	9.88%	8.56%	8.08%
Staff with a LTC or illness: Responses	878	1051	871	1393	1532
Staff without a LTC or illness: Responses	3421	3275	2734	3787	3995

This year's performance continues a downward (improving) trajectory and is our best score yet for disabled colleagues reporting experience of harassment, bullying or abuse from managers in the last 12 months, and, for the first time, is better than our national staff survey peer comparator group.

WDES Indicator 4a

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

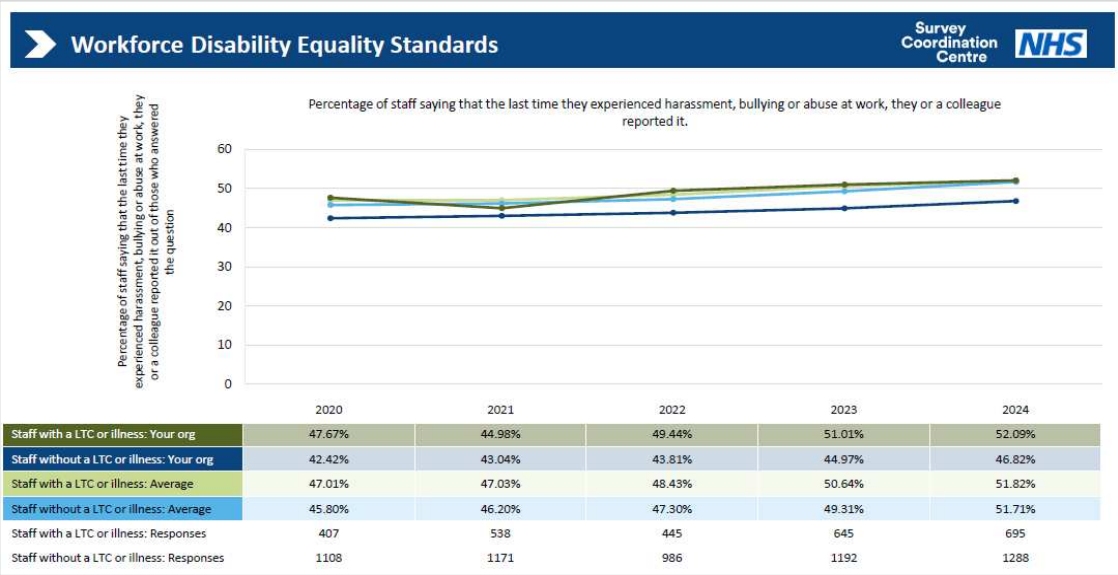


	2020	2021	2022	2023	2024
Staff with a LTC or illness: Your org	30.23%	31.87%	32.39%	31.19%	29.33%
Staff without a LTC or illness: Your org	19.03%	20.70%	22.09%	18.59%	18.45%
Staff with a LTC or illness: Average	26.89%	26.60%	26.93%	25.26%	25.24%
Staff without a LTC or illness: Average	17.79%	17.11%	17.67%	16.01%	16.22%
Staff with a LTC or illness: Responses	880	1051	880	1401	1541
Staff without a LTC or illness: Responses	3416	3270	2716	3787	3995

There has been an improvement in this indicator of 1.86%, but the gap between the experiences of colleagues with a disability/LTC and staff without is still greater than 10 percentage points. Our performance is worse than the National Staff Survey peer comparator group for all colleagues.

WDES Indicator 4b

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



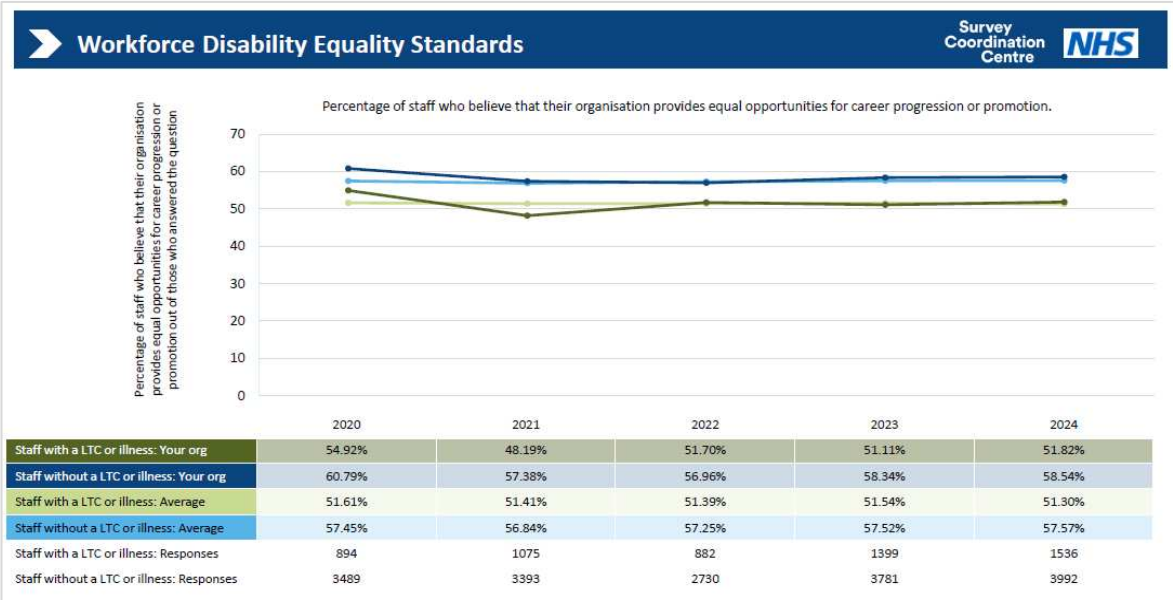
	2020	2021	2022	2023	2024
Staff with a LTC or illness: Your org	47.67%	44.98%	49.44%	51.01%	52.09%
Staff without a LTC or illness: Your org	42.42%	43.04%	43.81%	44.97%	46.82%
Staff with a LTC or illness: Average	47.01%	47.03%	48.43%	50.64%	51.82%
Staff without a LTC or illness: Average	45.80%	46.20%	47.30%	49.31%	51.71%
Staff with a LTC or illness: Responses	407	538	445	645	695
Staff without a LTC or illness: Responses	1108	1171	986	1192	1288

Positively this is our best performance since the WDES began for the percentage of colleagues with a long term condition (and those without) saying that they have reported their experience of harassment, bullying or abuse at work.

52.09% is better than our NSS peer comparator group average for colleagues with a long term condition and reflects the additional resources available from the Freedom to Speak Up service, Disability Champions and peer support from our Staff Networks.

WDES Indicator 5

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

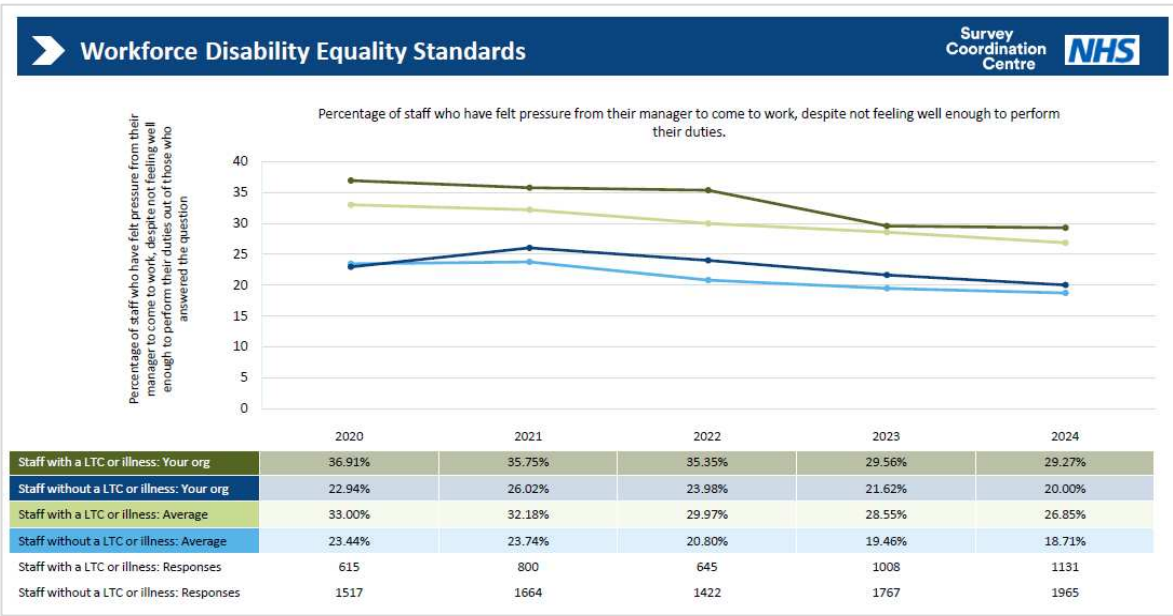


	2020	2021	2022	2023	2024
Staff with a LTC or illness: Your org	54.92%	48.19%	51.70%	51.11%	51.82%
Staff without a LTC or illness: Your org	60.79%	57.38%	56.96%	58.34%	58.54%
Staff with a LTC or illness: Average	51.61%	51.41%	51.39%	51.54%	51.30%
Staff without a LTC or illness: Average	57.45%	56.84%	57.25%	57.52%	57.57%
Staff with a LTC or illness: Responses	894	1075	882	1399	1536
Staff without a LTC or illness: Responses	3489	3393	2730	3781	3992

This indicator has improved by 0.71% and is better than our NSS peer comparator group. However the gap between colleagues with a disability/LTC and those colleagues who do not, has not seen meaningful change, a gap that is mirrored by the peer group averages.

WDES Indicator 6

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



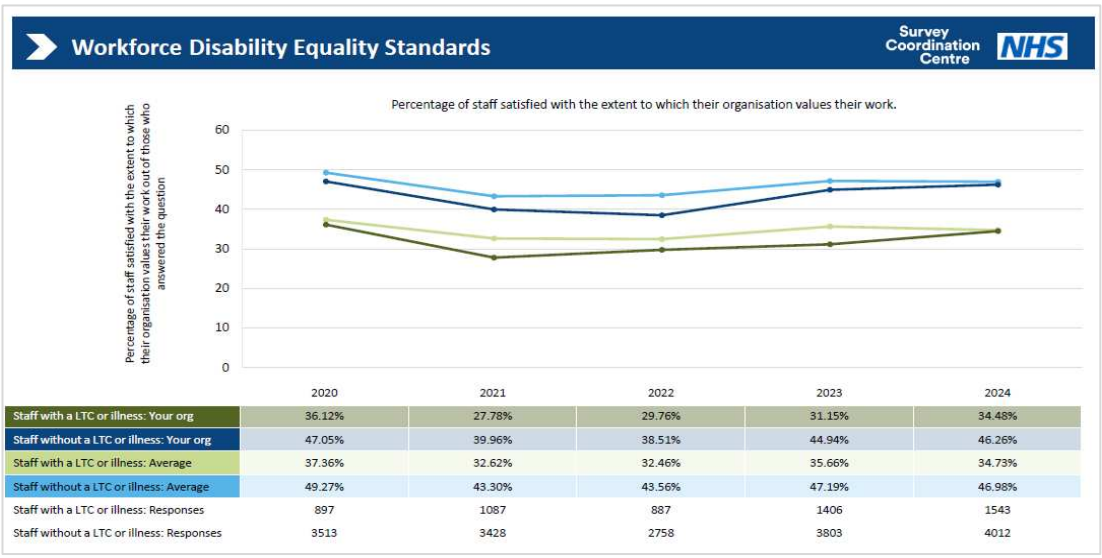
	2020	2021	2022	2023	2024
Staff with a LTC or illness: Your org	36.91%	35.75%	35.35%	29.56%	29.27%
Staff without a LTC or illness: Your org	22.94%	26.02%	23.98%	21.62%	20.00%
Staff with a LTC or illness: Average	33.00%	32.18%	29.97%	28.55%	26.85%
Staff without a LTC or illness: Average	23.44%	23.74%	20.80%	19.46%	18.71%
Staff with a LTC or illness: Responses	615	800	645	1008	1131
Staff without a LTC or illness: Responses	1517	1664	1422	1767	1965

This year's data shows continued improvement for disabled colleague experience of feeling pressure from their manager to come to work despite not feeling well enough to perform their duties (known as presenteeism). The difference between the experiences of colleagues with a long term condition compared to those who do not, has not improved at just over 9%.

The performance, which is our best ever for both colleagues with a disability/LTC and those without, is worse than the average for our NSS peer comparator group.

WDES Indicator 7

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



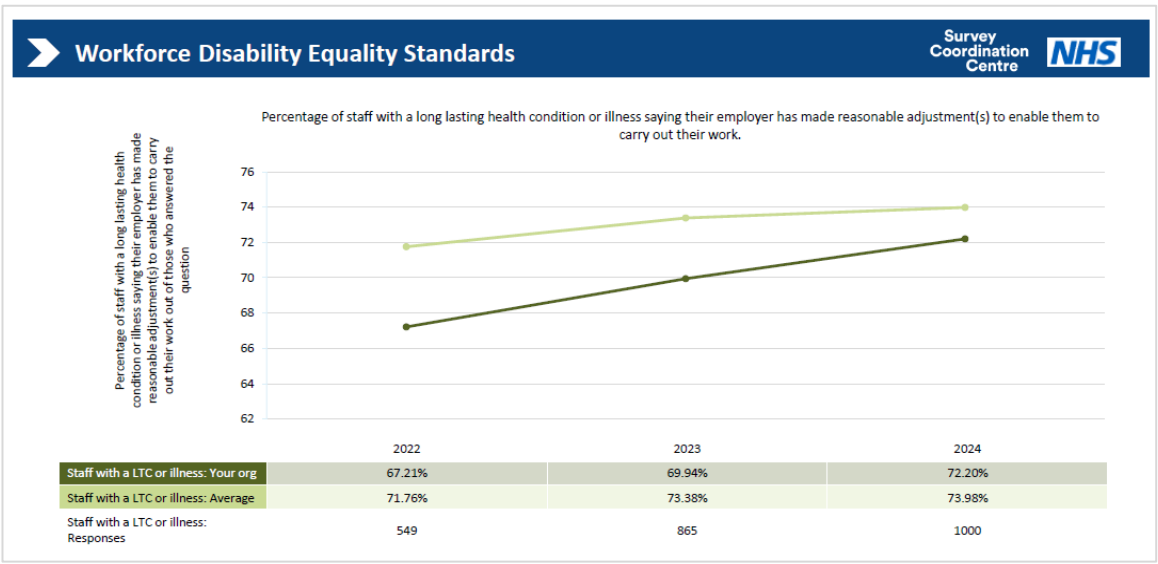
	2020	2021	2022	2023	2024
Staff with a LTC or illness: Your org	36.12%	27.78%	29.76%	31.15%	34.48%
Staff without a LTC or illness: Your org	47.05%	39.96%	38.51%	44.94%	46.26%
Staff with a LTC or illness: Average	37.36%	32.62%	32.46%	35.66%	34.73%
Staff without a LTC or illness: Average	49.27%	43.30%	43.56%	47.19%	46.98%
Staff with a LTC or illness: Responses	897	1087	887	1406	1543
Staff without a LTC or illness: Responses	3513	3428	2758	3803	4012

This indicator has improved on the previous year, and the third year of improvement for colleagues with a disability or long term condition.

Colleagues without a disability/LTC has also seen improvement and both scores are in line with our NSS comparator peer group average.

WDES Indicator 8

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



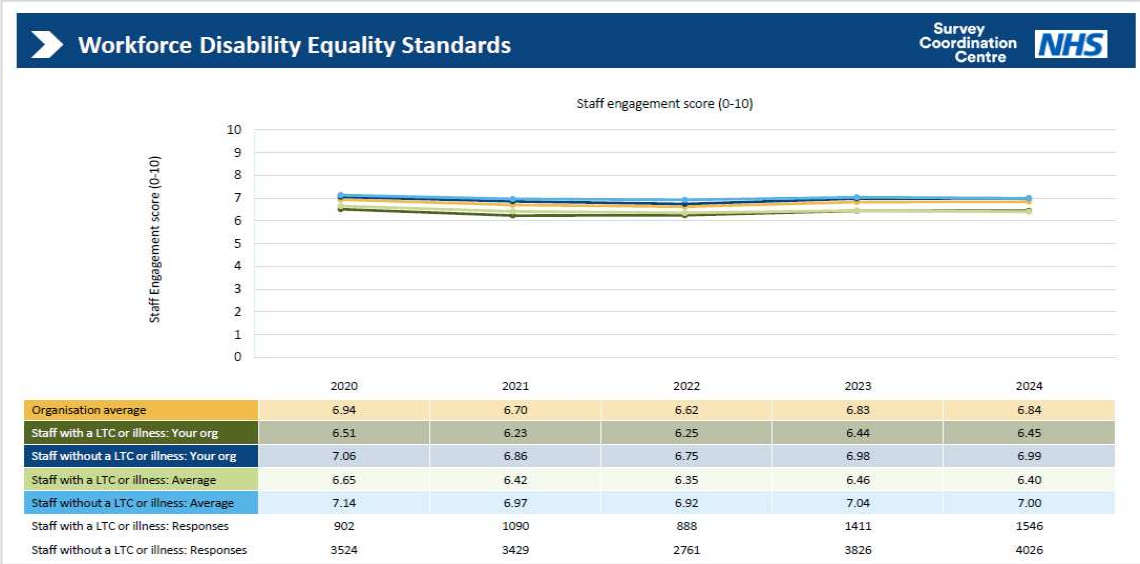
	2022	2023	2024
Staff with a LTC or illness: Your org	67.21%	69.94%	72.20%
Staff with a LTC or illness: Average	71.76%	73.38%	73.98%
Staff with a LTC or illness: Responses	549	865	1000

This metric has improved by 2.3% and the gap with peers has narrowed but remains lower than our NSS comparator group (73.98%) and the national WDES average of 74.5%.

This year's data demonstrates continued progress and it is particularly pleasing as the 2024 staff survey had a notably larger number of respondents to this question than previous national staff survey response rates.

WDES Indicator 9

Staff Engagement Score



	2020	2021	2022	2023	2024
Organisation average	6.94	6.70	6.62	6.83	6.84
Staff with a LTC or illness: Your org	6.51	6.23	6.25	6.44	6.45
Staff without a LTC or illness: Your org	7.06	6.86	6.75	6.98	6.99
Staff with a LTC or illness: Average	6.65	6.42	6.35	6.46	6.40
Staff without a LTC or illness: Average	7.14	6.97	6.92	7.04	7.00
Staff with a LTC or illness: Responses	902	1090	888	1411	1546
Staff without a LTC or illness: Responses	3524	3429	2761	3826	4026

Whist this indicator has seen improvement for all colleagues compared to the previous three years; it is better than our NSS peer comparator group for the first time for colleagues with a disability/LTC.

WDES Indicator 10

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

Disability Representation	2025
Difference Total Board: Overall Organisation	-0.47%
Difference Voting Membership: Overall Organisation	-5.73%
Difference Executive Membership: Overall Organisation	4.27%

Boards are expected to be broadly representative of their workforce. 5.3% of the UHNM board have a disability according to ESR. The national average percentage difference between boards and their overall workforce in 2024 was 0.8 and 1.9 in the midlands region

Summary and WDES Action Plan for 2025-26

The 2025 WDES metrics demonstrate continued year on year improvement in the workforce experiences of colleagues with a disability or long term condition with 9 of the 10 WDES indicators having improved on the previous year, reflecting the sustained focus we have placed on workplace adjustments and formalising these within policy and process.

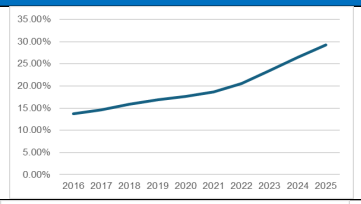
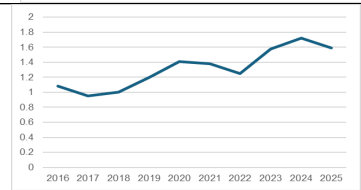
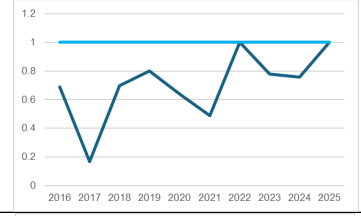
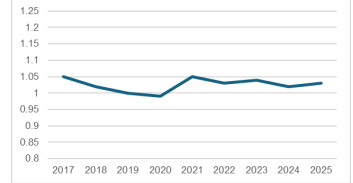
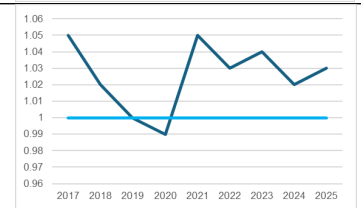
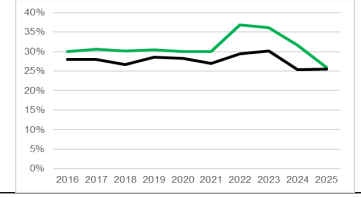
We know, from the lived experience of our staff network members the importance of positive attitudes to the provision of adjustments and employee experience and productivity. With more than one in four UHNM colleagues sharing through the national staff survey that they are working with a long term condition or illness it is essential that we close the gaps that exist in experience between colleagues and build upon the progress made in the last 12 months.

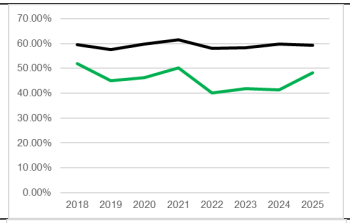
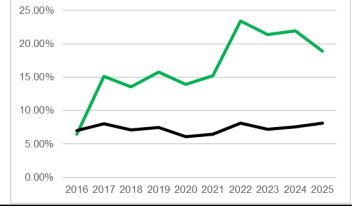
During 2025-26 we will continue to focus on workplace adjustments and neurodiversity, which is the most rapidly increasing disclosure on ESR:

	Reasonable Adjustments	Neurodiversity	Bullying, Harassment and discrimination
Actions	• High profile campaign to maintain awareness and increase understanding of the Reasonable Adjustments Policy, the Tailored Adjustments Plan and Disability Champions • Review effectiveness of the Management Essentials programme for line manager expectations relating to managing team members with a long term condition • Streamline procurement processes and speed up the purchase of equipment for colleagues	• Establish a neurodiversity sub-group to the Staff Network to provide dedicated safe space for identifying and improving the workplace experiences of colleagues and carers of individuals with a neurodifference • Enhance line manager and colleague understanding of reasonable adjustments for neurodiversity • Introduce a new guide for all colleagues on adjustments for neurodiverse colleagues	• Launch new Values and Behaviours Framework • Practical learning sessions for line managers (Having Conversations That Matter) to address behaviours that fall below those expected
Key Performance Indicator	**Metric 8** (reasonable adjustments) target 74%	**Metric 9** (staff engagement score) target 6.5	Metric 4a (experience of bullying and harassment from all sources) target of year on year reduction in the gap between colleagues with a disability/LTC and those that do not

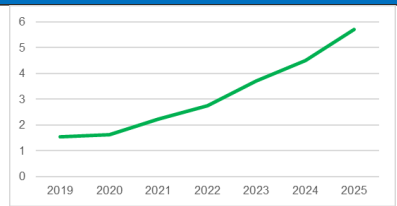
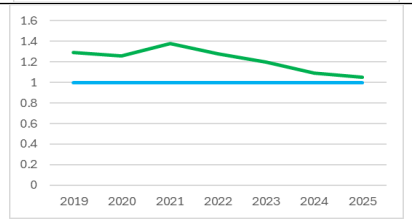
Progress will be measured by improved metric results in the 2025 Staff Survey, 2026 WDES submission and the monitoring of other relevant metrics including the Employee Voice feedback and the lived experiences of our Disability and Long Term Conditions Staff Network membership.

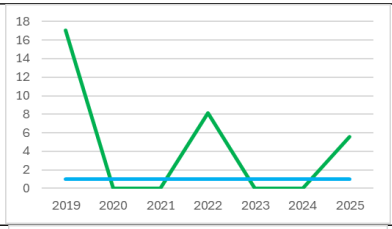
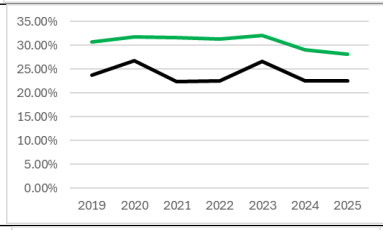
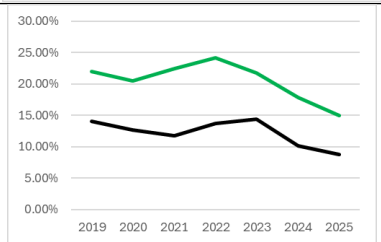
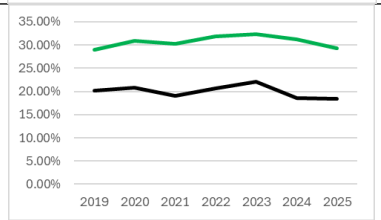
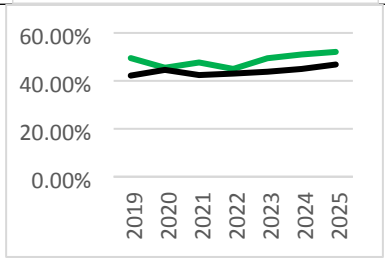
Appendix 1: Summary of WRES Indicator Trends

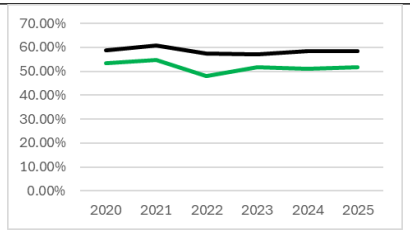
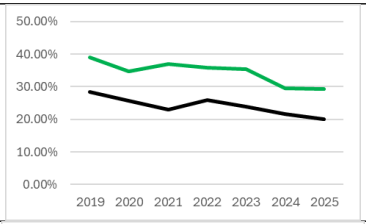
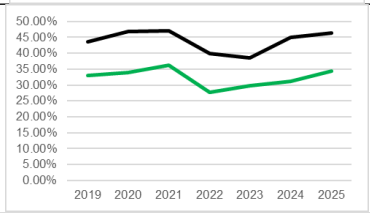
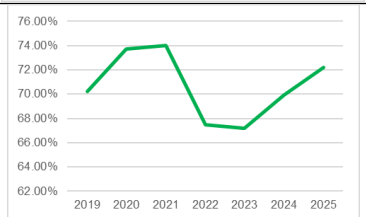
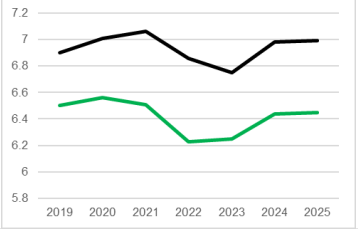
WRES Indicator			2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	
1	Percentage of Black, Asian & Minority Ethnic (BAME) colleagues within UHNM workforce		13.7%	14.6%	15.9%	16.9%	17.6%	18.6%	20.5%	23.5%	26.5%	29.2%	
2	Relative likelihood of white applicants being appointed from shortlisting compared to BAME applicants		1.08	0.95	1.0	1.20	1.41	1.38	1.25	1.58	1.72	1.59	
3	Relative likelihood of BAME staff entering formal disciplinary processes compared to white staff		0.69	0.17	0.70	0.80	0.64	0.49	1.0	0.78	0.76	1.0	
4	Relative likelihood of white staff accessing non - mandatory training/CPD compared to BAME staff		-	1.05	1.02	1.0	0.99	1.05	1.03	1.04	1.02	1.03	
5	% of staff experiencing harassment, bullying & abuse from patients, relatives and the public	BAME	35.5%	26.5%	26.7%	26.9%	29.15%	26.32%	26.20%	37.16%	29.98%	26.92%	
		White	24%	25%	25.%	24.7%	27.25%	23.73%	24.31%	26.30%	23.19%	23.38%	
6	% of staff experiencing harassment, bullying & abuse from other staff	BAME	30%	30.6%	30.2%	30.5%	30.03%	30.02%	36.80%	36.14%	31.66%	25.96%	
		White	28%	28%	26.7%	28.5%	28.26%	26.98%	29.36%	30.13%	25.39%	25.47%	

7	% of staff believing the trust provides equal opportunity for career progression/promotion	BAME			51.8%	45.0%	46.30%	50.07%	40.06%	41.82%	41.31%	48.28%	
		White			59.4%	57.5%	59.8%	61.6%	58.1%	58.4%	59.86%	59.25%	
8	% of staff personally experiencing discrimination from a manager / team leader / colleague	BAME	6.5%	15.1%	13.6%	15.8%	13.97%	15.19%	23.39%	21.44%	21.98%	18.92%	
		White	7%	8%	7.1%	7.5%	6.08%	6.44%	8.11%	7.25%	7.56%	8.17%	
9	BAME Board representation compared to overall organisation		-13.7%	-14.6%	-15.9%	-16.9%	-17.6%	-18.6%	-15%	-12.4%	-10.7%	-19%	

Appendix 2: Summary of WDES Metric Trends

WDES Indicator			2019	2020	2021	2022	2023	2024	2025	
1	Disability representation in the organisation		1.54%	1.64%	2.23%	2.76%	3.7%	4.5%	5.7%	
2	Relative likelihood of Disabled staff compared to non-disabled staff being appointed from shortlisting		1.29	1.26	1.38	1.28	1.20	1.09	1.05	

3	Relative likelihood of Disabled staff compared to non-disabled staff entering into the formal capability process		17.07	0.0	0.0	8.1	0.0	0.0	5.6	
4a	% of staff experiencing harassment, bullying or abuse from patients/service users, their relatives or the public in the last 12 months	Disabled	30.7%	31.77%	31.71%	31.37%	32.16%	29.05%	28.15%	
		Not Disabled	23.8%	26.76%	22.34%	22.58%	26.68%	22.55%	22.57%	
4b	% of staff experiencing harassment, bullying or abuse from managers in the last 12 months	Disabled	22.0%	20.49%	22.44%	24.17%	21.70%	17.80%	15.01%	
		Not Disabled	14.0%	12.63%	11.78%	13.74%	14.34%	10.11%	8.79%	
4c	% of staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months	Disabled	28.9%	30.88%	30.23%	31.87%	32.39%	31.19%	29.33%	
		Not Disabled	20.1%	20.83%	19.03%	20.70%	22.09%	18.59%	18.45%	
4d	% of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it	Disabled	49.5%	45.48%	47.67%	44.98%	49.44%	51.01%	52.09%	
		Not Disabled	42.2%	44.58%	42.42%	43.04%	43.81%	44.97%	46.82%	

5	% of staff that believe the Trust provides equal opportunities for career progression and promotion	Disabled	-	53.51%	54.92%	48.19%	51.70%	51.11%	51.82%	
		Not Disabled	-	58.76%	60.79%	57.38%	56.96%	58.34%	58.54%	
6	% of staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties	Disabled	38.9%	34.75%	36.91%	35.75%	35.35%	29.56%	29.27%	
		Not Disabled	28.3%	25.66%	22.94%	26.02%	23.98%	21.62%	20.00%	
7	% of staff satisfied with the extent to which the organisation values their work	Disabled	33.1%	33.96%	36.12%	27.78%	29.76%	31.15%	34.48%	
		Not Disabled	43.6%	46.82%	47.05%	39.96%	38.51%	44.94%	46.26%	
8	% of staff with a long lasting health condition or illness saying the organisation has made reasonable adjustments to enable them to carry out their work	Disabled	70.2%	73.7%	74.0%	67.5%	67.21%	69.94%	72.20%	
9	Staff Engagement Score	Disabled	6.5	6.56	6.51	6.23	6.25	6.44	6.45	
		Not Disabled	6.9	7.01	7.06	6.86	6.75	6.98	6.99	
10	Board disability representation		0.0	0.0	0.0	5.3%	11.1%	12.2%	5.3%	

Executive Summary

Trust Board | 8th October 2025

Equality, Diversity & Inclusion Annual Report 2024/25

University Hospitals of North Midlands NHS Trust

Purpose:	**Information**		**Approval**	✓	**Assurance**	**Agenda Item:**	18
Author:	Charlotte Lees, OD, Culture and Inclusion Business Partner/Sadaf Butt, OD Consultant						
Executive Lead:	Jane Haire, Chief People Officer / Ann Marie Riley, Chief Nurse						

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

Risk Register Mapping		
BAF 3	**Inability to improve workforce sustainability and organisational culture**	**Ext 15**

Executive Summary

Situation

University Hospitals of North Midlands NHS Trust (UHNM) continues to prioritise Equality, Diversity, and Inclusion (EDI) as a core part of its mission to deliver high-quality care, support staff, and serve its diverse communities. The Trust's EDI work is guided by national frameworks, legal requirements, and its own strategic objectives, with a focus on embedding inclusive practices, strengthening staff networks, and using data-driven approaches to identify and address disparities.

Background

- **Legal and Regulatory Context:** UHNM operates under the Equality Act 2010 and the Public Sector Equality Duty, which require the Trust to eliminate discrimination, advance equality of opportunity, and foster good relations. The Trust also adheres to national NHS EDI frameworks, including the Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES), Gender Pay Gap reporting, and others.
- **Strategic Alignment:** The Trust's new 2025–2035 strategy aims to position UHNM as a leader in health innovation, with EDI embedded in its priorities for people, patients, and population health.
- **Consultation and Engagement:** EDI delivery is shaped by ongoing engagement with staff networks, patient user groups, and community representatives, ensuring lived experience informs action.
- **Data and Monitoring:** Improved demographic data collection for both workforce and patients enables targeted interventions and effective measurement of progress

Assessment

The Trust has made notable progress in 2024/25, including:

- Enhanced patient feedback and involvement, with initiatives such as lived experience sessions and the appointment of a Patient and Public Involvement Co-ordinator.
- Improved accessibility and inclusivity in services (e.g., translated maternity leaflets, accessible eye clinic materials).
- Recognition for anti-racism work, with staff receiving national awards and the launch of a Trust-wide anti-racism statement and action plan.
- Growth and impact of staff diversity networks, including the launch of the Sunflower Hidden Disabilities Scheme and campaigns like "We're People Too."
- Targeted workforce development, with reductions in the gender pay gap, improvements in WDES and WRES metrics, and increased representation of Black, Asian, and Minority Ethnic staff in senior roles.
- Celebrations and awareness events for diverse communities, including Iftar, Pride, Disability History Month, and Black History Month.

Key Recommendations:

This report has been presented to the People, Culture and Inclusion Committee. The Trust Board is asked to approve this annual report, and for it to be placed on the organisations website. The Board is asked to take positive assurance of the ongoing work and commitment to advancing equity and inclusion at UHNM for our workforce, patients and communities.

The key recommendations arising from this report is that UHNM ensures that EDI is embedded in Organisational Strategy with the six high-impact actions of the NHS EDI Improvement Plan are fully integrated into the new UHNM Strategy and delivery plans. This includes:

- **Strengthen Leadership Accountability:** Maintain robust governance and oversight of EDI progress through Trust Management Committees and the Board, with clear KPIs and transparent reporting.
- **Enhance Data Quality and Use:** Continue efforts to improve demographic data collection and use this data to drive targeted interventions, particularly in areas of underrepresentation and pay gaps.
- **Expand Lived Experience Engagement:** Further develop mechanisms for patient, staff, and community voices to shape policy and practice, including through user groups and staff networks.
- **Address Persistent Inequities:** Focus on closing pay gaps and accessibility and outcomes for marginalised patient groups, with specific action plans and regular monitoring.
- **Promote Inclusive Culture:** Continue to invest in staff training, awareness campaigns, and support networks to foster a culture of civility, respect, and zero tolerance for discrimination or abuse.
- **Monitor and Report Progress:** Track impact through defined metrics (e.g., patient satisfaction, staff survey, WRES/WDES, pay gaps) and share progress transparently with stakeholders.

NHS
University Hospitals of North Midlands
NHS Trust

Equality, Diversity and Inclusion

Annual Report 2024-25

Introduction

At University Hospitals of North Midlands NHS Trust, our commitment to equality, diversity and inclusion (EDI) is central to the way we care for our patients, support our colleagues, and serve our communities. This annual report reflects the progress we have made over the past year in advancing equity across our workforce and services, while acknowledging the challenges that remain.

We have continued to embed inclusive practices, strengthen our staff networks, and align our efforts with national priorities such as the NHS Equality, Diversity and Inclusion Improvement Plan. Our data-driven approach—through the Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES), and the National Staff Survey—has helped us identify disparities, measure impact, and shape targeted action.

This report highlights how the voices of our patients, communities and colleagues guide our journey.

Legal Requirements

The Equality Act 2010:

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

How we show due regard to the Public Sector Equality Duty

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

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

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

- Workforce Race Equality Standard
- Workforce Disability Equality Standard
- Gender Pay Gap – published annually
- Accessible Information Standard
- Equality Delivery System (EDS)
- Disability Confident Accreditation
- NHS Health and Care LGBTQ+ Inclusion Framework
- Armed Forces Covenant

You can read these reports, which provide more in depth updates on progress against key metrics and action plans on our Equality and Diversity page on the Trust Website.

Consultation and engagement

We are committed to ensuring that our workforce and service users are involved in shaping our EDI delivery plans and have opportunity to influence and contribute through their lived experience. We do this through our employee diversity networks and patient user groups.

Equality Monitoring

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

Equality Impact Assessment

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

UHNM Strategy 2025-2035

Our new strategy guides our priorities for the next ten years. Our ambition is to be a leader in health by harnessing innovation to drive transformational change.

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

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

NHS EDI Improvement Plan

The NHS Equality, Diversity and Inclusion (EDI) Improvement Plan sets out a clear framework to create a more inclusive, compassionate, and fair health and care system. Focused on six high-impact actions, the plan aims to tackle discrimination, close equity gaps, and embed inclusive leadership across the NHS. It emphasises accountability, transparency, and the importance of lived experience in shaping change—the plan is a call to action for every NHS organisation to make meaningful progress on EDI as a core part of delivering high-quality care.

This year, NHS England Midlands awarded a 'good progress' rating for our progress against all six of the high impact actions.

How we delivered on our EDI Priorities in 2024/25

2024/25 is the last year of our current EDI delivery plan, which will be refreshed with our new UHNM Strategy for 2025-2035. Our priorities reflect our commitments to creating a more equitable working environment for colleagues and delivering patient services more inclusively. The priorities are:

1. Inclusive Patient Feedback - listen to and act on the lived experiences of our patients
2. Inclusive Patient Access - address inequalities in access to services
3. Inclusive Patient Involvement – involving our communities in service design
4. Listen to, Understand and Learn from the experience of all staff
5. Respect and value all colleagues and their contribution and have a strategic focus on civility and respect
6. Develop a culture of inclusive and compassionate leadership - build, strengthen and develop initiatives focused on staff experience, wellbeing and engagement and culture and leadership development
7. Ensure that people are recruited, trained and promoted according to their abilities and in the proportions one would expect for the populations represented

Progress against each of the EDI Priorities continues to be monitored through our governance structures, with oversight by the Trust Management Committees and Trust Board.

Our Patients and Communities

In this section, we present information about our patient services and is a small reflection of the extensive work we are doing to ensure that our services and patient experience is inclusive and equitable.

Lived Experience Champion helps UHNM leaders see hospital services through the eyes of wheelchair users

Senior leaders took part in a lived experience session, led by Lived Experience Champion, Lewis Bunn. Using an electric wheelchair to navigate the Royal Stoke hospital site to better understand accessibility challenges.

The session has led to improvements being implemented including new dropped curbs and more sessions are planned with the support of lived experience champions.

Patient and Public Involvement & Engagement Co-ordinator

Madeleine Roche is our newly appointed Patient and Public Involvement and Engagement Co-ordinator. This new role will lead on establishing a patient and carer council.

Maddie says “my role is to strengthen how we involve patients, carers and the public in shaping and improving our services. I want to make sure their input is meaningful and leads to real, positive change. A key focus for me is reaching out to diverse communities and those who may be less heard, so that everyone’s voice has a place in shaping the care we provide”

Maternity and Neonates Inclusivity Visit

The visit focused on reviewing language, imagery, and the accessibility of information within the maternity and neonatal services. A walkaround was followed by a group discussion, which has informed a report highlighting areas of celebration as well as opportunities for improvement. Featured in the visit were community groups and spiritual care services.

Maternity Services create translated welcome leaflets

Welcome leaflets in maternity services have been translated into 10 languages, created to support better communication with patients from diverse backgrounds and ensure all families feel informed and welcomed from the outset of their care journey.

Improving access for patients using the eye clinic

Following recommendations from a patient experience visit, the font size of text on outpatient tickets for patients attending the eye clinic have been made larger with positive feedback on the change received from service users.

UHNM nurses awarded prestigious national anti-racism award

Two nurses were awarded the prestigious anti-racism award by the Royal College of Nursing (RCN) Foundation in February 2025. Jokotade Adeshina, a Quality Nurse on the Frail Elderly Assessment Unit (FEAU) and Tenifayo Adeyemo, a Lead Research Practitioner in UHNM's Research and Innovation Department, have won the Michelle Cox RCN Foundation Anti-Racism Award.

The award recognises their project, 'Advancing Equality in Nursing: A Continuous Monitoring and Evaluation Initiative,' which looks to promote and ensure equal and inclusive career progression and workplace diversity within NHS nursing and midwifery. Jokotade and Tenifayo will now work with the RCN Foundation on their project over the next 18 months.

Jokotade said: "The project aims to address the inequalities in career progression for Black, Asian, and Minority Ethnic (BAME) nurses and midwives within the NHS. Despite their significant contributions to healthcare, BAME nurses and midwives often face barriers that hinder their career advancement, leading to a lack of diversity in leadership roles"

"By addressing these issues, we hope to create a more inclusive healthcare workforce, improving both the professional experiences of BAME staff and the quality of care delivered to patients from all backgrounds."

Nursing, Midwifery and Allied Health Professional workforce benefit from a lead inclusion educator

This role focuses on embedding equity and inclusion into workforce development and patient care, working closely with clinical teams on areas such as health inequalities, promoting anti-racism, increasing accessibility and supporting inclusive recruitment.

Health Information Week – health literacy and misinformation

During Health Information Week, we focused on raising awareness of health literacy and tackling misinformation. Colleagues were introduced to the concept of health literacy and the impact it has on patient outcomes, colleague wellbeing and NHS resources. The sessions highlighted the challenges that low health literacy can create and explored the practical strategies to improve communication, especially between staff and patients. The initiative is designed to support more informed, inclusive and effective healthcare delivery.

Trans inclusive hospital care resource

A new resource has been introduced from TransActual to help hospital staff provide culturally competent and inclusive care for trans patients.

Based on recent research into the experiences of trans individuals in healthcare settings, this guide offers practical advice to improve patient interactions, reduce barriers, and foster respectful, person-centred care. This resource supports our ongoing commitment to equality and inclusive practice across UHNM.

EDI Midwife awarded Rising Star honour

UHNM's first Midwife dedicated to equality, diversity & inclusion scooped the rising star award for her innovation and effective initiatives. Keelie Grindley joined UHNM in November 2024 with the aim of improving outcomes for those from marginalised groups and communities

The role includes ensuring fair treatment and equal opportunity is available for the maternity workforce at UHNM while making the environment accessible and inclusive for both patients and staff.

"A large amount of my work is to improve outcomes for global majority women and birthing people because the data over the last five years has shown us that they are massively at risk of morbidity and mortality in maternity in the UK compared to white women. My role is to look to close these gaps regionally, by developing equitable and accessible services and developing education for the maternity workforce.

Due to her work and advocacy for equality within maternity services, Keelie was nominated for the Rising Star Award at the Black Maternal Health Awards UK which celebrates excellence across maternal healthcare. Together, they recognise outstanding contributions in care quality and access, maternal mental health, policy change, education and empowerment, and community support networks.

Patient story

Compassionate and inclusive maternity care

Sophie Jebb Bowman, 32, from Burslem, shared her heartfelt story of exceptional maternity care provided by UHNM community midwife Sharon Seadon. Sophie, who lives with autism and mental health challenges gave birth to her son Harvey and described Sharon as her “absolute hero” and praised her for the understanding and support she offered throughout pregnancy and after Harvey’s birth. “I was very fortunate to have such a committed, caring, supportive midwife. Sharon was so understanding of my mental health needs and my autism.

Each appointment she was always so thorough, professional, and committed to mine and Harvey’s welfare.” Recognising Sophie’s individual needs, Sharon tailored her care with sensitivity and flexibility. She scheduled appointments around Sophie’s routine and her husband’s work schedule, ensuring continuity and emotional support.

Sharon identified signs of high blood pressure and ensured Sophie was admitted to the Maternity Assessment Unit. Sophie went on to deliver Harvey early due to pre-eclampsia—a potentially life-threatening condition. “Sharon essentially saved mine and baby’s life by identifying the pre-eclampsia,” Sophie shared. “She reassured me when I was apprehensive about going into hospital. Her calm, kind manner helped me stay focused and feel safe.” Following Harvey’s birth, Sharon continued her care, checking in with Sophie and ensuring she received support with breastfeeding—a journey that might otherwise have ended prematurely.

Reflecting on her experience, Sophie said: “Her wisdom, expertise, and caring nature really helped me and my baby. When she came to do my discharge, I was so emotional, in a good way. She had such a positive influence in our journey. She is a massive credit to the NHS.

UHNM Inclusion Awards

National Inclusion Week 2024 saw our first UHNM Inclusion Awards, an opportunity to showcase and celebrate the amazing work that individuals and teams across UHNM are doing to enhance equality and inclusion for patients and colleagues. Dozens of nominations were submitted for the Service User and Employee Inclusion Awards.

The Gold award was awarded to the Colposcopy Service for their work on tackling health inequalities by encouraging attendance at appointments. The project involved identifying referrals from marginalised groups and making contact in advance to ensure any adjustments and support are in place, this has included extended appointment times, adapted wristbands and playing music to accommodate sensory needs, hoists and easy read information amongst others. Feedback has been very positive and appointment DNA rates have reduced.

The Employee Inclusion Gold Award went to the Emergency Department Wellbeing Team, who listened to colleagues about what could make things better and as a result a fully functioning breastfeeding room within the department is open to any UHNM colleague and is equipped with a milk fridge, breastfeeding chair, lockable door, leaflets, breast pads and a mirror.

The department also supported colleagues observing the holy month of Ramadan. With the challenges of delivering quality patient care in a very busy environment like the emergency department, it can be difficult for practicing Muslims to honour Ramadan while on duty. The wellbeing team recognised the importance of prayer and fasting and also the specific timings involved with Iftar and Suhoor which can be impacted by working shift patterns.

In response a space was identified in the department and prayer mats, head coverings, chilled bottled water and dates for breaking fast, provided.

Feedback has been very positive, and one colleague said, “I feel as a department they strive to make the working environment a better place for all and it is shown in the little things they do and provide.”

The awards proved to be so successful, that a new equality, diversity and inclusion award category has been added to the Trusts Night Full of Stars 2025, which is our annual staff awards event.

Our People

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

Commitment to anti-racism

We are taking our commitment to anti-racism seriously, working towards an environment where all colleagues, patients and visitors , from all backgrounds can thrive, free from discrimination. We introduced a new Anti-racism Statement, which sets out in clear terms the trust’s commitment to becoming an ‘antiracist organisation’.

We are focusing, with the support of our Ethnic Diversity Staff Network to identify racism and bias in policy, process and culture. A Race Equality Task and Finish Group is leading this change through innovative actions informed by the lived experiences of our people and learning from best practice.

The three priorities that the group is targeting are:

Debiasing recruitment & selection processes	**Improving equity in career development /promotion**	**Tackling harassment, bullying and abuse**

The Task and Finish Group continues to meet monthly and will monitor progress of the implementation phase of the recommendations.

Sexual Safety

UHNM was an early adopter of the NHS Sexual Safety Charter. We commit to a zero-tolerance approach to any unwanted, inappropriate and/or harmful sexual behaviours towards our workforce. We commit to the 10 standards of the charter:

01 Working to eradicate sexual harassment and abuse in the workplace

02 Promoting a culture that fosters openness and transparency

03 Taking an intersectional approach to the sexual safety of our workforce

04 Providing support for those who experience unwanted or inappropriate sexual behaviours

05 Clearly communicate standards of behaviour

06 Ensuring appropriate, specific, and clear policies are in place

07 Ensuring appropriate, specific, and clear training is in place

08 Ensuring appropriate reporting mechanisms are in place for those experiencing these behaviours

09 Taking all reports seriously and appropriate and timely action will be taken in all cases

10 Capturing and sharing data on prevalence and staff experience transparently

We have been working with specialist sexual safety specialists Lime Culture and developed an action plan that covers training, specialist support and policy, progress is monitored through a Sexual Safety Steering Committee.

UHNM Diversity Staff Networks

Our Employee Diversity Networks continue to grow and develop. Each Network has a chair with protected time, and the support of an Executive Sponsor, whose role is to ensure the voice of the networks is heard and acted upon at Board level. The Networks identify priority areas of focus and work in partnership with the organisation in the shaping and delivery of initiatives to improve colleague experiences based on their lived experiences. This section showcases some of the initiatives the Networks have supported this year.

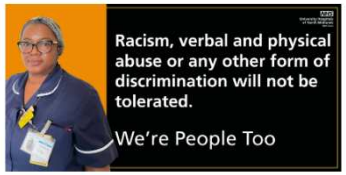
Launch of the Sunflower Hidden Disabilities Scheme

We were delighted to launch the Sunflower Hidden Disabilities Scheme during Disability History Month in December. Wearing a sunflower lanyard, or badge is a simple and discreet way to indicate that the wearer has a hidden disability and may need additional support.

We have also increased the number of Disability Champions to over 30. Disability Champions are UHNM colleagues and members of the Trust's Disability Network who are passionate about supporting people with disabilities and long term health conditions. Champions have undertaken specialist disability training and can provide confidential peer support to colleagues and new starters.

‘We're People Too’ Campaign

‘We’re People Too’ is a new campaign, developed in collaboration with our Staff Networks showing messages from UHNM colleagues who have experienced some form of physical or verbal abuse while at work. The campaign is aimed at raising awareness and reinforcing a zero-tolerance approach to all forms of abuse towards UHNM staff, including physical, verbal, racial, and disruptive behaviour.



Men’s and Women’s Health Groups

Our women’s health group was set up in September 2024, to provide a safe and supportive space to discuss and improve women’s health and wellbeing in the workplace. The group focuses on breaking the stigma and raising awareness of women’s health topics and has held drop in sessions, webinars and podcasts on subjects such as menstrual health, menopause and pelvic floor health.

The men’s health group continues its focus to raise awareness on key issues impacting on men’s health and wellbeing. Topics have included a suicide awareness workshop, sessions on alcohol abuse and healthy work-life balance.

A resource library of podcasts is available, with recorded conversations with specialists and colleagues with lived experience covering topics such as prostate health, fatherhood, baby loss and post-natal depression in men.

Seventh Cohort of Project SEARCH Graduates

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

The initiative, which is in partnership with Sodexo and Newfriars College has helped more than 30 young people with disabilities to find paid employment since it began. The graduates from our seventh cohort have worked in areas including the hospital restaurant, housekeeping and Royal Stoke’s older adult’s ward.

LGBTQ+ Inclusion Awareness

Working in partnership with Project 93, the LGBTQ+ Staff Network has co-created transgender awareness all colleagues, in addition to collaborating rks across Staffordshire and Stoke on Trent in creating a LGBTQ+ Toolkit.

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

Workforce Race Equality Standard

Our workforce ethnicity data shows consistent increases in Black, Asian and Minority ethnic representation, increasing to 29.2% at 31st March 2025.

This year's set of WRES metrics demonstrate progress in advancing racial equality at UHNM, including notable reductions in reports of harassment, bullying and abuse and improved confidence among colleagues regarding fair opportunities for career progression and promotion. There have been improvements in the race disparity ratio (which measures career progression rates) and a significant increase in ethnically diverse colleagues in senior roles, particularly at Band 8A. These gains reflect early impact from the Race Equality Task and Finish Group's focus.

Of the nine WRES indicators, six have improved, two are stable within acceptable range, and one has declined – this being a widening gap in board representation compared to the overall organisation.

Our WRES, WDES and Gender Pay Gap Reports can be read in full, together with the actions plans on our Trust Website. For 2025/26 we will begin formally reporting an ethnicity and disability pay gap.

Workforce Disability Equality Standard

The 2025 WDES results show continued year-on-year improvement in the experiences of colleagues with disabilities or long-term conditions, with 9 out of 10 metrics improving. This reflects UHNM's sustained focus on workplace adjustments and embedding inclusive practices into policy and practice.

Whilst 5.7% of colleagues have shared their disability status on the ESR system, nearly 28% of respondents to the 2024 National Staff Survey stated that they were working with a physical or mental health condition expected to last 12 months or longer.

During 2024-25, our Disability Staff Network self assessed the organisation and we gained Disability Confident Employer status, recognising the improvement in disabled colleague experiences.

Gender Pay Gap

The 2024-25 Gender Pay Gap shows continued improvement. There has been a 1.2% reduction in the median pay gap to 8% and a 1.3% reduction in the mean pay gap to 24.6%.

The main factor in our gender pay gap is that there is a higher proportion of males in higher pay quartile roles. Females represent 76% of the UHNM workforce and yet represent only 64% of the upper pay quartile. Men represent 24% of the workforce but are over-represented in the upper pay quartile at 36%.

Events that celebrate our diverse workforce and communities

We produce a cultural calendar every year to mark important events that celebrate our diverse community and workforce, the following are some of the activities held during 2024-2025

Iftar Celebration

Over 150 colleagues from across UHNM came together at a free Iftar gathering to mark the holy month of Ramadan. The event was supported by UHNM Charity and Sodexo and is the second year we have held the event. Colleagues attended with family members and friends to share in prayer and break their fast with a communal meal.

Mental Health Awareness Week

We marked the theme of movement – moving more for our mental health by encouraging colleagues to build movement into their working day with simple and accessible ways such as walking and stretching. The campaign promoted inclusive approaches to physical activity and how it helps reduce stress, improve focus, enhance sleep and support overall mental wellbeing.

Race Equality Week

February's National Race Equality Week was an opportunity for the organisation, supported by the Ethnic Diversity Network to mark a meaningful step toward building an inclusive and equitable workplace.

Centred around the theme 'every action counts' the week served as a powerful reminder that individual actions, no matter how small, can collectively drive significant change.

Pride Month

Pride month was celebrated with a range of drop in sessions and awareness, and UHNM was present as always at Stoke on Trent Pride, along with other NHS providers in Staffordshire and Stoke on Trent, we highlighted the work we have been doing in achieving our responsibilities of the NHS Health and Care LGBTQ+ Inclusion Framework.

Disability History Month

UHNM joined our Integrated Care System partners in a Disability History Month event, where best practice, colleague stories and an empowering session on self advocacy featured.

Diwali

As part of Diwali celebrations, we embraced the theme Tamasoma Jyothirgamaya – 'from darkness, lead us to light,' and the focus on coming together as one team, fostering unity, inclusivity and shared joy.

Armed Forces Week

A series of events were held to mark Armed Forces Week recognising and celebrating the contributions of our armed forces communities.

Drop in sessions, wellbeing events and an armed forces breakfast event, with British Legion and local armed forces charities and networks joining UHNM in marking the week.

South Asian Heritage Month

South Asian colleagues make a significant contribution to the NHS and at UHNM and we celebrated the stories that contribute to the vibrant south Asian community, and to honour the impact of South Asian heritage.

Black History Month

The theme for Black History Month was Reclaiming Narratives, recognising and correcting the stories of Black history and culture. A number of awareness events and activities were held throughout October including drop in sessions for colleagues to pledge their commitment to race equality and wear a see ME first badge. The Ethnic Diversity Network led a range of 'in conversation' events exploring themes such as personal branding and barriers to speaking up. Delicious BHM themed menus were on offer in our hospital restaurants.

International Women's Day

UHNMs Women's Network celebrated International Women's Day on 8th March with engaging events to empower women, this included the creation of a vibrant textile banner symbolising strength, diversity and unity, a poem that captured the words of colleagues to the question – what do women want in their professional and personal lives? A 'Bake Off' competition and an informative financial wellbeing for women online seminar were also held.

Looking forward: Our priorities for the year ahead

This report outlines the progress made across UHNM in 2024–25 and sets the direction for the year ahead. Anchored in our new UHNM Strategy, we are focused on delivering measurable impact for our patients, our population, and our people through our delivery plans (overleaf).

Our commitment to the six high-impact actions of the NHS Equality, Diversity and Inclusion Improvement Plan will be embedded within our organisational priorities for 2025–26.

Progress will be driven through robust delivery plans and tracked against defined KPIs, including patient satisfaction, the National Staff Survey, WRES and WDES and Equality Delivery System outcomes, and equity metrics such as gender, ethnicity, and disability pay gaps.

We will continue to centre the voices of our patients, staff, and communities—through our Hospital User Group, Patient Leaders, and Staff Networks—to ensure that lived experience informs the actions we take to eliminate discrimination, bias, and inequity. This work is fundamental to meeting our Public Sector Equality Duty and to building a truly inclusive organisation.

Our Population plan

We will improve the health of our population and reduce inequality.

What we will do:	How we will do it:
We will tackle inequalities in access, experience and outcomes	Consistently collect the data needed to identify and understand health inequalities. Implementing the national CORE20PLUS5 framework to reduce health inequalities Using population health data to reduce infant mortality, cardiovascular disease, respiratory disease, cancer, liver disease and improve vaccination uptake.
We will empower staff and patients to improve their health and wellbeing	Use our 'making every contact count' approach to introduce prevention as core business. Targeted programmes for tobacco, alcohol and obesity. Establish our hospitals as Smoke Free healthy campuses. Develop personalised care to prevent complications for those living with major conditions.
As a major employer we will use our resource to improve the overall health of our population	Develop our pathways into employment for local people. Listening to involve communities in decisions and learning from those exposed to social and health inequality. Make best use of our estate and resources to improve local communities.

Appendices

- Service User and Workforce Demographic Report

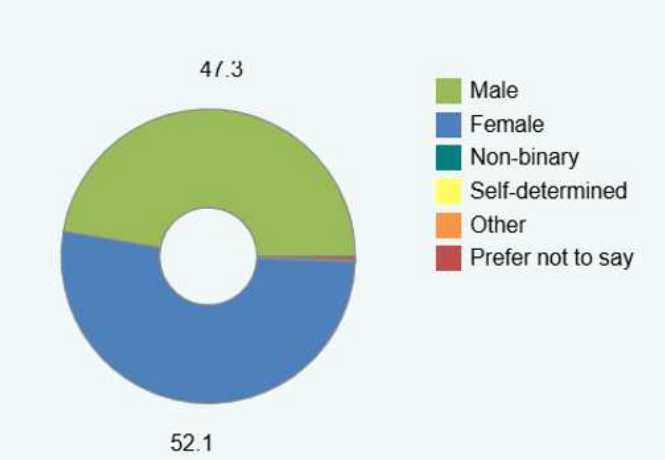
Contact:

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

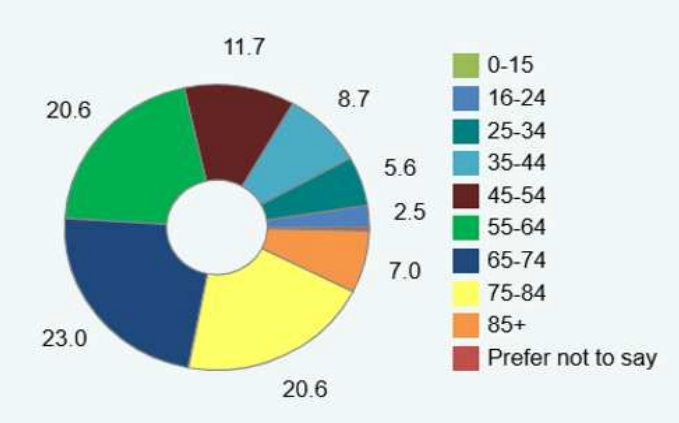
Appendices – Patient and Workforce Profile (as at 31st March 2025)

Patient Profile

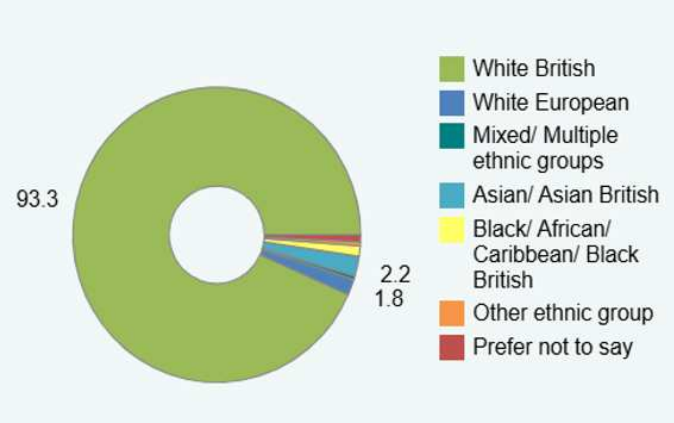
Gender:



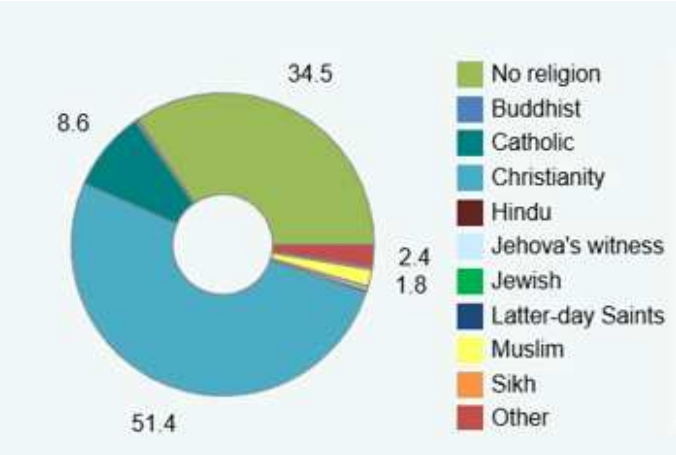
Age:



Ethnic Group:

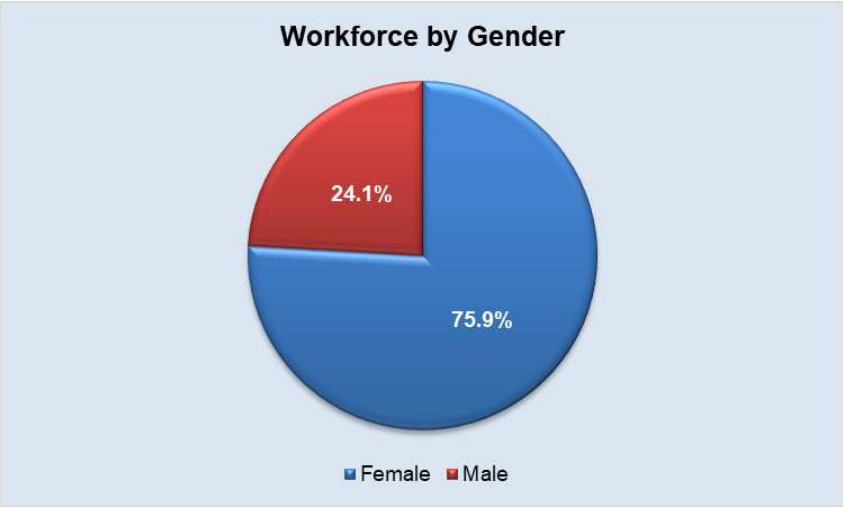


Religion/Belief:



Workforce Profile

Gender:



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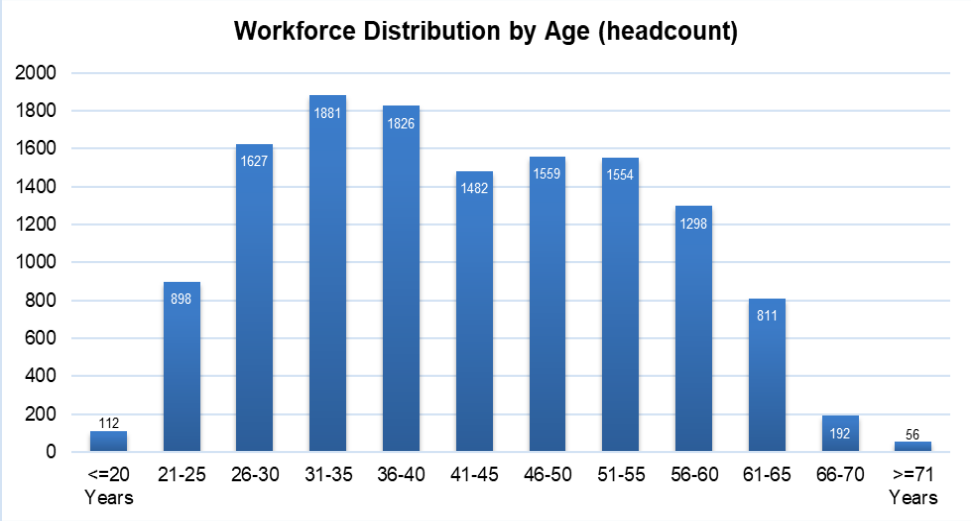
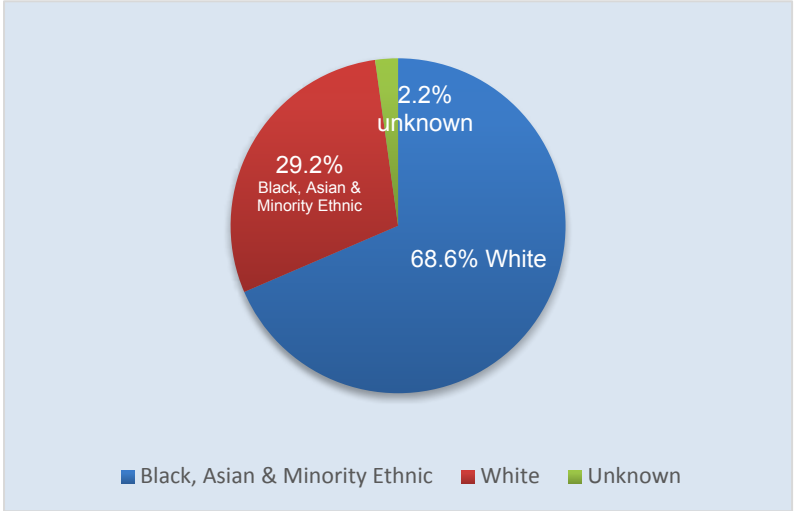
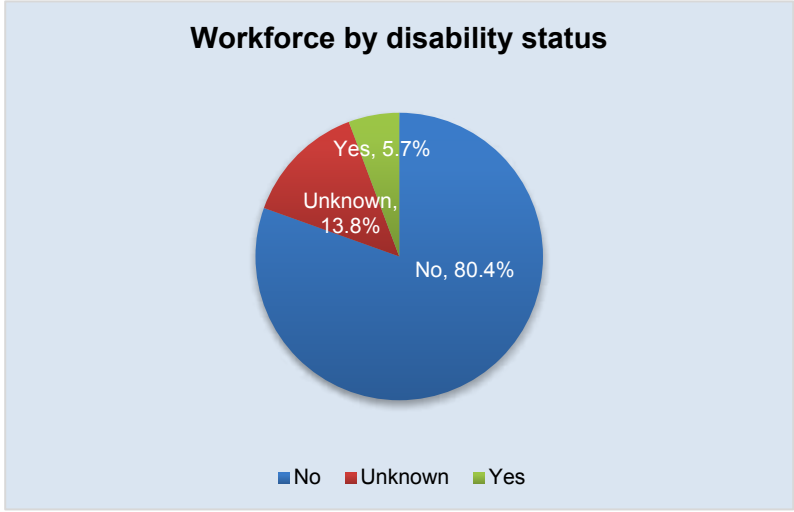


Ethnic Group:

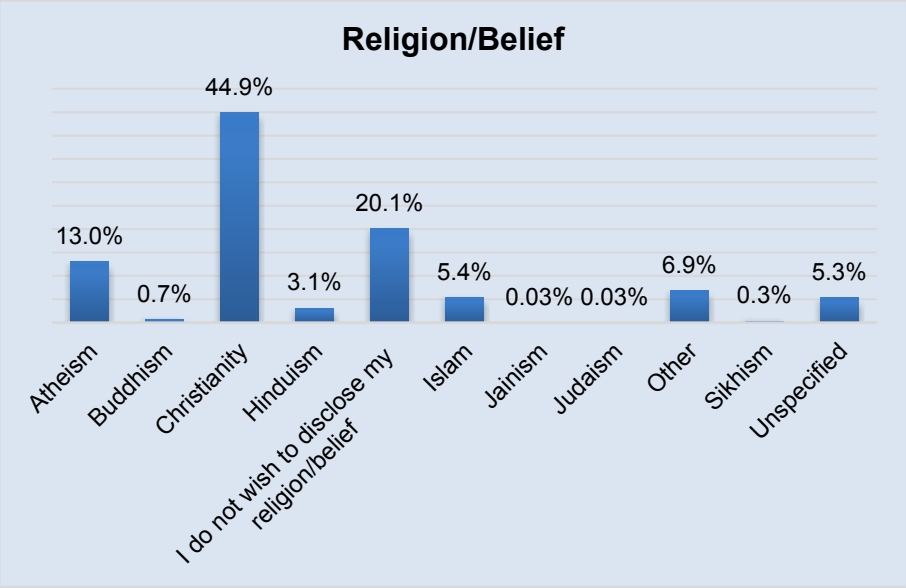


Disability:

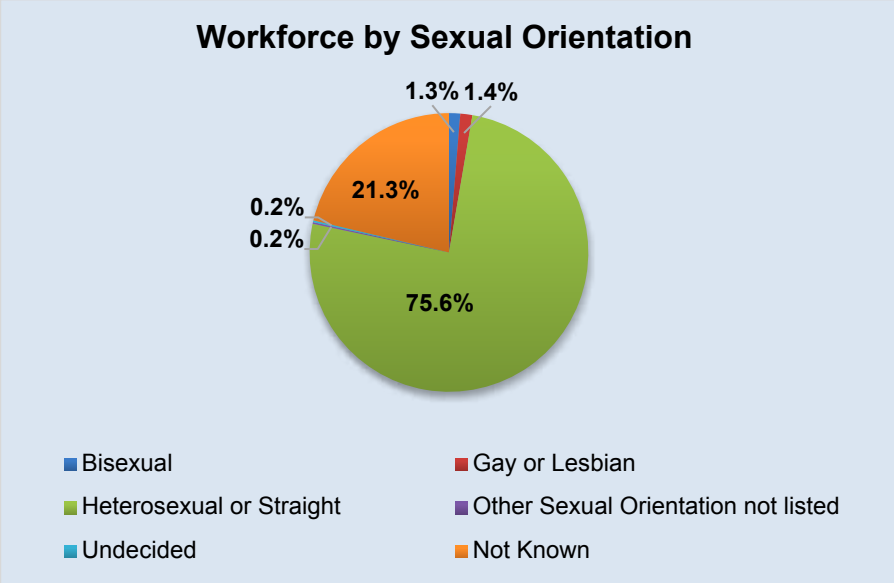


Disability Category (ESR)	%
Long-standing illness	32.4%
Learning disability/difficulty	19.8%
Other	12.9%
Mental Health Condition	11.6%
Yes (unspecified)	9.0%
Sensory Impairment	7.4%
Physical Impairment	6.8%

Religion / Belief:



Sexual Orientation:



Highlight Report

QUALITY, ACCESS & OUTCOMES COMMITTEE | 31st July 2025

University Hospitals of North Midlands NHS Trust

Matters of Concern / Key Risks to Escalate	Major Actions Commissioned / Work Underway
• The Committee were concerned regarding **operational performance** for June given the Trust did not achieve its improvement trajectory for 4 hour and 12 hour Emergency Department performance, despite fewer attendances, and ambulance handover times, which reflected ongoing variation in practice. As such, partial assurance was confirmed • The **Infection Prevention BAF** for quarter 1 highlighted 4 outstanding actions although it was noted that the launch of the cleaning manual had been completed. As such, partial assurance was agreed • The annual **mortality** assurance report provided partial assurance to the Committee, with particular attention drawn to the increase in mortality indices and the ongoing work required to address the clinical coding issues. It was agreed to provide the annual report to the Trust Board for assurance. • The update on **regulation 28** (prevention of future deaths) provided partial assurance, with the main actions focussing on improving processes between the legal services and quality, safety and compliance teams in addition to addressing any gaps arising from the difference in reports provided to the coroner, as a result of using the PSIRF methodology. • Quarter 4 **Patient Experience** report highlighted one complaint being upheld by the Parliamentary Health Service Ombudsman (PHSO) and 2 being partially upheld in the quarter. The Committee welcomed the increase in representation on the Hospital User Group and noted the increase in Patient Advice and Liaison Service (PALS) interactions whilst complaints rates had remained stable, reflecting the input provided by the PALS team. The Committee concluded with a rating of partial assurance	• Cross committee consideration from the Finance and Business Performance Committee regarding additional potential gaps in **staffing**, to be discussed with the Chief Nurse prior to an update being provided to the Committee • Format of the **Board Assurance Framework** (BAF) to continue to be refined, including clarifying which actions to be taken will lead to a reduction in the risk score towards target for BAF 1. In addition, the assurance provided to the Committee in relation to health inequalities/ population health was to be strengthened • To consider the way in which the quality improvement project into **lower limb wound pathway** could be publicised more widely • Quarterly update on **chaperoning**, including the outcome of interim audits, to be provided • To further strengthen the reporting on **waiting list inequalities** to ensure this provided adequate assurance to the Committee such as highlighting key areas of focus and accompanying narrative to highlight the actions being taken • The strategic plan for **patient experience** to be reviewed in light of revised guidance • To explore the additional ways in which **maternity patient feedback** could be obtained i.e. from health visitors
Positive Assurances to Provide	**Decisions Made**
• An update was provided in terms of the **waiting list** and ethnicity which demonstrated that the Trust had a positive reporting rate on recording ethnicity. In addition, levels of deprivation at specialty level had been reviewed which had identified some specialties which required further consideration as to the reasons for differences. When considering the waiting list data for ethnicity this did not identify any particular hot spots • Acceptable assurance was provided by the **infection prevention** annual report, with the 6.1% reduction in c-difficile infections particularly of note. In addition, the Committee noted the actions being taken to improve c-difficile at County Hospital, in addition to continuing to address the challenges with gram-negative bacteraemia's. The introduction of regular 6 monthly bed cleans were also commended • The **Patient Safety Incident Response Framework** (PSIRF) update highlighted 2 incidents reported as new patient safety incidents investigations (PSIIs) in quarter 1. In the same period, 24 cases had been considered by the Risk Management Panel and there had been no never events, with continuing actions taking place to consider learning from thematic reviews. The Committee concluded with a rating of acceptable assurance for this item.	• The Committee approved the **Quality and Outcomes Group Terms of Reference** • The Committee approved the **Chaperoning Policy**

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

Summary Agenda

No.	Agenda Item	BAF Mapping			Purpose	No.	Agenda Item	BAF Mapping			Purpose
		BAF No.	Risk	Assurance				BAF No.	Risk	Assurance	
1.	Board Assurance Framework Q1 2025/26	1	Ext 16	N/A	Approval	7.	Infection Prevention Board Assurance Framework Q1 2025/26	1	Ext 16	Partial	Assurance
2.	Executive Quality & Outcomes Group Assurance Report (23/7/25) • Terms of Reference	1	Ext 16	Not Rated N/A	Assurance Approval	8.	Patient Safety Incident Investigation Report Q1 2025/26	1	Ext 16	Acceptable	Assurance
3.	Chaperone Policy	-	-	N/A	Approval	9.	Annual Mortality Assurance Report 2024/25 (Revised)	1	ID36869	Partial	Assurance
4.	Access Performance Report Month 3, 25/26 • Executive Recovery Oversight Group Highlight Report (21/7/25) • SSoT ICB Waiting Inequalities List Report	1 2	Ext 16 High 10	Partial	Assurance	10.	Regulation 28 Update	1	Ext 16	Partial	Assurance
5.	System Winter Review	1	Ext 16	Not rated	Assurance	11.	Patient Experience Report Q4 2024/25	1	Ext 16	Partial	Assurance
6.	Infection Prevention, Vaccination and Sepsis Team Annual Report 2024/25	1	Ext 16	Acceptable	Assurance	12.	Quality Performance Report – Month 3 2025/26	1	Ext 16	Acceptable	Information

Highlight Report

QUALITY, ACCESS & OUTCOMES COMMITTEE | 28 August 2025

University Hospitals of North Midlands NHS Trust

Matters of Concern / Key Risks to Escalate

- Medical representation at the **Quality and Outcomes Group**; being addressed through the organisational restructure with Care Groups.
- Two deep dives underway within theatres and speech and language therapy (SLT), both of which will require improvements to be made – **Partial Assurance** rating assigned to the **Quality Report** as a result.
- Targets not met for duty of candour, falls with harm, pressure ulcers VTE assessments, medication incidents with moderate harm, single sex accommodation breaches, family and friends test, HSMR.
- **Partial Assurance** for **Infection Prevention and Control**, due to 4 MRSA bacteraemia being reported and clostridium difficile being above the upper limit for in quarter 1. Several actions were outlined.
- **Partial Assurance** for **Care Excellence Framework** due to there being wards with bronze and silver outcomes. However, the process itself was rated separately.
- **Partial Assurance** for **access** performance as challenges remain although there are some positive improvements being seen.
- **Partial Assurance** for **104+ day breach analysis** due to some concerns regarding engagement in the process which is to be explored further and reported back
- Drawing on key learning including from the rapid review – the main area of concern in relation to maternity services is in relation to culture, or 'transgressive behaviours'. A **maternity** culture programme is in place.

Major Actions Commissioned / Work Underway

- **Flu** Vaccination campaign in the planning stage, major change will be that only the Flu vaccination will be offered. Consideration to be given to the communications having a particular focus on carers.
- Plans underway to further develop the **Care Excellence Framework** to draw on other sources of assurance.
- Significant work underway through the **organisational restructure** and **UEC recovery programme.**
- **Electronic Prescribing and Medicines Administration** now due to go live.
- Enhanced reporting on **maternity sepsis** to be considered for future reports as well as the impact of learning from reviews.

Board Safety Champions are supporting their perinatal leadership team to better understand and craft local cultures, including identifying and escalating safety and quality concerns and offering support where required, this includes:

- *Meeting with the Perinatal Leadership Team and the MNVP a minimum of bi-monthly (a minimum of 3 in a reporting period) and that any support required of the Trust Board has been identified and is being implemented*
- *The Trust Board (or appropriate delegated Committee) demonstrates that progress with the maternity and neonatal culture improvement plan is being monitored, and any identified support being considered and implemented – this is achieved with the presentation and review of the Cultural Improvement Plan for Maternity and Neonatal Services*

Positive Assurances to Provide

- Posts to support **Clinical Effectiveness** within each of the Care Groups are being introduced as part of the organisational restructure.
- 100% **sepsis** screening compliance of clinical inpatient areas during June, as well as 100% for antibiotics within the hour.
- **Significant Assurance** received in relation to **Sepsis** in Children's Services, following the audit findings presented.
- **Significant Assurance** agreed in relation to the **Care Excellence Framework** process.
- **Acceptable Assurance** agreed in relation the **Maternity Dashboard** for quarter 1 with positive progress being reported, including a strong position within the regional heat map.
- **Significant Assurance** agreed for **Perinatal Mortality Review Tool** process, which demonstrated 100% compliance and exceeded the associated CNST target of 50% external reviews with performance at 90% - however, **Acceptable Assurance** was agreed in relation to outcomes.
- **Acceptable Assurance** agreed in relation to the **Maternity & Neonatal Workforce Plan**, with recent recruitment success being highlighted. **Acceptable Assurance** also identified for the **Maternity PSIRF** investigation report due to the processes in place to review and identify learning.

Decisions Made

- Approval of Terms of Reference and Membership for the **Executive Maternity & Neonatal Quality & Safety Oversight Report**

Comments on the Effectiveness of the Meeting	Cross Committee Considerations
• Large volume of material from Neonates / Maternity; views sought on the appropriateness of reinstating a separate meeting	No matters for other Committees.

Summary Agenda

No.	Agenda Item	BAF Mapping			Purpose	No.	Agenda Item	BAF Mapping			Purpose
		BAF No.	Risk	Assurance				BAF No.	Risk	Assurance	
1.	Executive Quality & Outcomes Group	1	Ext 16	n/a	Assurance	8.	Maternity Dashboard Q1 2025/26	1	Ext 16	Acceptable	Assurance
2.	Infection Prevention HAI Report Q1 2025/26	1	Ext 16	Partial	Assurance	9.	Perinatal Mortality Report Tool Q1 2025/26	1	Ext 16	Significant	Assurance
3.	Sepsis in Children's Services	1	Ext 16	Significant	Assurance	10.	NHS England Rapid Independent Investigation into Maternity and Neonatal Services	1	Ext 16	n/a	Information
4.	Care Excellence Framework (CEF) Summary / Staffing Report Q4 2024/25 and Q1 2025/26	1	Ext 16	Partial	Assurance	11.	Maternity & Neonatal Cultural Improvement Plan 2025 – 2027	1	Ext 16	Significant	Assurance
5.	Access Performance Report Month 4 2025/26	1	Ext 16	Partial	Assurance	12.	Maternity & Neonatal Workforce Annual Plan 2025	1	Ext 16	Acceptable	Assurance
6.	104+ Day Breach Analysis Q4 2024/25	1	Ext 16	Partial	Assurance	13.	Maternity and Neonatal PSIRF Investigation Report Q1 2025/26	1	Ext 16	Acceptable	Assurance
7.	Executive Maternity Quality & Safety Oversight Group Highlight Report / Terms of Reference	1	Ext 16	n/a	Approval						

Highlight Report

QUALITY, ACCESS & OUTCOMES COMMITTEE | 1st October 2025

University Hospitals of North Midlands NHS Trust

Matters of Concern / Key Risks to Escalate

- **Non-elective** performance demonstrated a slight deterioration in all 4 hour, 12 hour and ambulance handover metrics, partly due to early onset of winter pressures, increased attendances and the transition to a continuous flow model.
- In terms of **elective and cancer** pathways, there had been improvements in the faster diagnostic standard and 31 day metrics, although 62 day performance had been affected by a specific issue with the skin pathway, although the Trust had partnered with Medinet to support treating this backlog.
- It was noted that **DM01 performance** remained challenged due to non-obstetric ultrasound although recruitment to sonography posts was underway
- There continued to be challenges with **52 and 65 week wait** patients, particularly within ophthalmology and ear, nose and throat due to national workforce shortages and supply issues. However national support was being secured for corneal transplants to help address the long waits within ophthalmology.
- The Committee noted that the Trust had been notified by NHS England of the potential requirement to report patients waiting over 4 hours in a **temporary escalation space** although this had yet to be confirmed
- Progress with the **patient waiting list backlog** review process had stalled in terms of a digital solution due to issues with capacity which was raised with the committee for awareness
- Quarter 1 **mortality** update highlighted that mortality indices continued to be higher than expected although monthly reports for April and May 2025 demonstrated a reduction towards expected ranges. Crude mortality and in hospital deaths also remained consistent with previous months

Major Actions Commissioned / Work Underway

- Detail to be provided to the Committee in relation to the work undertaken to assess the **surgical site infection outliers** within spinal and cranial surgery following presentation to the Executive Quality and Outcomes Group
- Work remains ongoing to improve and standardise the **Quality Impact Assessment** process, aligning with the ICB model in addition to expanding this to cover inequalities
- **Emergency Care Intensive Support Team** (ECIST) support to be provided for medical portals, ward standard working and site team management
- Further assurance to be provided in relation to **104+ day cancer breach** reviews
- **Patient and public involvement and engagement group** to be brought into conversations regarding capital developments earlier, in order for them to be able to contribute to the design of spaces, as issues had been identified whereby the group had not been able to influence the spaces within the breast unit and hand centre
- Work was being undertaken to compare the difference between **PALS** and **complaints** responses, due to the spike in PALS cases transferring to formal complaints
- Further update on **coding** to be considered at November's meeting to include the historic issues and their implications (including benchmarking) and the actions being taken to address this and prevent recurrence
- To provide an update to a future meeting in relation to the new early warning system for **neonatal deaths and stillbirths** and the actions being taken in response

Positive Assurances to Provide

- Update provided in terms of the **Stay in the Bay** initiative, and an initial test of change which took place in April 2025. This highlighted a positive change in culture, and a reduction in patient harms and falls for the first time in 12 months which had since been sustained. However, it was recognised that there was a need to better understand the financial impact particularly avoidable costs and resource utilisation
- Alert from Neonatology that the **National Neonatal Audit Programme** (NNAP) for 2024 (to be published shortly) will highlight that the Trust was an outlier for Bronchopulmonary Dysplasia (BPD) which related to babies under 32 weeks. The Trust had already instigated changes which have resulted in improvements to the unpublished figures for the first 2 quarters of 2025, lower than others within the network. It was noted that all individual cases had been reviewed with nothing of note identified. It was noted that the national figures were due to be published on 9th October, and it was agreed to discuss the findings with the Trust Board at the meeting in December.
- Quarter 1 **Patient Experience** Report saw a 28% increase in the number of formal complaints, partly due to an increase in from PALS, with values and behaviours being the main theme
- **Safeguarding Children Annual Report** highlighted an 8% increase in safeguarding referrals from the previous year. The team had also contributed to 9 rapid reviews with learning used to improve local guidance and training. It was highlighted that the focus for 2025/26 was the roll out of the NHS safeguarding assurance framework. Whilst initial issues had been identified on the completion of child protection – information sharing (CP-IS) checks, this had improved since the process had been digitised and standardised with ED although this was subject to monthly re-audit to assess whether there had been sustained improvement

Decisions Made

- No decisions were required to be made

Comments on the Effectiveness of the Meeting	Cross Committee Considerations
• The meeting was not quorate although it was agreed to go head in advance due to no significant decisions needing to be made. It was agreed that assurance ratings not made given only 1 Non-Executive Director was in attendance. • The Committee view was that it was right to have gone ahead with the meeting as opposed to cancelling it, but that the discussion felt the loss of input from other Non-Executive Directors	• It was noted that the original trajectory for access targets had not yet changed to reflect the delays associated with the Urgent Treatment Centre, as discussions remained ongoing in terms of mitigating some of the impact, via discussion with NHS England and Tier 1

Summary Agenda

No.	Agenda Item	BAF Mapping			Purpose	No.	Agenda Item	BAF Mapping			Purpose
		BAF No.	Risk	Assurance				BAF No.	Risk	Assurance	
1.	Stay in the Bay	1	Ext 16	Not Assessed	Assurance	7.	National Neonatal Audit Programme (NNAP) Outlier for Bronchopulmonary Dysplasia (BPD) for 2024 Assurance	1	Ext 16	Not Assessed	Assurance
2.	Executive Quality & Outcomes Group Highlight Report (24-09-25)	1	Ext 16	Not Assessed	Assurance	8.	Patient Experience Report Q1 25/26	1	Ext 16	Not Assessed	Assurance
3.	Improving Quality Impact Assessments at UHNM	1	Ext 16	Not Applicable	Information	9.	Mortality Assurance Report Q1 25/26	1	Ext 16	Not Assessed	Assurance
4.	Access Performance Report Month 5 25/26 Executive Recovery Oversight Group Highlight Report (22-09-25)	1	Ext 16	Not Assessed	Assurance	10.	Safeguarding Children Annual Report	1	Ext 16	Not Assessed	Assurance
5.	Patient Waiting List Backlog	1	Ext 16	Not Applicable	Information	11.	Quality Performance Report – Month 5 2025/26	1	Ext 16	Not Applicable	Information
6.	104+ Day Breach Analysis Q4 24/25	1	Ext 16	Not Assessed	Assurance						

NHS
University Hospitals of North Midlands
NHS Trust

Integrated Performance Report

Month 05 Performance

2025/26

Kind Excellent Together

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.

NHS 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			Q1 2025/26 3	NOF Score	Provider value	
Average metric score			Q1 2025/26 2.47	NOF Score	Provider value	
Unadjusted segment			Q1 2025/26 3	NOF Score	Provider value	
Financial override	Q1 2025/26	No	Yes	Yes	Provider median	
Is the organisation in the Recovery Support Programme?	Q1 2025/26	No	No	No	Provider median	

Domain Scores	Data period	Provider value		Chart
Access to services domain segment	Q1 2025/26	3	NOF Score	
Access to services domain score	Q1 2025/26	2.55	NOF Score	
Effectiveness and experience of care domain segment	Q1 2025/26	2	NOF Score	
Effectiveness and experience of care domain score	Q1 2025/26	2.17	NOF Score	
Patient safety domain segment	Q1 2025/26	3	NOF Score	
Patient safety domain score	Q1 2025/26	2.63	NOF Score	
People and workforce domain segment	Q1 2025/26	2	NOF Score	
People and workforce domain score	Q1 2025/26	2.53	NOF Score	
Finance and productivity domain segment	Q1 2025/26	3	NOF Score	
Finance and productivity domain score	Q1 2025/26	2.36	NOF Score	

UHNM is placed in segment 3 and is positioned in the middle of this segment.
UHNM demonstrates a balanced performance across the NOF domains, with all domain scores within the mid range point nationally.

Kind Excellent Together

Assurance Grid

University Hospitals of North Midlands NHS Trust

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

VARIATION	ASSURANCE: Pass	Hit and Miss	Fail	No Target
Special Cause - Improvement		Patient falls with harm per 1000 bed days Sepsis - ED Portals IVAB Sepsis - Maternity Screening RTT Performance - <18 Weeks (Aged <18) RTT Performance - % Waiting 1st Contact (Aged <18)	RTT Performance - <18 Weeks RTT Performance - % 52+ Weeks RTT Performance - % Waiting 1st Contact RTT Performance - % 52+ Weeks (Aged <18)	
Common Cause	Induction of Labour Maternity Triage Sepsis - Adult Inpatient IVAB UEC 4 Hour Performance (Aged <18) Sickness Absence (R12M)	Patient Safety Incidents rate per 1000 bed days Patient Safety Incidents with moderate harm and above per 1000 bed days Medication Incidents % with moderate harm or above Patient Safety Incident Investigation (PSII's) instigated Never Events per month Pressure ulcers developed under UHNM per 1000 bed days Family & Friends Test - Inpatient Family & Friends Test - Maternity Sepsis - Adult Inpatient Screening Sepsis - ED Portals Screening Sepsis - Childrens Screening Over 12 hours in ED Ambulance Handover Average Time Cancer 28 Day FDS Cancer 31 Day Combined	Family & Friends Test - ED Single Sex Breaches UEC 4 Hour Performance Over 12 hours in ED (Aged <18) Cancer 62 Day Combined Appraisal (PDR)	
Special Cause - Concern		Medication Incidents per 1000 bed days Staff Turnover (R12M) Staff Vacancy Rate Agency Utilisation	Diagnostics DM01 Performance Employee Engagement	

NOF - Effectiveness and Experience

University Hospitals of North Midlands NHS Trust

Effectiveness and experience of care	Data period	Provider value		Chart
Effectiveness and experience of care domain score	Q1 2025/26	2.17	NOF Score	

Patient experience	Data period	Provider value		Chart
CQC inpatient survey satisfaction rate score	Q1 2025/26	2	NOF Score	
Summary Hospital-level Mortality Indicator score	Q1 2025/26	3	NOF Score	

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			Q1 2025/26 1.5	NOF Score	Provider value	
Average number of days from discharge ready date to actual discharge date (including zero days)	Jun 2025	0.4	0.7	0.7	Provider median	

UHNM performs well, with scores that reflect strong clinical outcomes and positive patient experience, resulting in a mid range position nationally. SHMI performance has deteriorated to the 9th worst performing nationally. The deterioration is not due to any increase in the number of recorded deaths or crude mortality but is owing to a drop in clinical coding of non elective spells causing the calculated risk of death to be artificially low for these patients.

NOF - Patient Safety

University Hospitals of North Midlands NHS Trust

Pateint Safety Domain Score	Data period	Provider value		Chart
Patient safety domain score	Q1 2025/26	2.63	NOF Score	

Patient safety	Data period	Provider value	Peer average	National value	National value method	Chart
NHS Staff Survey - raising concerns sub-score score			Q1 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 infections score			Q1 2025/26 3.81	NOF Score	Provider value	
Number of MRSA infections (12 months)	To Jun 2025	9.00	4.00	3.00	Provider median	
Rate of C-Difficile infections score			Q1 2025/26 2.85	NOF Score	Provider value	
Rate of C-Difficile infections (12 months)	To Jun 2025	1.22	1.19	1.22	Provider median	
Rate of E-Coli infections score			Q1 2025/26 1	NOF Score	Provider value	
Rate of E-Coli infections (12 months)	To Jun 2025	0.99	1.12	1.16	Provider median	

UHNM demonstrates a good and consistent performance across the Patient Safety domain, positioning itself favourably compared to other Acute Trusts nationally. While UHNM performs well overall, there remains opportunities for further improvement in the infection rates. Both MRSA and CDiff have seen a deterioration since April 2025, with MRSA being significantly below peer and national level.

Quality & Access | Overview

University Hospitals of North Midlands NHS Trust

Overview from the Chief Nurse and Chief Medical Officer

How are we doing against our trajectories and expected standards?

We continue to see continual improvements across a range of metrics and the NMAHP workforce remains stable. We have 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. A quality and staffing report is scrutinised by the Quality, Access & Outcomes Committee on a quarterly basis with key updates provided to Board via the committee highlight report.

We have met the required targets across a range of metrics. Where possible national benchmarking using PublicView 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 failed to meet the required target for DOC verbal and written, falls with harm, pressure ulcers developed at UHNM, VTE assessments, medication incidents with moderate harm, single sex accommodation breaches, FFT in ED and maternity, and HSMR. There is one new never events to report.

There have been 4 Calls for Concern (Martha's Rule) during July 2025 and 1 of these triggered review. Following further review there was no change in the original clinical treatment. The other 3 were related to non clinical issues including a patient raising concern as wanted further opioid prescription . The patients were recorded as White British ethnicity, no issues re language needs identified or learning disabilities.

Two dep dive reviews are currently under way –one relating to a range of issues in theatres at Stoke and the other relating to SLT performance. Early indications are that there are significant improvements required in both areas.

There are two deep dives in progress relating to RSUH theatres and the SLT service, both of which will require improvements so the current performance is at the level of limited assurance

What is driving this?

Single sex breaches were all in critical care and caused by an inability to transfer patients to wards due to capacity constraints. There are no reported concerns re privacy and dignity for any of these breaches.

HSMR performance continues to be higher than expected and has been discussed previously at the Committee continues and further assurance / mitigation has been requested.

There has been continued poor performance in relation to VTE assessments due to poor recording of date and time of the assessment.

The increase in rate of moderate harm PSIs due to increased reporting of procedures being rescheduled following introduction of new sedation guidelines within Endoscopy.

Two deep dive reviews are currently under way –one relating to a range of issues in theatres (this includes infection prevention concerns) at Stoke and the other relating to SLT performance in relation to timeliness to complete swallow assessments. Early indications are that there are significant improvements required in both areas. A summary of both reviews will be presented to the committee once completed.

Quality & Access | Overview

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?

Our work continues with all services across the Trust in our education and implementation of the National PSIRF methodologies and principles for incident responses and learning. A single harm free care action plan that will incorporate learning for fall, pressure damage and hospital acquired infection is in development and will be presented to QAOG for sign off and will then be applicable for all relevant wards/depts.

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

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

EPMA project continues –with scheduled implementation 2nd September 2025.

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

Pilot at County to trail decaffeinated drinks as standard – we will monitor impact and patient feedback and report this to the committee once the pilot is completed

Nutrition and Hydration Summit to take place before the end of Q3, with improvement actions being fed back to QAOG and the committee

What can we expect in future reports?

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

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

We will present learning from the deep dives for RSUH theatres, the swallow assessment performance for the SLT service and the Nutrition and Hydration Summit.

Whilst we have not witnessed increases in crude mortality similar to the HSMR and SHMI indices, since April 2025 the previously recorded AEC activity as inpatient admissions on Careflow to being recorded in the ED module. This means that these patients were, prior top April 2025, recorded as admissions/spell but will no longer be coded by the clinical coding team. Crude mortality will be impacted as around 1,300 spell per month will be removed from the denominator This will begin to impact SHMI and HSMR as there will be lower activity recorded as inpatient activity

Quality & Access | Dashboard

Provide safe, effective and caring services

University Hospitals of North Midlands NHS Trust

Metric	Target	Previous	Latest	Variation	Assurance	R12M Trend
Induction of Labour	95.0%	98.7%	98.6%			
Maternity Triage	85.0%	87.0%	87.0%			
Patient Safety Incidents rate per 1000 bed days	50.7	54.5	46.3			
Patient Safety Incidents with moderate harm and above per 1000 bed days	0.6	1.1	0.6			
Patient falls with harm per 1000 bed days	1.5	1.8	1.7			
Medication Incidents per 1000 bed days	6.0	5.3	4.8			
Medication Incidents % with moderate harm or above	0.50%	2.08%	1.97%			
Patient Safety Incident Investigation (PSII's) instigated	0.0	3.0	0.0			
Never Events per month	0.0	1.0	0.0			
Pressure ulcers developed under UHNM per 1000 bed days	1.6	1.7	0.9			
Family & Friends Test - Inpatient	95.0%	97.0%	96.0%			
Family & Friends Test - ED	85.0%	77.0%	76.0%			
Family & Friends Test - Maternity	95.0%	80.0%	86.0%			
Sepsis - Adult Inpatient Screening	90.0%	96.0%	100.0%			
Sepsis - Adult Inpatient IVAB	90.0%	97.0%	100.0%			
Sepsis - ED Portals Screening	90.0%	92.0%	100.0%			
Sepsis - ED Portals IVAB	90.0%	83.0%	90.0%			
Sepsis - Childrens Screening	90.0%	100.0%	98.0%			
Sepsis - Childrens IVAB	90.0%	91.0%	100.0%			
Sepsis - Maternity Screening	90.0%	83.0%	100.0%			
Sepsis - Maternity IVAB	90.0%	100.0%	100.0%			
Single Sex Breaches	0.0	128.0	91.0			

Related Strategy and Board Assurance Framework (BAF)

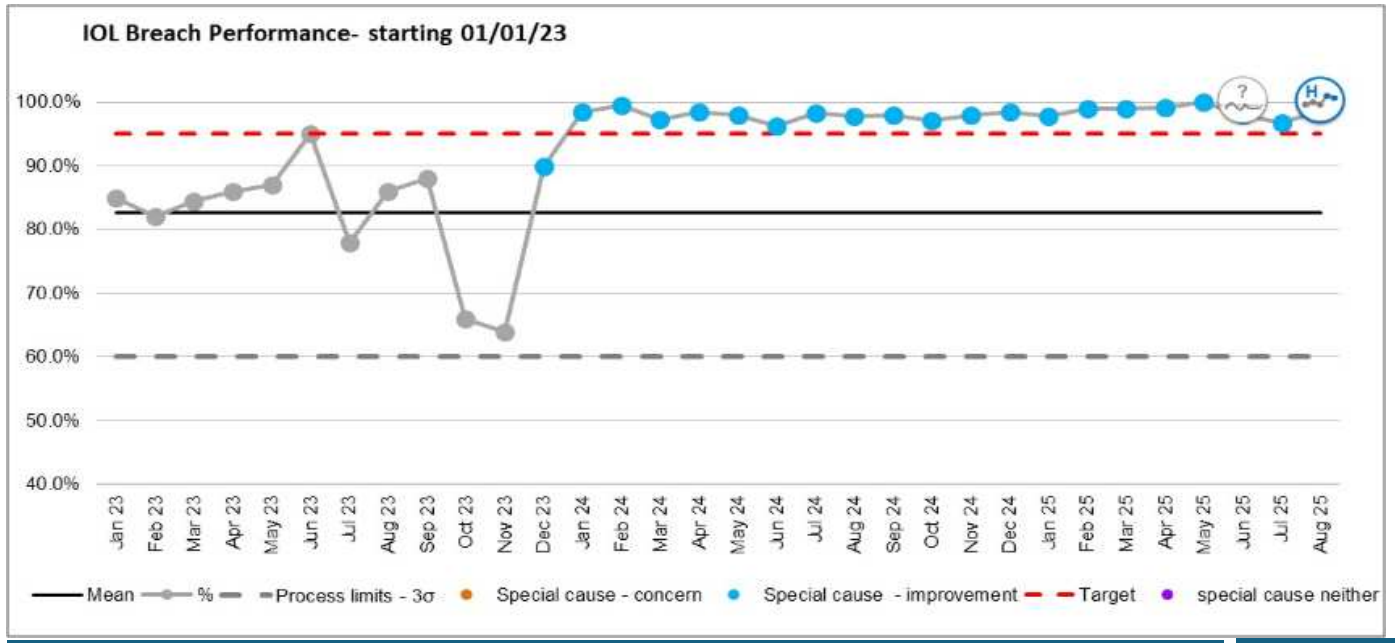
Quality Strategy

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

Quality & Access | [Induction of Labour]

Provide safe, effective and caring services

University Hospitals of North Midlands NHS Trust



What is the data telling us?

The target of 95% for timely admission of women for induction of labour has been consistently achieved since January 2024, with August being 98.6%

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

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

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

Consultant lead for IOL supports multi disciplinary working.

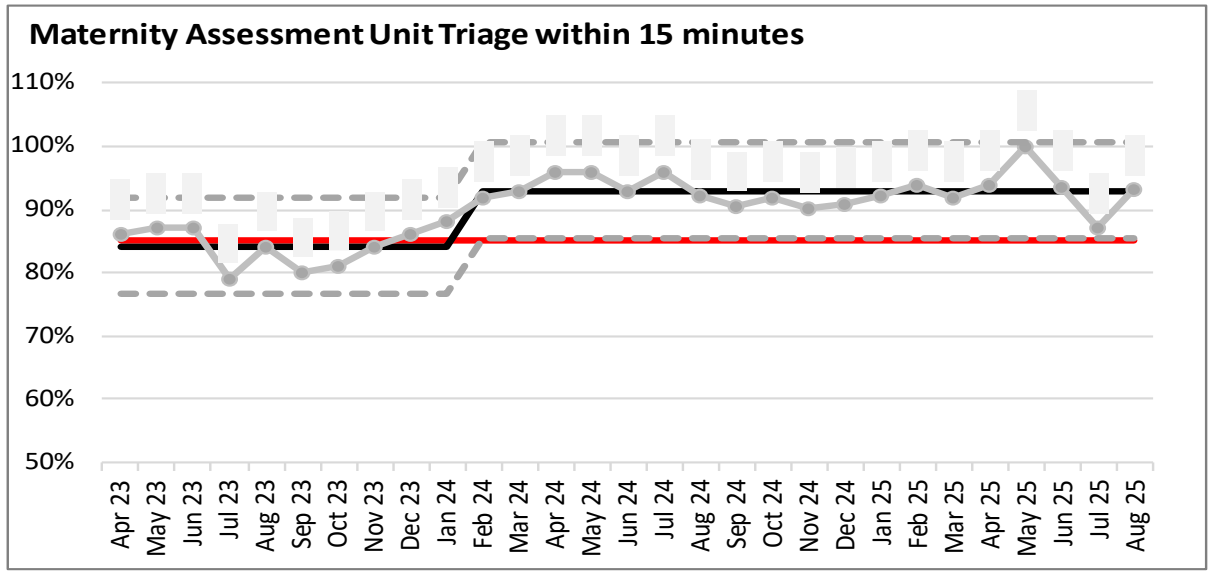
What are we doing about it?

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

Quality & Access | [Maternity Triage]

Provide safe, effective and caring services

University Hospitals of North Midlands NHS Trust



What is the data telling us?

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

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

August 1937 admissions, 87% compliance of patients seen within 15 mins.

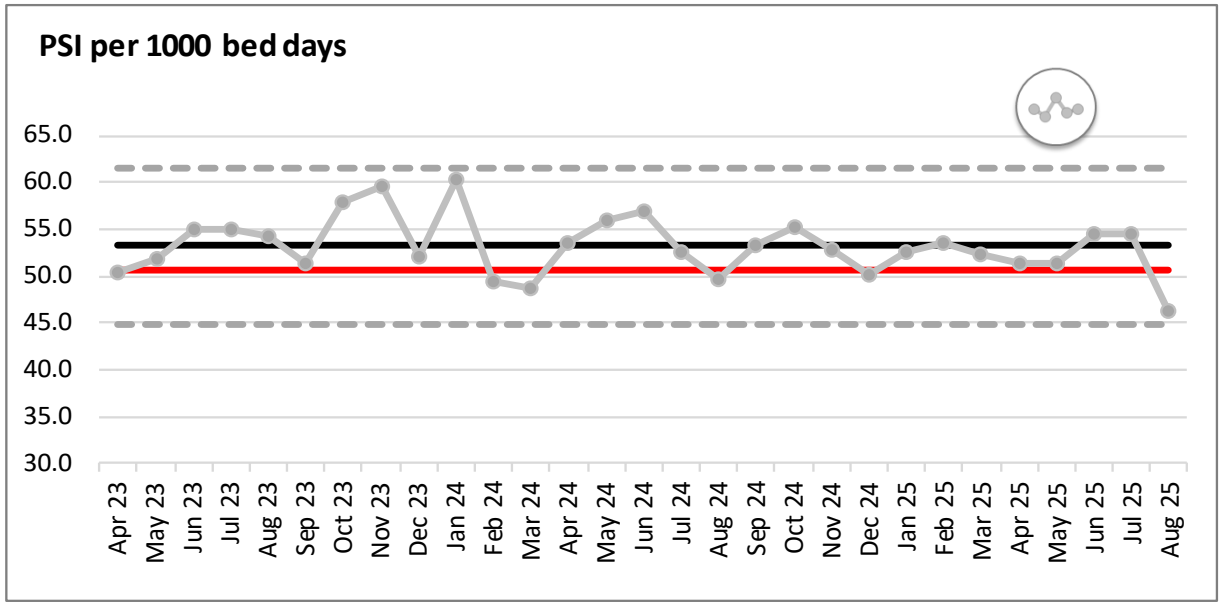
What are we doing about it?

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

Quality & Access | [PSIs per 1000 bed days]

Provide safe, effective and caring services

University Hospitals of North Midlands NHS Trust



What is the data telling us?

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

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

What are we doing about it?

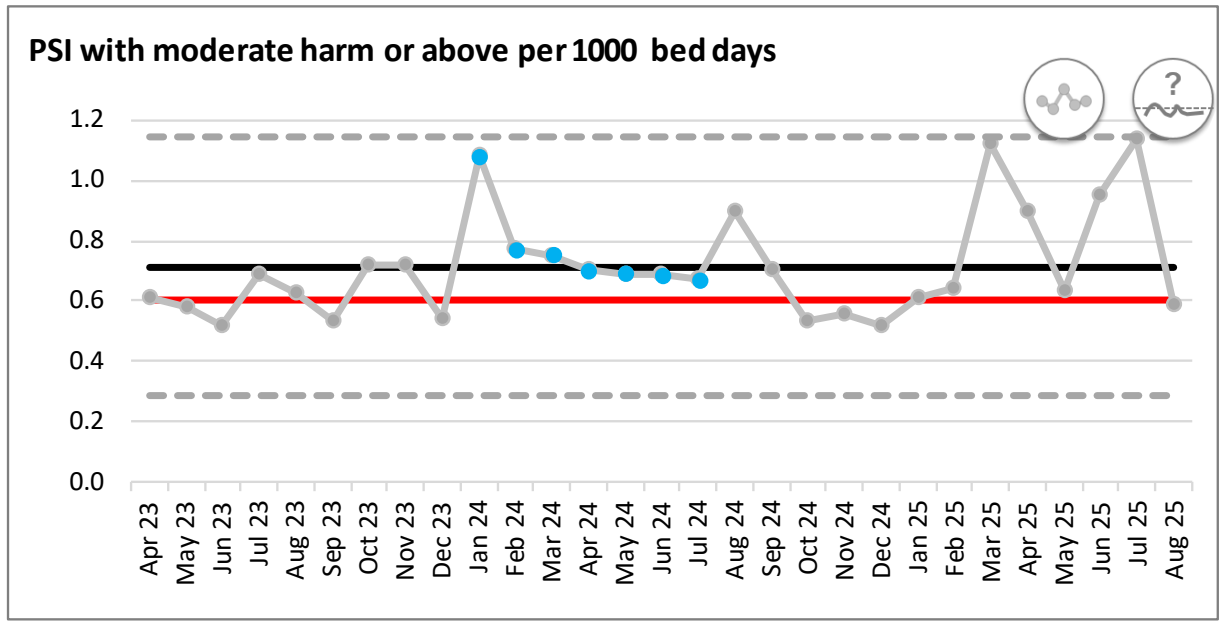
Will continue to monitor the internal reporting rates and identify if there are any specific reasons for reduced rate per 1000 bed days.

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

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

Provide safe, effective and caring services

University Hospitals of North Midlands NHS Trust



What is the data telling us?

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

The most common Categories are Treatment/procedure, Accident / Incident, Clinical assessment, Medication and Patient Falls.

What are we doing about it?

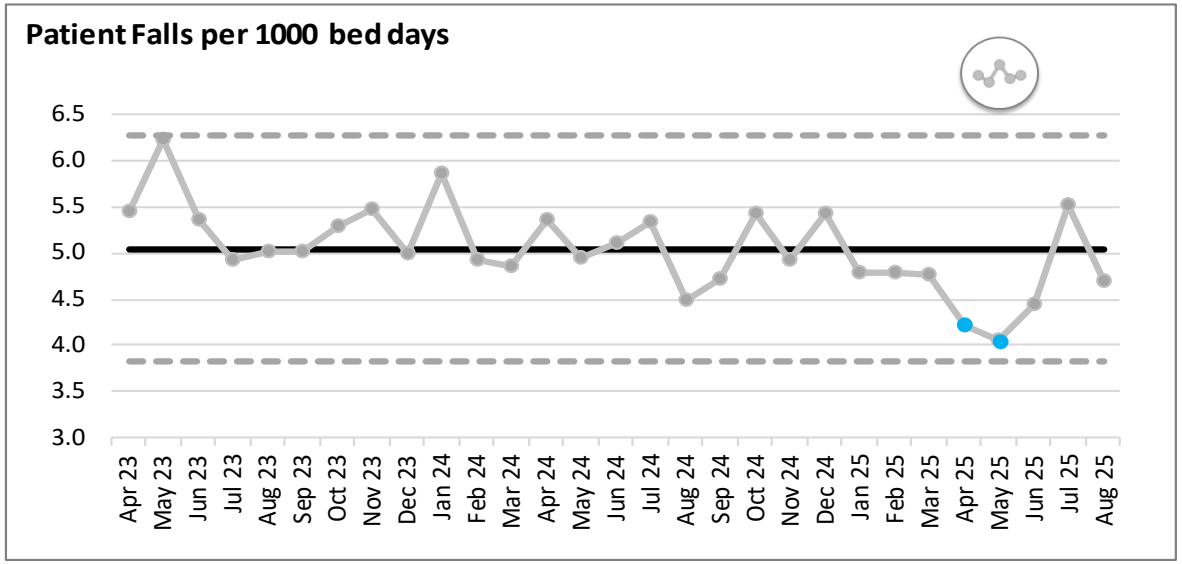
Reviewing harm profile and locations / categories for moderate harm and above incidents in relation to Endoscopy related incidents with the Directorate Team to determine impact on patients as result of changes in the sedation guidelines

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.

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

Provide safe, effective and caring services

University Hospitals of North Midlands NHS Trust



What is the data telling us?

The average rate of reported patient falls per 1000 bed days was within the usual range in August 2025.

The areas reporting the highest numbers of falls in August 2025 were:
Royal Stoke AMU – 16 falls, Ward 230 – 13 falls, Ward 126 – 12 falls, Royal Stoke ED – 11 falls.

Some of these areas are often among the top reporters, but none of the numbers for August were significantly higher than their averages based on previous months.

What are we doing about it?

From the 52 falls across the 4 areas there were no injuries.

AMU, Ward 126 and Ward 230 have all had patients that have been multiple fallers in the month of August. Ward 230 has the patient that have suffered 10 falls that have been due to seizures, all preventative measures were in place for this patient.

Tendable audits have been completed in these areas by the Q&S team:

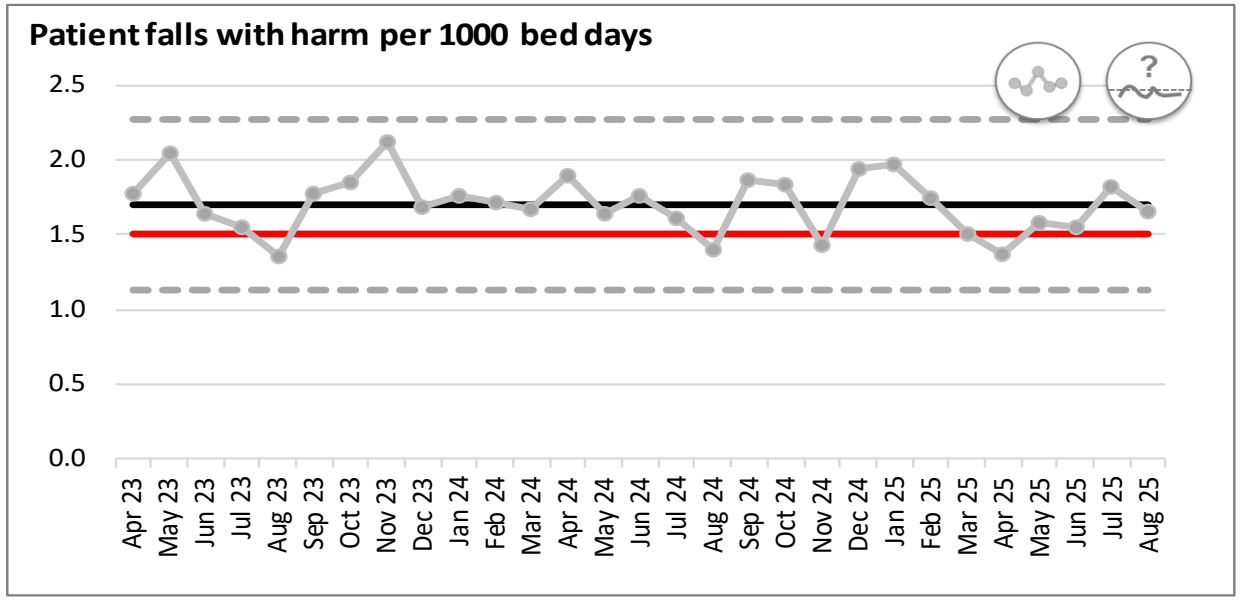
AMU	56.2%
Ward 230	64.2%
Ward 126	70.6%
ECC	58.8%

These results were discussed at the time of the visit.

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

Provide safe, effective and caring services

University Hospitals of North Midlands NHS Trust



What is the data telling us?

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

1 fall resulting in a serious injury was reported in August on the Ward 120.

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

What are we doing about it?

A lying and standing blood pressure had been recorded for the patient that had injured themselves on Ward 120. The patient was being treated for postural hypertension, however patient had stood quickly, became dizzy and fell.

Lying and standing blood pressure question remains on the Tendable audit.

Decaffeinated drinks are to be trialled on the County site.

Observational Tendable audits have taken place by the Q&S team, this covers both falls and tissue viability concerns.

Go Look Learn walks continue to take place.

Bed rail audits have taken place by the Q&S team on the paediatrics and maternity areas.

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

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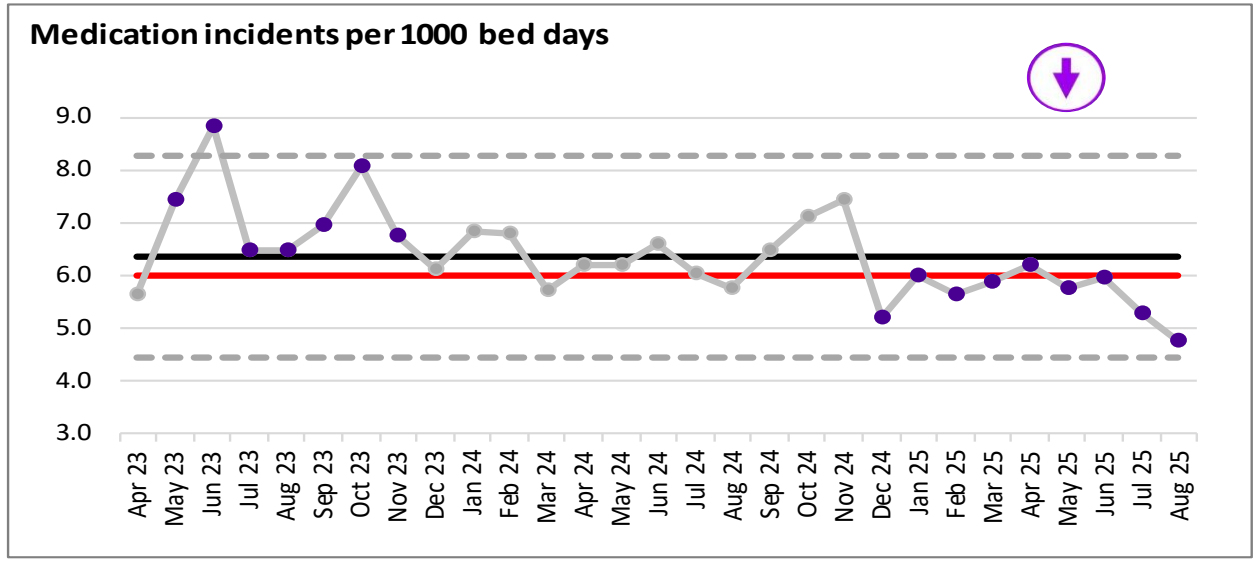

What is the data telling us?

The rate of reported medication-related incidents has been below the average for 9 consecutive months which may indicate a significant change.

What are we doing about it?

Controlled Drug audit and Theatres Controlled Drug audit reports completed – requires improvement as per escalation at the end of 2024. All areas issues with own self-assessment tools to support improving key patient safety and CD governance themes e.g. evidence of witness signatures for administration and waste late 2024. Next round of audits under way.

On-going supports and leadership provided regarding suspicious losses of Codeine phosphate 30mg tablets. Guideline &SBAR tool produced to collate learning from this on-going theme, ensure prompt escalation, staff wellbeing and the right teams are involved.

Improving missed doses of time critical medicines on admission:

Insulin Safety Group drafting SOP for self-administration of insulin pilot. Phase 1 will be on the diabetes wards.

Peri-operative insulin pump guidance approved for use – awaiting addition to the guidelines. Has been shared in the meantime.

Working with ED to review of missed doses of time critical medicines & proposal for a self-administration pilot in ED for a specific patient group yet to be confirmed (e.g. Parkinsons).

Missed doses audit data collection completed, await report & review of missed doses incidents completed for 24/25 financial year – themed review to follow.

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

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

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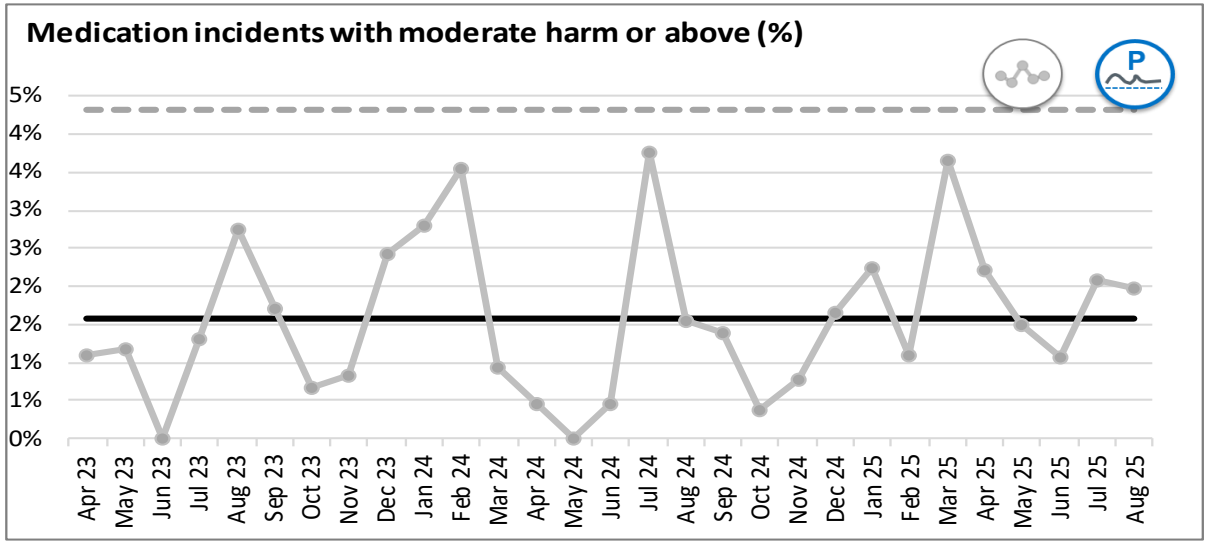

What is the data telling us?

In August 2025, three incidents were reported that resulted in moderate harm, which falls within usual monthly variation and remains consistently below the benchmark rate, offering positive reassurance that this standard is being met.

What are we doing about it?

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

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

ID	Incident Date	Sub Category	Location	Incident Description	Immediate Actions
375618	01/08/2025	Prescribing	Acute Care at Home	Patient was not informed of increase in Furosemide that was agreed during consultant ward round on 1st August, Patient has since become overloaded and required hospital admission on 3rd August for IV diuretics. Unsure whether this would have prevented the admission but patient was fluid overloaded on the 1st August, appears to have been discussed with the consultant who advises to increase the dose of Furosemide up to 80mg morning and 40mg lunch. Spoke with husband on 3rd August when we realised the error, no documentation regarding this other than the ward round note.	Senior clinicians informed for review
375976	03/08/2025	Prescribing	Pathology / Anticoagulation	Pt admitted 03/08/2025 with seizure - IC haemorrhage. Deteriorated despite GTN and Octaplex. RIP 03/08/2025. AF on Apixaban. Latest STAC CNS review states Apixaban 5mg BD, though 93 years, weight <60kg. Met dosing criteria for 2.5mg BD. *Note CT Head request highlights that Pt was severely hypertensive 220/160*	To be discussed in STAC MDT.
376	25/07/2025	Adverse Drug reaction	Theatres 30/31/32	Suspected anaphylaxis following cannulation and anaesthesia	Anaphylaxis treatment provided Cancellation of surgery Transfer to CICU

Quality & Access | [Never Events per month]

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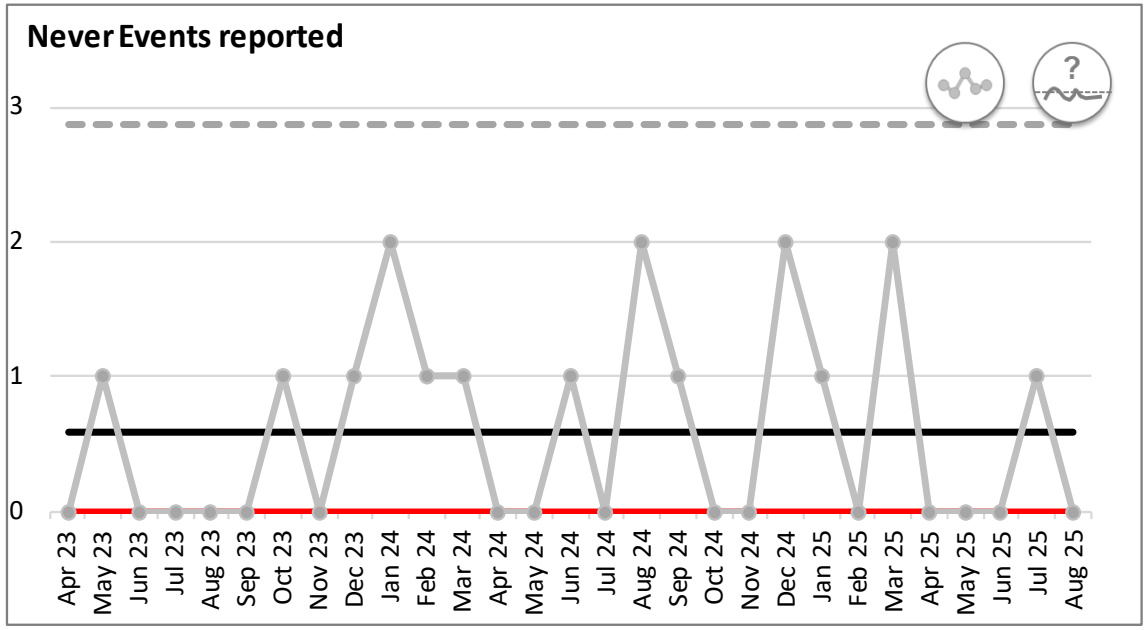

What is the data telling us?

There was 0 reported Never Events during August 2025.

What are we doing about it?

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

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

The national Never Event Review Findings have been published (17/09/2025) following consultation around the current approach. The consultation identified that 66% of respondents found the current framework unfit for purpose and the national team are now reviewing next steps and how to revise the framework, definition of Never Events and moving away from requiring all incidents to be 'wholly preventable'

A 6-12 month discovery phase is being launched involving further stakeholder engagement to revise the framework and focus on learning rather than rigid definitions and align to PSIRF principles and support just culture where staff feel confident to report.

While an alternative process is in development, the existing Never Events framework will remain active, and providers must continue recording patient safety events which meet the criteria for Never Events under the 'Never Event' category on the Learn from Patient Safety Events (LFPSE) service, however, in line with PSIRF, organisations should now take a proportionate response which focuses on learning and improvement. This will mean that potentially not all Never Events will require full PSII response by default.

Quality & Access | [PSIIs per month]

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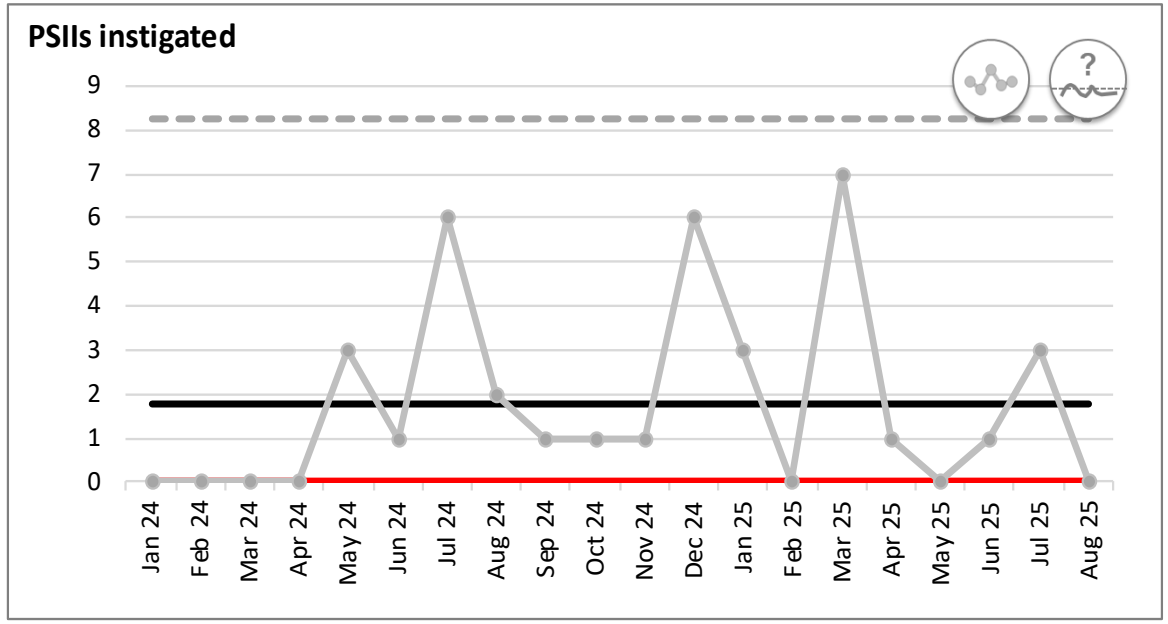

What is the data telling us?

We have reported 0 new PSIIs during August 2025.

What are we doing about it?

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

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

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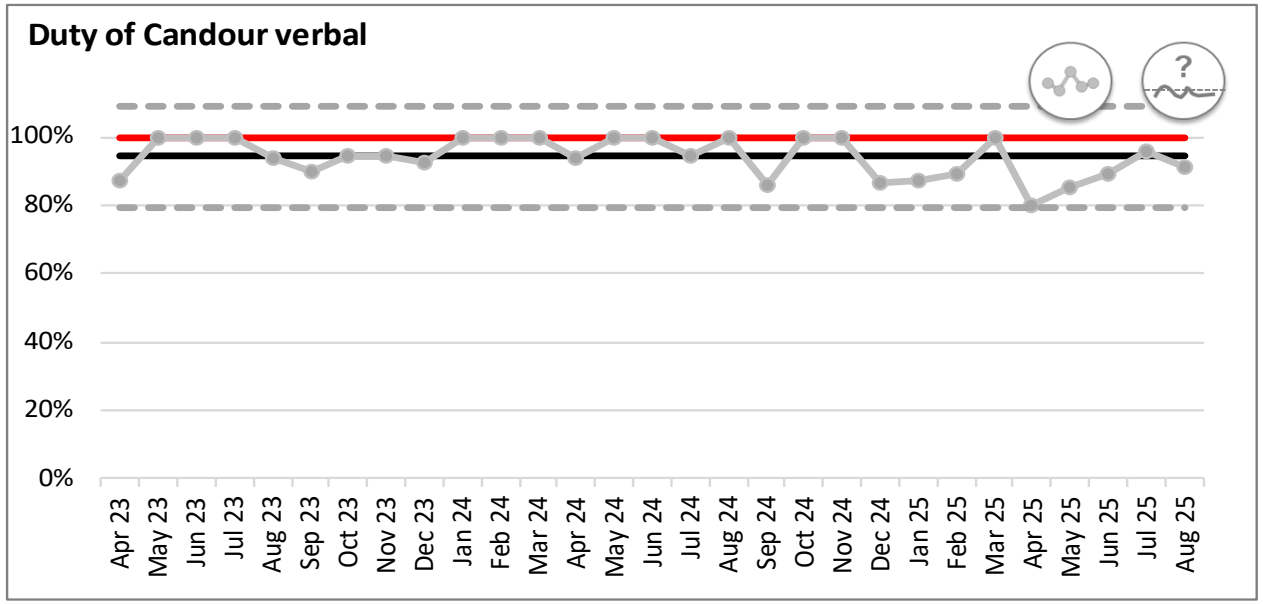

What is the data telling us?

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

In August 2025, there were 11 incidents that formally triggered duty of candour. 10 out of 11 (90.9%) have had verbal discussions/notifications recorded within Datix. The 1 case not recorded is within WCCSS.

What are we doing about it?

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

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

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

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

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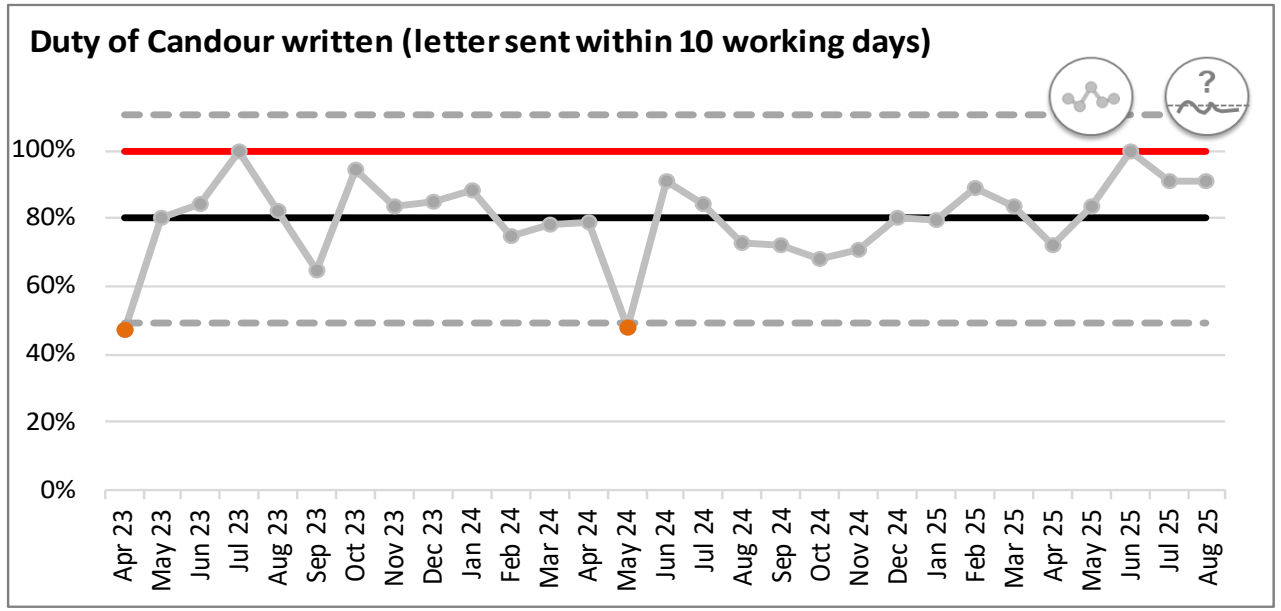

What is the data telling us?

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.

Out of the 11 cases, 10 of them met the 10-working day internal target. The 1 remaining cases are 1 in Non Emergency Medicine which have confirmed that the letter was sent to patient outside the 10 day target.

What are we doing about it?

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

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

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

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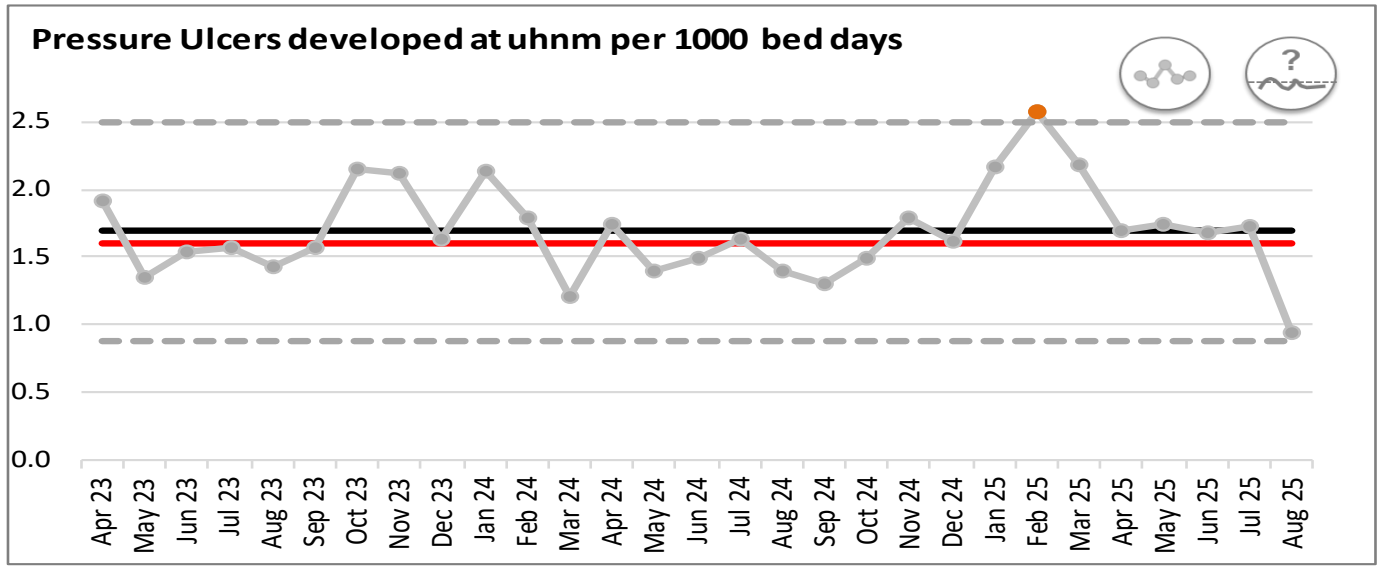

What is the data telling us?

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

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

In August 2025, there were 6 reported cases of urethral splits, 1 of which was noted to have lapses in care (3 TBC). This number is close to the usual average since Jul-24.

What are we doing about it?

To look at alternatives for the ESR package and training following Stat and Mand group unable to process request
Skin Health booklet now available to order. Educational video completed and shared with teams on how to complete the booklet. The electronic wound assessment has been approved, just waiting for a go live date.
Deep dive being completed for hospital acquired pressure ulcers which will also focus on vulnerable patients.
Increase in mattress pumps available with the pressure therapy teams completing drop in visits.
Chair audit to be completed at County following concerns of old seating.
Trezzo mattress have been rolled out in Royal Stoke ED
The champions programme continues. Resources from the champion days have been shared with easy access for the champions to cascade information.
The Harm Free Care Educators are continuing with education. Industry also supporting with education
Peer review audits being completed by the Quality and Safety team
Promotion of repose wedges to improve sustainability, reduce cost and provide more effective heel offloading. Reduction seen with heel damage reported with lapses in care
Looking at alternate system for collecting images following successful rollout of Consultant Connect

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

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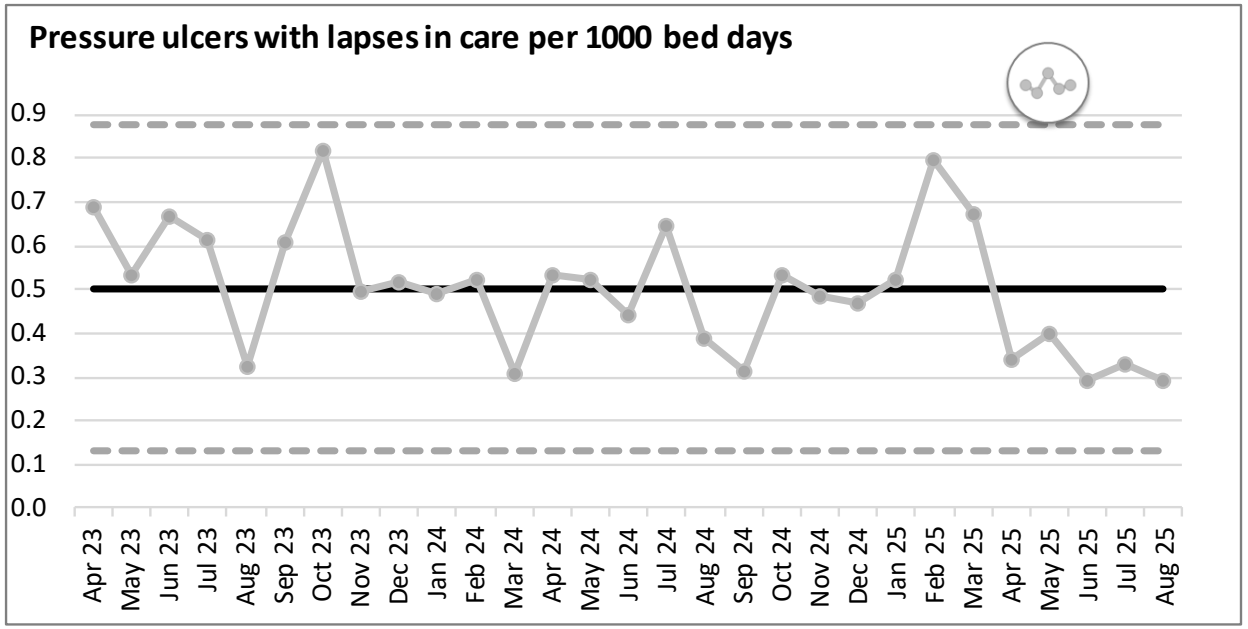

Type of Lapses - Aug 2025	Total
Management of repositioning	6
Management of heel offloading	3
Management of device	2

What is the data telling us?

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

Wards with more than one case with lapses identified for August: Ward 122 (n=2), Ward 226 (n=2)

On average, lapses in care have been identified for approximately 30% of the pressure ulcers reported as developing under UHNM care since April 2022. This meaning that the majority of reported pressure ulcers do not have an identified lapse in care.

What are we doing about it?

Toolkits being completed for pressure ulcers with lapses in care where areas will create an action plan.
Category 2's with lapses in care will now be part of a thematic review. This will be shared with each care group.
ED are completing a thematic review and to have one action plan to manage the increase of incidents. The action plan will be presented at steering group
Multiple reporting areas attend steering group to discuss improvements being made and share learning. Areas will have visits from the Quality and Safety team prior to attending assurance panel.
Review of the process for category 3 and 4 to include duty of candour outcome
Observational audits have been trialled to ensure care accuracy and reduce inaccurate documentation. Matrons have been informed of unannounced visits being made

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

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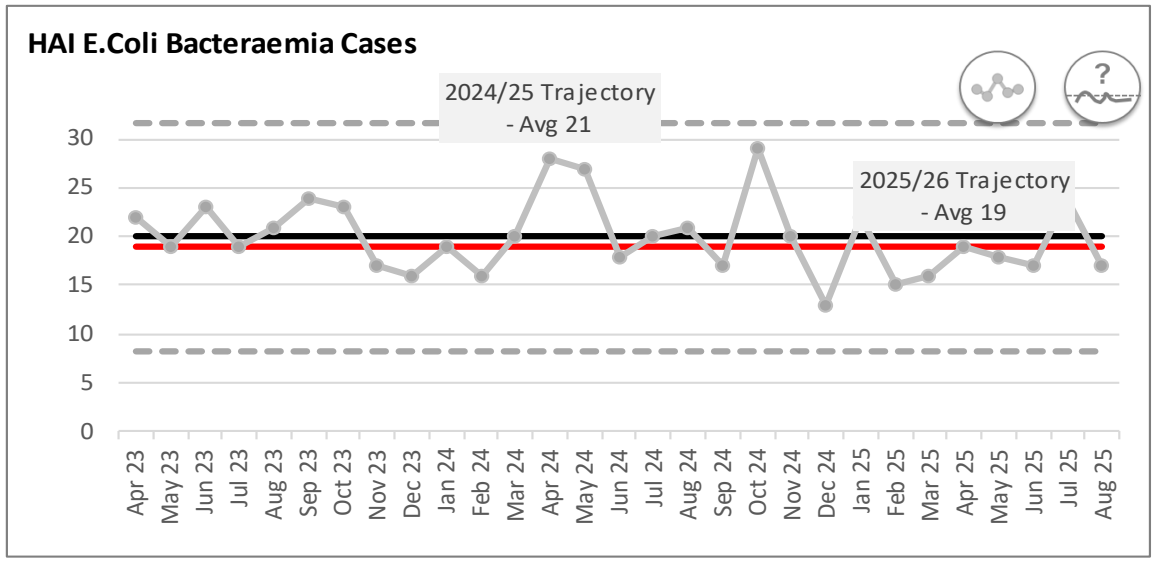

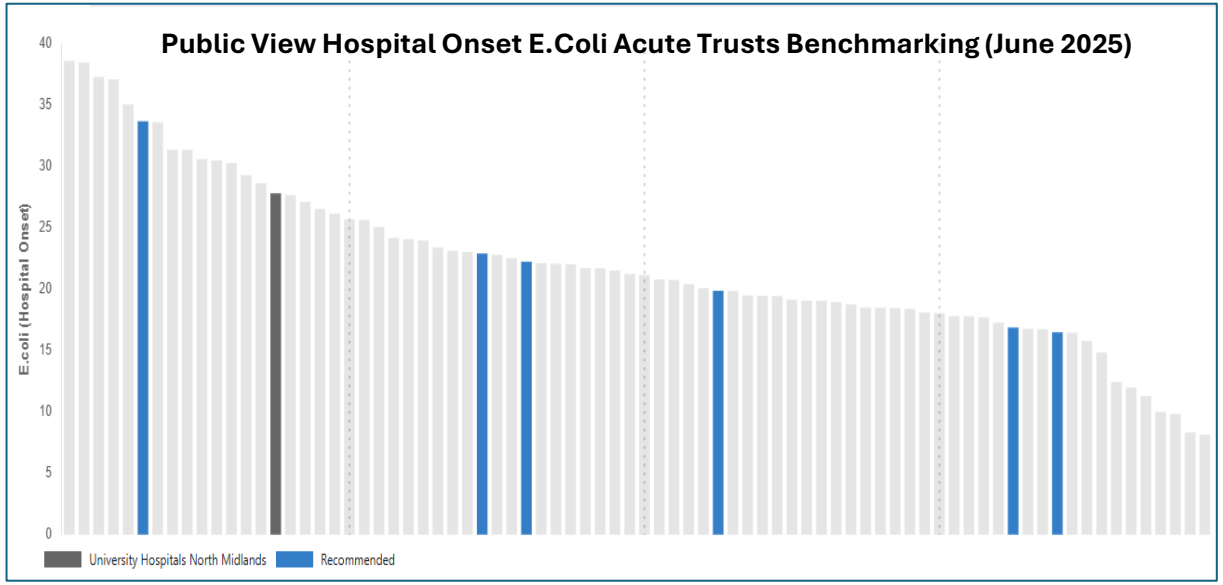

What is the data telling us?

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

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

As at August 2025 we have had 96 Trust apportioned cases (53 * HAI and 43 * COHA) versus a year to date upper limit of 96 (0.0% over trajectory)

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.

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

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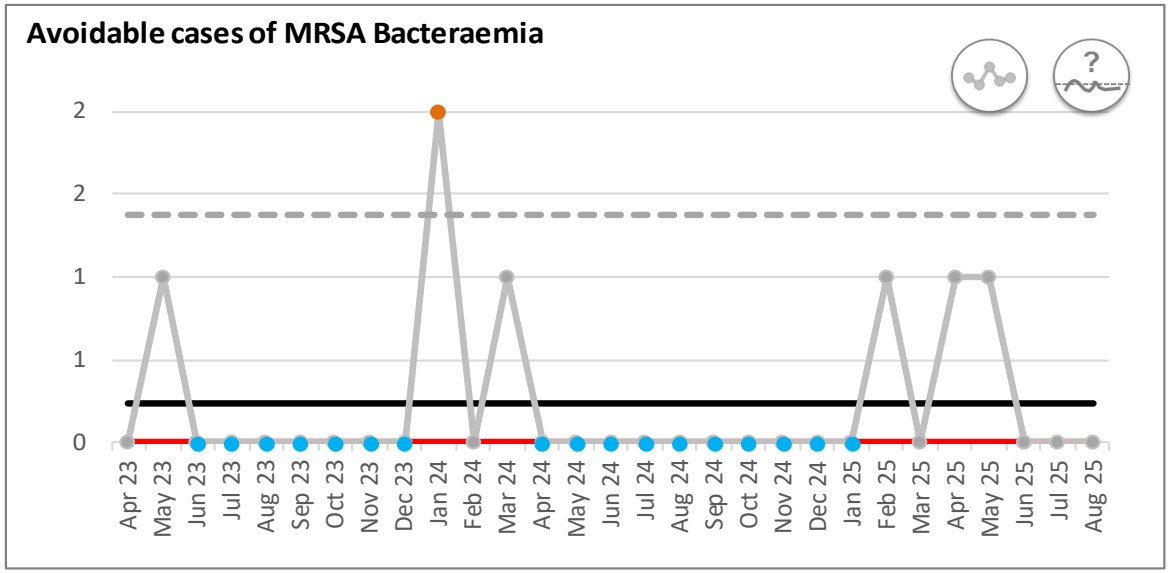

What is the data telling us?

No MRSA Bacteraemia cases reported in August 2025.

What are we doing about it?

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

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

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

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

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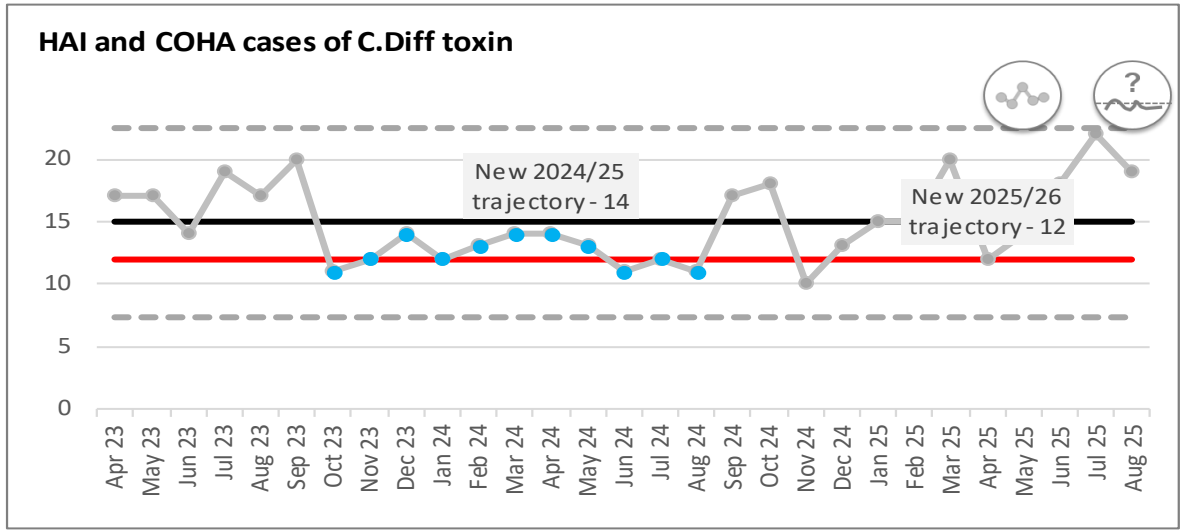

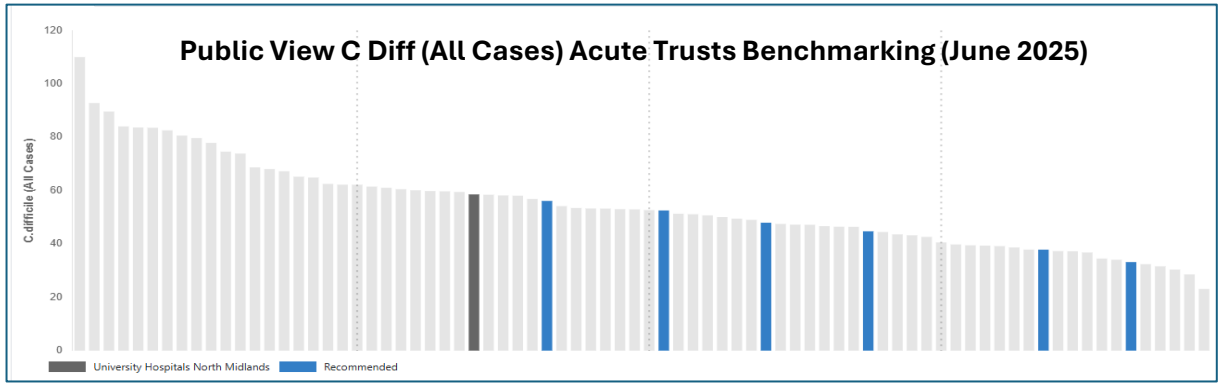

What is the data telling us?

The monthly number of C-Diff cases was within the usual range in August 2025. Cdiff 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 19 reported C diff cases in August 2025 - 9 x HAI and 7 x COHA
There have been two periods of increased incidence reported in August, however no areas with same ribotyping for which we are awaiting further typing results from the reference laboratory.

The 24/25 objective for C-Diff is 179 cases or less.
The 25/26 objective for C-Diff is 144 cases or less. This was released in June 2025.
As at August 2025 we have had 85 Trust apportioned cases (53 * HAI and 32 * COHA) versus a year to date upper limit of 60 (41.7% over trajectory).

What are we doing about it?

- Routine ribotyping of samples continues for samples from areas where we have periods of increased incidence only
- CURB -95 score added to CAP antimicrobial Microguide.
- Antimicrobial working group to remind clinical areas to send urine samples when UTI is suspected and ensure appropriate choice of antibiotic for treatment of UTI
- Additional oversight of C-Diff cases is being implemented where there is potential learning in terms of antibiotic use
- Big bed clean commenced from 9th July 2025
- PSIRF process and monthly themes report
- Weekly AMS presence at County to support antimicrobial prescribing
- Commode cleaning day completed January 2025, aim for twice yearly
- The existing Pneumonia guidelines were reviewed, revised and ratified through ASG and launched to prescribers in early January. Key changes involve the reduction in the use of Co-Amoxiclav in CAP, with a focus on using the narrower spectrum oral antimicrobials where possible or a prompt IV to oral switch
- 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

Quality & Access | [NPSA Alerts received and overdue]

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New Alerts received:

Year	Alert Type	CAS Status	Alert Reference Number	Alert Title/Device	Date Issued	Deadline Date	Comments	Actions

Open / Overdue Alerts:

Year	Alert Type	CAS Status	Alert Reference Number	Alert Title/Device	Date Issued	Deadline Date	Comments	Actions
2023	NHS Patient Safety Alert	Open	Nat/PSA/2023/ 010 MHRA	Medical beds, trolleys, bed rails, bed grab handles and lateral turning devices: risk of death from entrapment or falls.	31/08/23	01/03/24	Executive approval for Bed Rails training to be reinstated to ESR. Awaiting final confirmation of updated ESR Stat & Mand training from the Mandatory Learning Oversight Group. When confirmed the alert will be closed.	ESR Training to be updated
2024	Nat/PSA	Open	Nat/PSA/2024/ 004 MHRA	Reducing risks for transfusion-associated circulatory overload	04/04/24	04/10/24	Purchase Order has been raised and awaiting final delivery of the new prescription charts. When delivery confirmed the alert will be closed	To receive initial delivery of new prescription charts
2025	Nat/PSA	Open	Nat/PSA/2025/ 002/UKHSA	Potential contamination of non-sterile alcohol-free skin cleansing wipes with Burkholderia spp: measures to reduce patient risk	26/06/25	29/08/25	Deadline date met by 27/08/25, completed action plan submitted – awaiting final approval/sign off.	To be formally signed off at PSG 16.09.2025
2025	Nat/PSA	Open	Nat/PSA/2025/ 004/MVA	Shortage of Antimicrobial Agents Used in Tuberculosis (TB) Treatment.	29/07/25	15/08/25	Updated action plan/risk assessment for risk register submitted awaiting final approval/sign off.	To be formally signed off at PSG 16.09.2025

What is the data telling us?

In August 2025, UHNM received 0 new Patient Safety alerts.
At present, there are four NHS Patient Safety Alerts that remain open and overdue, however 3 of these are awaiting final sign off and closure.
The overdue alerts have been addressed, and actions are ongoing to ensure that the necessary requirements of the alerts are being effectively implemented.

What are we doing about it?

Nat/PSA 2023/010 MHRA is awaiting final approval for the Bed Rails Training to be back on ESR and part of Stat & Mand training. Approval awaited from Mandatory Learning Oversight Group
Nat/PSA/2024/004 MHRA is awaiting delivery of new prescription charts. *(Received 12th September and alert to be closed)*
The overdue alerts have agreed action plans in place and assurances have been received that actions are being taken. CAS / MHRA website are updated with progress

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

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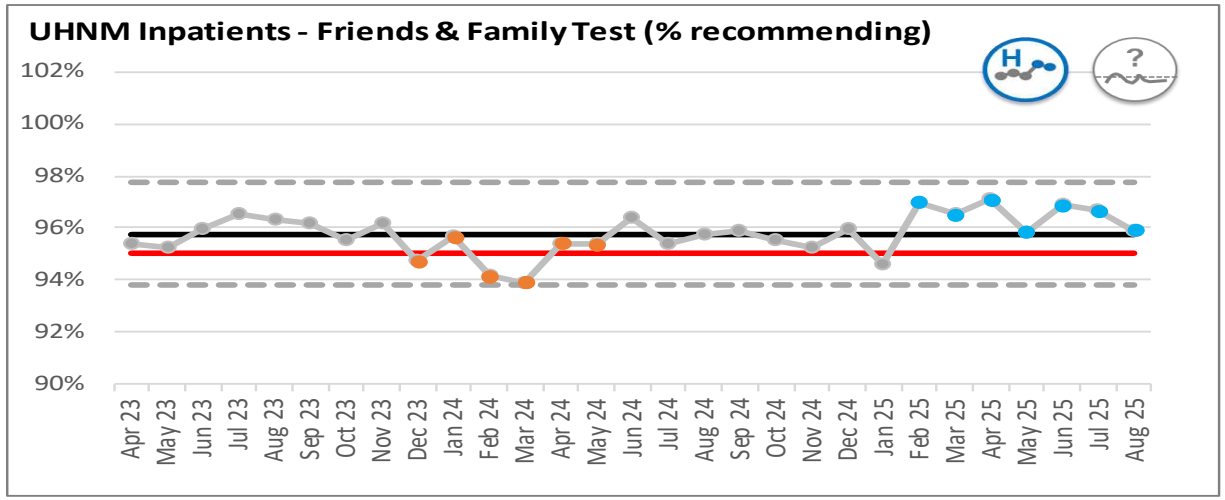

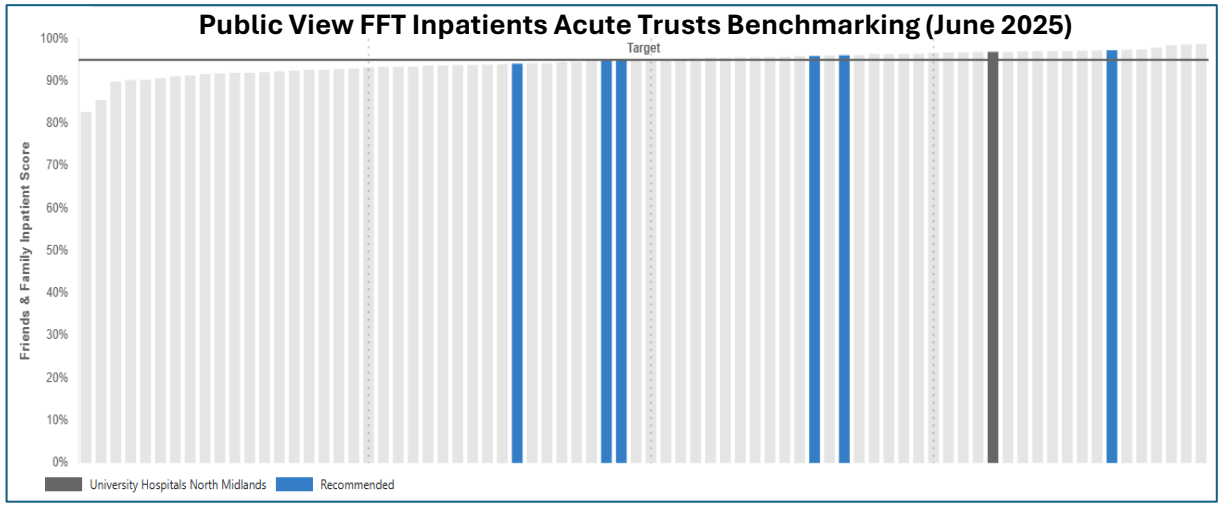

What is the data telling us?

The monthly satisfaction rate for inpatient areas has been above the previous average for 7 consecutive months which may be significant. The average rate remains above the national average of 95% (Jan 2025 NHS England).

In August 2025, a total of 2605 responses were collected from 67 inpatient and day case areas equating to a 24% return rate, which is close to the average for the past 12 months.
Average Divisional Scores are as follows:

- Network- 26% response rate 97% satisfaction score
- Surgery- 29% response rate 95% satisfaction score
- Medicine- 22% response rate 94% satisfaction score
- CWCSS (excluding Maternity, see separate slide)- average 26 % response rate since Apr-25, 99% satisfaction score

No significant shifts or trends are currently evident in Divisional satisfaction scores, but at 24%, CWCSS's response rate (Child Health Directorate) was significantly higher than the pre-April 2025 average.

What are we doing about it?

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

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

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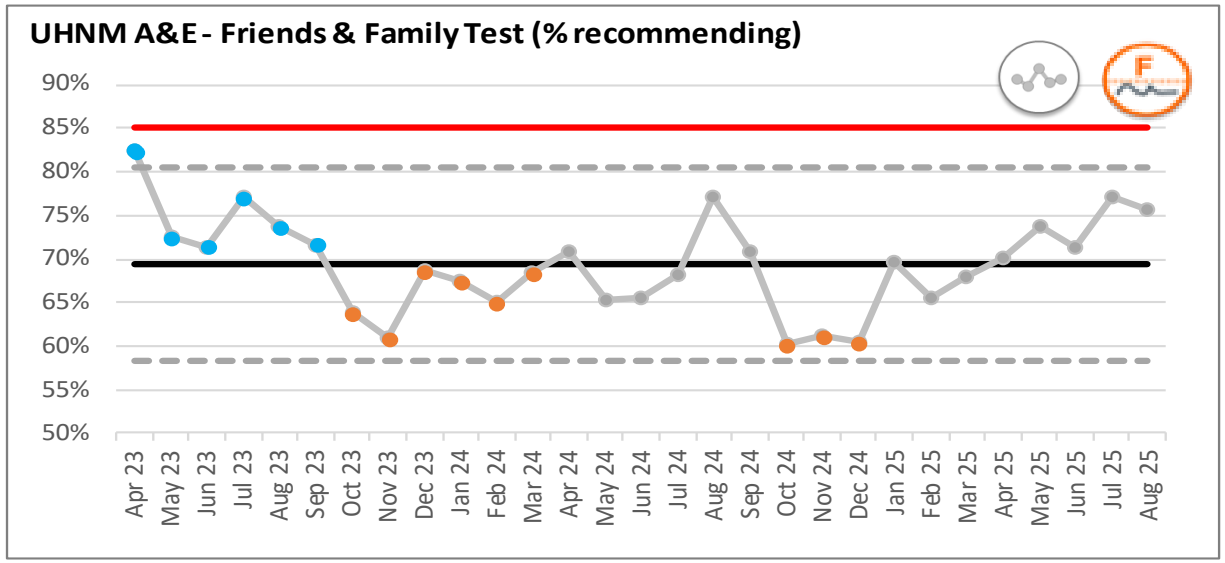

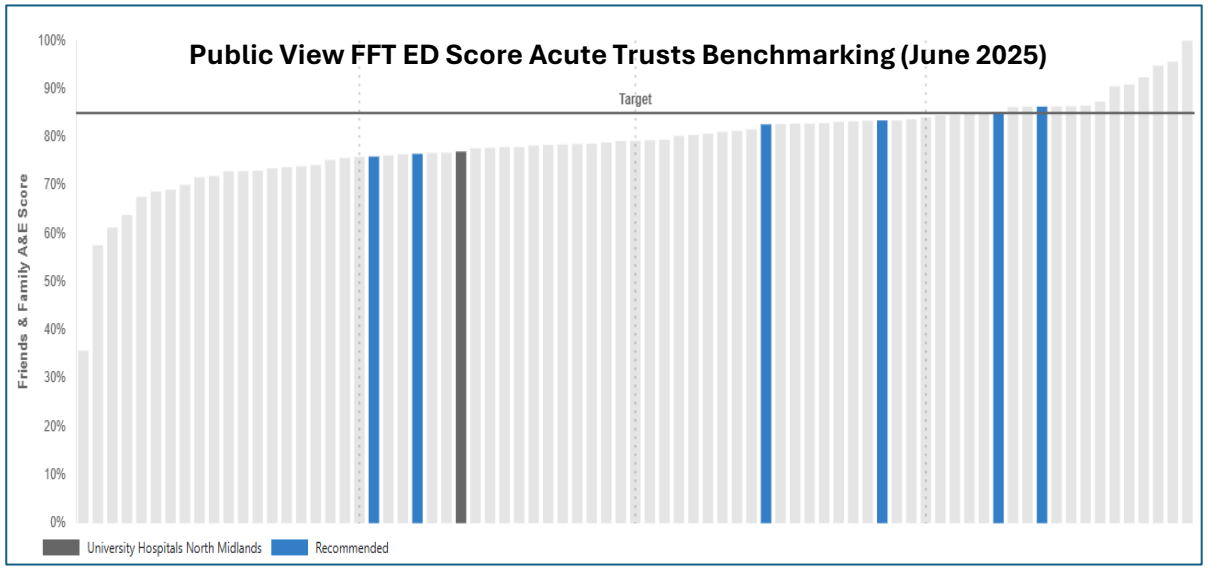

What is the data telling us?

The Trust received 913 responses in August 2025 - a 10% response rate which is close to the 9% average. The average satisfaction rate of 69% remains somewhat below the national average of 80% (NHS England Jan 2025).

UHNM is 28th out of 124 Trusts for the number of responses in ED and 83rd out of 124 Trusts for the percentage positive results (NHS England June 2025).

Themes for improvement from July 2025 continue to be long waits for both sites. With communication being a focal point for improvement specifically relating to expectations and wait times.

What are we doing about it?

- The digital system is not able to support more than one submission point each survey as each submission would then become a new survey. Therefore, to simplify, a trial period commenced from Feb 25 with the "ED Survey" now only containing the mandatory "Overall, how was your experience of our service?" with the 6 response options ("very good" through to "very poor" or "don't know". This commenced end of January 2025.
- QR code made visible throughout the department.
- Consideration to alternative methods of sharing QR code such as “business cards” available on reception and throughout the department.
- Dept Leads 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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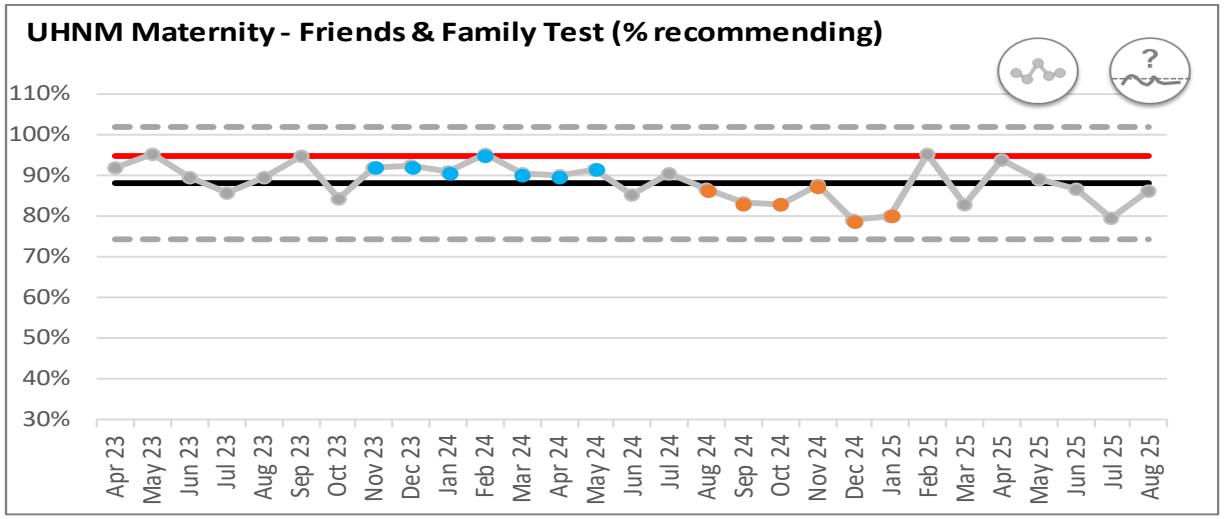


What is the data telling us?

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

There were a total of 108 surveys received in August 2025 across all 4 touch-points (ante-natal, birth, post-natal ward; post-natal community) with 47 of these being collected for the "Birth" touch-point, making the response rate 9% which was close to the usual average. The average satisfaction scores are Ante-natal: 80%, Birth: 90% and Post-natal ward: 90%. No significant shifts or trends are currently evident in any of these satisfaction scores. No Post-natal community surveys were received between Oct-24 and Jun-25, the score of 100% for August was within the range previously seen.

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.

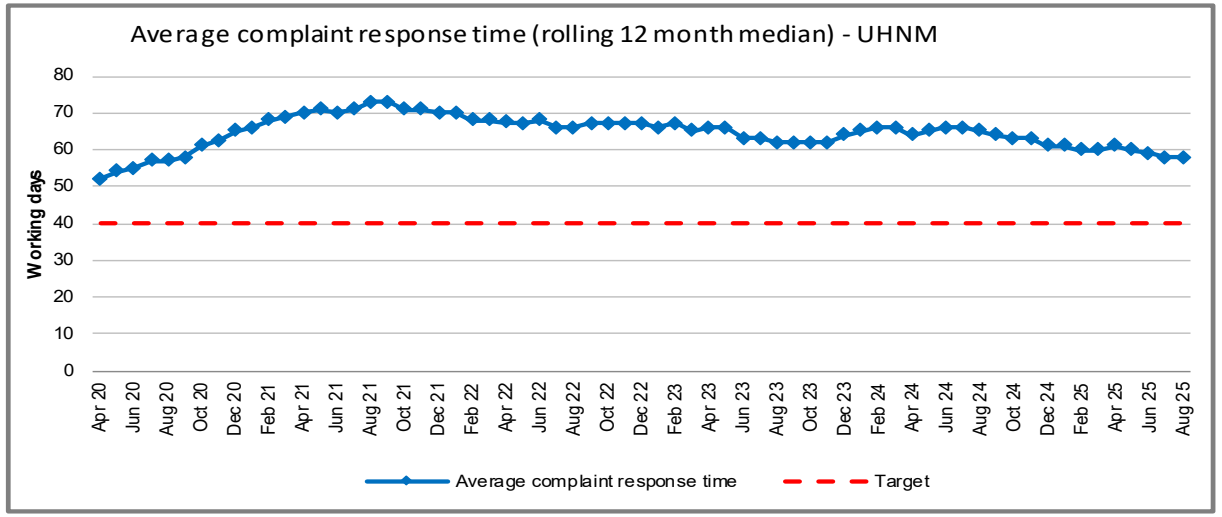
Look at incorporating the questions from the National Maternity Survey which requires the most improvement into the FFT survey.

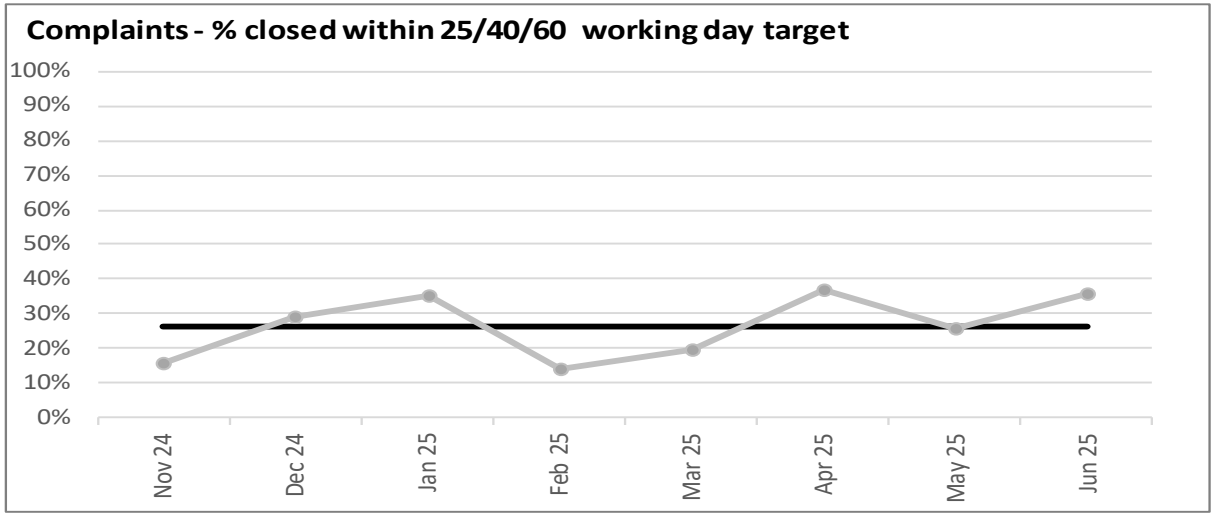
Discuss with management team with regards to increasing survey completion for post-natal community

Quality & Access | [Complaints Response Time]

Provide safe, effective and caring services

University Hospitals of North Midlands NHS Trust





What is the data telling us?

50 complaints were closed in August 2025, with a median average response time of 51 working days.

The chart shows the average complaint response time peaked in 2021 but remains some way above the 40 working day target.

245 complaints were open at the end of August 2025, of which:

- 3 had been open longer than 12 months
- 15 had been open 6 – 12 months
- 15 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 September, 27% of complaints opened between November 2024 and June 2025 were closed within target. Performance for July to date stood at 16%, with 45 complaints still open and within target.

What are we doing about it?

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

Quality & Access | [Timely Observations]

Provide safe, effective and caring services

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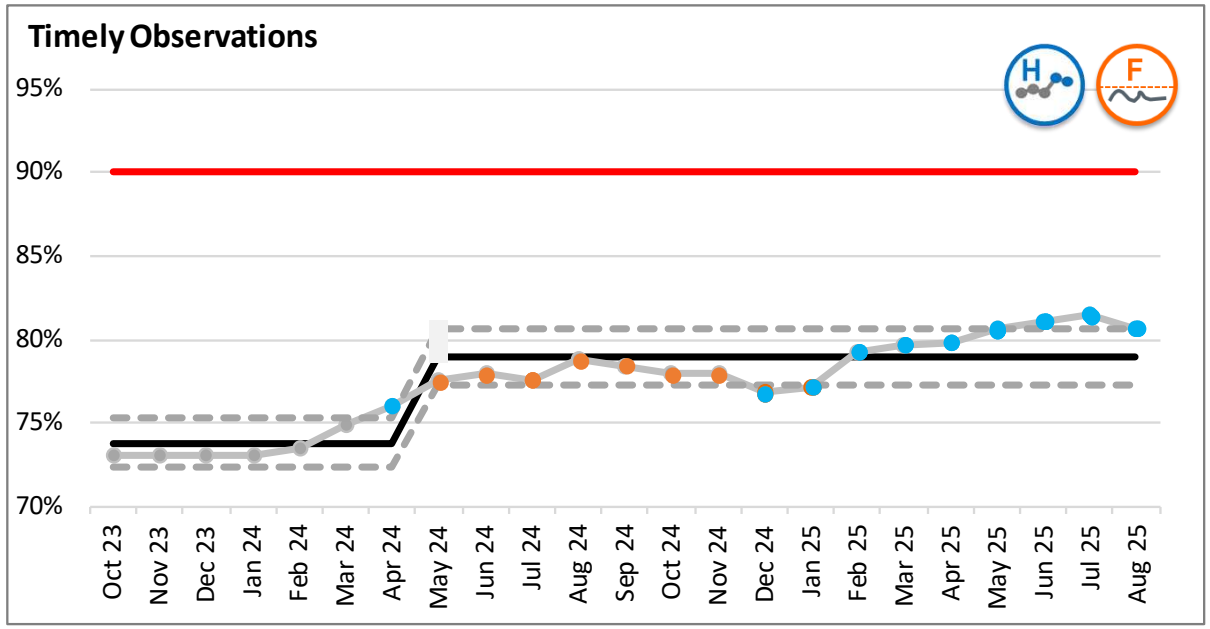

What is the data telling us?

The proportion of observations recorded as timely in August 2025 was 81%, just below the figures for June & July, bringing to an end the run of consecutive months of improvement.

- Only 14 wards/departments met the 90% target in August.
- 16 wards had compliance below 75% (11 from Medicine CBU): Ward 76A, Ward 121, Ward 78, Ward 113, Ward 120, Ward 124, Ward 76B, Ward 15, Stoke AMU, Ward 109, Ward 81, FEAU, Ward 108, Ward 128, Ward 106, Ward 12.

What are we doing about it?

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

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

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

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

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

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

Provide safe, effective and caring services

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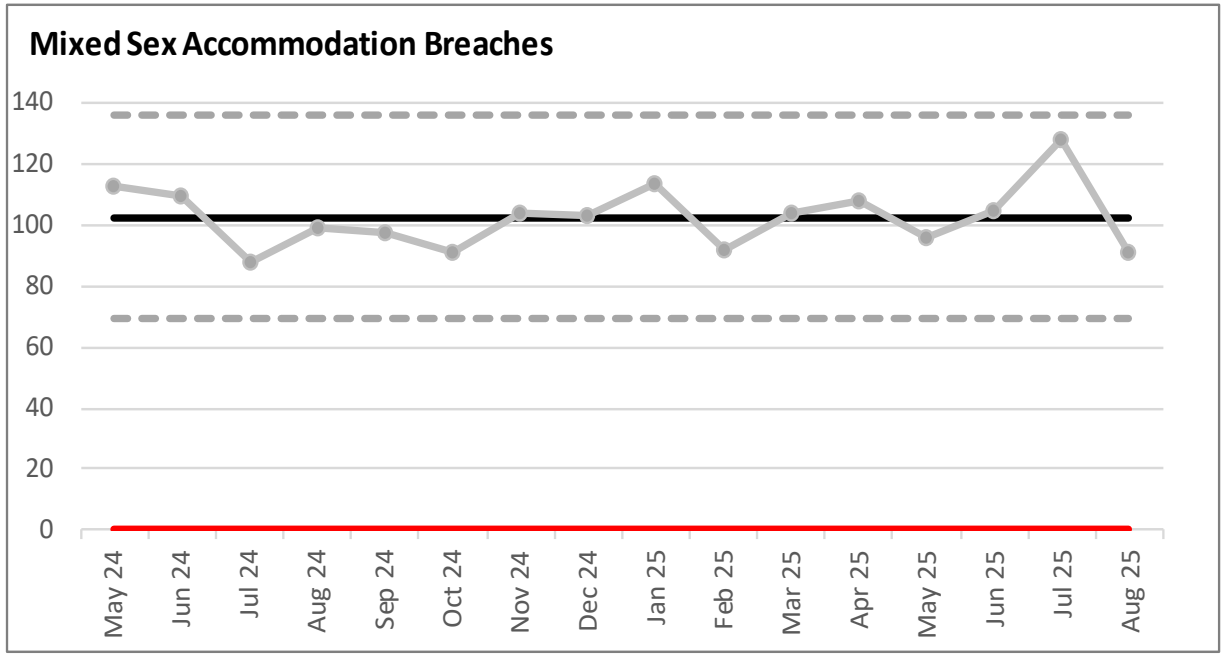

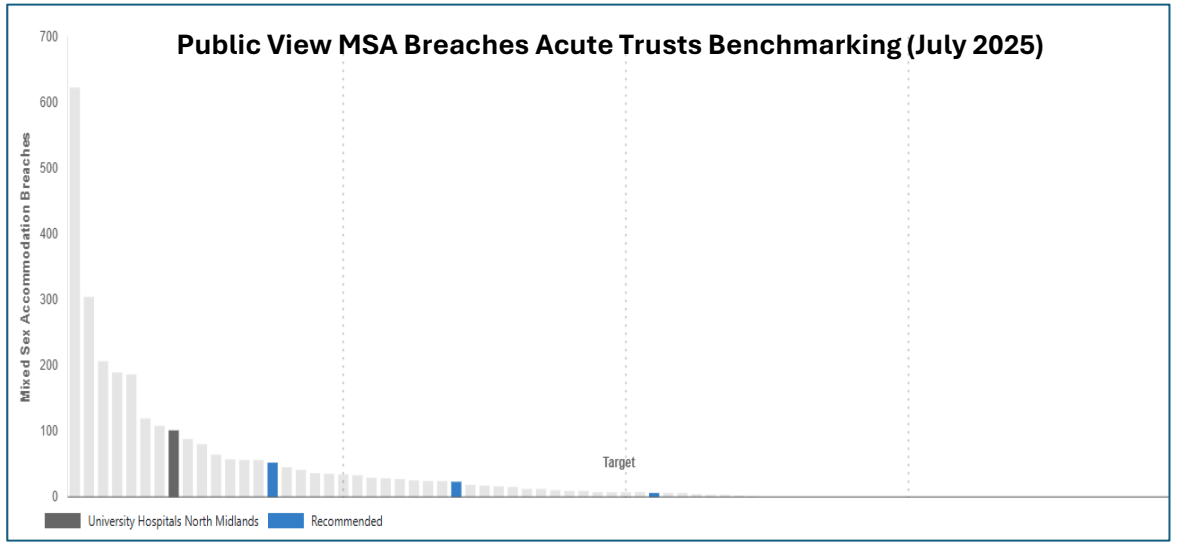

What is the data telling us?

The number of mixed sex accommodation breaches (91) reported in August 2025 was within the usual range, based on the previous numbers show, the in month reduction was below the long term mean.

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

What are we doing about it?

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

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

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

Quality & Access | [VTE Risk Assessment Completion]

Provide safe, effective and caring services

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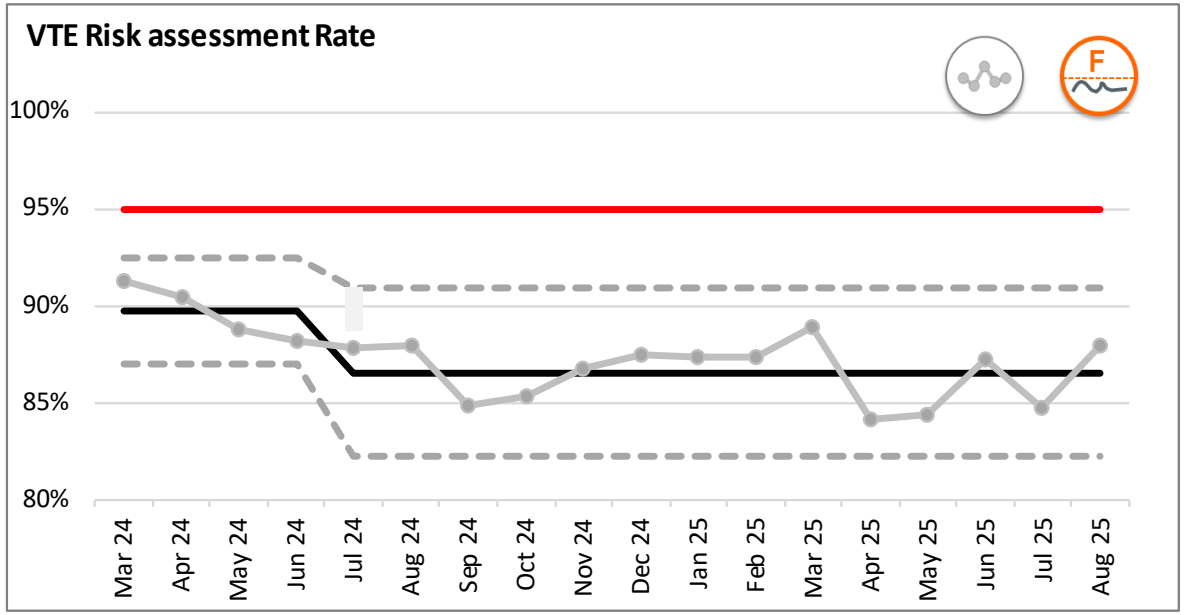


What is the data telling us?

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

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

Issues with performance are primarily related to the failure to document the date and time of the assessments, leading to a significant lack of assurance regarding the completion of these risk assessments. In August, Tendable results indicate 9% of charts audited failed due to missing date or time, and only 0.7% of assessments had not been completed at all. Tendable results also show that a consistent 98% of prophylaxis doses are given, or reasons documented if withheld.

What are we doing about it?

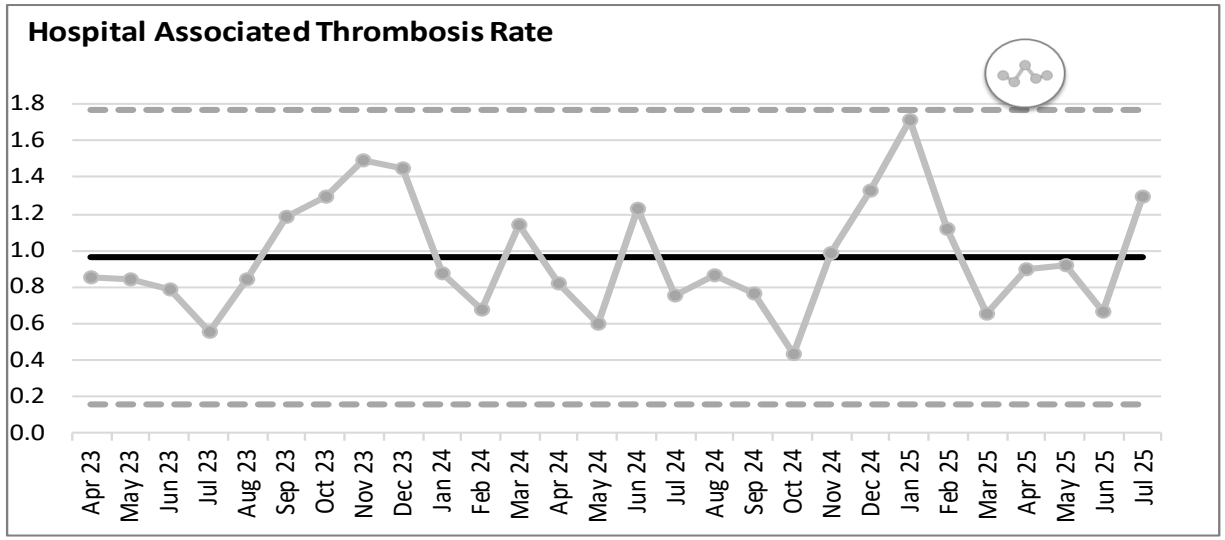
EPMA once introduced will provide accurate assurance of VTE risk assessment completion. Review of VTE risk assessments for patients admitted to Ward 15 since they have gone live with ePMA is reassuring. All patients reviewed had a VTE risk assessment completed within 12 hours of admission to the ward and the appropriate thromboprophylaxis prescribed.

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. The VTE Steering Group will meet in September to discuss the impact of the changes

Quality & Access | [Hospital Associated Thrombosis rate]

Provide safe, effective and caring services

University Hospitals of North Midlands NHS Trust



What is the data telling us?

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

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

What are we doing about it?

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

Key Themes identified from HAT Investigations; inconsistent daily recording of mechanical thromboprophylaxis.

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

The VTE Steering Group Have not met for a number of months, due to absence of a Chair. This has been escalated at Patient Safety Group for an interim Chair to be sought. The Steering Group plan to meet in September despite no chair to discuss any concerns and new guidance

Quality & Access | [HSMR / SHMI]

Provide safe, effective and caring services

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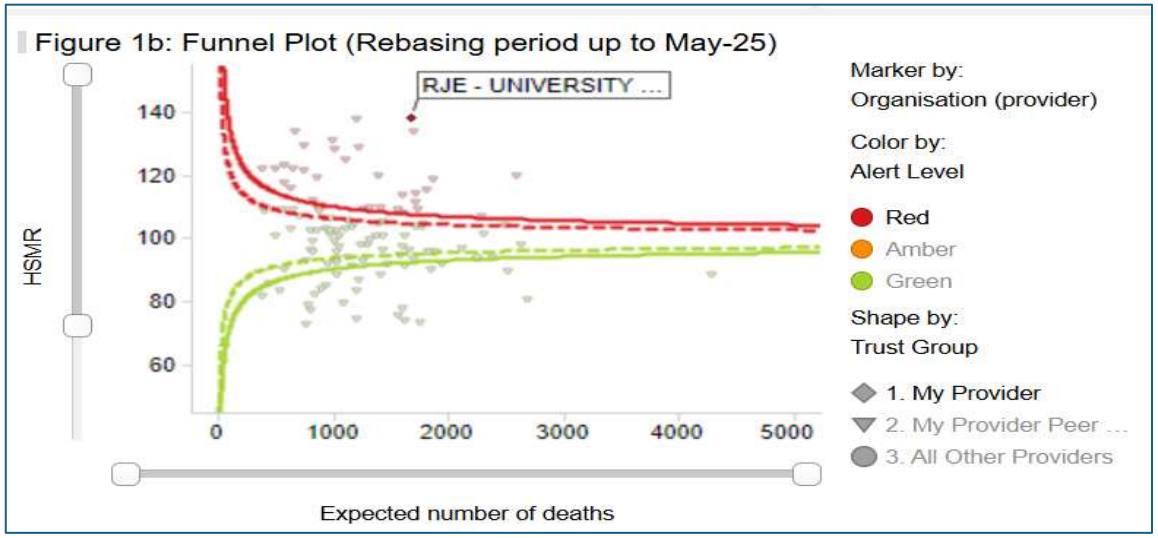

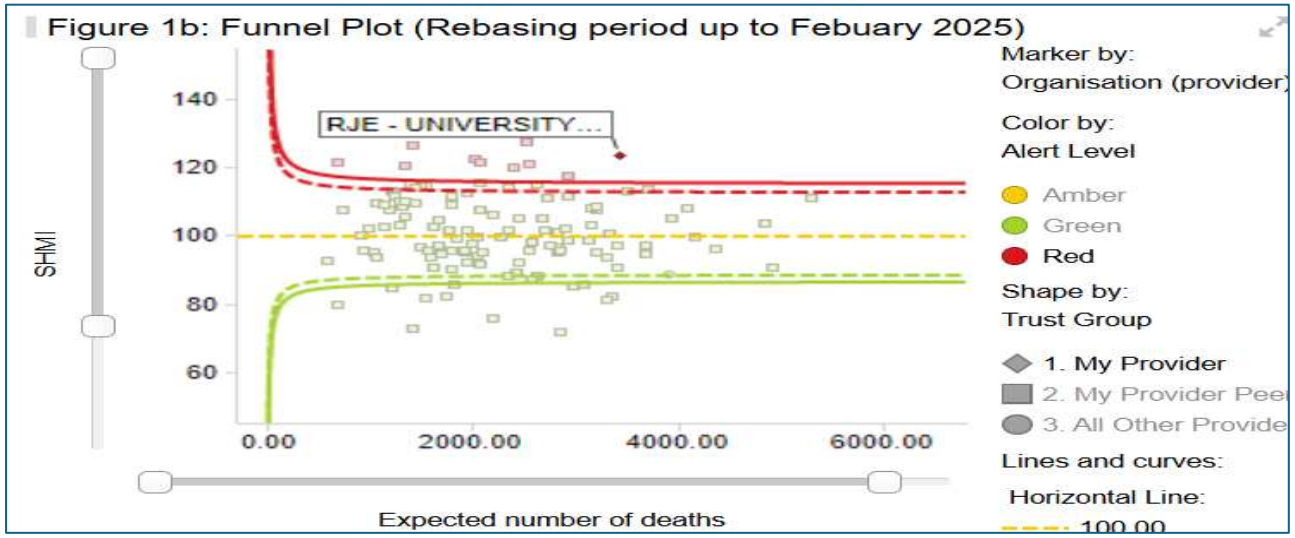

What is the data telling us?

UHNM HSMR is significantly higher than expected based on case mix and standardisation for current 12-month period (June 2024 – May 2025). The current 12-month HSMR is 138.44 compared to 136.12 in previous report.

UHNM SHMI is higher than expected at 123.6 for current 12-month period (May 2024 – April 2025) but has decreased from previous 12-month period with 123.72

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. The rolling 12-month crude rate has reduced slightly from 2.49% to 2.4%.

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 to await update to April HSMR/SHMI to assess implications/improvements in the rolling 12-monthly figures compared to the months when not all activity was fully coded. There have been monthly reductions for the fully coded months but this will not have had impact as yet to rolling 12-month figures
- Whilst we have not witnessed increases in crude mortality similar to the HSMR and SHMI indices, since April 2025 the previously recorded AEC activity as inpatient admissions on Careflow to being recorded in the ED module. This means that these patients were, prior top April 2025, recorded as admissions/spell but will no longer be coded by the clinical coding team. Crude mortality will be impacted as around 1,300 spell per month will be removed from the denominator This will begin to impact SHMI and HSMR as there will be lower activity recorded as inpatient activity
- Remains under review and have shared update with QAOC and ICB.

Quality & Access | [Sepsis – Adult Inpatient]

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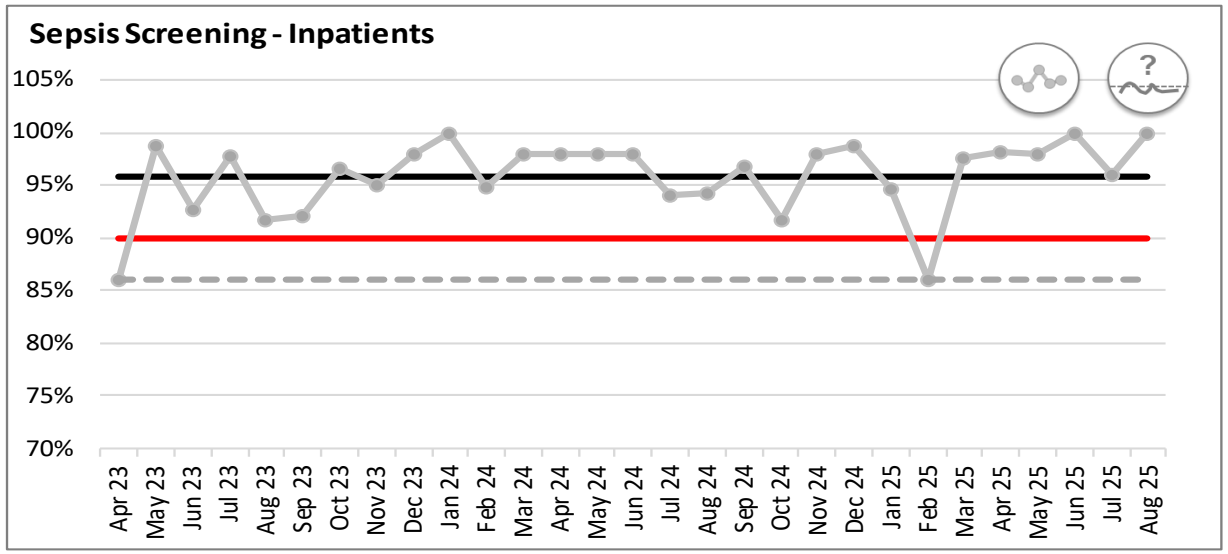
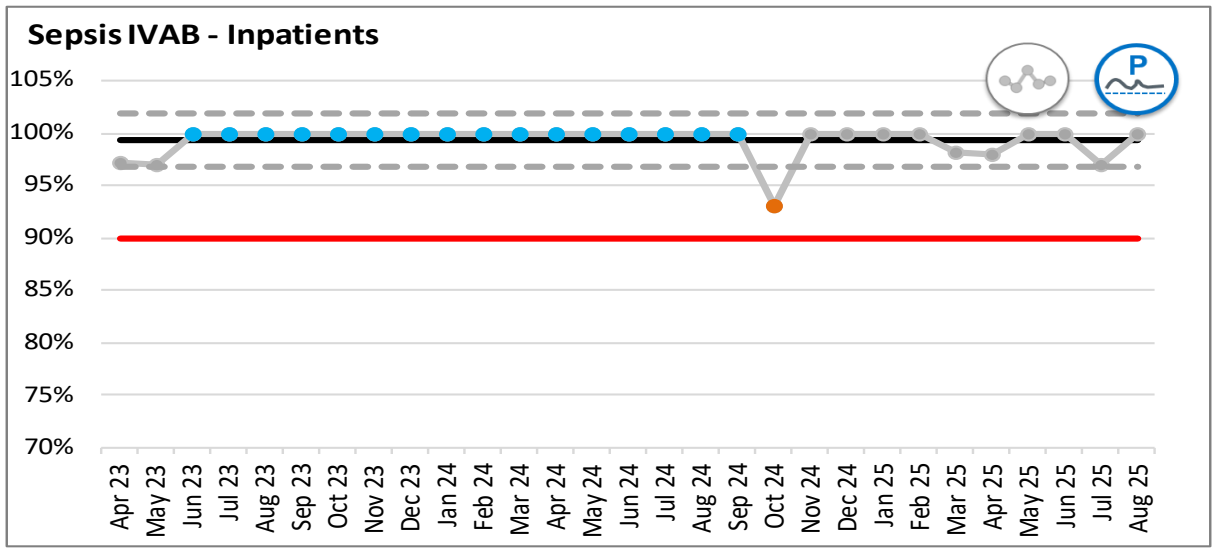




What is the data telling us?

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

A total of 104 cases were reviewed; there was no missed screenings. Among these, 67 cases were identified as red flag sepsis, with 40 receiving alternative diagnoses and 26 patients were already on IVAB treatment. Leaving one newly identified sepsis. This case received antibiotics within 1 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.

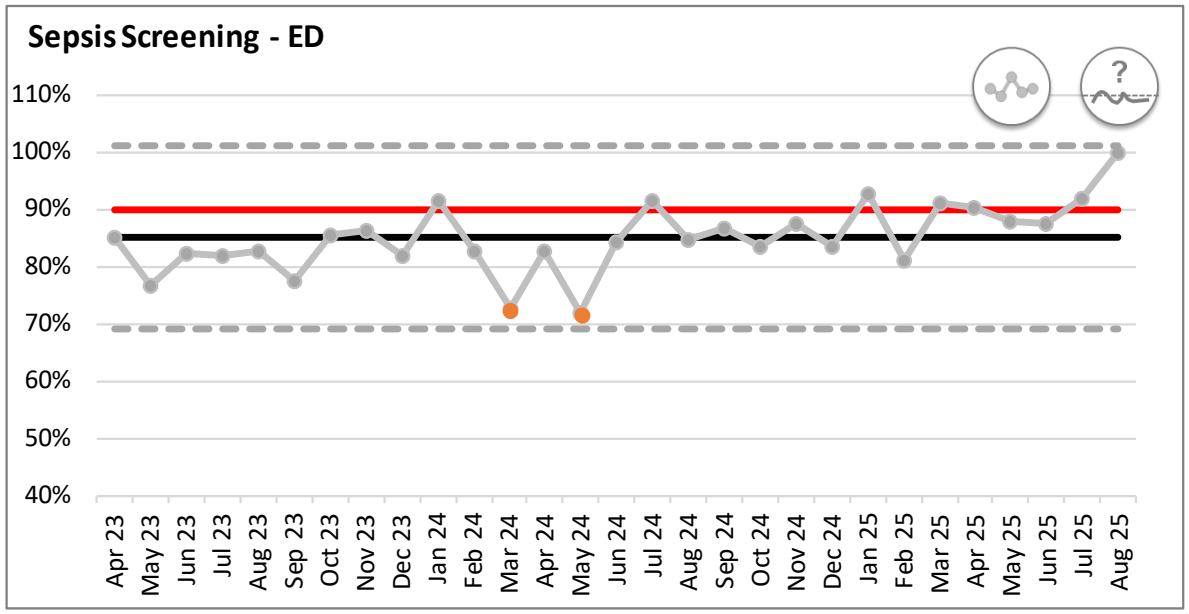
The sepsis team will continue to provide sepsis kiosks/ drop- in sessions to targeted clinical areas.

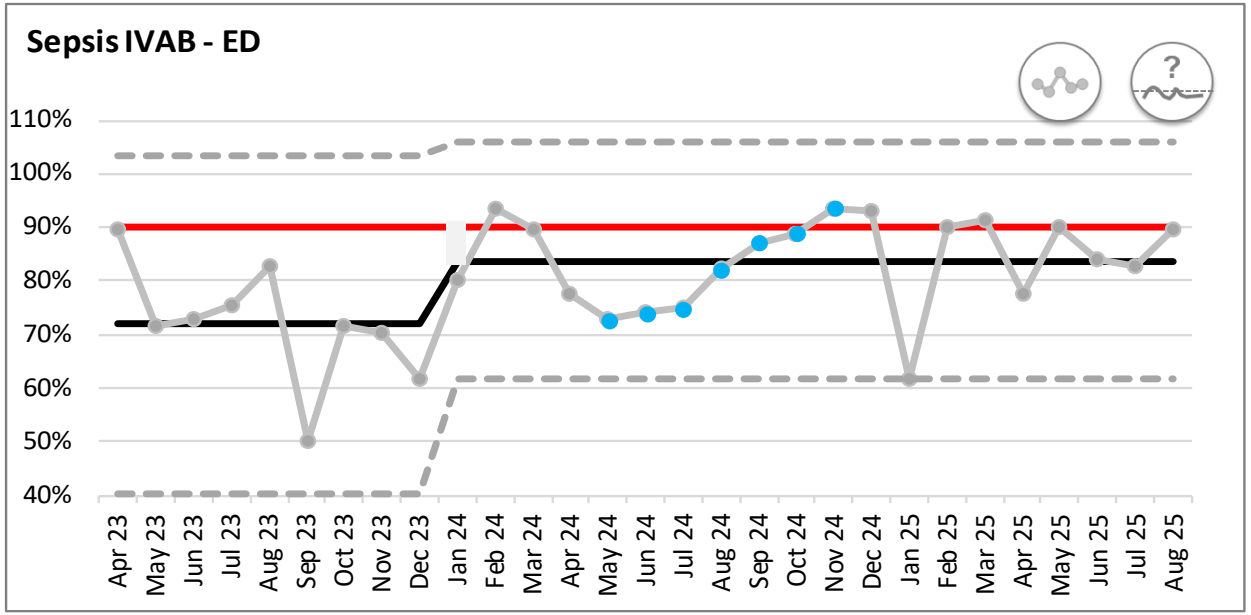
The sepsis team will continue to create drop-in training sessions for band 3s for all inpatient departments.

Quality & Access | [Sepsis – Emergency Portals]

Provide safe, effective and caring services

University Hospitals of North Midlands NHS Trust





What is the data telling us?

Average Adult Emergency portals screening compliance has been below the target of 90%, however, it was 100% in August 2025 for the first time..

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

In August, 142 red flag sepsis cases were audited in which 29 patients were already on IVAB. 64 patients had an alternative diagnosis leaving 20 newly identified sepsis patients. 4 patients received IVAB outside the target 1 hour window.

What are we doing about it?

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

Quality & Access | [Sepsis – Children]

Provide safe, effective and caring services

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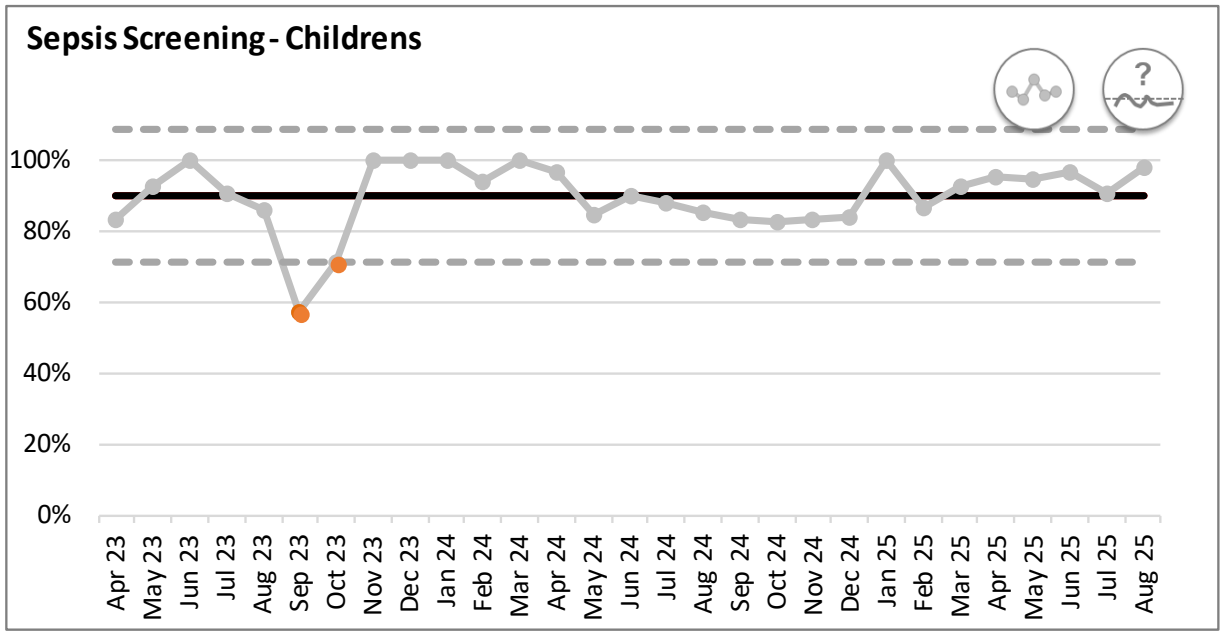
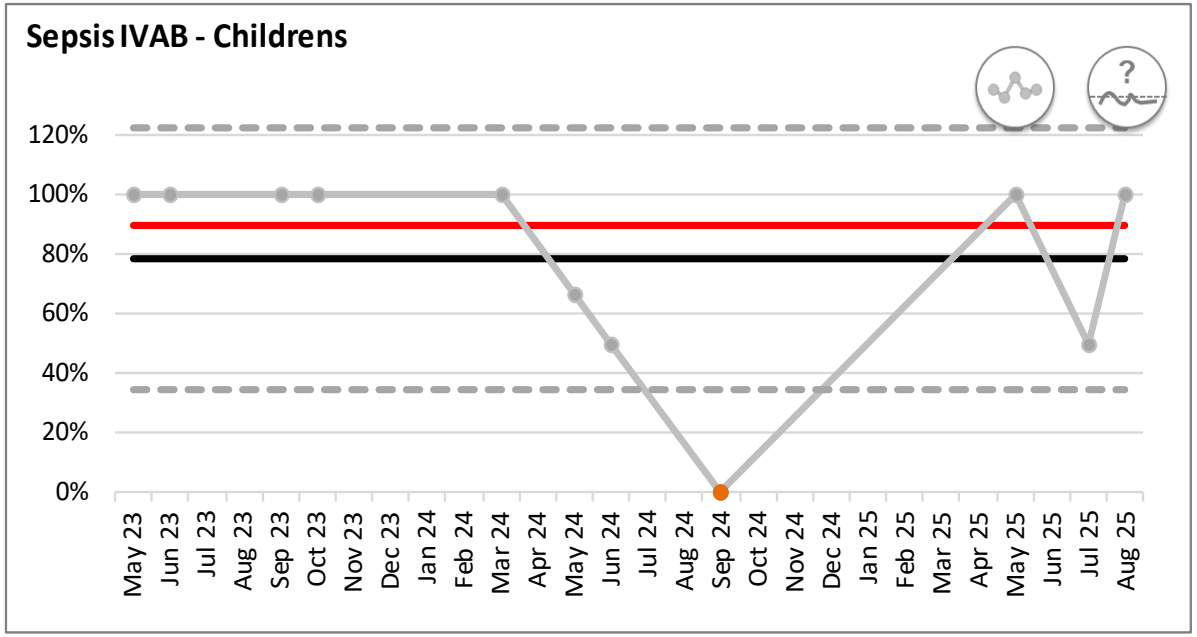




What is the data telling us?

We continue to see only a small number of children trigger with PEWS >5 and above in inpatient areas. Most inpatient paediatrics are already on oral or IV antibiotics prior to trigger of PEWS >5.

There were 30 cases audited for emergency portals with 1 missed screening. 6 cases audited for inpatients with no missed screening for inpatients.
No true red flag sepsis was identified from the randomised audits in the emergency portals or inpatients.

What are we doing about it?

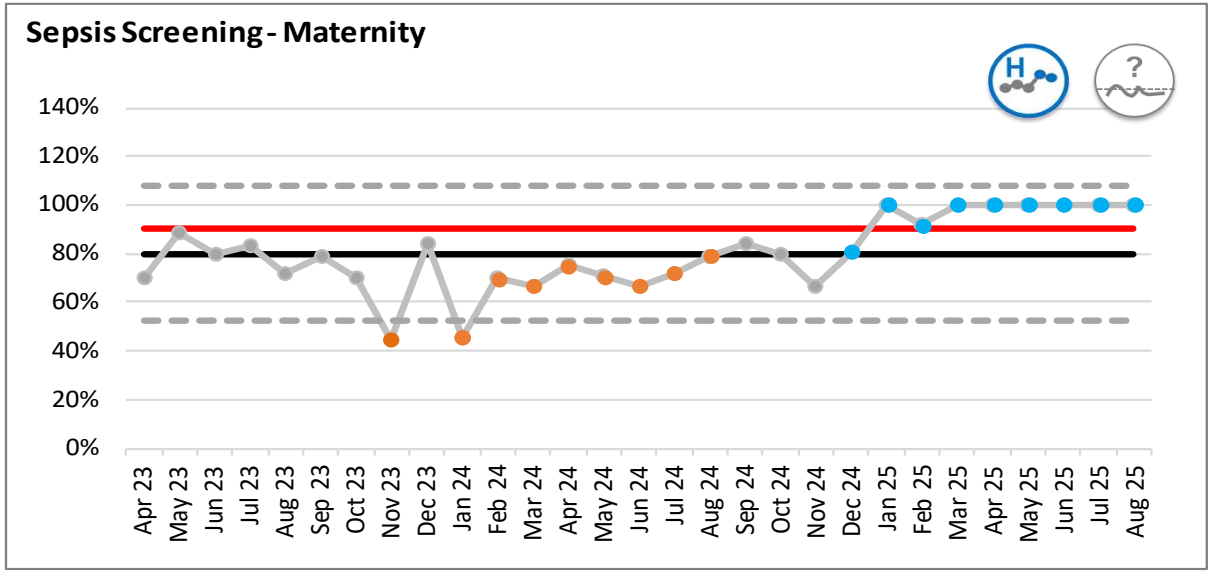
The sepsis team has continued to adjust the audit process in emergency portals to take smaller samples over a wider range of dates to give a more comprehensive perspective.

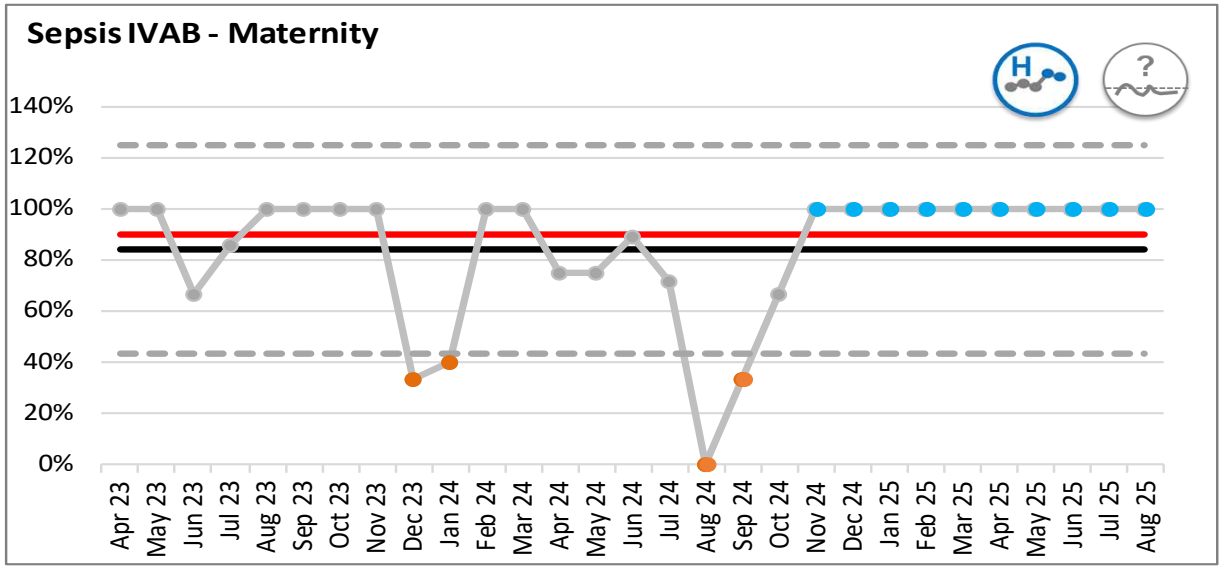
The sepsis team will continue to attend the mandatory training days and provide sepsis training to nursing staff and nursing assistants.

Quality & Access | [Sepsis – Maternity]

Provide safe, effective and caring services

University Hospitals of North Midlands NHS Trust





What is the data telling us?

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

A total of 7 cases were audited from the emergency portal MAU in August and 4 cases reviewed for inpatients, and there were no missed screenings.

What are we doing about it?

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

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

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

Quality & Access | [Clinical Effectiveness]

Provide safe, effective and caring services

University Hospitals of North Midlands NHS Trust

- 16 LocSSIP audits were published during Q1:
  - 10 Significant Assurance
  - 6 Significant Assurance with Minor Improvements
- 16 Pieces of NICE guidance outstanding for more than 12 months
- 3 External inspections were undertaken during Q1 – Awaiting final reports.
- 1 National Audit published during Q1 – Significant Assurance

1 NCEPOD report published during Q1 – Currently developing action plan

- 8 Clinical audits were published in Q1:
  - 2 Significant Assurance
  - 3 Significant Assurance with Minor Improvements
  - 3 Partial Assurance

What is the data telling us?

National Audit – Significant Assurance
National Paediatric Diabetes Audit

- Outcomes are like the previous years, and we are keeping pace with the West Midlands and national outcomes both in terms of median HbA1c and completion of care processes
- We were late adopters of insulin pumps regionally due to funding issues. We have increased patients on hybrid close loop insulin pumps by 100% in the last year.
- Our proposed plan of action is to target the patients in the lowest quintile of the socioeconomic stratification to see if we can improve the uptake of Hybrid closed loop pumps in this patient group. We also plan to focus on minority ethnic groups to improve the uptake in that cohort

Clinical Audit – Partial Assurance
Re-Audit of DNACPR

- Implementation of Level 2 training mandatory for those completing ReSPECT documentation
- Re-audit

Re-audit of ReSPECT Documentation

- The Mental Capacity Assessment will be integrated into Graphnet with digital prompts which will help facilitate this process.
- Information buttons have been added to the electronic document on Graphnet.
- Review of training
- Review of audit documents

Re-audit of Tissue Viability

- Educating staff in under- performing areas on how to complete the documentation
- Wards will utilise Tendable to provide self- assessment audit data
- Tissue Viability and Continence Champions to continue promoting cascade training
- Pressure Ulcer Prevention training package to be approved and uploaded onto ESR

What are we doing about it?

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

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

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

NOF - Access to Services

University Hospitals of North Midlands NHS Trust

Access to Services	Data period	Provider value	Chart
Access to services domain score	Q1 2025/26	2.55 NOF Score	

Elective Care	Data period	Provider value	Peer average	National value	National value method	Chart
Percentage of cases where a patient is waiting 18 weeks or less for elective treatment score			Q1 2025/26 2.04	NOF Score	Provider value	
Percentage of cases where a patient is waiting 18 weeks or less for elective treatment	Jun 2025	64.08%	56.59%	60.72%	Provider median	
Difference between planned and actual 18 week performance score			Q1 2025/26 1	NOF Score	Provider value	
Difference between planned and actual 18 week performance	Jun 2025	4.91%	1.42%	0.99%	Provider median	
Percentage of patients waiting over 52 weeks for elective treatment score			Q1 2025/26 2.83	NOF Score	Provider value	
Percentage of patients waiting over 52 weeks for elective treatment	Jun 2025	2.56%	2.75%	2.40%	Provider median	
Percentage of patients waiting over 52 weeks for community services score			Q1 2025/26 1	NOF Score	Provider value	
Percentage of patients waiting over 52 weeks for community services	Jun 2025	0.00%	0.15%	1.04%	Provider median	

Cancer Care	Data period	Provider value	Peer average	National value	National value method	Chart
Percentage of urgent referrals to receive a definitive diagnosis within 4 weeks score			Q1 2025/26 2.97	NOF Score	Provider value	
Percentage of urgent referrals to receive a definitive diagnosis within 4 weeks	Jun 2025	75.78%	75.42%	76.88%	Provider median	
Percentage of patients treated for cancer within 62 days of referral score			Q1 2025/26 3.36	NOF Score	Provider value	
Percentage of patients treated for cancer within 62 days of referral	Jun 2025	63.17%	61.66%	71.12%	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			Q1 2025/26 3.59	NOF Score	Provider value	
Percentage of emergency department attendances admitted, transferred or discharged within four hours	Jun 2025	68.00%	74.70%	76.00%	Provider median	
Percentage of emergency department attendances spending over 12 hours in the department score			Q1 2025/26 3.58	NOF Score	Provider value	
Percentage of emergency department attendances spending over 12 hours in the department	Jun 2025	15.15%	12.11%	8.36%	Provider median	

UHNM's access metrics show mixed performance. While elective recovery is progressing, urgent care pathways remain under pressure. Compared nationally, UHNM is positioned in the middle.

Quality & Access | Overview

University Hospitals of North Midlands NHS Trust

Overview from the Chief Operating Officer

How are we doing against our trajectories and expected standards?

Non-Elective

For the 4 hour standard in UEC our validated performance is 69.5% for August which is a deterioration of 1.4% from July and 5.2% behind trajectory of 74.7%. The national target for this standard is 78%.

In August 1757 patients waited longer than 12-hour in our Emergency Department compared with a validated position of 1559 patients in July. This is 192 patients over the trajectory for August.

Average handover time for ambulances attending our sites in August was 48.52 mins compared to 42 mins in July - all categories. The planning/improvement target agreed for August was 41 mins, 7.52 mins over plan. Total number of ambulances in August was 5543, of which 1532 had a delay of over 45 mins. This compares negatively to July, which had a total of 5692, of which 1342 were over 45 mins

The Trust has been escalated to tier 1 for our UEC performance.

Elective

Cancer: The combined faster diagnosis standard performance continues to see an improvement. FDS performance final July 2025 data, remained improved and above trajectory. August is currently unvalidated but is at 78.61% and an improved position from July and above trajectory (78.6% against trajectory of 76.4% + 2.3%). 31-day July validated performance was 93.4%, performance. Combined 62-day performance final July 2025 position at 70.6% against trajectory of 67.2% (+3.4%), and shows continuous improvement against June and May performance

Diagnostics: August DM01 data is unvalidated at time of writing this report however current performance is at 64.9% against the trajectory of 61.3%

RTT: Overall RTT performance is 62.3%; comfortably above trajectory which is 60%, the standard for this is 63%. Our 52-week performance is monitored as a % of patients on our total waiting list who are over 52 weeks, currently this is 2.2% which is better than our planned trajectory of 2.17%. This standard to achieve by the end of the year is to get to 1%.
We are ahead of our planned trajectory for wait for first appointment at 76.84%, the plan for this is 75.4%; 1.44% positive variance.

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

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

Quality & Access | Overview

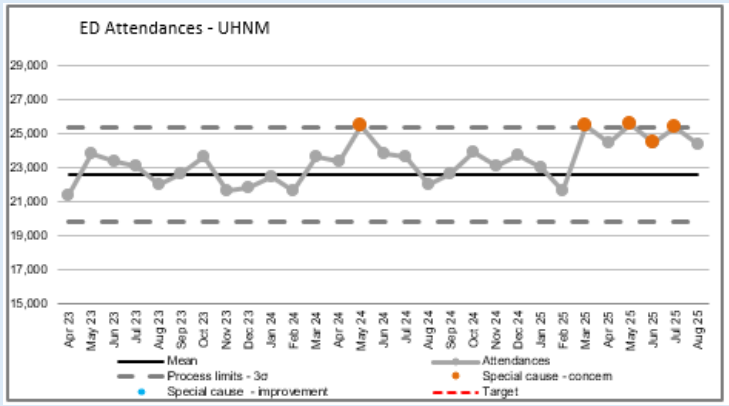
NHS University Hospitals of North Midlands NHS Trust

Overview from the Chief Operating Officer

What is driving this?

Non-Elective

4-hour performance is 5.2% outside our agreed improvement trajectory, Actual 69.5% verses a trajectory of 74.7%. Total attendance activity for July was 24364, a decrease on July's 25319 this is for all types and all portals. The attendance remains high and is remaining higher than it was over the winter period.



Variation	Assurance

Target	Jun 25	Jul 25	Aug 25
N/A	24461	25319	24364

Background

Total number of patients attending the Emergency Department including all Types (exc Type 5) for all Sites.

Flow for our patients from our Emergency Departments into inpatient bed base has been changed due to our UEC improvement programme and a switch from a YNP (your next patient) model, to a continuous flow model. Both the capacity of our Emergency Departments (overcrowding) and the profile of ambulance arrivals has impacted on the ability to offload in a timely manner. The Emergency department has adjusted its triage processes to improve clinical oversight of all patients and improve the departments time to triage within standard.

Elective

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

Non-Obstetric Ultrasound is the majority contributor for overall DM01 performance variance. Non obstetric ultrasound is currently in line with the trajectory developed to meet 95% DM01 performance by March 2026. The backlog has reduced from a high of 15500 patient in June to a current position of 11,500 patients. This trajectory has been developed to map through all the workstreams impacting NOUS with a view to delivering 95% DM01 by March 2026. BMUS guidance has now been turned on when vetting all new referrals and this standard has also been applied through validation to our current waiting list. This will bring US in line with other Trusts in the region in terms of vetting parameters. This has reduced conversion of referrals to scans by 15%

The reduction in patients waiting >65weeks to be treated has been possible due to an increase in capacity funded through ERF and close management of the waiting lists and booking processes. The volume of patients waiting 65 weeks reduced significantly to 105 in August from 131 in June. 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 now been in place since April 2025. We appointed a UEC Recovery Director who finishes in role in October now that ED and Acute Med have been placed back with our new Unplanned Care Group following some intensive work with the improvement leadership team.

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

There are now 6 workstreams due to the decision to extract the UTC Delivery programme from Workstream 1.

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

Alongside this there are tactical actions taken on a daily basis

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

Elective

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

As our UEC improvement programme develops, elective bed capacity is available to support our elective programme of work.

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

Quality & Access | Overview

University Hospitals of North Midlands NHS Trust

Overview from the Chief Operating Officer

What can we expect in future reports?

Non-Elective

August was challenging given the industrial action that aligned with a bank holiday weekend. We are expecting September to be increasingly challenged as the increased attendance usually associated with winter has begun two weeks earlier than usual at the start of the month, this is expected to be an increase on last years demand profile given the high summer starting point. The revised UEC Improvement Programme continues to develop. This will transition during October from our Improvement Programme Director to our newly appointed Deputy Coo for oversight with the Care Groups taking ownership of delivery, it is expected that this will begin to resolve our UEC performance – this will need to be systematic and prioritised.

At this point in the year the winter programme is stating to be mobilised and this will be covered in future reports.

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

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

Elective

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

The most immediate risk to cancer performance for September and October are the capacity pressures for first appointments and treatments for skin patients. All standards will be impacted by this specialty. Clinical and operational recovery meetings are taking place to stop and recover Skin position

County Elective Hub went live on the 7th April. Extended Weekend and evening sessions will start from September. Notably procedure numbers will significantly increase across County Theatres; activity increase to be tracked against delivery, specifically for Orthopaedics / General Surgery / Gynaecology

Quality & Access | Dashboard

University Hospitals of North Midlands NHS Trust

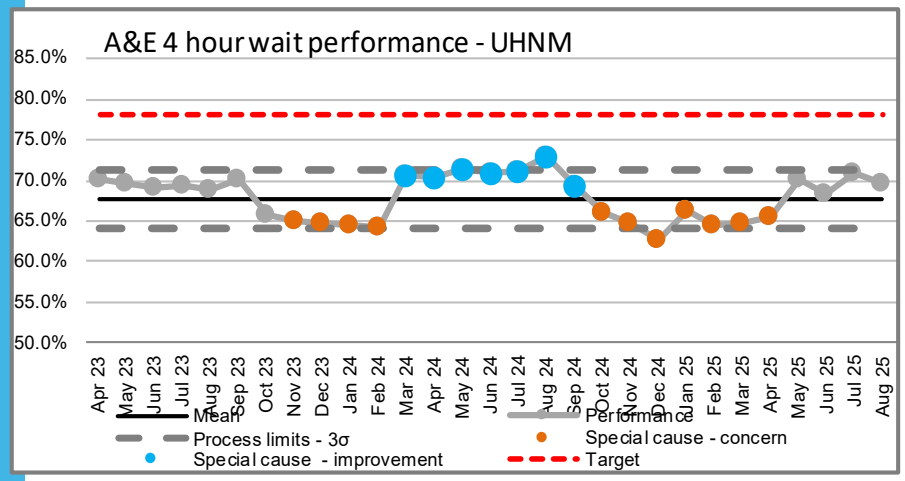
Metric	Target	Previous	Latest	Variation	Assurance	R12M Trend
UEC 4 Hour Performance	78%	70.9%	69.5%			
UEC 4 Hour Performance (Aged <18)	78%	90.7%	91.8%			
Over 12 hours in ED	2,128	1,559	1,757			
Over 12 hours in ED (Aged <18)	0	11	24			
Ambulance Handover Average Time	00:43:00	00:42:06	00:48:52			
Cancer 28 Day FDS	80%	77.3%	78.6%			
Cancer 31 Day Combined	96%	93.4%	92.2%			
Cancer 62 Day Combined	75%	70.6%	62.3%			
Diagnostics DM01 Performance	97%	59.7%	61.4%			
RTT Performance - <18 Weeks	63%	63.8%	62.3%			
RTT Performance - % 52+ Weeks	1%	2.3%	2.1%			
RTT Performance - % Waiting 1st Contact	77%	77.6%	76.9%			
RTT Performance - <18 Weeks (Aged <18)	63%	68.0%	67.0%			
RTT Performance - % 52+ Weeks (Aged <18)	1%	1.8%	1.6%			
RTT Performance - % Waiting 1st Contact (Aged <18)	77%	83.0%	82.5%			

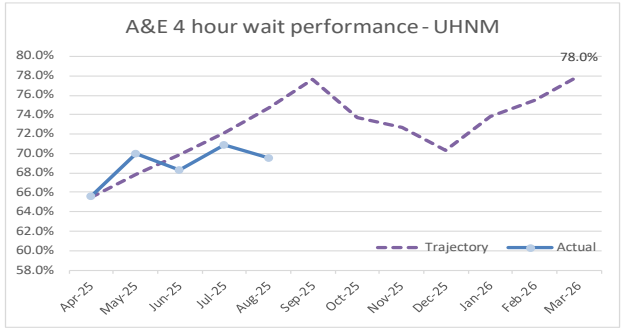
Related Strategy and Board Assurance Framework (BAF)

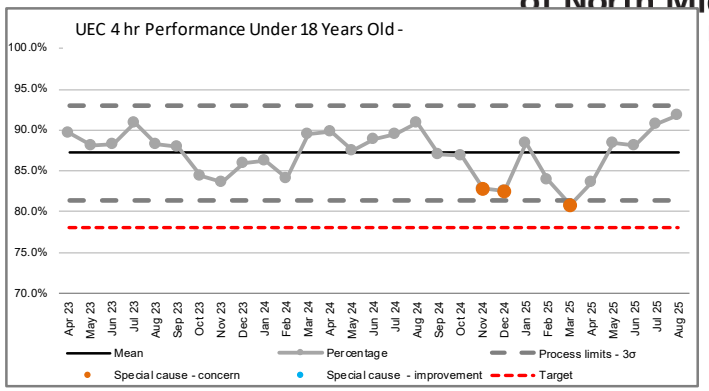
BAF Risk	Q1		Q2		Q3		Q4	
	Risk	Assurance	Risk	Assurance	Risk	Assurance	Risk	Assurance
BAF 1: Inability to Sustain Safe and Effective Care Delivery	Ext 16	Partial						

Quality & Access | UEC 4 hour Target

University Hospitals of North Midlands NHS Trust







Variation	Assurance	Monitoring against plan	May 25	Jun 25	Jul 25	Aug 25
	Target 78%	Actual	70.0%	68.3%	70.9%	69.5%
Background		Plan	67.9%	69.9%	72.2%	74.7%
The percentage of patients admitted, transferred or discharged within 4 hours of arrival at A&E		Variance	2.1%	-1.6%	-1.3%	-5.2%

What is the data telling us?

Validated performance is 69.5% for August, which is a marginal drop from 70.9% in July. Performance has stabilised well over summer with just 2.6% variation over a 4 month period (May – August)

The submitted improvement trajectory against the 4hr standard set for August was slightly short of Plan (Plan 74.7% vs Actual 69.5%), and also short of Target (Target 78% vs Actual 69.5%)

The teams ongoing work to improve this performance metric has sustained improvement since April '25

Type 1 4hr performance for Royal Stoke was 46.0% which marginally dropped since last month at 46.4%.

Type 1 4hr performance for County was 68.8% which has dropped by 3.3% since last month from 72.1%.

We are ranked as 106th out of 142 trusts which is a negative move down 13 Ranking places since April 2025 (119th).

What are we doing about it?

The UEC Improvement Programme has is supported by 5 workstreams and 1 enabling workstream designed to recovery, sustainability and delivery resilience

Development of co-located UTCs County and Royal sites. The UTC for Royal Stoke is now back in delivery programme but will not come on line in a phased way until January with June for full opening. County remains on pause

Develop clinical model delivery model for UTCs

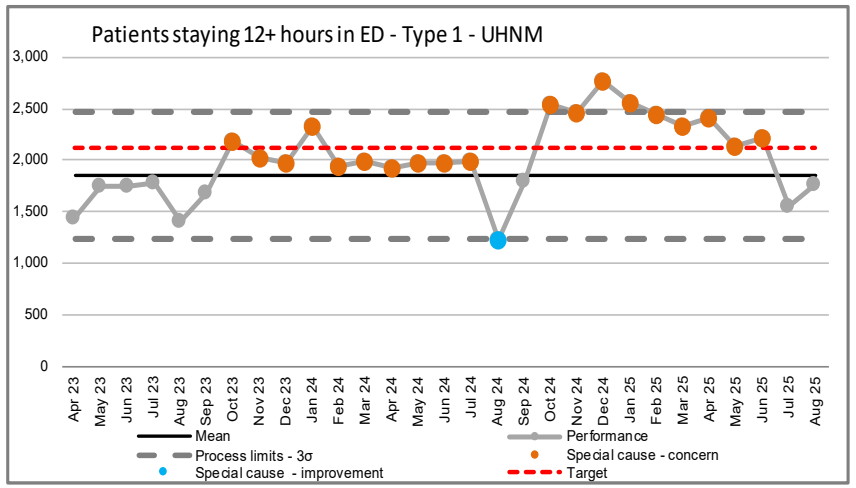
Our previous model of YNP (your next patient) has been transitioned to a continuous flow model.

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

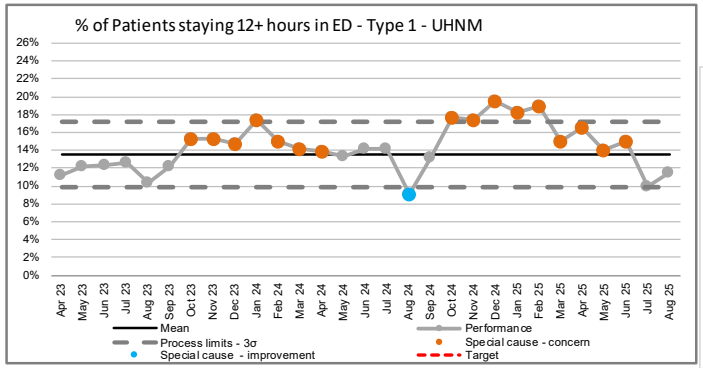
Plans to undergo a new ambulance offload test of change.

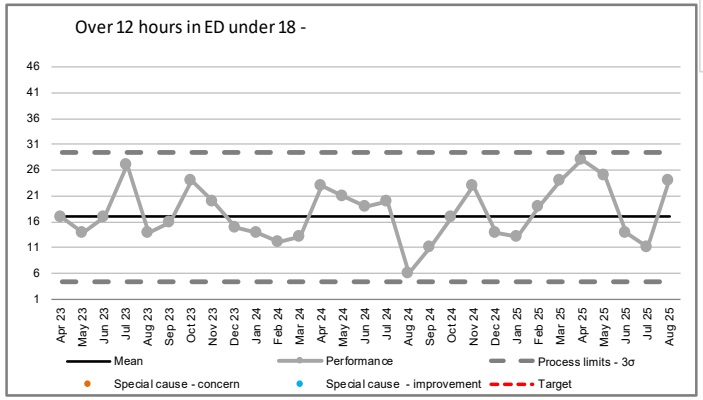
Quality & Access | Over 12 hours in ED From Arrival

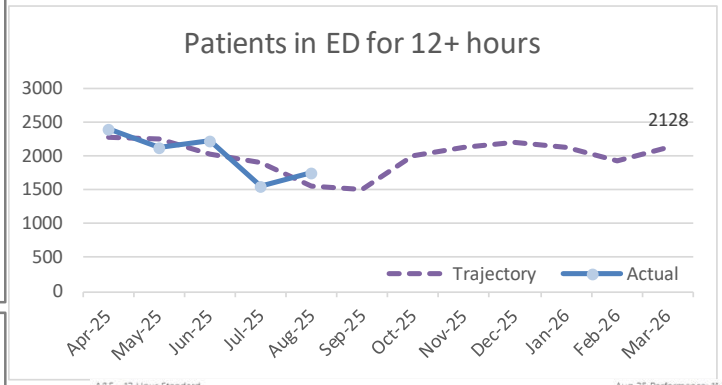
University Hospitals of North Midlands NHS Trust



Variation	Assurance		Monitoring against plan				
				May 25	Jun 25	Jul 25	Aug 25
	Target	2128	Actual	2,130	2,225	1,559	1,757
Background			Plan	2,259	2,031	1,907	1,565
The number of patients admitted,transferred or discharged over 12 hours after arrival at A&E			Variance	-129	194	-348	192







What is the data telling us?

In August, 1757 patients waited longer than 12 hours in ED compared to 1559 in July – demonstrating a 12% increase

The performance trajectory for August was 1565,wo we have underperformed against plan by 192.

Note, there has been a decreasing trend since January in the number of patients waiting over 10 hours albeit fluctuations against plan month on month.

What are we doing about it?

The UEC Improvement Programme is supported by 5 workstreams and 1 enabling workstream designed to advance recovery, sustainability and delivery resilience. The programmes which will support 12 hours are:

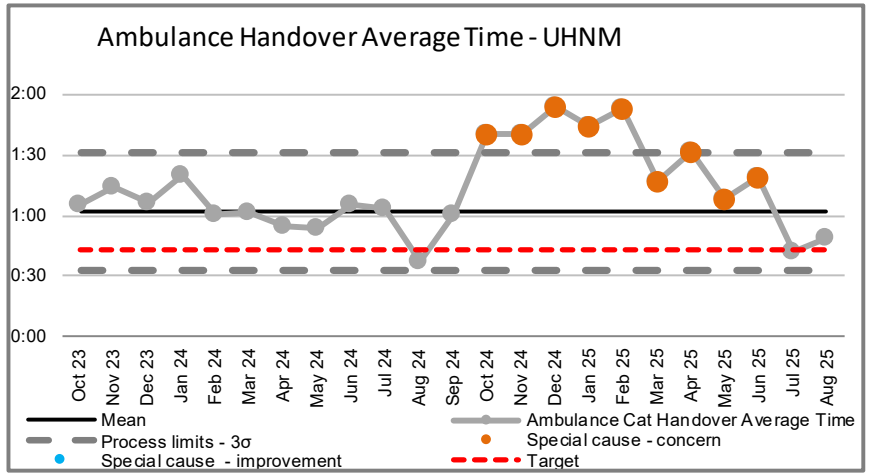
- WS1 Front Door Processes, WS2 Frailty Model, WS5 Ward Process and Discharge, including: -

1) review of demand and capacity across portals to streamline access
2) benchmark against best practice models
3) following the positive impact of the implementation of a Frailty Assessment Unit (FAU) at the County site over winter this unit will continue and replicated a Stoke
4) Use of the HRD tool
5) Improved utilisation of the discharge lounge and Acute Care at Home services to free up inpatient bed space

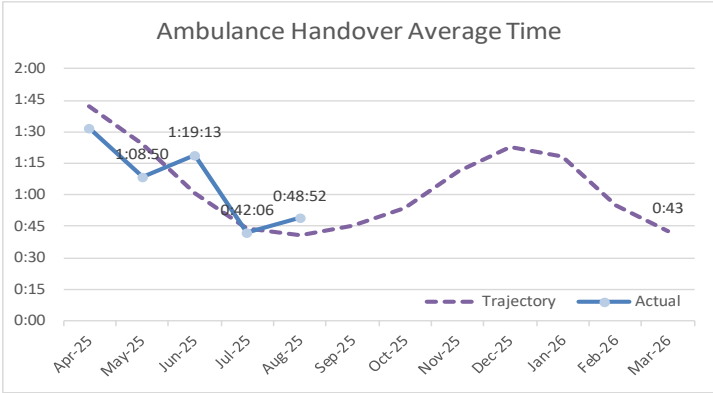
The above work continues to develop and mature, and will continue to provide more support in this domain. The actions above have been time-lined and are built into our planned recovery trajectory which you can see in the top right-hand graph.

Quality & Access | Ambulance Handover Average Time

University Hospitals of North Midlands NHS Trust



Variation	Assurance		Monitoring against plan	May 25	Jun 25	Jul 25	Aug 25
		Target 0:43:00	Actual	1:08:50	1:19:13	0:42:06	0:48:52
Background			Plan	1:24:00	1:01:00	0:44:00	0:41:00
The average time taken for patients to be handed over from Ambulances arriving at UHNM.			Variance	-0:15:10	0:18:13	-0:01:54	0:07:52



What is the data telling us?

Total number of ambulances in August was 5543, of which 1532 had a delay of over 45 mins (72.36% within 45 mins). This compares negatively to July, which had a total of 5692, of which 1342 were over 45 mins (76.42% within 45 mins)

Average handover time in August was 48 minutes, a marginal 6 minute increase since July.

The target for August was 43 minutes, meaning we underperformed against this by 5 minutes per ambulance (around 10% off target), and also fell short of plan which was 41 minutes, slightly less time than target.

What are we doing about it?

WS4 Bed & Site Management: - workstream is development and continues to mature

- Site management function review
- Review of patient flow resource
- Standardisation of processes including escalation levels – test of change in progress
- Continuous flow model (replacing YNP)

A review of escalation and triggers to support reduction in ambulance handover delays in partnership with WMAS is in train to replicate the London Ambulance Service model of no greater than 45 minutes to offload The corridor in the emergency department is utilised to support the risk of reducing the waiting ambulances

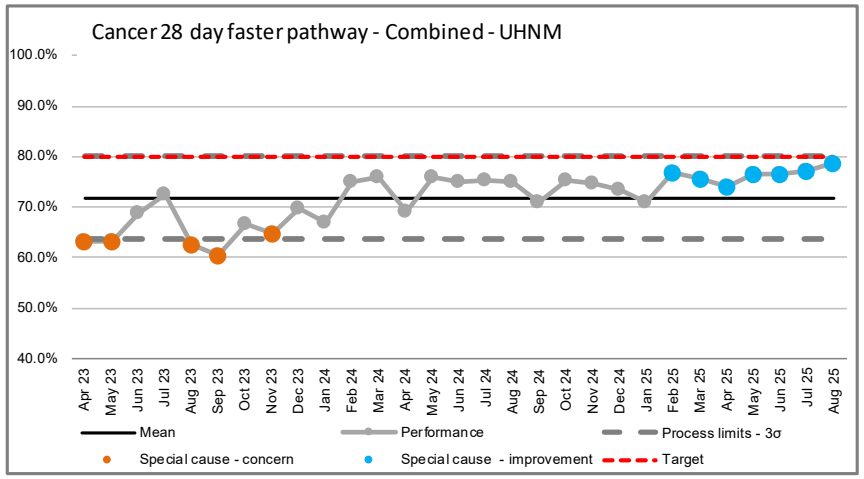
Review of current standard work and development of medical and nursing standard work to support ambulance offloads. This includes a piece of work that will look at the offload process

A revised HALO provision to cover 24/7 has been approved by The Urgent and Emergency Care Board and formal notification of funding has been received from the ICB

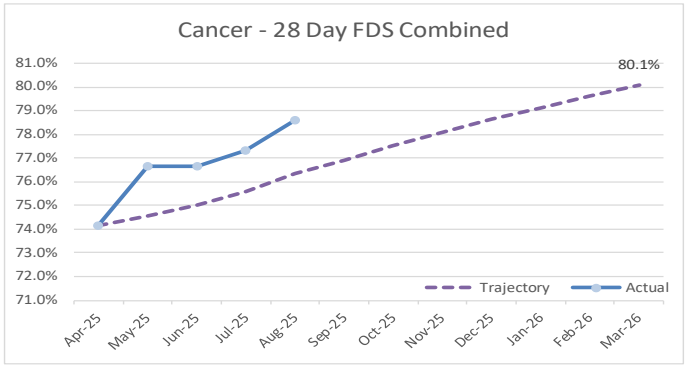
Regular daily contact with WMAS is in place to ensure confidence in actions taken and where possible deflects or diverts to County or Burton are agreed to support timely ambulance release

Quality & Access | Cancer 28 Day FDS

University Hospitals of North Midlands NHS Trust



Variation	Assurance		Monitoring against plan				
				May 25	Jun 25	Jul 25	Aug 25
	Target	80%	Actual	76.7%	76.6%	77.3%	78.6%
Background			Plan	74.5%	75.0%	75.6%	76.4%
Performance of confirmation or exclusion of cancer communicated with patients within the 28 day timeframe.			Variance	2.1%	1.6%	1.7%	2.3%



What is the data telling us?

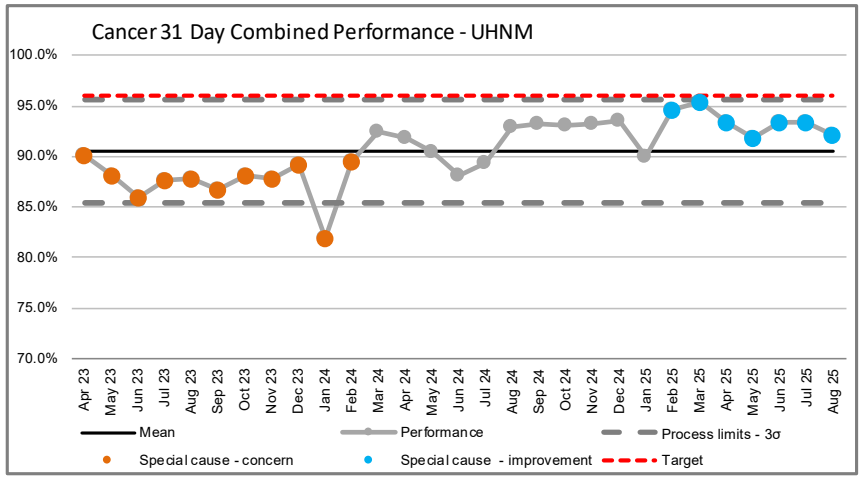
- Final July 2025 data, remained improved and above trajectory.
- August is currently unvalidated but is at 78.61% and again an improved position from July and above trajectory.
- Haematology, Sarcoma, Colorectal, Head and Neck and Urology are the most challenged specialties and are underperforming against their trajectories.
- Gynaecology have maintained their performance against trajectory and sit in a vastly improved position.
- We are continuing to see a year-on-year improvement for this standard.

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 of the recent WMCA funding to ensure teams enact their funding to assist in performance improvement.
- Two further improvement bids have been approved by NHSE to support the lung pathway and pathology turnaround times
- Renewed focus on specialty Improvement Groups to promote improvements for challenged sites.

Quality & Access | Cancer 31 Day Combined

University Hospitals of North Midlands NHS Trust



Variation	Assurance		Monitoring against plan				
				May 25	Jun 25	Jul 25	Aug 25
	Target	96%	Actual	91.9%	93.3%	93.4%	92.2%
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	-4.1%	-2.7%	-2.6%	-3.8%

What is the data telling us?

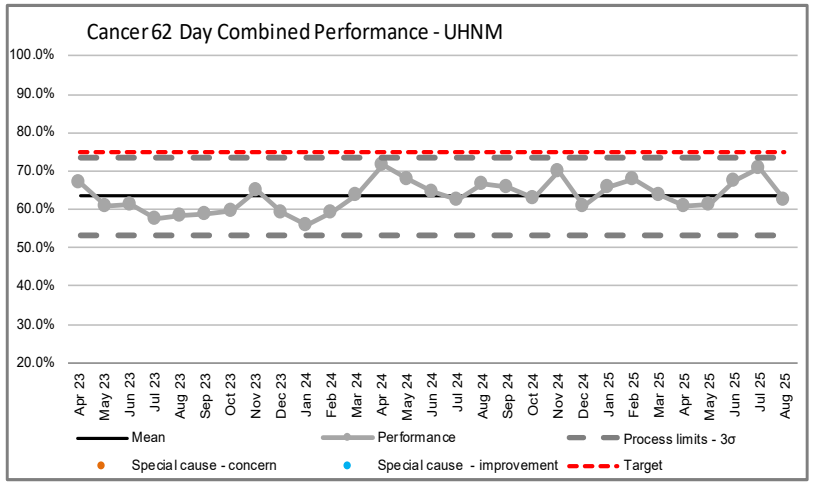
- Final performance validated position for July was 93.4%
- August 2025 unvalidated position currently 92.2%.
- The 31-day combined standard is mainly affected by the theatre capacity for treatment and improvements have plateaued due to the capacity pressures within skin.

What are we doing about it?

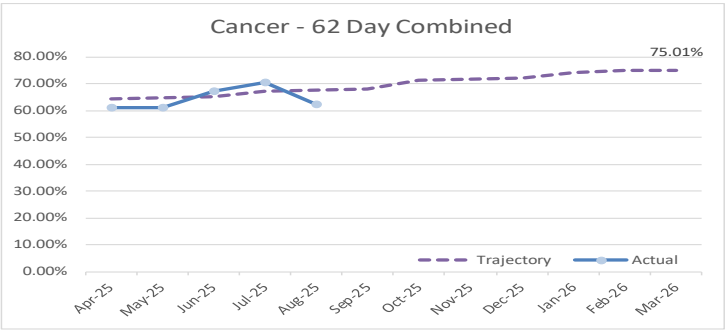
- Theatre capacity impacted during the summer due to the theatre improvement programme and the summer holiday period with AL (which also affects outpatient appointments). Mitigations were put in place to maintain the current position
- The Cancer Delivery Group and Specialty Improvement Groups are key forums to highlight pressures to performance and to action plan for improvements.
- The most immediate risk to cancer performance for September and October are the capacity pressures for first appointments and treatments for skin patients. All standards will be impacted by this specialty.
- The Cancer Team are aiming to validate pathways in real time to ensure the correct performance position is reported and any trends and themes that are impacting pathways can be raised with specialties.

Quality & Access | Cancer 62 Day Combined

University Hospitals of North Midlands NHS Trust



Variation	Assurance		Monitoring against plan	May 25	Jun 25	Jul 25	Aug 25
		Target 75%	Actual	61.2%	67.3%	70.6%	62.3%
			Plan	64.7%	65.4%	67.2%	67.9%
Background			Variance	-3.5%	1.9%	3.4%	-5.6%
% patients beginning their treatment for cancer within 62 days following an urgent GP referral for suspected cancer							



What is the data telling us?

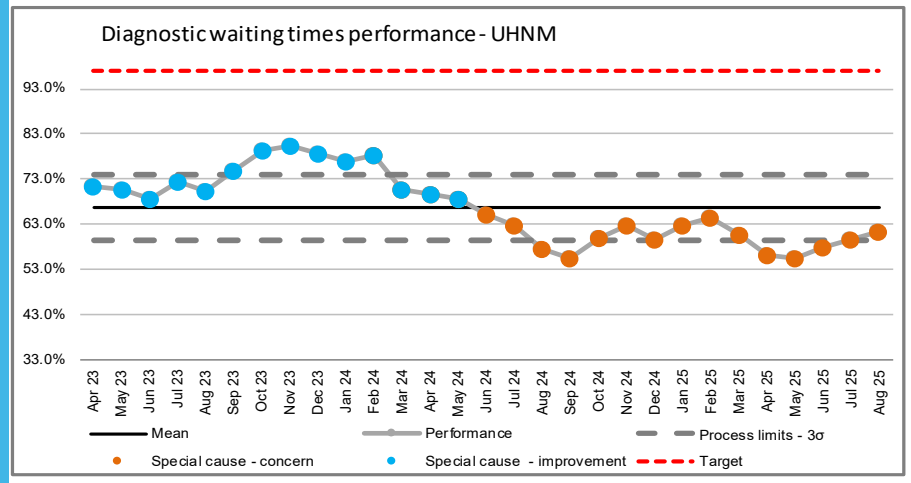
- Final July 2025 position (70.64%) demonstrated an improvement in performance and was above trajectory.
- Provisional August data shows performance of 62.34% against trajectory of 67.91% although this is expected to improve after validation.
- Colorectal, Gynae, Head & Neck, are below their trajectories.
- Skin performance is particularly challenged owing to capacity for diagnostics and treatment which is expected to impact on performance from September onwards.
- Surgical capacity constraints (including robotics) affecting Gynae, Colorectal and Skin

What are we doing about it?

- Increased oversight and adherence to improvement plans for support services such as pathology and radiology to bring down TAT in the diagnostic phase of challenged pathways, managed through Cancer Delivery Group.
- PMO style pathway reviews being undertaken. Lung and Gynae pathways have been reviewed.
- 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

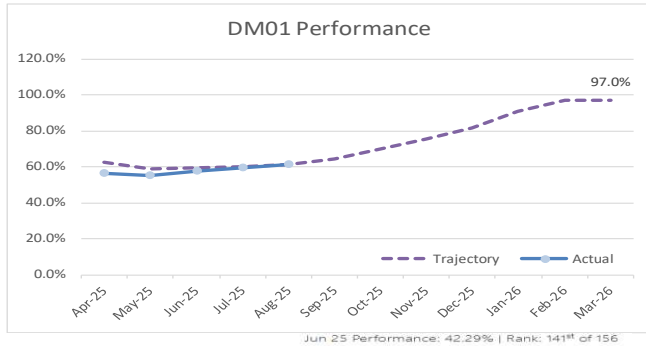
University Hospitals of North Midlands NHS Trust



Variation	Assurance		Monitoring against plan				
				May 25	Jun 25	Jul 25	Aug 25
	Target	97.0%	Actual	55.4%	57.8%	59.7%	61.4%
			Plan	58.7%	59.4%	60.1%	61.3%
			Variance	-3.3%	-1.6%	-0.5%	0.1%

Background

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



What is the data telling us?

July DM01 validated performance was 59.68% against trajectory of 60.1% (0.42% behind plan). August DM01 data is unvalidated at time of writing this report however current performance is at 64.9% against the trajectory of 61.3% (95% being the national standard).

Non-Obstetric Ultrasound is the majority contributor for UHNMs overall DM01 performance variance against the national standard, despite this, NOUS performance is on track against their monthly trajectory. DM01 position has improved by 3.8% due to NOUS recovery now taking grip.

Endoscopy has become a contributor to overall DM01 performance:

- Endoscopy performance reached 99% in June and July, however the position deteriorated in August to 78.3% as predicted due to loss of CDC capacity

What are we doing about it?

Non obstetric Ultrasound

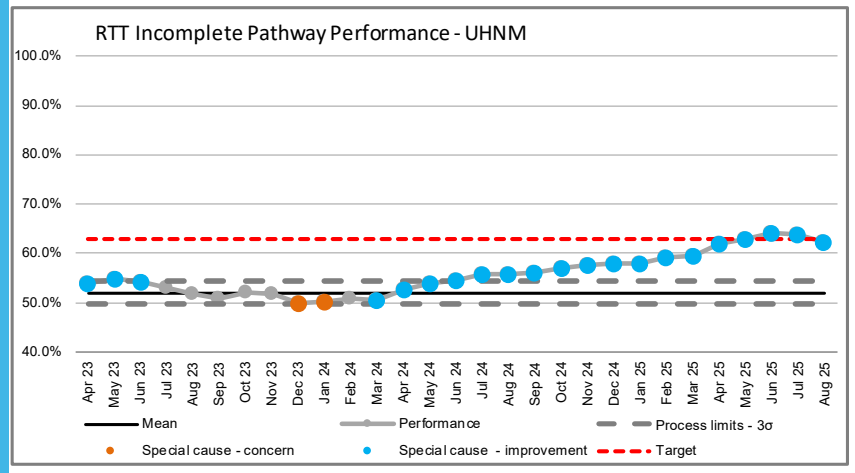
- Backlog position is starting to recover which will support an improvement in DM01 position in the coming months with a predicted end-of-week position of approximately 11,500 patients. Current backlog position has not been achieved for 12 months so strong sustained improvement now being delivered.
- 1000 patients have been discharged from NOUS backlog following clinical revalidation. LLC authorisation agreed
- Unvalidated performance is now 34.1%
- New MSK pathway being finalised with MPFT; new Non-medical referral SOP approaching sign-off which will allow diversion of appropriate activity to NIMS service

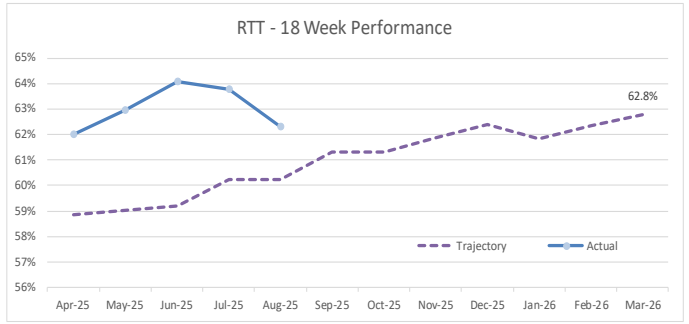
Endoscopy

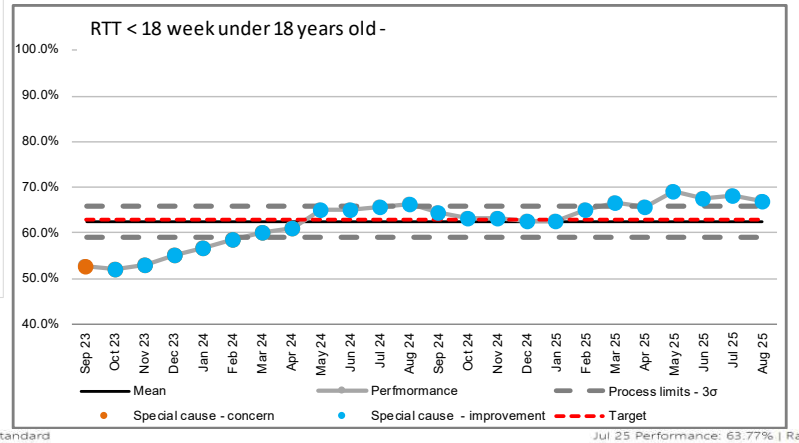
- WMCA bid not supported. Execs have approved Sept insourcing to provide c.1000 slots in month. Further paper to be drafted to support for Oct to allow recovery whilst rest of FY bus case developed.

Quality & Access | RTT Performance

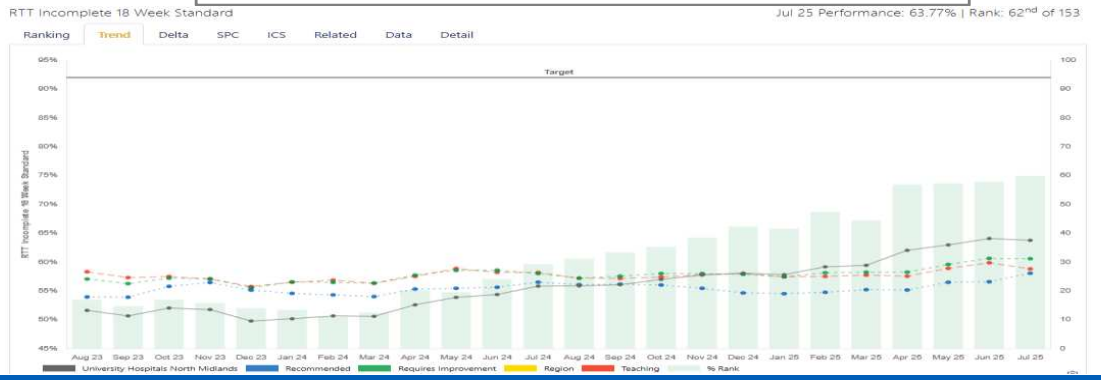
University Hospitals of North Midlands NHS Trust







Variation	Assurance		Monitoring against plan				
				May 25	Jun 25	Jul 25	Aug 25
	Target	63%	Actual	63.0%	64.1%	63.8%	62.3%
Background			Plan	59.0%	59.2%	60.2%	60.2%
The percentage of patients waiting less than 18 weeks for treatment.			Variance	3.9%	4.9%	3.5%	2.1%



What is the data telling us?

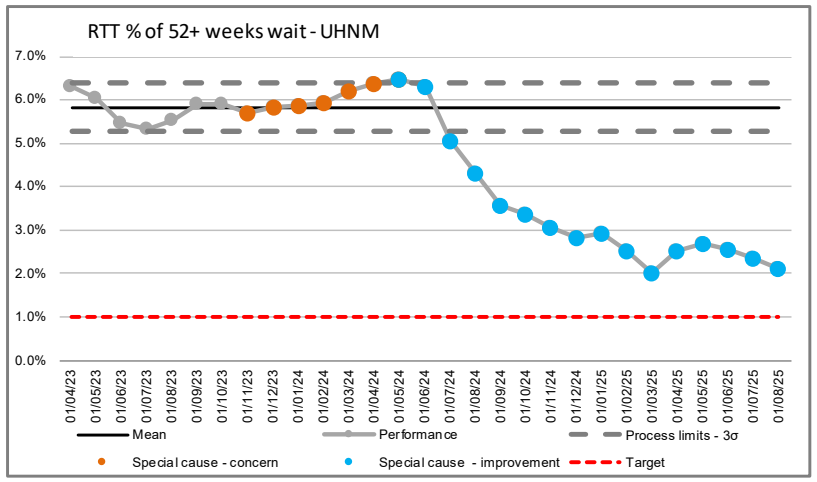
- Performance has improved significantly through extensive validation work completed by MBI, the Corporate Validation Team and the Care Groups. Performance is 62.3%; comfortably above trajectory
- Validated month end position in Total WL size has seen a further slight increase in August, from 65,919 to 66,865.

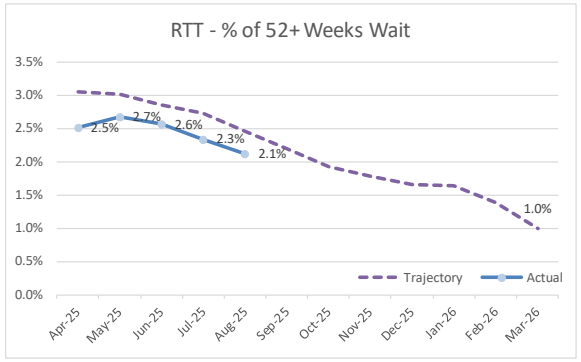
What are we doing about it?

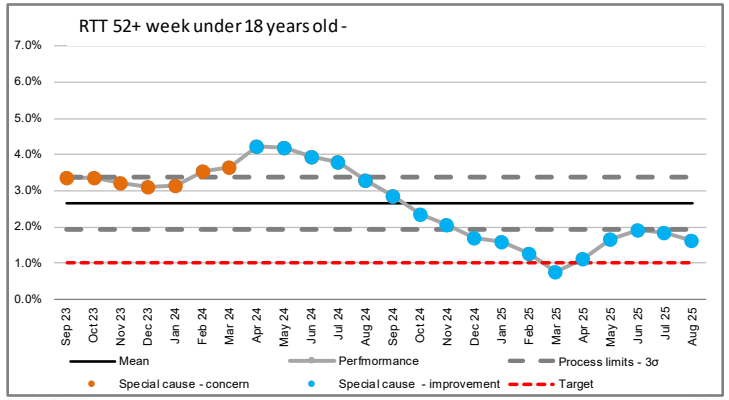
- Validation work will continue at pace to deliver the asks of the national validation sprint
- Work so far has targeted known areas of challenge with data quality and clock stop capture, which is disproportionally patients waiting 18+ weeks. 60% of the patients waiting <18 weeks have yet to be seen,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

Quality & Access | RTT Performance – % 52+ Weeks

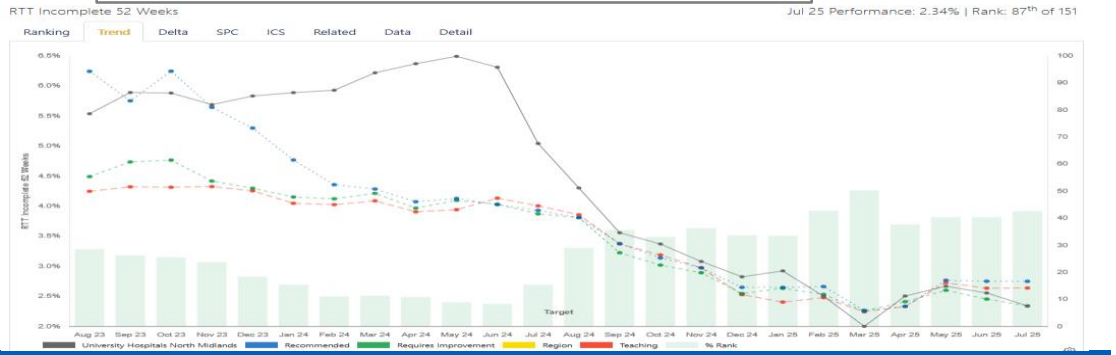
University Hospitals of North Midlands NHS Trust







Variation	Assurance		Monitoring against plan				
				May 25	Jun 25	Jul 25	Aug 25
	Target	1.00%	Actual	2.68%	2.57%	2.35%	2.13%
Background			Plan	3.01%	2.87%	2.74%	2.46%
The percentage of patients on a RTT pathway who have			Variance	-0.3%	-0.3%	-0.4%	-0.3%



What is the data telling us?

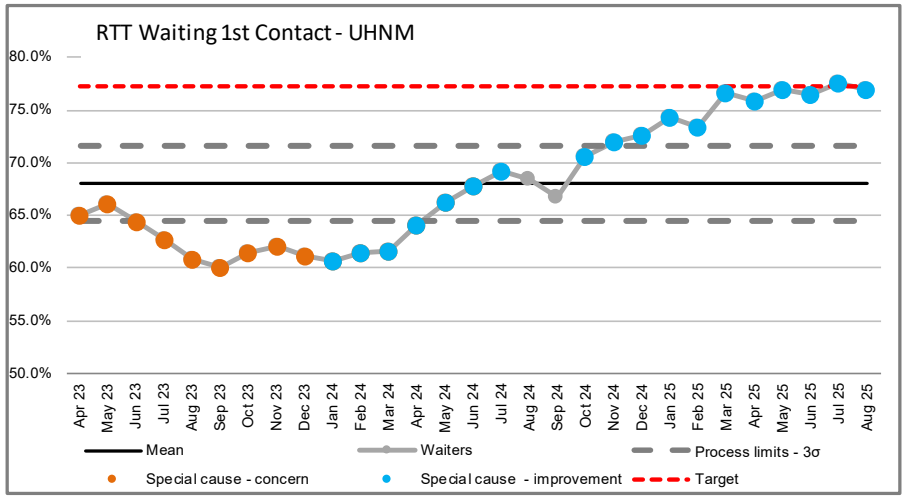
- We remain within plan for this standard
- This cohort is extensively validated, so there's not much scope for improvement through validation alone
- Another factor influencing this is the reduction in total waiting list size, so the unavoidable side effect of the validation programme is an increase in the percentage of the waiting list over 52 weeks

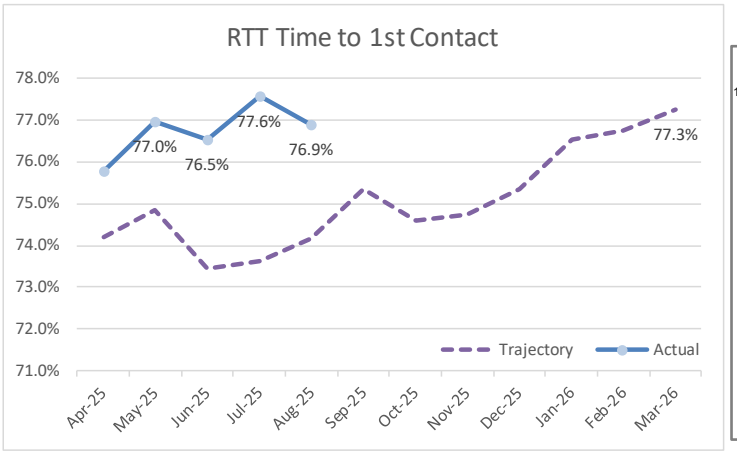
What are we doing about it?

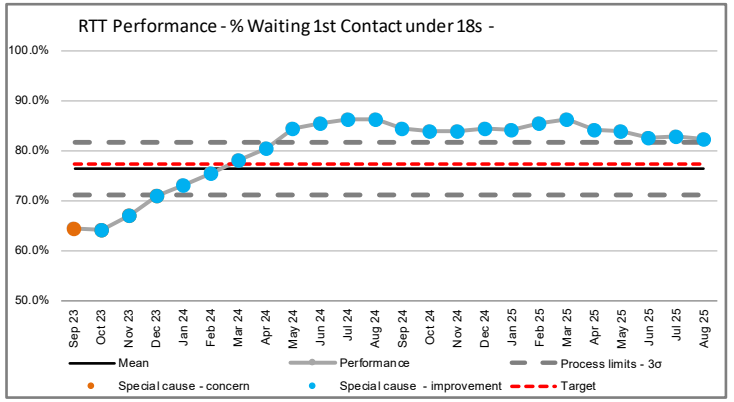
- The ROVA validation tool also highlights pathways where actions have not been taken, and groups pathways awaiting the same action for easier tracking of patients at all stages of the pathway
- Validation data is captured systematically in terms of what errors are being made and in which services, allowing for more targeted training and support for more challenged areas
- This metric will improve as the above takes hold, and far fewer patients reach 52 weeks

Quality & Access | RTT % Waiting 1st Contact

University Hospitals of North Midlands NHS Trust







Variation	Assurance		Monitoring against plan				
				May 25	Jun 25	Jul 25	Aug 25
	Target	77.3%	Actual	77.0%	76.5%	77.6%	76.9%
Background			Plan	74.8%	73.5%	73.6%	74.2%
Of all patients waiting for first event after referral - the percentage that are waiting under 18 weeks			Variance	2.1%	3.1%	3.9%	2.7%

What is the data telling us?

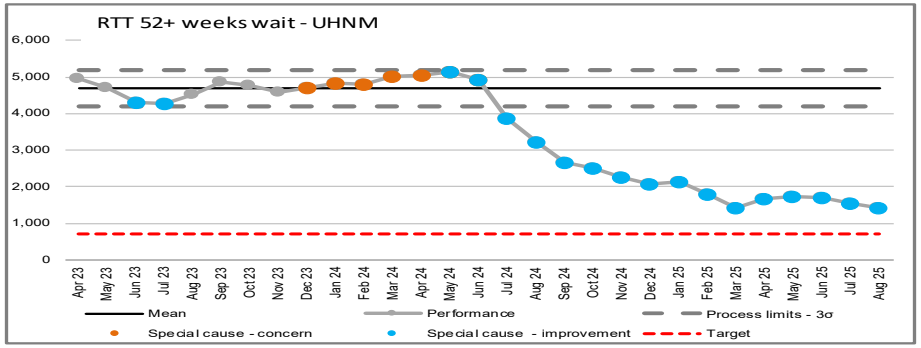
- UHNM is a regional leader on this metric and continue to be ahead of plan. August's position showed that 76.9% of patients were seen under 18 weeks against a plan of 74.5% (+2.4%)
- Performance continues to be steady

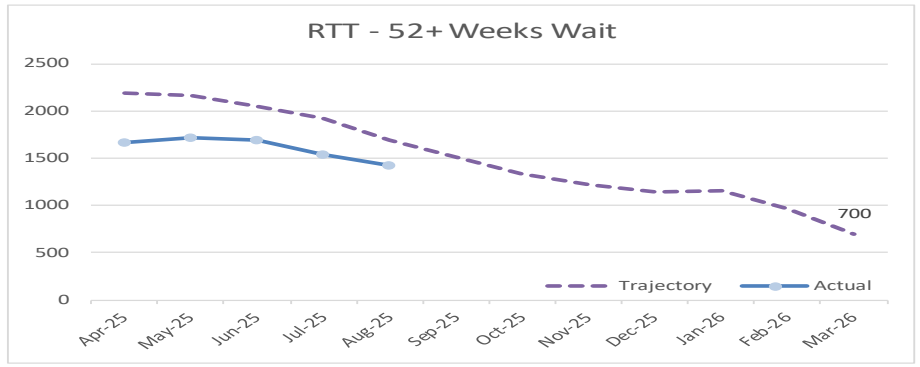
What are we doing about it?

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

Quality & Access | RTT No. of Long Waiting Patients

University Hospitals of North Midlands NHS Trust





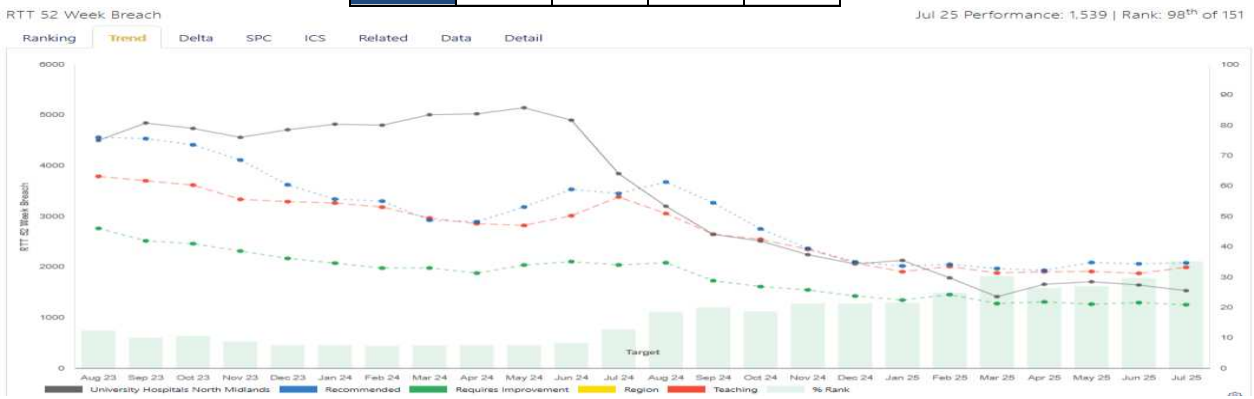
Variation	Assurance

Target	700

Background

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

Monitoring against plan	May 25	Jun 25	Jul 25	Aug 25
Actual	1,722	1,694	1,543	1,429
Plan	2,172	2,048	1,930	1,699
Variance	-450	-354	-387	-270
65+	233	131	110	108
78+	31	16	15	7
104+	0	3	1	0



What is the data telling us?

- Our overall ranking has improved from 111th out of 152 reporting Trusts to 98th out of 151 reporting Trusts
- The number of 78 week breaches has decreased from 14 in July to 7 in August
- 65 week waits have also reduced to 108 from 110 in July
- There is some risk with the extensive validation work underway of pop-up long waiters – these will be managed through the trust's "uncorrected breaches" process
- Particular specialties which impact are Orthopaedics, ENT, Ophthalmology and Gynaecology

What are we doing about it?

- Micromanaging long waiting patients at daily/weekly PTL meetings
- ERF funding approved to increase evening and weekend operating capacity

Highlight Report

Finance & Business Performance Committee | 28th July 2025

University Hospitals of North Midlands NHS Trust

Matters of Concern / Key Risks to Escalate	Major Actions Commissioned / Work Underway
• 3 / 5 of the strategic risks overseen by the Committee had been rated as extreme on the **Board Assurance Framework** (BAF); the in-year financial position (BAF 6), financial sustainability (BAF 7) and the ability to deliver digitally enabled care transformation (BAF 4). • An update was provided on the **Urgent Treatment Centre** (UTC) whereby there remained a gap in agreeing the revenue funding of £4.6 m. As such, it was agreed that the Trust could not continue to proceed at risk for the capital development. • Month 3 **financial performance** was on track with the £9.5 m deficit and the Committee noted that the contract with the Integrated Care Board (ICB) had since been agreed. There had been an overspend in pay due to the additional capacity which remained open although the Trust was delivering its agency outturn position, mainly due to the workforce controls in place. There had been slight slippage in capital (£8.9 m compared to the plan of £12.7 m) but this was expected to catch up in year. The Committee agreed with the rating of **partial assurance** • The Committee noted that there had been a £12 m improvement in **Cost Improvements** since the previous meeting, whereby over 50% of the schemes had been rated as Green, although £35 m remained in the ideas stage. The Committee welcomed the commencement of identifying savings for 2026/27 and noted the recalibration exercise, which was planned for September, the outcome of which was to be reported back to the Committee. The Committee concluded with a rating of **partial assurance**	• Further assurance to be provided within the next **BAF** update on the actions to be taken in order to reduce the strategic risks towards their target scores in addition to ensuring that these mitigated any gaps in control and assurance. • Update to be provided at the next meeting of the funding source for the **Child Health Tier 2 Resident Doctor** business case • To identify the potential operational performance impact of not continuing with the **UTC** in addition to continuing to escalate the implications of not securing the associated revenue • To consider what further assurance was required to be provided to the Committee in terms of **CIP** savings and updates from the Recovery Oversight Group

Positive Assurances to Provide	Decisions Made
• The Committee welcomed the refreshed format of the **BAF** which had been refined to include summary overviews, in addition to being mapped to the revised Strategic Priorities and the three primary issues facing the Trust	• The Committee supported the revised **Terms of Reference** for the Committee which would be taken to the Trust Board for approval, with slight amendments requested in terms of ensuring the focus was on the role of the Committee to seek assurance • The Committee approved **BC-0604: Child Health Tier 2 Resident Doctor Investment** • Given lack of agreement of revenue funding, the Committee agreed with the decision to not proceed with the **UTC** • The Committee approved the **Water Procurement Contract** and noted the collaboration with Walsall Healthcare and Royal Wolverhampton • The Committee approved **e-REAFs** 16525, 16494, 16215, 16180, 16599, 16609, 16639, 16780

Comments on the Effectiveness of the Meeting	Cross Committee Considerations
• Comments were sought from members electronically – the results from which would be shared with the Chair	Given the discussion regarding Tier 2 resident doctors, two cross-committee considerations were agreed: • Quality, Access & Outcomes Committee - further assurance was requested in terms of confirming whether there were other potential staffing risks within the organisation

	• People, Culture & Inclusion Committee – to consider the triangulation required to identify other potential areas of concern (i.e. exception reports and unfilled rotas)

Summary Agenda

No.	Agenda Item	BAF Mapping			Purpose	No.	Agenda Item	BAF Mapping			Purpose
		BAF No.	Risk	Assurance				BAF No.	Risk	Assurance	
1.	Board Assurance Framework Q1 2025/26	4, 5, 6, 7, 8		N/A	Approval	5.	Water Procurement Contract	5	High 12	N/A	Approval
2.	Finance & Business Performance Terms of Reference	4, 5, 6, 7, 8		N/A	Approval	6.	Finance Report – Month 3 2025/26	6, 7	Ext 20	Partial	Assurance
3.	BC-0604: Child Health Tier 2 Resident Doctor Investment	3	ID34826	N/A	Approval	7.	Cost Improvement Report	6, 7	Ext 20	Partial	Assurance
4.	Urgent Treatment Centre Update	1	Ext 16	N/A	Approval	8.	Authorisation of New Contract Awards, Contract Extensions and Non-Purchase Order (NPO) Expenditure	-		N/A	Approval

Highlight Report

Finance & Business Performance Committee | 1st September 2025

University Hospitals of North Midlands NHS Trust

Matters of Concern / Key Risks to Escalate	Major Actions Commissioned / Work Underway
• The Committee noted the risks arising from the **business cases** which had the potential to affect year end delivery and future year delivery. Although the Trust was not seeking further funds, these also did not help to improve the £30 m unmitigated cost improvement position • Month 4 **financial** position was on plan with a £11 m deficit, although risks remained, particularly in relation to activity, with an underperformance of up to £2.9 m and recovery plans were being worked up. It was noted that this had not yet been included in the position as the contract had not been signed and both the ICB and Trust were reporting the same position. The Committee concluded with a partial assurance rating • The update on the **Cost Improvement Programme** (CIP) provided partial assurance, although the Committee noted the positive movement to fully developed schemes of £48.3 m, of which £6.2 m had been implemented. However, £25 m remained at risk. The Mutually Agreed Redundancy Scheme (MARS) had closed, and the Trust was working through applications. • The provision of a **Urgent Treatment Centre** (UTC) at Royal Stoke was expected to be delayed to November 2025 and the Committee noted the potential difficulty in taking this forward during the winter period	• To provide further assurance with regards to confirmation of funding for **business case** BC-0597, including associated impact on the plan and the benefits realisation profile • Assurance to be provided to the Committee on the deep dive being undertaken into **grip and control** in terms of the £30 m unmitigated cost improvement risk • Continuing actions were being taken to explore potential additional CIP opportunities, working with regional and national teams • Future **finance** reports to include further assurance in relation to the future financial outlook • Further clarification to be provided in the bi-annual updates on the **Green Plan** in how the Trust was contributing to the national net zero targets against the baselines • To provide further assurance in relation to **e-REAFs** 16796, 16610 and 16607

Positive Assurances to Provide	Decisions Made
• Re-current funding identified for an **Urgent Treatment Centre** (UTC) at Royal Stoke and a revised capital business case had been articulated, although the revenue had yet to be formally confirmed • The revised **Green Pl**an was recognised by the Committee as an excellent document, providing acceptable assurance	• The Committee agreed to receive further assurance on **business case** (BC-0597) for additional elective caesarean section maternity theatre sessions in addition to uplift in maternity theatre staffing, via email. Once provided, it was agreed to approve this via email. In addition, the associated e-REAF 16610 was to be approved once the recurrent funding had been confirmed. • The Committee approved the NMCPS blood science managed service contract extension **business case** (BC-0615) • The Committee approved the increase in **capital** funding for Community Diagnostic Centre and Breast Care Unit and the associated realignment of schemes • The Committee supported the Outline Business Case for progression to a full Business Case for a **Digital Imaging Platform** • The Committee supported the revised UHNM **Green Plan** (2025-2028) which was to be further updated prior to being considered by the Trust Board • The Committee approved the revised capital business case for Royal Stoke **UTC** subject to formal confirmation of revenue funding • The Committee approved the following **e-REAFs** 16937, 16910, 16796, 16607, 16440, 16439 and 16905

Comments on the Effectiveness of the Meeting	Cross Committee Considerations
• Comments on effectiveness were requested from members via MS Forms	• The reliance on the **UTC** and the associated impact on access targets were to be considered by the Quality, Access and Outcomes Committee

Summary Agenda

No.	Agenda Item	BAF Mapping			Purpose	No.	Agenda Item	BAF Mapping			Purpose
		BAF No.	Risk	Assurance				BAF No.	Risk	Assurance	
1.	BC-0597 Recurrent Investment for Additional Elective Caesarean Section Maternity Theatre Sessions and Uplift in Maternity Theatre Staffing	1 & 3	Ext 16 / Ext 15	N/A	Approval	5.	UHNM Green Plan 2025/26 – 2028/29	5	High 12	N/A	Approval
2.	BC-0615 NMCPS Blood Science Managed Service Contract Extensions	-	-	N/A	Approval	6.	West Midlands Imaging Network CDIP Outline Business Case	-	-	N/A	Approval
3.	Finance Report – Month 4 2025/26	6, 7	Ext 20	Partial	Assurance	7.	Urgent Treatment Centre Update	-	-	N/A	Approval
4.	Cost Improvement Programme Report	6, 7		Partial	Assurance	8.	Authorisation of New Contract Awards, Contract Extensions and Non-Purchase Order (NPO) Expenditure	-	-	N/A	Approval

Highlight Report

Finance & Business Performance Committee | 29th September 2025

University Hospitals of North Midlands NHS Trust

Matters of Concern / Key Risks to Escalate	Major Actions Commissioned / Work Underway
• The **business case review** update provided **partial assurance** due to the number of reviews which remained overdue (x6) although 13 had been reviewed and completed since April 2025. It was agreed that future reports would include updates on the date for completing any outstanding reviews and the reasons for the delay • Month 5 **financial performance** delivered a deficit of £12.1 m, as planned. In addition, the Trust's updated forecast suggested a year-end deficit of £25 m which was an improvement since month 4, although an improvement plan to achieve breakeven was to be provided to NHS England. **Partial assurance** was therefore agreed • Month 5 **cost improvement** (CIP) update highlighted that 67% of the CIP target was green rated, with £14.9 m implemented. However, £20.1 m schemes continued to be rated 'red'. The Committee agree with the rating of **partial assurance** and requested further detail in terms of any delivery challenges in future updates, including the output of the recalibration exercise • **Productivity** report provided **partial assurance**. It was requested that a further deep dive into theatre productivity be undertaken, and it was agreed that this would be considered by Executives prior to being reported to the Committee.	• It was agreed to explore how many Trusts were expecting to state 10 / 10 compliance with **maternity** CNST for 2025/26 • Further improvements to the **business case review** process to be made in terms of monitoring benefits realisation and highlighting any key themes and learning from previous reviews • Further information to be provided to Non-Executive Directors of the associated metrics and methodology used within the **productivity** report • Future updates on **procurement** to identify any additional opportunities within research, development and innovation • To provide further detail as to the reason for only 10 new electric vehicles being in place within the Trust's **fleet** given the focus on sustainability • **Investment assurance** report to be provided to the Committee in due course to highlight the Trust's expenditure in totality

Positive Assurances to Provide	Decisions Made
• The committee received a new report in terms of **demand and activity**, which was provided following the change in focus of committee. Going forwards it was agreed that the report would avoid any duplication with the productivity report • **Acceptable assurance** was provided in relation to the **Sustainability and Net Zero Carbon** bi-annual report which particularly highlighted the launch of the low carbon care framework. Risks in terms of constraints on budget, workforce capacity and reduced capacity within the ICB were highlighted although mitigations had been considered • **Significant assurance** was provided by the **procurement** update with key highlights being the year-to-date savings of £10.95 m which was above target. Whilst the inclusion of the Staffordshire and Stoke on Trent ICB procurement team into the joint model was on hold, pending confirmation of the ICB restructure, discussions remained ongoing with regards to wider collaboration and consolidation opportunities	• The Committee approved **BC-0603 Business Case for Medical, Nursing and Administration Workforce for the Nephrology Service** • The Committee approved the **Birthrate Plus Midwifery Staffing** 2025 Business Case subject to further confirmation from the Executive of the funding source, which would be clarified as part of seeking approval from the Trust Board. It was noted that if approved this would also be subject to the double lock with the Integrated Care Board (ICB) • The Committee approved the reduction in the **capital programme** from £111.1 m to £103.3 m as a result of the re-profiled forecast due to slippage on deferral of the Urgent Treatment Centre, and approved the pre-committed capital schemes • The Committee approved the **Royal Stoke Heat Network Optimisation** business case • The Committee approved **e-REAFs** 16597, 16610, 16849, 16883, 16975, 16993, 17026 and 17069

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

Summary Agenda

No.	Agenda Item	BAF Mapping			Purpose	No.	Agenda Item	BAF Mapping			Purpose
		BAF No.	Risk	Assurance				BAF No.	Risk	Assurance	
1.	BC-0603: Phase 1 - Sustainability and Recurrent Investment in the Medical, Nursing and Administration Workforce for the Nephrology Service	1 & 3	Ext 16 / Ext 15	N/A	Approval	7.	Productivity Report	6, 7		Partial	Assurance
2.	Birthrate Plus Midwifery Staffing 2025	1 & 3	Ext 16 / Ext 15	N/A	Approval	8.	Sustainability and Net Zero Carbon (NZC) Bi-annual Performance Report	5		Acceptable	Assurance
3.	Business Case Review Update	-	-	Partial	Assurance	9.	BC-0620 Royal Stoke Heat Network Optimisation	5		N/A	Approval
4.	Finance Report – Month 5	6, 7	Ext 20	Partial	Assurance	10.	Procurement Report	6, 7		Significant	Assurance
5.	CIP Report	6, 7	Ext 20	Partial	Assurance	11.	Authorisation of New Contract Awards, Contract Extensions and Non-Purchase Order (NPO) Expenditure	-	-	N/A	Approval
6.	Draft Demand and Activity Report	-	-	N/A	Discussion						

Since 14th June to 14th September 2025, 12 contract awards over £1.5 m were made, as follows:

- **Linen & Laundry Services,** supplied by Elis (Berendsen), for the period 01.08.25 - 31.08.26, at a total cost of £4,275,917, approved on 10th July 2025
- **Maintenance of CDC Equipment,** supplied by Siemens Healthcare (via NHS SC), for the period 01.04.25 - 31.03.35, at a total cost of £3,548,224, providing savings of £13,838, approved on 10th July 2025
- **Surgical Drapes & Gowns Services,** supplied by Elis (Berendsen), for the period 01.08.25 - 31.08.26, at a total cost of £1,638,230, approved on 10th July 2025
- **Da Vinci Xi Surgical Robot,** supplied by Intuitive Surgical Ltd, Capital Bid 8444, at a total cost of £1,989,300, providing savings of £293,280, approved on 10th July 2025
- **Supply of X-ray Contrast Media,** supplied by Bayers, Bracco, GE & Gubert, for the period 01.09.25 - 31.08.26, at a total cost of £1,817,337, providing savings of £63,788 approved on 16th June 2025
- **Trauma, CMF and Orthopedic External and Internal Fixation Consumables,** supplied by Johnson and Johnson Medical Limited, for the period 01.09.25 - 31.08.26, at a total cost of £1,829,535, providing savings of £37,459 approved on 7th August 2025
- **Histopathology Outsourcing of Laboratory Specimens and Reporting,** supplied by Source Bioscience, for the period 01.09.25 - 31.08.26, at a total cost of £3,500,000, providing savings of £140,000 approved on 7th August 2025
- **Allied Health Professionals (AHP) and Health Science Services (HSS) Master Vendor contract,** supplied by HCRG, for the period 08.12.25 - 07.12.27, at a total cost of £6,161,873, providing savings of £53,916 approved on 7th August 2025
- **Managed Printed Stationery,** supplied by Harlow Printing Ltd, for the period 11.08.25 - 10.07.28, at a total cost of £1,721,938, providing savings of £32,390 approved on 7th August 2025
- **Water Supply, Waste Water and Storm Water Removal,** supplied by Water Plus, for the period 11.08.25 -10.08.29, at a total cost of £6,134,603, providing savings of £131,981 approved on 7th August 2025
- **Provision of O365 Licences,** supplied by CDW, for the period 01.08.25 – 31.07.26, at a total cost of £1,613,393, providing savings of £56,630 approved on 7th August 2025
- **Cath Lab Interventional Cardiology Consumables,** supplied by Vascular Perspectives, Terumo, Teleflex, Medtronic, Boston Scientific, BBraun, Biotronic, Actostak, Abbott Medical, Philips Volcano, Biosensors, Spectranetics, Cordis, for the period 01.10.25 - 31.09.28, at a total cost of £4,101,897, providing savings of £150,992 approved on 11th September 2025

NHS
University Hospitals of North Midlands
NHS Trust

Integrated Performance Report

Month 05 Performance

2025/26

Kind Excellent Together

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.

NOF - Finance and Productivity

Finance and productivity	Data period	Provider value		Chart
Finance and productivity domain score	Q1 2025/26	2.36	NOF Score	

Finance	Data period	Provider value	Peer average	National value	National value method	Chart
Combined finance score			Q1 2025/26 1	NOF Score	Provider value	
Planned surplus/deficit score			Q1 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			Q1 2025/26 1	NOF Score	Provider value	
Variance year-to-date to financial plan	Jun 2025	0.03	-0.62	0.00	Provider median	

Productivity	Data period	Provider value	Peer average	National value	National value method	Chart
Implied productivity level score			Q1 2025/26 3.73	NOF Score	Provider value	
Implied productivity level	Mar 2025	-2.47%	1.74%	2.91%	Provider median	

UHNM is demonstrating a good position when compared nationally, although latest months data is suggesting some deterioration across each metric. Productivity metrics require continued focus as these are positioned in the lowest quartile.

Kind Excellent Together

Finance | Financial Summary

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

This report presents the financial performance of the Trust for August 2025 (month five).

The Trust has delivered an £12.1m deficit, which is in line with the planned deficit of £12.1m for month five.

Income: The income is underperforming by £5.6m, 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 Trust must address the underperformance in Elective Inpatients and First Attendance to avoid potential financial repercussions; there is a risk at month four of £5.4m under delivery. The contract with the ICB has now been signed and agreed in principle and the implementation of action plans by the Financial Recovery Board are crucial steps in ensuring financial stability.

Expenditure: There is an underspend in Pay expenditure of £2.5m and non-pay is underspent by £8.2m year to date.

Financial Outlook 2025/26: The Trust's updated forecast shows a year-end deficit of £25.0m, an improvement since month four of £7.2m. However, NHSE has requested an improvement plan by the end of October 2025 outlining steps toward breakeven.

CIP: The Trust has a £74.8m CIP target for 2025/26. To month five, the Trust is reporting £14.8m savings in year, against a target of £16.7m, however £1.8m is being delivered non-recurrently above the original non recurrent plan of £5.1m.

Capital: The capital expenditure plan for 2025/26 is £111.1m with a reprofiled forecast of £103.3m. The reduction of £7.8m relates to slippage and deferral on the UTC and deferral of the discharge planning lounge. The year-to-date position shows spend of £23.1m against plan of £28.9m, mainly relating to CDC Phase 1, Breast Care Unit and PFI related payments. Spend is expected to recover and will be closely monitored at the Capital Investment Group.

Statement of Financial Position: The month five Statement of Financial Position shows total assets employed at £255.6m. The cash balance at month five is £103.2m against a plan of £63.0m. The variance is mainly due to cash received relating to ERF overperformance and additional deficit funding.

System Position: The system month five position has a favourable variance of £0.5m from the planned deficit of £20.9m.

Financial Risks: Several risks have been identified that could deteriorate the Trust's financial position, including additional unfunded escalation capacity, shortfall against CIP plans, winter planning, and lower activity levels than required to meet ERF income targets. In addition, recent developments in respect of Junior Doctors industrial action represents a further risk as there are no indications impact will be funded. Mitigations will need to be put in place if there is a deterioration in the financial position.

Finance | Income and Expenditure

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

The Trust has delivered a £12.1m deficit at month five, which is in line with the planned deficit of £12.1m.
The table below summarises the Income and Expenditure position at month five.

Income & Expenditure Summary Month 05 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	1,212.3	102.7	97.3	(5.4)	506.5	494.6	(11.9)
Other Operating Income	100.8	8.9	8.6	(0.3)	40.5	40.6	0.0
Total Income	**1,313.1**	**111.6**	**105.9**	**(5.7)**	**547.0**	**535.1**	**(11.9)**
Pay Expenditure	(777.2)	(67.0)	(64.6)	2.4	(332.6)	(330.1)	2.5
Non Pay Expenditure	(503.7)	(43.0)	(39.9)	3.1	(213.1)	(204.9)	8.2
Total Operational Costs	**(1,280.9)**	**(110.1)**	**(104.6)**	**5.5**	**(545.7)**	**(535.0)**	**10.7**
EBITDA	**32.2**	**1.5**	**1.3**	**(0.2)**	**1.3**	**0.1**	**(1.2)**
Interest Receivable	2.6	0.3	0.6	0.2	1.1	2.4	1.3
PDC	(4.8)	(0.4)	(0.4)	(0.0)	(2.0)	(2.1)	(0.1)
Finance Cost	(30.0)	(2.5)	(2.5)	(0.0)	(12.5)	(12.5)	(0.0)
Other Gains or Losses	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Surplus / (Deficit)	**(0.0)**	**(1.1)**	**(1.1)**	**0.0**	**(12.1)**	**(12.1)**	**0.0**

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. To month five, the Trust is reporting £14.8m savings in year, against a target of £16.7m, however £1.8m is being delivered non-recurrently above the original non-recurrent plan of £5.1m.

The table below summarises the month five position:

	Plan 31/08/2025 YTD £'000	Actual 31/08/2025 YTD £'000	Variance 31/08/2025 YTD £'000
Recurrent			
Pay - Recurrent	6,810	3,564	(3,246)
Non-pay - Recurrent	3,322	2,384	(938)
Income - Recurrent	1,460	1,874	414
Total recurrent efficiencies	**11,592**	**7,822**	**(3,770)**
Non recurrent			
Pay - Non-recurrent	1,460	4,372	2,912
Non-pay - Non-recurrent	2,791	2,326	(465)
Income - Non-recurrent	889	284	(605)
Total non-recurrent efficiencies	**5,140**	**6,982**	**1,842**
Total Efficiencies	**16,732**	**14,804**	**(1,928)**

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Finance | Capital

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

The tables below set out the updated base case capital expenditure plan for 2025/26 of £111.1m and the reprofiled forecast of £103.3m.
At month five capital expenditure is £23.1m against a plan of £28.9m, an underspend of £5.85m. Of this expenditure £9.8m is in relation to the payments committed under the PFI or IFRS16 leases. The main areas of underspend are in relation to the significant PDC funded schemes for the CDC enabling works (£4.5m) and the County Breast Unit (£3m). Overall there is an underspend of £0.8m on capital sub-group expenditure to month five.

UHNM Capital Expenditure Plan 2025/26	Revised Capital Plan £m	Forecast outturn £m	Variance £m	YTD plan M5 £m	YTD actual M5 £m	Variance £m
Pre-committed items - PFI and Loans						
PFI re-payment of liability	14.900	14.900	0.000	6.208	6.208	0.000
PFI lifecycle commitments	2.268	2.268	0.000	1.030	1.030	0.000
PFI PACS refresh - increase to PFI liability	0.200	0.200	0.000	0.000	0.000	0.000
PFI MES - increase to PFI liability TBC	7.131	7.131	0.000	0.737	0.737	0.000
Repayment of IFRS16 leases	4.272	4.272	0.000	1.780	1.780	0.000
Total PFI and IFRS16 lease repayments commitments	**28.771**	**28.771**	**0.000**	**9.755**	**9.755**	**0.000**
Investment items						
PFI enabling costs	0.181	0.181	0.000	0.000	0.000	0.000
Network & Comms BC525	0.748	0.349	0.399	0.713	0.041	0.672
Fortinet licences	0.000	0.399	0.000	0.000	0.000	0.000
LED lighting BC546	0.427	0.427	0.000	0.000	0.009	(0.009)
IM&T computer hardware refresh BC569	2.142	2.142	0.000	0.107	0.479	(0.372)
Investment funding for new business cases 25/26	0.250	0.250	0.000	0.000	0.000	0.000
Project Star - RI remedial work	0.010	0.010	0.000	0.000	0.000	0.000
ED ambulance off - enabling ward moves	0.006	0.006	0.000	0.006	0.006	0.000
Endoscopy works 7th room - PDC ICB allocation TBC	0.009	0.009	0.000	0.009	0.009	0.000
Completion of County Holding Bay	0.074	0.074	0.000	0.034	0.014	0.020
Managing H&S risk register - BC562 (from £500k)	0.043	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
Royal Stoke high voltage upgrade BC required	0.752	0.752	0.000	0.052	0.018	0.034
Printer lease refresh BC591	0.593	0.593	0.000	0.247	0.000	0.247
Elective hub 24/25 BC brought forward spend	0.632	0.632	0.000	0.000	0.487	(0.487)
County CT replacement	1.200	1.200	0.000	0.000	0.000	0.000
PSDS	0.000	0.096	(0.096)	0.000	0.000	0.000
Sustainability	0.000	0.110	(0.110)	0.000	0.000	0.000
Day case	0.000	0.097	(0.097)	0.000	0.000	0.000
Shine ambulatory unit	0.000	0.061	(0.061)	0.000	0.000	0.000
SoN CIG	0.100	0.100	0.000	0.000	0.000	0.000
Central Contingency & risk	0.000	0.000	0.000	0.000	0.000	0.000
Funding to allocate/(shortfall)	(0.373)	0.563	(0.936)	0.000	0.000	0.000
Total Pre committed Investment items	**6.924**	**8.224**	**(1.300)**	**1.298**	**1.193**	**0.105**
Capital sub-group (ICB allocation)						
IMT Sub Group Total Funding	2.535	2.535	0.000	0.714	0.315	0.399
Medical Devices Sub Group	3.600	3.600	0.000	0.785	0.621	0.164
Estates Sub Group Total Funding	5.462	5.462	0.000	0.679	0.456	0.223
Health & Safety compliance	0.156	0.156	0.000	0.004	0.000	0.004
Net zero carbon (sustainability) initiatives	0.100	0.100	0.000	0.000	0.000	0.000
Total Capital Sub-Groups	**11.853**	**11.853**	**0.000**	**2.182**	**1.392**	**0.790**

UHNM Capital Expenditure Plan 2025/26	Revised Capital Plan £m	Forecast outturn £m	Variance £m	YTD plan M5 £m	YTD actual M5 £m	Variance £m
IFRS16 leases						
Lease liability re-measurement	0.200	0.200	0.000	0.083	0.083	0.000
IFRS16 Guy Hilton	0.010	0.010	0.000	0.000	0.000	0.000
IFRS 16 New Vehicles lease	0.188	0.188	0.000	0.000	0.000	0.000
IFRS16 Leighton and Macclesfield Path Beckman	1.036	1.036	0.000	0.000	0.000	0.000
IFRS16 Endoscopic Equipment renewal/expansion	1.511	1.511	0.000	0.000	0.000	0.000
IFRS16 Stoke and County Pathology (Siemens lease ext Sep 26)	0.301	0.301	0.000	0.000	0.000	0.000
IFRS16 Bridge Centre	0.143	0.143	0.000	0.000	0.000	0.000
IFRS16 Payroll offices lease renewal (2 yrs)	0.066	0.066	0.000	0.000	0.000	0.000
Total IFRS 16 leases	**3.455**	**3.455**	**0.000**	**0.083**	**0.083**	**0.000**
Total Internal Capital Expenditure programme	**51.003**	**52.303**	**(1.300)**	**13.318**	**12.423**	**0.895**
Additional CRL / Externally Funded PDC (multi-year schemes)						
CDC phase 1 medical equipment	1.879	1.879	0.000	0.000	0.048	(0.048)
CDC IM&T	0.223	0.123	0.100	0.000	0.000	0.000
CDC phase 1 estates enabling	22.555	22.555	0.000	6.438	4.389	2.049
CDC phase 1 cost pressure	0.595	0.595	0.000	0.000	0.000	0.000
CDC endoscopy expansion	3.100	1.900	1.200	0.000	0.000	0.000
TIF 2 PDC (Breast Unit)	9.086	9.086	0.000	4.808	2.313	2.495
TIF 2 PDC (Breast Unit) cost pressure	0.430	0.430	0.000	0.000	0.000	0.000
Frontline Digitalisation - PDC funded 2024/25	1.120	1.120	0.000	0.898	0.404	0.494
Frontline Digitalisation EPR - PDC funded 2024/25	0.680	0.680	0.000	0.000	0.000	0.000
Charitable funded expenditure	3.834	3.834	0.000	3.382	3.382	0.000
Externally Funded PDC (2025/26 schemes)						
PDC Constitutional Standards Urgent Treatment Centre	7.775	2.300	5.475	0.080	0.116	(0.036)
PDC Constitutional Standards Imaging and MRI	2.583	2.583	0.000	0.000	0.000	0.000
PDC Constitutional Standards Equipment for Physiological Science	0.590	0.590	0.000	0.000	0.000	0.000
PDC County Discharge Lounge	2.375	0.000	2.375	0.000	0.000	0.000
PDC Elective equipment	0.839	0.839	0.000	0.000	0.000	0.000
PDC Digital Pathology Scanners	0.827	0.827	0.000	0.000	0.000	0.000
PDC Pathology LIMS	1.628	1.628	0.000	0.000	0.000	0.000
Total Additional CRL / PDC Funded expenditure	**60.119**	**50.969**	**9.150**	**15.606**	**10.652**	**4.954**
Total Capital Expenditure	**111.122**	**103.272**	**7.850**	**28.924**	**23.075**	**5.849**

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Finance | Balance Sheet

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

Balance sheet as at Month 5	31/03/2025	31/08/2025		
	Actual £m	Plan £m	Actual £m	Variance £m
Property, Plant & Equipment	715.7	718.3	717.5	(0.8)
Right of Use Assets	23.1	21.8	21.2	(0.6)
Intangible Assets	16.0	14.2	13.8	(0.4)
Trade and other Receivables	1.1	1.1	1.1	0.0
Total Non-Current Assets	**755.9**	**755.4**	**753.6**	**(1.8)**
Inventories	19.2	19.2	19.4	0.2
Trade and other Receivables	43.5	54.4	54.8	0.4
Asset held for sale	10.9	10.9	10.9	-
Cash and Cash Equivalents	84.2	63.0	103.2	40.2
Total Current Assets	**157.8**	**147.5**	**188.3**	**40.8**
Trade and other payables	(129.4)	(127.2)	(166.3)	(39.1)
Borrowings	(20.3)	(23.7)	(19.5)	4.2
Provisions	(8.5)	(9.4)	(8.9)	0.5
Total Current Liabilities	**(158.2)**	**(160.3)**	**(194.7)**	**(34.4)**
Borrowings	(490.3)	(487.1)	(489.3)	(2.2)
Provisions	(2.8)	(2.3)	(2.3)	(0.0)
Total Non-Current Liabilities	**(493.0)**	**(489.4)**	**(491.6)**	**(2.2)**
Total Assets Employed	**262.5**	**253.3**	**255.6**	**2.3**
Financed By:				-
Public Dividend Capital	734.9	734.9	734.9	(0.0)
Retained Earnings	(680.7)	(689.9)	(687.6)	2.3
Revaluation Reserve	208.3	208.3	208.3	0.0
Total Taxpayers Equity	**262.5**	**253.3**	**255.6**	**2.3**

Finance | Conclusion

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

The Trust has delivered a £12.1m deficit, which is in line with the planned deficit of £12.1m for month five.

Income: The income is underperforming by £5.6m, 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 Trust must address the underperformance in Elective Inpatients and First Attendance to avoid potential financial repercussions; there is a risk at month four of £5.4m under delivery. The contract with the ICB has now been signed and agreed in principle and the implementation of action plans by the Financial Recovery Board are crucial steps in ensuring financial stability.

Expenditure: There is an underspend in Pay expenditure of £2.5m and non-pay is underspent by £8.2m year to date.

Financial Outlook 2025/26: The Trust's updated forecast shows a year-end deficit of £25.0m, an improvement since month four of £7.2m. However, NHSE has requested an improvement plan by the end of October 2025 outlining steps toward breakeven.

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System Position: The system month five position has a favourable variance of £0.5m from the planned deficit of £20.9m.

Financial Risks: Several risks have been identified that could deteriorate the Trust's financial position, including additional unfunded escalation capacity, shortfall against CIP plans, winter planning, and lower activity levels than required to meet ERF income targets. In addition, recent developments in respect of Junior Doctors industrial action represents a further risk as there are no indications impact will be funded. Mitigations will need to be put in place if there is a deterioration in the financial position.

Highlight Report

PEOPLE CULTURE & INCLUSION COMMITTEE | 30th JULY 2025

University Hospitals of North Midlands NHS Trust

Matters of Concern / Key Risks to Escalate

- An update on the **workforce plan** highlighted a significant risk in delivering the challenging workforce cost reduction target, whereby current actions were being scoped to forecast for delivery. However, vacancy control panels were proving to be effective in controlling substantive workforce and agency spend was below plan. It was noted that bank use remained above plan, one of the reasons for which related to the continued use of unfunded areas due to levels of activity.
- An increase in exception reports were reported in Q4 via the **Guardian of Safe Working**, which was in part due to the end of rotations. 5 exception reports highlighted immediate safety concerns the detail of which was provided to the Committee, and it was noted that these were responded to at the time, although further actions were required to close the feedback loop of actions taken. The Committee agreed with the rating of partial assurance
- An update on the revised national system for **exception reporting** was also provided, which highlighted potential risks in terms of an increase in reporting which could subsequently create a financial pressure, in addition to requiring additional resource to implement the changes.
- Partial assurance was provided in respect of the **Freedom to Speak Up** report, particularly in relation to the fear of detriment and follow up of actions taken as a result of speaking up. The report highlighted themes from the National Guardian's Office whereby overseas workers feared speaking up and local themes related to limited awareness of the speaking up policy, engagement with the policy and need for greater independence and transparency. It was also noted that for the first time policy and procedure was the most reported category of concern.
- The **Chief People Officer** report provided partial assurance, particularly noting the actions requiring to be taken in relation to industrial action, implementing the updated national job profiles for nursing and midwifery, reflection from the Leng review and implementation of the Very Senior Manager pay framework
- The Committee received an update on job plans, whereby 74% **job plans** had been signed off to date (although 91% were engaging with the process). Actions were continuing to be taken to accelerate completion in addition to ensuring these were aligned to individual and Trusts priorities

Major Actions Commissioned / Work Underway

- To provide an update to the Trust Board on the **workforce reduction plan**, including consideration of associated impacts on operational, financial and quality metrics
- The **cross-committee consideration** from the Finance Committee was noted in terms of taking forwards learning regarding triangulation of staffing levels, exception reporting rates, patient outcomes and workforce experience. It was noted that work had already commenced in this respect, and it was agreed to provide an update on this to the next meeting.
- To provide further assurance in relation to the actions being taken to close the feedback loop following receipt of immediate safety concerns via the **Guardian of Safe Working**
- Ongoing recruitment to additional **Freedom to Speak Up** champions being undertaken with the aim of improving diversity and representation
- A further update on **sexual safety** was to be provided to the Committee in 6 months
- Future updates on **violence prevention and reduction** to focus on the 7 new domains reflecting the Health and Safety Executive guidance
- Separate **establishment reviews** to be undertaken within outpatients and urgent care, as part of the existing improvement workstreams
-

Positive Assurances to Provide

- The Committee noted the changes made to the **Board Assurance Framework** (BAF), which included mapping to the revised strategic priorities and considering the impact from the Trust's primary issues. BAF 3: Inability to improve workforce sustainability and organisational culture continued to be rated as Extreme 15 and given the target date for risk reduction was not expected until March 2027, it was agreed to consider whether there were any interim milestones. In addition, it was agreed to reflect upon the correlation between the assurance rating and the tracking of associated actions.
- An update on **sexual safety** and the outcome of the LimeCulture review was presented to the Committee, providing acceptable assurance. This highlighted 4 areas of focus, with actions identified to influence and contribute to improvement. Acceptable assurance was provided, and it was noted that associated policies and recruitment to specialist roles were to be introduced.
- Acceptable assurance was provided by the **violence prevention and reduction** update, although it was noted that there had been an increase in reported physical assaults, correlating with the increase in patient attendances. However, the Trust had continued to work with the police to proactively address concerns and take forward associated sanctions.
- Significant assurance was provided by the **undergraduate medical school** report which highlighted positive feedback following a GMC visit, citing the multidisciplinary approach in place. In addition, the school had improved in the league ratings to fourth in the country.
- An update on the **nurse establishment review** was provided to the Committee which highlighted the process undertaken. It was noted that associated business cases which could incorporate any recommended uplifts from the review would be considered following the conclusion of bed modelling. It was noted that a summary of the review would be provided to the Trust Board
- Acceptable assurance was provided by the **talent and succession planning** update whereby outputs from talent questionnaire and succession planning conversations were feeding into leadership and talent pipelines and targeted development pathways
- Updates on divisional staff survey action plans had been presented to the **Strategic Workforce Assurance Group** with further work being undertaken to provide targeted support, helping colleagues to understand the questions within the staff survey and taking forward planning for the 2025 staff survey

Decisions Made

- The Group approved the revised **Terms of Reference** for the Executive Health and Safety Group

Comments on the Effectiveness of the Meeting	Cross Committee Considerations
The committee particularly welcomed the approach used within the sexual safety update by focussing on the use of a driver diagram and suggested that this was used to simplify the messages within other reports.	• No cross-committee considerations were identified

Summary Agenda

No.	Agenda Item	BAF Mapping			Purpose	No.	Agenda Item	BAF Mapping			Purpose
		BAF No.	Risk	Assurance				BAF No.	Risk	Assurance	
1.	Board Assurance Framework Q1 2025/26	3	Ext 15	N/A	Approval	7.	Undergraduate Medical School Annual Report 2023-2024	3	Ext 15	Significant	Assurance
2.	Guardian of Safe Working Report Q4 2024/25 • Impact of Exception Reporting Changes	3	Ext 15	Partial	Assurance Information	8.	Nursing Establishment Review	3	Ext 15	Not Rated	Assurance
3.	Speaking Up Report Q3/Q4 2024/25	3	Ext 15	Acceptable Partial	Assurance	9.	Chief People Officer Report • Workforce Update (Actual Against Plan)	3	Ext 15	Partial	Assurance
4.	Sexual Safety Update Lime Culture Review	3	Ext 15	Acceptable	Assurance	10.	Talent and Succession Planning Report	3	Ext 15	Acceptable	Assurance
5.	Violence Prevention and Reduction Update			Acceptable	Assurance	11.	Strategic Workforce Group Highlight Report (19-06-25)	3	Ext 15	Not Rated	Assurance
6.	Executive Health & Safety Group Highlight Report (17-06-25) Terms of Reference			Not Rated N/A	Assurance Approval	12.	Job Planning Spotlight	3	Ext 15	N/A	Information

Highlight Report

PEOPLE CULTURE & INCLUSION COMMITTEE | 30th SEPTEMBER 2025

University Hospitals of North Midlands NHS Trust

Matters of Concern / Key Risks to Escalate	Major Actions Commissioned / Work Underway
• Training uptake in relation to the **Armed Forces** community was low, and some processes associated with recruitment will be subject to further review • National recruitment challenges and access to funds for training and continuing professional development of **healthcare scientists** • **Partial Assurance** for the **workforce plan** as there is general confidence with progress but identifying a route to reduce pay costs remains a key risk, a letter has gone to all Care Groups regarding the risk to breakeven • Concern expressed around exception reporting to the Guardian of Safe Working, which is subject to significant discussion via the Local Negotiating Committee • **Partial Assurance** for the Health & Safety quarterly report due to partial compliance with a number of requirements; risks remain around the number of 'competent persons' for the size of the organisation and also some delays in introduction of a digital system – plans are in place • **Partial Assurance** in relation to Equality, Diversity and Inclusion (EDI) as whilst there are notable improvements in colleague experience there remains work to do to ensure consistency across all aspects of the workplace	• Reaffirm commitment to the **Armed Forces Covenant**, a dedicated rehab lead, oversight and reporting as well as increased awareness identified as key priorities as well as reviewing training in line with national priorities • Confirmation of a non-executive lead for **Security** management in line with the national guidance • Significant further work identified in relation to the **healthcare scientist workforce** (whilst recognising the positive progress made) • Work is underway to increase the pool of case investigators for **Maintaining High Professional Standards (MHPS)** cases • **Workforce Plan** progress report to be shared with Care Groups for further analysis and understanding • Briefing to be included at the consultant away day with regard to exception reporting, as well as involvement in broader **speaking up** campaigns • Work is underway in relation to compliance with **Health & Safety training** for medical staff, which involves an e-learning package • Work underway in response to a letter from NHSE in relation to **'getting the basics right for resident doctors'** • Work underway in relation to the **Sexual Safety Assurance Framework**; a self-assessment is underway and a Board update is being arranged

Positive Assurances to Provide	Decisions Made
• A range number of measures in place to support the **Armed Forces** community such events, networks, training and policies / frameworks, system working and welfare support. • **Significant Assurance** for **Security** Management Annual Report as the service continues to be responsive to security related incidents • **Acceptable Assurance** for the **Chief Scientists** report due to the additional oversight and progress made, although workforce data requires further development • **Responsible Officer** report confirmed compliance with regulations although agreed that clarification is made where no further action is needed • An increase in exception reports to the **Guardian of Safe Working** was viewed as a positive reflection of the shift in culture around reporting • **Acceptable Assurance** in relation to the **EDI Annual Report** as it fulfils the requirements of the Public Sector Equality Duty as well as there being evidence of positive progress against a range of key metrics	• Approval of **Accountability Frameworks** for Speaking Up, Equality, Diversity & Inclusion and Health & Safety

Comments on the Effectiveness of the Meeting	Cross Committee Considerations
• Survey available to complete / provide feedback on effectiveness	• Concern associated with Health and Safety; number of competent persons and delays with implementation of the digital system

Summary Agenda

No.	Agenda Item	BAF Mapping			Purpose	No.	Agenda Item	BAF Mapping			Purpose
		BAF No.	Risk	Assurance				BAF No.	Risk	Assurance	
1.	Security Management Annual Report	5	High 12	Significant	Assurance	8.	Executive Health & Safety Group Highlight Reports (19-08-25 & 16-09-25)	3	ID18673 ID25412 ID22876	Partial	Assurance
2.	Chief Healthcare Scientist Update	3	Ext 15	Acceptable	Assurance	9.	Equality, Diversity and Inclusion Annual Report 2024/25	3	Ext 15	Acceptable	Assurance
3.	Appraisal and Revalidation Annual Report	3	Ext 15	Not Applicable	Approval	10.	Workforce Race and Workforce Disability Equality Standard Reports 2025	3	Ext 15	Partial	Assurance
4.	Supporting the Armed Forces Community			Not Assessed	Assurance	11.	EDI / FTSU / Health & Safety Accountability Frameworks	3	Ext 15	Not Applicable	Approval
5.	Workforce Plan Update	3	Ext 15	Partial	Assurance	12.	Resident Doctors 10 Point Plan			Not Applicable	Information
6.	Guardian of Safe Working Report Q1 2025/26	3	Ext 15	Not Assessed	Assurance	13.	Sexual Safety Charter Assurance Framework	3	Ext 15	Not Applicable	Information
7.	Health & Safety Report Q1 2025/26			Partial	Assurance						

NHS
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NHS Trust

Integrated Performance Report

Month 05 Performance

2025/26

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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.

NOF - People and Workforce

University Hospitals of North Midlands NHS Trust

People and workforce	Data period	Provider value		Chart
People and workforce domain score	Q1 2025/26	2.53	NOF Score	

Retention and Culture	Data period	Provider value	Peer average	National value	National value method	Chart
Sickness absence rate score			Q1 2025/26 2.43	NOF Score	Provider value	
Sickness absence rate	Mar 2025	5.29%	5.42%	5.35%	Provider median	
NHS staff survey engagement theme sub-score score			Q1 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	

This domain has seen an improvement owing to a reduced sickness absence rate to 5.29%. This being below the peer and national average.

People | Overview

Creating a great place to work for everyone

NHS
University Hospitals of North Midlands
NHS Trust

Overview from the Chief People Officer

How are we doing against our trajectories and expected standards?

Our most recent *Staff Engagement* score was 6.3 for July 2025, slightly down from the score of 6.8 for April 2025, against a target of 7.2. The Staff Voice Survey is now collected quarterly, but will be paused when the 2025 National Staff Survey is released on 25th September 2025.

Sickness absence remains above our expected standard of 3.39%. In month sickness decreased to 5.0%, while the 12-month cumulative rate increased slightly to 5.24%, from 5.23% in July 2025. The main driver of this continues to be stress and anxiety, followed by other musculoskeletal problems and gastrointestinal problems, as the second and third most common reasons.

Turnover and *vacancy* metrics continue to perform well against our expected standards. The turnover rate in August 2025 remained extremely low, at 7.2%, which remains consistently below our 11% target, for almost 3 years. Vacancies decreased to 7.47% (7.58% in July 2025). The main drivers of this were increases across Medical and Dental (+34) and ST&T (+13), with Support to Clinical Staff (-121), Infrastructure (-34) and Registered Nursing & Midwifery (-2.5) reducing. The overall increased were also affected by a +3.62 fte increase in the total budgeted establishment.

Agency costs decreased to 1.33%, in August 2025, from 1.78% in July 2025, which is below the threshold set by NHS England. In real-terms, overall agency usage decreased slightly to 92.43 WTE in July 2025 from 98.02 WTE in July 2025, which is still 3.38 WTE below plan.

What is driving this?

Sickness absence is driven by many factors, including stress and anxiety and seasonal changes such as colds, cough and chest & respiratory problems. August saw a decrease in in-month sickness absence, influenced by reductions in gastrointestinal problems.

Agency expenditure was 3.38 WTE below plan, influenced by the additional scrutiny at executive and divisional level which appears to also be having the desired effect in reducing overall agency spend, with some agency activity being converted to bank expenditure, as well.

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People | Overview

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Overview from the Chief People Officer

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

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

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

Agency Expenditure remains subject to continued scrutiny through the Divisional Performance Reviews and the Medical Workforce Assurance Group. There is also regular focus at ICB level on workforce numbers, agency spend and controls. Additional data sources are being provided to allow for more granular discussions, including the recent launch of a new temporary staffing dashboard, which is updated on a weekly basis.

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

What can we expect in future reports?

With the warm weather coming to an end, we may see an increase in sickness absence reasons associated with gastrointestinal, cold & flu, and Covid-19 related symptoms. With the observed increases in stress and anxiety, during July and August, we may see an increasing sickness absence rate, over the next quarter.

Agency is currently under plan, and we expect agency usage to track just under plan in August 2025, due to the higher levels of scrutiny. Despite this, and the additional scrutiny, of agency expenditure, the on-going elective recovery programme activity, and the continued need for escalation capacity and the additional demand in theatres and endoscopy services, and in the emergency portals, still influences the need for agency.

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People | Dashboard

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University Hospitals of North Midlands NHS Trust

Metric	Target	Previous	Latest	Variation	Assurance	R12M Trend
Staff Turnover (R12M)	11.0%	6.9%	7.2%			
Staff Vacancy Rate	8.0%	7.6%	7.5%			
Sickness Absence (R12M)	3.4%	5.2%	5.0%			
Appraisal (PDR)	95.0%	85.4%	85.3%			
Agency Utilisation	3.2%	1.8%	1.3%			
Employee Engagement	7.2	6.3	6.3			

Related Strategy and Board Assurance Framework (BAF)

People Strategy

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

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People | Employee Engagement

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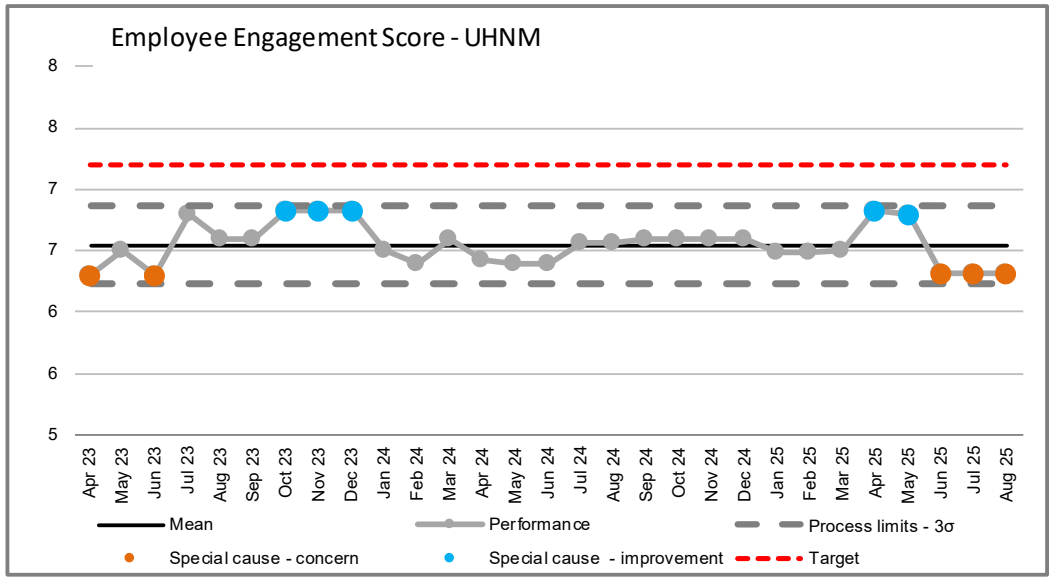

Variation	Assurance
L	F

Target	Jun 25	Jul 25	Aug 25
7.2	6.3	6.3	6.3

Background

What is the data telling us?

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

The Staff Voice Survey is now collected quarterly but will be paused when the 2025 National Staff Survey is released on 25th September 2025.

The 2024 National Staff Survey achieved an overall 45% response rate, which is comparable to the 44.9% response rate we achieved in 2023/24.

What are we doing about it?

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

Sustained operational pressures continue to impact on overall employee engagement.

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

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People | Sickness Absence in Month

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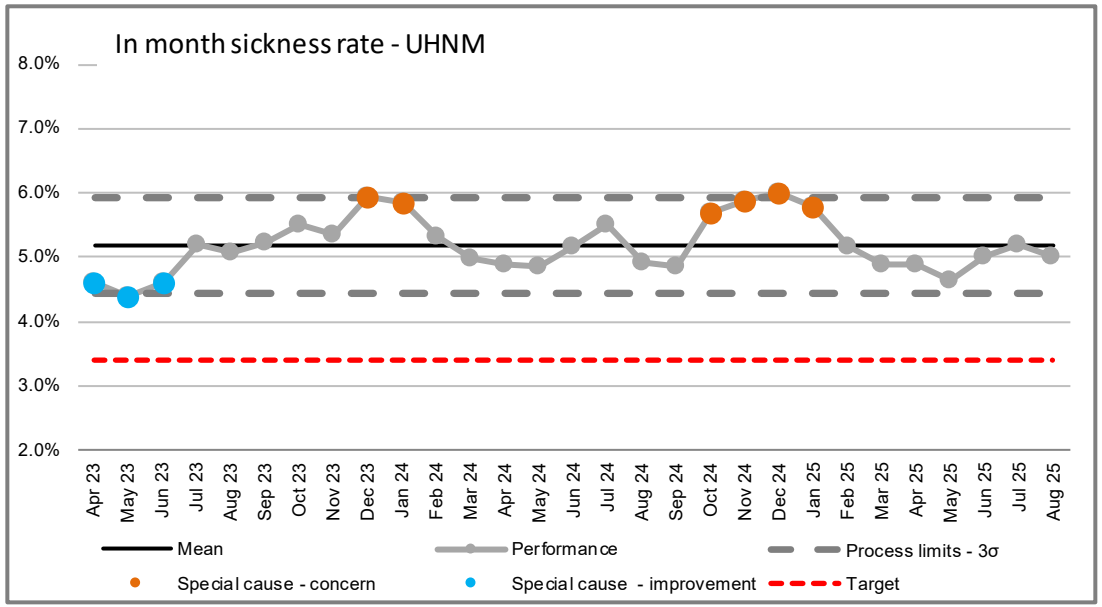

Variation	Assurance
	F

Target	Jun 25	Jul 25	Aug 25
3.4%	5.0%	5.2%	5.0%

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 July 2025- 5.0%)

What is the data telling us?

The rolling 12-month average sickness absence rate increased slightly to 5.24% (5.23% in July 2025) against the target of 3.4%.

The in-month sickness absence decreased to 5.0% in July (5.21% in July 2025) with other musculoskeletal problems seeing the biggest increase of 0.5%, followed by stress and anxiety increasing by 0.3%, with a 1.8% reduction in gastrointestinal problems.

In rank order (highest first), the top 3 reasons for absences during August were: (1) Anxiety/stress/depression/other psychiatric illnesses, (2) Other musculoskeletal problems, (3) Gastrointestinal problems, which is reflective of July's top 3 reasons.

What are we doing about it?

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

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

Network Division - commenced sickness assurance meetings.

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

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People | Vacancy Rate

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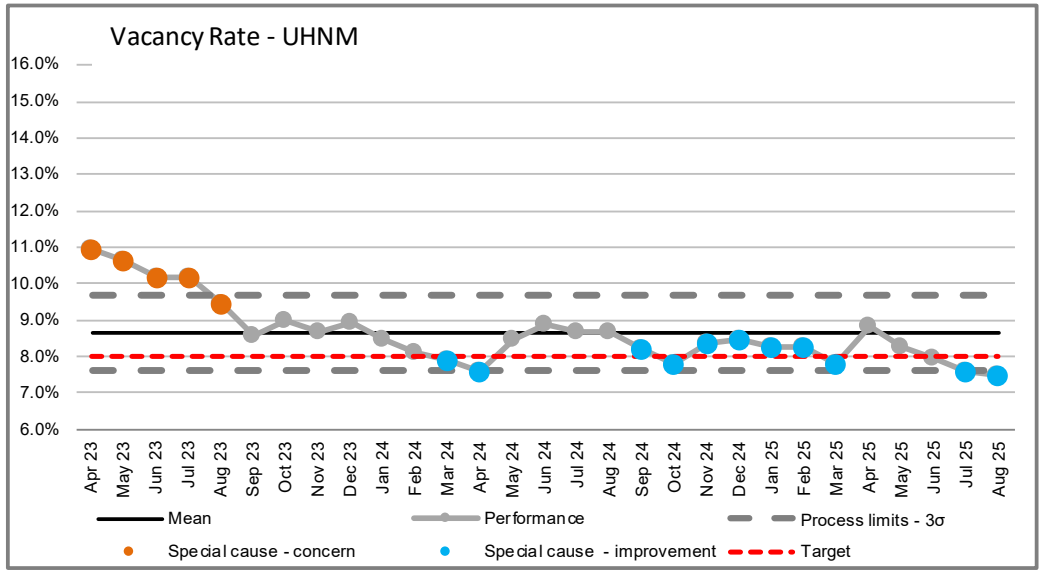
University Hospitals of North Midlands NHS Trust



Variation	Assurance

Target	Jun 25	Jul 25	Aug 25
8%	8.0%	7.6%	7.5%

Background

Based on Full Establishment (Substantive, Bank & Agency)

Vacancies at 31-08-25	Budgeted Establishment	Staff In Post fte	Vacancies	Vacancy %	Previous Month
Medical and Dental	1,811.56	1,623.51	188.05	10.38%	13.35%
Registered Nursing	3805.00	3670.15	134.85	3.54%	3.26%
All other Staff Groups	7087.81	6461.11	626.70	8.84%	8.41%
Total	12,704.37	11,754.77	949.60	7.47%	7.58%

What is the data telling us?

The summary of vacancies, by staff groupings, saw a 0.1% decrease in the overall vacancy rate. The reasons for this are explained below.

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

Colleagues in post increased in August 2025 by 17.17 fte, across ST&T (+13) and Medical and Dental (+34), with reductions in Registered Nursing (-2.5), Support to Clinical (-21) and Infrastructure (-34). Budgeted establishment increased by 3.62 fte, which, overall decreased vacancies by 13.56 fte.

[*Note: the Staff in Post fte is a snapshot at a point in time, so may not be the final figure for 31/08/25]

What are we doing about it?

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

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

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

People | Turnover Rate

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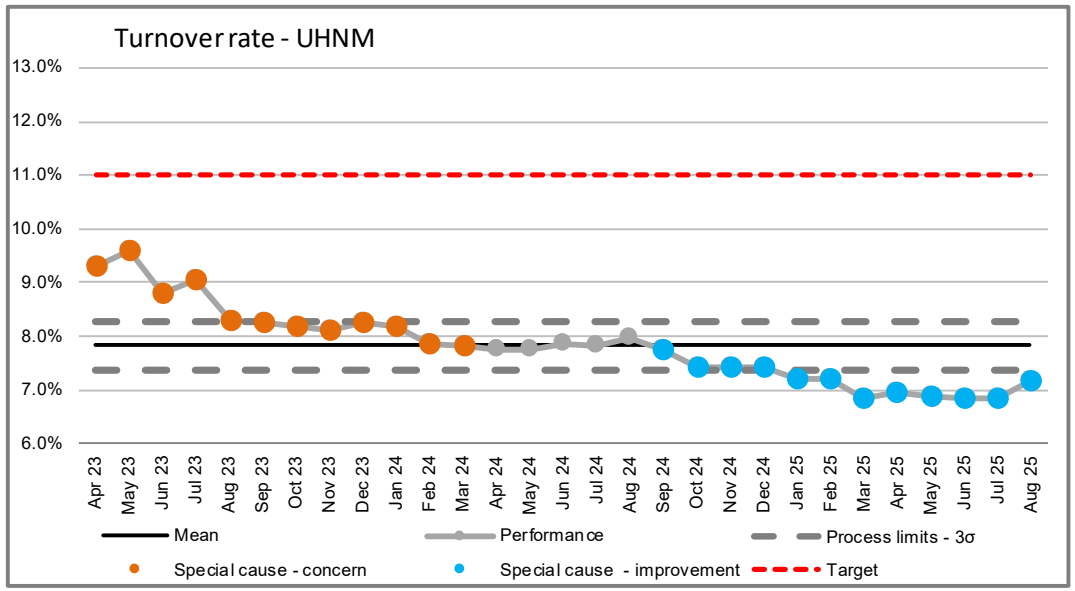


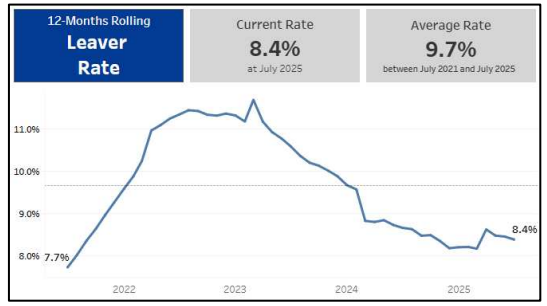
University Hospitals of North Midlands NHS Trust

Variation	Assurance

Target	Jun 25	Jul 25	Aug 25
11.0%	6.9%	6.9%	7.2%

Background

Turnover rate.



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

(Benchmarking data effective July 2025)

What is the data telling us?

The turnover rate in August 2025 remains extremely low, at 7.2%, (6.9% in July 2025), which is consistently below the Trust's 11% target, for almost three years.

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

What are we doing about it?

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

- Medical Staffing finishing school.
- Employment of a People Promise (Retention) Manager who currently continues in a fixed term post.
- Monthly targeted campaigns aligned to our Trust Values. For example, August included the Values Week, encouraging us to celebrate the behaviours which bring our values to life while fostering a culture of inclusive and values-led leadership.

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People | Appraisal Rate

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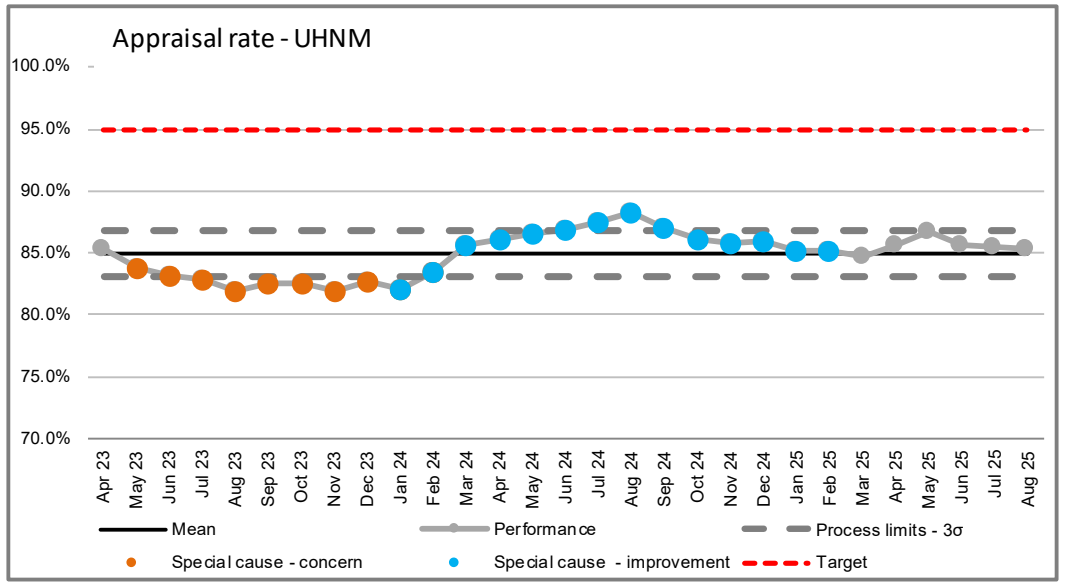
University Hospitals of North Midlands NHS Trust



Variation	Assurance
	F

Target	Jun 25	Jul 25	Aug 25
95%	85.6%	85.4%	85.3%

Background

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

What is the data telling us?

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

August's appraisal rates decreased slightly to 85.3% from 85.4% in July 2025, with Estates, Facilities and PFI Division achieving a compliance rating of 96.19%.

The Divisions continue to monitor and review their PDR performance.

What are we doing about it?

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

Network Division - Weekly PDR compliance hotspot and assurance meetings.

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

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

WCCSS – Weekly performance reports and assurance meetings.

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People | Agency Utilisation

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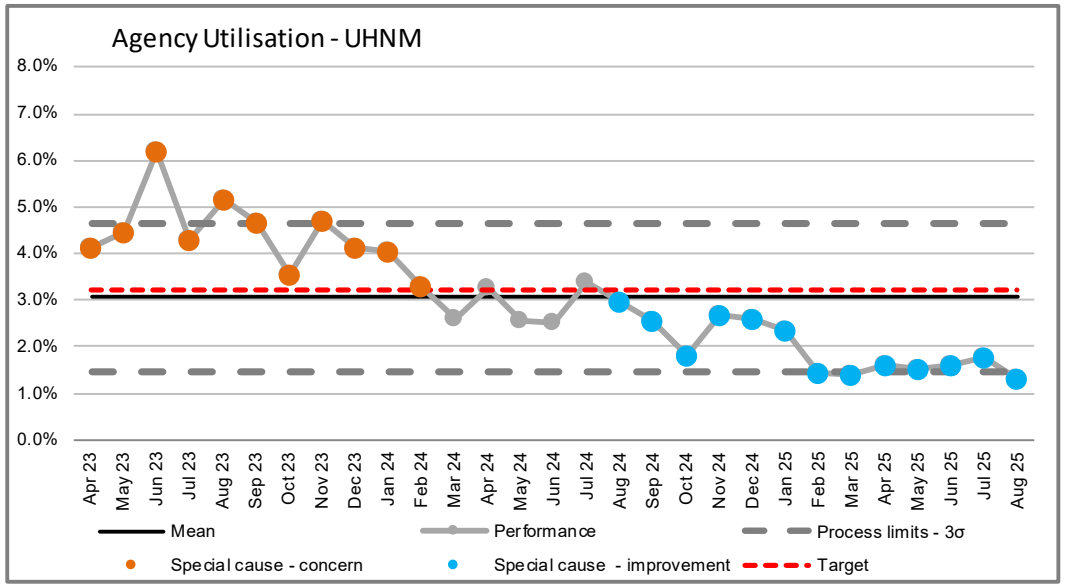
University Hospitals of North Midlands NHS Trust



Variation	Assurance

Target	Jun 25	Jul 25	Aug 25
3.2%	1.6%	1.8%	1.3%

Background

Agency cost as a percentage of total pay cost

What is the data telling us?

Agency cost is calculated as a percentage of the total Pay Costs, which decreased to 1.33% in August 2025, (1.78% in July 2025).

In real-terms, overall agency usage decreased slightly to 92.43 WTE in August from 98.02 WTE in July 2025, which is 3.38 WTE below plan.

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

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Highlight Report

AUDIT COMMITTEE | 31st July 2025

University Hospitals of North Midlands NHS Trust

Matters of Concern / Key Risks to Escalate	Major Actions Commissioned / Work Underway
• **Internal audit action tracker** highlighted 118 actions being tracked, 11 of which had been delayed and 14 which were problematic. Updates from individual executive directors were provided in terms of the rationale for movement in target dates and partial assurance was agreed • 98% compliance had been achieved for **declarations of interest** for 2024/25, and a cross-reference exercise had been undertaken for job planning; actions from which were being followed up with the Chief Medical Officer. The Committee particularly considered the actions required to reduce the number of out of date policies and noted the actions being taken to utilise AI in taking forward reviews. As such partial assurance was agreed	• Risk assessments to be undertaken for each proposal to supersede an **internal audit recommendation**, to identify the level of risk, prior to obtaining a view from internal audit as to the validity of the approach being proposed • To consider using AI to cross-reference the content of **declarations of interest** made to assess their relevance to the role and any potential impact to be managed

Positive Assurances to Provide	Decisions Made
• The Committee noted the process undertaken to update the **Board Assurance Framework** (BAF) for Quarter 1 and noted the further assurance to be provided in respect of BAF 2 and BAF 3. • Acceptable assurance was provided by the **Cyber Security Assurance** report which recognised the positive internal audit review of the cyber assessment framework (CAF) and that the CAF submission had been assessed as achieved. The outstanding actions being addressed as part of Shadow IT were considered and it was noted that these were being re-reviewed by Internal Audit • **Internal Audit** progress report highlighted the completion of the CAF with 3 internal audits having commenced in quarter 1. • The **Local Counter Fraud Specialist** progress update highlighted the work undertaken to review local policies, ongoing training and awareness sessions including specific training with the People team and planned completion of 3 proactive exercises. 6 reactive referrals had been made and 11 reviews remained open, with 4 having been closed in the quarter. • **Losses and special payments** highlighted total losses in the quarter equating to £249,714 mainly due to stock written off in pharmacy, theatres and interventional radiology in addition to inventory write-offs. It was noted that an update on bad debt write offs would be provided to the next meeting. The Committee concluded with a rating of acceptable assurance. • 107 **Standing Financial Instruction** (SFI) breaches and 5 **Single Tender Waivers** were reported in the period and the Committee agreed with the rating of acceptable assurance. It was noted that any trends and themes with breaches and waivers in any particular care group/business unit were to be highlighted within the next update • SFI breaches relating to **late termination and change forms** provided acceptable assurance whereby 84 overpayments had been made, with a slight increase in cases in quarter compared to the previous year but these were of a lower value	• The Committee approved the **Board Assurance Framework** for Q1, noting the ongoing actions being taken to further improve the format and identification of actions to reduce the risks towards their target scores • The Committee approved the revised **Standing Orders** Policy • The Committee approved the two changes to the **internal audit plan**

Comments on the Effectiveness of the Meeting	Cross Committee Considerations
Comments were requested via MS Forms	It was agreed to refer the conversation regarding levels of DBS checks to the Nomination and Remuneration Committee

Summary Agenda

No.	Agenda Item	BAF Mapping			Purpose	No.	Agenda Item	BAF Mapping			Purpose
		BAF No.	Risk	Assurance				BAF No.	Risk	Assurance	
1.	Audit Action Tracker	Various		Partial	Assurance	6.	Internal Audit Progress report • Cyber Assessment Framework	4	Ext 16	High	Assurance
2.	Corporate Governance Report	Various		Partial	Assurance	7.	Local Counter Fraud Specialists Progress Report • Self-Assessment against NHS CFA Pre-employment guidance checklist			Not rated	Assurance
3.	Board Assurance Framework Q1 2025/26	ALL	Various	Not Applicable	Approval	8.	Losses and Special Payments Update Q1 2025/26	6	Ext 20	Acceptable	Assurance
4.	Standing Orders Policy			Not Applicable	Approval	9.	SFI Breaches and Single Tender Waivers Q1 2025/26	6	Ext 20	Acceptable	Assurance
5.	Cyber Security Assurance Report	4	Ext 16	Acceptable	Assurance	10.	SFI Breaches related to Late Termination and Change Forms Q1 2025/26	6	Ext 20	Acceptable	Assurance

Trust Board

2025/26 BUSINESS CYCLE

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

Title of Paper	Executive Lead	May	July	Oct	Dec	Feb	Notes
		7	9	8	10	11	
PROCEDURAL ITEMS							
Patient / Staff Story	Chief Nurse / Chief People Officer	Pt	Staff	Pt	Staff	Pt	
Chief Executives Report	Chief Executive						
Board Assurance Framework	Director of Governance	Q4		Q1	Q2	Q3	
OUR PATIENTS: QUALITY, ACCESS & OUTCOMES							
Quality, Access & Outcomes Committee Assurance Report	Director of Governance						
Care Quality Commission Action Plan	Chief Nurse						Action plan closed down at QAOC in June 2025
Mortality Assurance Annual Report	Chief Medical Officer						
Maternity Serious Incident Report	Chief Nurse						
PLACE Inspection Findings and Action Plan	Director of Estates, Facilities & PFI						
Bi Annual Nurse Staffing Assurance Report	Chief Nurse						
Quality Account	Chief Nurse						Taken to June's Private Board
Winter Plan	Chief Operating Officer						
NHS Resolution Maternity Incentive Scheme	Chief Nurse						
Quality, Access & Performance Strategic Plan Update	Chief Nurse / Chief Medical Officer / Chief Operating Officer						TBC
Integrated Performance Report	Various						
OUR PEOPLE							
People, Culture & Inclusion Committee Assurance Report	Director of Governance						
Staff Survey Report	Chief People Officer						
Gender Pay Gap Report	Chief People Officer						
Raising Concerns Report	Director of Governance						
Revalidation	Chief Medical Officer						
Workforce Disability Equality 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
Bi-Annual Establishment Review (Other Professions)	Chief People Officer						TBC
OUR POPULATION							
Population Health Strategic Plan Update	Director of Strategy						TBC
FINANCE AND EFFICIENCY							
Finance & Business Performance Committee Assurance Report	Director of Governance						
Revenue Business Cases / Capital Investment / Non-Pay Expenditure £1,500,001 and above	Director of Strategy		N/A				
Annual Report and Accounts including Going Concern	Chief Finance Officer						Considered by Extraordinary Trust Board in June
Annual Plan	Director of Strategy						Considered at Board Seminar
Financial Plan including Capital Programme	Chief Finance Officer						
Standing Financial Instructions	Chief Finance Officer						Next due for review February 2026
Scheme of Reservation and Delegation of Powers	Chief Finance Officer						Next due for review February 2026
OUR STRATEGIC PLANS							

Title of Paper	Executive Lead	May 7	July 9	Oct 8	Dec 10	Feb 11	Notes
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 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						Next annual review - September/October 2025
Risk Management Policy	Director of Governance						Next due for review February 2027
Complaints Policy	Chief Nurse						Next due for review November 2027