NHS
University Hospitals of North Midlands
NHS Trust

Quality Account

2024/2025

Part A: Statement on Quality

Introduction to UHNM by Dr Simon Constable, Chief Executive

Welcome to the Quality Account for the University Hospitals of North Midlands NHS Trust (UHNM) 2024/2025. As we review the last 12 months and consider our priorities for the year ahead, we reflect on the impact the continuing challenges and developments have had on our hospitals, our colleagues and our patients.

Similar to 2024/2025 our quality priorities for 2025/26 will be delivered through our strategic objectives to provide high quality, safe care for all patients, and to learn from our errors. When we fall short of our high standards, we review our processes, with our Patient Safety Partners, improvement teams and clinicians to make these work better. We are committed to driving improvement and a culture of excellence throughout the organisation. Despite the complex operational challenges and the high demand for our services the Trust has faced during 2024/25, we have sought to deliver care in accordance with the quality priorities set out in our Quality Account. We have continued to work with our local departments as well as at an organisational, regional and national level, with clinical audit and patient safety improvement programs to drive continuous quality improvement.

Our colleagues have continued to adapt and show resilience under extreme pressure and acted with compassion and professionalism. That care and compassion was acknowledged with an 'Outstanding' rating in the care domain from the Care Quality Commission (CQC) This report aims to provide an open and honest account of where we have moved forward since the pandemic, and where we still have further improvements to make.

We are one of the largest teaching trusts in the country, primarily serving patients in Staffordshire and Stoke-on-Trent and acting as a tertiary centre to many more. We are proud to have a growing international reputation for the innovative treatments we provide and pioneer through our research, education and university partnerships.

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

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

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

Our Partnerships

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

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

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

2. Statement on quality

This Quality Account covers the period from 1 April 2024 to 31 March 2025. Our UHNM teams here at UHNM are dedicated to enhancing the quality, safety, and experience of patients and their families in our care. We would like to express, on behalf of the Trust Board, our profound gratitude to our colleagues for their unwavering commitment during a challenging year, recognising their professionalism, adaptability, and positivity.

The quality of care our patients receive, and their experience of that care, are central to our mission. Through our 'Improving Together' initiative and methodologies, we have focussed on areas requiring enhancement by actively listening to our patients and ensuring their feedback informs our practices from bedside care to Trust Board decisions.

Our priorities include providing safe, effective care and preventing harm, guided by the best available evidence. By empowering and investing in our outstanding team, we ensure the highest standard of care and treatment, fostering pride in serving our community.

We have continued with regular monitoring of patient safety incidents, with particular emphasis on our Emergency Department, where an increase in hospital-acquired pressure damage was observed due to ambulance handover delays and long waits within the Emergency Department. This proactive approach to incident reporting and management allows us to promptly identify concerns and take swift action.

Infection Prevention has remained a primary focus. The Trust has met the UKHSA targets for C Diff and E-Coli. However, challenges have persisted with flu, but the clinical and Infection Prevention teams have worked together to reduce the impact on operational flow, services, and patients. UHNM also supported regional initiatives to better understand the root cause of regional rises in infections,

The incidence of falls resulting in harm was reduced through targeted efforts aimed at individuals experiencing multiple falls. Nonetheless, we have noted an increase in in-hospital acquired pressure

damage, which was again attributed to the long waits within our Emergency Department. We will continue to closely monitor this issue and implement improvement interventions and mitigation strategies to minimise harm to our patients.

We successfully digitised nursing and clinical documentation in the Emergency Department, aligning with our digital priorities. This has enhanced patient care efficiency, reduced printing costs, and ensured legible and auditable documentation of care.

We prioritised the following key areas:

Safeguarding

The Safeguarding agenda at UHNM includes a comprehensive portfolio of work covering Adult and Child Safeguarding, the Mental Capacity Act, Deprivation of Liberty Safeguards, Domestic Abuse, PREVENT counterterrorism, and managing allegations against individuals in positions of trust. We are invested in providing services to meet the needs of our local vulnerable patient population in Stoke and Staffordshire and we also support out-of-area patients. We work closely with other agencies working in partnership with health colleagues at NSCHT, MPFT, ICB, Local Authorities, Police, and specialist services. The team works with system partners to safeguard the unborn, children and adults. THINK FAMILY is embedded in policy and practice to safeguard all patients at risk of or experiencing abuse. This year we have provided strategic direction for the development, implementation, and monitoring of the Safeguarding agenda across the Trust in line with our Trust policies.

We ensure Safeguarding training throughout our Trust, is in line with the Training Needs Analysis (intercollegiate document) and we have been monitoring progress across our divisions and Trust compliance, reporting to commissioners. We have continued to advise the Trust Quality and Safety Oversight Group on Trust priorities regarding our safeguarding agenda. We regularly undertake audits to inform policy and practice. Digital developments have occurred in the last financial year in terms of data collection and recording information. The safeguarding virtual dashboard enables the team to have oversight of adults and children with safeguarding concerns.

UHNM remains an active member of the Staffordshire and Stoke Safeguarding Partnership Board and the Children's Board/Partnership. Safeguarding Working Groups are held internally on a quarterly basis; this forum provides key updates of work from the safeguarding team and divisions. The meetings are pivotal for Divisions to highlight any areas for escalation, and to provide assurance relating to this agenda. Quarterly assurance reports are produced which evidence the safeguarding activity, developments, and assurance- alongside completion of safeguarding annual report. We remain committed to focusing on the strategic priorities as outlined by both Adult and Child Safeguarding Boards/Partnership to provide assurances regarding the implementation and monitoring of the safeguarding assurance framework which identifies all areas of work for the extensive portfolio and priorities for the next financial year for safeguarding at UHNM,

Vulnerable patients

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

Mental Health in the Acute Trust remains a key priority. We continue to work alongside our local Mental Health Trusts to ensure we safeguard patients in adherence to the legal framework. We continue to see increasing numbers for both adults and children presenting with mental health

concerns. We ensure that regular audits are undertaken to evaluate if we are lawfully compliant, alongside identifying areas of best practice and any areas for development. Digital developments now enable the team to have oversight of patients with a learning disability, and mental health detentions. The Vulnerable Patient Working Group is held on a quarterly basis and the Divisions attend to ensure that they are kept informed about the Learning Disability and Mental Health agenda. We also seek assurance from the Divisions that they are informed about the agenda and adhere to policy and procedures relating to Mental Health and Learning Disability. We collaborate with system partners across the portfolio of work and ensure learning is fed back internally to ensure appropriate adjustments are implemented. A quarterly performance and assurance report is produced which outlines all activity related to the portfolio of work.

We continue to raise the profile of patients with learning disabilities and the importance of making reasonable adjustments to ensure safe effective care when attending hospital for inpatient and outpatient or emergency portal attendance.

This year we have excelled in the facilitation of the Oliver McGowan Training and received outstanding feedback from health colleagues.

Equality, Diversity and Inclusion

We are working hard to meet the needs of our local population with Learning Disability, Autism, and Downs Syndrome. UHNM is ensuring we capture continuous learning and improvements for our vulnerable patients and have developed a new assurance framework for the vulnerable patient agenda which identifies the priorities and risks for the next financial year.

Within the last year we have approved our Population Health and Wellbeing Strategy, which has bought together our work to reduce health inequalities, prevent ill-health and use our resources as a major local employer to influence the wider local economy. The Strategy has enabled the the Trust to change how we deliver services and work with partners to improve health outcomes for the local population and patients, reducing local health inequalities and strengthening our approach to preventing illness and progression of long-term conditions

Health Inequalities: We continue to work to implement the national CORE20PLUS5 framework for adults and children. We have had notable success in bucking national trends in our cancer screening rates through targeted outreach and adjustments to services to addressing inequalities in access identified locally. To support inclusive elective care, we are delivering range of actions to improve equity of access and experience to our elective care services, with targeted work to understand and address higher missed appointments in minority ethnic groups and people from our more deprived communities. We also have developed work addressing health inequalities that impact on our local population with current focus on reducing infant mortality. In developing local insights and approach to address inequalities Trust leads have delivered a range of actions to make our services more accessible and inclusive to patients with protected characteristics, with partnership between health inequalities and Trust Equality, Diversity and Inclusion programmes.

Prevention: Areas of focus have been to embedded prevention services within alcohol care and tobacco dependency within the trust, which have been evaluated by the Trust to demonstrate impact in those accessing the services. The Trust also provides specialist weight management for the local population, hosting a system-led programme that is developing a tier 3 weight management service across Staffordshire and Stoke-on-Trent whilst continuing to deliver complications for excess

weight Clinics for Children and Young People. The Trust also provides accessible vaccinations to a range of patients who experience health inequalities, with a focus on improving winter vaccination uptake to prevent avoidable hospital admission in patients the Trust provides care for and addressing inequalities in maternal vaccination uptake we see locally.

As a major employer, we continue to expand our work to recruit from our local population, offering apprenticeships as a route to employment for people in the local population and developing partnership with system colleagues supporting recruitment in those with protected characteristics experiencing long term unemployment. With support of our charity, we have helped to combat social isolation, loneliness and to improve children's oral health, which have received national attention. We also continue to implement our journey to reduce our carbon footprint and procure services from local businesses to invest in the local economy and population.

Tissue Viability & Continence

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

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

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

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

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

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

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

Falls & Mobility

Promoting mobility and preventing falls remain a key focus of our dedicated Quality and Safety team.

The Quality and Safety team have delivered bespoke falls training to areas reporting multiple falls which has included one-to-one training for all colleagues. To align to national PSIRF processes, the Trust has introduced a bespoke falls toolkit incorporating a comprehensive after-action review. For areas where multiple toolkits are completed, and recurring themes are identified, the Quality and Safety team have established assurance panels where team support is offered, and learning is shared to promote consistent learning and recommended actions are delivered. The Quality and Safety team continue to complete weekly audits across the Trust and from the findings offer education specific to areas, for example the Emergency portals, care of the older adult and maternity.

Promoting mobility and prevention of deconditioning

In 2023/2024 UHNM implemented the Johns Hopkins Activity and Mobility Programme on 8 wards across UHNM with 9 further wards due to go live with the programme in 2025. This work has seen the development of an electronic patient record, using tools developed by Johns Hopkins Hospitals (Baltimore USA), which enables colleagues to document a patient's ability to complete activities of daily living and movement activities each day. Software built into the system then generates a mobility goal based on the patient's ability. Colleagues are supporting patients to achieve their goal at least twice a day with the highest level of mobility they complete being recorded within the electronic record. Further emphasis is being given to movement by including goal achievement discussion in ward rounds to ensure the multidisciplinary team can acknowledge and highlight patients that may need extra support to achieve their mobility goal to support the prevention of deconditioning and harm associated with loss of function. The impact of supporting improved mobility is being mapped against falls rates, hospital acquired pressure damage, venous thromboembolism, and length of stay.

Frailty

We continue to work with GIRFT recommendations to ensure frailty services across UHNM address and acknowledge the issues of inappropriately admitting older individuals living with frailty. The work we are currently completing through improvement delivery groups acknowledges the harm that can occur due to prolonged hospital stays, potentially leading to a decline in mobility, functional deterioration, and an elevated risk of unavoidable harm. We know that even in cases where acute hospital care is deemed necessary, extended length of stays (48 hours or more) contribute to increased risks such as deconditioning, falls, and preventable harm, especially when acute care is no longer required. Our vision is to ensure patients aged 75 and over with frailty receive the right care at the right place by providing timely access to initiatives to enhance the well-being of the patient.

Work currently underway includes the development of a new clinical model for our frailty assessment unit.

Medications

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

Nutrition & Hydration

There is clear evidence that what we eat and drink affects our health and wellbeing and that nutrition is fundamental in recovery from periods of sickness. Food provided at the Royal Stoke and County Hospitals must contribute to the health of our patients, visitors, and colleagues. As both a healthcare provider, and as an employer, we have a responsibility to support our colleagues, and those who use our services including visitors, to maintain a healthy lifestyle by offering appropriate food choices.

Good nutrition, optimal hydration and positive mealtime experiences are of vital importance for those recovering from illness and those at risk of malnutrition. Malnutrition and dehydration pose significant risk especially for older people and contribute to delayed recovery, development of co-morbidities, hospital acquired functional decline (deconditioning), increased risk of falls, risk to skin integrity and increased length of stay.

During 2024, new standard patient and Children's menus were introduced at Royal Stoke, these are fully compliant with the National Hospital Food Standards and the British Dietetic Association 'Nutrition and Hydration Digest. Monthly patient experience surveys highlight positive feedback for the menus.

Nutrition Excellence Leads (NELS) have been identified on all wards at County Hospital. These leads provide links between ward colleagues, catering and Dietetics. Meetings have taken place to taste new dishes, provide menu feedback, education regarding food handling and management of food allergy, The NELS programme is currently being evaluated and consideration of roll out at Royal Stoke during 2025/26 in partnership with Sodexo.

The dietetics team has trained over 1800 colleagues within UHNM on identifying malnutrition and using nutrition care plans to support best nutrition in hospital.

Audits reviewing compliance with Nutritional screening, review of Nutritional adequacy of tube fed patients and use of Total Parenteral Nutrition have taken place. These audits offer organisational assurance and identify opportunities for improvement.

UHNM is compliant with National Standards for Healthcare Food and Drink. The maturity matrix against NHSE guidance for the Standards has been reviewed and the agreed area of focus for 2025/26 relate to sustainability and the Green Plan, specifically reducing food waste and increased availability of plant-based meals for colleagues and visitors.

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

- Reduction in total patient falls per 1000 bed days and in falls resulting in any harm to patients per 1000 bed days in 2024/2025 compared to 2023/2024.
- Improvements in our CQC ratings for Medical Care at County, Maternity, and County Hospital overall rating which are all now rated GOOD

- Continued improvement in Sepsis Screening and IV antibiotics for inpatients, Emergency portals and Children
- Continued to embed the Patient Safety Incident Response Framework and approach to responding to incidents and system-based learning.
- Continued to exceed the national Friends and Family Test recommendation benchmark of 95% for Inpatients and Maternity Services
- 4 Patient Safety Partners as part of Patient Safety Incident Review Framework (PSIRF) implementation are in post and supporting patient safety initiatives
- 2 Patient Safety Specialists have completed the Level 3 and 4 National Training via Loughborough University
- During 2024/2025, the Trust has seen a reduction in like for like numbers compared to 2023/2024 for Clostridium Difficile (C Diff) and Trust apportioned MRSA.
- Call for Concern (Martha's Rule) has now been implemented across RSUH. We are working to co-design our solution to component 3 (daily feedback from patients/families/carers) which has been designed with Patient involvement and Digital Support for ease for colleagues.

We are proud of our achievements; however, we recognise that there are also areas where we need to continue to make further improvement, including:

- Improving ED waiting times
- Improving our cancer performance for 28, 31 and 62-days treatment standards
- Significantly reduce our ambulance handover delays
- Continued improvement in Sepsis screening compliance and pathway
- To further reduce harm from falls
- To improve recording of Timely Observations using Vitalpac electronic system
- To implement our new electronic Prescribing and Medine administration (ePMA) system
- To continue to reduce Hospital Acquired pressure ulcers and deep tissue injuries with lapses in care.
- To continue to reduce the number of C Difficile cases

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

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

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

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

- The Quality Account presents a balanced picture of the Trust's performance over the period covered.
- The performance information reported in the Quality Account is reliable and accurate.

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

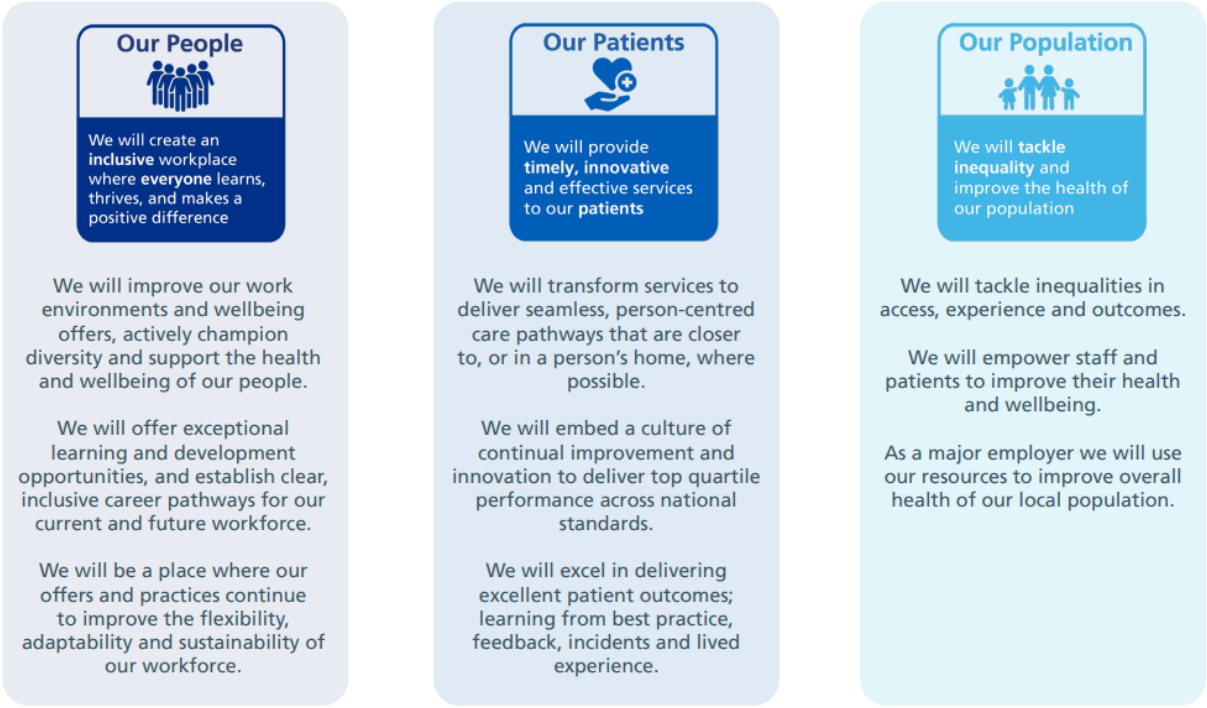
The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Account.

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

Our strategy has been developed to guide our priorities and decisions over the next 10 years.

Our priorities

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



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

3.1 Priorities for improvement

Quality Improvement

This has been the third year for the roll-out of our organisation wide quality improvement (QI) programme 'Improving Together' and we have seen some fantastic progress being made.

The programme has progressed on plan and our QI Academy have continued to provide our wards and departments with training, skills, tools and support. Just short of 5000 colleagues have received some level of Improving Together training, which is delivered through different approaches, including a 5 month change programme for frontline teams and a 2-day bootcamp for managers. An online offering is also available and has been refined during the year as this is the most accessed form of training to underpin the more detailed sessions. At the beginning of April, the Quality Improvement Academy was accredited by the Lean Competency System organization which is affiliated with the University of Cardiff. This means that colleagues completing several of our training programmes will now be eligible for a transferable, nationally recognized qualification.

> "I really enjoyed Bootcamp. It gave me lots of ideas about how I can introduce the tools into my day to day work and I've made some really positive improvements as a result."
>
> **Jason Dutton**
> Corporate Governance Support Manager

We use a dedicated Business Intelligence (BI) dashboard to measure the progress we are making with the programme and have provided regular reports on this to our Transformation and People Committee.

The impact of our training has been measured by the adoption of tools by teams who have been trained and during 2023/24 we saw a 15% improvement when compared to the previous year. Importantly, this was sustained through the winter months, which are the most challenging for us. We have set a target to increase adoption of tools by a further 15% for 2024/25. What has become clear in our data is that where these tools are used the performance of the teams improves. Some of the best examples of this are the improvement in the timeliness of induction of labour by our

maternity team and the achievement of the 28-day faster diagnosis standard by our surgical teams, both of which resulted in regional and national recognition.

To compliment the work, we have done within the clinical divisions, embedding this approach to working we have successfully extended this to several Executive Oversight Groups. Non- elective and planned care boards have now established the format of their meetings and the way they seek improvement to align to this methodology. In addition, the Executive R&I oversight group will also take this format from this next year.

Over the next 12 months, the application of a continuous improvement methodology as the way we work at UHNM will be embedded in our employees' life cycle. From first exploring our website to understand the organisation, to inclusion in job descriptions, forming part of the discussion in personal development reviews to signposting to the appropriate training.

We share the successes of our teams through monthly Spotlights on success (Improving Together spotlight - Team of the month | University Hospitals of North Midlands NHS Trust) and quarterly production of podcasts (Stream Improving Together | Listen to Improving Together Podcast playlist online for free on SoundCloud) of our conversations with UHNM's Exceptional People. In addition, we share news and updates regularly through a number of social media platforms.

Working together, learning together, Improving Together

Improving Together is our long-term cultural improvement programme designed to move us to a culture where everyone feels empowered to make small changes in their day-to-day work that result in improved care for our patients and work experience for our colleagues.

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

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

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

Our second cohort of CeNREE Fellows and Chief Nurse Fellows attending their first day of teaching alongside Associate Chief Nurse for NMAHP Research and Education and CeNREE Director Prof Alison Cooke, Programme Lead Rachel Houghton and Academic Development Officers Chris Murray and Tash Green

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

In their three years CeNREE:

- Have provided support to over 280 NMAHPs.
- Continue to host two National Institute for Health and Care Research (NIHR) Senior Research Leaders.
- Have supported and continue to support five prestigious NIHR Pre-doctoral Clinical & Practitioner Academic Fellowship (PCAF), one NIHR Doctor Clinical and Practitioner Academic Fellowship (DCAF), one NIHR pre-application support grant, one North Staffs Medical Institute grant and one UHNM Charity grant.
- Have hosted three successful showcases.
- Have hosted several student placements and an internship.
- Continue to facilitate 5 active research groups convened during the Catalyst event in November 2023, focused on Healthy Ageing, Workforce, Research Culture, Access and Health Inequalities, and Colleagues and Patient Quality, Risk and Experience.

- Actively participate in the CNO Research Transformation Leaders Network and the Council of Deans Health Clinical Academic Roles Implementation Network (CARIN) through the CeNREE Director providing a voice at a national level.
- Have hosted three NHS England Clinical Leadership Fellows.
- Have supported almost 40 colleagues to graduate from the Chief Nurse Fellow Programme, including 29 from cohort 2 who also achieved LEAN certificates from the QI Academy.
- Have recruited a further 29 fellows to join cohort 3 of the fellowship programme, including nurses, midwives, AHPs, pharmacy technicians, pharmacists, and clinical scientists.
- Have appointed more Research Ambassadors to signpost colleagues to CeNREE support and encourage evidence-based practice, joining a total Ambassador Network of 15.

3.2 Delivering our Quality Priorities in 2025/2026

Taking account of the views of our people, our patients, their carers and relatives and our healthcare partners, we have developed our Quality Delivery Plan which sets our priorities for our patients, which align with the NHS Long Term Plan, our obligations under the Health and Social Care Act (2012) and the expectations of our regulators.

Ann-Marie Riley, Chief Nurse

At UHNM we are committed to building a culture of continuous quality improvement, ensuring that our patients and colleagues are engaged and listened to. During 2024/2025 we have continued to implement the Patient Safety Incident Response Framework (PSIRF).

Our implementation of PSIRF has been successful during this first 12 months, utilising new tools and techniques to introduce a system thinking approach to our learning, supported by our Patient Safety Partners and Patient safety Specialists. This along with our continuing development of clinical effectiveness frameworks and active research programmes, will support improvements locally and to our wider population and system partners.

Our Patients

Prioritising our quality improvement areas

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

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

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

UHNM have developed our priorities by using internal intelligence and also engaging with variety of groups that use and access our services. Feedback has been gathered throughout 2024/25 through engagement and discussion with the following:

- Patient and families
- Colleagues
- Staff survey
- Integrated Care Board
- Hospital User Group
- National Inpatient Survey
- World Patient Safety Day 2024

Our quality priorities for 2025/2026

Improvement aim	Quality Improvements	Outcome
Improve patient safety & clinical effectiveness	To implement the Urgent & Emergency Care (UEC) Improvement programme and Elective Hub at County Hospital utilising standardised work and discharge processes to reduce avoidable harm To continue to embed and enhance the Trust's PSIRF by further development of our incident responses, sharing learning and development of organisational culture programme. Continue the Getting It Right First Time (GIRFT) programme delivering the Trust's objectives to deliver more effective patient care	Patient Safety is enhanced through our learning culture and practice based on evidence that we do things the right way to achieve best outcomes for our patients
Improve staff health and wellbeing	Improve support and access to mental health and physical wellbeing by providing safe environments and workplaces with appropriate facilities Increases engagement and sense of belonging by continuing to improve our equity, diversity, inclusion and hearing voice of our people	The wellbeing of our people is improved and moral improves providing a happier and more engaged workforce to provide high quality care.
Improve patient experience	To ensure patients are at centre of our decision making with implementation of Patient Leadership Council Ensure 95% completion of assessments relating to nutrition and hydration with assurance of appropriate action undertaken to improve clinical outcomes	Good quality patient experience is at the heart of all we do.
Develop a person centred practice framework	Develop clear professional development and leadership opportunities Work in partnership with our teams to create positive practice environments	Improved colleague experience and satisfaction at work

Commissioning for Quality and Innovation (CQUIN) Indicators for 2024/2025

The **Commissioning for Quality and Innovation (CQUIN)** indicators for 2024/2025 are designed to support improvements in the quality of services and the creation of new, improved patterns of care within the NHS. The mandatory CQUIN scheme has been paused, but a set of non-mandatory quality indicators which systems may choose to use can be found on the FutureNHS Collaboration Platform.

The indicators for 2024/2025 focus on various clinical priority areas, including:

- **Clinical Domain**: This includes indicators for conditions such as atrial fibrillation, coronary heart disease, cholesterol control, heart failure, hypertension, peripheral arterial disease, stroke, diabetes mellitus, asthma, chronic obstructive pulmonary disease, dementia, depression, mental health, cancer, chronic kidney disease, epilepsy, learning disabilities, osteoporosis, rheumatoid arthritis, palliative care, and non-diabetic hyperglycaemia.
- **Public Health Domain**: This includes indicators for blood pressure, obesity, smoking, vaccination and immunisations, and cervical screening.
- **Quality Improvement Domain**: This includes indicators for personalised care adjustments and other quality improvement measures.

These indicators are designed to be relatively simple to implement and form part of wider national delivery goals. They are supported by national implementation programs and stakeholder support to help providers deliver the improvements and integrate them into normal clinical practice.

The identified schemes for UHNM are as follows:

- Flu vaccinations for frontline healthcare workers (Continued from 2023/24)
- Tranexamic Acid prior to Surgery (New CQUIN)
- Supporting patients to drink, eat and mobilise (DrEaMing) after surgery (Continued from 2023/24)
- Recording of and response to NEWS2, or the National Early Warning Score2, for unplanned critical care admissions (Continued from 2023/24)
- Recording of Paediatric Early Warning System for patients aged <18 (New CQUIN)
- Identification and response to frailty in emergency departments (Continued from 2023/24)
- Prompt switching of Intravenous to oral antibiotics (Continued from 2023/24)
- Timely communication of changes to medicines to community pharmacists via the discharge medicines service (Continued from 2023/24)
- Compliance with timed diagnostic pathways for cancer services (Continued from 2023/24)
- Referral to radical treatment for 'non-small-cell lung cancer' (stage I or II) in line with the national optimal lung cancer pathway (Continued from 2023/24)
- Achieving high quality Shared Decision Making (SDM) conversations in specific pathways (Continued from 2023/24)
- Achieving high quality transition to adult services (New CQUIN)
- Improving the timeliness and quality of submissions to the Renal Registry to support real time analysis of patient outcomes (New CQUIN)
- Assessment and documentation of pressure ulcer risk (Continued from 2023/24)
- Achievement of revascularisation standards for lower limb ischaemia (Continued from 2023/24)

For the 2024/2025 period, 11 schemes are carried over from 2023/2024, and 4 new schemes have been introduced. Compliance with these quality improvement schemes is documented through existing reporting and clinical governance structures, including the Infection Prevention Committee, Clinical Effectiveness Group, Quality & Safety Oversight Group, and UEC Board.

4. Patient Stories

"I have been under the neuro team for 6 years. I was referred pre-covid as I had been suffering with headaches since I was 16. I remember the date- it was 1st May, and the pain in my head woke me up. It was like nothing I'd ever experienced before. I was referred and dismissed from every neuro department in Birmingham- young, female it must be stress… it was migraines, it was anxiety, I was making it up.

After the 5th neuro department dismissed me, I saw a locum GP who knew of Dr Davies at UHNM and he asked if I'd mind travelling to Stoke. I was 21 years old at the time and had no break from this pain since I was 16 years old. Within 30 seconds of seeing Dr Davies and describing the pain, Dr Davies said he knew what it was… it's a very rare type of headache called a nummular headache. I can't explain the feeling. I said to Dr Davies "you believe me then? I'm not making it up?" and he confirmed I wasn't. He explained that at the time, there were only 110 cases reported across the world. Dr Davies next suggestion was to try Botox injections- at this point, he was the only consultant I had ever genuinely trusted. I was then introduced to the injection nurse, (Headache Nurse specialist) Carrie. She has been just incredible. I was to have 5 injections in the area of my head where the pain was . The injections were over before I knew it. After 7 days I got up for work and immediately thought "there's something wrong- I feel different". My head didn't hurt. I hadn't been without a headache for 6 years so I couldn't remember what it felt like not to have a headache.

I can honestly say the Botox injections have changed my life. I'm not in pain. I can actually do things, have a life, get some sleep- all the basic things people take for granted are huge to me."

"I would like to bring to your attention the excellent experience I have had and in fact still having at Stafford Hospital. In July 2023 I was diagnosed with CHARCOT FOOT. Mr Ali and his secretary Jayne have given me an excellent professional service and kept me well looked after over the last 10 months resulting in a planned operation to reconstruct my left food mid-section. Also, I would like to show my appreciation for the kindness, professional service the girls in the plaster room at Stafford and the information and genuine care given.

Sheryl, Donna, Holly and Sarah have gone the extra mile looking after me and have always been there if I had any issues.

Being a retired Police Officer I know what a tough job everyone in the NHS does and I am forever grateful for everything the team have done for me.

Keep up the great work. Forever Grateful"

"I was impressed by every aspect of my care at this marvellous hospital. From rapid diagnosis to scans and X-rays, followed by a week in a room of my own, it could not be faulted. The sympathy and positive attitude of every member of staff were enough by themselves to make you feel better. Every request for assistance was met with a smile; medicines and drugs were dispensed with unfailing regularity; the surgeons were warm and approachable; the physios were challenging but understanding; and visitors were welcomed at all times. Meals were pleasant and varied, in ample quantity, and dispensed like clockwork every day. After a week I was moved into a small ward and saw for myself the care that was given to every other patient with needs much greater than my own.

Every person was treated with respect, no matter what help they needed. Anyone who has worked in a large organisation will know that all this does not happen by accident. It takes good management to motivate so many people so effectively, no matter how dedicated they may be. We read every day about the 'broken' NHS: what a pity we hear far less about the thousands of success stories that pass every day through its doors. I have seen the very best of private hospitals at first hand, and I cannot think of a single aspect of their care that was superior to the Royal Stoke. Thank you to everyone who works there."

5. Review of services

5.1 Care Quality Commission

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

The Trust is registered to provide the following services:

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

CQC conducted thorough inspections at County Hospital and our Maternity Unit. These inspections were pivotal in assessing the quality of care provided. Medical Care at County Hospital saw a significant improvement, moving from Inadequate to Good, a testament to the hard work and dedication of our people. This resulted in the County Hospital overall rating improving from Requires Improvement to Good.

We are also delighted to note that the CQC noted the quality improvements made within our Maternity Services with all inspected domains improving their ratings to Good and service rated Good overall.

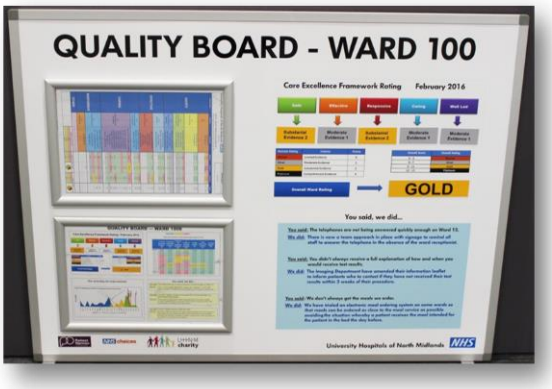
The table below shows the overall UHNM rating by the five key domains and compares results to previous inspections:

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

Section 29A Warning Notices

The requirements of the Section 29a notices relating to maternity care, and medical care at County Hospital were met and supported the subsequent improvement in CQC ratings for those services to GOOD.

5.2 Care Excellence Framework



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

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

It is supported by data from clinical indicators and intelligence and is an internal accreditation system providing assurance from ward to board which is aligned to the National quality agenda, the Health and Social Act (2021), the National Outcomes Framework (2022), the CQC Quality Statements and UHNMs Strategic priority objectives. An overall award for each ward/department based on evidence collated is given, the awards range through bronze, silver, gold and platinum

The CEF has been established at UHNM since 2016. The framework is subject to regular review and hasbeen modified and adapted to enable its use in all areas of the organisation. Bespoke toolkits are available for inpatients, paediatrics, maternity, outpatients, theatres and the emergency department. The toolkits are regularly reviewed to reflect current issues and areas requiring focused improvement. These toolkits are reviewed with subject matter experts.

Each ward/department will have at least one Care Excellence visit per year reviewing all domains and will receive ad hoc visits throughout the year to seek assurance with regards to individual domains. The CEF is delivered in a supportive style fostering a culture of learning, sharing and improving, as well as reward and recognition for achievement.

This year saw us introduce Mock Unannounced CQC inspections into the wards that are/were been monitored under the CEF Panel, this was a way in which we could invite external senior leaders from the ICB to arrive in an area unannounced and review that area in line with CQC's key lines of enquiry. This ensures we are not marking our own homework with CEF and that the improvements made are visible and palpable. We are able to

demonstrate improvements and trends over time which help to benchmark and spread excellence across the organisation.

In 2024/2025 improvements to the Care Excellence Framework have been made including:

- Opportunity for ward/department manager feedback
- Updated the award criteria to enable robust allocation of awards that are driven by quantitative as well as qualitative achievements
- Use of digital technology to improve accuracy and timeliness of data collection and report publication
- Worked with Quality Improvement Academy to use A3 methodology to highlight top contributing problems and how to address them
- Bronze areas meet monthly with the Deputy Chief Nurse, Head of Nursing and Matron Quality, Safety and Compliance alongside a patient leader to discuss what support is needed to support the required improvements. Each area presents recent data and discusses improvements, successes and challenges. The meeting is attended by subject area experts such as Patient Experience, Pharmacy, Dietetics, Estates and facilities and People Directorate
- Bronze areas have access to Professional Nurse Advocate support to provide supervision and coaching
- All overall Bronze areas will be revisited after 6 months of the published report for assurance
- Each quarter a mock CQC visit is undertaken by Senior Nursing leaders, Integrated Care Board colleagues and Patient Leaders. This helps to quality assure our own internal accreditation process.

5.3 PLACE Inspection

UHNM completed its Patient-led assessments of the Care Environment (PLACE) inspections in Autumn 2024. UHNM achieved above the national average for all the domains for a second year running. The PLACE scores achieved in 2023/4 for UHNM, and its sites Royal Stoke and County Hospitals, demonstrate that the hospital environment for patients from a non-clinical perspective at UHNM continues to provide a positive experience for our patients. Good environments and services that respond to the needs of our patients really do matter and thanks go to all colleagues for their continued hard work and commitment in this area.

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

The table below outlines the site scores for Royal Stoke University Hospital and County Hospital plus the overall UHNM Trust organisation score alongside the national average for 2024.

Site Name	CLEANING Score %	Combined FOOD Score %	Ward Food %	Organisational Food	PRIVACY, DIGNITY & WELLBEING Score %	CONDITION & MAINTENANCE Score %	DEMENTIA Score %	DISABILITY Score %
THE ROYAL STOKE UNIVERSITY HOSPITAL	99.08	96.59	96.13	98.44	94.65	99.72	91.08	94.06
THE COUNTY HOSPITAL	100	97.36	100	93.40	93.86	99.88	91.69	90.33
UHNM TRUST SCORE	99.83	96.69	96.63	97.79	94.55	99.75	91.16	93.58
NATIONAL AVERAGE	98.31	91.32	N/A	N/A	88.22	96.36	83.66	85.20

Patient Representative Comments

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

County Hospital

- It was obvious that staff cared and were dedicated in the area
- Considering the amount of footfall, the hospital is maintained to an excellent standard
- The staff in all areas visited were amazing, they were committed and patient centred
- County catering is always good

Royal Stoke Hospital

- General areas looked very clean and focus was on the patients
- Very quiet and calm environment
- Staff working well together and seemed happy in their roles
- Very clean and welcoming spaces
- Appeared to be well led
- Busy but well organised

5.4 Participation in clinical audit

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

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

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

The national clinical audits and the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) enquiries that the Trust participated in, and for which data collection was completed during 2024/25 alongside the number of cases submitted are referred to in the tables below:

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

The lead will be responsible for ensuring full participation in the audit.

National confidential enquiries

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

NCEPOD Study	UHNM Registered	Status
NCEPOD: Rehabilitation following critical illness	Yes	Action Planning
NCEPOD: Endometriosis	Yes	Completed
NCEPOD: Blood Sodium	Yes	Awaiting Report
NCEPOD: Acute Limb Ischaemia	Yes	Awaiting Report
NCEPOD: Emergency Procedures in Children and Young People	Yes	Awaiting Report
NCEPOD: Acute Illness in People with a Learning Disability	Yes	Planning / Data Collection

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

5.5 National Clinical Audits

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

National Clinical Audit	UHNM Registered	% of cases submitted
BAUS Penile Fracture Audit	Yes	100%
BAUS I-DUNC Audit	Yes	100%
BAUS Environmental Lessons Learned and Applied to Bladder Cancer Care Pathway Audit (ELLA)	Yes	100%
Breast and Cosmetic Implant Registry	Yes	100%
Case Mix Programme - Intensive Care National Audit and Research Centre (ICNARC)	Yes	100%
Cleft Registry and Audit Network (CRANE) continuous data collection	Yes*	100%
Emergency Medicine QIP: Adolescent Mental Health	Yes	100%
Emergency Medicine QIP: Care of Older People	Yes	100%
Emergency Medicine QIP: Time Critical Medications	Yes	100%
Epilepsy 12 – National Clinical Audit of Seizures and Epilepsies for Children and Young People	Yes	100%
Falls and Fragility Fracture Audit Programme: National Audit of Inpatient Falls	Yes	100%
Falls and Fragility Fracture Audit Programme: National Hip Fracture Database	Yes	100%
Falls and Fragility Fracture Audit Programme: The Fracture Liaison Service Audit	Yes	100%
Learning from Lives and Deaths in People with a Learning Disability and Autistic People (LeDeR)	Yes	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE – UK Collaborative)	Yes	100%
National Adult Diabetes Audit: National Diabetes Core Audit	Yes	100%
National Adult Diabetes Audit: National Diabetes Footcare Audit	Yes	100%
National Adult Diabetes Audit: National Diabetes Inpatient Safety Audit	Yes	100%
National Adult Diabetes Audit: National Pregnancy in Diabetes Audit	Yes	100%
National Adult Diabetes Audit: National Gestational Diabetes Audit	Yes	100%
National Audit of Cardiac Rehabilitation	Yes	100%
National Audit of Care at the End of Life (NACEL)	Yes	100%
National Audit of Dementia	Yes	100%
National Bariatric Registry	Yes	100%
National Cancer Audit Collaborating Centre: National Audit of Metastatic Breast Cancer	Yes	100%

National Clinical Audit	UHNM Registered	% of cases submitted
National Cancer Audit Collaborating Centre: National Audit of Primary Breast Cancer	Yes	100%
National Cancer Audit Collaborating Centre: National Bowel Cancer Audit	Yes	100%
National Cancer Audit Collaborating Centre: National Kidney Cancer Audit	Yes	100%
National Cancer Audit Collaborating Centre: National Lung Cancer Audit	Yes	100%
National Cancer Audit Collaborating Centre: National Non-Hodgkin Lymphoma Audit	Yes	100%
National Cancer Audit Collaborating Centre: National Oesophago-Gastric Cancer Audit	Yes	100%
National Cancer Audit Collaborating Centre: National Ovarian Cancer Audit	Yes	100%
National Cancer Audit Collaborating Centre: National Pancreatic Cancer Audit	Yes	100%
National Cancer Audit Collaborating Centre: National Prostate Cancer Audit	Yes	100%
National Cardiac Arrest Audit	No**	N/A
National Cardiac Audit Programme: National Adult Cardiac Surgery Audit	Yes	100%
National Cardiac Audit Programme: National Congenital Heart Disease Audit (NCHDA)	Yes	100%
National Cardiac Audit Programme: National Heart Failure Audit (NHFA)	Yes	100%
National Cardiac Audit Programme: National Audit of Cardiac Rhythm Management (CRM)	Yes	100%
National Cardiac Audit Programme: Myocardial Ischaemia National Audit Project (MINAP)	Yes	100%
National Cardiac Audit Programme: National Audit of Percutaneous Coronary Interventions	Yes	100%
National Cardiac Audit Programme: The UK Transcatheter Aortic Valve Implantation (TAVI) Registry	Yes	100%
National Cardiac Audit Programme: Left Atrial Appendage Occlusion (LAAO) Registry	Yes	100%
National Cardiac Audit Programme: Patent Foramen Ovale Closure (PFOC) Registry	Yes	100%
National Cardiac Audit Programme: Transcatheter Mitral and Tricuspid Valve (TMTV) Registry	Yes	100%
National Child Mortality Database (NCMD)	Yes	100%
National Comparative Audit of Blood Transfusion: 2023 Audit of Blood Transfusions against NICE Quality Standard 138	Yes	100%
National Comparative Audit of Blood Transfusion: 2023 Bedside Transfusion Audit	Yes	100%
National Emergency Laparotomy Audit (NELA): Laparotomy	Yes	100%
National Emergency Laparotomy Audit (NELA): No Laparotomy	Yes	100%
National Joint Registry	Yes	100%
National Major Trauma Registry	Yes	100%
National Maternity and Perinatal Audit (NMPA)	Yes	100%

National Clinical Audit	UHNM Registered	% of cases submitted
National Neonatal Audit Programme	Yes	100%
National Ophthalmology Audit Database: National Cataract Audit	No***	N/A
National Ophthalmology Audit Database: Age Related Macular Degeneration Audit	No***	N/A
National Paediatric Diabetes Audit (NPDA)	Yes	100%
National Perinatal Mortality Review Tool (PMRT)	Yes	100%
National Asthma and COPD Audit Programme: COPD Secondary Care	Yes	100%
National Asthma and COPD Audit Programme: Adult Asthma Secondary Care	Yes	100%
National Asthma and COPD Audit Programme: Children and Young People's Asthma Secondary Care	Yes	100%
National Vascular Registry	Yes	100%
Paediatric Intensive Care Audit Network (PICANet)	Yes	100%
Perioperative Quality Improvement Programme	Yes	100%
Sentinel Stroke National Audit Programme (SSNAP)	Yes	100%
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme	Yes	100%
Society for Acute Medicine Benchmarking Audit	Yes	100%
UK Renal Registry Chronic Kidney Disease Audit	Yes	100%
UK Renal Registry National Acute Kidney Injury Audit	Yes	100%

*UHNM only provides demographic data to the Cleft Registry, further patient care is provided at specialist centres.

** University Hospitals of North Midlands NHS Trust is currently not signed up to this national audit as the Resuscitation Team do not have the funding or the resource to complete the audit. The collection, submission and verification of information requires dedicated administrative support.

*** University Hospitals of North Midlands NHS Trust is currently not signed up to this national audit as the Ophthalmology Team do not have access to the electronic system required to participate. A funding review is currently in progress.

Corporate and local clinical audits

A total of 94 clinical audit projects were completed by clinical audit team and a further 556 clinician led audit projects were registered during 2024/25. These audits help us to ensure that we are using the most up-to-date practice and identify areas where we can make further improvements. An example of improvements made in response to the audit results is:

Audit of the Treatment of Acute Anaphylaxis in Adult Patients

Action	Co-ordinator	Status of Action
In order to improve the timely and effective diagnosis, treatment and management of patients admitted to UHNM with anaphylaxis, the following actions will be undertaken:		
A section of the Emergency Department monthly newsletter will be used to inform and promote the UHNM Acute Anaphylaxis guidelines.	Consultant Anaesthetist / Consultant in Emergency Medicine / Consultant Clinical Immunologist	Complete
New anaphylaxis packs will be made available in all clinical areas comprising of 2 blood bottles, a copy of the anaphylaxis management algorithm and request cards. This will ensure the first and second tryptase samples are sent at appropriate time points in accordance with the guidelines and improve administration of adrenaline when anaphylaxis is suspected	Consultant Anaesthetist / Pharmacy	Complete
The existing referral pathway on the Trust intranet will be amended to improve referrals of suspected anaphylaxis cases to Immunology. Subsequently, a referral process through Careflow will be created and incorporated in the guidelines.	Immunology / ICT	Complete
A bespoke pathway for the Emergency Department will be created to ensure all post event management and follow-up processes are completed for patients in accordance with the guidelines.	Consultant Anaesthetist / Consultant in Emergency Medicine	Complete
The results of this audit will be shared with the Directorate and Divisional Teams as well as via the following corporate functions: • Immunology • Pharmacy • The Resuscitation Committee	Consultant Anaesthetist / Consultant in Emergency Medicine / Immunology / Pharmacy	Complete
To determine if improvements in practice have taken place a re-audit will be undertaken.	Consultant Anaesthetist / Clinical Audit Team	2025 / 2026 Clinical Audit Programme

5.6 Clinical Effectiveness

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

The framework aims are:

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

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

Requirements around the following are included:

- Divisional Meetings – Governance Packs, terms of reference, attendance
- Provision of a Clinical Effectiveness Champion within each Division
- Process maps detailing receipt of external guidance, reports and audit results
- Reporting
- Risk management.
- Monitoring

Other key workstreams that are underway:

- Provision of a Divisional Scorecard / KPIs to highlight areas for improvement based on the Divisional Delivery Plans
- Meetings and Presentations with Clinical Governance Lead and Audit meetings
- Obtaining reports for all National Audits published over the last year - ensuring action plans are developed and shared within the Divisions.
- Review all outstanding NICE guidance - meet with Leads to implement.
- Relaunch of the WHO Surgical Safety Checklist
- Obtaining GIRFT reports - ensuring action plans are developed and shared within the Divisions.
- Agreeing and utilising 8 – 10 Model Hospital priorities per Division to focus and action.
- Develop and implement Divisional Clinical Audit Programmes to provide assurance against clinical effectiveness priorities.

5.7 Participation in clinical research

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

As a centre of clinical and research excellence we participate in clinical trials from across the healthcare sector including novel interventions, new drugs and device innovations. These cutting-edge developments are translated into our day-to-day clinical practice.

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

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

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

During 2024/25 we saw a record number of patients taking part in our clinical research trials with more than 2200 patients taking part, across both of our hospital sites. In total, 2247 patients agreed to take part in one of 265 studies.

This represents a 14% increase on figures from the previous year, with 50 new research studies also being opened.

We also support commercial research, and during 2024/25 we ranked in the top four trusts regionally with 140 patients taking part in commercial research, an 8.5% increase on last year.

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

Strategic Aims

1. Culture: To develop a Trust-wide culture of research and innovation.

2. Capacity: To grow the Trust's capacity to support research and innovation.

3. Finance: To develop a robust, sustainable and transparent financial model for research and innovation.

4. Governance: To support and enhance research and innovation through provision of a robust governance framework.

5.8 Data Quality

The Data Quality Strategic Plans and Data Quality Assurance Group continued to provide strategic and operational assurance to the Executive Business Intelligence Group, led by the Chief Financial Officer, throughout 2024/25. The corporate Data Quality Team has continued to provide assurance throughout the last year to support the improvement of data quality and the provision of excellent services to patients and other customers.

- The Data Quality Team continued to support UHNM colleagues, answering and resolving thousands of queries. The DQ User Support Process has been expanded to provide additional support, training and assurance of user understanding.
- The Data Quality Team provided specialist knowledge to various validation projects to support the national targets for Waiting Lists including the Elective Improvement Programme, amongst others.
- The Data Quality team held their inaugural Data Quality Awareness week in November 2024. This included walk-abouts to all ward and outpatient areas, information stands on both sites and various Trust communications across appropriate media channels.
- The latest Data Quality Service satisfaction survey reported 98% of colleagues said their queries were actioned in a timely manner and 93% said they were offered suitable resolutions.
- Support for IT projects also continued with testing, validation and systems expertise provided by the team.
- The Documentation Approval Group continues to review and approve the content of RTT and Data Quality training materials and guidance documents for accuracy before implementation.
- The divisional data quality groups are well established, with representation from all directorates in attendance. These groups fulfil an important role in the 'Data Quality Assurance Framework'.
- The Data Quality Strategy has been refreshed for the next 5 years, supporting the delivery of the Trust's strategic objectives.
- The Data Quality Policy (C27) has been reviewed and ratified in line with Corporate Governance timelines.
- The Terms of Reference and Calendar of Business for the Data Quality Assurance Group have been approved for 25/26 ensuring they address data quality obligations to the CAF / Data Security and Protection Assurance Framework.

2024/25 has been another productive year for the data quality team and we aim to build on this throughout 2025/26, supporting the strategic aims of the Trust.

5.9 NHS Number and General Medical Practice (GMP) code validity

UHNM submitted records to the Secondary Uses System (SUS) for inclusion in the Hospital Episode Statistics (HES) included in the latest published data. This is a single source of comprehensive data which enables a range of reporting and analysis in the UK. The figures below are for the period April 2024 to January 2025. The percentage of UHNM records in the published data which included the patient's valid NHS number is:

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

Valid General Medical Practice Code performance is:

- 100% for admitted patient care; national performance is 99.4%.
- 100% for outpatient care; national performance is 99.3%.
- 100% for Maternity care; national performance is 96.7%.

Valid Ethnic Category performance is:

- 96.3% for admitted patient care; national performance is 95.3%.
- 94.1% for outpatient care; national performance is 92%.
- 100% for Maternity care; national performance is 98.1%.

Additional benchmarking is carried out using the NHSE Data Quality Maturity Index (DQMI) dashboard. Throughout 2024/25 UHNM has consistently reported above the national average on all Inpatient, Outpatient and Maternity metrics. These are reported to the Data Quality Assurance Group and the Trust's Executive Business Intelligence Group for assurance purposes.

5.10 Clinical coding accuracy rate

Annual audit

- The Cyber Assurance Framework / Data Security and Protection Toolkit (CAF /DSPT) clinical coding audit was carried out by the Trust's clinical coding auditors during 2024/25.
- An overall 'Standards Met' rating was achieved across the audit:

Attainment Levels			
	Standards Met	Standards Exceeded	**Audit Results**
Primary Diagnosis	>90%	>95%	**94%**
Secondary Diagnosis	>80%	>90%	**90%**
Primary Procedure	>90%	>95%	**91%**
Secondary Procedure	>80%	>90%	**86%**

- All recommendations from the 2023/24 audit have been completed.
- Findings from the audit are fed back to all clinical coders to ensure lessons are learned and improve coding accuracy, working towards 'Standards Exceeded' in next year's audit.

Coding Improvement Project

- The coding team are currently working with an external company to identify areas for improvement both within the clinical coding process and clinical documentation used for coding purposes.
- The company has advised that the Trust's accuracy and depth of coding is significantly higher than other Trusts they've worked with.
- This has been confirmed by the lower-than-expected return rates.

Staff Audit Programme

- The internal audit programme continued throughout 2024/25 for all coding colleagues. The audit process is regularly reviewed and updated to provide a robust assurance process.
- Of the 33 staff audited in 2024/25, 31 achieved a minimum of the 90% accuracy rate. Improvement plans were designed for the other 2 coders who fell slightly short of the mark.

Training

- The Trust has a qualified Clinical Coding Trainer who annually reviews and updates the two-year training programme for trainee coders, including feedback from previous Trainees.
- The Trainer provides all mandatory national training, ensuring all coders are compliant with training requirements.
- The Trainer provided one Standards course in 2024/25 for the Trainee Coders and 5 Standards Refresher workshops for the continued development of the Lead Coders.
- All clinical coders have access to online training modules to enhance their knowledge and skill sets.

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

The Data, Security and Protection Toolkit is a self-assessment, seeking assurance that all standards supporting the integrity, confidentiality and availability of information have been achieved. The toolkit continues to evolve by incorporating best practice guidance; thereby ensuring continuous improvement in the Trust's DSP position.

The Trust submitted its final assessment for the period July 2023 to June 2024 declaring all standards had been achieved except for three. An improvement plan was developed and approved by NHS England and the Trust has been awarded a rating of 'standards not fully met (plan agreed)' pending completion of the improvement plan. Two standards have subsequently been implemented with one standard on-going, with a timescale of June 2025 for completion. The internal audit review confirmed the overall risk assurance across all 10 National Data Guardian standards was moderate with a moderate confidence level of the independent assessor in the veracity of the self-assessment.

This year sees a major change to the assessment, with a greater focus on cyber. Hence a cyber assessment framework has been developed with associated internal audit guidance. To support the Trust with the new assessment (for July 2024 to June 2025) an internal audit is scheduled for May 2025; the findings of which will be reported to the Executive Digital and Data, Security & Protection (DSP) Group. Areas for improvement will be monitored via an improvement plan with monthly reporting to the Executive Digital and DSP Group. As in previous years, if the Trust does not achieve all standards by the June submission, the Trust's rating will be classified as 'Standards not fully met (plan agreed)'. The Executive Digital and DSP Group will continue to seek assurance on the Trust's toolkit position, thereby providing assurance to the Trust Board via the Transformation & People Committee. In recognition of the importance of cyber an assurance report has been developed and is presented at the Audit Committee.

5.11 Seven-day services

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

These are:

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

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

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

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

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

Part B: Review of quality performance

6. Quality Priorities 2024/2025

In 2024/25, in partnership with our stakeholders we identified three specific priorities to focus on:

- **To reduce patient harm and improve clinical effectiveness and outcomes for our patients;**
- **To further develop staff engagement and wellbeing; and**
- **To improve patient experience.**

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

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

Table 1: Key quality Indicators Performance 2024/25 compared to 2023/24

Key Quality Performance Indicator	Target	2023/24 Performance	2024/25 Performance	
Induction of Labour	95%	87.6%	98.0%	↑
Maternity Triage	85%	85.6%	92.9%	↑
Patient Safety Incidents (PSI) rate per 1000 bed days	50.7	53.8	52.8	↓
PSI with moderate harm or above per 1000 bed days	0.6	0.7	0.6	↓
Patient Falls	5.6	5.3	5.0	↓
Patient Falls with harm per 1000 bed days	1.5	1.75	1.7	↓
Medication incidents per 1000 bed days	6.0	6.8	6.1	↓
Medication incidents % with moderate harm or above	5%	1.75%	1.6%	↓
Pressure Ulcers developed under UHNM per 1000 bed days	1.6	1.66	1.75	↑
Patient Safety Incident Investigation (PSII) instigated	N/A	82*	31	↓
Never Events	0	7	9	↑
Venous Thromboembolism (VTE) Risk Assessment	95%	95.2%		
Reported C Diffcile cases	179	180	169	↓
Avoidable MRSA Bacteraemia cases	0	4	1	↓
Friends & Family Test: Inpatient	95%	95.5%	95.7%	↑
Friends & Family Test: Emergency Department	85%	70.2%	66.9%	↓
Friends & Family Test: Maternity	95%	91.1%	86.4%	↓
Sepsis: Adult Inpatient Screening	90%	95.1%	95.4%	↑
Sepsis: Adult Inpatient Intravenous Antibiotics in 1 hour	90%	99.5%	99.1%	↓
Sepsis: Emergency Portals Screening	90%	82.5%	85.5%	↑
Sepsis: Emergency Portals Intravenous Antibiotics in 1 hour	90%	75.5%	81.9%	↑
Sepsis: Children's Screening	90%	89.0%	87.1%	↓
Sepsis: Children's Intravenous Antibiotics in 1 hour	90%	100%	75.0%	↓
Sepsis: Maternity Screening	90%	71.9%	78.9%	↑
Sepsis: Maternity Intravenous Antibiotics in 1 hour	90%	86.3%	78.7%	↓
Hospital Standardised Mortality Ratio (HSMR)	100	95.03	126.17	↑
Summary Hospital Mortality Index (SHMI)	100	98.50	113.29	↑

Priority 1 To reduce patient harm, learn from experience and incidents to improve clinical effectiveness and outcomes for our patients

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

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

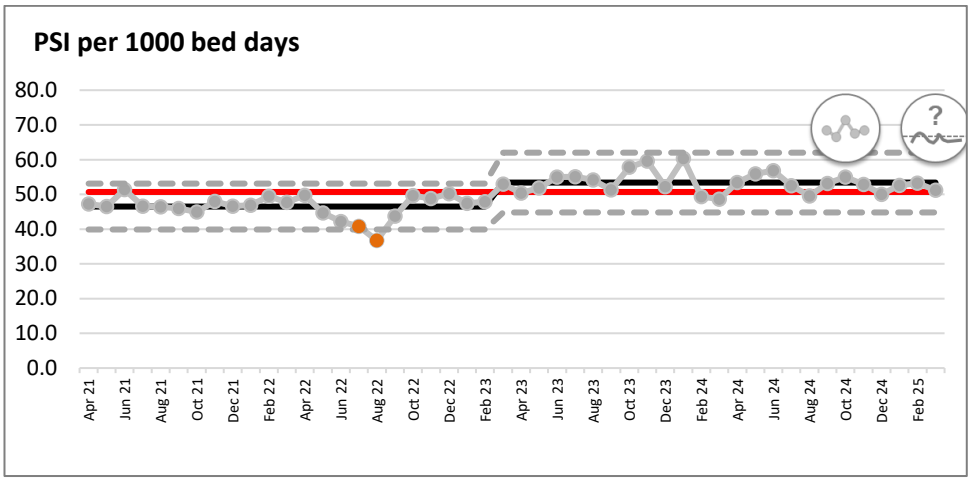
Performance for this priority has been monitored in 2024/25 using key indicators reported monthly through the Trust and Divisional Quality & Safety Reports. This section summarises these indicators' performance and their implications for our patients.

Patient Safety Incidents

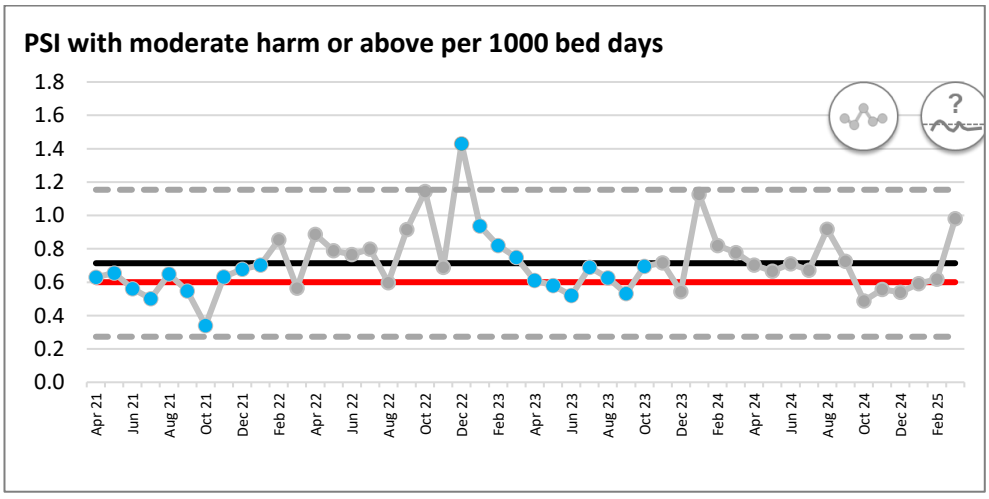
We continue to prioritise patient safety by closely monitoring patient safety incidents (PSIs) as a critical indicator. These incidents are evaluated by the total number reported, the rate per 1,000 bed days, and the number and rate of incidents resulting in moderate harm or above.

During the 2024/2025 period, our commitment to enhancing services and patient care through thorough incident reporting, review, and identification of actionable insights remains unwavering. We encourage and promote the reporting of patient safety incidents and near misses which has seen slight increase in total incidents reported from 26316 to 26457 in 2024/25.

To ensure a comprehensive understanding of incident trends, we also assess the rate of reported incidents per 1,000 bed days, thus accounting for variations in activity levels throughout the year and this year's rate has remained relatively constant to previous year with 52.8 patient safety incidents reported per 1000 bed days



It is noteworthy that despite the maintenance of the rate of incidents and slight increase in overall raw numbers, there has been a reduction in the rate of incidents resulting in moderate harm or above with 0.68 per 1000 bed days during 2024/25 which below the long term mean rate. This positive trend reflects increased transparency in reporting coupled with a decrease in patient harm incidents.

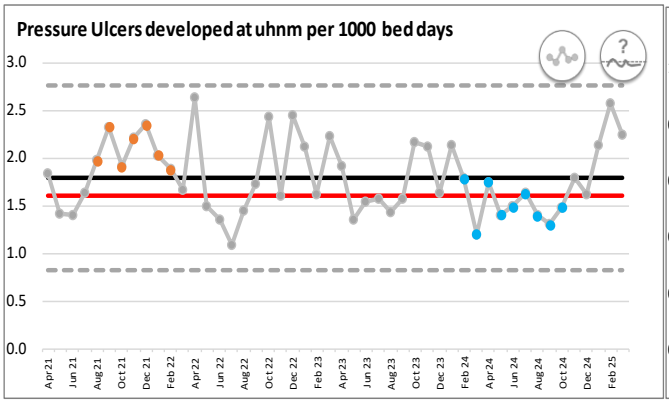


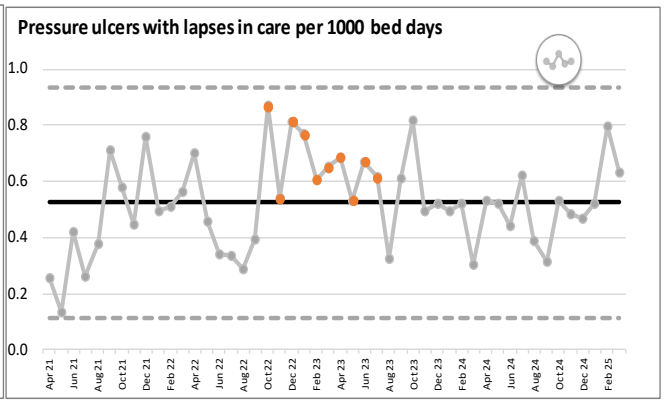
The increase in reported incidents can be attributed to enhanced reporting practices, including a higher number of low or no harm incidents, as well as near misses. This enables the review and identification of learning opportunities before more severe harm occurs. Moreover, the reduction in harm is a testament to

improvements in patient treatment and care, effectively mitigating and reducing the risk of patient harm while under our supervision.

Pressure ulcers developed under UHNM Care

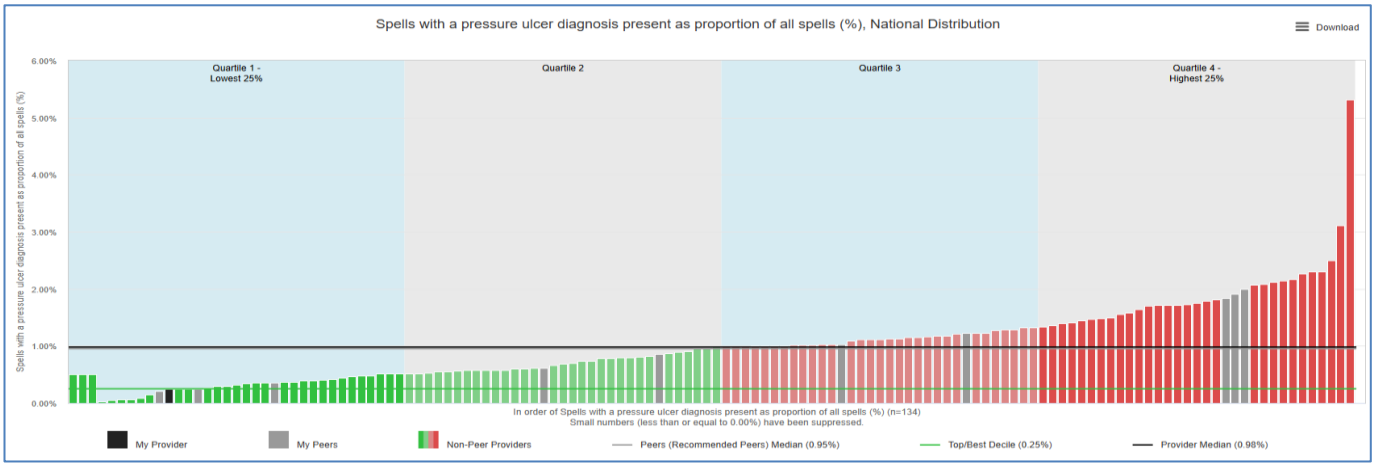
We have seen an increase in pressure ulcers developed whilst under the care of UHNM. During 2024/2025 there were 869 reported pressure ulcers developed at UHNM compared to 832 in 2023/2024. This equates to 4% increase in the total number and 2% increase in the rate per 1000 bed days for identified pressure ulcers. To allow for changes in activity these are reported using rate per 1000 bed days





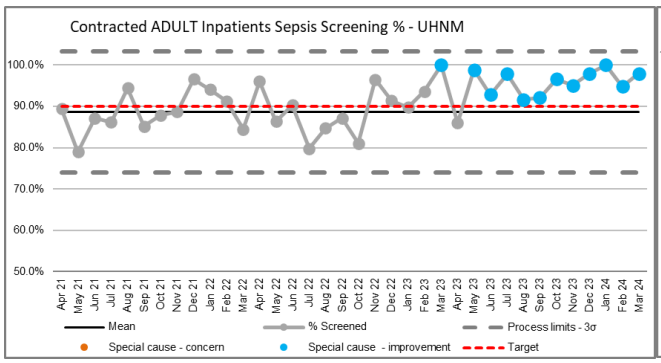
However, despite these increases in the total numbers there has been a reduction in the number and rate of pressure ulcers developed at UHNM with identified lapses in care. During 2024/2025 there were 261 cases with lapses in care identified at a rate of 0.52 per 1000 bed days, compared to 268 and 0.55 respectively in 2023/2024. These equate to 2.6% decrease in total number of pressure ulcers with lapses in care identified along with a 5.5% decrease in the rate.

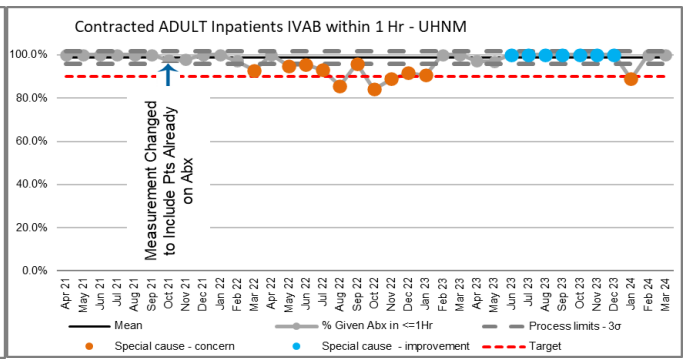
The decreases noted above are improvements and when comparing UHNM Pressure Ulcer diagnosis present as proportion of all inpatient spells shows that UHNM is in the lowest quartile nationally. This is positive benchmark



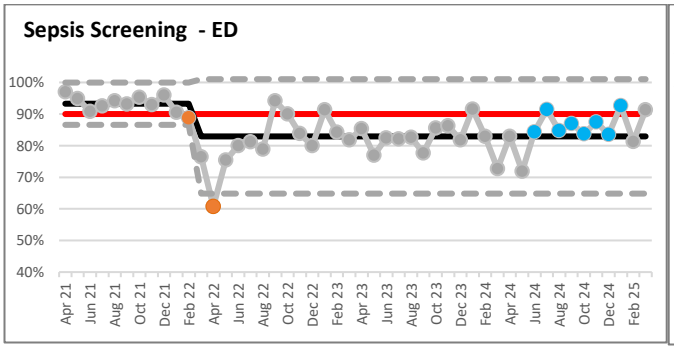
Sepsis recognition and treatment

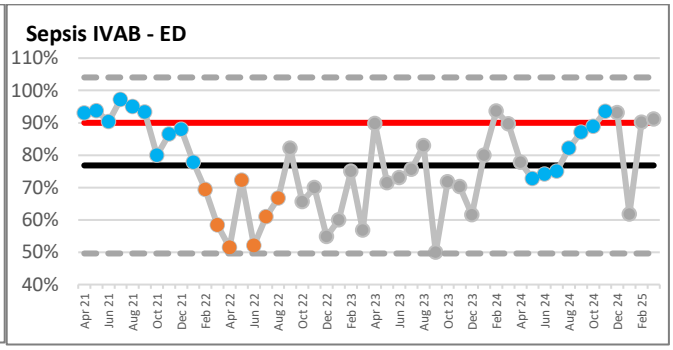
Inpatient areas have seen improvements in sepsis screening and Intravenous Antibiotics (IVAB) in one hour during 2024/2025. Sepsis screening improved from 95.1% to 95.4%. The IVAB in one hour has showed a very slight decrease from 99.5% to 99.1%.





Emergency Portals have seen improvement in screening and IVAB in one hour during 2024/2025. Sepsis screening increased from 82.5% to 85.5% and the IVAB in one hour from 75.5% to 81.9%.





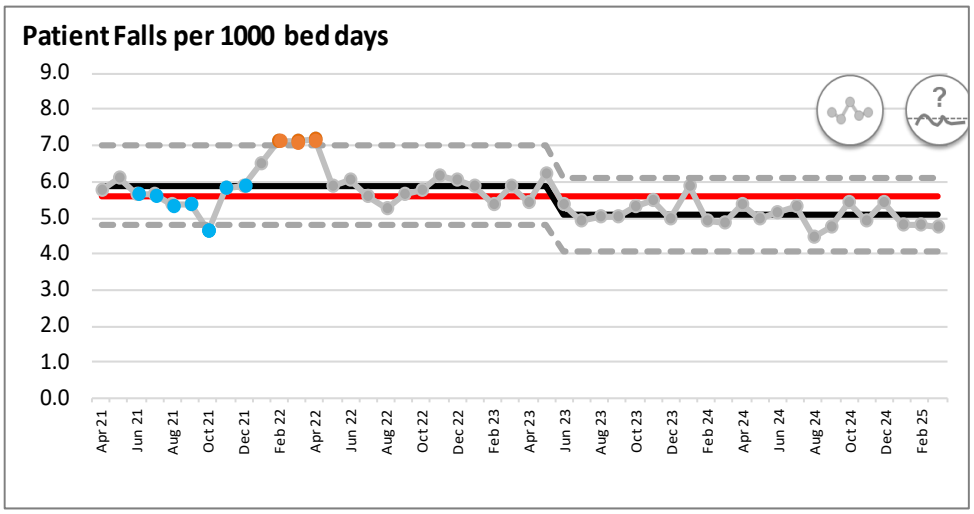
Actions and Next Steps

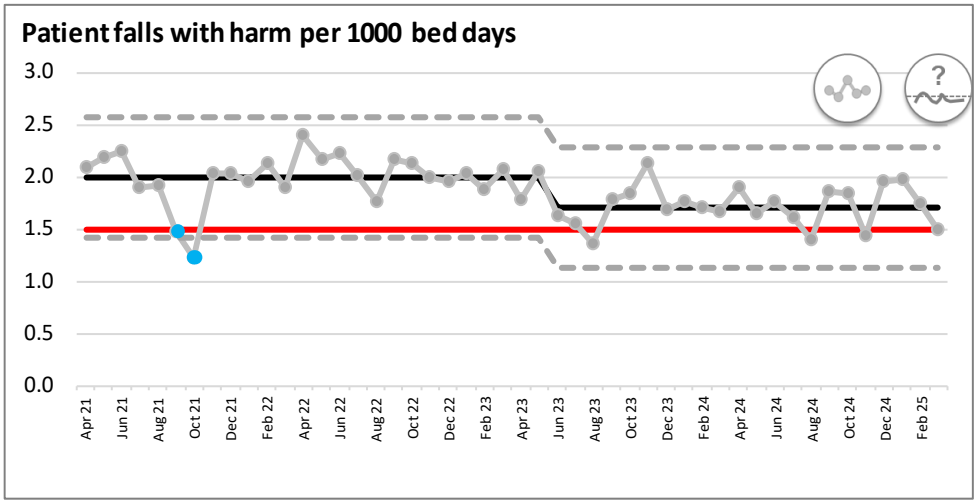
- The Sepsis team continue to work collaboratively with the ED Quality nurses, sepsis champions, senior team, and Sepsis ED lead to improve sepsis screening and IVAB compliance.
- Continued regular visits and sepsis audits in emergency portals particularly in ED RSUH
- World Sepsis Day and awareness events planned throughout the month of September.
- 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.
- We continue to work collaboratively with the maternity team and provide training sessions to all members of the team.

Patient falls

Patient falls remain the largest category of patient-related incidents within our organisation. During 2024-2023, there has been a further 3% reduction in total falls, with 2507 falls this year compared 2585 in 2023/2024. Additionally, the rate of falls per 1000 bed days has decreased from 5.3 to 5.0, continuing the steady improvement in reducing patient-related falls across the organisation, with the previous rate noted as 6.2 in 2020/2021. These reductions are contributing to better experiences and outcomes for patients

UHNM uses 5.6 falls per 1,000 bed days as an internal benchmark for improvement. This benchmark is likely to be adjusted in 2025-2026 as the Trust consistently sees rates at or below this figure.





The reduction in patient falls, with harm decreasing from 1.75 per 1000 bed days in 2023/2024 to 1.7 in 2024/2025, highlights the impact of our Falls Prevention team. Their dedication and the consistent efforts of ward colleagues are yielding positive results over time, improving patient safety and outcomes.

Patient Safety Incident Response Framework and Incident reviews

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

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

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

During 2024/2025, we have commissioned a total of 245 PSIRF-related learning responses. The breakdown of these different types of learning responses is summarized below. The central aim of PSIRF is to identify learning opportunities and provide recommendations to address system and process changes that will mitigate or reduce the risk of similar incidents occurring in the future. PSIRF employs the Systems Engineering in Patient Safety (SEIPS) approach.

PSIRF Response	Q1	Q2	Q3	Q4	Total
PSIRF – After Action Review	20	23	11	12	66
PSIRF – Case Record Review	13	5	6	5	29
PSIRF – Diagnostic Imaging After Action Review	1	1	1	1	4
PSIRF – Falls Toolkit	14	7	6	4	31
PSIRF – Hot Debrief	0	0	2	1	3
PSIRF – Patient Safety Incident Investigation	4	9	8	10	31
PSIRF – Thematic Review	2	6	2	3	13
PSIRF – Tissue Viability Toolkit	10	8	18	15	51
PSIRF – VTE Toolkit	0	1	0	0	1
PSIRF – Being Open Conversation	1	5	2	2	10
PSIRF – Process Audit	0	0	2	0	2
PSIRF – Outcome audit	0	0	1	0	1
PSIRF – MDT Review	0	0	0	3	3

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

Since the introduction of PSIRF, we have improved our engagement with patients and relatives and all the Trust's PSIIs, both completed and ongoing, have involved the patients and/or their relatives. This has happened at the

start of the review (as part of formal Duty of Candour), updates provided during the review and sharing the outcome of the review and talking through the report and its findings and recommendations.

We have 4 Patient Safety Partners in post and supporting patient safety initiatives and 2 Patient Safety Specialists have completed the Level 3 and 4 National Training via Loughborough University as part of the national Patient Safety Specialist (PSS) Cohort 1 training programme. Further training for additional PSS is awaited via NHS England during 20205/26.

As part of the ongoing development and refinement of our PSIRF processes, we are developing patient/relative's questionnaire to gather feedback and learning on the process and how we further support to ensure that the outcomes are most effectively shared and explained. The engagement and liaison with patients/relatives have increased during 2024/2025 as we undertake more PSIRF learning responses across the Trust. The commitment and expertise in liaising with these groups requires further review and we are currently developing a role with the QSC Team for a Patient Liaison Matron to support patients and families and to also support colleagues across the Trust to provide effective support. This role will take the lead on liaison and engagement for the Trust PSIIs and support local teams with other PSIRF learning responses.

Never Events

We review all incidents and during 2024/25 have undertaken reviews for incidents reported under the Never Events list. We undertook Patient Safety Incident Investigations of these incidents, in line with national PSIRF guidance, to identify and focus learning.

During 2024/25, we reported nine never events compared to seven reported in 2023/24.

- Wrong site surgery (June 2024)
- Wrong site surgery (August 2024)
- Wrong site surgery (August 2024)
- Wrong site surgery (September 2024)
- Wrong site surgery (December 2024)
- Wrong site nerve block (December 2024)
- Misplaced Nasogastric tube (January 2025)
- Misplaced Nasogastric tube (March 2025)
- Wrong site surgery - chest drain inserted in wrong side (March 2025)

As part of the reviews of the incidents we have adopted PSIRF approach to review the individual incidents and also thematic approach to the wrong site surgery incidents relating to incorrect lesions/biopsy, including the 5 listed above, to establish common themes and learning to help try and prevent similar incidents reoccurring in the future.

PSIRF & Never Event Learning

Following the series of Never Events for Wrong Site Surgery (incorrect lesions removed) noted in the 5 reported above and during 2023/2024 within the Plastics and Dermatology services we completed individual PSIIs but then subsequently reviewed these together as part of a thematic review approach to identify key themes and actions. The reports and action plans have been presented at Risk Management Panel on number of occasions to provide assurances that the recommendation made are being implemented and changes in practice have been embedded. The action plan was presented at Trust Risk Management Panel on 21st March 2025 to provide updates and assurances on the identified actions that were either completed or

being implemented. It is important to note that since the actions identified in the overarching action plan were implemented there have not been any subsequent incidents where Plastics / Dermatology have removed / biopsied the incorrect lesion.

The overarching action plan for these Never Events identified 29 separate actions that were categorised into 6 clear categories:

- Documentation
- Systems
- Training
- Process
- Equipment
- Audit

This approach to the having overarching action plan rather than individual actions for each incident has allowed the services and the Trust to review effectiveness of previous actions and identify clear themes/issues that were prevalent in all incidents. The combining of the actions into the1 action plan has allowed for much greater focus and allocation of resources. At the RMP meeting on 21st March 2025, it was noted that 19 of the 29 actions have already been completed and closed with 10 remaining open but within the agreed target dates for completion.

RMP has been provided with assurance and documented evidence that the completed actions have been closed appropriately. The services have introduced new Safety Checklists for use in Dermatology & Plastics Outpatients, Theatres and Central Treatment Suite. In addition to the Safety Checklists, there are also new SOPs for administrative and clinical colleagues to follow in the management and treatment of patients.

Key to these SOPs and agreed practices is the SOP for Skin Cancer Patients Photograph and Marking process and operative process. This explains the process for taking photographs and clearly identifying lesions for skin cancer patients in Face-to-Face clinics (see image opposite).

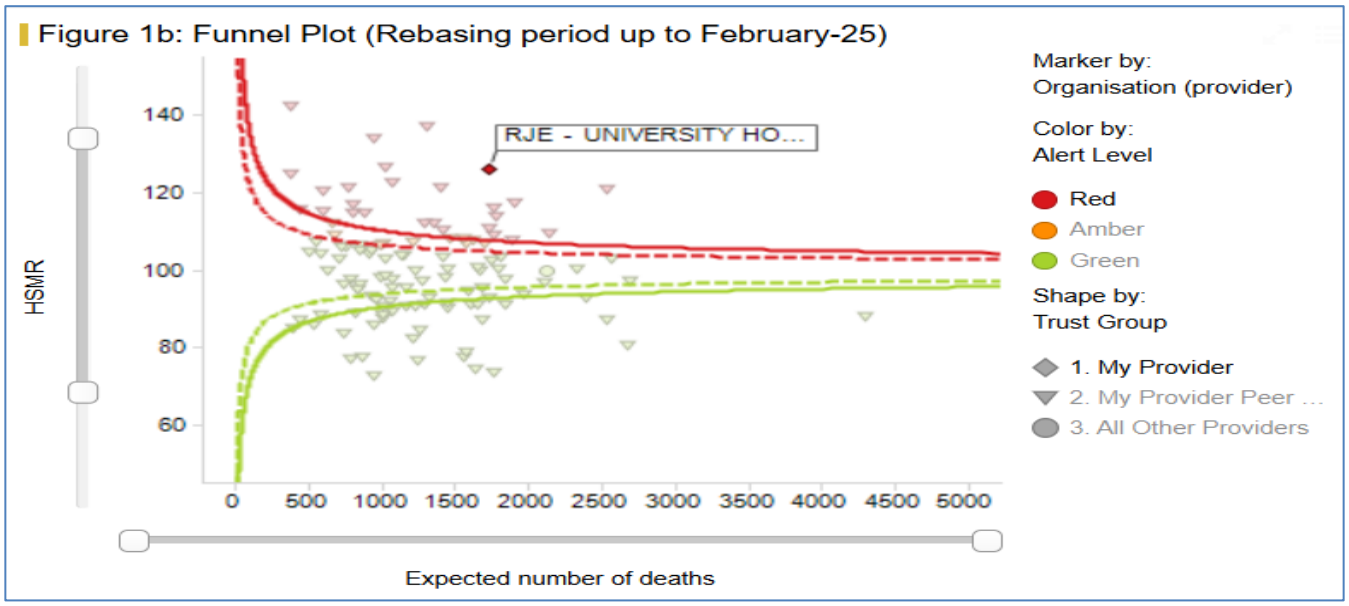
The SOP was agreed for use in both Dermatology and Plastic Surgery specialties along with external provider of community services, Health Harmonie. It ensures that there is an agreed process to follow and that the marking of lesions is consistent and that all photographs are uploaded to the WABA system so that surgical teams can check and confirm the correct procedure site.

- New SOPs introduced for Skin Cancer Patients Photograph and Marking process and operative process.
- SOPs ensure photographs and lesion markings are consistent across Dermatology and Plastic Surgery specialties.
- Photographs are uploaded to the WABA system for surgical teams to confirm the correct procedure site.

It is worth noting that since the introduction of the new revised actions outlined above that there have not been any new incidents reported relating to the incorrect lesion removal/biopsy.

Mortality

The Trust's mortality rate with the current 12 month rolling Hospital Standardised Mortality Ratio (HSMR) score (May 2024 – February) is 126.17. This means that UHNM's number of in-hospital deaths is higher than the expected range based on the type of patients that have been treated. This compares to 93.03 for May 2024 to February 2024.



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

The Summary Hospital-level Mortality Indicator (SHMI) is a measure of mortality, developed by the Department of Health, and like HSMR, this measure compares actual number of deaths with our predicted number of deaths.

Like HSMR the prediction considers factors such as age and gender of patients and their diagnosis. The current SHMI value for the Trust is 113.29 (as expected). This is a rolling 12-month measure and covers the period February 2024 – January 2025. The value for February 2023 to January 2024 was 97.72.

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

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

Why are the two measures different?

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

Learning from deaths - mortality reviews

During 2024/2025, the Trust continued to use its online Mortality Review Proforma to allow in hospital deaths to be electronically reported following review of the patient death. The outcomes of these reviews were included within Mortality Assurance Report presented at the Trust's Quality Governance Committee and reported to the Trust Board.

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

The Trust has completed 2,623 online proformas accounting for 75% of hospital deaths recorded during 2023/24. Each one of these deaths is assessed to classify the level of care the patient has. The overall number of mortality reviews submitted during 2023/24 is 3,363. This compared with 2,410 online proformas completed accounting for 70% of hospital deaths recorded during 2023/24.

It should be noted that the mortality reviews are currently ongoing, and these figures relate to deaths in 2024/25 that have also had completed reviews submitted by 12th May 2025. There are deaths that are still being reviewed as part of the Trust's local Mortality and Morbidity Review Meetings but, whilst the deaths may have occurred in 2024/25, the reviews will be completed in 2025/26.

	2024/25 Total		Q1		Q2		Q3		Q4[1]	
Total number of deaths in reporting period	3503		864		761		922		956	
Total number of deaths in reporting period reviewed (% of total deaths)	2623	75%	729	84%	641	2623	75%	729	84%	641
Total number of reviewed deaths with suboptimal care identified – NCEPOD grade E (% of reviews)	0	-	0	-	0	0	-	0	-	0

* The Royal College of Physicians removed the scoring system on preventability following a national pilot. UHNM continue to use the NCEPOD classification system:
A: Good practice - a standard that you accept for yourself
B: Room for improvement - regarding clinical care
C: Room for improvement - regarding organisational care
D: Room for improvement - regarding clinical and organisational care
E: Less than satisfactory - several aspects of all of the above

[1] As at time of updating the list of inpatient deaths ran up to March 2025 deaths

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

The following provides a summary of issues identified during the Structured Judgment Review process that could be improved for SJRs submitted during 2024/2025:

- Importance of reviewing test results in timely way to facilitate diagnosis/decision making and to consider alternative causes of patient's illness.
- Importance of timely clinical reviews and adherence to monitoring guidelines, including escalation to senior clinicians when indicated by NEWS scores.
- Importance of implementing established pathways when indicated e.g. Sepsis.
- Issues with patient flow affecting patient care (especially in the Emergency Department).
- Inappropriate patient transfers.
- Importance of communication with families around DNAR and End of Life Care, ceilings of care; including timely discussion of these with the patient when it is recognised that they are approaching end of life, timely uploading of these into medical records and ensuring relatives are given time to make decisions and establishing ceilings of care for patients.
- Importance of completing key documentation in timely and accurate way, including updating and signing of care records, medication charts and scoring tools, fluid balance charts, cause of death and discharge summaries, RESPECT and DNAR documentation, falls proformas, nutritional assessments, learning disability hospital passports and treatment plans, ward clerking.
- Importance of timely monitoring and review of patients' manner and for escalation to senior clinicians for review where appropriate especially re fluid balance, hypoglycaemia and during dialysis.
- Medication issues including accuracy of prescriptions, timeliness of administration (and discontinuation) and review of medication (especially antibiotics and anticoagulants); timeliness of prescribing; ensuring decisions around medication are fully documented in notes and that guidelines are adhered to

Hospital acquired infections

The Trust continues to strive to reduce the number of avoidable hospital associated infections. Two of the key infection associated indicators that are used are Methicillin-resistant Staphylococcus aureus (MRSA) and Clostridium Difficile (C Diff). During 2024/2025, the Trust has seen a reduction in like for like numbers compared to 2023/2024 for Clostridium Difficile and Trust apportioned MRSA.

Indicator	2024-25 Target	2022/23	2023/24	2024/25
To reduce C Difficile infections	179	144	180	169
To reduce MRSA infections (Trust apportioned)	0	1	4	1

Actions and Next Steps

- C Diff Nurse role fully embedded and the role is 50% focussed on patient reviews and 50% on colleagues training.
- Bi-weekly Cdiff MDT meetings continue to take place
- Themes are reviewed on a monthly basis and learnings shared across the Trust as well being presented at IPCC and the ICB.
- All C Diff cases measures are instigated and PSIRF process adhered
- C Diff awareness plan to involve all clinical and medical colleagues underway
- Collaborative work with multidisciplinary team and Antimicrobial Stewardship Group
- Routine ribotyping of samples continues for samples from areas where we have periods of increased incidence only
- CURB -95 score added to Community Acquired Pneumonia (CAP) antimicrobial Microguide.
- Antimicrobial working group to remind clinical areas to send urine samples when UTI is suspected and ensure appropriate choice of antibiotic for treatment of UTI
- Additional oversight of C-Diff cases is being implemented where there is potential learning in terms of antibiotic use
- Big bed clean completed October 2024
- PSIRF process and monthly themes report introduced
- Weekly AMS presence at County to support antimicrobial prescribing
- Commode cleaning day completed January 2025
- The existing Pneumonia guidelines have been reviewed, revised and ratified through ASG and launched to prescribers in early January 2025. Key changes involve the reduction in the use of Co-Amoxiclav in Community Acquired Pneumonia, with a focus on using the narrower spectrum oral antimicrobials where possible or a prompt IV to oral switch

Priority 2: To further develop staff wellbeing and experience

The health and wellbeing of our workforce is paramount and in 2024/25 associated activity related to our People Strategy domain 1 'We look after our people'

We said we would do this by:

- Promoting mental health wellbeing and support, and continued collaboration with our Staff Support and Counselling and Staff Psychological and Wellbeing Hub, promoting their support services and workshops
- Roll out of Wagestream (financial wellbeing platform) to bank colleagues across the trust
- We championed flexible and agile working for both wellbeing and colleague retention
- Rest facilities maintained with the support of Staff Good Causes, providing the essential items for the purpose of wellbeing
- Continued to offer RESPOND and an introduction to Psychological Safety (to support colleagues to undertake wellbeing conversations)
- Our revised PDR (appraisal) paperwork has sections to encourage discussions on wellbeing, behaviours and flexible workings approaches
- Menopause guidance, support via our Conversation Cafe with our clinical experts

In addition, we:

- Empowered all to focus on agendas relating to wellbeing including Being Kind, Sexual Safety and a targeted Violence and Aggression campaign 'We are people too'
- Responsive in Urgent and Emergency Care, supporting during critical incident
- Promotion of Women's Health, Men's Health, Menopause at Work and Period Poverty in related networks and steering groups and our podcast series
- We have engaged with key stakeholders to plan to become a 'Smoke Free' Organisation
- Continued delivery of our Improving Together Programme methodology and training
- Provide colleagues with research, professional and academic development opportunities through CeNREE.
- Continue to work in partnership with our Professional Nurse/Midwifery Advocates who offer restorative, career coaching support
- Provided Mental Health Practitioner training

Performance against the above is measured via our Staff Engagement metric, National Staff Survey, Staff Voice, Sickness/Absence metric, Occupational Health and Counselling data.

We have launched our new ten-year Strategy 'The best joined up care for all' whereby we have 'Our People' strategic objective focused into three key areas of: Health & Wellbeing, Learning & Development and Flexibility & Agility. We will improve our work environments and wellbeing offers, actively champion diversity and support the health and wellbeing of our people.

Our People delivery plan clearly gives priority for staff wellbeing and experience for the coming year 2025/26 including aims, objectives and measures for success.

Performance against this priority and its aims has been monitored during 2023/24. The following section provides a summary of the performance for these indicators and what these results mean for our patients.

Freedom to Speak Up
Your voice matters at UHNM

During 2024/2025 we have continued plans to further develop our service and continue our commitment to improving the speaking up culture at UHNM. We have again used our self-reflection tool to target areas for development and improvement and we have recruited to a Deputy Freedom to Speak Up Guardian role and Administrative Support Secretary to enhance our ability to focus on strategic aims and goals in the coming financial year.

In line with our People Strategy and our communication and engagement plan we have continued to promote our speaking up service across the organisation.

In October 2024 we participated in national Freedom to Speak Up Month where we organised a series of events and encouraged colleagues to wear green each Wednesday to raise awareness through social media. Our work around Speaking Up Month 2023 was nationally recognised as our Lead Guardian was asked to present at a national webinar on preparing for and maximising impact of Speaking Up Month

Professor Andrew Hassell is our designated Non-Executive Director Lead for Speaking Up and we have four 'Associate Guardian's' to support the Lead and Deputy Guardians. We also began the recruitment to and roll out of our network of Freedom to Speak Up Champions who will increase visibility of the team and signpost individuals to the appropriate speaking up mechanism when required.

Each quarter we provided our People, Culture and Inclusion Committee with a comprehensive, confidential report on the work undertaken by the service in line with national and local priorities. The report also provides a breakdown of the types of concerns we have received as well as comparisons with data available from the National Guardian's Office (NGO).

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269 FTSU concerns raised in 2024/2025

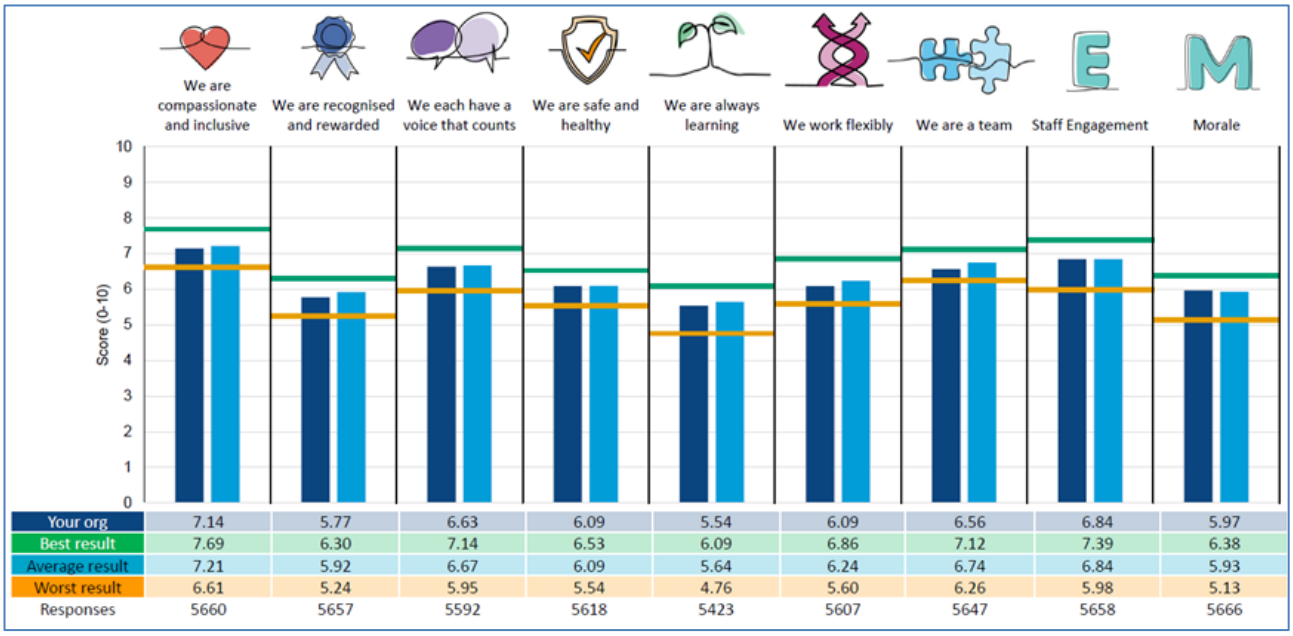
Throughout the year we have seen an increase in the concerns being raised with our service, with 269 concerns raised in 2024/25 (compared with 215 in 2023/24 and 169 in 2022/23), which we see as a positive reflection of the healthy speaking up culture we are building at UHNM.

2024 National NHS Staff Survey

The national staff survey measures staff engagement and morale as well as mapping the whole result set against the 7 national people promises. 5,680 colleagues participated, representing a 45% response rate, which is consistent with the previous year but below the benchmarking group's median of 49%

The Trust's overall Staff Engagement score is 6.84, equal to the benchmarking group average. Scores for Motivation are equal, Involvement is below, and Advocacy is above the benchmarking group average. The Trust scored above the benchmarking group average for morale (5.97) reflecting the increased focus on colleague support and wellbeing.

Chart: National Benchmark Comparison



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	7.14	5.77	6.63	6.09	5.54	6.09	6.56	6.84	5.97
Best result	7.69	6.30	7.14	6.53	6.09	6.86	7.12	7.39	6.38
Average result	7.21	5.92	6.67	6.09	5.64	6.24	6.74	6.84	5.93
Worst result	6.61	5.24	5.95	5.54	4.76	5.60	6.26	5.98	5.13
Responses	5660	5657	5592	5618	5423	5607	5647	5658	5666

The key successes to celebrate:

Morale

Morale is one of the Trust's most improved scores when compared to the 2023 NHS Staff Survey results as it has increased from a score of 5.92 in 2023 to 5.97 in 2024. It also sits above the benchmarking group average score of 5.93. Colleagues feeling that there are enough staff at the Trust for them to do their job properly has improved. Scores regarding relationships at work being strained and colleagues feeling that their immediate manager encourages them at work have also improved. The Trust has invested in Leadership programmes to encourage positive working relationships and exemplary leadership from those in management positions.

PP6 – We work flexibly

The Trust's score for 'We work flexibly' is the only statistically significant change achieved by the Trust, improving from a score of 5.98 in the 2023 NHS Staff Survey to a score of 6.09 in the 2024 NHS Staff Survey. It should be noted however that this score is still below the benchmarking group average of 6.24. All questions scores improved in this People Promise, with notably two of the questions being two of the Trust's most improved question scores. These relate to colleagues feeling satisfied with the opportunities

for flexible working patterns and agreeing that the Trust is committed to helping them balance their work and home life. This is a testament to the focused efforts on the Trust's Flex Focus Campaign.

PP7 – We are a team

The score for this People Promise has also improved from the 2023 NHS Staff Survey from a score of 6.52 to 6.56. Colleagues feeling that their team meets often to discuss the team's effectiveness has improved as well as feeling that that their team has enough freedom in how to do its work. The line management question scores have also improved in this People Promise, with colleagues feeling that their immediate manager gives clear feedback on their work, asks for their opinion before making decisions that affect their work and takes a positive interest in their health and wellbeing. This is great to see as a result of the Leadership programmes that the Trust has in place to support managers to be compassionate and supportive leaders.

Staff Engagement

The overall Staff Engagement score for the organisation is 6.84 which is equal to the score for the benchmarking group average. The sub-scores which contribute to the Trust's overall Staff Engagement score is a mixed picture, with scores for Motivation being equal to the benchmarking group average, scores for Involvement being below the benchmarking group average and scores for Advocacy being above the benchmarking group average. Within the Advocacy sub-score, the Trust remains above average for colleagues being happy with the standard of care and continues a three-year trend of improvement for the other two questions: recommending the organisation as a place to work, and care being the organisation's top priority. The latter is now above the benchmarking group average.

Areas of focus for 2025

Based on the review of the 2024 NHS Staff Survey results detailed above and to align with our new Trust Strategy and Trust People Plan, there will be a focus at a corporate / Trust-wide level on the following four areas shown below.

People Promise 4 **We are safe and healthy***	**People Promise 5** **We are always learning***
Corporate actions include going back to basics, addressing colleague burnout, morale and ensuring the Trust wellbeing offer supports mental, physical and financial wellbeing. There will be a particular focus on: • Burnout • Sexual Misconduct • Violence & Aggression • Bullying & Harassment • Anti-Racism **mapped to Trust's People Plan Priority 1: Health & Wellbeing*	Corporate actions include increasing the effectiveness of PDRs, developing the capability of our managers and leaders and establishing and defining career pathways. There will be a particular focus on: • Ability to make suggestions for improvement • Conduct effective appraisals to support colleagues in their roles • Equitable access to opportunities for learning and development **mapped to Trust's People Plan Priority 2: Learning & Development*
People Promise 6 **We work flexibly**	**People Promise 7** **We are a team***
Corporate actions to include consistent and continued rollout of our Flex Focus Campaign, sharing of staff stories and manager training programmes. There will be a particular focus on: • Supporting teams to be flexible and agile by improving how they work together to manage service demands and navigate change • Achievement of work life balance **mapped to Trust's People Plan Priority 3: Flexibility & Adaptability*	Corporate actions include ensuring effective team working and supporting our leaders to effectively lead their teams. There will be a particular focus on: • Psychological Safety • Autonomy, Belonging & Contribution • Reducing silo working • Value & Recognition • Open, honest, regular communication and feedback **our worst performing People Promise when benchmarked nationally*

Running as a golden thread throughout these four corporate areas of focus will be Equality, Diversity and Inclusion and Staff Engagement. In respect of Equality, Diversity and Inclusion, the Trust has performed well when looking at the WRES and WDES metrics in the 2024 NHS Staff Survey results. Although there is improvement when comparing our results to the previous year, the Trust is not yet fully in line with our benchmarking group average. We will continue to engage with our Staff Networks to analyse the 2024 NHS Staff Survey results and help to drive forward relevant actions relating to this important agenda.

The national staff survey data doesn't sit in isolation and must be seen in the context the wider people metrics.

Through our divisional leaders, we will encourage teams to discuss the results and share their understanding of the issues. Divisions are producing action plans to pick up the nuances within the Divisions for appropriate areas of focus needed for their teams.

We will identify ways to measure impact of our actions and share regular updates with all colleagues on the progress we are making throughout the year.

The Trust is pleased with the progress and sustained improvements from the 2023 survey results but acknowledges the need for further improvement compared to the benchmarking group average. Through our collective work at a corporate and a divisional level we aim to improve beyond the average and ensure that UHNM is a great place to work for everyone.



Priority 3: To improve patient experience

We said we would do this by:

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

Performance against this priority and its aims has been monitored during 2024/25. The following section provides a summary of the performance for these indicators and what these results mean for our patients.

UHNM aspires to achieve a culture where the voice of our patients, their carers and families is at the heart of all that we do and we believe that patients can be equal partners in creating positive changes through identifying where barriers and challenges exist in our systems.

The Trust has worked in partnership with stakeholders on quality improvement activities including:

- Hospital User Group (HUG) – has continued their monthly meetings, using a mixture of face to face and virtual meetings to maximise attendance. We are continuing to actively seek more diverse representation from "seldom heard" groups and have representatives from young people, people with disabilities and include representatives from our LGBTQ+ community.
- Raising the profile of our Patient Leaders to increase involvement in projects across the Trust including CEF audits, obtaining feedback around specific initiatives and working with the Quality, Safety and Compliance team to support improvements.
- The recruitment of four Patient Safety Partners to support with PSIRF and individual projects, ensuring the voice of the patient is at the front and centre of our improvement work.
- Healthwatch – our close relationship with Healthwatch has been further strengthened through regular meetings alongside their membership of the HUG. Healthwatch has been invaluable for collecting and sharing feedback from our patients and they continue to work with us undertaking their Enter & View visits. They have also been supporting with our bi-monthly "Fundamentals of Care" visits to the Emergency Departments on both sites, specifically looking at patient experience in the department;
- Maternity and Neonatal Voices partnership
- Patient Information Ratification Group has continued to meet monthly to ensure a robust process to produce literacy appropriate Trust patient information leaflets;
- Assist, dDeaflinks and Language Line have continued to provide interpretation services. The Trust has expanded the use of the on demand "interpreter on wheels", providing access to over 200 languages, 24 hours a day. There are now 30 machines across the Trust, all of which are in continual use, ensuring our

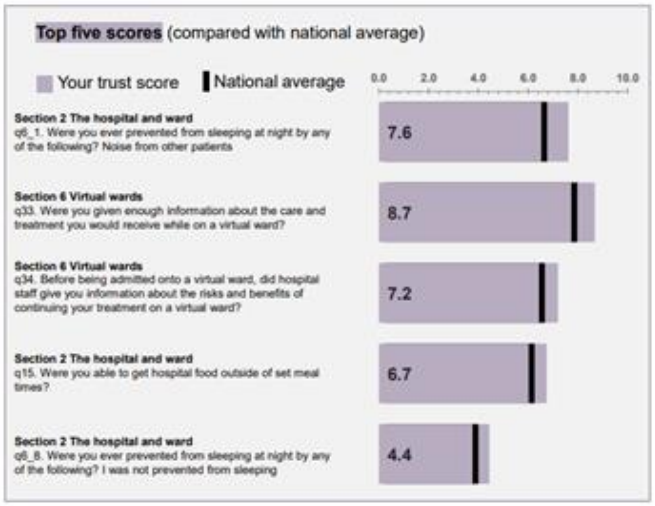
patients and visitors are receiving communication support with their interpretation needs.

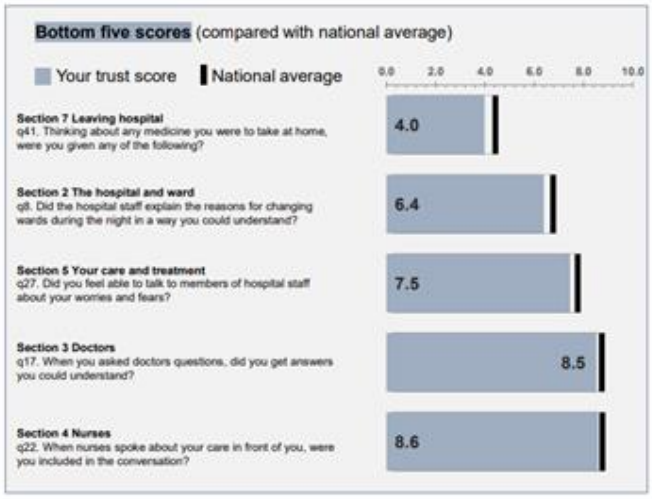
- Accessibility Alert usage has continued to expand, with greater engagement from areas across the Trust, ensuring our patients receive support for their communication needs with alternative formats.
- UHNM membership of the CCG Community and Engagement Group to provide consistent messaging to the public and seldom heard groups throughout Staffordshire;
- The launch of the new Trust Carer's strategy to demonstrate our commitment to working in partnership with carer's.
- Working with MPFT, Combined Health and the CCG to agree a consistent approach and peer review of local Equality Delivery System objectives.

Annual Inpatient Survey

The 2023 Inpatient Survey results were published by the CQC in August 2024. 1,250 patients who were in hospital in November 2023 were invited to participate in the survey and the Trust had a 37% response rate, a slight improvement on the previous year. The Trust scored significantly better in comparison to previous years scores in 6 areas, and scored somewhat better than expected or better than expected in 5 areas in comparison to other Trusts. We did not score worse than expected in any areas.

UHNM top and bottom five scores compared with trust average.





The way we communicate with our patients continues to have a significant effect on overall patient experience. The Trust continues to work towards improving the way we provide information and support to our patients to ensure they are able to be more involved in decisions that affect their care and treatment.

Improvement initiatives include:

- Involving our Patient Leaders more robustly in our CEF process, including at Bronze panels to ensure appropriate challenge and that the patient voice is represented.
- Working with our Spiritual, Pastoral and Religious Care (SPaRC) team to ensure wider inclusivity in our Patient Representatives.
- Promotion of the "Interpreter on Wheels" software to provide accessible interpretation services 24 hours a day, 7 days a week.

- A review of the "Accessible Communication Alerts" expanding these in-line with feedback from our d/Deaf community.
- A relaunch of the inpatient Friends & Family questionnaires to try and improve the response rate and free text narrative to better understand what we could do better.
- Triangulation of quality and safety data to identify themes; allocation of specific "harms" to each of the Patient Safety Partners to support with improvements and ensure the patients have a voice.
- Continuing to provide Health literacy training across the Trust and more widely, working with the Health Library.
- Expansion of our Patient Experience Group with new membership and a more structured approach for accountability and sharing of Patient Experience initiatives and improvements as a result of feedback, FFT and CQC National surveys.
- Recruitment of a dedicated Patient and Public Involvement and Engagement Coordinator.

Complaints

The total number of complaints opened at Royal Stoke University Hospital during 2024/25 was 588 which is similar to the previous year (595) and slightly lower than the pre-COVID 3-year average of 617.

The total number of complaints opened at County Hospital during 2024/25 was 59 which is similar to the past 3 years and significantly (47%) lower than the pre-COVID 3-year average of 112.

During 2024/25, the Complaints Team has achieved the following:

- Continued effective working with the PALS Team to resolve complaints informally where possible;
- Relaunch of the new Complaints Policy to include structured escalation process to support with response times
- A new triage process for timescales has been implemented to ensure complaints and concerns are addressed in the most effective and efficient manner.

Patient Priorities

As part of UHNM Quality Strategy 2022-2025, five patient priority areas were identified from patient feedback as focus for improvement.

Timely medications

- The Parkinson's Team have been working together to ensure the best patient experience by ensuring the teams caring for them both in the hospital and in the community have a good understanding of the importance of medications in Parkinson's.
- Resource boxes have been provided on several wards across the Trust, alongside specific training regarding the contents to support with medication administration.
- Training sessions provided via Teams for trauma regarding Parkinson's including importance of medication and mobility.
- The Trust webpage for Neurosciences is currently under development to provide wider access to information and resources.
- Training has been provided to students at Keele University on Parkinson's symptoms, treatment and management; alongside further training for local hospices and the Acute Community Care Team.

- The use of 'Get it on Time' stickers within the Trust for prescription charts and above the beds for all patients with Parkinson's has been implemented and promoted. admitted to hospital.
- The Trust's Carer's strategy has been completed to support with ensuring colleagues listen to the voice of the carer around the support of vulnerable patients, including critical medications. New health passports have been launched across the ICB.
- Alongside over 100 acute Trusts, for 2024/2025, UHNM is working in collaboration with Parkinson's UK and has pledged to improve the delivery of time-critical medication for patients with Parkinsons disease.

Oncology- improving the patient experience

- Work has continued on the new cancer centre and is planned to be completed by Autumn 2025. Patients with lived experience have supported with the design and development of this new facility to ensure a holistic approach to care.
- Significant work around waiting times and scheduling on the Chemotherapy Units has been undertaken to improve this with feedback and support from a member of our HUG.
- Friends & Family Test survey feedback has significantly increased for the Chemotherapy Unit at County to improve their response rates.

Maternity- the Voice of the Patient

- Midwife advocates in place for patients wishing to raise concerns/speak to someone. This service is widely advertised in all areas in the Maternity Units.
- A new Equality, Diversity and Inclusion Midwife has been recruited
- Patient Experience Team and Maternity Teams have been collaboratively working with Maternity & Neonatal Voices Partnership to gain specific feedback regarding induction of labour and other areas.
- Friends & Family Test survey via text messaging was launched to increase the volume of surveys and therefore the patient voice.
- Patient Experience Team providing regular workshop sessions with Maternity staff regarding themes, trends, outcomes of complaints/PALS.
- Following the CQC visit to Maternity in March 2025, Maternity Services have been rated as "Good" in all domains.

Shared Decision Making

- Patient Experience Team have liaised with the Health Library around Health Literacy Training to ensure colleagues are communicating with our patients in a way they understand to allow them to make informed choices.
- Clinic letters are now written directly to patients and with copies to GP's. There was collaborative work with our Hospital User Group to support communication with this new initiative.
- Interpreter on Wheels usage continues to increase, with 30 machines across the Trust and into the community to support our patients and visitors with ensuring they have the correct information to enable informed decision-making.

Pain Relief

- This has been identified as an on-going issue in the Emergency Department and from feedback from Maternity. Results from the most recent CQC survey correlate with this and will be an area for focused improvement in 2025/2026.

Part C: Statements from our key stakeholders

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

Quality Account - Staffordshire & Stoke on Trent Integrated Care Board

The quality assurance framework that the ICB uses reviews information on quality, safety, patient experience, outcomes, and performance, in line with national and local contractual requirements. The ICBs' Quality team representatives meet with the Trust monthly to seek assurance on the quality and safety of services provided. The ICB work closely with the Trust and undertake continuous dialogue as issues arise, attend relevant Trust internal meetings, and conduct quality visits to clinical areas to experience the clinical environment, listening to the views of patients and front-line staff.

The report demonstrates the progress made by the Trust against the 2024/25 priorities. It identifies where the organisation has done well, where further improvement is required and what actions are required to achieve these goals and the priorities set for 2025/26. The ICB would like to recognise the Trust's commitment to improving quality as demonstrated by the following achievements:

- Continuing to embed the Patient Safety Incident Response Framework (PSIRF) and approach to responding to incidents and system-based learning. Along with recruiting four Patient Safety Partners to support patient safety initiatives and having two Patient Safety Specialists who have completed the Level 3 and 4 National Training via Loughborough University.

- The Trust had two CQC inspections with significant improvements during 2024:
    - The County Hospital during July 2024 with ratings improving from overall Requires Improvement to Good.
    - Maternity Services in October 2024 with all requirements of the Section 29A warning notice issued the previous year met and ratings improved to Good overall and for all five individual domains.

- The ongoing implementation of the Care Excellence Framework (CEF) and the introduction this year of Mock unannounced CQC inspections into the wards that are/were been monitored under the CEF Panel, including inviting external senior leaders from the ICB to arrive in an area unannounced and review that area in line with CQC's key lines of enquiry.

- Promoting mobility and prevention of deconditioning through starting to implement the Johns Hopkins Activity and Mobility Programme.

- Implementing 'Call for Concern' (Martha's Rule) across RSUH.

However, 2024/25 has continued to be a challenging time with a continued high demand for both urgent care and elective services. We look forward to continuing collaborative working with the Trust and other system partners to see further quality improvements in the following areas over the coming year:

- To improve the Emergency Department waiting times and significantly reduce ambulance handover delays.
- To see a continued improvement in Sepsis screening compliance and pathway in the Emergency department.
- To improve recording of Timely Observations using Vitalpac electronic system.

- To see the implementation of the electronic Prescribing and Medine administration (ePMA) system.
- To reduce Hospital Acquired pressure ulcers and deep tissue injuries with lapses in care.
- To reduce the number of C Difficile cases

Priorities for 2025/26

The Integrated Care System will continue to support and collaborate in respect of the Trust's Quality priorities for 2025/26 and agree that the following areas as requiring further focused work to ensure that required standards are consistently achieved:

- To reduce patient harm, learn from experience and incidents and improve clinical effectiveness and outcomes for patients by continuing to work to reduce patient waiting lists. To reduce ambulance handover delays and improve patient flow through the Emergency Department.
- To Improve sharing of learning from patient feedback and involve patients in learning and improvement with a particular focus on ''seldom heard' patient groups and to use the Patient Safety Partners to support and enhance the patients' voices in learning from incidents and improving services.

- To further develop staff wellbeing and experience by supporting the Trusts wellbeing programme and activities that focus on staff wellbeing and empowerment including Being Kind compact.

We look forward to working together with the Trust to ensure continued improvement over the coming year. The ICB wish to state that to the best of their knowledge, the data and information contained within the quality account is accurate.

Heather Johnstone
Chief Nursing & Therapies Officer
NHS Staffordshire and Stoke-on-Trent ICB

Dr Paul Edmondson-Jones MBE, (GMC Number 2549042)
Chief Medical Officer & Deputy Chief Executive
NHS Staffordshire and Stoke-on-Trent ICB

City of Stoke-on-Trent

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

On behalf of Stoke-on-Trent City Council's Adult Social Care, Health, Integration and Wellbeing Overview & Scrutiny Committee, I wish to acknowledge the hard work and dedication of staff and it is hoped that enhancements to quality, safety and the experience of patients and their families will lead to improvements to CQC ratings, particularly in Urgent and Emergency Services.

Councillor Joan Bell
Chair of the Adult Social Care Health Integration and Wellbeing Overview & Scrutiny Committee

Quality Account – Staffordshire County Council Overview and Scrutiny Committee

Staffordshire County Council held elections in May 2025 and due to the timescales were unable to comment on the Quality Accounts this year.

healthwatch Staffordshire

The Quality account for 2024/2025 for the trust University Hospital for North Midlands outlines their quality priorities, performance and commitment to patient care. UHNM approximately serves 3 million patients with around 12,500 staff and 1,450 inpatient beds, averaging 14,000 patients through the emergency department per month. UHNM have many positive partnerships in with the county such as Keele University and University of Staffordshire for research and education, and the VCSE sector.

The trust has many quality improvement initiatives such as staff training and development as well as implementing the Patient Safety Incident Response Framework (PSIRF) to enhance learning from incidents. The trust has seen an increase in reported incidents but a decrease in those resulting in moderate harm.

For our focused deep dives 2024/2025 we followed the patient journey; Patient Experiences of the 999 Ambulance Service, Avoiding Hospital Admission (Patient experiences of virtual wards) and Hospital Discharge which gave us feedback from all hospital trusts including UHNM.

Throughout the year we have been invited and have taken part in various events at UHNM such as the Bowel Cancer screening event that took place in February but also quality visits and fundamentals of Care visits. One of these visits was in March, which we visited Royal Stoke Emergency Department, where we spoke to 4 patients who were receiving care and were happy to share their experiences with us. We had a mixed review of experiences, with patients reporting having different experiences such as receiving food, or knowing where to access a toilet but all either had waited or were waiting for a bed on a ward/cubicle.

We are also invited and take part in the Hospital User Group (HUG) meetings to be an independent voice for patient engagement and feedback as well as working with the collaborating with the PALS team and ICB to ensure complaints are followed up in a timely manner and patients feedback is heard and acted upon.

Anna Mather
Healthwatch Staffordshire Manager

healthwatch Stoke-on-Trent

We thank the University Hospitals of North Midlands NHS Trust (UHNM) for the opportunity to comment on its Quality Account for 2024 to 2025. There were many points to consider this year. Rather than provide a lengthy narrative response we have decided to provide a theme-by-theme response, comment or observation where necessary and reference the page it is on. We hope this provides a better way to consider our points.

We note there are no statistics within the report to how many safeguarding issues have taken place that relate to failures in care or treatment, i.e. neglect or physical abuse, which could then impact the issues encountered in some aspects of the quality account reporting.

We look forwards to seeing the improvement actions listed within the account in next year's publication and are hopeful for even more improvements than shown in this one in making people's experiences and journeys through their care better

Page	
5-12	'Statement on quality' – this is noted but feel this would be better served with greater illustration of performance to bring subjects together rather than in separate parts of the overall report to aid the readers understanding of overall performance for each key area and priority action.
22-23	the inclusion of patient stores is very welcome. Perhaps as a balance some stories where things haven't gone so well and followed up with what was done to address matters that weren't as good as the trust hoped.
24	We note the CQC ratings. We hope come the next inspection that the ratings for 'Safe' and 'Responsive' move to Good.
34-38	We make the same observation for these pages as pages 5-11. In fairness there are some statistics included on 35-36 which aid the readers' understanding and appreciation of the results achieved.
40	'Key quality Indicators Performance 2024/25 compared to 2023/24' Some good performance is seen at the top of the table like 'Induction of Labour' and 'Maternity Triage' exceeding targets. Even PSIs dropping. Patient falls are dropping but harm rate is the same, an indicator more work needs to be done as why aren't the two tracking each other. Good to see 'medication incidents' falling though still above target, but those with harm showing a good reduction well below target, a cause for well done. Of great concern is the increasing number of 'never events' increasing year on year, well above target of 0, albeit positive that they are being recorded so actions can be taken to prevent further occurrences. It would be good to find a way to show in this tabular format what are new themes of issues or a repeat of previous ones which would give more cause for concern. Positive to see 'Reported C Diffcile cases' dropping and below target, plus the drop in 'Avoidable MRSA Bacteraemia cases' though still above target.

	'Friends & Family Test: Inpatient' results are positive with a slight increase and above target. Unfortunately the results for the 'Emergency Department' are dropping and now almost 20 percentage points below target, another cause for concern. Likewise the 'Maternity' score has dropped and now nearly 10 percentage points below target. Two key areas to work on. Good to see 'Sepsis: Adult Inpatient Screening' increasing and above target, but contrasted with 'Sepsis: Adult Inpatient IVAB' falling. It is still above target so good, but then what is IVAB? Again, unexplained use of acronym. Very frustrating for the reader. 'Sepsis: Emergency Portals' – good to see increases for 'Screening' and 'IVAB', still below target but on the right path for whatever Portals and IVAB are. 'Sepsis: Children's Screening' – some concern that the result is falling in the wrong direction from last year which was still below target and more drift. 'Sepsis: Children's IVAB' shows an alarming drop from a very good 100% compliance the year before and 10% over target to then see a 25% drop in compliance now. 'Sepsis: Maternity Screening' – good to see an increase on previous year though still some way behind target. 'Sepsis: Maternity IVAB' – shows a drop in performance from almost meeting target the year before to now being over 10% away from target. So, gains in one area and drops in another – a link? 'Hospital Standardised Mortality Ratio (HSMR)Summary' – at last an explained acronym. The joy ends there to see the figure exceeding the target with a considerable increase on previous years figures and now well over target. Similarly, ' Hospital Mortality Index (SHMI)' is also showing an increase, not as pronounced as the first one but still a sizeable increase and well over target. If one figure is based on traditional set of targets and the other a more reliable or fairer way to measure is potentially besides the point as they together paint a very worrying picture on increasing mortality over target. We have taken time to provide commentary in how these figures appear at first read. In some cases it looks good but there is a lot of areas for concern that outweigh the positive.
42-43	'Patient Safety Incidents' – Good to see the work and better reporting methods are giving greater insight into patient safety incidents (PSI) enabling an opportunity to address safety issues before they result in harm. A very good result.
43	'Pressure ulcers developed under UHNM Care' – The table has no key though does show being above both lines and a considerably increase on the previous year. Good that 'lapses in care' are reducing but still has numbers of them increasing. We hope to see both figures reducing next Qaity Account.
44	'Sepsis recognition and treatment' – figures show Adult Inpatient Screening' increasing and above target but contrasted with 'Sepsis: Adult Inpatient Intravenous Antibiotics (IVAB)' falling. Improvements in Emergency Portals, though still below target. Some mention of actions to improve results, though a very concerning absence of any actions to address the very poor performance of administering antibiotics for children or actions to improve the drop in screening. We would have hoped equally for more detailed actions to address the underperformance in maternity. We hope to see significant improvements in each area next year.

45	'Patient falls' - are dropping and hopefully with more work, we will see the figures drop again next year.
46	'Patient Safety Incident Response Framework and Incident reviews' – It is interesting to read of the steps to introduce the new framework and the Trusts approach. We look forward to seeing the impacts of this in future years. One additional statistic to demonstrate the openness of the approach would be to have details of how many patients and/or relatives are involved and whether fully or in being offered the chance to be fully involved.
47	'Never Events' – good that we now can see the themes of the never events. However, to see 5 of the disclosed themes as wrong site surgery does great concern as the checks and balances prior to each surgical procedure. If the missing theme is also wrong site surgery our concerns would be even higher.
47	'PSIRF & Never Event Learning' – It is interesting to read the steps being taken to address the never events. It can be seen as in the approach to Skin Cancer Patients Photograph and Marking process, as simple but apparently successful approach. Congratulations are in order.
49	'Mortality' – a confusing page. Our takeaway is that deaths have increased but were not being coded correctly and this has impacted on what the targets would have been. It leaves us concerned about the accuracy and reliability of the numbers and how much is due to other factors that are outside the normal markers.
51	We note the list of themes/issues taken from the 'Structured Judgment Review process'. It may be helpful to indicate in future quality accounts how frequently the themes/issues are being established to then use as a tool for further actions in prioritised way.
52	Its positive to see 'Hospital acquired infections' falling supported with further actions – we look forward to seeing this figure improve.
53-54	Its positive to see the steps being taken to support the staff within the trust especially the 'Promotion of Women's Health, Men's Health, Menopause at Work and Period Poverty in related networks and steering groups and our podcast series'. It is also good to see more people feeling they can share their concerns.
55-58	'2024 National NHS Staff Survey' – reassuring to see the levels of satisfaction being fed back by staff. We hope the planned actions continue to build a better feeling like what is being achieved so far.
59-60	'To improve patient experience' – it is good to see the steps and the organisations involved in delivering this. It would be good if both Healthwatch can have the same opportunities at involvement as detailed in the report given our dual statutory duties for our respective geographic areas so there is parity, which for us hasn't been delivered.
60	We note the 'Annual Inpatient Survey' results and the positive progress but that some key areas need further work so that patients have a more complete experience.

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