NHS
University Hospitals of North Midlands
NHS Trust

Quality Account

2025/2026

Contents

Part A: Statement on Quality

Introduction to UHNM by Dr Simon Constable, Chief Executive

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

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

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

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

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

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

Our Partnerships

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

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

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

2. Statement on quality

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

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

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

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

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

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

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

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

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

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

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

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

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

Quality Reporting Themes 2025/26

Key themes from our quality reporting during 2025/26:

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

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

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

What we will prioritise going forward:

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

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

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

During 2025/2026 we prioritised the following key areas:

Safeguarding

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

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

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

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

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

Vulnerable patients

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

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

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

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

Tissue Viability & Continence

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

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

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

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

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

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

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

Falls & Mobility

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

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

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

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

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

Medications

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

Areas with Good Progress during 2025/2026

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

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

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

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

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

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

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

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

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

Areas for Further Improvement during 2026/2027

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

Emergency Department Waiting Times

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

Elective Performance

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

Ambulance Handover Delays

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

Sepsis Screening Compliance and Pathway

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

Reducing Harm from Falls

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

Timely Observations Using Vitalpac Electronic System

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

Hospital Acquired Pressure Ulcers and Deep Tissue Injuries

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

Clostridium Difficile Cases

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

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

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

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

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

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

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

Jackie Small
Chair

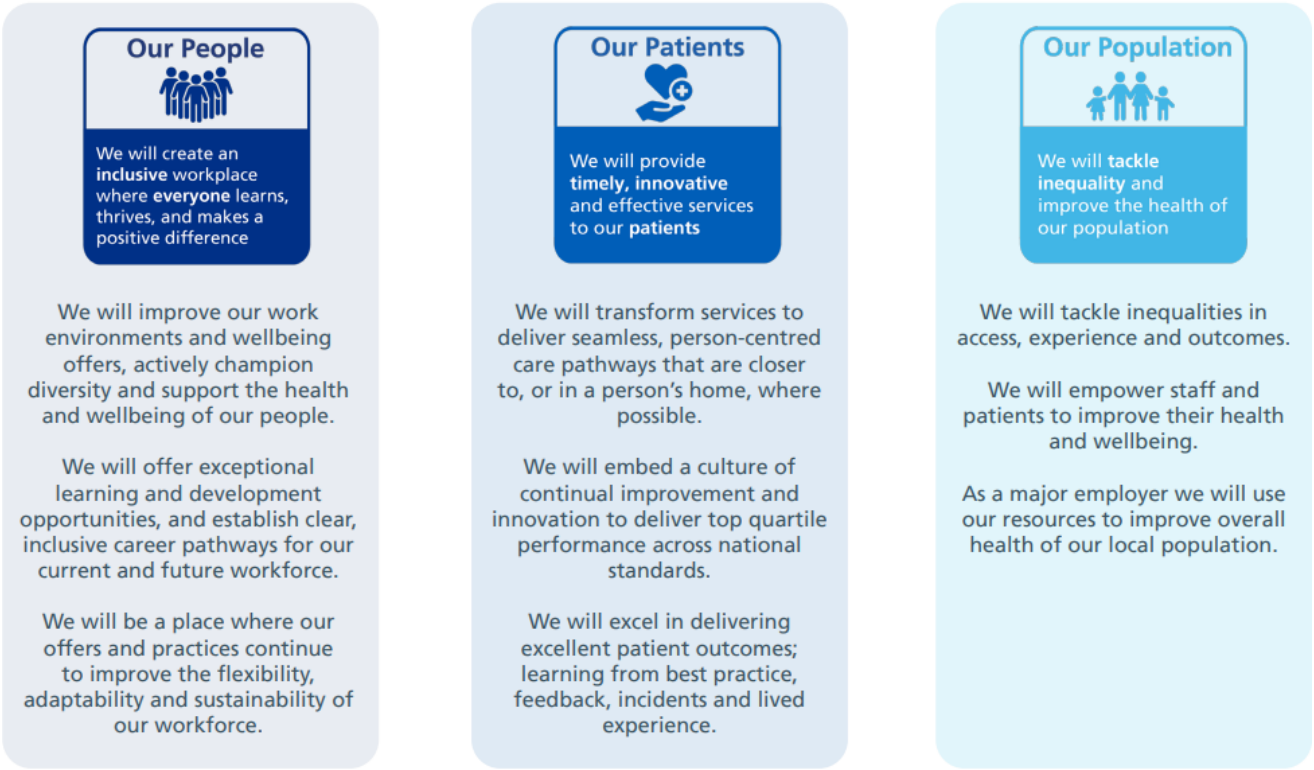
Dr Simon Constable
Chief Executive

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

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

Our priorities

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



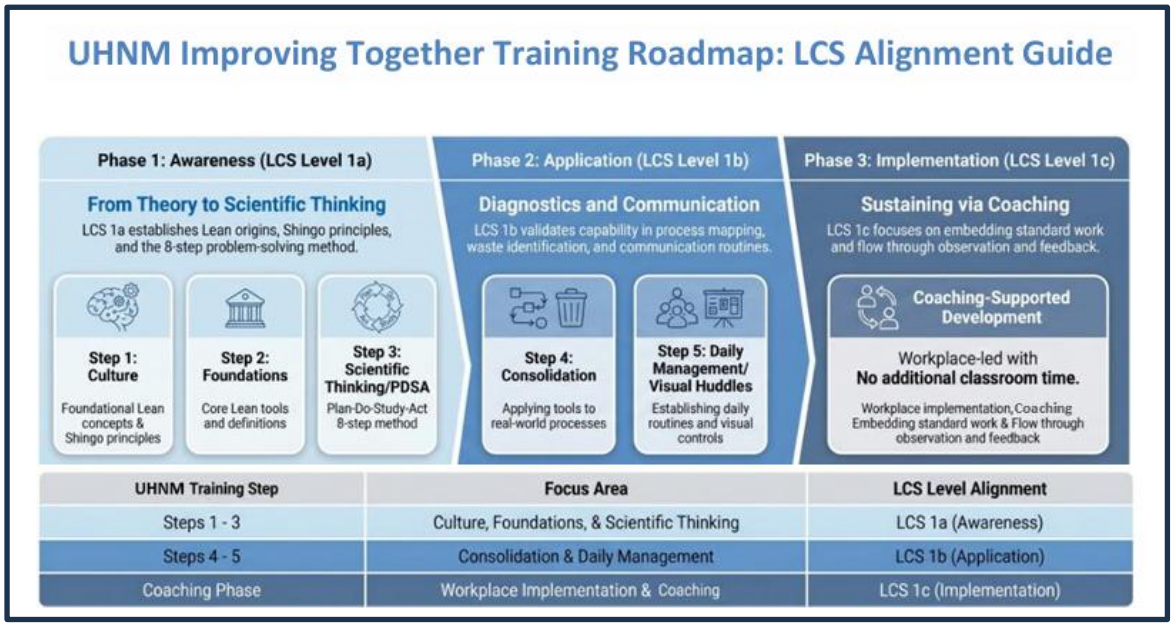
Our Vision is available via our website: www.uhnm.nhs.uk .

3.1 Priorities for improvement

Continuous Improvement (CI)

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

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

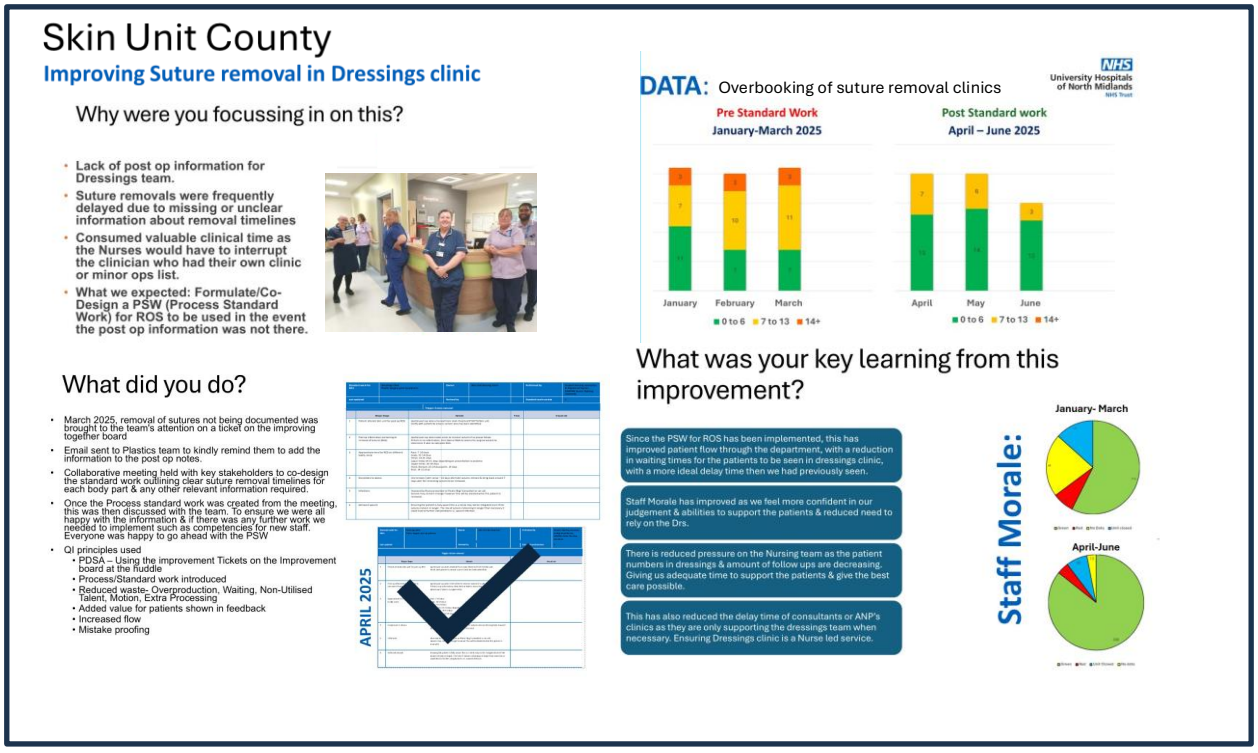


Over the past 12 months a further **2068** colleagues have been trained through **2973** training points, bringing the Trust total of staff with some level of improvement training on their ESR to **7018**. This training is accredited by the Lean Competency System (LCS), the industry standard for Lean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

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

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

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



Maternity Assessment Unit – Royal Stoke

March 2026

Blood Pressure Assessment Improvement

Why were you focussing in on this?

Background:

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

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

Understanding the problem:

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

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

SMART Aim:

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

What did you do?

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

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

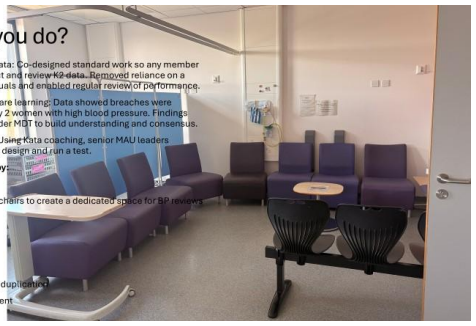
Step 3 – Test a change: Using kata coaching, senior MAU leaders coached one another to design and run a test.

A BP Bay was created by:

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

QI principles used:

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



What impact have you had?

How do we know this was an improvement?

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

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

Staff report:

Greater clarity and confidence in managing BP presentations

Improved ability to prioritise high-risk women

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

Learning from testing:

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

What was your key learning from this improvement?

Key learning

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

Next steps – Adapt

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

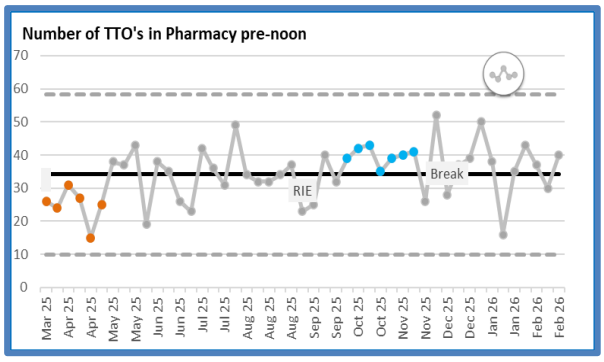
Reduce unnecessary waits for medical review where clinically appropriate.

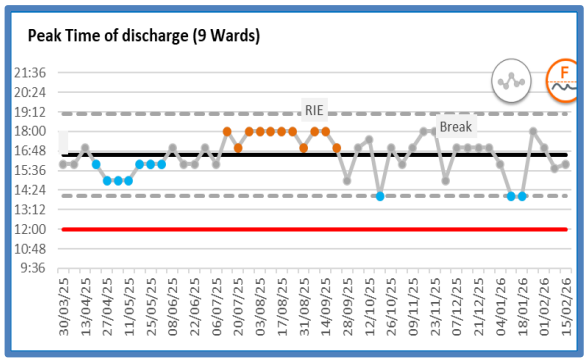
Future plans:

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

Over the past 5 years that the programme has been running, 56 frontline teams have been trained in this approach with 20 sustaining this over the longer term. Continual Improvement remains a priority for the Trust and supports a number of strategic programmes and priorities from ward to executive level.

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





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

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

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

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

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

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

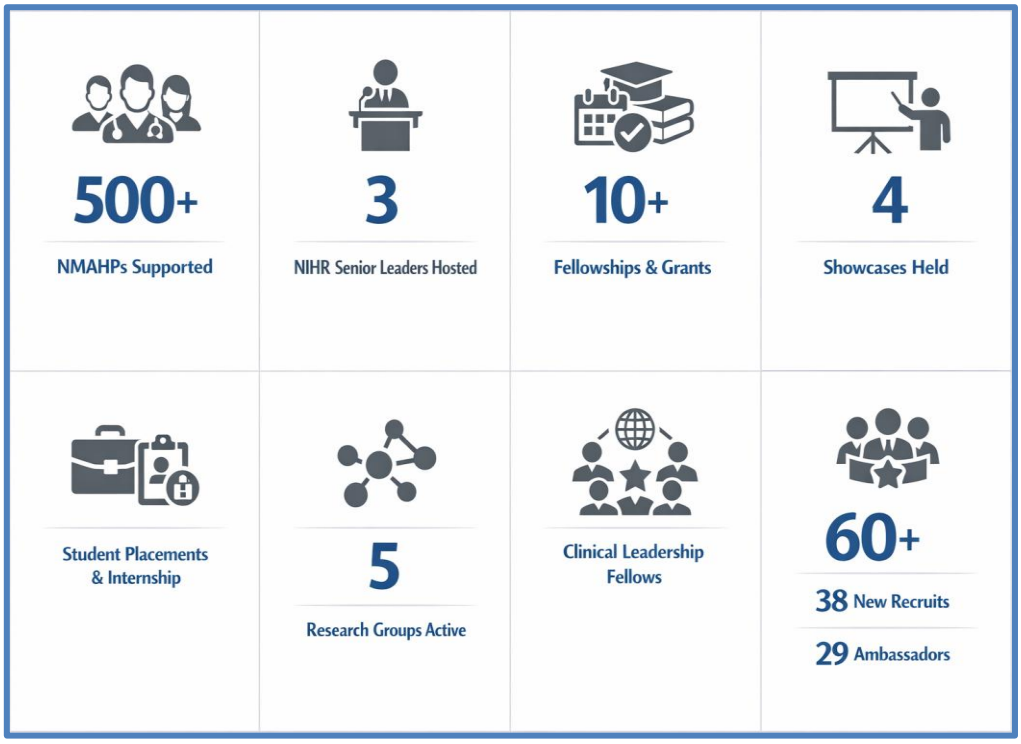
Our third cohort of CeNREE Fellows and Chief Nurse Fellows attending their 'graduation' alongside Chief Nurse Ann-Marie Riley OBE, and Programme Lead Rachel Houghton

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

In their four years CeNREE:

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

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



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

3.2 Delivering our Quality Priorities in 2026/2027

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

Ann-Marie Riley OBE
Chief Nurse

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

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

Our Patients

Prioritising our quality improvement areas

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

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

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

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

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

Our quality priorities for 2026/2027

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

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

4. Patient Stories

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

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

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

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

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

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

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

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

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

5. Review of services

5.1 Care Quality Commission

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

The Trust is registered to provide the following services:

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

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

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

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

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

The CQC said:

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

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

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

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

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

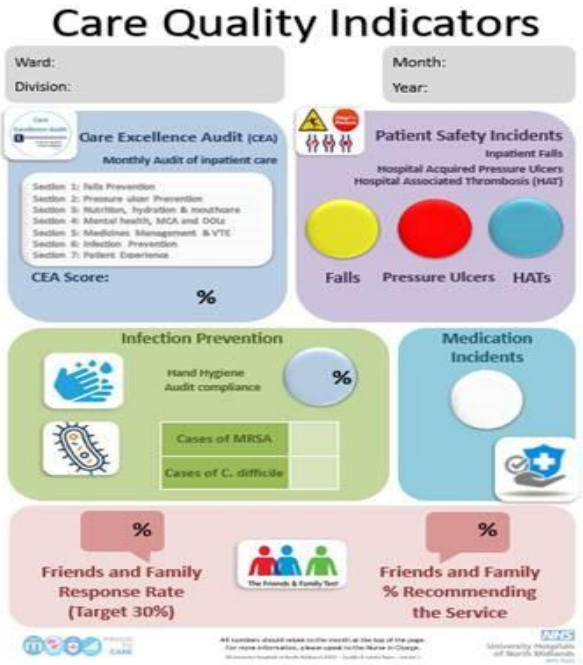
5.2 Care Excellence Framework

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

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

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

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



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

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

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

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

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

5.3 PLACE Inspection

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

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

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

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

Patient Representative Comments

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

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

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

5.4 Participation in clinical audit

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

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

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

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

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

National confidential enquiries

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

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

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

5.5 National Clinical Audits

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

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

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

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

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

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

Corporate and local clinical audits

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

Audit of Alcohol Assessments in UHNM Emergency Departments

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

5.6 Clinical Effectiveness

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

The framework aims are:

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

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

Requirements around the following are included:

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

Other key workstreams that are underway:

Patient Outcomes

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

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

Key aspects of patient outcomes include:

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

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

Key Performance Indicators

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

Getting It Right First Time at UHNM

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

Clinical Areas Under GIRFT Review with Action Plans in Progress

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

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

Key Themes Identified Across Specialties

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

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

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

Examples of actions/progress reported in 2025/26

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

5.7 Participation in clinical research

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

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

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

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

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

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

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

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

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

5.8 Data Quality

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

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

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

5.9a Secondary Uses Service (SUS) Data Validity

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

Valid NHS number performance is:

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

Valid Registered GP Code performance is:

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

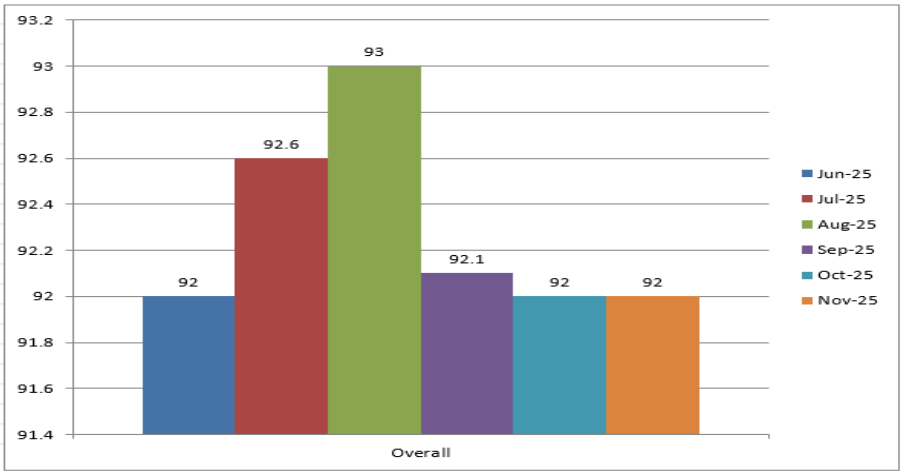
Valid Ethnic Category performance is:

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

5.9b NHSE Data Quality Maturity Index

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

UHNM - overall



National Averages

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

5.10 Clinical Coding Accuracy Rate

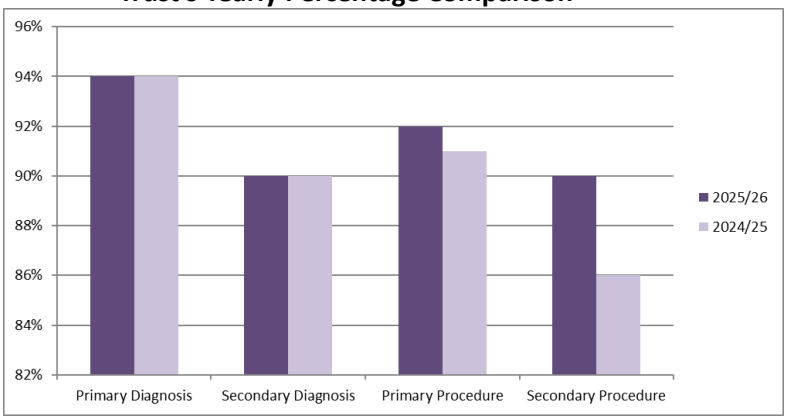
Annual audit

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

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

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

Trust's Yearly Percentage Comparison



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

Coding Improvement Projects:

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

Staff Audit Programme

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

Training

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

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

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

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

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

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

5.12 Seven-day services

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

These are:

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

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

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

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

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

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

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

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

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

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

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

Part B: Review of quality performance

6. Quality Priorities 2025/2026

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

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

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

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

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

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

*1st February 2025 – 31st January 2026

**1st January 2025 – 31st December 2025

Priority 1 To improve patient safety and clinical effectiveness

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

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

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

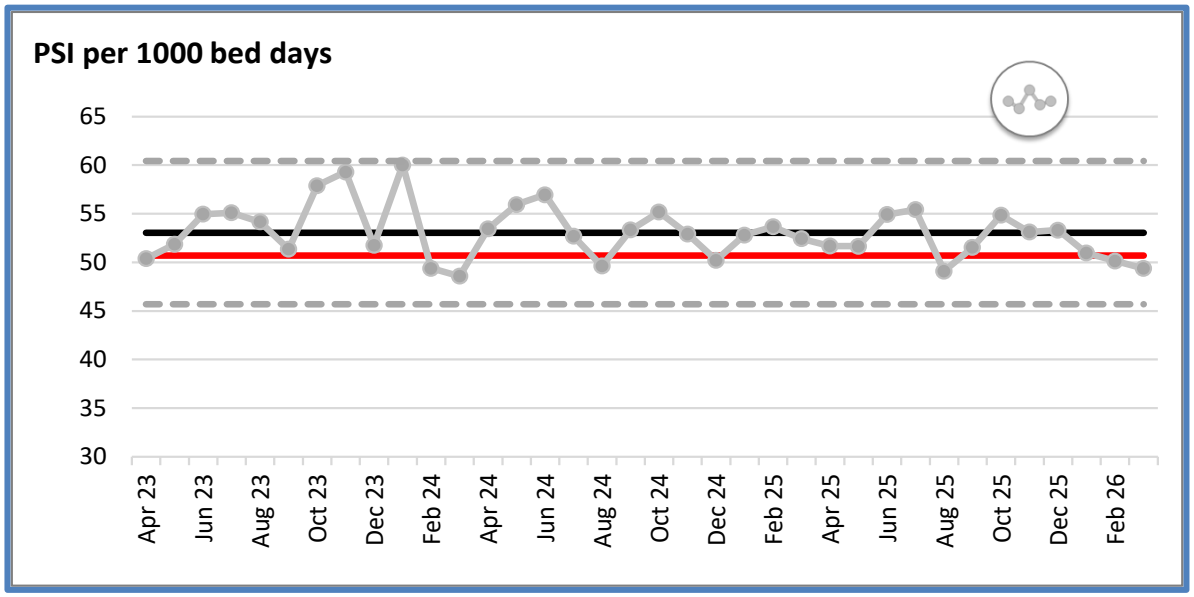
Patient Safety Incidents

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

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

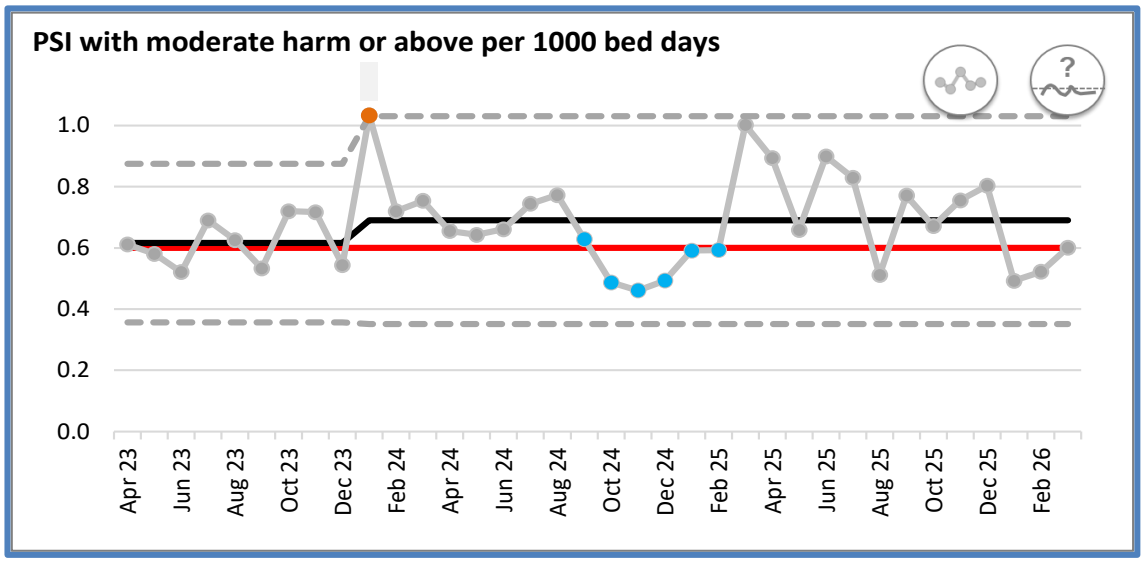
To ensure a comprehensive understanding of incident trends, we also assess the rate of reported incidents per 1,000 bed days, thus accounting for variations in activity levels throughout the year and this year's rate has remained relatively constant to previous year with 52.2 patient safety incidents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

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



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

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

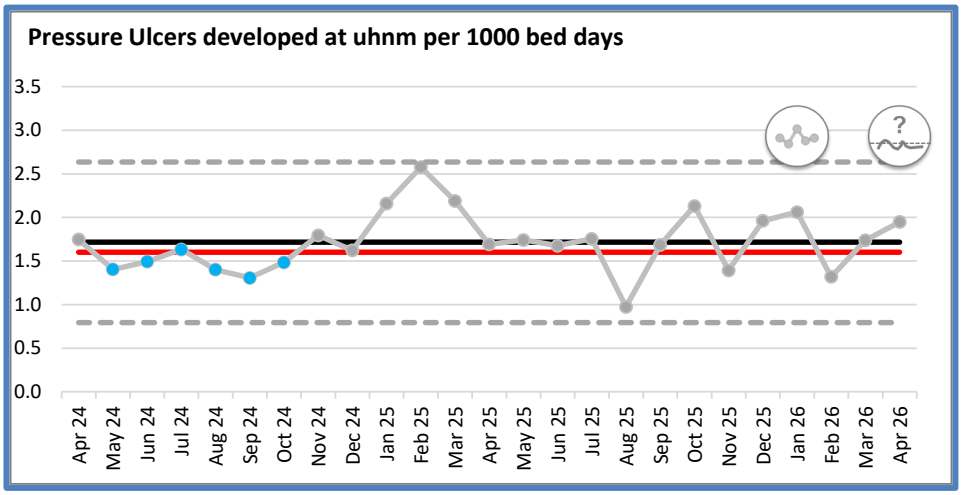


We continue to use thematic review and learning processes to ensure that learning is identified and translated into improvements in care. This includes reviewing harm profiles and incident themes (including those related to moderate harm and above), triangulating learning through Trust governance routes,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

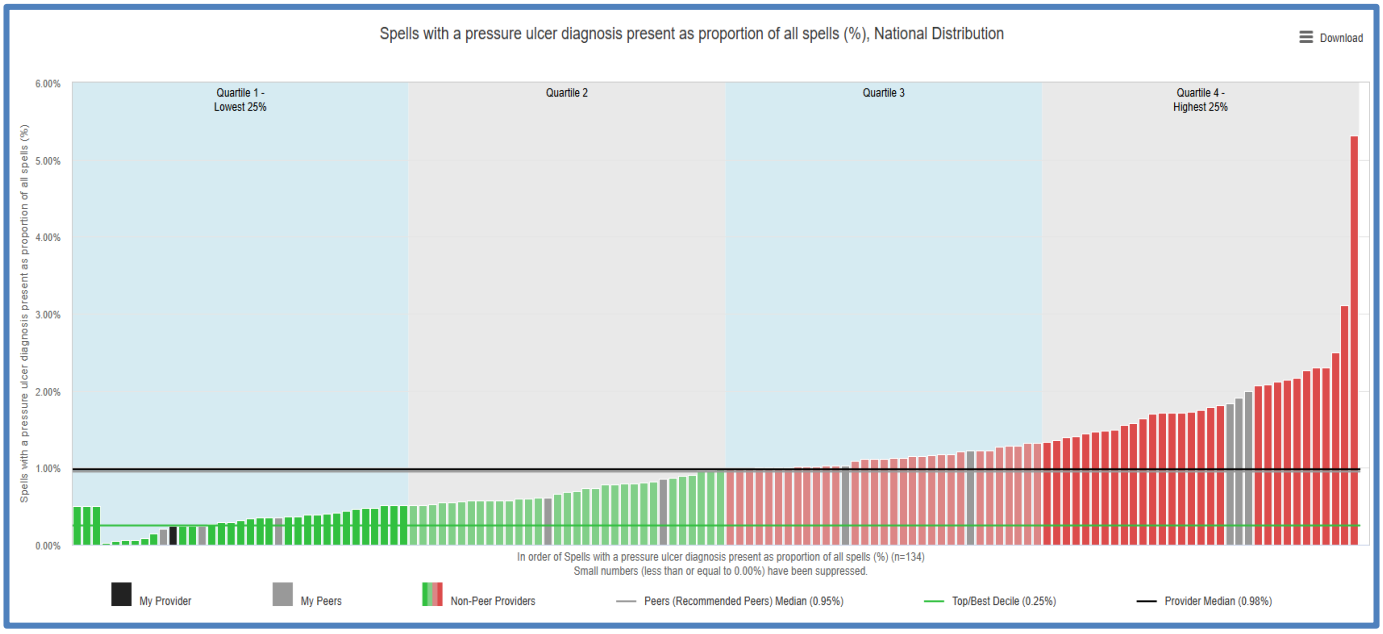
Pressure ulcers developed under UHNM Care

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

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

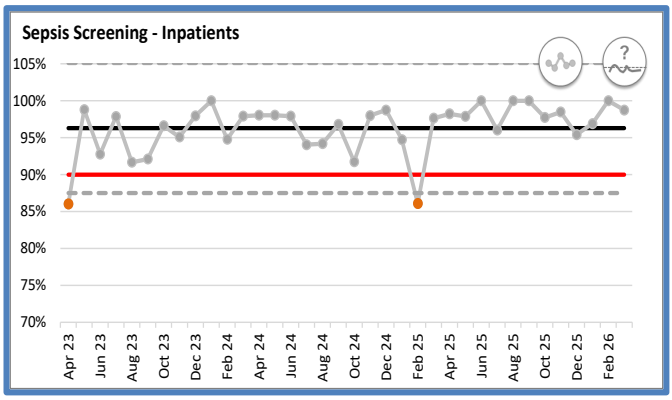


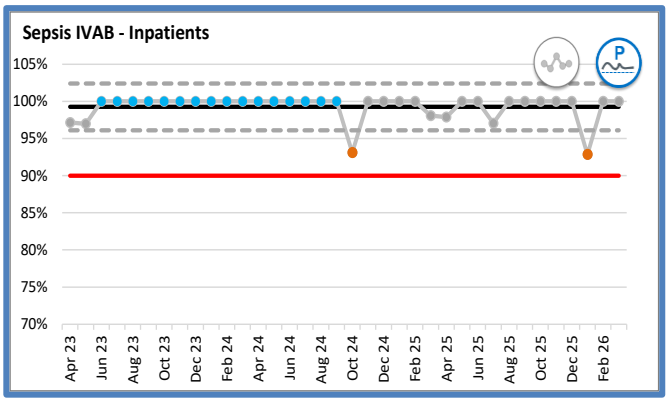
The chart below shows that UHNM is in the lowest quartile nationally for spells with a Pressure Ulcer diagnosis present as proportion of all inpatient spells.



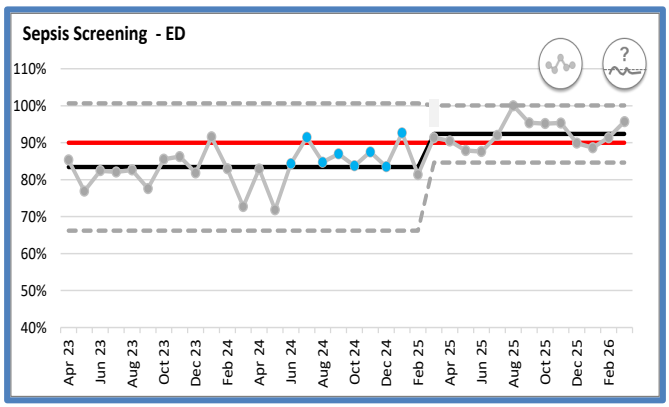
Sepsis recognition and treatment

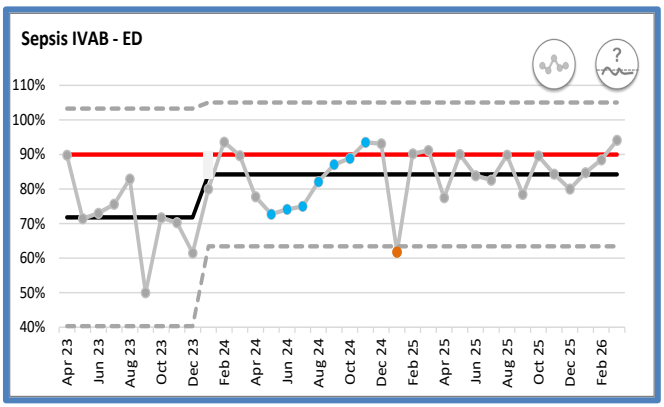
Inpatient areas have seen improvements in sepsis screening and Intravenous Antibiotics (IVAB) in one hour during 2025/2026. Sepsis screening improved from 95.4% to 98.2%. The IVAB in one hour has showed a very slight decrease from 99.1% to 98.9%.





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





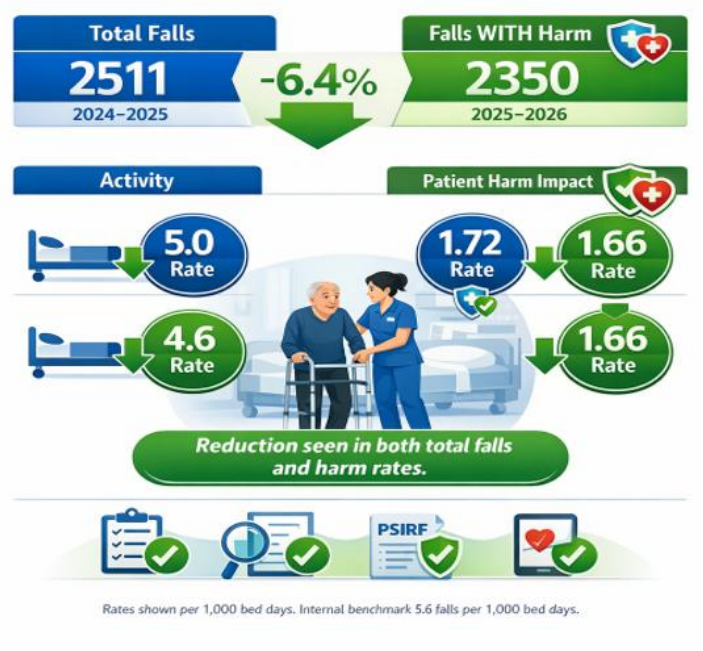
Actions and Next Steps

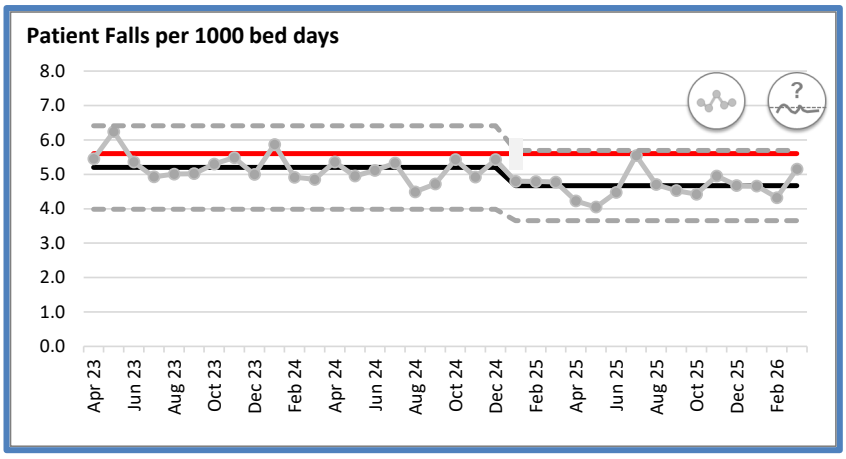
- The Sepsis Team continues to work collaboratively with ED Quality Nurses, Sepsis Champions, the senior team, and the ED Sepsis Lead to improve sepsis screening and intravenous antibiotic (IVAB) compliance.
- Regular visits and sepsis audits are ongoing across emergency portals, particularly within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

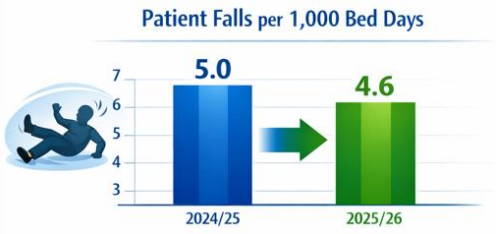
Patient falls

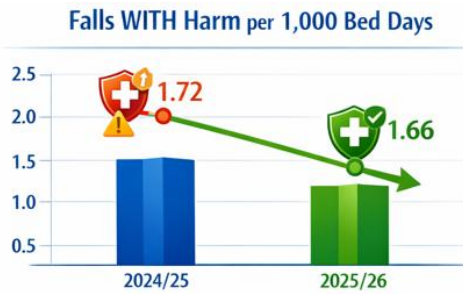
Patient falls remain the largest category of patient-related incidents within our organisation. During 2025-2026, there has been a further 6.4% reduction in total falls, with 2350 falls this year compared 2511 in 2024-2025. Additionally, the rate of falls per 1000 bed days has decreased from 5.0 to 4.6,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

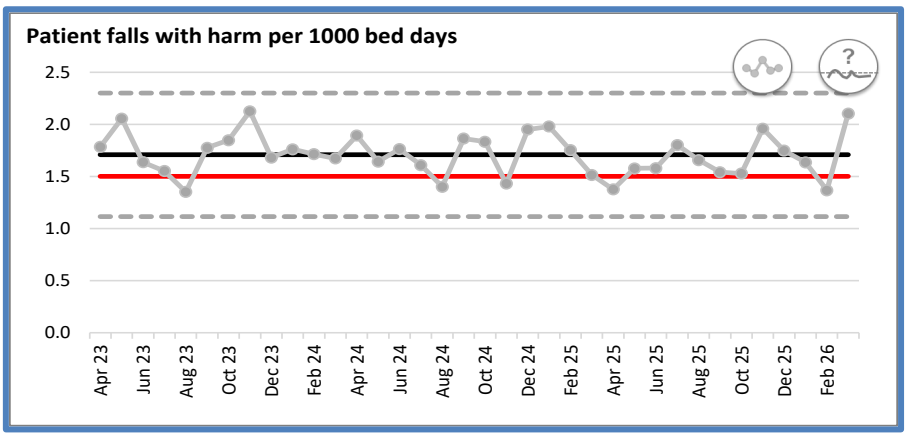
UHNM uses 5.6 falls per 1,000 bed days as an internal benchmark for improvement. This benchmark is likely to be adjusted in 2026-2027 as the Trust has consistently seen rates at or below this figure.











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

Patient Safety Incident Response Framework and Incident reviews

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

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

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

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

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

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

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

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

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

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

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

Never Events

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

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

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

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

PSIRF & Never Event Learning

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

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

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

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

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

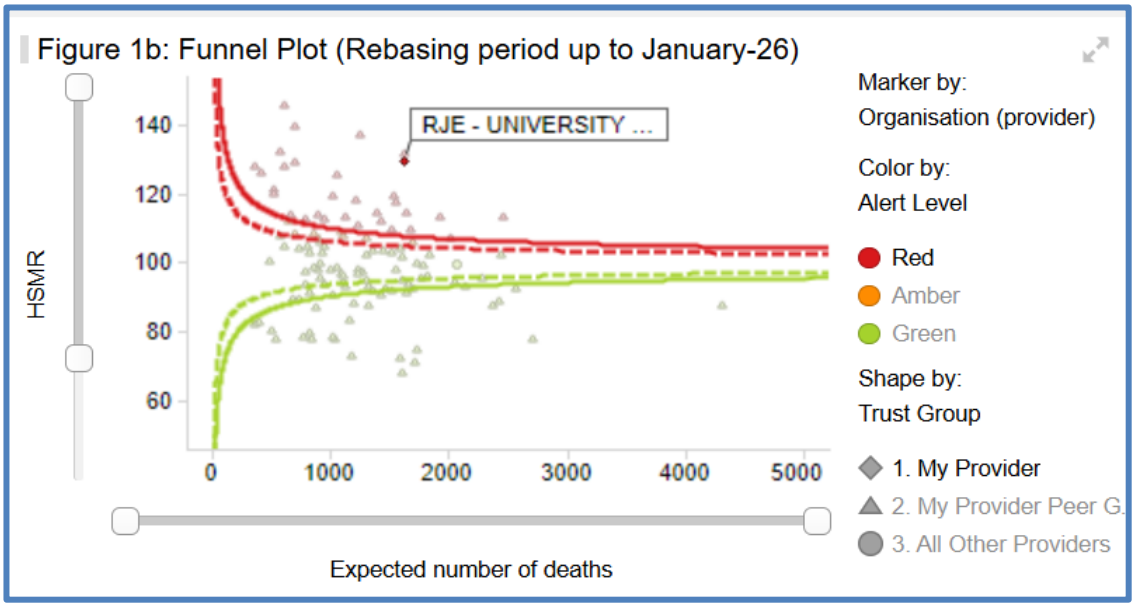
Mortality

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

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

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

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



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

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

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

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

Why are the two measures different?

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

Learning from deaths - mortality reviews

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

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

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

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

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

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

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

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

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

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

1. Emergency Department Flow and Delays

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

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

2. Recognition and Escalation of Deterioration

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

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

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

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

4. Communication Failures

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

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

5. Documentation and Information Continuity

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

6. Outliers, Ward Moves, and Specialty Access

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

Cross-Cutting Observations

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

Hospital associated infections

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

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

Actions and Next Steps

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

Priority 2: To further develop staff wellbeing and experience

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

We said we would do this by:

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

In addition, we:

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

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

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

Freedom to Speak Up

Your voice matters at UHNM

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

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

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

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

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

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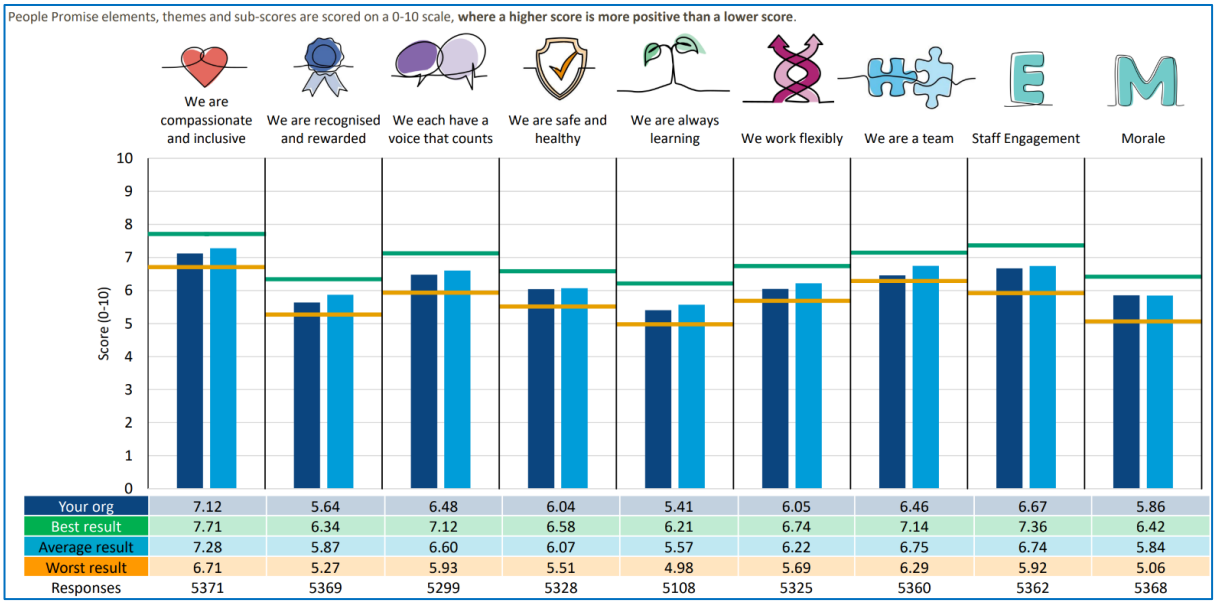
405 FTSU concerns raised in 2025/2026

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

2025 NHS Staff Survey

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

Chart: National Benchmark Comparison



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

Reflecting on the past 12 months

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

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

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

Staff Engagement

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

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

Areas of focus for 2026/27

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

We are always learning

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

The role of the line manager

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

Targeted organisational development support

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

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

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

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

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

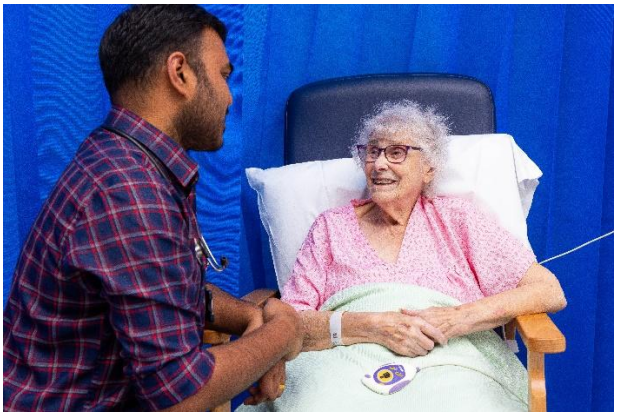



FIRE EXIT

Priority 3: To improve patient experience

We said we would do this by:

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



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

Patient Experience Team

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

The teams' key contributions for 2025/2026 include:

- **Ensuring strengthened patient voice across the Trust**
  - We have expanded and actively facilitated the Hospital User Group (HUG), ensuring patient and carer insight informed service design, estates, catering, accessibility and discharge processes.
  - We have started to embed co-production in major projects, including the new Breast Care Unit, with specific engagement from people with disabilities and sensory loss.
  - The stakeholder statement was not received in time for inclusion before publication.

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

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

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

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

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

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

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

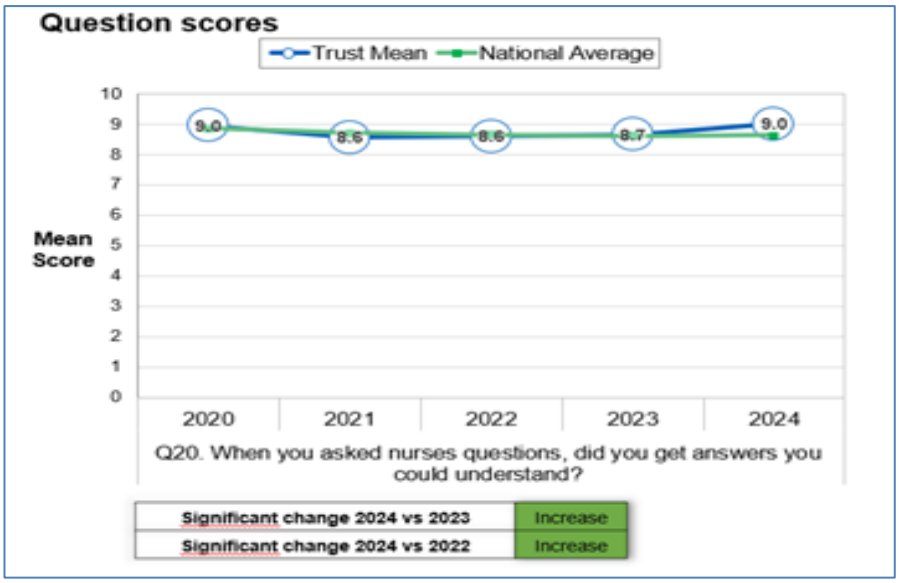
- **Recognition of positive care**
  - We have processed and shared a high volume of compliments, ensuring positive feedback was passed to teams and reinforced Trust values and
  - Highlighted examples of compassionate, dignified care—especially in emergency, maternity, frailty and end-of-life services.

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

Annual Inpatient Survey

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

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



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

Where patient experience is best

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

Where patient experience could improve

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

Impacts of the Patient Experience Team:

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

Complaints

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

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

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

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

Moving Forward- 2026/2027 Patient Experience Priorities.

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

1. Sustain and Further Reduce Complaint Response Times

Why:

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

Improvement

Build capacity and consistency in complaint handling:

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

2. Deepen and strengthen Co-production and Patient Leadership

Why:

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

Improvement:

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

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

Chair/Deputy Chair of the Patient & Carer Engagement Council

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

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

3. Use Triangulated Insight to Target Improvement

Why:

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

Improvement:

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

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

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

Why:

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

Improvement:

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

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

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

Why:

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

Improvement

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

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

Why:

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

Improvement:

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

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

Part C: Statements from our key stakeholders

NHS Shropshire, Telford and Wrekin
NHS Staffordshire and Stoke-on-Trent

Statement for University Hospital of North Midlands NHS Trust Quality Account 2025/2026

Staffordshire & Stoke-on-Trent Integrated Care Board (ICB) are pleased to comment on this Quality Account 2025/2026.

The ICB would like to thank the Trust for their continued commitment to improving services and quality of patient care through their '*Improving Together'* approach, alongside the ongoing embedding of Patient Safety Incident Response Framework (PSIRF).

The Trust continues to strengthen ward-to-board oversight through the Care Excellence Framework (CEF), supported by targeted improvement activity where wards or services require additional support. This is further enhanced through the Trust's Continuous Improvement Academy, which provides training and support to staff on quality improvement methodology.

The ICB would like to recognise the Trust's commitment to making progress, improving the following quality and safety priorities during 2025/26:

- Learning and response to deterioration: Calls for Concern (Martha's Rule) reporting became more consistent with national interpretation.
- Avoidable harm focus: Trust-wide focus has continued on reducing avoidable harm. Particularly work to reduce number of falls.
- Continued improvement in Sepsis Screening and IV antibiotics for inpatients, Emergency portals and Children.
- Patient-led assessments of the Care Environment (PLACE): Achieving above the national average for all the domains for a third year running.

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:

- Emergency Department wait times including reducing ambulance handover delays and eliminating corridor care.
- Improvement in Mortality indicators focusing on clinical coding capacity and improvement plans to address backlog and coding depth and completeness.
- Avoidable harm focus: Trust-wide focus on reducing avoidable harm, including targeted work on timely observations and pressure ulcer prevention.
- Reducing the number of Clostridium Difficile (C Difficile) cases

The Integrated Care System will look forward to seeing the outcomes of the priorities for 2026/27 and looks forward to working together with the Trust to ensure continued improvement over the coming year.

Vanessa Whatley
Chief Nursing Officer
NHS Shropshire, Telford & Wrekin ICB
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

Unfortunately, the Stakeholder statement was not received prior to publication

Quality Account – Staffordshire County Council Health & Care Scrutiny Committee

As Chair of the Health and Care Scrutiny Committee, I have reviewed the UHNM Quality Account 2025/26 and recognise the significant effort made by staff in delivering improvements despite sustained operational pressures, particularly in urgent and emergency care.

The report provides a comprehensive and generally transparent overview of performance, highlighting progress in areas such as reductions in falls, improvements in sepsis screening, and strengthened patient experience activity. However, it also acknowledges ongoing challenges, including higher than expected mortality indicators, infection control performance, and continued pressures across urgent care pathways. While the report identifies ambulance handover delays and Emergency Department pressures as key priorities for improvement, I would encourage the Trust to strengthen transparency in this area by including clearer, measurable data on handover performance and trends over time, to support effective scrutiny.

In addition, further clarity on how improvements in data quality and coding will translate into better patient outcomes would be beneficial. Overall, the report presents a balanced picture of a Trust making progress while remaining open about the areas requiring sustained focus and improvement.

Antonia Orlandi-Fantini
Chair – Health & Care Scrutiny Committee

healthwatch Staffordshire

Statement for University Hospital of North Midlands NHS Trust Quality Account 2025/2026

Healthwatch Staffordshire welcomes the opportunity to review and provide comment on the University Hospitals of North Midlands NHS Trust Quality Account 2025/26.

We recognise UHNM's ongoing commitment to improving the quality, safety and experience of care for local people, particularly during a year marked by sustained operational pressures. It is encouraging to see the Trust's continued focus on reducing avoidable harm, learning from incidents, and embedding the Patient Safety Incident Response Framework (PSIRF) to strengthen system-wide learning and transparency.

Through our engagement with patients, carers and communities across Staffordshire, we know that access to timely care, effective communication during periods of waiting, and meaningful involvement in decisions about treatment remain key priorities. We therefore welcome the Trust's continued emphasis on improving patient experience, including the use of feedback from complaints, the Friends and Family Test, and co-production initiatives to inform service improvement.

We are particularly pleased to note the following areas of progress:

- Strengthening of patient voice through expanded engagement mechanisms, including the Hospital User Group and plans to establish a Patient and Public Engagement Council
- Improvements in complaint handling processes, with a clear focus on learning and service change arising from patient feedback
- Work to improve accessibility and inclusion, including engagement with Deaf communities and support for patients with additional needs
- Continued progress in patient safety initiatives, including reductions in some areas of harm and an increased focus on early recognition of deterioration

However, insight from local communities indicates that continued focus is required in the following areas:

- Experiences in urgent and emergency care, particularly in relation to long waits and communication during delays
- Consistency of care and communication across pathways, especially during transitions between services
- Ensuring that all patients, including seldom-heard groups, feel listened to and meaningfully involved in decisions about their care

We encourage UHNM to further strengthen co-production with patients and carers, ensuring that feedback is translated into visible and meaningful service improvements through clear "you said, we did" reporting. Continued collaboration with voluntary, community and social enterprise (VCSE) partners will be important in reaching underserved populations and addressing health inequalities.

Healthwatch Staffordshire looks forward to continuing to work in partnership with UHNM to ensure that the experiences of patients, carers and communities remain central to service improvement, and that measurable progress is made in the areas that matter most to local people.

Anna Mather
Healthwatch Staffordshire Manager

healthwatch Stoke-on-Trent

Statement for University Hospital of North Midlands NHS Trust Quality Account 2025/2026

Healthwatch Stoke-on-Trent appreciates being given the opportunity to provide a comment on the Quality Account for 2025/2026.

Healthwatch is the independent health and social care champion. We are here to listen to the experiences of local people using local health and care services, and about the issues that matter to the people of Stoke-on-Trent.

We believe having a small number of priorities means a greater chance of success and this is especially important to Healthwatch Stoke-on-Trent, given one of the priorities was improving the patient experience.

During the period covered by the Quality Accounts, almost 100 people provided feedback about UHNM via our website, email, phone, and during our outreach. The feedback included stories that were both positive and negative. We heard about the Emergency Department, Outpatients, and Inpatients.

Feedback covered the following key themes:

- Caring, kindness, respect and dignity
- Communication with patients
- Integration of services and communication between professionals
- Staffing levels
- Quality of treatment
- Waiting times

We welcome the focus on co-production and hope to see this grow and expand over the coming year.

We note that enhancing the patient experience is a priority for the coming year and look forward to working with UHNM to share what we hear

Clare Trenchard
Chief Executive Officer