University Hospitals Birmingham
NHS Foundation Trust

Quality Account 2025/26

This report covers the period 1 April 2025 to 31 March 2026

2025/26 Quality Account

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1 Chief Executive's Statement

This report sets out the approach we have taken to improving quality and safety at University Hospitals Birmingham NHS Foundation Trust. The Trust's Council of Governors, Board of Directors and the Birmingham and Solihull Integrated Care Board have all been engaged in discussions on our quality priorities for 2026/27.

Our priority is to provide high quality, safe care for all patients. We are committed to driving improvement and a culture of excellence throughout the organisation. Despite the operational and financial challenges, and high demand for our services the Trust has faced during 2025/26, we have sought to deliver care in accordance with our quality priorities.

Some of our key achievements over the past year include:

- We continue to work with our quality leads across the Trust, as well as our patient safety partners, to deliver our Trust Patient Safety Incident Response Plan, and improvement plans aligned to our patient safety priorities.
- Following the launch of the "Listen, Learn, Share" (LLS) initiative, this has become routine practice for sharing learning from incidents widely across the Trust. LLS encourages us all to actively listen to our patients and colleagues, learn from their experiences, and share our insights to improve care. LLS has helped the Trust identify and address potential issues before they become significant areas requiring immediate attention, ensuring that patient safety remains our top priority.
- The Trust has established a "SWARM" style approach to incident response, with the purpose of helping local teams to identify immediate learning from incidents to prevent recurrence of harm to patients and staff, drive continuous quality improvement, and foster an open, transparent safety culture. This enables more timely feedback to patients and their relatives following an incident.
- We're proud of the diversity of both our staff and the patient population we serve and are working hard to ensure our organisation is a truly welcoming place for all. The Trust has developed a Health Inequalities (HI) strategy for 2024-29, to demonstrate our commitment to understanding and addressing the complex issues which lead to inequalities in healthcare. A major focus of this year's work has been the development of baseline health inequality positions across all clinical services, led by the Associate Medical Directors. By assessing data maturity, specialty level priorities, workforce capability and resource needs, we have established a comprehensive picture of inequities in access, outcomes and experience. This work provides the foundation for targeted action, and helped inform the development of the Health Inequalities implementation plan, which will shape future priorities and align Trust wide action with population need.
- Clinical metrics scorecards have been developed on the Performance Information Management System (PIMS) on PowerBI for our Patient Safety Priorities (PSP), to serve as a repository for real time data monitoring using SPC charts to support our continuous improvement programmes.
- We will continue working with health and social partners, regulators and other organisations to implement improved models of care delivery and further improvements to quality during 2026/27.
- UHB continues to demonstrate sustained improvement within the National Oversight Framework rankings.
- The Trust strategy focuses on the "Five Ps": Patients, People, Potential, Place and Performance, which all of the Trust's strategic objectives are aligned. Quality is integral to the delivery of the strategy and underpins the achievement of its objectives.
- The outpatient transformation programme is focusing on demand, delivery and quality. The programme has been piloting a follow-up reduction initiative in five high-demand specialties, which is progressing well and has contributed to a reduction in the backlog. Colleagues are also working on a new patient-led booking system that will enable patients to book their own appointments, and are working on other improvements to support delivery of the outpatients transformation programme.

Jonathan Brotherton, Chief Executive
5 June 2025

2 Part 2: Priorities for improvement and statements of assurance from the Board of Directors

2.1 Priorities for Improvement

The Trust's 2024/25 Quality Account set out three priorities for improvement during 2025/26;

1. Patient Experience
2. Embedding PSIRF
3. Clinical Effectiveness and Quality Improvement

The priorities were agreed by the Chief Medical Officer and Chief Nurse at the Group Clinical Quality Meeting (GCQM). The priorities support the Trust Strategy 2024-29 and the Trust's PSIRF Plan. Reducing health inequalities is integral to our new approach to continuous improvement, and introducing and embedding a continuous improvement methodology will enable UHB to become a learning organisation.

The Deputy Chief Medical Officer for Quality has appointed three Associate Medical Directors for Health Inequalities who are working with Informatics on the development of equality indicators as part of patient safety priorities and other quality indicators.

For 2026/27 the Chief Medical Officer and Chief Nurse have agreed on the following priorities; this was confirmed at the Group Clinical Quality Meeting (GCQM):

1. Patient Experience
2. Delivering PSIRF
3. Clinical Effectiveness & Quality Improvement
4. Reducing Health Inequalities

The approach for 2026/27 is to ensure the quality priorities reflect the breadth of work within the Trust's PSIRF Plan and supports the Trust Strategy for 2024-29. Reducing health inequalities is integral to our new approach to continuous improvement, and introducing and embedding a continuous improvement methodology will enable UHB to become a learning organisation.

Our Quality Priorities for 2025/26

Our quality priority	What success will look like	Progress 2025/26
Patient Experience		
To ensure that all patients, relatives and carers are able to provide feedback on their experience of care via the Friends and Family Test.	Patients, relatives and carers will provide feedback via the digital FFT offering, or an easy read paper FFT version where paper is required. Feedback will reflect diverse patient group experiences and teams will understand the experience of their patients by demographics.	› In 2025, the Patient Experience Team rolled out a digital approach to the Friends and Family Test (FFT), enabling patients to provide feedback via the UHB website. ReachDeck functionality allows patients to access the survey in their preferred format and respond in any language. An Easy Read version of the FFT was also developed and implemented to improve accessibility. › Following the digital rollout, there was a significant improvement in the proportion of respondents providing demographic information. Previously, around 30% of FFT responses included demographic data; this has increased to 95%. A new demographic profiling section was added to the Patient Experience dashboard, providing deeper insight into patient experience across different patient groups. Teams can now review FFT responses by demographic characteristics, supported by training delivered to all Hospital Patient Experience Groups to help them use these insights effectively. › In 2025/26, a total of 44,119 FFT responses were received, with 84.2% of patients reporting a positive experience.

Our quality priority	What success will look like	Progress 2025/26
Patient Experience		
Increased opportunities for patient and public collaboration with UHB to improve patient experience.	An increase in the number of patient and public representatives on the forums and demonstrable activity where the representatives have been involved in co-producing with UHB to improve patient experience.	› The Medium-Term Planning Framework set out the strategic expectations for Patient Experience, identifying the strengthening of how Trusts collect, interpret and act on patient feedback as a key priority for 2026. Particular focus was placed on three areas at UHB: ▸ Capturing the experiences of patients while they are waiting ▸ Gathering near real-time feedback ▸ Triangulating patient experience insights, including complaints › In December 2025, a formal partnership was established with Newcastle NHS Foundation Trust to support the delivery of a real-time patient experience measurement programme at UHB. This programme provides opportunities for inpatients to share verbal feedback about their current experience, enabling teams to respond in real time. Twelve pilot wards across all four hospital sites were selected to take part, and the pilot was formally launched in March 2026. › This approach also supports the reduction of health inequalities by creating more inclusive and accessible ways for patients to share their experiences. Real-time, conversational feedback reduces reliance on written surveys, which can exclude people with low literacy levels, language barriers, cognitive impairments, or limited digital access. This enables teams to identify inequities earlier, tailor responses to individual needs, and ensure that improvement actions benefit those who may have experienced the poorest outcomes. › In January 2026, a new patient survey was developed to capture the experiences of patients while they are waiting. Over 2,000 patients waiting for their first outpatient appointment at UHB shared their experience through this mechanism. › The Patient Experience Team triangulated patient feedback received during 2025 and identified three Group-level priority areas for improvement in 2026: Communication, Hydration and Discharge.

Our quality priority	What success will look like	Progress 2025/26
Patient Experience		
To improve the responsiveness, transparency and effectiveness of the Trust's complaints handling process, ensuring patients and families experience clear communication, timely responses and meaningful resolution.	› Consistent delivery against Trust response standards (25/40/65 working days) › Sustained achievement as close as possible to the 80% internal compliance KPI › Strong performance within national six-month timescales › Improved expectation-setting through early contact › Reduced complaint escalation and fewer reopened complaints	› During 2025/26, significant work was undertaken to stabilise and strengthen complaints handling amid a sustained and unprecedented increase in complaint volume (+33.9%; 2,270 complaints received between April 2025 and March 2026). › The tiered response timeframe model was successfully reintroduced from June 2025 and embedded through strengthened triage, grading and staff training. Early implementation challenges affected internal performance, but corrective actions enabled recovery of process control and improved consistency across the year. Worth noting that we have witnessed a substantial increase in the complexity of complaints, with a significant proportion of potentially AI-generated concerns. › A key improvement was the embedding of early contact (introductory calls/emails) with complainants. Compliance consistently exceeded the 80% target, improving expectations, scope clarity, and communication quality. This proactive engagement has contributed to: ▸ A 5.5% reduction in reopened complaints, building on an 8.0% reduction the previous year ▸ Improved equity of access and support, particularly for patients requiring reasonable adjustments › Internal timeframe performance is currently at 63.35%, below the Trust's 80% ambition but reflective of the increased complexity and volume of cases. January, February, and March cases are ongoing, and March will not fully close for reporting until early July, so that the above figure may change by our year-end. › Importantly, performance within national six-month timescales remained strong at 88.74%, indicating that cases that breached internal deadlines were generally resolved shortly thereafter. This metric does not experience the same time lag as above, as it focuses on all cases closed within a month. › Additional system improvements, including the introduction of a multi-language web-based complaints form, enhanced accessibility, and potentially contributed to increased reporting. Complaint volume was also affected by an increase in escalated PALS cases, indicating opportunities for process refinement within the service, which will be explored in full in 2026/27 and form part of next year's quality accounts. › PALS concerns reduced by 7.47%, following a renewed emphasis on early, speciality-led local resolution in line with refreshed PHSO guidance, supporting a preventative approach to formal escalation.

Our quality priority	What success will look like	Progress 2025/26
Patient Experience		
To ensure complaints are managed to a consistently high standard, with robust governance, quality assurance and learning mechanisms that translate patient feedback into tangible service improvement.	› A formally established Quality Improvement Group (QIG) with clear governance › Consistent assurance of response quality through structured review › Alignment of complaint learning with PSIRF and national taxonomies › Evidence that learning from complaints drives service improvement and reduces recurrence	› Throughout 2025/26, the Trust focused on building the foundations for a sustainable, system-wide approach to learning from complaints. Engagement across clinical and corporate services strengthened over the year, resulting in agreement to formally convene the Quality Improvement Group (QIG) in Q1 2026/27, with senior medical and nursing representation. › While the QIG was not operational during 2025/26, substantial preparatory work was completed, including: ▸ Development of a clear remit and governance framework ▸ Explicit inclusion of equity and health inequalities within the group's purpose ▸ Alignment work to integrate complaints learning with PSIRF principles and national taxonomies › The Trust also committed to piloting the Healthcare Complaints Analysis Tool (HCAT) within selected clinical delivery groups and PHSO cases, strengthening the quality and consistency of learning extracted from complaints. This work is being combined with a triangulation and machine-learning project, designed to analyse multiple patient feedback datasets without relying on manual categorisation, ensuring the patient voice remains primary and unfiltered. › This preparatory year has positioned the Trust to move from assurance to measurable improvement impact in 2026/27, with clear structures now in place to ensure learning from complaints informs Trust-wide priorities.

Our quality priority	What success will look like	Progress 2025/26
Patient Experience		
To build staff confidence and capability in complaint handling through structured training, supported by transparent, accessible data to drive learning, accountability and early resolution.	› High-quality complaint investigation training embedded across the Trust › Accessible digital booking and learning platforms › Strong staff feedback and demonstrable impact on early resolution › Fully developed Power BI dashboards providing real-time, equitable insight into complaints and PALS data	› The Investigating Complaints training programme was successfully launched and delivered across multiple sites during the year, with consistently high satisfaction scores (average 4.8/5.0) from over 200 staff. Demand was strong, particularly at Birmingham Heartlands Hospital, necessitating additional sessions. › Delivery was temporarily paused due to service pressures and a critical incident in December 2025. Preparatory work continued to ensure: ▸ Training resumes in April 2026, and Patient Relations Managers regularly monitor compliance with: a) Investigating Complaints Training, b) Action Plan completion for Partially and Fully Upheld Complaints & PALS. ▸ Ongoing evaluation links training coverage to complaint reduction and quality outcomes Significant progress was also made in strengthening the Trust's data and reporting infrastructure. The PALS and Complaints Power BI dashboard became fully operational and accessible to all staff, with enhancements introduced to improve transparency and local reporting. › By year-end, dashboards included improved demographic and health-inequality reporting (age, gender, ethnicity, IMD, language and religion), with the first health inequalities report presented at IQR. Preparatory work also advanced machine-learning-supported thematic analysis, postcode-based insights, and complaints-timing analysis, positioning the Trust to better understand variation in access, experience, and outcomes in 2026/27.

Our quality priority	What success will look like	Progress 2025/26
Embedding PSIRF		
To ensure the NHSE Patient Safety Incident Review Framework is fully embedded	› Positive assurance received by KPMG audit on the Trusts implementation of the standards › 100% Mandatory Training Requirements, as set out in the NHSE PSIRF training document met › 100% PSIIs completed within 6 months from being commissioned › Improved Patient and Staff engagement – 100% patients/ families engaged with as part of the investigation for all PSIIs. Staff who have been involved in the incident are included in the learning responses (PSII, AAR and Roundtable) › Benefit of PSIRF is realised i.e. Volume of Investigations v measurable improvement	› Audit Completed by KPMG with positive assurance and minor improvements › Achieved: 100% for training (evidence detailed in the PSIRF report to CQ&PS Committee & GCQM) › In progress: the backlog of PSIIs has been cleared and reached the trajectory target level. The 100% target was achieved in December 2025, however not achieved in Q4. Remedial actions are in place and a fortnightly report is being provided to the CMO/CN. › Patient/Family engagement for PSII: Achieved 100% in Q4. › We continue to ensure learning responses are commissioned in line with the Trusts PSIRF Policy/ Plan. › During Q4 a review with of all the refreshed PSPs was conducted to ensure they are set up adequately and in line with the IHI methodology. All have presented to the steering group although some project aims are being refined, and Maternity priorities are to be presented at a meeting in Q1 2026/27. › An audit was conducted in Q4 2025/26 to assess if the actions implemented from PSIIs have resulted in a reduction in those incidents occurring, and this will be presented in Q1 2026/27

Our quality priority	What success will look like	Progress 2025/26
Clinical Effectiveness and Quality Improvement		
Developing a culture of Continuous Quality Improvement (CQI) is a cornerstone of the new Trust strategy, which launched October 2024. Embedding CQI within the organisation has the potential to deliver: › Improved patient outcomes and experience, through the creation of a positive, collaborative and inclusive workplace environment. › Improved staff morale and engagement, by giving staff more control over the system they work in, more autotomy to make changes, and equipping them with the tools and skills to tackle these. › Improved organisational culture, enabling all staff to focus on continual learning and improvement of patient care. › Reduced costs and improving productivity through a sustained focus on reducing unwanted variation in services and practices. › Sustained and lasting change, through providing constancy of purpose, momentum and infrastructure needed for complex improvement initiatives. To ensure patients care is delivered in line with national standards	The Improvement Programme has identified several measures to help determine its success. (These are currently subject to change and approval.) Primary outcome measure: › NHS Staff Survey question 3c "I am able to make improvements happen in my area of work" (latest performance 49% for the Trust – Apr-25 QSS). Process measures: › Number of staff trained in QI methodology (for agreed improvement priorities) › Number of QI projects registered (with measures and impact complete) › NHS IMPACT self-assessment of 'maturity' (moving components from 'starting' & 'developing' to 'progressing', 'spreading' and 'sustaining') Balancing measures: › NHS Staff Survey questions 3a-b National standards: › Trust is 90% compliant/ working towards compliance with NICE guidance › Trust Clinical Guideline Procedure is revised and in place to reflect the work being led by the Deputy CMO Clinical Governance › 100% of specialities have audit plans in place › No National Audit Outlier/ alerts – where there are any robust plans are in place to rectify	Quality Improvement › The Institute of Healthcare Improvement started a 2.5-year partnership with UHB in August 2025, and the trust's new improvement team (created through a restructure of existing teams) started on 1 September. Key workstreams have been set up as part of the improvement programme (overseen by the Exec led Improvement Board) to develop: › 1) Standardised approach and methodology: improvement approach agreed at Execs (January 2026); improvement getting started guide developed to ensure all improvement is undertaken with consistent approach (March 2026) › 2) Building capability and capacity: training programmes have started (foundation, specialist and coach programme) - strategies and trajectories set until the end of 2027. Moodle content in development and further specialist programme to run in June with a focus on productivity › 3) QI infrastructure: new QI module on Radar due Q1 26/27; site-based QI clinics in development; improving sharing and dissemination of QI (learning and improvement conference on 22 April 2026); and building QI networks (created through training community, "train all, teach all" › 4) Embedding improvement: further embedding safety huddles and introducing improvement huddles (focussed initially on wards piloting real time patient feedback); Board, Executive and hospital leadership development (QE leadership session - January 2026; Board micro-teaches started April 26; other SLT sessions to be scheduled). Brand and logo agreed and communication plan for the programme in place › 5) Improvement prioritisation: working closely through new improvement business partners (aligned to hospitals and GCSS) and with other improvement resources and the PSIRF priority refresh, the identification of an aligned view of the organisation's quality improvement priorities. National Standards: › See figures for Q4 in the clinical compliance report – Reaching the KPI target to be compliant/working toward compliance for 90% of NICE guidance at end of Q4. › The CG&PS department are working with the Chair of the Clinical Guidelines Group and the Deputy CMO Clinical Governance to revise the approach to clinical guidelines and update the guidelines procedure – the aim is to move to a model where more emphasis is on using NICE or BMJ best practice guidance and only adopt a trust specific clinical guideline if there is no national standard guideline available. › See Q4 IQR for National Audit Outlier status – each of the outliers have plans in place to improve performance. Area of risk is the National Joint Registry Audit › Work is underway to revise the way Audits are registered to improve both registration of audits and reporting against local audits by July 2026 (moving from CARMS to RADAR).

2.2 Statements of assurance from the Board of Directors

2.2.1 Service income

As at Q2 University Hospitals Birmingham NHS Foundation Trust provided and/or sub-contracted 74 relevant health services.

The Trust has reviewed all the data available to them on the quality of care in 74 of these relevant health services*.

The income generated by the relevant health services reviewed in 2025/26 represents 100 per cent of the total income generated from the provision of relevant health services by the Trust for 2025/26.

* The Trust has appropriately reviewed the data available on the quality of care for all its services. Due to the sheer volume of electronic data the Trust holds in various information systems, this means that UHB uses automated systems and processes to prioritise which data on the quality of care should be reviewed and reported on.

2.2.2 Information on participation in clinical audits and national confidential enquiries

For 2025/26, there are 59 national clinical audit programs and a total of 88 workstreams that are included on the quality accounts listing. Of the 88 national audit workstreams 81 are mandatory and eligible for UHB participation, this includes two national confidential enquiries. The two national confidential enquires have five open studies with two additional study projects in early development that UHB plan to participate.

During the 2025/26 period UHB participated in 71 (88%) of national clinical audits and 7 (100%) national confidential enquiries which it was eligible to participate in.

Information regarding UHB participation in national audits for 2026/27 is currently under review with the first level of enquiries having commenced.

The national clinical audits and national confidential enquiries that UHB are eligible to participate in during 2025/26 are included in the table below.

National audit outliers and non-participation are captured within the Integrated Quality Report to Trust board including improvement activities undertaken to address issues. Board papers are accessible on the UHB website for information - UHB Board of Directors papers

National Clinical Audits

Project name	Workstreams	UHB participation 2025/26	Comments
BAUS Urology Audits - Nephrostomy Audit	British audit of the investigation and referral of investigation and referral of women with recurrent urinary tract infection using recent Guidance (BOOMERANG)	No	Both are new workstreams and have been reviewed by the Urology department and concluded that these are voluntary research projects by BAUS, and not registries of key urological procedures. Resources will be used to continue data submission to the National Consultant Information Programme (HCIP) for oversight of surgical outcomes data to help improve clinical quality and patient safety. Non-participation has been endorsed by the CMO.
	Evaluating the Management Pathway for Suspected Testicular Cancer Referrals (EMPAST)	No	

Project name	Workstreams	UHB participation 2025/26	Comments
Breast and Cosmetic Implant Registry		Yes	Participation planned for QEH & SHH
British Spine Registry		Yes	New workstream with planned participation
Case Mix Programme (Intensive Care National Audit & Research Centre)		Yes	Planned participation. N/A for SH
Child health Clinical Outcome Review Programme	NCEPOD	Yes	
Cleft Registry and Audit Network (CRANE) Database		N/A	UHB not eligible- specialist units providing cleft services only.
Emergency Medicine QIPs:	Adolescent Mental Health	N/A- postponed till 2026	
	Care of Older People	Yes	
	Time Critical Medications	Yes	
Epilepsy12: National Audit of Seizures and Epilepsies in Children and Young People		Yes	Non-participation status for 24/25. Re-commenced participation for 2025/26.
Falls and Fragility Audit Programme	Fracture Liaison Service (QEH only)	Yes	NHFD outlier identified
	National Audit of Inpatient Falls (NAIF)	Yes	
	National Hip Fracture Database (NHFD)	Yes	
Learning from lives and deaths - People with a learning disability and autistic people (LeDeR)		Yes	
Maternal and Newborn Infant Clinical Outcome Review Programme Project includes: › Maternal morbidity confidential enquiry - annual topic based serious maternal morbidity › Maternal mortality confidential enquiries › Maternal mortality surveillance › Perinatal mortality and serious morbidity confidential enquiry › Perinatal Mortality Surveillance › Managing acute illness people with learning disability		Yes	
Medical and Surgical clinical outcome review programme	NCEPOD	Yes	
Mental Health Clinical Outcome Review Programme		N/A	UHB not eligible: NHS Mental Healthcare

Project name	Workstreams	UHB participation 2025/26	Comments
National Adult Diabetes Audit	National Diabetes Core Audit	Yes	
	Diabetes Prevention Programme (DPP) Audit	N/A- primary care audit	
	National Diabetes Footcare Audit (NDFA)	Yes	
	National Diabetes Inpatient Safety Audit (NDISA)	Yes	
	National Pregnancy in Diabetes Audit (NPID)	Yes	
	Transition (Adolescents and Young Adults) and Young Type 2 Audit	Yes	
	Gestational Diabetes Audit	*N/A*	*Removed from the directory*
National Audit of Cardiac Rehabilitation		QEH: Partial HGS: Full	QEHB rehabilitation piloting a version of Dendrite & reviewing resources to support audit. IG review completed however participation not commenced.
National Audit of Cardiovascular Disease Prevention in Primary Care (CVDPrevent)		N/A	Primary care data submission by GP services
National Audit of Care at the End of Life (NACEL)		Yes	
National Audit of Dementia		Yes	
National Audit of Eating Disorders (NAED)		N/A	UHB not eligible: Participation expected for Eating Disorder Services
National Bariatric Surgery Registry		Yes	BHH & SH are participating
National Cancer Audit Collaborating Centre (NATCAN)	National Audit of Metastatic Breast Cancer (NAoMe)	Yes	
	National Audit of Primary Breast Cancer (NAoPri)	Yes	
	National Bowel Cancer Audit (NBOCA)	Yes	
	National Kidney Cancer Audit (NKCA)	Yes	
	National Lung Cancer Audit (NLCA)	Yes	
	National Non-Hodgkin Lymphoma (NNHLA)	Yes	
	National Oesophago-gastric Cancer Audit (NOGCA)	Yes	
	National Ovarian Cancer Audit (NOCA)	Yes	
	National Pancreatic Cancer Audit (NPaCA)	Yes	
	National Prostate Cancer Audit (NPCA)	Yes	
National Cardiac Arrest Audit		Yes	

Project name	Workstreams	UHB participation 2025/26	Comments
National Cardiac Audit Programme	National Adult Cardiac Surgery Audit (NACSA)	Yes	National Cardiac Audit Programme
	National Congenital Heart Disease Audit (NCHDA)	Yes	
	National Heart Failure Audit (NHFA)	Yes	
	National Audit of Cardiac Rhythm Management (NACRM)	Yes	
	Myocardial Ischaemia National Audit Project (MINAP)	Yes	
	National Audit of Percutaneous Coronary Intervention (NAPCI)	Yes	
	UK Transcatheter Aortic Valve Implantation (TAVI)	Yes	
	Left Atrial Appendage Occlusion (LAAO) Registry	Yes	
	Patent Foramen Ovale Closure (PFOC) Registry	Yes	
	Transcatheter Mitral and Tricuspid Valve Procedure (TMTV)	Yes	
National Child Mortality Database (NCMD)		Yes	
National Clinical Audit of Psychosis (NCAP)		N/A	UHB not eligible: NHS Mental Healthcare
National Comparative Audit of Blood Transfusion	2025 Major Haemorrhage Audit	Yes- planned	
National Early Inflammatory Arthritis Audit		Yes	Full participation for patients who consent.
National Emergency Laparotomy Audit (NELA)	Laparotomy	Yes	National Emergency Laparotomy Audit (NELA)
	No Laparotomy		
National Joint Registry		Yes	Compliance concern letter received. More information detailed in IQR.
National Major Trauma Registry		Yes	Audit workstream merged to NMTR from TARN in 2024.
National Maternity and Perinatal Audit (NMPA)		Yes	
National Neonatal Audit Programme (NNAP)		Yes	
National Obesity Audit (NOA)		Yes	
National Ophthalmology Database Audit (NOD)	Age-related Macular Degeneration (AMD) Audit	Yes	
	National Cataract Surgery Audit		
National Paediatric Diabetes Audit (NPDA)		Yes	HGS only QE – N/A

Project name	Workstreams	UHB participation 2025/26	Comments
National Perinatal Mortality Review Tool		Yes	HGS only QE – N/A
National Pulmonary Hypertension Audit		N/A	UHB not eligible: Only the eight designated centres participate.
National Respiratory Audit Programme (NRAP)	COPD Secondary Care	Partial	Participation re-established end of 2025 for the Adult Asthma workstream. More information detailed in IQR
	Pulmonary Rehabilitation	Yes	
	Adult Asthma Secondary Care	Partial	
	Children and Young People's Asthma Secondary Care	BHH: Yes GHH: Yes	
National Vascular Registry (NVR)		Yes	
Out-of-Hospital Cardiac Arrest Outcomes (OHCAO)		N/A	UHB not eligible: Ambulance Service Region & NHS primary care.
Paediatric Intensive Care Audit Network (PICANet)		Yes	Commenced participation in September 2025.
Perioperative Quality Improvement Programme (PQIP)		No	More information detailed in IQR. Non-participation endorsed by CMO.
Prescribing observatory for Mental Health (POMH)	Improving the quality of valproate prescribing in adult mental health services	N/A	
	Use of clozapine		
	Use of medicines with anticholinergic (antimuscarinic) properties in older people's mental		
Sentinel Stroke National Audit Programme (SSNAP)		Yes	More information detailed in IQR.
Serious Hazards of Transfusion (SHOT) UK National Haemovigilance Scheme		Yes	
BTS UK Interstitial Lung Disease (ILD) Registry		Yes	New workstream for 2025/26
UK Parkinson's Audit		Yes	New workstream for 2025/26. Planed participation
UK Cystic Fibrosis Registry	Adult	Yes	
	Children	Yes	New workstream for 2025/26 planned participation for BHH
UK Renal Registry Chronic Kidney Disease Audit		Yes	
UK Renal Registry National Acute Kidney Injury Audit		Yes	

The following National Audits have been removed from the Quality Accounts listings for 2025/26

Project name	Workstreams	UHB participation 2025/26	Comments
BAUS Urology Audits - Nephrostomy Audit:		› Environmental Lessons Learned and Applied to the Bladder Cancer Pathway (ELLA) Audit › Impact of Diagnostic Ureteroscopy on Radical Nephroureterectomy (I-DUNC) Audit › Penile Fracture (SNAP) Audit	
British Hernia Society Registry			
Prescribing Observatory for Mental Health (POMH):		› Rapid tranquillisation in the context of the pharmacological management of acutely disturbed behaviour › The use of melatonin › Use of medicines with anticholinergic (antimuscarinic) properties in older people's mental health services	
Emergency Medicine QIPs:		› Mental Health Self Harm	
National Comparative Audit of Blood Transfusion:		› National Comparative Audit of NICE Quality Standard QS138 › National Comparative Audit of Bedside Transfusion Practice	
Quality and Outcomes in Oral and Maxillofacial Surgery		› Oncology & Reconstruction › Trauma › Orthognathic Surgery › Non-melanoma skin cancers › Oral and Dentoalveolar Surgery	

National Confidential Enquiries (NCEPOD)

NCEPOD Project Name	NCEPOD workstream	Participation	UHB participation 2025/2026
Child Health Clinical Outcome Review Programme	Stabilisation of the critically ill child	Planned data collection: July 2025 Date of publication: due December 2026	Yes
	Managing acute illness people with learning disability	Planned data collection: spring 2025 Date of publication: due summer 2026	Yes
Medical and Surgical Clinical Outcome Review Programme	Pleural procedures	Planned data collection: September 2025 Date of publication: Due Late 2026	planned
	Rib Fractures	Planned data collection: January – July 2026 Date of publication: Spring 2027 Due Late 2026	Yes

NCEPOD projects now closed and have been published

NCEPOD Project Name	NCEPOD workstream
Child Health Clinical Outcome Review Programme	Juvenile Idiopathic Arthritis
	Emergency procedures in children and young people
Medical and Surgical Clinical Outcome Review Programme	End of Life Care
	Endometriosis
	Managing acute illness people with learning disability
	Rehabilitation following critical illness – Published June 2025
	Blood Sodium Study- Newly published October 2025
	Acute Limb Ischaemia (ALI)

Percentages are given wherever available and relevant.

Local Audits

At UHB a wide range of local clinical audits are undertaken. This includes Trust-wide audits and specialty-specific audits which reflect local interests and priorities. A total of 383 clinical audits were registered with UHB's clinical audit team during Q4 2025/26. 654 audits were completed in the financial year to date. (See separate clinical audit appendix published on the Quality web pages: http://www.uhb.nhs.uk/quality.htm).

2.2.3 Information on participation in clinical research

The total number of UHB patients recruited into open studies at the Trust during 2025/26 was:

NIHR Portfolio Recruitment	7,107	Commercial 370 Non commercial 6,737
Non-NIHR Portfolio Recruitment	1,656	Commercial 40 Non commercial 1,616
Total Patient Recruitment	**8,763**	**Commercial 410** **Non commercial 8,353**

Please note the below data uses portfolio recruitment data only (to allow comparison to other Acute Trusts)

Regionally UHB continues to outperform other partnership organisations for recruitment to trials:

- UHB are 1st in West Midlands for overall commercial recruitment for 25/26 (15 Acute Trusts)
- UHB are ranked 17th nationally for number of open commercial recruiting studies for 25/26 (130 Acute Trusts)

Embedding Health Equalities within Research, Development, and Innovation (RDI)

UHB RD&I has made demonstrable progress in closing the gap between ethnic minority trial participation and the hospital population, with the difference reducing from 12.7 percentage points in 2023/24 to 10.4 percentage points in 2025/26. The trajectory toward parity by 2028-29 is consistent with current trends. The KPI is benchmarked against the UHB hospital patient population rather than census data, reflecting the fact that trials recruit from attending patients, and from Q1 2026/27 will be reported at site level to enable more targeted equity monitoring. A dedicated working group, engaging the Health Inequalities Steering Group and site executives, has been established to address the recruitment inequality identified at Heartlands, with its first meeting planned for Q1 2026/27. Health inequalities considerations are embedded across the RD&I portfolio, from data infrastructure and governance through to trial recruitment, PPIE, and study design.

2.2.4 Information relating to registration with the Care Quality Commission (CQC) and special reviews / investigations

UHB is required to register with the Care Quality Commission (CQC). There are currently no conditions on the Trusts CQC license.

The Care Quality Commission has not taken any enforcement action against UHB during 2025/26.

Birmingham and Solihull Integrated Care Board did not commission any reviews during 2025/26.

CQC Inspection Ratings Grids

Four CQC inspections have taken place across services at University Hospitals Birmingham during 2025/26:

Date	Core Service	Site
10 April 2025	Runcorn Road Dialysis	Community
28 April 2025	Castle Vale Dialysis	Community
29-30 April	Maternity Services	BHH
29 April – 1 May 2025	Well-led	UHB Trust-level Assessment

All final reports for the CQC inspections that took place in Q4 2024/25 and Q1 2025/26 have been published, including the Well-Led inspection report. The outcomes are summarised in the table below:

Date of inspection	Site	Core Service	Publication date	Overall Rating 2025
25-26 February 2025	GHH	Urgent and Emergency Care	21/08/2025	Requires Improvement
25-26 February 2025	GHH	Medical Care including care for older people	21/08/2025	Requires Improvement
25-26 February 2025	GHH	Children and Young People	21/08/2025	Good
4-5 March 2025	BHH	Urgent and Emergency Care	28/08/2025	Requires Improvement
4-5 March 2025	BHH	Children and Young People	28/08/2025	Good
18-19 March 2025	SOH	Outpatients Department	18/07/2025	Outstanding
19-20 March 2025	QEH	Urgent and Emergency Care	22/08/2025	Requires Improvement
19-20 March 2025	QEH	Surgical Care	22/08/2025	Requires Improvement
24-26 March 2025	GHH	Maternity Services	21/08/2025	Requires Improvement
10 April 2025	Community	Runcorn Road Dialysis	06/08/2025	Outstanding
28 April 2025	Community	Castle Vale Dialysis	06/08/2025	Good
29-30 April	BHH	Maternity Services	28/08/2025	Requires Improvement
29 April – 1 May 2025	UHB Trust-level Assessment	Well-led	29/08/2025	Good

Overall Trust Rating

	Well-led
Trust Overall	Good

Ratings for Core Services by Site, for inspections during 2024/25 and 2025/26

Birmingham Heartlands Hospital (BHH)

	Safe	Effective	Caring	Responsive	Well-led	Overall
Maternity	Inadequate (March 2025)	Requires Improvement (April 2025)	Good (April 2025)	Requires Improvement (April 2025)	Requires Improvement (April 2025)	Requires Improvement (April 2025)
Children & Young People	Requires Improvement (March 2025)	Good (March 2025)	Good (March 2025)	Good (March 2025)	Good (March 2025)	Good (March 2025)
Urgent & Emergency Care	Requires Improvement (March 2025)	Good (March 2025)	Good (March 2025)	Requires Improvement (March 2025)	Good (March 2025)	Requires Improvement (March 2025)
Overall	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated

Good Hope Hospital (GHH)

	Safe	Effective	Caring	Responsive	Well-led	Overall
Maternity	Requires Improvement (March 2025)	Good (March 2025)	Good (March 2025)	Requires Improvement (March 2025)	Requires Improvement (March 2025)	Requires Improvement (March 2025)
Medical Care (including older people)	Requires Improvement (February 2025)	Requires Improvement (February 2025)	Good (February 2025)	Requires Improvement (February 2025)	Good (February 2025)	Requires Improvement (February 2025)
Children & Young People	Requires Improvement (February 2025)	Good (February 2025)	Good (February 2025)	Good (February 2025)	Good (February 2025)	Good (February 2025)
Urgent & Emergency Care	Requires Improvement (February 2025)	Good (February 2025)	Good (February 2025)	Requires Improvement (February 2025)	Good (February 2025)	Requires Improvement (February 2025)
Overall	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated

Solihull Hospital (SoH)

	Safe	Effective	Caring	Responsive	Well-led	Overall
Outpatients	Good (March 2025)	Good (March 2025)	Outstanding (March 2025)	Good (March 2025)	Outstanding (March 2025)	Outstanding (March 2025)
Overall	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated

Queen Elizabeth Hospital (QEH)

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Requires Improvement (March 2025)	Good (March 2025)	Good (March 2025)	Requires Improvement (March 2025)	Good (March 2025)	Requires Improvement (March 2025)
Urgent & Emergency Care	Requires Improvement (March 2025)	Good (March 2025)	Good (March 2025)	Requires Improvement (March 2025)	Requires Improvement (March 2025)	Requires Improvement (March 2025)
Overall	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement	Requires Improvement

Community Services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Castle Vale Renal Unit	Good (April 2025)	Good (April 2025)	Outstanding (April 2025)	Good (April 2025)	Good (April 2025)	Good (April 2025)
Runcorn Road Dialysis Unit	Good (April 2025)	Good (April 2025)	Outstanding (April 2025)	Outstanding (April 2025)	Good (April 2025)	Good (April 2025)
Overall	Outstanding					

2.2.5 Information on the quality of data

Secondary Uses Service data

UHB submitted records during 2025/26 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

Which included the patient's valid NHS Number was:
- 100% for admitted patient care (April 2025 – March 2026)
- 100% for outpatient care (April 2025 – March 2026)
- 99% for accident and emergency care (April 2025 – March 2026)

Which included the patient's valid General Medical Practice Code was:
- 100% for admitted patient care (April 2025 – March 2026)
- 100% for outpatient care (April 2025 – March 2026)
- 100% for accident and emergency care (April 2025 – March 2026)

Percentages are as at currently available National data.

Data Security & Protection Toolkit

The Trust has achieved an overall status from NHSE of 'Standards Met' for the DSPT v7 in June 2025.

Payment by Results clinical coding audit

UHB was not subject to the Payment by Results clinical coding audit during 2025/26 by the Audit Commission.

(Note: the Audit Commission has now closed and responsibility now lies with NHS Improvement).

Clinical Coding Audits

All of the targets are being met in clinical coding for 2025/26. The figures for primary and secondary diagnoses and procedures met expectations in line with the audit assurance levels.

Errors in the assignment of ICD-10 and OPCS-4 codes affecting accuracy were due to:
- omission of 38 diagnoses and 43 procedures
- incorrect code assignment at three, four and five category level affecting 44 diagnoses and 19 procedures
- 46 secondary diagnoses coded to management specification.

A total of 2237 FCEs were audited. Of which:
- 183/200 – 92% of primary diagnosis were correct.
- 1408/1528 – 92% of secondary diagnosis were correct.
- 124/133 – 93% of primary procedures were correct.
- 321/376 – 85% of secondary procedures were correct.

Table: Trusts performance against coding standards 2025/26.

	Q1% 2025/26	Q2% 2025/26	Q3% 2025/26	2025/26 Full Year	Required Standard
Primary Diagnosis	96%	92%	94%	92%	>=90%
Secondary Diagnosis	94.6%	96.4%	85.5%	92%	>=80%
Primary Procedure	93.1%	90.1%	97%	93%	>=90%
Secondary Procedure	97.5%	93.7%	85%	85%	>=80%

UHB will be taking the following actions to improve data quality (DQ):

The Data Quality Issues Group (DQIG) are responsible for monitoring and recording data quality issues identified within the organisation. The issues are prioritised via the DQIG. Action plans for prioritised areas are created, maintained, and managed through the DQIG. There are 10 active issues and 69 resolved issues to date. A DQIG sub group is now in place also which is a meeting to discuss any issues identified by ward clerk and ED receptionists site teams.

There are 4 high priority issues being addressed at DQIG:
- Non deceased patients on PICS
- Missing / Late cashed up activity
- Outpatients with Unusual HRG
- Community Services Data Quality

Ward clerk and ED reception teams routinely monitor quality of data entry through a routine series of quality monitoring checks carried out by the ward clerk site teams across the QEH and SOL sites

Site	Month	Indicator Checks Completed	Errors	% Accuracy	Target
QEHB	April 2025 – March 2026	22,350	756	96.61%	>=95%
SH	April 2025 – March 2026	5250	182	96.53%	>=95%
BHH	April 2025 – March 2026	16,728	1038	93.79%	>=95%
GHH	April 2025 – March 2026	6872	340	95.00%	>=95%

The trust monitors the national Data Quality Maturity Index (DQMI) across all eligible CDS returns (A&E, Inpatient, Outpatient, Maternity, Community). This is routinely reviewed as part of the trust Data Quality Improvement Group.

Health Informatics have created the PowerBI reports listed below to enable a drill down into the DQMI indicators. These are reviewed by the Health Informatics compliance team and can be made available to users throughout the Trust as required. Each report has a drill down facility to enable users to identify any areas of concern.

1. Community Data Quality Report
2. Potential Lost to Follow-Up Report
3. Waiting List Data Quality Markers
4. RTT Data Quality Metrics
5. Inpatient Waiting List Data Quality Metrics

The Clinical Coding team carry out the DSPT (Data Security and Protection Toolkit) audit that is required annually. This is an audit of 200 FCEs (Finished Consultant Episodes) and is carried out by the Trust's internal clinical coding auditor. The DSPT audit results will be reported back to the Trust's DQIG and IGG as required.

The Informatics service are expecting DSPT audits in clinical coding and National Data Opt Out (NDOO) / pseudonymisation. The NDOO Audit report for Q3 (April 25 - December 25):

- 20 records were audited by the group for April 2025 – December 2025
- Of the 20 records 11 needed further investigating, all had NDOO correctly applied

The next NDOO meeting is to take place in May 2026 for Q4 results. Informatics Standard Operating Procedures outlining technical processes for Pseudonymisation / National Data opt Out are currently in place.

In order to ensure compliance with requirements, an audit group has been set up involving Heads of Research Governance, Clinical Governance & Patient Safety, Health Informatics, Directors of Health Research, & Research Governance Manager to look at data requests via LANDesk where NDOO had been applied to check for correctness.

The Trust Deputy CMO is also commencing a review and discussion the process for requesting research data / audit data is also being which may impact upon the work above (timescales to be confirmed), including replacement for approval and tracking systems (e.g. CARMS).

A programme of continuous improvement audits on Clinical Coding is in place, and monthly audits take place. These audits are at individual coder level and by specialty / diagnosis / procedure as required. Quarterly audit updates will be provided to the CMO. Annual reports are provided as part of the DSPT requirements, and updates are routinely provided through the trust Data Quality Improvement Group (DQIG) and Data Strategy & Governance Group (DSGG).

The Trust's internal Clinical Coding trainer delivers the following training: Coding Standards, Refresher and Exam Revision using NHS Digital approved material, Classification Updates, ad hoc issues that arise from validation and audit.

Clinical Coding reports are in place to ensure quality of coding is maintained and continually approved - examples include HED Report, MHA, SHMI, Palliative Care and the Sepsis Dashboard.

Short-term depth of coding issues now resolved. Latest depth of coding report indicates UHB remains having high coding depth, with 2nd highest depth in west midlands trusts, and 5th highest in Shelford group (with minimal gap to highest providers).

2.2.6 Learning from Deaths

UHB currently has a team of Medical Examiners who are required to review the vast majority of inpatient deaths. The role includes reviewing medical records and liaising with bereaved relatives to assess whether the care provided was appropriate and whether the death was potentially avoidable.

Any death where a concern has been raised by the Medical Examiner is escalated for further review, either to a specialty mortality & morbidity meeting, to the Clinical Governance for review or managed via the Trust's Patient Safety Incident Response Plan (PSIRP). The outcomes of reviews are reported to each of the four main Site Quality and Safety meetings for oversight, and published in the Trust's annual Learning from Deaths report. Assurance of the process is via the Trust's Mortality and Morbidity Review Committee, Group Clinical Quality Meeting (GCQM) and the Clinical Quality and Patient Safety Committee of Trust Board.

The UHB Medical Examiner Service restructure and recruitment has been completed in line with statutory requirements and the National Medical Examiner Framework. The statutory date for the Medical Examiners service was announced as 9th September 2024; provision of Medical Examiners service to community providers undertaken via a phased approach as we have multiple types of organisations to engage with across over 200 sites. Acute cases are scrutinised by Medical Examiners and recorded on an in-house database. Any concerns arising from these reviews are escalated up through Governance and assigned a further level of investigation appropriate to the concerns. Plans for escalation and reporting of community cases through the ICB governance team are still in discussion.

1.	During 2025/26, 5188 UHB inpatients died. This comprised the following number of deaths which occurred in each quarter of that reporting period: ▸ 1274 in the first quarter; ▸ 1232 in the second quarter; ▸ 1371 in the third quarter; ▸ 1311 in the fourth quarter
2.	For deaths occurring up to end March 2026, 4296 case record reviews have been carried out in relation to 5188 of the deaths included in item 1. In some cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review was carried out was: ▸ 854 in the first quarter; ▸ 1060 in the second quarter; ▸ 1210 in the third quarter; ▸ 1173 in the fourth quarter
3.	27 deaths, representing 0.6% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter, this consisted of: ▸ 7 representing 0.8% for the first quarter; ▸ 5 representing 0.5% for the second quarter; ▸ 5 representing 0.4% for the third quarter; ▸ 7 representing 0.6% for the fourth quarter
4.	As part of every investigation a detailed report that includes all learning points and an in-depth action plan is produced. Each investigation can produce a number of recommendations and changes, and each individual action is specifically designed on a case by case basis to ensure that the required changes occur. The implementation of these actions and recommendations is robustly monitored to ensure ongoing compliance. Actions are varied and may include changes to, or introductions of, policies and guidelines, changing systems or changing patient pathways. Similarly, the outcomes of every case record review are monitored and ongoing themes and trends are reported and escalated as required to ensure any and all required changes are made.
5.	As described in item 4, each investigation involves the creation of a detailed, thorough action plan which will involve numerous actions per investigation. These actions are specifically tailored to individual cases and monitored on an on-going basis to ensure the required changes have been made. Examples are provided in the quarterly Learning from Deaths report.
6.	All actions are monitored to ensure they have had the desired impact. If this has not happened, actions will be reviewed and altered as necessary to ensure that sustainable and appropriate change has been implemented.
7.	No case record reviews and no investigations completed after 31st March 2026 related to deaths which took place before the start of the reporting period.
8.	None of the patient deaths before the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. These numbers have been obtained based on the findings of thorough, independent investigations of all deaths considered potentially avoidable after case record review, using recognised root cause analysis tools and a human factors perspective.
9.	No patient deaths during 2024/25 were subsequently reviewed and judged to be more likely than not to have been due to problems in the care provided to the patient.

3 Part 3: Other information

3.1 Overview of quality of care provided during 2025/26

Awaiting full year update for 1a, 1b, 2a, 2b, 5a and 5b once nationally published data is available in July 2026.

The tables below show the Trust's latest performance for 2025/26 and the last two financial years for a selection of indicators for patient safety, clinical effectiveness and patient experience.

The latest available data is shown below and has been subject to the Trust's usual data quality checks by the Health Informatics team. Benchmarking data has also been included where possible.

Indicator	Data source	2023/24	2024/25	2025/26	Peer Group Average (where available)
Patient Safety Indicators					
1a. Patients with MRSA infection / 100,000 bed days Includes all bed days from all specialties › Lower rate indicates better performance	› Trust MRSA data reported to PHE, HES data (bed days)	**0.833**	**1.210**	**0.602** (Apr-Jan)	**0.889** Acute trusts in West Midlands
1b. Patients with MRSA infection / 100,000 bed days Aged >15, excluding elective orthopaedics › Lower rate indicates better performance	› Trust MRSA data reported to PHE, HES data (bed days)	**0.870**	**1.262**	**0.627** (Apr-Jan)	**0.946** Acute trusts in West Midlands
2a. Patients with C. difficile infection / 100,000 bed days Includes all bed days from all specialties › Lower rate indicates better performance	› Trust CDI data reported to PHE, HES data (bed days)	**28.85**	**31.15**	**29.81** (Apr-Jan)	**21.23** Acute trusts in West Midlands
2b. Patients with C. difficile infection / 100,000 bed days Aged >15, excluding elective orthopaedics › Lower rate indicates better performance	› Trust CDI data reported to PHE, HES data (bed days)	**30.12**	**32.49**	**31.03** (Apr-Jan)	**22.59** Acute trusts in West Midlands
3a. Patient safety incidents Reporting rate per 1000 bed days › Higher rate indicates better reporting	› Datix (incident data), Bed days data	**65.2**	**60.9**	**65.3**	Not available
3b. Never Events Number of Never Events that been reported on STEIS during the time period › Lower number indicates better performance › Figures for 2023/24 are based on nationally published data (as at time of writing)	› Datix (incident data)	**12**	**13**	**10**	Not available

Indicator	Data source	2023/24	2024/25	2025/26	Peer Group Average (where available)
Patient Safety Indicators					
4a. Percentage of patient safety incidents which are no harm incidents › Higher % indicates better performance	› Datix (incident data)	**79.79%**	**70.42%**	**66.99%**	**64.19%**
4b. Percentage of patient safety incidents reported to the National Reporting and Learning System (NRLS) resulting in severe harm or death › Lower % indicates better performance	› Datix (patient safety incidents reported to the NRLS)	**0.36%**	**0.36%**	**0.39%**	**1.01%**
4c. Number of patient safety incidents reported to the National Reporting and Learning System (NRLS)	› Datix (patient safety incidents reported to the NRLS)	**48,989**	**56,372**	**54,708**	Not applicable
Clinical Effectiveness Indicators					
5a. Emergency readmissions within 28 days (%) Elective and emergency admissions aged >17 › Lower % indicates better performance	› HED data	**14.79%**	**15.9%**	**15.46%** (Apr-25 to Oct -25)	**13.45%** (Apr-25 to Oct -25) Acute trusts in West Midlands
5b. Emergency readmissions within 28 days (%) All specialties › Lower % indicates better performanc	› HED data	**14.71%**	**15.05%**	**15.01%** (Apr-25 to Oct -25)	**13.21%** (Apr-25 to Oct -25) Acute trusts in West Midlands

Notes on patient safety & clinical effectiveness indicators

The data shown is subject to standard national definitions where appropriate. The Trust has also chosen to include infection and readmissions data which has been corrected to reflect specialty activity, taking into account that not all hospitals within the Trust undertake paediatric, obstetric, gynaecology or elective orthopaedic activity. These specialties are known to be very low risk in terms of hospital acquired infection, for example, and therefore excluding them from the denominator (bed day) data enables a more accurate comparison to be made with peers.

1a, 1b:

- Peer group figures are not final.

1a, 1b, 2a, 2b:

- These indicators use HES data for the bed days, as this allows trusts to benchmark against each other. UHB also has an internal measure of bed days which uses a different methodology, and this number may be used in other, similar, indicators in other reports.
- Receipt of HES data from the national team always happens two to three months later, these indicators will be updated in the next report.

3a:

- The NHS England definition of a bed day ("KH03") differs from UHB's usual definition. For further information, please see this link: http://www.england.nhs.uk/statistics/statistical-work-areas/bed-availability-and-occupancy/
- NHS England have also reduced the number of peer group clusters (trust classifications), meaning UHB is now classed as an 'acute (non specialist)' trust and is in a larger group. Prior to this, UHB was classed as an 'acute teaching' trust which was a smaller group.

3a, 4a, 4b, 4c:

- NRLS data (peer group data) is no longer being published by NHS England. Their website states "we have paused the annual publishing of this data while we consider future publications in line with the current introduction of the Learn from Patient Safety Events (LFPSE) service to replace the NRLS". Therefore the data provided is the latest available.

3b:

- This is based on incident date between 01 April 2025 and 31 March 2026 and reported to STEIS as per the published NHS Never Events data.

4c:

- The number of incidents shown only includes those classed as patient safety incidents and reported to the National Reporting and Learning System.

Patient experience indicators

The National Inpatient Survey is run by the Picker Institute on behalf of the Care Quality Commission (CQC); UHB's results for selected questions are shown below. Data is presented as a score out of 10; the higher the score for each question, the better the Trust is performing.

Time period	2022		2023		2024	
Data source	Trust's Survey of Adult Inpatients 2022 Report, CQC		Trust's Survey of Adult Inpatients 2023 Report, CQC		Trust's Survey of Adult Inpatients 2024 Report, CQC	
Patient survey question	Score	Comparison with other NHS trusts in England	Score	Comparison with other NHS trusts in England	Score	Comparison with other NHS trusts in England
Overall were you treated with respect and dignity	9.1	About the same	9.0	About the same	8.9	About the same
Involvement in decisions about care and treatment	6.8	About the same	7.0	About the same	7.0	About the same
Did staff do all they could to control pain	8.6	About the same	8.6	About the same	8.7	About the same
Cleanliness of room or ward	8.8	About the same	8.7	About the same	8.7	About the same
Overall rating of experience	7.8	About the same	8.0	About the same	7.9	About the same
Response rate	35% (422 respondents) National: 40%		35% (414 respondents) National: 42%		36% (415 respondents) National: 41%	

3.2 Performance against indicators included in the NHS Improvement Single Oversight Framework

Operational performance data against indicators in the NHS Oversight Framework is submitted within the Productivity and Performance report to the Board of Directors. Board papers are accessible on the UHB website for information - UHB Board of Directors papers. Performance against key indicators is summarised below:

Indicator	Target	Performance		
		2023/24	2024/25	2025/26
A&E: maximum waiting time of 4 hours from arrival to admission / transfer / discharge	95%	54.6%	61.2%	62.6%
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway	92%	47.5%	50.9%	68.6%
All cancers – maximum 62-day wait for first treatment from urgent suspected cancer referral, breast symptomatic referral, urgent screening referral or a consultant upgrade	85%	40.3%	41.3%	72.3%
Maximum 6-week wait for diagnostic procedures	99%	62.0%	72.4%	59.6%

3.3 Mortality

Awaiting full year update once nationally published data is available in July 2026.

The Trust continues to monitor mortality as close to real-time as possible with senior managers receiving daily emails detailing mortality information and on a longer term comparative basis via the Trust's Group Clinical Quality Meeting. Any anomalies or unexpected deaths are promptly investigated with thorough clinical engagement.

The Trust has not included comparative information due to concerns about the validity of single measures used to compare trusts.

Measure	Value	Data period
SHMI, calculated by UHB Informatics	91.91 – within tolerance	2025/26 (April-25 – October-25)
SHMI, from NHS Digital website	93.05 - within tolerance	2024/25 (Apr-24 – August-25)
HSMR, calculated by UHB Informatics	88.88 - within tolerance	2025/26 (April-25 – November-25)

SHMI: Summary Hospital-level Mortality Indicator

NHS Digital first published data for the Summary Hospital-level Mortality Indicator (SHMI) in October 2011. This is the national hospital mortality indicator which replaced previous measures such as the Hospital Standardised Mortality Ratio (HSMR). The SHMI is a ratio of observed deaths in a trust over a period time divided by the expected number based on the characteristics of the patients treated by the trust. A key difference between the SHMI and previous measures is that it includes deaths which occur within 30 days of discharge, including those which occur outside hospital.

The SHMI should be interpreted with caution as no single measure can be used to identify whether hospitals are providing good or poor quality care . An average hospital will have a SHMI around 100; a SHMI greater than 100 implies more deaths occurred than predicted by the model but may still be within the control limits. A SHMI above the control limits should be used as a trigger for further investigation.

HSMR: Hospital Standardised Mortality Ratio

NHS England / Improvement have decommissioned the HSMR, so UHB no longer includes it in the Quality Account. UHB continues to robustly monitor mortality in a variety of ways as detailed above.

3.4 Statement regarding resident doctor rota

The Guardian of Safe Working (GSW) is responsible for overseeing the Resident Doctors' Exception Reporting (ER) process. The purpose of ER is to ensure prompt resolution and/or remedial action to ensure that safe working hours are maintained and work schedule remain fit for purpose. ER can be submitted where there are significant variations from the agreed work schedule (rota template), including, but not limited to:

- differences in hours of work (including opportunities for rest breaks)
- the work pattern itself
- educational opportunities and support available to the doctor
- differences in the support available during service commitments

ER was rolled out to locally-employed doctors (LEDs) at UHB in August 2024, which allows for equal access to ER for all resident doctors working at UHB. The figures for April 2025 – March 2026 are as below.

Trends and themes in ER across specialties and sites are reviewed in the Guardian exception reporting review group (GERRG), and actions are identified to address any issues.

Rota Gaps / Vacancies

Rota	No. of Gaps	Issue Resolutions/ Management	Other Issues	Comments
BHH Medicine	3	Backfilled with LEDs	N/A	N/A
General Surgery	0	N/A	N/A	N/A
Obs & Gynae	2x Reg gaps	Covered by ad-hoc locums and consultants stepping down	N/A	N/A
GHH Medicine	11	Locum for on-calls when below shortfalls	N/A	N/A
Emergency Medicine	20	Only cover ad-hoc shifts, where minimum shift numbers are not met on daily rota - we do not fill whole rota slots with LT locums, as all shifts are not always required.	10 LTFT	N/A

Exception Reporting Data:

	QEHB	BHH	GHH	SOL	TOTAL
TYPE					
Hours	89	88	58	0	235
Educational	10	10	1	0	21
Pattern	22	11	3	0	36
Service support	33	4	6	0	43
Total	154	113	68	0	335
OUTCOME					
Toil	39	57	36 (inc 1 educational opportunity reinstated)	0	132
Payment	58	28	24	0	110
No further action	48	17	8	0	73
Pending (STATE)	1	9	0	0	10
Request for more info	0	0	0	0	0
Prospective changes	8	2	0	0	10
Total	154	113	68	0	335
GSW FINE					
	9	6	0	0	15
ISC					
	14	6	4	0	24

3.5 Freedom to Speak Up

UHB's Freedom to Speak Up Guardian is supported by two deputies and 37 Confidential Contacts and Champions across the Trust who provide additional points of contact for raising concerns.

Staff can contact the Freedom to Speak Up Guardian and the Confidential Contacts using a 24/7 telephone line, a dedicated email address, and an internal webpage with further direct contact information for the Guardian and confidential contacts.

The Freedom to Speak Up Guardian meets quarterly with the Chief Executive, Chief Medical Officer, Chief Nurse and Chief People Officer to present a summary of contacts (anonymised where required) and to discuss specific issues requiring the attention of the Trust leadership. The Guardian reports formally twice a year to the Trust Board and to the Governors, attends and reports to the People and Culture Committee, and meets four-monthly with the Chair of the Trust Board.

A summary of concerns raised via the Freedom to Speak Up process are also reported quarterly to the National Guardian's Office based at the Care Quality Commission, which allows national data to be collated on the sources and types of concerns being raised.

The Freedom to Speak Up Guardian process has an existing reporting and governance process as a statutory function and is no longer reported in the Quality Account.

Annex 1: Statements from commissioners, local Healthwatch organisations and Overview and Scrutiny Committees / Boards

The Trust has shared its 2025/26 Quality Account with:

- NHS Birmingham and Solihull Integrated Care Board (ICB)
- Birmingham and Solihull Joint Health Overview and Scrutiny Committee (JHOSC)
- Healthwatch Birmingham and Solihull

These organisations have provided the statements below.

Statement of the Chairs of the Birmingham and Solihull Joint Health Overview and Scrutiny Committee (JHOSC) for 2025-26

We welcome this opportunity to submit the following statement, as Chairs of the Birmingham and Solihull Joint Health Overview and Scrutiny Committee (JHOSC) for 2025-26, setting out the reporting to the local Scrutiny function during this period:

Performance Reporting:

Over the course of the year, the Birmingham and Solihull Joint Health Overview and Scrutiny Committee (JHOSC) considered performance reporting relating to the Trust. The Birmingham and Solihull (BSol) Integrated Care Board (ICB) Delivery vs Plan Update reports were reviewed at each JHOSC meeting, providing a summary of the latest position of the BSol system against a range of key national targets set out in the NHS plans for 2025/26.

At the initial JHOSC meeting in July, Members were informed how Urgent and Emergency Care faced pressures, with the increased number of ambulances demand into BSOL. It was reported this was due to the ceasing of Intelligent Conveying to other boundaries, the decommissioning of winter wards over the summer and general demand increasing. Plans were being put in place to mitigate further the bed occupancy at UHB. Also, Winter planning had commenced and would be stressed tested during August, with all stakeholders contacted, in order to participate in plans.

Further actions to support Urgent and Emergency Care performance were reported to the JHOSC during the year, which included increasing the utilisation of Urgent Treatment Centre (UTC) capacity, enhancement of GP Out of Hours Services, as well as a programme of improvement work for hospital discharges.

Again, at the July meeting, Members took account of how the target for Cancer 62 day delivery was challenging and performance was below the monthly plan. At this meeting Members were informed how a visit by the national cancer team had taken place the previous month and recommendations had been fed into UHB and shared with the ICB. Further actions to improve cancer performance were reported during the year, which included the successful undertaking of a Cancer Bus Tour, with over 350 health checks completed. Also, a bid was submitted to support further screening promotion for bowel cancer in challenged communities.

At the March meeting of the Birmingham Health Scrutiny Committee, Jonathen Brotherton, CEO of University Hospitals Birmingham NHS Foundation Trust gave a progress update to Members. Members were encouraged to hear that UHB had demonstrated improvements in 11 of 12 services in the most recent Care Quality Commission inspection. The Committee was informed that two services were rated as outstanding and four rated as good. The Committee was also positively informed that the proportion of patients waiting for care in excess of the 18-week standard had reduced significantly, and UHB had some of the shortest waiting time for care in the region. This was of particular importance for the Committee, as patients had consistently highlighted waits for care as an issue.

Members noted from the presentation that UHB still needed to make improvements in the delivery of urgent and emergency care, which was a complex and system wide issue across health and social care, and that delivering cost savings of 5.5% was a key challenge for UHB.

Members were informed that UHB's ability to deliver the current level of service in the future was a key challenge for UHB and this would require transformational activity, including the re-design of clinical administration services, the redesign of corporate services, and the modernisation of outpatient services.

Quality Oversight Reporting - Care Quality Commission inspection:

In November, the JHOSC received a paper that updated on the outcomes of the Care Quality Commission (CQC) inspections at UHB, conducted earlier in the year, as part of the Well-Led inspection framework.

The report outlined that thirteen core services were reviewed overall, with no immediate concerns identified during the inspection. Also, that the Trust had made significant improvements in leadership, culture, governance and staff wellbeing – the CQC report published in August confirmed a significant improvement in the Trust's leadership rating—from 'Inadequate' following the 2023 inspection, to 'Good'.

Members also raised queries on the actions being taken in relation to the areas requiring improvement. This included staffing and governance concerns for Medical Services at GHH, with a Section 29A warning notice issued. Also, staff experience overall, with some staff still reporting bullying, intimidation and fear of speaking up.

Members were also informed of the CQC findings for UHB maternity services – both Birmingham Heartlands Hospital (BHH) and Good Hope Hospital (GHH) maternity services overall were now rated 'Requires Improvement.' However, BHH maternity services CQC rating for Safe remained 'Inadequate'. As part of the paper, Members were updated on the delivery of UHB Maternity improvements.

Review of Urgent Treatment Centre provision across Birmingham and Solihull:

At its July and November meetings the BSol JHOSC received reporting on the UTC Review process undertaken to date. Members were informed how the Urgent Treatment Centres (UTCs) across Birmingham and Solihull were providing a variable and inconsistent service provision, with no single overarching model of care/delivery. Also, the current UTC provision in Birmingham and Solihull did not fully meet the principles and standards set out in NHS England's national UTC guidance. The aim of the review was to create a future model that met national standards, reflected the needs of our populations and ensure a consistent and standardised approach.

The reporting allowed Members to take account of the pre-consultation engagement undertaken, including with Healthwatch, NHS Staff, Political Stakeholders. Also, the findings of VCFSE organisations, who were commissioned to engage with seldom heard communities.

The reporting and findings enabled the Scrutiny Committee to formally agree that the review of the future provision of UTC services in Birmingham and Solihull should be deemed as "substantial variation" in services, triggering the duty to undertake formal consultation.

Further engagement and reporting from BSol ICB allowed the Scrutiny Committee to consider and input to arrangements for the consultation. This included taking account of key stakeholder and audience groups. Also, different consultation channels and methods, including surveys, social media and engagement events. The role of the VCFSE sector, as well as ensuring accessibility, were also considered.

Members appreciated the considerable work that has gone into developing this project and agreed that, subject to timelines, the JHOSC will review the consultation outcomes and scrutinize the final decision making process after the consultation closed.

Statement of Healthwatch Birmingham and Solihull

Thank you for sharing the draft Quality Account and for involving us in the process. We recognise the statutory importance of Quality Accounts and the work involved in preparing them.

At present, our Board approved work programme and statutory priorities do not allow us to undertake formal review or provide organisational comment on Quality Accounts.

For this reason, we will not be able to contribute comments on this occasion. This should not be taken as a reflection on the document or the work of the Trust.

Statement of NHS Birmingham and Solihull Integrated Care Board (ICB)

Birmingham and Solihull Integrated Care Board (ICB) as coordinating commissioner for University Hospitals Birmingham, welcomes the opportunity to provide this statement for inclusion in the Trusts 2025/2026 Quality Account.

A draft copy of the Quality Account was received by the ICB on 1st May 2026, and the review has been undertaken in accordance with the Department of Health and Social Care Guidance. This statement of assurance has been developed from the information provided to date.

The information provided within this account presents a balanced report of the healthcare services that University Hospital Birmingham provides. The report demonstrates the progress made by the Trust against the 2025/2026 priorities. It identifies what the organisation has done well, where further improvement is required and what actions are needed to achieve these goals and the priorities set for 2026/2027.

We have worked closely with University Hospital Birmingham over the course of 2025/2026 working collaboratively to review the organisations' progress in implementing its quality improvement initiatives. We are committed to continuing to engage with the Trust in an inclusive and innovative manner and hope to continue to build on these relationships as we move forward into 2026/2027.

Annex 2: Statement of directors' responsibilities for the quality report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare quality accounts for each financial year.

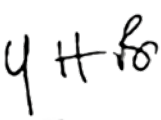
NHS England has issued guidance to NHS foundation trust boards on the form and content of annual Quality Accounts (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the Quality Account.

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

- the content of the Quality Account meets the requirements set out in the NHS foundation trust annual reporting manual 2019/20 and supporting guidance Detailed requirements for Quality Accounts 2019/20
- the content of the Quality Account is not inconsistent with internal and external sources of information including:
  - board minutes and papers for the period: April 2025 to March 2026
  - papers relating to Quality Account to the board over the period: April 2025 to March 2026
  - feedback from the commissioners dated: 13/05/2026
  - feedback from local Healthwatch organisations: 12/05/2026
  - feedback from Overview and Scrutiny Committee dated 12/05/2026
  - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009: Date to be added once received.
  - the 2024 national patient survey
  - the Head of Internal Audit's annual opinion of the trust's control environment: Date to be added once received.
  - CQC inspection reports dated: GHH Inspection Report 21/08/2025. BHH Inspection Report 28/08/2025. SH Inspection Report 18/07/2025. QEH Inspection Report 22/08/2025. Community Inspection Report 06/08/2025. Well Led Inspection Report 29/08/2025.
- the Quality Account presents a balanced picture of the NHS foundation 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.
- the Quality Account has been prepared in accordance with NHS England's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Account.

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

By order of the board

Date: 4 June 2026 Signed  Chair

Date: 4 June 2026 Signed  Chief Executive

Annex 3: Independent Auditor's Report on the Quality Account

NHS England and NHS Improvement has advised that trusts' external auditors are not required to provide assurance on the 2025/26 Quality Accounts.