University Hospitals Birmingham
NHS Foundation Trust

Quality Account 2024/25

This report covers the period 1 April 2024 to 31 March 2025

2024/25 Quality Account

Contents

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 2025/26.

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 2024/25, we have sought to deliver care in accordance with our quality priorities.

Some of our key achievements over the past year include:

- We transitioned to the new patient safety incident response framework in November 2023. We continue to work with our quality leads across the Trust, as well as our patient safety partners, to implement our Trust Patient Safety Incident Response Plan, and improvement plans aligned to our patient safety priorities.
- We have launched the Listen Learn Share initiative in March 2025, which encourages us all to actively listen to our patients and colleagues, learn from their experiences, and share our insights to improve care. The concept fosters a culture of openness and collaboration, where every voice is valued, and everyone feels empowered to speak up about concerns and share their ideas. It also helps us identify and address potential issues before they become serious problems, ensuring that patient safety remains our top priority.
- 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 strategy for 2024-29, to demonstrate our commitment to understanding and addressing the complex issues which lead to inequalities in healthcare.
- 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 have successfully implemented our new incident reporting system, Radar, in July 2024, which has allowed the Trust to focus on identification of themes, trends and system issues when incidents are reported. Radar helps us take a fresh approach and put our excellence and good care events in the same place as incidents, so all safety events are together to ensure we learn from events that can either go wrong or go well. We continue to optimise the system to further improve the safety and quality of care for our patients, including implementation of additional modules such as Mortality and Morbidity.
- 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 2025/26.

On the basis of the processes the Trust has in place for the production of the Quality Account, I can confirm that to the best of my knowledge the information contained within this report is accurate.

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 2023/24 Quality Account set out four priorities for improvement during 2024/25;

1. Improving VTE prevention
2. Improving standards around discharge (previously improving ward rounds)
3. Improving nutrition and hydration
4. Improving the safety of invasive procedures

For 2025/26 the Chief Medical Officer and Chief Nurse have agreed that the existing improvement priorities will be incorporated within the following overarching priorities; this was confirmed at the Group Clinical Quality Meeting (GCQM):

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

The approach for 2025/26 is to ensure the quality priorities reflect the breadth of work within the Trust's PSIRF Plan and supports the recently launched Trust Strategy for 2024-29. The priorities for 2025/26 will also apply to all our patients across all of our sites, including emergency, outpatients, community, inpatients and virtual wards. 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 recently appointed three Associate Medical Directors for Health Inequalities who will work with Informatics on the development of equality indicators as part of patient safety priorities and other quality indicators.

Priority 1: Improving VTE prevention

Background

Venous thromboembolism (VTE) is the term used to describe deep vein thrombosis (blood clot occurring in a deep vein, most commonly in the legs) and pulmonary embolism (where such a clot travels in the blood and lodges in the lungs). VTE is associated with periods of immobility such as when a patient is in hospital. VTE can either develop during a patient's hospital stay or after they have left hospital.

The Trust has chosen to focus on reducing the number of hospital-associated thromboses (blood clots) because they cause considerable harm to patients and can often be avoided if appropriate preventative measures are taken. Preventative measures usually include compression stockings and/or prophylactic medication to reduce the risk of blood clots forming. It is important to note that these preventative measures do not reduce the risk to zero; a few patients will still go on to develop VTE even when all appropriate measures have been taken.

The Trust uses an electronic VTE risk assessment tool within its Prescribing Information and Communication System (PICS) for inpatients. The tool provides tailored advice regarding preventative treatment based on the assessed risk.

Preventable hospital acquired thrombosis is part of the High Risk Medications Trust Patient Safety Priority (PSP).

PSPs are reported to the Group Clinical Quality Meeting (GCQM), jointly chaired by the Chief Medical Officer and Chief Nurse.

Improvement priority and progress during 2024/25

Reviews of hospital associated thromboses are ongoing and are undertaken by a specialist nurse and thrombosis Consultant. The lower limb immobilisation pathway has been developed.

An education matrix has been created looking at the various staff groups, including identification of ward-based champions and audits of patient information provision.

Progress is monitored via reporting of various indicators that are now available on a PowerBI scorecard.

As of 1st April 2024, NHS England re-instated the Venous Thromboembolism (VTE) Risk Assessment data collection. Due to substantial changes with the information systems within the Trust, the Trust informatics department are working alongside clinical leads to re-establish data feeds for the collection of this data. The Trust is working to define the cohort approach to this data:

- Elective patients under 24 hours
- Emergency patients under 24 hours
- Elective patients under 24 hours, no procedure
- Emergency patients under 24 hours, no procedure
- Maternity

Informatics continue to meet with VTE leads to review and validate the indicators. Once indicators are validated, Informatics develop additional indicators including Statistical Process Control (SPC) charts.

The indicators are available at Trust, Site, and CDG level, and include data on:

- AES prescription completed within 6h of recommendation (location and specialty level)
- AES prescriptions paused (location)
- Enoxaparin completed within 14h of recommendation (location and specialty level)
- LMWH (enoxaparin) recommended and administered within 24h (location)
- Missed Enoxaparin (%)
- Thrombosis form completed (specialty)
- Thrombosis form completed within 14 hr (location and specialty level)
- Thrombosis form completed within 24 hr (location and specialty level)
- Enoxaparin prescriptions paused (location)
- Patient unable to give history/no clinical information (location and specialty level)

Targets for all indicators are being met, with the exception of Missed Enoxaparin. The target is 6% or lower, and the Trust's compliance is currently 9.78%.

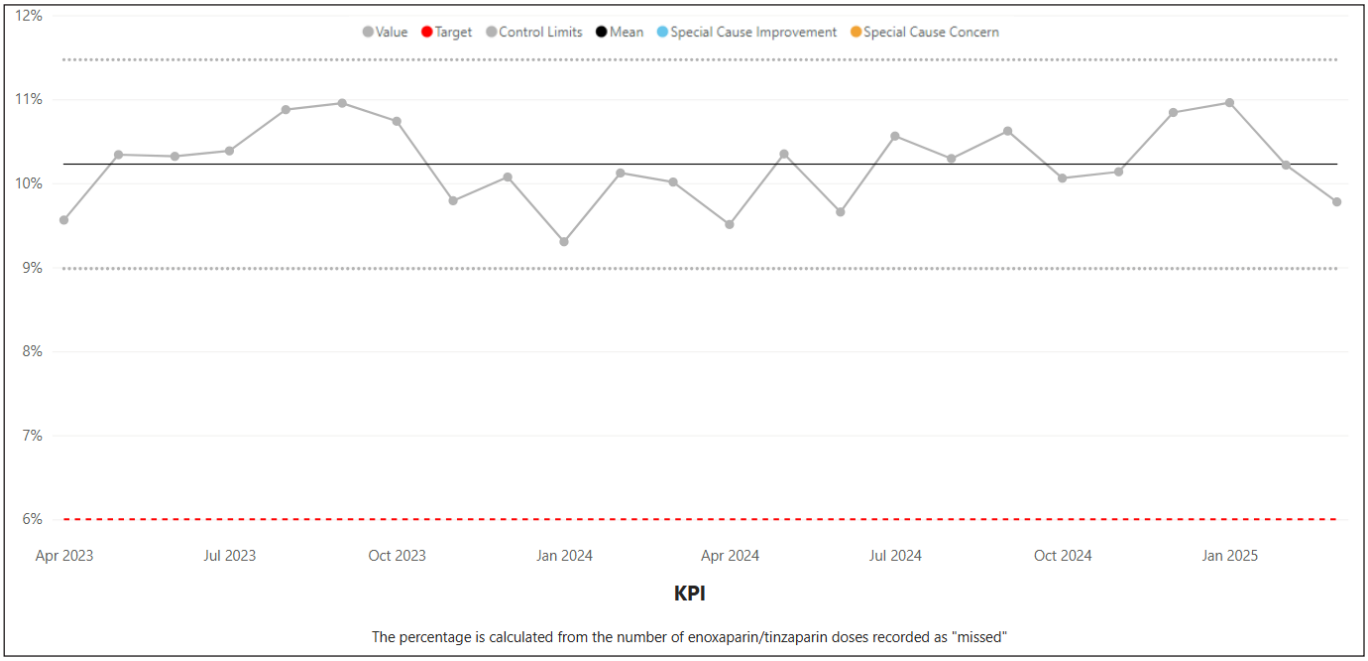


Figure 1: Missed enoxaparin data for the Trust has consistently sat above the 6% target.

Due to recent evidence suggesting that anti-embolism stockings may not provide additional benefit when used in conjunction with low molecular weight heparin, the group are reconsidering their use within the Trust, when not otherwise indicated, for medical patients.

Priority 2: Improving standards around discharge (previously improving ward rounds)

Background

This priority is about improving the consistency and effectiveness of ward rounds and improvements in discharge.

This priority is reported to the Operational Delivery Board, chaired by the Chief Operating Officer, via the Enabler Groups.

There is an expectation that senior leadership on all sites will ensure that regular progress reports are being reviewed and acted on in order to improve safer more efficient discharges at individual ward level.

Improvement priority and progress during 2024/25

- "Home of Discharge" has been developed which contains information for staff on discharge processes as well as standards for board rounds and ward rounds. The rollout of the "Home of Discharge" has been paused. User testing with three wards at Heartlands Hospital has been completed. User feedback has been collected and there continue to be discussions with Hospital Sites regarding the effectiveness of the tool.
- To continue to emphasise the importance of the quality of ward rounds as this impacts on discharge planning and other aspects of patient care.
- "Your Day", a system that gives information to patients on what they can expect during their day on the ward, has been updated following site reconfiguration and is accessible via Home of Discharge and Intranet.
- The quality improvement intranet site is now live for staff education and sharing of best practice. A SharePoint website has also been developed.

Internal Professional Standards

- Following consultation with the CSLs, led by the Chief Medical Officer and Hospital Medical Directors, the Trust has developed new Internal Professional Standards (IPS) which were launched on 1st July 2024.
- The IPS is a clinical charter which sets out standards across EDs, AMU, SAU and inpatient wards.
- Relevant IPS for ward rounds and discharge include:
  - We commit to provide a daily ward round 7 days a week of these patients and place a clear plan in the patient notes.
  - Twice daily board rounds, to ensure timely and agile decision making, will be conducted on wards Monday - Friday (daily at weekends).
  - An expected date of discharge (EDD) will be set within 24 hours of admission be reviewed daily and clearly visible to teams, alongside reason to reside and medically fit for discharge status.
  - Supported discharges and more complex patients will be identified early (48 hours prior to being medically optimised).
  - Criteria led discharge will be promoted where safe to do so.
  - Morning board rounds will be performed by 9am, Monday to Friday, led by a consultant or senior doctor. Expected discharge dates and diagnostics required before discharge will be identified as will referrals to therapies/social services.
  - TTOs will be written (where possible) the day before discharge and flagged during board rounds. Discharges should be made before 11am. Transport arrangements should be well-timed to avoid discharge delays.
  - Delays in referrals and diagnostics will be escalated to consultants and ward managers for action. Deteriorating patients should be identified for consultant review directly after the board round, and critical care outreach/ ITU review considered.
- Each Hospital site can adapt the IPS where appropriate, e.g. how patient flow is managed within the Emergency Department (i.e. to reflect services at each site)

The Chief Operating Officer is the Executive Lead for IPS. Informatics are developing an IPS dashboard which includes indicators to demonstrate compliance with IPS, using real time data and SPC charts.

Indicators are available in the Health Observatory to show percentage of patients who have a daily ward round. The data is shown as SPC charts.

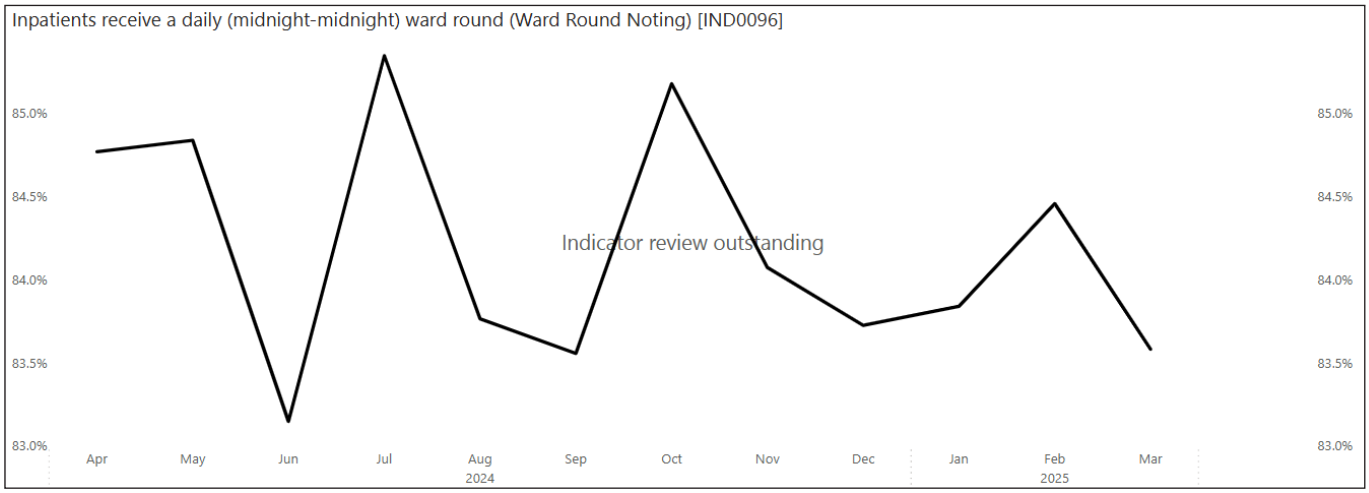


Figure 2: The percentage of inpatients receiving a daily ward round across the whole Trust. This has remained between 83% and 86% in 2024/25.

Priority 3: Improving Nutrition and Hydration

Background

This priority is about improving nutrition and hydration management across the Trust following a series of serious incidents.

Nutrition and hydration related incidents, including safer swallow, are one of the Trust's patient safety priorities.

PSPs are reported to the Group Clinical Quality Meeting (GCQM), jointly chaired by the Chief Medical Officer and Chief Nurse.

Two areas of focus for this priority were:

1. Improving the management of patients who are nil by mouth (NBM), including pre-operative patients who need to fast before their procedure, and patients with dysphagia (difficulty in swallowing).
2. Ensuring patients' baseline and on-going weight and Malnutrition Universal Screening Tool (MUST) risk assessments are accurately completed.

Improvement priority and progress during 2024/25

The group continue to monitor completion of Nutrition and Hydration related training courses, and target staff groups and areas to improve compliance and education. A food and drink strategy has been developed under the overarching aim of better sustainability within nutrition and hydration.

An NG audit took place across the Trust in August 2024, which identified education priorities to improve the use of the LocSSIP. The NG patient information booklet was updated with the HCOP team to take in to account the needs of this patient group.

Progress is monitored via reporting of various indicators that are now available on a PowerBI scorecard. The indicators are available at Trust, Site, and CDG level, and include data on:

- Hydration assessment every whole calendar day (location and specialty level)
- MUST Assessment (%)
- MUST Assessment ITU (%)
- Accurate Weight (location and specialty level)
- Mouthcare Assessment within 24h of admission and every 168h (location and specialty level)

MUST Assessment completion and accurate weight assessments are areas of focus to improve compliance. The Trust target is 95%, and the compliance is currently 80.9% for MUST and 81.1% for accurate weight recording.

Indicators continue to be monitored at ward level by Directors of Nursing, ADNs and matrons, supported by dietetics and the wider therapy team has increased recording of actual weights.

MUST guidance and the guidance for weighing complex patients has been updated.

Work is in progress on PICS to make recording of weight more accurate, including a drop-down action plan rather than free text. Work is ongoing in PICS regarding the NG insertion record to aid accurate documentation and the addition of nutrition and hydration monitoring charts.

UHB does not meet the recommendation on MUST screening in outpatients. This would involve an uplift in dietetic staff (to review patients with a MUST score of 2) and a large education program. Other areas not fully met are feeding aids availability across wards, and dietetic staffing levels limiting access to those at risk having the required level of input.

Safer swallow is a key priority in improving and managing nutrition and hydration. There is a separate QI group that leads on this work. There has been an increase in low harm, no harm and near miss events across sites. The group plan to address this via engagement with matrons, ward managers and DONs to raise awareness of increase incidents; support to roll out a new electronic meal ordering system at QE; and ongoing training and education. The group are monitoring the outcome of these changes via metrics and process measures, including: reduction in level of harm of incidents, reduction incident themes and trends, meal service audits, training records, and reduction in incidents related to patients who are nil by mouth.

There is ongoing work in the Emergency Department (ED) to develop a strategy to manage safe food provision, enhance nutrition and hydration and reduce risks in ED.

Training packages have been developed to support patients with swallowing problems and airway compromise, and this continues to be delivered to all clinical teams.

Priority 4: Improving the Safety of Invasive Procedures

Background

Local Safety Standards for Invasive Procedures (LocSSIPs) were introduced at UHB following a patient safety alert from NHS England to improve the safety of invasive procedures. The Trust has implemented a large number of LocSSIPs within a wide range of specialties. LocSSIPs follow the introduction of National Standards for Invasive Procedures (NatSSIPs), which aim to reduce the number of patient safety incidents related to invasive procedures in which surgical Never Events could occur.

Improving the Safety of Invasive Procedures is part of the Operative Management relating to Safety Checks Trust Patient Safety Priority (PSP).

PSPs are reported to the Group Clinical Quality Meeting (GCQM), jointly chaired by the Chief Medical Officer and Chief Nurse.

Improvement priority and progress during 2024/25

The Trust continues to support specialties to develop and implement LocSSIPs and are working towards embedding the revised NatSSIPs 2 standards.

New departmental LocSSIPs have been approved in:

- Trauma and Orthopaedics - Joint injection and aspiration / Minor Procedures
- Radiology – MRI GA Procedures
- Allergies – Allergies Status Checklist (Piloted mid-October across BHH/GHH/SHH theatres)
- Lower GI Surgery – Haemorrhoid banding

The LocSSIPs checklist for Head and Neck procedures has been developed and agreed, pending publication to the intranet. LocSSIPs in Interventional Radiology and Vascular access have been updated with additional safety checks requested by staff.

The current LocSSIPs tracker has 58 LocSSIPs approved. Audits are completed by local departmental staff and reports discussed in LocSSIPs steering group meetings. Recommendations and outcome feedback are provided to local teams.

An information pack of tools and templates has been created for departments to support development of LocSSIPs. This includes the LocSSIPs 6 key elements and NatSSIPs[2] 8 as key requirements in new checklists being developed, as well as an audit tool. The information pack, incident data and audit outcomes are shared with Sites and progress is reported via the Quality and Safety reports.

Departments are sub-categorised into Red, Amber, and Green (RAG) according to engagement and compliance. Quarterly audits of compliance are completed following the introduction of each LocSSIP. There is increased frequency of audits where there are concerns with compliance or a Never Event has occurred.

A LocSSIPs audit tool has been developed and tested in the new Trust wide safety event management system 'RADAR'. The audit tool is currently being piloted in three different specialities across sites.

The audit results completed quarterly for 2024-2025 are displayed in the table below. For specialties with several LocSSIPs in place, an average percentage has been calculated.

Assurance		
Red <60%	Amber 60-80%	Green 80-100%
	Q1	
QE Critical Care C	BHH IR MRI GA	IR PICC Line insertions Simple IR
	BHH/SH/GHH Critical Care	QE Endoscopy
	QE Critical Care A B D	QE Renal
		Ophthalmology Intravitreal injection
		BHH GHH SH Interventional Radiology BHH IR MRI GA
		SH Ultrasound Dept BHH Ultrasound Dept
		QE Urology
	Q2	
QE Critical Care C	QE Critical Care A B D	
	Q3	
	QE Critical Care A B C	GHH Endoscopy
		QE Critical Care D
		BHH MRI
	Q4	
BHH Critical Care		QE Vascular Access
		GHH Endoscopy
		BHH USS
		All sites Ophthalmology

Other Patient Safety / Quality Improvement (QI) Programmes

In addition to the Trust's Quality Improvement Priorities listed above, the NHS England PSIRF advocates a co-ordinated and data-driven response to patient safety incidents. As part of the development of the PSIRF at UHB, the following Trust Patient Safety Incident Priorities have been identified:

- Vulnerable Patients
- Nutrition and Hydration related incidents
- Management of Deteriorating patient
- End of Life Care
- Management of Patient treatment pathways including associated Booking Processes
- Urgent or critical radiology results not acted upon
- Discharge planning and Communication
- Preventable Falls
- Preventable Pressure Ulcers
- Preventable hospital acquired infections
- Operative Management relating to Safety checks
- High Risk Medications

PSPs are reported as part of the Integrated Quality Report (IQR) to the Group Clinical Quality Meeting (GCQM), jointly chaired by the Chief Medical Officer and Chief Nurse. The IQR is published within the Board of Directors meeting papers and are accessible here: UHB Board of Directors papers.

Quality Improvement at UHB

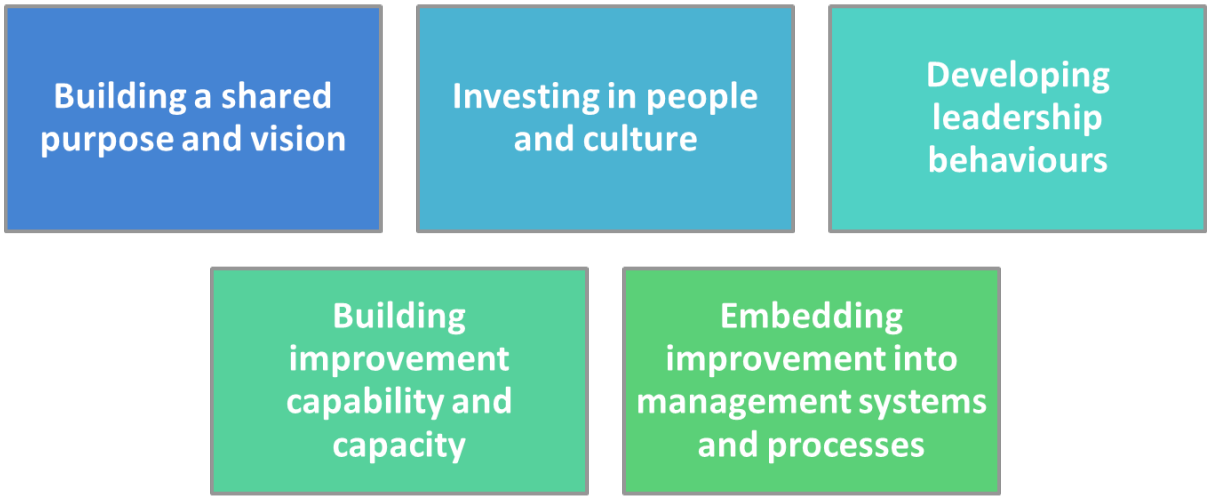
Developing a culture of Continuous Quality Improvement (CQI) is a cornerstone of the new Trust strategy, which launched October 2024.

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.

Our programme of work (spearheaded by the Trust's Quality Improvement Steering Group with executive-level sponsorship from the Chief Medical Officer) will look to drive forward the core domains of NHS IMPACT which includes:



A self-assessment against the five components of NHS IMPACT (Improving Patient Care Together – the single, shared NHS improvement approach), highlighted the need for UHB to source some additional expertise in this area, to help realise its strategy.

Following an open, competitive procurement process, the Trust has appointed the Institute for Healthcare Improvement (IHI) to work with the Trust for a period of 30 months, commencing in the Summer.

Working with the Trust, IHI will ensure that improvement becomes a core part of daily work. This will involve:

- Engaging all levels of the organisation to co-develop a CQI system that is fully owned by the Trust.
- Building local improvement capability through structured coaching, training, and leadership development.
- Leveraging measurement-for-improvement principles to ensure data-driven decision-making and meaningful impact.
- Strengthening the Trust's quality management systems and practices.
- Delivering results by working alongside us on some of our biggest priorities and areas for improvement.

In March a new SharePoint site was launched to share resources, tools and methodologies relating to QI. This site will continue to be developed to provide a comprehensive resource for all colleagues that are involved and wish to be involved in QI.

Work is underway to consolidate and unify existing functions/teams who support QI projects at UHB, helping to maximise this resource and make it easier for staff to access support.

2.2 Statements of assurance from the Board of Directors

2.2.1 Service income

During 2024/25 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 2024/25 represents 100 per cent of the total income generated from the provision of relevant health services by the Trust for 2024/25.

* 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 2024/25, there are 58 national clinical audit programs and a total of 91 workstreams that are included on the quality accounts listing. Of the 91 national audit workstreams 41 are mandatory and eligible for UHB participation, this includes two national confidential enquiries. The two national confidential enquires have seven open studies with an additional one in early development.

During the 2023/2024 period UHB participated in 57 (92%) national clinical audits and 4 (100%) national confidential enquiries which it was eligible to participate in. Information regarding UHB participation in national audits for 2024/25 remains pending with several national audit workstreams awaiting data submission deadlines to close.

The national clinical audits and national confidential enquiries that UHB was eligible to participate in during 2024/25 are included in the table below.

The national clinical audits and national confidential enquiries that UHB participated in, and for which data collection was completed during 2024/25, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

National audit outliers 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	QA 24/25 / HQIP commissioned	UHB participation 24/25	Comments
BAUS Urology Audits - Nephrostomy Audit	Environmental Lessons Learned and Applied to the Bladder Cancer Pathway (ELLA) Audit	Yes / No	TBC	Confirmation on UHB participation not currently confirmed. Pending further information.
	Impact of Diagnostic Ureteroscopy on Radical Nephroureterectomy (I-DUNC) Audit		TBC	
	Penile Fracture (SNAP) Audit		TBC	
Breast and Cosmetic Implant Registry		Yes / No	Yes: planned for QEH & SHH	Pending further information
British Hernia Society Registry		Yes / No	No: 0%	UHB not participating in this non-mandatory audit More information detailed in IQR report.
Case Mix Programme (Intensive Care National Audit & Research Centre)		Yes / No	Yes: Full	
Cleft Registry and Audit NEtwork (CRANE) Database		Yes / No	N/A	UHB not eligible- specialist units providing cleft services only.
Emergency Medicine QIPs:	Adolescent Mental Health	Yes / No	N/A- postponed until 2026	Awaiting RCEM publication
	Care of Older People		Yes	
	Time Critical Medications		Yes	

Project name	Workstreams	QA 24/25 / HQIP commissioned	UHB participation 24/25	Comments
Epilepsy12: National Audit of Seizures and Epilepsies in Children and Young People		Yes / Yes	No: 0%	Non-participation status for 24/25. More information detailed in IQR.
Falls and Fragility Audit Programme	Fracture Liaison Service (QEH only)	Yes / Yes	Yes: Full	
	National Audit of Inpatient Falls (NAIF)		Yes: Full	
	National Hip Fracture Database (NHFD)		Yes: Full	
Learning from lives and deaths - People with a learning disability and autistic people (LeDeR)		Yes / No	Yes: Full	
Maternal and Newborn Infant Clinical Outcome Review Programme		Yes / No	Yes: Full	
Mental Health Clinical Outcome Review Programme		Yes / Yes	N/A	UHB not eligible: NHS Mental Healthcare
National Adult Diabetes Audit	National Diabetes Core Audit	Yes / Yes	GHH- Yes Remaining sites: TBC	Confirmation on UHB participation not currently confirmed. Pending further information.
	Diabetes Prevention Programme (DPP) Audit		TBC	
	National Diabetes Footcare Audit (NDFA)		TBC	
	National Diabetes Inpatient Safety Audit (NDISA)		TBC	
	National Pregnancy in Diabetes Audit (NPID)		GHH: Yes BHH: TBC	
	Transition (Adolescents and Young Adults) and Young Type 2 Audit		TBC	
	Gestational Diabetes Audit	No / Yes	N/A	Audit not on QA 24/25
National Audit of Cardiac Rehabilitation		Yes / No	QEH: Partial HGS: Full	QEHB rehabilitation piloting a version of Dendrite & reviewing resources to support audit.

Project name	Workstreams	QA 24/25 / HQIP commissioned	UHB participation 24/25	Comments
National Audit of Cardiovascular Disease Prevention in Primary Care (CVDPrevent)		Yes / Yes	N/A	Primary care data submission by GP services
National Audit of Care at the End of Life (NACEL)		Yes / Yes	Yes: Full	
National Audit of Dementia		Yes / Yes	Yes: Full	Round 6 data published 12/24 BHH no longer outlier.
National Bariatric Surgery Registry		Yes / No	Yes: Full	
National Cancer Audit Collaborating Centre (NATCAN)	National Audit of Metastatic	Yes / Yes	Yes: Full	
	Breast Cancer (NAoMe)		Yes: Full	
	National Audit of Primary Breast Cancer (NAoPri)		Yes: Full	
	National Bowel Cancer Audit (NBOCA)		Yes: Full	
	National Kidney Cancer Audit (NKCA)		Yes: Full	
	National Lung Cancer Audit (NLCA)		Yes: Full	
	National Non-Hodgkin Lymphoma (NNHLA)		Yes: Full	
	National Oesophago-gastric Cancer Audit (NOGCA)		Yes: Full	
	National Ovarian Cancer Audit (NOCA)		Yes: Full	
	National Pancreatic Cancer Audit (NPaCA)		Yes: Full	
	National Prostate Cancer Audit (NPCA)		Yes: Full	
National Cardiac Arrest Audit		Yes / No	Yes: Full	

Project name	Workstreams	QA 24/25 / HQIP commissioned	UHB participation 24/25	Comments
National Cardiac Audit Programme	National Adult Cardiac Surgery Audit (NACSA)	Yes / No	Yes- planned participation for all 10 workstreams	Submission deadline for 2024/25 audits is 31/05/2025. Pending further information
	National Congenital Heart Disease Audit (NCHDA)			
	National Heart Failure Audit (NHFA)			
	National Audit of Cardiac Rhythm Management (CRM)			
	Myocardial Ischaemia National Audit Project (MINAP)			
	National Audit of Percutaneous Coronary Intervention (NAPCI)			
	UK Transcatheter Aortic Valve Implantation (TAVI)			
	Left Atrial Appendage Occlusion (LAAO) Registry			
	Patent Foramen Ovale Closure (PFOC) Registry			
	Transcatheter Mitral and Tricuspid Valve Procedure (TMTV)			
National Child Mortality Database (NCMD)		Yes / Yes	Yes: Full	
National Clinical Audit of Psychosis (NCAP)		Yes / Yes	N/A	UHB not eligible: NHS Mental Healthcare
National Comparative Audit of Blood Transfusion	National Comparative Audit of NICE Quality Standard QS138	Yes / No	TBC QEH: Full	Pending further information
	National Comparative Audit of Bedside Transfusion Practice			
National Early Inflammatory Arthritis Audit		Yes / Yes	Yes: Full	Full participation for patients who consent.
National Emergency Laparotomy Audit (NELA)	Laparotomy	Yes / Yes	Yes: Full planned	Submission deadline is 31 May for 24-25. SHH N/A
	No Laparotomy			

Project name	Workstreams	QA 24/25 / HQIP commissioned	UHB participation 24/25	Comments
National Joint Registry		Yes / No	Yes: Full QEH 100% BHH 100% GHH 100%	Case ascertainment figures published Jan 2024 and updated Dec 2024 covers data period 2022/23
National Major Trauma Registry		Yes / No	Yes: Partial due to new audit workstream commencing in 2024.	Audit workstream merged to NMTR from TARN in 2024. TARN had been offline prior to data collection recommencing.
National Maternity and Perinatal Audit (NMPA)		Yes / Yes	Yes: Full	
National Neonatal Audit Programme (NNAP)		Yes / Yes	Yes: Full	
National Obesity Audit (NOA)		Yes / Yes	Yes: Full	Previous concerns regarding data, however; UHB submission data available online.
National Ophthalmology Database Audit (NOD)	Age-related Macular Degeneration (AMD) Audit	Yes / No	Yes: Full UHB 99.7%	Case ascertainment figure published May 2024 and updated Feb 2025, covers data period 01/04/22-31/03/23
	National Cataract Surgery Audit			
National Paediatric Diabetes Audit (NPDA)		Yes / Yes	Yes: both sites	Deadline for final data submission 25/04/2025.
National Perinatal Mortality Review Tool		Yes / No	Yes: Full	
National Pulmonary Hypertension Audit		Yes / No	N/A	UHB not eligible: Only the eight designated centres participate.
National Respiratory Audit Programme (NRAP)	COPD Secondary Care	Yes / Yes	Partial: QEH 85.5% BHH 41.9% GHH 42% Full: UHB 97.6% Partial: QEH 58.5% BHH 26.6% GHH 0% SHH 0% Partial: BHH 7% GHH 0%	NRAP Case ascertainment figures published in June 2024 and covers 2022/23 data period.
	Pulmonary Rehabilitation			
	Adult Asthma Secondary Care			
	Children and Young People's Asthma Secondary Care			
National Vascular Registry (NVR)		Yes / Yes	Yes: Full planned	Final deadline for validated submission by 16th May

Project name	Workstreams	QA 24/25 / HQIP commissioned	UHB participation 24/25	Comments
Out-of-Hospital Cardiac Arrest Outcomes (OHCAO)		Yes / No	N/A	UHB not eligible: Ambulance Service Region & NHS primary care.
Paediatric Intensive Care Audit Network (PICANet)		Yes / Yes	No: 0%	More information detailed in IQR
Perioperative Quality Improvement Programme (PQIP)		Yes / No	No	UHB are not participating in this non-mandatory audit
Prescribing observatory for Mental Health (POMH)	Rapid tranquillisation in the context of the pharmacological management of acutely disturbed behaviour	Yes / No	N/A	UHB not eligible: NHS mental healthcare & Independent Sector Healthcare (non-NHS)
	The use of melatonin			
	The use of opioids in mental health services			
Quality and Outcomes in Oral and Maxillofacial Surgery	Oncology & Reconstruction	Yes / No	Yes	Pending further information
	Trauma			
	Orthognathic Surgery			
	Non-melanoma skin cancers			
	Oral and Dentoalveolar Surgery			
Sentinel Stroke National Audit Programme (SSNAP)		Yes / Yes	Yes: Full	
Serious Hazards of Transfusion (SHOT) UK National Haemovigilance Scheme		Yes / No	Yes: Full	
Society for Acute Medicine Benchmarking Audit		Yes / No	Yes: Full	
UK Cystic Fibrosis Registry		Yes / No	Yes: Full	
UK Renal Registry Chronic Kidney Disease Audit		Yes / No	Yes	Changes made to data collection. On-going work being completed with PICS to ensure full participation for 25/26
UK Renal Registry National Acute Kidney Injury Audit		Yes / No	Yes	

National Confidential Enquiries (NCEPOD)

NCEPOD Project Name	NCEPOD workstream	Participation	UHB participation 2024/2025
Child Health Clinical Outcome Review Programme	Emergency surgery in children and young people	Data collection stage commenced June 2024. Date of publication: due late 2025	Yes Participating in retrospective study. Did not participate in optional pilot of prospective data collection
	Juvenile Idiopathic Arthritis	Case notes 100% (submitted) Clinician questionnaires closed Organisational questionnaire closed. Date of publication: 13 February 2025	Yes N.B. UHB had advised NCEPOD that audit not relevant/UHB not able to provide required data as does not provide service.
Medical and Surgical Clinical Outcome Review Programme	Acute Limb Ischaemia (ALI)	Data collection stage Date of publication: due November 2025	Yes
	Blood Sodium Study	Data collection stage Date of publication: due winter 2025	Yes
	End of Life Care	20 cases selected 6 clinician questionnaires returned 19 sets of case notes returned Date of publication: November 2024	Yes
	Endometriosis	22 cases selected 11 clinician questionnaires returned 11 sets of case notes returned Date of publication: July 2024	Yes
	Managing acute illness people with learning disability	Planned data collection: spring 2025	TBC
	Rehabilitation following critical illness	Data collection stage closed Date of publication due: Spring 2025	Yes

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 1220 clinical audits were registered with UHB's clinical audit team during April 2024 to December 2024. Of these audits, 475 were completed during 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 2024/25 was:

NIHR Portfolio Recruitment	7117	Commercial 485 Non commercial 6632
Non-NIHR Portfolio Recruitment	1403	Commercial 64 Non commercial 1339
Total Patient Recruitment	**8520**	**Commercial 549** **Non commercial 7971**

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

- UHB were first in West Midlands for overall commercial recruitment for 2024/25.
- UHB achieving 7% of total recruitment to commercial portfolio compared to regional average of 2% (40% ahead of last year's UHB commercial recruitment total)
- Exceptional performance in 24/25 - recruitment to cancer research trials up 119% compared to 23/24 figures, ENT by 1354%, reproductive health and childbirth by 337% and Haematology by 69%.

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).

Two conditions were formally imposed on the Trusts CQC registration on 10 July 2023 the for the regulated activity of Treatment of disease, disorder or injury:

- Condition 1: the provider must implement an effective system to ensure service users are safeguarded from the risk of abuse and improper treatment. This condition is in relation to UHBs 3 Emergency Departments.

This condition was removed on 24 May 2024

- Condition 2: the registered provider must devise and implement an effective system to ensure that there are sufficient numbers of suitably qualified, skilled and experienced NMC (Nursing and Midwifery Council) and HCPC (Health and Care Professions Council) registered and non-registered staff throughout the medical wards at Good Hope Hospital to support the safe care and treatment of patients.

This condition was removed on 30 September 2024.

There are currently no conditions on the Trusts CQC license.

The Care Quality Commission has taken the following enforcement action against UHB during 2024/25:

Section 29a Warning Notice issued for Surgical Wards at Good Hope Hospital – September 2024

Following an unannounced focussed assessment carried out by the CQC at Good Hope Hospital Surgery and Gynaecology wards on 18-19 June 2024, a Section 29A Warning Notice was issued on 19 September 2024. The Notice outlines the CQCs findings and concerns surrounding governance systems, stating that they are not operating effectively to ensure risk and performance issues were identified, escalated effectively, and addressed with timely action. The Trust was required to make significant improvements by 31 December 2024. A response was submitted to the CQC outlining the actions taken to address the findings, as well as those the Trust will be taking going forward to make the necessary improvements.

Section 29a Warning Notice issued for all regulated activities at all UHB hospital sites following a Well-Led inspection of the Trust in October 2023.
A Warning Notice was issued due to concerns around board assurance and the culture of the Trust. The Trust was required to: 1. make significant improvements to board assurance, accountability for actions and measurable improvements regarding the quality of healthcare by 30 June 2024 2. make significant improvements to culture, staff safety and wellbeing by 31 December 2024. Responses were submitted to the CQC outlining the actions taken to address the findings and to make the required improvements.

Birmingham and Solihull Integrated Care Board did not commission any reviews during 2024/25.

CQC Inspection Ratings Grids

Six CQC inspections and one focussed assessment took place across services at University Hospitals Birmingham during 2024/25. These inspections covered a variety of core services and across all hospital sites.

Final reports have been published for two of the inspections.

Year	Type of CQC Inspection	Site	Outcome
2024	Unannounced Inspection of Surgery and Gynaecology	GHH	See grids below
2024	Unannounced focussed assessment at Solihull Hospital Minor Injuries Unit.	SoH	See grids below
2025	Unannounced Inspection of Medicine and Children and Young People	GHH	TBC
2025	Unannounced Inspection of Urgent and Emergency Care and Children and Young People	BHH	TBC
2025	Unannounced Inspection of Outpatient services	SoH	TBC
2025	Unannounced Inspection of Urgent and Emergency Care and Surgery	QEH	TBC
2025	Unannounced Inspection of Maternity services	GHH	TBC

Overall Trust Rating

	Safe	Effective	Caring	Responsive	Well-led	Overall
Trust Overall	Requires improvement	Good	Good	Requires improvement	Inadequate	Requires improvement

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

Good Hope Hospital (GHH)

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Requires Improvement (June 2024)	Good (June 2024)	Good (June 2024)	Requires Improvement (June 2024)	Requires Improvement (June 2024)	Requires Improvement (June 2024)
Overall	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated

Solihull Hospital (SoH)

	Safe	Effective	Caring	Responsive	Well-led	Overall
Minor Injuries	Good (July 2024)	Good (July 2024)	Good (July 2024)	Good (July 2024)	Good (July 2024)	Good (July 2024)
Overall	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated

2.2.5 Information on the quality of data

Secondary Uses Service data

UHB submitted records during 2024/25 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 2024 – March 2025)
- 100% for outpatient care (April 2024 – March 2025)
- 99% for accident and emergency care (April 2024 – March 2025)

Which included the patient's **valid General Medical Practice Code** was:

- 100% for admitted patient care (April 2024 – March 2025)
- 100% for outpatient care (April 2024 – March 2025)
- 100% for accident and emergency care (April 2024 – March 2025)

Percentages are as at currently available National data.

Data Security & Protection Toolkit

The Trust is compliant with the majority of assertions and submitted its self-assessment on DSPT v6 in June 2024. The Trust has been working to an improvement plan agreed with NHSE, leading to the overall status of '23/24 Approaching Standards'.

Payment by Results clinical coding audit

UHB was not subject to the Payment by Results clinical coding audit during 2024/25 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 2024/25. The Trust's Coding Auditor is writing up the audit results in the report required for DSPT/IG. The figures for primary and secondary diagnoses and procedures met expectations in line with the audit assurance levels, as shown in the table below.

Errors in the assignment of ICD-10 and OPCS-4 codes affecting accuracy were due to:

- incorrect selection of a code at third- and fourth character level.
- omission of diagnoses and procedures / interventions relevant to the episode of care; and
- sequencing of the primary diagnosis.

A total of 1,995 FCEs were audited. Of which:

- 185/200 – 93% of primary diagnosis were correct.
- 1,218/1,274 – 96% of secondary diagnosis were correct.
- 11/133 – 92% of primary procedures were correct.
- 18/388 – 95% of secondary procedures were correct.

Table: Trusts performance against coding standards 2024/25.

	Q1% 2024/25	Q2% 2024/25	Q3% 2024/25	Q4% 2024/25	2024/25 Full Year	Standard
Primary Diagnosis	94%	90%	90%	100%	93%	>=90%
Secondary Diagnosis	98%	94%	95%	96%	96%	>=80%
Primary Procedure	94%	83%	91%	97%	92%	>=90%
Secondary Procedure	93%	91%	98%	98%	95%	>=80%

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

1. A Data Quality Issues Group (DQIG) was established in November 2021. There are Terms of Reference (TOR) for this group and the Chair is the Head of Health Informatics. The group meets monthly, and reports to the IGG (Information Governance Group) quarterly.

   The DQIG are responsible for monitoring and recording data quality issues identified within the organisation. The issues are prioritised via the DQIG. DQIG have established processes for DQ issues to be raised within the organisation. Currently work is in progress to identify ways of getting DQ risks recorded on the Trust's risk register (currently held in Datix). The Compliance team is working with the Head of Health Informatics, Chief Technology Officer (IT Services) and Head of Operational Support (Corporate Affairs) to enable this now Datix has been replaced by RADAR. Now RADAR is implemented, plans will be developed to enable Trust's DQ issues to be recorded on the central organisational incident reporting system. This will provide a mechanism for users across the Trust to flag issues centrally.

Action plans for prioritised areas are created, maintained, and managed through the DQIG. There are 18 active issues and 49 resolved issue to date on the issues log.

There are 6 high priority issues being addressed at DQIG:

- Non deceased patients on PICS
- Clinical Haematology clinics changing treatment function code
- Trust system vs Oceano reconciliation
- Missing / Late cashed up activity and modality
- Discrepancies between front and back end of Badgernet (PIDS)
- Current UHB Submissions <1% for ISTV

A DQIG subgroup is now in place, which meets to discuss any issues identified by Ward Clerk and ED receptionists. Ward clerk and ED reception teams routinely monitor quality of data entry through a routine series of quality monitoring checks across the QEH and SOL sites. BHH and GHH ward clerk data quality checks will commence in April 2025.

Site	Month	Indicator Checks Completed	Errors	% Accuracy	Target
QEHB	Apr 24 – Mar 25	14,225	419	97.53%	>=95%
SH	Apr 24 – Mar 25	1,850	55	95.94%	>=95%

2. The Health Informatics Compliance Team check NHS Digital's DQMI (Data Quality Maturity Index) and SUS dashboards once per month to identify any areas of concern. Any issues identified are flagged to DQMI and action plans put in place to address.

   Health Informatics have created PowerBI reports 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

3. 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.

4. The Informatics service are expecting DSPT audits in clinical coding and National Date Opt Out (NDOO) / pseudonymisation. Following review of requirements, the service are confident they can display full compliance with NDOO Audit Report Q1& Q2 - April - September: 10 records were audited on 24th September 2024, of these 1 was incorrect as opt out was not applied . Informatics Analysts are aware that they should contact the R&D governance email if they are unsure if out opt should be applied or not. In Q3 8 records were audited, all were correct NDOO was applied, but not required or requested due to Patients having consented. For pseudonymisation, an audit on Celonis data was carried out.

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

   The Trust is also commencing a review and discussion around 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).

5. 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. Plans are in place for a reciprocal clinical coding audit with Leicester Trust. Preliminary discussions will take place in March 2025.

6. 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.

7. 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.

8. The Trust's Data Quality policy is in place and is currently being reviewed to ensure the DQIG processes are reflected and that we continue to review the Data Quality Policy and develop associated procedures. There is point to note that this policy covers the DQ for the Health Informatics department primarily and there is a need for the other departments such as finance and workforce to either contribute to the overall policy or to create their own. This will be picked up through DSGG.

9. The Trust continues to support improvement of the data quality programme for the operational teams by providing data in relation to 18-week referral to treatment time (RTT).

10. In high traffic medical areas such as MAU, spot check audits have been set up to ensure that paperwork relating to patients is scanned on to PICS.

11. The DQIG have also escalated to the IT department that the reinstatement of face-to-face training on the Trusts PAS system would be beneficial. This is being explored.

12. UHB has high coding depth, with the 2nd highest depth in Midlands Trusts, and 4th highest in the Shelford group.

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 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 2024/25 YTD, 5424 UHB inpatients died. This comprised the following number of deaths which occurred in each quarter of that reporting period: ▸ 1350 in the first quarter; ▸ 1169 in the second quarter ▸ 1458 in the third quarter ▸ 1447 in the fourth quarter
2.	Up to 31st March 2025, 4612 case record reviews have been carried out in relation to 5424 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: ▸ 1106 in the first quarter; ▸ 1016 in the second quarter ▸ 1221 in the third quarter ▸ 1269 in the fourth quarter
3.	21 deaths, representing 0.5% 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: ▸ 5 representing 0.37% for the first quarter; ▸ 5 representing 0.49% for the second quarter ▸ 5 representing 0.4% for the third quarter ▸ 6 representing 0.5% 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 2025 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 2023/24 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 2024/25

The tables below show the Trust's latest performance for 2024/25 and the last two financial years for a selection of indicators for patient safety, clinical effectiveness and patient experience.

The patient safety and clinical effectiveness indicators were originally selected by the Clinical Quality Monitoring Group because they represent a balanced picture of quality at UHB. The patient experience indicators were selected in consultation with the Care Quality Group which has Governor representation to enable comparison with other NHS trusts.

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	2022/23	2023/24	2024/25	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)	**0.546**	**0.833**	**1.327** (Apr-Jan)	**0.820** (Apr-Jan) 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)	**0.569**	**0.870**	**1.385** (Apr-Jan)	**0.870** (Apr-Jan) Acute trusts in West Midlands

Indicator	Data source	2022/23	2023/24	2024/25	Peer Group Average (where available)
Patient Safety Indicators					
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)	**22.92**	**28.85**	**31.36** (Apr-Jan)	**25.96** (Apr-Jan) 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)	**23.90**	**30.12**	**32.74** (Apr-Jan)	**27.73** (Apr-Jan) 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	**59.0**	**65.2**	**60.9**	**57.5** Apr-21 – Mar-22 Acute (non specialist) hospitals NRLS website (Organisational Patient Safety Incidents Workbook)
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)	**10**	**12**	**13**	Not available
4a. Percentage of patient safety incidents which are no harm incidents › Higher % indicates better performance	› Datix (incident data)	**74.70%**	**79.79%**	**70.42%**	**73.60%** Apr-21 – Mar-22 Acute (non specialist) hospitals NRLS website (Organisational Patient Safety Incidents Workbook)
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)	**0.34%**	**0.36%**	**0.36%**	**0.40%** Apr-21 – Mar-22 Acute (non specialist) hospitals NRLS website (Organisational Patient Safety Incidents Workbook)
4c. Number of patient safety incidents reported to the National Reporting and Learning System (NRLS)	› Datix (patient safety incidents reported to the NRLS)	**53,717**	**48,989**	**56,372**	**14,368** Apr-21 – Mar-22 Acute (non specialist) hospitals NRLS website (Organisational Patient Safety Incidents Workbook)

Indicator	Data source	2022/23	2023/24	2024/25	Peer Group Average (where available)
Clinical Effectiveness Indicators					
5a. Emergency readmissions within 28 days (%) Elective and emergency admissions aged >17 › Lower % indicates better performance	› HED data	**14.34%**	**14.79%**	**15.10%** (Apr-Dec)	**13.22%** (Apr-Dec) Acute trusts in West Midlands
5b. Emergency readmissions within 28 days (%) All specialties › Lower % indicates better performanc	› HED data	**14.23%**	**14.71%**	**15.01%** (Apr-Dec)	**13.00%** (Apr-Dec) 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 2024 and 31 March 2025 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	2021		2022		2023	
Data source	Trust's Survey of Adult Inpatients 2021 Report, CQC		Trust's Survey of Adult Inpatients 2022 Report, CQC		Trust's Survey of Adult Inpatients 2023 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	8.8	About the same	9.1	About the same	9.0	About the same
Involvement in decisions about care and treatment	6.7	About the same	6.8	About the same	7.0	About the same
Did staff do all they could to control pain	8.3	Worse than expected	8.6	About the same	8.6	About the same
Cleanliness of room or ward	8.7	About the same	8.8	About the same	8.7	About the same
Overall rating of experience	7.7	Somewhat worse than expected	7.8	About the same	8.0	About the same
Response rate	34% (399 respondents) National: 39%		35% (422 respondents) National: 40%		35% (414 respondents) National: 42%	

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		
		2022/23	2023/24	2024/25
A&E: maximum waiting time of 4 hours from arrival to admission / transfer / discharge	95%	52.0%	54.6%	61.2%
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway	92%	41.2%	47.5%	50.9%
All cancers – maximum 62-day wait for first treatment from urgent GP referral for suspected cancer	85%	37.1%	40.3%	41.3%
All cancers – maximum 62-day wait for first treatment from NHS cancer screening service referral	90%	54.1%	50.9%	50.2%
Maximum 6-week wait for diagnostic procedures	99%	52.9%	62.0%	72.4%

3.3 Mortality

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	91.73 - within tolerance	2024/25 (Apr-24 – Dec-24)
SHMI, from NHS Digital website	92.61 - within tolerance	2024/25 (Apr-24 – Nov-24)
HSMR, calculated by UHB Informatics	89.41 - within tolerance	2024/25 (Apr-24 – Jan-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 2024 – March 2025 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.

The Trust is working on a long-term plan to adjust rotas in line with the March/October clock change as part of the Daylight Saving Time. The HR team will communicate the adjustment to Resident Doctors in due course.

[1] Freemantle N, Richardson M, Wood J, Ray D, Khosla S, Sun P, Pagano, D. Can we update the Summary Hospital Mortality Index (SHMI) to make a useful measure of the quality of hospital care? An observational study. BMJ Open. 31 January 2013.

Rota Gaps / Vacancies

Rota	No. of Gaps Dec 2024 – April 2025	Issue Resolutions/ Management	Other Issues	Comments
QE Medicine	**Dec 24** Acute Medicine -x 4 gaps - (HEE)	Replaced with LEDs in Feb 25	**Current April Gaps** – x 1 Diabetes (covered by locum) X 2 HCOP (covered by locum)	N/A
General Surgery	**BHH FY1 Vascular x1** **GHH SHO GS:** 1 OH no nights 1 OH no nights (pregnant) Mat leave from May 1 Vacant Slot	On-calls covered by locum On-calls covered by Locum On-calls covered by Locum On-calls covered by Locum On-calls covered by Locum	N/A	N/A
Emergency Medicine	SPR vacancies across all sites.	Recurring job advert in place.	N/A	N/A

Exception Reporting Data:

	QEHB	BHH	GHH	SOL	TOTAL
TYPE					
Hours	87	57	11	1	156
Educational	11	1	4	0	16
Pattern	25	6	0	0	31
Service support	10	7	2	0	19
Total	133	71	17	1	222
OUTCOME					
Toil	46	53	6	1	106
Payment	53	5	5	0	63
No further action	28	10	6	0	44
Pending (STATE)	0	3	0	0	3
Cancelled (STATE)	6	0	0	0	6
Total	133	71	17	1	222
GSW FINE					
	22	9	1	0	32
ISC					
	7	5	5	0	17

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 2024/25 Quality Account with:

- NHS Birmingham and Solihull Integrated Care Board (ICB)
- Birmingham Health & Social Care Overview and Scrutiny Committee
- Solihull Health and Adult Social Care Scrutiny Board
- Healthwatch Birmingham
- Healthwatch Solihull

These organisations have provided the statements below.

Statement from Birmingham and Solihull Integrated Care Board:

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 2024/25 Quality Account.

A draft copy of the Quality Account was received by the ICB on 6 May 2025 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 Hospitals Birmingham, provides. The report demonstrates the progress made by the Trust against the 2024/25 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 2025/26

We have worked closely with University Hospitals Birmingham, over the course of 2024/25, 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 2025/26.

Statement from the Birmingham Health & Social Care Overview and Scrutiny Committee:

The Birmingham Health and Adult Social Care Overview and Scrutiny Committee considered the Integrated Care Board Quality Report at the Committee meeting on 16 October 2024. It was reported that University Hospitals Birmingham NHS Foundation Trust was rated by the Care Quality Commission as overall as 'Requires Improvement'. Against the individual standards the Trust was rated 'Good' against the Caring and Effective standards, 'Requires Improvement' against the Safe and Responsive standards and 'Inadequate' against the Well-Led standard.

Statement from the Birmingham and Solihull Joint Health Overview and Scrutiny Committee:

The Joint Health Overview and Scrutiny Committee meeting on 26 September 2024 considered two reports relating to the Trust. The Integrated Care Board Delivery versus Plan report in October 2024 reported on the A&E waiting times, Cancer Services, Elective Care waiting times and A&E referrals to Psychiatric Liaison Service. Members were informed that performance against the 4 hour performance metric in the Emergency Department was better than the same time the previous year and there has been a reduction since April 2024 in the number of patients wating twelve hours in the Emergency Department, however the patient experience in the Emergency Department was a long way from there the Trust would like it to be. It was also reported that the Elective Hub coming to the Solihull site would make a difference to access to theatres, the surgical side of treatment for cancer pathways and diagnostics. Members were informed that high bed occupancy resulted in long ambulance delays in the system which had daily clinical oversight.

The Committee also considered an update report on delivery of maternity services at the Trust following the Care Quality Commission (CQC) rating of maternity services at Heartlands Hospital and Good Hope as Inadequate following the inspection and subsequent reports in February 2023. The report included the actions taken to address the concerns raised in the CQC report

including the establishment of the Maternity and Neonatal Improvement Programme. Members were informed that action had been taken to address midwifery staffing, pregnancy assessment and the emergency room, investment at the Heartland Hospital site, training for midwifery students as part of a multidisciplinary team, strengthened midwifery leadership through the appointment of the Director of Midwifery and using data to ensure the needs of vulnerable group are understood.

At the committee meeting on 30 January 2025 members considered 2 reports relating to the Trust. The Birmingham and Solihull ICS Headline Finance Report included information on the Birmingham Heartlands Hospital Urgent and Emergency Care Project. The Committee welcomes this proposal and the Joint HOSC Chairs provided a letter of support for the Outline Business Case.

The Birmingham and Solihull Integrated Care Board Report informed members that urgent and emergency care pressures and Elective Care and Cancer services continued but there had been slight reductions in the number of 24 hour breaches in the first week in December 2024.

The Chief Executive and Chief Medical Officer of University Hospital Birmingham NHS Foundation Trust attended the meeting with the Chief Executive Officer of the Integrated Care Board to report on the Leadership, Patient Safety and Governance at the Trust since 2023. Members were informed of the new operating model implemented in October 2023 and also the work to shift culture in the Trust. The 106 actions from 3 independent reviews (Patient Safety, the NHS Developmental Well-Led Review, and the Culture Review) have been brought together in the integrated Trust Improvement Plan and over 85% of the actions were implemented or underway. Members were also informed of the work regarding clinical quality and safety and strengthening clinical governance.

The Joint Health Overview and Scrutiny Committee on 15 April 2025 considered the Birmingham and Solihull Integrated Care System Headline Finance Report that included the Trust's Cost Improvement Target as part of the ICS Cost Improvement Programme. The Integrated Care Board Delivery versus Plan update included performance on Urgent and Emergency Care, Elective Care, Cancer, and Diagnostics. Members were informed that there had been an improvement in waiting times for elective care but there was significant work to meet the 18 week standard during 2025/26. It was reported that the performance for the Trust against the cancer target has improved compared to the position last year, however this was below the national target. There had been improvements for Urgent and Emergency Care the 4 hour A%E waiting time target, however there remained significant handover delays resulting from issues with patient flows. It was noted that looking forward to 2025/26 that there will be a significant challenge to meet the cancer 62 day target to stretch from 60% to 75%.

Statement from the Birmingham and Solihull Health and Adult Social Care Scrutiny Board:

The Health and Adult Social Care Scrutiny Board welcomes the opportunity to comment on the University Hospitals Birmingham (UHB) NHS Foundation Trust Quality Account for 2024/25.

Priorities for Improvement

Members take account of how the Trust's 2023/24 Quality Account set out four priorities for improvement during 2024/25;

1. Improving VTE prevention
2. Improving standards around discharge (previously improving ward rounds)
3. Improving nutrition and hydration
4. Improving the safety of invasive procedures

Also, that for 2025/26, the following overarching priorities have been identified:

1. Patient Experience
2. Embedding PSIRF (patient safety incident response framework)
3. Clinical Effectiveness & Quality Improvement

Members, of course, welcome the focus upon patients, safety and clinical effectiveness. However, they express their concern about how these priorities are much broader than previous years, such as improving VTE prevention. Whilst recognising the Quality Account is for the previous year 2024-25, Members would welcome further information on how these improvement priorities will be delivered – including how the improvements may be measured, what the desired outcomes are, as well as what resources may be required.

Freedom to Speak Up

As part of last years report, it was explained how UHB had chosen to discontinue the Freedom to Speak Up priority for 24/25, with this work overseen elsewhere by governance processes separate to the Quality Account. At the time, Members expressed their concerns about this decision, especially when taking into account the findings outlined in last year's Quality Account.

For instance, as part of last year's report, it detailed results from the NHS Staff Survey, including for the following two statements:

- I feel safe to speak up about anything that concerns me in this organisation.
- If I spoke up about something that concerned me, I am confident my organisation would address my concern.

This allowed Members to take account of how the proportion of responding staff at UHB who agreed with these propositions had declined over the year prior, despite there being an improvement in the mean for the NHS as a whole. This also enabled Members to express their particular concern that UHB had recorded the lowest result nationally for the first statement.

Members also question the decision to discontinue the Freedom to Speak Up priority when considering the serious concerns raised through the media and other stakeholders regarding patient safety, leadership and culture, during 2023/24. Also, in light of the findings of the previous independent external review of organisational culture of UHB – whilst recognising the considerable volume of work undertaken at the Trust to support delivery of the recommendations of this review.

Members request for a summary of the latest results of the NHS Staff Survey, as well as the delivery of the Freedom to Speak Up arrangements to be reported at the earliest opportunity to the Birmingham and Solihull Joint Health Overview and Scrutiny Committee (JHOSC), or individual Scrutiny Board, as appropriate.

Members also ask for a summary of concerns raised via the Freedom to Speak Up process to be included as part of future Quality Account reporting.

Care Quality Commission Enforcement Action and Inspection Ratings

Members take into account how the Care Quality Commission (CQC) has taken the following enforcement action against UHB during 2024/25:

- Section 29a Warning Notice issued for Surgical Wards at Good Hope Hospital – September 2024
- Section 29a Warning Notice issued for all regulated activities at all UHB hospital sites following a Well-Led inspection of the Trust in October 2023 – which required improvement actions to be implemented during 2024/25.

It is recognised that, for both Warning Notices, the Quality Account states responses were submitted to the CQC outlining the actions taken to address the findings and to make the required improvements.

Specifically relating to the second Warning Notice, Members request for the ongoing delivery of the recommendations arising from the independent reviews on the culture, leadership, patient safety and governance at UHB to continue to be reported to the BSOL Joint Health and Overview Scrutiny Board.

Members also take into account that overall CQC Trust rating is Requires Improvement and note, with concern, it has been rated Inadequate for Well led – and that the actions being taken will continue to be presented to the JHOSC, including as part of the reporting on the independent reviews at UHB, referenced above.

Members also take into consideration that, in terms of ratings of Core Services by Site, Surgery at Good Hope Hospital has been rated as Requires Improvement, whilst they welcome that Minor Injuries at Solihull Hospital has been rated as Good.

Member request for the latest CQC ratings, for all Hospitals and Trusts across the BSOL system, to be presented to the JHOSC, as part of BSOL ICB quality reporting.

New Surgical Hub at Solihull Hospital

A particular highlight for the Scrutiny Board during 2024-25 was the invitation to the tour of the new Elective Hub at Solihull Hospital, alongside Mayor Shahin Ashraf MBE. It was remarkable to see the brand new state-of-the art theatres, as well as the two trailblazing robots. Members especially welcomed the transformative effect these facilities will have upon local peoples' lives, including how the new theatres have the capacity to provide over 11,500 additional procedures every year. Solihull Hospital's new operating theatres demonstrate the commitment to providing high quality care for our local community.

The Scrutiny Board looks forward to continuing working together with University Hospital Birmingham during 2025-26.

Joint Statement provided by Healthwatch Birmingham and Healthwatch Solihull:

Healthwatch Birmingham and Solihull have advised that they are unable to respond this year.

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.

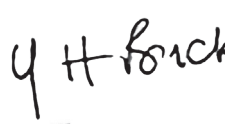
NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual Quality Accounts (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the Quality 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 2024 to June 2025
  - papers relating to Quality Account to the board over the period: April 2024 to June 2025
  - feedback from the commissioners dated: 13/05/2025
  - feedback from governors dated: 10/04/2025
  - feedback from local Healthwatch organisations: Healthwatch have confirmed they will not be providing feedback.
  - feedback from Overview and Scrutiny Committee dated 21/05/2025 (Birmingham) and 29/05/2025 (Solihull).
  - 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 2023 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 21/03/2025. SH Inspection Report 21/11/2024.
- 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 Improvement'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: 5 June 2025 Signed  Chair

Date: 5 June 2025 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 2024/25 Quality Accounts.