

University Hospitals
of North Midlands
NHS Trust



Quality

Account

2015/16



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Introduction to UHNM

This year University Hospitals of North Midlands NHS Trust has continued its focus on delivering quality excellence for our patients. The Trust continues to grow in size, with nearly one million patients treated this year, and it is important that patients receive the highest standards of care from NHS staff who want to learn, work and research.

Over the year we have focused on spreading excellent care across our two hospitals, improving access to our services and working towards our 2025Vision to provide world-class services. A first step to achieving this is the Trust's aim to reduce avoidable patient harm by a further 20% by 2018.

We recognised that staff at County Hospital in Stafford have been through a very difficult few years and that it was important they were supported. What we have found is that those staff, with the right support, have been able to quickly make fundamental changes to the way care is provided. Over the past year County Hospital has a patient quality and safety record that other parts of the NHS would be envious of. Across the Trust we have continued to perform well on keeping people safe, as demonstrated by low mortality rates and high levels of harm free care.

We want to build a network of hospitals providing safe, responsive and effective local services. Our 11,000 staff have been working hard to provide a full range of general acute hospital services for approximately 860,000 people locally in Staffordshire, South Cheshire

and Shropshire and specialised services for three million people in a wider area, including neighbouring counties and North Wales.

The Trust continues to grow a culture of becoming a clinically led organisation, enhance its status as a large acute teaching hospital and invest in research. Our partnerships with Keele University Faculty of Health and Staffordshire University are critical to our role as a university hospital. All of which allows us to attract staff for our specialised services, such as cancer diagnosis and treatment, cardiothoracic surgery, neurosurgery, renal and dialysis services, neonatal intensive care, paediatric intensive care, trauma, respiratory conditions, spinal surgery, upper gastro-intestinal surgery, complex orthopaedic surgery, laparoscopic surgery and the management of liver conditions.

As a Trust we face the same challenges as other hospitals across the country, but we are dedicated to ensuring that quality is not only safeguarded, it continues to improve. We remain committed to supporting our staff to make the necessary continued improvements. We also recognise our services must remain affordable and we believe that better care can be delivered at a lower cost. Making explicit the link between quality improvement and cost improvement is vital to our ongoing success.

**Mr Courteney-Harris, Chief Executive,
University Hospitals of North Midlands NHS Trust**



Statement on Quality

2014/15 has been another momentous year with the further integration of the Royal Stoke University Hospital and the County Hospital. We have continued to progress our ambition to be a leading centre in health care, driven by excellence in patient experience, research, teaching and education, our overall ambition being to equal or exceed the best performing Trusts in England. I am therefore pleased to report that the Quality Account for 2015/16 once again reflects a positive year for the Trust in our pursuit of putting our patients first.

We have re-emphasised our commitment to providing high quality care through our Patient Care Improvement Programme with quality, safety and patient experience remaining our number 1 priority. The continued efforts of our staff to drive this on a daily basis is key to our success. We know staff are committed to placing patient care at the heart of everything we do and it is absolutely acknowledged by the Trust Board that high quality, safe care is only possible and delivered with the hard work of our staff, and their daily commitment to the Trust's vision and core values.

We recognise however that providing health is not without risk and we acknowledge that we don't get it right for every patient every time. It is important therefore that we learn from our mistakes and listen to our patients, the communities we serve and key stakeholders about their personal experiences and the health needs of our population. It is through engagement with and involvement of our patients and local communities that we are able to understand better and can respond to their concerns and needs on both sites. Feedback from our patients tells us that the UHNM continues to provide a positive inpatient experience with 97% saying they would definitely recommend the hospital to family and friends. However we recognise that we have further to go in our journey.

We have received several external reviews of the quality of our services, of significance our planned CQC

inspection in April 2015. The CQC was looking for evidence of whether services are safe, effective, caring, responsive and well led. The CQC concluded that although there were a number of areas where we need to make improvements; they heard directly from our patients and staff that the care we give is done so with pride, commitment and compassion.

There were a number of services across both hospital sites that were praised as being good. These were maternity and gynaecology and children and young people at the Royal Stoke University hospital Site and surgery and maternity and gynaecology at the County Hospital site. In its formal report on UHNM inspection, the CQC identified other areas of outstanding practice, including:

- Specialised Neurological Unit at the County Hospital.
- The Alcohol Liaison Team at Royal Stoke
- Frailty Passport
- Excellence in Practice Accreditation Scheme
- Children's Service at Royal Stoke
- Imaging Services Accreditation Scheme

However the CQC also identified areas for improvement and it is these areas that have helped to shape our Quality Account. Specifically, the CQC identified that we have continued to experience significant pressure in our Accident and Emergency Department, despite the continuous efforts to build effective strategic partnerships across health and social care to deliver earlier safe discharge, introduce admission avoidance schemes and create additional capacity in the community. In addition the CQC identified that we need to continue to make improvements in the care of patients at the end of life and the experiences of their family.



Statement on Quality

The Trust has achieved the following during 2015/16:

April 2015

Patients at County Hospital had access to a specialist inpatient Diabetes and Endocrine Service

Trust launched its integrated Cardiology Department

May 2015

Transfer of acute inpatient paediatric services from County Hospital in Stafford to Royal Stoke University Hospital in Stoke-on-Trent, meanwhile Children's Emergency Centre opened at County Hospital

June 2015

County Hospital opened the doors to the new Women's Health Centre following the completion of a redevelopment

The final car park opened at Royal Stoke, completing the eight year rebuild of the site

July 2015

Work began on a new £3.2m satellite Renal Unit at County Hospital.

First-time mums were given the choice to have their babies at County Hospital in the dedicated Women's Health Centre

A new laminar flow 'clean air' theatre opened at County Hospital

The cardiac unit at the Royal Stoke University Hospital soared to the top five for clinical outcomes nationally

The £15m redevelopment of the wards at County Hospital began

October 2015

The Trust launched a new rapid access centre at Royal Stoke University Hospital for Multiple Sclerosis patients

A permanent MRI scanner was installed at County Hospital for the first time

An Ambulatory Emergency Care Unit was launched at Royal Stoke

November 2015

A new The Treatment and Investigation Unit (TIU) opened at County Hospital

January 2016

More than 20,000 men were screened for Abdominal Aortic Aneurysm (AAA) since 2012, coinciding with the one millionth patient nationally

Midwifery staff at County Hospital in Stafford celebrated their one year anniversary by delivering their 100th baby

A new £1.5m Poswillo Cataract Suite unit opened at Royal Stoke University Hospital.



Statement on Quality

To deliver on-going improvements, the Quality Account sets out a number of areas that we need to focus on and whilst we have made progress in some key areas over the past year we are not complacent and recognise that we can always do better.

Looking forward, we will therefore continue our quality journey through the continued delivery of our Patient Care Improvement Plan which sets out how we will continue to deliver improvements over the next three years, alongside our key priority areas reflected in our Quality Account for 2016/17.

We hope that this Quality Account provides you with a clear picture of how important quality improvement and patient safety are to us at the University Hospitals of North Midlands NHS Trust. It shows areas we have progressed well and it identifies where we need to improve even further.

Statement on Quality

A year of success at UHNM

The following is a summary of the awards and recognition received by UHNM and its staff in 2015/16

Mandie Burston won Nurse of the Year at the Nursing Standard Awards for her work in raising awareness of domestic violence.

Mandie and her domestic violence awareness team also collected the Innovations Award, which recognises nurses who have made an outstanding contribution to patient care or who have initiated projects which have made a real difference to the lives of the people they care for. This project has already supported more than 400 people locally.



Nurse Ian Chamberlain won a Beacon of Hope Award from the Lymphoma Association



The sepsis team and cardiac rehabilitation team were highly commended at the national Patient Safety Awards.



First-time mums were given the choice to have their babies at County Hospital in the dedicated Women's Health Centre

The cardiac unit at the Royal Stoke University Hospital soared to the top five for clinical outcomes nationally

Staff at UHNM swept the board in the 'Hero of the NHS 2015' category at The Sentinel's Our Heroes Awards

Estates and facilities staff working on the integration of the new Trust were rewarded for the efforts with a national Institute of Healthcare Engineering & Estate Management award



Paediatric oncology clinicians were rewarded for their work treating seriously ill children with a national WellChild Award



UHNM is just the third NHS Trust in the country to achieve the prestigious Gold Food for Life Catering Mark for serving fresh and healthy meals

Duty of Candour

In response to the new Duty of Candour regulations the Trust developed and introduced a new Duty of Candour Policy and the process to follow. To support the policy the Trust have implemented a training programme for all staff groups to attend on what the Duty of Candour is and their and the Trust's responsibilities on identifying any incidents that formally trigger the Duty of Candour.

During the CQC inspection in April 2015 the Trust's process and culture towards Duty of Candour was reviewed and this was reported as meeting the statutory requirements.

Incidents are reviewed weekly at a Quality Panel with involvement of Divisional Governance & Quality Managers. The Panel reviews reported incidents and agrees whether the incident has directly caused any harm and if the level of harm triggers the Duty of Candour threshold.

Summary of incidents that have triggered the formal Duty of Candour requirements have been included in the quarterly Quality & Safety Reports which are reported at the Public Trust Board.

Sign up to Safety Campaign

UHNM has joined a 3 year national campaign for the NHS in England, which aims to reduce avoidable harm by half and save 6000 lives. The key philosophy of the campaign is that by everyone working together as never before, large scale, long lasting change can be achieved which shifts Organisations from good to great. The national campaign will help to reinforce local messages and re-energise individuals and teams and will help with local community campaigns.

The Sign up to Safety Campaign will support organisations to create their own safety improvement plans which focus on the things that matter to those who will be implementing them. Within UHNM, the establishment of the Quality Academy and the development of the Care Excellence Framework will drive forward and co-ordinate improvement projects and plans that fulfil the key philosophy and aims of the Sign up to Safety Campaign.

Quality Academy

As part of UHNM's commitment to the Sign up to Safety Campaign, we have set up a Quality Academy, which is a team of people with knowledge and skills to facilitate creative thinking and empower staff to deliver improvements themselves.

The purpose of the Quality Academy is to provide a co-ordinated approach to quality improvement across all hospital sites of UHNM, with a key aim to provide a trained cohort of staff, who can support the identification and trying out of improvement ideas generated by front line staff using quality huddles.

NHS Staff Survey and Improvement Plans

As part of the staff survey in 2015, the staff were specifically asked for their responses to whether they have experienced and bullying or harassment and whether the Trust is seen as offering equal opportunities for career progression.

The following summarises the Trust's scores for these 2 questions and the actions that the Trust has subsequently put in place to address the issues raised and improve on the 2015 results to raise staff experience.

KF19 Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months

The results of the 2015 Staff Survey were that 28% of respondents said they had experience of harassment, bullying or abuse from staff in the last 12 months

Actions:

In addition to implementing the recommendations of the "Freedom to speak up" review, bullying and harassment will be tackled through the Values and Behaviours Framework and by working with managers to improve staff engagement across the Trust. The Organisational Development Strategy sets out actions to implement a "Leading with compassion" philosophy to create an environment centred on people quality and impact. These actions include:

- Greater promotion of Trust Values and behaviours and ensuring Trust Values are included in policies, practices and processes
- Development of a full and robust Staff Engagement strategy to ensure that engagement activity is measurable and impactful
- Delivering an effective appraisal process

KF27 Percentage believing that Trust provides equal opportunities for career progression or promotion

The results of the 2015 Staff Survey were that 87% of respondents said they believed the Trust provides equal opportunities for career progression or promotion

Actions:

- A new appraisal process and documentation is being issued (April 2016) that includes a consistent approach to talent identification and management
- In 2016/17, a programme of coaching and mentoring will be implemented and promoted
- Training for meaningful /effective appraisals will be improved and will include training for appraisers and appraisees

Priorities for Improvement and Statements of Assurance

Our Quality Priorities and Objectives for 2016/2017

Prioritising our quality improvement areas

This is now our fourth year of intense focus on quality improvement with our Patient Care Improvement Programme setting out clearly our priorities, namely:

- Patient experience will in the top 20% of all NHS hospitals by 2018
- We will continually reduce errors of all kinds and promote reliability. We will reduce avoidable harm by a further 20% by 2018
- The Trust will use Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Index (SHMI) as one of the outcome measures for clinical effectiveness with the aim of being in the top 10% of organisations in the NHS by 2018

Our aim is to provide safe, clean and effective person centred care to every patient, every time. To achieve this we recognise that we must continue to:

- Build stronger clinical leadership
- Provide valid, reliable and meaningful information as a basis for measurement
- Build greater capacity and capability of our staff to interpret the information and implement sustainable change



Stakeholder Workshops

In April, we held a number of stakeholder workshops and invited our Shadow Governors, members of staff and our partners from the local council, Clinical Commissioning Groups and Healthwatch. The aim of the workshops was to agree our priority quality objectives for 2016/17 with a focus on continuing to improve the on the priorities set in 2015/16.

As a result of these sessions we have committed to focus on the following priorities during 2016/17:

Priority 1: To improve further the safety of our patients

Priority 2: To improve further the experience of our staff

Priority 3: To improve further the experience and engagement with patients

Priority 4: To ensure appropriate, timely and equitable access to all hospital sites and ensure safe and timely discharge



Priority 1: To improve further the safety of our patients

We will achieve this by:

- Reducing avoidable harm by a further 10%
- Improving patients outcomes
- Introducing an informal accreditation process throughout a Care Excellence Framework

Measuring Performance

We will measure improvements through:

- Mortality rates
- Hospital acquired infections
- Blood clots
- Pressure Ulcers
- Falls
- Catheter associated Urinary Tract Infections
- Serious Incidents and level of harm
- Access Targets (including 18 week referral to treatment time, A&E 4 hour wait, Cancer waiting times)
- Performance will be reported via the Quality and Safety Forum

Priority 2: To improve the experience of our staff

We will achieve this by:

- Promoting a culture of compassionate leadership
- Revitalising and embed trust values and behaviours
- Promoting a no blame culture and encourage staff to speak out when things go wrong
- Celebrating and rewarding good practice
- Providing better support for our trainees
- Reducing reliance on bank/agency staff and improve retention
- Further improving information and communication with staff

Measuring Performance

We will measure improvement through:

- National Staff Survey
- In Year 'Pulse Check'
- Appraisal Rates
- Statutory and Mandatory Training Rates
- Performance will be reported via the Quality and Safety Forum

For further information, please contact Jamie Maxwell, Head of Quality, Safety & Compliance on 01782 676487 or Trish Rowson, Director of Nursing - Quality and Safety on 01782 676622.



Priority 3: To improve the experience and engagement with patients

We will achieve this by:

- Improving our understanding of the needs of diverse groups
- Setting clear and realistic expectations of patients and families
- Recognising and empowering independence
- Improving further our communication with patients
- Ensuring patients receive appropriate and timely care that manages their condition or supports a dignified death according to their individual needs

Measuring Performance

We will measure improvements through:

- National Surveys (Inpatients, Accident & Emergency)
- Local in-year surveys
- Friends and Family Test
- Complaints and PALS reporting
- Focus Groups
- Patient Stories and Patient Diaries
- Ward-based Care Excellence Framework Reviews

Priority 4: To ensure appropriate, timely and equitable access to all hospital sites and ensure safe and timely discharge

We will achieve this by:

- Working with other health and social care providers to improve patient flow throughout the health economy
- Reducing delays in the Accident and Emergency department
- Avoiding delays for patients medically fit for discharge
- Streamlining clinical pathways particularly for those patients with long term conditions, therefore avoiding admission
- Maximise the capacity of all hospital sites

Measuring Performance

We will measure improvement through:

- Access Targets (including 18 week referral to treatment time, A&E four hour wait, Cancer waiting times)
- Complaints and PALS
- National Patient Surveys
- Performance will be reported via the Quality and Safety Forum



For further information, please contact Jamie Maxwell, Head of Quality, Safety & Compliance on 01782 676487 or Trish Rowson, Director of Nursing - Quality and Safety on 01782 676622.

Domain 1	Preventing people from dying prematurely;
Domain 2	Enhancing quality of life for people with long-term conditions;
Domain 3	Helping people to recover from episodes of ill health or following injury;
Domain 4	Ensuring that people have a positive experience of care; and
Domain 5	Treating and caring for people in a safe environment; and protecting them from avoidable harm.

Quality Indicator	Previous Period		Current Period	
The value of the Summary Hospital level Mortality Indicator (SHMI)	July 2014—June 2015 1.05 (Band 2)		October 2014—September 2015 1.04 (Band 2)	
The percentage of deaths with palliative care coded at either diagnosis and/or speciality level	32%		33.8%	
Patient Reported Outcome Measures scores* (National Average)	Participation Rate 2014/15	Average Health Gain 2014/15	Participation Rate 2015/16	Average Health Gain 2015/16
<ul style="list-style-type: none"> Groin hernia surgery Varicose Vein Surgery Hip Replacement Surgery Knee Replacement Surgery *EQ-5D scores	37.3% (49.5%)	0.089(0.084)	25.4% (56.4%)	0.103 (0.088)
	4.2% (51.9%)	* (0.278)	3.0% (31.6%)	-
	106.3% (88.3%)	0.442 (0.437)	97.8% (84.1%)	-
	115.3% (80.6%)	0.287(0.315)	103.4% (93.4%)	0.324 (0.334)
Percentage of patients aged	UHNS (2010/11)	England (2010/11)	UHNS (2011/12)	England (2011/12)
<ul style="list-style-type: none"> 0 to 14; and 15 and over 	13.62%	-	11.78%	-
Readmitted to a hospital which forms part of the Trust within 28 days of being discharged from hospital	11.55%	11.40%	11.89%	11.45%
This indicator on the HSCIC Indicator Portal was last updated in December 2013 and the next update is due to take place in August 2016.				
The Trust's responsiveness to the personal needs of its patients	75.1 (2012/13) (National average 76.5) (Range 68—88.2)		Awaiting publication and update from HSCIC Portal	
Percentage of staff employed by the Trust who would recommend the trust as a provider of care to their friends and family	69% (2014) (National Average Acute Trusts 67%)		75% (2015) (National Average Acute Trusts 70%)	
Percentage of patients who were admitted to hospital and who were risk assessed for Venous Thromboembolism (Acute Trusts)	April 2014—December 2014 98.33% (National Average 96%) (Range 84.86%-100%)		April 2015—December 2015 98.4% (National Average 95.8%) (Range 74.2%—100%)	
The rate per 100,000 bed days of Clostridium Difficile infection reported within the Trust amongst patients aged two or over (Trust apportioned)	2013/14 19.1 (National Average 14.7) (Range 0—32.2)		2014/15 19.9 (National Average 15.1) Range 0—62.2)	
The number and rate of patient safety incidents reported within the trust - for large acute trusts	5036 (April —September 2014) 26.26 per 1000 bed days (National Average 35.89)		6646 (April 2015 —September 2015) 30.11 per 1000 bed days (National average 39.29)	
The number and percentage of such patient safety incidents that resulted in severe harm or death— acute (non specialist)	20 (April 2014—September 2014) 0.3% (National average 0.48%)		8 (April 2015—September 2015) 0.1% (National average 0.4%)	

PATIENT STORY

My first time in hospital

I came to A&E feeling very unwell and very anxious as this was my first time in hospital. The staff were fantastic making sure that I was aware of what was going on and what the doctors needed to do. My bloods were taken and a porter then took me for a chest X-ray. I had to wait for a porter to collect me after my x-ray for 20 minutes – this made me more anxious as it felt like they had forgotten about me.

At 1 am the doctor informed me I would need to stay in hospital overnight. There was not a bed on the ward so I had to spend the night in A&E. I had spent many hours on a trolley which was very back breaking despite the fact that I am young. A bed was found for me from another ward and it was lovely to be transferred onto it. Overnight in A&E the staff were lovely. They attended to my every need and generally chatted with me which made me feel less anxious. The only criticism I have is that the side rooms in A&E were very cold. There was no heating and no curtains at the window. I had 6 blankets on and as soon as daylight came I was awake due to the light. I was also forgotten about at breakfast time and did not receive any until 10:30 as the day shift forgot I was in a side room! I must say that I felt cared for by the staff in A&E but I do feel that an unwell elderly person could be made to feel worse if they had the same experience.

During the morning a Consultant came to see me in A&E. He was with me for 1 minute and told me I could go home if my results were Ok. He didn't explain what was wrong with me or what the tests were for. At around 11:15 I was taken to a bed on the ward. I was put in a side room as the staff didn't know what was wrong with me. Staff introduced themselves to me. The side room had lovely views and I felt I was in a penthouse suite! I asked the staff why they were covering up when they came in to my room and they were surprised the doctor hadn't told me. The ward manager came in and explained that I may have meningitis but this wouldn't be confirmed for a couple of days when the blood cultures came back. I was shocked that the Consultant thought I would be able to go home from A&E and that he hadn't discussed this possible diagnosis with me.

The staff on Ward 12 have been fantastic. They kept me informed at all times always asking me what I would like to eat and drink and if they could do anything to help me. I could also hear them caring for other patients outside of my room. On every handover staff introduced themselves to me and as a patient I was given choice. For instance I needed 4 hourly blood pressure recordings. As I had not been sleeping well the nurse asked me if it was OK to wake me at 02:00 or if I preferred to be left alone. Being given a choice and taking my views into consideration was really important to me it made me feel respected.

The doctors that came to see me informed me of their plans and answered my questions fully.

I have had a very pleasurable stay here on the ward and would give anyone a glowing response regarding the hospital.

Thank you

My Planned Surgery Experience

1st October 2015 – The ward Clarke found me bemused in the corridor as I couldn't find the ward. She escorted me to where I needed to be and I received a lovely reception from the ward staff. My operation was delayed due to a latex allergy but I was kept informed throughout of the reason. I attended x-ray where staff were polite and explained the procedure well. The staff in theatre were very pleasant although the spinal injection was not very brilliant so I ended up having a general anaesthetic. The clerk in recovery was blooming lovely!

Sue made us welcome on the ward and did my observations regularly. Mum came to visit me. Hayley was lovely. She couldn't have done anything any better, I had adequate pain relief and my IVI was attended to. I was offered coffee and toast and it stayed down – result!

James and Hayley gave me my 10pm medication with a smile. My venflon tissueed and the Doctor came to re-cannulate - he was awesome. I needed help at around 4am, Hayley has a fantastic attitude, she is extremely caring. Healthcare Support Worker Sue came in at 6am as we were both awake and offered us a lovely cup of tea. She's a diamond!

2nd October – Doctor's round at 8:20am – bloods, x-ray and physiotherapy requested. My dressings can come down later – hurrah! I may be able to go home on Saturday. I was given pain control which really helped.

10:30am Walked with physiotherapist's but became hot, bothered and sweaty so they helped me back to bed.

11:35am A lovely looking and extremely polite porter came and took me to x-ray. Elaine in x-ray was beautifully patient, caring and helpful. When I returned to the ward I walked to the shower room without any incidence. Painful but getting easier.

The patient in the next bed walked with her husband to the toilet but she became unwell and fainted on the way back. The nurses responded immediately to help her out, this was very reassuring.

3rd October – The night staff made sure that my pain was well controlled.

I went to the shower on my own this morning and slowly removed my dressing and replaced it as it was falling off. I was feeling off on return and wanted to lie down but had to wait ages to get the bed made and I don't know why. I was given analgesia when I requested it – my pain control was spot on, thanks. The doctor came and gave me conflicting advice.

When mum visited and she took me down to get some fresh air and coffee.

The physiotherapist came. She was a lovely girl who was merry and reassuring throughout. I felt reassured afterwards. Very loud staff on the ward today discussing Christmas do etc. they were very noisy all day.

2am Woken by very noisy staff who were talking loud and laughing. I requested analgesia and asked them to be quieter please. The ward was much quieter afterwards. Martin was lovely offering tea and help transferring etc.

In the morning Selma introduced herself as our nurse and the drugs round was performed. Marshall called in to say hello. Helen and Selma were very good at making us comfortable. The doctor came again. It was really hard for him to listen to what I am asking for. He gave me the impression that he tends to think he knows best, not the patient. Mum and Josie visited and went out for an hour of fresh air and had coffee in the cafe.

16:30pm Went to the toilet and noticed my knee was more swollen and painful. I told Selma and Helen. My temperature had risen a bit but my BP was Ok. The doctor was informed as they think I may need antibiotics. The doctor visited and asked that I have my bloods taken tomorrow, staff keep an eye on my temperature and that I keep my leg elevated. The day staff are off home now and a lovely bunch of night staff arrived. Martin and James so far been in to check we are OK.

4th October –Physiotherapist's Greg and Paulette did the stairs and exercises with me and I passed! They have discharged me as good to go. The OT and Physiotherapist were excellent, patient, caring and educational.

In agony again but I have done a lot this morning. I asked for pain relief and was given it as prescribed. Just waiting for the doctor to discharge me!

The lovely pharmacist came to see me she ordered and sent down for my tablets. Staff have been ace. They have kept me informed of the discharge process throughout.

Overall a brilliant stay with good care which was just marred slightly by one or two inconsiderate noisy staff who I must admit soon quietened down when politely asked to do so. Thank you for caring for me in such a happy, clean, friendly, sociable ward.

Statement of Assurances

Review of services

The Trust has continued to undertake reviews of wards and departments as part of the Clinical Assurance Framework. These reviews adopt the same approach as a CQC inspection and focus on the 5 domains used by the CQC.

In addition to the planned Quality Review visits, the Commissioners have also undertaken a programme of announced visits to the Emergency Department throughout the 2015/16. The Commissioners have also completed a number of visits to the A&E Department during times of extreme pressure.

The purpose of the review programme was to provide assurance and review the quality of the services within the provider organisation and to explore the views of staff and patients on the care they receive/deliver. The programme of visits formed part of an integrated approach to drive high quality patient care forward and to have confidence and assurance that local health services are patient centred on their needs and are safe, effective and responsive.

The visits supported CCGs assurance in respect of both the services it commissioned and the quality of care/support delivered to patients and carers. As part of the visits patients, carers, and members of staff offered their views on the care received/delivered in A&E. The main themes/findings are highlighted below:

- privacy and dignity – curtains were being used appropriately, patients were all appropriately covered and being observed by staff
- interactions observed between staff were professional

- interactions observed between staff and patients were professional, polite and friendly.
- Hand gels were readily available and were observed to be being used.
- Staff were well presented and complied with uniform code.
- The areas appeared to be clean, tidy and uncluttered.
- Although busy all areas were calm and quiet
- Relatives / carers were able to stay with the patients
- Very good infection prevention and control practice with plentiful PPE (personal protective equipment)
- Good evidence of the management of EMSA (eliminating mixed sex accommodation) with innovative double sided signage depicting the current gender status of the ensuite bathroom (CDU).
- 6 C's information was displayed in the Children's A&E and also in CDU where the Emergency Unit Elderly Care Group, 10 Commandments were displayed.
- Patient information was comprehensive and well displayed for example; children specific information leaflets and Domestic Violence posters.
- Safeguarding and IMCA were observed as screensavers on staff computers.
- An Emergency Care Centre Quality Information board was observed and contained information for patients such as: number of falls, complaints this month, medication incidents, plaudits, MRSA.



Participation in Clinical Audit

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

- National audit where specialities/Directorates are asked to be involved
- Corporate and Divisional audits
- Local audits which clinical teams and specialties determine and reflect their local priorities and interests

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

During 2015/16 51 National Clinical Audits and four National Confidential Enquiries covered the NHS Services that the Trust provides. During that period we participated in 100% of National Clinical Audits and NCEPOD.

The National Clinical Audits and National Confidential enquiries that the Trust participated in, and for which data collection was completed during 2015/16 alongside the number of cases submitted, are referred to in the tables below on page 17.

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

The lead will be responsible for ensuring full participation in the audit. The reports of 44 National Clinical Audits were reviewed by the Trust in 2015/16 and local action plans were developed and implemented.

National Confidential Enquiries

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

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

National Confidential Enquiry	Participation & % of cases submitted
NCEPOD Sepsis Study	Yes – 100%
NCEPOD Acute pancreatitis	Yes – 100%
NCEPOD Child Health Review	Yes – Sample identification
NCEPOD Mental Health Study	Yes – 100%

Compliance Spot Check Audits

The provision of feedback sessions and the development of ward specific action plans provide a mechanism for wards to identify areas requiring improvement with a view to implementing timely, effective changes at Ward level.

Initiatives such as themed weeks, poster development, ward audits, peer reviews and dissemination of good practice demonstrate that wards are taking positive action to ensure compliance.

During 2015/16 these spot checks have shown general improvements in different elements of clinical care.

Element of Clinical Care	% Improvement
MEWS	6%
Falls	10%
Coding of missed doses	4%
Pressure Ulcers	8%

National clinical audits

National Clinical Audit National Audit	UHNM Registered	% of cases Submitted
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	Yes	100%
Adult Asthma	Yes	100%
Bowel Cancer (NBOCAP)	Yes	100%
Cardiac Rhythm Management (CRM)	Yes	100%
Case Mix Programme (CMP)	Yes	100%
Child health clinical outcome review programme	Yes	100%
Congenital Heart Disease (Paediatric cardiac surgery) (CHD)	Yes	100%
National Diabetes Footcare Audit	Yes	100%
National Pregnancy in Diabetes Audit	Yes	100%
National Diabetes Inpatient Audit	Yes	100%
Diabetes (Paediatric) (NPDA)	Yes	100%
Elective surgery (National PROMs Programme	Yes	100%
Falls and Fragility Fractures Audit Programme (FFFAP)	Yes	100%
Fracture Liaison Database"	Yes	100%
Hip Fracture Database"	Yes	100%
Inflammatory Bowel Disease (IBD) programme	Yes	100%
Lung cancer (NLCA)	Yes	100%
Major Trauma: The Trauma Audit & Research Network (TARN)	Yes	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)	Yes	100%
National Adult Cardiac Surgery Audit	Yes	100%
National Audit of Intermediate Care	Yes	100%
National Audit of Seizures in Hospitals (NASH)	Yes	100%
National Cardiac Arrest Audit (NCAA)	Yes	100%
National Comparative Audit of Blood Transfusion programme	Yes	100%
National Complicated Diverticulitis Audit (CAD)	Yes	100%
National Emergency Laparotomy Audit (NELA)	Yes	100%
National Heart Failure Audit	Yes	100%
National Joint Registry (NJR)	Yes	100%
National Ophthalmology Audit	Yes	100%
National Prostate Cancer Audit	Yes	100%
National Vascular Registry	Yes	100%
Neonatal Intensive and Special Care (NNAP)	Yes	100%
Oesophago-gastric cancer (NAOGC)	Yes	100%
Paediatric Asthma	Yes	100%
Pulmonary Hypertension (Pulmonary Hypertension Audit)	Yes	100%
Rheumatoid and Early Inflammatory Arthritis	Yes	100%
Sentinel Stroke National Audit Programme (SSNAP)	Yes	100%
UK Cystic Fibrosis Registry	Yes	100%
Vital signs in Children (care in emergency departments)	Yes	100%
VTE risk in lower limb immobilisation (care in emergency departments)	Yes	100%

National Audits

These audits indicate our level of compliance with national standards and provide us with benchmark information on to which to compare practice. The results of the audits inform the development of local action plans to improve patient care. The following is a sample of local improvement initiatives implemented as a result of the audits.

National Falls Audit.

The National Audit of Inpatient Falls was conducted in May 2015, both County Hospital and Royal sites participated.

The audit consisted of two parts:

Organisational audit sections that were completed at hospital trust or health board level.

- 1 – background details of the organisation including occupied bed days and number of falls
- 2 – policies, protocols and paperwork
- 3 – leadership and service provision.

Unfortunately for UHNM, at the time of the audit, there was no single falls policy that covered both the Royal and County sites; therefore the data details submitted were not accepted for this part of the audit.

The corporate position now however is; that a Falls Prevention and Management Policy has been ratified which will resolve this issue for the next audit due in September 2016.

Clinical audit was a snap shot of care provided to a sample of up to 30 patients (15 consecutively admitted patients over 2 days) aged over 65, who were in hospital for over 48 hours, after being admitted for a non-elective reason. The clinical audit consisted of two sections.

- 1 – evidence of assessment and intervention in case notes
- 2 – observation at bedside / patient environment.

A gap analysis has been completed against the Royal College of Physicians RCP audit recommendations and was presented to the Falls Steering Group in May 2015 Falls Prevention and Management Training is on-going along with Ward Based Training, Corporate Briefing sessions, New Falls Champion Training, Champions Refresher Training

Corporate and Local Clinical Audits

A total of 87 clinical audit projects were completed by Clinical Audit Staff and a further 192 clinician led audit projects were registered during 2015/16. These audits help us to ensure that we are using the most up to date practices and identify areas where we can make further improvements. Examples of improvements made in response to the audit results are:

Trust wide Re-Audit of Do Not Attempt Resuscitation Orders Report at Royal Stoke Hospital

This re-audit was prioritised to ascertain the current standard of good working practices and to determine if any improvements in practice have been made and sustained.

Within UHNM, to ensure that all patients with an active Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) order are easily identifiable, a red form documenting the DNACPR order was introduced in 2002. The form outlines the patient's details, the reason for the order, the date the order became active, the lead consultant and the dates for review. Clinicians are also required to document the order clearly and in line with Trust Resuscitation Policy (C09).

Monitoring of compliance with the Policy is completed via a programme of clinical audits undertaken every two years. However, the frequency of audits has been increased to every six months and a programme of clinical audits has been developed to review and improve practice as result of CQC standards

Re Audit of Antipsychotic/Anxiolytic Drug Prescribing, Administration and Communication on Discharge

An initial audit was undertaken in 2012 and this re-audit was undertaken to ensure on-going compliance with the guidelines for the prevention, diagnosis and management of delirium in older people and NICE Clinical Guideline 103 – Delirium: diagnosis prevention and management.

As a result of the audit the actions undertaken include:

- Review of the antipsychotic checklist and updated and included within the dementia care toolkit currently being devised.
- Prescribing practice will be adopted in line with best practice and embedded across the Trust
- Education of medical and nursing staff with regard to dementia care, including prescribing practices, will be encouraged using a variety of methods and approaches including:
 - Why challenging behaviours can occur and how to most effectively manage these.
 - The relevance of skilled assessment and the care available so that the patient is not disabled or harmed by inappropriately prescribed medication

CQC Inspection and Improvement Plan

The Care Quality Commission (CQC) inspected the Trust in April 2015, as part of their planned comprehensive inspection programme. All core services, across both sites were inspected during 22nd – 24th April 2015. In addition the CQC undertook an unannounced visit on 5th May 2015 to A&E, Medical Care Services and Critical Care.

The Quality Report was published 28th July 2015 with the CQC rating the Trust as *Requires Improvement*. The individual ratings for both the Royal Stoke Hospital and the County Hospital are detailed in tables below.

Our ratings for The Royal Stoke University Hospital						
	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good	Requires improvement	Good	Inadequate	Requires improvement	Requires improvement
Medical care	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
Surgery	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Critical care	Requires improvement	Requires improvement	Good	Inadequate	Requires improvement	Requires improvement
Maternity and gynaecology	Good	Good	Good	Requires improvement	Good	Good
Services for children and young people	Good	Good	Outstanding	Good	Good	Good
End of life care	Requires improvement	Requires improvement	Good	Requires improvement	Inadequate	Requires improvement
Outpatients and diagnostic imaging	Requires improvement	Not rated	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Inadequate	Requires improvement	Requires improvement

Our ratings for The County Hospital						
	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good	Good	Good	Requires improvement	Requires improvement	Requires improvement
Medical care	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Surgery	Good	Good	Good	Requires improvement	Good	Good
Critical care	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Maternity and gynaecology	Good	Good	Good	Good	Good	Good
Services for children and young people	Requires improvement	Requires improvement	Good	Good	Good	Requires improvement
End of life care	Requires improvement	Requires improvement	Good	Requires improvement	Inadequate	Requires improvement
Outpatients and diagnostic imaging	Good	Not rated	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Areas of Outstanding Practice

- Specialised Neurological Unit at the County Hospital.
- The Alcohol Liaison Team at Royal Stoke
- Frailty Passport
- Excellence in Practice Accreditation Scheme
- Children’s Service at Royal Stoke
- Imaging Services Accreditation Scheme

Improvement Plan

Following the publication of the report, a comprehensive improvement plan was developed and implemented to address the key recommendations and to facilitate the steps to be taken to move the Trust towards a Good and ultimately an Outstanding CQC rating,

Patient Flow through the Emergency Department

Patient flow through the Trust is being supported via the implementation of a Patient Flow and Capacity Escalation Plan which is supported, monitored and reviewed by the Emergency and Urgent Care Programme Board

In conjunction with the plan, emergency and urgent care pathways and improvement plans have been developed and implemented in to practice.

The development of electronic dashboards now enable the divisions to have better visibility of the Emergency Department

Staffing

The Trust continues with its on-going recruitment plan to employ permanent members of staff and reduce the number of agency staff

At ward level, an initiative to update the staffing boards on every shift will inform patients / visitors of the staffing levels on the wards

Resuscitation

A review has been undertaken to ensure that required resuscitation equipment is available in the Outpatients Department

Across the Trust, a multifaceted approach to training and increasing the provision of information to staff has been undertaken, incorporating the availability of comprehensive audit results

Critical Care

Following a comprehensive capacity mapping exercise, a business case has been approved to increase the number of critical care beds and staffing levels. 12 additional beds have been commissioned and additional qualified and unqualified resources are to be made available. The increase in capacity has been supported by the development of an educational strategy for all new and existing staff

Outpatients

A comprehensive review of the current appointments backlog has been undertaken to ensure that there is no clinical risk to patients. In addition, the review has incorporated discussions / input from GPs and the Trust's Commissioners to identify specialties with high numbers of appointments, mutually challenge the referral process and develop an improvement plan to encompass new approaches to the management of the outpatient clinics.

Inter site Pathways

A comprehensive review of hospital pathways and protocols has been undertaken to ensure that patients admitted to each site are managed in line with the Trust Special Administrator's Clinical Model and to ensure that patients are transferred safely and effectively between hospital sites.

End of Life Care

An End of Life Strategy has been developed and incorporates the process for the continued roll out of the Amber Care pathway across the Trust. A e-learning package has been introduced to inform staff and support the pathway roll out. Adherence to relevant NICE and local guidelines is now being monitored via a comprehensive audit programme and the process is now being supported by a new End of Life Facilitator and a Non Executive Lead for End of Life care.

Fridge Monitoring

A standard operating procedure has been developed and rolled out across the Trust informing staff of the correct procedures to follow in relation to fridge temperature and monitoring. Adherence to the SOP will be monitored via regular pharmacy audits and as part of the Clinical Excellence Framework.

Participation in Clinical Research

Patients have a constitutional right to be offered the opportunity to take part in research and as a Trust we are charged with making that opportunity available to them. Research is offered to patients as a treatment pathway. In this respect research is very important in that it gives patients access to current cutting edge treatments and therapies that they may not have been offered as part of their routine clinical care. In addition to the possible direct benefits for themselves they also have the opportunity to contribute to broadening our understanding and knowledge of new treatments which will help to improve the care for others. 3574 patients receiving NHS services provided or sub-contracted by UHNM in 2015/2016 were recruited during that period to participate in research approved by a research ethics committee. Of these, 3389 were recruited into National Institute for Health Research (NIHR) portfolio studies while 185 were recruited into non-NIHR portfolio studies.

UHNM is currently ranked 43rd out of 247 Trusts for patient recruitment and 31st based on number of studies open in the NIHR/Guardian research league table. Participation in clinical research demonstrates UHNM's commitment to improving the quality of care we offer and to making our contribution to wider health improvement. Our clinical staff stay abreast of the latest treatment possibilities and active participation in research leads to successful patient outcomes. Offering patients an opportunity to take part in high quality research projects continues to be a high priority at UHNM and is a major part of our research Strategy for 2014-2019. The University Hospitals of North Midlands opened 110 new clinical research studies (79 NIHR portfolio studies and 31 non NIHR portfolio studies) during 2015/16. 168 NIHR portfolio studies have actively recruited research participants in 2015/16. There were 124 whole time equivalent funded clinical staff participating in and supporting Research approved by the Research Ethics Committee at UHNM during 2015/16. These staff participated in research covering 30 medical and surgical specialties out of 45. As of 1st February 2016 193 publications have resulted from our involvement in research, which shows our commitment to transparency and desire to improve patient outcomes and experience across the NHS. Our engagement with clinical research also demonstrates the University Hospitals of North Midlands NHS Trust commitment to testing and offering the latest medical treatments and techniques.

The NHS has a wealth of untapped potential in terms of staff having ideas about how services can be improved for the benefit of patients. This could be an

idea for a new gadget to overcome a particular clinical challenge or it may mean a novel way of imparting information to patients so they are less anxious about a particular treatment. To date we have not capitalised on these ideas within the Trust yet they have the potential to significantly improve the quality of the care we provide. UHNM aims to become a nationally recognised Centre of Excellence for the identification, protection and commercialisation of health related innovation and Intellectual Property by 2018-19, for the benefit of our patients, staff and local health economy.

This will be through the expansion of our commercialisation activity capitalising on innovation and intellectual property opportunities from across the organisation. An Innovation Advisory Group has been established to oversee development and implementation of our Commercialisation Strategy which sits alongside the Research Strategy. The following on-going projects are worth noting:

- (i) COPD-Single Point of Care monitoring project - Respiratory Medicine
- (ii) Radiotherapy Patient Phone/Tablet App—Imaging Department
- (iii) Fresh Hair – Oncology project

In addition, UHNM is a founding member of the Medical Devices Alliance (MDA) which aims to support the medical device and pharmaceutical sector in the development and evaluation of novel medical devices and pharmaceutical agents for the benefit of patients.

On the academic front the following is worth noting:

- (i) The total grant income for this financial year was £870,728.00.
- (ii) The total value of grants submitted this financial year was £5.9M against a target of £5.4M
- (iii) UHNM was ranked 58th in NIHR Research Capability Funding ranking table for 2015/2016 out of 239 in the league table.
- (iv) The academic team is increasingly engaging with new clinical, nursing and support staff, with 22 new researchers working with the team to develop grants during 2015/2016. In addition the team continues to work with external NHS trusts, higher education institutions and companies to develop innovative grant applications.

2015/16 has been a good year for research at UHNM and we aim to build on this during 2016/17.

Data Quality

Good Data Quality supports the planning and provision of excellent patient care and supporting services. The strategic aims of the Trust rely on the management of information to a sufficient standard to support the planning, decision making and the provision of excellent services to patients and other customers. The Trust continue to take the following actions to support and maintain improvement of data quality:

- A programme of regular data quality audits
- A number of data quality key performance indicators are monitored through the Trust's Data Quality Steering Group and regular updates are provided for assurance to the Executive Committee of the Trust
- The Data Quality Strategy is supported by robust monitoring via the Trust's Data Quality Steering Group, providing an assurance framework to assist with feedback to the Executive Committee
- The Strategy and Policy was reviewed to incorporate County Hospital processes and ratification in October 2015
- A programme of Data Quality Workshops, incorporating mandatory Information Governance training, continued throughout 2015/16
- The Team are working closely with the strategic teams to validate data to ensure accurate, robust migration of this data to the Medway PAS in November 2016

Clinical Coding Accuracy Rate

The annual internal Information Governance clinical coding audit took place during 2015/16, achieving level 2 in all areas of the audit. All recommendations from the 2014/15 audit have been actioned.

The Trust were not subject to an external Payments by Results (PbR) audit in 2015/16.

The internal Staff Audit Programme was extended in 2015/16 to include County coding staff and has been

NHS Number and General Medical Practice Code Validity

University Hospitals of North Midlands NHS Trust submitted records to the Secondary Uses System (SUS) for inclusion in the Hospital Episode Statistics (HES) which are included in the latest published data. This is a single source of comprehensive data which enables a range of reporting an analysis in the UK. The Trust reported all indicators, with the exception of Pathway indicators, as "green" (equal to or above the national average) for the first time and have maintained these results.

The percentage of records in the published data which included the patient's valid **NHS number** was:

- 99.8% for admitted patient care; national target is 99.2%
- 99.9% for outpatient care; national target is 99.4%
- 98.5% for accident & emergency care; national target is 95.3%

All of these results are higher than the national average.

Valid **General Medical Practice Code** performance is:

- 100% for admitted patient care; national target is 99.9%
- 100% for outpatient care; national target is 99.8%
- 99.9% for accident & emergency care; national target is 99.1%

All of these results are higher than the national average.

updated for 2016/17. The Trust's Clinical Coding auditor achieved the national audit qualification in 2015 and carried out this year's Information Governance audit.

U-codes (no associated income due to missing information) have reduced significantly throughout 2015/16, reporting only 1% of activity as u-codes at April's Flex (1st) submission.

Information Governance Toolkit Attainment Levels

The attainment levels assessed within the information governance toolkit (IGT) provide an overall measure of the quality of data systems, standards, and processes within an organisation. Forty five standards are assessed; the Trust must gain level 2 or above for each standard in order to achieve a “satisfactory” status.

The Trust’s overall IGT score has increased from 85% in 2014/15 to 87% in 2015/16. The number of requirements at level 2 or above has increased to 45 out of 45.

Previously the Trust declared level 1 for one standard – the requirement to train 95% of staff annually in information governance (IG). This graded the IGT as “Not Satisfactory” overall for 2014/15.

During quarter 2 2015/16, the Health and Social Care Information Centre (HSCIC) contacted the Trust to request a training plan detailing how the Trust will achieve the requirement for 95% of staff to complete

information governance training. Following their review of the training plan, the Health and Social Care Information Centre (HSCIC) rated the Trust as “satisfactory with action plan” for the 2014/15 submission.

The final submission of the 2015/16 IGT took place at the end of quarter 4. The Trust submitted a score of 87%, achieving the required level for all 45 requirements. Although the Trust did not train the required 95% of staff, the action plan from quarter 2 was resubmitted with evidence to show compliance rates have improved and the plan continues to be followed. This therefore grades the Trust as “satisfactory with action plan”. Compliance with IG training continues to be monitored across the Trust.

The HSCIC will continue to follow the Trust’s progress against the delivery plan with the potential to downgrade the Trust to “unsatisfactory” if they feel improvement has been insufficient.

A comparison of IGT scores for previous years is shown below:

	Information governance toolkit score	Grading Colour	Number of requirements				
			Level 0	Level 1	Level 2	Level 3	n/a
2015/16	87%	Green	0	0	17	28	0
2014/15	85%	Red	0	1	17	26	1
2013/14	84%	Red	0	1	19	24	1
2012/13	73%	Red	0	2	31	11	1
2011/12	68%	Red	1	8	23	12	1

An internal audit of the IGT looked at 18 standards. At the time the audit was carried out it was reported that evidence provided by the Trust for 2015/16 was sufficient for 17 out of 18 standards, with the acknowledgment that information was due to be updated before the final submission which would provide sufficient evidence. This update was carried out as expected.

The Trust will work to maintain and further develop compliance with information governance standards. The IG training requirement will continue to be reviewed against the Trust action plan to ensure compliance with this standard continues to increase.

IG progress continues to be monitored at the Trust Information Governance Steering Group and associated IG working groups. These are chaired by the Trust Caldicott Guardian and Senior Information Risk Owner (SIRO).



Review of Quality Performance 2015/16

Our Quality Priorities and Objectives

In 2015/16, in partnership with our stakeholders, we identified 5 specific priorities to focus on:

- **Priority 1: To improve our patients experience**
- **Priority 2: To reduce avoidable harm**
- **Priority 3: To improve staff experience**
- **Priority 4: To consolidate and harmonise the integration of clinical pathways to improve the patient flow through UHNM and deliver efficient admission, diagnosis, treatment and discharge**
- **To improve communication with patients and stakeholders**

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



Feedback from our patients

The Trust actively seeks comments from our patients and their relatives and carers about their experience. We take every opportunity to reflect and learn from the negative comments and share the good practices. These are some of the comments we have received over the last 12 months.

“All the staff we encountered were very helpful and friendly. Kevin Brown went out of his way for us and told us to come into the warmth whilst waiting for our taxi and he even watched out for it for us. Absolutely fantastic service and felt really looked after.”

“Ward 12 - Could not fault any of the staff that dealt with me during my stay. I also saw how compassionate they were with other patients, nothing was too much trouble and the staff were very experienced.”

“Ward 225 - The level of care was without doubt unbeatable. You set your standards high and maintain them. To all who took great care of me many, many thanks.”

“Orthodontic - Staff are always polite, welcoming and friendly. Treatment is always thorough and all my questions are answered. This puts me at ease and makes me more comfortable. This department is amazing.”

“All staff were professional, caring and understanding. The sister was extremely helpful. Thank you for making me feel safe.”

“The nursing staff were excellent but the quality of food was not good.”

“The food should be better quality.”

“Ward 108 - Staff were lovely and helped every time I asked. Always told me what they were doing and kept me involved. They were all very polite and happy to help, made my stay very comfortable and relaxed. Very friendly atmosphere and I would definitely recommend.”

Performance against Objectives

Performance Against Key Performance

Indicator	Target for the Year 2016	Actual for the Year
To reduce C Difficile infections - Royal Stoke	74	90
To reduce C Difficile infections - County		13
To reduce MRSA infections	0	4
Mixed sex accommodation breaches (number of patients affected)	0	0
A&E: Total time in A&E - 95% target	95%	76.53%
A&E: No waits from decision to admit to admission (trolley waits) over 12 hours	0 >12 hours	103
Ambulance handover delays of >30 minutes	0	1180
Ambulance handover delays of >60 minutes	0	15
Referral to treatment wait - non-admitted patients	95%	91.4%
Referral to treatment wait - admitted patients	90%	76.8%
Referral to treatment wait - incomplete pathways	92%	90.5%
Zero tolerance to RTT waits of more than 52 weeks	0	53
Diagnostic Waits < 6 weeks from referral	99%	96.8%
Cancer: two week wait from GP referral to first seen	93%	94.7% (M11)
Cancer: two week wait from GP referral to first seen - breast symptoms	93%	97.8% (M11)
Cancer: 31 Day diagnostic to first treatment	96%	96.7% (M11)
Cancer: 31 day second or subsequent treatment - anti cancer	98%	100.0% (M11)
Cancer: 31 day second or subsequent treatment - surgery	94%	92.6% (M11)
Cancer: 31 day second or subsequent treatment - radiotherapy	94%	96.6% (M11)
Cancer: 62 Day - Urgent GP referral to treatment	85%	68.6% (M11)
Cancer: 62 Day - Urgent GP referral to treatment - Screening	90%	61.5% (M11)
Cancer: 62 Day - Urgent GP referral to treatment - Consultant Upgrade	93%	94.2% (M11)
Cancelled Operations - breaches of the 28 Day standard	0	44 (M11)
Cancelled Operations - urgent operations cancelled for a 2nd time	0	0

Priority 1: To improve our patients' experience

We recognise that there is an important link between staff wellbeing and the quality and safety of care delivered. The evidence suggests that, NHS Trusts that prioritise staff health and well being perform better and have improved patient satisfaction.

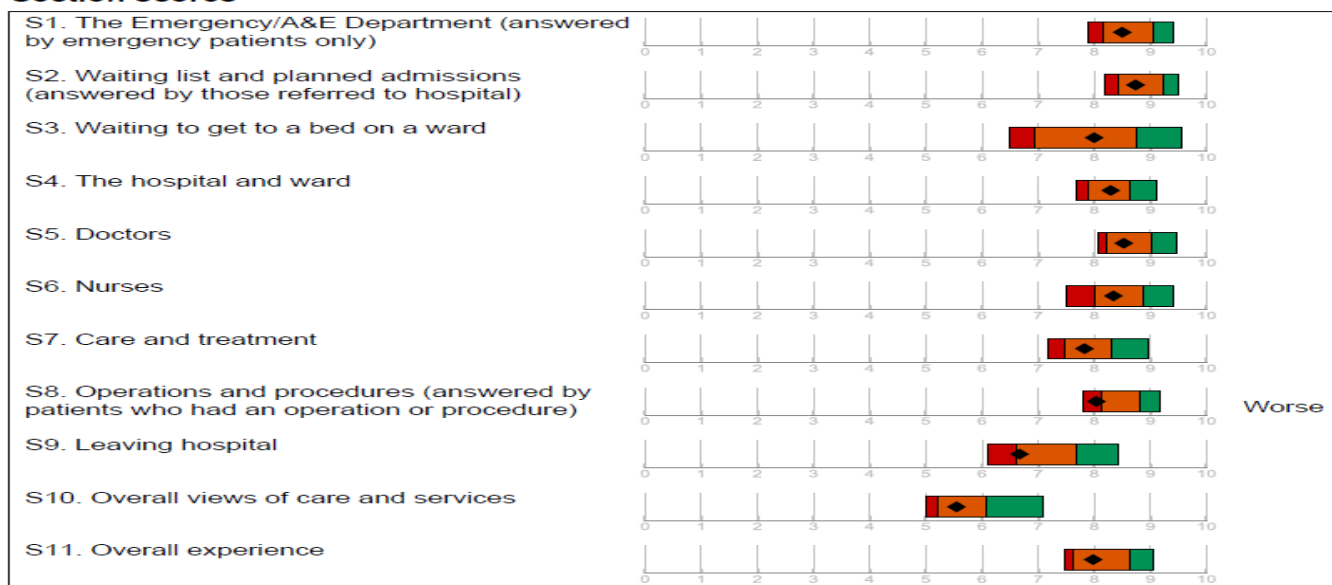
Inpatient Survey

The Survey was conducted on a sample of patients, aged 16 or over who had at least an overnight stay in the UHNS between June and August 2015. All in-patients with the exception of maternity were included.

Questionnaires were sent to 1250 patients – 566 responded, a response rate of 48%. The target response for organisations was 60%.

The Trust continues to implement a comprehensive improvement programme to support our overall ambition of being within the top 20% of Trusts nationally. The chart below show the Trust's performance. Green shows top 20%, Red Bottom 20% and Orange is the middle 60% of trust nationally.

Survey of adult inpatients 2015 The University Hospitals of North Midlands NHS Trust Section scores



In 2015 there were no areas where UHNM scored in the highest 20% of all Trusts. However, there was 1 area, Operations and Procedures, where UHNM was worse than most other Trusts. The Trust's in-year surveys continue to monitor progress during the year.

Improvement initiatives include:

- The roll out of a Home First initiative on exemplar wards has provided an opportunity to improve patient involvement and documentation based on feedback received. The project aims to support patients to return home as soon as possible after assessment and treatment avoiding unnecessary delays and has been rolled out on all inpatient wards.
- A revised discharge leaflet has been produced to improve patient awareness of their hospital journey and estimated discharge date.
- Healthwatch have been commissioned to support the development of Long Term Conditions pathways and obtain feedback on the effect of the Trust integration from both a patient and staff perspective
- Reconfiguration of the County Hospital wards has been informed by patient feedback
- The Patient Carer Council and Patient Council groups have been merged to form a Trust Hospital User Group
- The Patient Experience, Communication and Organisational Development teams are working together to promote awareness and drive improvement. A number of initiatives are in development to facilitate this including; "It's OK to Ask" bookmarks and posters to encourage patients to ask questions about their care and treatment plan. A revised Induction Programme for all new starter includes both Patient Experience and Living the Values presentations.
- An end of life care delivery programme has been developed to support National recommendations and guidance for improved end of life care. Newly designed End of Life documentation is being rolled out to facilitate this.
- The numbers of volunteers has been increased in the Emergency Department to support patient comfort
- A contact folder has been developed in the Emergency Department to signpost self-harm patients to appropriate community support.

Quality Walkabouts

University Hospitals of North Midlands has an established programme of Quality Walkabouts, which provide members of the Trust Board and Shadow Governors the opportunity to meet with patients, carers and Trust staff, to review the environment in which patients are cared for and identifying best practice and potential areas for improvement. More recently, the process has become a key quality indicator within our Clinical Assurance Framework.

In 2015/2016, 48 Quality Walkabouts were undertaken and comprehensive reports detailing the findings were presented to the clinical teams. All visits have highlighted areas of excellent practice and some areas for improvement. Examples of the improvements initiated as a result of the process are detailed below:

- Quality boards have been updated to display the most up to date audit results and quality information.
- Cleanliness on the wards has been improved. Tidiness and storage issues have also been addressed to ensure that safety and effective use of space are maintained at all times.
- Problems with televisions on the wards have been rectified. New aerials and signal boosters have been fitted where necessary and replacement remote controls ordered.
- Staff awareness of the hearing loop system has been reviewed. Wards have also been encouraged to order hearing loops if they aren't in place, to ensure they are responsive to individual needs.
- The checking and cleaning of the Resus Trolleys has been improved. New equipment such as hoists and scales has also been ordered to ensure patient and staff safety.

The Friends and Family Test

The Friends and Family Test (FFT) is a simple, single question survey that asks inpatients and patients discharged from the Accident and Emergency Department to what extent they would recommend the service they have received at a hospital department to family or friends who needed similar treatment.

The goal is to have a percentage score of 70% or above for patients recommending the service for use by their friends or family

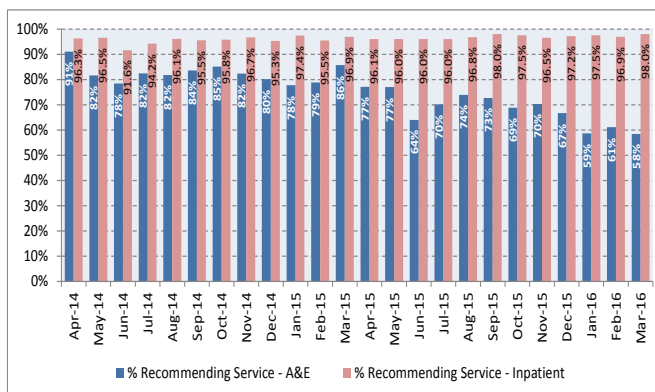
At UHNM systems are in place for patients to provide feedback via iPads, Smart Phones, the Trust website or comment cards entitled "What Our Patients Really Think of Us". A&E on both sites and the outpatients department on the County site also have the option of an automated telephone call to patients within 48 hours of discharge.

Returns from the inpatient wards have resulted in an overall response rate of 27% against the end of 2015/16 year target of 40%. The overall response rate for A&E patients was 21.7% against a target of 20%.

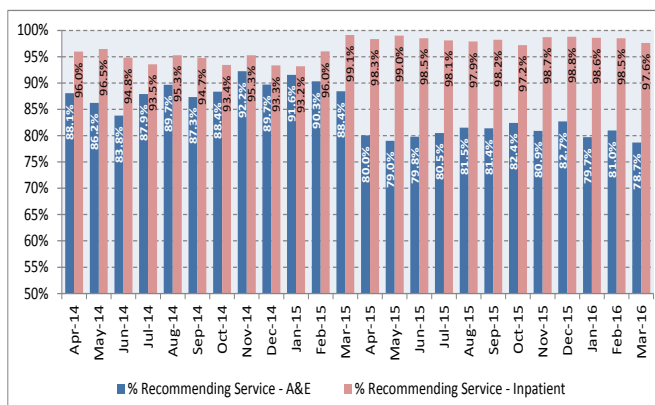
The feedback is used to support teams to make real improvements on issues which matter to their patients. Wards and departments are able to access their own results and use the comments to share areas of good practice, where actions are required and identify real time improving or declining trends in patient care.

As the questionnaires are anonymous, patients do not receive individual feedback unless, as happens occasionally, they have clearly indicated they wish to be contacted and their details are provided.

Friend & Family Test Scores—RSUH



Friend & Family Test Scores—County Hospital



Complaints

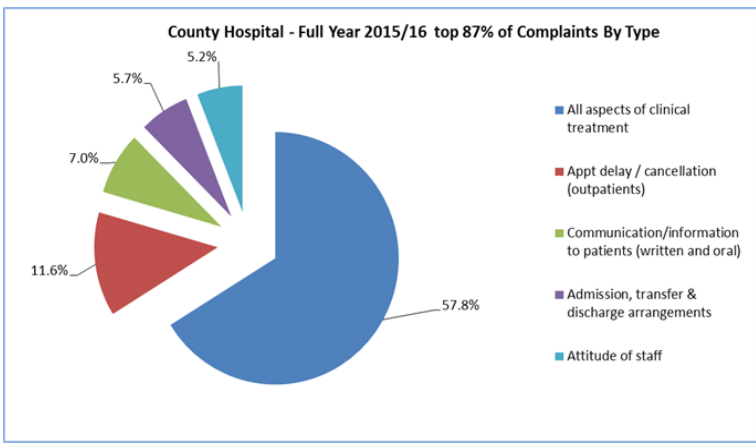
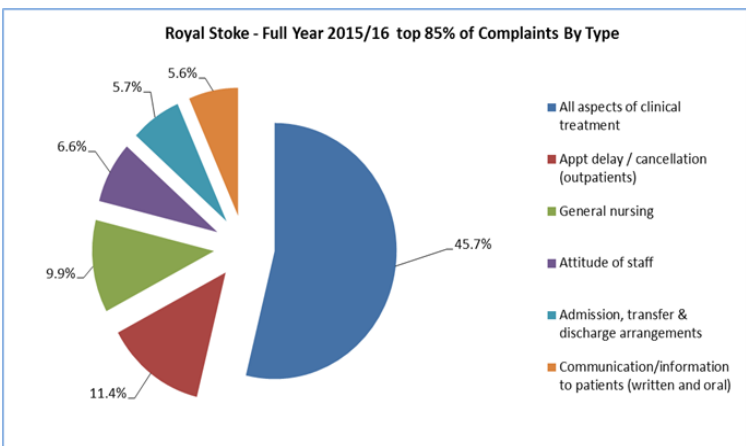
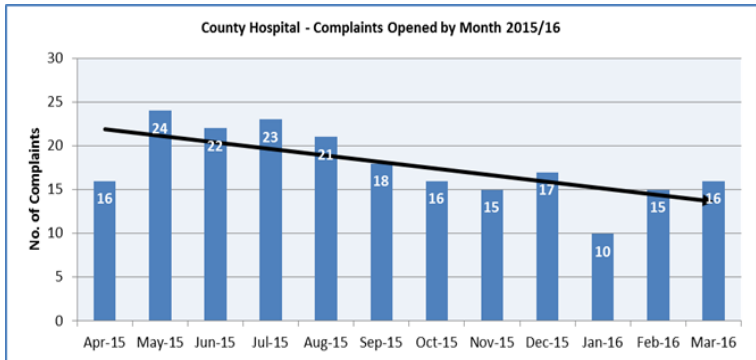
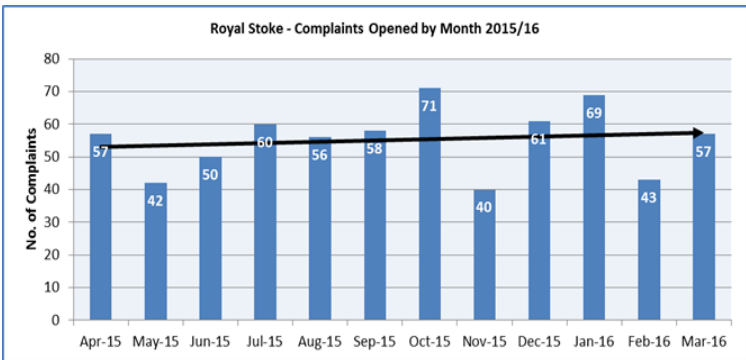
The total number of complaints opened at Royal Stoke University Hospital during 2015/16 is 664 which is a decrease of 18.6% over the same period in 2014/15 when the Trust saw 816 complaints opened.

The total number of complaints opened at County Hospital was 213 in 2015/2016, which is a 10.9% reduction from 2014/15 with 26 fewer complaints than the 239 complaints received in 2014/15

Royal PALS contacts have gone from 2436 in 2014/15 to 3053 in 2015/16. The complaints management team will be looking at the reduction in formal complaints and the increase in PALS complaints to determine if complaints are being most appropriately assigned.

Following the centralisation of complaints in June 2014 when the Trust radically changed the way the complaints process was managed, the complaints management process has continued to evolve and develop based on feedback from complainants, lay representatives and trust staff.

- Work is underway to develop the web based complaints module on Datix to improve the way complaints are categorised to assist in analysing their trends and themes. There were approximately 53 complaint 'subjects' and 798 'sub-subjects' and this has already been reduced to 23 subjects and 172 sub-subjects.
- Complaints processes have been aligned across UHNM sites so working practices are consistent
- More timely responses from receipt of complaint to final response
- Improved consistency and quality of responses
- An increase in complaints closed within the agreed deadline
- At year end there has been a reduction in the number of 'come back' complaints



Learning From Complaints

One of the most important aspects of the complaints process for the Trust is to learn lessons and make changes to enhance the experience for our patients, carers and relatives. The section below describes some of the improvements made as a direct result of complaint investigations.

- New oral hygiene equipment has been introduced to the wards
- A number of complaints have been anonymised and shared with medical and nursing staff on the wards for educational purposes in order to improve care and communication in the future
- Additional consultants, nurses and physiotherapists have been employed to reduce waiting times and improve access to services
- Improvements to referral pathways have been introduced, for example referrals to Birmingham

clinical Genetic Clinic

- The Imaging Department have reviewed their reporting times across all examinations to ensure patients have results as soon as possible
- The Clinical Audit Department has undertaken audits of response time to call bells on wards where patients felt they waited too long to be responded to.
- A poor experience for a day case patient resulted in a doctor attending a 1:1 communication course at a Midlands university and the patient was transferred to another clinicians care
- The appointment schedulers have put a system in place to reduce the likelihood of patients having their procedures cancelled through insufficient information about any additional requirements they have



Priority 2: To reduce avoidable harm

The Trust emphasises its commitment to improve quality, safety and access to all. Performance against this priority has been monitored during 2015/16 using a range of indicators. The following section provides a summary of performance for these indicators.

Patient Safety Incidents and Never Events

In general terms the number of patient safety incidents reported to the National Reporting & Learning System (NRLS) in UHNM has increased with 13402 reported in 2015/16 compared to 11306 in 2014/15.

The Trust continues to not only review actual numbers of patient safety incidents but also use benchmarking tools to assess changes in reporting levels. To assist in assessing reporting levels and changes in activity 2 different rates are used:

- Rate per 1000 bed days
- Rate per 100 admissions

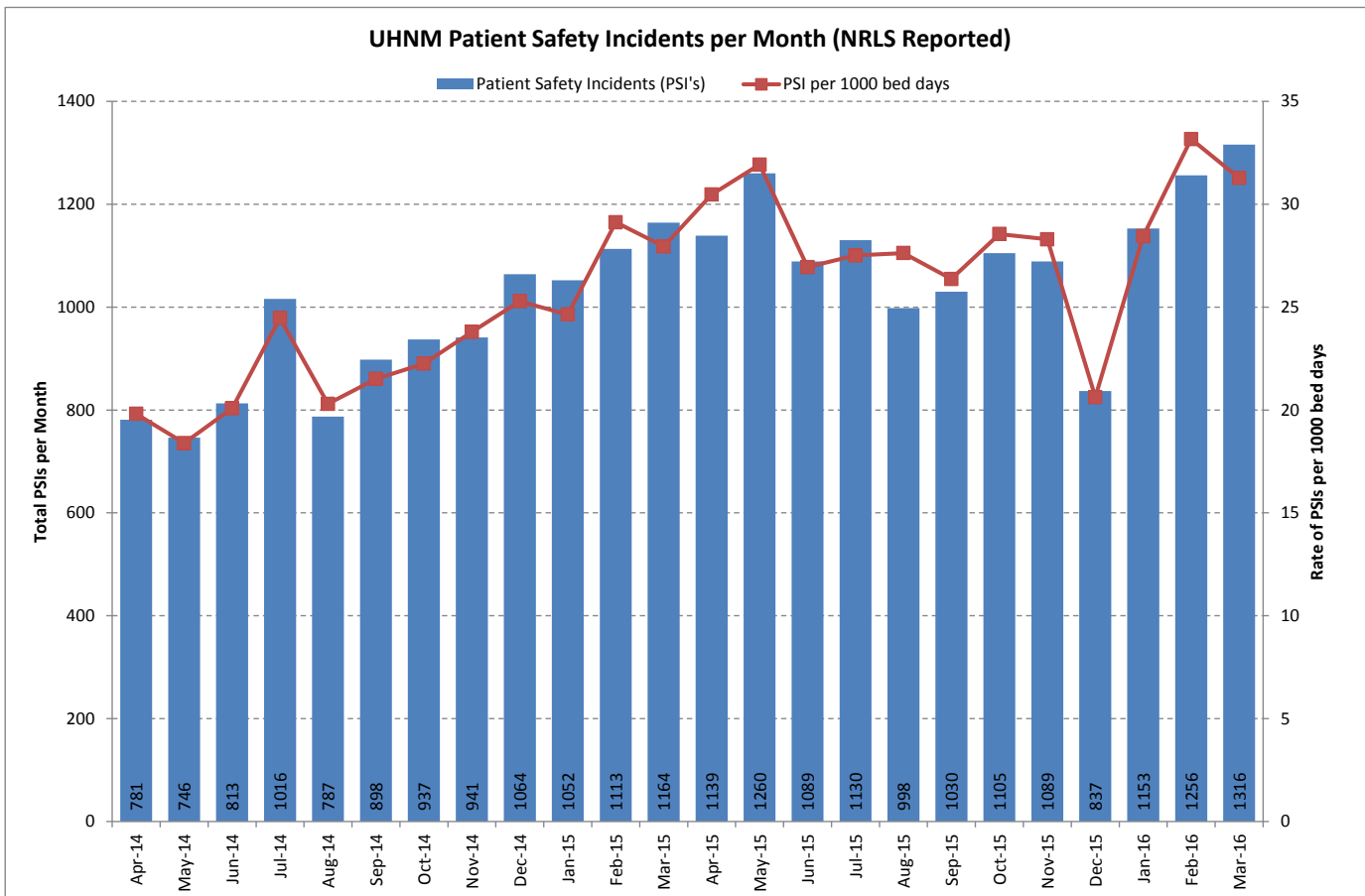
These allow the Trust to compare performance whilst making allowances for activity changes internally but also to benchmark against other Trusts and national average rate.

The rate of incidents per 1000 bed days has increased but is similar to the Institute for Healthcare Improvement (IHI) indicator rate of 30 patient safety incidents per 1000 bed days.

During 2015/16 UHNM had an average rate of 28.1 patient safety incidents per 1000 bed days compared to 22.8 in 2014/15.

The Chart below shows the number of NRLS reported incidents and rate per 1000 bed days per month for 2014/15 and 2015/16

During 2015/16, UHNM reported zero Never Events.



Hospital acquired Pressure Ulcers

Pressure ulcers are a recognisable measure for quality and safety of patient care, the Trust has seen a gradual decline in hospital acquired pressure ulcers since 2012/13. In the last year the numbers have reduced by a further 12% with particular improvement noted at the County site.

Although the figures when broken down show an increase in grade 2 pressure ulcers the number of grade 3 ulcers has decreased with no grade 4 pressure ulcers being attributed to the Trust during the last year.

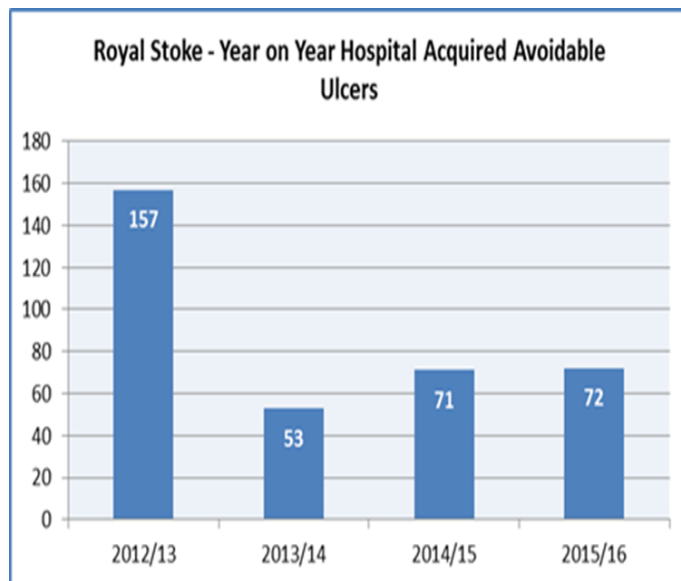
The Trust monitors all grade 2, 3, and 4 pressure ulcers and undertakes a root cause analyses (RCA) for all hospital acquired pressure ulcers. Staff are actively involved in this process as a learning opportunity.

A process of monitoring is also in place from the Quality Improvement Team who will support areas who are reporting pressure ulcers recurrently. This support looks at improving the standard of preventative care, documentation and treatment to avoid deterioration of skin integrity.

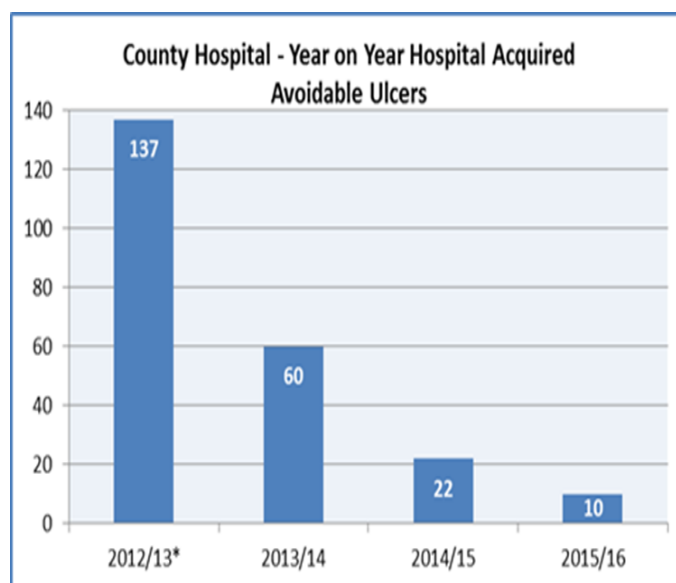
46% of reported pressure ulcers within the Trust relate to heels in line with national trends and the Trust has been working to address this with a programme called Happy Heels designed to raise awareness of this issue and ensure all staff have the knowledge and access to equipment to reduce this risk.

Documentation to assess and record pressure ulcers is now consistent across both sites and compliance spot checks are carried out on a regular basis.

Royal Stoke University Hospital - year on year hospital acquired avoidable pressure ulcers

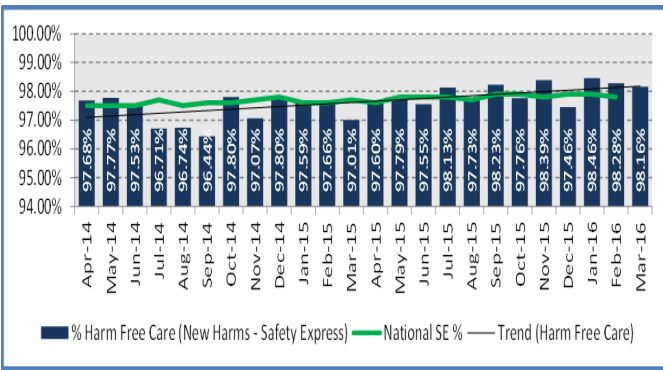


County Hospital—year on year hospital acquired avoidable pressure ulcers



*NB: Mid Staffs were not grading ulcers as Avoidable / Unavoidable until 2013/14.

Harm Free Care (New Harms)

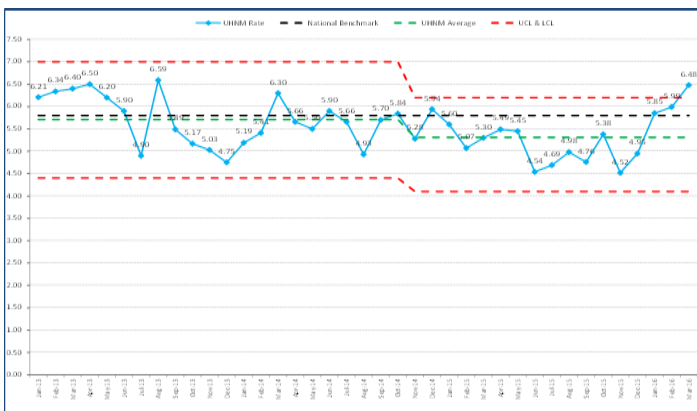


Since the establishment of UHNM, the Harm Free Care percentage has improved across the Trust. The national target is 95% and UHNM has continually achieved this target during 2015/16 and year end performance was 97.96% and above the national average for Safety Thermometer.

Patient Falls

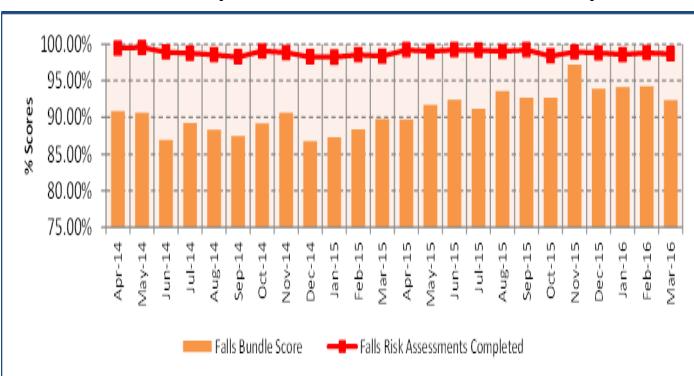
During 2015/16 there have been 2450 patient falls reported compared to 2465 during 2014/15. The falls rate per 1000 bed days for 2015/16 at UHNM is 5.19 compared to 2014/15 rate of 5.54 and national benchmark rate (based on NPSA figures) of 5.8.

Patient Falls per 1000 bed days (Jan 2013 – March 2016)



During 2015/16 there has been continued reductions in the level of harm reported from falls. There has been a reduction in moderate to severe harm as a result of a fall whilst in hospital and a corresponding increase in patients not experiencing any harm as a direct result of the fall.

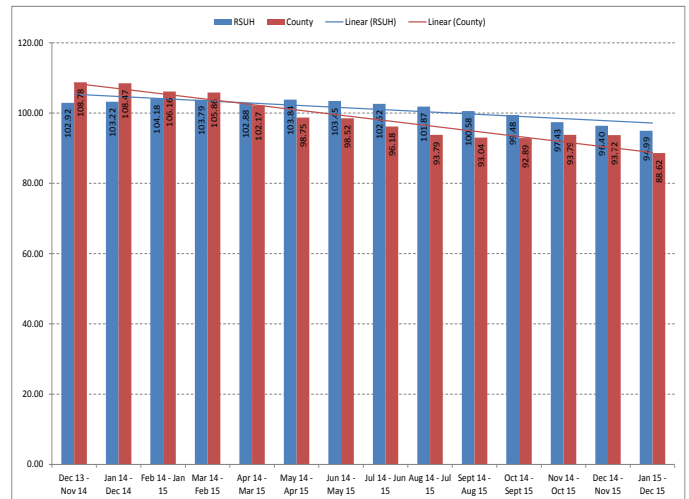
Falls Bundle Compliance and Risk Assessment Completion



2015/16 saw continued excellent performance for falls risk assessments with 98.9% completion rate against a national target of 95% and 2014/15 performance of 98.7%. The Falls Bundle compliance has also seen improvement with 92.99% compared to 2014/15 performance of 88.9% compliance.

Mortality

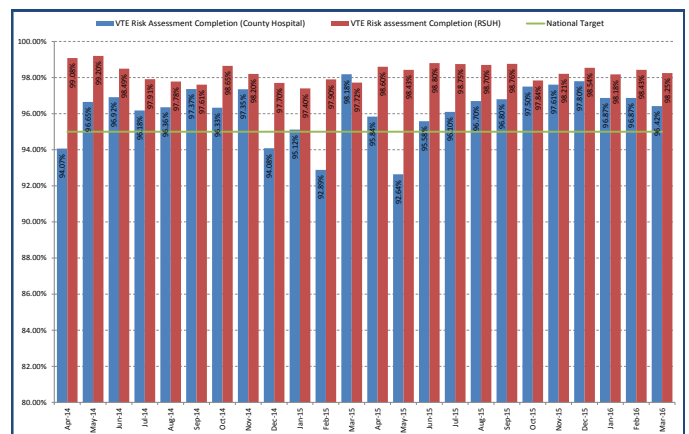
The HSMR during 2015/16 has continued to improve and the current UHNM figure for the latest available 12 months (January—December 2015 is 94.07 compared to the final 2013/14 figure of 101.94. Chart below shows RSUH and County HSMR figures.



The most recent published Summary Hospital-level Mortality Indicator (SHMI) for October 2014—September 2015 is 1.04 (Band 2—within expected ranges).

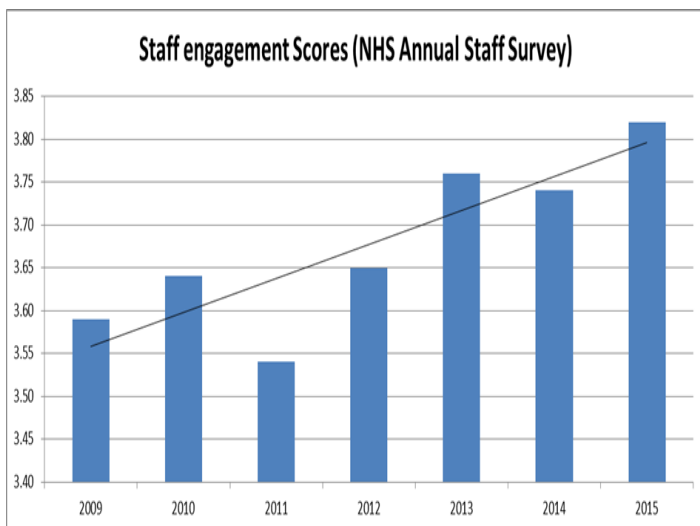
Venous Thromboembolism

Proactive assessment, prevention and management of blood clots is vital in avoiding harm to patients. The graph illustrates that the Trust is consistently exceeding the national and more challenging local target for completing assessments for this potential harm.



Priority 3: To improve staff experience

The staff engagement score is used as an indicator of the direction of travel regarding the quality of care being delivered to patients. The indicator is made up of scores for staff job satisfaction, motivation, levels of involvement and willingness to act as an advocate for the organisation by recommending it. The Chart below shows the improving trend for staff engagement scores.



Year-end Outcomes

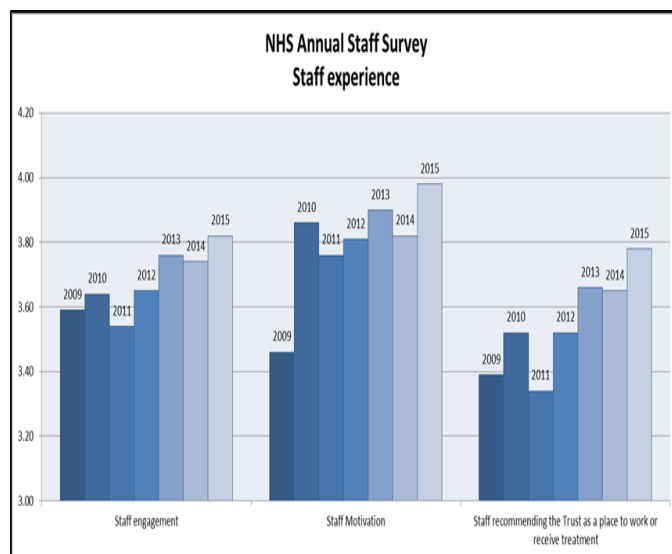
Compared to the 2014 Staff Survey results, there were no areas of significant deterioration. It should be noted that direct comparison to the 2014 Staff Survey is not possible as that survey related to the previous UHNS organisation only. Also, there were significant changes to the 2015 Survey questionnaire.

In 2015, the key findings were restructured with significant changes to the survey questionnaire. It should also be noted that the data provided in the Staff Survey Report is weighted to take account of differing response rates from different staff groups.

UHNM is in the best 10 performing trusts in the Midlands and East region for staff recommending the organisation as a place to receive care (Health Service Journal)

The main issues arising in the 2015 Survey were:

- UHNM staff engagement score increased from 3.74 to 3.82 Comparisons are illustrated in chart below.
- Staff not reporting harassment, bullying or abuse
- Staff putting themselves under pressure and coming into work despite not feeling well enough
- How the organisation encourages reporting of errors
- Staff motivation at work (the extent to which they look forward to going to work and are enthusiastic about and absorbed in their jobs) is better than average for acute Trusts Overall.



2016/17 Next Steps

A Task and Finish Group has been established to review the results of the Staff Survey, to develop a detailed action plan and to drive forward actions to improve the results. The Group includes Equality and Diversity, Raising Concerns, Wellbeing and Staff-Side representation as well as Staff Engagement Champions. Actions being developed include:

- Enhancing the structures and processes around raising concerns at work, in line with the recommendations from the Francis Review and the provision of training for managers on creating an environment where the raising of concerns is part of everyday practice and that the improvements made as a result are celebrated.
- Expanding the role of the Employee Support Advisors to include advising and supporting staff that wish to raise a concern at work (whistleblowing)
- Raising awareness of the Trust Mediation service for enabling staff experiencing conflict or difficulties in the workplace to find a way forward and improve working relationships.

This Trust will be implementing the national *"Commissioning for Quality and Innovation"* (CQUIN) Scheme to improve health and wellbeing for staff, part of which includes providing the opportunity for staff to access schemes and initiatives that promote physical activity, and provide them with mental health support and rapid access to physiotherapy where required. The milestones are:

- To develop a plan to introduce and actively promote the three initiatives by July 2016
- To have implemented the planned initiatives and actively promoted these services to staff to encourage uptake of initiatives by 31 March 2017

In addition to implementing the recommendations of the "Freedom to speak up" review, bullying and harassment will be tackled through the Values and Behaviours Framework and by working with managers to improve staff engagement across the Trust. The Organisational Development Strategy sets out actions to implement a "Leading with compassion" philosophy to create an environment centred on people quality and impact. These actions include:

- Greater promotion of Trust Values and behaviours and ensuring Trust Values are included in policies, practices and processes
- Development of a full and robust Staff Engagement strategy to ensure that engagement activity is measurable and impactful
- Delivering an effective appraisal process

To improve the staff engagement score to better than the 2015 national average for acute trusts (3.79), staff engagement activities will continue throughout 2016/17, including:

- Implementation of the Staff Engagement tool (WWL) as a pilot rebranded as "engage@UHNM"
- Support for Managers to access an engagement toolkit to drive this within their areas of responsibilities
- Facilitation of Staff Engagement events across all sites, including support for Staff Engagement Champions

Training on the reporting of errors, omissions and near misses is being reviewed and updated to encourage greater reporting. The Datix system is being restructured to make reporting more straightforward for staff to complete and easier for them to access.

An options analysis is being prepared to assess the value in increasing the sample size and for offering mixed mode method of surveying staff.

Priority 4: To consolidate and harmonise the integration of clinical pathways to improve the patient flow through UHNM and deliver efficient admission, diagnosis, treatment and discharge

The Trust has been working towards making the patient pathway into and through the Trust as efficient and patient friendly as possible. During 2015/16, UHNM has faced significant challenges in meeting the different access and discharge targets that are monitored locally and nationally. The final end of year performance for these target have been provided on pages 23.

- Home First initiative has provided an opportunity to improve patient involvement and documentation based on feedback received. The project aims to support patients to return home as soon as possible after assessment and treatment avoiding unnecessary delays. Rolled out to all inpatient wards during Quarter 3 of 2015/16.

Emergency Care Pathway

Emergency demand pressures have continued throughout 2015/16 with both A&E attendances and emergency admissions in excess of planned levels. The Trust has underachieved against

- The 12 hour Trolley wait standard
- The 4 hour wait standard during 2015/16 with Year To Date delivery at 83.4%.

Actions to improve

In order to improve performance within the Emergency Care Pathway the Trust, along with local health economy partners, have taken the following actions:

- UHNM have established an Emergency and Urgent Care Improvement Programme Board, who's remit is to recommend and oversee the actions arising in relation to the delivery of the 12 high impact actions and associated activities detailed in the review. This is chaired by Chief Executive / Chief Operating Officer.
- Pathways between County & RSUH developed within surgery and medicine
- MEDWAY implementation for electronic records access across sites
- Simple and timely discharge targets continue to be achieved
- An integrated home first culture - the Trust is discharging 92.4% of all patients, and 83% of patients >70 years of age to their usual place of residence
- Ward moves during May 2015 resulted in the opening of 28 additional medical beds.
- A new larger discharge lounge opened in May 2015.
- New Ambulatory Emergency Care Centre, opened from September 2015.

Priority 4: To improve communication with patients and stakeholders

UHNM is committed to Patient and Public Involvement and wants to ensure improvements are patient led and standards are developed from a patient perspective. During 2015/16 UHNM undertook a number of actions to help improve the communication with patients and other stakeholders.

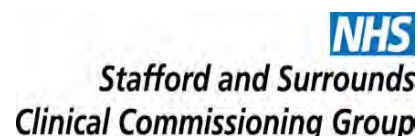
Examples of these are provided below and link in with the work that is being undertaken to improve patient and staff experience as well as harmonising clinical pathways and patient flow to reduce avoidable harm.

- A Hospital User Group on each hospital site which reports quarterly to the Shadow Governors.
- A Patient Information Leaflet Group on the Royal Stoke site
- Developed the 'Its OK to Ask' bookmarks and posters (see opposite) for patients along with a communication training video for staff and a revised discharge leaflet produced
- Maternity Services improved communication about choice of where to give birth by ensuring all women are given a leaflet explaining their options at the point of booking.
- Promoted engagement by encouraging women to write any questions down in their hand held notes
- Proactive encouragement for patient feedback on their experience via patient surveys and patient stories



Statements from our key Stakeholders

We would like to thank our partners from our local commissioning bodies, Stoke-on-Trent and Staffordshire Healthwatch and Stoke & Staffordshire Overview and Scrutiny Committees for reviewing our Quality Account and providing us with feedback. As a result of the feedback we have received, we have made a number of changes. A summary of changes can be found on page 41.



Joint Statement for University Hospital of North Midlands NHS Trust Quality Account

Stoke-on-Trent CCG, North Staffordshire CCG and Stafford and Surrounds CCG are making this joint statement as the nominated commissioners for the University Hospital of North Midlands NHS Trust.

The contract and service specifications with the Trust detail the level and standards of care expected and how these will be; measured, monitored, reviewed and performance managed.

As part of the contract monitoring process, North Staffordshire CCG, Stoke-on-Trent CCG and Stafford and Surrounds CCG meet with the Trust on a monthly basis to monitor and seek assurance on the quality of services provided. In addition to the contract meetings, the CCGs work closely with the Trust and undertake continuous dialogue as issues arise to seek assurance, which is also obtained via quality visits and attendance at the Trust's internal meetings. The CCGs are looking forward in 2016/17 to working with the Trust and other local health economy partners to take forward the Quality Improvement agenda.

The Quality Account covers many of the areas that are discussed at these meetings, which seek to ensure that patients receive safe, high quality care.

Review of 2015/16

It is pleasing to note the Trust's commitment to improving quality as demonstrated by the following achievements:

- The CCGs have been pleased to work with the Trust and recognise the hard work undertaken in 2015/16 to ensure further integration of the Royal Stoke University Hospital and County Hospital and look forward in 2016/17 to the integration of Bradwell and Cheadle Hospitals.
- The CCGs have received regular positive quarterly update reports on the implementation of the action plan agreed in response to the CQC Hospital Inspection (April 2015). Commissioners have also agreed 2016-17 CQUIN schemes which will further support the Trust to improve their overall rating.
- The establishment of the Quality Academy as part of the Trust's commitment to the "Sign up to Safety" campaign is welcomed, as is the open invitation to commissioners to participate in the ongoing development and implementation of the Care Excellence Framework. This is a good example of how the Trust and Commissioners continue to develop their relationship and work together to support quality improvement and patient safety.
- The Trust has not reported any "Eliminating Mixed Sex Accommodation breaches" or Never Events during 2015/2016 and Mortality remains within "expected ranges".

Statements from our key Stakeholders

The Trust has experienced challenges 2015/16 :

- NHS Constitution targets are performing below threshold in relation to A&E - 4hrs wait, Referral to Treatment 18 weeks incomplete pathways and Cancer Performance. There are also a number of Key performance indicators where the zero target for the year has been breached, for example ambulance handover and cancelled operations.
- Commissioners continue to work collaboratively with the Trust to improve quality and performance. We will continue to review patient experience, safety and quality through a wide variety of data sources, monitoring of key quality and performance indicators and quality visits.
- Although the Trust has exceeded the 2015/16 targets for healthcare acquired infections. The Trust has a robust infection prevention control team with well -established systems and processes in place. The team actively engages with the CCGs and Local health economy partners in implementing the work plan to reduce avoidable health care associated infections.

Priorities for 2016/17

The Commissioners welcome the quality priorities for 2016/17 which the Trust has developed in consultation via the Stakeholder Workshops.

Commissioners are particularly pleased at a time of economic challenge to see that the Trust is committed to making explicit the link between quality improvement and cost improvement as being vital to their future success.

We particularly support the Trust's ambition to reduce avoidable patient harm by a further 20% by 2018 as part of their journey to achieving their 2025 vision to provide world class services.

To the best of the commissioner's knowledge, the information contained within this report is accurate.

Jayne Downey
Director of Nursing & Quality
North Staffordshire and Stoke-on-Trent CCGs.

Dr Andrew Bartlam
Clinical Accountable Officer
Stoke-on-Trent CCG

Marcus Warnes
Clinical Accountable Officer
North Staffordshire CCG

Andrew Donald
Accountable Officer
Stafford and Surrounds CCG

Statements from our key Stakeholders



Response to UHNM Quality Account from Healthwatch Stoke-on-Trent and

The Quality Account was presented and considered by patient representatives at Healthwatch Stoke-on-Trent on 23 May 2016. The questions raised and responses received are reflected in this statement. Healthwatch Stoke-on-Trent welcomes the clear and succinct approach adopted for both the presentation and the written Quality Account together with the inclusion of patient stories.

We recognise that during the year the Trust has undergone further integration of the Royal Stoke University and County Hospitals and welcome the continuous commitment to the Patient Care Improvement Programme together with the commitment demonstrated to develop areas of improvement identified by the CQC. We are pleased to hear of the introduction of a Care Excellence Programme which will involve a team of 'inspectors', including a Healthwatch Stoke-on-Trent volunteer, completing a CQC style inspection of a service or ward and look forward to working with the Trust to implement this initiative.

The Trust continues to experience daily pressures in the Accident and Emergency Department and has underachieved against the 12 hour trolley wait standard and the 4 hour wait standard. Whilst we acknowledge that efforts are being made to achieve these targets the situation remains unacceptable and we hope that the implementation of a Patient Flow and Capacity Escalation Plan, new pathways, improvement plans and the introduction of electronic dashboards will drive the journey for acceptable standards in 2016/17. The reduction in patients falls and harm is welcomed and going forward we would like to see the same pattern for patient safety incidents.

Furthermore, Healthwatch Stoke-on-Trent welcomes the development of the End of Life Strategy together with further training for staff, and the introduction of a new End of Life Facilitator and a Non Executive Lead for End of Life care. We hope to see significant improvements in relation to the End of Life services for both patients and families in 2016/17.

Healthwatch Stoke-on-Trent is concerned about the high percentage of staff experiencing harassment, bullying or abuse from staff and how this may impact on patients and their families. Accordingly, we welcome the commitment the trust has expressed to resolving this with reference to the Values and Behaviours Framework together with implementing a 'Leading with Compassion' philosophy.

We are pleased that the alignment of complaints processes across UHNM sites will support consistent working practices including meaningful comparison of types of complaints which we hope will in turn support areas for learning. We welcome the introduction of the Trust Hospital User Group, 'It's OK to Ask', and the revised Induction Programme. Healthwatch Stoke-on-Trent would be interested to have sight of the outcomes of these initiatives and to work with the Trust to support safe and quality patient experience.

We would like to acknowledge the Trusts welcoming approach to our winter pressures survey, outpatients report and Enter and View visits of wards 112 and 113 and look forward to supporting and working with the trust in the coming year.

Healthwatch Stoke-on-Trent

May 2016

Statements from our key Stakeholders



Response to UHNM Quality Account from Healthwatch Staffordshire

Healthwatch Staffordshire welcomed the University Hospitals of North Midlands NHS Trust presentation by Jamie Maxwell, Head of Quality, Safety & Compliance, of its draft Quality Account which was received by an audience of Healthwatch representatives. We acknowledge that the development of the Quality Account is set against the Quality Accounts toolkit and guidance which has remained the same since 2010/11 and is somewhat prescriptive in terms of the structure of the Quality Account. We were advised that this year there had been an attempt to shorten the report in order to make it more user friendly.

The core of the draft report presents a Review of Quality Performance 2015/16, with statistical evidence, where possible, of the priorities that were identified last year.

UHNM pointed out that the Patient Experience priority is difficult to audit, because of the anonymous nature of the Friends & Family Test and acknowledgement that more needs to be done in relation to patient experience and learning from the feedback provided by patients, carers and relatives. The Quality Account sets out the current overall response rate from inpatient wards of 27% against the year-end target of 40%. Several initiatives were highlighted including engagement with Patient Groups, the newly established Hospital User Groups, new discharge information leaflets and work with both Healthwatch Staffordshire and Healthwatch Stoke-on-Trent to improve patient engagement.

Patients can raise their concerns via PALS, the Complaints Process and surveys as well as more publicity being demonstrated to encourage patients to give their feedback including posters, leaflets and the newly introduced It's Ok to Ask campaign. Two patient stories are included in the section setting out the priorities for 2016/17 which may better serve the report if included in the reporting on 2015/16 priority 'to improve our patients' experience' with the addition of a response from the Trust to demonstrate how the feedback has been used to improve the services as well as highlighting good practice from the patients' perspective. It was recognised that poor communication is one of the main challenges that the Trust faces and is also reflected in the feedback received by Healthwatch.

The Trust reports a decrease in complaints and an increase in PALS contacts across both sites. We are encouraged that the Trust, states in its report, that it is looking into the reduction in formal complaints and increase in PALS complaints to determine if complaints are being most appropriately assigned. This is important to ensure that concerns are resolved most effectively as well as the capturing the learning from concerns and complaints to improve service delivery and patient experience.

The Trust's monitoring of its priority to reduce avoidable harm has seen an increase in the number of patient safety incidents in 2015/16 which appears in line with its aim to see an increase in the reporting of incidents and a reduction in the rates of harm, so that reporting is encouraged. There is still work to be done but there is a better understanding of pressure ulcer causation. Heel ulcers are still needing to be more understood however, particularly in relation to those patients being admitted with heel ulcers. Harm Free Care is improving e.g. patients falls and now needs to be compared with other Trusts. It was noted that there was a spike in the mortality measure in the winter of 2014/15 which seems to follow a harsher winter when there was less flu incidence.

Statements from our key Stakeholders

The Quality Account indicates that A&E provides ongoing challenges with the Trust falling short of the targets for patients to be seen and treated in A&E. In terms of integrating clinical pathways between Royal Stoke and County Hospitals, the Trust advised that the challenge of communication will be easier when the MEDWAY electronic records are fully implemented across all sites in 2016/17, which will greatly assist the clinical pathways in all areas.

Healthwatch noted with concern the results of the 2015 staff survey which reported that 28% of staff respondents had experienced harassment, bullying or abuse from staff in the last 12 months, and asked if this was benchmarked against other Trusts as it seemed high. This had been but the results were not available at the time of reporting. It was noted that the Trust's 2016/17 priorities included Priority 2: To improve the experience of our staff and the performance measures being put in place which will be reported via the Trust's Quality and Safety Forum. The staff survey on equal opportunities/career progression was positive and a new appraisal process is now being rolled out across the Trust.

The Quality Accounts provides a progress report in relation to the priority for improving communication with patients and stakeholders including the establishment of a new Hospital User Group for each hospital site as well as a Patient Information Leaflet Group. Healthwatch Staffordshire is represented on the Hospital User Group and is able to provide feedback to the Group which it has received from its own patient feedback mechanisms. There is an expectation that staff are being proactive in encouraging patients to provide feedback on their experiences using patient surveys and patient stories.

The Quality Account sets out the Trust's priorities for 2016/17 and we are pleased to see Priority 4: To ensure appropriate, timely and equitable access to all hospital sites and ensure safe and time discharge be a focus for improvements as recent feedback received by Healthwatch demonstrates that patients are experiencing delays in discharge when medically fit to be discharged but also in terms of delays in discharge when waiting in the discharge lounge, particularly at County Hospital. Healthwatch Staffordshire is undertaking an Enter & View programme of work including discharge from hospital and will share their findings and report with UHNM when completed.

We recognise that this has been, and continues to be, a challenging time for the Trust and Healthwatch welcomes the opportunities for closer working with UHNM to ensure that the communities it represents are offered a voice during the ongoing development and delivery of services by the Trust.

Healthwatch Staffordshire

Statements from our key Stakeholders

Stoke City Councils Adult and Neighbourhoods Overview and Scrutiny Committee

Presentational comments

Committee welcomed the draft report as it had good layout, was the right length and level of jargon. However, some of the diagrams were too small. The committee's main point was that the presentation given on 16 May did not tally with the draft report. Furthermore the information provided was different, we found that the up to date position was in the report and not the presentation.

Quality Account

We were informed on the 16th May that the CQC report would be made available to the committee, we look forward to receiving it (It was received by the Trust on 13th May).

The report tells us on page 7 that the UHNM was the third trust in the country to achieve a GOLD Food for Life Catering Mark but it was confirmed this only related to the County Hospital. It was agreed to amend this to make it clear.

Staff Survey

The committee were concerned that the 2015 Staff Survey found that 28% of respondents said they had experience of harassment, bullying or abuse from staff in the last 12 months. We acknowledged that the response rate was 30%. We were informed HR were working with certain areas and across the board but we were informed that there was no particular poor service highlighted in patient surveys. We noted that there was a task and finish group to review the results of the staff survey and we asked that be sent a copy of the findings.

Safe discharges

We asked about priority 4 and how improvements / new initiatives were measured as we are aware that this has been an issue for our residents. The hospital had recently taken control of community hospitals at Bradwell and Cheadle which will assist safe discharges. It was acknowledged that there was much work to be done here including discharges from Community hospitals.

Waiting Times at A&E

Most of the committee members were aware of people who have had to wait on trolleys at a&e. We noted that the hospital's targets had been missed. We were informed that the hospital does take responsibility for patients when they arrive by ambulance. Committee noted there were 1180 waiting in ambulances for up to 30 minutes which reduced to 15 when the measure was up to 60 minutes. We asked for details of the initiatives in place and how these relate to the priorities. We also asked how many people have been referred to the Nuffield hospital. We have been promised this information.

Partnership working

Given the complexity of the processes in terms of community based care there is a greater need than ever before to make sure that organisations are working closely together to ensure that the processes runs smoothly and patients don't suffer needlessly. Over the past year, the committee does not feel that those relationships are in place to ensure that cracks don't appear in the process between where one organisation stops and another starts.

Statements from our key Stakeholders

Staffordshire Health Scrutiny Committee

We are directed to consider whether a Trust's Quality Account is representative and gives comprehensive coverage of their services and whether we believe that there are significant omissions of issues of concern.

There are some sections of information that the Trust must include and some sections where they can choose what to include, which is expected to be locally determined and produced through engagement with stakeholders.

We focused on what we might expect to see in the Quality Account, based on the guidance that trusts are given and what we have learned about the Trust's services through health scrutiny activity in the last year.

We also considered how clearly the Trust's draft Account explains for a public audience (with evidence and examples) what they are doing well, where improvement is needed and what will be the priorities for the coming year.

Our approach has been to review the Trust's draft Account and make comments for them to consider in finalising the publication. Our comments are as follows.

Introduction.

We note that the document presents a clear vision, Trust values, achievements and purpose. The statement from the Board summarising the view and quality of NHS services is present. We suggest that the inclusion of a statement that to the Boards knowledge the information contained in the document is accurate should be included. The signature of the CEO is present but as in our last commentary we suggest the signature of the Chair also be added before publication. The list of services provided is noted but more detail of services sub contracted would have been helpful.

Priorities .The explanation as to choice, linkage with the domains of patient care, fit with strategy, views of stakeholders and how achieved is present. There is evidence of a process for measurement and a mechanism to report performance via t the Quality and Safety Forum to the Board. In relation to the Statement of Quality we are pleased to note the Trusts successful participation in national schemes of accreditation. The Trusts progressive response to the duty of Candour regulations, participation in the 3 year national Safety Campaign and the subsequent establishment of the Quality Academy is noted.

Statements of Assurance

We note the supplementary text and relevance of the mandated information in relation to quality and services. In relation to improvement of communication with patients and stakeholders, the inclusion of the patient's stories provides a balanced account for the benefit of the reader. In respect of Quality indicators and in particular the statistical information relating to hospital re admissions we are of the view that the integrity of the documented would be elevated with inclusion of statistical information year on year and not in the current 3 year cycle. The inclusion of more detailed information on income streams a breakdown of source, expenditure and the deficit would be of assistance to the reader.

We note the presence of information in respect of the participation in local and national audits, numbers of patients recruited to take part in research and the rational applied to the process as a whole. We would suggest that the report would benefit from additional detail concerning positive outcomes. Further information concerning CQUIN registration, conditions and income would also add value to the document.

We note the presence of the CQC registration and Improvement Plan initiated following the inspection of the Trust by the CQC during 2014/15.As a result we anticipate a focus A&E, End of Life Care services and the other areas identified following the inspection. The Committee look forward to a progress report.

Statements from our key Stakeholders

Staffordshire Health Scrutiny Committee

Hospital episodes score Information is present. We note the Governance Report and subsequent actions identified to improve data quality. The assessment as, satisfactory with action plan by the Health and Social Care Information Centre is noted. The Committee looks forward to an update in the future. We are pleased acknowledge the continued improved performance in this area since 2011.

Review of Quality Performance

We note the explanation of how the contents/priorities have been determined who was involved, and the rationale applied for selection. Information about specific services and specialities and what patients and public say is present. Indicators and evidence including complaints, patient and staff surveys are also included.

Performance against objectives and targets is present .The data concerning In Patient Experience appears to be out of date and may need revisiting prior to publication. The Quality Walkabouts are well embedded as are the Friends and Family Test in the latter the results appear positive.

We note that we are commenting on a draft document; our comment is based on the information available with the expectation that the outstanding information be added before publication. To conclude we are of the view that as a public the document it could have been presented in a more sequential and user friendly format.

Glossary of Terms Used

Term	Description
A&E	Accident and Emergency
ACS	Acute Coronary Syndrome
AMS	Anaesthetic Management Service
CABG	Coronary Artery Bypass Graft
CAUTI	Catheter Associated Urinary Tract Infection
CCG	Clinical Commissioning Group
C Diff	Clostridium Difficile
CQUIN	Commissioning for Quality and Innovation Indicators
CQC	Care Quality Commission
CNST	Clinical Negligence Scheme for Trusts
EPAS	Excellence in Practice Accreditation Scheme
ESR	Electronic Staff Record
GP	General Practitioner
HDU	High Dependency Unit
HES	Hospital Episode Statistics
HSMR	Hospital Standardised Mortality Ratio
IG	Information Governance
IGRT	Image-guided Radiation Therapy
IT	Information Technology
ITU	Intensive Care Unit
LINK	Local Involvement Network
MEWS	Modified Early Warning Score
MRI	Magnetic Resonance Imaging
MRSA	Methicillin Resistant Staphylococcus Aureus
MUST	Malnutrition Universal Screening Tool
NCEPOD	National Confidential Enquiries into Patient Outcome and Death
NHS	National Health Service
NHSLA	National Health Service Litigation Authority
NICE	National Institute for Clinical Excellence
NIHR	National Institute for Health Research
OSC	Overview and Scrutiny Committee
PCT	Primary Care Trust
PROMS	Patient Reported Outcome Measures
PSED	Public Sector Equality Duties
ROP	Retinopathy of Prematurity
RPV	Renal Patient View
RR	Relative Risk
SHMI	Summary Hospital-level Mortality Indicator
SUS	Secondary Users Service
TPN	Total Parenteral Nutrition
UHNS	University Hospital of North Staffordshire
UNICEF	United Nations Children's Fund
UCIP	Unscheduled Care Improvement Programme
VTE	Venous Thromboembolism
WHO	World Health Organisation

List of services

A	B	C
Accident & Emergency (A&E) Ambulatory Emergency Care (AEC) Antenatal Clinic Anticoagulant Management Service Audiology	Bariatric Surgery Breast Surgery	Cancer Services Cardiology Chemotherapy Children's wards and services Clinical Haematology Critical Care (ITU) Central Treatment Suite Cystic Fibrosis
D	E	F
Day Surgery and Admissions Unit Delivery Suite Dentist Services Dermatology Diabetes and Endocrinology Discharge Lounges	Elderly Care (Older People) Endocrinology End of Life ENT (Ear, Nose & Throat)	Frail Elderly
G	H	I
Gastroenterology Genitourinary Medicine Gynaecology	Haematology Haemophilia	Infection Control Infectious Diseases Interpreter Services Imaging (X Ray) ITU (Critical Care)
K	L	M
Kidney	Lower Gastrointestinal Lymphoedema	Major Trauma Maternity Maxillofacial Musculo-skeletal
N	O	P
Neonatal Intensive Care Unit (NICU) Neurology Neurophysiology Neurosurgery Nuclear Medicine Nephrology Nutrition & Dietetics	Obstetrics Occupational Therapy Oncology Outpatient Parenteral Antibiotic Therapy Ophthalmology Oral and Maxillofacial Surgery Orthodontics Orthopaedics Outpatients	Pain Management Palliative Care Pathology Pharmacy Plastic Surgery Pre Anaesthetic Management Physiotherapy
R	S	T
Radiotherapy Renal (Kidney) Respiratory Restorative Dentistry	Short Stay Unit (SSU) Stroke Surgery Surgical Appliances Spinal Services	Trauma Theatres
U	V	X
Urology	Vascular Syrgery	X Ray (Imaging)

Summary of Changes as a result of feedback

Independent Auditors Limited Assurance Report to the Directors of University Hospital of North Midlands NHS Trust on the Annual Quality Account

We are required to perform an independent assurance engagement in respect of University Hospitals of North Midlands NHS Trust's Quality Account for the year ended 31 March 2016 ("the Quality Account") and certain performance indicators contained therein as part of our work. NHS trusts are required by section 8 of the Health Act 2009 to publish a quality account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010, the National Health Service (Quality Account) Amendment Regulations 2011 and the National Health Service (Quality Account) Amendment Regulations 2012 ("the Regulations").

Scope and subject matter

The indicators for the year ended 31 March 2016 subject to limited assurance consist of the following indicators:

- Rate of Clostridium Difficile infections
- Percentage of patient safety incidents resulting in severe harm or death.

We refer to these two indicators collectively as "the indicators".

Respective responsibilities of directors and auditors

The Directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the Regulations).

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

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

The Directors are required to confirm compliance with these requirements in a statement of Directors' responsibilities within the Quality Account.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the NHS Quality Accounts Auditor Guidance 2014-15 issued by DH in March 2015 (“the Guidance”); and
- the indicators in the Quality Account identified as having been the subject of limited assurance in the Quality Account are not reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

We read the Quality Account and conclude whether it is consistent with the requirements of the Regulations and to consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Account and consider whether it is materially inconsistent with:

- Board minutes for the period April 2015 to June 2016;
- papers relating to quality reported to the Board over the period April 2015 to June 2016;
- feedback from the Commissioners dated 20/06/2016;
- feedback from Local Healthwatch dated 22/06/2016;
- the Trust’s complaints report published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009, dated April 2016;
- the latest national patient survey dated 08/06/2016;
- the latest national staff survey dated 23/02/2016;
- the Head of Internal Audit’s annual opinion over the Trust’s control environment dated 25/05/2016;
- the Annual Governance Statement dated 27/05/2016; and
- the Care Quality Commission’s Intelligent Monitoring Report dated May 2015.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with these documents (collectively the “documents”). Our responsibilities do not extend to any other information.

This report, including the conclusion, is made solely to the Board of Directors of University Hospitals of North Midlands NHS Trust.

We permit the disclosure of this report to enable the Board of Directors to demonstrate that they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permissible by law, we do not accept or assume responsibility to anyone other than the Board of Directors as a body and University Hospitals of North Midlands NHS Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement under the terms of the guidance. Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- testing key management controls;
- analytical procedures;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content of the Quality Account to the requirements of the Regulations; and
- reading the documents.

A limited assurance engagement is narrower in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable, measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Account in the context of the criteria set out in the Regulations.

The nature, form and content required of Quality Accounts are determined by the Department of Health. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS organisations.

In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by University Hospitals of North Midlands NHS Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2016:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the Guidance; and
- the indicators in the Quality Account subject to limited assurance have not been reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

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29/06/2016

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