NHS
University Hospitals of North Midlands
NHS Trust

Trust Board (Open)

March 2020

Together Compassion Safe Improving

University Hospitals of North Midlands NHS Trust

Trust Board (Open)

Meeting held on Wednesday 11th March 2020 at 9.30 am to 12.30 pm
Trust Boardroom, Third Floor, Springfield, Royal Stoke

AGENDA

Time	No.	Agenda Item	Purpose	Lead	Format
09:30	**PROCEDURAL ITEMS**				
30 mins	1.	Patient Story	Information	Prof G Crowe	Verbal
5 mins	2.	Chair's Welcome, Apologies and Confirmation of Quoracy	Information	Prof G Crowe	Verbal
	3.	Declarations of Interest	Information	Prof G Crowe	Verbal
	4.	Minutes of the Meeting held 5th February 2020	Approval	Prof G Crowe	Enclosure
5 mins	5.	Matters Arising via the Post Meeting Action Log	Assurance	Prof G Crowe	Enclosure
10 mins	6.	Chief Executive's Report - February 2020	Information	Mrs T Bullock	Enclosure
10:20	**PROVIDE SAFE, EFFECTIVE, CARING AND RESPONSIVE SERVICES**				
5 mins	7.	Quality Governance Committee Assurance Report (27-02-20)	Assurance	Ms S Belfield	Enclosure
20 mins	8.	Staffing Establishment Reviews Report	Assurance	Mrs M Rhodes	Enclosure
10 mins	9.	Care Quality Commission Report	Assurance	Mrs M Rhodes	Enclosure
10 mins	10.	Quality & Safety Report – Quarter 3	Assurance	Mrs M Rhodes	Enclosure
10 mins	11.	Patient Experience Report – Quarter 3	Assurance	Mrs M Rhodes	Enclosure
11:15 – 11:25 COMFORT BREAK					
11:25	**ENSURE EFFICIENT USE OF RESOURCES**				
5 mins	12.	Performance & Finance Committee Assurance Report (25-02-20)	Assurance	Mr P Akid	Enclosure
10 mins	13.	Financial Performance Report – Month 10	Assurance	Mr M Oldham	Enclosure
11:40	**ACHIEVE EXCELLENCE IN EMPLOYMENT, EDUCATION, DEVELOPMENT AND RESEARCH**				
5 mins	14.	Transformation and People Committee Assurance Report (27-02-20)	Assurance	Prof G Crowe	Enclosure
10 mins	15.	Staff Survey Report	Assurance	Mrs R Vaughan	Enclosure
5 mins	16.	Gender Pay Gap Report	Approval	Mrs R Vaughan	Enclosure
12:00	**ACHIEVE NHS CONSTITUTIONAL PATIENT ACCESS TARGETS**				
20 mins	17.	Integrated Performance Report – Month 10	Assurance	Mr P Bytheway Mrs M Rhodes Mrs R Vaughan Mr M Oldham	Enclosure
12:20	**CLOSING MATTERS**				
5 mins	18.	Review of Meeting Effectiveness and Business Cycle Forward Look	Discussion	Prof G Crowe	Enclosure
5 mins	19.	Questions from the Public **Please submit questions in relation to the agenda, by 12.00 pm 6th March 2020 to claire.rylands@uhnm.nhs.uk**	Discussion	Prof G Crowe	Verbal
12:30	**DATE AND TIME OF NEXT MEETING**				
	20.	**Wednesday 8th April 2020, 9.30 am – 12.30 pm, Trust Boardroom, Third Floor, Springfield, Royal Stoke**			
	EXCLUSION OF THE PRESS AND MEMBERS OF THE PUBLIC				
		Resolution: To exclude the press and public from the meeting at this point, on the grounds that publicity of the matters being reviewed would be prejudicial to public interest, by reason of the confidential nature of business. The press and public are requested to leave at this point (Section 1 [2] Public Bodies [Admission to Meetings] Act 1960)			

University Hospitals of North Midlands NHS Trust

Trust Board (Open)

Meeting held on 5th February 2020 at 9.30 am to 12.25 pm
Trust Boardroom, Third Floor, Springfield, Royal Stoke

MINUTES OF MEETING

Attended	Apologies / Deputy Sent	Apologies

Voting Members:			A	M	J	J	A	O	N	D	J	F	M
Mr D Wakefield	DW	Chairman											
Mr P Akid	PA	Non-Executive Director											
Ms S Belfield	SB	Non-Executive Director											
Mr P Bytheway	PB	Chief Operating Officer											
Mrs T Bullock	TB	Chief Executive											
Prof G Crowe	GC	Non-Executive Director						Chair					
Dr L Griffin	LG	Non-Executive Director											
Prof A Hassell	AH	Non-Executive Director											
Mr M Oldham	MO	Chief Financial Officer	JT	JT	JT								
Dr J Oxtoby	JO	Medical Director											
Mrs M Rhodes	MR	Chief Nurse	LR	LR	LR	TR							
Mr I Smith	IS	Non-Executive Director											
Mrs R Vaughan	RV	Director of Human Resources											

Non-Voting Members:			A	M	J	J	A	O	N	D	J	F	M
Ms H Ashley	HA	Director of Strategy & Transformation											
Mr A Butters	AB	Director of Business Development											
Mr M Bostock	MB	Director of IM&T											
Ms N Duggan	ND	Director of Communications											
Miss C Rylands	CR	Associate Director of Corporate Governance											
Mr J Scott/ Mr P Orwin	JS/ PO	Chief Operating Consultant											
Mrs F Taylor	FT	Associate Non-Executive Director											
Mrs L Whitehead	LW	Director of Estates, Facilities & PFI											

In Attendance:		
Mr S Bell	SB	Patient Story (item 1)
Mrs A Grocott	AG	Head of Patient Experience (item 1)
Mrs N Hassall	NH	Deputy Associate Director of Corporate Governance (minutes)
Miss S Matthews	SM	Patient Story (item 1)
Mrs R Pilling	RP	Quality Improvement Facilitator (item 1)

Members of Staff, Public & Press 4

No.	Agenda Item	Action
1.	**Patient Story**	
015/2020	Mr Bell recalled his story while he was an inpatient and highlighted issues with the way in which he found it difficult to obtain information about his condition. Although he described his care as very good he highlighted that communication was lacking and he and his family received contradictory information about his condition and encountered difficulties when trying to plan for his discharge. He referred to a subsequent outpatient appointment which was positive, and provided him with information about what treatment he had received and the reasons for	

PROUD TO CARE

	this, while he was in hospital, and felt that if this information had been provided to him while in hospital he and his family would have been far less anxious. Miss Matthews recalled a similar experience where she described the care given as excellent and the staff very compassionate but during her experience when visiting her grandfather in hospital there was a breakdown in communication between the staff and his relatives, in terms of the plan of care for her grandfather. She also recalled an inpatient admission whereby she also experienced difficulties in receiving information about her treatment and plan of care. She referred to her subsequent outpatient appointment which was helpful in terms of explaining the treatment she received in hospital and the reasons for the different tests. Mr Wakefield apologised for the distress caused to both Mr Bell and Miss Matthews and their families, in not receiving the information required. He queried how communication could be improved. Mr Bell suggested that a brief summary could be provided to the patient and relatives in terms of the proposed treatment plan. Miss Matthews stated that the information could be provided either verbally or written, and just needed to summarise what had happened, the plan of care and the reasons for this. Mrs Rhodes apologised for both experiences and stated that in order to improve this for other patients, she would share the story with Ward Sisters. She stated that a written summary should not be required and noted how this would very quickly become out of date as provisional diagnoses change and also noted the summary and plan of care should be provided by a doctor or nurse, and this was an omission from their inpatient stay. Dr Oxtoby agreed that providing adequate information to patients and their relatives was part of the care being provided and it was important for patients to understand what was happening to them. He added that providing the information to patients also helped in their recovery. Mr Bytheway added that communication between patients and the team enabled planning to take place for a timely discharge and therefore this featured as part of the urgent care improvement programme. Professor Hassell queried if they felt that there were any advocates on the ward for them as a patient to which they both responded to say that they felt this was not the case. Professor Hassell also queried whether they had been involved with any junior doctors during their stay to which they confirmed they had not. Mr Wakefield summarised both stories which highlighted a lack of communication, having an impact on both the patient and their relatives. He also added that this led to a lack of confidence in patients feeling able to ask for information. He reflected on how vulnerable they both felt while in hospital and that this needed to be considered when revisiting initiatives such as the 'It's OK to Ask' campaign and #hello my name is. Mr Wakefield welcomed the kind words provided by both Mr Bell and Miss Matthews, about the staff on the wards and the care provided. Mr Bell, Miss Matthews, Mrs Grocott and Mrs Pilling left the meeting. Mr Wakefield queried how the Board could consider the learning from the stories and Mrs Bullock stated that sharing the stories with staff would have an impact and that this should be highlighted within complaints training and engagement sessions. Mrs Rhodes agreed that the 'It's OK to Ask' campaign also needed to be reinvigorated.	**MR**

	Professor Crowe suggested filming the stories so that they could be used elsewhere and Mrs Bullock stated that Mr Bell and Miss Matthews had already agreed to be filmed. She added that this would also be shared with NHS England/Improvement (NHSEI) so that staff across the NHS could learn from it. Professor Hassell suggested sharing the film with foundation doctors too. **The Trust Board noted the patient story.**	
2.	**Chair's Welcome, Apologies & Confirmation of Quoracy**	
016/2020	Mr Wakefield welcomed members of the Board, public and press to the meeting. Apologies were received as noted above and it was confirmed that the meeting was quorate. Mr Wakefield welcomed Mrs Taylor to the meeting who had joined the Trust on a placement for a year, as a Non-Executive Director.	
3.	**Declarations of Interest**	
017/2020	The standing declarations were noted.	
4.	**Minutes of the Meeting Held 8th January 2020**	
018/2020	The minutes of the meeting held on 8th January 2020 were approved as a true and accurate record.	
5.	**Matters Arising via the Post Meeting Action Log**	
019/2020	PTB/357 – Mrs Rhodes confirmed that the nursing establishment review would be brought to the meeting in March.	
6.	**Chief Executive's Report**	
020/2020	Mrs Bullock highlighted a number of areas from her report. Mr Wakefield queried the reference to u-codes and it was noted that this related to recording of activity which was subject to ongoing scrutiny. Mr Wakefield referred to the flu vaccination programme and queried if the percentage of staff who had the vaccine and had since developed flu, was known. It was confirmed that the Trust was undertaking detailed research to get a better understanding of the impact of this winters flu whilst acknowledging it would be difficult to provide comparisons with other NHS Trusts unless they were obtaining the same data. Mrs Whitehead referred to the bug which had been identified on the network, which was not having a clinical impact, but was affecting the access layer of the network. She highlighted that a partial fix had been put in place which had addressed the symptom and a total resolution was being worked on. It was confirmed that the bug was not malicious and Mr Wakefield summarised that it was not having an impact on patient safety and systems were able to continue to be used as normal. Mrs Bullock highlighted that the NHS operational planning and contracting guidance had been received which would start to feature in Trust planning going	

	forwards. Mr Wakefield referred to the additional beds referred to in the guidance and queried whether these related to community or acute beds. Mrs Bullock confirmed that the guidance did not stipulate the type of beds to be introduced and outlined the process by which the number and type of beds would be arrived at across the Country. Mrs Rhodes provided an update on Coronavirus. She stated that the Trust was following the guidance from Public Health England and had an isolation ward on site which would be utilised as required. She stated that work was being undertaken with the Emergency Preparedness, Resilience and Response (EPRR) teams in terms of the patient pathways for any patients suspected of having the virus and she confirmed that Personal Protective Equipment was available. Mr Wakefield queried how quickly the Trust would be able to determine whether a patient had flu or Coronavirus and Mrs Rhodes stated that national guidance suggested that patients should first contact 111 rather than attend A&E in order to reduce the possibility of patients with Coronavirus attending A&E. She stated that the test was undertaken via a swab and if anyone was suspected they would be moved to the isolation ward while waiting for the results. She added that national teams were working on setting up a home swabbing service. Mr Akid queried if the Trust was on a shortlist for quarantining suspected cases and Mrs Rhodes confirmed that the Trust was not on such a shortlist however noted that all Trusts had completed a self-assessment to determine what facilities and resources were available in each Trust and noted that UHNM was lucky as it has its own infectious diseases (ID) unit, a significant number of side rooms available and highly skilled healthcare professionals in relation to ID and Microbiology. **The Trust Board received and noted the report and approved the contract award in relation to the E-REAF 3294, Supply Chain Coordination Limited (SCCL) - Trust wide Annual Expenditure, noting that actions were being taken to review the cost and efficiency of the contract.**	
PROVIDE SAFE, EFFECTIVE, CARING AND RESPONSIVE SERVICES		
7.	**Quality Governance Committee Assurance Report (23-01-20)**	
021/2020	Professor Hassell highlighted the following: • The Committee noted the perception that staff were slightly less engaged with fire safety which was being addressed • An audit of transfers from County Hospital was received and no concerns were raised. • It was agreed that the safety element of the staffing report would continue to be received at Quality Governance Committee (QGC) as well as being considered at the Transformation and People Committee (TAP) Mr Wakefield referred to the recent national news highlighting the malpractice of Dr Paterson and another Surgeon and queried how the QGC could be assured of the practices in place at the Trust which should prevent this from occurring. Dr Oxtoby stated that once concerns are raised against an individual, these were acted upon and sanctions taken. Mr Wakefield asked Dr Oxtoby to provide assurance of the processes in place for medics and other professionals, in terms of the management of concerns about individuals practice to the TAP and management of concerns of quality/safety to the QGC.	**JO**

	The Trust Board received and noted the assurance report.	
8.	**Annual PLACE Inspection Scores 2019**	
022/2020	Mrs Whitehead highlighted that the inspection had resulted in the Trust having received consistently high scores for both sites which were above the national average. Mrs Rhodes stated that she had been asked if the site could be used as an exemplar, in terms of infection prevention and control given the scores received, and agreed that the results should be celebrated. Mrs Taylor queried if the visits were announced and Mrs Whitehead confirmed that these were unannounced and only the inspection team were aware of the specific date and the specific areas to be visited. Mr Wakefield congratulated the Trust on the results and queried whether the visits included areas such as the Costa/Subway or retail areas. Mrs Whitehead stated that the visits did not cover those areas but she had raised this with Sodexo in terms of improving the cleanliness of these areas. **The Trust Board considered the report and noted the very positive scores achieved.**	
ENSURE EFFICIENT USE OF RESOURCES		
9.	**Performance and Finance Committee Assurance Report (21-01-20)**	
023/2020	Mr Akid highlighted the following: • The Committee significantly focussed on operational performance in terms of cancer standards and seeking assurance in relation to the urgent care improvement plan • The Committee was expecting to receive the cancer improvement plan by February/March and an improvement in performance from quarter 2 **The Trust Board received and noted the assurance report.**	
10.	**Financial Performance Report – Month 9**	
024/2020	Mr Oldham highlighted the following: • At the end of quarter 3, the Trust had achieved a break-even position • The Trust was forecast to achieve a surplus by the end of the year • Key variances were as previously noted and additional capital funding had been received in month to support the replacement of imaging equipment and emergency capital for Project STAR • Spending was within the financial envelope for the winter plan • The Trust was getting close to reaching the agency ceiling for the year therefore improvements were required in order to reduce the impact in 2020/21 Mr Wakefield congratulated the Executive team on the work undertaken to achieve a break-even position by the end of month 9. Professor Crowe referred to the costs for the winter plan and queried whether this had been costed at risk. Mr Oldham stated that the initial plan had included £2.4	

	m in the base budget and reforecast to include an additional £1.8 m for winter. He stated that the submitted plan assumed spending the same amount for 2020/21 although the impact of the planning guidance needed to be considered. Professor Crowe referred to the volume variations and outpatients being more than planned, and queried if there were any consequences on the Trust for the variation. Mr Oldham stated that this was being discussed with commissioners in terms of outcomes versus input targets. **The Trust Board received and noted the report.**	
ACHIEVE EXCELLENCE IN EMPLOYMENT, EDUCATION, DEVELOPMENT AND RESEARCH		
11.	**Transformation and People Committee Assurance Report (24-01-20)**	
025/2020	Professor Crowe highlighted the following: • The first meeting had been held and he thanked Board members for their attendance and commitment • The inaugural meeting considered the Terms of Reference and boundaries with other Committees, and meeting effectiveness would be reviewed after 3 months • Some actions were identified in relation to freedom to speak up, review of the strategic risks for 2020/21 and the input from groups underneath the Committee i.e. professional standards • It was noted that organisational transformation needed to be broader and the Committee requested an outline of how the activities were to be coordinated. Mrs Ashley stated that the timing of bringing this piece of work back to the Committee needed to be confirmed and Mrs Bullock advised it should only be undertaken once the Clinical Strategy and Quality Improvement Programme were concluded as these were major components of the future transformation programme. Mrs Bullock advised that initially, it would be useful to establish a baseline in terms of the transformation activity already underway. Mr Wakefield welcomed the number of values recognition badges being provided to staff over the years. **The Trust Board received and noted the assurance report.**	
ACHIEVE NHS CONSTITUTIONAL PATIENT ACCESS TARGETS		
12.	**Integrated Performance Report - Month 9**	
026/2020	<u>Operational Performance</u> Mr Bytheway highlighted the following in relation to urgent care performance: • There were 321, 12 hour breaches in December, and lessons on the primary cause of the breaches had been considered • There had been issues in terms of occupancy and the number of simple and timely discharges and going forwards the urgent care improvement plan would reflect on this, in order to seek to address the issues experienced • Daily metrics continued to demonstrate poor specialty performance • Going forwards the resilience at County Hospital needed to improve Mr Wakefield queried performance for the end of January and Mr Bytheway stated that the Trust was 75th out of 137 Trusts. He added that there had been 200, 12 hour breaches in the first 6 days of January and none since that time.	

Professor Crowe queried the processes in place to learn from these breaches and Mr Bytheway referred to the debrief which took place in January, which concluded that the main issue was the acuity of patients and until occupancy was at the right level, the impact on flow would result in there continuing to be risks of breaches.

Professor Crowe queried the process in place to ensure simple/complex discharges were taking place as required and Mr Bytheway stated that there was not one person responsible for this, but this was being considered in terms of improving planning for discharge.

Dr Oxtoby added that focusing on the criteria for discharge was imperative in order to discharge patients more efficiently, particularly at weekends. Professor Hassell stated that the plans and criteria for discharge also needed to be shared with patients.

Mr Wakefield summarised that learning from the 12 hour breaches was taking place and there were a number of actions in train in order to build the urgent care improvement plan for 2020/21.

Mr Bytheway highlighted the following in terms of cancer performance:

- There was a plan in place for urology and the new robot had been introduced, which was not yet at full capacity. The plan was that by the end of February / beginning of March, long waiters will have been brought forward, enabling an improvement in 62 day performance from May 2020. Mr Wakefield queried if the robot would improve efficiency or outcomes and Mrs Bullock stated that although less cases were undertaken as robotic surgery generally took longer, the patient's stay in hospital would be reduced after the surgery due to being less invasive and outcomes are also better when using robotics. However, Mrs Bullock also added that as the Urologists were so experienced with robotics, the numbers they can do on one list had increased to almost that of open procedures.
- Improvements were required in terms of colorectal performance and a plan was in place for triage to test although this was having an impact on the workforce required to track cases
- Key actions were being identified to reduce the number of 62 day wait patients, and those patients approaching 104 days, and the Intensive Support Team had been engaged to look at the colorectal pathway and suggest improvements, although the issues facing the Trust were reflected nationally.

Mr Wakefield queried the timeline in terms of improvement and Mr Bytheway stated that work was ongoing to improve 28 day performance and that by quarter 2 he was aiming for the 62 day target to be achieved.

Mrs Taylor queried if more referrals reflected an increase in the number of inappropriate referrals and Mr Bytheway confirmed that an audit of referrals was being undertaken, as the Trust was seeing more patients but not seeing an associated increase in those diagnosed with cancer.

<u>Caring and Safety</u>

Mrs Rhodes highlighted that the Trust was linking in with other organisations which had better A&E Friends and Family Test (FFT) scores, in terms of lessons learned. She added that there had been an increase in the number of c-difficile cases, whereby there were 18 cases in December and these were being investigated. She stated that there had been transmission on one ward and immediate measures had been put into place in addition to a Root Cause

	Analysis (RCA) being undertaken. Dr Oxtoby referred to a never event which occurred in September and was reported in December, relating to wrong site surgery the investigation for which would be considered by the Risk Management Panel (RMP) in March. Professor Crowe queried the progress in relation to the Care Quality Commission (CQC) Section 31 notices and Mrs Rhodes confirmed that discussions had taken place with the CQC and the Trust was to apply to remove the notices, once all required information was available to be submitted with the application. Mr Wakefield queried, given the number of 12 hour breaches in December, how the Board could be assured that no patients came to harm. Mrs Rhodes stated that harm reviews had been undertaken for 22% of patients and this had been reported to QGC. She stated that 2 patients cases had been referred for additional in-depth review and the outcome was awaited. It was noted that the outputs from these reviews would be considered at the RMP as well as being shared with NHSEI and the Clinical Commissioning Group (CCG). <u>Financial Rating</u> No further questions were raised. <u>Organisational Health</u> Mrs Vaughan highlighted the following: • Slow progress had been made in some areas in relation to appraisal rates, which was in part due to operational pressures, and the rate had improved to 81.20% • There had been a dip in statutory and mandatory training, to 90.20% • There had been a slight improvement in month for sickness absence, at 5.85% and there remained more work to do in respect of managing sickness absence **The Trust Board received and noted the report.**	
GOVERNANCE		
13.	**Audit Committee Assurance Report (23-01-20)**	
027/2020	Professor Crowe highlighted the following: • The Committee had completed the majority of its work plan with the exception of the internal audit into risk management which was to be reported to the next Committee meeting • A number of internal audit reports with positive assurances were received which was pleasing to note • Positive feedback was provided in relation to the effectiveness of internal and external audit services • 100% response rate for declaration of interests had been achieved, which was particularly positive for the health sector and reflected the way in which the approach had been embedded within the organisation • The Committee reviewed and approved the revised Standing Financial Instructions (SFI) and Scheme of Delegation • The Committee challenged the Board Assurance Framework (BAF) for Quarter 3 in terms of the gap between the score and target risk score and actions being taken. The Committee noted the ongoing work to revise and reconsider the strategic risks for 2020/21	

	• The Committee debated the number of SFI breaches and asked for further analysis in relation to whether additional actions were required. Mr Oldham stated that information needed to be provided to the Committee in terms of whether the breaches were of concern or not. **The Trust Board received and noted the assurance report.**	
14.	**Board Assurance Framework (BAF) – Quarter 3**	
028/2020	Miss Rylands stated that an extract of the BAF, rather than the full document, had been considered at each of the Committees, following the recommendation from the NHSEI Well Led Review, which worked well and helped to focus the discussion. She referred to the discussions held at each of the Committees in relation to the specific risks on the BAF, and the way in which they had reflected on the process in place and recognised the need to consider whether the risks included on the BAF reflected reality. She stated that a session had been held with the Executive Team to reconsider the strategic risks facing the Trust, and these were due to be discussed and agreed with the Board in the closed session. Mr Wakefield referred to K-Com risk and reduction in the risk score and queried whether this was correct given the bug which had been identified. Mrs Whitehead stated that the bug had been identified since the document had been updated. Mr Wakefield referred to the continued most extreme risk being in relation to the Royal Infirmary site, which needed further reflection when compared to the risks to patients as a result of the issues affecting operational performance. Mr Wakefield referred to the risk in relation to delivery of 7 day services and queried the rationale for reducing the risk score. Dr Oxtoby stated that the evidence in place was that the Trust was delivering the standards and this would be confirmed in the next submission. **The Trust Board noted the Board Assurance Framework for Quarter 3 and noted the further discussion which was due to take place in determining the strategic risks for 2020/21.**	
15.	**Quarterly Speaking Up Report – Quarter 3**	
029/2020	Mrs Vaughan highlighted the following: • 15 concerns had been received by the Freedom to Speak Up Guardian and additional contacts had been made to the Employee Support Advisors • An anonymous reporting system for junior medical staff had been launched, the effectiveness of which would be reflected on, before considering the roll out • Freedom to Speak Up training was being embedded within the Trust and two new Associate Freedom to Speak Up Guardians had been appointed • Further work was to be undertaken in terms of reviewing the self-assessment in relation to Freedom to Speak Up Mr Akid queried whether the level of concerns were similar to other organisations and Mrs Vaughan stated that benchmarking was not always available although a peer network comparison was being established in order to determine this. Mr Wakefield referred to the information in relation to the high percentage of staff	

	knowing how to report unsafe practice which was positive but that this did not seem to correlate with the 65% feeling able to report it. Mrs Vaughan stated that the information related to the specific questions in the staff survey and the results from last year's survey were required in order to determine whether the actions taken had had a positive impact on the scores. Mrs Vaughan added that a Speaking Up Charter was to be introduced which was hoped to provide reassurance to staff. In addition, improvements would be made in terms of providing feedback to staff in relation to the actions taken as a result of investigating their concern. **The Trust Board considered the themes and type of concerns raised during Quarter 3 and the actions proposed during Quarter 4 to further encourage and promote a culture of speaking up at UHNM.**	
16.	**Standing Financial Instructions and Scheme of Delegation Policies**	
030/2020	Mr Oldham highlighted some of the main changes to the policies: • Re-phasing of budgets were to be signed off by the Chief Finance Officer • Agreement of changes to medical and nursing establishment were to be strengthened by including the Medical Director and Chief Nurse • The Trust Executive Committee had been removed from the approval process for business cases, and the limits had been reduced so that the Board would consider any cases above £1 m • The annual report and accounts were to be signed off by the Trust Board, removing the delegated authority to the Audit Committee • The sums written off for debt recovery had been changed • Single Tender Waivers were to be signed off by the Chief Finance Officer • Changes had been made to the delegated authority for pharmacy Professor Crowe welcomed the thorough piece of work undertaken to review the policies. **The Trust Board approved the revised policies.**	
CLOSING MATTERS		
17.	**Review of Meeting Effectiveness / Business Cycle Forward Look**	
031/2020	The Board agreed that there had been adequate time to discuss the papers which were of sufficient quality. Miss Rylands requested confirmation whether the Board had found the revised style of Committee Assurance Reports beneficial, to which it was agreed that the format was useful. It was agreed to include the list of acronyms within Board Intelligence.	**CR**
18.	**Questions from the Public**	
032/2020	Mr Syme queried whether the Trust had drawn down any 'bail out'/interim revenue loans from the Department of Health and Social Care and if so, what the Trust's revenue loan debt was at April 2019. He also queried what the total interest payable on that amount was for the year. Mr Oldham stated that the Trust had drawn down loans to maintain liquidity of £186,671,000 and the total interest was £7,272,000. Mr Syme referred to the performance report which indicated a surge of child attendees at A&E in November continuing into December. He queried whether the surge had abated and queried the reasons for the unprecedented child attendee numbers. Mr Bytheway confirmed that the surge had abated and the main cases	

	were flu and Respiratory Syncytial Virus (RSV). It was recognised that the child vaccination uptake was low and additional communications had been utilised to try to improve the level of uptake and earlier planning communications for winter 2020 was taking place. Mr Syme referred to the winter plan and the extra capacity defined for 'Step Down' within Midlands Partnership NHS Foundation Trust. He referred to the temporarily closed beds/capacity identified at Bradwell Community Hospital and queried whether the extra capacity was available and if so when it became available. Mr Bytheway confirmed that the capacity was available and 21 beds came online in December and a further 21 in January, at the Haywood as planned.	
DATE AND TIME OF NEXT MEETING		
19.	Wednesday 11th March 2020, 9.30 am – 12.30 pm, Trust Boardroom, Third Floor, Springfield, RSUH	

Trust Board (Open)

Post meeting action log as at **04 March 2020**

CURRENT PROGRESS RATING		
B	Complete / Business as Usual	Completed: Improvement / action delivered with sustainability assured.
GA / GB	On Track	Improvement on trajectory either: A. On track – not yet completed *or* B. On track – not yet started
A	Problematic	Delivery remains feasible, issues / risks require additional intervention to deliver the required improvement e.g. Milestones breached.
R	Delayed	Off track / trajectory – milestone / timescales breached. Recovery plan required.

Ref	Meeting Date	Agenda Item	Action	Assigned to	Due Date	Done Date	Progress Report	RAG Status
PTB/357	08/05/2019	Bi-annual Nurse Staffing Assurance Report	To include within future safe staffing reports considered by the Quality Assurance Committee, a reflection on the trends in relation to the 10 points in addition to the outcome of the audit of robustness of acuity being entered onto the system.	Michelle Rhodes	05/03/2020	11/03/2020	Included on March's agenda.	B
PTB/382	14/08/2019	Patient Story	To take the revised dementia strategy to the Quality Assurance Committee.	Michelle Rhodes	22/04/2020		Action not yet due.	GA
PTB/395	06/11/2019	Armed Forces Covenant Overview	To invite Col Griffin to talk to an existing senior nurse meeting.	Michelle Rhodes	05/02/2020	07/02/2020	Invited Col Griffin on 17 Dec and followed up on 12 Jan. As of 29 Jan he has not responded to the invite.	B
PTB/403	11/12/2019	Patient Story	To look at the ways in which communication could be improved with critical care patients, in addition to promoting the different meal choices available as well as listening to the family and patient in terms of their wishes and assessment of their capability.	Michelle Rhodes	31/03/2020		Action not yet due.	GB
PTB/406	11/12/2019	Patient Experience Report	To request an audit be undertaken of the length of time patients have waited for their medication.	Michelle Rhodes	29/02/2020	04/03/2020	Audit requested.	B
PTB/407	11/12/2019	Patient Experience Report	To take the outputs from the review into the 4 areas whose CEF results had reduced, to the Quality Governance Committee.	Michelle Rhodes	29/02/2020	27/02/2020	Presented to QGC on 27/02/2020.	B
PTB/409	11/12/2019	Information Management and Technology Strategy Progress Report	To provide a demonstration of the projects being undertaken in relation to digitalisation.	Mark Bostock	31/03/2020	11/03/2020	Time scheduled on the Board agenda for March, for a demonstration to take place.	B
PTB/410	11/12/2019	Information Management and Technology Strategy Progress Report	To identify any problem areas with Wi-Fi, before considering what solutions were available.	Mark Bostock Lorraine Whitehead	29/02/2020		Wifi Audit completed. Report/summary currently being produced.	GA
PTB/412	08/01/2020	Matters Arising	To provide a paper to the Transformation and People Committee, outlining the impact of the changes to the junior doctors contract.	Ro Vaughan	28/02/2020	27/02/2020	Paper presented to TAP February 2020.	B
PTB/413	08/01/2020	Chief Executive's Update	To provide an update to the Quality Governance Committee regarding Medical Examiner Role.	John Oxtoby	31/03/2020	11/03/2020	Presentation to be provided to the Board on 11/03/2020.	B
PTB/415	08/01/2020	Update on Influenza	To establish a research project into the numbers of patients with flu and whether they received the flu vaccine, linking in with Public Health England.	Michelle Rhodes John Oxtoby	30/04/2020		Action not yet due.	GA
PTB/417	05/02/2020	Patient Story	To confirm how the Trust had shared the story with staff in order to learn from the experiences described, and to reinvigorate the 'It's OK to Ask' campaign.	Michelle Rhodes	30/04/2020		Action not yet due.	GB
PTB/418	05/02/2020	Quality Governance Committee Assurance Report	To provide assurance of the processes in place for medics and other professionals, in terms of the management of concerns about individuals practice to the TAP and management of concerns of quality/safety to QGC.	John Oxtoby	31/03/2020		Action not yet due.	GB
PTB/419	05/02/2020	Meeting Effectiveness	To include a list of acronyms within Board Intelligence.	Claire Rylands	29/02/2020	19/02/2020	Completed and uploaded	B

Chief Executive's Report to the Trust Board

FOR INFORMATION

Part 1: Trust Executive Committee

The Trust Executive Committee met on Wednesday 26th February. The following provides a summary of the key items which were discussed:

- A presentation regarding the **Community Rapid Intervention Service (CRIS),** which provided an overview of the team, their scope and outputs since establishment.
- **Updates from the Executive Team**, communicating current matters to divisional colleagues.
- **Updates from the Divisional Chairs**, highlighting the latest challenges and successes from their areas.
- A number of **Trust Policies** which were approved by the Committee including C23 Managing Risks Associated with Safeguarding Children, C32 Single Sex Accommodation, C36 Protection of Adults from Abuse and Neglect who have Care and Support Needs, EF25 Pest Control, G01 Development and Control of Policies and Procedures, HR26 Work Experience, HR28 Employment Break Scheme, HR50 Performance and Development Review (appraisal), HS04 Use of Visual Display Units.
- A report from the **Executive Risk Oversight Group** which provided Committee members with the most up to date Corporate Risk Register for review.
- High level findings of the **2019 Annual Staff Survey** – which has also been shared with the Transformation and People Committee and will be presented to the Trust Board.
- **IM&T Programme Board** meeting minutes from the latest meeting held in January 2020.
- A six-month follow up review of the **role and function of the Trust Executive Committee** and discussion regarding the format of future meetings.

1.1 Items to be Considered by Committees of the Trust Board

Transformation and People Committee	Performance and Finance Committee
• 2019 Staff Survey Findings	• Month 10 Integrated Performance Report

1.2 Key Items to be Escalated to the Trust Board

- There were no specific items agreed for escalation although the month 10 Integrated Performance Report and the Staff Survey findings will be considered by the Board in accordance with the Annual Business Cycle.

Any Board member seeking to obtain further information regarding the items considered by the Trust Executive Committee should contact Claire Rylands, AssociateDirector of Corporate Governance.

Part 2: Chief Executive's Highlight Report

1. Contract Awards and Approvals

Department of Health Procurement Transparency Guidance states that contract awards over £25,000 should be published in order that they are accessible to the public. During January, 3 contract awards, which met this criteria were made, as follows:

- **Occupational Health Services Contract (REAF 3356)** supplied by Team Prevent at a total cost of £1,115,500.00 for the period 01/02/20 - 31/12/21, providing savings of £3,600, approved on 09/01/2020
- **Salary Sacrifice Sodexo Childcare Voucher Monies (REAF 3334)** supplied by Sodexo Motivation Solution Ltd for the period 01/02/20 – 31/01/21, at a total cost of £700,000.00, approved on 08/01/2020.
- **Cytotoxic Dose Banded - Chemotherapy, Immunotherapy and Monoclonal Medicines (REAF 3237)** supplied by Qualasept for the period 03/19/19 – 02/11/20, at a total cost of £5,300,000.00, approved on 08/01/2020.

In addition, the following contracts were approved by the Performance and Finance Committee on 25th February, and due to the value of the contract, requires approval via the Trust Board:

CCN Microbiology Total Lab Automation into Biomerieux MES (REAF 3393)

Contract Value	£5,978,801.00 Inc. VAT
Award of Contract	
Duration	01/04/2020-31/03/2030
Supplier	Biomerieux

This requirement is to award a 10 year agreement for the lab automation that was introduced several years ago in various diagnostic disciplines such as chemistry, haematology and molecular biology. The first laboratory automation system for clinical bacteriology was released in 2006, and has rapidly proved its value by increasing productivity by allowing a continuous increase in sample volumes against a backdrop of limited budgets and qualified specialist BMS shortages.

The contract is on standard NHS terms and conditions.

The contract is an new investment as approved in the N8 Pathology network business case which releases additional staff time and contributes to the total £2M efficiency saving once fully implemented. The specific staff savings relating to this award and REAF 3403 equates to circa £500,000 of the total savings

Roche Pathology Managed Equipment Service contract (REAF 3383)

Contract Value	£24,000,000.00 Inc. VAT
Award of Contract	
Duration	01/04/2020-31/03/2030
Supplier	Roche

This requirement is to award a new 10 year agreement for the 'Pathology Laboratory Managed Service Contract' for the N8 Pathology network which will initially include Cellular Pathology, Molecular Microbiology, Bacterial & Viral Serology & the Associated Items/Services, Consumables & Maintenance. The amalgamation of the contracts will provide economies of scale and realise synergistic savings through rationalisation of equipment, simplified ordering and quarterly invoicing.

Contract is on standard NHS terms and conditions.

This is a replacement contract which also builds additional capacity to support the N8 network as per the approved business case. The procurement delivers an initial real terms cost reduction of £85,000 and when the N8 partners activity comes on line when the target operating model is fully deployed will deliver a further £300,000 saving which will be realised by all parties to the N8 network proportional to agreed shares.

CCN to include Sakura Fintek Histology Laboratory Automation into Roche MES (REAF 3403)

Contract Value £2,409,662.00 Inc. VAT
Award of Contract
Duration 01/04/2020-31/03/2030
Supplier – Roche

This requirement is to award a 10 year agreement for the Sakura Histology Laboratory Automation into the Trusts existing Roche MES. The introduction of automation in histology will reduce the laboratory space required to deliver the service and it will create additional capacity without requiring additional staffing resource. It will also be strategically aligned to the NHSi N8 pathology hub and bespoke model which is a key enabler to facilitate centralisation of histopathology to the RSUH site by June 2021.

Introduction of automation will drive efficiency and financial savings and provide necessary capacity to allow for skill mix review and reducing reliance on locums. Histopathology has historically been a very manual process, but recently there has been demand for Automation, Standardisation and Traceability in the Histopathology laboratory. The change has been driven as a result of an increase of Histology requests year on year, a higher complexity of cases and changes to the work force skill mix due to fewer qualified BMS staff being available.

Contract is on standard NHS terms and conditions.

Energy Management & Procurement Services (REAF 3425)

Contract Value £36,000,000.00 Inc. VAT
Award of Contract
Duration 01/04/2020-31/03/2025
Supplier BiU (British Independent Utilities)

The requirement is to award a 5 year Contract to BiU (British Independent Utilities) for the provision of energy management. Electricity and gas has been procured via Crown Commercial Service (CCS) for many years as the default public sector energy procurement provider, however, market testing has identified that CCS has fallen behind other framework providers, both in terms of value for money, and services offered.

Contract is on standard NHS terms and conditions.

2. Consultant Appointments

The following table provides a summary of medical staff interviews which have taken place during February 2020:

Post Title	Reason for advertising	Appointed (Yes/No)	Start Date
Consultant Haematologist	Vacancy	Yes	01/03/2020
Consultant Geriatrician with an interest in Major Trauma	New	Yes	01/07/2020

The following table provides a summary of medical staff who have joined the Trust during February 2020:

Post Title	Reason for advertising	Start Date
Associate Tutor for SAS Doctors	Vacancy	01/02/2020
Locum Consultant Vascular Surgeon	New	01/02/2020
Locum Consultant Spinal Surgeon	Vacancy	03/02/2020
Consultant Plastic Surgeon	Extension	03/02/2020
Medical Oncologist- Upper GI and Lung	New	03/02/2020
Locum Consultant Haematologist	Extension	05/02/2020
Locum Consultant Haematologist	Extension	05/02/2020
Locum PICU Consultant	Maternity Cover	10/02/2020
Consultant Gastroenterologist	Vacancy	14/02/2020
Locum Consultant Plastic Surgeon	Extension	15/02/2020
Locum Consultant in Emergency Medicine	Extension	17/02/2020
Locum Urology Consultant	New	17/02/2020
Locum Cardiothoracic Anaesthetist	Extension	19/02/2020

Post Title	Reason for advertising	Start Date
Locum Consultant Orthopaedic Surgeon, Specialising in Foot & Ankle	Vacancy	24/02/2020
Locum Consultant Spinal Surgeon	Vacancy	24/02/2020
Oral & Maxillofacial Consultant Surgeon	Vacancy	24/02/2020

The following table provides a summary of medical vacancies which closed without applications / candidates during February 2020:

Post Title	Closing Date	Note
Consultant in Emergency Medicine	04/02/2020	5 posts – No applications
Respiratory Consultant - Interstitial Lung Disease	05/02/2020	No Applications
Locum Consultant Neonatologist	10/02/2020	No Applications
Consultant Clinical Oncologist with specialist interest in Breast and Skin malignancy	11/02/2020	No Applications

3. Coronavirus

Coronavirus remains high on everybody's radar and is a cause of concern for many. As health professionals we play a key role in remaining calm and keeping our patients safe by following the guidance published by Public Health England.

Staff from across the Trust have pulled together to help with our preparations as the outbreak has inevitably created additional responsibilities on top of an already busy workload.

Our Infection Prevention and Control Team, Estates and PFI teams, Emergency Planning and the Medical Division have been working extremely hard to ensure that things are running as smoothly as possible with a constantly evolving situation and guidance and my thanks go out to everybody involved.

4. Clinical Service Reviews

We are well on the way with our individual Clinical Service Reviews which will be the basis for our Clinical Services Strategy. This will set out a clear way forward in our Trust for the years ahead. In order to ensure that all staff have the opportunity to contribute and to receive an update on the outputs of the reviews, we will be organising a series of road shows in March and April and asking divisions to send representatives from a range of staff groups to attend and feed back to colleagues.

5. Lesbian, Gay, Bisexual and Transgender + (LGBT+)

February was LGBT+ history month and we have held a number of initiatives to celebrate. This included an event on Monday 24th February where our LGBT+ Network, alongside our BAME and Disability Networks came together to showcase the work they are doing to support us to be a more inclusive and diverse place to work.

Our LGBT+ Network meets quarterly and is a place for staff to come together to support, network and to support us in improving staff experiences.

6. Shift in the Emergency Department

One of the highlights of my month was doing a late shift with the team in our Emergency Department at Royal Stoke. They put me to work and I thoroughly enjoyed myself. The visit was very timely as our latest CQC report had just been published and as well as taking opportunity to feedback to staff what the report says, I was able to experience first-hand some of the very tangible progress that has been made since our inspection in May 2019.

7. Children's Hospital Launch

11th March will mark the official launch of our Staffordshire Children's Hospital at Royal Stoke. This is fantastic news for us and in particular our children's services as it will give them the recognition that they deserve – I'm looking forward to joining them for the launch after our Public Board meeting today

8. MP Engagement

We had a meeting with four of our Members of Parliament who all continue to be extremely supportive of us and we can expect to see them doing a shift in various areas across the Trust before too long. Sadly we won't be seeing them at the launch of our Children's Hospital on 11 March as it is Budget Day, but they have all passed on their best wishes and are delighted that our excellent children and young people's services will get a higher profile going forward.

9. Intensive Support Team Visit

The Intensive Support Team have visited during the month with a specific focus on Cancer Services. From the initial debrief we received, they were impressed with the speciality team, understanding and grip of the Patient Tracking List and level of clinical engagement. They took away a number of areas of good practice from their interviews, which they are keen to share more widely.

Whilst they appreciate that we have lots to do, they plan to offer some enablers for us to consider and are keen to keep tracking our recovery as they described some of our transformation work as being 'ahead of the curve'.

10. NHS Midlands Business Meeting

On the 27th February I attended the NHS Midlands Business Meeting where we received updates from our Regional NHS England, NHS Improvement team. Interesting areas of focus included:

- Integrated Care Systems (ICS) nationally they are looking to bring some forward and will introduce legislation to help
- The Financial Special Measures will be replaced by the Improvement & Support Team and the process will very much link to oversight framework
- A significant focus on COVID 19 and operational plans including the setup of incident coordination centres and review of capacity
- Nottingham University Hospital and Kettering General Hospital gave an update on the potential new NHS Standards for UEC. Fourteen pilot areas have been looking at different standards and an evaluation is underway. The new standards may be approved later this year
- It was an informative session with sharing of good learning from these two pilot Trusts
- Other areas covered were performance, finance, quality

Quality Governance Committee Chair's Highlight Report to Board

27th February 2020

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• 15 confirmed cases of **Coronavirus** in the UK to date although none confirmed at UHNM – a number of measures are in place to ensure preparedness • A review of complex **readmissions** identified that 43% were deemed to be preventable by the review team that an intervention could have taken place outside the acute setting although further clarification / analysis is needed • Continued concerns with regard to levels of compliance with **Statutory and Mandatory** training • There remain a number of **CQUIN** areas which remain a risk and work continues to focus on improvement • Assessment for urgent care within the **CQC report**; the urgent care improvement programme will be refreshed to incorporate concerns identified • Falsified **medicines** directive now written into UK law which has significant implications for the Pharmacy Team in terms of implementation	• Review of all **quality indicators** being undertaken; the full set of 80 + will be reported going to the Committee in the future with the exceptions / highlights being drawn to the attention of the Committee • Further triangulation of **sepsis data** with serious incident data to be undertaken in order to provide greater assurance to the Committee • New **maternity dashboard** produced which provides a high level overview of performance / risk on a quarterly basis – this is an iterative process which will continue to be developed • Development and implementation of action plan in response to the **CQC inspection** and application to stand down Section 31 referrals being progressed • Outpatient Transformation Programme to review the complaints highlighted within the **Patient Experience** Report • Revised process for **Quality Impact Assessment** being developed
Positive Assurances to Provide	**Decisions Made**
• Above national average for the second consecutive year for all domains achieved for the **PLACE assessment** • Positive examples of learning identified in response to closed **serious incidents** • The annual staff **flu vaccination** campaign is well underway with 8, 216 staff having been vaccinated by the end of January – the highest ever achieved • An expression of interest to become a testing site for **Coronavirus** has been submitted • Compliance with all **CNST Maternity Standards** in respect of perinatal mortality was provided • All divisions showing an improvement for **Data Security and Protection Training** with 91% compliance achieved in January 2020 • Risk to achievement of 3 key **CQUIN** areas has been reduced	There were items for approval / decisions made
Comments on the Effectiveness of the Meeting	
• All items in the Business Cycle for February had been covered • Improved papers as a result of the use of SPC charts and more analysis by Division	

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	Q3 Quality & Safety Report	Assurance	10.	Data, Security and Protection Progress Report	Assurance
2.	Q3 Serious Incident Summary	Assurance	11.	CQUIN Achievement Forecast	Assurance
3.	Infection Prevention Update	Assurance	12.	Medicines Optimisation Report Q3	Assurance
4.	Sepsis Update	Assurance	13.	Annual PLACE Inspection Scores 2019	Assurance
5.	Complex Readmissions Audit	Assurance	14.	Q3 Patient Experience Report	Assurance
6.	Q3 Perinatal Mortality	Assurance	15.	Outputs from the Review of Reduced CEF Scores	Assurance
7.	Quarterly Maternity Dashboard	Assurance	16.	Mental Health Act Policy	Assurance
8.	Q3 Compliance and Effectiveness Report	Assurance	17.	Quality Impact Assessment Report	Assurance
9.	CQC Inspection Report	Information	18.	Quality and Safety Oversight Group Highlight Report	Assurance

3. 2019 / 20 Attendance Matrix

			Attended	Apologies & Deputy Sent	Apologies

Members:			A	M	J	J	A	S	O	N	D	J	F	M
Ms S Belfield	**SB**	Non-Executive Director (Chair)												
Dr L Griffin	**LG**	Non-Executive Director												
Mr P Bytheway	**PB**	Chief Operating Officer												
Professor A Hassell	**AH**	Non-Executive Director												
Mr J Maxwell	**JM**	Head of Quality, Safety & Compliance												
Dr J Oxtoby	**JO**	Medical Director			GH									
Mrs M Rhodes	**MR**	Chief Nurse	LR	LR	TR	TR	TR							
Miss C Rylands	**CR**	Associate Director of Corporate Governance				NH	NH	NH	NH	NH				
Mr I Smith	**IS**	Non-Executive Director												
Mrs R Vaughan	**RV**	Director of Human Resources			EO				JH					

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	11th March 2020
Report Title:	Staffing Establishment Reviews Report	**Agenda Item:**	8.
Author:	Michelle Rhodes, Chief Nurse		
Executive Lead:	Michelle Rhodes, Chief Nurse		

Purpose of Report:					
Assurance	✓	**Approval**		**Information**	

Alignment to Strategic Objectives:		
SO1	Provide safe, effective, caring and responsive services	✓
SO2	Achieve NHS constitutional patient access standards	✓
SO3	Achieve excellence in employment, education, development and research	✓
SO4	Lead strategic change within Staffordshire and beyond	✓
SO5	Ensure efficient use of resources	✓

Summary of other meetings presented to and outcome of discussion:

Executive Team Discussion Feb 2020

Summary of Report, Key Points for Discussion including any Risks:

The majority of wards meet the minimum requirement of 1:8 on the day time shifts which is very positive. Some areas fall below this on nights, only 1 ward is significantly below on the night shift.

Quality metrics across the organisation show a positive trend of improvement, a small number of wards however require additional support to improve.

The review has identified that a number of wards do not have the funded establishment to provide the current template, this needs correcting as a priority.

The review identified a number of wards that should be considered a priority for further investment following the skill mix, a business case approach should be taken for all new investment.

The acuity and dependency data that is collected 3 times a day in each area is inconsistent and therefore cannot be used to fully support this review. Training is a priority across all areas.

The skill mix ratio across the organisation falls below the national expectation in many areas. This requires a deep dive into those areas, focussing on the medicine division initially. This will then enable the division to develop a formal workforce plan that will correct the skill mix over a period of time.

This plan will include the introduction of registered Nursing Associates onto the wards which will commence from September 2019 and the potential conversion of overseas nurses who are registered in their country but not in the UK, and we have a number of those and we have a significant band 4 workforce. Any workforce plan will require a quality impact assessment to consider skill mix.

Once the skill mix review, in medicine initially, is complete a business case should be developed with regard to new investment required into the nursing workforce. This piece of work will then follow for each division.

The Birthrate plus review of midwifery suggests a deficit in the number of midwives that the Trust requires.

There are workforce challenges on the Neonatal unit and an in-depth review is currently taking place which includes reviewing all the metrics for the unit. The activity numbers will be reviewed as part of this work.

Key Recommendations:

The Board is asked to agree:

1 An extensive recruitment campaign needs to be undertaken as soon as possible with a focus initially on Medicine and ward 225
2 Additional training for nursing staff on the use of the safe care tool needs to carried out
3 The budget for all areas is adjusted to match the current ward staffing templates (28.75 Wte) in line with the annual planning cycle
4 An increase in the midwifery workforce (12 wte over 2 years)
5 A potential increase in the neonatal workforce (10.4 wte) this should form part of a business case to be discussed with the Executive.)
6 Review the usage of level 1 beds across the Trust
7 That a workforce review should be carried out on the nonregistered workforce to include robust plans to convert band 4's and overseas nurses to RN
8 A full business case to be developed to fund current and any future tNAs
9 Establish the 'Team around the Patient' principles starting with medicine
10 Encourage the use of technology to release nursing time (RITA)
11 To agree a pragmatic and realistic phased approach to addressing workforce shortfalls, skills mix, staffing ratios and budgeted establishments which will be incorporated into subsequent annual planning cycles

Nurse Staffing Establishment Review

December 2019

Introduction

In 2013, following the findings of the Francis Report the National Quality Board (NQB) set out 10 expectations and a framework within which organisations and staff should make decisions about safe staffing.

In 2016 the NQB published up-dated safe staffing guidance and a set of expectations regarding nursing and midwifery staffing. The guidance emphasises that the NHS provider boards are accountable for ensuring that their organisations have the right skills in place for safe, sustainable and productive staffing. The NQB guidance makes explicit the requirements of NHS providers.

Expectation One	Expectation Two	Expectation Three
Right Staff	**Right Skills**	**Right Place and Time**
• Evidence based workforce planning • Professional judgement • Compare staffing with peers	• Mandatory training, development and education • Working with the Multi-disciplinary Team • Recruitment and retention	• Productive workforce and eliminating waste • Efficient deployment and flexibility • Efficient employment and minimise agency

Developing Workforce Safeguards was issued by NHSI in October 2018. This publication provides detailed guidance in relation to process and systems that all NHS Organisations should have in place. The Trust Board is expected to confirm this through its annual governance statement.

This paper describes the process that was carried out in undertaking the review and gives the Trust Board assurance that the National expectations with regard to safe nursing staffing are being delivered at UHNM. The paper lays out the priority areas of investment for each division and summarises the key findings with recommendations based on the findings.

Nursing & Midwifery Staffing Review December 2019

The NQB Guidance expects a review of the nursing and midwifery workforce to be presented to the Trust Board twice a year, a full review should take place once a year and an overview review six months later. The review should enable the Trust Board to be assured that the Trust has safe staffing levels and skill mix, it should also alert the Board to areas of concern where a deeper review and remedial plan are required. This establishment review constitutes a full review.

Research suggests that harm can occur to patients if the Registered Nurse (RN) to patient staffing ratio is 1:8 or more on adult in-patient wards. Additionally Royal College of Nursing guidance suggests on acute wards there should be a RN:Nursing Assistant skill mix ratio of no less that 65:35 for base wards, 70:30 for specialty wards and 80:20 for speciality units eg ITU. Therefore as part of the review each ward was assessed against these standards.

Bed provision	Descriptor	Expected staffing level	Skill Mix Required
Intensive Care	Beds identified in critical care areas	1 Registered Nurse:1 Patient	80:20
High Dependency	Designated Beds, usually in defined units or areas	1 Registered Nurse:2 Patients	80:20

Bed provision	Descriptor	Expected staffing level	Skill Mix Required
Level 1	Designated beds on general wards	1 Registered Nurse: 4 Patients	70:30
General Care	Majority of in-patient wards	No less than 1 Registered Nurse:8 Patients during the day	65:35

There is no agreed minimum RN:patient ratio laid out in guidance with regard to nights shifts, however 1:11 is often quoted. Each ward should be assessed individually taking into account the acuity and dependency of its patients to determine whether alternative models can be safely put in place.

Approach

The Chief Nurse or Deputy Chief Nurse led a discussion with each ward team, the team included the Ward Sister, the Matron, the Associate Chief Nurse, and the finance lead. The information collected at the reviews included, funded establishment (which was agreed by Finance), quality and HR metrics, shift patterns and a discussion about ward layout and other professional judgement factors that might affect the number of registrants and non registrants required.

For those inpatient wards where the Safecare tool is appropriate the information gained from this tool was used to inform the debate, however it became evident that where wards were demonstrating less that 95% compliance the scores were unreliable and as only 1 period of data was considered (usually this would be 2 or 3 months) the acuity scoring could not be solely relied upon to determine the safe staffing level.
The reviews enabled useful discussion around the correct use of the tool and this will result in changes in application and an extensive training programme will be delivered.

Quality metrics for the previous 3 months were also considered, including harm free care metrics, Clinical Excellence Framework (CEF) score and relevant HR data.

At the end of the discussion a decision was taken based on all the information as to whether the current shift pattern was safe or whether it requires adapting.

Findings

This section of the paper will firstly describe the overall findings from across the Trust and then the findings from each Division.

Trust wide findings

Staffing Ratio
Overall, in adult areas across the Trust the staffing ratio for Registered Nurses to patients is at the expected rate or better in the day time hours which is very encouraging, however over night the ratio is worse than expected in many areas and this does need addressing.

Skill Mix
The skill mix (registered to non registered) was generally acceptable in 3 Divisions, however the skill mix in the Medicine Division is poor. In the main this is due to the high number of health care support workers, band 2's 3's and band 4's.

Prior to the reviews it had been identified that the Model Hospital was suggesting that the care hours per patient day were high at our Trust compared with peers and this information was largely influenced by the high number of health care support workers. This exercise confirmed this to be the case as in some areas the geographical layout of the wards mean additional staff are required to allow visibility of all patients, this has been considered as part of the review using the Sister's professional judgement.

There may be some additional factors influencing the high health care support worker levels:

- when extra capacity was introduced to the new PFI build on a number of wards no additional Registered Nurses were identified for these extra beds, but health care support workers were increased in some areas.

- Skill mix reviews have occurred with the conversion of band 5 posts into Band 4 posts to accommodate the new roles of assistant practitioner and nursing associate.

- Some wards have a team of Allied Health Professionals (AHP) who contribute to the care of patients but are not included within the skill mix or staffing ratio. This is particularly relevant to the fracture neck of femur ward (ward 225) and stroke ward (ward 231)

Work has started with our local universities to develop a programme to convert those band 4's that want to into either Nursing Associates or to RNs. It is anticipated that this course will take up to 2 years to complete due to the number of practice hours required by the NMC.

There are currently 69 trainee Nursing Associates in the Trust. It has become apparent that our current cohort of trainee Nursing Associates who are required to be supernumerary for 2 days per week have no back fill arrangements. These Nursing Associates that start to qualify in September will become part of the registered workforce.

Ward Sister/Charge Nurse supervisory time
The current establishments and templates are inconsistent with regard to the current management time for the sister/charge nurse. Best practice would assume 2-3 days a week supervisory for the ward lead.

The large number of vacancies, particularly within the Medical Division, need to be addressed to allow a further review of this. Therefore at this stage the paper does not ask for additional investment to fund any management time. This will be determined by a future review.

Vacancies
The Trust has c300 registered nurse vacancies, the majority of which sit in the Medical Division. This needs to be addressed quickly with an extensive recruitment campaign. A workforce plan by Division is also required that takes into account future reviews of non registered nurses and future advanced nursing roles.

MEDICAL DIVISION (Escalation wards were not included within this review).

Assessment/Admission Wards

Acute Medical Unit (County)
This ward has 31 beds which includes 14 level 1 beds. These beds are used for more acutely unwell patients that require monitoring and as such require a higher number of registered nurses to look after them.

Recommendations
- Review the number of level 1 beds required on AMU
- Increase the number of RNs to 6 per shift this can be done within the existing budget
- Additional RNs will be required if the additional 7 escalation beds in the AMU annex are opened
- The division should review the clinical model on AMU to consider a reduction in HCSW, this cannot take place until the current RN vacancies are filled
- The actions above will move the current skill mix ratio closer to the expected 65/35.

AMU (Royal Stoke)
This is an emergency portal with 48 beds (does not include 2 triage beds) and should run on consistent staffing levels. The current staffing levels rostered are not reflected in the budget and this needs to be aligned. The current RN budget allows for 9.69 wte RNs each shift and 10 wte are required.

Recommendations

- Increase the budget to allow for the current template of 10 RN's per shift
- Additional staffing will be required if the 2 triage beds are open. Due to their position in the ward these beds offer a poor environment for patients and should be kept closed if possible.
- Review the role of the band 4's on the ward. There is potential to support these individuals to become registrants over 2 years.
- Recruitment campaign is required
- Review the number of HCSW once the RN vacancies are filled.
- This unit could be supported by an ACP role

FEAU

This is an admission ward consisting of 21 beds and 4 triage beds (which are not routinely staffed at night).

Recommendations

- Increase the budget to allow for the current template
- Review the non registered workforce

SSU (Ward 127)

At the time on the review, this ward had moved on a temporary basis to a 32 bedded ward although staffing was based on a 25 bedded template. For the purposes of the review the staffing requirement was based on 25 beds, as the additional beds were used as escalation.

Recommendations

- Uplift the number of RNs on night duty which will require an increase in establishment
- Review of non registered staff required

Ward 222

A 29 bedded acute respiratory ward incorporating 16 level 2 NIV beds and 4 Level 1 NIV beds. An increase in the number of NIV beds was agreed via a business case but no corresponding increase in staffing levels was agreed. The day room on this ward was converted to a patient area with 3 additional beds and no corresponding staffing uplift. This ward currently provides an outreach service to other areas of the hospital, this is unfunded.

Recommendations

- The current budget needs uplifting to cover the current staffing template
- A further uplift will be required to increase the staffing numbers overnight and provide coordinator time.
- A business case for the funding of the outreach team should be developed separately asap.

Ward 124

A 28 bedded renal unit.

Recommendations

- Review again in 6 months

Ward 113

This is a 26 bedded respiratory ward.

Recommendations

- The template should remain the same
- Uplift the budget to fund the current template
- Review the Band 4 workforce

Ward 117

This is a 14 single roomed Infectious Diseases ward.

Recommendations

- Increase the number of RNs on nights by 1 per night as 2 RN for this unit overnight is difficult as the ward has 2 separate parts and therefore checking drugs leaves 1 side with no registrants for a period of time
- Increase the budget to fit the current template

Ward 122

- 25 bedded general medicine ward. Template to remain the same for RN's.

Recommendations

- Skill mix review required
- Current RN template to remain the same

Ward 230

This is a 36 bedded gastro/liver ward. The day room on this ward was converted to a patient area with 4 additional beds and no corresponding staffing uplift.

Recommendations

- The current budget needs increasing to cover the current template
- Increase the number of RN's on nights by 1 per night for patient safety
- Review the number of HCSW's
- Plan to improve the skill mix

Ward 232

This is a 29 bedded medical ward. The day room on this ward was converted to a patient area with 3 additional beds and no corresponding staffing uplift.

Recommendations

- Current template for RN's to remain the same
- Budget requires increasing to achieve the current template
- Skill mix review required

Ward 233

This is a 36 bedded ward that caters for patients with a tracheostomy or cystic fibrosis, and very complex drug regimes. The day room on this ward was converted to a patient area with 4 additional beds and no corresponding staffing uplift.

Recommendations

- The current budget does not reflect the current template this needs to be addressed
- The template on the ward should be increased on both days and nights to increase patient safety
- Skill mix review is required

Ward 76a

25 bedded elderly care ward

Recommendations

- Template to remain the same
- Introduction of RITA
- Skill mix review
- Additional training for food and nutrition assistants and dementia practitioners and activity coordinators- within current budget

Ward 76b

A 19 bedded elderly persons ward

Recommendations

- As for ward 76a

Ward 78
This is a 26 bedded older people's ward

Recommendation
- As for ward 76a & b

Ward 80 & 81
18 bedded older people's wards. The unusual layout of these wards makes them inefficient for staffing, with both wards having 2 separate sides which means observing patients is more difficult.

Recommendations
- Increasing to 3 RN on each shift
- Develop new dementia friendly older peoples wards as soon as possible
- Skill mix review as per ward 75a & b

Ward 126
A 32 bedded elderly care ward

Recommendations
- Increase template by 1 RN over night
- Skill mix review as per elderly care wards above

Ward 7 (County)
This is a 32 bedded general medical ward. This ward was made permanent during 2019, having previously been an escalation ward and recruitment has been the main challenge.

Recommendations
- RN template to remain the same
- Skill mix review required
- Recruitment campaign

Ward 12 (County)
A respiratory ward of 28 beds of which 10 have just been assigned to palliative care.

Recommendations
- Template to remain the same
- Skill mix review required

Ward 14 & 15 (County)
General medical wards with 28 beds.

Recommendations
- Template to remain the same
- Skill mix review required to include additional training
- Wards would benefit from RITA
- Urgent recruitment campaign

Summary of proposed priority investment areas for the medicine division

Ward	Current RN Establishment Band 5	Proposed Uplift RN	Variance	Reason	Quality Metrics Included at Appendix 1	
AMU Stoke	52.43	54.08	1.65	To support current template		
SSU Stoke	21.8	24.3	2.50	Uplift of 1 RN on LN		
Ward 222	45.8	60.00	14.2	To support current template (3.4) & Increase LN by 2 RN's (10.8)		
Ward 222-ORS	0	5.40	5.40	Trust wide outreach service not currently funded. Requires a business case		
Ward 124	31.7	32.4	0.70	To support current template		
Ward 113	16.9	21.60	4.70	To support current template		
Ward 117	13.4	16.20	2.80	To increase RN from 2 to 3 per night		
Ward 230	25.9	32.40	6.50	To support current template		
Ward 232	21.60	27.00	5.40	To support current template		
Ward 233	24.2	35.1	10.90	Budget does not meet current template (4.3). Increase levels of RN by 1 LD and 2 LN (6.6)		
Ward 80	14.3	16.2	2.07	Uplift RN's on LN to 3		
Ward 81	15.13	16.2	1.07	Uplift RN's on LN to 3		
Ward 126	21.6	24.30	2.70	Uplift RN's on LN to 4		
Total			**60.59 (54.56 without ORS)**		**26.65 to correct budget**	**27.91 additional increase**

SPECIALISED DIVISION

Pods 1 & 2

A 16 bedded critical care facility, of which 10 are funded as Level 3 intensive care beds and 6 funded as level 2 high dependency beds.

Recommendations

- Review again in 6 months

Ward 231

30 bedded ward incorporating 12 hyper acute stroke beds. The ward also has a dedicated team of Allied Health Professionals which are not reflected within the skill mix. The SEAT (Stroke Emergency Assessment Team) is incorporated into the staffing numbers and it would be useful if these were kept separate for purposes of assessing the relevant staffing.

Recommendations

- The staffing establishment for the SEAT team should be separate to the ward establishment to ensure consistency of ward and SEAT numbers of staff
- Consider the impact of ward based AHP's on care hours
- An increase in RN establishment by 3.6 wte would ensure a 1:8 ratio on night shifts and increase the RN/NA ratio.

Ward 227 (Acute rehabilitation trauma unit)

A 27 bedded unit which includes 8 Level 1 beds which are staffed according to national guidance. The acuity scoring identifies the RN numbers to reflect the acuity but there is a higher number of nursing assistants justified due to the number of patients who require log rolls for positioning however there is opportunity to look at the skills of the unregistered workforce to reflect the needs of a rehabilitation unit.

Recommendations

- The impact of Band 4 positions on the skill mix needs to be reviewed.
- Consider the impact of ward based AHP's on care hours

Ward 220

41 beds inclusive of 13 Coronary care beds and 28 ward beds. This ward had an increase of 4 beds with no additional resource when a day room was converted to a patient bay. There is a higher ratio of RN for the coronary care beds. The ratio on nights for the ward areas fall to 1:9. The ward is also supported by cardiac assessment nurses.

Recommendation

- Increasing RN on the night shift by 1 per night
- Consider the introduction of Band 4 roles into this area

Ward 223

This is a 28 bedded ward consisting of 8 Level 1 beds and 20 ward beds. There are 4 trolleys used as a theatre preparation area and are used when there is no ward capacity to support flow to theatre.

Recommendations

- The utilisation of the trolleys needs to be reviewed to determine whether this impacts on the inpatient ward activity as the establishment does not enable high use for this area.
- The current acuity scoring does not reflect the Level 1 beds and requires further review.
- The role and impact of Band 4 posts also needs to be reviewed.

Ward 228

A 36 bedded ward which includes 8 level 1 beds. This ward was originally a 32 bedded ward, but was increased by 4 beds following conversion of a day room and clinical room. There was an increase in establishment at this time. This ward caters for patients requiring neurosurgery. The current acuity suggests the RN numbers are correct for the day shift but1 RN short overnight. The higher level of Nursing Assistants reflects the number of patients who experience agitation and confusion after trauma or surgery.

Recommendations
- Increase the numbers of RN by 1 on each night shift
- Skill mix review is required

Elective Orthopaedic Unit (County)
A 29 bedded Elective orthopaedic area that predominantly accommodates day case patients but is seeing an increasing number of inpatient activity.

Recommendations
- Review again in 6 months with acuity and dependency data

Ward 110
During the review this was ward 112 and its function has since changed

Recommendations
- Review the plan for this ward since the move of location and function to determine staffing required going forward

Ward 218
A neurological ward that comprises 20 inpatient beds and a VT beds utilised Monday to Friday. The number of NA appears high compared to RN and consideration needs to be given as to whether 1:1 support is required in additional to the staffing present. However one nursing assistant is always allocated to the VT bed.

Recommendations
- RN template to remain the same
- Skill mix review required

Ward 221
A cardiac ward consisting of 27 beds. There is an additional 2 beds used during the day for additional capacity for the Cardiac Department. There is a RN: patient ratio of 1:9 on late and nights. This ward has a high compliance with the SafeCare tool and the acuity indicates the need review again at 6 months.

Recommendations
- Review at 6 months
- Assess the opportunity for nursing associates on this ward

Ward 225
A 36 bedded ward catering for patients with a fractured neck of femur most of whom are frail elderly. The initial template for the ward was 32 beds, but this was increased with no additional staffing resource. The skill mix is currently low but achieving a ratio of 1:7 on days and 1:9 on nights. This area has recruitment challenges and may benefit from the introduction of diversion therapists/activity co-ordinators to support the clinical teams in the management of the confused patient.

Recommendations
- The impact of Band 4 roles needs to be considered on the skill mix.
- Increase in RN by 5.4.
- Consider the impact of ward based AHP's on care hours

Ward 226
A 29 bedded trauma unit.

Recommendations
- The impact of Band 4 roles needs to be considered in the skill mix.

Summary of proposed priority investment areas for the specialised division

Ward	Current RN Establishment Band 5	Proposed Uplift RN	Variance	Reason
Ward 220	44.97	47.57	2.7	Uplift of 1 RN on LN
Ward 231	26.20	29.80	3.6 (0.8 incl Wte to correct the budget)	Uplift of 1 RN on LN and correct current budget
Ward 228	31.19	33.79	2.7	Uplift of 1 RN on LN
Ward 225	25.25	30.64	5.4 (1.7Wte to correct budget)	Uplift of 1 RN on each shift and correct current budget
Total			11.7 uplift and 2.5 Wte to correct budget	

SURGICAL DIVISION

SAU

A Surgical Assessment Unit comprising of 18 beds and also a recently expanding Surgical Ambulatory Care area supported by winter planning money. The staffing reflects both areas to enable the units to be flexible; however there is need to consider ward clerk support for a longer period due to the assessment activity over a 24 hour period.

Recommendations

- Review at 6 months
- Assess the opportunity for nursing associates on this ward

SSCU

The staffing for this High Dependency Ward matches the national requirements.

Recommendations

- Review at 6 months

Pods 3 – 6

A critical care facility with 36 beds that are staffed to an acuity of 32. The staffing meets the national requirements for 1:1 care for intensive care patients and 1:2 care for high dependency patients. The Unit is supported by staff who co-ordinate the care of patients whilst not included in the nursing numbers and a small number of staff from the armed forces. Consideration needs to be given on how Band 4 posts could be utilised in this area.

Recommendation

- Review at 6 months

Ward 103

A 23 bedded surgical ward which incorporates 8 level 1 beds. On the current establishment if all the level 1 beds were utilised there would only be 1 RN for the remaining 15 patients which is not acceptable. An urgent review of the Level 1 utilisation is required and if there is a need for the number of Level 1 beds the establishment needs to increase to reflect the requirement for 1:4 RN for Level 1 Beds and at least 1:8 RN for the ward patients. The utilisation of Band 4 posts also needs to be considered.

Recommendations

- If 8 Level 1 beds required an increase in RN establishment is required to maintain the 1:8 ratio for ward patients over night as currently at 1:15

- Consider the introduction of Band 4 roles into this area

Ward 111
A 28 bedded surgical ward which incorporates 4 level 1 beds which is reflected in the budget.

Recommendation
- Review at 6 months

Ward 110
A 28 bedded surgical ward. Skill mix will require adjustment when Nursing Associates register. Currently ward budget needs to be reviewed as it does not accommodate Band 4 posts.

Recommendation
- Review at 6 months

Ward 102
A 25 bedded surgical ward. Band 4 posts are to be introduced to this area which may impact on skill mix. There is no requirement to change establishment at this time.

Recommendation
- Review at 6 months

Ward 106/7
This ward is established for 28 beds. However additional activity from Shrewsbury and Telford Hospitals require the beds to be increased to 32. This is currently only partly funded. The extra beds should not be opened without proper investment in the nursing establishment.

This ward does have an ambulatory area and ideally the funded for this area should be separated out from the ward funding to ensure staffing skill mix and nurse:bed ratios are clearly identified.

Recommendations
- The current budget is sufficient for a 28 bedded ward but a further 5.4 RN required for the additional beds a business case for the funding of these should be developed
- The establishment for the ambulatory area should be split out

Ward 108
Gastro-intestinal ward with 27 beds which experiences issues with registered nurse recruitment. There is opportunity to develop overseas nurses currently assigned to this area and not on the NMC register.

Recommendation
- Review at 6 months

Ward 109
Gastro-intestinal surgical ward with 27 beds. This area experiences difficulty with recruitment and work is on-going with student nurses to promote careers in this area although the current ability to support the number of students is under review.

Recommendation
- Review at 6 months

Ward 8 (County)
A 31 bedded ward which accommodates short staff and day case surgery and is staffed for 5 days a week. Establishment will require review if number of patients requiring overnight stay increases or weekend work becomes routine.

Recommendation
- Review at 6 months

Ward 105
A day case/23 hour ward comprising of 46 beds and 7 chairs. The Unit remains open to 14 patients Monday to Friday night. The unit now opens on a Saturday.

Recommendation
- Review at 6 months

Summary of proposed priority investment areas for the surgical division

Ward	Current RN Establishment Band 5	Proposed Uplift RN	Variance	Reason
103	**21.97**	**24.67**	**2.7**	Nightshift currently running at 1:15 if 8 level 1 beds open
Ward 106/7	**21.02**	**26.42**	**5.4**	To provide an additional 4 beds. A business case will be required
Total			**8.1**	

CHILDRENS, WOMEN and DIAGNOSTICS DIVISION

Ward 201
A 40 bedded ward that accommodates Oncology and haematology patients. It also has a 5 bedded assessment area. There is concern that the assessment area did not have an identified budget, and skill mix reviews have occurred to try and provide staff. To identify staffing the establishment required for the assessment area need to be separated out of the ward establishment. Consideration needs to be given as to the role of Band 4 nurses in this area. The current budget does not match the roster template.

Recommendations
- **T**he establishment for the assessment area to be separated out
- An additional 6.14 RN required

Ward 217
This is a children's ward that has 13 inpatient beds and a 7 bed day case area

Recommendations
- Establish an additional RN on nights for winter pressures
- Review the uses of a 0.4wte to work in MRI on a daily basis as this is not funded separately

Ward 216
This is a 32 bedded children's ward which also incorporates an area to support oncology day cases.

Recommendation
- Current staffing reflects activity but may benefit from splitting the ward establishment from that of the day case oncology unit.

NICU
This is a Neonatal Intensive Care area with the potential of providing 6 ICU, 6 HDU, 14 Special care and 10 transitional care beds. Against the national guidance there is a shortfall in staffing numbers. The evidence in combination suggests there should be 13 RN per shift to provide the level of care required against the current level of 11. In the first instance the current budget needs to be checked to ensure that it matches

the current rosters and then consideration needs to be given around the introduction of Band 4 Nursing Associates to the transitional care beds. Occupancy rates need to be reviewed against required establishment.

Recommendations

- Following review a potential investment in staffing to match the beds required of 10.8 wte required
- Assess the opportunity for nursing associates in this ward

PICU

Paediatric intensive care area which currently caters for 6.5 dependency with the required establishment, but with plan to increase to 8 beds. A retrieval service is also provided from this establishment. A business case needs to be prepared and supported to enable these beds to open as currently staffing levels cannot safely open the extra capacity.

Recommendations

- A business case needs to be prepared and supported to increase the units dependency to 8
- The establishment required for the retrieval service needs to be split out of the budget

Midwifery Workforce Review

In November 2018, Pan Staffordshire Local Maternity System (LMS) commissioned and external review of maternity staffing using the recognised BirthRate Plus tool (NICE 2015).

Birthrate Plus (BR+) is a framework for workforce planning and strategic decision-making and has been in use in UK maternity units for a significant number of years. It is based upon an understanding of the total midwifery time required to care for women and on a minimum standard of providing one-to-one midwifery care throughout established labour.

The recommendations from the report are based on activity and acuity of women in every part of the service, not just the birthing episode. The BR+ review conducted between November 2018 and February 2019 with the recommendation that Trust should aim toward a midwife to birth ratio of 1:25 (currently at a 1:28) to account for the complexity and acuity of the women in the service (currently 1:28 is accepted ratio nationally however RCM and BR+ trying to change this).

Based on this; BR+ suggested that there is a shortfall of 24 WTE midwifery staff if the recommendations from Birthrate+ was accepted.

Challenges

- Financial investment required for staffing uplift
- Recruitment is becoming a challenge especially for experienced band 6 midwives; this is within the context of a national shortage of midwives with a reported one newly qualified midwife for 29 leavers every year.
- The age profile of the midwifery staff shows that 29.4% are aged 50+
- The implementation of the Better Births, specifically Continuity of Carer is extremely difficult within the current establishment. The Royal College of Midwives advise that unless a service is fully established, implementing this model of care is not recommended.
- There is a minimum of 10 WTE midwives on maternity leave of at any one time which is not backfilled due to the difficulty in attracting staff for fixed term contracts

The skill mix between midwives and MSWs has been maximised to recommended numbers and cannot be increased unless there is an increase in midwifery staffing to counter this

Summary of proposed priority investment areas for the CWD division

Ward	Current RN Establishment Band 5	Proposed Uplift RN	Variance	Reason
Ward 201	36.66	42.8	6.14	To staff the assessment area and maintain 1:8 ratio on all shifts
NICU	70.29	81.09	10.8	Potential investment to support current commissioned activity
Midwives	218	230	12	To deliver the additional 37hrs training per year per midwife and deliver Continuity of Care National Policy
Total				

Summary

The majority of wards meet the minimum requirement of 1:8 on the day time shifts which is very positive. Some areas fall below this on nights, only 1 ward is significantly below on the night shift.

Quality metrics across the organisation show a positive trend of improvement, a small number of wards however require additional support to improve.

The review has identified that a number of wards do not have the funded establishment to provide the current template, this needs correcting as a priority.

The review identified a number of wards that should be considered a priority for further investment following the skill mix, a business case approach should be taken for all new investment.

The acuity and dependency data that is collected 3 times a day in each area is inconsistent and therefore cannot be used to fully support this review. Training is a priority across all areas.

The skill mix ratio across the organisation falls below the national expectation in many areas. This requires a deep dive into those areas, focussing on the medicine division initially. This will then enable the division to develop a formal workforce plan that will correct the skill mix over a period of time.

This plan will include the introduction of registered Nursing Associates onto the wards which will commence from September 2019 and the potential conversion of overseas nurses who are registered in their country but not in the UK, and we have a number of those and we have a significant band 4 workforce. Any workforce plan will require a quality impact assessment to consider skill mix.

Once the skill mix review, in medicine initially, is complete a business case should be developed with regard to new investment required into the nursing workforce. This piece of work will then follow for each division.

The Birthrate plus review of midwifery suggests a deficit in the number of midwives that the Trust requires.

There are workforce challenges on the Neonatal unit and an indepth review is currently taking place which includes reviewing all the metrics for the unit. The activity numbers will be reviewed as part of this work.

Conclusion

Overall the review has highlighted a number of key issues as described in this paper. The number 1 priority is for the Trust to develop a brilliant and exciting recruitment campaign that will attract RN's, this should focus on Medicine initially as nearly a third of all Registered Nurse vacancies sit within that division.

The next step should be to establish those areas that currently do not have the full budget to cover their current template, that is the funding for 27 Wte RNs in the Medicine Division.

Investment in midwives is also required to achieve the Continuity of Care National Policy in maternity.

The paper identifies priority areas for investment within each division, a further review is required for each area to develop a workforce plan that takes into account the large numbers of non registrant workforce including the tNAs who begin to qualify in September 2020.

These plans will be considered at the Transformation and People Committee or the Quality Governance Committee in 3 months prior to discussion at the Trust Board in July.

Recommendations

The Board is asked to agree:

1 An extensive recruitment campaign needs to be undertaken as soon as possible with a focus initially on Medicine and ward 225
2 Additional training for nursing staff on the use of the safe care tool needs to carried out
3 The budget for all areas is adjusted to match the current ward staffing templates (28.75 Wte), this needs to be done as part of the annual planning cycle
4 An increase in the midwifery workforce (12 wte over 2 years)
5 A potential increase in the neonatal workforce (10.4 wte) this should form part of a business case to be discussed with the Executive.)
6 Review the usage of level 1 beds across the Trust should be reviewed
7 That a workforce review should be carried out on the nonregistered workforce to include robust plans to convert band 4's and overseas nurses to RN
8 A full business case to be developed to fund current and any future tNAs
9 Establish the 'Team around the Patient' principles starting with medicine
10 Encourage the use of technology to release nursing time (RITA)
11 To agree a pragmatic and realistic phased approach to addressing workforce shortfalls, skills mix, staffing ratios and budgeted establishments which will be incorporated into subsequent annual planning cycles

	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20
FEAU						
CEF	N/A	SILVER	N/A	N/A	N/A	N/A
SI'S (date of incident)	0	FALL L3 #	FALL # distal radius	0	0	0
MEDICATION	0	1 near miss	2 no harm	1 no harm 1 low harm	0	2 no harm
FALLS WITH HARM	1 low harm	1 moderate	1 low harm 1 moderate	2 low harm	1 low harm	1 low harm
PU'S WITH HARM	4 low harm 1 moderate	6 low harm	1 low harm	2 low harm	5 low harm	4 low harm
COMPLAINTS	0	0	1	0	0	0
Ward 113						
CEF	March 2019 - awarded Gold					
SI'S (date of incident)	0	0	0	0	0	0
MEDICATION	1 no harm 1 low harm	1 no harm 1 low harm	0	2 no harm	1 no harm 1 low harm	2 no harm
FALLS WITH HARM	2 low harm	1 low harm	0	0	1 low harm	0
PU'S WITH HARM	5 low harm	4 low harm	3 low harm	2 low harm	3 low harm	2 low harm
COMPLAINTS	1	1	0	0	0	0
Ward 222						
CEF	N/A	N/A	N/A	SILVER	N/A	N/A
SI'S (date of incident)	0	0	FALL # wrist	0	0	FALL # rib
MEDICATION	2 no harm 1 low harm	1 no harm 2 low harm	1 near miss 1 no harm	1 near miss 2 no harm 2 low harm	1 near miss 1 no harm 1 low harm	0
FALLS WITH HARM	2 low harm	3 low harm	1 moderate harm	0	1 low harm	1 moderate
PU'S WITH HARM	5 low harm	2 low harm 1 moderate	2 low harm	4 low harm	2 low harm	5 low harm

COMPLAINTS	0	0	0	0	0	1
Ward 230						
CEF	N/A	N/A	SILVER	N/A	N/A	N/A
SI'S (date of incident)	0	0	0	0	Methotextrate o/d	0
MEDICATION	1 no harm	2 no harm	0	1 no harm 2 low harm	1 no harm 2 low harm 1 severe harm	1 low harm
FALLS WITH HARM	3 low harm	1 low harm	1 low harm	0	2 low harm	1 low harm
PU'S WITH HARM	2 low harm	1 low harm	6 low harm	1 low harm	2 low harm	0
COMPLAINTS	0	0	0	0	0	1
Ward 233						
CEF	N/A	N/A	N/A	N/A	SILVER	N/A
SI'S (date of incident)	0	0	0	0	0	0
MEDICATION	1 near miss	0	2 no harm	3 no harm	4 no harm 1 low harm	2 no harm
FALLS WITH HARM	1 low harm	0	0	2 low harm	2 low harm	1 low harm
PU'S WITH HARM	3 low harm	0	1 low harm	3 low harm	3 low harm	4 low harm
COMPLAINTS	2	0	2	1	1	0
Ward 232						
CEF	N/A	N/A	N/A	N/A	SILVER	N/A
SI'S (date of incident)	0	0	0	0	0	0
MEDICATION	1 near miss 2 no harm 1 low harm	1 no harm	2 no harm 2 low harm	1 no harm	1 no harm	1 no harm
FALLS WITH HARM	3 low harm	0	1 low harm	0	3 low harm	0
PU'S WITH HARM	6 low harm	2 low harm 1 moderate	3 low harm	1 low harm	4 low harm	9 low harm
COMPLAINTS	0	0	1	2	0	0
Ward 80						
CEF	SILVER	N/A	N/A	N/A	N/A	N/A

SI'S (date of incident)	0	0	0	0	0	0
MEDICATION	0	0	0	1 no harm	1 low harm	1 near miss 2 no harm
FALLS WITH HARM	0	0	0	0	0	0
PU'S WITH HARM	1 low harm	1 low harm	1 low harm	3 low harm	0	3 low harm
COMPLAINTS	0	0	0	0	0	0
Ward 81						
CEF	SILVER	N/A	N/A	N/A	N/A	N/A
SI'S (date of incident)	0	0	0	0	0	0
MEDICATION	0	2 low harm	0	0	0	0
FALLS WITH HARM	0	0	0	1 low harm	0	1 low harm
PU'S WITH HARM	0	1 low harm	2 low harm	0	0	1 low harm
COMPLAINTS	1	0	1	0	1	0
Ward 126						
CEF	Last visit in April 2019 SILVER					
SI'S (date of incident)	0	0	0	0	0	Fall, Subdural Haemorrhage
MEDICATION	1 near miss	2 no harm 1 low harm	1 low harm	0	1 near miss	0
FALLS WITH HARM	0	2 low harm	0	0	1 low harm	1 low harm 1 moderate harm
PU'S WITH HARM	0	1 low harm	3 low harm	6 low harm	2 low harm	3 low harm
COMPLAINTS	0	1	0	0	0	0

University Hospitals of North Midlands NHS Trust

Executive Summary

Meeting:	Trust Board (open)	**Date:**	11th March 2020
Report Title:	UHNM CQC Inspection Report	**Agenda Item:**	9
Author:	CQC		
Executive Lead:	Mrs Michelle Rhodes, Chief Nurse		

Purpose of Report:					
Assurance		**Approval**		**Information**	✓

Alignment to Strategic Objectives:		
SO1	Provide safe, effective, caring and responsive services	✓
SO2	Achieve NHS constitutional patient access standards	✓
SO3	Achieve excellence in employment, education, development and research	✓
SO4	Lead strategic change within Staffordshire and beyond	
SO5	Ensure efficient use of resources	✓

Summary of other meetings presented to and outcome of discussion:

The attached report was published by the CQC on Friday 14th February 2020 and shared with UHNM QGC on 27th February 2020, who approved the proposed management and monitoring of required actions through performance management reviews. The Committee noted that an Urgent Care improvement programme was already in place and would be refreshed and monitored through internal and system delivery groups and that the Trust would be writing to the CQC to apply for removal of the Section 31 notices.

The Quality Governance Committee will be asked to note the on-going management of the action plans, which will consolidate the recommendations from the CQC Inspection, in order to provide a high level framework of assurance to the Trust Board.

Summary of Report, Key Points for Discussion including any Risks:

Between June and August 2019, the CQC inspected the core services of Medical care, Urgent and Emergency care, Outpatients, Children and Young People and Maternity at the Royal Stoke University Hospital and Maternity, Outpatients and Urgent and Emergency Care at the County Hospital.

The final report was published on 14th February 2020.

The overall rating for the Trust stayed the same. The CQC rated us as requires improvement because:

- The CQC had concerns regarding the care and treatment of patients in the Emergency Department at Royal Stoke Hospital
- They also raised concerns in relation to the care and treatment of patients with mental health needs and patients who lacked mental capacity to make decisions
- Governance systems although embedded were over complicated and unreliable. The CQC acknowledged that the newly appointed CEO was undertaking extensive work to improve these systems
- In rating the Trust, the CQC took into account the current ratings of services not inspected this time
- Immediate actions have been taken to address the issues identified with regard to the care of patients with mental health needs
- Improvements to the triage system and process were implemented immediately and the Board subsequently agreed significant investment for nurse staffing

- The ED Improvement plan seen by the Board in Sept 2019 remains in place and is being refreshed following the challenges in December 2019

The attached report details the improvements identified as well as 12 examples of outstanding practice. Briefing sessions have been held for staff and action plans are being developed. A report on actions, which the Trust MUST take in order to comply with its legal obligations needs to be submitted to the CQC by 20th March 2020.

Monitoring progress and subsequent completion of each action will take place at a local level via existing Divisional Groups. Actions following recommendations for improvement within the Emergency Department will be monitored through the internal and health economy urgent care board. Each Group will be required to submit a monthly progress report to the Trust Quality and Safety Oversight Group detailing current position, areas for escalation and areas of good practice / learning. In addition, each group will be required to identify any areas at risk of delivery.

The Quality Governance Committee will be asked to note the on-going management of the action plans, which will consolidate the recommendations from the CQC Inspection, in order to provide a high level framework of assurance to the Trust Board.

Key Recommendations:
UHNM CQC report is provided to the Trust Board (open) for information

University Hospitals of North Midlands NHS Trust

Inspection report

Newcastle Road
Stoke On Trent
Staffordshire
ST4 6QG
Tel: 01782715444
www.uhnm.nhs.uk

Date of inspection visit: 05 Jun to 01 Aug 2019
Date of publication: xxxx> 2017

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

This report is a summary of our inspection findings. You can find more detailed information about the service and what we found during our inspection in the related Evidence appendix.

Ratings

Overall rating for this trust	Requires improvement
Are services safe?	**Requires improvement**
Are services effective?	**Requires improvement**
Are services caring?	**Good**
Are services responsive?	**Requires improvement**
Are services well-led?	**Requires improvement**

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

Summary of findings

Background to the trust

The University Hospitals of North Midlands NHS Trust provides general acute hospital services for approximately 900,000 people in Staffordshire, South Cheshire and Shropshire.

The trust also provides specialised services for three million people across a wider area, including neighbouring counties and north Wales. These specialised services include cancer diagnosis and treatment, cardiothoracic surgery, complex orthopaedic surgery, laparoscopic surgery, the management of liver conditions, neurosurgery, neonatal intensive care, paediatric intensive care, renal and dialysis services, respiratory conditions, spinal surgery, trauma and upper gastrointestinal surgery.

The trust employs over 10,000 staff and has more than 1,250 inpatient beds. Services are provided at Royal Stoke University Hospital, County Hospital and a small number of community settings.

(Source: Routine Provider Information Request (RPIR) – Context acute tab)

Acute hospital sites at the trust

Details of the trust's two hospital sites are below. The trust noted that both sites cover the following geographical areas: Herefordshire, Mid Staffordshire, North Staffordshire, North Wales (trauma), Shrewsbury, Shropshire, South Cheshire and Worcestershire.

(Source: Routine Provider Information Request (RPIR) – Sites tab)

Overall summary

Our rating of this trust stayed the same since our last inspection. We rated it as Requires improvement 

What this trust does

The trust provides a full range of hospital services including urgent and emergency care, critical care, medical care, surgery, end of life care, maternity and gynaecology, and outpatients services at both hospitals. Services for children and young people are provided at Royal Stoke University Hospital and County Hospital. In addition to these services, the trust is also a tertiary centre on the Royal Stoke site for trauma, cardiology and spinal care.

- **Royal Stoke Hospital:**

The Royal Stoke Hospital is a large acute hospital in Stoke on Trent. They offer several secondary care services including medical care, maternity, surgery and children and young people services. The hospital is also a regional trauma centre and offers direct major trauma care to patients from across the region and north Wales.

- **County Hospital:**

The County Hospital is a smaller hospital site in Stafford. This hospital provides services including medical care, elective surgery, outpatients and diagnostics, a paediatric minor injuries unit and a standalone midwifery led unit.

(Source: Trust website)

Key questions and ratings

We inspect and regulate healthcare service providers in England.

Summary of findings

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Where we have a legal duty to do so, we rate the quality of services against each key question as outstanding, good, requires improvement or inadequate.

Where necessary, we take action against service providers that break the regulations and help them to improve the quality of their services.

What we inspected and why

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse.

Between June and August 2019, we inspected the core services of Medical care, Urgent and Emergency Care, Outpatients, Children and Young People and Maternity at the Royal Stoke Hospital and Maternity, Outpatients and Urgent and Emergency Care at the County Hospital.

What we found

Overall trust

Our rating of the trust stayed the same. We rated it as requires improvement because:

- We found significant concerns regarding the care and treatment of patients in the emergency department at Royal Stoke Hospital.
- We found serious issues in relation to the care and treatment of patients with mental health needs and patients who lacked mental capacity to make decisions. These concerns were mainly focussed within medical care and urgent care services. As a result of these concerns we took urgent enforcement actions to ensure patients were safe.
- Governance systems although embedded were over complicated and unreliable. However, we found that the newly appointed chief executive was undertaking extensive work to improve these systems.
- In rating the trust, we took into account the current ratings of services not inspected this time.

Our full inspection report summarising what we found and the supporting evidence appendix containing detailed evidence and data about the trust is available on our website – www.cqc.org.uk/provider/reports.

Are services safe?

Our rating of safe stayed the same. We rated it as requires improvement because:

- One core service was rated as inadequate and four core services were rated as requires improvement for safe at Royal Stoke Hospital.
- All three core services inspected at County Hospital were rated as requires improvement for safe.
- In rating safe, we took into account the current ratings of services not inspected this time.

Are services effective?

Our rating of effective went down. We rated it as requires improvement because:

- Two core services were rated as requires improvement and two core services were rated good at Royal Stoke Hospital for effective.

Summary of findings

- One core service was rated as requires improvement and one core service was rated as good at County Hospital for effective.
- We do not currently rate outpatient services in the effective domain.
- In rating effective, we took into account the current ratings of services not inspected this time.

Are services caring?

Our rating of caring went down. We rated it as good because:

- One core service at Royal Stoke Hospital was rated as outstanding.
- All other core services at Royal Stoke were rated as good for caring.
- All core services at County Hospital were rated as good for caring.
- In rating caring, we took into account the current ratings of services not inspected this time.

Are services responsive?

Our rating of responsive stayed the same. We rated it as requires improvement because:

- One core service was rated as requires improvement and four core services were rated as good at Royal Stoke Hospital for responsive.
- All core services at County Hospital were rated as good for responsive.
- In rating responsive, we took into account the current ratings of services not inspected this time.

Are services well-led?

Our rating of well-led went down. We rated it as requires improvement because:

- Two core services were rated as requires improvement and three core services were rated as good at Royal Stoke Hospital for well led.
- Two core services were rated as requires improvement and one core service was rated as good at County Hospital for well led.
- In rating well led, we took into account the current ratings of services not inspected this time.

Ratings tables

The ratings tables show the ratings overall and for each key section, for service, hospital and service type, and for the whole trust. We took all ratings into account in deciding overall ratings. Our decisions on overall ratings also took into account factors including the relative size of services and we used our professional judgement to reach fair and balanced ratings.

Outstanding practice

We found 12 examples of outstanding practice at The Royal Stoke University Hospital.

For more information, see the Outstanding practice section of this report.

Areas for improvement

We found areas for improvement including 34 breaches of legal requirements that the trust must put right. We found 46 things that the trust should improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement, or to improve service quality.

Summary of findings

For more information, see the Areas for improvement section of this report.

Action we have taken

We issued requirement notices to the trust. Our action related to breaches of legal requirements at a trust-wide level and in core services. We also took urgent enforcement action in relation to the safety of urgent and emergency care and the effectiveness of medical care to ensure that patients were safe.

For more information on action we have taken, see the sections on Areas for improvement and Regulatory action.

What happens next

We will check that the trust takes the necessary action to improve its services. We will continue to monitor the safety and quality of services through our continuing relationship with the trust and our regular inspections.

Outstanding practice

We found the following areas of outstanding practice:

The Royal Stoke University Hospital

Services for children and young people

- The service worked with the local authority and National Literacy Trust to provide each neonate with a story pack. These packs contained a book for parents to read to their neonate helping parents to bond with their child when they were unable to hold them for lengthy periods. The packs also contained a notebook and pen for parents to keep a diary of their neonate's journey.
- The service had produced a number of resources including, 'tips for nurses' covering topics such as; what to say and not to say to young people with mental health needs, eating disorders and gender dysphoria. These resources alongside the support from the trust's lead mental health nurses equipped staff with the skills needed to support children and young people with mental health need.
- Distraction bags were given to children and young people with mental health needs. These bags contained items to help children and young people manage their mental health during their assessment and/or admission. Items contained within the bags included; fidget toys, stress toys, puzzles, therapeutic colouring and a notepad and pen. The bags could also be personalised to meet individual needs as required. For example, drawing books were added if a child or young person showed an interest in art.
- The service provided children and young people with vast and varied resources to help them learn more about their mental health needs. This included short and snappy information leaflets. Leaflets available included; Looking after your wellbeing and a bereavement leaflet. Leaflets were designed specifically for children and young people and included apps that could be used to help monitor and manage wellbeing.
- Staff used innovative methods to support family units during challenging times. For example, staff on CICU and CHDU held family pizza nights where families could gather together, watch a film and eat pizza within private areas on the unit. This provided families with the opportunity to relax and reconnect with family.
- Staff recognised the need to provide hope, reflect on treatment journeys and to celebrate success. For example, staff recognised the need to show families of neonates hope and light at the end of the tunnel. The entrance to the NICU

contained a 'wall of hope'. This comprised of well-presented photos of children who had previously been admitted to the NICU. The photo's showed the babies who had grown into children and each photo stated the child's birth gestational age and the number of days spent on the unit. This provided parents and families with hope for their neonates' future.

- The whole staff team, from consultants to health care support workers prioritised their time to celebrate the end of treatment with children, young people and their families. We attended a bell ringing celebration during our inspection and saw the staff had decorated and personalised the wall around the bell for the child and staff who had been involved in the child's care and treatment made time to attend the celebration.
- In addition to outpatient appointments that were carried out at the Royal Stoke, appointments were also offered to children and young people within specialist schools. This meant children and young people could be seen in environments where they were comfortable, and the staff could consult with parents, carers and school staff to get updates about any changes in presentation and/or behaviours.

Outpatients

- The service received accreditation for its work on health literacy. It achieved excellence level in the Health Literacy Friendly scheme. The team were praised for their, 'enthusiasm, dedication and professionalism which your team has directed towards improving the health literacy environment within all of the Outpatients departments'.
- The service ran a 'Make Stoke Smile Again' campaign about oral hygiene. The campaign aimed to help educate young people in Stoke on Trent about the damaging effects of too much sugar on teeth. As part of this campaign the service has made videos which are available on the internet. Staff also run social media accounts which are linked to the campaign. As part of the campaign billboards have also been put up in the city.
- Staff in the fracture clinic developed a 'Care of your Plaster' leaflet in 2018. In response to incidents plaster technician staff then developed an 'Inpatient/Outpatient Daily Cast Checklist' which was given out to patients or relatives/carers at the time of application for them to take away with them. The checklist focussed on key areas that patients can monitor and focus on in order to prevent any issues. This checklist was rolled out in April 2019 and staff delivered training on the checklist to staff in the hospital.
- Plaster technician staff ran a casting skills study day which was open to NHS staff nationally as well as staff from local residential and care homes. The study day was focussed on aftercare and early identification of issues which may lead to problems such as pressure ulcers. The day was well attended so there is a plan in place to repeat the training day yearly with a different focus.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is to comply with a minor breach that did not justify regulatory action, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve

We told the trust that it must take action to bring services into line with 34 breaches of legal requirements.

The Royal Stoke University Hospital

Urgent and emergency services

Summary of findings

- The provider must ensure that each person's privacy must be maintained at all times. All reasonable efforts should be made to make sure that discussions about care treatment and support only take place where they cannot be overheard. Regulation 10
- The provider must ensure it supports patients to make informed decisions about their care and treatment and follow national guidance to gain patients' consent. Regulation 11
- The provider must ensure that staff did follow a consistent approach to monitoring and recording observations. Regulation 12
- The provider must ensure that navigating patients in the department is done by a suitably trained and qualified member of staff. Regulation 12
- The provider must have systems and process in place to enable them to identify and assess risks to the health, safety and/or welfare of people who use the service. Regulation 17
- The provider must be able to show how they have used information from external stakeholders to make improvements and demonstrate how they have been made. Regulation 17
- The provider must ensure all staff have completed all of the essential and required training to undertake their roles safely and effectively. Regulation 18
- The provider must deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff to make sure that they can meet people's care and treatment needs. Regulation 18

Medical care (including older people's care)

- The trust must ensure all patients detained under the Mental Health Act (1983) have their rights maintained as per the act. Regulation 15
- The trust must ensure all patients subject to a Deprivation of Liberty Safeguards order have these reviewed regularly; and have had the required capacity assessments prior to these being applied as per the Mental Capacity Act (2005) DOLS. Regulation 15
- The trust must ensure staff meet mandatory training targets, including safeguarding and consent. Regulation 12
- The trust must ensure patient observations are completed within required timeframes to monitor potential deterioration of health. Regulation 12
- The trust must ensure all patients who require nutritional risk assessments have these undertaken in a timely manner. Regulation 10

Maternity

- The service must ensure all staff are up to date with mandatory training. Regulation 12
- The service must ensure all staff are up to date with safeguarding training. Regulation 13
- The service must ensure all staff are up to date with their appraisals. Regulation 17
- The service must ensure all staff comply with infection prevention control procedures. Regulation 12
- The service should ensure all staff complete all crucial stages of the surgical safety checklist. Regulation 17
- The service must ensure staff comply with the Maternal Sepsis Screening Tool and escalate risks as appropriate. Regulation 12

Services for children and young people

Summary of findings

- The trust must ensure the risks associated with ligature points are assessed and mitigated in the CAU. Regulation 12
- The trust must ensure all medicines on CICU are consistently stored securely and in line with manufacturers guidance. Regulation 12

Outpatients

- The provider must ensure quality and risk management processes identify all clinical and non-clinical risks to patients. Regulation 17
- The provider must ensure systems for monitoring patient outcomes and key performance indicators are comprehensive and reliable. Regulation 17

The County Hospital

Urgent and emergency services

- The trust must ensure staff complete all mandatory training. Regulation 12(2)
- The trust must ensure staff complete the required level of safeguarding training. Regulation 12(2)
- The trust must ensure all documentation is completed consistently and in a timely manner. Regulation 12(2)
- The trust must ensure there is sufficient paediatric resuscitation equipment within the emergency department. Regulation 12(2)

Maternity

- The service must ensure all staff are up to date with mandatory training. Regulation 12
- The service must ensure all staff are up to date with safeguarding training. Regulation 13
- The service must ensure all staff are up to date with their appraisals. Regulation 17
- The service must ensure that systems and processes are effective at identifying dates of expiry for equipment and replacing them in a timely way. Regulation 15

Outpatients

- The trust must ensure deliveries of chemotherapy are timely. Regulation 12
- The trust must ensure quality and risk management processes identify all clinical and non-clinical risks to patients. Regulation 17
- The trust must ensure systems for monitoring patient outcomes and key performance indicators are comprehensive and reliable. Regulation 17

Action the trust SHOULD take to improve

We found 46 things that the trust should improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement, or to improve service quality.

The Royal Stoke University Hospital

Urgent and emergency services

- The provider should ensure they continue to improve the flow through the department to keep patients waiting in corridors to a minimum. Regulation 12
- The provider should ensure that the information gathered is up to date and accurate. Regulation 17

Summary of findings

- The provider should ensure they regularly seek the views of patients and their families. Regulation 17
- The provider should ensure it develops a policy for patients who have been detained under the mental health act. Regulation 17
- The provider should continue to embed the work they have done on the Mental Health Act to ensure this becomes embedded practice. Regulation 17
- The department should consider having call bells available for all patients in the department.

Medical care (including older people's care)

- The trust should ensure patient records are consistently secured. Regulation 17
- The service should ensure patients who require support with eating and drinking are provided with this in a timely manner. Regulation 14
- The trust should ensure documentation relating to environmental checks and equipment checks such as fire safety checks and resuscitation trolleys are updated and in place. Regulation 15
- The trust should ensure that sharps bins are disposed within appropriate timescales. Regulation 12
- The trust should ensure that curtains around patient beds are laundered and/ or replaced as per the trust protocols. Regulation 12
- The trust should ensure missed medicines are coded appropriately. Regulation 12
- The trust should ensure patients requiring antimicrobial medicines have these as per national guidance. Regulation 12
- The service should ensure they improve the appraisal completion rate for nursing staff. Regulation 18
- The trust should ensure that all staff follow the trust policy on securing interpretation services for patients. Regulation 17
- The trust should ensure that levels of staffing are reviewed to enable staff are consistently able to provide compassionate care to patients. Regulation 18
- The trust should consider how to consistently ensure patients who require a side room have this need met.
- The trust should consider how to develop a consistent level of meaningful activity to ensure emotional support.

Maternity

- The service should ensure they always follow best practice when prescribing, giving, recording and storing medicines. Regulation 12

Services for children and young people

- The trust should ensure all staff consistently complete mandatory training, including safeguarding children and adults. Regulation 18
- The trust should ensure capacity assessments are clearly recorded in patient records. Regulation 11
- The trust should ensure that the individual care preferences and needs of children and young people are consistently and clearly recorded in patient care records. Regulation 9
- The trust should consider ensuring staff complete regular training in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS).

Summary of findings

Outpatients

- The provider should ensure it produces a documented procedure for the management of a deteriorating child or young person in the outpatients department. Regulation 12
- The provider should ensure they continue to monitor patient outcome more effectively in order to improve the service. Regulation 17
- The provider should consider how it utilises the waiting room in the fracture clinic as it has not got enough seating for the amount of patients who attend.

The County Hospital

Urgent and emergency services

- The trust should ensure they use effective audits to improve the quality of treatment for patients. Regulation 17
- The trust should ensure that all staff appraisals are completed. Regulation 18
- The trust should ensure they improve the timeliness of care provided to meet national standards. Regulation 17
- The trust should ensure they reduce staff sickness and vacancy rates and reduce bank and locum usage. Regulation 18
- The trust should ensure they reduce the unplanned re-attendance rates. Regulation 17
- The trust should consider the appropriateness of the care environment including décor and location of facilities.

Outpatients

- The trust should ensure they produce a documented procedure for the management of a deteriorating child or young person in the outpatients department. Regulation 12
- The trust should risk assess the use of the children's outpatients resuscitation trolley in the main outpatients department. Regulation 12
- The trust should ensure all incidents are reported on the incident reporting system. Regulation 17
- The trust should ensure learning from incidents and serious incidents is disseminated to all staff. Regulation 17
- The trust should ensure medical staff are responsible for deciding the time to a patients next appointment. Regulation 12
- The trust should ensure multidisciplinary team meetings have a formal agenda and minutes to ensure there is a record of what was discussed at the meeting. Regulation 17
- The trust should ensure there is a system of audit for patient notes at County Hospital. Regulation 17
- The trust should ensure the correct codes are used for clinic lists when booking patient appointments. Regulation 17
- The trust should ensure the 'choose and book' system is reliable. Regulation 17
- The trust should ensure visible management and leadership in the County Hospital outpatients department. Regulation 17
- The trust should ensure visible representation of County Hospital staff at governance and risk management meetings. Regulation 17
- The trust should ensure staff at County Hospital outpatients are engaged in trust initiatives. Regulation 17

Summary of findings

- The trust should ensure the timely updating of training compliance spreadsheets. Regulation 17
- The trust should ensure medical staff complete all relevant safeguarding training modules. Regulation 18

Is this organisation well-led?

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, we look at the quality of leadership at every level. We also look at how well a trust manages the governance of its services – in other words, how well leaders continually improve the quality of services and safeguard high standards of care by creating an environment for excellence in clinical care to flourish.

We rated well-led at the trust as requires improvement because:

- The newness of trust board meant collective capability and effectiveness of the recently established team remained to be tested.
- We found that the trust was not meeting the fit and proper person requirement fully due to refusal by the disclosure and barring service to undertake enhanced checks.
- The strategy for mental health was significantly lacking in key areas.
- Although there were established governance systems in place, these were complicated and we found these systems were not effective in ensuring safe and high-quality services were provided.
- The board assurance framework was not aligned to the strategic objectives and lacked clarity.
- There was a lack of curiosity and interrogation of the information presented through governance to board sub committees and the board itself.
- Systems in place to manage risks, issues and performance were not always effective.
- We found risks were not always appropriately recognised or acted upon sufficiently to secure improvement.
- Interrogation of data was limited and was often relied on as a source of reassurance rather than assurance.
- The data provided to board was not always reliable, validated or easy to interpret.
- We were not assured that important information reached the board in a timely way and not assured that notifications were consistently submitted to external organisations as required. There were several areas within core services which had undertaken innovative pieces of work and research. However, we found that arrangements to ensure continuous improvement and learning at a trust wide level required strengthened strategic drive and effective oversight.

However;

- Leaders were visible, approachable and possessed all the skills and capabilities required to lead effectively.
- We consistently heard positive staff reflections of and a high degree of whole trust confidence in the skills and capabilities offered by the recently appointed chief executive.
- This included confidence taken from the balance of approach and expertise between chief executive and chair.
- The trust had a vision and strategy in place.

Summary of findings

- Board had recognised the requirement to ensure mechanisms were established to secure its delivery and alignment to STP objectives.
- The new board were focussed on improving trust culture at all levels and had already seen some positive impact of this work. The ambition was to secure a culture focused on clinical and quality excellence. However, there were improvements required to secure this and ensure the trust had an open and transparent culture which learned from issues and significant events. This included for board to ensure it owned and appreciated the importance of some aspects of the equality and diversity agenda.
- The trust had acknowledged the need to improve its governance processes.
- The trust collected a large amount of data and analysed it. Staff could find the data they needed, in accessible formats and information systems were integrated and secure.
- The trust engaged with staff and the public and was working to improve its engagement position. There was an engagement strategy, and this was in place and monitored regularly through complaints and public engagement teams.

Ratings tables

Key to tables					
Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	➔🡐	🡅	🡅🡅	🡇	🡇🡇
Month Year = Date last rating published					

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement ➔🡐 Feb 2020	Requires improvement 🡇 Feb 2020	Good 🡇 Feb 2020	Requires improvement ➔🡐 Feb 2020	Requires improvement 🡇 Feb 2020	Requires improvement ➔🡐 Feb 2020

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
The Royal Stoke University Hospital	Requires improvement ➔➔ Feb 2020	Requires improvement ➔➔ Feb 2020	Good ➔➔ Feb 2020	Requires improvement ➔➔ Feb 2020	Requires improvement ➔➔ Feb 2020	Requires improvement ➔➔ Feb 2020
The County Hospital	Requires improvement ➔➔ Feb 2020	Requires improvement ➔➔ Feb 2020	Good ➔➔ Feb 2020	Requires improvement ➔➔ Feb 2020	Requires improvement ➔➔ Feb 2020	Requires improvement ➔➔ Feb 2020
Overall trust	Requires improvement ➔➔ Feb 2020	Requires improvement ➔➔ Feb 2020	Good ➔➔ Feb 2020	Requires improvement ➔➔ Feb 2020	Requires improvement ➔➔ Feb 2020	Requires improvement ➔➔ Feb 2020

Ratings for the trust are from combining ratings for hospitals. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Ratings for The Royal Stoke University Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Inadequate ↓↓ Feb 2020	Requires improvement ↓ Feb 2020	Requires improvement ↓ Feb 2020	Requires improvement →← Feb 2020	Requires improvement ↓ Feb 2020	Requires improvement ↓ Feb 2020
Medical care (including older people's care)	Requires improvement →← Feb 2020	Requires improvement ↓ Feb 2020	Good →← Feb 2020	Good →← Feb 2020	Requires improvement ↓ Feb 2020	Requires improvement ↓ Feb 2020
Surgery	Requires improvement Feb 2018	Good Feb 2018	Good Feb 2018	Good Feb 2018	Good Feb 2018	Good Feb 2018
Critical care	Good Feb 2018	Good Feb 2018	Outstanding Feb 2018	Good Feb 2018	Outstanding Feb 2018	Outstanding Feb 2018
Maternity	Requires improvement ↓ Feb 2020	Good →← Feb 2020	Good →← Feb 2020	Good ↑ Feb 2020	Good →← Feb 2020	Good →← Feb 2020
Services for children and young people	Requires improvement ↓ Feb 2020	Good →← Feb 2020	Outstanding →← Feb 2020	Good →← Feb 2020	Good →← Feb 2020	Good →← Feb 2020
End of life care	Good Feb 2018	Requires improvement Feb 2018	Outstanding Feb 2018	Good Feb 2018	Good Feb 2018	Good Feb 2018
Outpatients	Good →← Feb 2020	Not rated	Good →← Feb 2020	Requires improvement →← Feb 2020	Requires improvement →← Feb 2020	Requires improvement →← Feb 2020
Overall*	Requires improvement →← Feb 2020	Requires improvement ↓ Feb 2020	Good ↓ Feb 2020	Requires improvement →← Feb 2020	Requires improvement ↓ Feb 2020	Requires improvement ↓ Feb 2020

*Overall ratings for this hospital are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Ratings for The County Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement ↓ Feb 2020	Requires improvement ↓ Feb 2020	Good →← Feb 2020	Good →← Feb 2020	Good →← Feb 2020	Requires improvement ↓ Feb 2020
Medical care (including older people's care)	Requires improvement Feb 2018	Good Feb 2018	Good Feb 2018	Good Feb 2018	Requires improvement Feb 2018	Requires improvement Feb 2018
Surgery	Good Jul 2015	Good Jul 2015	Good Jul 2015	Requires improvement Jul 2015	Good Jul 2015	Good Jul 2015
Critical care	Requires improvement Jul 2015	Good Jul 2015	Good Jul 2015	Good Jul 2015	Requires improvement Jul 2015	Requires improvement Jul 2015
Maternity	Requires improvement ↓ Feb 2020	Good →← Feb 2020	Good →← Feb 2020	Good →← Feb 2020	Good →← Feb 2020	Good →← Feb 2020
End of life care	Good →← Feb 2018	Requires improvement →← Feb 2018	Good →← Feb 2018	Good →← Feb 2018	Good →← Feb 2018	Good →← Feb 2018
Outpatients	Requires improvement ↓ Feb 2020	Not rated	Good →← Feb 2020	Requires improvement →← Feb 2020	Requires improvement →← Feb 2020	Requires improvement →← Feb 2020
Overall*	Requires improvement →← Feb 2020	Requires improvement ↓ Feb 2020	Good →← Feb 2020	Requires improvement →← Feb 2020	Requires improvement →← Feb 2020	Requires improvement →← Feb 2020

*Overall ratings for this hospital are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

The Royal Stoke University Hospital location report

Newcastle Road
Stoke On Trent
Staffordshire
ST4 6QG
Tel: 01782 675778
www.uhns.nhs.uk

Key facts and figures

The Royal Stoke Hospital is a large acute hospital in Stoke on Trent. They offer several secondary care services including medical care, maternity, surgery and children and young people services. The hospital is also a regional trauma centre and offers direct major trauma care to patients from across the region and north Wales.

The University Hospitals of North Midlands NHS Trust provides general acute hospital services for 900,000 people in Staffordshire, South Cheshire and Shropshire.

The trust employs over 10,000 staff and has more than 1,250 inpatient beds. Services are provided at Royal Stoke University Hospital, County Hospital and a small number of community settings.

Summary of services at The Royal Stoke University Hospital

Requires improvement 

Our rating of services went down. We rated them as Requires Improvement because:

- Our rating of safe was Requires Improvement overall. Risks within the emergency department were not always identified and escalated appropriately. We were not assured that all patients allocated to wait on the corridor were safe. Not all staff had completed all of the required mandatory training. Not all staff had training on how to recognise and report abuse. However, despite the low training figures, staff we spoke with were knowledgeable on how to recognise and report abuse. Both nursing and medical staff throughout the core service did not meet the trusts targets for safeguarding training. The service did not always have enough nursing staff with the right qualifications, skills and experience to keep patient's safe from avoidable harm and to provide the right care and treatment on all wards. Staff did not always undertake observations of patients' vital signs in a timely manner. Risk assessments relating to patient malnutrition were not undertaken in line with the trust target
- Our rating of effective was Requires Improvement overall. The service did not always provide care and treatment based on national guidance and evidence of its effectiveness. The service did not always ensure staff were competent for their roles. Managers sometimes appraised staff's work performance to provide support and monitor the

effectiveness of the service. Staff did not always assess and monitor patients regularly to see if they were in pain. Staff did not always understand their roles and responsibilities under the Mental Capacity Act 2005. They did not always know how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

- Our rating of caring was good overall. Staff provided emotional support to patients to minimise their distress. Staff involved patients and those close to them in decisions about their care and treatment. Staff cared for patients with compassion however, patient dignity was sometimes compromised.
- Our rating of responsive was requires improvement overall. People could not always access services when they needed. The service treated concerns and complaints seriously however, complaints were not always responded to within appropriate time frames or learning effectively shared.
- Our rating of well led was requires improvement overall. Not all managers had the right skills and abilities to run services providing high-quality sustainable care. Departments did not always have effective systems for identifying risks.

Urgent and emergency services

Requires improvement 

Key facts and figures

Details of emergency departments and other urgent and emergency care services

- Royal Stoke University Hospital emergency department. Open 24 hours a day, seven days a week.

(Source: Routine Provider Information Request (RPIR) – Sites tab)

The trust is a major trauma centre and receives patients from a wide area, by helicopter as well as land ambulance.

(Source: Routine Provider Information Request (RPIR) – Acute context tab)

Number of beds/bays

Ambulance Assessment– 6 cubicles and two process cubicles

Paediatric – four cubicles, two treatment rooms, one triage room and one counselling room

Ambulatory area (inclusive of minors and ambulatory patients)- triage cubicle, ARAT (ambulatory rapid assessment and treatment) cubicle, four cubicles, three treatment rooms (inclusive of eye cubicle) and two spaces in a plaster room

Majors –19 (including three treatment rooms/isolation cubicles) treatment bays

Resus – eight (including one trauma bay and one paediatric bay) treatment bays

Clinical Decision Unit (CDU)- three ambulatory bays, one side room, six female cubicles and six male cubicles)

Separate entrances and facilities were available for Adults and Children. Each department had a main entrance and separate ambulance entrance.

The adult emergency department also had an Air Ambulance helipad which was adjacent to and used the adult ambulance entrance to access the department.

Ambulance triage, assessment and the main resus areas were adjacent to the ambulance entrance, meaning patients entered directly into the area which best met their needs.

Paediatric trauma patients or those arriving by Air Ambulance would be admitted through the adult entrance. A dedicated paediatric resuscitation bay was available in resus for such emergencies.

Summary of this service

Our rating of this service went down. We rated it as requires improvement because:

- Not all staff had completed all of the required training.
- Staff did not always receive training in how to recognise and act on abuse. However, despite the low training figures, staff we spoke with were knowledgeable on how to recognise and report abuse.
- Facilities were not designed to keep people safe.
- Navigating in the department was not managed in a way to keep people safe.
- Staff did not follow a consistent approach to monitoring and recording observations.

Urgent and emergency services

- The service had enough nursing staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. However, during busy periods we were not assured of the levels of staff available to manage patients safely in the corridor. The service also had high sickness, vacancy rates and bank usage for their nursing staff.
- Some patient outcomes were worse than national averages. However; staff monitored the effectiveness of care and treatment. They used the findings to make improvements to improve outcomes for patients.
- Staff did not always support patients to make informed decisions about their care and treatment. They did not always follow national guidance to gain patients' consent. They did not always support patients who lacked capacity to make their own decisions or were experiencing mental ill health.
- Patients privacy and dignity was not always maintained.
- Call bells were not always available for patients to enable them to alert staff if they were required.
- The department lacked flow and patients were often waiting in corridors.
- The service did not ensure patients did not stay longer than they needed to.
- Staff told us that morale had been adversely affected due to the corridor care.
- The department did not always identify and escalate relevant risks and issues.
- The service did not always collect reliable data.
- The service did not routinely engage with patients.

However

- The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.
- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.
- The service used systems and processes to safely prescribe, administer, record and store medicines.
- The service managed patient safety incidents well.
- The service made sure staff were competent for their roles.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.
- Staff treated patients with compassion and kindness and took account of their individual needs.
- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patient's personal, cultural and religious needs.
- The service was inclusive and took account of patients' individual needs and preferences.
- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.
- The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders.
- Leaders operated effective governance processes, throughout the service and with partner organisations.

Urgent and emergency services

- Following the 2018 CQC inspection visit there were nine areas for improvement identified, of which the service had shown improvement towards achieving eight of these.

Is the service safe?

Inadequate ↓↓

Our rating of safe went down. We rated it as inadequate because:

- Not all staff had completed all of the required training.
- Not all staff had training on how to recognise and report abuse. Both nursing and medical staff did not meet the trusts targets for safeguarding training.
- Facilities were not designed to keep people safe.
- Navigating in the department was not managed in a way to keep people safe. Staff did not follow a consistent approach to monitoring and recording observations.
- During busy periods we were not assured of the levels of staff available to manage patients safely in the corridor.
- The service had high vacancy rates for their medical staff.
- The service had high sickness, vacancy rates and bank usage for their nursing staff.

However:

- The service provided mandatory training in key skills including the highest level of life support training to all staff.
- However, staff understood how to protect patients from abuse and the service worked well with other agencies to do so.
- The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.
- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.
- The service used systems and processes to safely prescribe, administer, record and store medicines.
- The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Is the service effective?

Requires improvement ↓

Our rating of effective went down. We rated it as requires improvement because:

- The service performed worse than average in some national clinical outcome audits. However, the department was performing well in relation to outcomes in patients presenting with major trauma.

Urgent and emergency services

- Staff did not always support patients to make informed decisions about their care and treatment. They did not always follow national guidance to gain patients' consent. They did not always support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

However:

- The service provided care and treatment based on national guidance and best practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983, however, further work was needed to ensure this became embedded practice.
- Since the trust acquired Major Trauma Centre status in 2012, they have delivered an above expected survival rate for patients suffering from major trauma.
- Staff gave patients enough food and drink to meet their needs and improve their health.
- Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.
- Key services were available seven days a week to support timely patient care.
- Staff gave patients practical support and advice to lead healthier lives.

Is the service caring?

Requires improvement 

Our rating of caring went down. We rated it as requires improvement because:

- Patients privacy and dignity was not always maintained.
- Call bells were not always available for patients to enable them to alert staff if they were required.

However:

- Staff treated patients with compassion and kindness and took account of their individual needs.
- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patient's personal, cultural and religious needs.
- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Is the service responsive?

Requires improvement 

Our rating of responsive stayed the same. We rated it as requires improvement because:

- The department lacked flow and patients were often waiting in corridors.

Urgent and emergency services

- The service did not ensure patients did not stay longer than they needed to.

However:

- The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.
- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.
- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

Is the service well-led?

Requires improvement 

Our rating of well-led went down. We rated it as requires improvement because:

- Staff told us that morale had been adversely affected due to the corridor care.
- Leaders did not always operate good governance processes, throughout the service and with partner organisations. This included risks not being escalated and notified to the senior team. Several issues we found were not identified by the trust in their routine governance processes for monitoring safety and performance.
- The department did not always identify and escalate relevant risks and issues.
- The service did not always collect reliable data.
- The service did not routinely engage with patients.
- The trust had not used the last CQC inspection report to improve their service.

However:

- Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.
- The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development.
- Data and notifications were consistently submitted to external organisations as required.
- Leaders and staff actively and openly engaged staff and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.
- Leaders encouraged innovation and participation in external reviews.

Areas for improvement

We found 14 areas for improvement in this service. See the Areas for Improvement section above.

Medical care (including older people's care)

Requires improvement 

Key facts and figures

The medical care service at Royal Stoke University Hospital provides care and treatment for specialties including cardiology, dermatology, gastroenterology, geriatric medicine, neurology and respiratory medicine. The hospital is a regional centre for cardiology, renal and non-invasive ventilation.

The trust's emergency cardiology and gastroenterology services are based at Royal Stoke University Hospital. Therefore, patients that require these services are moved to Stoke.

The hospital opened two modular wards at the end of February 2019, wards 126 and 127, to assist with patient flow.

(Source: Routine Provider Information Request AC1 - Acute context)

The hospital has 794 medical inpatient beds located across 29 wards and units.

The trust had 114,803 medical admissions from February 2018 to January 2019. Emergency admissions accounted for 50,126 (43.7%), 2,046 (1.8%) were elective, and the remaining 62,631 (54.6%) were day case.

Admissions for the top three medical specialties were:

- General medicine: 37,049
- Clinical oncology: 22,287
- Gastroenterology: 21,468

(Source: Hospital Episode Statistics)

At the time of inspection commencing on 5 June 2019, wards 78 and 79 had just closed and were not in use. The trust had used these additional beds as 'escalation beds' to cover winter pressures.

During the inspection from 5 to 7 June 2019, we spoke with 61 members of staff. This figure included nurses, medical staff, management up to senior divisional directors, health care assistants, housekeepers, allied health professionals and members of the pharmacy team.

We spoke with 14 patients and five visiting relatives.

We reviewed 20 patient records and looked at an additional five patient prescription cards.

We visited the following areas:

- Elderly Care
- ASU/ HASU
- Gastro ward and endoscopy
- Discharge lounge
- Oncology
- CCU and cardiac ward
- Respiratory wards

Medical care (including older people's care)

- Renal Ward

We observed the following activities:

- Mortality and morbidity meeting
- Two 'bed meetings' to manage patient flow through the hospital
- One handover
- Two board rounds
- Two wards during patient meal times
- General observations of patient care throughout the inspection

Summary of this service

Our rating of this service went down. We rated it as requires improvement because:

- Both nursing and medical staff showed poor compliance to the trust target for mandatory training. The 95% target was met for one of the 10 mandatory training modules for which qualified nursing staff were eligible. The 95% target was not met for any of the eight mandatory training modules for which medical staff were eligible. Neither medical or nursing staff had met their training targets on how to recognise and report abuse. The environment within elderly care wards was not always suitable to prevent the spread of infection due to a lack of side rooms. The service did not always have enough nursing staff with the right qualifications, skills and experience to keep patient's safe from avoidable harm and to provide the right care and treatment on all wards. Documentation demonstrating some environmental safety checks was not always present. Staff did not always undertake observations of patients' vital signs in a timely manner. Records were kept in record trolleys which were not always locked whilst unattended on wards. We found that missed doses of medicines were not always coded appropriately; and at times antimicrobial medicines had not been administered in line with best practice guidance. Managers mostly ensured that actions from patient safety alerts were implemented and monitored; although evidence showed that this was not always effective to prevent recurrence of similar incidents.
- Staff did not always protect the rights of patients who were subject to the Mental Health Act 1983. Nutritional risk assessments were not consistently undertaken. Staff gave patients enough food and drink to meet their needs and improve their health. However, this was not always done in a timely manner. Staff did not always know how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. Deprivation of Liberty Safeguards were found to be out of date and not applied as per the Mental Capacity Act (2005). Relevant staff had not met the trust target for training in this area.
- Staff reported, and we saw, not always having time to do this consistently to manage patients' emotional needs.
- Not all staff received regular team meetings. We found that there was no policy regarding the management of detained patients during our inspection. Staff did not always feel engaged with organisational or local changes. Patients we spoke with had not been involved in the wider planning of care or involved in shaping or improving services.

However, we also found:

Medical care (including older people's care)

- The service controlled infection risk well. Staff assessed some risks to patients, acted on them and kept reasonable care records. They mostly managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff provided good care and treatment, gave patients pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff mostly treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Local leaders ran services well. Staff understood the service's vision and values, and how to apply them in their work. Staff felt supported. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. Staff were committed to improving services continually.

Is the service safe?

Requires improvement 

Our rating of safe stayed the same. We rated it as requires improvement because:

- The service did not ensure all staff completed mandatory training. Compliance with the trust target for mandatory training was poor for both nursing and medical staff.
- Neither medical nor nursing staff had met their training targets on how to recognise and report abuse.
- The design and use of facilities and premises did not always keep people safe. Documentation demonstrating some environmental safety checks was not always present.
- The service did not always have enough nursing staff with the right qualifications, skills and experience to keep patient's safe from avoidable harm and to provide the right care and treatment on all wards.
- Staff did not always undertake observations of patients' vital signs in a timely manner. Risk assessments relating to patient malnutrition were not undertaken in line with the trust target.
- Records were not always fully completed, up-to-date and easily available to all staff providing care. Records were kept in record trolleys which were not always locked whilst unattended on wards.
- Staff did not always document or record medicines safely.
- Managers mostly ensured that actions from patient safety alerts were implemented and monitored; although evidence showed that this was not always effective to prevent recurrence of similar incidents.

However,

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.
- The service mostly controlled infection risk well. Staff mostly used equipment to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Medical care (including older people's care)

- The design, maintenance and use of equipment kept people safe.
- Staff completed and updated risk assessments for most patients and acted to remove or minimise risks. Staff mostly identified and quickly acted upon patients at risk of deterioration.
- The service had enough medical staff with the right qualifications, skills, training and experience to keep patient's safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix.
- The service mostly used systems and processes to safely prescribe, administer, record and store medicines.
- The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with some teams and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.
- Staff collected safety information and shared it with staff, patients and visitors on some wards but not all.

Is the service effective?

Requires improvement 

Our rating of effective went down. We rated it as requires improvement because:

- Staff did not protect the rights of patients who were subject to the Mental Health Act 1983.
- Staff did not always give patients enough food and drink to meet their needs and improve their health in a timely manner. Nutritional assessments and patient weight recordings were not consistently undertaken.
- The service had a higher than expected risk of readmission for care than the England average.
- The service did not always use findings of audits and results to make improvements, and therefore achieved varied outcomes for patients.
- Managers did not meet the trust target for completion of appraisals for nursing staff.
- Staff did not always know how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. Deprivation of Liberty Safeguards were found to be out of date and not applied as per the Mental Capacity Act (2005). Relevant staff had not met the trust target for training in this area.

However,

- The service provided care and treatment based on national guidance and best practice. Managers checked to make sure staff followed guidance. The service had been accredited under relevant clinical accreditation schemes.
- Staff used special feeding and hydration techniques when necessary.
- Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.
- The service made sure staff were competent for their roles via ongoing training or updates.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.
- Key services were available seven days a week to support timely patient care.

Medical care (including older people's care)

- Staff gave patients practical support and advice to lead healthier lives. The service had relevant information promoting healthy lifestyles and support on every ward.
- Staff supported patients, who had capacity, to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent.

Is the service caring?

Good  

Our rating of caring stayed the same. We rated it as good because:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff provided emotional support to patients, families and carers to minimise their distress. Staff understood patients' personal, cultural and religious needs.
- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

However,

- Staff did not always have time to manage patients' emotional needs.

Is the service responsive?

Good  

Our rating of responsive stayed the same. We rated it as good because:

- The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.
- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.
- People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were mostly in line with national standards.
- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

However,

- Some new premises were not always suitable for all patients.

Is the service well-led?

Requires improvement 

Our rating of well-led went down. We rated it as requires improvement because:

- Not all stakeholders, such as staff, were involved in or kept up to date with service developments.
- Governance did not always enable the highest standards of clinical care. The trust did not have a full range of policies; learning was not consistently shared with all staff and not all staff received team meetings.
- Not all risks to the service were captured. Speciality local leaders were aware of risks to their service; but did not have local risk registers. Not all risks were identified or escalated; therefore, a consistent approach to action planning was not embedded.
- Information systems were not always integrated and secure.
- Staff did not always feel engaged with organisational or local changes. Patients we spoke with had not been involved in the wider planning of care or involved in shaping or improving services on a wider scale.

However,

- Local leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. Local leaders were visible and approachable in the service for patients and staff.
- The service had a vision for what it wanted to achieve. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders understood and knew how to apply them and monitor progress.
- Staff felt supported. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.
- We saw some effective governance processes throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities.
- Local leaders and teams used systems to identify performance.
- The service collected some data and analysed it. Staff could find some of the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. Data or notifications were consistently submitted to external organisations as required.
- The service did seek views from patients to improve care locally. The service collaborated with partner organisations to help improve services for patients.
- Staff were committed to continually learning and improving services. Some staff were involved in research, service development and recognised accreditation schemes. Leaders encouraged innovation and participation in research.

Areas for improvement

We found 16 areas for improvement in this service. See the Areas for Improvement section above.

Maternity

Good

Key facts and figures

From January 2018 to December 2018 there were 6,276 deliveries at the trust.

A comparison from the number of deliveries at the trust and the national totals during this period is shown below.

Number of babies delivered at University Hospitals of North Midlands NHS Trust – Comparison with other trusts in England

A profile of all deliveries and gestation periods from January to December 2018 can be seen in the tables below.

Notes: A single birth includes any delivery where there is no indication of a multiple birth. This table does not include deliveries where delivery method is 'other' or 'unrecorded'.

Notes: This table does not include deliveries where delivery method is 'other' or 'unrecorded'.

Gestation periods were unrecorded for 1.9% of deliveries at this trust compared to 16.9% nationally.

(Source: Hospital Episodes Statistics (HES) – Provided by CQC Outliers team)

The number of deliveries at the trust by quarter for the last nine quarters can be seen in the graph below.

Number of deliveries at University Hospitals of North Midlands NHS Trust by quarter

Summary of this service

We rated this service as good because:

- The service had enough staff to care for patients and keep them safe. Staff, understood how to protect patients from abuse, and managed safety well. Staff assessed risks to patients, acted on them and kept good care records. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.

Maternity

- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However:

- Not all staff had training in key skills.
- Staff did not always manage medicines well.
- Not all staff were up to date with their appraisals.
- Staff did not always complete all crucial stages of the surgical safety checklist.

Is the service safe?

Requires improvement

We previously inspected this service jointly with gynaecology we are not therefore able to compare ratings. We rated safe as requires improvement because:

- The service did not make sure everyone completed mandatory training in key skills.
- Staff were not up to date with training on how to recognise and report abuse and how to apply it.
- The service did not always follow best practice when prescribing, giving, recording and storing medicines. Patients received the right medication at the right dose at the right time.

However,

- The service had enough midwives and medical staff, with the right mix of qualification and skills, to keep patients safe and provide the right care and treatment.
- The service mostly controlled infection risk well. Staff keep themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.
- The service had suitable premises and equipment and looked after them well.
- Staff identified and quickly act upon women at risk of deterioration. Staff completed and updated risk assessments for each woman and acted to remove or minimise risks. They kept clear records and asked for support when necessary.
- Staff kept detailed records of patients' care and treatment. Records were mostly clear, up-to-date and easily available to all staff providing care.
- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.
- The service used safety monitoring results well. Staff collected safety information and shared it with staff, patients and visitors. Managers used this to improve the service..

Maternity

- The service used safety monitoring results well. Staff collected safety information and shared it with staff, patients and visitors. Managers used this to improve the service.

Is the service effective?

Good

We previously inspected this service jointly with gynaecology we are not therefore able to compare ratings. We rated effective as good because:

- The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.
- Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other preferences.
- Staff assessed and monitored patients regularly to see if they were in pain. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain. Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.
- The service made sure staff were competent for their roles. If need be they could offer supervision meetings with them to provide support and monitor the effectiveness of the service.
- Staff of different kinds worked together as a team to benefit patients. Consultants, midwives and other healthcare professionals supported each other to provide good care.
- Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the trust policy and procedures when a patient could not give consent. Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

However,

- Not all staff were up to date with their appraisals.

Is the service caring?

Good

We previously inspected this service jointly with gynaecology we are not therefore able to compare ratings. We rated caring as good because:

- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- Staff provided emotional support to patients to minimise their distress.
- Understanding and involvement of patients and those close to them.
- Staff involved patients and those close to them in decisions about their care and treatment

Maternity

Is the service responsive?

Good

We previously inspected this service jointly with gynaecology we are not therefore able to compare ratings. We rated responsive as good because:

- Service delivery met the needs of the local people
- The service took account of patients' individual needs.
- People could access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with good practice.
- The service mostly treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff. However, complaints were not investigated and closed in line with their complaints policy.

Is the service well-led?

Good

We previously inspected this service jointly with gynaecology we are not therefore able to compare ratings. We rated well led as good because:

- Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care.
- The service had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.
- Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- The service used a systematic approach to continually improve the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.
- The service mostly had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.
- The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.
- The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.

Areas for improvement

We found seven areas for improvement in this service. See the Areas for Improvement section above.

Services for children and young people

Good ➔➔

Key facts and figures

The trust's services for children and young people are located at Royal Stoke University Hospital over eight units and wards and provided 84 inpatient paediatric beds (including cots).

The Neonatal intensive care unit (NICU) was a regional centre that offered level three care (level three means the service provided care to very sick neonates) meaning it attracted admissions from out of the local area.

Wards 216 and 217 shared indoor and outside play areas, an adolescent room, a classroom and a sensory room. Parent kitchens, rest areas and overnight accommodation was also available.

We inspected all areas of children and young people's services at the Royal Stoke University Hospital. This included:

- Children's assessment unit (CAU) – eight trollies and one triage area
- Children's high dependency unit (CHDU) – nine beds
- Children's intensive care unit (CICU) – two long term ventilation beds and four high dependency beds
- Neonatal intensive care unit (NICU) – 26 cots
- Ward 216 – 16 beds
- Ward 217 – 25 beds
- Ward 217a – six trollies, four chairs and two beds
- Ward 217b – four cubicles
- Children's outpatients

(Source: Routine Trust Provider Information Request (RPIR) – Sites tab)

The trust had 13,490 spells for its children and young people's service from February 2018 to January 2019.

Emergency spells accounted for 76% (10,242 spells), 17% (2,261 spells) were day case spells, and the remaining 7% (987 spells) were elective.

Summary of this service

Our rating of this service stayed the same. We rated it as good because:

- The service had enough staff to care for children and young people and keep them safe. Staff knew how to protect children and young people from the risk of abuse. They managed infection prevention and control systems well and most medicines were managed safely. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff provided good care and treatment, gave children and young people enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of children and young people, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.

Services for children and young people

- Staff exceeded the expectations of children, young people and their families in their passion for patient care. There was a strong, visible person-centred culture where staff genuinely valued their relationships with children, young people and their families. They also extended their compassion towards others outside of their service. Staff recognised and respected the importance of the totality of people's needs and used innovative methods to support family units during challenging times. Staff consistently supported and empowered children, young people and their families to understand their condition and make decisions about their care and treatment. Staff showed an excellent understanding and a non-judgmental attitude when caring for or discussing children and young people with mental health needs. They worked in a creative and innovative manner to provide exceptional, strong and caring emotional support to children, young people and their families to minimise their distress.
- The service planned care to meet the needs of local people, took account of children and young peoples' individual needs, and made it easy for them to give feedback. Children and young people could access the service when they needed it and did not have to wait too long for treatment.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of the children and young people receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However, we also found:

- Staff were not always up to date with their mandatory training. Improvements were needed to ensure records relating to risk were kept and maintained. Some ligature points were present in the CAU which posed a potential risk to children and young people.
- Assessments that identified if children and young people could consent to their care and treatment were not always clearly documented.
- There was a risk that children and young people's individual preferences and needs may not be consistently met as these preferences and needs were not always clearly recorded or accessible to staff.

Is the service safe?

Requires improvement 

Our rating of safe went down. We rated it as requires improvement because:

- The service provided mandatory training in key skills to all staff. However, the trust's training compliance targets were not always met.
- Staff had training on how to recognise and report abuse. However, staff were not up to date with this training.
- Formal recorded risk assessments were not always evidenced in care records.
- Ligature points were present in a room used for distressed children and young people who attended the CAU.
- Safe systems were not in place on CICU to ensure medicines were consistently stored safely and securely.

However:

- The service controlled infection risk well. Staff used equipment and control measures to protect children, young people, their families, themselves and others from infection. They kept equipment and the premises visibly clean.

Services for children and young people

- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.
- Staff identified and quickly acted upon children and young people's risk of deterioration.
- The service had enough staff with the right qualifications, skills, training and experience to keep children and young people safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix.
- Staff kept detailed records of children and young peoples' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.
- The service mostly used systems and processes to safely prescribe, administer, record and store medicines.
- The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service.
- When things went wrong, staff apologised and gave children, young people and their families honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.
- The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, children, young people, their families and visitors.

Is the service effective?

Good ➔➔

Our rating of effective stayed the same. We rated it as good because:

- The service provided care and treatment based on national guidance and best practice. Managers checked to make sure staff followed guidance.
- Staff gave children, young people and their families enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary.
- Staff assessed and monitored children and young people regularly to see if they were in pain, and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.
- Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and staff had the opportunity to access supervision sessions to provide them with support.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.
- Key services were available seven days a week to support timely care for children, young people and their families.
- Staff gave children, young people and their families practical support and advice to lead healthier lives.

- Staff supported children, young people and their families to make informed decisions about their care and treatment. They knew how to support children, young people and families who lacked capacity to make their own decisions or were experiencing mental ill health.

However:

- Outcomes of capacity assessments were not always recorded
- The majority of staff working with children, young people and their families did not complete training in the Mental Capacity Act 2005 as the service did not deem this training as essential within this area.

Is the service caring?

Outstanding ☆ ➔➔

Our rating of caring stayed the same. We rated it as outstanding because:

- Staff exceeded the expectations of children, young people and their families in their passion for patient care.
- Staff were committed, motivated and inspired to provide kind and dignified care that supported the needs of children, young people and their families on every level.
- There was a strong, visible person-centred culture where staff genuinely valued their relationships with children, young people and their families.
- Staff recognised and respected the importance of the totality of people's needs. This included caring for the families of children and young people.
- Staff showed an excellent understanding and a non-judgmental attitude when caring for or discussing children and young people with mental health needs.
- Staff extended their compassion towards others outside of their service.
- Staff worked proactively with other agencies and departments to ensure compassionate and individualised palliative and end of life care was provided.
- Staff worked in a creative and innovative manner to provide exceptional, strong and caring emotional support to children, young people and their families to minimise their distress. They also understood patients' personal and cultural needs.
- The service provided children and young people with vast and varied resources to help them learn more about their mental health needs.
- Staff used innovative methods to support family units during challenging times.
- Staff recognised the need to provide hope, reflect on treatment journeys and to celebrate success.
- The whole staff team, from consultants to health care support workers prioritised their time to celebrate the end of treatment with children, young people and their families.
- Staff consistently supported and empowered children, young people and their families to understand their condition and make decisions about their care and treatment. They ensured a family centred approach.

Services for children and young people

Is the service responsive?

Good 

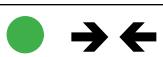
Our rating of responsive stayed the same. We rated it as good because:

- The service planned and provided care in a way that met the needs of local children, young people, their families and the communities served. It also worked with others in the wider system and local organisations to plan care.
- The service was inclusive and took account of children, young people and their family's individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.
- Children and young people could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.
- It was easy for children, young people and their families to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

However:

- There was a risk that the care preferences of children, young people and their families may not consistently be met. Although we saw staff demonstrate that they knew individual children and young people's care preferences and needs, these preferences and needs were not always recorded in care records.

Is the service well-led?

Good 

Our rating of well-led stayed the same. We rated it as good because:

- Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.
- The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.
- Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.
- Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Services for children and young people

- The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.
- Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for children, young people and their families.
- All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Outstanding practice

We found eight examples of outstanding practice in this service. See the Outstanding practice section above.

Areas for improvement

We found six areas for improvement in this service. See the Areas for Improvement section above.

Outpatients

Requires improvement

Key facts and figures

At Royal Stoke University Hospital's outpatients department, most clinics in the outpatients department are open from Monday to Friday from 8 am to 5 pm. The exceptions are the chronic obstructive pulmonary disease (COPD) clinic, which is open from Monday to Friday from 8 am to 6 pm, and the radiotherapy service, which is open from 8 am to 8 pm from Monday to Friday. Additional clinics are held on the neurology ward on Saturdays and Sundays. From time to time consultant-led clinics are held within the community.

The trust holds general neurology consultant-led clinics at the outpatient department at Leighton Hospital at Crewe in Cheshire on a Monday, Wednesday, Thursday and Friday. From time to time, the trust holds clinics within the community in other areas of Cheshire, including Nantwich Health Centre, Ashfield's Primary Healthcare Centre in Sandbach and Victoria Infirmary in Northwich.

In addition, patients with epilepsy, Parkinson's, multiple sclerosis, motor neurone disease and headache can be seen by a specialist nurse-led service provided by the trust at both of its acute sites, and at Leighton Hospital. Clinics in these specialties are also held at various locations within the community.

The trust had 856,491 first and follow up outpatient appointments from January 2018 to December 2018. Royal Stoke Hospital accounted for 631,022 of these.

This report relates to our inspection of Royal Stoke Hospital in Stoke.

Summary of this service

We rated it as requires improvement because:

- People could not always access services when they needed it and receive the right care promptly. Waiting times from referral to treatment were not always in line with good practice for some clinics.
- Systems to manage performance and risk were not always effective in identifying and escalating relevant risks and performance issues or in identifying actions to reduce their impact.
- Although staff completed and updated risk assessments for each patient and removed or minimised risks. Staff were unaware of whether there was a policy to guide them in identifying and quickly acting upon patients at risk of deterioration.
- There was a lack of effective monitoring of patient outcomes. This meant they could not be used to improve services.
- The fracture clinic waiting room was not big enough for the amount of people attending clinics.

However;

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.

Outpatients

- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback.
- Leaders ran services well and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

Is the service safe?

Good

We previously inspected this service jointly with diagnostic imaging, we are not therefore able to compare ratings. We rated it as good because:

- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.
- The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.
- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.
- The service used systems and processes to safely prescribe, administer, record and store medicines.
- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

However;

- Although staff completed and updated risk assessments for each patient and removed or minimised risks. Staff were unaware of whether there was a policy to guide them in identifying and quickly acting upon patients at risk of deterioration.

Outpatients

Is the service effective?

We do not rate this domain.

- The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.
- Staff gave patients enough food and drink whilst in outpatients.
- Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.
- Staff gave patients practical support and advice to lead healthier lives.
- Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.

However;

- There was a lack of effective monitoring of patient outcomes. This meant they could not be used to improve services.

Is the service caring?

Good

We previously inspected this service jointly with diagnostic imaging, we are not therefore able to compare ratings. We rated it as good because:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.
- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Is the service responsive?

Requires improvement

We previously inspected this service jointly with diagnostic imaging, we are not therefore able to compare ratings. We rated it as requires improvement because:

Outpatients

- People could not always access services when they needed it and receive the right care promptly. Waiting times from referral to treatment were not always in line with good practice for some clinics.
- The fracture clinic waiting room was not big enough for the amount of people attending clinics.

However;

- The service mostly planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.
- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.
- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

Is the service well-led?

Requires improvement

We previously inspected this service jointly with diagnostic imaging, we are not therefore able to compare ratings. We rated it as requires improvement because:

- Systems to manage performance and risk were not always effective in identifying and escalating relevant risks and performance issues or in identifying actions to reduce their impact.

However;

- Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.
- The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.
- Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.
- The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required
- Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.
- All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Outpatients

Outstanding practice

We found four examples of outstanding practice in this service. See the Outstanding practice section above.

Areas for improvement

We found five areas for improvement in this service. See the Areas for Improvement section above.

The County Hospital

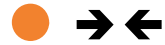
Weston Road
Stafford
Staffordshire
ST16 3SA
Tel: 01785 857731
www.midstaffs.nhs.uk

Key facts and figures

The County Hospital is a smaller hospital site in Stafford. This hospital provides services including medical care, elective surgery, outpatients and diagnostics and a standalone midwifery led unit.

The trust employs over 10,000 staff and has more than 1,250 inpatient beds. Services are provided at Royal Stoke University Hospital, County Hospital and a small number of community settings.

Summary of services at The County Hospital

Requires improvement 

Our rating of services stayed the same. We rated it them as Requires improvement because:

Our rating of safe was Requires Improvement overall. Risks within the emergency department were not always identified and escalated appropriately. Not all staff had completed all of the required mandatory training. Not all staff had training on how to recognise and report abuse. Both nursing and medical staff throughout the core service did not meet the trusts targets for safeguarding training. Staff did not update all risk assessment documentation completely and consistently. There was not enough of all suitable equipment for resuscitation of children and did not have effective systems for identifying risks associated with out of date equipment. In outpatients the service did not always manage patient safety incidents well. Staff did not recognise incidents and report them appropriately. When things went wrong, staff apologised and gave patients honest information and suitable support. However, feedback to staff from managers was inconsistent and lessons learnt were not always shared with the whole team.

Our rating of effective was Requires Improvement overall. There was a lack of effective monitoring of patient outcomes and did not always provide care and treatment based on national guidance and evidence of its effectiveness. Staff did not always assess and monitored patients regularly to see if they were in pain. Staff did not always understand their roles and responsibilities under the Mental Capacity Act 2005. They did not always know how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

Our rating of caring was good overall. Staff provided emotional support to patients to minimise their distress. Staff involved patients and those close to them in decisions about their care and treatment. Staff cared for patients with compassion however, patient dignity was sometimes compromised.

Our rating of responsive was requires improvement overall. In outpatients people could not always access services when they needed it and receive the right care promptly. Waiting times from referral to treatment were not always in line with

good practice for some clinics. There were issues with the 'choose and book' system as it was not always reliable. Call centre staff booked patients first appointments and sometimes used incorrect codes. This meant there was a risk of patients not being identified on clinic lists, resulting in them being delayed in clinic or having to rebook their appointment. However, the service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care. The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers. It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Our rating of well led was requires improvement overall. In outpatients' systems to manage performance and risk were not always effective in identifying and escalating relevant risks and performance issues or in identifying actions to reduce their impact. The service did not always have a systematic or consistent approach to improving the quality of its services. The governance structure for outpatients services at the fracture clinic was not always clear and consistent which meant that lines of accountability and management were not always clear. However, most managers had the right skills and abilities to run services providing high-quality sustainable care. Departments had effective systems for identifying risks.

Urgent and emergency services

Requires improvement 

Key facts and figures

Details of emergency departments and other urgent and emergency care services

- County Hospital emergency department. Open 14 hours a day, seven days a week.

(Source: Routine Provider Information Request (RPIR) – Sites tab)

County hospital urgent and emergency services department is open between the hours of 8am and 10pm, seven days a week. For patients who required treatment for major trauma, the ambulance service would transport directly to The Royal Stoke University Hospital site. A GP out of hours service was co located within the department and had separate facilities.

A paediatric minor injuries unit (MIU) provided treatment for children aged 16 years and younger between 8am and 10pm. Children who were acutely unwell or presented with anything other than a minor injury would be transferred to another hospital.

The County Hospital urgent and emergency care service comprised of:

- Ambulance assessment: three cubicles
- Ambulatory care area: four treatment rooms.
- Resuscitation area: three treatment bays
- Majors area: eight treatment bays, five cubicles (including three used as isolation cubicles).
- Clinical decision unit: three treatment bays and a sitting area.
- Minor Injuries Unit: four treatment rooms (including one specifically for treating eye injuries and one for plaster).
- Children's Minor Injuries Unit: two treatment rooms and separate waiting area.
- Interview/Counselling room (used as the mental health assessment room when required).
- Relatives room
- X-ray facilities

Activity and patient throughput

Total number of urgent and emergency care attendances at University Hospitals of North Midlands NHS Trust compared to all acute trusts in England, January 2018 to December 2018

From January 2018 to December 2018 there were 208,296 attendances at the trust's urgent and emergency care services as indicated in the chart above.

(Source: Hospital Episode Statistics)

From January 2018 to December 2018 there were 43,055 attendances at The County Hospital.

Urgent and emergency care attendances resulting in an admission

The percentage of A&E attendances at this trust that resulted in an admission increased in 2018/19 compared to 2017/18. In both years, the proportions were higher than the England averages.

Urgent and emergency services

(Source: NHS England)

Urgent and emergency care attendances by disposal method, from January 2018 to December 2018

The trust coded nearly all attendances at their emergency department from January 2018 to December 2018 as having a disposal method of discharged. There were fewer than six exceptions (coded as transferred).

(Source: Hospital Episode Statistics)

The trust provided the following data to demonstrate disposal methods at The County Hospital between June 2018 and May 2019:

Disposal Outcome	Grand Total
Admission Rate	**29.8%**
Discharged - follow up treatment to be provided by GP	**23.7%**
Left department before being treated	**3.3%**
Left department having refused treatment	**0.3%**
Nurse navigator discharge	**29.0%**
Other	**2.1%**
Patient Died	**0.1%**
Referred to A&E Clinic	**0.2%**
Referred to Fracture Clinic	**8.9%**
Referred to Other Health Care Professional	**0.5%**
Referred to Physiotherapy Clinic	**1.3%**
Transferred to other Health Care Provider	**0.9%**

(Source DR442)

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

During the inspection we spoke with 23 members of staff including doctors, nurses, healthcare support workers, housekeeping and administrative staff.

We attended staff handovers including regular staff huddles where patient care and treatment was discussed.

We spoke with eight patients and family members. We observed care and treatment and reviewed waiting areas and the overall environment. We reviewed 25 patient records.

Urgent and emergency services

Summary of this service

Our rating of this service went down. We rated it as requires improvement because:

- The service did not make sure all staff completed mandatory training in key skills. Staff did not update all risk assessment documentation completely and consistently. There was not enough of all suitable equipment for resuscitation of children.
- There was a lack of effective monitoring of care and treatment. Staff did not consistently document capacity assessments or information relating to pain relief. Not all clinical staff completed training on the Mental Capacity Act and Deprivation of Liberty Safeguards. Data provided by the trust below showed low completion rates of staff appraisals.

However:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

We rated safe and effective as requires improvement and caring, responsive and well-led as good.

Is the service safe?

Requires improvement 

Our rating of safe went down. We rated it as requires improvement because:

- The service did not make sure all staff completed mandatory training in key skills. The number of staff who completed it did not meet trust targets.
- Staff had not completed safeguarding training at the required level for those working with children.
- Staff did not update all risk assessment documentation completely and consistently.
- There was not enough of all suitable equipment for resuscitation of children.

However:

- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses.
- The service used systems and processes to safely prescribe, administer, record and store medicines.
- The service-controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Urgent and emergency services

Is the service effective?

Requires improvement  

Our rating of effective went down. We rated it as requires improvement because:

- There was a lack of effective monitoring of care and treatment. This meant audit findings could not be used to improve services. They did not meet the standards in any national clinical outcome audits.
- The service had a higher than expected risk of re-attendance than the England average.
- Staff did not consistently document pain scores and reasons for not providing pain relief.
- Staff did not always clearly document that they followed national guidance to gain patients' consent.
- Not all clinical staff completed training on the Mental Capacity Act and Deprivation of Liberty Safeguards.
- Data provided by the trust below showed low completion rates of staff appraisals.

However:

- The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.
- Staff supported patients to make informed decisions about their care and treatment.

Is the service caring?

Good  

Our rating of caring stayed the same. We rated it as good because:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.
- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Is the service responsive?

Good  

Our rating of responsive stayed the same. We rated it as good because:

- The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Urgent and emergency services

- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.
- People mostly received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were mostly in line with national standards.
- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Is the service well-led?

Good 

Our rating of well-led stayed the same. We rated it as good because:

- Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and most of the issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.
- The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.
- Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.
- Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.
- The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.
- Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

However:

- Leaders did not operate effective governance processes, throughout the service and with partner organisations.

Areas for improvement

We found 10 areas for improvement in this service. See the Areas for Improvement section above.

Maternity

Good

Key facts and figures

From January 2018 to December 2018 there were 6,276 deliveries at the trust.

A comparison from the number of deliveries at the trust and the national totals during this period is shown below.

Number of babies delivered at University Hospitals of North Midlands NHS Trust – Comparison with other trusts in England

A profile of all deliveries and gestation periods from January to December 2018 can be seen in the tables below.

Notes: A single birth includes any delivery where there is no indication of a multiple birth. This table does not include deliveries where delivery method is 'other' or 'unrecorded'.

Notes: This table does not include deliveries where delivery method is 'other' or 'unrecorded'.

Gestation periods were unrecorded for 1.9% of deliveries at this trust compared to 16.9% nationally.

(Source: Hospital Episodes Statistics (HES) – Provided by CQC Outliers team)

The number of deliveries at the trust by quarter for the last nine quarters can be seen in the graph below.

Number of deliveries at University Hospitals of North Midlands NHS Trust by quarter

In both 2017/18 and 2018/19 the number of deliveries was relatively high in quarter 2. In 2018/19 the number of deliveries remained high in quarter 3 2018/19.

(Source: Hospital Episode Statistics - HES Deliveries (January 2018 - December 2018))

Summary of this service

We rated this service as good because:

- The service had enough staff to care for patients and keep them safe. Staff understood how to protect patients from abuse, and managed safety well.
- Staff assessed risks to patients, acted on them and kept good care records. The service managed safety incidents well and learned lessons from them.
- Staff collected safety information and used it to improve the service.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.

Maternity

- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Some staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However:

- Not all staff had training in key skills.
- Not all staff were up to date with their appraisals.

Is the service safe?

Requires improvement

We previously inspected this service jointly with gynaecology and cannot therefore compare the rating. We rated safe as requires improvement because:

- The service did not make sure everyone completed mandatory training in key skills.
- Not all staff had received training on how to recognise and report abuse and how to apply it.
- The trust did not have effective systems for identifying risks associated with out of date equipment.

However,

- The service had enough midwives and medical staff, with the right mix of qualification and skills, to keep patients safe and provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix.
- The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.
- The service had suitable premises and equipment, although some equipment was removed because it was out of date. Staff managed clinical waste well.
- Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary.
- Staff kept detailed records of patients' care and treatment. Records were mostly clear, up-to-date and easily available to all staff providing care.
- The service used systems and processes to safely prescribe, administer, record and store medicines.
- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Maternity

- The service used safety monitoring results well. Staff collected safety information and shared it with staff, patients and visitors. Managers used this to improve the service.

Is the service effective?

Good

We previously inspected this service jointly with gynaecology and cannot therefore compare the rating. We rated effective as good because:

- The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.
- Staff gave patients enough food and drink to meet their needs and improve their health. The service made adjustments for patients' religious, cultural and other preferences.
- Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieve good outcomes for women.
- The service made sure staff were competent for their roles. If need be they could offer supervision meetings with them to provide support and monitor the effectiveness of the service.
- Staff of different kinds worked together as a team to benefit patients. Consultants, midwives and other healthcare professionals supported each other to provide good care.
- Staff supported women to make informed decisions about their care and treatment. They followed national guidance to gain women's consent. They knew how to support women experiencing mental ill health and those who lacked the capacity to make decisions about their care.

However,

- Not all staff were up to date with their appraisals.

Is the service caring?

Good

We previously inspected this service jointly with gynaecology and cannot therefore compare the rating. We rated caring as good because:

- Staff treated women with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. Feedback from patients confirmed that staff treated them well and with kindness.
- Staff provided emotional support to women, families and carers to minimise their distress. They understood women's personal, cultural and religious needs.
- Staff supported women, families and carers to understand their condition and make decisions about their care and treatment.
- Staff involved women and those close to them in decisions about their care and treatment.

Maternity

Is the service responsive?

Good

We previously inspected this service jointly with gynaecology and cannot therefore compare the rating. We rated responsive as good because:

- The service planned and provided care in a way that met the needs of local people and the communities service. It also worked with others in the wider system and local organisations to plan care.
- The service was inclusive and took account of women's individual needs and preferences. Staff made reasonable adjustments to help patients access services. They co-ordinated care with other services and providers.
- People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge women were in line with national standards.
- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

Is the service well-led?

Good

We previously inspected this service jointly with gynaecology and cannot therefore compare the rating. We rated well led as good because:

- Managers at all levels in the trust had the right skills and abilities to run a service providing high-quality sustainable care.
- The trust had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.
- The trust collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.
- The trust engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.

However:

- The service did not have effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.
- Managers across the service did not always promote a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- The service did not always use a systematic approach to continually improve the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.

Areas for improvement

We found four areas for improvement in this service. See the Areas for Improvement section above.

Outpatients

Requires improvement

Key facts and figures

At County Hospital's outpatients department, most clinics are open from approximately 8.30 am to 5.30 pm from Monday to Friday. The exception is the COPD clinic, which is open from 8 am to 6 pm from Monday to Friday. Otherwise there is a mixture of general neurology clinics and sub-speciality clinics.

At Royal Stoke University Hospital's outpatients department, most clinics in the outpatients department are open from Monday to Friday from 8 am to 5 pm. The exceptions are the chronic obstructive pulmonary disease (COPD) clinic, which is open from Monday to Friday from 8 am to 6 pm, and the radiotherapy service, which is open from 8 am to 8 pm from Monday to Friday. Additional clinics are held on the neurology ward on Saturdays and Sundays. From time to time consultant-led clinics are held within the community.

The trust holds general neurology consultant-led clinics at the outpatients department at Leighton Hospital at Crewe in Cheshire on a Monday, Wednesday, Thursday and Friday. From time to time, the trust holds clinics within the community in other areas of Cheshire, including Nantwich Health Centre, Ashfield's Primary Healthcare Centre in Sandbach and Victoria Infirmary in Northwich.

In addition, patients with epilepsy, Parkinson's, multiple sclerosis, motor neurone disease and headache can be seen by a specialist nurse-led service provided by the trust at both of its acute sites, and at Leighton Hospital. Clinics in these specialties are also held at various locations within the community.

The trust had 856,491 first and follow up outpatients appointments from January 2018 to December 2018. County Hospital accounted for 225,469 of these.

This report relates to our inspection of County Hospital in Stafford.

Summary of this service

We previously inspected this service jointly with diagnostic imaging and are not therefore able to compare the ratings. We rated it as requires improvement because:

- People could not always access services when they needed it and receive the right care promptly. Waiting times from referral to treatment were not always in line with good practice for some clinics.
- There had been issues with chemotherapy treatments not being on transports from Stoke. This meant the trust could not be assured that patients' medicines would be available in a timely way at all times.
- Systems to manage performance and risk were not always effective. The risk register was not effective in identifying and mitigating risks to patient care and treatment. Therefore, we were not assured that all patient risks had been identified and acted upon.
- Some incidents were not reported on the electronic incident reporting system. For example, staff requiring to stay beyond their working hours to ensure patients were chaperoned whilst waiting for transport. There were discrepancies in the recording of 'near misses' on the electronic incident reports, these are incidents which might have resulted in harm to a patient.
- Although, staff told us how they would respond to an emergency involving a child or young person, there was no policy staff were aware of in regards to a deteriorating child in the main outpatients department. This meant staff did not have clear guidelines for managing a paediatric emergency.

Outpatients

- There was a lack of records audits for County Hospital, this meant the trust could not be assured that patient records were full and complete. Staff in the outpatients 'hub' told said consultants occasionally omitted the time to next booking from patients paper based outcomes forms. Staff at the hub told us they had been advised to put these patients on the six week waiting list. This meant administrative staff were making decisions about when some patients should attend their next appointment.
- Not all leaders were visible and approachable for staff. Most staff we spoke with described local leaders as present and approachable. Local managers told us senior managers were accessible and visible. However, some staff told us it was difficult for staff based in County Hospital to access senior managers that were based at Royal Stoke Hospital
- There was a lack of effective monitoring of patient outcomes at County Hospital. This meant audit findings could not be used to improve services. The outpatients' dashboard did not gather information on patient outcomes.
- The governance structure for all outpatients services was not always clear and consistent. Governance was devolved to divisions and each care division operated independently. County Hospital was under represented at some governance meetings
- Although staff said the trust promoted a culture of outpatients across sites being 'one team,' this was not fully embedded. Some staff told us there was a 'them and us' culture between Royal Stoke Hospital and County Hospital. Although most staff said this was improving.

However:

- The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.
- The service provided mandatory training in key skills to all staff and made sure staff completed it.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.
- The service controlled infection risk well.
- The service provided care and treatment based on national guidance and evidence of its effectiveness.
- The service made sure staff were competent for their roles.
- Staff involved patients and those close to them in decisions about their care and treatment.
- Staff cared for patients with compassion. Staff were mindful of the emotional wellbeing of patients and took steps to support patients and families where necessary.
- The service was inclusive and took account of patients' individual needs and preferences.
- It was easy for people to give feedback and raise concerns about care received.
- Staff were committed to continually learning and improving services.

Is the service safe?

Requires improvement

We previously inspected this service jointly with diagnostic imaging and are not therefore able to compare the ratings. We rated it as requires improvement because:

Outpatients

- The service did not always manage patient safety incidents well. Staff did not recognise incidents and report them appropriately. When things went wrong, staff apologised and gave patients honest information and suitable support. However, feedback to staff from managers was inconsistent and lessons learnt were not always shared with the whole team.
- Although locally staff completed and updated risk assessments for each patient and removed or minimised risks. Staff were unaware of whether there was a policy to guide them in identifying and quickly acting upon paediatric patients at risk of deterioration.
- The service used systems and processes to safely prescribe, administer, record and store medicines locally. However, some pharmacy services were based in Stoke and medication deliveries were not always timely.
- Although most staff kept detailed records of patients' care and treatment, there was a lack of records audits, this meant the trust could not be assured that patient records were full and complete. Some staff reported that consultant notes did not always identify the time to next appointment and this had led to administrators placing patients on a six week list without consulting a clinician.

However:

- The service provided mandatory training in key skills to all staff and made sure staff completed it. Training completion at County Hospital was in accordance with the trust's standards, with most modules being recorded locally as above the trust target of 95%. Although, the training spreadsheet for chemotherapy outpatients, had not been updated to reflect all staff with completed training.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Most staff had received training on relevant safeguarding modules and knew how access to guidelines and further advice where needed. However, medical staff had not met the trust's 95% training standard for one safeguarding module.
- The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them.
- The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix.

Is the service effective?

We do not currently rate effective for outpatients services. Our findings are as follows:

- The service provided care and treatment based on national guidance and evidence of its effectiveness.
- Staff assessed patients to see if they were in pain.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide effective care. However, some multidisciplinary team meetings did not have discussions recorded which meant records of the meeting could not be shared with other staff for learning.

Outpatients

- The service supported patients to live healthier lives. Staff worked with community services to promote healthy lifestyle choices in the community.
- Although the trust did not audit patients consent. Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the trust policy and procedures when a patient could not give consent.

However:

- There was a lack of effective monitoring of patient outcomes at County Hospital. This meant audit findings could not be used to improve services.

Is the service caring?

Good

We previously inspected this service jointly with diagnostic imaging and are not therefore able to compare the ratings. We rated it as good because:

- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- Staff provided emotional support to patients to minimise their distress. Staff we spoke with were mindful of the emotional wellbeing of patients and took steps to support patients and families where necessary.
- Staff involved patients and those close to them in decisions about their care and treatment. Patients who attended services on a regular basis spoke positively of staff, describing them as taking the time to reassure patients and talk them through the procedure.

Is the service responsive?

Requires improvement

We previously inspected this service jointly with diagnostic imaging and are not therefore able to compare the ratings. We rated it as requires improvement because:

- People could not always access services when they needed it and receive the right care promptly. Waiting times from referral to treatment were not always in line with good practice for some clinics.
- There were issues with the 'choose and book' system as it was not always reliable.
- Call centre staff booked patients first appointments and sometimes used incorrect codes. This meant there was a risk of patients not being identified on clinic lists, resulting in them being delayed in clinic or having to rebook their appointment.

However:

- The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.
- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients' access services. They coordinated care with other services and providers.

Outpatients

- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learnt with staff.

Is the service well-led?

Requires improvement

We previously inspected this service jointly with diagnostic imaging and are not therefore able to compare the ratings. We rated it as requires improvement because:

- Not all leaders were visible and approachable for staff. Most staff we spoke with described local leaders as present and approachable. However, staff across outpatients told us that there was limited visibility of senior trust management including the executive team.
- Systems to manage performance and risk were not always effective in identifying and escalating relevant risks and performance issues or in identifying actions to reduce their impact.
- Staff were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. Staff felt positive and proud to work in the hospital and there was a strong local identity. However, we saw limited connection to the trust identity.
- The service did not always have a systematic or consistent approach to improving the quality of its services. The governance structure for outpatients services at the fracture clinic was not always clear and consistent which meant that lines of accountability and management were not always clear.
- Although the trust engaged well with patients, the public and local organisations to plan and manage appropriate services. The trust did not always engage well with staff.

However:

- The trust had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy.
- Staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Areas for improvement

We found 18 areas for improvement in this service. See the Areas for Improvement section above.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

For more information on things the provider must improve, see the Areas for improvement section above.

Please note: Regulatory action relating to primary medical services and adult social care services we inspected appears in the separate reports on individual services (available on our website www.cqc.org.uk)

This guidance (see goo.gl/Y1dLhz) describes how providers and managers can meet the regulations. These include the fundamental standards – the standards below which care must never fall.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

Regulated activity	Regulation
Maternity and midwifery services	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

This section is primarily information for the provider

Enforcement actions

We took enforcement action because the quality of healthcare required significant improvement.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment
Diagnostic and screening procedures	
Treatment of disease, disorder or injury	

Our inspection team

Victoria Watkins, Head of Hospitals Inspection led the inspection. A range of highly experienced specialist advisers supported our inspection of well-led for the trust overall.

The team included one inspection manager, nine inspectors and a range of specialist advisers.

Specialist advisers are experts in their field who we do not directly employ.

University Hospitals of North Midlands NHS Trust

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	11th March 2020
Report Title:	UHNM Quality & Safety Report – Q3	**Agenda Item:**	10
Author:	Head of Quality, Safety & Compliance Department		
Executive Lead:	Chief Nurse		

Purpose of Report:					
Assurance	✓	**Approval**		**Information**	

Alignment to Strategic Objectives:		
SO1	Provide safe, effective, caring and responsive services	✓
SO2	Achieve NHS constitutional patient access standards	
SO3	Achieve excellence in employment, education, development and research	
SO4	Lead strategic change within Staffordshire and beyond	
SO5	Ensure efficient use of resources	

Summary of other meetings presented to and outcome of discussion:

Quality & Safety Oversight Group (10th February 2020) – The QSOG noted the new report format and new indicators. The key achievements and the indicators that require improvement were discussed and agreed that future reports will include narrative/assurance on the actions being taken to improve performance against agreed targets along with analysis of any trends/themes identified.

Quality Governance Committee (27th February 2020)

Summary of Report, Key Points for Discussion including any Risks:

The report provides update on performance against the identified key Quality Indicators. The indicators are presented in a new format which utilises SPC charts to provide assurance of performance and identify trends in the data being recorded.

Key Points:

The Trust achieved:

- The Family & Friends for Inpatients and Maternity were above target for positive reporting
- Zero MRSA Bacteraemia Infections
- Achieved the target reduction of the number of patient falls resulting in low harm or above (47 vs. 60, internal target)
- Achieved the target reduction for all categories of Hospital Acquired, Trust Apportioned, Pressure Ulcers
- 100% of all incidents triggering duty of candour were verbally informed
- Number of PSIs with moderate harm or above have reduced and are showing consistently low (positive) levels. There have been 9 consecutive months below the monthly mean.
- The rate of PSIs with harm shows positive trends with 16 consecutive months below the mean and towards the Lower control limit.
- The Trust is positively under the target rate of 5.6 falls per 1000 bed days for the past 6 months
- HSMR and SHMI are both within or below expected ranges at 97.48 and 1.00 respectively

The Trust failed the set standards for:

- Family & Friends for A&E 65.2% positive response against a National target of 70%
- C-Diff cases were over target during December 2019

- VTE Risk Assessment compliance 92.1% against an operational standard of 95%
- 1 Never Event (Wrong Site Surgery)
- During December 2019 78% of duty of candour notification letters were sent out within 10 working day target. Overall 100% of the reported duty of candour incidents in December have recorded having letter sent out.

Key Recommendations:

The Trust Board are asked to:

- Approve the new format of the report
- Note the assurances provided regarding improvements and actions being undertaken to improve performance where targets are not being met.
- To identify any further information required

NHS
University Hospitals of North Midlands
NHS Trust

Quality Report

Quarter 3 2019/20

Together Compassion Safe Improving

Quality | Operational | Workforce | Finance

Contents

Introduction to SPC

University Hospitals of North Midlands NHS Trust

The following report uses statistical process control (SPC) methods to draw two main observations of performance data;

Variation - are we seeing significant improvement, significant decline or no significant change

Assurance - how assured of consistently meeting the target can we be?

The below key and icons are used to describe what the data is telling us;

Variation			Assurance		
					
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target

Together Compassion Safe Improving

Quality | Operational | Workforce | Finance

Quality

Caring and Safety

2025 Vision "Provide safe, effective, caring and responsive services"

Quality Spotlight Report

University Hospitals of North Midlands NHS Trust

Key messages

The Trust achieved in December 2019:

- The Family & Friends for Inpatients and Maternity were above target for positive reporting
- Zero MRSA Bacteraemia Infections
- Achieved the target reduction of the number of patient falls resulting in low harm or above (47 vs. 60, internal target)
- Achieved the target reduction for all categories of Hospital Acquired, Trust Apportioned, Pressure Ulcers
- 100% of all incidents triggering duty of candour were verbally informed
- The UHNM rate for written complaints is 28 per 10,000 bed days compared to the national average rate of 21.8.
- Number of PSIs with moderate harm or above have reduced and are showing consistently low (positive) levels. There have been 9 consecutive months below the monthly mean.
- The rate of PSIs with harm shows positive trends with 16 consecutive months below the mean and towards the Lower control limit.
- The Trust is positively under the target rate of 5.6 falls per 1000 bed days for the past 6 months
- HSMR and SHMI are both within or below expected ranges at 97.48 and 1.00 respectively

The Trust failed the set standards for:

- Family & Friends for A&E 65.2% positive response against a National target of 70%
- C-Diff cases were over target during December 2019
- VTE Risk Assessment compliance 92.1% against an operational standard of 95%
- 1 Never Event (Wrong Site Surgery)
- Increased number of Serious Incident reported during Quarter 3, largest category relate to patient related falls
- During December 2019 78% of duty of candour notification letters were sent out within 10 working day target. Overall 100% of the reported duty of candour incidents in December have recorded having letter sent out.

Quality Dashboard

NHS University Hospitals of North Midlands NHS Trust

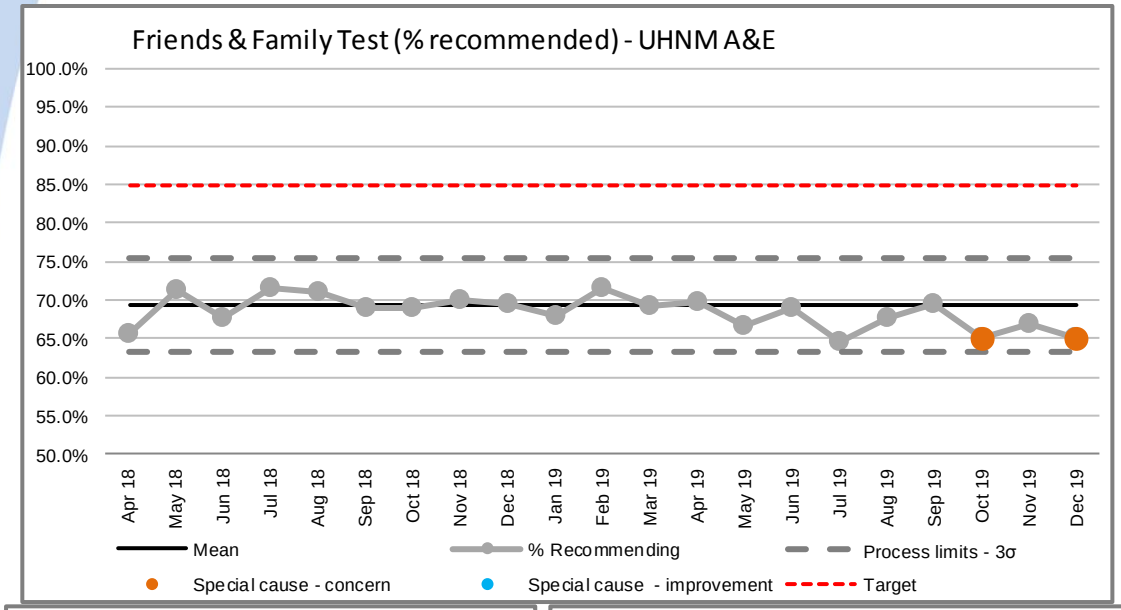
Metric	Target	Latest	Variation	
Friends & Family Test - A&E	85%	65%	L	F
Friends & Family Test - Inpatient	95%	98%		P
Friends & Family Test - Maternity	95%	100%		?
Written Complaints per 10,000 spells	35	18	L	?
Patient Safety Incidents	TBC	1297	H	
Patient Safety Incidents per 1000 bed days	TBC	30.72		
Patient Safety Incidents with moderate harm +	TBC	20	L	
Patient Safety Incidents with moderate harm + per 1000 bed days	TBC	0.47	L	
Harm Free Care (New Harms)	95%	98%	H	P
Patient Falls per 1000 bed days	5.6	5.5		?
Patient Falls with harm per 1000 bed days	1.5	1.4	L	

Metric	Target	Latest	Variation	
Category 2 Pressure Ulcers with lapses in Care	8	2		?
Category 3 Pressure Ulcers with lapse in care	4	2		?
Category 4 Pressure Ulcers with lapses in care	0	0		?
Unstageable Pressure Ulcers with lapses in care	0	0		?
Serious Incidents reported per month	TBC	15		?
Never Events reported per month	0	1		?
Duty of Candour - Verbal	100%	100%		?
Duty of Candour - Written	100%	78%	H	F
Reported C Diff Cases	8	18	H	?
VTE Risk Assessment Compliance	95%	92%	L	?
Medication Incidents per 1000 bed days	TBC	4.1	H	?
Medication Incidents % with moderate harm or above	TBC	1.7%		?

Together Compassion Safe Improving

Quality | Operational | Workforce | Finance

Friends & Family Test (FFT) – A&E



Variation	Assurance
L	F

Target	Oct 19	Nov 19	Dec 19
85%	65.1%	67.0%	65.2%

Background

The % of patients who would recommend the service to friends and family if they needed similar care or treatment

What is the data telling us?

The % of patients who would recommend A&E is consistently below the 85% target. Variation is small showing no signs of real change from month to month.

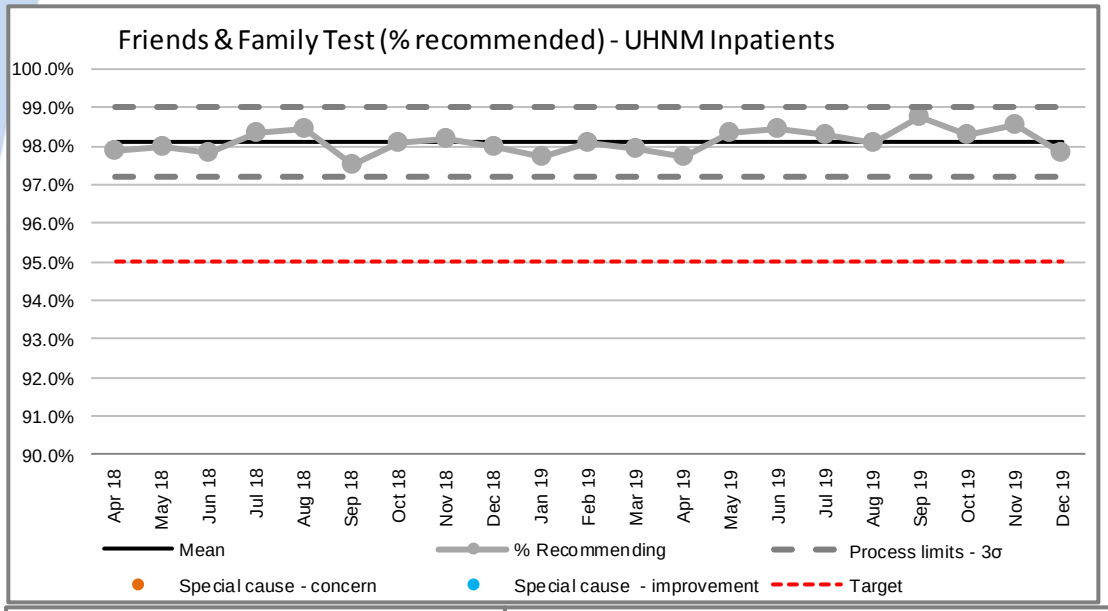
What do the results tell us?

- Patients do not always feel they are provided with adequate information about their condition and treatment or that the doctors and nurses listened to them. They also do not feel they are updated about waiting times.
- An improvement plan has been developed based on those areas that have been identified as mattering most to our patients.

Actions

- Encourage patients to ask questions and confirm understanding following the "It's OK to ask" campaign and using "teach back" methodology
- Staff to ensure the patient is aware of who to contact post discharge should they have any worries or concerns
- Role specific teaching sessions include complaint themes, barriers, how to gain feedback and why this is important. Specific training for A&E Staff includes Dementia and Health Literacy Awareness
- Common themes for complaints and actions made as a result of these are displayed in the handover room and are discussed both at the morning and evening handover.
- Patient Experience listening event workshops are held with patients invited in to talk about their experience in the A&E Department.
- The new escalation plan includes a directive for the nurse in charge to keep patients and relatives who may be queuing in the corridor updated during busy periods

Friends & Family Test (FFT) - Inpatient



Variation	Assurance

Target	Oct 19	Nov 19	Dec 19
95%	98.3%	98.5%	97.8%

Background

Number of cases

What is the data telling us?

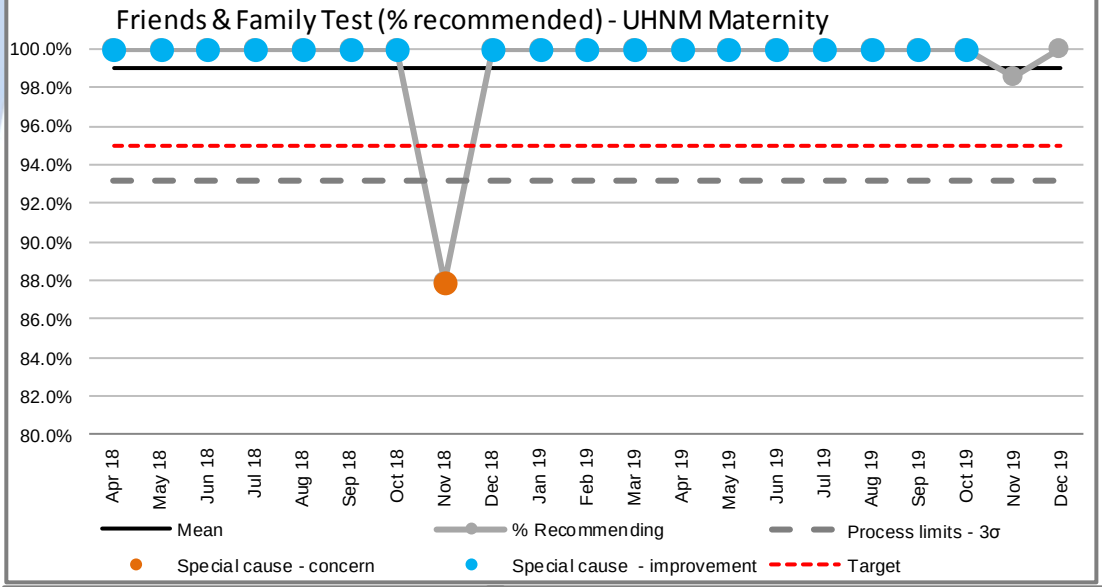
What do the results tell us?

- Our patients are extremely happy with the care and compassion they receive when accessing our daycase and inpatient services and this remains a constant theme.
- The UHNM target response rate of at least 30% footfall is not always achieved in all areas.

Actions

- All clinical areas have been reminded of the importance of gaining feedback from their patients to inform practice and identify what matters most to our patients
- The Quarterly Patient Experience Report triangulates those areas with a poor response rate with other quality and safety measures as an early warning system to highlight where additional support may be needed
- The "Top 20 Wards" report is circulated each month to provide friendly competition and recognise those areas that are exceeding the target response rate.

Friends & Family Test (FFT) - Maternity



Variation	Assurance

Target	Oct 19	Nov 19	Dec 19
95%	100.0%	98.5%	100.0%

Background

FFT Maternity % patients Recommending Service

What is the data telling us?

What do these results tell us?

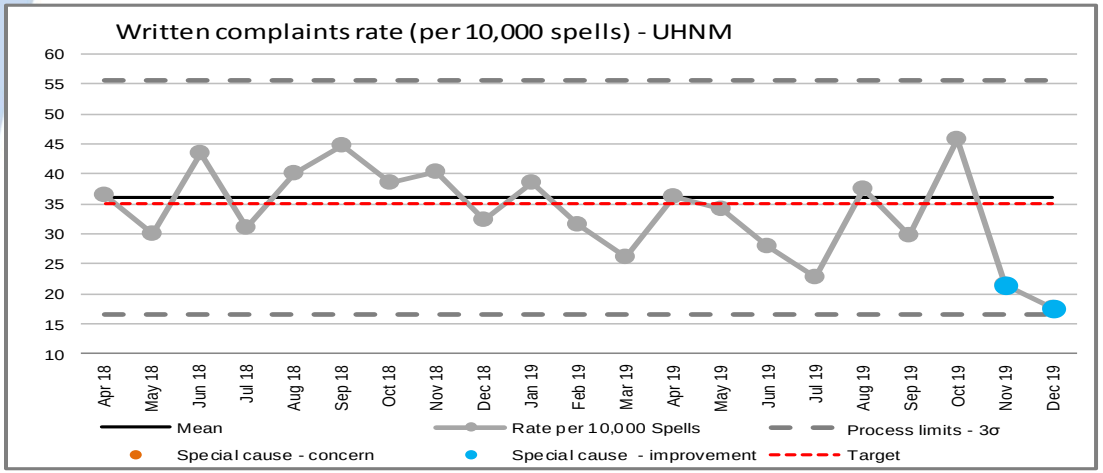
- The likely to recommend score may not be statistically significant due to the extremely low response rate.

Actions

- The Maternity Services and Patient Experience Team are working to improve the response rate
- 10 new iPad's have been purchased through UHNM charitable funds to encourage midwives to ask ladies for their feedback at all 4 key touch points in their journey.

Quality | Operational | Workforce | Finance

Written Complaints per 10,000 Spells



Variation	Assurance
	

Target	Oct 19	Nov 19	Dec 19
35	46	21	18

Background

Written complaints rate per 10,000 spells

What is the data telling us?

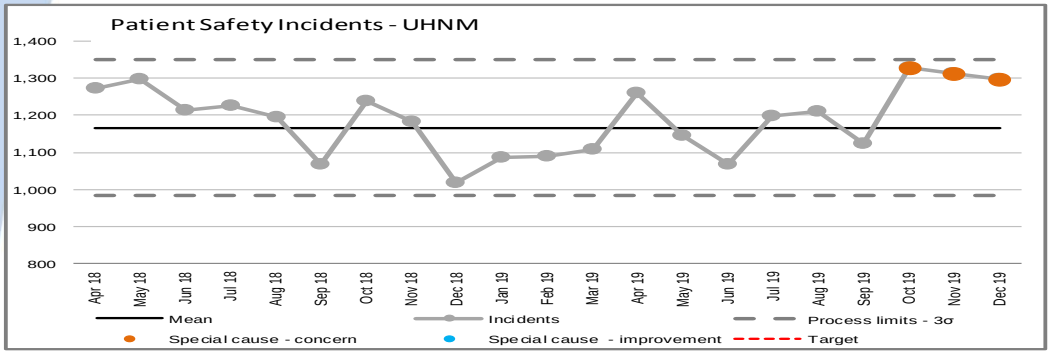
The data tells us that the rate of written complaints received by UHNM each month is reducing and the last 2 months of Quarter 3 are significantly near the lower control limit which represents a potentially significant change.

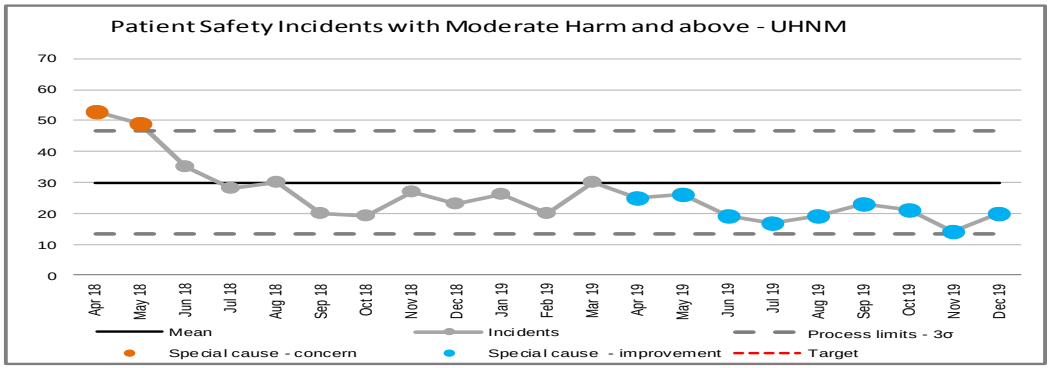
The average rate during Quarter 3 is 28 written complaints per 10,000 spells.

Actions

- The common complaint themes are monitored monthly to inform learning
- The Quarterly Patient Experience Report triangulates those areas receiving the highest number of complaints in each Division with other quality and safety measures as an early warning system to highlight where additional support may be needed
- Early resolution with complaint handling through PALS is managed wherever possible.
- Medicine have requested bespoke Complaint training during February for all Senior Sisters to provide them with the tools to de-escalate situations before they turn into a complaint. This will be offered to the other Divisions is successful.
- Quarterly Complaint Peer Review workshops are held with staff and patients to provide feedback on complaint responses and initiate improvements.

Reported Patient Safety Incidents





Variation	Assurance
H	

Target	Oct 19	Nov 19	Dec 19
N/A	1330	1313	1297

Background

Reported patient safety incidents

What is the data telling us?

Variation	Assurance
L	

Target	Oct 19	Nov 19	Dec 19
N/A	21	14	20

Background

Patient safety incidents with reported moderate harm and above

What is the data telling us?

The above data relates to all reported Patient Safety Incidents (PSIs) across the Trust increased in Q3 2019/20. The data is telling us that the total number of patient safety incidents has increased however, despite the increase in the total numbers in the top chart, the total number of patient safety incidents which have resulted in moderate harm or above has ben reducing. This profile is to be encouraged and noted that increase reporting is also reflection of open culture but harm is remaining at low (positive) levels.

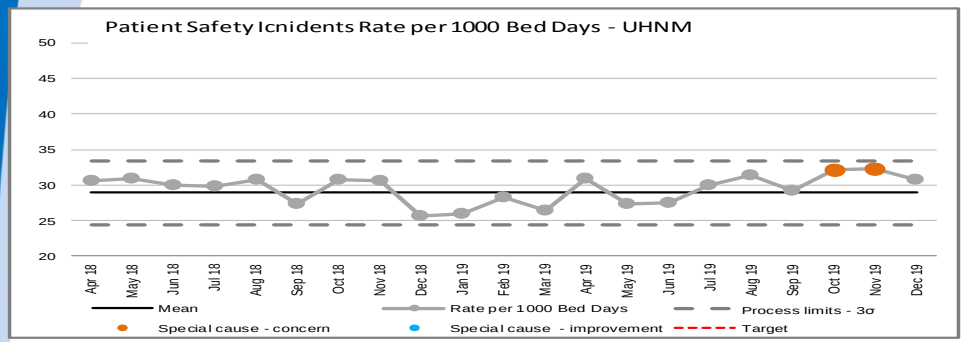
Whilst there has been increased reporting during Quarter 3 the trend for incidents with moderate harm or above has had 9 consecutive months below the Trust's monthly mean.

Across the Divisions, all Divisions have seen increase in the incidents reported and it is not just within a particular area that the increase in numbers can be attributed. There has been 15% increase in reported patient safety incidents during Q3 2019/20 compared to Q3 in 2018/19

The largest category for reported patient safety incidents is Patient related Slip/Trip/Fall. This accounts for 16% of all reported patient safety incidents.

Patient safety Incidents reviewed and analysis on locations and themes undertaken. Specific incidents are reviewed at specialist forums for themes / trends as well at Divisional level.

Patient Safety Incidents per 1000 bed days

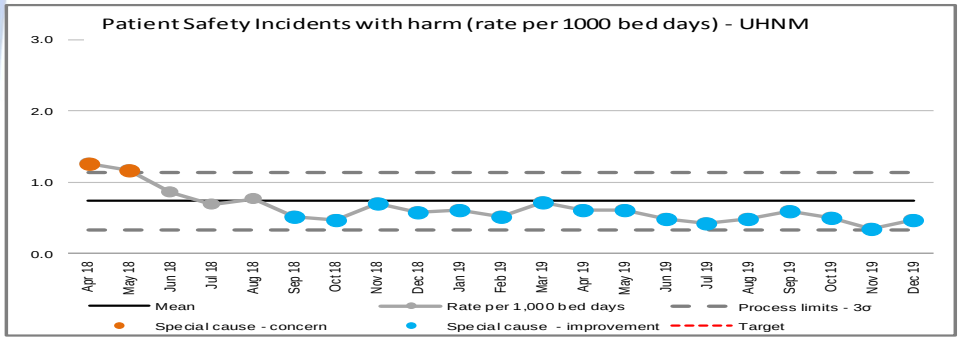


Variation	Assurance

Target	Oct 19	Nov 19	Dec 19
N/A	32.24	32.29	30.72

Background

Patient Safety Incidents rate per 1,000 bed days



Variation	Assurance

Target	Oct 19	Nov 19	Dec 19
N/A	0.51	0.34	0.47

Background

Patient safety incidents reported with moderate harm and above rate per 1,000 bed days

The Rate of Patient Safety Incidents per 1000 bed days allows Trust to compare levels of reporting by making allowances for changes in activity. Whilst there have been noted increases in the total number of reported patient safety incidents which were close to the Upper control limit, when the calculations to make allowances for activity changes these increases are not as marked. During December 2019, the actual rate of reported patient safety incidents has retruned towards the Trust mean. It appears that the increase in the number of reported patient safety incidents during the current Quarter 3 winter period is an effect of increased activity and increased bed capacity resulting in more patients being treated.

The rate of reported patient safety incidents has much less monthly variation than the raw total numbers. However, when calculating the rate this is much more stable.

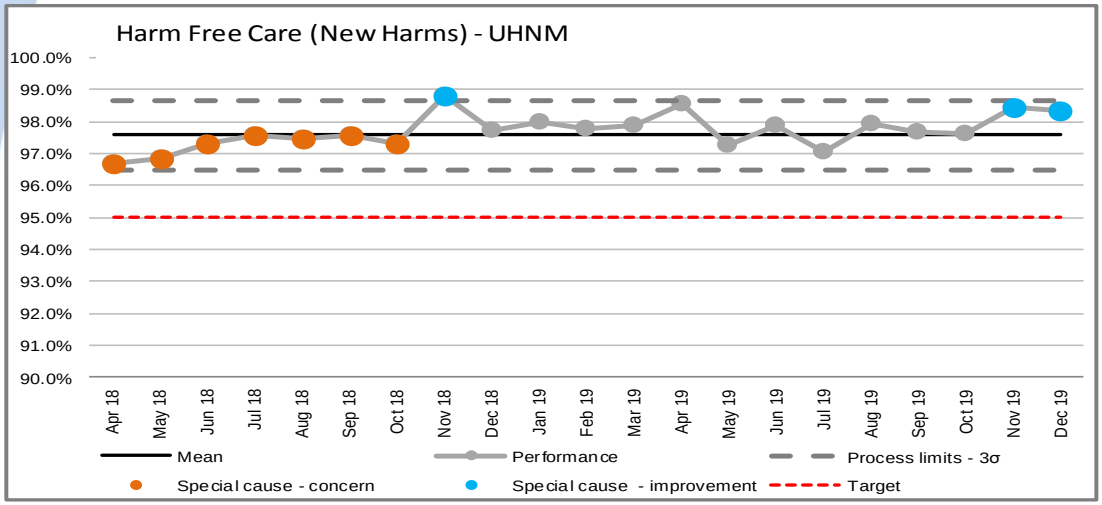
When comparing the rate of PSIs with moderate harm or above there are similar positive trends with 16 consecutive months below the mean and towards the Lower control limit. This demonstrates positive outcomes from the incidents being reported and the continued reporting of incidents and near misses should be encouraged to allow learning to be shared across the Trust.

Summary of Learning from Patient Safety Incidents

Learning from incidents at Risk Management Panel during Quarter 3:

- Importance of prescriptions and administration of medication to have robust and documented second check process as per Trust Policy
- All specimen/samples to be clearly labelled and stored separately for Pathology Laboratory. Theatres SOP to be updated and re issued.
- Agreed by Imaging that where a patient is known to have more than one aneurysm the entire vascular tree is to be scanned
- Where a report fails to cover the anatomical region of clinical interest the referring clinician has a responsibility to question a potential systems error
- All staff with the authority to request imaging to be reminded of the importance of providing accurate and thorough clinical information when requesting scans / tests
- Women being cared for in the forget me not rooms should have appropriate ward round reviews led by the lead consultant for Delivery Suite
- All female patients in the age range of 12-55 for IR procedures should be scheduled using the 10 day rule. This is IRMER policy. The IRMER C policy to be shared with all visiting teams; this includes Neuro anaesthetic teams and vascular anaesthetic and theatre teams.
- A scheduling SOP for the 10 day rule to be written and disseminated to all the Neuro and IR schedulers and medical secretaries.
- Nursing paperwork to be reviewed to ensure sufficient IRMER checking is incorporated that needs to be completed fully prior to taking any patient into the room/theatre. A working party is to be implemented with stakeholders from Imaging, Anaesthetics and Trust WHO governance team to consider a combined radiology WHO form specifically for high radiation GA cases in Interventional Theatre.
- To ensure all intravenous lines are appropriately and clearly labelled. A new develop Standard Operating Procedure is to be developed for use across the Trust.
- Monitoring / auditing of the 2 check process prior to medication administration included within the Trust Clinical Excellence Framework .

Harm Free Care – New Harms



Variation	Assurance
H	P

Target	Oct 19	Nov 19	Dec 19
95%	97.6%	98.5%	98.4%

Background

The percentage of patients assessed via Safety Thermometer as receiving harm free care per month

What is the data telling us?

The above charts shows the Trust's performance for patients experiencing Harm Free Care during their latest inpatient admission. These results are gathered during the monthly Safety Thermometer assessments. This involves all inpatients in UHNM being reviewed on 1 day of the month to assess whether they have experienced harm from a fall, pressure ulcer, pulmonary embolism/deep vein thrombosis or catheter associated urinary tract infection during their current inpatient admission. The results from this survey are returned nationally and the target is for at least 95% of all inpatients to experience 'Harm Free Care'

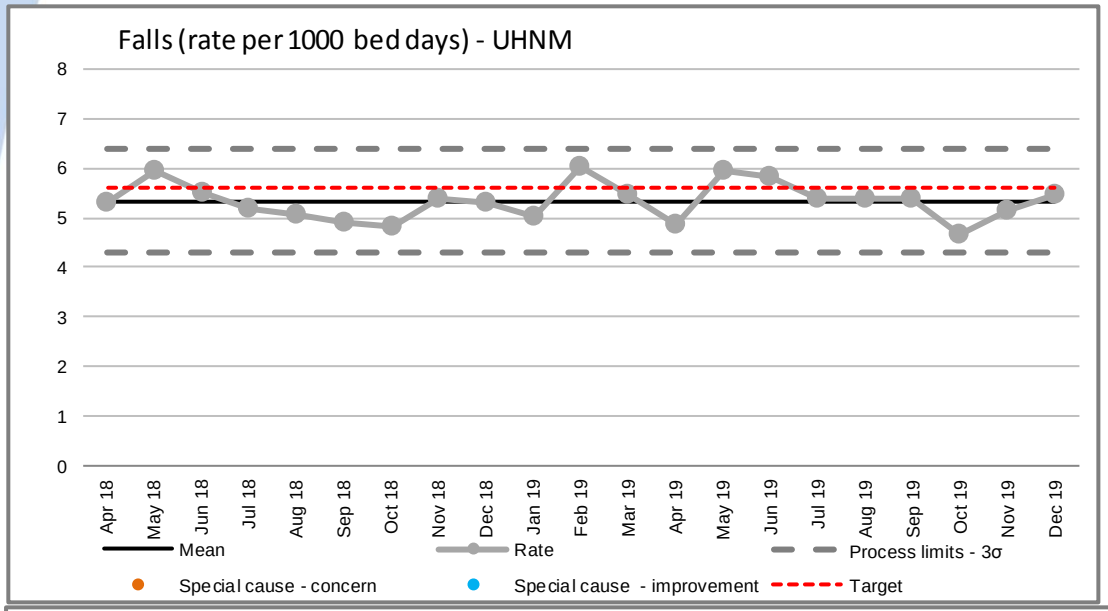
UHNM continues to exceed the national 95% target rate for new harms. During Quarter 3, the average harm free care rate was 98.2%. This is not only above the national target but is also above the Trust mean rate of 97.6%.

Current performance is above (better than) target and close to the upper control limit signifying a significant change / improvement during November and December 2019.

The importance of undertaking and acting upon the various risk assessments for patients i.e. falls, pressure area, VTE will contribute to patients receiving Harm Free Care.

It is important to note that this measure is based on information collected on 1 day and differs from reported incidents which can occur at any time. If a patient falls after the Safety Thermometer review and discharged prior to the next monthly data collection the fall will not be included in the Harm Free Care data.

Reported Patient Falls Rate per 1000 bed days



Variation	Assurance

Target	Oct 19	Nov 19	Dec 19
5.6	4.7	5.1	5.5

Background

The rate of reported patient falls per 1000 occupied bed days

What is the data telling us?

The date shows the Trust's rate of reported patient falls per 1000 bed days. Using the rate makes allowance for changes in activity/increased patient numbers. The Trust set a target rate, based on the Royal College of Physicians National Falls Audit published rate for acute hospitals, of 5.6 patient falls per 1000 bed days.

The data provides reassurance that the rate of falls is stable without wide variation and that on average the Trust is under (positive) the target rate. During Quarter 3, the rate was 5.1. Whilst there were increases during November and December this is more a result of October 2019 being lower than other months. During 2019/20 the trend is reducing. The Corporate Quality and Safety Team continue to focus on falls prevention and introduce new initiatives where appropriate

The Trust is positively under the target rate of 5.6 falls per 100 bed days for the past 6 months

Actions taken to reduce impact and risk of patient related falls include:

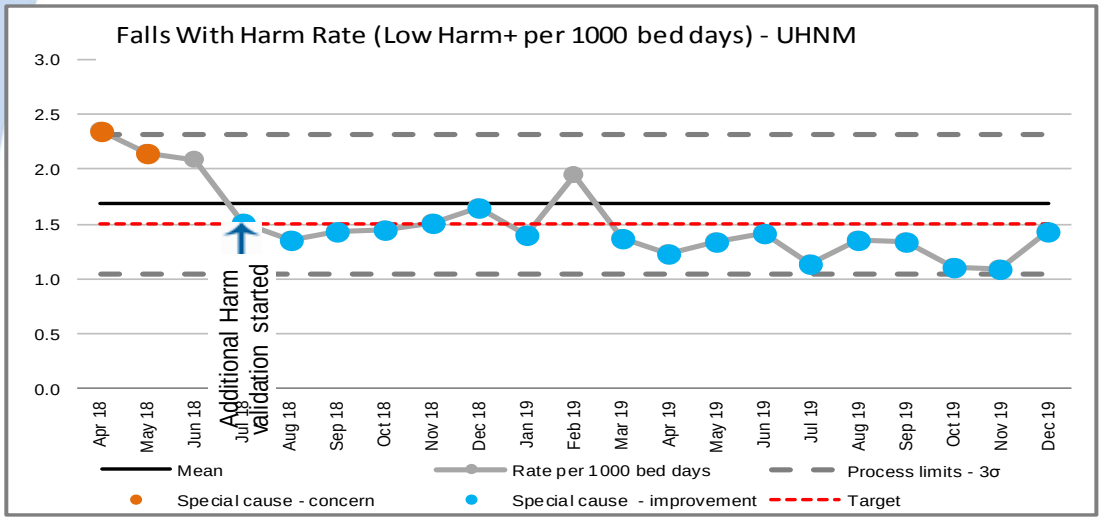
New Trolley rail departmental protocol introduced at County Hospital Emergency Department and Radiology Day Case Unit at Stoke. Plans are in place to extend this to Royal Stoke Emergency Department and also Day Case wards on both sites

Training days for new falls champions and refresher training for existing champions have been set and advertised for staff to book onto via ESR

Work with wards on CQUIN compliance is on-going. The accuracy of mobility assessments and completion of lying and standing has been a focus.

The falls steering group has made the decision to adapt the RCoP's falls safe bundle monthly audit and we have launched a new falls audit. This was trailed in 5 areas in December and it has been rolled out Trust wide in January. It is hoped the new focus will improve CQUIN compliance.

Patient Falls with Harm rate per 1000 bed days



Variation	Assurance
	

Target	Oct 19	Nov 19	Dec 19
1.5	1.1	1.1	1.4

Background

The rate of patient falls reported with low harm or above per 1000 bed days. Excludes collapses and managed falls

What is the data telling us?

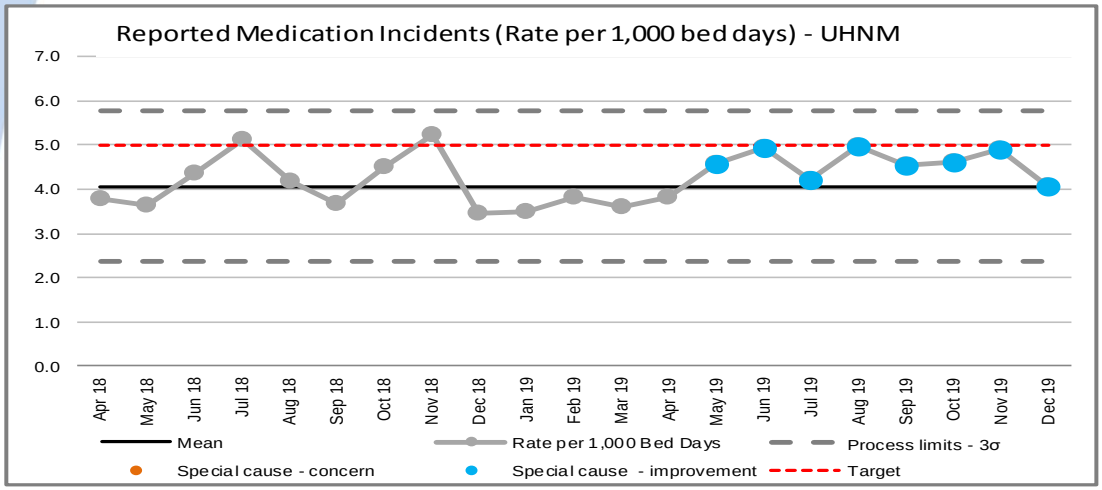
The rate of patient falls with harm continue to show positive trends with 10 consecutive months below the mean and approaching the lower control limit.

There is a comprehensive process in place for reviewing all falls on a daily basis to identify harm. Serious harms are investigated through the RCA process and action plans created to prevent future harms occurring.

Actions:

- Validation of level of harm reported on datix continues on a monthly basis supported by the divisional governance managers
- The process for duty of candour is now well established. Patients receive a card informing them of the RCA process and staff complete a notes sheet to capture initial conversations and if the patient/family wish to receive an outcome letter
- Hip protectors have been introduced at County Hospital site and a review of numbers of Hip factures following this introduction is planned later this year
- Following an incident a further evaluation of assistive technology is to take place on ward 201 supported by ACN Tracy Taylor

Reported Medication Incidents Rate per 1000 bed days



Variation	Assurance
	

Target	Oct 19	Nov 19	Dec 19
N/A	4.6	4.9	4.1

Background

Reported Medication incidents rate per 1,000 bed days

What is the data telling us?

The data above shows that in recent months there have been consistent increases above the UHNM mean rate of reported medication errors via the Datix adverse incident reporting system per 1000 bed days. The rate of medication incidents includes all incidents reported across UHNM irrespective of whether there was any harm to patients

There is currently no target rate set but the aim is to encourage reporting of all medication incidents and near misses via Datix system. The last 8 months are all above the mean rate of 4.1 medication incidents per 1000 bed days.

During Quarter 3 2019/20 there were 566 reported medication incidents across the Trust, compared to 521 in same period 2018/19. This equates to 8.6% increase in the total number of reported medication incidents. There was a corresponding increase of 4.5% in the rate of reported medication incidents for the same periods. This shows that the increase in reported medication incidents that is not just a result of increased activity (which also increased by 4%).

To review national benchmarks for medication incidents and medication incidents with moderate harm or above to agree internal target for improvement (i.e. reduction in medication incidents resulting in moderate harm or above).

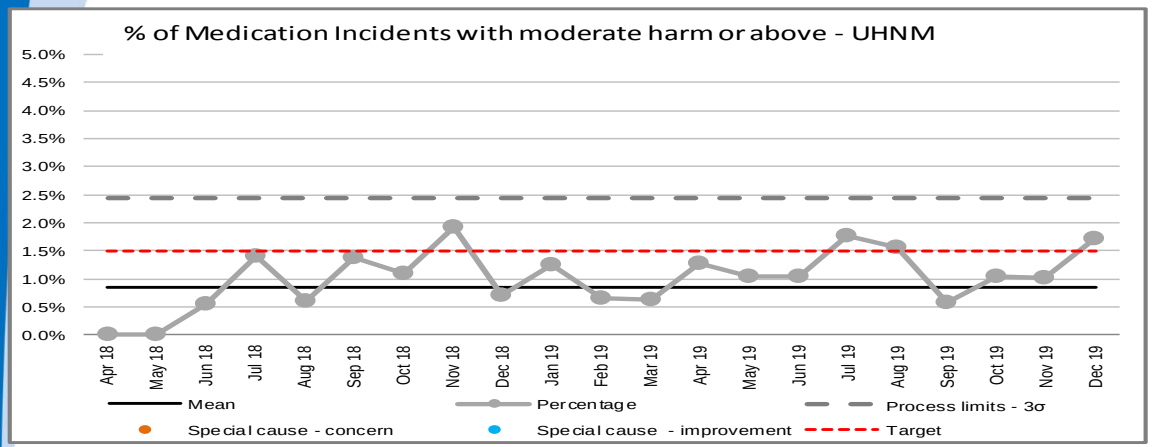
The number of reported medication incidents remains around the same rate for quarter 3 with a slight dip in December – potentially as staff too busy to report the no harm incidents. We still need to increase the number of reported medication incidents. Trusts are benchmarked on numbers of medication incidents reported and Increased reporting of no and low harm medication incidents is encouraged – i.e. trusts that are performing well have higher rates of reporting medication incidents.

Actions :

Medication Safety team will work with the governance team to look at potential barriers to reporting

Campaign in the Spring to encourage all staff to report medication incidents even when no harm.

Percentage of Medication Incidents with moderate harm or above



Variation	Assurance

Target	Oct 19	Nov 19	Dec 19
2%	1.0%	1.0%	1.7%

Background

The percentage of medication incidents reported as causing moderate harm or above

What is the data telling us?

The data shows the percentage of reported medication incidents that are recorded as causing harm to the patient. The harm is assessed and noted at time of reporting the incident and then reviewed by Pharmacy Governance Team. Whilst there have been increases in the rate of reported medication incidents noted previously, 1.3% of these reported incidents were rated as moderate harm or above. This is the same as the previous quarter.

The increase in the total number of reported medication incidents is in the number of incidents identified which have recorded low harm. There have been 6 incidents reported resulting in moderate harm and 1 resulting in severe harm.

The Trust are reviewing to reporting of medication errors and determining benchmark target based on Model Hospital and National Reporting rates. To support and promote increased reporting the Trust Pharmacy Team are raising awareness of medication errors and learning via training with Medical Students, Junior Doctors and as part of Trust Training. Incidents are reviewed at the Trust Safe Medications Group and learning disseminated across Divisions as result of these investigations and safety/learning alerts produced and circulated via the Trust Communications Team where applicable.

Reporting Themes identified:

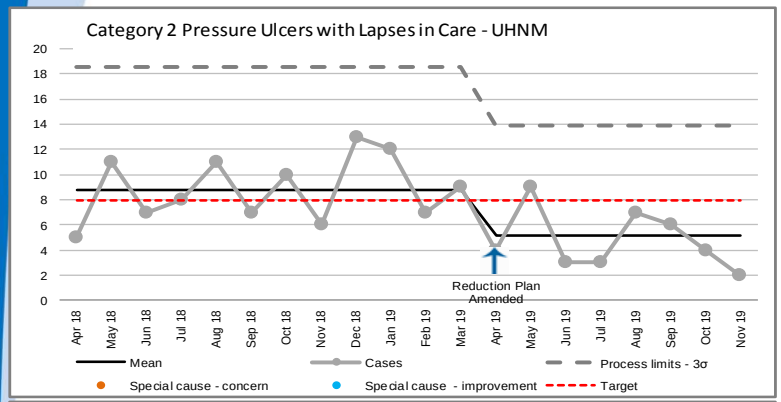
Anticoagulants

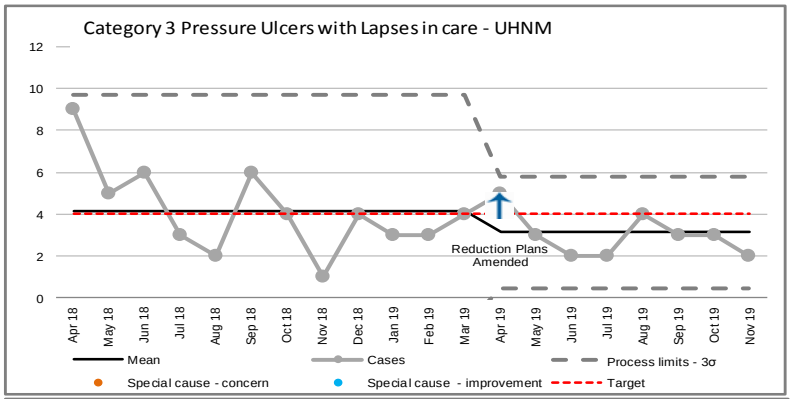
- Recent months have seen an increase in prescribing and administration of DOACs.
- Included in medication safety quiz
- Specialist group to look at rationalising choice of agents to reduce confusion and review prescription chart.

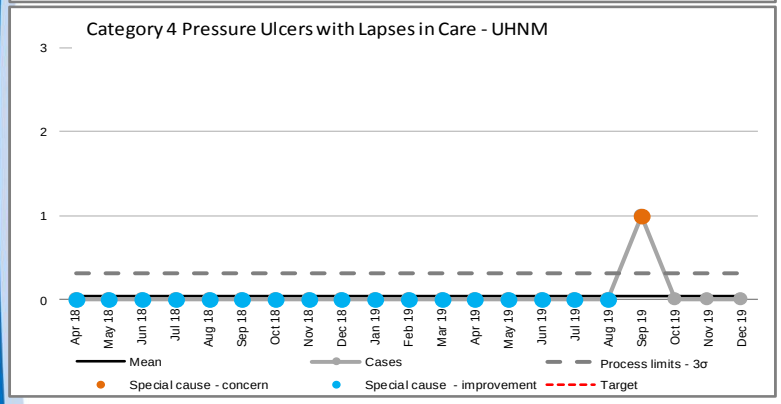
Extravasation

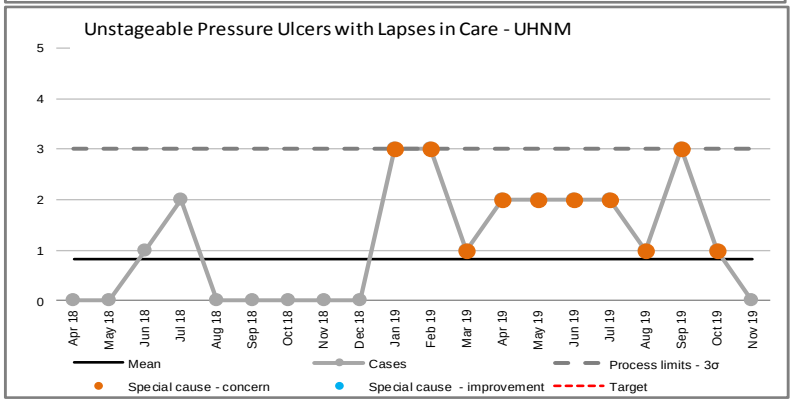
- Increase in reporting due to raised awareness of extravasation injuries and logging as adverse incident. New process for tracking themes within CWD being implemented

Pressure Ulcers with lapses in care







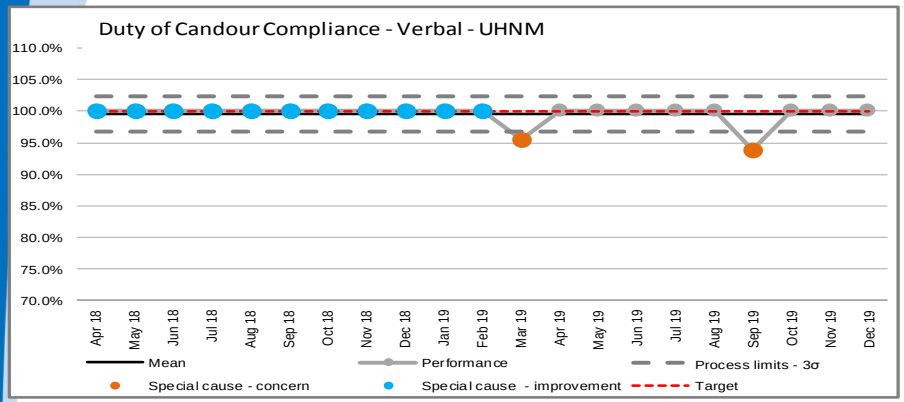


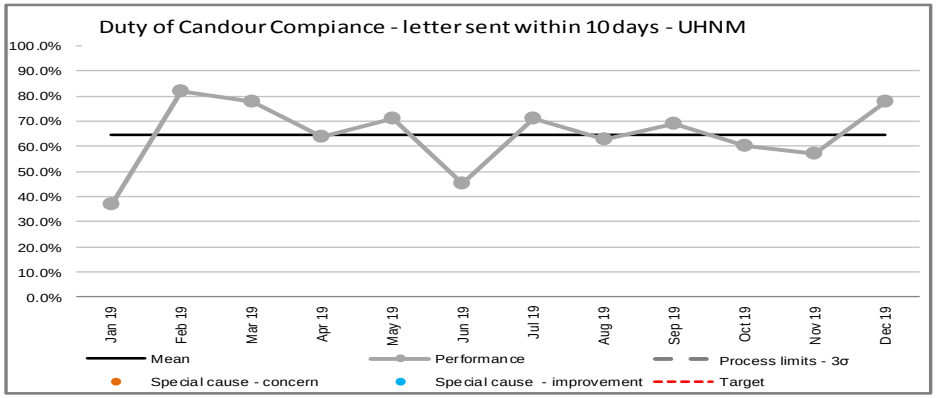
The data above shows that there have been reductions in the number of Pressure Ulcers (category 2 – 3) with lapses in care and both categories are below their target numbers per month. There has been 1 category 4 pressure ulcer where lapses in care were identified during 2019/20 and this has had a full RCA and robust action Plan developed and agreed

The final chart shows an increase in unstageable pressure ulcers since the introduction of new reporting criteria in June 2018. In line with the NHSI revised guidance unstageable pressure ulcers are monitored closely, with weekly reviews by the Tissue Viability team, to prevent deterioration.

Following a successful trial the new aSSKINg bundle is being rolled out across RSUH in February 2020 aimed at reducing the common omissions in documentation identified through the root cause analysis (RCA) process. The improvement in documenting assessments and actions taken as result of the assessments will further improve learning and contribute to reducing any further lapses in care.

Duty of Candour Compliance





Variation	Assurance

Target	Oct 19	Nov 19	Dec 19
100%	100.0%	100.0%	100.0%

Background

The percentage of duty of candour incidents reported per month with verbal notification recorded/undertaken

What is the data telling us?

Variation	Assurance

Target	Oct 19	Nov 19	Dec 19
100%	60.0%	57.0%	78.0%

Background

The percentage of notification letters sent out within 10 working day target

What is the data telling us?

Verbal Duty of Candour has been recorded in 100% of all incidents that have formally triggered meeting the threshold within October, November and December 2019.

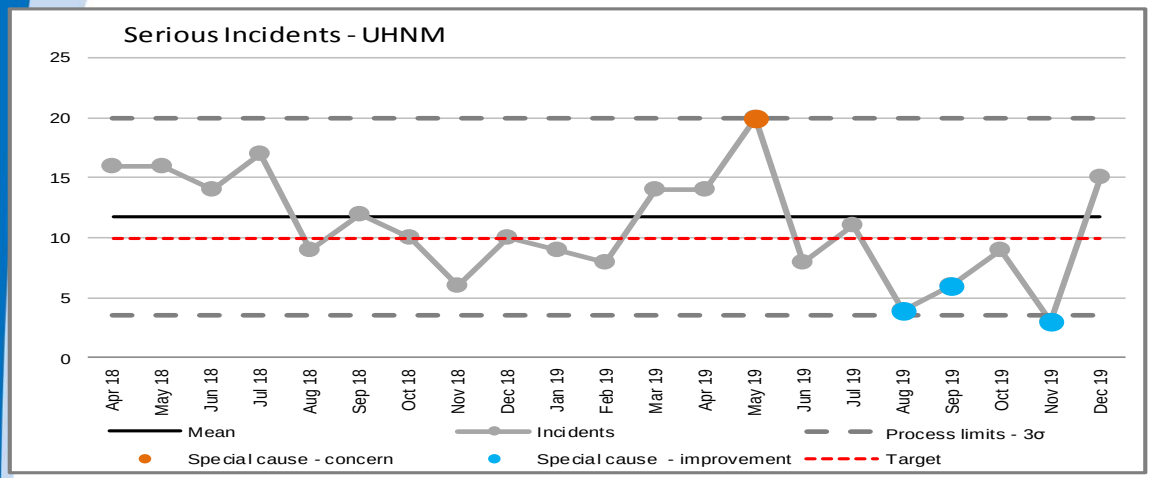
Written Duty of Candour Compliance for receiving the letter within 10 working days of verbal notification has improved during December 2019 with 78% of letters being sent out. It should be noted, that 100% of the reported duty of candour incidents in December 2019 have now been recorded as having letter sent out.

The Trust has established a Duty of Candour Task & Finish Group during December 2019 to work across the Trust on actions and initiatives to improve awareness and compliance of the need for Duty of Candour letters to be sent out within 10 working days of the verbal notification and awareness of the adverse incident.

From the information and performance, staff are aware of the need to be open, honest with patients and their relatives with all incidents being initially explained to the affected persons. The improvement is ensuring that the written follow up notification is completed within the 10 working days.

Progress will continue to be monitored and reported.

Serious Incidents per month



Variation	Assurance

Threshold	Oct 19	Nov 19	Dec 19
10	9	3	15

Background

The number of reported Serious Incidents per month

What is the data telling us?

Summary:

Whilst there is wide variation in monthly totals of reported Serious Incidents these are generally within normal variation. December 2019 increase result of patient falls meeting the SI reporting criteria which is linked to previously noted increase in December 2019 of the rate of patients falls with harm.

There were there are currently 39 open active incidents on STEIS

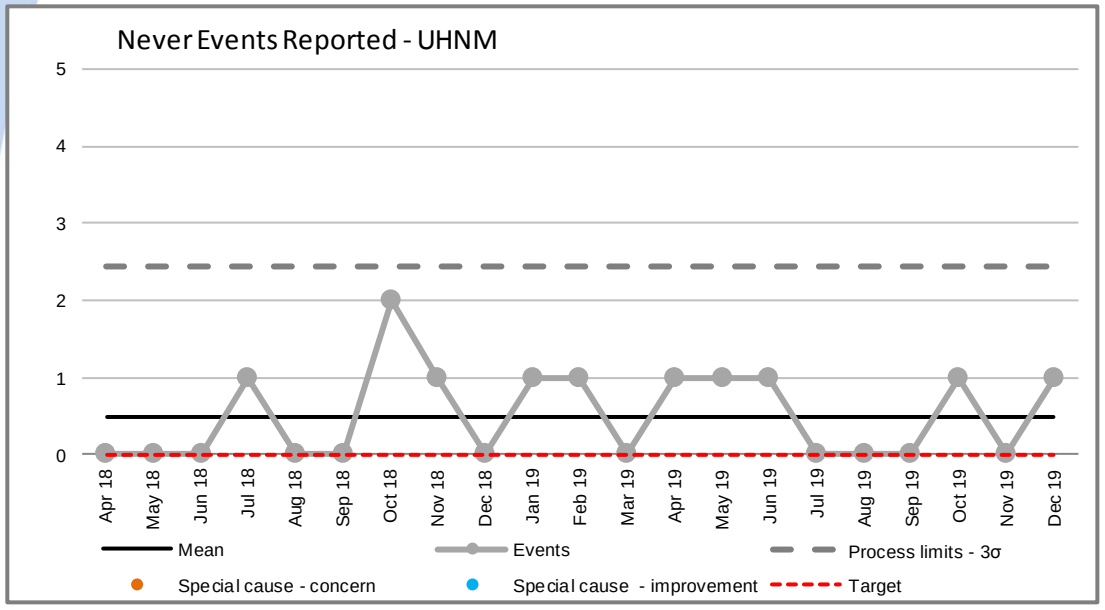
14 incidents are open with a 60 days due date and over including:

- 1 Stop the Clock as subject to HSIB review
- 4 reports which are now overdue – CCG have been kept informed of progress.
- 9 incidents have had RCAs submitted and are undergoing review process with CCG

Of the remaining 25 cases.

- 8 cases were reported in October and the 60 days due date is January 2020 (3 of these case have already been submitted for review)
- 3 cases reported in November awaiting submission due end of January/February 2020
- 15 cases reported in December with 60 day due date in March 2020

Never Events



Variation	Assurance

Target	Oct 19	Nov 19	Dec 19
0	1	0	1

Background

Defined as Serious Incidents that are wholly preventable, as strong systemic protective barriers should be in place

What is the data telling us?

UHNM has reported 5 Never Events during 2019/2020.

2 Never Events reported during Quarter 3.

The target is to have 0 Never Events. However, from national data and local incidents these incidents still occur.

It is imperative that these events are fully reviewed and leaning identified and shared across the local area / Division / Trust to reduce the likelihood of future recurrence. There have been 2 new Never Events reported during Quarter 3.

1 Never Event reported in October 2019 relating to incorrect lens within Ophthalmology.

1 New Event reported in December 2019 relating to wrong site surgery.

Patient referred for right side nerve root injection to provide pain relief for severe pain in right buttock and leg. In error the Patient was given the injection into their left lower back which would help with pain in their left hand side.
The patient went to PALS on 27/11/19 to inform them that they had found out that the injection went into the incorrect side.

Full investigation is underway and will be presented at Risk Management Panel and SI Review Group with the CCGs

Learning from Never Events

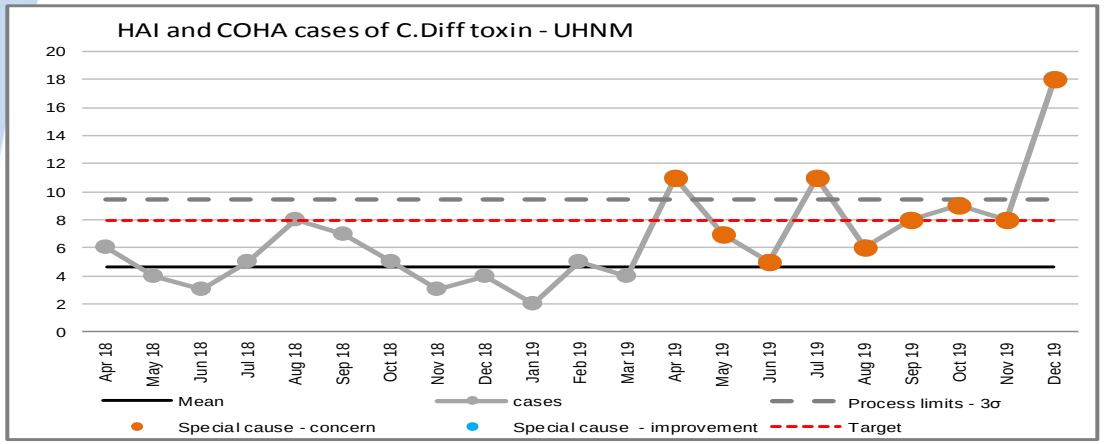
Learning from previously reported Never Events
The following summary provides an update on the learning and actions taken from previously reported Never Events.

Wrong / Incorrect Lens (reported October 2019)
On checking the patient's notes when completing the WHO check list for this times surgery it appears that when the last cataract surgery was done there was the wrong biometry used and in the notes. The patients name was correct but unit number and date of birth were wrong, there was another a scan stapled on top the wrong biometry (this was for the correct patient) but the biometry which was used and underneath this was for the wrong patient. It was only picked up when we were doing the second eye as a new biometry had been performed since the last surgery

Lessons learned / Actions Taken:

- A" scan, new machine examination date is chronologically a day out
- Adopting sticker on Biometry sheet and integrate into process of WHO checks. And inform all Theatre Teams
- Reviewing the adoption of an Ophthalmology specific WHO Surgical Safety Checklist
- Pre-printed patient labels are not to be used on any printed results sheets (including biometry sheets) which have patient details (name, unit number, date of birth) already printed on them.
- Introducing a second check process for complex biometry requiring double signature
- WHO checklist documentation to be updated in the booklets to avoid use of photocopies.

Reported C Diff Cases per month



Variation	Assurance
H	?

Target	Oct 19	Nov 19	Dec 19
8	9	8	18

Background

Number of HAI + COHA cases reported by month

What is the data telling us?

What do these results tell us?

Chart shows the number of reported C Diff cases per month at UHNM. Previous 9months are all above the Trust mean for monthly cases.

The winter pressures involving an increase in admissions of Influenza and Norovirus patients has had an impact on the number of C.Diff cases the Trust has seen in December.

As at YTD at the end of December 2019, 45 of the 83 cases would have been attributed as hospital acquired under the previous definition; whereas 38 would have been non-trust apportioned (9 'Day 3' samples and 29 COHA cases).

Actions

Continue surveillance for HAI C diff with continued immediate implementation of control measures to prevent transmission

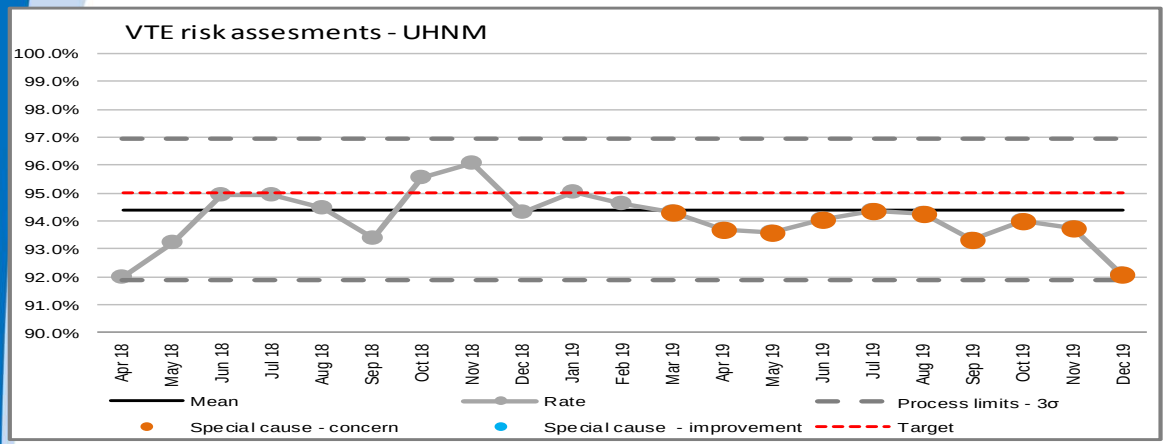
Continue to work with health economy colleagues around antimicrobial prescribing

MPFT to refresh primary care and care homes around not sending repeat stool specimens to check for C diff clearance

PII meeting to discuss three cases from the same ward area to determine whether transmission has occurred

Investigation of all 18 cases to see if there are any links that can be elicited, or whether they are an unusual coincidental increase in relation to the influenza A cases during December to see if there is any link to antimicrobials to treat secondary bacterial infection, and Norovirus

VTE Assessment



Variation	Assurance
	

Target	Oct 19	Nov 19	Dec 19
95%	94.0%	93.7%	92.1%

Background

The percentage of patients receiving a VTE risk assesment

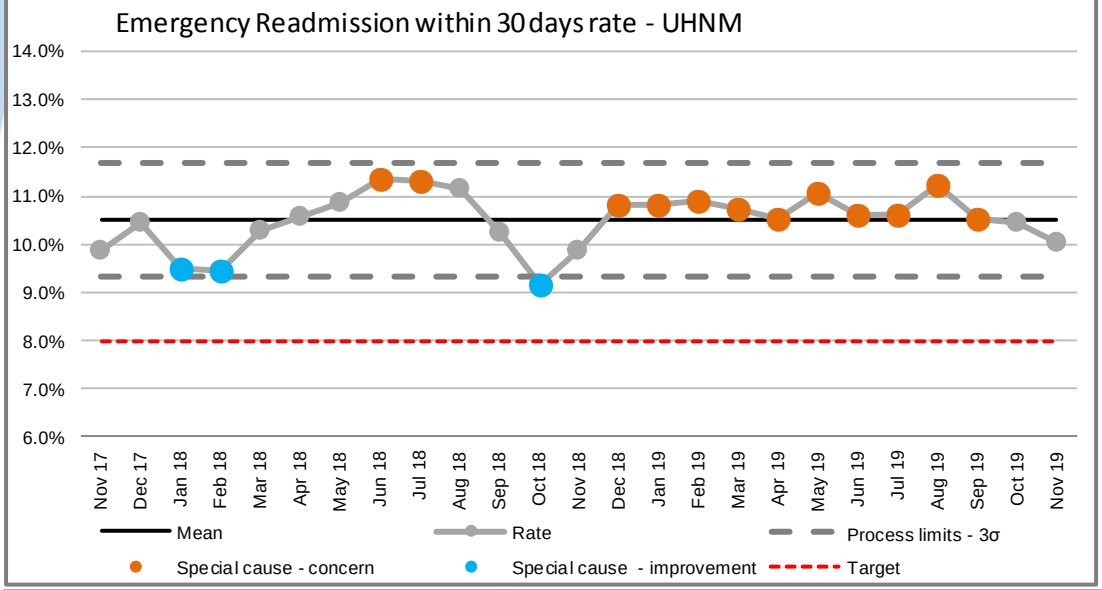
What is the data telling us?

The data reports the Trust's completion of VTE Risk assessments. VTE assessments on admission are reported quarterly to Unify. The definition of the Indicator is the number of inpatients aged 16 and over reported as having had a VTE risk assessment on admission to hospital using the clinical criteria of the national tool divided by the number of adults who were admitted as inpatients (includes day cases, maternity and transfers; both elective and non-elective admissions).

- For December 2019 92.1% of VTE risk assessments were completed within 24 hours of patient admissions (all inpatient admissions during December 2019 captured on the WIS), which falls short of the National 95% target. However, results from the monthly point prevalence Safety Express audit shows that for the last six months, over 99.0% of VTE risk assessments have been completed (ward based audit of every inpatient on one specified day of the month).
- This suggests that VTE Risk Assessments are completed on admission but not uploaded accurately onto the WIS Board. This is supported by the internal audit of UHNM Quality Account 2018/2019, which concluded that UHNM was under-reporting compliance with VTE risk assessments.

- Continued focused work is ongoing to improve compliance with timely inputting of VTE risk assessments onto WIS. The VTE Steering Group are also liaising with other Trust working groups to explore other means of data collection of VTE risk assessment compliance, including Vitalpac and EPMA.
- Development of an eLearning package to provide training on uploading indicator results onto WIS
- Email sent to all ward managers and Matron for Medical wards at County to improve compliance and face to face ad hoc training has been provided during weekly 'walk arounds'
- Liaising with emergency portals at RSUH, where biggest impact on overall compliance can be achieved.
- A monthly report is sent to the senior sister and matron of AMU at Royal Stoke regarding compliance. The senior sister has planned to meet with the lead consultant to help improve compliance in completion of VTE assessments.
- Monitoring and encouragement to complete indicators within WIS is provided by the quality team during Care Excellence Framework (CEF) visits of inpatient wards and admission portals.

Emergency Readmissions within 30 days



Variation	Assurance
	F

Target	Jul 19	Aug 19	Sep 19
8.0%	10.6%	11.0%	9.5%

Background

the percentage of patients who return as an emergency admission within 30 days of an inpatient/daycase spell.

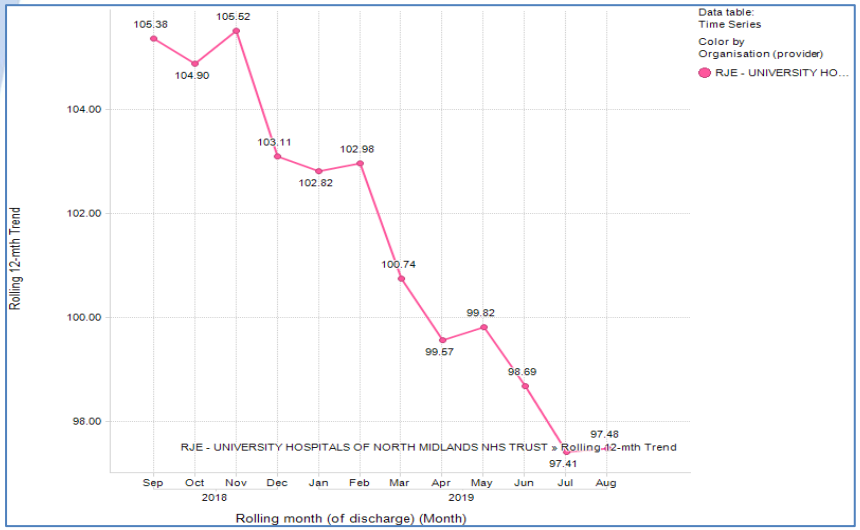
What is the data telling us?

The rate of emergency re-admissions is consistently above the 8% target. After a period of 9 months above the 2 year mean September shows the trend has stopped.

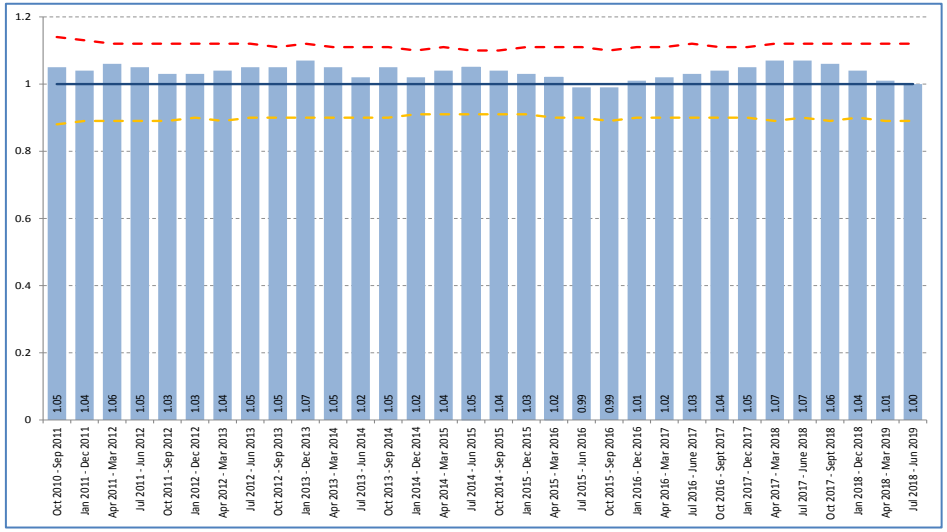
Mortality Indicators

University Hospitals of North Midlands NHS Trust

HSMR – rolling 12 months



SHMI – rolling 12 months



Current Position:

- SHMI – GREEN rating – July 2018 to June 2019 = 1.00
- HSMR – GREEN rating – September 2018 to August 2019 = 97.48

UHNM is not an outlier for SHMI based on the latest published SHMI data from NHS Digital. UHNM Has SHMI value of 1.00 for July 2018 to June 2019. The result was assigned the banding 'as expected'

UHNM's HSMR falls within the 99.8% and 95% control limits shown on the Poisson distribution based funnel plot . HSMR has improved from previous month

Both Royal Stoke University Hospital and County Hospital HSMR are within expected ranges at 97.23 and 98.98 respectively

Septicaemia Diagnosis Group is showing improvement

Pneumonia Diagnosis Group is showing improvement and is within expected range and currently no outlier alert

Trust is currently investigating Chronic Renal Failure and Therapeutic Operations of the Jejunum and/or Ileum after receiving CuSum alert notifications.

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	11th March 2020
Report Title:	UHNM Patient Experience Report: Q3 2019/20	**Agenda Item:**	11
Author:	Angela Grocott, Head of Patient Experience		
Executive Lead:	Michelle Rhodes, Chief Nurse		

Purpose of Report:					
Assurance	✓	**Approval**		**Information**	

Alignment to Strategic Objectives:		
SO1	Provide safe, effective, caring and responsive services	✓
SO2	Achieve NHS constitutional patient access standards	
SO3	Achieve excellence in employment, education, development and research	
SO4	Lead strategic change within Staffordshire and beyond	
SO5	Ensure efficient use of resources	

Summary of other meetings presented to and outcome of discussion:

Quality & Safety Oversight Group 10/02/2020 – Feedback on content requested from staff and patients
Quality Governance Committee 27/02/2020
Patient Experience Group 27/02/2020 – Staff feedback: Comprehensive report which provides clear information. Patient Feedback: Too complicated for some to understand. More examples of what we are doing to improve.

Summary of Report, Key Points for Discussion including any Risks:

In summary, the Q3 Patient Experience Report is telling us that there is a decrease in the number of complaints received. The top 90% of complaints in Q3 2019/20 fall into 7 complaint types predominantly relating to aspects of clinical treatment, patient care and communication. The two highest themes in the Clinical Treatment category relate to diagnosis and issues following surgery or a procedure. These themes are also reflected in the type of PALs contacts and FFT responses.

The report demonstrates that 73% of the complaints are upheld or partly upheld, the majority of which relate to clinical treatment. It also shows that none of the Divisions or the Trust overall is achieving its target response time to complaints of 40 days. This needs to be a focus for improvement within the Divisions.

There has been a reduction in the number of PALS concerns received compared to Q2 with Appointments including delays and cancellations, Communication and clinical treatment as the top 3 themes.

The Inpatient Friends and Family Test indicates that whilst we are not achieving our internal target response rate of 30% we are 5th in the league compared to our Peers and all other remaining Trusts combined. The inpatient recommendation score averages 98% which is significantly higher than the National average of 96%.

Through the triangulation of key quality and safety indicators the report indicates the hotspot areas which need focus for improvement and monitoring through the Divisional Board Meetings, the Quality and Safety

Oversight Group and the Divisional Performance Reviews.

Specifically, the Medicine Division needs to focus on learning from complaints, improve their response time to complainants, improve their FFT response rate, reduce falls and medication errors. Staffing should remain an area of consideration specifically on wards 233, 113 and ward 7.

The Surgical Division should consider focus on recruitment and retention for hot spot areas and encourage FFT feedback to initiate improvement based on what matters to our patients.

The ED FFT is under achieving the target response rate and the recommendation rate despite continued efforts to improve. New approaches to address these concerns are being discussed.

The Specialised Division should consider staffing on Wards 112 and 228 with a specific focus on Ward 228 regarding falls, pressure ulcers and medication incidents. The Specialised OPD areas should focus on learning from complaints and PALS concerns

The Maternity FFT is achieving 100% recommendation rate; however the significant under achievement of the target response rate means the recommendation is unreliable. All areas across the 4 Maternity touch points are encouraged to gain feedback through a variety of routes for convenience.

The OPD FFT is consistently exceeding the national average recommendation score of 96%. Although the response rate is not measured in OPD the number of patients providing feedback has fallen over quarter 3 therefore, for assurance of patient satisfaction concentration to improve this during Q4 is required.

Key Recommendations:

The Trust Board is asked to note the monitoring and progress of the improvement considerations highlighted in this report and to support an internal FFT target of at least 30% across all areas of the Trust

QUALITY REPORT

PATIENT EXPERIENCE

Quarter 3: October-December 2019

3rd February 2020

NHS

University Hospitals of North Midlands

NHS Trust

IN THIS REPORT

NHS University Hospitals of North Midlands NHS Trust

1 INTRODUCTION

Improving patient experience is at the heart of the Trust's vision and values and our Patient Experience Strategy.

This paper presents a review of the patient experience data collected through complaints, compliments, PALs enquiries, and the Friends and Family Test (FFT).

The report identifies the key themes from this data and triangulates this with other key quality and safety measures to inform focused improvement.

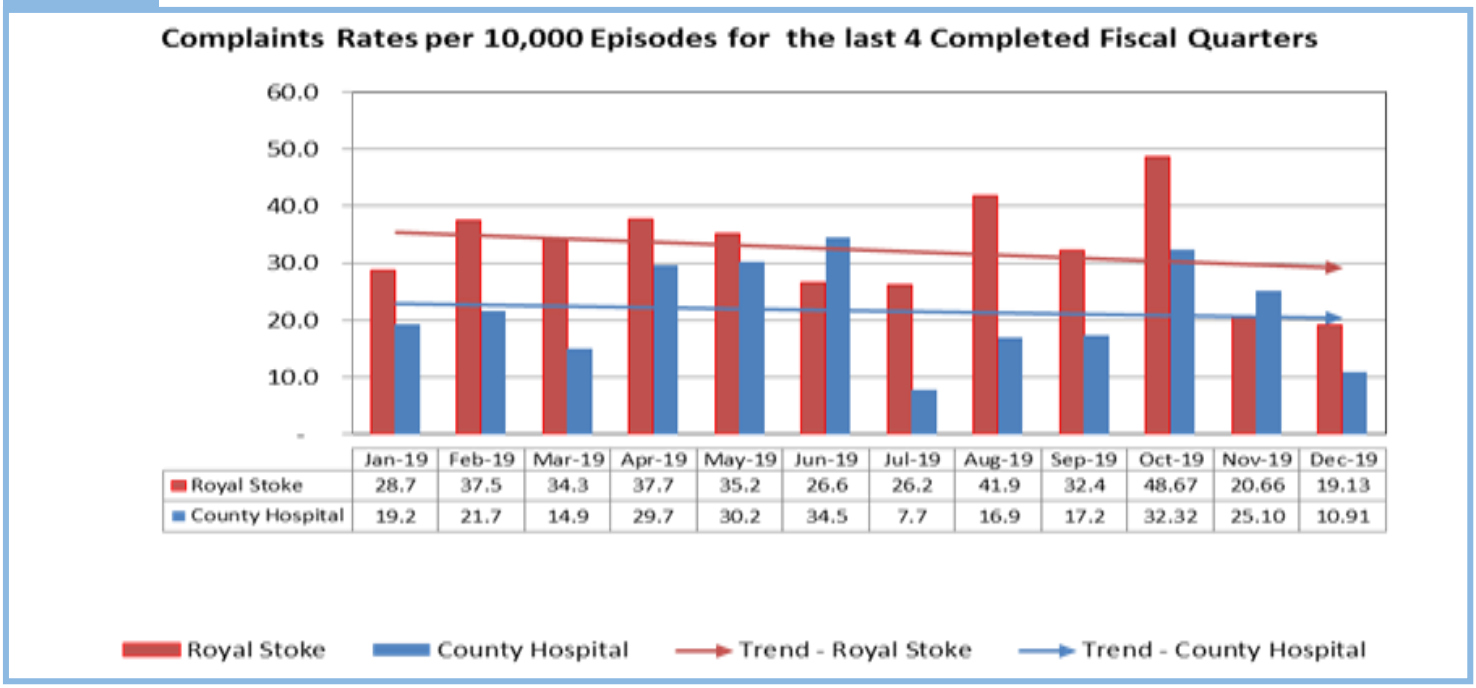
2 COMPLAINTS AND PALS

2.1 Complaints Received per 10,000 Spells

One of the most important aspects of the complaints process for the Trust is to learn lessons and make changes to enhance the experience of our patients, carers and relatives. For the purpose of this report, complaints are categorised as being a written or verbal complaint not resolved within 24 hours to 5 days. These are what we often refer to as 'formal' complaints where resolution cannot be found at an informal stage.

The quarterly rate of complaints received is a key indicator for the Trust. There is currently no target set for 2019/20 and therefore the rate received during this period will be used as the baseline. During Q3, the Trust received 175 complaints, 150 were received by RSUH and 25 by County Hospital of these the Medical Division received 67, Surgery received 38, Specialised received 38 and CWD received 30. There are also 2 complaints for Estates which haven't been included in the tables found later. The actual numbers of complaints and PALS are variable with time and therefore when the report is written the figures will provide a snapshot of the numbers on the day the information is reviewed.

CHART 1



	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
Royal Stoke	28.7	37.5	34.3	37.7	35.2	26.6	26.2	41.9	32.4	48.67	20.66	19.13
County Hospital	19.2	21.7	14.9	29.7	30.2	34.5	7.7	16.9	17.2	32.32	25.10	10.91

Chart 1 shows the number of complaints per 10,000 spells at both hospital sites. The graph shows that there is a decreasing rate of complaints received at both sites since January 2019.

The UHNM rate for written complaints is 14.2 per 10,000 bed days compared to the national rate of 21.8.

CHART 2

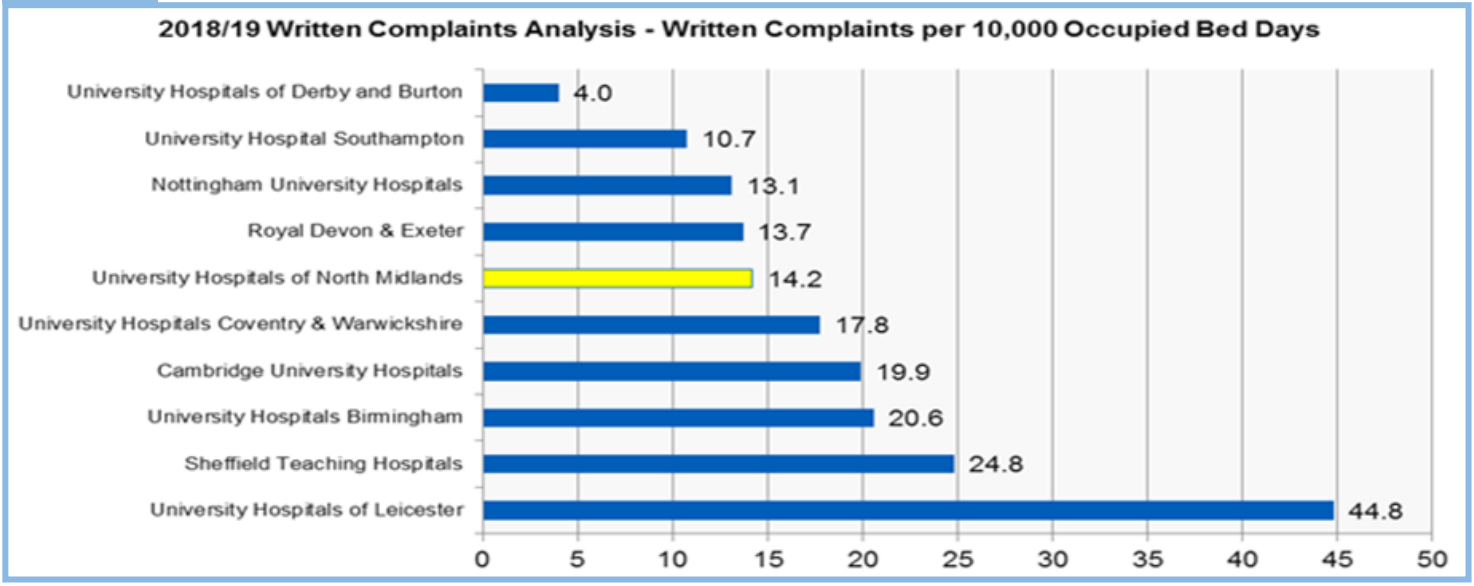


Chart 2 above shows that when compared with our peer group UHNM is 5th of the 10 Trusts analysed.

2.2 Complaints by Type

CHART 3

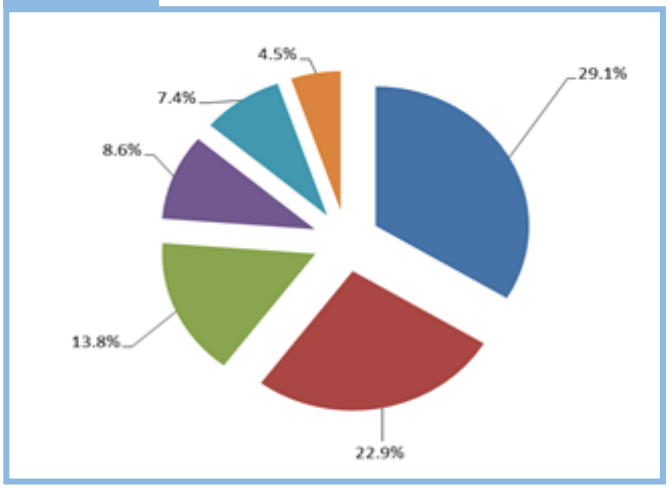


Chart 3 shows that across the Trust the top 90% of complaints in Q3 2019/20 fall into 7 complaint types predominantly relating to aspects of clinical treatment, patient care and communication. The two highest themes in the Clinical Treatment category relate to diagnosis and issues following surgery or a procedure.

2.3 Complaints by Division, Speciality and Ward

The following tables only include those areas that have had a complaint raised against them. There are other areas within the Divisions where no complaints have been received and are therefore not identified below. The numbers shown for each of the Divisions will exceed the number of complaints received as a single complaint may cover more than 1 area.

Medical Division

Ward/Dept. Name	Q1	Q2	Q3	Q4	Total YTD
Medical Admin	9	10	1		19
Endoscopy Suite Royal	1	2	1		4
Endoscopy Suite County	1				1
Renal Unit County		2	1		3
Lung Function Lab County	1				1
AMU Royal			7		7
Ward 123 SSU	1				1
Ward 122			1		1
Ward 124	2				2
Ward 232	3		3		6
Ward 230	1		1		2
Ward 233	4	3	4		11
Ward 76a			1		1
Ward 76b	1				1
Ward 113	3	3	1		7
Ward 78		2	1		3
Ward 79	1				1
Ward 80		1			1
Ward 81	1		2		3
Ward 126	2	1			3
Ward 127	2		1		3
Ward 14 County	3	2			5
AMU County	2	1			3
Ward 15 County	2				2
Ward 7 County	3		5		8
CDU Royal	3	1	3		7
Emergency Dept. Royal	24	17	22		63
AEC		3			3
Emergency Dept. Paeds RSUH		2	3		5
Emergency Dept County	5	6	6		17
Ward 12			1		1
AMU County			1		1
Totals:	75	56	66		197

Within medicine the areas with the highest number of complaints in Q3 are AMU at RSUH, Ward 233, Ward 7, the Emergency Department at RSUH and the Emergency Department at County. The key themes identified within these areas are listed below:

- **Poor attitude./behaviours.** Staff involved have been reminded to treat patients and their relatives with dignity and respect and have written a reflection.
- **Poor behaviour/communication.** Staff to receive bespoke complaint training to recognise and address patient/relative concerns before these escalate.
- **Information/Communication.** An on line patient information pack is in development. An improved handover process has been implemented to ensure all vital information is passed over the next shift
- **Delay in answering call bells.** Staff have been reminded to answer call bells as quickly as possible. Regular audits have been carried out to monitor compliance and staffing levels have been reviewed.
- **Care below expected standard.** Recruitment drive to fill nurse vacancies and regular bank staff booked as much as possible for continuity. Falls refresher training for all staff.

Other key quality and safety indicators are triangulated for each of the areas above in section 5 of the report to identify and inform focused improvement.

Surgical Division

Ward/Dept. Name	Q1	Q2	Q3	Q4	Total YTD
Theatres			1		1
SSCU		1	1		2
SACU	1	2	4		7
Ward 8	3	1	1		5
Ward 102	1	2			3
Ward 103	2	2	2		6
104/105	2		3		5
Ward 106/107	3	1	5		9
Ward 108		2			2
Ward 109		2	2		4
Ward 110		1			1
Ward 111	1	2	1		4
OPD clinics	15	8	13		36
Surgical admin	13	14	5		32
Total	41	38	38		117

Within surgery the areas with the highest number of complaints in Q3 are SACU, Ward 106/107, surgical outpatient clinics and surgical administration. The key themes identified within these areas are listed below:

- **Clinical treatment.** Doctor to provide education around the importance of prescribers communicating their prescription request to nursing staff as early as possible and the importance of prioritising antibiotic treatment in sepsis
- **Delay in follow up appointment.** Surgical Management team have reminded their teams to personally telephone the relevant department or Registrar on call when referring the patient to another team.

- **Discharge.** The discharge process has been changed to bring it in line with practice at County hospital. The discharge summary will be checked as completed/signed off by ward before a patient is discharged.
- **Waiting times for operation/procedure.** The Bariatric Team are looking into the possibility of restarting the treatment initiative theatre sessions in order to improve waiting times for patients.
- **Communication.** A patient's wife was incorrectly told by the ward that the hospital would provide her with transport home. The staff have been reminded to give more support and clear information to family members or visitors on the best and safest way to get home from the Trust.
- **Care and treatment.** staff perceived that because a patient was confused they were deemed to have dementia. The complaint has been shared with the senior nursing team who will cascade this information to staff and provide education and training to ensure this does not happen again.

Specialised Division

Ward/Dept. Name	Q1	Q2	Q3	Q4	Total YTD
Ward 112 EOU		7	4		11
Ward 218 (Neuro)	1		2		3
Ward 220	1				1
Ward 221	3	1	1		5
Ward 223	3	1	1		5
Ward 225	1	1			2
Ward 226	1	1	3		5
Ward 227 ARTU	2	1			3
Ward 228	2	1	5		8
Ward 231 (ASU)		3			3
Cardiac Critical Care		1			1
Orthopaedic OPD	13	8	9		30
Neurology OPD	6	5	4		15
Neurosurgical OPD	1	2	1		4
Cardiology OPD		3	4		7
Specialised Admin	3	9	2		14
Total	**37**	**44**	**36**		**117**

Within specialised, the areas with the highest number of complaints in Q3 are from Ward 112, Ward 228, Orthopaedic OPD, Neurology OPD and Cardiology OPD. The key themes identified within these areas are listed below:

- **Cancelled out-patient appointment (by hospital).** Attempts were made to bring the appointment forward as additional clinic capacity was identified.
- **Delay in clinic appointment.** Long waits and limited seating capacity in fracture clinic. Patients attending Ed are now given a specific time to attend fracture clinic rather than just being asked to turn up. Pagers available for patients who have a long wait.
- **Communication.** Trauma patients often have very complex needs. Staff trained to break information sharing down into the right language at the right time to support patient understanding/shared decision making.
- **Communication.** The information provided to patients preoperatively is under review to ensure that patient understanding of the assessment process for care package and/or equipment on discharge are met.

Other key quality and safety indicators are triangulated for each of the areas above in section 5 of the report to identify and inform focused improvement.

CWD Division

Ward/Dept. Name	Q1	Q2	Q3	Q4	Total YTD
Ward 201	1	1			2
Ward 202	2	8	1		11
Ward 205			3		3
Ward 206	1	1	2		4
Ward 215	1				1
Ward 216	1		1		2
MAU			3		3
Delivery Suite & Theatre	4	2	2		8
Midwife Led Service		1			1
Gynae			2		2
Children's Assessment Unit	2	1			3
OPD and diagnostics	24	9	10		43
MRI			1		1
CWD Admin	1	1	4		6
Total	**37**	**24**	**29**		**91**

Within CWD the areas with the highest number of complaints in Q3 are Ward 205, MAU, Outpatient & Diagnostic departments and CWD administration. The key themes identified within these areas are listed below:

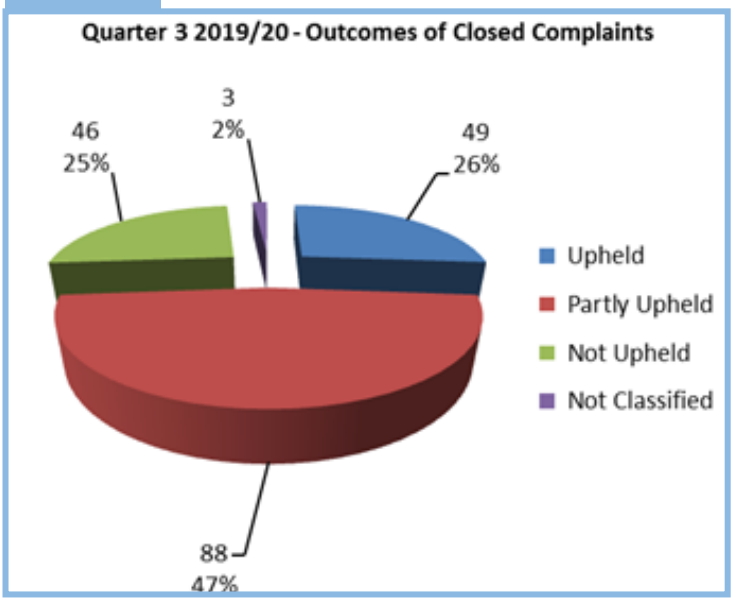
- **Inconvenience for cancer patients requiring a prescription.** The design of the Cancer Centre is under review to improve the patient experience. This includes the possibility of a pharmacy within the building.
- **Communication.** Feedback from patients who have struggled to understand the explanation about their care and treatment is shared with the relevant Consultants to promote the use of teach back methodology in clinic.

Communication. Ensure that patients are fully aware of the reasons why questions are asked prior to x-rays being undertaken as part of the justification process. Ensure patients are always given an explanation on why they need to remove clothing which is to ensure that the area of the body that is being x-rayed is free from clothing that may show up on the x-ray.

Other key quality and safety indicators are triangulated for each of the areas above in section 5 of the report to identify and inform focused improvement.

2.4 Outcome of Closed Complaints

CHART 4



Of the 186 Complaints closed during Q3 26% (n=49) were upheld and 47% (n=88) were partly upheld. The total of upheld and partly upheld complaints for Quarter 3 is 73% compared to 72% in Q2.

The key themes of those complaints fully upheld were:

- Clinical Treatment (15)
- Appointments, including delays and
- cancellations (9)
- Values and Behaviours (staff) (5)
- Communications (5)

2.5 Complaints Completed Within Target Date

CHART 5

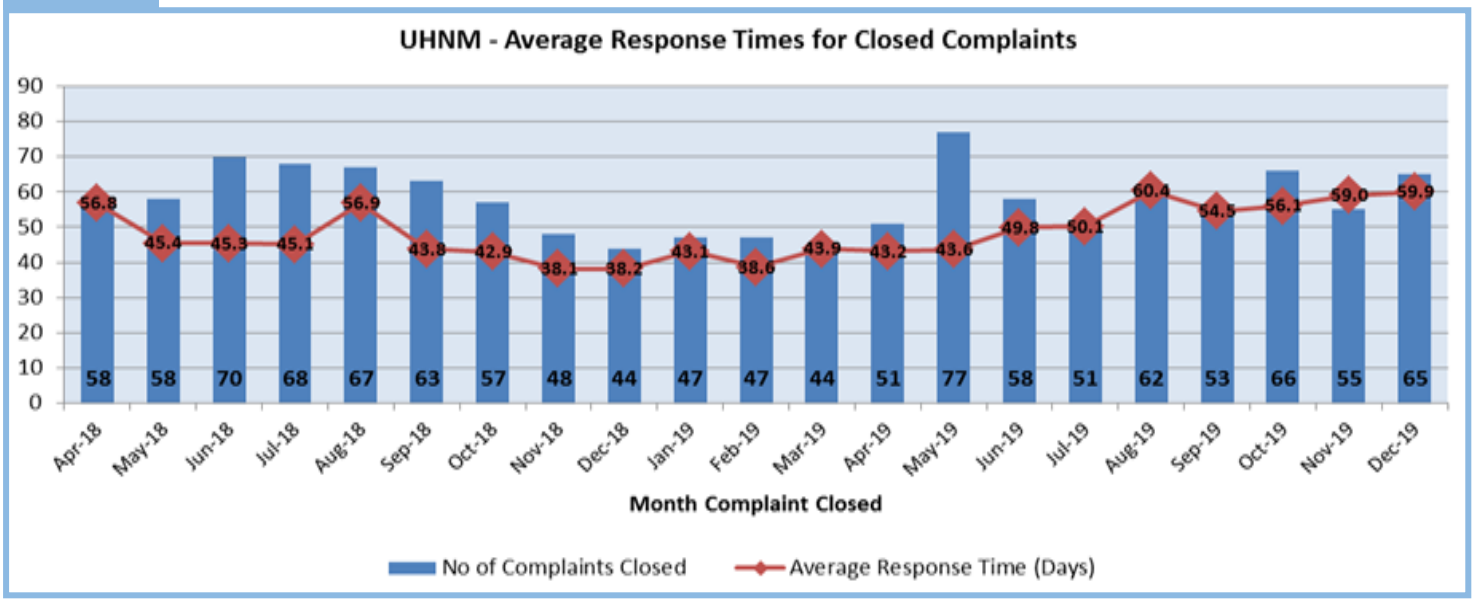


Chart 5 shows the average response time for closing complaints for UHNM since April 2018. The Trust's aim is to respond to all formal complaints within 40 days, however if the complaint is complex the deadline date may exceed this. The chart above shows that the average response time in Q3 was 59 days. On review, none of the Divisions are achieving the target average response time to complainants of 40 days. This is reflective of the increased number and complexity of the complaints received at RSUH. In response to this the complaints team have worked with the Associate Chief Nurses to expedite the sign off process, for example further questions that may arise at the final stage are now forwarded directly back to the directorate investigating manager rather than via the complaints department.

The number of complainants dissatisfied with their response is a further key target for the Trust. There is currently no target set for 2019/20 and therefore the number of reopened complaints during this period will be used as the baseline. During quarter 1 there were 29 re-opened complaints and 21 during quarter 2 with a further 17 re-opened during Q3.

2.6 Parliamentary Health Service Ombudsman (PHSO) Update

No. of cases	Q1 19/20	Q2 19/20	Q3 19/20	Q4 19/20	Totals
New referrals	6	2	2		
Closed	2	2	3		
Upheld					
Partly Upheld	1				
Not Upheld	1	2	2		

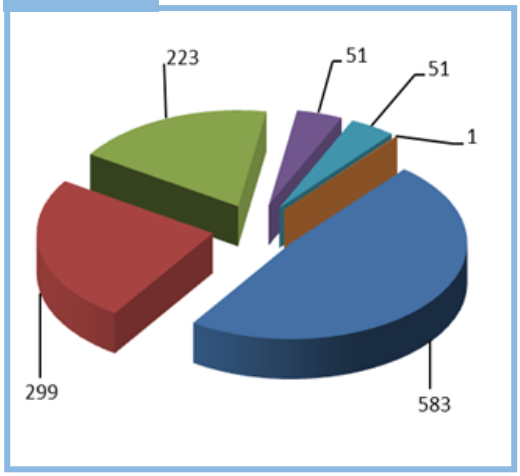
The number of complaints referred to the Ombudsman is a key indicator for the trust. There is currently no target set for 2019/20 and therefore the number referred during this period will be used as a baseline.

During Q3 no complaints were upheld by the PSO and 1 was closed with no further action.

2.7 PALS Contacts

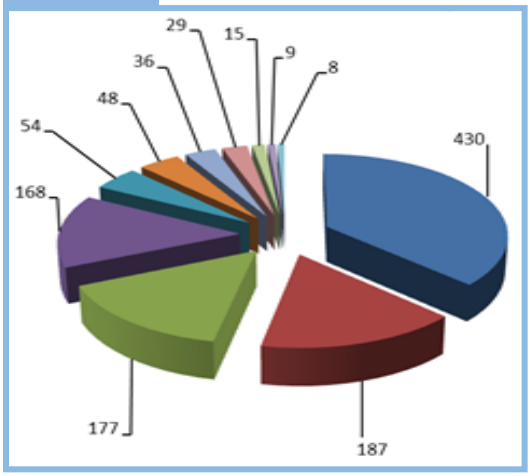
In Q3 there were 1,338 contacts closed at the PALS stage, which are broken down into categories in Chart 6. Chart 7 shows the outcomes of those contacts.

CHART 6



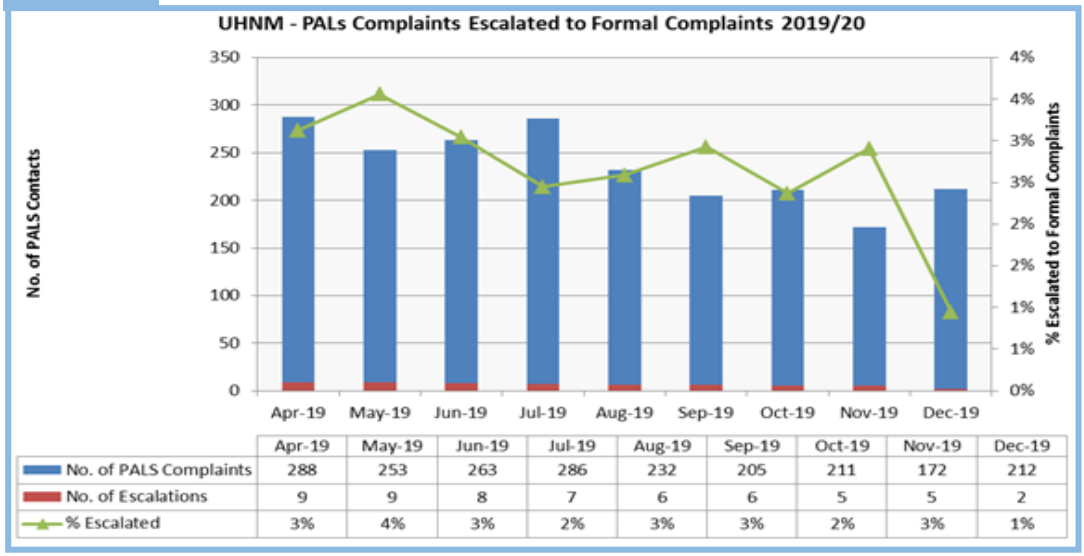
	Complaint
	General Enquiry
	GP Concern
	Feedback
	Compliments
	Other

CHART 7



	Information Given		Not Specified
	Not Needed to Continue		Referred (to more appropriate person)
	Happy with Outcome		Unhappy with Outcome
	Accepted the Outcome		Passed to Formal Complaints
	Resolved		Informal Meeting
	Compliment Passed On		

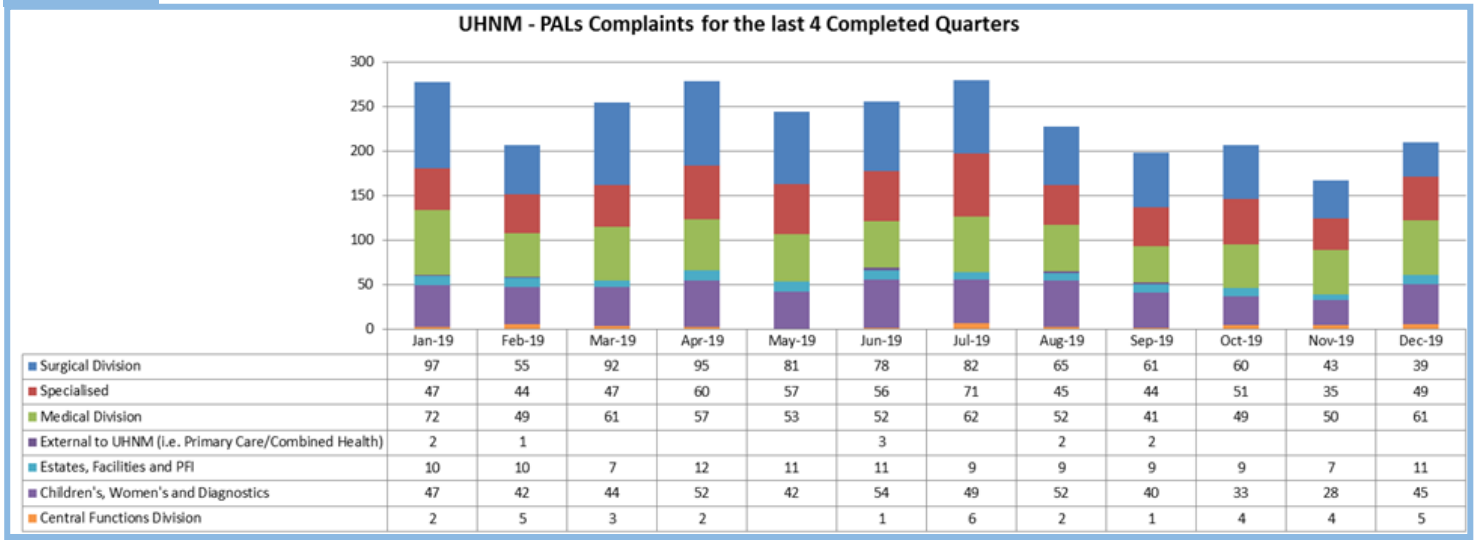
CHART 8



	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
No. of PALS Complaints	288	253	263	286	232	205	211	172	212
No. of Escalations	9	9	8	7	6	6	5	5	2
% Escalated	3%	4%	3%	2%	3%	3%	2%	3%	1%

The number of PALs enquiries converting to a formal complaint is a key indicator for the Trust. There is currently no target set for 2019/20 and therefore the number converting during this period will be used as a baseline. Chart 8 shows the monthly PALs to complaints conversions. During Q3 2% of PALs enquiries were converted into a complaint.

CHART 9



	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
Surgical Division	97	55	92	95	81	78	82	65	61	60	43	39
Specialised	47	44	47	60	57	56	71	45	44	51	35	49
Medical Division	72	49	61	57	53	52	62	52	41	49	50	61
External to UHNM (i.e. Primary Care/Combined Health)	2	1				3		2	2			
Estates, Facilities and PFI	10	10	7	12	11	11	9	9	9	9	7	11
Children's, Women's and Diagnostics	47	42	44	52	42	54	49	52	40	33	28	45
Central Functions Division	2	5	3	2		1	6	2	1	4	4	5

Those wards/departments receiving the most PALs complaints are triangulated with other key quality and safety indicators in section 5 of the report to identify and inform focused improvement.

The key themes of the 583 PALS complaints in Q3 were:

- Appointments including delays and cancellations
- Communication
- Clinical treatment

Example of concerns received and actions taken.

A patient contacted PALS as she was consistently not receiving letters from the hospital and therefore missing her appointments. It was identified that her address had incorrectly been entered on to the system and the department team believed that this could only be changed by the patients GP. The PALS officer discussed this with the department team leader who explained to her staff that they did have access to the National Spine and could therefore contact the GP for confirmation of the correct address. This was then resolved immediately to the patients satisfaction.

A mother brought her son, with Cerebral Palsy, into A&E on a Friday morning at 08:30. A chipped ankle bone was diagnosed and she was asked to bring him back to fracture clinic on the Monday morning. When they arrived home her son was in agony with the pain so mum phoned PALS for advice. The PALS officer immediately phoned the fracture clinic who agreed for mum to bring her son back to the hospital. A back slab was applied to provide support and comfort for the son until he could be seen by the clinician on Monday morning.

3 FRIENDS AND FAMILY TEST

The Friends and Family Test (FFT) is a national survey designed to give the public an easy way to express their feedback and is a key indicator for the Trust. Feedback is received from patients, within 48 hours of discharge, either via paper, electronic or automated telephone call.

3.1 Inpatients

CHART 10

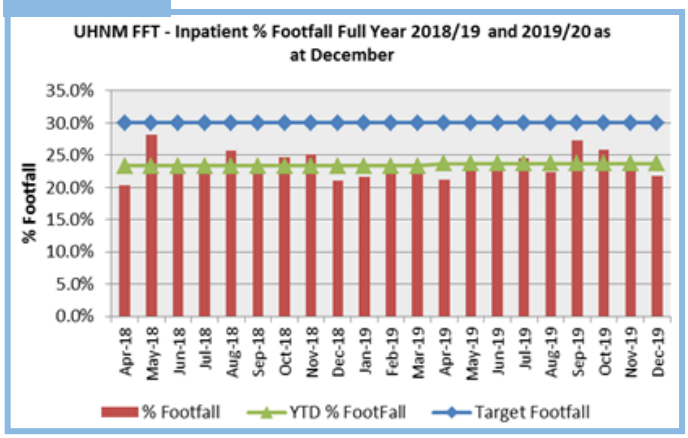


CHART 11

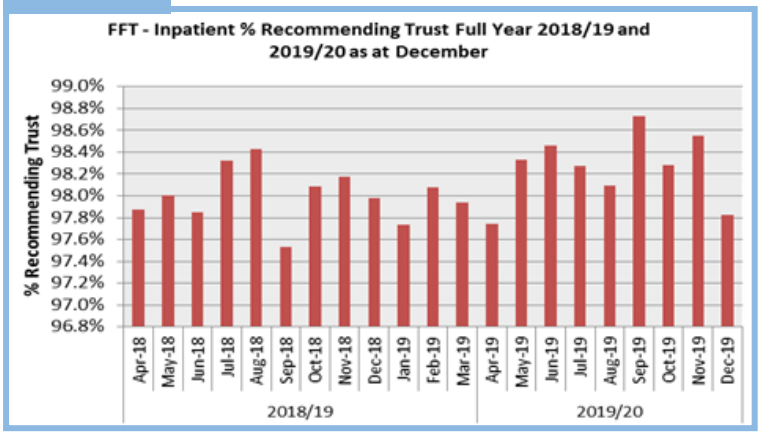


Chart 10 shows the response rate for adult inpatient wards from April 2018 to Dec. 2019. The response rates described as 'footfall' are the numbers of patients completing the questionnaire within 48 hours of discharge. Chart 11 shows that the percentage recommendation score for adult inpatients remains consistently high with an average score of 98.3% which exceeds the national average of 96%.

The number of patients responding during Q3 was 8417 resulting in a 23% response rate. Whilst the Trust is underachieving against its internal target of 30%, Chart 12 below shows our inpatient footfall rate places us 5th in the league compared to our peers and all other remaining Trusts combined.

Chart 12

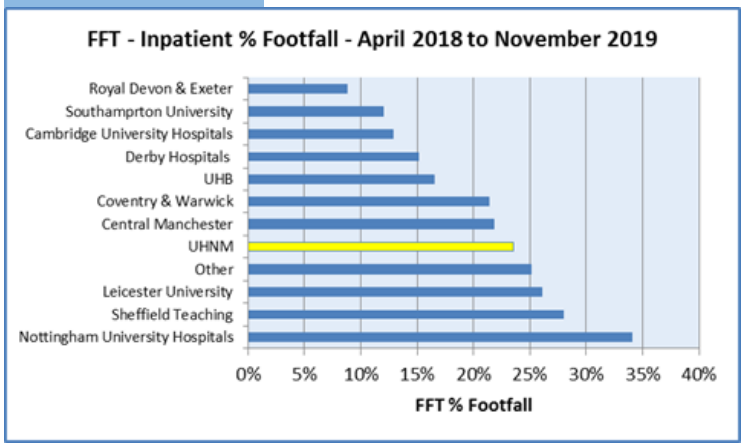


Chart 13

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3.2 FFT by Division and Ward

Medical Division

Overall the response rate within medicine inpatients for Q3 is 40% with an average likely to recommend score of 98%.

Ward	AMU	75	76a	76b	80	81	113	117	124	126
Response Rate (%)	9	15	96	42	22	18	22	48	89	63
Recommendation	97	100	96	100	98	100	97	100	100	98

							County:				
Ward	127	222	230	232	233	FEAU	AMU	7	12	14	15
Response Rate (%)	38	45	54	19	34	13	2	10	30	39	16
Recommendation	98	97	100	100	100	100	100	100	98	98	100

The table above shows that there are 10 wards not achieving the target response rate of 30%, i.e. AMU (Royal) (9%) AMU (County) (2%), Ward 75 (15%) Ward 80 (22%), Ward 81(18%), Ward 113 (22%), Ward 232 (19%), FEAU (13%), and Ward 7 (County) (10%) and Ward 15 County (16%).

Because of the low response rate in these areas the percentage recommendations are not reliable. Those areas which are failing to achieve the minimum expected response rate are triangulated with other key quality and safety in section 5 of the report to identify and inform focused improvement.

Surgical Division

Overall the response rate within surgery inpatients is 35% with an average likely to recommendation score of 98%.

Ward	100	102	103	106/107	108	109	110	111	8 (County)
Response Rate (%)	45%	31%	19%	8%	22%	38%	74%	34%	48%
Recommendation	97%	97%	99%	98%	100%	97%	99%	95%	99%

The table above shows that there are 3 wards not achieving the target response rate of 30%, i.e. Ward 103 (19%), Ward 106/107 (8%) and Ward 108 (22%).

These areas which are failing to achieve the minimum expected response rate are triangulated with other key quality and safety in section 5 of the report to identify and inform focused improvement.

Specialised Division

The average response rate within specialised inpatients is 62% with an average likely to recommend score of 98%.

Ward	112	218	220	221	223	225	226	227	228	231	EOU (County)
Response Rate (%)	54%	43%	37%	36%	38%	71%	91%	83%	68%	71%	91%
Recommendation	98%	98%	99%	100%	99%	97%	98%	95%	98%	99%	100%

The table above shows that all of the Wards in the Specialised Division have achieved the target response rate of 30% during Q3 with the majority far exceeding this.

This demonstrates a culture which is fully supportive of the benefits of listening to our patients to inform improvement.

3.3 Emergency Department

CHART 14

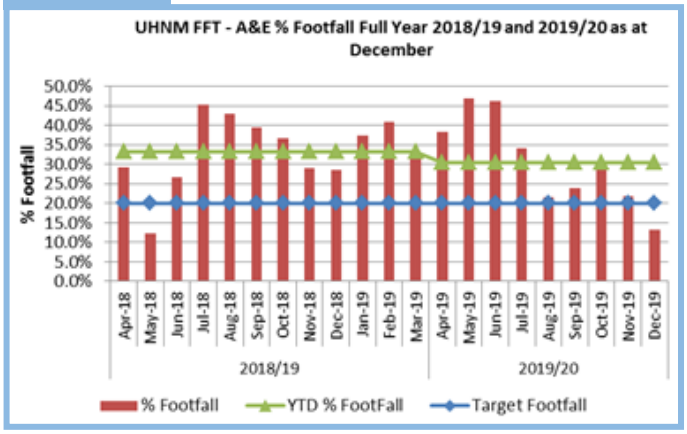


CHART 15

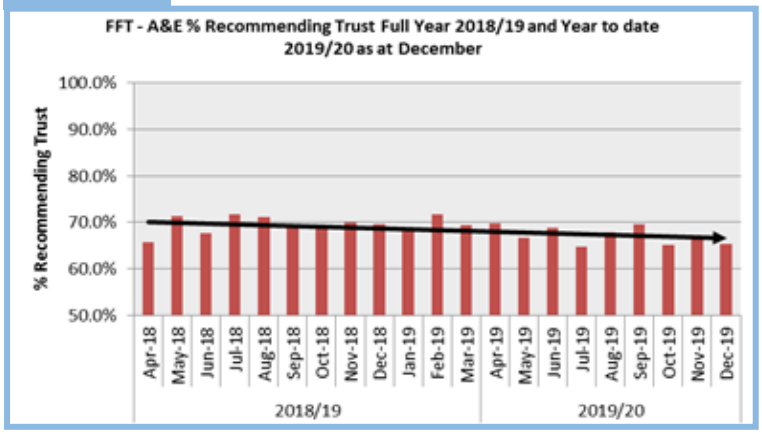


Chart 14 shows the footfall for A&E from April 2018 to December 2019. This represents the number of patients who completed the FFT questionnaire within 48 hours of being discharged from A&E. During Q3 6,920 patients responded resulting in an average response rate of 18% comparing favourably to the National response rate of circa 12%

Chart 15 is showing no improvement in the percentage recommending score for A&E compared to the previous 6 months. This remains well below the national average of 88%. These results are triangulated with other key quality and safety indicators at the end of the report to identify and inform focused improvement.

The Trust Board have questioned the A&E Friends and Family Test performance which is consistently below the national average. These results should be viewed with caution as:

- There are only a handful of Trusts who have an average response rate (12%) and an average likely to recommend rate (84%). As the national average response rate is so low the results are unlikely to be statistically significant.
- There are many Trusts who have a very poor response rate and a higher than average likely to recommend score which falsely pushes the overall national average likely to recommend score up.

Patient feedback tells us that:

- UHNM waiting times have an impact on patient satisfaction for those patients who have been discharged from A&E (there tends to be a more positive response when we talk to patients who had a long wait but were eventually admitted as they feel they are safe and in the right place).
- The most current theme for dissatisfaction from patient feedback continues to be long waits, followed by communication and this is consistent with other Trusts.

Sharing best practice: some ideas that work in other Trusts:

- Waiting patients who are regularly updated by a nurse are more likely to report a positive experience. It is the waiting and not knowing what is happening that increases patients anxiety
- Always inform patients what will happen next and roughly how long before this happens
- Never make a person feel they are wasting our time by coming to ED
- Ensure patients know who to call/what to do if they feel unwell/concerned after they have been discharged (some Trusts have an ED helpline)
- Look at lighting, seating and general environment in the ED waiting rooms
- Develop a video to introduce ED staff, procedures and common reasons for delay to show on the screens in the waiting areas
- Some Trusts ask for feedback via text and this gives an opportunity to ask them to contact to discuss if they are dissatisfied. We don't have that facility with the automated telephone call but there would be a significant cost to introducing this.

3.4 Maternity

CHART 16

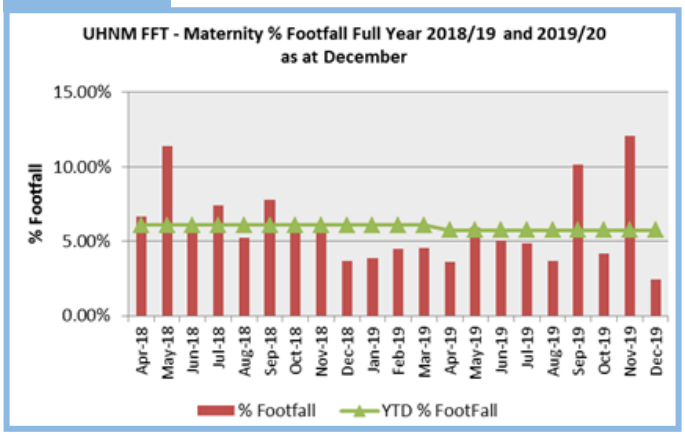


CHART 17

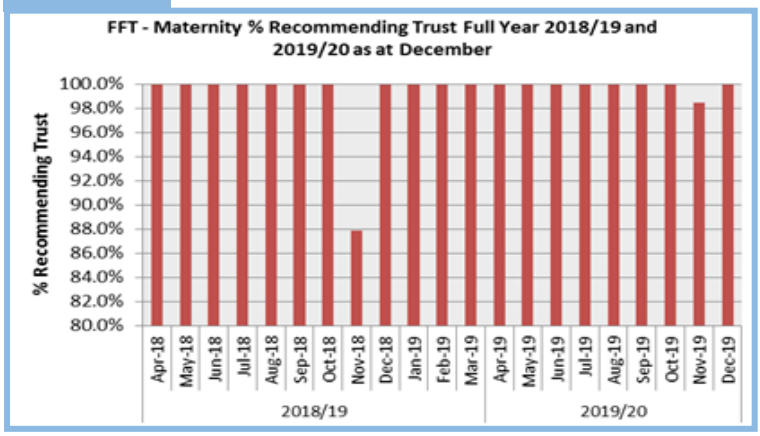


Chart 16 shows that maternity services are significantly underperforming against the Trusts internal target of 30% footfall, which means that the recommendation score of 100% indicated in chart 17 is unreliable.

Maternity have purchased 10 iPad's through charitable funds to encourage parents to provide their feedback electronically.

3.5 Outpatients

CHART 18

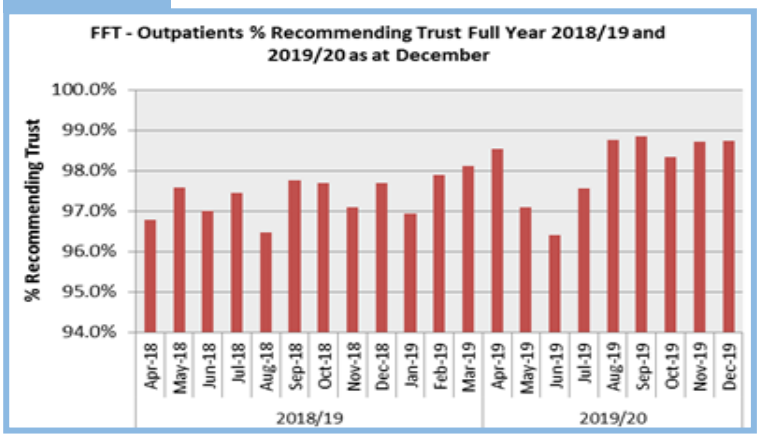
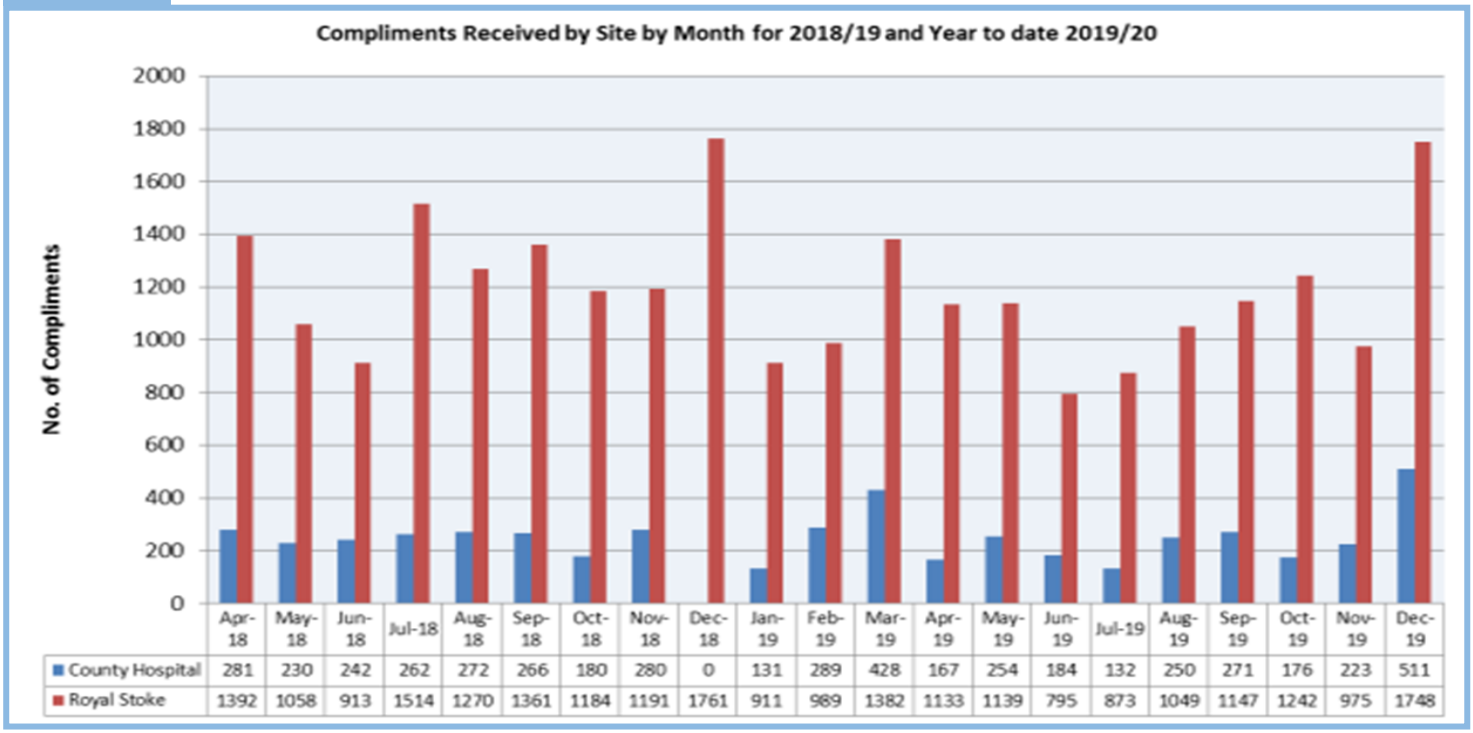


Chart 18 shows that the outpatients consistently exceed 96% recommendation score. The response rate for outpatients is not reported nationally.

4 COMPLIMENTS

Chart 17 shows the number of reported compliments received by UHNM per month since April 2018. These compliments are given in a wide variety of formats including social media and patient stories.

CHART 19



	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
County Hospital	281	230	242	262	272	266	180	280	0	131	289	428	167	254	184	132	250	271	176	223	511
Royal Stoke	1392	1058	913	1514	1270	1361	1184	1191	1761	911	989	1382	1133	1139	795	873	1049	1147	1242	975	1748

Compliment received:

"I am contacting you having just be discharged from ward 107 at Royal Stoke Hospital following an emergency operation for an acute hernia incarceration and a weeks nursing to recover. I felt that every aspect of my stay was excellent.

The staff on the Surgical Assessment Unit were professional and effective. My surgical team led by Ms Hall was excellent. At every point, I was fully informed and reassured by the calmness and professionalism of the team. As an ex healthcare worker, who worked in theatre myself., I cannot recommend this team highly enough. In my opinion they are one of the best teams I have had experience with.

The staff on ward 107 were committed and showed a high degree of professional ability . They were always approachable and responsive to concerns and questions. Their skills were appreciated and reassuring during a time which could have been painful and scary. You have an effective and friendly team there. I felt that they managed my recovery extremely well.

I should also mention the porters and x-ray staff who were equally prompt, effective and efficient. Whilst no one chooses to stay in hospital, I felt that during my stay, I was in very good hands throughout.".

5 TRIANGULATION AND EVALUATION OF INFORMATION GATHERED IN Q3

5.1 Medicine

Ward	Complaints	PALS	FFT % Footfall	FFT Score %	Plaudits	SI's	Falls		Pressure Ulcers (cat 2 and above).		Medication Incidents		Latest CEF Results	Staffing (average CHPPD for quarter)		
							Per 1000 bed days	Number of falls	Per 1000 bed days	Number of ulcers	Per 1000 bed days	Number of errors		Reg.	UnReg.	Total
233	4	8	34%	100%	90	0	4.66	16	0.58	2	2.62	9	silver	3.0	3.2	6.2
ED (RSUH)	22	62	23%	60%	0	3	N/A	0	N/A	0	N/A	0	silver			
ED (County)	6	32	16%	70%	27	0	N/A	3	N/A	0	N/A	21	silver			
AMU (RSUH)	7	9	9%	97%	27	0	6.04	23	0	5	0	15	gold	4.9	4.8	9.7
AMU (County)	1	6	2%	100%	141	0	7.23	17	0	0	7.23	17	silver	5.6	4.5	10.2
75	0	1	15%	100%	8	0	1.69	1	0	0	71.43	5	silver	3.2	5.2	8.5
232	3	9	19%	100%	224	0	7.20	19	0.58	2	2.62	9	gold	3.0	6.1	9.1
FEAU	0	2	13%	100%	48	0	8.40	17	0	0	32.22	29	silver	6.9	3.4	10.4
7	5	4	10%	100%	43	2	9.71	29	0	0	0	0	silver	3.1	3.7	6.8
15	0	5	16%	100%	168	0	9.30	24	0	0	3.35	10	gold	2.9	4.0	6.9

The national average for falls per 1,000 bed days is 5.6. There is no similar comparator for pressure ulcers or medication errors.

The table above highlights the hotspot areas in medicine.

Wards 233, Royal AMU, Ward 7, Ward 232, ED at Royal and ED at County have high numbers of complaints with only Ward 233 achieving the target 30% FFT footfall rate and a 100% recommendation score. Wards 233, 75, 15 and 7 are not achieving the national average for CHPPD of 8.9 (registered nurses 5.1 and Unregistered 3.8). However, during this quarter these wards did/did not report any "red flags" regarding staffing. ED at Royal and Ward 7 at County have both reported patient harm incidents. These wards therefore need to be monitored in terms of the number of complaints/PALs and improvement in their CEF Award.

AMU, Ward 7 and Ward 15 at County and AMU, Ward 232 and FEAU at Royal are hotspot areas with regards to falls. All of these areas have an improvement plan in place and are supported by the Quality Improvement Team.

Both AMUs have got good CHPPD numbers however both have a high number of PALs concerns and very low response rates to the FFT making the recommendation score unreliable. Both AMUs are also reporting high medication errors. Both of these areas have an improvement plan in place and are supported by the Quality Improvement Team.

The Emergency Departments on both sites are of concern with regard to the number of complaints/ PALs and the number of harm incidents reported by RSUH ED. Both departments have received Silver CEF awards indicating that there is room for improvement. The departments have a comprehensive improvement plan in response to this which is monitored through the Divisional Governance meeting.

All areas above should be actively encouraged to improve their FFT response rate.

5.2 Surgery

Ward	Complaints	PALS	FFT % Footfall	FFT Score %	Plaudits	SI's	Falls		Pressure Ulcers (cat 2 and above).		Medication Incidents		Latest CEF Results	Staffing (average CHPPD for quarter)		
							Per 1000 bed days	Number of falls	Per 1000 bed days	Number of ulcers	Per 1000 bed days	Number of errors		Reg.	UnReg.	Total
SACU/SAU	4	15	45%	97%	0	0	1.27	3	0.42	1	2.12	5	silver	5.0	4.0	9.0
103	2	5	19%	99%	245	0	4.97	10	0	0	2.28	2	gold	3.4	2.3	5.6
106/107	5	7	8%	98%	0	0	1.93	5	0.39	1	1.54	4	silver	3.2	2.5	5.7
108	0	11	22%	100%	31	0	2.23	5	0	0	0.45	1	silver	3.5	2.3	5.9
Surgical OPD	13	42	N/A	99%	0	0	0	0	0	0	0	0	platinum			
Admin and Management	5	78	N/A	N/A	0	0	0	0	0	0	0	0	N/A			

The national average for falls per 1,000 bed days is 5.6. There is no similar comparator for pressure ulcers or medication errors.

The table above highlights the hotspot areas in Surgery

SACU/SAU, 106/107, OPD and Surgical Admin all have high numbers of complaints with only Ward SACU/SAU achieving the target 30% FFT footfall rate. Wards 103, 106/107 and 108 are not achieving the national average for CHPPD of 8.9 (registered nurses 5.1 and Unregistered 3.8). However, during this quarter only Ward 108 reported concerns with 5 "red flags" as a result of staffing shortages. None of the areas reported patient harm incidents. These wards therefore need to be monitored in terms of the number of complaints/PALs and improvement in their CEF Award.

Surgical OPD, administration and management raise cause for concern predominately around waiting times and multiple cancellations

None of the above are hotspot areas with regards to falls exceeding the national average per 10,000 bed days.

Although the FFT scores are above the national average the low response rates for Wards 103, 106/107 and 108 makes the recommendation scores unreliable. These areas should be actively encouraged to improve their FFT response rate to at least 30%.

5.3 Specialised

Ward	Complaints	PALS	FFT % Footfall	FFT Score %	Plaudits	SI's	Falls		Pressure Ulcers (cat 2 and above).		Medication Incidents		Latest CEF Results	Staffing (average CHPPD for quarter)		
							Per 1000 bed days	Number of falls	Per 1000 bed days	Number of ulcers	Per 1000 bed days	Number of errors		Reg.	UnReg.	Total
Ward 112 EOU	4	0	54%	98%	120	0	3	5	0	4	2.40	4	silver	4.8	3.0	7.8
Ward 228	5	9	68%	98%	85	0	11.3	32	0	0	0.35	1	silver	3.6	2.9	6.5
Orthopaedic OPD	9	12	N/A	100%	0	0	0	0	0	0	0	0	gold			
Neurology OPD	4	20	N/A	94%	0	0	0	0	0	0	0	0	platinum			
Cardiology OPD	4	33	N/A	100%	0	0	0	0	0	0	0	0	platinum			

The table above highlights the hotspot areas in Specialised

All have a high numbers of complaints with only Ward 112 having no PALS concerns raised suggesting that any concerns raised are dealt with in a timely, appropriate way on the ward without the need for escalation. Both Ward 112 and Ward 228 consistently achieve the target 30% FFT footfall rate. Wards 112 and 228 During this quarter Ward 228 reported concerns with 5 "red flags" as a result of staffing shortages. None are achieving the national average for CHPPD of 8.9 (registered nurses 5.1 and Unregistered 3.8). the areas reported patient harm incidents. These wards therefore need to be monitored in terms of the number of complaints/PALs and improvement in their CEF Award.

Ward 228 is a hotspot areas with regards to falls exceeding the national average per 10,000 bed days.

Neurology OPD has a FFT likely to recommend score below the national average. The Divisional Lead is currently taking the lead on improvement with a review of the current service.

5.4 CWD

Ward	Complaints	PALS	FFT % Footfall	FFT Score %	Plaudits	SI's	Falls		Pressure Ulcers (cat 2 and above).		Medication Incidents		Latest CEF Results	Staffing (average CHPPD for quarter)		
							Per 1000 bed days	Number of falls	Per 1000 bed days	Number of ulcers	Per 1000 bed days	Number of errors		Reg.	UnReg.	Total
205	3	2	N/A	100%	78	0	0	0	0	0	0	1	silver	5.9	2.0	7.8
Midwife Led Service	3	8	N/A	0	0	0	0	0	0	0	0	0	platinum			
OPD and diagnostics	10	0	N/A	98%	0	0	N/A	2	N/A	0	N/A	7	gold			
CWD Admin	4	0	N/A	N/A	0	0	N/A	0	N/A	0	N/A	0	N/A			

The table above highlights the hotspot areas in CWD

OPD and Diagnostics have the highest number of complaints, however they also have a high footfall. During Q3 there were no "red flags" raised as a result of staffing shortages. Ward 205 is not achieving the national average for CHPPD of 8.9 (registered nurses 5.1 and Unregistered 3.8). There were no reported patient harm incidents. Ward 205 therefore needs to be monitored in terms of the number of complaints/PALs and improvement in their CEF Award

6 SUMMARY AND CONCLUSION

In summary, the Patient Experience Report is telling us that there is a decrease in the number of complaints received. The top 90% of complaints in Q3 2019/20 fall into 7 complaint types predominantly relating to aspects of clinical treatment, patient care and communication. The two highest themes in the Clinical Treatment category relate to diagnosis and issues following surgery or a procedure. These themes are also reflected in the type of PALs contacts and FFT responses.

The report demonstrates that 73% of the complaints are upheld or partly upheld, the majority of which relate to clinical treatment. It also shows that none of the Divisions or the Trust overall is achieving its target response time to complaints of 40 days. This needs to be a focus for improvement within the Divisions.

There has been a reduction in the number of PALS concerns received compared to Q2 with Appointments including delays and cancellations, Communication and clinical treatment as the top 3 themes.

The Inpatient Friends and Family Test indicates that whilst we are not achieving our internal target response rate of 30% we are 5th in the league compared to our Peers and all other remaining Trusts combined. The inpatient recommendation score averages 98% which is significantly higher than the National average of 96%.

Through the triangulation of key quality and safety indicators the report indicates the hotspot areas which need focus for improvement and monitoring through the Divisional Board Meetings, the Quality and Safety Oversight Group and the Divisional Performance Reviews.

Specifically, the Medicine Division needs to focus on learning from complaints, improve their response time to complainants, improve their FFT response rate, reduce falls and medication errors. Staffing should remain an area of consideration specifically on wards 233, 113 and ward 7.

The Surgical Division should consider focus on recruitment and retention for hot spot areas and encourage FFT feedback to initiate improvement based on what matters to our patients.

The ED FFT is underachieving the target response rate and the recommendation rate despite continued efforts to improve. New approaches to address these concerns are being discussed.

The Specialised Division should consider staffing on Wards 112 and 228 with a specific focus on Ward 228 regarding falls, pressure ulcers and medication incidents. The Specialised OPD areas should focus on learning from complaints and PALS concerns

The Maternity FFT is achieving 100% recommendation rate, however the significant underachievement of the target response rate means the recommendation is unreliable. All areas across the 4 Maternity touch points are encouraged to gain feedback through a variety of routes for convenience.

The OPD FFT is consistently exceeding the national average recommendation score of 96%. Although the response rate is not measured in OPD the number of patients providing feedback has fallen over quarter 3 therefore, for assurance of patient satisfaction concentration to improve this during Q4 is required.

Performance and Finance Committee Chair's Highlight Report to Board

25th February 2020

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• Cancer performance remains below target with the West Midlands Region being at the worst for performance in the Country; largely attributed to the increase in referrals in line with NICE guidelines • Ability to deliver the savings identified within the system wide financial plan for 2020/21 • Concern expressed with regard to the levels / lack of productivity savings identified within the Contract Award Report	• Working with a number of other organisations, the Intensive Support Team and NHSE/I and have strengthened cancer performance governance arrangements to support the improvements / transformation programme • Strategy for capital funding over the next 5 years to be set out to the Committee • Draft Financial Plan for 2020/21 continues to be developed and will be submitted on 5th March with a final version to be submitted on 29th April – discussion regarding Risk Appetite will need to take place • Implementation of Windows 10 as part of an organisation wide replacement programme • Commercials / partnership agreement remain underway with regard to the implementation of the Pathology Network
Positive Assurances to Provide	**Decisions Made**
• Principle approval has been given for non-recurrent funding to support improvement to the colorectal cancer pathway; this is in addition to the central investment allocation for 2020/21 against which cancer is being identified as a top priority • A Cancer Improvement Plan is in place which seeks to recover performance by the end of Quarter 2 2020/21 • Within Urgent Care there has been a specific focus on a number of 'quick wins' in terms of de-escalation, additional weekend workforce, speciality in-reach; progress has been seen in all of these areas during January alongside a reduction in flu cases / ED attendances which has helped to improve performance • Financial position at month 10 is £2.6m surplus which is £6.2m better than plan	• Draft Capital Plan for 2020/21 approved by the Committee • Data, Security and Protection Strategy approved by the Committee • Business Case for Windows 10 Device Replacement recommended to the board for approved by the Committee • Transforming Outpatients Business Case approved *in principle* for submission to NHSIE with some caveats agreed

Comments on the Effectiveness of the Meeting

- Time spent per item needs to be flexible and in accordance with the annual cycle
- Helpful to have some key slides being made available to the Committee in order to focus the discussion – this will be addressed through the new Executive Summary

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	Cancer Improvement Programme	Assurance	6.	Month 10 CIP Report	Assurance
2.	Month 10 Operational Performance Report	Assurance	7.	Data, Security and Protection Strategy	Approval
3.	Month 10 Finance Report	Assurance	8.	Business Case Approvals: • BC-0351 Windows 10 Device Replacement • Transforming Outpatients • Pathology Network Update	Approval
4.	Financial Plan 2020/21 Update	Assurance	9.	Business Case Reviews	Information
5.	Draft Capital Plan 2020/21 and Future Years	Assurance	10.	Authorisation of New Contract Awards and Extensions	Approval

3. 2019 / 20 Attendance Matrix

			Attended	Apologies & Deputy Sent	Apologies

Members:			A	M	J	J	A	S	O	N	D	J	F	M
Mr P Akid	PA	Non-Executive Director												
Ms H Ashley	HA	Director of Strategy & Performance												
Ms S Belfield	SB	Non-Executive Director												
Mrs T Bullock	TB	Chief Executive												
Mr P Bytheway	PB	Chief Operating Officer										BW	BW	
Prof G Crowe	GC	Non-Executive Director												
Dr L Griffin	LG	Non-Executive Director												
Mr M Oldham	MO	Chief Finance Officer												
Mrs S Preston	SP	Strategic Director of Finance												
Mrs M Ridout	MR	Director of PMO												
Miss C Rylands	CR	Associate Director of Corporate Governance	NH	NH	NH	NH	NH		NH	NH	NH			
Mr J Tringham	JT	Director of Operational Finance												
Mrs R Vaughan	RV	Director of Human Resources			CS					CS				

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	11th March 2020
Report Title:	Month 10 Finance Report – 2019/20	**Agenda Item:**	13
Author:	Jonathan Tringham, Director of Operational Finance Sarah Preston, Strategic Director of Finance		
Executive Lead:	Mark Oldham, Chief Finance Officer		

Purpose of Report:					
Assurance	✓	**Approval**		**Information**	

Alignment to Strategic Objectives:			
SO1		Provide safe, effective, caring and responsive services	
SO2		Achieve NHS constitutional patient access standards	
SO3		Achieve excellence in employment, education, development and research	
SO4		Lead strategic change within Staffordshire and beyond	
SO5		Ensure efficient use of resources	✓

Summary of other meetings discussed with and outcome of discussion:

n/a

Summary of Report, Key Points for Discussion including any Risks:

This report presents the financial performance of the Trust for January (Month 10); key elements of the financial performance for the year to date are:

- The actual year to date performance of a £2.6m surplus is £6.2m better than the Trust's plan for a £3.6m deficit for the first 10 months of the year.
- Total Commissioning income is £1.9m behind plan for the year to date; within this Electives and Critical Care are under recovered by £2.1m and £1.6m respectively offset by Tariff excluded Drugs income which is £4.9m above plan for the year to date.
- Pay expenditure is £6.2m better than plan with the most significant variances being within Registered Nursing (£3.9m) and NHS Infrastructure (£3.1m) which are both underspent for the year to date.
- Non pay expenditure is £2.4m overspent although within this pass through drugs is £5.8m overspent.
- The Trust has delivered £28.8m CIP for the year to date which is £1.6m behind plan; in month the Trust has delivered £3.8m CIP which is £0.2m behind the final plan submitted to NHSI in April.
- Capital expenditure for the year to date stands at £12.9m which is £0.8m behind of plan.
- The month end cash balance is £21.2m which is £13.2m higher than plan.
- The Trust continues to assume that it will receive FRF and PSF funding in full.

Key Recommendations:

The Trust Board are asked to consider and review this report.

Subject

Month 10 Finance Report 2019/20

1. Overall Summary

The Trust achieved a surplus of £2.5m in Month 10 against a planned surplus of £1.9m. The Month 10 year to date plan is to deliver a £3.6m deficit; the actual performance of a £2.6m surplus is a £6.2m positive variance to plan.

The table below provides a summary Income and Expenditure position for Month 10 and for the year to date.

I&E Summary (£'m)	Annual Plan	In Month			YTD		
		Plan	Actual	Variance	Plan	Actual	Variance
NHS Patient Income	636.2	53.3	52.8	(0.5)	529.9	523.2	(6.7)
Tariff Excluded Drugs Income	53.6	4.6	5.9	1.2	44.7	49.6	4.9
Total Commissioning Income	689.7	57.9	58.7	0.7	574.6	572.7	(1.9)
Private Patients / ICR	4.1	0.3	0.4	0.1	3.4	4.2	0.8
Other Non Clinical Income	82.0	6.8	8.0	1.1	68.2	70.6	2.3
Total Income	775.8	65.1	67.1	1.9	646.2	647.5	1.3
Medical	(145.8)	(12.3)	(12.7)	(0.5)	(121.3)	(123.0)	(1.7)
Registered Nursing	(148.1)	(12.6)	(12.3)	0.3	(123.0)	(119.1)	3.9
Scientific Therapeutic & Technical	(54.8)	(4.6)	(4.6)	(0.0)	(45.5)	(45.2)	0.3
Support to Clinical	(63.5)	(5.4)	(5.3)	0.1	(52.8)	(52.2)	0.6
Nhs Infrastructure Support	(75.5)	(6.2)	(5.9)	0.2	(62.9)	(59.7)	3.1
Total Pay	(487.6)	(41.1)	(40.9)	0.2	(405.5)	(399.3)	6.2
Tariff Excluded Drugs Expenditure	(53.0)	(4.6)	(6.3)	(1.8)	(44.2)	(50.0)	(5.8)
Other Drugs	(21.8)	(1.8)	(1.7)	0.1	(18.3)	(17.8)	0.5
Supplies & Services - Clinical	(69.7)	(5.7)	(5.8)	(0.1)	(58.4)	(58.8)	(0.4)
Supplies & Services - General	(7.5)	(0.8)	(0.7)	0.1	(6.3)	(6.1)	0.2
Purchase of Healthcare from other Bodies	(12.0)	(1.0)	(1.0)	(0.0)	(10.1)	(10.2)	(0.2)
Consultancy Costs	(3.5)	(0.3)	(0.3)	0.0	(3.0)	(3.0)	(0.1)
Clinical Negligence	(20.6)	(1.8)	(1.8)	(0.0)	(17.7)	(17.7)	(0.0)
Premises	(28.5)	(2.6)	(2.8)	(0.2)	(24.0)	(23.6)	0.4
Depreciation	(27.8)	(2.3)	(2.3)	0.0	(22.7)	(22.5)	0.2
Other	(51.1)	(2.9)	(2.6)	0.3	(43.9)	(41.1)	2.8
Total Non Pay	(295.4)	(23.6)	(25.3)	(1.7)	(248.5)	(250.8)	(2.4)
Total Operating Costs	(783.0)	(64.7)	(66.2)	(1.5)	(654.0)	(650.1)	3.9
Surplus / Deficit from Operations	(7.2)	0.4	0.9	0.5	(7.8)	(2.6)	5.2
Finance Costs, Interest, PDC, etc.	(25.5)	(2.1)	(2.0)	0.1	(21.3)	(19.9)	1.4
Total Non Operating Costs	(25.5)	(2.1)	(2.0)	0.1	(21.3)	(19.9)	1.4
Total Costs	(808.5)	(66.9)	(68.2)	(1.3)	(675.3)	(670.0)	5.3
Net Surplus / Deficit	(32.8)	(1.7)	(1.1)	0.6	(29.1)	(22.5)	6.6
Donated Asset / Impairment Adjustment	(0.8)	(0.1)	(0.1)	(0.0)	(0.6)	(0.3)	0.4
Operational Net Surplus / Deficit	(32.0)	(1.7)	(1.1)	0.6	(28.4)	(22.2)	6.2
Mariginal Rate Emergenct Tariff	4.2	0.4	0.4	0.0	3.5	3.5	0.0
Providor Sustainability fund	15.9	1.8	1.8	0.0	12.2	12.2	0.0
Financial recovery fund	11.9	1.4	1.4	0.0	9.1	9.1	0.0
	0.0	1.9	2.5	0.6	(3.6)	2.6	6.2

2 Income

Total Commissioning income was over recovered by £0.7m in Month 10 against a plan of £57.9m and now stands at £572.7m for the first 10 months of the year which is £1.9m worse than plan.

The table below shows the Trust's Commissioning Income and activity position by point of delivery (POD)

Income from patient Activity to Month 10 2019/20	Annual Plan		Income In Month			Activity Year to date			Income Year to date		
	Activity	£m	Budget £m	Actual £m	Variance £m	Budget	Actual	Variance	Budget £m	Actual £m	Variance £m
Elective Inpatient Spells	15,409	65.7	5.7	5.1	(0.6)	12,695	11,707	(988)	54.7	52.7	(2.1)
Day case Spells	83,696	58.4	5.1	5.0	(0.1)	69,766	67,566	(2,200)	48.7	48.1	(0.6)
Non Elective Emergency Inpatient Spells	85,671	186.9	15.8	15.6	(0.3)	71,628	70,837	(791)	156.3	155.3	(1.0)
Non Elective Non Emergency Inpatient Spells	23,572	30.1	2.5	2.5	(0.0)	19,708	20,746	1,038	25.2	25.0	(0.2)
Outpatient Attendances & Procedures	719,001	88.1	7.7	7.7	0.1	598,939	588,903	(10,036)	73.4	73.9	0.5
Accident & Emergency Attendances	181,191	26.1	2.2	2.2	(0.0)	151,488	148,813	(2,675)	21.8	21.9	0.1
Critical care	31,796	39.2	3.3	3.2	(0.2)	26,580	25,879	(701)	32.8	31.2	(1.6)
Direct Access		13.2	1.1	1.1	(0.0)				11.0	11.0	(0.0)
Other		122.6	9.3	10.0	0.6				100.9	99.8	(1.2)
PBR Excluded & Chemotherapy Drugs (Pass through)		53.6	4.6	5.9	1.3				44.7	49.6	4.9
Pass through devices		10.1	0.8	0.7	(0.1)				8.6	8.1	(0.5)
Fines & Penalties		-	-	(0.0)	(0.0)				-	(0.2)	(0.2)
Emergency Threshold		(4.2)	(0.4)	(0.4)	(0.0)				(3.5)	(3.5)	0.0
Total		689.7	58.0	58.7	0.7				574.6	572.7	(1.9)

The year to date position is heavily influenced by an over recovery against plan of £4.9m for PbR excluded drugs and Chemotherapy Drugs (Pass through)

Income from Electives was £0.6m behind in plan which is £0.4m higher than the average level of underperformance seen during the year. In January 14 Elective beds were given to the Medicine Division in response to pressures within urgent care resulting in the loss of 37 Elective Spinal case and 112 Elective Orthopaedic cases with an estimated loss of income of £0.2m

The following table provides a draft summary of Total Commissioning Income by Commissioner; further detail is included in Appendix 1 and 2.

Patient Income Position at Month 10 19/20	External Plan / Contract	Income (£m)				
		Finance (£m)	Plan (£m)	Actual (£m)	Variance (£m)	Variance
NORTH / SOUTH STAFFORDSHIRE CCGS	416.8	416.6	347.1	347.1	(0.0)	0%
NHS ENGLAND	223.2	218.4	182.7	177.3	(5.4)	-3%
OTHER CCG ASSOCIATES	29.1	30.8	25.6	27.4	1.8	7%
OTHER NON NHS CONTRACTS	6.5	7.5	6.3	7.3	1.0	16%
NON CONTRACT ACTIVITY	4.2	4.2	3.5	3.4	(0.1)	-2%
OTHER	13.9	13.9	10.6	11.5	0.9	8%
	693.7	691.2	575.8	574.0	(1.9)	0%
Less Other Non Patient Income	(1.5)	(1.5)	(1.3)	(1.3)	-	0%
	692.2	689.7	574.6	572.7	(1.9)	0%

Income from Staffordshire CCGs is based on the Intelligent Fixed Payment Mechanism (IFPM) and is fixed for the year. Several additional contracts have been negotiated with the commissioners, repatriating activity previously carried out by GPs or independent providers, to UHNM. These additional contracts relate to Diagnostics in the form of plain film x-rays and non obstetric ultrasound and phlebotomy services at Leek. In addition the VirginCare Contract has now returned to East Staffs CCG responsibility and has been varied into the IFPM.

The income plan for NHS England is £4.8m lower than the contract value; this relates to Specialised Services. This is as a result of differing growth assumptions and pass though devices that have moved to a zero cost model during the year as opposed to pass through cost for which we have requested a contact variation.

Associate CCGs – the total income plan for these CCGs is £30.8m with the over recovery at Month 10 being £1.8m (7%). The most significant variance is against Shropshire CCG which is showing an over recovery of £0.8m (19% higher than plan for the year to date). The internal income plan is higher than the contract reflecting the increase in activity seen during the year which was transacted as part of the budget reset at Quarter 1.

Within the reported position for Total Commissioning income the Trust has made provision for £0.2m of fines; these relate to contracts with Associate CCGs and NHSE as under the IFPM fines are automatically reinvested. The table below provides details of the contractual fines for the first 8 months of 2019/20.

Contractual Fines 2019/20	Operational Standards	Consequence of breach	Staffordshire		Other		Total	
			Total	Value £000	Total	Value £000	Total	Value £000
52 Week waits	Zero tolerance RTT waits over 52 weeks for incomplete pathways	£5,000 per Service User with an incomplete RTT pathway waiting over 52 weeks at the end of the relevant month	0	0.0	0	0.0	0	0.0
C Difficile incidences	Minimise rates of Clostridium difficile	£10,000 for each breach above target	14	140.0	1	10.0	15	150.0
Cancelled Ops	All Service Users who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within 28 days, or the Service User's treatment to be funded at the time and hospital of the Service User's choice	Non-payment of costs associated with cancellation and non- payment or reimbursement (as applicable) of re-scheduled episode of care	102	181.0	46	158.5	148	339.5
MRSA Incidences	Zero tolerance methicillin-resistant Staphylococcus aureus	£10,000 in respect of each incidence in the relevant month	0	0.0	0	0.0	0	0.0
MSA Breaches	Zero tolerance against Mixed Sex Accomodation	£250 per day per patient	0	0.0	0	0.0	0	0.0
Urgent Ops	No urgent operation should be cancelled for a second time	£5,000 per incidence in the relevant month	0	0.0	6	30.0	6	30.0
Total			116	321.0	53	198.5	169	519.5

The table below shows the planned growth in activity for the first 10 months of the year and the actual change seen over the same period. It should be noted that the table below will not correlate to the actual variances against income reported elsewhere in this paper as income is fixed for Staffordshire CCGs and is not linked to actual activity delivered.

	2019/20 M1-10			2018/19 M1-10			
POD	Plan	Actual		Plan	Actual	Planned Growth	Actual Growth
Elective	12,725	11,726		13,954	12,321	3.3%	-4.8%
Day case	81,335	80,801		80,601	79,066	2.9%	2.2%
Emergency	91,343	91,588		78,633	89,670	1.9%	2.1%
Outpatient	646,781	616,581		648,591	626,994	3.2%	-1.7%
A&E Attendance	151,488	148,813		133,257	147,395	2.8%	1.0%

3. Expenditure

Pay expenditure was £40.9m in Month 10 generating an underspend of £0.2m with year to date pay expenditure now standing at £399.3m resulting in an underspend of £6.2m.

Overall Pay expenditure for the first 10 months of the year was 2.6% higher than for the first 10 months of 2018/19 against a planned increase of 4.2%.

Additional costs planned for winter were £1.0m in January with the actual costs being £0.9m; the underspend was mainly as a result of additional capacity within Critical Care and SAU not being needed.

Registered nursing costs underspent by £0.3m in January with the actual pay costs of £12.3m being in line with the increase seen in December; this is as a result of the opening of the Trust's additional winter capacity.

NHS Infrastructure costs are underspent by £0.2m in month and now stand at £3.1m underspent for the year to date; Corporate functions account for £2.1 of the year to date underspend.

Medical pay overspent by £0.5m in January with the year to date overspend now standing at £1.7m. As in previous months this is predominantly within Emergency Medicine which is £0.2m overspent for the month and now stands at £2.3m overspent for the year to date. This is mainly driven by high levels of consultant vacancies across the ED and AMU as well as gaps in junior doctor rotas.

After 10 months of the financial year the Trust's expenditure on agency staff is £0.2m higher than the year to date profile of the ceiling set by NHSI of £18.0m. This is as a result of Medical agency costs being £0.1m higher per month on average than for 2018/19. The Trust will need to monitor performance closely to ensure that it does not breach it ceiling; performance for the year to date is shown in the table below.

Agency Cap Target	Annual	In Month			Year to Date		
	Target £m	Target £m	Actual £m	Variance £m	Target £m	Actual £m	Variance £m
Total	**(18.0)**	**(1.5)**	**(1.6)**	**(0.1)**	**(14.8)**	**(15.0)**	**(0.2)**

Non-pay expenditure is overspent by £1.7m in January and now stands at £2.4m overspend for the year to date within this pass through drugs are overspent by £1.8m in the month and £5.8m for the year to date.

In Month 10 the Trust has released £1.3m of general reserves into the position in line with the forecast agreed at Month 6; this has been accounted for within Other Non-Pay expenditure.

4 CIP

The total original CIP plan for the year is £40.0m.

The table below summarises the performance against the CIP for the first 10 Months of the year; this performance is built into the Trust's position for the year. The planned performance is as per the final plan submitted to NHSI in April.

CIP 2019/20	Annual Plan	In month			Year to date		
		Plan	Actual	Variance	Plan	Actual	Variance
	£m	£m	£m	£m	£m	£m	£m
Income	6.9	0.6	2.7	2.0	5.6	19.1	13.5
Pay	17.5	2.0	0.7	(1.3)	13.4	5.9	(7.5)
Non Pay	15.6	1.3	0.4	(0.9)	11.4	3.8	(7.6)
Total	40.0	3.9	3.8	(0.2)	30.4	28.8	(1.6)

The CIP delivery in Month 10 is £0.2m behind plan and £1.6m behind plan for the year to date. The CIP report contains further detail including a forecast for the year.

5 Capital

The Trust capital expenditure plan for 2019/20 is £26.2m and includes the changes reported to Performance and Finance Committee along with additional capital funding confirmed by NHSE/I. The Trust has spent £1.3m in month 10 and £12.9m year to date against a planned spend of £13.7m, an under spend of £0.8m. The planned spend for the last 2 months of the financial year is £9.2m; details of the significant items are included below.

Capital Expenditure as at Month 10 2019/20 £m	Revised Budget	In Month			Year to Date		
		Budget	Actual	Variance	Budget	Actual	Variance
ICT Infrastructure	(4.7)	(0.4)	(0.1)	0.3	(4.1)	(3.7)	0.4
Estates Infrastructure	(4.2)	(0.2)	(0.2)	(0.0)	(2.1)	(1.9)	0.2
Medical Equipment	(3.0)	(0.4)	(0.6)	(0.2)	(1.4)	(1.8)	(0.4)
PFI lifecycle & equipment	(3.2)	(0.2)	(0.3)	(0.1)	(1.9)	(2.1)	(0.2)
PFI enabling	(0.1)	(0.1)	-	0.1	(0.1)	-	0.1
Pathology tracker - Finance Lease	(0.5)	-	(0.0)	(0.0)	(0.5)	(0.1)	0.4
Health & Safety Compliance	(0.2)	-	-	-	(0.2)	(0.1)	0.1
Other Central schemes	(1.4)	(0.1)	0.1	0.2	(0.9)	(0.3)	0.6
LIMS	(1.5)	(1.6)	(0.0)	1.6	(1.5)	(1.5)	-
PDC award for HSLI	(1.3)	(0.0)	-	0.0	(1.0)	(1.2)	(0.2)
Project STAR	(0.8)	-	(0.1)	(0.1)	-	(0.1)	(0.1)
NHSI imaging funding	(1.2)	-	-	-	-	-	-
Total capital expenditure	(22.1)	(3.1)	(1.3)	1.8	(13.7)	(12.9)	0.8
PFI equipment pre-payment	(4.1)	-	-	-	(4.1)	(3.3)	0.8
Total CDEL	(26.2)	(3.1)	(1.3)	1.8	(17.8)	(16.2)	1.6

Expenditure for the ICT sub-group is £0.4m behind plan. There is a £0.35m underspend on the EPMA scheme where required infrastructure work has been delayed, the forecast year-end underspend has been built in to the revised capital plan and a business case review is scheduled. There is an under spend of £0.3m on Microsoft licences offset by expenditure on Windows 10 and the data centre being ahead of plan. Spend of £1.0m is planned in month 11/12, of this £0.6m is on Windows 10 and Microsoft licences with expenditure also due on EPMA and the data centre. ICT sub group have raised no risks with regard to this expenditure.

There is a £0.2m underspend on Estates Infrastructure expenditure mainly due to the fire alarm phase 3 replacement being behind plan. Expenditure of £2.3m is planned over the next 2 months relating to a number of schemes including Trent building heating pipework, accommodation for MPFT at County, electrical and fire safety work, enabling works for replacement imaging scanners and further security work at the RI site. Estates sub group have raised no risks with regard to this expenditure.

Medical devices expenditure is £0.4m ahead of plan. Expenditure of £1.0m is planned over the next 2 months relating to a number of schemes including Echo machines £0.2m, blood gas analysers £0.1m, PFID tagging £0.1m and ultrasounds £0.3m. Medical Equipment sub group have raised no risks with regard to this expenditure.

PFI equipment is £0.2m ahead of plan due to the replacement PACS equipment being earlier than expected. The remaining lifecycle costs will be incurred in year along with the remaining equipment within the revised agreed replacement programme for the contract year.

The Pathology Tracker is £0.4m behind plan; the equipment is a refresh via a finance lease and was carried forward from 2018/19. The equipment refresh is due to be completed by the end of February and the required enabling work has now been undertaken.

Other central schemes are £0.5m behind plan; this is due to VAT now reclaimed on prior year expenditure along with the write off of prior year GRN's and the allocation of contingency to sub-groups. The remaining contingency has now been allocated to additional medical equipment and to the IM&T sub-group in relation to Share Point; this expenditure will be incurred in month 12.

Expenditure to be incurred relating to Project STAR is mainly in relation to the hoarding for the RI site and the Estates team are working with local planners and the contractors to ensure this work can take place in year. There is a risk around this expenditure being in place prior to the year end.

Expenditure on Pathology LIMS of £1.5m was incurred in month 9 via a bullet payment to the supplier on 31st December 2019 and is in line with the revised plan.

HSLI expenditure is £0.2m ahead of plan this is mainly due to a milestone payment for the Robotic Process Automation scheme being required to be paid earlier than anticipated. The Trust has received confirmation that it can draw down the cash from the DHSC and this will be received on 17th February 2020. The remaining costs for the electronic patient records scheme will be incurred in month 11/12.

The remaining balance of the PFI pre-payment of £0.8m relates to the remaining Cath Lab replacement which is being replaced in February 2020.

6. Cash

The Trust holds cash of £21.2m at Month 10 which is £13.2m higher than plan.

Cash Summary at Month 10 2019/20		In Month			Year to date		
	Budget £m	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
Opening balance	8.4	8.0	19.4	11.4	8.4	8.4	-
Contract Income 2019/20	658.7	56.9	56.4	(0.5)	568.7	568.6	(0.1)
Contract income 2018/19	3.2	-	-	-	3.2	12.1	8.9
Other Income	103.2	7.0	12.9	5.9	76.0	85.4	9.4
Uncommitted Revenue support facility 2019/20	-	(3.7)	-	3.7	9.5	18.9	9.4
PSF, FRF and MRET funding	32.0	1.1	1.1	-	14.0	14.0	-
Department of Health and NHS England Deficit support	24.8	6.2	-	(6.2)	18.6	-	(18.6)
Capital funding (PDC capital)	1.3	-	-	-	-	-	-
Total Receipts	823.2	67.5	70.4	2.9	689.9	698.9	9.0
Payroll (excluding agency)	(436.8)	(38.1)	(38.3)	(0.3)	(378.0)	(377.5)	0.4
Accounts payable	(366.3)	(28.7)	(29.6)	(0.9)	(297.0)	(294.2)	2.8
PDC Dividend	(1.5)	-	-	-	(0.4)	(0.4)	-
Capital	(19.5)	(0.7)	(0.7)	-	(15.0)	(14.0)	1.0
Total Payments	(824.1)	(67.5)	(68.6)	(1.2)	(690.4)	(686.1)	4.2
Closing Balance	7.5	8.0	21.2	13.2	8.0	21.2	13.2

Overall cash is £13.2m higher than plan at month 10. This is mainly due to cash being received in month 6 of £9m cash relating to the outcome of the 2018/19 expert determination and the receipt of £5.7m cash relating to Q4 Health Education England a month earlier than plan.

Contract income relating to 2019/20 is in line with plan year to date.

The cash received for 2018/19 contract income is £8.9m ahead of plan year to date mainly due to cash relating to the outcome of the 2018/19 expert determination being received from commissioners in early September. A number of credit notes (£1.6m) relating to the prior year have not yet been taken by commissioners, this is being escalated as part of the month 9 Agreement of Balances exercise.

Other income is higher than plan in month (£5.9m) and year to date (£9.4m); in month other income is above plan due to the Q4 training cash being received from Health Education England in Month 10 rather than Month 11. The year to date variance (in addition to the HEE training income being received ahead of plan) is due to higher than planned cash received from the VAT return (in prior months) and also payment of NHS invoices from 2018/19, not relating to contract income.

The Trust has not accessed any of its Uncommitted Interim Revenue Support Facility in Month 9 but has not received cash relating to Q3 PSF/FRF or the £24.8m deficit support funding. The cash drawdown request is required to be submitted to NHSI a month in advance of the cash receipt date. The 13 week cash flow forecast submitted on in February does not forecast further draw down of cash support as a result is holding a higher than planned cash balance.

The Trust expects to receive £14.9m of deficit support from Stafford and Surrounds CCG on 2nd March 2020 which will enable repayment of £6.4m deficit support borrowing taken out in year in March 2020. However as the Trust has not had confirmation as to when either the Q3

PSF/FRF cash or the £9.9m deficit support from DHSC will be received, the revised forecast is for net borrowing in the year to be £8m rather than nil as per the plan.

General accounts payable and capital payments are £2.8m and £1.0m behind plan mainly as a result of reported underspends on non-pay and the timing of capital payments.

The table below shows the actual and forecast cash position for 2019/20. The cash support received to date relating to deficit support and PSF/FRF funding and the expected repayment in year is also detailed.

Cash and borrowing position 2019/20	Actual 30/04/19 £m	Actual 31/05/19 £m	Actual 30/06/19 £m	Actual 31/07/19 £m	Actual 31/08/19 £m	Actual 30/09/19 £m	Actual 31/10/19 £m	Actual 30/11/19 £m	Actual 31/12/19 £m	Actual 31/01/20 £m	Plan 29/02/20 £m	Plan 31/03/20 £m	Total
Month end cash balance per NHSI plan	8.0	8.0	8.0	8.0	8.0	8.0	8.0	8.0	8.0	8.0	8.0	7.5	7.5
Month end cash balance actual/forecast	4.7	5.1	20.9	15.0	16.6	25.5	15.4	22.1	19.4	21.2	11.1	11.5	11.5
Deficit/Working capital cash support received	4.4	4.3	7.9	-	-	-	-	-	-	(0.9)	-	-	15.7
Deficit/Working capital cash repayment	-	-	-	-	-	-	(4.2)	-	-	-	0.0	(3.6)	(7.7)
Planned PSF/FRF cash received	-	-	-	-	-	4.2	-	2.4	3.2	-	-		9.7
PSF/FRF cash support received/repayment	1.4	1.4	-	1.9	1.9	-	-	-	-	0.9	(4.6)	(2.8)	(0.0)
DHSC & NHS England deficit support cash	-	-	-	-	-	-	-	-	-	-		14.9	14.9

The plan was that at the year end the net cash support borrowing for the year will be nil. However as the Trust has not had confirmation as to when either the Q3 PSF/FRF cash or the £9.9m deficit support from DHSC will be received, the forecast is for net borrowing in the year to be £8m. The Trust is currently holding a higher than cash plan as confirmation has not yet been received of the items above and to allow the repayment of year to date deficit support and PSF/FRF borrowing in February (£4.6m) and March 2020 (£6.4m).

The forecast is that £15.2m of loans at 6% interest rate will be repaid in the year. The quarter 4 PSF/FRF cash of £9.7m will be received in 2020/21 in addition to the £8.3m quarter 3 PSF/FRF cash and the £9.9m deficit support from DHSC (unless confirmed that the Trust will receive the cash prior to 31 March 2020).

7 Balance Sheet

The Month 10 Statement of Financial Position (Balance Sheet) is shown below.

Balance Sheet as at 31st January 2020	31/03/2019	31/01/2020			
	Actual £m	Plan £m	Actual £m	Variance £m	
Property, Plant & Equipment	504.0	501.5	496.6	(5.0)	Note 1
Intangible Assets	22.1	21.9	23.2	1.4	Note 1
Total Non Current Assets	526.1	523.4	519.8	(3.6)	
Inventories	12.8	12.4	12.4	0.0	
Trade and other Receivables	40.9	42.1	58.4	16.3	Note 2
Cash and Cash Equivalents	8.4	8.0	21.2	13.2	Note 3
Total Current Assets	62.1	62.5	92.0	29.5	
Trade and other payables	(59.1)	(66.1)	(72.1)	(6.0)	Note 4
Borrowings	(23.4)	(22.9)	(22.3)	0.6	
Provisions	(3.3)	(3.3)	(2.4)	0.9	Note 5
Total Current Liabilities	(85.8)	(92.3)	(96.7)	(4.5)	
Borrowings	(462.0)	(459.5)	(472.1)	(12.5)	Note 6
Provisions	(0.9)	(0.9)	(0.9)	-	
Total Non Current Liabilities	(462.9)	(460.4)	(472.9)	(12.5)	
Total Assets Employed	39.6	33.3	42.2	8.9	
Financed By:				-	
Public Dividend Capital	407.1	408.4	407.1	(1.3)	Note 7
Retained Earnings	(466.4)	(474.0)	(464.1)	9.9	Note 8
Revaluation Reserve	98.9	98.9	99.1	0.3	
Total Taxpayers Equity	39.6	33.3	42.2	8.9	

The Month10 Statement of Financial Position (Balance Sheet) is broadly in line with plan with the main variances explained below:

Note 1: Property Plant & Equipment and Intangibles are £3.6m lower than plan. Overall additions are lower than the original plan on Trust funded capital schemes by £2.0m and on the revised plan by £1.7m, due to slippage in and reprioritisation of the capital spend The variance between PPE and intangibles is due to the LIMS capital scheme being included in the PPE plan figure rather than Intangibles.

Note 2: Trade and other receivables are £16.3m higher than plan. This is mainly due to invoices relating to the deficit support raised with the Department of Health and Social Care and also Stafford and Surrounds CCG (relating to NHSE deficit support) remaining unpaid, and the Trust not yet receiving cash relating to Q3 PSF/FRF funding.

Note 3: Cash is £13.2m higher than plan at Month 10. Cash received is higher than plan as the Trust received payment of invoices relating to the outcome of the 2018/19 Expert Determination in month 6 of £8.9m, which was not included in the original plan. The Trust has received the Q4 training income from Health Education England (£5.7m) in month 10 rather than month 11. General account payable and capital payments are behind plan, partly as a result of underspends on non-pay and the timing of capital payments.

Note 4: Provisions are £0.9m lower than plan and this reflects redundancy payments made in 2019/20 relating to provisions held at the year end.

Note 5: Trade and other payables are £6m higher than plan. This is mainly due to deferred income of £3.8m relating to the Q4 training income being received from Health Education England a month earlier than plan. Trade payables are slightly higher than plan due to the timing of the pharmacy payment run in the last week of the month.

Note 6: Borrowings are £11.9m higher than plan. The variance is partly due to the £4m working cash support requested earlier in the financial year relating to the increased 2018/19 deficit. The plan also reflects a timing difference on the repayment of 2019/20 borrowing relating to Q3 PSF/FRF funding which has been delayed. The Trust has not yet received confirmation of when the £9.9m deficit support cash will be received from DHSC. A repayment of borrowing £4.6m has been made in Month 11.

Note 7: PDC is £1.3m lower than plan due to the Trust not yet being able to draw down capital PDC relating to HSLI capital expenditure that has been incurred to date in 2019/20. This cash is due to be received on 17th February.

Note 8: Retained earnings show a £9.9m variance from plan at Month 10. Of this £4m relates to the final adjustment to the prior year closing balance to reflect the outcome of the expert determination, this was not reflected in the plan due to timing. The remaining variance reflects the income and expenditure variance to position at Month 10.

7.1 Trade & Other Receivables

Total Trade and other receivables stood at £58.4m at 31st January 2020, £16.3m higher than plan. The main variances are explained below:

Trade / Other Receivables & Current assets Actuals	Actual 31/03/19 £m	Plan 31/1/20 £m	Actual 31/1/20 £m	Variance 31/1/20 £m	
Trade Receivables	42.3	21.7	34.3	12.6	Note 1
Deficit support invoice not yet due	-	-	(4.1)	(4.1)	Note 1
Prepayments	8.8	9.1	10.1	1.0	Note 2
Accrued Income	19.2	23.6	31.7	8.1	Note 3
Bad Debt Provision	(2.7)	(2.8)	(2.7)	0.1	
VAT Receivable	1.6	1.6	-	(1.6)	Note 4
Credit Note accrual	(30.0)	(12.4)	(12.2)	0.2	
Other Receivable	1.8	1.3	1.3	0.0	
Total	40.9	42.1	58.4	16.3	

Note 1: Trade receivables are £12.6m higher than plan as the Trust raised invoices to DHSC and Stafford and Surrounds CCG in Month 4 for the £24.8m 2019/20 deficit funding. The plan figure assumed that only £6.2m would be outstanding at the end of Month 10. Further details on aged receivables can be seen below. From a revenue perspective the deficit support for months 11-12 is not yet due, this balance of £4.1m is shown above as an adjustment to the receivables total.

Note 2: Prepayments are £1.0m higher than plan mainly due to the PFI equipment pre-payment outstanding relating to the Cath lab replacement as part of the capital programme.

Note 3: Accrued income is £8.1m higher than plan mainly due to the accrual for Q3 PSF/FRF funding of £8.3m, the plan assumed that this would have been paid in January 2020; the payment date is yet to be confirmed

Note 4; VAT receivable is £1.6m lower than plan as the cash was received prior to 31st January in relation to the VAT return submitted in January.

Trade receivables: The table below shows the ageing of the outstanding NHS and Non-NHS trade receivable debt and highlights the larger outstanding balances.

NHS Trade Receivables - Aged Debt	Actual 31/03/19 £m	Actual 31/12/19 £m	Actual 31/1/20 £m	
Less than 30 Days	24.3	3.1	3.3	Mid Cheshire £1.1m, NHS England £0.6m, £0.1m Royal Wolverhampton, £0.2m NHSI, £0.7m Mid Cheshire, NHS Stafford & Surrounds CCG £0.2m
31 to 60 Days	1.6	1.5	1.7	Mid Cheshire £0.6m, Royal Wolverhampton £0.3m, NHS England £0.2m, NHS South East Staffs CCG £0.2m
61 to 90 Days	0.5	0.6	0.9	Mid Cheshire £0.2m, Royal Wolverhampton £0.2m, NS Combined £0.1m
91+ Days	12.3	26.1	26.0	DHSC £9.9m and Stafford & Surrounds CCG £14.9m for 2019/20 deficit support, NS Combined £0.4m
Total	38.7	31.3	31.9	
Non NHS Trade Receivables - Aged Debt	Actual 31/03/19 £m	Actual 31/12/19 £m	Actual 31/1/20 £m	
Less than 30 Days	1.4	0.6	1.2	Sodexo Healthcare £0.4m, Alliance Medical £0.2m, Keele University £0.1m
31 to 60 Days	0.5	0.2	0.2	Katherine House Hospice £42k, Lloyds Pharmacy £20k
61 to 90 Days	0.2	0.1	0.1	
91+ Days	1.5	1.4	0.9	£0.54m overseas visitors, £0.2m salary overpayments
Total	3.6	2.3	2.4	

The largest balance within the aged receivables is NHS debt over 90 days old. Of this £9.9m and £14.9m relate to 2019/20 deficit support from the DHSC and NHS England (via Stafford and Surrounds CCG) respectively. The revenue position includes £20.6m of this income to month 10. The Trust has received confirmation that it will receive £14.9m from Stafford and Surrounds CCG on the 2nd March, discussions remain on-going with NHSE/I on the remaining £9.9m.

There are a number of outstanding invoices and credit notes with NHS bodies. The financial accounts team is reviewing the 2019/20 agreement of balances exercise and is continuing to

liaise with NHS England and other NHS bodies where significant balances are outstanding for an update on when the Trust can expect the invoices and credit notes to be settled.

Older Non-NHS debt is proactively managed by the credit control department. This includes credit control, monthly conference calls with the Trust as well as increased referrals to a third party debt recovery service.

The outstanding debt has been reviewed and a write-off of £0.45m Non-NHS debt was reported to Audit Committee in January 2020. The benefits of this proactive action should be seen over the remainder of the year with a reduction in longer term non-NHS debt and as per the table above where debt over 90 days old has significantly reduced compared to Month 9.

7.2 Trade and Other Payables

Trade and other payables stood at £72.1m at 31st January 2020, which is £6.0m higher than plan. A breakdown of this figure and the reasons for the variance against plan are shown below:

Trade and Other Payables Actuals	Actual 31/03/19 £m	Plan 31/1/20 £m	Actual 31/1/20 £m	Variance 31/1/20 £m	
Trade Payables	(15.6)	(12.7)	(13.8)	(1.1)	Note 1
Manual Accruals	(12.0)	(20.0)	(20.9)	(0.9)	
Deferred Income	(5.0)	(5.5)	(9.3)	(3.8)	Note 2
GRN Accruals	(8.5)	(9.0)	(9.2)	(0.2)	
Tax/NI Payables	(9.8)	(10.5)	(10.5)	0.0	
Pension Payables	(5.9)	(6.2)	(6.3)	(0.1)	
Other Payables	(2.2)	(2.1)	(2.1)	0.0	
Total	(59.0)	(66.1)	(72.1)	(6.0)	

Note 1: Trade payables are £1.1m higher than plan this reflects the timing of the Accounts Payable interface with the pharmacy system at the month end (payments were made in early Feb 2020).

Note 2: Deferred income is £3.8m higher than plan which reflects the receipt of the Q4 training income from Health Education England in Month 10 rather than Month 11 as per the plan.

8 Forecast, Risks and Opportunities

As presented to the Committee in November the Trust carried out a full forecast for the year based on the Month 8 run rate; this forecast showed that the Trust still expected to meet its forecast surplus for the year of £5m. The reported position at Month 10 is £4k better than the forecast carried out at Month 8.

The Trust continues to hold a small number of specific reserves at Month 10 which are assumed to be committed during the year and have therefore been fully provided for within the Month 10 position; these are summarised in the table below The general risk reserve and non-pay inflation reserve are being released over the second half of the year in line with the forecast.

Reserve	Annual Value £m	YTD Value £m	Provided at Mn 10 £m
Winter	0.0	0.0	0.0
Risk Reserve	4.6	5.2	0.2
Activity Reserve	1.3	1.1	1.1
Windows 10	0.2	0.2	0.2
PFI RoE	0.1	0.1	0.0
Non Pay Inflation	1.7	1.6	0.5
Total Income	8.0	8.2	1.9

A “profiling” adjustment has also been made at Month 10 to ensure the Trust’s internal plan agrees with the external plan that NHSI use for the Performance Management of the Trust. This adjustment arises as we transacted £11.8m of additional CIP that has been profiled evenly throughout the year but the unidentified CIP schemes which have been removed were profiled for delivery in Q2-Q4. This profiling adjustment is neutral over the year; its impact in Month 10 is £1.4m.

The actual run rate performance at Month 9 is therefore

Underlying I&E	£m
Reported I&E deficit at month 10	2.6
Provision reserve	1.9
Profiling adjustment	1.4
Run rate performance	5.9

9 System Wide Position

At Month 9 (before PSF/CSF) the system reported a ytd deficit of £84.1m against a planned deficit of £70.4m resulting in an adverse variance of £13.7m. This is summarised in the table below alongside the amount of PSF/CSF assumed in the Month 8 position.

Organisation	M9 ytd £m			
	Annual Plan	ytd Budget	ytd Actual	Variance
CCGs	(73,915)	(55,434)	(75,671)	(20,237)
UHNM	(32,000)	(26,786)	(21,181)	5,605
MPFT	(2,477)	(1,881)	(626)	1,255
NSCHT	338	120	125	5
Aggregate system position before PSF/CSF	(108,054)	(83,981)	(97,353)	(13,372)
PSF/CSF/MRET				
CCGs	0	0	0	0
UHNM	32,000	18,095	18,095	0
MPFT	4,229	2,326	2,326	0
NSCHT	700	385	385	0
Ttoal PSF/CSF/MRET	36,929	20,806	20,806	0
Surplus/(deficit) after PSF/CSF/MRET	(71,125)	(63,175)	(76,547)	(13,372)

At Month 9 (before PSF/CSF) each organisation in the system is forecasting that it will meet its financial plan for the year with the exception of UHNM who are forecasting a £5m surplus. This results in an overall deficit for the system of £103.1m. In addition to this there is a further £24.5m of risk to internal savings plans that has been identified with the largest element relating to CCG QIPP risk. The system is forecasting that it will receive £36.9m of PSF/CSF resulting in an actual deficit of £66.1m

Within the forecast position the system is assuming £119.7m of internal savings and £1.4m of programme savings (against the £20m plan).

10 Conclusion/recommendations

The Trust was £0.6m better than plan in January and within £4k of its forecast for the month. The favourable performance was supported by the position against expenditure which continues to underspend and the release of provisions made in the first half of the year. It is important that the Trust continues to maintain a tight control on expenditure over the last 2 months of the year.

There is nothing in the Month 10 position to suggest the Trust will not meet its revised forecast of a £5m surplus.

The Committee is asked to consider and review this report.

Appendix 1 – Patient income POD summary

Patient Income Position at Month 10	Annual Plan		Activity				Income (£m)			
	Activity	Finance (£m)	Plan	Actual	Variance	Variance	Plan (£m)	Actual (£m)	Variance (£m)	Variance
NORTH / SOUTH STAFFORDSHIRE CCGS										
Daycase / Elective Inpatients	82,890	74.7	68,978	66,819	(2,159)	-3%	62.2	59.5	(2.7)	-4%
Non-Elective Emergency Inpatients	73,164	137.5	61,157	60,632	(525)	-1%	114.9	126.2	11.2	10%
Non-Elective Non Emergency Inpatients	21,442	21.4	17,926	18,995	1,069	6%	17.9	17.6	(0.3)	-2%
Critical Care	13,254	14.4	11,081	11,005	(77)	-1%	12.0	11.9	(0.1)	-1%
Excluded Drugs / Devices	12,638	13.3	10,511	9,584	(927)	-9%	11.1	10.8	(0.3)	-3%
Other	5,729,735	80.6	4,782,308	4,926,398	144,090	3%	67.2	68.9	1.7	3%
Outpatients	550,732	59.1	458,708	429,475	(29,233)	-6%	49.2	48.9	(0.4)	-1%
IFPS Adjustment		14.2					11.3	2.2	(9.2)	
	6,483,856	415.0	5,410,670	5,522,907	112,238	2%	345.8	345.8	(0.0)	0%
Other Non Patient Income		1.5					1.3	1.3	-	0%
	6,483,856	416.5	5,410,670	5,522,907	112,238	2%	347.1	347.1	(0.0)	
NORTH / SOUTH STAFFORDSHIRE CCGS NON BLOCK	-	-	-	-	-		-	-	-	
	-	-	-	-	-		-	-	-	
NHS ENGLAND										
Daycase / Elective Inpatients	23,576	39.9	19,675	20,360	685	3%	33.3	31.4	(1.9)	-6%
Non-Elective Emergency Inpatients	7,823	36.3	6,541	6,051	(490)	-7%	30.4	28.5	(1.9)	-6%
Non-Elective Non Emergency Inpatients	914	5.8	764	751	(13)	-2%	4.8	4.5	(0.3)	-7%
Critical Care	15,893	21.9	13,285	12,006	(1,279)	-10%	18.3	15.9	(2.4)	-13%
Excluded Drugs / Devices	741	42.2	619	1,317	699	113%	35.4	38.7	3.3	9%
Other	212,654	48.6	177,475	180,754	3,279	2%	40.8	38.8	(2.0)	-5%
Outpatients	188,542	23.7	157,227	150,413	(6,814)	-4%	19.8	19.5	(0.3)	-1%
	450,143	218.4	375,586	371,652	(3,934)	-1%	182.7	177.3	(5.4)	-3%
OTHER CCG ASSOCIATES										
Daycase / Elective Inpatients	5,579	7.5	4,608	4,547	(61)	-1%	6.2	5.5	(0.6)	-10%
Non-Elective Emergency Inpatients	3,106	8.8	2,597	2,802	205	8%	7.4	7.6	0.3	3%
Non-Elective Non Emergency Inpatients	922	2.2	771	807	36	5%	1.8	2.1	0.3	14%
Critical Care	1,249	1.3	1,045	1,471	427	41%	1.1	1.6	0.5	47%
Excluded Drugs / Devices	2,572	3.2	2,139	2,102	(37)	-2%	2.7	2.8	0.1	6%
Other	16,492	3.3	13,728	15,928	2,200	16%	2.8	3.2	0.5	17%
Outpatients	34,377	4.5	28,579	33,948	5,370	19%	3.8	4.5	0.8	21%
	64,297	30.8	53,466	61,605	8,139	15%	25.6	27.4	1.8	7%
OTHER NON NHS CONTRACTS										
Daycase / Elective Inpatients	181	0.8	151	176	25	16%	0.7	0.7	0.0	1%
Non-Elective Emergency Inpatients	455	2.7	396	485	89	23%	2.3	3.0	0.7	30%
Non-Elective Non Emergency Inpatients	109	0.5	93	81	(12)	-13%	0.5	0.4	(0.0)	-11%
Critical Care	1,235	1.6	1,033	1,147	115	11%	1.3	1.5	0.2	15%
Excluded Drugs / Devices	54	0.5	45	61	16	36%	0.4	0.5	0.1	15%
Other	3,456	1.1	2,918	1,419	(1,499)	-51%	0.9	0.9	0.0	4%
Outpatients	1,964	0.3	1,711	1,815	104	6%	0.2	0.2	0.0	8%
	7,455	7.5	6,346	5,184	(1,162)	-18%	6.3	7.3	1.0	16%
NON CONTRACT ACTIVITY										
Daycase / Elective Inpatients	498	1.3	415	406	(9)	-2%	1.1	0.9	(0.2)	-15%
Non-Elective Emergency Inpatients	1,004	1.4	839	810	(29)	-3%	1.1	1.2	0.0	2%
Non-Elective Non Emergency Inpatients	141	0.2	118	96	(22)	-19%	0.2	0.1	(0.0)	-19%
Critical Care	129	0.1	108	181	73	67%	0.1	0.2	0.1	88%
Excluded Drugs / Devices	86	0.1	72	92	20	28%	0.1	0.1	0.0	23%
Other	4,000	0.6	3,343	3,363	20	1%	0.5	0.5	(0.0)	-3%
Outpatients	3,855	0.5	3,197	3,094	(103)	-3%	0.4	0.4	(0.0)	-7%
	9,713	4.2	8,093	8,042	(51)	-1%	3.5	3.4	(0.1)	-2%
OTHER										
Daycase / Elective Inpatients	278	-	232	219	(13)	-6%	-	0.0	0.0	
Non-Elective Emergency Inpatients	128	0.1	105	62	(43)	-41%	0.1	0.0	(0.1)	-95%
Non-Elective Non Emergency Inpatients	44	0.0	36	16	(20)	-56%	0.0	-	(0.0)	-100%
Critical Care	35	-	29	69	40	139%	-	-	-	
Excluded Drugs / Devices	2	4.4	2	16	14	858%	3.7	4.5	0.9	24%
Other	400	9.3	328	293	(35)	-11%	6.8	6.9	0.1	2%
Outpatients	1,046	0.0	860	970	110	13%	0.0	0.0	(0.0)	-96%
	1,932	13.9	1,592	1,645	53	3%	10.6	11.5	0.9	8%
	7,017,396	691.2	5,855,752	5,971,036	115,283	1%	575.8	574.0	(1.9)	0%
Less Other Non Patient Income	-	(1.5)	-	-	-		(1.3)	(1.3)	-	0%
TOTAL PATIENT INCOME	7,017,396	689.7	5,855,752	5,971,036	115,283	2%	574.6	572.7	(1.9)	0%

Appendix 2 – Patient income Commissioner summary

Patient Income Position at Month 10	Annual Plan		Activity				Income (£m)			
	Activity	Finance (£m)	Plan	Actual	Variance	Variance	Plan (£m)	Actual (£m)	Variance (£m)	Variance
NORTH / SOUTH STAFFORDSHIRE CCGS										
NHS CANNOCK CHASE CCG	370,305	21.9	309,065	319,667	10,602	3%	18.3	18.6	0.3	2%
NHS EAST STAFFORDSHIRE CCG	7,493	3.2	6,136	6,611	475	8%	2.6	3.2	0.6	23%
NHS NORTH STAFFORDSHIRE CCG	1,957,541	121.3	1,633,473	1,715,643	82,170	5%	101.3	105.3	4.0	4%
NHS SOUTH EAST STAFFS AND SEISDON PENINSULAR CCG	4,351	2.0	3,624	3,748	124	3%	1.7	1.6	(0.0)	-3%
NHS STAFFORD AND SURROUNDS CCG	1,335,622	72.8	1,114,704	1,119,470	4,765	0%	60.7	62.5	1.7	3%
NHS STOKE ON TRENT CCG	2,808,544	179.7	2,343,667	2,357,768	14,101	1%	150.0	152.5	2.5	2%
IPFS ADJUSTMENT	-	14.2	-	-	-		11.3	2.2	(9.2)	-81%
	6,483,856	415.1	5,410,670	5,522,907	112,238	2%	345.8	345.8	(0.0)	0%
Other Non Patient Income		1.5					1.3	1.3	-	0%
	6,483,856	416.6	5,410,670	5,522,907	112,238	2%	347.1	347.1	(0.0)	
NORTH / SOUTH STAFFORDSHIRE CCGS NON BLOCK	-	-	-	-	-		-	-	-	
	-	-	-	-	-		-	-	-	
NHS ENGLAND										
CHESHIRE AND MERSEYSIDE AT DENTAL	1,431	0.3	1,195	1,218	23	2%	0.2	0.3	0.0	13%
CHESHIRE AND MERSEYSIDE AT SCREENING	4,614	0.5	3,851	3,334	(517)	-13%	0.4	0.3	(0.2)	-41%
NHS ENGLAND - ARMED FORCES	1,151	0.4	961	-	(961)	-100%	0.3	-	(0.3)	-100%
NORTH MIDLANDS AT DENTAL	37,692	7.9	31,461	30,429	(1,032)	-3%	6.6	6.8	0.1	2%
NORTH MIDLANDS AT SCREENING	14,977	6.0	12,500	10,566	(1,934)	-15%	5.2	4.9	(0.2)	-5%
SPECIALISED COMMISSIONING TEAM	390,278	203.3	325,619	326,105	486	0%	170.0	165.1	(4.9)	-3%
	450,143	218.4	375,586	371,652	(3,934)	-1%	182.7	177.3	(5.4)	-3%
OTHER CCG ASSOCIATES										
NHS BIRMINGHAM AND SOLIHULL CCG	1,159	0.7	964	1,215	251	26%	0.5	0.8	0.2	41%
NHS DERBY AND DERBYSHIRE CCG	1,957	1.0	1,631	1,747	116	7%	0.8	0.8	(0.0)	-3%
NHS DUDLEY CCG	514	0.3	427	399	(28)	-7%	0.3	0.2	(0.1)	-20%
NHS EASTERN CHESHIRE CCG	5,151	2.4	4,289	4,695	407	9%	2.0	2.2	0.2	9%
NHS REDDITCH AND BROMSGROVE CCG	179	0.2	149	164	15	10%	0.1	0.1	0.0	14%
NHS SANDWELL AND WEST BIRMINGHAM CCG	976	0.8	812	609	(203)	-25%	0.6	0.3	(0.3)	-49%
NHS SHROPSHIRE CCG	10,564	4.7	8,784	10,214	1,429	16%	3.9	4.7	0.8	19%
NHS SOUTH CHESHIRE CCG	28,337	12.6	23,566	27,238	3,672	16%	10.5	11.2	0.7	7%
NHS SOUTH WORCESTERSHIRE CCG	285	0.2	236	210	(26)	-11%	0.1	0.1	(0.0)	-26%
NHS TELFORD AND WREKIN CCG	6,413	3.1	5,315	5,641	325	6%	2.5	2.1	(0.5)	-18%
NHS VALE ROYAL CCG	5,018	3.2	4,177	5,879	1,702	41%	2.7	3.1	0.4	13%
NHS WALSALL CCG	1,189	0.5	988	1,291	303	31%	0.4	0.6	0.2	42%
NHS WEST CHESHIRE CCG	708	0.5	590	692	102	17%	0.4	0.5	0.1	34%
NHS WIRRAL CCG	199	0.1	166	185	19	12%	0.1	0.1	0.1	69%
NHS WOLVERHAMPTON CCG	1,432	0.6	1,191	1,266	75	6%	0.5	0.5	0.1	14%
NHS WYRE FOREST CCG	218	0.2	181	160	(21)	-11%	0.1	0.1	0.0	3%
	64,297	30.8	53,466	61,605	8,139	15%	25.6	27.4	1.8	7%
OTHER NON NHS CONTRACTS										
BETSI CADWALADR UHB	2,220	4.3	1,853	2,884	1,031	56%	3.6	4.5	0.9	26%
WALES	4,481	2.9	3,740	1,509	(2,230)	-60%	2.4	2.5	0.0	2%
VIRGIN HEALTHCARE	754	0.3	754	791	37	5%	0.3	0.3	(0.0)	0%
	7,455	7.5	6,346	5,184	(1,162)	-18%	6.3	7.3	1.0	16%
NON CONTRACT ACTIVITY										
NON CONTRACT ACTIVITY	9,713	4.2	8,093	8,042	(51)	-1%	3.5	3.4	(0.1)	-2%
	9,713	4.2	8,093	8,042	(51)	-1%	3.5	3.4	(0.1)	-2%
OTHER										
CANCER DRUGS FUND	-	3.7	-	-	-		3.1	3.9	0.8	26%
NHS ENGLAND DRUGS - NON CONTRACT	-	0.6	-	-	-		0.5	0.6	0.1	15%
OTHER	505	9.5	401	455	54	13%	7.0	6.9	(0.0)	-1%
OVERSEAS VISITORS	658	0.0	549	405	(144)	-26%	0.0	-	(0.0)	-100%
PRIVATE PATIENTS	768	-	641	785	144	22%	-	-	-	
	1,932	13.9	1,592	1,645	53	3%	10.6	11.5	0.9	8%
	7,017,396	691.2	5,855,752	5,971,036	115,283	1%	575.8	574.0	(1.9)	0%
Less Other Non Patient Income	-	(1.5)	-	-	-		(1.3)	(1.3)	-	0%
TOTAL PATIENT INCOME	7,017,396	689.7	5,855,752	5,971,036	115,283	2%	574.6	572.7	(1.9)	0%

Transformation and People Committee Chair's Highlight Report to Board

27th February 2020

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• Junior medical staff compliance with **Statutory and Mandatory Training;** this challenge is mirrored nationally and a programme of support / streamlining is in place	• Revised **Governance Structure** has now been signed off by Executive Directors and will be presented to the Board for approval in March; this outlined the Executive Groups which will report into the Committee • **Appointment Panels** for medical posts are scheduled throughout the course of the year; important to ensure Non-Executive Director participation • Development of action plans in response to the **Staff Survey**; the Committee requested a breakdown by Division for a future meeting along with details of their top 3 actions • Staff Development, Inclusion and Equality, Just and Learning Culture and Health and Wellbeing are all key areas of focus, aligned to the **Staff Survey** • A comparison against similar organisations will be undertaken in respect of the **Gender Pay Gap** report
Positive Assurances to Provide	**Decisions Made**
• **Operational Excellence in Healthcare** Readiness Assessment has been undertaken which is being used to inform the scope of the programme • There are a number of statistically significant improvements in the 2019 **Staff Survey** Scores when compared to the previous year's data and there was no deterioration in any theme • Some positive progress in the **Gender Pay Gap** report in respect of Clinical Excellence Awards • There are some very strong female leaders within the organisation and this is not necessarily reflected as positively as it should be within our **Gender Pay Gap** report • Comprehensive briefing provided in relation to the **Junior Doctor** contract amendments • All exceptions identified within the **Guardian of Safe Working** report have been addressed • Extremely positive report on the **Keele University School** of Medicine national survey	• Endorsement of the approach being taken to implement '**Operational Excellence in Healthcare**' with recognition of the further work needed on the proposal and arrangements for communicating and engaging the organisation with the approach • Refer to Chair of Quality Governance Committee with regard to the **Effective Nursing and Midwifery Staff Utilisation Report** to determine the most appropriate Committee to scrutinise this report
Comments on the Effectiveness of the Meeting	
• Further focus will be on areas where deeper assurance is needed so that the Committee can ensure that it adds value	

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	Operational Excellence in Healthcare Business Case	Assurance	6.	Gender Pay Gap Report	Assurance
2.	M10 Workforce Performance Report	Assurance	7.	Keele University School of Medicine Response to the 2019 National Student Survey	Assurance
3.	2019 NHS Annual Staff Survey	Assurance	8.	Guardian of Safe Staffing Report	Assurance
4.	Junior Doctor Contract Amendment 2019	Assurance	9.	Effective Nursing and Midwifery Staff Utilisation Report	Assurance
5.	Wellbeing Plan	Assurance	10.	Review of Meeting Effectiveness and Business Cycle	Assurance

3. 2019 / 20 Attendance Matrix

			Attended	Apologies & Deputy Sent	Apologies

Members:			A	M	J	J	A	S	O	N	D	J	F	M
Professor Gary Crowe	GC	Non-Executive Director (Chair)												
Mrs Helen Ashley	HA	Director of Strategy and Transformation												
Ms Sonia Belfield	SB	Non-Executive Director												
Mr Paul Bytheway	PB	Chief Operating Officer												
Dr Leigh Griffin	LG	Non-Executive Director												
Mr Mark Oldham	MO	Chief Finance Officer												
Miss Claire Rylands	CR	Associate Director of Corporate Governance												
Mrs Ro Vaughan	RV	Director of Human Resources												

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	11th March 2020
Report Title:	2019 NHS Annual Staff Survey	**Agenda Item:**	15.
Author:	Claire Soper, Head of HR Governance and Workforce Information		
Executive Lead:	Ro Vaughan, Director of Human Resources		

Purpose of Report:					
Assurance	✓	**Approval**		**Information**	

Alignment to Strategic Objectives:		
SO1	Provide safe, effective, caring and responsive services	✓
SO2	Achieve NHS constitutional patient access standards	
SO3	Achieve excellence in employment, education, development and research	✓
SO4	Lead strategic change within Staffordshire and beyond	
SO5	Ensure efficient use of resources	✓

Summary of other meetings presented to and outcome of discussion:

The report has been presented to the Transformation and People Committee who

- Further queried the theme of team working, where the main issue seems to be that teams are either not meeting, or not meeting regularly, to discuss their objectives and this has led to a small decline in staff saying they feel supported by colleagues. This issue will be addressed in the Divisional action plans, where remedial actions can be tailored as required to specific areas.
- Asked how many Trusts were in the Acute benchmarking group
- Considered the next steps set out below. Progress against these actions will be reported to the Transformation and Performance Committee in August 2020 and the effectiveness of our actions will be measured via staff feedback through focus groups and pulse check surveys, as well as through our culture assessment work.
- As additional level of information at a Divisional level will be provided for the Transformation and People Committee, providing a breakdown of each Division's RAG rating, the Divisional priorities to respond to these and assurance on follow up. The outcomes of the feedback from Divisional Performance Reviews and/or Performance Executive Group will be presented to the Transformation and People Committee.

The report has also been presented to the Trust Executive Committee, following which actions were agreed with regards to a staff security to review and strengthen Trust Policy and initiate a high profile communications campaign assuring staff that there is 'no tolerance' to violence against staff

Summary of Report, Key Points for Discussion including any Risks:

The 2019 NHS Annual Staff Survey was carried out between September and December 2019 and the Trust response rate was 45%. The national response rate was 47% and there were 85 organisations in the acute benchmarking group.

There have not been any changes to the reporting methodology. All ten themes are scored on a 0-10 scale, where a higher score is more positive than a lower score.

There were a number of statistically significant improvements in the 2019 scores when compared to the previous year's data.

- Equality and Diversity
- Morale
- Safety Culture, and
- Immediate Managers
- Quality of Appraisals
- Staff Engagement

There was no deterioration in any theme and no overall significant change in Health and Wellbeing; Quality of Care and Team Working.

Although there was no overall significant change in the theme 'Safe Environment – Bullying and Harassment / Violence', there was an increase in staff saying they experienced violence, harassment, bullying and abuse from patients/service users, which was offset in the scoring by a reduction in staff experience of violence from colleagues, and harassment, bullying and abuse from managers.

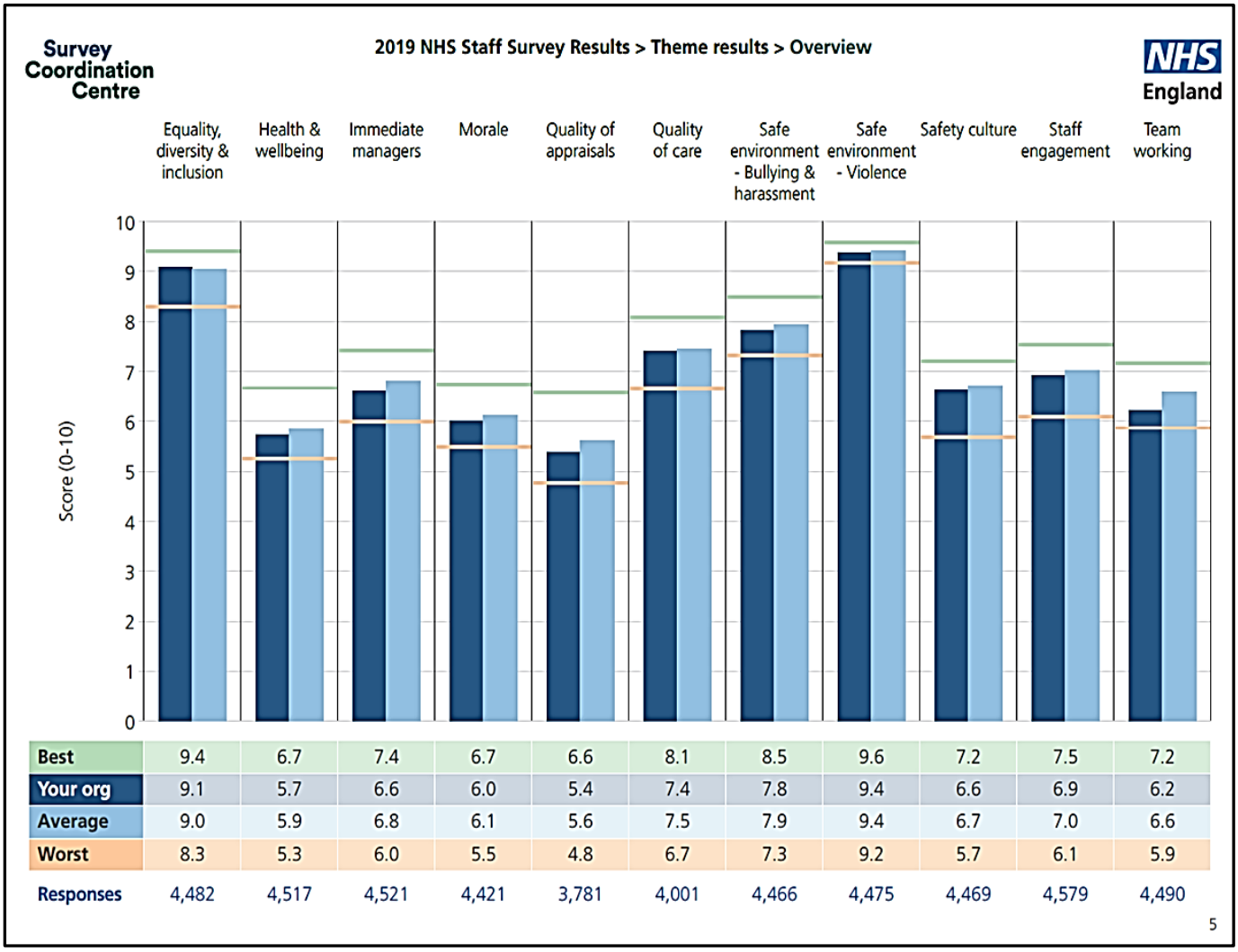
Activities are planned corporately for 2020/21, aimed at continuing the improvements in organisational culture and maximising the potential of our people to improve patient outcomes.

Additionally, as there are variations in the staff survey results across each Division, separate Divisional plans are being developed to tailor actions to address staff survey findings as appropriate to each area. These plans will reflect not only delivery of the Trust's People Strategy objectives, but actions to improve staff engagement and motivation within each Division

NHS Annual Staff Survey Findings 2019

1. Introduction

The following table presents an overview of the 10 themes, comparing this Trust's results to the national average for acute trusts, and indicating the scores of the best and worst performing acute trusts.



	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement	Team working
Best	9.4	6.7	7.4	6.7	6.6	8.1	8.5	9.6	7.2	7.5	7.2
Your org	9.1	5.7	6.6	6.0	5.4	7.4	7.8	9.4	6.6	6.9	6.2
Average	9.0	5.9	6.8	6.1	5.6	7.5	7.9	9.4	6.7	7.0	6.6
Worst	8.3	5.3	6.0	5.5	4.8	6.7	7.3	9.2	5.7	6.1	5.9
Responses	4,482	4,517	4,521	4,421	3,781	4,001	4,466	4,475	4,469	4,579	4,490

The chart shows that the main themes where this Trust scores lower than national average are:

1. **Equality and Diversity –** The theme score was 9.0 out of 10 against an acute trust average of 9.0. The main issue for staff in 2018 was their perception of fairness as regards career progression and/or promotion. This perception improved from 80.9% in 2018 to 84.3% in 2019.

   Staff experience of discrimination at work from colleagues/managers also improved from 8.6% to 7.4%, better than the national average of 7.5%

2. **Health and wellbeing** – all aspects of this theme improved except the percentage of staff experiencing MSK problems, which increased from 26.1% to 27.0%. Positively, however, staff perceptions on opportunities for flexible working improved from 47.5% to 48% and the organisation taking positive action on health and wellbeing improved from 21.9% to 24.4%. Also, fewer staff said they had felt unwell due to work related stress (reduced from 41.8% to 40.2%).
3. **Immediate Managers – In 2018, staff** perception was that immediate managers did not appear to take a positive interest in staff health and well-being. This perception improved from 63.3% to 65.25%. Staff also reported improved support and feedback from managers, and that they felt managers value their work.
4. **Morale -** Staff say they have unrealistic time pressures, less choice in deciding how to do their work, and that relationships are increasingly strained. However, staff noted small improvements in receiving the respect they deserve from colleagues and encouragement from their immediate manager. This has reduced the percentage of staff who said they are thinking of leaving the Trust.
5. **Quality of Appraisals -** all aspects of staff perceptions around appraisals improved, with more staff saying it helped them improve how they do their job; agree clear objectives for their work and left them feeling their work is valued by the Trust
6. As regards **Team Working** however, fewer staff felt their team had shared objectives and the percentage saying they meet to discuss team objectives reduced from 52.9% to 50.9%, which is well below the national average of 60.3%
7. **Safety Culture –** Positively, staff reported improvements in every aspect of this theme:
    - those involved in an error, near miss or incident are treated fairly improved from 55.9% to 57.4%
    - organisational action to ensure errors or incidents don't happen again improved from 67.6% to 70%
    - feedback to staff in response to reported incidents improved from 57.7% to 58.9%
    - feeling secure about raising unsafe clinical practice improved from 65.6% to 67.8%
    - confidence that the organisation would address staff concerns increased from 52.7% to 56.2%, and
    - Trust acting on concerns raised improved from 68.8% to 71.4%
8. **Safe Environment –** Sadly, there was an increase in staff saying they experienced harassment, bullying and abuse from patients/service users (from 26.4% to 28.2%), and an increase in experience of violence (15.9% up to 16.5%) from patients/services users

    Staff experience of harassment, bullying and abuse from managers reduced from 15.6% to 14.1%, but increased from colleagues (22.0% up to 22.9%). Experience of violence from colleagues reduced from 1.9% to 1.4%, which is now below the national average
9. **Staff engagement –** At 6.9, the staff engagement score remains just below the acute trust average of 7.0.

    Although fewer staff said they look forward to coming to work, there was an improvement in the percentage who said they are enthusiastic about their job and that time passes quickly for them while at work. Despite this, there were improvements in staff saying care of patients is the Trusts top priority; they would recommend the Trust as a place to work, and if a friend or relative needed treatment, they would be happy with the standard of care provided, which scored 73.9% compared to a national average of 70.5%.
10. **Quality of Care** – there has been very little change in staff perceptions around quality of care, which scores 7.4 against a national average of 7.5. The main issue for staff is that they say they feel less able to deliver the care they aspire to.

Improvement activities planned for 2020/21 are set out below. These are aimed at creating an organisational culture where everyone is valued and is able to thrive at work, thus maximising the potential of our people to improve patient outcomes.

Additionally, as there are variations in the staff survey results across each Division, the results are being analysed for each individual Division or Directorate and separate plans are being developed to tailor actions to address staff survey findings as appropriate to each area. These plans will reflect not only delivery of the Trust's People Strategy objectives, but actions to improve staff engagement and motivation within each Division.

The report has been presented to the Transformation and People Committee who

- Raised concerns about team working, where the main issue seems to be that teams are either not meeting, or not meeting regularly, to discuss their objectives and this has led to a small decline in staff saying they feel supported by colleagues. This issue will be addressed in the Divisional action plans, where remedial actions can be tailored as required to specific areas.
- Asked how many Trusts were in acute benchmarking group (85 acute trusts)
- Considered the next steps set out below. Progress against these actions will be reported to the Transformation and People Committee in August 2020 and the effectiveness of our actions will be measured via staff feedback through focus groups and pulse check surveys, as well as through our culture assessment work.
- As additional level of information at a Divisional level will be provided for the Transformation and People Committee, providing a breakdown of each Division's RAG rating, the Divisional priorities to respond to these and assurance on follow up. The outcomes of the feedback from Divisional Performance Reviews and/or Performance Executive Group will be presented to the Transformation and People.

The report has also been presented to the Trust Executive Committee, following which actions were agreed with regards to a staff security to review and strengthen Trust Policy and initiate a high profile communications campaign assuring staff that there is 'no tolerance' to violence against staff.

Key Recommendations:

The Trust Board is asked to approve the following next steps:

To improve and evidence the positive action taken on health and wellbeing, we will:

- Continue to embed the Empactis system to support improvements to sickness absence case management and continue to promote staff wellbeing, including financial wellbeing, in line with the Trust's wellbeing plan. We will undertake specific work with the health and safety team and staff physiotherapy service to consider how we can provide further support to those staff members with musculoskeletal problems.

Towards improving equality and diversity, staff morale and a culture of safety, we will maintain the focus on:

- Building on the work that commenced during 2019 to promote careers, i.e. Apprenticeships; Project Search; career campaigns with a focus on diversity; engagement with Department for Work and Pensions, and ensuring that recruitment campaigns are targeted at a broad pool of talent from protected staff groups.
- Continuing to promote inclusion at all levels of our workforce and promoting workforce diversity by raising awareness of under-represented groups through our leadership offerings. We will continue to work with our staff networks to identify any barriers to accessing development opportunities.
- Embedding a just and learning culture, approach into disciplinary and capability processes and promoting civility and respect across all areas of the Trust.
- Working with the security team to redesign conflict resolution training to increase the number of sessions and tailor to particular service needs and raise awareness of the Trust's zero tolerance to violence and aggression

- Introducing disability awareness training for managers and further promote disability leave as a reasonable adjustment
- Reviewing freedom to speak up messaging at Induction to ensure all staff feel able to raise concerns. We will also introduce a ‘Speaking Up’ Staff Charter and embed ‘Cut It Out’ as ongoing messaging that violence, bullying and harassment are unacceptable behaviours.
- We will support Divisions to produce tailored action plans to address the survey findings specific to teach area and ensure that Divisional People Plans incorporate actions to address the above and to improve team working, promote team discussions and awareness of objectives.

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	11th March 2020
Report Title:	Gender Pay Gap Report	**Agenda Item:**	16
Author:	Assistant Director of HR/Head of HR Governance and Workforce Information Workforce Equality Manager		
Executive Lead:	Director of Human Resources		

Purpose of Report:					
Assurance	✓	**Approval**		**Information**	

Alignment to Strategic Objectives:		
SO1	Provide safe, effective, caring and responsive services	✓
SO2	Achieve NHS constitutional patient access standards	✓
SO3	Achieve excellence in employment, education, development and research	✓
SO4	Lead strategic change within Staffordshire and beyond	✓
SO5	Ensure efficient use of resources	✓

Summary of other meetings presented to and outcome of discussion:

Transformation and People Committee – 27.02.2020

Summary of Report, Key Points for Discussion including any Risks:

UK organisations employing 250 or more employees are required to publicly report on their gender pay gap in six different ways:

- the mean gender pay gap
- the median gender pay gap
- the mean gender bonus gap
- the median gender bonus gap
- the proportion of men and women who received bonuses, and
- the number of men and women according to quartile pay bands

The gender pay gap is a measure that shows the difference in average earnings between men and women across an organisation. It is expressed as a percentage of men's earnings. It is important to recognise that the gender pay gap differs to equal pay. Equal pay deals with the pay differences between men and women who carry out the same jobs, similar jobs or work of equal value, which is unlawful.

The issues that surround the gender pay gap and its reporting are complex and the causes are a mix of work, family and societal influences. As employers we will only be able to influence those factors associated with the workplace. Our People Strategy focuses on developing our culture and supporting all that we do to attract, recruit, develop, retain, support and reward our diverse workforce.

Positively, our 2019 Gender Pay Gap indicates a reduction in the gap between average earnings for women compared to men. The bonus gender pay gap has increased compared to the previous year although women are better represented in Clinical Excellence Awards than previously, which is very encouraging.

Key Recommendations:

Trust Board is asked to approve this report and the recommended actions to further reduce the Gender Pay Gap at UHNM.

University Hospitals of North Midlands NHS Trust

Gender Pay Gap Report

Employers with more than 250 employees must calculate figures comparing men and women's average pay across the organisation. This is known as the gender pay gap and is calculated as the percentage difference between average hourly earnings for men and women. It is important to note that the gender pay gap is different to equal pay, which looks at salaries for jobs with the same or similar responsibilities.

UHNM's pay approach supports the fair treatment and reward of all staff irrespective of gender. This is in line with our equality and diversity statement that was launched in May 2016. Remuneration to all staff, regardless of gender, is made in accordance with National Terms and Conditions.

This report fulfils the Trust's reporting requirements, analyses the figures in more detail and sets out what we are doing to close the gender pay gap in the organisation.

How do we compare with other similar organisations?

We can compare our gender pay performance against our Model Hospital recommended peers using the gender pay gap data from last year (31st March 2018 snapshot), which is available from the Government Gender Pay Gap Service website.

This tells us that UHNM is performing positively when compared with this group:

Trust	Mean Pay Gap	Median Pay Gap	Mean Bonus Pay Gap	Median Bonus Pay Gap	% of Women & Men in receipt of a bonus	% of Women in the highest paid roles
UHNM	**28.1%**	**10.3%**	**1.5%**	**1.2%**	**0.5% Women** **6.7% Men**	**66.4%**
Derby Teaching Hospitals NHS Foundation Trust	30.6%	17.1%	69.5%	98.2%	1.6% Women 7.9% Men	68.9%
Gateshead Health NHS Foundation Trust	29.8%	14.3%	45.0%	51.2%	0.8% Women 7.9% Men	70.9%
Nottingham University Hospitals NHS Trust	24.7%	7.7%	44.4%	34.3%	1.0% Women 6.7% Men	78.2%
Royal Wolverhampton NHS Trust	31.4%	16.2%	29.7%	17.8%	0.6% Women 5.4% Men	64.7%
Sheffield Teaching Hospitals NHS Foundation Trust	23.7%	9.2%	76.0%	92.0%	56.7% Women 43.3% Men	65.0%
University Hospitals Southampton NHS Foundation Trust	28.1%	10.6%	38.6%	19.2%	1.8% Women 9.7% Men	78.5%
University Hospitals Birmingham NHS Foundation Trust	28.7%	12.6%	67.7%	76.3%	1.0% Women 4.9% Men	57.6%
University Hospitals Coventry and Warwickshire NHS Trust	34.7%	25.9%	46.2%	55.8%	0.5% Women 5.2% Men	60.1%

Our Latest Gender Pay Gap Data

The data is a snapshot of pay taken on 31st March 2019

Based on Hourly Pay	At 31st March 2018	At 31st March 2019	What this means
Average (Mean) Pay Gap			
The mean gender pay gap is the difference in the average hourly rates of pay that male and female employees receive. The hourly rates of all male or female full-pay are added, and then divided by the number of male or female employees. The gap is calculated by subtracting the results for females from results for males and dividing by the mean hourly rate for males. This number is multiplied by 100 to give a percentage	28.05%	27.55%	Positively there has been a slight increase in the percentage of women in the upper pay quartile which has resulted in both the mean (average) and the median pay gap improving (i.e. reducing)
Median Pay Gap			
The median gender pay gap shows the difference in the midpoints of the ranges of hourly rates of pay for men and women. The individual hourly rates of pay are ordered from lowest to highest and the middle value is compared	10.34%	8.83%	
We are confident that our gender pay gap is a result of the workforce distribution, rather than an equal pay issue. This is because we adhere to the Agenda for Change system, national terms and conditions of service (TCS) for Medical staff and, for very senior managers (VSMs), there is a specific VSM pay framework. The Trust also has a robust job evaluation process in place.			

Bonus Pay Gap	At 31st March 2018	At 31st March 2019	What this means
Average (Mean) Bonus Pay Gap			
The mean gender bonus gap is the difference in the average bonus payment that male and female employees receive. Bonus payments (*see below) for all male or female employees are added, then divided by the number of male or female employees. The gap is calculated by subtracting the results for females from results for men and dividing by the mean hourly rate for men. This number is multiplied by 100 to give a percentage	1.45%	10.97%	The mean and median bonus pay gap have both increased this time, however, very positively the number of women in receipt of a Clinical Excellence Award (CEA) increased from 44 to 51. The number of males in receipt of a CEA, in comparison, increased by only 3 in the same period. Whilst this improvement in female representation is
Median Bonus Pay Gap			
The median gender bonus gap is calculated by arranging the bonus payments of all male or female employees from highest to lowest and find	1.15%	29.17%	

the point that is in the middle of the range			notable, new entrants to CEA Awards are likely to be at the lower end of the awards scale, which produces a greater gap in the mean and median bonus pay.
* Bonus payments relates only to Clinical Excellence Award (CEA) payments made to eligible Medical Consultant Staff. Clinical Excellence Awards recognise and reward NHS consultant medical staff who perform 'over and above' the standard expected of their role and who can demonstrate achievements in developing and delivering high quality care, and commitment to the continuous improvement of the NHS.			

The proportion of male and female workforce in each pay quartile was as follows at 31st March 2019:

	Female	Male
% of employees in the lower pay quartile	81.01%	18.99%
% of employees in the lower middle pay quartile	80.02%	19.98%
% of employees in the upper middle pay quartile	84.20%	15.80%
% of employees in the upper pay quartile	65.82%	34.18%
Number of employees receiving bonus pay (i.e. a Clinical Excellence Award)	51 (0.55% of all female employees)	186 (6.73% of all male employees)

Having a predominantly female workforce means that even small fluctuations in the proportion of male to female employees in each quartile will have a significant impact on our gender pay gap.

Supporting Gender Equality at UHNM:

- UHNM actively promotes careers and roles within the organisation and the wider NHS through our Widening Participation strategy and this includes breaking down traditional stereotypes and demonstrating female role models
- We ensure the consistent application of Agenda for Change job evaluation rules through the job evaluation process including consistency panels
- We use a transparent structured approach to shortlisting and interviews with agreed criteria to reduce bias in the recruitment process and we provide recruitment training to our managers
- We actively promote and publicise our commitment to flexible working options for all staff and through the provision of a range of family friendly policies and benefits including shared parental leave and paternity leave
- We promote our internal leadership development brochure to all staff and monitor applications to ensure all protected groups are represented
- We provide career coaching and mentoring
- We demonstrate through our inclusive recruitment strategy a range of women role models in various clinical and non-clinical roles
- We ensure all staff have a Personal Development Review, which uses the Maximising Potential Tool as an inclusive approach to identifying talent
- We use a Values Based approach into our recruitment processes

Progress from our previous Gender Pay Gap Report:

- We have reviewed and updated our Parental/Maternity Leave policy, to include occupational shared parental pay
- We have introduced a Special Leave Policy, including carer/domestic leave
- We have reviewed and updated our Clinical Excellence Award Policy and continue to monitor the diversity of applications
- We have reviewed our recruitment data to establish if there are gender imbalances, particularly for more senior positions in the organisation. A review of 12 months recruitment data for Agenda for Change Band 7 and above positions showed that 60% of applications were received from females and 40% male. Therefore, whilst men apply for senior roles in higher numbers than their representation in the workforce, and less so for females the data also indicates that women have a higher success rate of being shortlisted from application and going on to be appointed
- Launched the UHNM Talent Management Strategy
- Reviewed entries into our internal leadership development programmes to ensure they are representative of our workforce
- Reviewed our leaver information and found that women are not disproportionally leaving the organisation

The outcomes of this work can be measured in terms of improvements in the Annual Staff Survey Results:

2019 Annual NHS Staff Survey Results:	2018	2019
Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age?	80.9%	84.3%
In the last 12 months have you personally experienced discrimination at work from manager / team leader or other colleagues?	8.6%	7.4%
Has your employer made adequate adjustment(s) to enable you to carry out your work?	70.1%	73.4%
My appraisal left me feeling that my work is valued by my organisation	28.1%	31.2%
I would recommend my organisation as a place to work	57.2%	60.4%

Actions to reduce the Gender Pay Gap:

The information from this gender pay gap audit will be used to help understand any underlying causes for the gender pay gap so that the Trust can take suitable steps to minimise it. Whilst structural changes to the workforce will take time to work through, we are prioritising the following areas for action:

- Reviewing our Flexible Working Policy
- Promoting women's networking forums and development opportunities
- Talent management and introduction of divisional learning and education boards
- Launch of the Staffordshire High Potential Scheme - a fully funded 24-month career development scheme to help high potential, aspiring middle level clinical or non-clinical NHS leaders accelerate their career to senior executive roles at a faster pace. There has been particular emphasis on encouraging applications from protected groups including females
- Undertake an agile working review across the organisation
- Focus on menopause in the workplace as part of our wellbeing activities
- Be proactive in our conversations with staff who may be thinking about leaving the organisation to understand the reasons

This report must be published on the UHNM website and the data reported on a designated government website at www.gov.uk/genderpaygap

Appendix 1

Notes and Explanations

1 Explaining the Gender Pay gap:

Our gender pay gap is influenced by the make-up of our workforce which has:

- A greater proportion of male employees in the upper pay quartile compared to lower quartiles and
- A greater proportion of female employees in the lower pay quartiles compared to the upper quartile

Having a predominantly female workforce means that even small fluctuations in the proportion of male to female employees in each quartile will have a significant impact on our gender pay gap

An example of how a Gender Pay Gap can come about:

~ *An organisation comprises 10 staff and 1 manager*
~ *The 10 staff are 9 females and 1 male and they all earn exactly £50,000 per year so they are all on equal pay*
~ *The manager, who is a man, earns £100,000 per year*
~ *The average salary for women in this organisation is £50,000*
~ *The average salary for men is (£50,000 + £100,000 / 2) = £75,000*
~ *The gender pay gap is therefore £25,000 or 50%*

2 Explaining the Data

The data is a snapshot of pay taken on 31st March 2019 with the data presented in line with six key indicators:

- Average gender pay gap as a mean average
- Average gender pay gap as a median average
- Average bonus gender pay gap as a mean average
- Average bonus gender pay gap as a median average
- Proportion of males and females receiving a bonus payment
- Proportion of males and females when divided into four quartile pay bands

It is important to note that the gender pay gap may vary by occupation, age group and even working patterns.

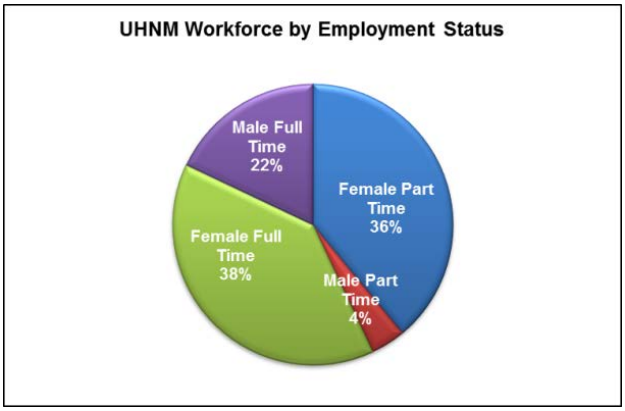
Note: The Trust does use agency workers who are not included in the data because they are part of the headcount of the agency company that provides them

3 How our workforce was made up (as at 31st March 2019)

UHNM is typical of any NHS Trust in that it has a higher number of females than males in its workforce. From a total headcount of 10,724, 78% were female compared to 22% men.

Staff Group	Female	Male
Additional Professional, Scientific and Technical	77%	23%
Additional Clinical Services	84%	16%
Administrative and Clerical	83%	17%
Allied Health Professionals	79%	21%
Estates and Ancillary	53%	47%
Healthcare Scientists	65%	35%
Medical and Dental	36%	64%
Nursing and Midwifery Registered	91%	9%

Agenda for Change Pay Band	Female	Male
Band 1	74%	26%
Band 2	82%	18%
Band 3	84%	16%
Band 4	82%	18%
Band 5	87%	13%
Band 6	85%	15%
Band 7	82%	18%
Band 8a	77%	23%
Band 8b	67%	33%
Band 8c	71%	29%
Band 8d	56%	44%
Band 9	70%	30%



Executive Summary

Meeting:	Trust Board (Open)	**Date:**	11th March 2020
Report Title:	Operational Performance, month 10	**Agenda Item:**	
Author:	Performance & Information team		
Executive Lead:	Helen Ashley: Director of Strategy & Performance		

Purpose of Report:					
Assurance	✓	**Approval**		**Information**	

Alignment to Strategic Objectives:		
SO1	Provide safe, effective, caring and responsive services	✓
SO2	Achieve NHS constitutional patient access standards	✓
SO3	Achieve excellence in employment, education, development and research	✓
SO4	Lead strategic change within Staffordshire and beyond	✓
SO5	Ensure efficient use of resources	✓

Summary of other meetings discussed with and outcome of discussion:

Summary of Report, Key Points for Discussion including any Risks:

1. OPERATIONAL PERFORMANCE

EMERGENCY CARE

The 4 Hour Access Standard in January achieved 76.35% (December 73.34%) against the NHSI 90% performance trajectory. The 2019/20 winter plan has been modelled on the demand and acuity profile for 2017/18. In January 2020 performance was better compared to 2017/18 (76.35% compared to 69.10%).

In January, there were 246 breaches of the 12 hour standard compared to 321 in December 2019 with contributory factors being the final flu demand cohort impact,1st – 9th January with similar profile of higher acuity of patients and demand for overnight beds.

Summary:

From the 9th January, the drivers for performance started to change. Flu cases started to abate but then the and majors attendance profile reduced but length of stay increased due to the impact of norovirus at UHNM (46 patients) which resulted in closure of 3 wards, with restricted beds. This aligned to Community IPC issues resulting in closed CCG/Community beds which increased MFFD, stranded and super stranded length of stay with delayed complex discharges. Whilst urgent care demand returned to forecast levels, simple discharges started to increase after the first week January which released capacity to decongest ED which significantly offset any further 12 hour breaches.

The following measures have been implemented following lessons learnt from December to mitigate against the risk of further 12 hour breaches should UHNM experienced similar spikes in urgent care demand/acuity:-

De-escalation plan enacted to secure 14 beds on Ward 110 and up to 19 beds on Ward 75 with a reduction of outlier volumes.

Bolstering the workforce to ensure more comprehensive 7 day cover, especially in ED and acute medicine and the provision of Discharge Facilitators over the weekend (this was in addition to what was included in

the Winter Plan).
Reviewed the simple and timely and complex discharge targets by day of the week compared to daily demand profiles (i.e. increased discharges Monday/Tuesdays with emphasis on Golden Pts. for pre 10 am discharge to support early decongestion of ED.
A&E and EPIC decisions on pts. waiting over 12 hours with no decision to admit, and daily, early escalation of pts. in CDU for Social Care to ensure daily clearance to support ED 4 hour performance.
Winter plan debrief sessions with multi stakeholder attendance planned for March 2020 to inform lessons learnt to support 20/21 winter plans which includes a focused session with ED and Specialty Leads around IPS standards compliance.
Introduction of the Specialised Decision Unit Portal (1st March) to improve IPS pull for patients and improvement in 4 hour performance.

Next Steps:

- Progress actions to support improved ED processing and sustained delivery of 4 hr. performance against trajectory and improving the long waits
- Review of Medical Workforce using ECIST model as a benchmark.
- Progress work on active pull from ED into portals (Specialised portal on line from 1st March 2020)
- Maximise the simple and timely discharges
- Continue with the improved oversight simple/complex discharges against demand on a daily/weekly basis through review of performance reports (MADE).
- Smaller more targeted MADE events to continue to tackle long stay/complex patients that need multi stakeholder support to discharge.
- Escalation beds to remain open in line with Winter plan plus additional capacity (ward 110 -14 beds) for medicine to manage the demand.
- De-escalation of Ward 110 and half of W75 on plan for delivery by 14th February 2020 to support further surge in demand over predictor. Surgery and Specialised also cohorting patients to preserve some ward escalation capacity across their respective ward footprints.

RTT

RTT performance is 80.15% against an Internal trajectory of 85.32% and an NHSi trajectory of 83.5%. The number RTT incomplete pathways are tracked against the waiting list size required to deliver 92% and 85%. Currently the waiting list size is 48,357 which is an increase on the numbers reported in December (48, 140) This is above the internal target of 46,236.

PTL Growth Drivers:
Winter impact electives & creation of escalation bed capacity to offset extreme pressure
Leighton PTL impact
Specialty demand: dermatology, UGI, Urology, Neurology
RTT performance deterioration marked in Spinal pathways from 70.3% in Nov-19 to 62.9%.
Trauma and Orthopaedics ceased elective operating at the Royal Stoke site on December 15th in order to de-escalate 14 beds to provide Medical Division with additional capacity. Although urgent cases including scoliosis continued. Mitigations included transfer of activity to County hospital - 19 theatre sessions commissioned (40 pts.)
Oral Surgery saw deterioration in performance down to 65.2%. This is due to vacancies and the Directorate are exploring the market for a locum until new appointment begins end of February.

Next steps:

- Divisional performance improvement trajectories reset to end of March to ensure 52 ww compliance and tracking of RTT standard.
- T&O Elective beds used for escalation capacity to be returned to Ward 110 in February.
- Re organisation of the theatre performance group now to be chaired by the AD
- Weekly monitoring 40/52 wk. position with expedited escalation and mapping of specialty service changes
- Tactical Validation oversight of Incomplete Waiting List to keep focus on attainment of trajectory at month end

- Risk Stratification of the follow ups waiting list
- Validation Rules for the identified follow up cohorts and development of the SOPs in relation to the follow up backlog.

CANCER

Performance / Assurance
The Cancer 62 day performance is 63.19% against an internal trajectory of 74.0%.
Total cancer 62 day treatments for January '20 to date are 159. However, there are an additional 64 treatments (46 skin) with no confirmed diagnosis many of which are waiting histology results, this may yield more treatments and improve the month end.
2WW appointments in January 20 were slightly more at **2562** (*not including breast symptomatic*) against December **2517**.

WMCA has offered 100k to West Midlands Trusts to support improvement in cancer performance before year end. UHNM primary scheme submission in support of PTL deep dive validation to support opportunities for improved performance due to strict application of best practice guidance. (Outcomes to be subject to clinical and corporate governance approval).
A deep dive of the Gynaecology specialty is underway to accelerate recovery to improve overall Trust performance whilst sustainability plans are developed and strengthened. This is to be followed with UGI, Urology, Breast and Skin.
The recently introduced Governance & Performance framework is beginning to work well with attendance monitored, focus given to ensuring effective plans are in place to manage patients through their pathway within target, escalating blockages and ensuing that assurance and risk are clearly documented. These meetings feed directly into the Corporate Cancer / COO meeting and the new cancer weekly report.
A new weekly cancer operational meeting covering 11 key action areas has been planned to support CWT performance recovery, these meetings are attended by specialty Divisional Managers together with support services. First session 17th February 2020.
A series of 2WW audits with WMCA have commenced from 14th February 2020 with new colorectal referrals having a priority focus given the volume.
IST critical friend visit on 24th and 27th February 2020 to support our cancer recovery programme, particularly supporting with patient access and user compliance, cancer performance / assurance cycle, and the colorectal referrals increase / plan.
Colorectal recovery plan is in final draft. This is a complex, multi stakeholder plan that will require investment and Commissioner support to deploy to full benefits realisation. Commencing Triage to Test backlog recovery plan from 1st March 2020.

Next Steps:
- A comprehensive Deep Dive/validation of the cancer PTL is planned from 17th February 2020 to seek improvements in year end cancer performance.
- Design and development of new Cancer Performance Dashboard is in progress to facilitate one stop access to information and visibility of in week actions, forecasting and performance. .
- Final draft Cancer Transformation, Improvement and Recovery Programme completed.
- Triage to Test (TTT) colorectal pilot commissioned to end of March with daily monitoring of outputs.
- NHSEi follow up meeting 12th March 2020 to review outcomes of enabler works in train around cancer recovery with focus on colorectal and UHNM support requirements – Commissioner support with demand management/funding opportunities.

DIAGNOSTICS
The standard achieved 99.40%

2. CARING AND SAFETY

The Trust achieved in January 2020:

• Zero mixed sex accommodation breaches

• Zero never events
• Written Complaints (31.41 Vs. a target of 35 per 10,000 spells)
• The Family & Friends for Inpatients and Maternity were above target for positive reporting
• Family & Friends for A&E, 95.6% positive response against a National target of 70%
• Zero MRSA Bacteraemia Infections
• Achieved the target reduction for all categories of Hospital Acquired, Trust Apportioned, Pressure Ulcers
• The number of patient falls resulting in low harm or above (58 vs. 60, internal target)

The Trust failed the set standards for:
• VTE, 92.48% against an operational standard of 95%
• C-Diff cases were 12 for the month against the plan of 8

3. FINANCE

The financial position for the Trust at Month 10 is a £2.6m surplus, which is £6.2m positive variance against the £3.6m deficit plan.
Operating income at month 10 of the financial year is £647.5m; this is £1.3m above plan.
Pay expenditure is £399.3m at Month 10, £6.2m positive variance to plan. Non Pay spend is £50.8m at Month 10 which is an overspend of £2.4m.
The CIP Target within the plan is £40.0m. At month 10 the Trust has achieved £28.8m of savings, which is £1.6m below plan.
The Trust's Planned Capital Expenditure for the year is £26.2m. The Trust has spent £16.2m to Month 10.
The Trust's current liabilities exceed its current assets by £4.7m.

4. ORGANISATIONAL DEVELOPMENT

In January the in-month sickness rate reduced to 5.41% (5.85% in December) and the 12m Cumulative Rate reduced to 4.55%. The sickness rate is in line with previous year trends over the winter period and an increase in reported absence was expected with the implementation of Empactis.
The PDR rate was 79.28% (76.1% previously). This is now reported from ESR for all Divisions
The Statutory and Mandatory training rate at 31st January 2020 was 90.03% (90.20% at 31st December 2019). The slight decrease was a result of an increase in staff in post headcount rather than a decrease in compliance. The Statutory & Mandatory training rate shows compliance against the seven (Core for All) 3 yearly competency requirements and 83.29% of staff have completed all 7 modules

Key Recommendations:

To note performance

University Hospitals of North Midlands NHS
NHS Trust

PROUD TO CARE

Author: Karan Allman: Head of Performance
Executive Lead: Helen Ashley: Director of Strategy & Performance

Month 10 2019/20 Integrated Performance Report

Contents

Feb-20

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Context & NHS I Single Oversight Framework

The NHS Improvement (NHSI) single oversight framework was implemented from October 2016 and revised August 2019. The framework is comprised of 35 metrics across the following domains:
1. Finance and use of resources
2. Operational performance
3. Organisational health
4. Quality of Care - safety, caring and Effectiveness

Changes to oversight is categorised by several key principles: NHSE & NHSi speaking with a single voice; a greater emphasis on system performance, working with and through system leaders, matching accountability for results; greater autonomy for systems with evidenced capability for collective working and track record of successful delivery of NHS priorities.

The metrics identified in the framework are used as triggers by the regional teams to identify potential concerns and support levels required. There are four levels of support, ranging from 1. maximum provider autonomy to 4. special measures. As a consequence of the application of financial special measures the Trust has been placed in 4.

The following sections of this performance report provide detail in relation to performance drivers and recovery actions at Trust and Hospital Site level in relation to the NHSI single oversight framework indicators.

Performance against National Constitutional Standards
The NHSI single oversight framework includes five constitutional standards:
1. A&E
2. Diagnostic six week waits
3. RTT 18-weeks
4. All cancer 62 day waits
5. 62 day waits from screening service referral

NHS Improvement Single Oversight Framework

The following report is designed to present performance, by exception, against the NHS Improvement Single Oversight Framework. In addition the Trust is developing other domains against which to view performance; however additional domains will be constructed over time. Spotlight reports are also included where performance against indicators that sit outside current domains have been flagged as exceptions, or where specific areas require highlighting.

Operational Performance:

The following performance standards were achieved in January 2020:
• Cancer, 2ww Symptomatic Breast (100%) – national standard 93%
• Zero > 52 weeks RTT waits
• 6 week Diagnostic wait (0.60%) - national standard of 1%

The following standards were not achieved in January 2020:
• Cancer, 2ww Suspected Cancer (74.16%) - national standard 93%
• Cancer, 31 Day First Treatment (94.07%) - national standard 96%
Cancer, Subsequent Surgery (75.93%) - national standard 94%
• Cancer, Subsequent Anti-Cancer Drug (95.52%) - national standard 98%
• Cancer, Subsequent Radiotherapy (91.45%) - national standard 94%
• Cancer, 62 day (62.25%) – national standard is 85%
• Cancer, 62 day screening (76.92%) – national standard 90%
• 4 hour emergency access standard (76.35%) – national standard 95%
• 246 12 hour trolley waits
• 18 week referral to treatment (RTT) standard (80.15%) – national standard 92%

*cancer performance for January remains provisional at 26/02/20, deadline for submission is 7th March 2020. Week end validation at end of February has improved 31 and 62 day performance with further work being conducted on 14 and 28 days ahead of the cut off.This will be profiled ahead of the cut off. Further validation against best practice pathways will continue for Q3 and Q4 with an option for resubmission of data set following NHSEI approval.

Caring and Safety:
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Context

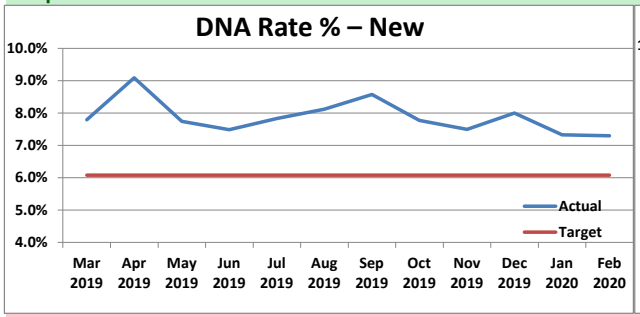
12 month rolling		Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Variance of current vs. pervious month (no adjustments for Nos. of days in the month)
A&E	A&E Attendances - RSUH, County, Emerg Eye Clinic, WIC & MIU	19247	21008	21165	21355	20872	22366	21483	21163	21697	21697	21099	20665	0	**-20665**
	Urgent Care Centre only - Vocare	1663	1821	1897	1879	1624	1735	1541	1557	1637	1757	2325	1857		**-1857**
	Total A&E Attendances	20910	22829	23062	23234	22496	24101	23024	22720	23334	23454	23424	22522		**-22522**
	Daily average for total attendances	746.8	736.4	768.7	749.5	749.9	777.5	742.7	757.3	752.7	781.8	755.6	726.5	0.0	**-726.5**
Inpatients	Elective - overnight	1216	1253	1141	1201	1180	1210	1196	1221	1326	1235	1067	1053	1108	**55**
	Elective - day cases	7692	8481	7825	8111	7537	8238	7797	7854	8273	7999	7327	8194	7339	**-855**
	Non-Elective discharges	10168	10797	10720	11288	10459	10741	10685	10416	11137	10942	10532	10622	9843	**-779**
	Other - regular day/ night	352	353	389	386	353	402	367	357	405	370	361	423	357	**-66**
Outpatient	First new	28074	30027	28186	27861	25402	27366	24489	26833	29839	26093	24970	27144	24724	**-2420**
	Subsequent	40271	41620	39811	43611	40055	43912	39530	40751	45515	42264	36594	43971	39232	**-4739**

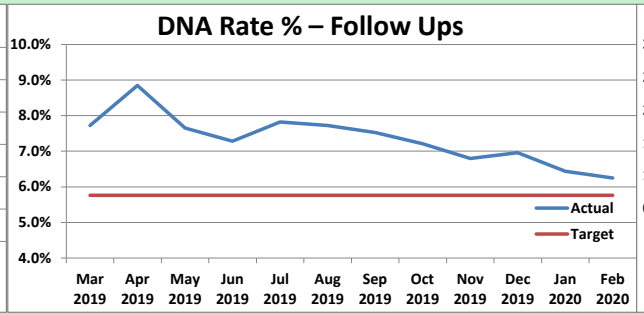
Summary:
All activity in Non-elective care was down this month compared to last month. The daily average for total ED attendances was 726.5 and for Type 1 Royal Stoke only the daily average was 362.

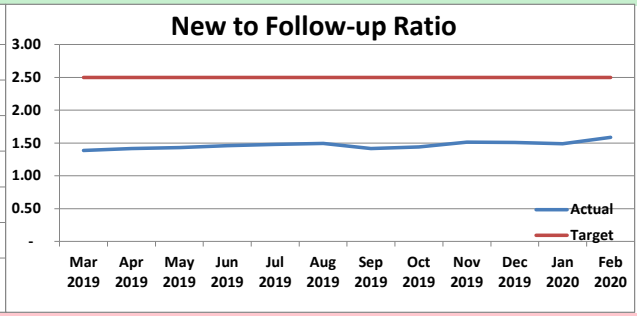
Total A&E attendances (excluding UCC) in January were up by 1.4% from the same period last year.

Productivity

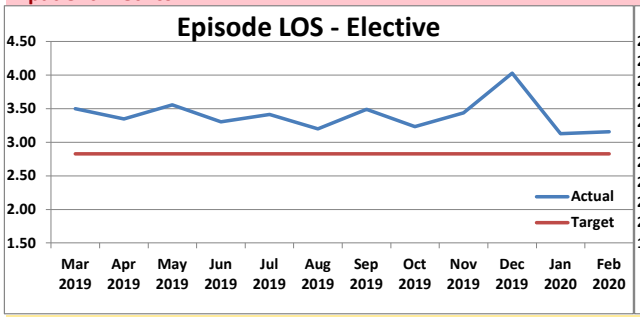
Outpatient Metrics

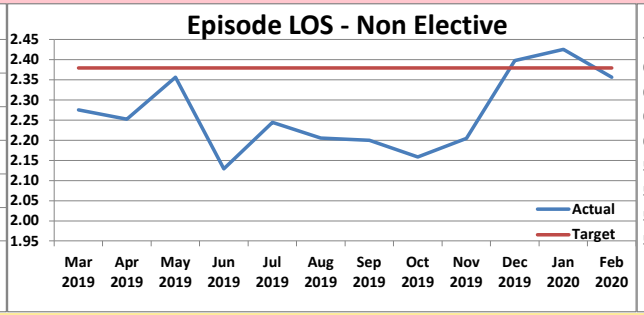


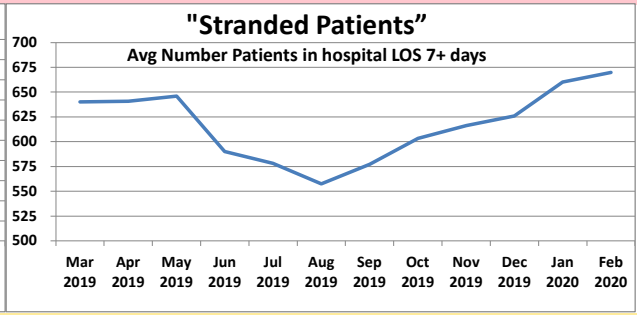




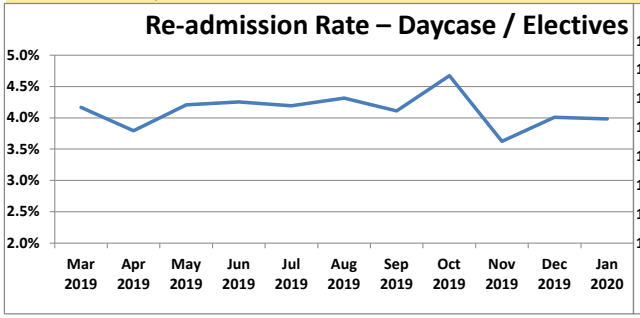
Inpatient Metrics

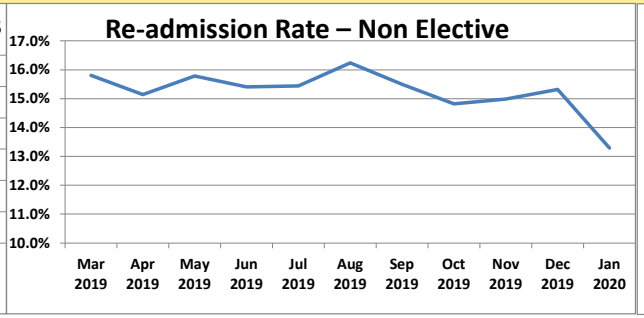


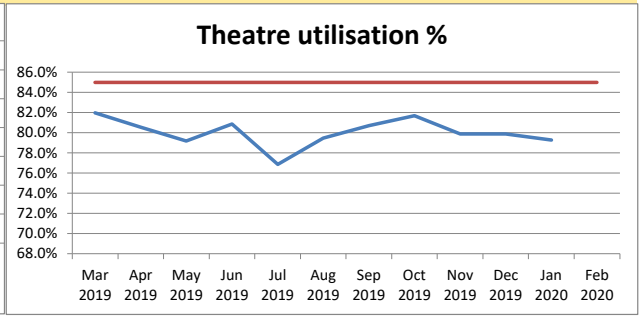




Re-admission Rates; Theatre Utilisation







re-admission rates are reported for previous month

NHS Improvement Framework

		Rolling Qtr. 18/19/20				2019 -20				
		Q4	Q1	Q2	Q3	Jan-20	Feb-20	Mar-20	Q4	
Financial Rating	Capital service capacity	4	4	4	4	4				G
	Liquidity (days)	4	3	3	3	3				G
	I&E margin	4	4	4	4	4				G
	Distance from financial plan*	3	1	1	1	1				G
	Agency spend	1	1	1	1	1				G
Operational Performance	A&E- 95% of patients admitted, transferred or discharged within 4-hours	80.76%	80.81%	79.38%	74.99%	76.35%			76.35%	R
	Diagnostic 6-week wait performance 99% target	98.59%	97.89%	98.61%	99.47%	99.40%			99.40%	G
	RTT 18-weeks incomplete pathways - 92%	80.02%	79.98%	79.81%	81.81%	80.15%			80.15%	R
	All Cancer 62 day wait for first treatment:									
	from urgent GP referrals - 85%	76.38%	71.43%	71.78%	69.07%	62.25%			62.25%	R
	from a screening service - 90%	82.28%	79.33%	87.43%	89.41%	76.92%			76.92%	R

NHS Improvement Framework

		Rolling Qtr. 18/19/20				2019-20				
		Q4	Q1	Q2	Q3	Jan-20	Feb-20	Mar-20	Q4	
Organisational health	Staff Sickness (12m cumulative rate as at end of each quarter)	-	4.52%	4%	4.51%	4.55%			4.55%	R
	Staff turnover (Leavers in previous 12 months as % of Average Headcount)	-	0.0961	10%	9.05%	9.05%			9.05%	G
	Statutory and Mandatory Training Rate - for seven 3 yearly competencies	-	92.53%	92%	90.20%	90.03%			90.03%	R
	Proportion of Temporary staff (as a % of budgeted establishment) In month figure only	-	6.24%	6%	6.27%	6.35%			6.35%	
	Appraisal rates (12 month rolling average) - Trust (excl Consultant Medical Staff)	-	91.54%	85%	83.44%	79.28%			79.28%	R
	Staff Friends & Family Test % Recommended- Care, Quarterly (HR)	80.4%	n/a		n/a	73.9%			74%	G
	Agency costs as a % of total pay cost	-	3.56%	4%	4.05%	3.91%			3.91%	
Caring	Written Complaints- rate (per 10,000 spells)	30.67	32.89	30.04	29.68	31.41			31.41	G
	Mixed Sex Accommodation Breaches	0	0	0	0	0				G
	Inpatient Scores from Friends & Family Test- % positive	97.90%	98.20%	98.40%	98.3%	98.4%			98.4%	G
	A&E Scores from Friends & Family Test- % positive	69.70%	68.40%	67.00%	65.1%	95.6%			95.6%	G
	Maternity Scores from Friends & Family Test- % positive	100.00%	100.00%	100.00%	99.1%	100.0%			100.0%	G

NHS Improvement Framework

		Rolling Qtr. 18/19/20				2019-20				
		Q4	Q1	Q2	Q3	Jan-20	Feb-20	Mar-20	Q4	
Safe	Never Events	2	3	0	2	0			0	G
	Emergency C-section Rate (as a % of total births)	15.03%	14.93%	13.01%	14.24%	15.26%	14.86%		15.06%	
	VTE Risk Assessment	94.67%	93.79%	93.99%	93.29%	92.48%			92.48%	R
	Clostridium Difficile- variance from plan	-9	-1	1	13	5			5	R
	Clostridium Difficile- numbers	11	23	25	35	12			12	R
	MRSA bacteraemia	0	0	0	0	0			0	G
	Potential under-reporting of patient safety incidents	-	-	-	-	-				
Effective	Hospital Standardised Mortality Ratio (HED)*	tbc	tbc	tbc	tbc	tbc				G
	Hospital Standardised Mortality Ratio- Weekend admission (HED)*	tbc	tbc	tbc	tbc	tbc				G
	Summary Hospital Mortality Indicator*	tbc	tbc	tbc	tbc	tbc				G
	Emergency re-admission within 30 days following an elective or emergency spell at the Provider - 1 month behind	3378	3732	3692	3194	974	not yet available			G

1. FINANCIAL RATING

Domain Scorecard

Feb-20
Page 9

	Ref	Indicator	Exception Triggers			Period	Performance			
			Month Target	Step Change	Conti. Limit		This Period Target	Last Period	This Period	YTD
Financial Planning	F1	Capital service capacity	4			Feb-20	4	4	4	4
	F2	Liquidity (days)	4			Feb-20	4	3	3	3
	F3	I&E margin	4			Feb-20	4	4	4	4
Financial Control	F4	Distance from finance plan	1			Feb-20	1	1	1	1
	F5	Agency spend	1			Feb-20	1	1	1	1

Finance KPI Ratings Key

			Ratings			
			1	2	3	4
Financial Sustainability	**F1**	Capital service capacity (times)	>2.5x	1.75-2.5x	1.25-1.75x	<1.25x
	F2	Liquidity (days)	>0	(7) - 0	(14) - (7)	<(14)
Financial Efficiency	**F3**	I&E margin (%)	>1%	1-0%	0 - (1)%	< - (1)%
Financial Controls	**F4**	Distance from financial plan (%)	> = 0%	(1) - 0%	(2) - (1)%	< = (2)%
	F5	Agency spend above ceiling (%)	< = 0%	0% - 25%	25 - 50%	>50%

1. FINANCE - Key Metrics - Trust Wide	Domain Scorecard	Feb-20 Page 10

		2019/20	RAG		
	£millions	Year To Date	Year To Date		
Trust Deficit	Budget	-3.6			
	Actual	2.6	G	↑	The financial position for the Trust at Month 10 is a £2.6m surplus which is £6.2m positive variance against the £3.6m deficit plan
	Variance	6.2			
Trust Income	Budget	646.2			
	Actual	647.5	G	↑	Operating income at month 10 of the financial year is £647.5m; this is £1.3m above plan.
	Variance	1.3			
Operating Expenditure	Budget	-654.0			
	Actual	-650.1	G	↑	Pay expenditure is £399.3m at Month 10, £6.2m positive variance to plan. Non Pay spend is £50.8m at Month 10 which is an overspend of £2.4m.
	Variance	3.9			
	Budget	30.4			
Cost Improvement	Actual	28.8	R	↓	The CIP Target within the plan is £40.0m At month 10 the Trust has achieved £28.8m of savings, which is £1.6m below plan.
	Variance	-1.6			
Capital Spend	Budget	-17.8			
	Actual	-16.2	G	↑	The Trust's Planned Capital Expenditure for the year is £26.2m. The Trust has spent £16.2m to Month 10.
	Variance	1.6			
Working Capital	Current Assets	92.0			
	Current Liabilities	-96.7	A	↑	The Trust's current liabilities exceed it's current assets by £4.7m
	Total	-4.7			

Key to RAG Status

Colour Indicates YTD status of variance / working capital position(green is favourable, red is adverse) Arrow indicates change in the metric since last month(up is improving, down is deteriorating)

2. OPERATIONAL PERFORMANCE	Domain Scorecard	Feb-20 Page 11

			Exception Triggers					*Performance*				*Site Breakdown*			
	Ref	**Indicator**	**Month Target**	**Step Change**	**Conti. Limit**	**Period**	**This Period Target**	**Last Period**	**This Period**	**YTD**	**RSUH ED only**	**County ED only**	**UHNM total**	**Except.**
Waiting Times	R1	A&E 4 Hours Waiting Time	R			Feb-20	85%	76.35%					0.00%	√
	R7	Cancer 62 days from Urgent GP Referral	R			Feb-20	85%	72.02%	62.25%	70.11%			62.25%	√
	R13	Cancer 62 Days from Screening Programme	R			Feb-20	90%	80.00%	76.92%	84.52%			76.92%	√
	R6	Diagnostic Waits Under 6 Weeks	G			Feb-20	>99%	99.40%					0.00%	
RTT- 18 Weeks	OP34	RTT Incomplete	R			Feb-20	92%	80.15%					0.00%	√
Service User Support	R30	Duty of Candour	G			Feb-20	100.0%	100.0%	100.0%	100.0%			100%	

The 4 Hour Access Standard in November achieved 76.35% (73.34% in December)

Summary:

The 4 Hour Access Standard in January achieved 76.35% (December 73.34%) against the NHSI 90% performance trajectory. The 2019/20 winter plan has been modelled on the demand and acuity profile for 2017/18. In January 2020 performance was better compared to 2017/18 (76.35% compared to 69.10%).

In January, there were 246 breaches of the 12 hour standard compared to 321 in December 2019 with contributory factors being the final flu demand cohort impact,1st – 9th January with similar profile of higher acuity of patients and demand for overnight beds.

From the 9th January, the drivers for performance started to change. Flu cases started to abate but then the and majors attendance profile reduced but length of stay increased due to the impact of norovirus at UHNM (46 patients) which resulted in closure of 3 wards, with restricted beds. This aligned to Community IPC issues resulting in closed CCG/Community beds which increased MFFD, stranded and super stranded length of stay with delayed complex discharges. Whilst urgent care demand returned to forecast levels, simple discharges started to increase after the first week January by c80 patients per week and which released capacity to decongest ED which significantly off set any further 12 hour breaches.
The following measures have been implemented following lessons learnt from December to mitigate against the risk of further 12 hour breaches should UHNM experienced similar spikes in urgent care demand/acuity:-

De-escalation plan enacted to secure 14 beds on Ward 110 and up to 19 beds on Ward 75 with a reduction of outlier volumes.
Bolstering the workforce to ensure more comprehensive 7 day cover, especially in ED and acute medicine and the provision of Discharge Facilitators over the weekend (this was in addition to what was included in the Winter Plan).
Reviewed the simple and timely and complex discharge targets by day of the week compared to daily demand profiles (i.e. increased discharges Monday/Tuesdays with emphasis on Golden Pts. for pre 10 am discharge to support early decongestion of ED.
A&E and EPIC decisions on pts. waiting over 12 hours with no decision to admit, and daily, early escalation of pts. in CDU for Social Care to ensure daily clearance to support ED 4 hour performance.
Winter plan debrief sessions with multi stakeholder attendance planned for March 2020 to inform lessons learnt to support 20/21 winter plans which includes a focused session with ED and Specialty Leads around IPS standards compliance.
Introduction of the Specialised Decision Unit Portal (1st March) to improve IPS pull for patients and improvement in 4 hour performance.

Positive Assurances:

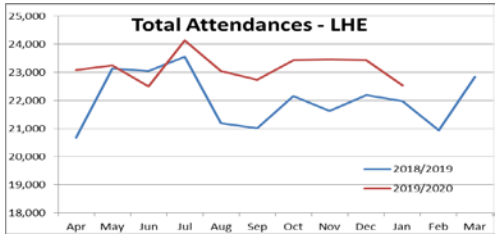
4 hour performance across all localities improved in January. The greatest performance increase was seen at County (increase of 5% from December) with a rise in attendances of 2.6% .
The median time to initial assessment for type 1 attendances was 11 mins, below the 95th percentile target of 15 mins. This was 11 mins at the same time last year.
Although January started with 12 hour breaches (246 in total), there has been zero reported since the 9th January and of those that were reported and RCAs undertaken no harm to patients has been identified.
The number of patients admitted to Same day Emergency Care returned to > 30%.
Performance in February against the 4 hour standard has improved (>8th February over 80%) – accepting demand profile and acuity reduction possibly linked to Covit-n19 awareness.
The number of simple and timely discharges in January increased to an average of 1040 per week from a previous five week average of 992.

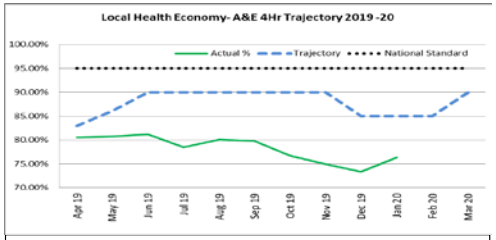
Next Steps:

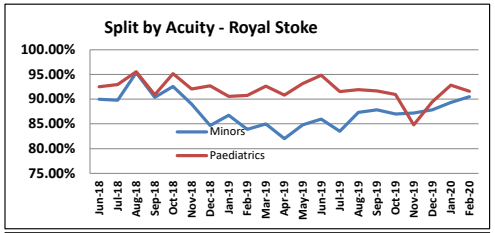
Progress actions to support improved ED processing and sustained delivery of 4 hr performance against trajectory and improving the long waits
Review of Medical Workforce using ECIST model as a benchmark.
Progress work on active pull from ED into portals (Specialised portal on line from 1st March 2020)
Maximise the simple and timely discharges
Continue with the improved oversight simple/complex discharges against demand on a daily/weekly basis through review of performance reports (MADE).
Smaller more targeted MADE events to continue to tackle long stay/complex patients that need multi stakeholder support to discharge.
Escalation beds to remain open in line with Winter plan plus additional capacity (ward 110 -14 beds) for medicine to manage the demand.
De-escalation of Ward 110 and half of W75 on plan for delivery by 14th February 2020 to support further surge in demand over predictor. Surgery and Specialised also cohorting patients to preserve some ward escalation capacity across their respective ward footprints.

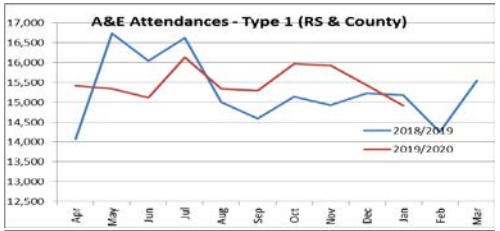
Risks:

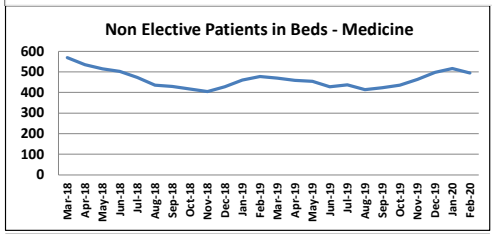
The possibility of prolonged surges particularly with Flu and Noro Virus – de-escalation plans enacted to mitigate.
Covit-n19 escalation - urgent care demand and any related impact on workforce linked illness.
Ability of UHNM to drive timely simple discharges through earlier discharge planning and use of Discharge Lounge/Golden patient moves.
Availability of system capacity to support more complex discharges. EMI/Specialist mental health, out of county repats – Mini MADES to enable.
MFFD clearance to time is not sustained in the South. Focus of System Leader calls but impact not sustained.

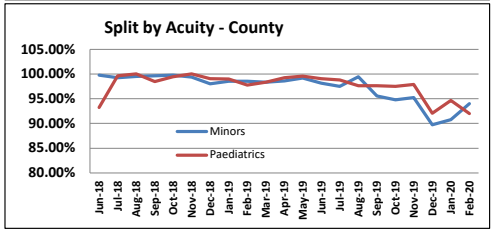


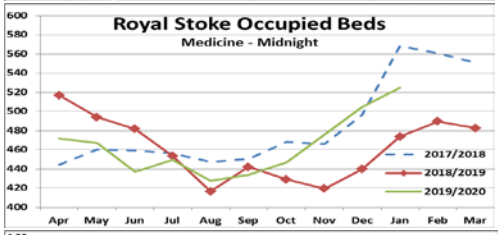


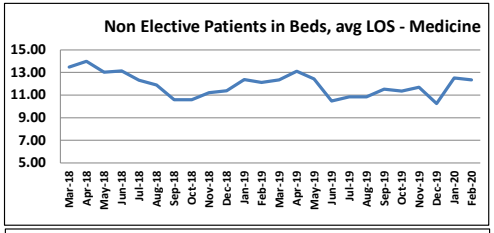


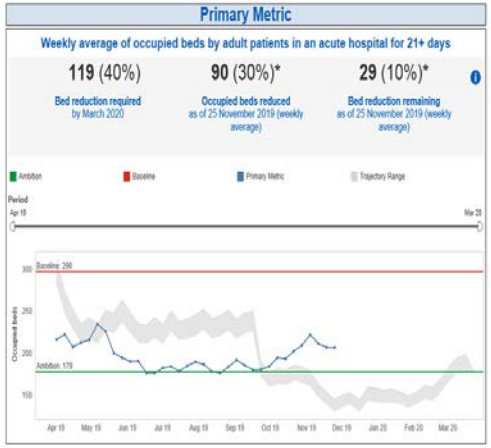


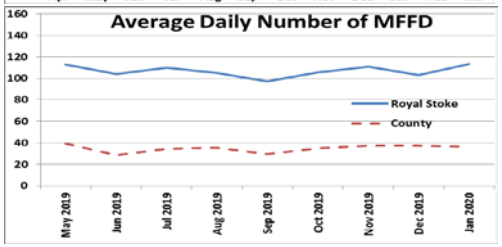


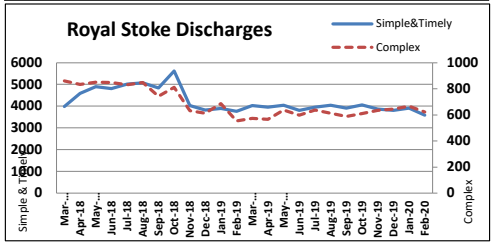












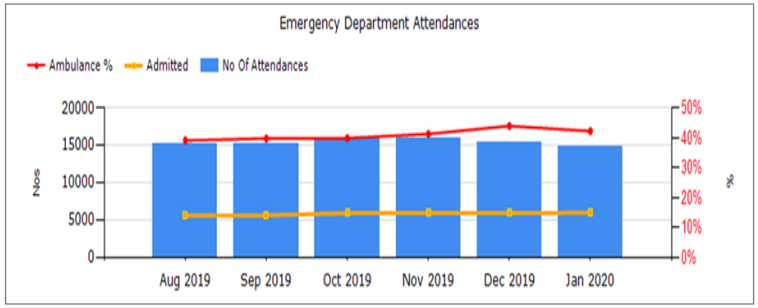
Summary

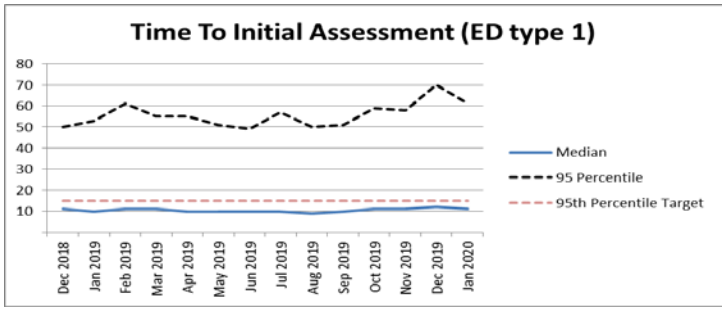
Operational A&E performance was 76.35% against the national standard (95% of patients seen and treated / transferred in A&E within 4-hours).

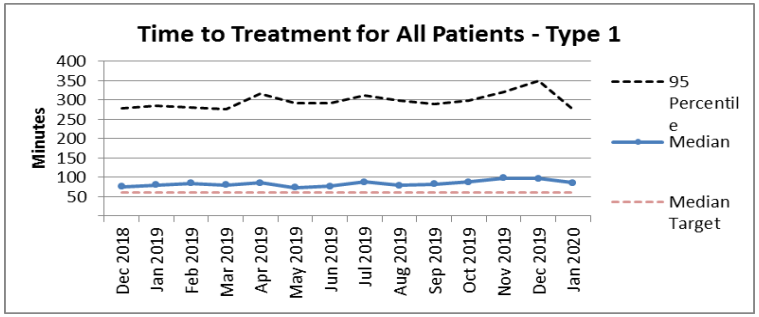
In Medicine, the number of non-elective patients in beds continued the rise which began in October and rose to an average of 515 per day. The total number of occupied beds in Medicine at midnight continues to rise although in January the level fell below that of 2017/18.

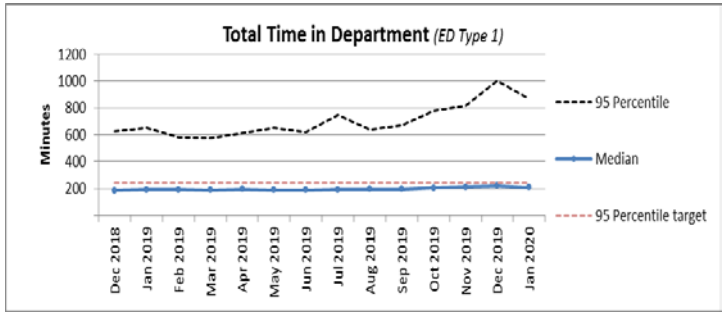
The average number of stranded (7+ days) and Super stranded (21+ days) patients per week also continued to increase in January further indicating a longer length of stay for patients admitted in December and early January.

Simple discharges started to increase after the first week January which released capacity to decongest ED. The number of MFFD patients rose in January from an average of 11 to 14 patients a day.









Summary

Initial Assessment

The initial assessment is when a patient is assessed by an emergency care doctor or nurse to allow them to determine a priority for treatment (sometimes called triage). The assessment would normally include a brief history of the patient's condition, pain score and vital signs (blood pressure, temperature, pulse).

The median Time to initial Assessment for Type 1 attendances was 11 minutes (December 12 mins) and the average for the year was 11 minutes against the standard of 15 minutes. The 95th percentile was 61 minutes versus the 70 minutes in December (with an average of 56 over the year).

Target: A 95th Percentile time to assessment at or below 15 minutes

Treatment time

The treatment time is the time when a patient is seen by a doctor who can diagnose the problem, decide the management plan for the patient and arrange or start treatment if required.

Time to treatment (95th percentile) reduced in January to 277 minutes (December 350 minutes). For the same period last year the 95th percentile was 285 minutes. The average for the year was 299 minutes.

Target: A median wait at or below 60 minutes.

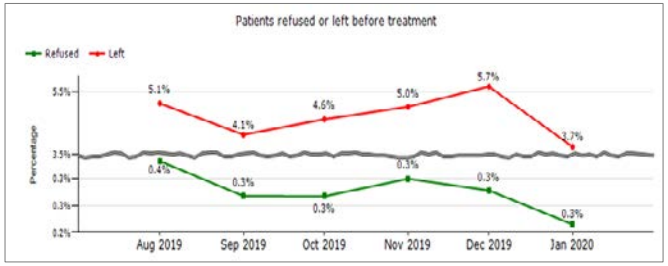
Total time in department

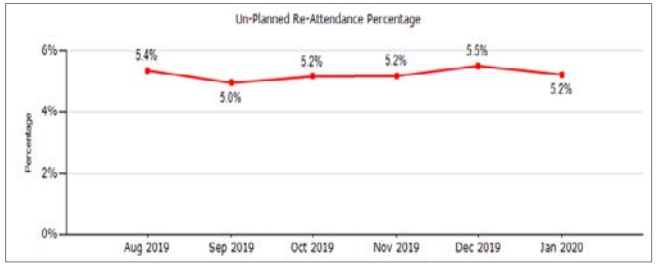
The time a patient spends in the A&E department under the care of hospital staff.

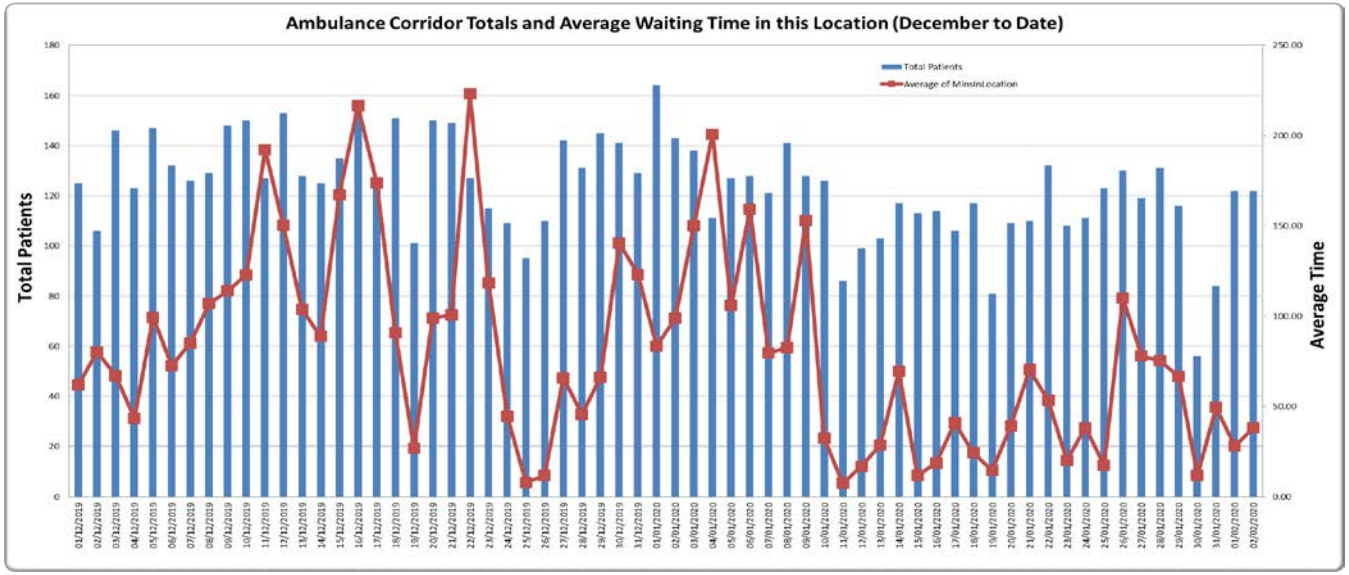
In December. the 95th percentile reduced to 867minutes (December 1001 mins). January 2019 was 651 minutes.

Target: A 95th percentile wait at and below 4 hours.

This is based on a total number of attendances for Royal Stoke & County, Type 1 of 14911







Summary

Left without being seen

A patient who leaves without being seen is one who registered with the receptionist in the ED but then left the department before they saw a doctor.
Patients leaving before being seen for Type 1 attendances (Royal Stoke and County) was 3.7%, down from 5.7% in December. For those patients who refused the performance was 0.3%
Target: A rate at or below 5%.

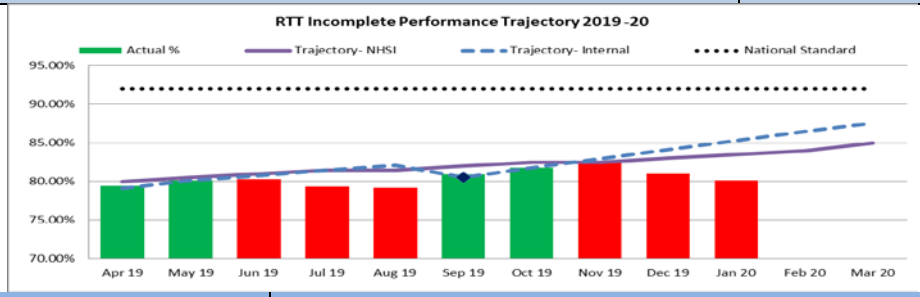
Unplanned re-attendance

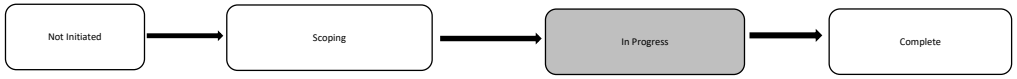
An unplanned re-attendance is where a patient returns to an ED within 7 days of a previous ED attendance. This may be for the same condition or a different one.
For Type 1 (Royal Stoke and County), Re-attendances in January are at 5.2% - just above the threshold of 5%.
Target: A rate at or below 5%.

Ambulance Corridor

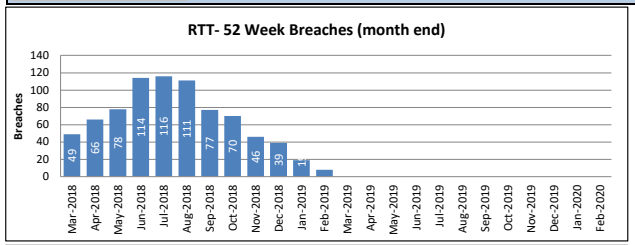
Ambulance corridor occupancy fell in January with the average number of minutes reducing (numbers fell from 2686 patients in December to 2130 in January).

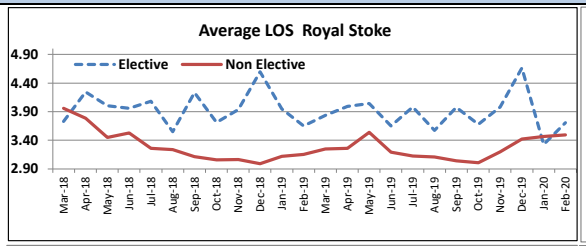
OP34: RTT Incompletes

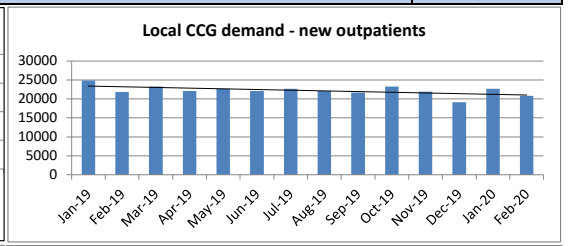


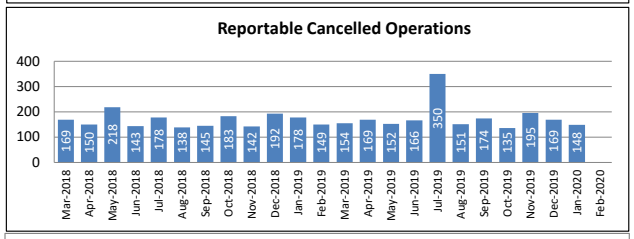
Root cause analysis/ Key lines of enquiry	Action Plan	RAG
Delivery of the standard RTT performance is 80.15% against an Internal trajectory of 85.32% and a NHSi trajectory of 83.5%. The number RTT incomplete pathways are tracked against the waiting list size required to deliver 92% and 85%. Currently the waiting list size is 48,357 which is an increase on the numbers reported in December (48, 140) This is above the internal target of 46,236. **PTL Growth Drivers:** Winter impact electives & creation of escalation bed capacity to offset extreme pressure Leighton PTL impact Specialty demand: dermatology, UGI, Urology, Neurology RTT performance deterioration marked in Spinal pathways from 70.3% in Nov-19 to 62.9%. Trauma and Orthopaedics ceased elective operating at the Royal Stoke site on December 15th in order to de-escalate 14 beds to provide Medical Division with additional capacity. Although urgent cases including scoliosis continued. To mitigate 19 additional theatre sessions were put on at County. Up to the end of January a total of 107 elective operations. Oral Surgery saw a deterioration in performance down to 65.2%. This is due to vacancies and the Directorate are exploring the market for a locum until new appointment begins end of February. Theatre touch time Utilisation in January was 79.3% (December was 79.9%). This was mainly due to the number of cancellations (both at last minute or close to last minute), reasons for these included both the pressures from the ED but also patient cancellations due to minor illnesses, FLU etc. **Positive Assurance:** January has again proved a challenging month with the pressures from the non-elective attendances, admissions. However some specialties were able to maintain or improve on their RTT performance. Ophthalmology have maintained their performance against trajectory, up 5% since Mar-19: Breast Surgery has increased performance by1%: Colorectal, whilst not achieving trajectory, increased performance by 1.3%. Cardiology improved performance by 1.6%: Plastics have maintained performance against trajectory and Dermatology are consistently achieving 98% – 99%: Paediatrics achieved trajectory and Paediatric Cardiology significantly improved performance from 85.1% to 95.6% in January NHS Operational Planning and Guidance report changes to waiting list cut off to end of January rather than end of March. Internal validation teams linked to specialty teams maintaining tactical validation in month and month end to support optimised performance position. **Risks to Delivery and Mitigation** Pressures in Emergency department and increase in surgical non elective demand January – adverse impact on elective operations due to extended NCEPOD lists., Specialty demand and IR 35 impact.	Enhanced governance grip through a revised Accountability Framework; Weekly Divisional Access meetings. Weekly COO led Divisional check and challenge performance meetings with ADs. The Trust is working to improve the position of the long waiters currently on the PTL by conducting targeted validation within our most challenged specialties.40 week plans have been developed and the required capacity to improve the position is being sourced. Improvements are also being made to operational grip and performance assurance processes in this area. T&O Elective beds used for escalation capacity to be returned to Ward 110 in February. Re organisation of the theatre performance group now to be chaired by the AD. RTT Recovery Plans are currently been populated by the operational teams this to be monitored via the COO led Access & performance meetings. Working with CCG to manage demand ,external providers assisting in activity clearance (SHS),incentivised internal lists ,increase in length of theatre lists	A
	Next Steps: Divisional performance improvement trajectories reset to end of March to ensure 52 ww compliance and tracking of RTT standard. Weekly monitoring 40/52 wk position with expedited escalation and mapping of specialty service changes Tactical Validation oversight of Incomplete Waiting List to keep focus on attainment of trajectory at month end Risk Stratification of the follow ups waiting list Validation Rules for the identified follow up cohorts and development of the SOPs in relation to the follow up backlog.	A
		

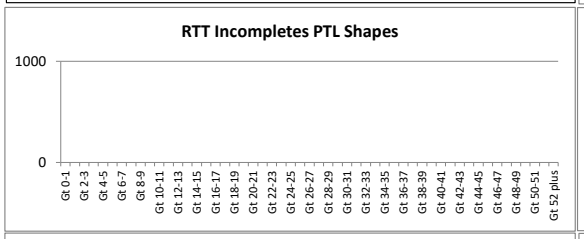
OP34: RTT Incompletes- Key Drivers

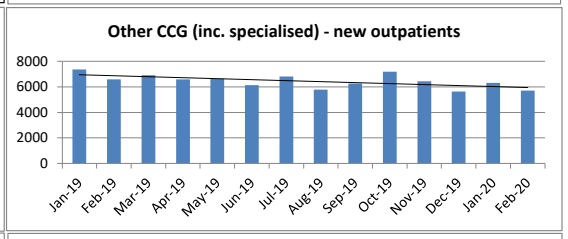


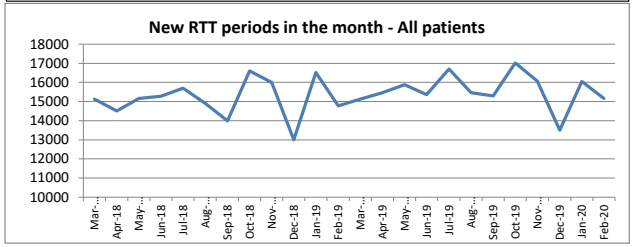


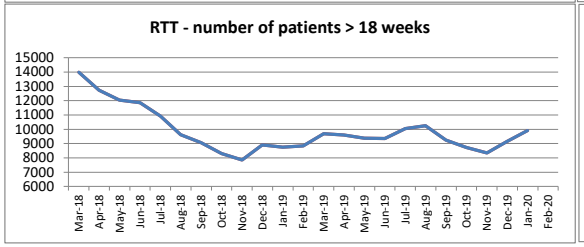


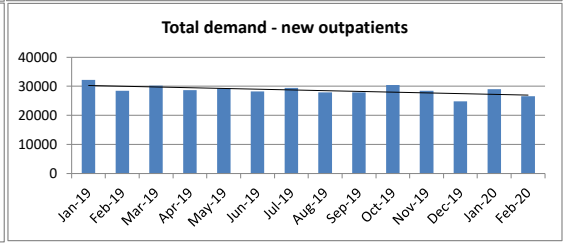












Summary
The graphs above present the key drivers for the Trust RTT performance against the national standard.

Key drivers to note for January:
There were zero > 52 week waiters reported.

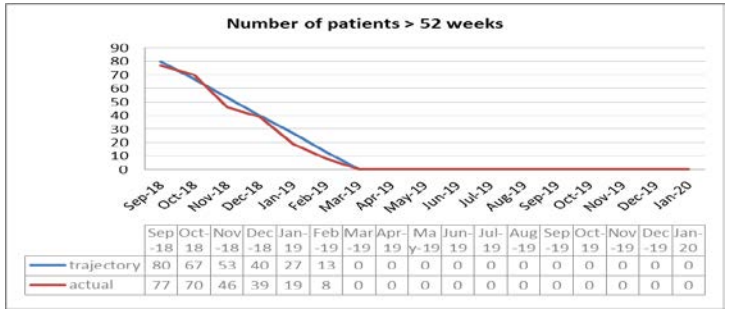
There was a total of 148 operations cancelled at the last minute. No significant variance was noted against previous months. Theatre touch time Utilisation in January was 79.3% (December was 79.9%). This was mainly due to the number of cancellations (both at last minute or close to last minute). Reasons for these included both the pressures from the ED but also patient cancellations due to minor illnesses, FLU etc.

The remaining top 4 reasons for cancellations:
1. No Consultant available
2. Consultant - Cancelled for an emergency - this increased
3. No Suitable Beds Available
4. No theatre time available

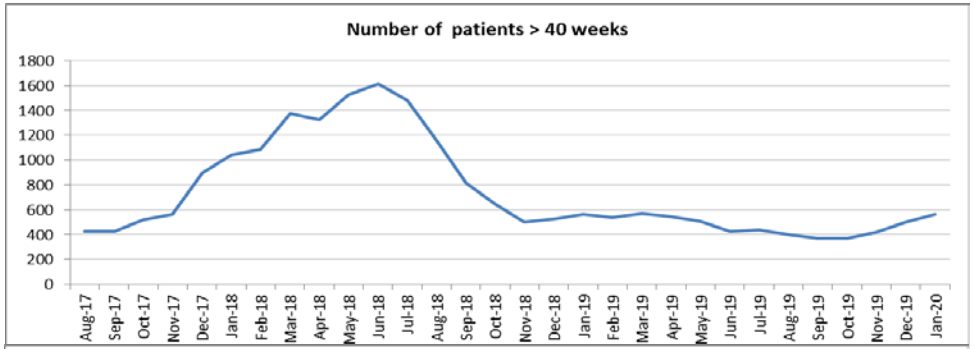
LOS reduced in January due to the increased number of simple discharges.

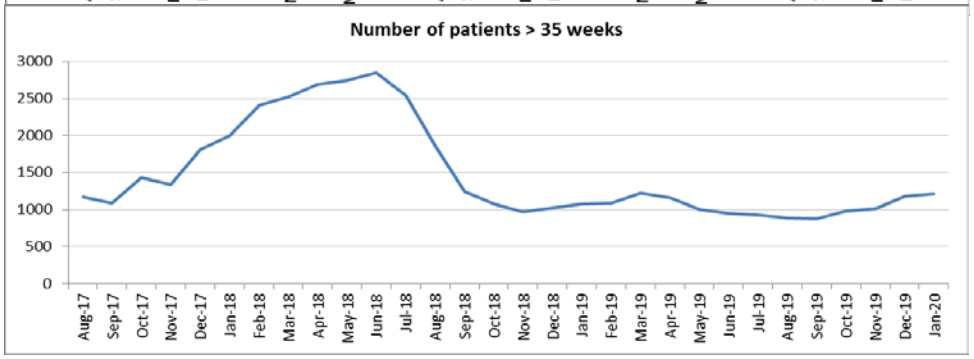
The number of patients over 18 weeks has risen through December and January due to the challenges faced by some specialties e.g. T&O whose elective capacity has reduced in line with the Winter plan and in neurology where patients previously recorded at Leighton have been transferred over to UHNM.

DEMAND: The three demand graphs represent - Total demand and demand split by local CCG's and other CCG's (which includes specialised commissioning). Overall demand is decreasing.
For Total demand - there has been an 0.2% fall compared to the same time last year (December 18).
For local demand there was a decrease of 1.4%.



	Sep -18	Oct-18	Nov -18	Dec -18	Jan-19	Feb -19	Mar -19	Apr-19	May-19	Jun-19	Jul-19	Aug -19	Sep -19	Oct-19	Nov -19	Dec -19	Jan-20
trajectory	80	67	53	40	27	13	0	0	0	0	0	0	0	0	0	0	0
actual	77	70	46	39	19	8	0	0	0	0	0	0	0	0	0	0	0





Over 40 week patients

Treatment Function	Total
100 General Surgery	18
101 Urology	92
104 Colorectal	45
106 Upper Gastrointestinal Surgery	31
107 Vascular Surgery	6
108 SPINAL Surgery	39
110 Trauma & Orthopaedics	16
120 ENT	7
130 Ophthalmology	10
140 Oral Surgery	1
143 Orthodontics	1
144 Maxillo-Facial	12
160 Plastics	4
301 Gastroenterology	37
320 Cardiology	20
340 Respiratory Medicine	167
400 Neurology	26
502 Gynaecology	10
420 Paediatrics	2
other	19
Grand total	563

OUTPATIENTS

All graphs/information derived from the OP Session Slot Utilisation DNA and Hosp Cancellations Report, and OP Appts Hospital / Patient Cancellation Grid (04/02/20), for clinics flagged as 'yield'.

KPI Descriptions:

- Clinic Utilisation ('Yield') = Slot booking % x (1-DNA rate)
- Slot Booking % = Patients Booked Total / Capacity Total
- DNA (Did not attend) = Patients who didn't attend / Total Booked
- Hospital initiated Cancellations (HICs) <6 weeks = Booked appointments cancelled by the trust less than 6 weeks before the appointment date / Total hospital initiated Cancellations.

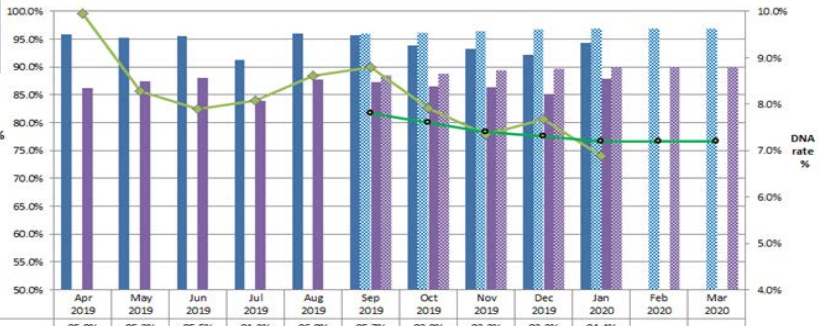
KPI Targets: January 2020

- Clinic Utilisation ('Yield') = 90%
- Slot Booking % = 97%
- DNA (Did not attend) = 7.2%
- HICs < 6 Weeks = Half baseline of 6291 per month: 3145

Measure	National Target (NHSI)	BASELINE Last 13 weeks as at we 25/08/19 excl we 07/07/19	Local Trajectory Target (by Jan 2020)
% Booked	96.0%	95.9%	97.0%
DNA rate	6.0%	8.0%	7.2%
Clinic Utilisation (Yield) %	90.0%	88.2%	90.0%

UHNM

Slot Booking %, DNAs & Clinic Utilisation ('Yield') %
Monthly Actual & Trajectories 19/20



	Apr 2019	May 2019	Jun 2019	Jul 2019	Aug 2019	Sep 2019	Oct 2019	Nov 2019	Dec 2019	Jan 2020	Feb 2020	Mar 2020
% Booked	95.8%	95.3%	95.5%	91.2%	96.0%	95.7%	93.9%	93.3%	92.2%	94.4%		
Trajectory Booked %						96.0%	96.2%	96.5%	96.8%	97.0%	97.0%	97.0%
Clinic Utilisation (Yield) %	86.3%	87.4%	88.0%	83.9%	87.7%	87.3%	86.5%	86.4%	85.1%	87.9%		
Trajectory Clinic Utilisation (Yield) %						88.5%	88.9%	89.4%	89.7%	90.0%	90.0%	90.0%
DNA rate	9.9%	8.3%	7.9%	8.1%	8.6%	8.8%	7.9%	7.3%	7.7%	6.9%		
Trajectory DNA rate						7.8%	7.6%	7.4%	7.3%	7.2%	7.2%	7.2%

Measure	BASELINE Last 13 weeks as at we 25/08/19 excl we 07/07/19	Local Trajectory Target (by Jan 2020)
Hospital Cancellations <6Wks (per month)	6291	3145

UHNM

Hospital Cancellations < 6Wks & Pt Cancellations <24hrs
Monthly Actual & Trajectories 19/20

	Apr 2019	May 2019	Jun 2019	Jul 2019	Aug 2019	Sep 2019	Oct 2019	Nov 2019	Dec 2019	Jan 2020	Feb 2020	Mar 2020
Hospital Cancellations <6Wks	6860	6272	6240	9488	5589	6497	7217	6651	6129	6718		
Trajectory Hospital Cancellations <6Wks						5662	5032	4403	3774	3145	3145	3145
Pt Cancellations <24hrs Before Appt	7386	8786	8498	9489	8297	9261	9830	8861	9099	8934		

Clinic Utilisation % (Key composite target) 90% by January 2020. **87.9%** vs trajectory of **90%** trajectory

Booking % (94.4% vs target 97.0%) – % bookings have increased in all divisions vs last month; fortnightly specialty meetings include the identification of outlier clinics (prospectively & retrospectively). Specific Specialties requiring further intervention have been identified.

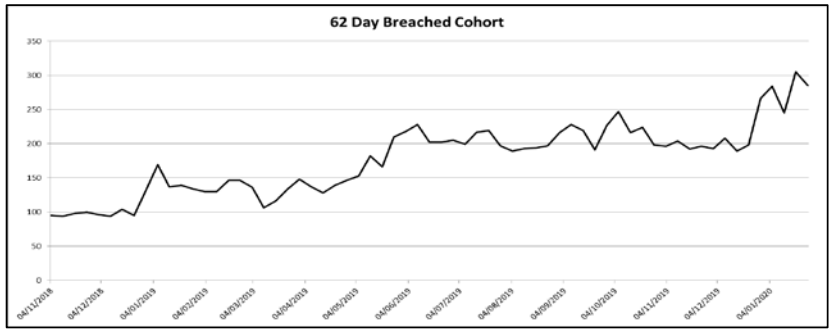
DNA% (6.9% vs target 7.0%) – The DNA rate has continued to reduce and is now below 7%. From discussions with BI, the Netcall load is no longer dependent on the timing of the data warehouse load so this risk has now been successfully mitigated (whilst reminders may be not be based on the most recent changes if a load is delayed). Divisions are being challenged to identify specialty-specific actions to improve on their performance, and a rollout plan for movement to partial booking is being confirmed. SOP for clinicians for viewing DNAs in iPortal has been shared in clinics to help apply DNA policies, with a supporting letter sent via Deputy Medical Director.

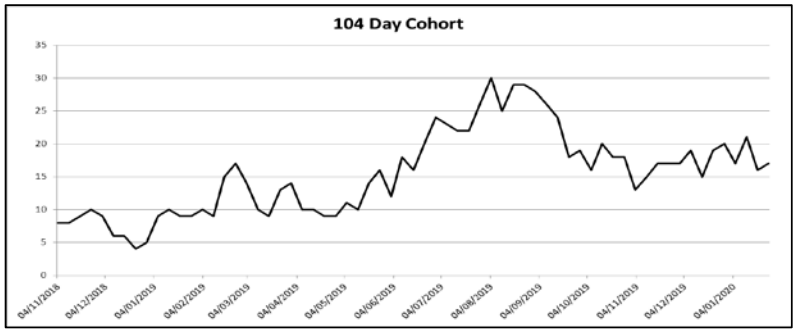
Hospital cancellations (6718 vs target 3774) – Still significantly above target. Reasons for cancellations now being provided; although there are over 40 drop down options. All divisions have been asked to investigate drivers for hospital cancellations, and opportunities to address these, with a plan to reduce Electronic CAF to be progressed.

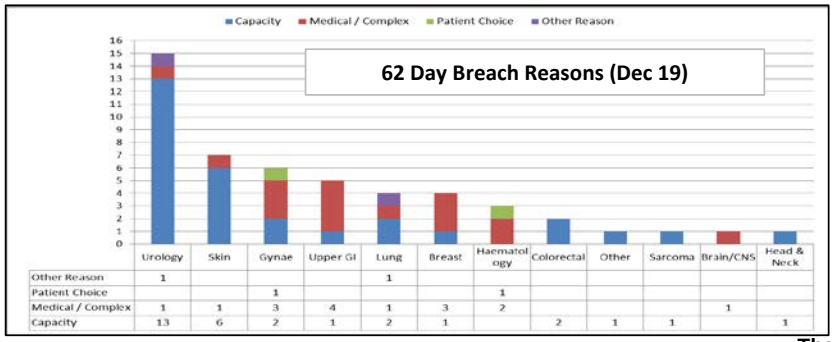
OP KPIs Summary Update

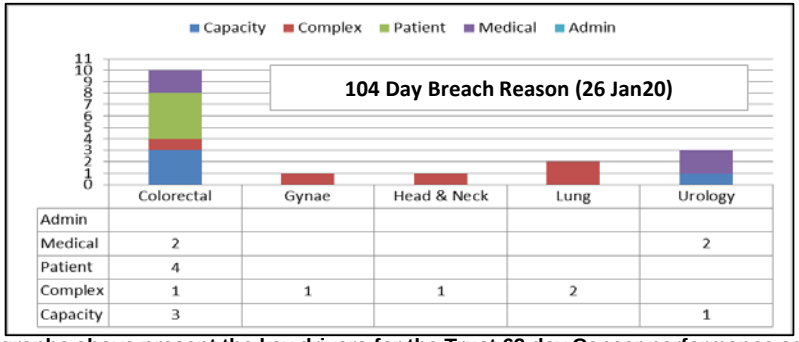
			Jan 2020		
Level	KPI	Jan 2020 Target	Current Performance	RAG	vs last month
UHNM	Clinic Utilisation %	90.0%	87.9%	A	2.8%
	Bookings %	97.0%	94.4%	A	2.2%
	DNAs %	7.2%	6.9%	G	-0.8%
	Hospital Cancellations	3145	6718	R	589
CWD	Clinic Utilisation %	90.0%	90.4%	G	5.5%
	Bookings %	96.3%	96.4%	G	5.2%
	DNAs %	6.6%	6.2%	G	-0.7%
	Hospital Cancellations	579	1208	R	30
Medical	Clinic Utilisation %	85.9%	81.9%	A	1.0%
	Bookings %	96.0%	90.9%	R	0.1%
	DNAs %	10.5%	9.9%	G	-1.1%
	Hospital Cancellations	329	666	R	72
Specialised	Clinic Utilisation %	89.1%	84.8%	A	0.5%
	Bookings %	96.5%	91.8%	R	0.2%
	DNAs %	7.7%	7.6%	G	-0.4%
	Hospital Cancellations	762	1713	R	300
Surgical	Clinic Utilisation %	92.3%	90.5%	A	3.9%
	Bookings %	98.7%	96.2%	A	3.0%
	DNAs %	6.5%	6.0%	G	-1.1%
	Hospital Cancellations	1476	3131	R	187

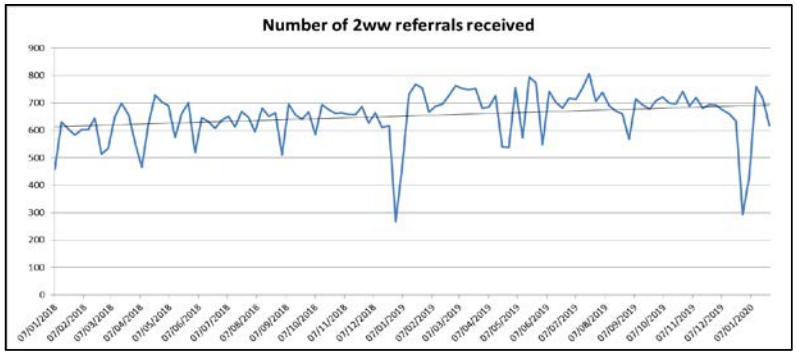
R7: Cancer 62 Days- Key Drivers











The graphs above present the key drivers for the Trust 62 day Cancer performance against the national standard (85% of patients treated within 62 days from referral). The NHS Single Oversight Framework requires Trust's to achieve the national 85% standard as a measure of operational performance, however failure to deliver the this is used as a trigger in relation to NHSI considering appropriate levels of support for providers. The provisional Trust level performance for 62 day Urgent GP referrals in January is 62.25% (as at 26.02.20).

Due to the increase in colorectal GP 2ww referrals the Trust has not achieved the 2ww standard in January (74.16% as at 10.02.20), as predicted.

104 Day improvement actions in place since September 2019. Plan is for the directorate teams to closely monitor this cohort of patients and to reduce capacity delays down to minimum so we can baseline the expected number of pt. choice/complex tertiary pathway delays we would expect given our cancer centre status and volumes of referrals for discussion with NHSE/I.

R7: Cancer 62 Days of Urgent GP Referral

62 Day Standard (GP 2ww Referrals)
University Hospitals of North Midlands NHS
85.0% National Standard (treated within 62 days)
*Provisional Data** *Last Updated 28/02/2020*
Confirmed Diagnosis: Jan-20

		Actual Patients			Accountable Patients			
Cancer Site	Location	<62 days	>62 days	Total	<62 days	>62 days	Total	%<62
Brain/CNS (Specialised)	UHNM Combined	0	0	0	0.0	0.0	0.0	
Breast (Surgery)	UHNM Combined	20	3	23	20.0	3.0	23.0	86.96%
Breast Symptom (Surgery)	UHNM Combined	0	0	0	0.0	0.0	0.0	
Colorectal (Surgery)	UHNM Combined	2	7	9	2.0	6.5	8.5	23.53%
Gynae (CSS/W&C)	UHNM Combined	8	4	12	7.5	4.0	11.5	65.22%
Haematology (Medicine)	UHNM Combined	3	3	6	3.0	3.0	6.0	50.00%
Head & Neck (Surgery)	UHNM Combined	2	2	4	2.0	2.0	4.0	50.00%
Lung (Medicine)	UHNM Combined	8	10	18	8.0	7.5	15.5	51.61%
Other	UHNM Combined	1	1	2	1.0	1.0	2.0	50.00%
Paediatrics (CSS/W&C)	UHNM Combined	0	0	0	0.0	0.0	0.0	
Sarcoma (Specialised)	UHNM Combined	0	2	2	0.0	2.0	2.0	0.00%
Skin (Surgery)	UHNM Combined	35	12	47	35.0	12.0	47.0	74.47%
Upper GI (Medicine)	UHNM Combined	10	4	14	9.5	4.0	13.5	70.37%
Urology (Surgery)	UHNM Combined	27	23	50	27.0	22.0	49.0	55.10%
Trust Exc Breast Symptom	UHNM Combined	116	71	187	115.0	67.0	182.0	63.19%
Trust Inc Breast Symptom	UHNM Combined	116	71	187	115.0	67.0	182.0	63.19%

	Dec-19	Jan-20	Jan-20 Trajectory NHSi	Jan-20 Trajectory Internal	Standard
Two week wait	78.04%	74.74%	95.61%		93%
2ww Breast Symptomatic	89.36%	100.00%	97.30%		93%
31 Day First Treatment	93.96%	93.90%	97.39%		96%
31 Day Subsequent Surgery	85.71%	77.19%	94.92%		94%
31 Day Subsequent Anti-Cancer Drugs	96.00%	96.20%	100.00%		98%
31 Day Subsequent Radiotherapy	88.57%	90.91%	98.18%		94%
62 Day (2ww) First Treatment	71.94%	63.19%	85.03%	74.00%	85%
62 Day Screening First Treatment	80.00%	73.17%	91.30%		90%

updated 28/02/20, final position 7/3/2020

Root cause analysis/ Key lines of enquiry

Positive Assurance:
WMCA has offered 100k to West Midlands Trusts to support improvement in cancer performance before year end. UHNM primary scheme submission in support of PTL deep dive validation to support opportunities for improved performance due to strict application of best practice guidance. (Outcomes to be subject to clinical and corporate governance approval).
A deep dive of the Gynaecology specialty is underway to accelerate recovery to improve overall Trust performance whilst sustainability plans are developed and strengthened. This is to be followed with UGI, Urology, Breast and Skin.
The recently introduced Governance & Performance framework is beginning to work well with attendance monitored, focus given to ensuring effective plans are in place to manage patients through their pathway within target, escalating blockages and ensuing that assurance and risk are clearly documented. These meetings feed directly into the Corporate Cancer / COO meeting and the new cancer weekly report.
A new weekly cancer operational meeting covering 11 key action areas has been planned to support CWT performance recovery, these meetings are attended by specialty Divisional Managers together with support services. First session 17th February 2020.
A series of 2WW audits with WMCA have commenced from 14th February 2020 with new colorectal referrals having a priority focus given the volume.
IST critical friend visit on 24th and 27th February 2020 to support our cancer recovery programme, particularly supporting with patient access and user compliance, cancer performance / assurance cycle, and the colorectal referrals increase / plan.
Colorectal recovery plan is in final draft. This is a complex, multi stakeholder plan that will require investment and Commissioner support to deploy to full benefits realisation.
Commencing Triage to Test backlog recovery plan from 1st March 2020.

Delivery of the 2ww and 62 day standards:
The Cancer 62 day performance is **63.19%** against an internal trajectory of 74.0%.
Total cancer 62 day treatments for January '20 to date are 159. However, there are an additional 64 treatments (46 skin) with no confirmed diagnosis many of which are waiting histology results, this may yield more treatments and improve the month end.
2WW appointments in January 20 were slightly more at 2562 (not including breast symptomatic) against December 2517.
Focus on 2ww and 104 day performance improvement.

Risks to Delivery and Mitigation
2WW demand - LGI referrals risking delivery for Feb/Mar- local audit commenced on PTL to identify management options.
2WW patient non compliance – rewriting scripts to support adherence to appts and reviewing best practice pathways for step down pathways.
Diagnostic capacity outstrips demand – capacity being sourced.

External Pressures / Increased Referral Rates
• UHNM receives 63.1% of all Staffordshire and S-O-T 2ww referrals. This has increased from 60.7% in the last 3 years. More cancer activity is referred to UHNM as a proportion, than other planned care activity and this percentage is growing, confirmed by NSHE.

• UHNM receives 68.8% of all Staffordshire and S-O-T lower GI 2ww referrals.

• Lower GI activity from Staffordshire and S-O-T CCGs to UHNM has grown 48% in the last 3 years (growth from SOT CCG is less [42%])

• Lower GI activity from NS CCGs to UHNM has grown 54 % in the last 3 years. If we disregard East Cheshire reductions this equates to 48% growth to UHNM not offset by reductions elsewhere so the East Cheshire reduction does explain some of why NS growth is higher. It doesn't fully explain the differences in growth between NS and SOT.

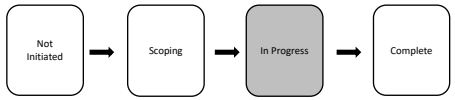
• Of further concern for Lower GI is the conversion rate to a diagnosis which has fallen over the past four years against the increased demand. In 15/16 the demand was 4538 with a conversion rate of 4.4% whereas in 18/19 the demand was 6731 (48% increase) with aconversion rate of 2.9%. This is a targeted area for improvements.

Action Plan

Next Steps:
A comprehensive Deep Dive/validation of the cancer PTL is planned from 17th February 2020 to seek improvements in year end cancer performance.
Design and development of new Cancer Performance Dashboard is in progress to facilitate one stop access to information and visibility of in week actions, forecasting and performance. .
Final draft Cancer Transformation, Improvement and Recovery Programme completed.
Triage to Test (TTT) colorectal pilot commissioned to end of March with daily monitoring of outputs.
NHSEi follow up meeting 12th March 2020 to review outcomes of enabler works in train around cancer recovery with focus on colorectal and UHNM support requirements – Commissioner support with demand management/funding opportunities.

Cancer Alliance:
IST review of Cancer Services PTL and Governance meetings; to commence 24th Feb 2020
A cancer Alliance-led external review of Colorectal demand, pathway delivery and recovery plans, to commence March-20
The Cancer Alliance to support an external review of the quality of the 2ww Colorectal referrals, commenced early February-20
The Alliance transformation monies is supporting the implementation of best practice pathways in Colorectal, UGI, Lung; and Urology prostate – timelines agreed and UGI has already commenced the pilot
Cancer alliance are supporting UHNM in the delivery of the Lung Health check programme which commenced April 2019. Further finding has been secured for year 2 (20/21). This will allow more patients to be assessed through the screening programme.
Funding from the Cancer Alliance has supported a daily mini Lung MDT, this has streamlined the front end of the pathway.

Progress



RAG

A

R13: Cancer 62 Day screening

62 Day Standard (Screening Referrals) 90.0% National Standard (treated within 62 days)

University Hospitals of North Midlands NHS

Provisional Data *Last Updated 10/02/2020*

Confirmed Diagnosis:

		Jan-20						
		Actual Patients			Accountable Patients			
Cancer Site	Location	<62 days	>62 days	Total	<62 days	>62 days	Total	%<62
Breast (Surgery)	UHNM Combined	12	3	15	12.0	2.5	14.5	82.76%
Colorectal (Surgery)	UHNM Combined	1	2	3	1.0	2.0	3.0	33.33%
Gynae (CSS\W&C)	UHNM Combined	0	0	0	0.0	0.0	0.0	
Trust	UHNM Combined	13	5	18	13.0	4.5	17.5	74.29%

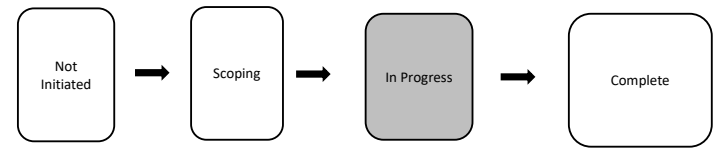
Cancer 62 Day screening

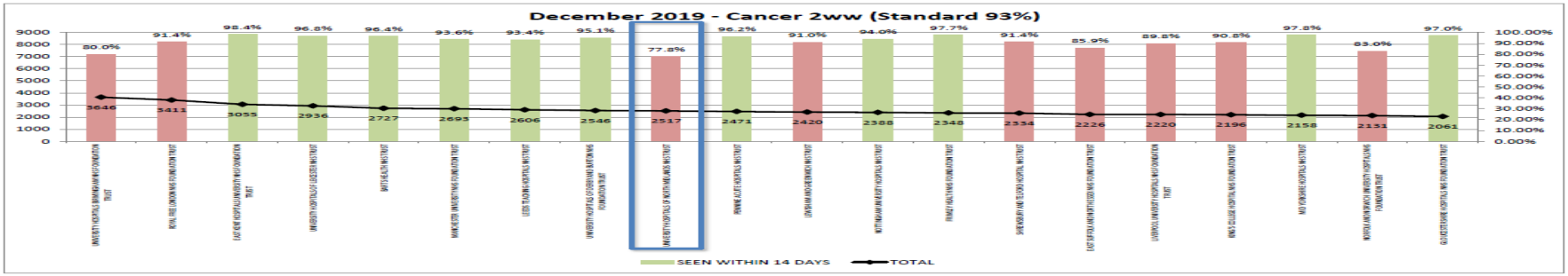
Site	Jan-19	Jan-20	Variance
UHNM	71.4%	76.9%	5.5%

Month	Within	Outside	Total	%
Apr-19	28.5	5	33.5	85.07%
May-19	13	5	18	72.22%
Jun-19	18	5.5	23.5	76.60%
Jul-19	26	5	31	83.87%
Aug-19	23	3.5	26.5	86.79%
Sep-19	24	2	26	92.31%
Oct-19	38	1.5	39.5	96.20%
Nov-19	16	2	18	88.89%
Dec-19	22	5.5	27.5	80.00%
Jan-20	13	4.5	17.5	74.29%

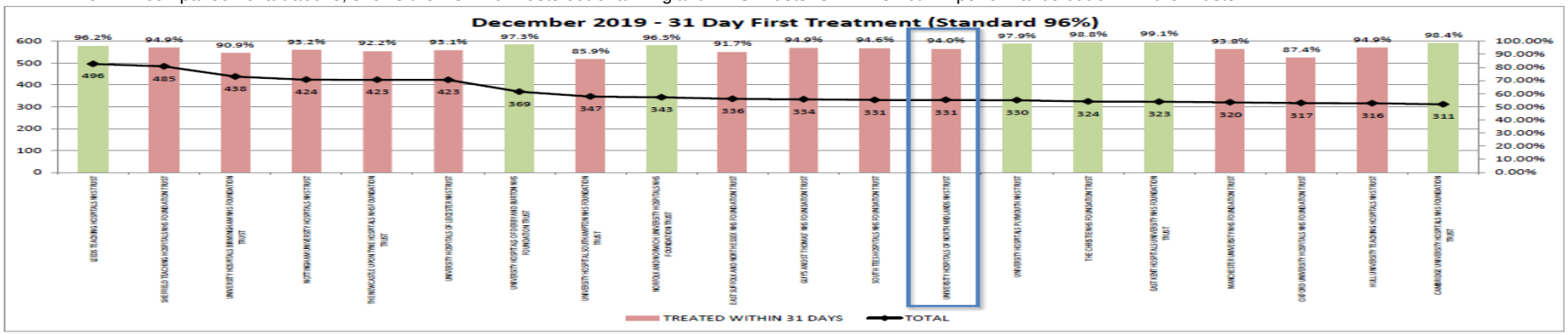
Root cause analysis/ Key lines of enquiry	Action Plan	RAG
The patients on the 62 day cancer screening pathway are patients referred from the national screening programme. The operational standard is 90%. The number of patients in this category are low and as a general rule any more than 1 or 2 breaches will result in under achievement of the standard. There were 4.5 breaches in January, 2.5 breast (1 patient, 1 inconclusive diagnostic result, 0.5 tertiary day 51) & 2 colorectal (1 outpatient capacity, 1 inconclusive diagnostic result), data remains provisional at the moment.	• Breast screening pathway representatives from screening and generally surgery attend cancer forecast meetings	G
	• The weekly cancer PTL meetings continue, each individual patient's pathway is discussed to identify updates and actions to mitigate delays in the pathway.	G

Progress

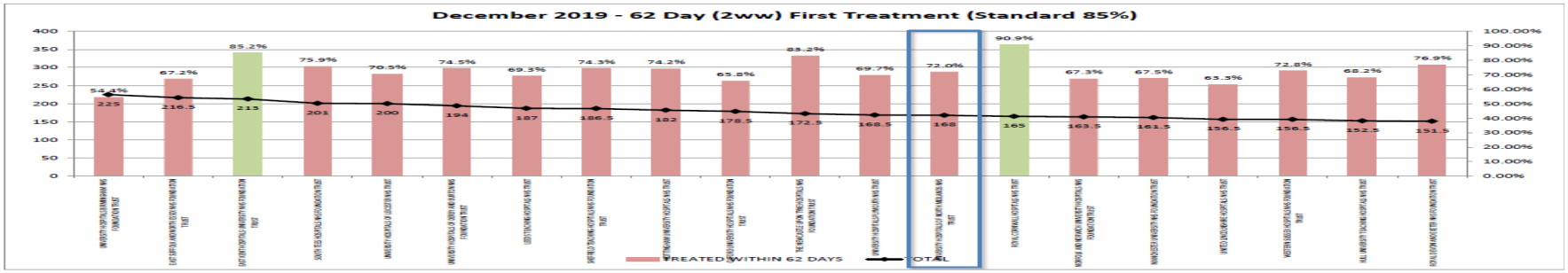




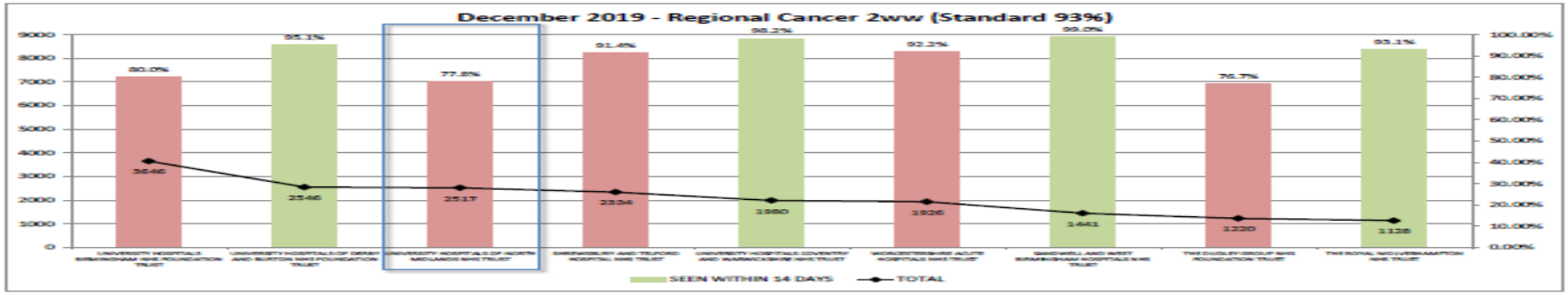
The 2ww comparison chart above, shows the TOP 20 Trusts out of all England NHS Trusts. UHNM is 20th in performance out of ALL the Trusts.

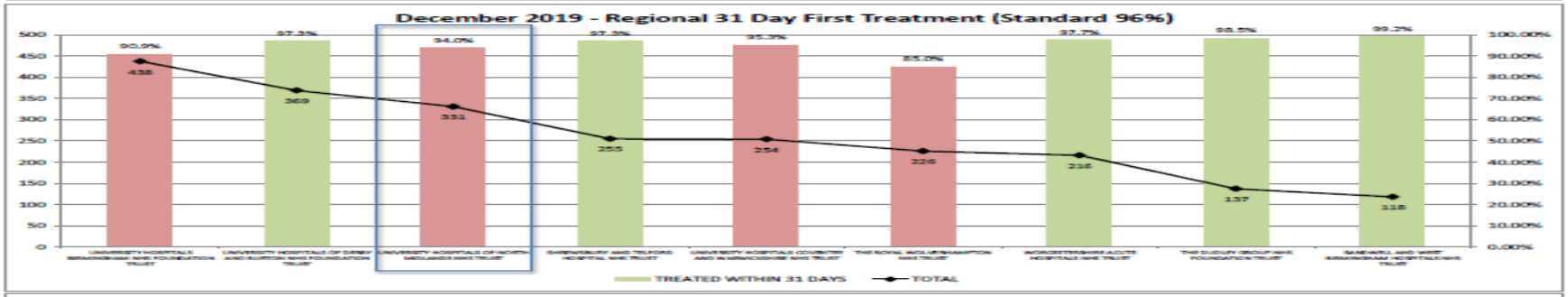


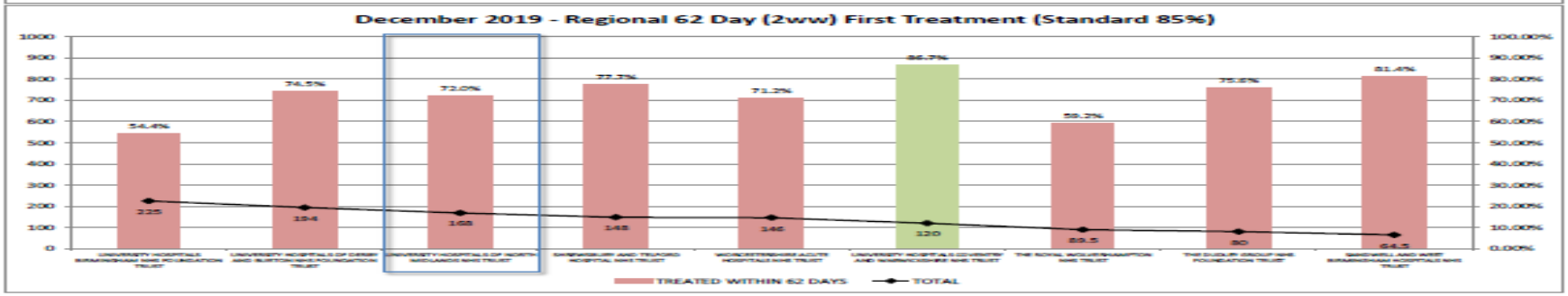
The 31 Day comparison chart above, shows the TOP 20 Trusts out of all England NHS Trusts. UHNM is 12th in performance out of ALL the Trusts.



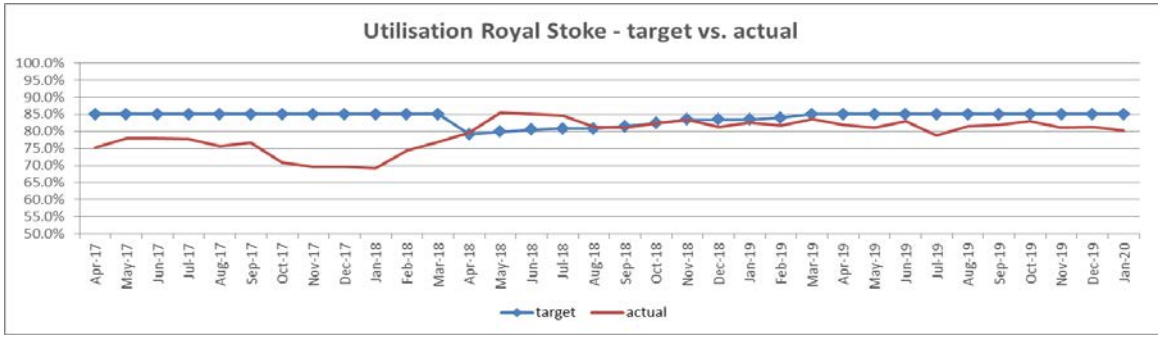
The 62 Day comparison chart above, shows the TOP 20 Trusts out of all England NHS Trusts. UHNM is 11th out of ALL the Trusts, with only two other Trusts achieving the standard







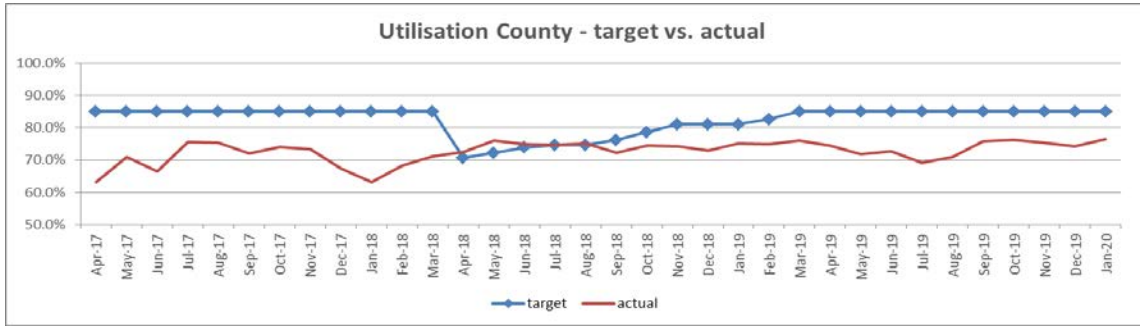
Compared to the Region, UHNM has the 3rd highest number of 2ww referrals and 8th best performing. For 31 day, 3rd highest in referrals and 7th in performance. For 62 day treatments 3rd highest in referrals and 6th best performing.



	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
target	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%
actual	75.2%	77.8%	77.9%	77.7%	75.7%	76.7%	70.9%	69.6%	69.5%	69.2%	74.5%	76.9%

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
target	79.2%	79.9%	80.5%	80.8%	80.8%	81.5%	82.4%	83.4%	83.4%	83.4%	84.0%	85.0%
actual	79.7%	85.4%	85.0%	84.6%	81.4%	81.1%	82.3%	83.4%	81.3%	82.5%	81.6%	83.6%

	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
target	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%
actual	82.0%	81.1%	82.9%	78.8%	81.4%	81.9%	83.0%	81.1%	81.3%	80.2%		

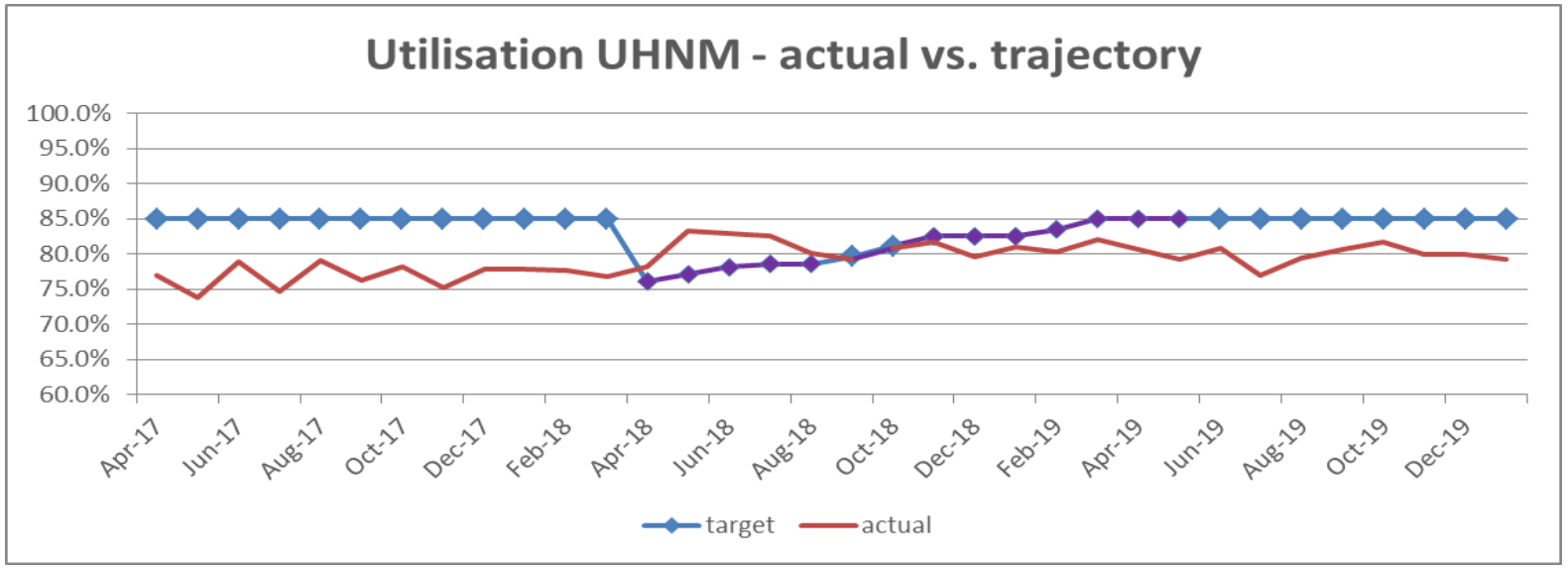


	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
target	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%
actual	63.1%	70.9%	66.5%	75.6%	75.3%	72.1%	73.9%	73.3%	67.3%	63.1%	68.2%	71.0%

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
target	70.6%	72.2%	73.8%	74.6%	74.6%	76.2%	78.6%	81.0%	81.0%	81.0%	82.6%	85.0%
actual	72.4%	75.9%	75.0%	74.6%	75.1%	72.2%	74.5%	74.3%	72.9%	75.1%	74.9%	75.9%

	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
target	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%
actual	74.4%	71.7%	72.6%	69.1%	70.9%	75.8%	76.2%	75.3%	74.3%	76.4%		

Theatre Utilisation



	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
target	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%
actual	76.9%	73.8%	78.8%	74.6%	79.1%	76.2%	78.2%	75.2%	77.9%	77.9%	77.7%	76.8%

trajectory	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
actual	76.1%	77.1%	78.1%	78.6%	78.6%	79.6%	81.1%	82.5%	82.5%	82.5%	83.5%	85.0%
	78.2%	83.3%	83.0%	82.6%	80.2%	79.2%	80.8%	81.6%	79.5%	81.0%	80.3%	82.0%

	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
target	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%
actual	80.6%	79.2%	80.9%	76.9%	79.5%	80.7%	81.7%	79.9%	79.9%	79.3%		

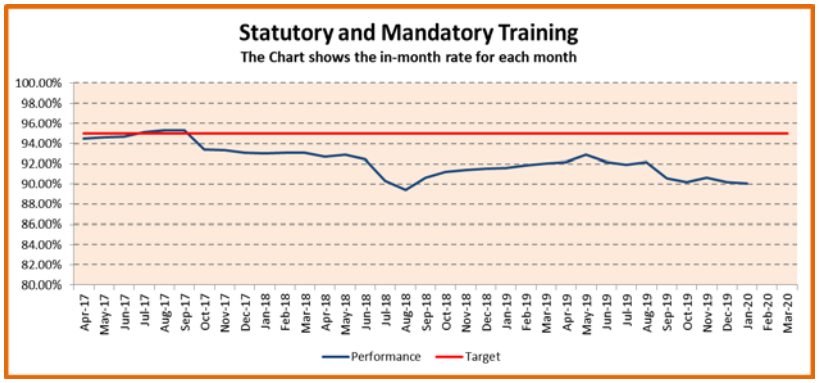
theatre utilisation includes Obsterics

3. ORGANISATIONAL	Domain Scorecard	Feb-20 Page 28

	Ref	Indicator	Exception Triggers			Period	Performance				Site Breakdown			Except.
			Month Target	Step Change	Conti. Limit		This Period Target	Last Period	This Period	YTD	RSUH	County	UHNM	
Workforce	OH5	Executive Team Turnover	G			Feb-20	3.00%	0.00%	0.00%	50.0%				
	W19	Turnover Rate	G			Feb-20	<11%	8.85%	9.02%					
	OH7	Proportion of temporary staff (snapshot)				Feb-20		5.49%	6.35%					
	W20	Sickness Absence Rate **12m Cumulative Rate**	R			Feb-20	<3.39%	4.58%	4.55%					✓
	W22	Appraisal Rate	R			Feb-20	>95%	81.20%	79.28%					✓
	W23	Agency Costs as a % of Total Pay Costs				Feb-20		3.92%	3.81%					
Patient Feedback	OH4	CQC Inpatient Survey (annual)					-	-						
Staff Feedback	OH6	NHS Staff Survey (annually) Staff Engagement Rate				Reporting in Feb 20		-	6.9					
Compliance	W50	Mandatory and Statutory Training	R			Feb-20	>95%	90.20%	90.03%					✓

site breakdown not available

3. ORGANISATIONAL HEALTH	W50: Statutory and Mandatory Training	Feb-20 Page 29



The Statutory and Mandatory training rate at 31st January 2020 was 90.03% (90.20% at 31st December 2019). This was due to an increase in the staff in post headcount rather than a decrease in compliance (Headcount increased by 125, of which 83.2% have completed at least 6 of the 7 modules)

Competence Name	Assignment Count	Required	Achieved	Compliance %
205|MAND|Duty of Candour - 3 Years|	9841	9841	8882	90.26%
205|MAND|Security Awareness - 3 Years|	9841	9841	8869	90.12%
NHS|CSTF|Equality, Diversity and Human Rights - 3 Years|	9841	9841	8916	90.60%
NHS|CSTF|Health, Safety and Welfare - 3 Years|	9841	9841	8865	90.08%
NHS|CSTF|Infection Prevention and Control - Level 1 - 3 Years|	9841	9841	8803	89.45%
NHS|CSTF|Safeguarding Adults - Level 1 - 3 Years|	9841	9841	8804	89.46%
NHS|CSTF|Safeguarding Children (Version 2) - Level 1 - 3 Years|	9841	9841	8878	90.21%

Compliance rates for the Annual competence requirements, completed via e-learning, were as follows:

Competence Name	Assignment Count	Required	Achieved	Compliance %
NHS|CSTF|Fire Safety - 1 Year|	9841	9841	8472	86.09%
NHS|CSTF|Information Governance and Data Security - 1 Year|	9841	9841	8970	91.15%

Root cause analysis/ Key lines of enquiry

HR will be supporting Divisions to use ESR to produce their own performance reports around PDRs and Statutory and Mandatory Training

A meeting is being arranged with the Post Graduate Education leads to discuss junior medical staff compliance, including a discussion on IG performance

Duty of Candour training is to be removed from 'Core of All' and covered at induction. It will then become Essential to Role for clinical staff, with a requirement to complete every 3 years

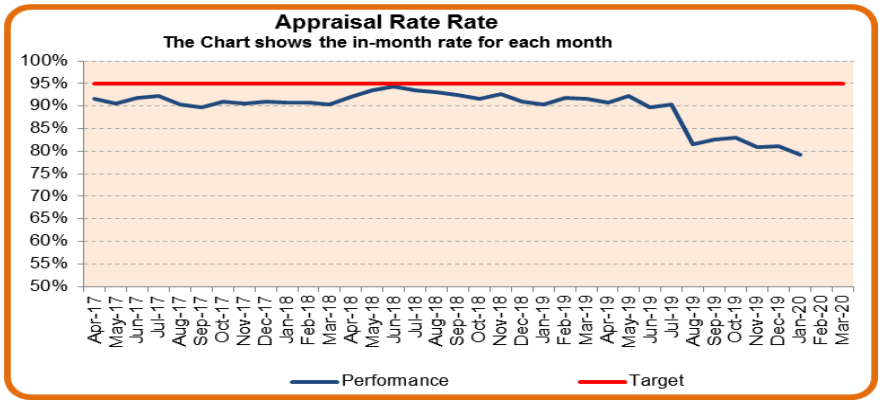
Action Plan

Improve signposting to eLearning guides by adding a "Local Links" portlet to ESR which directly links to the Sops. In progress	G
Ensure that the correct "Essential to Role" training requirements are identified for each role on ESR so that finding relevant training is easier	G
Monthly data quality check. Use ESR to identify any records that remain "confirmed" and follow up with the trainer. Additional training to be provided if required.	G

Progress

Not → Scoping → In Progress → Complete

W22: Appraisal Rates (PDR's)



PDR data is now reported only from ESR

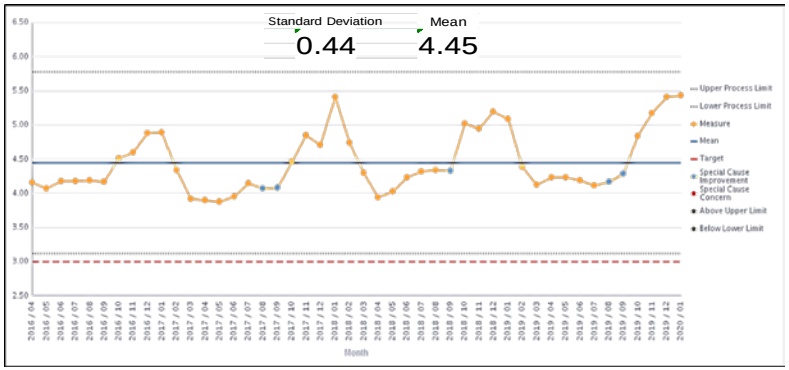
Overall, 79.28% of Non-Medical PDRs were recorded in ESR as at 31st January 2020 (76.91% at 31st December 19)

Root cause analysis/ Key lines of enquiry	Action Plan	RAG
Actions being taken to improve the PDR compliance rate include: • HR will supporting Divisions to use ESR to produce their own performance reports around PDRs and Stat & Mand Training • Managers with low compliance rates are being contacted and offered support	Support with data uploads continues to be provided.	G

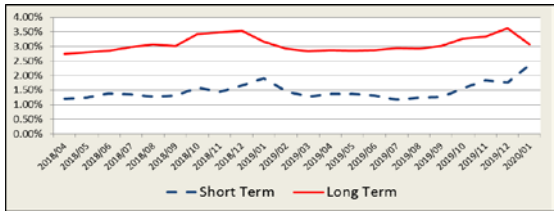
Progress

Not Initi → Scoping → In Progress → Complete

3. ORGANISATIONAL HEALTH	W20: Sickness Absence Rate	Feb-20 Page 31



In January, the in-month sickness rate was 5.41% and the 12m Cumulative Rate reduced to 4.55%.. The rates reported for December were 5.85% (in month) and 4.58% (12m cumulative)
The sickness rate is in line with previous year trends over the winter period and an increase in reported absence was expected with the implementation of Empactis.
Managers and staff are being supported to close down sickness absence episodes in a timely manner.



Root cause analysis/ Key lines of enquiry

In January 2020, the top reasons for sickness absence were:

Absence Reason	Headcount	Abs Occurr	Abs Days	%
S99 Unknown causes / Not specified	787	795	4,152	22.3
S10 Anxiety/stress/depression/other psychiatric illness	205	206	4,014	21.5
S12 Other musculoskeletal problems	81	81	1,669	9.0
S13 Cold, Cough, Flu - Influenza	150	151	1,122	6.0
S25 Gastrointestinal problems	176	177	1,091	5.9

• The Additional Annual Leave Purchase Scheme has been launched for 2020/21. This is designed to give extra flexibility to the working lives of staff.
• Work is ongoing with senior nurses to develop mental health pathways to support our staff.
• We are partnering with the Money and Pensions Service to develop our financial wellbeing support for the year
• A new Occupational Health management portal will be launched during February, improving navigation for managers
• Empactis – We are streamlining processes; building line manager engagement and preparing for Phase 2 rollout

Action Plan	RAG
Escalate / fast-track a change request with supplier to automate the absence type and reason based on the callers response to the trigger questions.	G
Open absences where the expected date of return has lapsed have been cross checked against Allocate and closed where applicable.	G
Managers have been identified for further training and employees reminded to close absences in Empactis	G

Progress

Not Initiated → Scoping → In Progress → Complete

Domain Scorecard

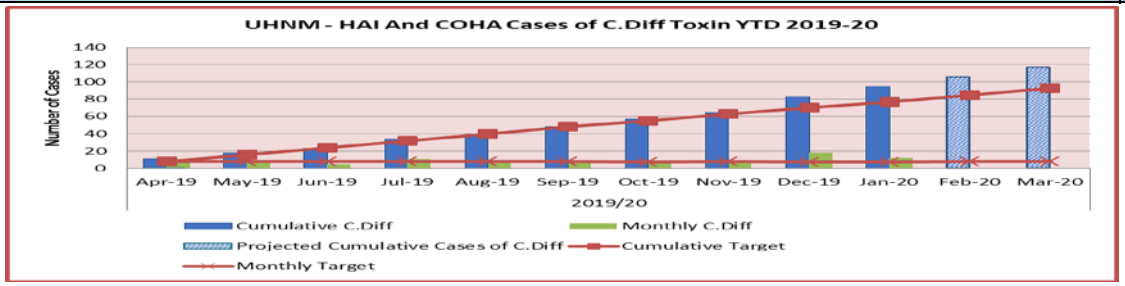
	Ref	Indicator	Exception Triggers			Period	Performance				Site Breakdown			Except.
			Month Target	Step Change	Conti. Limit		This Period Target	Last Period	This Period	YTD	RSUH	County	UHNM	
Patient Feedback	C12	Mixed Sex accommodation breaches	G			Feb-20	0	0	0	0	0	0	0	
	C7	Written Complaints Rate (per 10,000 spells)	G			Feb-20	35.00	20.22	31.41	30.92	34.12	20.18	31.41	
	C1	FFT Recommended %- Inpatients	G			Feb-20	95.0%	97.8%	98.4%	98.3%	98%	100%	98.4%	
	C2	FFT Recommended %- A&E	G			Feb-20	85.0%	65.2%	95.6%	67.4%	96%	72%	95.6%	
	C3	FFT Recommended %- Maternity	G			Feb-20	95.0%	100.0%	100.0%	99.7%	100.0%	100.0%	100.0%	
Staff Feedback	C6	Staff FFT Percentage Recommended- Care - Qtr.	G			Qtr4	70.0%	n/a	n/a	73.90%				

Domain Scorecard

	Ref	Indicator	Exception Triggers: Month Target	Exception Triggers: Step Change	Exception Triggers: Conti. Limit	Period	Performance: This Period Target	Performance: Last Period	Performance: This Period	Performance: YTD	Site Breakdown: RSUH	Site Breakdown: County	Site Breakdown: UHNM	Except.
Infection Control	S10	Clostridium Difficile- Infection number	R			Feb-20	8	18	12	95	9	3	12	✓
	S11	Clostridium Difficile- Variation from Plan	R			Feb-20	8	11	5	22	3	2	5	✓
	S2	Avoidable MRSA cases	G			Feb-20	0	0	0	0	0	0	0	
Incidents	S3	Never Events				Feb-20	0	1	0	5	0	0	0	
	S19	Falls Resulting in Harm (Including Low - Excluding Collapses and Managed Falls)	G			Feb-20	60	60	58	526	53	11	64	
	S25	Medication Errors: Rate per 10,000 bed days				Feb-20	-	40.8	41.4	44.6	42.8	32.2	41.4	
Harm Free Care	S38	Pressure Ulcers- Hospital Acquired Category 2 Lapse in Care	G			* Dec-19	8	2	2	42	2	0	2	
	S38	Pressure Ulcers Hospital Acquired Category 3 Lapse in care	G			* Dec-19	4	2	0	27	0	0	0	
	S29	Pressure Ulcers Hospital Acquired Category 4 Lapse in Care	G			* Dec-19	0	0	0	1	0	0	0	
	S17	Emergency C-Section Rate as % of total births				Feb-20	-	15.05%	15.23%	14.15%			15.23%	
Screening	S36	VTE risk assessments	R			Feb-20	95.0%	92.07%	92.48%	93.6%	91.7%	96.4%	92.5%	✓

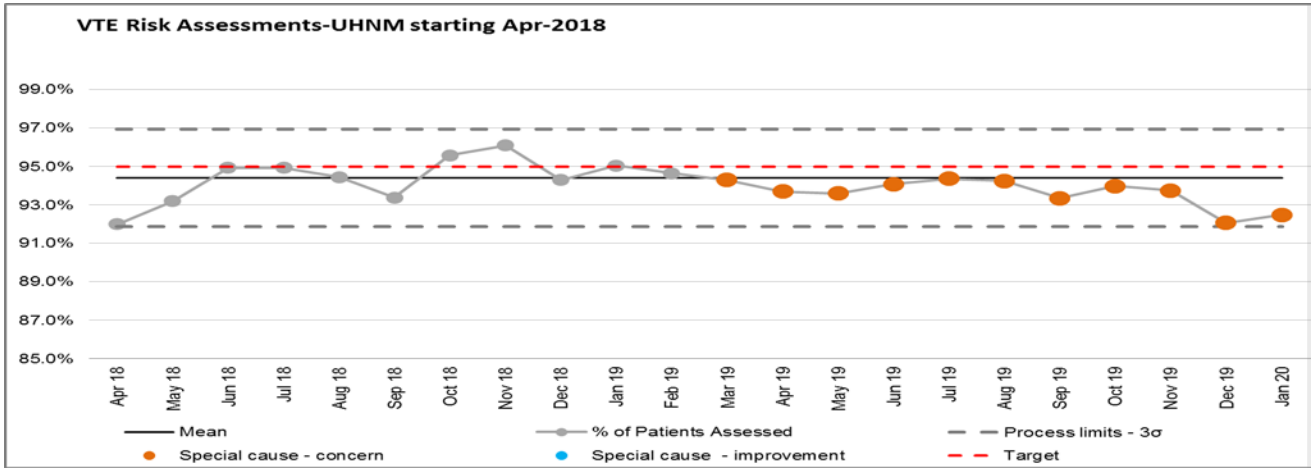
*reported for previous month

5. Safe	S11 - C-Diff	Feb-20 Page 37



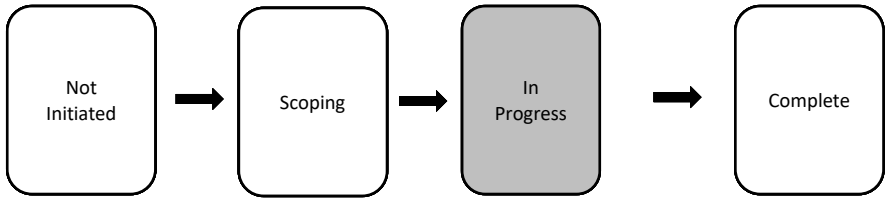
Root cause analysis/ Key lines of enquiry	Action Plan	RAG
In April 2019 new national definitions for C difficile (C diff) cases were announced, with further clarification received from NHSi in late July regarding the reporting of cases. This has resulted in UHNM having 95 cases of C diff to report at the end of January 2020 against a target of 77. The new definitions are: • Cases sampled C diff toxin positive on day 3 or more of admission are classed as hospital acquired (HAI). Previously these cases would have been non-trust apportioned. • Cases sampled C diff toxin positive within 28 days of discharge from hospital is classed as community acquired healthcare associated (COHA) and are now apportioned to the trust. Previously these cases would have been non-trust apportioned. As at YTD at the end of January 2019: 53 of the 95 cases would have been attributed as hospital acquired under the previous definition; whereas 42 would have been non-trust apportioned (9 'Day 3' samples and 33 COHA cases). Clearly there are many factors outside the trust control within 28 days from discharge, including stool samples sent by GPs/Care Homes, antimicrobial prescribing by primary care or other regional centres participating in a patients shared care. This change affects every trust in England. Each case undergoes an RCA. An investigation is currently underway of all cases in December and January to see if there are any links that can be elicited, or whether they are an unusual coincidental increase. The Trust has seen 774 influenza A cases as at the end of Jnauary, many of whom were poorly so we will be looking to see if there is any link to antimicrobials to treat secondary bacterial infection, and Norovirus.	Continue surveillance for HAI C diff with continued immediate implementation of control measures to prevent transmission	G
	Continue to work with health economy colleagues around antimicrobial prescribing	G
	3. MPFT to refresh primary care and care homes around not sending repeat stool specimens to check for C diff clearance	G
	PII (Periods of Increased Incidents) meeting to discuss three cases from the same ward area to determine whether transmission has occurred	A
	Investigation of all 18 cases to see if there are any links that can be elicited, or whether they are an unusual coincidental increase in relation to the influenza A cases during December to see if there is any link to antimicrobials to treat secondary bacterial infection, and Norovirus	A
	Progress	
	Not Initiated → Scoping → In Progress → Complete	

5. Safe	S36 - VTE risk assessments	Feb-20 Page 35



Jan-20	
Target	95%
Jan-19	95.04%
Jan-20	92.48%

Root cause analysis/ Key lines of enquiry	Action Plan	RAG
VTE assessments on admission are reported quarterly to Unify. The definition of the Indicator is the number of inpatients aged 16 and over reported as having had a VTE risk assessment on admission to hospital using the clinical criteria of the national tool divided by the number of adults who were admitted as inpatients (includes day cases, maternity and transfers; both elective and non-elective admissions). For January 2020 92.48% of VTE risk assessments were completed within 24 hours of patient admissions (all inpatient admissions during January 2020 captured on the WIS), which falls short of the National 95% target. However, results from the monthly point prevalence Safety Express audit shows that for the last six months, over 99.0% of VTE risk assessments have been completed (ward based audit of every inpatient on one specified day of the month). This suggests that VTE Risk Assessments completed on admission but not uploaded accurately onto the WIS Board. This is supported by the internal audit of UHNM Quality Account 2018/2019, which concluded that UHNM was under-reporting compliance with VTE risk assessments. The four admission areas with the poorest compliance that would have the biggest impact on the Trusts overall performance are AMU (RSUH), FEAU, Ward 127 (short stay) and Ward 220. Recent spot checks of the VTE risk assessments within prescription charts, within these areas, conclude VTE assessments are being completed but not inputted onto the WIS system. These spot checks will be ongoing and fed back	Development of an E-Learning package to instruct users how to accurately upload VTE risk assessment times on the Ward Information System (WIS) and how to avoid loss of data has been available on ESR Since end of January 2020. Reminder cards have been attached to all WIS boards within the clinical area. Uptake of training will be monitored by the Corporate Quality & Safety Team.	G
	The Corporate Quality & Safety Team are providing focused support to admission portals to improve compliance with VTE risk assessment completion and data capture, as required.	A
	Areas of non-compliance are escalated to the relevant matron by the Corporate Quality & Safety Team, on a monthly basis.	G
	The VTE Steering Group are liaising with other Trust working groups to explore other means of data collection of VTE risk assessment compliance, including Vitalpac and EPMA.	A
	A workstream is underway to improve compliance with NICE Guidance on VTE risk assessment for patients aged 16-18 years.	G

to the Ward Managers, Matrons and Divisional Leads. A work stream is underway to improve VTE risk assessment for patients aged 16-18 years . Monthly email/ indicator results are sent to paediatric medical governance lead to improve compliance for children aged 16yrs and 17yrs as these are currently low and are now included within the trusts Quarterly reports to unify. Continued focused work is ongoing to improve compliance with timely inputting of VTE risk assessments onto WIS. The VTE Steering Group are also liaising with other Trust working groups to explore other means of data collection of VTE risk assessment compliance, including Vitalpac and EPMA.	**Progress** 

Trust Board

2019/20 BUSINESS CYCLE

KEY TO RAG STATUS	
Paper rescheduled for future meeting	
Paper rescheduled for next meeting	
Paper taken to meeting as scheduled	

Title of Paper	Executive Lead	Apr 3	May 8	Jun 5	Jul 10	Aug 14	Sep 4	Oct 9	Nov 6	Dec 11	Jan 8	Feb 5	Mar 11
PROVIDE SAFE, EFFECTIVE, CARING AND RESPONSIVE SERVICES													
Chief Executives Report	Chief Executive												
Patient Story	Chief Nurse												
Quality Assurance Committee Assurance Report	Associate Director of Corporate Governance												
Emergency Preparedness Annual Assurance Statement and Annual Report	Chief Operating Officer												
Patient Safety Report	Chief Nurse		Q4			Q1			Q2			Q3	→
Care Quality Commission Action Plan	Chief Nurse									→	→	→	→
Revised Patient Care Improvement Strategy	Chief Nurse												
Bi Annual Nurse Staffing Assurance Report	Chief Nurse								→	→	→	→	→
Quality Account	Chief Nurse												
Patient Experience Report	Chief Nurse			Q4			Q1	→		Q2			Q3
7 Day Services Board Assurance Report	Medical Director												
NHS Resolution Maternity Incentive Scheme	Chief Nurse												
Winter Plan	Chief Operating Officer							→	→				
PLACE Inspection Findings and Action Plan	Director of Estates, Facilities & PFI												
ACHIEVE NHS CONSTITUTIONAL PATIENT ACCESS STANDARDS													
Integrated Performance Report	Various												
ACHIEVE EXCELLENCE IN EMPLOYMENT, EDUCATION, DEVELOPMENT & RESEARCH													
Gender Pay Gap Report	Director of Human Resources												
Research and Development Update	Medical Director			→				→	→				
People Strategy Progress Report	Director of Human Resources												

Title of Paper	Executive Lead	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
		3	8	5	10	14	4	9	6	11	8	5	11
Revalidation	Medical Director												
Workforce Disability Equality Report	Director of Human Resources												
Workforce Race Equality Standards Report	Director of Human Resources												
Staff Survey Report	Director of Human Resources												
LEAD STRATEGIC CHANGE WITHIN STAFFORDSHIRE AND BEYOND													
Sustainability and Transformation Partnership Update	Director of Strategy			→									
ENSURE EFFICIENT USE OF RESOURCES													
Finance and Performance Committee Assurance Report	Associate Director of Corporate Governance												
Revenue Business Cases / Capital Investment / Non-Pay Expenditure £3,000,001 and above	Director of Strategy												
IM&T Strategy Progress Report	Director of IM&T								→				
Going Concern	Chief Finance Officer												
Estates Strategy Progress Report	Director of Estates, Facilities & PFI											→	
Annual Plan 2020/21	Director of Strategy												
Financial Plan 2020/21	Chief Finance Officer												
Capital Programme 2020/21	Chief Finance Officer												
GOVERNANCE													
Nomination and Remuneration Committee Assurance Report	Associate Director of Corporate Governance												
Professional Standards and Conduct Committee Assurance Report	Associate Director of Corporate Governance												
Audit Committee Assurance Report	Associate Director of Corporate Governance												
Board Assurance Framework	Associate Director of Corporate Governance		Q4			Q1			Q2			Q3	
Raising Concerns Report	Director of Human Resources		Q4			Q1			Q2			Q3	
Annual Evaluation of the Board and its Committees	Associate Director of Corporate Governance												
Annual Review of the Rules of Procedure	Associate Director of Corporate Governance												
G6 Self-Certification	Chief Executive												
FT4 Self-Certification	Chief Executive												
Board Development Programme	Associate Director of Corporate Governance												
Integrated Business Plan	Director of Strategy												
Well-Led Review	Chief Executive												