



# Quality Account 2017/18



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# Part A: Statement on Quality



## OVERVIEW

### 1. Introduction to UHNM

Welcome to our new Quality Account about the University Hospitals of North Midlands NHS Trust (UHNM). 2017/18 has been a challenging yet exciting year for us, although we have continued to deliver on our commitment to transform health services in Staffordshire, ensuring stability and future resilience.

University Hospitals of North Midlands (UHNM) NHS Trust was created in 2014 with an investment of over £250 million to bring together clinical services in Stoke and Stafford across two hospital sites; Royal Stoke University Hospital, located in Stoke-on-Trent and County Hospital, located in Stafford. This was a major, positive change for the people of Staffordshire and their local NHS. The substantial investment into NHS services has enabled us to expand and develop our hospitals to the very real benefit of local people

We provide a full range of general acute hospital services for approximately 900,000 people locally in Staffordshire, South Cheshire and Shropshire. We employ over 11,000 staff members and with approximately 1,500 inpatient beds, we also provide specialised services for three million people in a wider area, including neighbouring counties and North Wales.

We are one of the largest hospitals in the West Midlands and have one of the busiest emergency departments in the country, with more than 175,000 patients attending our A&E departments last year.

Many emergency patients are brought to us from a wide area by both helicopter and land ambulance because of our Major Trauma Centre status.

As a university hospital, we work with Keele University and Staffordshire University and have strong links with local schools and colleges.

Royal Stoke University Hospital



The County Hospital (Stafford)



Our specialised services include cancer diagnosis and treatment, cardiothoracic surgery, neurosurgery, renal and dialysis services, neonatal intensive care, paediatric intensive care, trauma, respiratory conditions, spinal surgery, upper gastrointestinal surgery, complex orthopaedic surgery, laparoscopic surgery and the management of liver conditions.

We are a key player in the Staffordshire Sustainability and Transformation Partnership (STP) and take an active part in the planning and discussions. The health economy plan remains focused on minimising admissions to and discharging as soon as possible from the major acute site at Royal Stoke University's Hospital (RSUH), with as much care as possible being delivered in community settings or at County Hospital (CH).

We benefit from being able to attract and retain high quality staff. In order to do this we need to continue to maintain and expand our tertiary capabilities to service the populations of the north west Midlands, Derbyshire, Wales, south Manchester and the northern suburbs of Birmingham.



28.06.2018

Steve Burgin  
**Interim Chairman**



28.06.2018

Paula Clark  
**Chief Executive**



## 2. Statement on Quality

This is now my second year at UHNM as Chief Executive and I am amazed at the progress made over the two years despite the increasing pressure at all levels to deliver safe, effective care and an ever growing focus on the delivery of operational performance and cost improvement. Clearly, achieving all of this relies on the commitment, dedication and hard work of our staff and recognition and reward for their valuable contribution.

Our core vision continues to be a leading centre in health care, driven by excellence in patient experience, research, teaching and education, our overall ambition is to equal or exceed the best performing Trusts in England. Listening to our patient and our staff has been and will remain a priority. We believe that through listening to our patients and staff we are promoting engagement and a contribution to the success of the Trust and therefore achieving our ambition together.

This Account reaffirms our relentless commitment to developing a culture of continuous improvement and to empowering and equipping all staff to achieve excellence in quality, safety and patient experience, and in turn improve patient outcomes, staff morale, productivity and efficiency.

Our Quality Account therefore describes our shared successes and also some of the challenges we face and will continue to face in the future. These challenges have guided our Quality Priorities for the year ahead. We have continued to strive to improve our services and experiences for staff and patients. We made strong progress against many of the quality and safety priorities identified in last year's account:

- Reduction in overall harm from Patient Safety Incidents
- Reduction in total patient falls reported and reduction in overall rate of falls per 1000 bed days.
- Reductions in harm to patients as result of falls
- Exceeding the 95% National Target throughout 2017/18 for Safety Thermometer
- The percentage of staff saying they perceived an experience of bullying, harassment or abuse from other staff in the last 12 month (colleagues and managers) reduced from 28% to 27% and remained at 26% from patients and the public.
- Elective Surgery (Bariatric and Trauma & Orthopaedics) has been significantly increased at County Hospital
- Reductions in complaints received at both Royal Stoke University Hospital and The County Hospital compared to 2016/17

In October and November 2017 the CQC Inspectors visited both hospital sites and whilst the overall rating of Requires Improvement has not changed inspectors found a number of significant improvements had been made since their previous visit in 2015. The trust is now rated as Outstanding for being caring, where it was previously rated as Good. It is also rated as Good for whether services are effective and well-led, where it had previously been rated as Requires Improvement, and the trust is now rated as Requires Improvement for whether services are responsive, where it was previously rated as Inadequate. The CQC commended our hard working, compassionate and dedicated staff, and observed many examples of good and excellent practice.

However, while we are proud of our achievements, we recognise that there are other areas where we need to make further improvement. These areas are detailed within the account. Of significance, we did not achieve our accident and emergency 4 hour access target. This is despite the enormous efforts of our staff across the organisation and the investment in additional beds and staff. The unpredictable surges in demand on our emergency services and the increase in older and sicker patients being admitted into our beds has put our services under intense pressure particularly during the winter months. This demand on our beds has meant that patients

have often had to wait longer than we would want and on occasions we have had to cancel planned operations. We are committed to continuously improving our internal process to expedite diagnosis, treatment and discharge and to working closely with our local health economy partners to improve patient flow through the health and social care systems.

Furthermore, as with all NHS organisations, the trust faces increasing financial pressure as an impact of the continuing national economic downturn. In March 2017 we were placed in Financial Special Measures by NHS Improvement. Our staff have responded positively to the challenge of achieving the new financial targets and significant progress has been made. This demonstrates our determination and our ability to better manage our budgets whilst continuing to deliver high quality care thus ensuring long term sustainability

Overall, we are proud of the progress we have made over the last year and we value the work of our staff in their contribution in achieving this. We know our staff strive for excellence for our patients and we are confident that through strong team working we will achieve our full potential together.

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

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

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

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



**Paula Clark**  
Chief Executive Officer



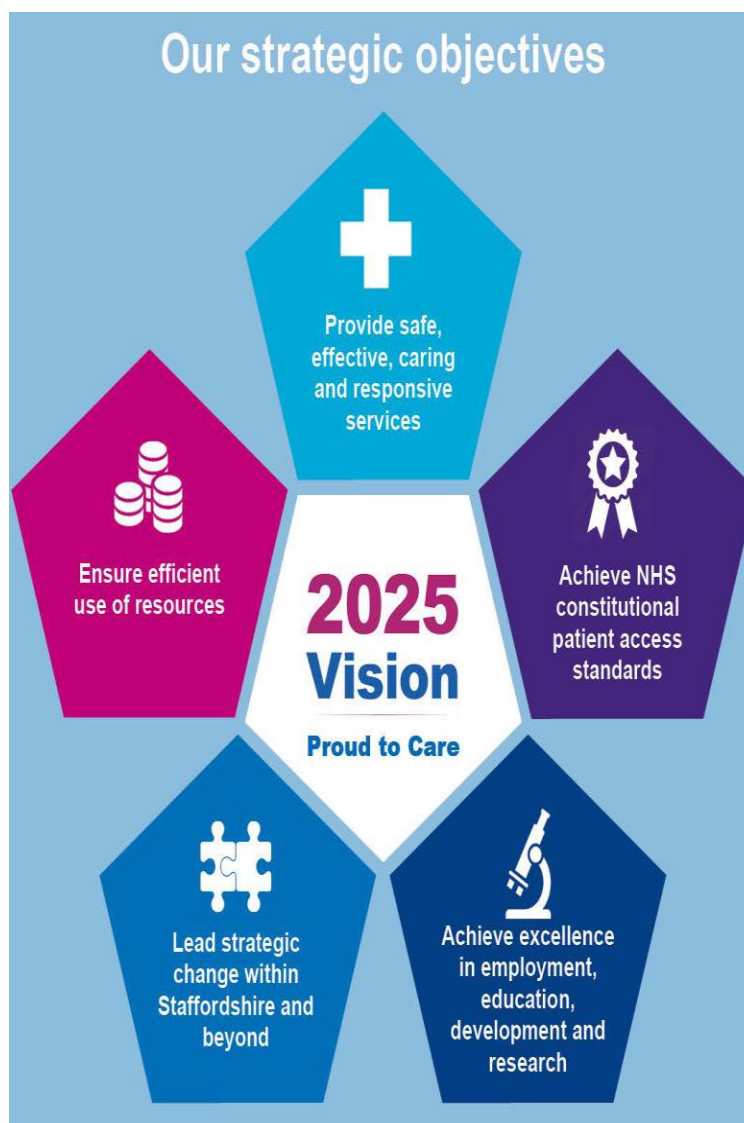
**Steve Burgin**  
Interim Chairman

28.06.2018

## 2.2 Strategic Objectives

In 2017, we refreshed our core strategy '2025Vision' which we launched at our Annual General Meeting in September 2017. The strategy sets out our vision, values and key priorities for moving forward and delivering services that our own families would choose should they need care, delivered by staff who take pride in everything they do.

Our 5 key Strategic Objectives are set out within our core strategy and form the basis of our Integrated Business Plan (IBP) and Annual Plan. Our objectives are underpinned by our core values and provide us with a clear focus and drive to deliver our strategy.



# University Hospitals of North Midlands

## Our 2025 Vision

### What we will deliver - our strategic objectives



Provide safe, effective, caring and responsive services

- Improved CQC ratings through implementation of our Care Excellence framework
- Maintaining strong performance in relation to the Summary Hospital-level Mortality Indicator (SHMI)
- Positive Patient Led Assessment of the Care Environment (PLACE) annual inspections across UHNM



Achieve NHS constitutional patient access standards

- Improving pathways in and out of hospital
- Consistent implementation of best practice
- Provision of seven day services



Achieve excellence in employment, education, development and research

- Recruitment and retention of highly skilled staff & implementation of UHM improvement methodology
- On-going development of specialist services
- Building our links with Staffordshire & Keele Universities



Lead strategic change within Staffordshire and beyond

- Increased income from NHS specialised commissioning services & elective care at County
- Leading role in the Staffordshire and Stoke-on-Trent STP
- Reduced number of Medically Fit for Discharge patients in acute beds



Ensure efficient use of resources

- Delivery of Financial Recovery Plan
- Optimum use of our estate
- Digitisation

### How will we deliver this? - Our values



- We are a team
- We are appreciative
- We are inclusive



- We are supportive
- We are respectful
- We are friendly



- We communicate well
- We are organised
- We speak up



- We listen
- We learn
- We take responsibility

[www.uhnm.nhs.uk](http://www.uhnm.nhs.uk)





## A year of success at UHNM

During 2017/18, our staff have been gaining recognition, both internally and externally, for their efforts and expertise from judges, panelists and patients alike. The nominations, awards and special presentations have been received and undertaken by staff right across the Trust, showcasing the professionalism, quality and talent of our workforce.

### **Royal Stoke University Hospital Neonatal Unit wins prestigious award**

The neonatal unit at Royal Stoke University Hospital has received the first Parents' Choice Award from Bliss, the UK's leading charity for babies born premature or sick.

<http://www.uhnm.nhs.uk/news/pages/Neonatal-Unit-wins-prestigious-award.aspx>

### **HSJ Partnership award win**

UHNM, in partnership with Sodexo, has scooped a coveted HSJ Partnership Award at a ceremony in London. The award was in the 'Facilities Management Supplier of the Year' category, and highlights continued partnership working between UHNM and Sodexo.

<http://www.uhnm.nhs.uk/news/Pages/HSJ-partnership-award-winners.aspx>

### **UHNM announced as a winner at this year's AF association Healthcare pioneer awards**

UHNM has been announced as one of the Atrial fibrillation Association "Healthcare Pioneers 2018, Showcasing Best Practice in AF" winners at the Arrhythmia Alliance Awards Ceremony.

<http://www.uhnm.nhs.uk/news/Pages/AF-team-win-national-award.aspx>

### **Doctor at Royal Stoke awarded prestigious honour**

A Foundation Trainee Doctor at Royal Stoke University Hospital has been named as one of Medscape's Physicians of the Year for 2017. Dr Tirej Brimo was given the prestigious award after achieving his dream of becoming a doctor after a long journey from the war in Syria.

<http://www.uhnm.nhs.uk/news/Pages/Doctor-at-Royal-Stoke-awarded-prestigious-honour.aspx>

### **Ann Barton award**

The Endoscopy Ward Band 6 team have won the Ann Barton award, which is awarded once a year to an individual or team for outstanding performance, innovation or appreciation to any clinical staff in the midlands working in the gastroenterology field.

<http://www.uhnm.nhs.uk/news/Pages/Ann-Barton-award.aspx>

### **Centre of Excellence award in Myeloma care presented to UHNM by Myeloma UK**

Myeloma UK has recently recognised the outstanding quality of care provided to myeloma patients by the University Hospitals of North Midlands, by awarding the hospital the Myeloma UK Clinical Service Excellence Programme Award (Myeloma UK CSEP Award).

<http://www.uhnm.nhs.uk/news/Pages/Centre-of-Excellence-award-in-Myeloma-.aspx>

**HSJ Award win for Mechanical Thrombectomy**

University Hospitals of North Midlands wins Specialised Services Redesign at the 2017 HSJ Awards.

<http://www.uhnm.nhs.uk/news/Pages/HSJ-Award-win-for-Mechanical-Thrombectomy-.aspx>

**National award for Dr Al-Araji**

UHNMs Dr Adnan Al-Araji, has won the prestigious 'Outstanding Physician' award at the 2017 QuDoS in Multiple Sclerosis (MS) recognition programme.

<http://www.uhnm.nhs.uk/news/pages/National-award-for-Dr-Al-Araji.aspx>

**Dr Sanjeev Nayak wins national award**

UHNMs Consultant Neuroradiologist, Dr Sanjeev Nayak was a winner at the recent 'The Sun, Who Cares Wins' as he picked up the 'Groundbreaking Pioneer or Discovery award'.

<http://www.uhnm.nhs.uk/news/Pages/Dr-Sanjeev-Nayak-wins-national-award.aspx>

**UHNM staff star at The Sentinel Our Heroes awards**

Staff from University Hospitals of North Midlands were recognised at The Sentinel's annual Our Heroes awards evening on Thursday 28 September.

<http://www.uhnm.nhs.uk/news/Pages/UHNM-staff-star-at-The-Sentinel-Our-Heroes-awards.aspx>

**UHNM teams star at WMAHSN awards evening**

Teams and staff from UHNM made the West Midlands Academic Health Science Network an evening to remember with two award wins and several shortlisted teams.

**Second national award for UHNM Cardiology team**

The Cardiology Department at University Hospitals of North Midlands have won another prestigious national award following a previous win just a matter of weeks ago.

The Cardiac Assessment Nurses (CAN) team scooped the "British Heart Foundation Team of the Year" award at the British Cardiac Society meeting in Manchester, after also receiving the Team of the Year accolade at the BMJ awards in May 2017.

<http://www.uhnm.nhs.uk/news/Pages/Second-national-award-for-Cardiology-team.aspx>

**National award for Excellence in Organisational Development**

The Shropshire and Staffordshire Leadership Leads Group have won the HPMA Academi Wales Award for Excellence in Organisational Development 2017 for their "Leading with Compassion" recognition Scheme. They received the award at last week's HPMA Awards ceremony.

<http://www.uhnm.nhs.uk/Pages/Award-for-Organisational-Development-.aspx>

**Prestigious prize for UHNM Registrar**

UHNM Anaesthetic Registrar, Dr Felicity Jayne Avann, has received the prestigious 'Harvey Granat prize' after showcasing her experience of treating stroke patients to the Neuro Anaesthesia & Critical Care Society of Great Britain and Ireland (NACCSGIBI).

<http://www.uhnm.nhs.uk/news/Pages/Prestigious-prize-for-UHNM-Registrar.aspx>

**UHNM's Cardiology team rated no.1 after national award win.**

The Cardiology team at University Hospitals of North Midlands have won the prestigious British Medical Journal (BMJ) 'Cardiology team of the year' award.

<http://www.uhnm.nhs.uk/news/Pages/UHNM-Cardiology-team-rated-number-1-.aspx>

**Royal Stoke MS centre wins prestigious national award**

A 'Centre of Excellence' in Stoke-on-Trent which supports people with multiple sclerosis (MS) has been crowned the 2017 'MS Professional of the Year' at the MS Society Awards.

<http://www.uhnm.nhs.uk/news/pages/Royal-Stoke-MS-centre-wins-prestigious-national-award.aspx>

**National Award for Critical Care audit team**

A team from the Trust's Critical Care Unit have won a national award for monitoring patient outcomes. The Intensive Care National Audit & Research Centre have awarded Senior Audit Clerk Sarah Wilson and her team the Case Mix Programme (CMP) Quarterly Prize for their work in Critical Care.

<http://www.uhnm.nhs.uk/news/Pages/National-Award-for-Critical-Care-audit-team.aspx>

## Priorities for Improvement

### 3.1 Our Quality Priorities and Objectives for 2018/19

**Our core vision continues to be a leading centre in healthcare, driven by excellence in patient experience, research, teaching and education. Our overall ambition is to become one of the top University Teaching Hospitals in the UK by 2025.**

We want everyone who works at UHNM to share this vision and place quality at the heart of everything we do by embracing and demonstrating the following values:



## Prioritising our quality improvement areas

We have continued our focus on quality improvement with our Patient Care Improvement Programme which is aligned to our Strategic Objectives and 2025 Vision.

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

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

## Stakeholder Workshops

In April 2018, we held a stakeholder workshop and invited our members of staff and our partners from local councils, Clinical Commissioning Groups and Healthwatch. The aim of the workshops was to agree our priority quality objectives for 2018/19 with a focus on continuing to improve the priorities set in 2017/18.

## Our Overall Goal is:

To support our staff to get it right first time every time for our patients

### Aims

#### One: To keep our patients safe and free from harm

What we will do

##### ✓ **Improve timely recognition and treatment of Sepsis.**

We will achieve this by:

- Ensuring that timely identification and treatment of sepsis is a key patient safety objective across UHNM
- Developing a permanent corporate resource to support the on-going training, awareness and management of sepsis in order to improve patient safety and reduce mortality.
- Continuing to strive to deliver the 2017-19 National CQUIN 'Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)
- Reviewing outcomes of local reviews and where necessary, make recommendations to address any gaps identified
- Monitoring adverse incident reports and reflect any findings as part of the improvement plan
- Reviewing findings from audit projects and reflect any findings as part of the improvement plan
- Escalating any issues of concern to the Quality & Safety Forum
- Share best practice through Trust working groups, Risk management Panel and Quality & Safety Forum.

We will complete monthly audits to measure the number of patients screened for sepsis and receiving antibiotics within 1 hour in both the emergency portals and inpatient wards. This will be monitored by the Infection Prevention & control Committee

##### ✓ **Recognise and respond to deteriorating patients**

- Providing strategic direction for the development, implementation and monitoring of safer care of the deteriorating patient, across the Trust.



- Reviewing national legislation and guidance and address local implications of such guidance and inform the Deteriorating Patient Steering Group of issues to be reviewed
- Maintaining an up to date and accurate risk register with associated improvement plans; progress against which will be monitored by the Deteriorating Patient Steering Group
- Reviewing outcomes of local reviews and where necessary, make recommendations to address any gaps identified
- Monitoring adverse incident reports and reflect any findings as part of the improvement plan
- Reviewing findings from audit projects and reflect any findings as part of the improvement plan
- Escalating any issues of concern to the Quality & Safety Forum
- Share best practice through Trust working groups, Risk management Panel and Quality & Safety Forum.

We will complete a root cause analysis on any patient coming to harm as a result of failure to recognise and respond to deterioration. We will report the number of serious incidents and level of harm on a monthly basis in the Serious Incident report. This will be monitored by the Deteriorating Patient Steering Group.

✓ **Reduce harm from falls by 20%. We will achieve this by:**

- Providing dedicated support from a Quality Improvement facilitator for high reporting areas.
- Review of availability of distraction therapy across the Trust
- Development of a visual assessment tool as recommended by the RCP National Audit
- Implementation of lying and standing blood pressure
- On-going education of Falls Champions
- Review and standardisation of falls prevention equipment across the Trust, including pressure sensors, crash mats and low rise beds.
- Regular campaigns about falls prevention as part of UHNM commitment to the national Sign Up to Safety Campaign

We will complete a root cause analysis on every patient coming to harm from a fall and we will report the number of incidents and level of harm on a monthly basis in the falls report. This will be monitored by the Falls Steering Group

✓ **Eliminate avoidable hospital acquired grade 4 pressure ulcers and reduce the incidence of avoidable grades 2 and 3 pressure ulcers by 5%. We will achieve this by:**

- Providing dedicated support from a Quality Improvement facilitator for high reporting areas.
- Piloting rapid intervention to support ward teams to identify grade 1 pressure damage in a timely manner and to prevent further deterioration.
- On-going education of Tissue Viability Link Nurses
- Review of device related incidents
- Review of patient seating and standardisation of pressure relieving seating across the Trust
- Awareness campaigns including, Stop the Pressure.

We will complete a root cause analysis on every patient with a grade 2 or above hospital acquired pressure ulcer and we will report the number of hospital acquired avoidable and unavoidable pressure ulcers on a monthly basis in the pressure ulcer report. This will be monitored by the Pressure Ulcer Steering Group.

✓ **Improve the confidence of staff in the application of Mental Capacity act assessments**

We will achieve this by:

- Agreeing a training programme and focus on specific staff groups i.e. Consultants and Matrons priority and then disseminate to other staff on rolling programme
- Divisional Teams to agree roll out.
- Reviewing current e-learning package and MCA policy

How we will measure progress?

- Training compliance to be reported corporately and divisionally on quarterly basis
- Audit the quality of Mental Capacity Assessments documented in medical records
- Exception reporting to target areas for improvement

What forum we will report progress?

- Safeguarding Steering Group
- Divisional Performance Reviews
- Quality & Safety Forum

**Two: To improve staff engagement, resilience, feeling valued**

What we will do

✓ **Improve staff experience through a range of activities focusing on staff wellbeing, reward and recognition**

We will achieve this by:

- Putting in place a range of corporate actions focussing on the concerns raised.
- Divisional teams will review their 3 main areas of focus this year and develop action plans to address these.
- We are currently running an engage at UHNM survey which will provide local, more current feedback and we will use this data to triangulate with the outputs of the national staff survey.
- We will continue with our staff appreciation visits and recognition activities such as employee and team of the month awards.

How we will measure our progress ?

- Progress will be measured via performance reviews, listening events and staff feedback as well as our quarterly staff surveys

What forum we will report progress?

- Quality Assurance Committee

### Three: To ensure service users' experiences help to shape service developments and improvements at all levels of the organisation.

We will achieve this by:

- Supporting patients to be involved in decisions about their own care.
- Provide a variety of forums/opportunities for patients to provide feedback
- Developing a culture that welcomes public engagement to actively influence the strategic direction of the Trust.
- Providing transparent patient feedback data for both staff and the public.
- Continue to develop close links with the community and expert groups to enable the voice of the hard to reach populations to be heard and identify need.
- Introducing a structured Patient Leadership training programme to provide Patient Leaders with the confidence and skills to become effective agents of change to improve the quality of services and promote health and wellbeing within communities.
- Supporting ideas and generate solutions to current health care problems from the patients' perspective.
- Providing learning and support for staff, patients, carers and the public.
- Moving from 'nice to have' to a 'must do' (always events)

How we will measure our progress?

- Collate, receive and analyse all national and local relevant data and maintain a live dashboard of all patient experience data including examples of patient led changes.
- Effectively triangulate the data in the context of clinical, safety and other quality
- Indicators such as staff experience.
- Effective Patient Leaders embedded in the organisation

What forum we will report progress

- Document progress quarterly in the Patient Experience report which is presented to:
- Quality & Safety Committee
- Quality Assurance Committee
- Trust Board



## 3.2 How we have performed against Quality KPIs during 2017/2018

Quality Indicator	Previous Period		Current Period	
The value of the Summary Hospital level Mortality Indicator (SHMI)	<b>October 2015 – September 2016</b> 0.99 (Band 2)		<b>October 2016 – September 2017</b> 1.04 (Band 2)	
The percentage of deaths with palliative care coded at either diagnosis and/or specialty level	38%		39.5%	
Patient Reported Outcome Measures scores* (National Average)	<b>Participation Rate 2015/16</b>	<b>Adjusted Health Gain 2015/16</b>	<b>Participation Rate 2016/17</b>	<b>Adjusted Health Gain 2016/17</b>
☑ Groin hernia surgery	25.4% (56.4%)	0.881 (0.878)	29.6% (57.8%)	0.096 (0.086)
☑ Varicose Vein Surgery	3.0% (31.6%)	- (0.837)	2.2% (35.0%)	- (0.092)
☑ Hip Replacement Primary Surgery	97.8% (84.1%)	0.756 (0.800)	81.6% (85.9%)	0.446 (0.445)
☑ Knee Replacement Primary Surgery	103.4% (93.4%)	0.743 (0.743)	89.5% (94.6%)	0.328 (0.324)
*EQ-5D scores				
Percentage of patients aged	<b>UHNS (2011/12)</b>		<b>No new data publication available from NHS Digital portal</b>	
☑ 0 to 15; and	11.78%			
☑ 16 and over	11.89%			
Readmitted to a hospital which forms part of the Trust within 28 days of being discharged from hospital				
The Trust's responsiveness to the personal needs of its patients	<b>2015/16 Survey</b> 66.5 (National average 69.6)		<b>2016/17 Survey</b> 65.1 (National Average 68.1)	
Percentage of staff employed by the Trust who would recommend the trust as a provider of care to their friends and family (Agree / Strongly Agree)	<b>2016</b> 69% (National Average Acute Trusts 70%)		<b>2017</b> 71% (National Average Acute Trusts 70%)	
Percentage of patients who were admitted to hospital and who were risk assessed for Venous Thromboembolism (Acute Trusts) (National Average)	<b>2016/17</b> Q1 98.37% (95.65%) Q2 97.38% (95.47%) Q3 97.17% (95.57%) Q4 95.57% (95.46%)		<b>2017/18</b> Q1 91.26% (95.11%) Q2 94.53% (95.21%) Q3 92.80% (95.30%) Q4 91.23% (95.89%)	
The rate per 100,000 bed days of Clostridium Difficile infection reported within the Trust amongst patients aged two or over <sup>1</sup> (Trust apportioned)	<b>2015/16</b> 22.5 (National Average 14.9) (National Range 0 – 66.0)		<b>2016/17</b> 19.9 (National Average 13) (National Range 0 – 82.7)	
The number and rate of patient safety incidents reported within the trust - Acute trusts (non specialist)	7044 (April - September 2016) 31.7 per 1000 bed days		6244 (April – September 2017) 27.6 per 1000 bed days	
The number and percentage of such patient safety incidents that resulted in severe harm or death—acute (non specialist)	16 (April - September 2016) 0.07 per 1000 bed days		31 (April – September 2017) 0.14 per 1000 bed days	

<sup>1</sup> All NHS Trusts are required to report the data published via NHS Digital's national Quality Account portal. There is a difference in the Clostridium Difficile rates reported via NHS Digital portal and the rates reported in

Trust's Integrated Performance Report because of a difference between the Public Health England figures and the NHS Digital's figures. This difference is due to different methodologies used by these national databases for calculating bed day rates. The Integrated Performance Report data uses the data from the Public Health England database.

## Commissioning for Quality and Innovation (CQUIN) Indicators for 2017/18

CQUIN is a payment framework which allows Commissioners to agree payments to hospitals based on agreed improvements. The Trust's performance against the CQUINs for 2017/18 can be seen on p24. 1.5% of income was dependent of the achievement of the CQUINs together with a further 1% available associated with STP engagement and achievement of the financial control total. The Trust submitted an overall CQUIN performance of 95% for the Specialised Commissioning Contract and 76% for the Local Commissioning Contract and await confirmation of achievement from Commissioners.

### Main Contract CQUIN 2017/18

- **Health & Wellbeing - Staff:** Achieving an improvement in 2 of the 3 NHS annual staff survey questions on health and wellbeing, MSK and stress
- **Health & Wellbeing - Food:**
  - a) **Maintaining the changes introduced in 2016/17:** banning of price promotions on sugary drinks and foods high in fat, sugar or salt (HFSS); banning of advertisements on NHS premises of sugary drinks and foods HFSS; banning of sugary drinks and foods HFSS from checkouts; ensuring health options are available for staff working night shifts
  - b) **Introduce 3 new changes:** 70% of drinks lines to be sugar free; 60% of confectionary and sweets do not exceed 250kcal; 60% of pre-packed sandwiches contain 400kcal or less
- **Health & Wellbeing - Flu:** Improving the uptake of flu vaccinations for front line clinical staff with a target to achieve 70% by the end of February 2018
- **REDUCING THE IMPACT OF SERIOUS INFECTIONS (ANTIMICROBIAL RESISTANCE AND SEPSIS)**
  - a) **Timely identification of sepsis in emergency departments and acute inpatient settings** – target 90% of patients meeting the criteria are screened for sepsis
  - b) **Timely treatment of sepsis in emergency departments and acute inpatient settings** – target 90% of patients red flag for sepsis receive antibiotics within an hour of identification
  - c) **Antibiotic review** – target 90% of patients have an antibiotic review within 3 days
  - d) **Reduction in antibiotic consumption per 1,000 admissions**
    - total antibiotic consumption – 1%
    - carbapenem – 2%
    - piperacillin-tazobactam – 1%
- **IMPROVING SERVICES FOR PEOPLE WITH MENTAL HEALTH NEEDS WHO PRESENT TO A&E:** Working with an identified cohort of patients that have presented at A&E with primary or secondary mental health needs together with local partner organisations (primary care, police, ambulance, WIC) to ensure that these needs are met more effectively. Target to reduce the number of attendances for the selected cohort by 20%. Ensure that robust systems are in place to capture the coding of mental health needs within A&E data submissions
- **ADVICE & GUIDANCE:** Develop and operate Advice & Guidance services for non-urgent GP referrals, allowing GPs to access consultant advice prior to referring patients in to secondary care. Target to operationalise A&G services for specialties covering at least 35% of GP referrals by Quarter 4 2018
- **E-REFERRALS:** Ensure that all consultant led 1<sup>st</sup> outpatient services are published and first outpatient appointment slots are available on the NHS e-Referral Service by 31 March 2018
- **SUPPORTING PROACTIVE AND SAFE DISCHARGE:** Increasing the proportion of patients admitted via a non-elective route discharged from acute hospital to their usual place of residence within 7 days of admission by 2.5%. Commence timely submission of the Emergency Care Data Set.

### Specialised Contract CQUIN 2016/17



- **HAEMOPHILIA HAEMTRACK PATIENT HOME REPORTING:** Improving the recording of self-managed bleeding episodes and usage of blood factor products to support treatment compliance, optimising home therapy and home stock control
- **NATIONALLY STANDARDISED DOSE BANDING FOR ADULT INTRAVENOUS ANTICANCER THERAPY:** Implementation of nationally standardised doses of SACT using the dose-banding principles and dosage tables published by NHS England
- **SHARED DECISION MAKING (CARDIAC, ILD & ASTHMA):** To ensure all relevant treatment options are discussed with patients, to enable choices aligned to a patient's overall needs and values and clinical ability to benefit
- **CYSTIC FIBROSIS PATIENT ADHERENCE (ADULT):** Improved adherence and self-management by patients, enabling better health outcomes and much less time off work and other life activities.
- **COMPLEX DEVICE OPTIMISATION:** Enhancement and maintenance of local governance systems to ensure compliance with national policies and specifications; development of sub-regional network policies to encourage best practice when determining device choice; ensure that referral pathways and robust MDT decision making processes are developed for complex and clinically unusual cases, revisions and lead extractions
- **SPINAL SURGERY: NETWORKS, DATA, MDT OVERSIGHT:** Establishment and operation of regional spinal surgery networks, data flows and MDT for surgery patients. The scheme aims to promote the better management of spinal surgery by creating and supporting a regional network of a hub centre and partner providers that will ensure data is collected to enable evaluation of practice effectiveness and that elective surgery only takes place following MDT review
- **MEDICINES OPTIMISATION:** Aims to support the procedural and cultural changes required to fully optimise use of medicines commissioned by Specialised Services.
- **PAEDIATRIC NETWORKED CARE:** Aligns to the national Paediatric Intensive Care service review and aims to gather information which allows the demand across the whole paediatric critical care pathway to be considered
- **ARMED FORCES:** Embedding the Armed Forces Covenant to support improved health outcomes for the Armed Forces Community

For further information, please contact Trish Rowson, Director of Nursing, Quality & Safety, on 01782 675679

## Performance against objectives (as at 6.4.18)

Ref no.	Indicator	Target for the Year	Internal assessment of performance for the Year
<b>Main Contract CQUIN 2017/18</b>			
1a	HEALTH & WELLBEING – STAFF	To achieve	<i>Not achieved</i>
1b	HEALTH & WELLBEING – FOOD	To achieve	<i>Part achieved</i>
1c	HEALTH & WELLBEING – FLU	70% (Feb)	<i>Achieved - 75.4%</i>
2a	TIMELY IDENTIFICATION OF SEPSIS IN EMERGENCY DEPARTMENTS AND ACUTE INPATIENT SETTINGS	90% screened	<i>Part achieved – 69%</i>
2b	TIMELY TREATMENT OF SEPSIS IN EMERGENCY DEPARTMENTS AND ACUTE INPATIENT SETTINGS	90% receive antibiotics within 1hour	<i>Part achieved – 74%</i>
2c	ANTIBIOTIC REVIEW WITHIN 3 DAYS	90%	<i>Achieved – 100%</i>
2d	REDUCTION IN ANTIBIOTIC CONSUMPTION PER 1,000 ADMISSIONS	▪ total antibiotic consumption – 1%	<i>Not achieved</i>
		▪ carbapenem – 2%	<i>Achieved</i>
		▪ piperacillin-tazobactam – 1%	<i>Achieved</i>
4	IMPROVING SERVICES FOR PEOPLE WITH MENTAL HEALTH NEEDS WHO PRESENT TO A&E	20% reduction in attendance	<i>Achieved – 41% reduction</i>
6	ADVICE & GUIDANCE	A&G services available	<i>Achieved</i>
		80% responded to within 2 days	<i>Achieved – 87%</i>
		95% responded to within 5 days	<i>Achieved – 98%</i>
7	E-REFERRALS	e-Referral service in place	<i>Achieved</i>
		4% ASI March 2018	<i>Part achieved</i>
8	SUPPORTING PROACTIVE AND SAFE DISCHARGE	ECDS submission	<i>Part achieved</i>
		2.5% improvement	<i>Not achieved</i>
<b>Specialised Contract CQUIN 2017/18</b>			
1	HAEMOPHILIA HAEMTRACK PATIENT HOME REPORTING	To achieve	<i>Achieved</i>
2	NATIONALLY STANDARDISED DOSE BANDING FOR ADULT INTRAVENOUS ANTICANCER THERAPY	To achieve	<i>Achieved</i>
3	SHARED DECISION MAKING	To achieve	<i>Achieved</i>
4	CYSTIC FIBROSIS PATIENT ADHERENCE (ADULT)	To achieve	<i>Achieved</i>
5	COMPLEX DEVICE OPTIMISATION	To achieve	<i>Achieved</i>
6	SPINAL SURGERY: NETWORKS, DATA, MDT OVERSIGHT	To achieve	<i>Achieved</i>
7	MEDICINES OPTIMISATION	To adopt best value generic products	<i>Achieved</i>
		Improve drug MDS	<i>Part achieved</i>
		Increase use of cost effective dispensing route for outpatient medicines	<i>Achieved</i>
		Improved data quality with SACT and IVIg)	<i>Achieved</i>
8	PAEDIATRIC NETWORKED CARE	To achieve	<i>Achieved</i>
9	ARMED FORCES	To achieve	<i>Achieved</i>

To note that the above is subject to evidence/information being reviewed by Commissioners and agreement that the associated milestones have been met

## 4. Patient Story

### 4.1 Memories from a relative



I just found this tin of Minestrone soup rolling around in my car. My mum left it there the last time she was in my car and I had to stop myself crying when I saw it. It got me thinking about all the things that NHS Staff did the last few months of Mum's life easier for her and for us. So many of these things went above and beyond a job description, this is what I remember and value the most.

1-One of the nurses called me at work because Mum was anxious about having Dialysis. I couldn't get there for a couple of hours so I asked the nurse to give mum a hug for me. She did.

2-Mum was struggling with her diagnosis and asking why this had happened to her. One of the nurses spent a long time chatting to her. The best thing she said and the thing that comforted mum the most was that there is no reason for these things, 'sometimes life is just unfair'. It really helped mum and it has really helped me.

3-One of the nursing assistants provided me with a constant supply of ham sandwiches as it was one of the only things I wanted to eat in the first trimester of my pregnancy.

4-Knowing I was pregnant, nurses and nursing assistants working with mum always asked how I was, checked if I was eating and taking care of myself. One of them even made me tell her what I had eaten that day. 5-When mum became really ill with an infection, two of the

nurses sat with her and wouldn't leave her until we got there.

6-A couple of days after this one of the nursing assistants who had been with mum that night came to see us and said how happy she was to see mum feeling better. She told us she had been worried about mum, she called work to check on her. On her day off.

7-When mum moved to the renal unit she (and we) had lots of questions. The consultant and registrar on duty spent as much time as we needed answering our questions. They never made us feel rushed or stupid. Throughout mum's stay on ward 124 I always felt like there was someone we could talk to and if they weren't available in the moment I knew they would make time later.

8-When it became apparent that mum wasn't getting any better and she made the decision to go home we had a multidisciplinary team meeting. There were members of 5 different teams there. We knew they had mums wellbeing at the centre of what they were doing. They were completely honest with mum, helped her understand things and gave her control when it had probably felt like she hadn't had any.

9-When mum made the decision to go home there were still two weeks until our anomaly scan. We knew that there was a possibility that mum might not be here for the scan and she was desperate to know whether we were having a boy or girl although she did say 'well obviously it will be a boy who looks just like Chaz'. I asked the ward sister if it would be possible to have an ultrasound while mum was there so she could see the baby. I knew it was a long shot and didn't expect it to happen but two days later I had a call from the hospital at work to get to the hospital ASAP because the renal unit had arranged with the maternity unit for me to have an extra scan and they were getting mum ready to come with me. When I got there mum was sat in a wheelchair ready to go. We were so excited and

overwhelmed at the amount of organisation and work from people who had one million other things to do. I'll never be able to express what it means to me that Mum saw my son. It created a connection that wouldn't have otherwise been there and I will be

forever grateful for that. There will be numerous other things that NHS staff did that I have either forgotten or didn't see.

#### 4.2 Working together for the benefit of the patient

I attended an outpatient appointment to see my Orthopaedic Consultant on February 14<sup>th</sup> to talk about having surgery on my knees. I had recently undergone hip surgery and had unfortunately developed a sinus infection in my right hip which was proving very difficult to heal. My Consultant wanted to lance the abscess there and then but I explained to him that my vascular specialist was due to do a procedure to veins in both my legs the next morning and wouldn't do it if I had an open wound on my leg.

My Consultant reassured me straight away. He told me not to worry as he would speak to the Vascular Consultant and arrange to lance the abscess in the Central Treatment Suite the following day after he had finished his procedure.

My Orthopaedic Consultant came down to the Central Treatment Suite at 7am the following morning to tell me he had to go to theatre urgently. He asked me not to go home after my procedure as he still planned to lance the abscess at 2pm in the Fracture Clinic as all of the rooms in the Central Treatment Suite were booked. I have always received an excellent service from him and this experience was an example of how he always goes out of his way for the benefit of his patients

While I was in the Clinical Treatment Suite I had the same excellent service from the Vascular Consultant who was very gentle and professional doing an uncomfortable operation while I was fully awake with just a local anaesthetic. He talked to me the whole time explaining what he was doing and showing me on the computer screen as he did it. He was assisted by a team of three people who were all very good. One of

them in particular deserves a special mention as she was exceptional. She literally held my hand all through the procedure asking if it was hurting and explaining every stage as it happened along with the Consultant so I knew what to expect.

After the operation I was brought into the recovery area where I had to sit with my legs raised for half an hour to rest and have my vital signs checked including a blood test. Because I had been there from 7am and am diabetic they brought me some lunch as well as a drink and looked after me until lunchtime when a Porter came to take me up to the Fracture Clinic ready for my Orthopaedic Consultant.

As planned my abscess was lanced and dressed before I was sent home. All staff were very supportive and helped to put me at ease throughout my whole experience. .



## 5. Statement of Assurances

### 5.1 Review of Services

#### Internal Audit

In May 2017 KPMG undertook a review of UHNM services regarding the process for assessing quality in line with CQC standards. The outcome of the audit was significant assurance with minor improvements.

#### Care Quality Commission

The Care Quality Commission (CQC) inspected the Trust in October 2017; the inspection followed the new regime for inspection. Between 3<sup>rd</sup> and 11<sup>th</sup> October the CQC inspected 5 services provided at the Royal site. This included:

- Urgent and Emergency Care
- Medical Care
- Surgical
- Critical Care
- End of Life Care

The inspection did not include maternity, services for children and young people and outpatients and therefore the ratings awarded to these core services in 2015 remain the same.

As the CQC have found strong links between the quality of overall management of a trust and the quality of its services, an additional aspect has been added as part of the new inspection regime. During November the CQC spoke with members of the Board and Senior Management Team as part of the new 'well led' visit.

The CQC rates the Trust via the 5 domains (Safe, Effective, Caring, Responsive and Well-led) and by core service. The ratings are shown below.

The table below shows the rating by the 5 key domains and compares results to the 2015 inspections:

Domain	April 2015 Ratings	October 17 Ratings	
<b>Are services safe?</b>	Requires Improvement	<b>Requires Improvement</b>	●
<b>Are services effective?</b>	Requires Improvement	<b>Good</b>	●
<b>Are services caring?</b>	Good	<b>Outstanding</b>	☆
<b>Are services responsive?</b>	Requires Improvement	<b>Requires Improvement</b>	●
<b>Are services well led?</b>	Requires Improvement	<b>Good</b>	●
<b>Overall</b>	Requires Improvement	<b>Requires Improvement</b>	●

The CQC rated UHNM's Critical Care as an Outstanding Service.



## Good Governance Institute

In August 2017, the Good Governance Institute were appointed to undertake a Well led review programme and the work undertaken between October and November 2017. Overall the review found that UHNM was a developing organization with the potential for rapid and sustained improvement in a number of areas. More specifically the review felt there was a firm foundation for further development building upon:

- Strong organizational vision supported by realistic ambition
- New Board which works to a good ethos
- Well-respected and effective CEO supported by a team strengthened with new appointments
- Ownership and optimism in divisions and directorates
- Visible, accessible and effective trust Executive committee which balances operational and strategic priorities
- Sound embedded quality assurance models

## Care Excellence Framework

Internal Care Excellence Framework (CEF) is the vehicle we use to take forward improvement findings from external reviews / assessments which is a unique, integrated tool of measurement, clinical observations, patient and staff interviews, benchmarking and improvement.

It provides an internal accreditation system providing assurance from ward to board around the domains of caring, safety, effectiveness, responsive and well led. The framework provides an award system for each domain and an overall award for the ward/department based on evidence. The awards range through bronze, silver, gold and platinum.



The CEF is supported by a bespoke IT system, acting as a data warehouse to store a suite of measures, with the ability to triangulate and present high level and granular information at ward/departmental level therefore ensuring that ward visits are intelligence driven and tailored. Managers are able to interrogate the system and benchmark themselves against others. The measures provide robust information to identify areas for improvement and areas of good practice. The clinical area is supported to develop and deliver a bespoke improvement plan and spread good practice.

Every ward has at least one Excellence visit per year reviewing all domains and receives ad hoc visits throughout the year to seek assurance with regards to individual domains. The CEF is delivered in a supportive style fostering a culture of learning, sharing and improving, and reward and recognition for achievement. The IT system demonstrates improvements and trends over time and helps to benchmark and spread excellence across the organisation.

The improvement process is supported by the Trusts recently established Quality Academy. The purpose of the Academy is to:

- extend the scope of quality and safety by facilitating creative thinking and empowering staff to deliver improvement themselves
- develop internal capacity and capability to undertake improvement

- encourage successful spread of innovation and learning
- support the implementation of the National Sign Up to Safety Campaign

Specifically the Academy:

- facilitates clinical teams
- implements improvement methodologies
- supports the measurement of improvement
- analyses and presents data

In addition, the Commissioners, along with NHS Improvement and NHS England, have also undertaken a programme of announced visits to the Emergency Department throughout the 2017/18. The Commissioners have also completed a number of visits to the A&E Department during times of extreme pressure. The visits supported CCGs assurance in respect of both the services it commissioned and the quality of care/support delivered to patients and carers. As part of the visits patients, carers, and members of staff offered their views on the care received/delivered in A&E.

## PLACE Inspection

We have now held our 2018 PLACE Inspections and received fabulous feedback from our PLACE Assessors. These inspections review the standard of the environment including cleanliness and the importance of the built environment and estates and facilities services to patient care/experience.

### County Hospital PLACE Inspection 24th April 2018

*Although some of the buildings externally look tired, the internal areas are remarkably clean and well maintained and year on year are continuing to improve. The newly refurbished areas really supported patient mobilisation and recovery in their design and décor which had been very carefully thought through. All the staff we saw were extremely welcoming and their smiling faces was a real positive which is real progress and this gave confidence to the patients about their care. The ward teams clearly work really well together which includes every member of staff we saw from the housekeepers to the clinical staff who all displayed an obvious pride in their workplace. The food was excellent including the presentation and taste which is first class. The PLACE inspection has left a lasting impression of excellence.*

Patient Assessor - PLACE, Healthwatch

### Royal Stoke University Hospital PLACE Inspection 28th March 2018

*The conversion of under utilised space to make additional beds is fantastic to see. Every single member of staff we saw and spoke to today had an extremely positive attitude and were all very proud of their role no matter what job they did. The quality and service of the food was very good and the cleaning was generally first class - even inside cupboards !. There is still some work to finish off on the site but all in all both the new and old estate are in very good condition.*

Patient Assessor



## 5.2 Participation in Clinical Audit

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

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

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

During 2017/18 - 51 National Clinical Audits and 6 - National Confidential Enquiries covered the NHS Services that the Trust provides.

The National Clinical Audits and NCEPOD enquiries that the Trust participated in, and for which data collection was completed during 2017/18 alongside the number of cases submitted, are referred to in the tables below:

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

The lead will be responsible for ensuring full participation in the audit. The reports of 42 National Clinical Audits were reviewed by the Trust in 2017/18 and local action plans were developed and implemented.

### National Confidential Enquiries

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

NCEPOD Study	UHNM Registered	Completed
Non- Invasive Ventilation	Yes	Awaiting action plan
Cancer in Children, Teens and Young Adults	Yes	Data collection in progress
Acute Heart Failure	Yes	Analysis
Perioperative Diabetes	Yes	Data collection
Chronic Neurodisability	Yes	Awaiting report
Young Peoples Mental health	Yes	Awaiting action plan

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

### Compliance Spot Check Audits

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

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

During 2017/18 these spot checks have shown general improvements in different elements of clinical care.

### 5.3 National Clinical Audits

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

National Clinical Audit National Audit	UHNM Registered	% of cases Submitted
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	Yes	100%
Adult Asthma	Yes	100%
Bowel Cancer (NBOCAP)	Yes	100%
Cardiac Rhythm Management (CRM)	Yes	100%
Case Mix Programme (CMP)	Yes	100%
Child Health Clinical Outcome Review Programme	Yes	100%
Congenital Heart Disease (Paediatric cardiac surgery) (CHD)	Yes	100%
National Diabetes Footcare Audit	Yes	100%
National Pregnancy in Diabetes Audit	Yes	100%
National Diabetes Inpatient Audit	Yes	100%
Diabetes (Paediatric) (NPDA)	Yes	100%
Elective surgery (National PROMs Programme)	Yes	100%
Falls and Fragility Fractures Audit Programme (FFFAP)	Yes	100%
Fracture Liaison Database	Yes	100%
Hip Fracture Database	Yes	100%
Inflammatory Bowel Disease (IBD) programme	Yes	100%
Lung cancer (NLCA)	Yes	100%
Major Trauma: The Trauma Audit & Research Network (TARN)	Yes	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)	Yes	100%
National Adult Cardiac Surgery Audit	Yes	100%
National Audit of Intermediate Care	Yes	100%
National Audit of Seizures in Hospitals (NASH)	Yes	100%
National Cardiac Arrest Audit (NCAA)	No	0%
National Comparative Audit of Blood Transfusion programme	Yes	100%
National Complicated Diverticulitis Audit (CAD)	Yes	100%
National Emergency Laparotomy Audit (NELA)	Yes	100%
National Heart Failure Audit	Yes	100%
National Joint Registry (NJR)	Yes	100%
National Ophthalmology Audit	Yes	100%

National Prostate Cancer Audit	Yes	100%
National Vascular Registry	Yes	100%
Neonatal Intensive and Special Care (NNAP)	Yes	100%
Oesophago-gastric cancer (NAOGC)	Yes	100%
Paediatric Asthma	Yes	100%
Pulmonary Hypertension (Pulmonary Hypertension Audit)	Yes	100%
Rheumatoid and Early Inflammatory Arthritis	Yes	100%
Sentinel Stroke National Audit Programme (SSNAP)	Yes	100%
UK Cystic Fibrosis Registry	Yes	100%
Vital signs in Children (care in emergency departments)	Yes	100%
VTE risk in lower limb immobilisation (care in emergency departments)	Yes	100%

### Corporate and Local Clinical Audits

A total of 67 clinical audit projects were completed by Clinical Audit Staff and a further 156 clinician led audit projects were registered during 2017/18. These audits help us to ensure that we are using the most up to date practices and identify areas where we can make further improvements. Examples of improvements made in response to the audit results are:

### Audit of the Management of patients with Learning disabilities:

Action	Co-ordinator	Action to be Completed By
Preparation and anticipation of patient care <ul style="list-style-type: none"> <li>To consider an internal flagging system to alert professionals prior to, during and following a hospital experience to enhance the consistency of support</li> <li>To work proactively to contact known patients with a learning disability, promoting the use of passports and other helpful information</li> </ul>	Lead Adult Safeguarding Nurse	June 2017
	Learning Disability co-ordinator	December 2017
Support of Patients <ul style="list-style-type: none"> <li>Work to establish a system of preparing patients with a learning disability for hospital attendance / admission</li> <li>Conduct a scoping exercise to identify what resources exist, what is needed and where they can be made accessible to staff and patients</li> </ul>	Learning disability co-ordinator	December 2017 June 2017
Knowledge and information for both staff and patients <ul style="list-style-type: none"> <li>Identify opportunities to provide regular training sessions around learning disabilities</li> <li>Promote clear information that will be beneficial for any patients with a cognitive impairment</li> <li>Scope materials already available and designed for patients with learning disabilities</li> </ul>	Lead Adult Safeguarding Nurse Leading disability Co-ordinator	April 2017 December 2017 December 2017

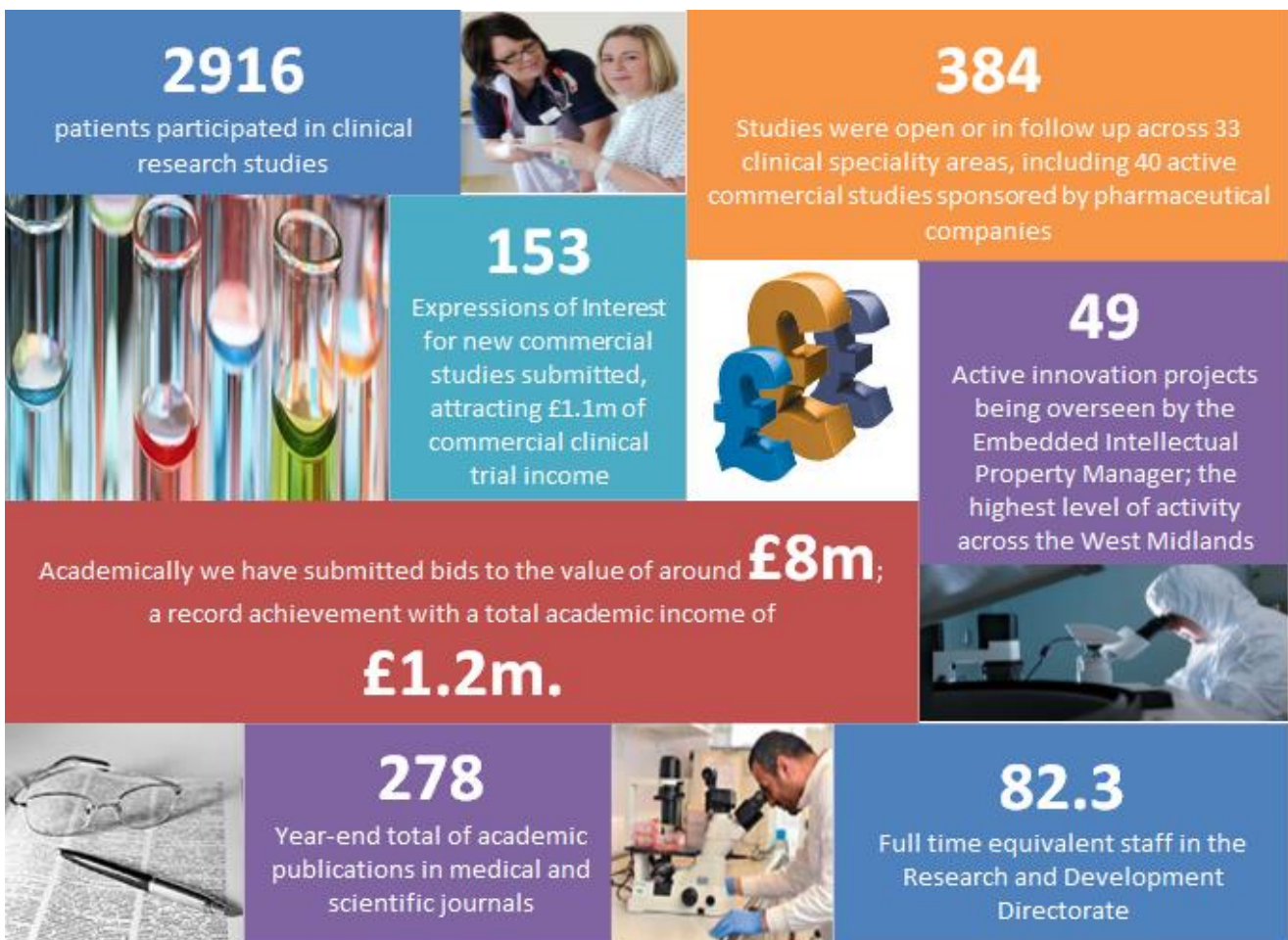


## 5.4 Participation in Clinical Research

Patients have a constitutional right to be offered the opportunity to take part in research and as a Trust we are charged with making that opportunity available to them. Research is offered to patients as a treatment pathway. In this respect research is very important in that it gives patients access to current cutting edge treatments and therapies that they may not have been offered as part of their routine clinical care. In addition to the possible direct benefits for themselves they also have the opportunity to contribute to broadening our understanding and knowledge of new treatments which will help to improve the care for others

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

- Research activity is inversely correlated with the likelihood of being in Special Measures
- improves clinical outcomes
- brings a range of finance benefits
- improves UHNM’s reputation
- enhances recruitment & retention of high quality staff
- improves staff knowledge & skills
- is key to our academic partnerships
- enhances patient experience





2017/18 has been a challenging year due to changes in the external funding landscape, the need to overhaul our Quality Management System and changes within the department. The coming year will present challenges as the restructuring process is implemented and the new Quality Management System is rolled out, but the end product will be a more robust, efficient and sustainable Directorate, with a more prominent profile within the Trust. The support from the Quality, Safety & Compliance, Organisational Development and Transformation Teams has been, and will continue to be, extremely valuable in supporting these changes. Our aim is to develop a portfolio of research, innovation and service evaluation activity that brings the best opportunities for our patients, the latest innovations to our service provision, and incentivises staff to get more involved in delivering this activity.

## 5.5 Data Quality

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

A programme of regular data quality audits

- A number of data quality key performance indicators are monitored through the Trust's Data Quality Steering Group and regular updates are provided for assurance to the Executive Committee of the Trust
- An additional strategic Data Quality Group is being implemented to provide assurance to the Recovery Programme Board on actions being taken to improve and maintain accuracy
- The Data Quality Strategy is supported by robust monitoring via the Trust's Data Quality Steering Group, providing an assurance framework to assist with feedback to the Executive Committee
- The Strategy and Policy is currently under review and will include RTT data monitoring and management
- The Team worked closely with the strategic teams to validate data to ensure accurate, robust data was achieved throughout the PAS migration in January 2017

2017/18 has been a productive year for the data quality team and we aim to build on this throughout 2018/19.

## 5.6 NHS Number & General Medical Practice Code Validity

University Hospitals of North Midlands NHS Trust submitted records to the Secondary Uses System (SUS) for inclusion in the Hospital Episode Statistics (HES) which are included in the latest published data. This is a single source of comprehensive data which enables a range of reporting an analysis in the UK. The Trust reported the majority indicators as "green" (equal to or above the national average) in 2017/18 and has maintained these results.

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

- 99.6% for admitted patient care; national target is 99.4%
- 99.8% for outpatient care; national target is 99.5%
- 98.1% for accident & emergency care; national target is 97.3%

All of these results are higher than the national average.

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

- 100% for admitted patient care; national target is 99.9%
- 100% for outpatient care; national target is 99.8%
- 99.6% for accident & emergency care; national target is 99.3%

All of these results are higher than the national average.

## 5.7 Clinical Coding Accuracy Rate

The annual internal Information Governance clinical coding audit took place during 2017/18, again achieving an overall rating of level 2 in all areas of the audit and level 3 in 3 of the 4 areas audited. All recommendations from the 2016/17 audit have been actioned.

The Trust were not subject to an external Payments by Results (PbR) audit in 2017/18.

The internal Staff Audit Programme has been updated for 2018/19. The Trust's Clinical Coding auditor carried out this year's Information Governance audit, supported by the Trust's Trainee Auditor

U-codes (no associated income due to missing information) have decreased throughout 2017/18, reporting less than 2% at most monthly submissions

## 5.8 Information Governance Toolkit Attainment Levels

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

The Trust's overall IGT score for 2017/18 is 71%. All 45 requirements achieved a minimum of level 2. Please see scores below.

An internal audit of the IGT during 2017/2018 looked at 8 standards. At the time the audit was carried out, the auditors agreed with scores submitted for 5 out of 8 standards. A total of 4 recommendations were made; rated as moderate priority. At the time of the publication of the report 2 of these recommendations had been implemented, the final two were implemented prior to the final submission.

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

	Information governance toolkit score	Grading Colour	Number of requirements				
			Level 0	Level 1	Level 2	Level 3	n/a
<b>2017/2018</b>	71%	Green	0	0	39	6	0
<b>2016/17</b>	71%	Green	0	0	38	7	0
<b>2015/16</b>	87%	Green	0	0	17	28	0
<b>2014/15</b>	85%	Red	0	1	17	26	1

Last year's audit recommendation to review level 2 evidence with approval at Information Governance Steering Group for level 3 evidence was adopted for this year's toolkit. The results show there was an increase in the number of requirements achieving level 3.

As part of the Executive Summary, the internal audit reported stated ' the Trust is building General Data Protection Regulation related compliance into its IG processes and procedures to ensure its ongoing legislative obligations will be met.' Work is now underway to ensure the Trust is meeting its obligations under GDPR and the Data, Security and Protection Toolkit/ requirements

# Part B: Review of Quality Performance



## 6. Quality Priorities 2017/18



In 2017/18, in partnership with our stakeholders we identified 4 specific priorities to focus on:

**Priority 1: To reduce avoidable harm**

**Priority 2: To improve staff engagement and empowerment**

**Priority 3: To improve access to and discharge from services within UHNM with better communication to patients**

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

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





## Priority 1: To reduce avoidable harm

Quality, safety and patient experience remains our number 1 priority and is described within our Patient Care Improvement Strategy. Our strategy confirms our relentless commitment to the elimination of error, to systematic promotion of safety, embracing wholeheartedly learning from our mistakes and those of others, changing our clinical services to improve the outcomes for patients and the delivery of excellent clinical results.

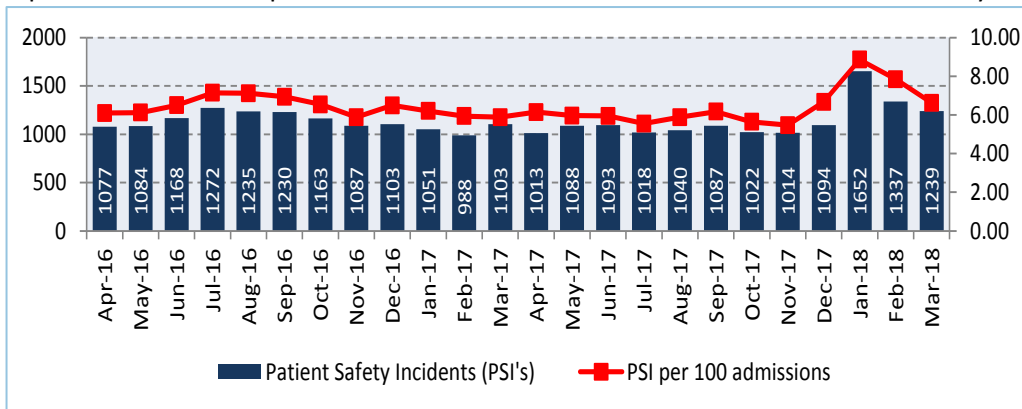
As an organization we stated that we would improve safety of our patients by

- **Reducing avoidable harm by a further 10%** - will continually strive to reduce harm from errors and promote reliability to consistently deliver good quality care to patients
- **Improving patients outcomes** - aim to be in top 10% of NHS organization by 2018 for mortality and patient outcomes
- **Introducing a formal accreditation process through a Care Excellence Framework**

Performance against this priority and its aims has been monitored during 2016/17 using a range of key indicators. The following section provides a summary of the performance for these indicators and what these results mean for our patients.

### Patient Safety Incidents

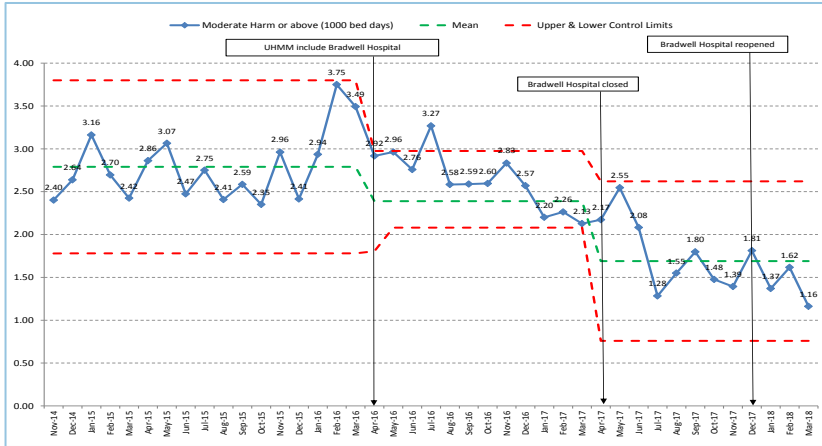
We continue to aim to reduce harm to our patients. A key indicator of this is the number of patient safety incidents\* reported and the rate per 100 admissions. The chart below illustrates the monthly totals for these indicators.



**0.9% increase reported Patient Safety Incidents from 2016/17 to 2017/18**

During 2017/18, UHNM has seen a slight increase in the total number of patient safety incidents but the rate of patient safety incidents has remained unchanged with 6.4 incidents per 100 admissions. This means that whilst UHNM has seen increased activity, the safety of our patients has continued to improve with less patients experiencing harm whilst receiving care at UHNM.

\* Includes Patient Safety Incidents that are reported to NRLS



Despite the increases in the number of total PSIs being reported, the level of harm as a direct result of the reported incidents is continuing to show improvements with lower rate of incidents recorded as moderate harm or above

**Never Events**

UHM has introduced strong systems to allow for the reporting of adverse incidents to ensure lessons are learnt whenever possible. During 2017/18, we have reported 3 Never Events. The following provides a summary of the 3 Never Events together with primary root causes and key recommendations to prevent recurrence. It should be noted that only 1 of the Never Events has concluded the root cause analysis and identified learning.

3 reported Never Events during 2017/18

**Never Event (2017/25755) – Retained Swab**

Surgeons found a medium surgical swab inside the abdomen which had been retained. Scrub nurse confirmed that the swab was extra from her count. Original surgery was completed in January 2017. It was confirmed that the swab had been retained during the original surgery prior to the new swab count procedures being introduced

**Learning identified / Actions taken:**

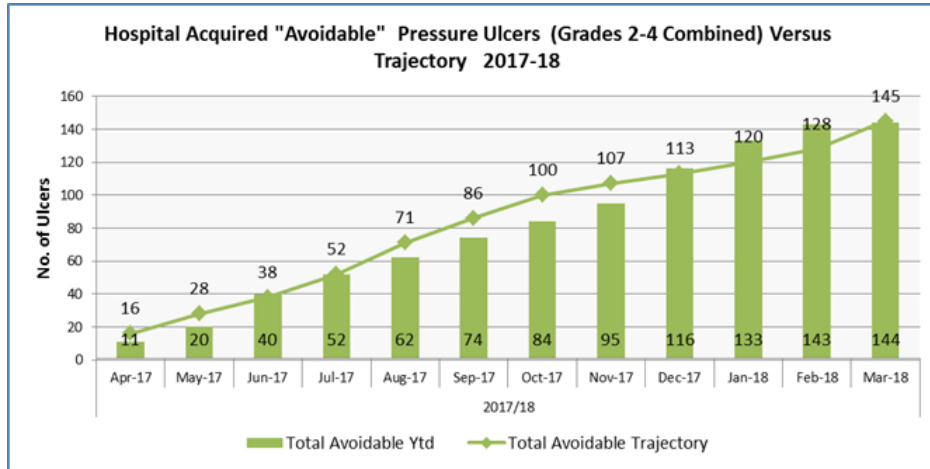
- Good communication and sharing of learning via Divisional Governance Meeting and Trust Risk Management Panel.
- New handover sheets have been introduced as result of review of incident and are already in use.
- Observational audits being undertaken throughout Theatres on completion of handover sheets.
- Human Factors training is to be re run within Theatres and the results of the RCA is to be shared with multidisciplinary staff at Audit Meeting on 3<sup>rd</sup> May 2018.

Wrong site surgery – incorrect ophthalmology patient had laser treatment following incorrect patient proceeding to treatment when called (no harm and patient improved ocular pressure). Correct patient received treatment as well and no harm.

Wrong site surgery – patient received nerve block in right arm prior to surgery (as part of their planned post operative pain control). Patient was receiving general anaesthetic for surgery and nerve block was pain control. Error identified prior to surgery. Patient told. No harm or extended delay in discharge for patient.

### Hospital Acquired Pressure Ulcers

We are currently on trajectory to achieve 5% reduction of Hospital Acquired Avoidable Grade 2 to 4 pressure ulcers during 2017/18\*

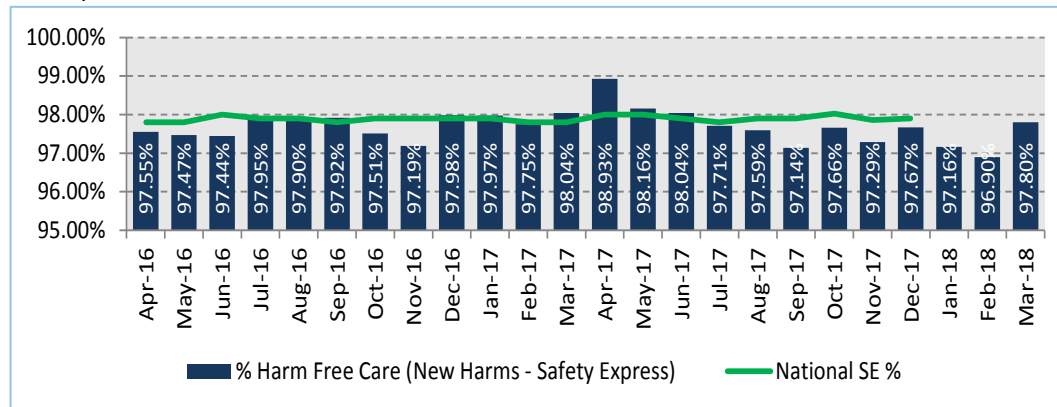


**1 Hospital Acquired Grade 4 Pressure Ulcer reported during 2017/18**

\*Current position as at 24/04/2018, awaiting final validation

### Harm Free Care (New Harms)

The national target for Harm Free Care (New Harms) is 95% and UHNM have continually exceeded this target and during 2017/18 the final result is 97.67% which is similar to the national average for the Safety Thermometer (refer to chart below).



**Exceeding the 95% National Target throughout 2017/18**

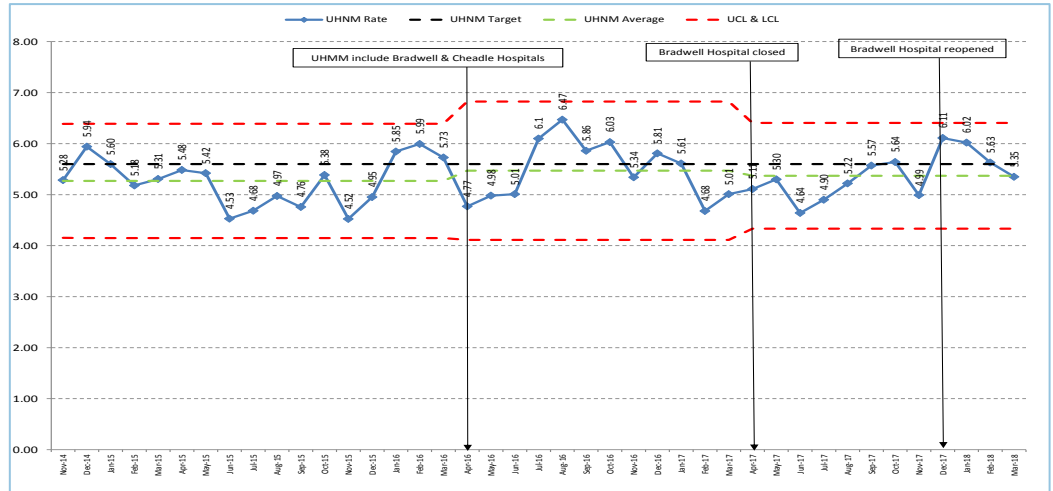


### Patient Falls

During 2017/18 there were 2368 patient falls reported compared to 2788 patient falls in 2016/17, 2450 in 2015/16 and 2712 in 2014/15. During, 2017/18 Bradwell Hospital has been included since December 2017. What is important to note is that the Trust also reviews the rate of patient falls per 1000 bed days which allows for comparisons taking into account changes in activity. During 2017/18 the falls rate was 5.37 compared to 2016/17 falls rate of 5.47 and 5.19 in 2015/16, 5.54 in 2014/15.

**Reduction in total patient falls reported and reduction in overall rate of falls per 1000 bed days.**

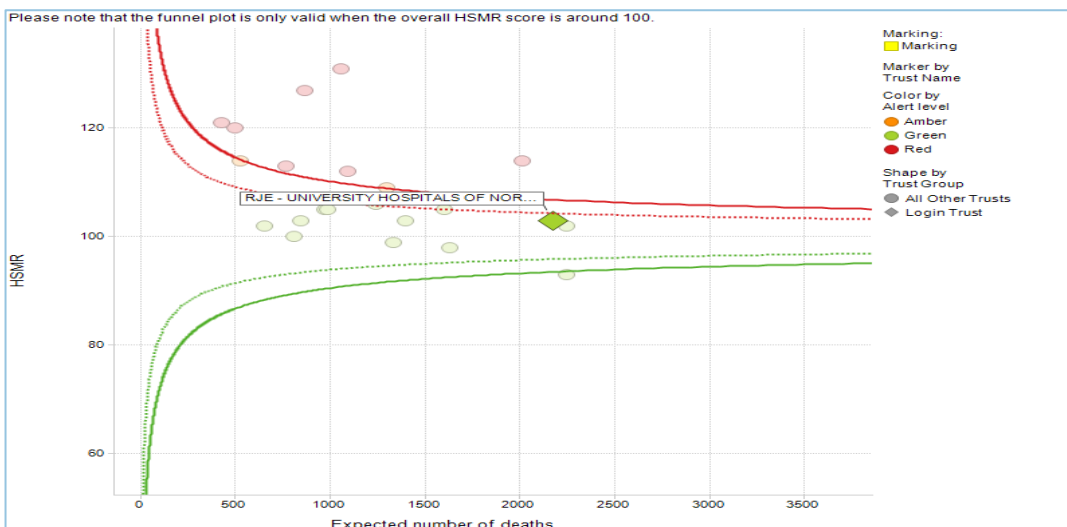
**Reductions in harm to patients as result of falls**



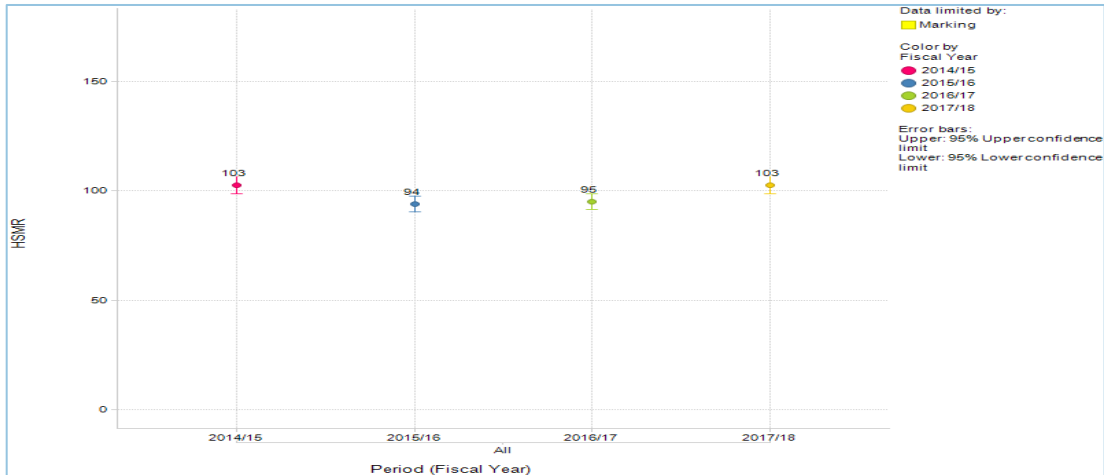
Allied to the decrease in total falls and rate during 2017/18 compared to 2016/17, the level of harm reported for these incidents has decreased with 0.21 falls per 1000 bed days resulting in moderate harm or above compared to 0.23 in 2016/17. This is positive in the reduction of harm to our patients as a result of proactively managing patients, identifying risks and taking actions to minimize the risk, and impact, of any falls.

### Mortality

Our mortality rate with current HSMR for 2017/18 year to date (April 2017 – December 2017) reported at 103. This means that UHNM’s number of in hospital deaths is within expected range based on the type of patients that have been treated.



**UHNM continues to compare well against Midlands peers during 2017/18**



**Mortality remains within expected range during 2017/18 despite increase compared to 2016/17**

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

The Summary Hospital-level Mortality Indicator (SHMI) is a measure of mortality, developed by the Department of Health, like HSMR this measure compares actual number of deaths with our predicted number of deaths.

Like HSMR the prediction takes into account factors such as age and sex of patients and their diagnosis. The current SHMI value for the Trust is 0.98. This is a rolling 12 month measure.

### Why are the two measure different?

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

### Learning from Deaths Mortality Reviews

**1853 patient deaths (61.2% of all in hospital deaths during 2017/18) have been reviewed during 2017/18**

During 2017/18, we continued to use our online Mortality Review Proforma to allow in hospital deaths to be electronically reported following review of the patient death and included the outcomes of these reviews within our quarterly Patient Safety Report which was presented at the public session of the Trust Board meetings. These reviews required reviewing clinicians to assess the care provided prior to death using the NCEPOD A-E categories. In addition, from December 2017, adopted a more detailed review proforma based on the Royal College of Physicians Structured Joint Review form.\*

During April 2017 – March 2018, the Trust have completed 1853 completed online proformas, accounting for 61.2% of all the hospital deaths recorded during 2017/18. Each one of these deaths is assessed to classify the level of care the patient received. It should be noted that the mortality reviews are currently ongoing and these figures relate to deaths in 2017/18 that have also had completed reviews submitted by 31<sup>st</sup> March 2018. There are deaths that are still being reviewed as part of the Trust's local Mortality & Morbidity Review meetings but whilst the deaths may have occurred in

217/18 the review will not have been completed within 2017/18 especially for deaths in Quarter 4 and Quarter 3. These reviews will be completed and reported during 2018/19 reporting period.

	2017/18 Total		Q1		Q2		Q3		Q4	
<b>Total Number of Deaths in reporting period</b>	3027		701		738		748		840	
<b>Total Number of Deaths in reporting period subject to review (% of total deaths)</b>	1853	61.2%	581	82.9%	499	67.9%	470	62.8%	303	36.1%
<b>Total Number of reviewed deaths with suboptimal care identified – NCEPOD grade E (% of reviews)</b>	2	0.11%	1	0.17%	0	0%	0	0%	1	0.33%

\* The RCP removed the scoring system on preventability following a national pilot. UHNM continue to use the NCEPOD classification system:

A: Good practice - a standard that you accept for yourself

B: Room for improvement - regarding clinical care

C: Room for improvement - regarding organisational care

D: Room for improvement - regarding clinical & organisational care

E: Less than satisfactory - several aspect of all of the above

From these reviews 2 were classified as receiving care below acceptable standards.

Learning identified from the reviews undertaken. The learning identified is summary from all reviews and does not just relate to those deaths where suboptimal care has been identified. The learning relates to where improvements can be made but did not directly contribute to a patient's death.

#### **Elderly Care learning:**

1. DNACPR was in place for a patient but Cardiac Arrest Call was still put out
2. Poor care ,patient sent to step down ward , stated as medically fit ; but was not fit , developed new weakness due to subdural haematoma
3. Patient remained on antibiotic treatment despite decision made regarding end of life care. Decision to remain on antibiotics was not clear.
4. Patient was not reviewed by stroke team after new symptoms developed; delay in getting a plan re tube feed; delay in getting stroke physio to see patient. These had negative impact on the patient.
5. Patient had multiple ward moves; sent back from Bradwell Hospital on 12/12/2017 to A & E , but then sent back to Bradwell Hospital; 13/12/2017 sent back to FEAU. Family raised concerns regarding the multiple moves.
6. Patient had been kept nil by mouth ; treated with antibiotics; on 23/12 it was decided to insert an NG tube ; this was not discussed with his family and caused some bleeding
7. End of Life care was not started appropriately. Patient did not appear stable when transferred from RSUH to County on 16/2/2018; changed to a new antibiotic on arrival; no indication given as to why ; no summary has been done.

#### **Acute Internal Medicine learning:**

1. Patient attending County Hospital had a significant delay in starting an effective antibiotic during admission and initial management of immuno compromised patient who presented with features of pulmonary sepsis.

Condition evolved into likely irreversible multi organ failure within 12 - 24 hours. The delayed recovery possibly deprived him of potential anti myeloma treatment for relapsed disease.

**Neurosurgery learning:**

1. Delayed diagnosis of sagittal sinus thrombosis (provisional radiology report wrong). Consultant radiologist addendum was delayed. Delay in treating physicians (County) being informed of CT report. This has been reported as Serious Incident and RCA presented at Trust Clinical Risk Management Panel.

**Hospital Acquired Infections**

The Trust continues to strive to reduce the number of hospital associated infections. 2 of the key infection associated indicators that are used are Methicillin-resistant Staphylococcus aureus (MRSA) and Clostridium Difficile (C Diff). During 2017/18, we have seen reductions in like for like numbers compared to 2016/17 and continue to see longer term improvements in reducing these infections associated with treatment received in UHNM.

Indicator	2017/18 Target	2016/17	2017/18	Change
To reduce C Difficile infections	82	85	71	↓
To reduce MRSA infections	0	1	0	↓



## Priority 2: To improve Staff Engagement and Empowerment

### Organisational Development and Staff Experience

The Trust's evidence-based Organisational Development strategy has five priority themes for improving staff experience and wellbeing:

1. Support & Connection / Strong Visible Leadership – leaders who listen and communicate well
2. Recognition and value – staff who feel respected and respect each other, valued for their hard work, given constructive feedback and praise
3. Staff engagement and motivation – staff are listened to and involved in decisions
4. Improved manager capability, including poor performance being addressed
5. Organisation and management interest in and action on health and wellbeing

Actions to deliver these priorities are linked to, and support the Trust's Strategic Objectives, Critical Success Factors and CQC Well Led framework. Set out in the 'Happier@Work' plan, these actions are aligned to local plans, including the divisional staff experience and engagement action plans, to ensure momentum and sustainability. Progress on delivery is monitored, ensuring that all plans are regularly informed by an on-going process of staff engagement, listening activities and surveys to ensure the actions are having the desired effect on staff experience

### 2017 NHS Staff Survey – The National Context and Trust Outcomes

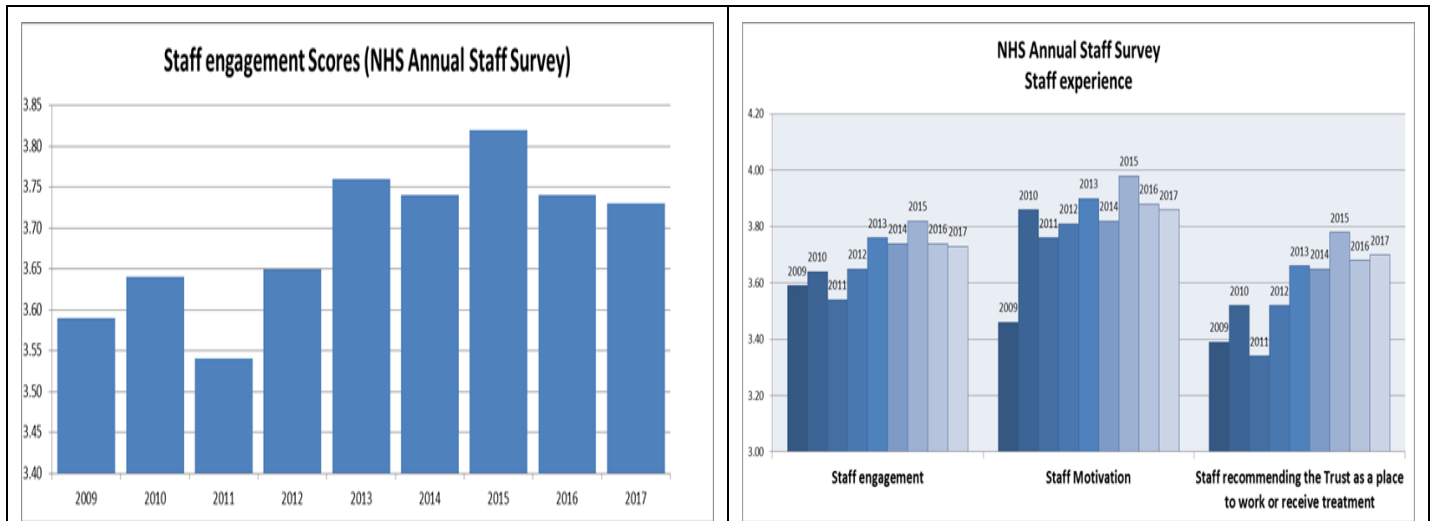
Nationally, the 2017 NHS Staff Survey results showed a general deterioration and NHS Employers analysed the results as *“Challenging and showing a service under strain. Staff report that they are working under more pressure and feel less able to deliver a good quality service. They feel less enthusiastic about their jobs and more dissatisfied with their pay. Across a range of indicators they report worse experience than in 2016 although scores are still higher than in 2014. Some progress has been made in areas such as increased support from managers and more confidence that the organisation takes action on health and wellbeing.”*

For this Trust, there were no statistically significant changes to the National Staff Survey results compared to 2016, except that the percentage of staff believing that the organisation provides equal opportunities for career progression or promotion reduced from 84% to 82%.

### Staff Experience and Engagement

As part of the NHS Annual Staff Survey, staff are also specifically asked for their responses to whether they have experienced bullying, harassment or abuse and whether the Trust is seen as offering equal opportunities for career progression. The following summarises the Trust's scores for these 2 questions and the actions that the Trust has subsequently put in place to address the issues raised and improve staff experience.

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



### Staff experience of harassment, bullying or abuse from other staff in the last 12 months

The Trust implemented the recommendations of the “Freedom to speak up” review in 2015/16 and has since been working with managers and staff across the trust to tackle bullying and harassment.

The Trust has a “Leading with compassion” philosophy to create an environment centered on people quality and impact including greater promotion of Trust Values and behaviours and implementation of a Staff Engagement strategy to ensure that engagement activity is measurable and impactful

Positively, the percentage of staff saying they perceived an experience of bullying, harassment or abuse from other staff in the last 12 month (colleagues and managers) reduced from 28% to 27% and remained at 26% from patients and the public.

Although only 45% of staff said they reported their last experience of bullying, harassment or abuse, 66% of staff said they would feel confident raising concerns.

### Staff perceptions of equal opportunities for career progression or promotion

For this Trust, the National Staff Survey results remained the same as in 2016 except that the percentage of staff believing that the organisation provides equal opportunities for career progression or promotion reduced from 84% to 82%.

Towards improving staff perceptions around career progression opportunities, the Trust is:

- Targeting specific areas to improve the quality of appraisals and work is being carried out to ensure there is better identification of development opportunities during the appraisal process.
- Providing communications around career development opportunities and support people with advice and guidance
- Working with some Directorates to pilot succession planning



## Next Steps

The Trust is holding a 'Harassment Round Table' in April to review intelligence concerning harassment; assess current practice in preventing & managing harassment; to develop actions to improve the culture and approach to reporting harassment and dealing with concerns. The overall aim is to promote a culture which prevents harassment from occurring.

Towards improving staff engagement and overall staff experience, the Trust has launched the "Engage @ UHNM" survey for staff to share their views and experiences of what it is like to work at UHNM. This information from the survey will be used to direct activities to improve staff experience and wellbeing for 2018-19.

Additionally, the Trust has:

- Provided all line managers with access to a 'Gateway to Leadership' programme to give them the tools to better interact with staff;
- Cascaded messages of recognition and support to all staff during a "Thank You" week and
- Actively encouraged staff to put forward local ideas to improve services and team working and to promote the Trust values recognition scheme



### Priority 3:

To improve access to and discharge from services within UHNM with better communication to patients

University Hospitals of North Midlands places the quality of patient and carer experience at the heart of everything we do. We are always striving to exceed expectations, with the belief that patient experiences can always be improved on. We recognise that to achieve our Trust values we need to deliver an organisational culture centred on patient involvement, engagement and experience and that putting the people who use our services at the centre of decision making will improve the quality of services we deliver.

Members of the Board including Non-Executive Directors and Shadow Governors actively participate in Quality Walkabouts each month and are involved in working with staff to enable improvements where the need is identified.

The Trust has also worked in partnership with stakeholders on quality improvement activities including:

- Hospital User Group
- Clinical Quality Review Group
- Healthwatch
- Overview and Scrutiny Committee
- Quality review visits of the patient pathway which are Director led with Clinical Commissioning Group and GP involvement
- Complaint Peer Review Workshops
- Patient Information Ratification Workshops
- PLACE inspections

### Annual Inpatient Survey

The Survey was conducted by Picker Institute, on behalf of the Care Quality Commission, on a sample of patients, aged 16 or over who had at least an overnight stay in University Hospital of North Midlands during July 2017. All in-patients with the exception of maternity were included. Questionnaires were sent to 1250 patients – 496 responded, a response rate of 41%. The average response for organisations using Picker was 41%.

The Trust continues to implement a comprehensive improvement programme to support our overall ambition of being within the top 20% of Trusts nationally.

The way we communicate with our patients continues to have a significant effect on their overall experience of our Trust. We know we need to improve the way we share information to support patients to feel more involved in decisions that affect their care and treatment.

Improvement initiatives include:

- “It’s OK to ask” campaign: to encourage patients to ask the questions about their care and treatment that matter to them.
- “Top 20 wards” introduced to encourage staff to gain patient feedback about their experience of the Trust
- Redesign of patient information leaflets to promote patient awareness.
- Measurement of effectiveness of initiatives with in-month surveys and the Clinical Excellence Framework
- Introduction of revised discharge leaflet and bedside name boards with space to include estimated discharge date.
- Triangulation of quality and safety data through an internally designed Quality Management System data base to identify themes.
- Various staff and patient focus groups including “In your Shoes” and a medication focus group to inform change through identification of what good looks like to our patients
- Trust roll out of an “on the day, for the day” electronic tablet meal ordering system.
- Production of a Food and Hydration strategy which pays close attention to the end quality of food and drink served so that everyone received meals they enjoy.
- There is a firm focus on patient experience at Trust induction.
- Purple Bow initiative rolled out to all areas to provide additional support for relatives of end of life patients.
- Proactive recruitment of volunteers to assist with the improvement of service delivery and the patient experience.

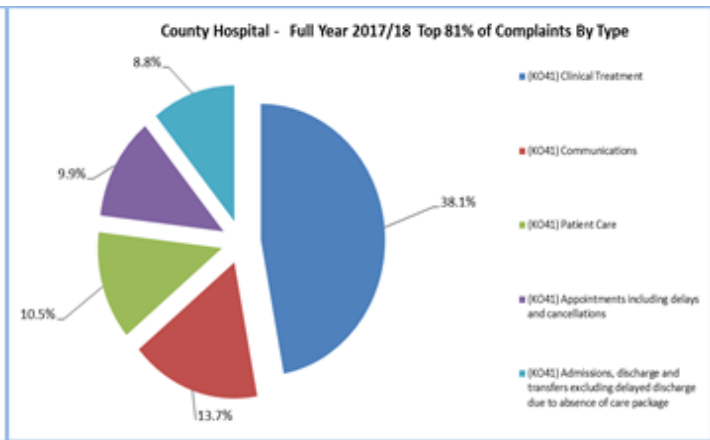
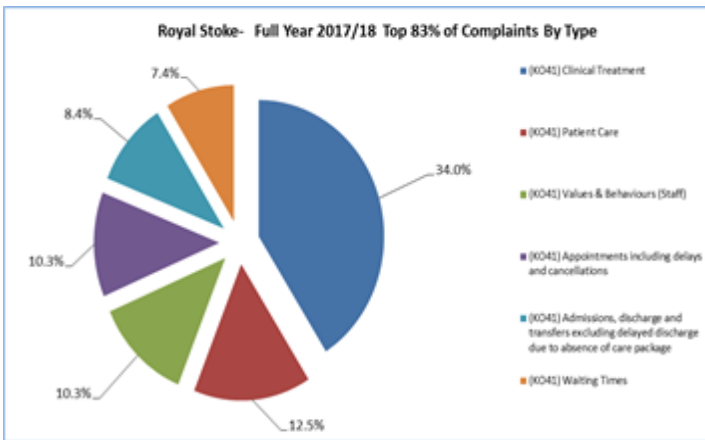
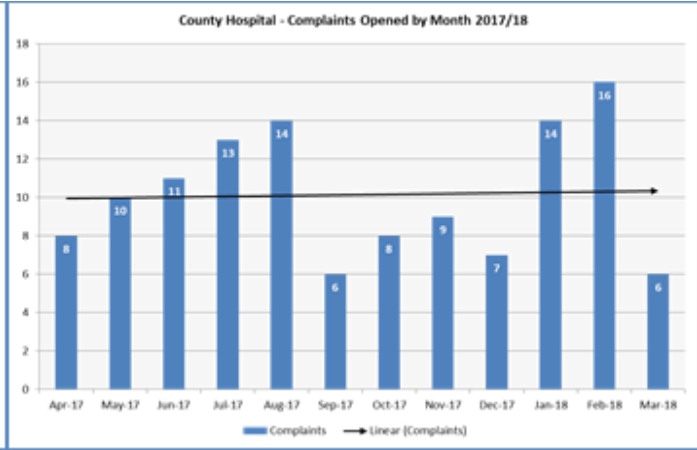
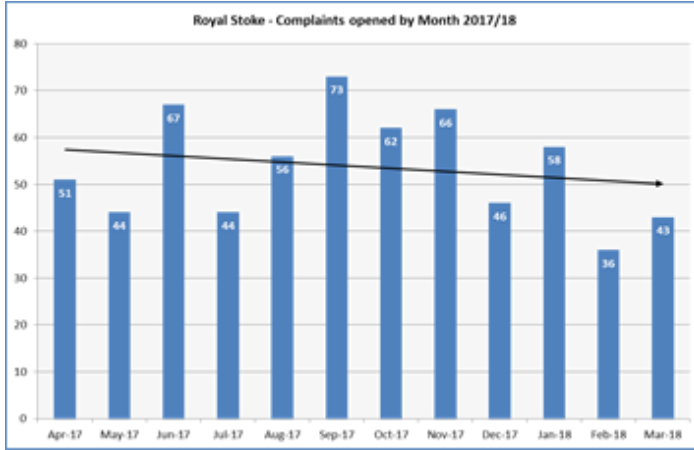
### Complaints

The total number of complaints opened at Royal Stoke University Hospital during 2017/18 is 646 which is a decrease of 5.7% over the same period in 2016/17 when the Trust saw 685 complaints opened.

The total number of complaints opened at County Hospital was 122 in 2017/18, which is an 11.6% reduction from 2016/17 with 138 complaints received.

During 2017/18, the Complaints Team have achieved the following:

- Complaints are now categorised to assist in analysing their trends and themes.
- Complaints processes have been aligned across UHNM sites so working practices are consistent
- On-going review of the current process to facilitate an improvement in the timeliness of responses from receipt of complaint to final response
- Improved consistency and quality of responses
- Average of 42.5 days during 2017/18 for complaints to be closed compared to 53.9 days in 2016/17
- At year end there has been a reduction in the number of ‘come back’ complaints. There were 138 ‘Comebacks’ during 2016/17
- Development of a Trust-wide Peer Review Programme which provides consistency of approach to reviewing complaints across both hospital sites and forms an integral part of the Trust’s governance for evidencing the learning from complaints through a robust peer review programme.



## Learning from Complaints

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

- The dental team have written a leaflet to support their verbal communication for patients who require braces.
- Oncology secretaries have reviewed their office procedures to ensure that staff are picking up and responding to messages in a timely manner. Telephones are diverted to their colleagues to support and cover during any leave so that patients are always able to contact the department.
- A more robust system has been implemented to prevent any patient being missed when they have been referred for imaging/tests. The waiting list is monitored and acted upon by the Orthopaedic secretarial staff
- Child Health have introduced follow up emails with telephone calls when clinics have to be cancelled at short notice and Outpatient staff will leave short messages with parents when they cannot get in touch with them to let them know about a cancelled appointment at short notice
- Child Health have introduced follow up emails with telephone calls when clinics have to be cancelled at short notice and Outpatient staff will leave short messages with parents when they cannot get in touch with them to let them know about a cancelled appointment at short notice
- Ambulance crews have been given additional training and guidelines to ensure they close ambulance doors between collecting patients so those already in the ambulance will not be left in the cold.
- A patient missed his oncology appointment as no one booked his transport from another Trust site. As a result, staff have been made aware that they must always transfer accurate information to the following week's handover sheet, that clear documentation is made in nursing notes regarding ambulance bookings, and that all ambulance bookings are checked with the Ward Clerk at 09:00 on the day of any patient's appointment to ascertain that the booking is secured



### Priority 4: To better utilise County Hospital

During the past 12 months we have started various initiatives and plans that are targeted at improving patient pathways and ensuring that patients received appropriate, timely and equitable access and ensure safe and timely discharge.

Greater utilization of the County Hospital site have seen developments of pathways at both sites continue. Elective Surgery (Bariatric and Trauma & Orthopaedics) has been significantly increased at County Hospital providing more acute capacity at the Royal Stoke University Hospital Site.

The following table provides as summary of the key national targets and standards that UHNM is set and current 2017/18 performance compared to 2016/17.

National Target and Minimum Standards	Indicator	2016/17 Target	2016/17	2017/18	Change
	Mixed sex accommodation breaches (number of patients affected)	0	0	0	↑
Access to A&E	A&E: Total time in A&E - 95% target	95%	78.26%	77.65%	↓
	A&E: No waits from DTA to admission (trolley waits) over 12 hours	0 >12 hours	590	447	↑
	Ambulance handover delays of >30 minutes	0	2158	*	↑
	Ambulance handover delays of >60 minutes	0	129	*	↑
Access to Treatment	Referral to treatment wait - incomplete pathways	92%	80.91%	78.60%	↓
	Zero tolerance to RTT waits of more than 52 weeks	0	360	317	↑
	Diagnostic Waits within 6 weeks from referral	99%	99.53%	99.25%	↓
Access to Cancer Services	Cancer: two week wait from GP referral to first seen	93%	93.10%	98.20%	↑
	Cancer: two week wait from GP referral to first seen - breast symptoms	93%	92.00%	98.80%	↑
	Cancer: 31 Day diagnostic to first treatment	96%	95.10%	97.40%	↑
	Cancer: 31 day second or subsequent treatment - anti cancer	98%	98.10%	98.70%	↑
	Cancer: 31 day second or subsequent treatment - surgery	94%	94.20%	93.80%	↓
	Cancer: 31 day second or subsequent treatment - radiotherapy	94%	96.80%	96.60%	↓
	Cancer: 62 Day - Urgent GP referral to treatment	85%	71.00%	78.00%	↑
	Cancer: 62 Day - Urgent GP referral to treatment - Screening	90%	81.80%	87.30%	↑
	Cancer: 62 Day - Urgent GP referral to treatment - Consultant Upgrade	93%	93.60%	91.50%	↓
	Cancelled Operations - breaches of the 28 Day standard	0	147	169	↓
	Cancelled Operations - urgent operations cancelled for a 2nd time	0	0	0	↑



# Part C: Statements from our key stakeholders



Healthwatch Stoke-on-Trent is once again pleased to comment on the Quality Account Statement for University Hospital of the North Midlands (UHNM) 2017/18.

The importance of the acute work undertaken by the hospital is widely recognised and the Healthwatch office frequently receives feedback from members of the public, whether they be patients, family members, or carers. The overwhelming sentiment of this feedback is complimentary, recognising that the medical staff all work extremely hard and provide care in a safe, secure manner, often in challenging circumstances.

As Healthwatch Stoke-on-Trent, most of the feedback we receive concerns the Royal Stoke site and the two main 'criticisms' we receive are NOT about 'overlong waits in A and E', they are mainly comments regarding the 'hospital being too small' to handle the number of patients and, of course, the inadequate car parking facilities! Of course, we do get complaints of a more worrying nature, principally concerning falls and safe discharge.

It is re-assuring to see that amongst the priorities for the forthcoming year are a commitment to reduce harms from falls by 20%, to improve timely recognition and treatment of Sepsis and to eliminate avoidable pressure ulcers.

With the inevitable advance of the Staffordshire STP, Healthwatch Stoke-on-Trent would, however, wish to see a major push towards achieving far better performance regarding safe, effective and timely discharge. We appreciate this requires far greater 'joined up' work between other Agencies working with UHNM (principally the City Council and the 'new Trust' which will emerge from SSOTP/SSSFT) but would urge this essential work be given the highest priority.

As the Staffordshire STP work continues to evolve, Healthwatch Stoke-on-Trent will continue to monitor the vital work undertaken by UHNM and trust its' endeavours to further improve will continue throughout next year.

We wish to publicly thank the Doctors, Consultants, Nurses and other medical staff who continue to provide a high level of safe healthcare to the public.

*Healthwatch Stoke-on-Trent*

*29<sup>th</sup> May 2018*



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

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

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

As part of the contract monitoring process, North Staffordshire CCG, Stoke-on-Trent CCG and Stafford and Surrounds CCG meet with the Trust on a monthly basis to monitor and seek assurance on the quality of services provided. In addition to the contract meetings, the CCGs work closely with the Trust and undertake continuous dialogue as issues arise to seek assurance, which is also obtained via quality visits and attendance at the Trust's internal meetings. The CCGs are looking forward in 2018/19 to working with the Trust and other local health economy partners to take forward the Quality Improvement agenda.

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

### Review of 2017/18

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

- The CCGs were pleased to note that following the CQC inspection in 2017 whilst the CQC overall rating remained the same, "Requires Improvement", inspectors recognised that the Trust has made considerable improvements since their visit in 2015. The CCGs were delighted to see the Trust receive a rating of "Outstanding" for caring.
- The CCGs congratulate the Trust on the national recognition received as demonstrated by the number of awards and special presentations that have been received by staff and teams from across the Trust.
- The Trust continues to provide an open invite to commissioners who regularly participate in the Care Excellence Framework (CEF) visits at both Royal Stoke and County Site.
- The Trust has attended the CCGs Joint Quality Committee in Common on a number of occasions in 2017/18 with teams presenting their Quality Improvement work in the following areas: Falls Improvement, Care Excellence Framework, Deconditioning – "PJ Paralysis" and Transforming Maternity Services.
- The CCGs have an open invitation and regularly attend a number of the Trusts internal quality assurance/improvement meetings for e.g. Falls Steering Group, Tissue Viability panel, Quality & Safety Forum and the Strategic Sepsis group.
- The CCGs acknowledge the hard work undertaken by Trust staff to deliver the CQUIN schemes. Throughout the year they have provided reports detailing the successes and the substantial improvements made for patients.

However, 2017/18 has not been without its challenges and these will remain key areas of focus in 2018/19:

- Delivery of the NHS Constitutional targets has proved particularly challenging; specifically A&E and Cancer wait time standards. The CCG's Quality Committee and Governing Body/Board have discussed concerns about the impact that failing to achieve these targets has on patients. The CCGs have undertaken, along with NHSI and NHSE regular quality assurance visits to the Emergency Departments throughout 2017/18. Commissioners also regularly attend UHNM's harm review panels for example: 12 hour breaches and 52 week waits. Information has also been shared with health economy stakeholders at the Quality Surveillance Group. The CCGs and Trust, through Board to Board meetings, have discussed ways to resolve these issues, through working as a collaborative system.
- Commissioners have and will continue to work collaboratively with the Trust to ensure quality and safety.
- The Trust has reported three Never Events in 2017/18 whilst this is disappointing the clinical teams involved undertake robust investigations which results in substantial learning and change to existing systems and processes.
- It is pleasing to see that the Trust has seen reductions in like for like Clostridium Difficile numbers compared to 2016/17. The Trust has reported no Methicillin-resistant Staphylococcus aureus (MRSA) infections during the year.
- It is good to see the Trusts Mortality remains with expected range.

### Priorities for 2018/19

Commissioners were pleased to attend and contribute to the development of Trust's Quality priorities for 2018/19.

Commissioners are pleased that the Trust continues to be an active partner within the Staffordshire Sustainability and Transformation Partnership.

Commissioners have agreed 2018/19 national CQUIN schemes which will further support the Trust to improve their overall rating.

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



Heather Johnstone  
Director of Nursing and Quality  
Staffordshire CCGs



City of  
**Stoke-on-Trent**

The committee would like to thank the University Hospital for North Midlands (UHNM) for the invitation to the Stakeholder Workshop in April 2017 to enable committee members to contribute to the discussions around the development of the priorities for 2018/19.

We would also like to thank Jamie Maxwell and Debra Meehan for their presentation of the draft Quality Account to the committee on 14 May 2017, which provided further opportunity to comment and ask questions on the draft Account.

### **General Comments**

The Quality Account is well presented, with a good level of detail and demonstrates clearly the presence of the required elements as set out in the guidance to NHS Trusts.

### **Priorities for Improvement 2018/19**

The committee supports the priorities for 2018/19 and considers them as an accurate reflection of the views expressed at the stakeholder event. However, safe and timely discharge from hospital was also considered as an important issue for UHNM and was regarded as a potential priority for attendees at the stakeholder event. The continuation of the priorities to keep patients safe and free from harm and to improve staff engagement is particularly welcomed. Many of the priorities continue to build on the improvements made in 2017/18 and evidence the Trust's commitment to improve the quality of services and ensure patient safety. The committee would have liked some information detailing the reasons why the targets for particular CQUIN schemes were not achieved and suggested that the Trust considers including a summary of the key milestones.

The Trust's participation in national clinical audit and research projects is clearly documented within this section of the Account.

### **Review of Quality Performance – Priorities 2017/18**

The review of progress against the priorities for 2017/18 is well described in the document.

With the exception of the three 'Never Events', which appeared to highlight issues with monitoring and communication, the committee were pleased to note the Trust's performance against most of the priorities for 2017/18 relating to patient safety, for example, the number of patient falls and hospital acquired pressure ulcers and mortality rates and hospital deaths; which were all on target to be achieved.

A continuing area of concern for the committee remained the percentage of staff who reported that they had experienced bullying, harassment or abuse by a patient or the public. More alarming for the committee was the fact that, despite the slight reduction from 28% to 27%, more staff reported being bullied, harassed or abused by their own colleagues than by patients or the public. The committee asked questions about the measures in place to resolve this unsatisfactory situation.

The committee were also concerned about the morale of staff at UHNM, but accepted that analysis of the Staff Survey results on a national basis had identified a challenging and worsening picture in terms of the way NHS staff feel about their job.



Healthwatch Staffordshire was pleased to have been invited to comment on the Quality Account of the Trust and welcomes the detailed and comprehensive report.

The report provides an encouraging picture of improving service and performance, although there are areas for improvement. The performance for A&E remains a concern, but we understand the ongoing pressures that impact upon waiting times in A&E and the measures that the Trust and the wider health and social care economy have put in place to alleviate the pressures.

Healthwatch Staffordshire have worked with the Trust in the development and early facilitation of the complaints peer review. Therefore, it is gratifying to see that it is having a positive impact on learning from complaints. However, the learning examples seem to be largely aimed at administrative and support services, and it would be of interest to understand the impact of learning on clinical practice.

It is encouraging to see the number of audits both locally and nationally that the Trust is involved with that can contribute to ongoing performance improvements and the wide number of clinical trials that patients are able to access across a variety of medical conditions.

The patient stories exemplify the commitment of the Trust and its staff to patient care and the ways in which the staff are going out of their ways to improve patient experience.

We look forward to reviewing the Quality Account for the Trust in 2018/19.

## **Independent Practitioner's Limited Assurance Report to the Board of Directors of University Hospitals of North Midlands NHS Trust on the Quality Account**

We have been engaged by the Board of Directors of University Hospitals of North Midlands NHS Trust to perform an independent assurance engagement in respect of University Hospitals of North Midlands NHS Trust's Quality Account for the year ended 31 March 2018 ("the Quality Account") and certain performance indicators contained therein as part of our work. NHS Trusts are required by section 8 of the Health Act 2009 to publish a Quality Account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010, as subsequently amended in 2011, 2012, 2017 and 2018 ("the Regulations").

### **Scope and subject matter**

The indicators for the year ended 31 March 2018 subject to the limited assurance engagement consist of the following indicators:

- percentage of patients risk-assessed for venous thromboembolism (VTE); and
- patient safety incidents resulting in severe harm or death.

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

### **Respective responsibilities of the directors and Practitioner**

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

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

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

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

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

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the NHS Quality Accounts Auditor Guidance 2014-15 issued by the Department of Health in March 2015 ("the Guidance"); and

- the indicators in the Quality Account identified as having been the subject of limited assurance in the Quality Account are not reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

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

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

- Board minutes for the period 1 April 2017 to 28 June 2018;
- papers relating to quality reported to the Board over the period 1 April 2017 to 28 June 2018;
- feedback from each of NHS Stoke-on-Trent CCG, NHS North Staffordshire CCG and NHS Stafford and Surrounds CCG dated 25 May 2018;
- feedback from Healthwatch Staffordshire dated 9 May 2018 and Healthwatch Stoke-on-Trent dated 29 May 2018;
- feedback from the Overview and Scrutiny Committee dated 21 May 2018;
- the Trust's complaints report published under regulation 18 of the Local Authority, Social Services and National Health Service Complaints (England) Regulations 2009, dated 9 May 2018;
- the national patient survey dated February 2017;
- the national staff survey dated 6 March 2018;
- the Head of Internal Audit's annual opinion over the Trust's control environment dated 25 May 2018;
- the annual governance statement dated 25 May 2018; and
- the Care Quality Commission's inspection report dated 2 February 2018.

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

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

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

#### **Assurance work performed**

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



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

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

### **Limitations**

Non-financial performance information, given the characteristics of the subject matter and the methods used for determining such information.

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

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

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

Our audit work on the financial statements of University Hospitals of North Midlands NHS Trust is carried out in accordance with our statutory obligations. This engagement will not be treated as having any effect on our separate duties and responsibilities as University Hospitals of North Midlands NHS Trust's external auditors. Our audit reports on the financial statements are made solely to University Hospitals of North Midlands NHS Trust's directors, as a body, in accordance with the Local Audit and Accountability Act 2014. Our audit work is undertaken so that we might state to University Hospitals of North Midlands NHS Trust's directors those matters we are required to state to them in an auditor's report and for no other purpose. Our audits of University Hospitals of North Midlands NHS Trust's financial statements are not planned or conducted to address or reflect matters in which anyone other than such directors as a body may be interested for such purpose. In these circumstances, to the fullest extent permitted by law, we do not accept or assume any responsibility to anyone other than University Hospitals of North Midlands NHS Trust and University Hospitals of North Midlands NHS Trust's directors as a body, for our audit work, for our audit reports, or for the opinions we have formed in respect of those audits.

**Basis for qualified conclusion**

The indicator reporting the “percentage of patients risk-assessed for venous thromboembolism (VTE)” did not meet the six dimensions of data quality in the following respects:

- Accuracy and Validity: in our testing we identified three cases where there was evidence in the patient record that a VTE risk assessment had been completed within 24 hours of admission, but the Trust had reported them as not being compliant with the VTE standard.

**Qualified conclusion**

Based on the results of our procedures, with the exception of the matter reported in the basis for qualified conclusion paragraph above, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2018:

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

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28 June 2018