NHS
University Hospitals of North Midlands
NHS Trust


# Quality Account

**2019 / 2020**

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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). The past 12 months 2019/2020 have been another challenging yet exciting year for us, nevertheless we have continued to deliver on our commitment to transform health services in Staffordshire, ensuring stability and future resilience. The past year will without question be remembered primarily for the devastating impact of Covid-19. Across the country the personal and family tragedies inflicted upon thousands of people across the UK were truly heartbreaking. Our sympathies and condolences go out to every single person affected by this terrible disease.**

University Hospitals of North Midlands NHS Trust was formed in November 2014 following the integration of University Hospital of North Staffordshire NHS Trust and Mid Staffordshire NHS Foundation Trust. We have two hospitals, Royal Stoke University Hospital and County Hospital, and we are very proud of both.

We are a large, modern Trust in Staffordshire, providing services in state of the art facilities. We provide a full range of general hospital services for approximately 900,000 people locally in Staffordshire, South Cheshire and Shropshire. We employ around 11,000 members of staff and we provide specialised services for a population of three million, 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 an average of nearly 15,000 patients attending each month across both of our sites. 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 we are the specialist centre for the North Midlands and North Wales.

As a University Hospital, we work very closely with our partners at Keele and Staffordshire University and we are particularly proud of our medical school, which has an excellent reputation. We also have strong links with local schools and colleges. As a major teaching Trust, we hold a large portfolio of commercial research, which provides us with a source of income. Our research profile also enables us to attract and retain high quality staff.

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

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 gastro-intestinal surgery, complex orthopaedic surgery and laparoscopic surgery.

### Royal Stoke University Hospital

### The County Hospital (Stafford)


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 is 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.

# 2. Statement on Quality

We are proud to say that University Hospital of North Midlands NHS Trust continues to show commitment of our staff to improve the quality, safety and experience of patients in our care. We will continue to achieve this by our staff understanding their role and empowering and equipping them towards delivering excellence every day resulting in improved patient outcomes, staff morale, productivity and efficiency.

The year ended with us completely transforming the way we do things as a result of the Covid-19 pandemic and we have been overwhelmed with the professionalism, flexibility and positive attitudes from our staff. They have developed and implemented new ways of working and have been innovative and creative in finding solutions to sometimes seemingly impossible problems. Whilst we are fortunate to have escaped some of the levels of pressure seen in other parts of the country; with the support of our partners within the system and beyond, we are confident that our planning will provide us with the capacity needed to continue to provide safe and quality care should it become necessary to utilise. Covid-19 will continue to bring further challenges for us throughout 2020/21 and beyond but we have no doubt that together, we will come through and we look forward to seeing how the 'new NHS' evolves.

Our workforce is our greatest asset as without them, we would not be able to provide the care we do for our patients. We expect that staff will be professional, respectful and kind to each other and instil pride in their teams, working together for our patients. We will actively listen to our staff and encourage them to speak openly about their concerns or when things go wrong. We will learn from our mistakes and further develop knowledge and skills to improve.

We recognise that our patients expect and deserve the highest standards of care from the services we provide and this is why we continually strive to set challenging targets and place quality at the heart of everything we do, ensuring we absolutely put the interests of our patients ahead of individual or organisational ambition. Listening to the community we serve remains a priority. Through engaging with our local and wider population we can understand better and respond to their concerns and needs. We believe that by doing this we are promoting a contribution from our patients and the public to the success of the Trust and therefore achieving our ambition together.

We made strong progress against many of the quality and safety priorities identified in last year's account, including:

- 29% reduction in rate of Patient Safety Incidents with harm per 100 admissions from 2018/19 to 2019/20
- 34% and 49% reduction respectively in Category 2 and Category 3 Hospital Acquired Pressure Ulcers with 'lapses in care' in 2019/20 compared to 2018/19
- Continued improvement in both the sepsis screening results for 2019/20 (over 90%)
- Exceeding the 95% National Target for Harm Free Care (New Harms) throughout 2019/20
- 23% Reduction in rate patient falls reported per 1000 bed days with harm during 2019/20 compared to 2018/19
- UHNM continues to compare well against peers during 2019/20 and remains within expected ranges for both HSMR and SHMI mortality indicators

We are proud of our achievements, however we recognise that there are also areas where we need to make further improvement, for example:

- Emergency Department 4 hour target performance
- Continued improvement in Sepsis pathway and provision of Antibiotics within 1 hour
- Cancer 62 day standard

- 18 week Referral to Treatment standard
- Staff health, wellbeing and morale

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.

**David Wakefield**
Chairman

**Tracy Bullock**
Chief Executive Officer

## 2.2 Strategic Objectives

**Our '2025Vision' was developed to set a clear direction for the Organisation to become a world class centre of clinical and academic achievement and care. One in which our staff all work together with a common purpose to ensure patients receive the highest standard of care and the place in which the best people want to work.**

**To achieve the 2025 Vision we must respond to the changing requirements of the NHS as they emerge and operate in ever more challenging times. This means that we have to think further than the here and now and continue to look beyond the boundaries of our organization for inspiration. Out involvement in the STP is crucial in enabling us to move towards our vision and to become a sustainable provider of healthcare services.**

# Our Strategic Objectives

Our Vision is underpinned by 5 key Strategic Objectives (SO):

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

# Our Values

We continue to encourage a compassionate culture through our values, which identify the attitude and behavioural expectations of our staff.


| | |
|---|---|
| Together | • We are a team<br>• We are appreciative<br>• We are inclusive |
| Compassion | • We are supportive<br>• We are respectful<br>• We are friendly |
| Safe | • We communicate well<br>• We are organised<br>• We speak up |
| Improving | • We listen<br>• We learn<br>• We take responsibility |

Our full 2025 Vision is available via our website: www.uhnm.nhs.uk .

# Priorities for Improvement

## 3.1 Our Quality Priorities and Objectives for 2020/21

**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:


### Delivering Exceptional Care

During 2020/21, we are beginning our new exciting quality improvement journey with the introduction of our Delivering Exceptional Care programme. Delivering Exceptional Care will help us become and world-class centre of clinical and academic achievement where staff work together to deliver high standards of care.

We are establishing a new Quality Improvement Academy to build greater capacity and support for all of our staff to use established quality improvement methodologies and lead in local and organizational quality improvement projects.

As part of the Quality Improvement Academy, UHNM are working closely with our local Universities to support the programme and link with the national NHS Patient Safety Strategy and the development of Patient Safety Specialists and involving our patients with the introduction of our Patient Safety Partners to help improve the quality of our services and care. The coming year and the identified priorities will form part of our improvement journey as UHNM moves forward in Delivering Exceptional Care.


## Prioritising our quality improvement areas

We have continued our focus on quality aligned to our Strategic Objectives and 2025Vision.

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 or staff to interpret the information and implement sustainable change.

## Stakeholder Workshops

In September 2020, 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 2020/21 with a focus on continuing to improve the priorities set in 2019/20.

## Our Overall Goal for 2020/21 is:

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

### Aims

#### To continue to improve safe care and treatment to patients

**How will we do this:**

- Improve sepsis treatment and recognition of deteriorating patients
- To evaluate and reduce long waiters following the COVID-19 pandemic
- To support the Recovery & Restoration Plan across the health economy
- Ensure that services follow appropriate infection prevention guidance, are COVID secure and social distancing continues.
- Aim to reduce harm from patient falls and hospital acquired pressure damage by further 10%
- Evaluate and introduce new technologies and techniques for treating patients.
- Improve the number of reported medication errors and implementation of new ePMA system
- Delivering Exceptional Care

**Measure this through:**

- Quality Performance Report
- Harm Free Care
- Serious Incidents analysis
- Legal claims
- Mortality reviews and outcomes
- Clinical Audits
- Wards Performance Boards as part of Delivering Exceptional Care

## To improve staff engagement and well being

**How will we do this:**

- To support the introduction of the Trust's Wellbeing Programme and activities that focus on staff wellbeing and empowerment
- Ensure that staff are working within COVID secure environments and support provided to staff
- Support staff and services in providing care in 'new ways' following COVID
- To introduce the Trust's new Quality Improvement Methodology during 2020/21 and the cultural change programme
- Promote mental health wellbeing and support
- Delivering Exceptional Care

**Measure this through:**

- Staff survey
- Pulse Check
- Chief Executive Briefings
- Freedom to Speak up report

## To improve patient experience

**How will we do this:**

- Utilise patient and visitor feedback
- Seek wider engagement with 'harder to reach' patient groups
- Ensure patients are fully informed of COVID-19 requirements and Trust continues to provide the best possible communication with patients/relatives by working with other key stakeholders and groups
- To introduce the Trust's new Quality Improvement Methodology during 2020/21 and the cultural change programme
- Review patients experiences during COVID and identify positive changes to adapt service provisions
- Review the different ways that patient experience and views are gathered and acted upon within UHNM

**Measure this through:**

- Inpatient and Outpatient survey
- Complaints & PALS themes
- Patient Stories

## 3.2 How we have performed against Quality KPIs during 2019/20

| Quality Indicator | Previous Period | | Current Period | |
|---|---|---|---|---|
| The value of the Summary Hospital level Mortality Indicator (SHMI) | **October 2017 – September 2018**<br>1.06 (Band 2) | | **March 2019 – February 2020**<br>0.98 (Band 2) | |
| The percentage of deaths with palliative care coded at either diagnosis and/or specialty level | 43.8% | | 47% | |
| Patient Reported Outcome Measures scores*<br>*(National Average)*<br>Groin hernia surgery<br>Varicose Vein Surgery<br>Hip Replacement Primary Surgery<br>Knee Replacement Primary Surgery<br>**EQ-5D scores finalised data release* | **Participation Rate 2017/18**<br>6.5% *(49.6%)*<br>0.0% *(55.8%)*<br>67.3% *(67.0%)*<br>72.4% *(65.7%)* | **Adjusted Health Gain 2017/18**<br>- *(0.089)*<br>- *(0.096)*<br>0.443 *(0.468)*<br>0.309 *(0.338)* | **Participation Rate 2018/19**<br>-<br>-<br>57.7% *(66.4%)*<br>66.3% *(73.7%)* | **Adjusted Health Gain 2018/19**<br>-<br>-<br>0.447 *(0.465)*<br>0.327 *(0.338)* |
| Percentage of patients aged<br>0 to 15; and<br>16 and over<br>Readmitted to a hospital which forms part of the Trust within 28 days of being discharged from hospital | **No new data publication available from NHS Digital portal** | | **No new data publication available from NHS Digital portal** | |
| The Trust's responsiveness to the personal needs of its patients | **2018/19 Survey**<br>**64.3**<br>*(England average 67.2)* | | **2019/20 Survey**<br>**66.0**<br>*(England average 67.1)* | |
| 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) | **2018**<br>**71.5%**<br>*(England Average Acute Trusts 71.3%)* | | **2019**<br>**74%**<br>*(England Average Acute Trusts 71%)* | |
| Percentage of patients who were admitted to hospital and who were risk assessed for Venous Thromboembolism (Acute Trusts)<br>*(National Average)* | **2018/19**<br>Q1 93.4% (95.63%)<br>Q2 94.27% (95.49%)<br>Q3 95.34% (95.65%)<br>Q4 94.67% (95.74%) | | **2019/20**<br>Q1 93.79% (95.56%)<br>Q2 93.99% (95.47%)<br>Q3 93.29% (95.33%)<br>Q4 TBC % (TBC%) | |
| The rate per 100,000 bed days of Clostridium Difficile infection reported within the Trust amongst patients aged two or over [1]<br>(Trust apportioned) | **2017/18**<br>39.0<br>*(England Average 23.9)* | | **2018/19**<br>29.1<br>*(England Average 22.1)* | |
| The number and rate of patient safety incidents reported within the trust - Acute trusts (non specialist) | *6322 (Oct 2017 – March 2018)*<br>*26.0 per 1000 bed days* | | *6332 (Oct 2018 – March 2019)*<br>*27.3 per 1000 bed days* | |
| The number and percentage of such patient safety incidents that resulted in severe harm or death—acute (non specialist) | 18 *(Oct 2017 – March 2018)*<br>0.4% | | 1 *(Oct 2018 – March 2019)*<br>0.01% | |

[1] 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 Public Health England.

# Commissioning for Quality and Innovation (CQUIN) Indicators for 2019/20

CQUIN is a payment framework which allows Commissioners to agree payments to Providers based on agreed qualitative improvements. Below is a summary of the CQUIN schemes for 2019/20, the targets for each scheme together with an assessment of the Trust's performance. Whilst there was no financial claw back against the Local CCG CQUINs, all CQUINS were monitored for improvements to service delivery and quality benefits to patients. 0.75% of Specialised Commissioning income was dependent on achievement of the CQUINs and whilst not all elements were achieved in full, no CQUIN funding was withheld. To note, that due to COVID19 pressures some of the data was not available for Quarter 4 and submission requirements were relaxed therefore the below is based on Quarter 1-4 performance where data was available and submitted.

The national CQUIN guidance set out that Trusts would be paid proportionally based on their performance however, as UHNM was paid on an Intelligent Fixed Payment agreement, there was no financial claw back for underachievement of any schemes that did not achieve the maximum threshold. Where achievement is described as partially achieved, this reflects that the minimum threshold was achieved but not the maximum threshold however CQUIN funding was not affected.

## Performance against objectives

| Ref no. | Indicator | Target for the Year | Internal assessment of performance |
|---|---|---|---|
| **Main Contract CQUIN 2019/20** | | | |
| **1** | ANITMICROBIAL (AMR) RESISTANCE | **a)** Lower UTI in older people: Achieving 90% of antibiotic prescriptions for lower UTI in older people meeting guidance for diagnosis and treatment of lower UTI. | *Part achieved - 77%* |
| | | **b)** Antibiotic Prophylaxis in Colorectal Surgery: Achieve 90% of antibiotic surgical prophylaxis prescriptions for elective colorectal surgery being a single dose and prescribed in accordance to local antibiotic guidance | *Achieved 92%* |
| **2** | STAFF FLU VACCINACTIONS | Achieving an uptake of flu vaccinations by frontline clinical staff of 80% by the end of February 2020 | *Achieved - 86.5%* |
| **3** | ALCOHOL & TOBACCO | a) Tobacco screening: Achieving 80% of adult inpatient admissions are screened for both alcohol and tobacco use | *Achieved - 90%* |
| | | b) Tobacco brief advice: Achieving 90% of patients identified as smoking tobacco are given brief advice | *Part achieved - 86%* |
| | | c) Tobacco referral and medication offer: Achieving 90% of patients identified as drinking above low risk levels are given brief advice or offered a specialist referral | *Achieved - 91%* |
| **4** | FALLS | Achieving 80% of older inpatients receiving key falls prevention actions:<br>▪ Lying and standing blood pressure to be recorded<br>▪ no hypnotics or anxiolytics to be given during stay or rationale documented<br>▪ mobility assessment and walking aid to be provided (if required) | *Part achieved - 35%* |
| **5** | SAME DAY EMERGENCY CARE (SDEC) | a) Pulmonary Embolus: Achieving 75% of patients with confirmed pulmonary embolus are managed in a same day setting where clinically appropriate | *Achieved - 98%* |
| | | b) Atrial Fibrillation: Achieving 75% of patients with confirmed atrial fibrillation are managed in a same day setting where clinically appropriate | *Achieved - 95%* |
| | | c) Community Acquired Pneumonia: Achieving 75% of patients with confirmed Community Acquired Pneumonia are managed in a same day setting where clinically appropriate | *Achieved - 79%* |

| Specialised Contract CQUIN 2019/20 | | | |
|---|---|---|---|
| 1 | CYSTIC FIBROSIS SELF-CARE | Recruit 50-70% of patients with chronic pseudomonas to the self-management programme. This supports a change in clinician and patient behaviour that will transform Cystic Fibrosis care from a clinician led reactive hospital based rescue service to a patient led community based prevention. Self-management approach supported by electronic tracking. | *Achieved* |
| 2 | ENABLING THROMBECTOMY | Training of 2 new interventionists to support the expansion of mechanical thrombectomy from to allow more people to be independent after their stroke each year | *Part achieved - 1 trainee recruited* |
| 3 | MEDICINES OPTIMISATION | 4 Triggers:<br>a) Improving efficiency in the IV chemo pathway<br>b) Accurate completion of prior approval proformas<br>c) Faster adoption of prioritised best value medicines and treatments<br>d) Implementation of Antifungal Stewardship | *Achieved* |
| 4 | ARMED FORCES | Embedding the Armed Forces Covenant to support improved health outcomes for the Armed Forces Community | *Achieved* |
| 5 | AAA SCREENING | Identify and reduce local inequalities in abdominal aortic aneurysm screening | *Achieved* |
| 6 | BREAST SCREENING | Identify and reduce local inequalities in breast cancer screening | *Achieved* |

**For further information, please contact Debra Meehan, Acting Director of Nursing (Quality & Safety), on 01782 675679**

# 4. Patient Story

## *4.1 "I had no doubt our son was in safe hands following a car accident"*

Our 19 year old son had just finished his first year at Birmingham University where he was studying Biochemistry. A neighbour knocked on my door to tell me he had been involved in a road traffic accident a couple of miles from home. After a long, dry summer it had rained for the first time in ages causing the roads to be extremely slippy. Even though a witness's dash cam showed that he was driving at a safe speed he lost control of his car on a corner causing him to skid round a bend, a car coming the opposite way hit him and then he went through a hedge into a field.

When I arrived at the scene there were already fire engines and ambulances there. They could see how critically unwell our son was and pulled him out of his car as quickly as possible. I travelled with him in the ambulance to Royal Stoke A&E where he was diagnosed with collapsed lungs, 5 or 6 fractured ribs and a severe head injury to the back of his skull. The staff in A&E were excellent. I had no doubt that our son was in safe hands and they even found time to make sure I was Ok and make me a cup of tea. I remember joking with the anaesthetist that this was an ideal opportunity to remove a recently acquired tattoo! A brain scan identified a fracture and air around the brain so my son had a pressure monitor fitted and was put into an induced coma and taken to POD 6 in Critical Care. The staff in Critical Care were very understanding of the extremely difficult time this was for us and I was able to stay at my son's bedside throughout the night.

A few days later the team tried to bring my son out of his coma but this was unsuccessful so he had to be quickly put back under and sent for a repeat scan. The scan showed that he had experienced a watershed stroke and that this had damaged areas all over his brain. We were kept well informed of our son's condition throughout his time in critical care and understood that he was extremely unwell. We were warned that his recovery was unpredictable and that it was likely that his brain injuries may cause permanent damage. The next month was the most worrying time for us all. Our son had to be fully paralysed to stop him shivering and he had to undergo lumber punctures to help to relieve the pressure on his brain. He developed both lung and a spinal fluid infections and we were so close to losing him at times. Despite all the odds he did slowly regain consciousness and although he couldn't talk I was so relieved when I realised he could communicate with his tongue to show me he could understand what I was saying.

We can't begin to thank the critical care team enough for the care and treatment both our son and his friends and family received over this awful time. We were involved in his care every step of the way and incredibly well informed. I trusted the team enough to go home overnight and I would phone every morning for an update from the night shift. My ex-husband or I then stayed with my son every day from 10 in the morning until 10 at night, The care I witnessed during this period was second to none. The whole team cared for our son, without any hierarchy as every member of the team, regardless of their role, helped with every aspect of his care.

We were also helped through this difficult time as our

son's friends were allowed to visit him without restrictions. They brought him a Manchester City football shirt that they had all signed and his aunt was allowed to bring her dog to his bedside. Everyone including physio's, nurses and doctors made such a fuss of our son and we really felt that they genuinely cared about him. Nothing was too much trouble; the physio even put him in a wheelchair and took him outside for some extra stimulation which was really appreciated.

On the 3rd October 2019 our son was strong enough to be moved to a ward to continue with his rehabilitation. Although we had been warned that he would no longer be receiving the 1:1 care that he had on Critical Care it still came as a shock when we realised how stretched the team were on the ward. It was also immediately apparent that it was considered a healthcare support workers role to carry out personal care and we were used to the whole team getting involved on the unit. This really took some getting used to and it took a while for us to gain confidence that his care would be of a good standard. As our son was still unable to communicate we knew it was our responsibility to speak for him to ensure his needs were met. At first it felt like we were having to ask for even the most basic things like could he be sat out in a chair or could he have his hair washed, however over time we did build up a good relationship with the staff and we could see that they were fond of him. One nurse in particular was lovely. She always included our son in her conversation speaking to him as she would any other person and we valued that a lot.
We did complete an "about me" tool so that the staff knew our son's likes and dislikes making conversation easier. The staff were also very flexible with my prolonged visiting hours as they understand that I felt I needed to be there to support him as he couldn't move or communicate himself. It was lovely when we could sit in the dayroom for a change of scenery. Initially our son was in a 4-bedded bay with 3 other patients who were unconscious. Eventually they were all moved into single rooms, only one of which had a window looking over the helipad. Unfortunately our son wasn't given the room with the view which was disappointing as he was the only one who would have benefited from this at the time with being the only one conscious and able to look out.

The Physio team on the ward were excellent, they made the activities fun and interesting and you could tell our son loved his sessions with the team. They recognised that he was a young lad so could chat about teenage nights out and university with him.

On the 25th October 2019 our son was well enough to be cared for on a less acute ward with a mini tracheostomy. One of the male nurses was a Liverpool fan and he had an immediate rapport with our son despite supporting Manchester City. The tracheostomy was eventually removed on a Monday morning. It was a real turning point when we received a phone call from the tracheotomy nurse telling us our son had said he was hungry and wanted a Chinese meal as his first words!

At around this time there was a planned procedure to insert a shunt into our son's brain, however his temperature was raised on the day of theatre and he was sick on the way there so the procedure was postponed and everything started to improve from that day onwards so the shunt wasn't needed after all.

The physiotherapy was great on this ward too and available 7 days a week, this was good as there would typically be one extra session at the weekend. Our son still had a nasogastric tube for feeding and it was really difficult persevering with the pureed food to regain his swallowing reflex as the food was so unpalatable. It was the thought of eventually being able to eat a pizza that kept him going! He did find the cultural menu appetising and felt that this could have been advertised a bit better as the majority of patients don't know about this is an option.

Our son was desperate to be taken outside for a change of scenery but staff were extremely cautious about this. We knew he would be ok but he had to undergo a psychological test first. This left us all feeling quite deflated as the staff wouldn't trust our judgement that he would be ok. He "failed" the test on the first attempt but this made him all the more determined to pass it so he knew he had to take it seriously. Visiting was also a lot stricter on this ward from 2-7pm. This made it quite difficult for his dad to visit as he works in Manchester so had very little time with our son by the time he got back to Stoke in the evening.

After 3 months as an inpatient, our son said goodbye to the Royal Stoke hospital and was transferred to the Haywood on the 30th November. It felt like everything was going in slow motion initially. He was desperate to get back onto his own two feet and he became quite impatient while the physiotherapy concentrated on strengthening his core. However, after Christmas things progressed rapidly and all aspects of our son's independence gradually recovered with the intensive rehabilitation including crossing the road and paying for items when shopping.

Our son returned home on the 29th March 2019, 7 months after his accident. He plans to return to university as soon as possible and we will be eternally grateful for the skills and expertise of Mr Harrison and his teams at Royal Stoke University Hospital and the Haywood. His rehabilitation continues in a local Stoke Boxing gym that we had been told about by Headway and he is getting physiotherapy at Macclesfield hospital now too. The local support after leaving hospital took 6-8 weeks to get started. He is also proactively raising charitable funds for the Royal Stoke Hospital raising over £3000 to date.

We have made some close relationships with other families who were in hospital at the time including one lady whose son died and are able to offer each other for on-going support. Keeping a patient diary was an enormous help during our son's time on Critical Care and we now have this in our possession to refer too. We did have to ask for this and were told that they are only issued once a patient leaves and is ready to receive it. This is a good idea but we were a little worried for a while as the nurses on the wards didn't seem to know anything about it. It would be really good to be given a name and contact number of a person to contact so we always know who to ask when the relative and/or patient is ready. The presentation of the diary and the opportunity to meet the teams again was wonderful. We can never find the right words to thank them enough for all they have done

# 5. Statement of Assurances

## 5.1 Review of Services

### Care Quality Commission

The Trust was inspected June 2019; the inspection followed the new regime for inspection. 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

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

The final report was published on 14th February 2020. The overall rating for the Trust stayed the same. The CQC rated UHNM as **requires improvement** because:

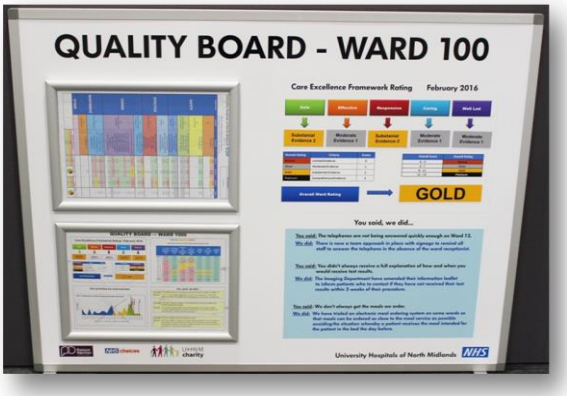
- The CQC had concerns regarding the care and treatment of patients in the Emergency Department at Royal Stoke Hospital
- They also raised concerns in relation to the care and treatment of patients with mental health needs and patients who lacked mental capacity to make decisions
- Governance systems although embedded were over complicated and unreliable. The CQC acknowledged that the newly appointed CEO was undertaking extensive work to improve these systems
- In rating the Trust, the CQC took into account the current ratings of services not inspected this time
- Immediate actions have been taken to address the issues identified with regard to the care of patients with mental health needs
- Improvements to the triage system and process were implemented immediately and the Board subsequently agreed significant investment for nurse staffing
- The ED Improvement plan seen by the Board in Sept 2019 remains in place and is being refreshed following the challenges in December 2019

The inspection did not include surgical care or critical care and therefore the ratings awarded to these core services in 2017 remain the same. The CQC rated UHNM's Critical Care as an Outstanding Service.

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

| Domain | October 17 Ratings | June 2019 Ratings | |
|---|---|---|---|
| **Are services safe?** | Requires Improvement | Requires Improvement |  |
| **Are services effective?** | Good | Requires Improvement |  |
| **Are services caring?** | Outstanding | Good |  |
| **Are services responsive?** | Requires Improvement | Requires Improvement |  |
| **Are services well led?** | Good | Requires Improvement |  |
| **Overall** | Requires Improvement | Requires Improvement |  |

## Care Excellence Framework




The Care Excellence Framework (CEF) is a unique, integrated tool of measurement, clinical observations, patient and staff interviews, benchmarking and improvement. It reflects CQC standards and provides assurance around the CQC domains of:

- Safety
- Effectiveness
- Responsive
- Caring
- Well led

Each clinical area 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. Each domain consists of clinical observations, documentation reviews, patient interviews and feedback from staff forums.

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 and are displayed in each clinical area. The clinical area is supported to develop and deliver a bespoke improvement plan and spread good practice.
Areas with a bronze award are supported to make improvements by the Quality and Safety team and areas rated platinum are encouraged to share their good practices via the CEF Steering Group.

## PLACE Inspection

The 2019 PLACE inspections were undertaken at the Royal Stoke University Hospital on 22nd October 2019 and 7th November 2019 at County Hospital. Inspections are patient led by their nature and cannot take place without 50% patient representation. A number of patient assessors and managers were representatives across both PLACE inspections and ensured consistency in approach and opportunity to compare environmental standards across both sites. The PLACE scores were published nationally on 30th January 2020 and UHNM achieved scores well above the national average against all domains assessed, overall as a Trust and for each site respectively, as summarised below.

| Site Name | CLEANING Score % | FOOD Score % | PRIVACY, DIGNITY & WELLBEING Score % | CONDITION & MAINTENANCE Score % | DEMENTIA Score % | DISABILITY Score % |
|---|---|---|---|---|---|---|
| **THE ROYAL STOKE UNIVERSITY HOSPITAL** | 99.94 | 94.75 | 90.17 | 99.51 | 90.34 | 92.45 |
| **THE COUNTY HOSPITAL** | 100 | 96.75 | 99.56 | 99.88 | 96.47 | 96.10 |
| **UHNM TRUST SCORE** | 99.95 | 95.03 | 91.49 | 99.56 | 91.21 | 92.97 |
| **NATIONAL AVERAGE** | **98.6** | **92.2** | **86.1** | **96.4** | **80.7** | **82.5** |

Of particular note is the 100% cleaning score achieved at the County Hospital site for the second consecutive year.

In summing up the inspections our Patient Assessors provided very positive comments in relation to what they had observed on the day. These comments are confirmed below and are testament to the hard work and commitment of all staff, clinical and non-clinical and our private sector partners, in providing a high quality care environment.

**UHNM – Royal Stoke PLACE Inspection Feedback 22nd October 2019. Our patient assessors said:-**
*"100% positive response from the patients they spoke to about the care and compassion they are receiving. We've never seen such dedicated staff in every single area they went to and although the areas are very busy every single ward area greeted us with a friendly welcome and a smile. The staff are clearly working together very well in teams from the cleaners to the head of the department. We definitely saw a more positive attitude from staff this year and we were very impressed with West Building and the older estate considering its age and layout. There was a definite improvement on site overall across each of PLACE domains from last year. The food on the wards that we tasted was excellent."* Rob Beddis and Margaret Foulkes – Patient Assessors

**UHNM County Hospital Inspection Feedback 7th November 2019. Our patient assessors said:-** *"The site was immaculately clean including the corridors and common areas and the environment was calm and supported patients privacy and dignity very well. The patient care we saw was second to none with very dedicated medical, nursing and support staff who were very open and welcoming who should be proud of their work. The grounds and gardens were also exceptionally well kept by the grounds team and the food we tasted on the wards was superb. It was evident that all the teams worked together to care for their patients and the continuity of staff on each area was noticeable and paid off. We felt very confident about the environment we saw".* John Duggan, Volunteer and Patient Assessor and David Hardy, Patient Assessor

External Validator – Rosemary Brown, Head of PFI and Commercial Services, Birmingham Mental Health NHS Trust said "the wards and departments were spotless and I couldn't fault anything throughout the inspections"


MAIN ENTRANCE
DROP OFF ONLY

## 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 2019/20 - 50 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 2019/20 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.

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

| NCEPOD Study | UHNM Registered | Completed |
|---|---|---|
| Bowel Obstruction | Yes | Action Planning / Implementation |
| Pulmonary Embolism | Yes | Action Planning / Implementation |
| Long Term Ventilation | Yes | Awaiting Report |
| Out of Hospital Cardiac Arrest | Yes | Data Collection |
| Dysphagia in People with Parkinson's | Yes | With Lead to complete Organisational Questionnaire |

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 2019/20 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 |
|---|---|---|
| Assessing Cognitive Impairment in Older People / Care in Emergency Departments | Yes | 100% |
| BAUS – Cystectomy Audit | Yes | 100% |
| BAUS – Female Stress Incontinence Audit | Yes | 100% |
| BAUS – Nephrectomy Audit | Yes | 100% |
| BAUS – Percutaneous Nephrolithotomy Audit | Yes | 100% |
| BAUS – Radical Prostatectomy Audit | Yes | 100% |
| Care of Children in Emergency Departments | Yes | 100% |
| Case Mix Programme (CMP) | Yes | 100% |
| Child Health Clinical Outcome Review Programme | Yes | 100% |
| Elective surgery (National PROMs Programme | Yes | 100% |
| Endocrine and Thyroid National Audit | Yes | 100% |
| Falls and Fragility Fractures Audit Programme (FFFAP) | Yes | 100% |
| Inflammatory Bowel Disease (IBD) Registry, Biological Therapies Audit | Yes | 100% |
| Major Trauma: The Trauma Audit & Research Network (TARN) | Yes | 100% |
| Mandatory Surveillance of Bloodstream and Infections and Clostridium Difficile Infection | Yes | 100% |
| Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK) | Yes | 100% |
| Medical and Surgical Clinical Outcome Review Programme | Yes | 100% |
| Mental Health – Care in Emergency Departments | Yes | 100% |
| National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme (NACAP) | Yes | 100% |
| National Audit of Breast Cancer in Older People (NABCOP) | Yes | 100% |
| National Audit of Cardiac Rehabilitation (NACR) | Yes | 100% |
| National Audit of Care at End of Life (NACEL) | Yes | 100% |
| National Audit of Dementia (Care in general hospitals) | Yes | 100% |
| National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12) | Yes | 100% |
| National Bariatric Surgery Registry (NBSR) | Yes | 100% |
| National Cardiac Arrest Audit (NCAA) | No | 0% |
| National Cardiac Audit Programme | Yes | 100% |
| National Diabetes Audit - Adults | Yes | 100% |
| National Emergency Laparotomy Audit (NELA) | Yes | 100% |

| | | |
|---|---|---|
| National Gastric-Intestinal Cancer Programme | Yes | 100% |
| National Joint Registry (NJR) | Yes | 100% |
| National Lung Cancer Audit (NLCA) | Yes | 100% |
| National Maternity and Perinatal Audit (NMPA) | Yes | 100% |
| National Neonatal Audit Programme - Neonatal and Special Care (NNAP) | Yes | 100% |
| National Ophthalmology Audit | Yes | 100% |
| National Paediatric Diabetes Audit (NPDA) | Yes | 100% |
| National Prostate Cancer Audit | Yes | 100% |
| National Smoking Cessation Audit | Yes | 100% |
| National Vascular Registry | Yes | 100% |
| Neonatal Intensive and Special Care (NNAP) | Yes | 100% |
| Neurosurgical National Audit Programme | Yes | 100% |
| Paediatric Intensive Care Audit Network (PICANet) | Yes | 100% |
| Perioperative Quality Improvement Programme (PQIP) | Yes | 100% |
| Reducing the impact of serious infections (Antimicrobial resistance and Sepsis) | Yes | 100% |
| Sentinel Stroke National Audit Programme (SSNAP) | Yes | 100% |
| Serious Hazards of Transfusion: UK National Haemovigilance Scheme | Yes | 100% |
| Society for Acute Medicine Benchmarking Audit (SAMBA) | Yes | 100% |
| Surgical Site Infection Surveillance Service | Yes | 100% |
| UK Cystic Fibrosis Registry | Yes | 100% |
| UK Parkinson's Audit | Yes | 100% |

**Corporate and Local Clinical Audits**

A total of 132 clinical audit projects were completed by Clinical Audit Staff and a further 330 clinician led audit projects were registered during 2019/20. 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 Delirium: NICE Clinical Guidance 103**

| Action | Co-ordinator | Action Completed By |
|---|---|---|
| To ensure that all relevant staff are aware of the results of the audit, the report was shared with:<br>a) The Lead Consultants of the three portals of entry asking them to cascade the results to their colleagues.<br>b) The Elderly Care Audit Meeting. | Audit Lead<br><br>Audit Lead | Complete<br><br>Complete |
| **In order to ensure that all patients have their delirium risk assessed:** | | |
| Consultants at County Hospital have been reminded of the importance of completing a timely 4AT Assessment on admission. If the assessment is not completed in the emergency portal, then is must been completed on admission to the ward. | Audit Lead | Complete |
| Consultants in FEAU and AMU at Royal Stoke and County will ensure that the 4AT has been completed by the clerking doctor. In FEAU, box 6 on the consultant review orange form must be completed. | All Consultants / Junior Doctors | Complete |
| All Junior Doctors have been reminded to complete the score in full on the scoring columns entering the date and their grade; circling ad hoc items on the left side of the page is not sufficient | All Consultants / Junior Doctors / ANPs | Complete |
| Staff have been re-educated about the difference between the 4AT and 6CIT. A screensaver will be developed to ensure on-going awareness. | Audit Lead | Complete |
| To determine if improvements in practice have taken place a re-audit will be undertaken as part of the 2020/21 Clinical Audit programme. | Clinical Audit Department | May 2020 |

## 5.4 Participation in Clinical Research

UHNM participates in clinical trials across the healthcare sector from novel interventions and drugs to device innovations which aim to improve quality of life and outcomes for our patients. Research Practitioners and Midwives work alongside clinical teams and support services to identify and consent potential research participants, discussing trials with patients and providing care throughout the studies.

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

- is associated with better clinical outcomes
- brings a range of finance benefits, including savings on medicines and staff time
- improves UHNM's reputation
- enhances recruitment & retention of high quality staff
- improves staff knowledge & skills
- is key to our academic partnerships
- enhances patient experience

Furthermore, the Care Quality Commission (CQC) are increasingly recognising the value of research and it has been identified that research active organisations fare better in CQC inspections. A key development has been the recent agreement by CQC to include, for the first time, a question about research opportunities offered to patients in the CQC Annual Survey of Inpatient Experience.

**Strategic Aims**

1. Culture: To develop a Trust-wide culture of research and innovation.
2. Capacity: To grow the Trust's capacity to support research and innovation.
3. Finance: To develop a robust, sustainable and transparent financial model for research and innovation.
4. Governance: To support and enhance research and innovation through provision of a robust governance framework.

Research and Innovation highlights from 2019/2020

- At the end of 2019/2020 we had more than 350 open studies across a wide range of specialities. In the last year we recruited over a thousand patients to these studies.
- We continued to support the management and evaluation of the £1.2M Innovate UK Heart Failure Test Bed. This project uses commercially available digital technologies combined with a more efficient and responsive heart failure pathway to improve early detection of deteriorating health in Heart Failure patients.
- R&I also continued their support of the FLiP-GD2 study (Professor Hanna), which aims to determine whether women with gestational diabetes mellitus (diabetes first detected during pregnancy) who also have fat in the liver, have a higher risk of developing full diabetes.
- The Academic Development Team submitted 10 grants to external funders (value in excess of £4M). Two have already been funded (discussed below) with the others still under review.
- In January 2020, A&E Department were awarded £15k to undertake a project aiming to improve patient flow within A&E and enable services to more easily flex to patient demand.
- In February 2020, Research & Innovation Department's bid for £96k from the Clinical Research Network Improvement and Innovation Strategic fund was successful. The aim of the project is to develop an accreditation programme that recognises organisations according to their degree of engagement with patients and public during the research process.

## 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 inpatient Data Quality audits is being undertaken with valuable feedback for improvements encouraged within ward teams.
- 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
- A corporate level Data Quality Strategy has been formulated to be supported by robust monitoring via the Trust's Data Quality Steering Group, providing an assurance framework to assist with feedback to the Executive Committee
- A Data Quality Assurance Indicator has been developed for implementation within Board Integrated Performance reporting.

2019/20 has been a productive year for the data quality team and we aim to build on this throughout 2020/21, supporting the strategic aims of the Trust.

## 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 2019/20 and has maintained these results.

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

- 99.3% for admitted patient care; national performance is 99.4%
- 99.7% for outpatient care; national performance is 99.7%
- 97.0% for accident & emergency care; national performance is 97.8%

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

- 100% for admitted patient care; national performance is 99.7%
- 100% for outpatient care; national performance is 99.6%
- 99.8% for accident & emergency care; national performance is 97.9%

Trust performance for GMP code is higher than the national average.

## 5.7 Clinical Coding Accuracy Rate

The annual internal Data Security & Protection Toolkit (DSPT) clinical coding audit took place during 2019/20, achieving an overall 'mandatory' rating in all areas of the audit and 'advisory' in 3 of the 4 areas audited. This is an improvement on last year's audit which identified 2 out of 4 areas as 'advisory' All recommendations from the 2018/19 audit have been actioned. The Trust's Clinical Coding auditors carried out this year's audit.

The Trust was not subject to an external Payment by Results (PbR) audit in 2019/20.

The internal Staff Audit Programme continues for all coding staff and has been updated for 2020/21.

The Trust has a qualified Clinical Coding Trainer who has established a 2 year training programme for trainee coders and in-house workshops for existing staff. In addition, they provide all mandatory national training, ensuring all coders are compliant with training requirements.

U-codes (no associated income due to missing information) have remained consistently low throughout 2019/20, reporting 2% or less at all monthly submissions.

## 5.8 Information Governance Toolkit Attainment Levels

This year was the second iteration of the new data security and protection toolkit and it should be noted that it is still being refined. This is a self-assessment tool which the Trust must complete and it is usually submitted to NHS Digital on the 31st March every year.

However due to the current COVID-19 pandemic, Trusts were given an extension to 30th September 2020. This extension includes the timeframe for completion of the mandatory Data Security & Protection training which was also been extended to 30th September 2020. The toolkit was revised to embrace the National Data Guardian's 10 data security standards. (The National Data Guardian. 2016 National Data Guardian for Health and Care Review of Data Security, Consent and Opt-Outs Crown Copyright) although the emphasis is more on Cyber Security measures rather than the traditional data protection requirements of previous toolkits. The toolkit submission for 2019/2020 requires all 40 assertions to be completed.

The Trust has submitted its self-assessment, using the extension to ensure all 40 assertions have been addressed. An action plan is in place, incorporating feedback from the internal auditors, with the key focus on the percentage of staff successfully completing the level 1 data security awareness training. The Trust's Executive Data Security & Protection Group is monitoring the situation providing assurance to the Trust Board, via the Finance & Performance Committee and Quality Governance Committee. However, if the Trust does not achieve the training target, the Trust's rating will be classified as 'Standards not fully met (plan agreed)' and we will need agreement from NHS Digital on this point.

## 5.9 Seven Day Services

The seven day services programme is designed to ensure patients that are admitted as an emergency, receive high quality consistent care, whatever day they enter hospital. There were 10 clinical standards for seven day services in hospitals developed and four of the ten were identified as priorities on the basis of their potential to positively affect patient outcomes.
These are:

- Standard 2 – Time to first consultant review
- Standard 5 – Access to diagnostic tests
- Standard 6 – Access to consultant-directed interventions
- Standard 8 – Ongoing review by consultant twice daily if high dependency patients, daily for others

Achieving the 4 high priority clinical standards for 7 day working sits as a Critical Success Factor (CSF) under Strategic Objective 1: Provide safe, effective, caring and responsive services. UHNM 7 day services Clinical Steering Group in agreed to adopt a targeted improvement approach in order to maintain assurance around achievement of the 4 high priority and associated standards with 3 specialties of focus:

- ENT
- Paediatrics
- Elderly Care

# Part B: Review of Quality Performance

## 6. Quality Priorities 2019/20

In 2019/20, in partnership with our stakeholders we identified 4 specific priorities to focus on:

**One: To further reduce patient harm**

**Two: To improve staff feeling of belonging and ownership through increased involvement in the development and delivery of the UHNM Clinical Strategy**

**Three: To increase the involvement of people at all levels, from the patient and carers at the bedside about their care, to the wider community in the planning and evaluation of the services we provide.**

**Four: To promote further the use of technology to improve the efficiency and effectiveness of patient care.**

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

## Priority 1:
## To further reduce patient harm

Quality, safety and patient experience remains our number 1 priority and 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.

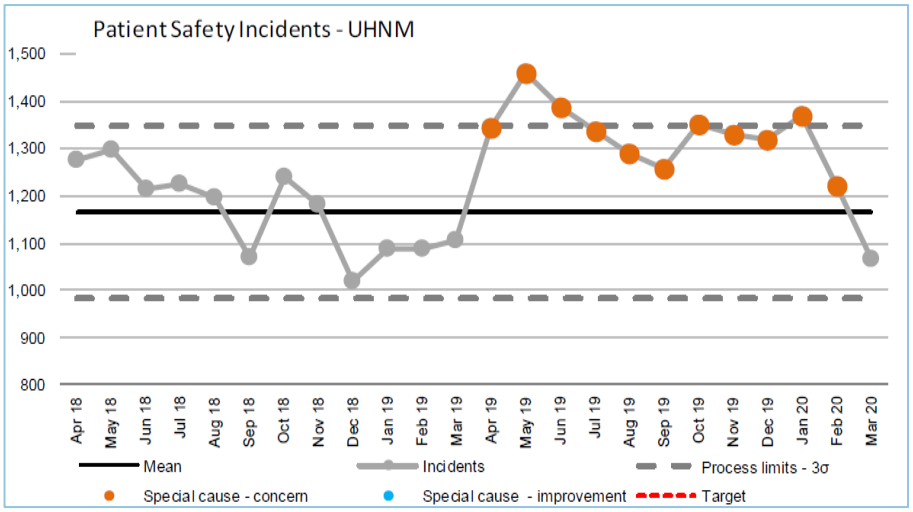
We said we would achieve this by

- ✓ **Improving timely recognition and treatment of Sepsis.**
- ✓ **Recognising and responding to deteriorating patients**
- ✓ **Reducing by 10% patient falls resulting in moderate harm or above.**
- ✓ **Eliminating hospital acquired Category 4 pressure ulcers and reducing the incidence of Category 2 and 3 pressure ulcers with lapses in care by 5%:**
- ✓ **Undertaking RCAs to learn from reported incidents**
- ✓ **To report on key indicators in monthly reports to provide analysis and assurance on actions taken**

Performance against this priority and its aims has been monitored during 2019/20 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.

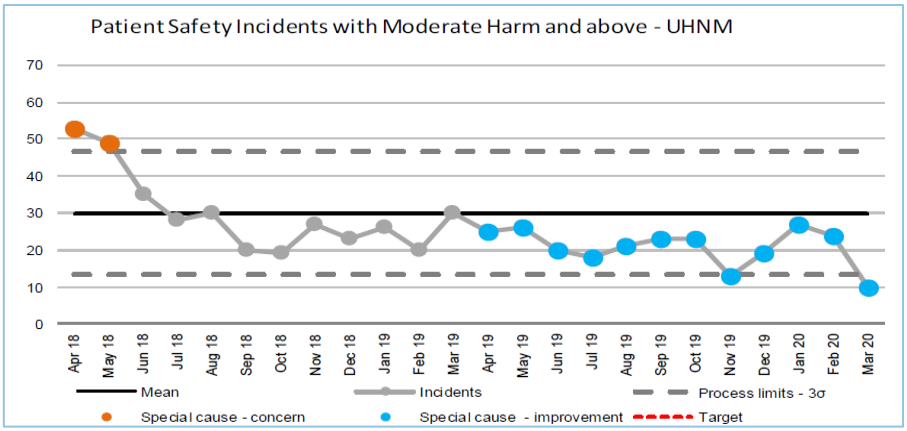
### Patient Safety Incidents

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 1000 bed days and the number and rate of patient safety incidents with moderate harm or above. The charts below illustrate the monthly totals for these indicators.

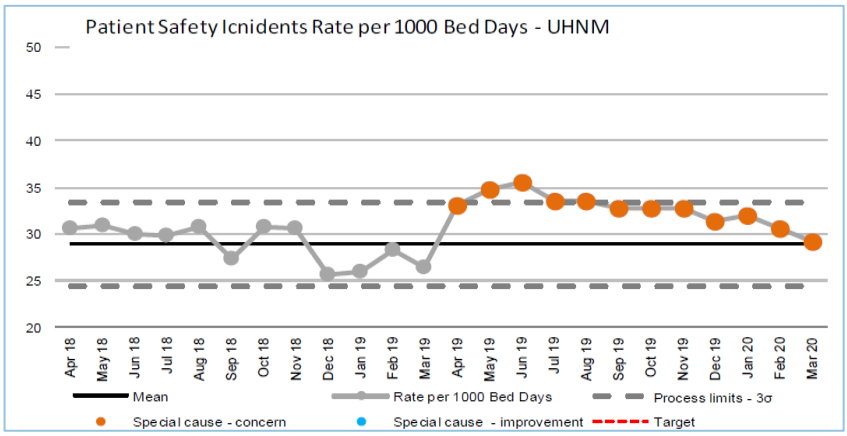



**12% increase in total reported Patient Safety Incidents from 2018/19 to 2019/20**
**Increase result of inclusion of Non hospital acquired pressure damage to reflect NRLS reporting requirements to include all pressure damage identified by the provider**

**30% reduction in total reported Patient Safety Incidents with harm 2018/19 to 2019/20**

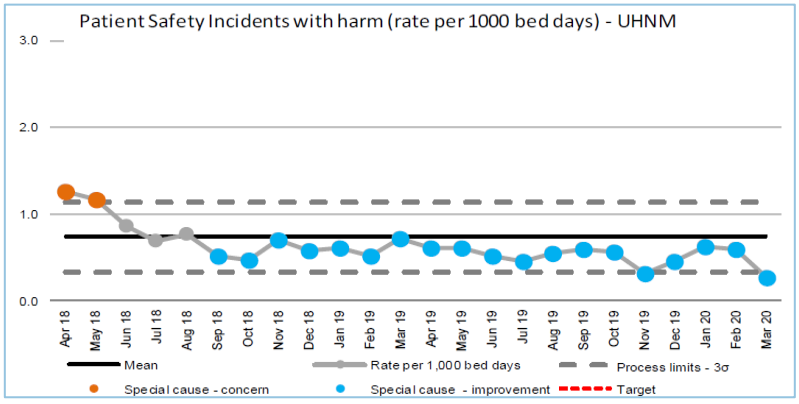



Total reported patient safety incidents have increased as result of including all pressure damage identified on admission to UHNM in line with including these incidents in the Trust submission to the National Reporting & Learning System (NRLS) from April 2019. However, there have been reducing numbers of patient safety incidents reported as resulting on moderate harm or above during 2019/20 compared to 2018/19.




**13% increase in rate of reported Patient Safety Incidents per 1000 bed days from 2018/19 to 2019/20**

**29% reduction in rate of reported Patient Safety Incidents with harm per 1000 bed days from 2018/19 to 2019/20**



## Never Events

UHNM has introduced strong systems to allow for the reporting of adverse incidents to ensure lessons are learnt whenever possible. During 2019/20, we have reported 6 Never Events which compares to 6 reported in 2018/19. The following provides a summary of these Never Events, per Quarter, together identified learning to prevent recurrence.

**6 reported Never Events during 2019/20**

**Quarter 1 (April - June)**

**Retained foreign object post procedure – retained guidewire (2019/7835)**

***Learning identified:***

A full check of a guidewire after a procedure should ensure that the full length of the guidewire has been removed and that the outer sleeve and inner core elements have not separated. Possible consideration regarding measurement of the guide wire on removal (if logistically and financially possibly).

***Actions Taken:***

- An internal safety alert regarding the possibility that the outer sleeve and the inner stiffener of a guidewire can become separated was developed and shared Trust wide
- Current stock were checked to see if any issues with the batch used had been identified. No other incidents/issues identified
- Notified guidewire manufacturers of incident regarding outer sleeve and inner sleeve stiffener becoming seperated

**Wrong site surgery – incorrect lesion removed (2019/11200)**

***Learning identified:***

The operating surgeon had difficulty accessing iPortal. This meant that he was unable to view the patient's clinical notes and the dermatology doctor's photograph detailing the correct lesion that was to be operated upon. Surgeon did not follow the correct procedure for surgical site marking as laid out in policy C04 - Ensuring the Safety of Patients Undergoing Surgical Interventions. Policy states that a surgical site must be marked and checked against reliable documentation i.e. iPortal clinic notes. No significant harm to the patient.

***Actions taken:***

- All plastic surgery consultants ensure that they have sufficient access to ICT systems.
- All plastic surgery consultants to ensure aware of Policy C04.

**Wrong site surgery – incorrect procedure undertaken (2019/14295)**

***Learning identified:***

Error in the consent process and incorrect patient identified during checking process before procedure commenced. Patient had correct procedure.
There was Incomplete theatre list and the Theatre List was not available at consent stage
Theatre lists not available to Anaesthetist.
Theatre list not available at check in to theatre.

***Actions Taken:***

- Processes for checking patients prior to procedure changed and details entered onto electronic system which is available within Theatres
- Newly defined and agreed booking process for urgent cases identified.
- Pause and Check stage of WHO process reasserted with all staff
- The team brief Must include the anaesthetist.
- The WHO checklist must be completed.

**Quarter 2 (July – September)**

No Never Events reported

**Quarter 3 (October – December)**

**Wrong site surgery – wrong side nerve root injection (2019/26942)**

***Learning identified:***

There was a lack of clarity on initial referral to imaging and this led to confusion as the initial referral should have been rejected. Consent was discussed and taken from the patient – but for the incorrect side. No significant harm to the patient. Correct nerve block subsequently administered

***Actions taken:***

- All referrals reviewed and protocolled / justified.
- Any confusion or lack of clarity the referrals are now rejected and new referral requested to confirm clinical details.

**Wrong site surgery – incorrect ophthalmology procedure (2019/23043)**

***Learning identified:***

Patient underwent cataract procedure but incorrect biometry used and current checks are not adequate and required change to process in theatres

Do not use pre-printed patient labels on any printed results sheets (including biometry sheets) which have patient details (name, unit number, date of birth) already printed on them.

Printed Biometry sheets to be signed, printed name and dated by staff member printing off the sheets and filing in the notes.

To ensure that the correct cataract surgery consent form is used (including Cataract WHO Checklist) for all appropriate patients.

No significant harm to the patient and vision improved.

***Actions taken:***

Have communicated to Ophthalmic Pre Assessment Clinics not to use pre printed patient labels on printed results sheets

Second check process introduced in Ophthalmic Pre Assessment Clinics

New Cataract Consent From introduced and old versions removed from use

**Quarter 4 (January – March)**

**Wrong implant/prosthesis – incorrect hip prosthesis (2020/3961)**

***Learning identified:***

Failure in the 3 person check to identify the femoral head implant was the wrong size.

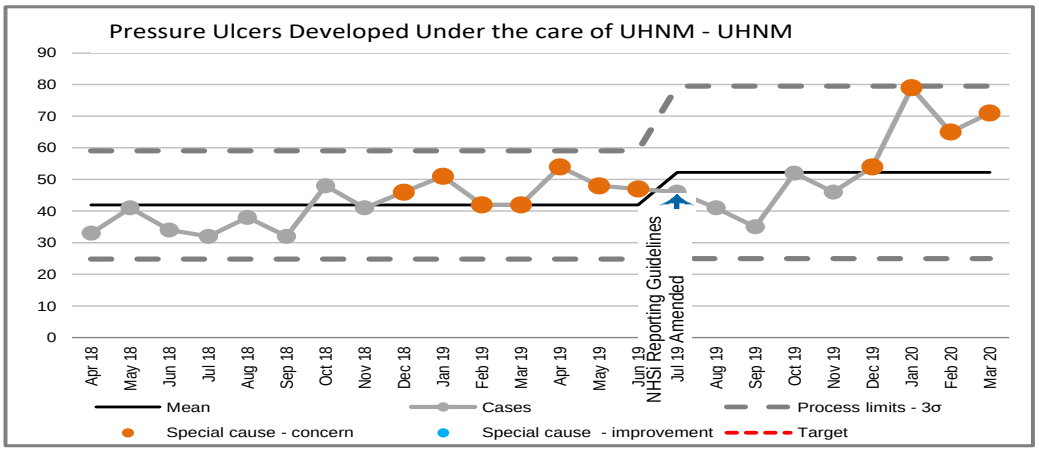
***Actions taken:***

SOP developed by theatres including:

- Continuation of the 3 person check and confirmation of the implant prior to opening
- Implant details to be written on the whiteboard by the Theatre runner after passing to the scrub nurse
- All staff are empowered to query any implant issues or potential mismatch.

## Pressure Ulcers developed under UHNM Care

We have seen an increase in Pressure Ulcers developed whilst under the care of UHNM. During 2019/20 there were 638 reported pressure ulcers developed at UHNM compared to 480 in 2018/19. This equates to 33% rise in identified pressure ulcers.

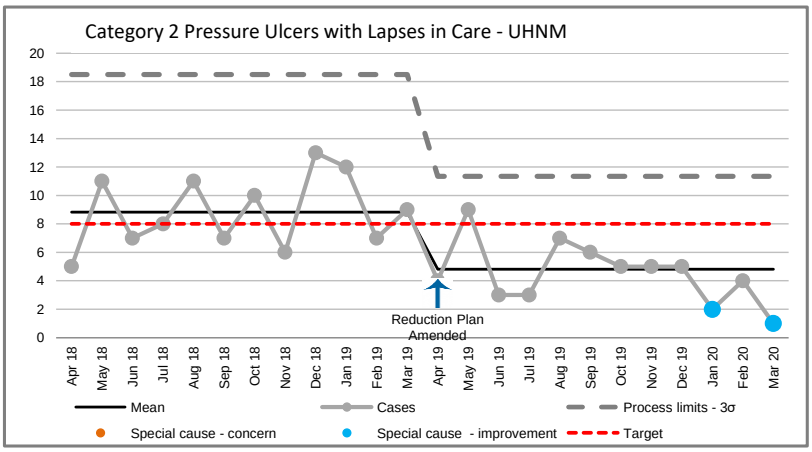


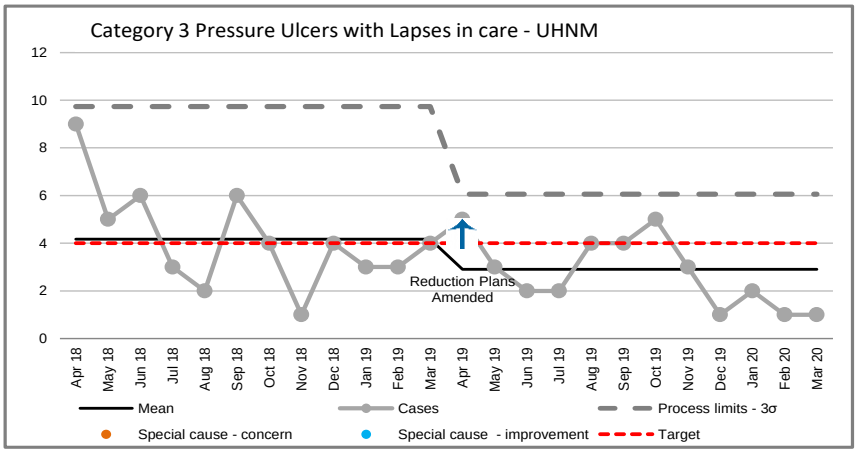

**33% increase in reported Pressure Ulcers Developed whilst under care of UHNM**

**1 Category 4 Hospital Acquired Pressure Ulcer with lapse in care identified during 2019/20**

However, there have been reductions in Categories of Pressure Ulcers which have had lapses in care identified during 2019/20, due to the high standard of care provided.

**34% reduction in Category 2 Pressure Ulcers with 'lapses in care' in 2019/20 compared to 2018/19**




**49% reduction in Category 3 Pressure Ulcers with 'lapses in care' in 2019/20 compared to 2018/19**

### Improvement in Sepsis Recognition and Treatment

During 2019/20, there has been a marginal decrease in the sepsis screening results whilst there has been an improvement in the performance for anitibiotics being administered with 1 hour in Emergency Portals and Inpatient areas from the sepsis audits undertaken.

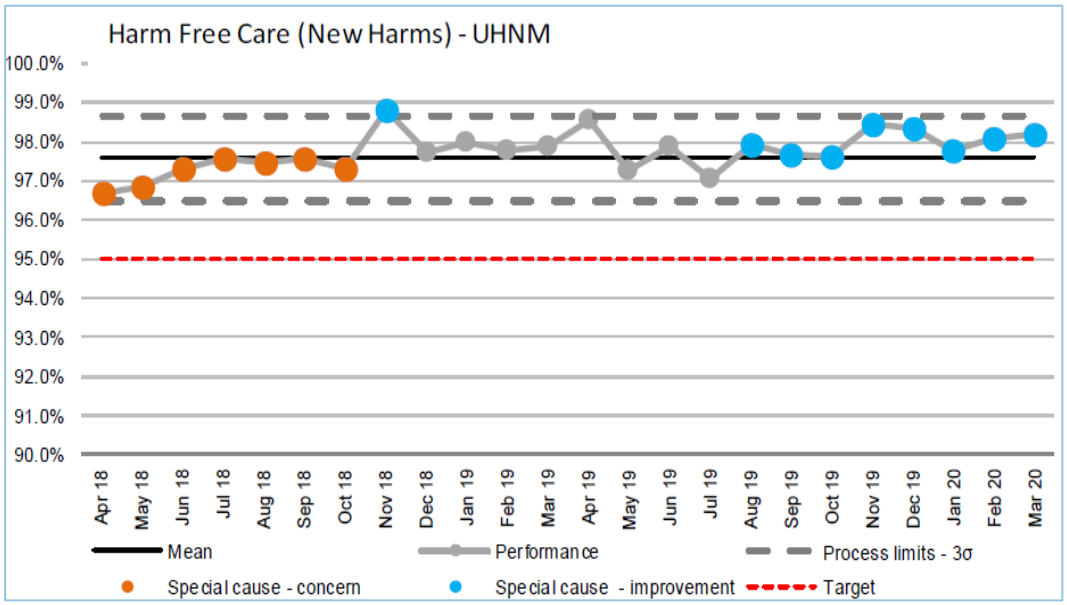
**SEPSIS Audit Quarterly Summary – 2019/20**

| | | | Sepsis Screening Results | | | Abx Given within 1 Hr | | |
|---|---|---|---|---|---|---|---|---|
| Clinical Area | Qtr | Fiscal Month | Pt Count | Screened Count | % Screened | RED Flag Pts | Abx IN 1 Hr | % Abx in 1Hr |
| **Emergency Portals** | Qtr 1 | | 236 | 213 | 90.3% | 118 | 103 | 87.3% |
| | Qtr 2 | | 242 | 221 | 91.3% | 96 | 87 | 90.6% |
| | Qtr 3 | | 303 | 266 | 87.8% | 119 | 93 | 78.2% |
| | Qtr 4 | | 241 | 215 | 89.2% | 77 | 69 | 89.6% |
| **Emergency Portals Total** | | | **1022** | **915** | **89.5%** | **410** | **352** | **85.9%** |
| **Inpatients** | Qtr 1 | | 182 | 148 | 81.3% | 13 | 12 | 92.3% |
| | Qtr 2 | | 151 | 127 | 84.1% | 13 | 9 | 69.2% |
| | Qtr 3 | | 222 | 178 | 80.2% | 21 | 21 | 100.0% |
| | Qtr 4 | | 359 | 335 | 93.3% | 16 | 16 | 100.0% |
| **Inpatients Total** | | | **914** | **788** | **86.2%** | **63** | **58** | **92.1%** |
| **Grand Total** | | | **1936** | **1703** | **88.0%** | **473** | **410** | **86.7%** |

The UHNM Sepsis Team has continued to support and raise awareness to all levels of clinical/medical staff in emergency portals and in-patient areas at both sites to continue to embed the sepsis pathway and improve sepsis screening and antibiotic timeliness.

## 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 2019/20 and the final overall average rate is 97.9% (refer to chart below). The results are gathered during the monthly Safety Thermometer assessments where all UHNM Inpatients are reviewed on 1 day of the month to assess whether they have experienced harm from a fall, pressure ulcer, pulmonary embolism/deep vein thrombosis or catheter associated urinary tract infection during their current inpatient admission. These results are reported nationally on monthly basis.



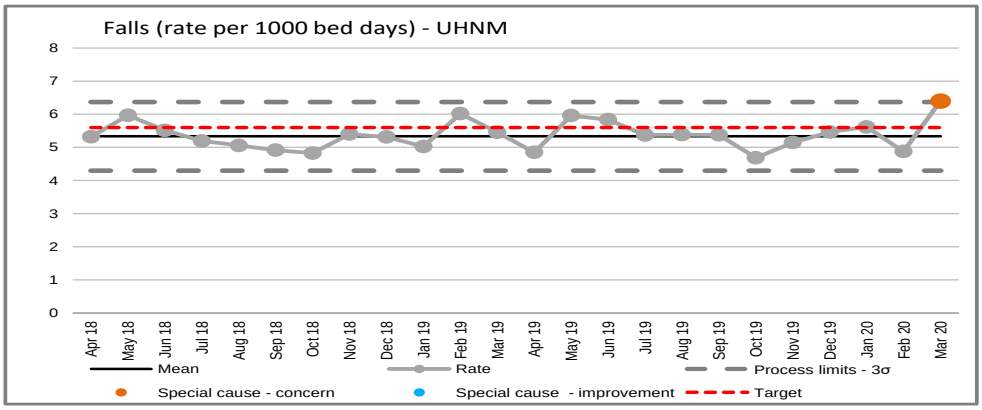

**Exceeding the 95% National Target for Harm Free Care (New Harms) throughout 2019/20**

**Average Rate 97.9%**

## Patient Falls

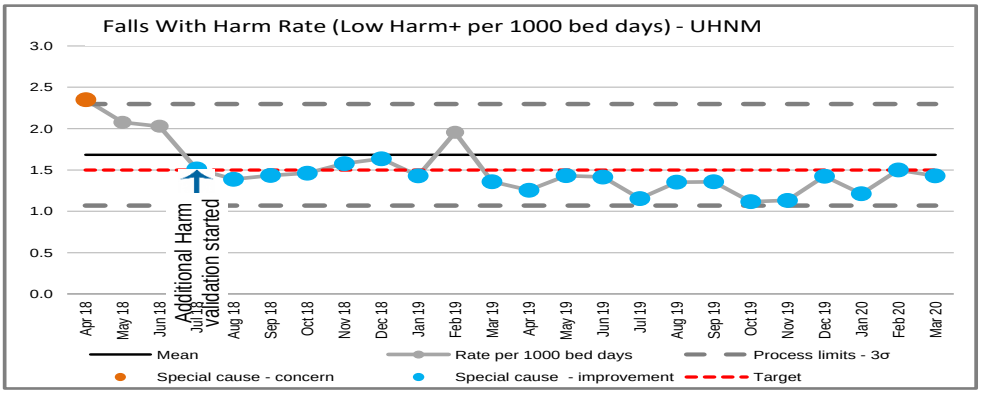
During 2019/20 there were 2603 reported patient falls compared to 2587 in 2018/19 which is 0.6% increase. In order to be able to account for changes in activity the Trust uses the patient falls rate per 1000 bed days. During 2019/20 the overall rate was 5.4 compared to 5.3 in 2018/19.

The Royal College of Physicians national average for acute NHS Trusts from previous national audit report is 5.6 falls per 1000 bed days.




**1.8% increase in rate of reported patient falls in 2019/20 compared to 2018/19.**

**23% reduction in rate of harm to patients as result of falls per 1000 bed days in 2019/20 with 1.3 compared to 1.7 in 2018/19**




Whilst there have been overall increases in the total number and rate of all reported patient falls there have been reductions in both the total numbers and rate of patient falls that have resulted in harm. This is important as the aim was to reduce harm from falls by 10% whilst encouraging incidents to be reported.

Total falls with harm have reduced by 21.9%, with 631 in 2019/20 compared to 808 in 2018/19. This has also seen the rate of falls with harm reducing by 23%.

## Mortality

Our mortality rate with current HSMR for 2019/20 reported at 92.68. This means that UHNM's number of in hospital deaths is less than expected range based on the type of patients that have been treated. This compares to 100.34 for 2018/19.


**UHNM continues to compare well against peers during 2019/20 and is better than expected based on standardized casemix**

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 0.99. This is a rolling 12 month measure and covers the period January 2019 – December 2019

**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

During 2019/20, 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 Mortality Summary Report presented at the Trust's Quality Governance Committee and reported to the Trust Board.

**2837 patient deaths (83% of all in hospital deaths during 2019/20 have been reviewed during 2019/20**

These reviews required reviewing clinicians to assess the care provided prior to death using the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) A-E categories. In addition, from December 2017, we adopted a more detailed review proforma based on the Royal College of Physicians Structured Joint Review form.

During April 2019 – March 2020, the Trust have completed 2837 online proformas, accounting for 83% of all the hospital deaths recorded during 2019/20. 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 2019/20 that have also had completed reviews submitted by 31st March 2020. 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 2019/20 the review will be completed in 2020/21.

| | 2019/20 Total | | Q1 | | Q2 | | Q3 | | Q4 | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Total Number of Deaths in reporting period** | 3404 | | 824 | | 758 | | 906 | | 916 | |
| **Total Number of Deaths in reporting period subject to review (% of total deaths)** | 2837 | 83% | 709 | 86% | 672 | 89% | 776 | 86% | 680 | 74% |
| **Total Number of reviewed deaths with suboptimal care identified – NCEPOD grade E (% of reviews)** | 2 | 0.07% | 1 | 0.14% | 0 | 0% | 0 | 0% | 1 | 0.15 |

* The Royal College of Physicians 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

A summary of the learning identified from the completed mortality reviews is provided below 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.

The following provides summary of issues identified during the Structured Judgement Review process that could be improved.

- The importance of the timely involvement of the Palliative Care Team and care given that met the patient's Advance Directive
- Importance of clear documentation and legibility
- The impact of multiple ward moves on patients and their relatives
- Inappropriate times of transfers between wards / sites can have negative impacts on patients care

- Awareness of potential effects of prescribed medications i.e. coamaxiclav could contributed to patient experiencing diarrhoea
- Delay in requesting CT scan for potential bowel perforation but delay not contribute to death
- Importance of timely observations and checking of medication as prescribed
- Regular review of medications to ensure appropriate as patients' conditions change.
- Patient sent to Step Down but was not MFFD
- Ensuring there is a more timely referral to ITU
- Improvements in communication and sharing of information between teams
- Importance of clear documentation of agreed Do Not Attempt Cardio Pulmonary Resuscitation decisions to allow delivery of agreed care
- Good discussions and involvement with families and patients in discussing DNACPR decisions

### Hospital Acquired Infections

The Trust continues to strive to reduce the number of avoidable hospital associated infections. Two of the key infection associated indicators that are used are Methicillin-resistant Staphylococcus aureus (MRSA) and Clostridium Difficile (C Diff). During 2019/20, we have seen increases in like for like numbers compared to 2018/19 for C Diff. It is important to note that from 1st April 2019 the national definitions used for C Diff were changed, consequently we expected there to be higher numbers and although the target was increased to accommodate this change UHNM, like many other Trusts, saw much higher numbers of infections than expected.

| Indicator | 2019/20 Target | 2018/19 | 2019/20 |
|---|---|---|---|
| To reduce C Difficile infections | 93 | 56 | 116 |
| To reduce MRSA infections | 0 | 1 | 0 |

## Priority 2:
## To improve staff feeling of belonging and ownership through increased involvement in the development and delivery of the UHNM Clinical Strategy

We said we would do this by:

- ✓ **Improving staff experience through a range of activities focusing on staff wellbeing, reward and recognition**
- ✓ **Undertake further work at Board and Divisional level to share our vision and strategy, and progress on delivery throughout the year**
- ✓ **Increase visibility of senior leaders across both sites via walkabouts, holding local meetings and CEO staff forums at which UHNM clinical and non-clinical developments will be shared**
- ✓ **Respond to the Staff Survey results via the Divisional and corporate action plans**
- ✓ **Continue with our staff appreciation visits and recognition activities such as employee and team of the month awards.**

Performance against this priority and its aims has been monitored during 2019/20. The following section provides a summary of the performance for these indicators and what these results mean for our patients.

### Freedom to Speak Up

The Trust has continued to promote Freedom to Speak Up Guardians and supporting staff in raising concerns or issues. There are regular reports are provided to the Quality Assurance Committee and Trust Board on matters raised and resolved

Actions taken in 2019/20:

- Our Speaking Up Policy (previously Raising Concerns at Work (Whistleblowing) Policy has reviewed and updated during 2019 and includes our commitment to a Just and Learning Culture is available on the intranet.
- The Trust's intranet has a Speaking Up page on the Staff Room section, with guidance for workers and managers.
- The Raising Concerns and Workforce Equality Manager is the Trust Freedom To Speak Up (FTSU) Guardian, supported by three Associate Guardian roles and a network of Employee Support Advisors.
- The FTSU Guardians have ready access to senior leaders and others to enable rapid escalation of issues, maintaining confidentiality as appropriate.
- The Trust has named Executive and Non-Executive Leads for speaking up who meet regularly with the FTSU Guardian.
- The FTSU Guardian reports quarterly to the Transformation and People Committee, and through this to Trust Board.
- UHNM has outlined its vision and strategy for speaking up in its Speaking Up Plan created from FTSU Self Review Tool
- The updated Guidance for boards was presented to the Trust Board by the Executive Lead for Speaking Up in September 2019 which summarised the expectations of Executive Directors in relation to freedom to speak up, and the roles and responsibilities of individual Trust Board members.
- The Trust Board had a board development session on Speaking Up delivered by NHS England & Improvement in January 2020
- Updated our Disciplinary Policy to include the Just and Learning framework

## 2019 NHS Staff Survey – The National Context and Trust Outcomes

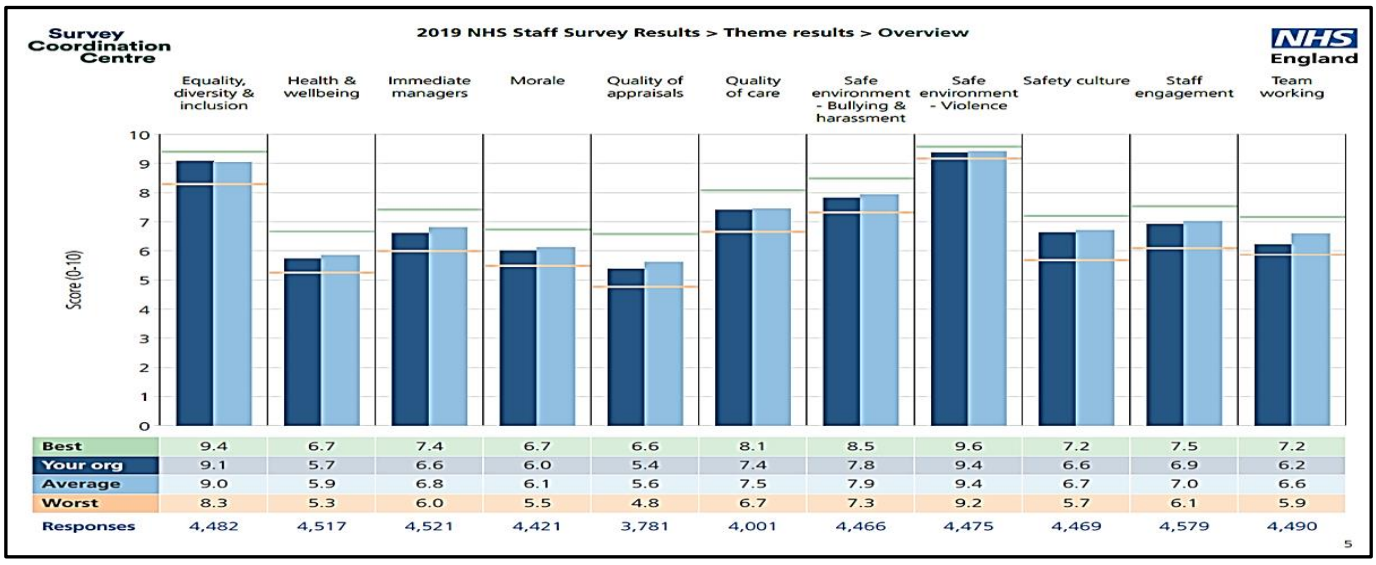
The 2019 NHS Annual Staff Survey was carried out between September and December 2019 and the Trust response rate was 45%. The national response rate was 47% and there were 85 organisations in the acute benchmarking group.

It should be noted that the published Staff Survey report is based on a sample population of 1250, regardless of the number of staff surveyed. Also, data in the national results is weighted to reflect the distribution of staff according to staff group.

There were a number of statistically significant improvements in the 2019 scores when compared to the previous year's data.

- Equality and Diversity
- Morale
- Safety Culture
- Immediate Managers
- Quality of Appraisals
- Staff Engagement

The following table presents an overview of the 10 themes, comparing this Trust's results to the national average for acute trusts, and indicating the scores of the best and worst performing acute trusts.




The chart shows that the main themes where this Trust scores lower than national average are:

1. **Equality and Diversity –** The theme score was 9.0 out of 10 against an acute trust average of 9.0. The main issue for staff in 2018 was their perception of fairness as regards career progression and/or promotion. This perception improved from 80.9% in 2018 to 84.3% in 2019.

   Staff experience of discrimination at work from colleagues/managers also improved from 8.6% to 7.4%, better than the national average of 7.5%

2. **Health and wellbeing** – all aspects of this theme improved except the percentage of staff experiencing MSK problems, which increased from 26.1% to 27.0%. Positively, however, staff perceptions on opportunities for flexible working improved from 47.5% to 48% and the organisation taking positive action on health and wellbeing improved from 21.9% to 24.4%. Also, fewer staff said they had felt unwell due to work related stress (reduced from 41.8% to 40.2%).

3. **Immediate Managers – In 2018, staff** perception was that immediate managers did not appear to take a positive interest in staff health and well-being. This perception improved from 63.3% to 65.25%. Staff also reported improved support and feedback from managers, and that they felt managers value their work.
4. **Morale -** Staff say they have unrealistic time pressures, less choice in deciding how to do their work, and that relationships are increasingly strained. However, staff noted small improvements in receiving the respect they deserve from colleagues and encouragement from their immediate manager. This has reduced the percentage of staff who said they are thinking of leaving the Trust.
5. **Quality of Appraisals -** all aspects of staff perceptions around appraisals improved, with more staff saying it helped them improve how they do their job; agree clear objectives for their work and left them feeling their work is valued by the Trust
6. As regards **Team Working** however, fewer staff felt their team had shared objectives and the percentage saying they meet to discuss team objectives reduced from 52.9% to 50.9%, which is well below the national average of 60.3%
7. **Safety Culture –** Positively, staff reported improvements in every aspect of this theme:
    - those involved in an error, near miss or incident are treated fairly improved from 55.9% to 57.4%
    - organisational action to ensure errors or incidents don't happen again improved from 67.6% to 70%
    - feedback to staff in response to reported incidents improved from 57.7% to 58.9%
    - feeling secure about raising unsafe clinical practice improved from 65.6% to 67.8%
    - confidence that the organisation would address staff concerns increased from 52.7% to 56.2%, and
    - Trust acting on concerns raised improved from 68.8% to 71.4%
8. **Safe Environment –** Sadly, there was an increase in staff saying they experienced harassment, bullying and abuse from patients/service users (from 26.4% to 28.2%), and an increase in experience of violence (15.9% up to 16.5%) from patients/services users

    Staff experience of harassment, bullying and abuse from managers reduced from 15.6% to 14.1%, but increased from colleagues (22.0% up to 22.9%). Experience of violence from colleagues reduced from 1.9% to 1.4%, which is now below the national average
9. **Staff engagement –** At 6.9, the staff engagement score remains just below the acute trust average of 7.0.

    Although fewer staff said they look forward to coming to work, there was an improvement in the percentage who said they are enthusiastic about their job and that time passes quickly for them while at work. Despite this, there were improvements in staff saying care of patients is the Trusts top priority; they would recommend the Trust as a place to work, and if a friend or relative needed treatment, they would be happy with the standard of care provided, which scored 73.9% compared to a national average of 70.5%.
10. **Quality of Care** – there has been very little change in staff perceptions around quality of care, which scores 7.4 against a national average of 7.5. The main issue for staff is that they say they feel less able to deliver the care they aspire to.

## Next Steps

To improve and evidence the positive action taken on health and wellbeing, we will:

- Continue to embed the Empactis Absence Management system to support improvements to sickness absence case management and continue to promote staff wellbeing, including financial wellbeing, in line with the Trust's wellbeing plan. We will undertake specific work with the health and safety team and staff physiotherapy service to consider how we can provide further support to those staff members with musculoskeletal problems.

Towards improving equality and diversity, staff morale and a culture of safety, we will maintain the focus on:

- Building on the work that commenced during 2019 to promote careers, i.e. Apprenticeships; Project Search; career campaigns with a focus on diversity; engagement with Department for Work and Pensions, and ensuring that recruitment campaigns are targeted at a broad pool of talent from protected staff groups.
- Continuing to promote inclusion at all levels of our workforce and promoting workforce diversity by raising awareness of under-represented groups through our leadership offerings. We will continue to work with our staff networks to identify any barriers to accessing development opportunities.
- Embedding a just and learning culture, approach into disciplinary and capability processes and promoting civility and respect across all areas of the Trust.
- Working with the security team to redesign conflict resolution training to increase the number of sessions and tailor to particular service needs and raise awareness of the Trust's zero tolerance to violence and aggression
- Introducing disability awareness training for managers and further promote disability leave as a reasonable adjustment
- Reviewing freedom to speak up messaging at Induction to ensure all staff feel able to raise concerns. We will also introduce a 'Speaking Up' Staff Charter and embed 'Cut It Out' as ongoing messaging that violence, bullying and harassment are unacceptable behaviours.

We will support Divisions to produce tailored action plans to address the survey findings specific to each area and ensure that Divisional People Plans incorporate actions to address the above and to improve team working, promote team discussions and awareness of objectives

## Priority 3:
## To increase the involvement of people at all levels, from the patient and carers at the bedside about their care, to the wider community in the planning and evaluation of the services we provide.

We said we would do 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)**
- ✓ **Implementing the refreshed Patient Involvement Strategy**

Performance against this priority and its aims has been monitored during 2019/20. The following section provides a summary of the performance for these indicators and what these results mean for our patients

University Hospitals of North Midlands aspires to achieve a culture where the voice of our patients, their carers and families is at the heart of all that we do and we believe that patients can be equal partners in creating positive changes through identifying where barriers and challenges exist in our systems.

The introduction of Volunteer Patient leaders is an integral part of this commitment. During Quarter 2 we formally recruited our first cohort of four Patient Leaders.
We have developed a training programme in collaboration with the West Midlands Leadership Academy and the UHNM Organisational Development team to support us to equip our Patient Leaders with the skills they need to:

- Work with the Trust to find meaningful opportunities, identified through lived experience, to influence the on-going work of the Trust
- Use creative and innovative thinking in developing solutions
- Actively influence the strategic direction of the Trust.
- Work with us to co-create a culture which is 'patient-centred '
- Support the development of high quality patient and public engagement.

Our Patient Leaders bring a wealth of expertise to the Trust including:

- A willingness to develop their understanding and be committed to improving the NHS and its services.
- The ability to think widely about health and wellbeing.

- The ability and willingness to reflect; and represent the different views and diversity of patients/users, including those living with different conditions and who may be from different backgrounds.
- An understanding of the different challenges faced by the local community accessing the hospital.
- Experience of recently accessing NHS services and/or have experience of caring for or managing health/long term condition(s).

From left to right: Mr John James, Mr David Thorley, Mrs Lorraine Dale and Mrs Nicki Haywood.

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 actively participate in Quality Walkabouts 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 Leaflet Ratification Workshops
- PLACE inspections
- dDeaflinks
- Local pregnancy loss support groups

- Learning Disability Service User Group
- Stoke on Trent Public Health
- Community Health Learning Foundation

**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 2019. A total of 1250 patients, who were discharged from UHNM during July 2019, were sent a postal questionnaire asking them to feedback on their experience. The questionnaire consisted of 72 questions in total. 42% of patients responded. This is an improvement on the 2018 response rate of 36% but slightly below the average "Picker" response rate of 44%.

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

| | Top 5 scores (compared to average) |
|---|---|
| 68% | Q14. Hospital: not bothered by noise at night from other patients |
| 25% | Q71+. Overall: received information explaining how to complain |
| 76% | Q6. Planned admission: was admitted as soon as necessary |
| 18% | Q70+. Overall: asked to give views on quality of care |
| 84% | Q13. Hospital: staff completely explained reasons for changing wards at night |

| | Bottom 5 scores (compared to average) |
|---|---|
| 56% | Q56. Discharge: patients given written/printed information about what they should or should not do after leaving hospital |
| 51% | Q19+. Hospital: food was very good or good |
| 53% | Q29. Nurses: always or nearly always enough on duty |
| 80% | Q59+. Discharge: given clear written/printed information about medicines |
| 58% | Q9. Admission: did not have to wait long time to get to bed on ward |

| | Most improved from last survey |
|---|---|
| 78% | Q62+. Discharge: family, friends or carers given enough information to help care |
| 25% | Q71+. Overall: received information explaining how to complain |
| 71% | Q33. Care: staff did not contradict each other |
| 88% | Q46. Procedure: told how to expect to feel after operation or procedure |
| 93% | Q47. Procedure: explained how it had gone in an understandable way |

| | Least improved from last survey |
|---|---|
| 58% | Q9. Admission: did not have to wait long time to get to bed on ward |
| 11% | Q52. Discharge: delayed by no longer than 1 hour |
| 53% | Q29. Nurses: always or nearly always enough on duty |
| 83% | Q48+. Discharge: felt involved in decisions about discharge from hospital |
| 76% | Q6. Planned admission: was admitted as soon as necessary |

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. This campaign has been extended in the community to prepare patients for their GP

Consultation and hospital visit and support Shared Decision Making. The Health Literacy training is now being rolled out to other areas in the Trust.

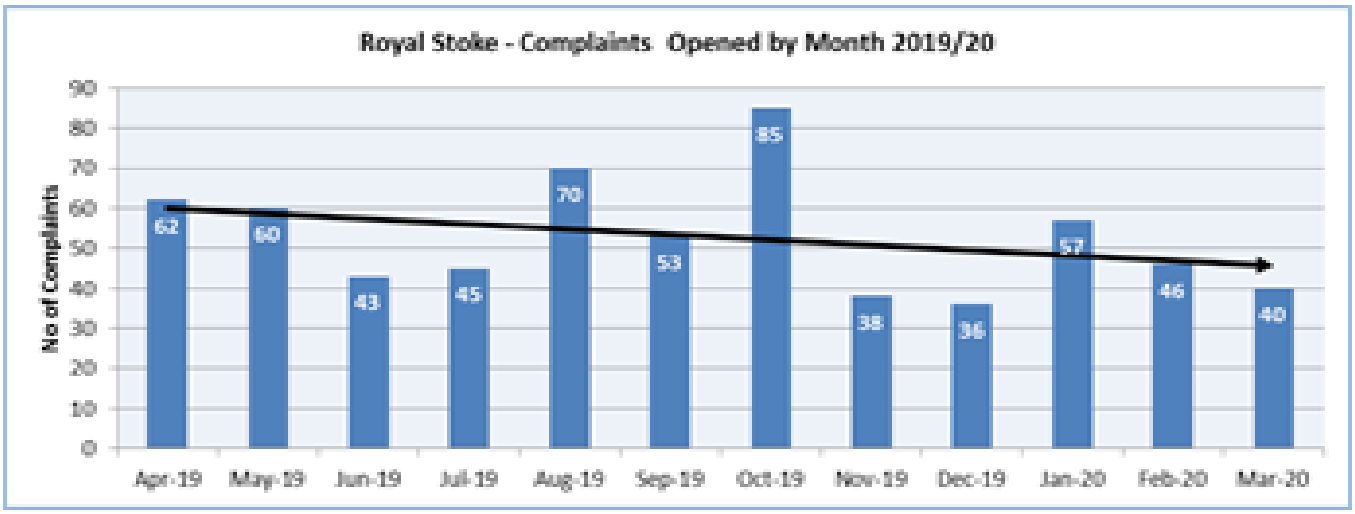
- "Top 20 wards" introduced to encourage staff to gain patient feedback about their experience of the Trust
- Redesign of patient information leaflets to promote patient awareness and development of an electronic Patient Information library to support staff to have easy access to patient information leaflets
- Measurement of effectiveness of initiatives with patient surveys to inform the Clinical Excellence Framework audit programme
- Triangulation of quality and safety data through an internally designed Quality Management System data base to identify themes.
- 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 continues to be a firm focus on patient experience at Trust induction.
- Purple Bow initiative established 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.

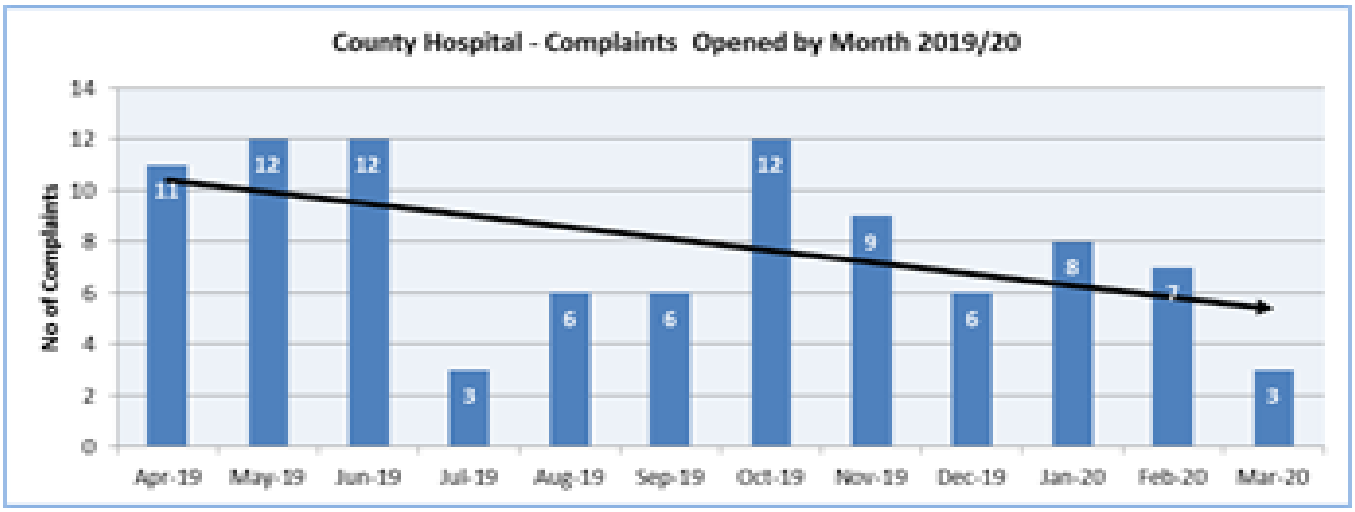
**Complaints**

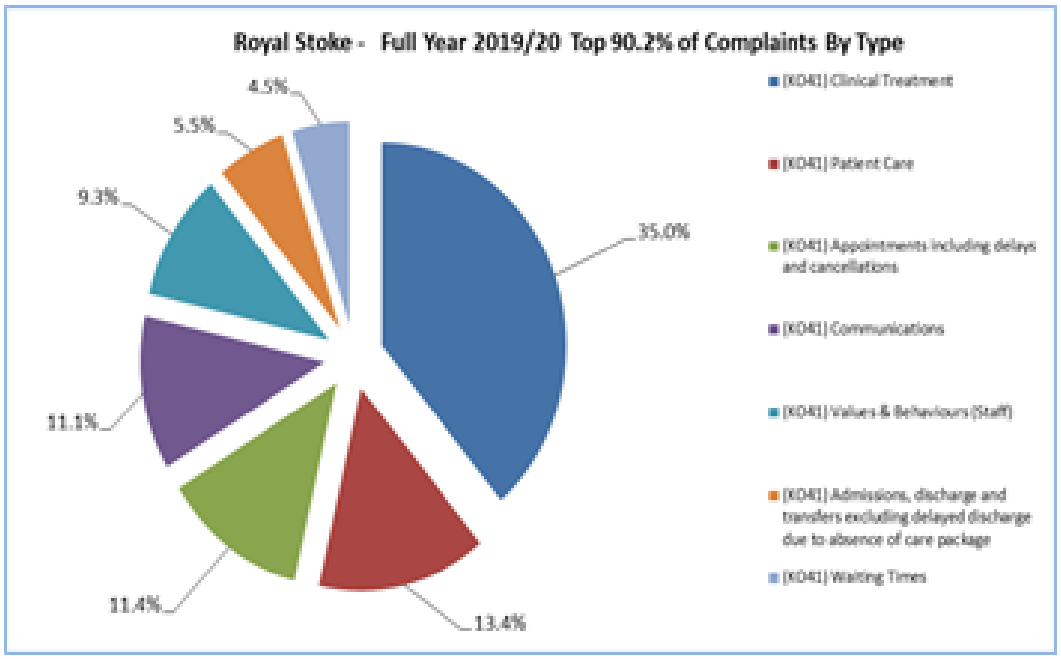
The total number of complaints opened at Royal Stoke University Hospital during 2019/20 is 635 which is an increase of 12.6% over the same period in 2018/19 when 564 complaints were opened.
The total number of complaints opened at County Hospital was 95 in 2019/20, which is a 15.2% reduction from 2018/19 with 112 complaints received.

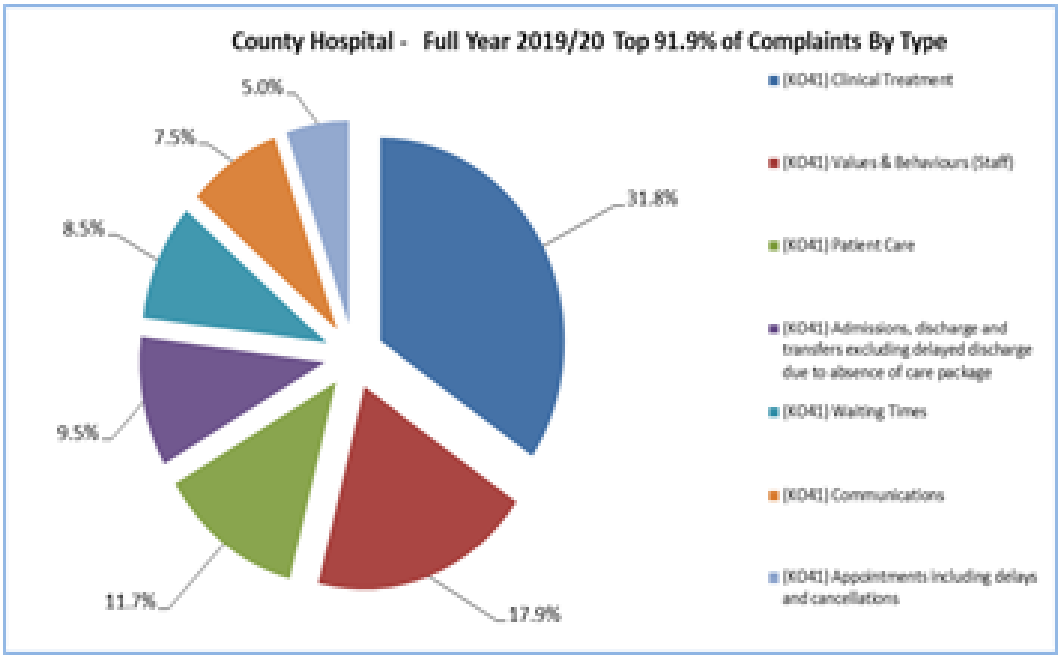
During 2019/20, the Complaints Team have achieved the following:

- Complaints are 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 56.6 days during 2019/20 for complaints to be closed compared to 45.4 days in 2018/19 and 47.7 days in 2017/18. However, during COVID-19 Pandemic holding letters were sent to every complainant explaining there would be delay in responding to concerns raised whilst the Trust were managing the pandemic.
- 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.


Royal Stoke - Complaints Opened by Month 2019/20
No of Complaints
90
80
70
60
50
40
30
20
10
0
62
60
43
45
70
53
85
38
36
57
46
40
Apr-19
May-19
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
Mar-20


County Hospital - Complaints Opened by Month 2019/20
No of Complaints
14
12
10
8
6
4
2
0
11
12
12
3
6
6
12
9
6
8
7
3
Apr-19
May-19
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
Mar-20


Royal Stoke - Full Year 2019/20 Top 90.2% of Complaints By Type
4.5%
5.5%
9.3%
35.0%
11.1%
11.4%
13.4%
[KO41] Clinical Treatment
[KO41] Patient Care
[KO41] Appointments including delays and cancellations
[KO41] Communications
[KO41] Values & Behaviours (Staff)
[KO41] Admissions, discharge and transfers excluding delayed discharge due to absence of care package
[KO41] Waiting Times


County Hospital - Full Year 2019/20 Top 91.9% of Complaints By Type
5.0%
7.5%
8.5%
31.8%
9.5%
11.7%
17.9%
[KO41] Clinical Treatment
[KO41] Values & Behaviours (Staff)
[KO41] Patient Care
[KO41] Admissions, discharge and transfers excluding delayed discharge due to absence of care package
[KO41] Waiting Times
[KO41] Communications
[KO41] Appointments including delays and cancellations

## 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.

**You said:** You were told by your Consultant that you would receive Physiotherapy but this did not happen.
**We did:** The therapy discharge documentation has been reviewed, to ensure that there is a fully robust process in place

**You said:** That you were unhappy with your relatives care and the lack of documentation on wound care.
**We did:** The ward is in the process of producing a separate documentation sheet solely for the purpose of wounds and dressing changes. This concern has also been discussed with staff in ward meetings alongside patient's notes to give examples of the lack of documentation.

**You said:** That you were unhappy that you were not weighed at your appointment, only given a blood card
**We did** A process has been put in place to ensure that in the future all patients that attend the Gastroenterology clinics are weighed prior to their consultation

**You said:** You were concerned that the Children's Emergency Department reception is unmanned, and children are opening the main doors which is allowing anyone to enter the department.
**We did:** An additional intercom system is to be installed near the main nursing workspace so that clinical staff can ensure that only the appropriate patients and relatives are allowed to enter the Children's ED area.

**You said:** The medication to treat your pneumonia was delayed in ED, as there was a confusion as to which prescription chart was being used due to there being two.
**We did**: Our ED Governance Lead and the Lead Pharmacist for Medication Safety are currently investigating ways in the Emergency Department that we can simplify the process of drug prescription as we currently use both the ED prescription chart within the casualty card and separate hospital drug cards.

**You said**: That following an iron transfusion you have had yellow marks over your arm and did not know why this was
**We Did:** Your experience and the need for ensuring that patients are fully aware of the potential consequences of an iron transfusion will be shared with the Gastroenterology Consultant Team. A Trust wide communication/memo will be sent to all clinicians with a safety alert reminding them of the potential consequences of an iron transfusion.

**You said:** You were unhappy with lack of attention to your relative's dietary needs
**We did:** As a result of your complaint Ward 15 now has an allergen box containing gluten free products. Your concerns regarding the gluten free diet will be fed back to staff to ensure lessons are learnt and to ensure that staff are responding effectively to the dietary needs and allergen risks of patients. The meal service will be monitored to ensure that this does not occur again.

**You said:** You were unhappy that your daughter was discharged from the Emergency Department without clear diagnosis of her problem
**We did**: The clinician confirms that the issue you have raised with be shared in the ED monthly newsletter, so that all ED consultants can reflect and ensure if presented with a similar case, they would be mindful to consider x-ray at an earlier opportunity if appropriate

**You said**: You were unhappy with the delay you experienced waiting for bariatric surgery
**We Did:** The Bariatric Team are now looking into the possibility of restarting the treatment initiative theatre sessions in order to improve waiting times for patients.

## Priority 4:
## To promote further the use of technology to improve the efficiency and effectiveness of patient care.

During 2019/20 UHNM have promoted and improved patient care with the innovative use of technology. These include:

### World Class Surgical Robot

The surgical system consists of a four-arm robot connected to a remote console which the surgeon operates while seated. Foot pedals are used for control, and 3-D displays provide a unique depiction of the surgical field.

**February 2020 saw the exciting installation of the latest and most advanced generation of surgical robot, providing our patients with the very latest in surgical care.**

The 'Da Vinci Xi' is the second surgical robot to be used at our Royal Stoke site, making us the only Trust in the West Midlands to have two robots and the latest robotic technology. Together they will radically improve the treatment of our urology, general surgery and gynaecology patients.

The robot is the most advanced in its range and the surgical system provides a surgeon with a cutting edge set of instruments to use in performing robotic assisted minimally invasive surgery.

### Improved Vascular Patient Care

**Our Vascular patients are now being treated and discharged more quickly, thanks to the innovative work of the specialist nursing team.**

The team created a 'complex dressing clinic' to help facilitate a more timely discharge and patient flow within our surgical division. The initiative helped to save more than £40, 000 and has contributed to successful patient discharges.

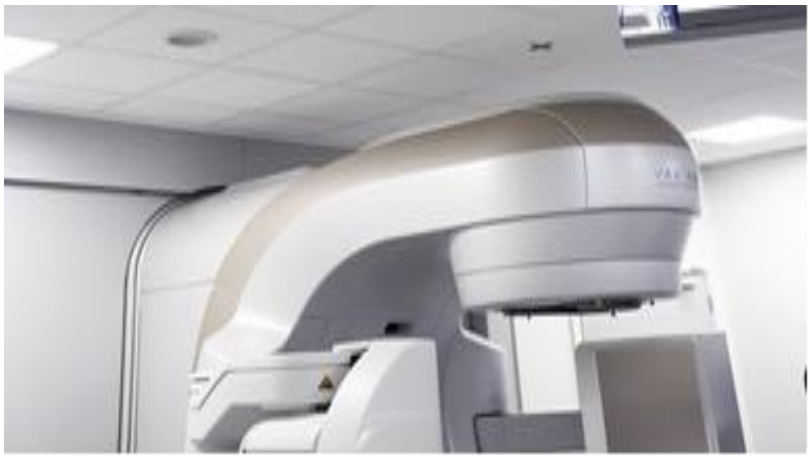
The clinic has also proven to be beneficial to the patient pathway and reducing inpatient hospital stays.

The team were invited to present the initiative at the Society for Vascular Nursing's Annual Conference in Manchester.

**New Linac Accelerator Machine**

Our new Linac Accelerator machine was installed in June 2019, providing Stereotactic Ablative Radiotherapy, a more intensive form of treatment which only causes minimal damage to surrounding organs.

The linac machine, which cost £1.7million has enabled clinicians to treat smaller tumours in areas of the body that were previously difficult to access and therefore improve change of survival and quality of life



# **Part C:** Statements from our key stakeholders

Healthwatch Stoke-on-Trent and Healthwatch Staffordshire will not be commenting this year due to being unable to distribute the draft to our volunteers nor discuss the document in the normal way due to the COVID-19 pandemic. It is our intention to fully participate and comment on the UHNM Quality Account next year.

In the meantime, we would simply pass on our sincere thanks to the staff at the UHNM who have worked so hard to minimise the impact of the Covid-19 pandemic and we look forward to renewing our contact with the hospitals early in 2021.

Stoke-on-Trent Clinical Commissioning Group

North Staffordshire Clinical Commissioning Group

Stafford and Surrounds Clinical Commissioning Group

Staffordshire & Stoke-on-Trent Clinical Commissioning Groups (CCGs) are pleased to comment on this Quality Account 2019/2020.

The quality assurance framework that Commissioners use reviews information on quality, safety, patient experience, outcomes and performance, in line with national and local contractual requirements. The CCGs' Quality representatives meet with the Trust on a monthly basis to seek assurance on the quality of services provided. The CCGs work closely with the Trust and undertake continuous dialogue as issues arise, attend relevant Trust internal meetings and conduct quality visits to clinical areas to experience the clinical environment, listening to the views of patients and front line staff.

The CCGs would like to recognise the Trust's commitment to improving quality as demonstrated by the following achievements:

- 29% reduction in rate of Patient Safety Incidents with harm per 100 admissions from 2018/19 to 2019/2020
- 34% reduction in Category 2 and 49% reduction in Category 3 Hospital Acquired Pressure Ulcers with 'lapses in care' in 2019/20 compared to 2018/19
- 23% reduction in the rate of patient falls reported per 1000 bed days with harm during 2019/20 compared to 2018/19
- HSMR and SHMI mortality indicators are both within expected ranges
- The PLACE scores published nationally on 30th January 2020 achieved scores well above the national average.
- The CQC rated Critical Care as an Outstanding Service following the inspection June 2019

However, 2019/20 has not been without its challenges and we look forward to working closely with the Trust to see further improvements in these areas over the coming year:

- The CQC inspection rated the Trust as 'requires improvement' (summer 2019). Concerns were raised regarding the care and treatment of patients in the Emergency Department (Royal Stoke) and patients with mental health needs and those who lacked capacity to make decisions.
- The Emergency Department 4 hour performance target has for many years not been achieved. The CCG would welcome patients being seen and treated in a timely manner.
- Improvement in the Cancer 62 day standard to improve patient outcomes and experience
- Continued focused work towards achieving the 18 week Referral to Treatment standard for patients
- Strive towards ensuring and embedding learning from Never events to prevent reoccurrence
- Continued focused work on Infection, prevention control to reduce the number of avoidable hospital associated infections
- Continued improvement in Sepsis pathway and provision of Antibiotics within 1 hour

**Priorities for 2020/21**

Commissioners attended (virtually) and contributed to the development of the Trust's Quality priorities for 2020/21 and have recognised the following areas as requiring further focused work to ensure that required standards are consistently achieved:

- To continue to improve safe care and treatment to patients and to improve patient experience
- The introduction of the 'Delivering Exceptional Care programme' supported by the establishment of a new Quality Improvement Academy to build greater capacity and support staff to use established quality improvement methodologies to deliver high standards of care.
- To improve staff engagement and well being

Commissioners recognise the impact Covid-19 has had on patients, families and staff. We would like to thank all of the staff for their continued hard work, resilience and adaptability at an extremely challenging time.

We look forward to working together with the Trust to ensure continued improvement over the coming year. The CCGs wish to state that to the best of their knowledge, the data and information contained within the quality account is accurate.

Heather Johnstone
Director of Nursing and Quality
Staffordshire and Stoke on Trent CCGs

Marcus Warnes
Accountable Officer
Staffordshire and Stoke on Trent CCGs

City of
Stoke-on-Trent

Unfortunately, due to the pandemic the Adults and Neighbourhoods Overview and Scrutiny Committee has not been meeting until recently. Mindful of the pressure on our NHS colleagues and our own Health Directorate, the business we are undertaking at present is very limited. Consequently we are not in a position to comment on this year's accounts. Hopefully, we will all be in a better position in 2021 and able to comments on next year's accounts.