NHS
University Hospitals of North Midlands
NHS Trust

QUALITY ACCOUNT 2018/19

CONTENTS

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). 2018/19 has been a challenging yet exciting year for us, although we have continued to deliver on our commitment to transform health services in Staffordshire, ensuring stability and future resilience.

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

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

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

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

Royal Stoke University Hospital

The County Hospital (Stafford)

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

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

David Wakefield
Chairman

Tracy Bullock
Chief Executive Officer

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.

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 abandon blame as a tool and 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 skill 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:

- 8% reduction in rate of Patient Safety Incidents per 100 admissions from 2017/18 to 2018/19
- 18.5% reduction in Hospital Acquired Pressure Ulcers with 'lapses in care' in 2018/19 compared to 2017/18
- Zero Category 4 Hospital Acquired Pressure Ulcers during 2018/19
- Continued improvement in both the sepsis screening results (over 90%)and antibiotics being administered with 1 hour in Emergency Portals (over 92%)and Inpatient Areas.
- Exceeding the 95% National Target for Harm Free Care (New Harms) throughout 2018/19
- 3% Reduction in total patient falls reported and 2% reduction in overall rate of patient falls per 1000 bed days during 2018/19 compared to 2017/18
- 15% reduction in rate of harm to patients as result of falls rated as moderate harm or above per 1000 bed days in 2018/19 with 0.17 compared to 0.20 in 2017/18
- UHNM continues to compare well against peers during 2018/19 and remains within expected ranges for Hospital Standardised Mortality Ratio (HSMR)
- 14% reduction in the total number of complaints opened at UHNM during 2018/19 compared to 2017/18
- Purple Bow initiative established to provide additional support for relatives of end of life patients.
- 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
- Zero 52 week waits for surgery at end of 2018/19

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
- Continued reductions in pressure ulcers with identified lapses in care
- Cancer 62 day standard
- 18 week Referral to Treatment standard
- Staff health, wellbeing and morale

In addition and in common with many other NHS trusts we face an ever growing focus on the delivery of operational performance and cost improvement. Specifically, in March 2017 we were placed in Financial Special Measures by NHS Improvement. Our staff have responded positively and significant progress has been made in achieving the financial targets set which demonstrates our ongoing determination and ability to better manage our budgets whilst continuing to deliver high quality care and ensuring long term sustainability.
Our Quality Account for 2018/19 therefore describes our successes and also some of the challenges we face and will continue to face in the future. These challenges have guided our Quality Priorities for the year ahead.

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.

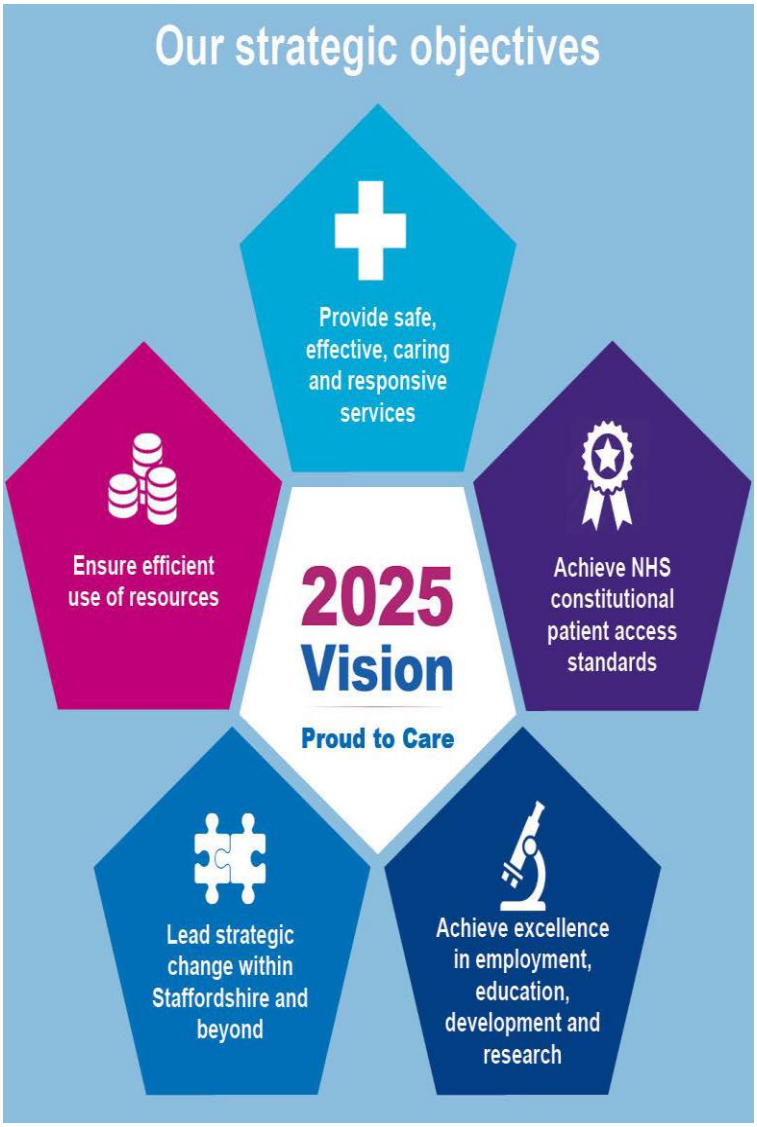
Tracy Bullock
Chief Executive Officer

David Wakefield
Chairman

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.



A Centre of Excellence – Our Awards

Key to our 2025Vision is to be a world class centre of clinical and academic achievement and care – where our staff work together to ensure our patients receive the highest standard of care and one where the best people want to work.

2025 Vision

During 2018/19 we've been doing just that and it's been fantastic to see how many awards have been received in recognition!

Health Service Journal (HSJ) Awards

We've had a fantastic year and were a regular feature at the Health Service Journal (HSJ) awards ceremonies this year, including HSJ Partnership Award win with Sodexo HSJ Value Awards win with the Mechanical Thrombectomy team who walked away with the 'Specialist Service' award and the 'Improving the Value of Surgical Services' award.

Dr Amit Arora, our Widening Participation team and Sodexo/UHNM were also finalists and the Widening Participation team were highly commended for their work around Staffordshire Whole Population Health.

Student of the Year

Lily Aston, who completed her training with us now works in the Cancer Centre at Royal Stoke was presented with the Society of Radiographers Radiography Student of the Year Award at a ceremony in November 2018.

Top 50 Healthcare Leaders

Consultant Anaesthetist and Clinical Fellow Vijay Jeganath received the Top 50 Healthcare Leaders Award at the 2018 Smart Health Conference in Dubai.

The conference brought together more than 500 healthcare professionals from across the world with the mission of improving healthcare, by facilitating an open dialogue across the industries.

Inspiring the Biomedical Workforce

Katie Berger, Quality Manager and Training Lead for Pathology won a major UK award for her work to create a programme of support staff development and deliver a new pathway to train as Biomedical Scientists.

Katie won the IBMS Award

Dedicated Service

Kath Barlow, nursing assistant was recognised for 21 years of dedicated service to endoscopy. Kath came runner up for the Ann Barson Award recently and was awarded a special trophy certificate by the Midland Gastroenterological Nurses Society (MGNS), which recognises commitment and innovation in the field.

Excellence in Infection Prevention

Infection prevention nurse Jay Lennon was given the prestigious Marian Reed award. The award was presented at the end of a three month course where professionals from across the region came together to celebrate innovation and development in infection prevention.

His presentation on his work with patients resistant to certain organisms saw him beat 22 other candidates to the accolade.

Getting it Right First Time

Our Stroke Team received recognition for the world class care they provide. The team were given plaudits from experts at NHS England's 'Getting it Right First Time' lead for stroke and were awarded our Chief Executive's Award too.

2018 New Year's Honours

Lieutenant Colonel Simon Davies was awarded at the Royal Red Cross as part of the 2018 New Years Honours. Simon, who is a major trauma nurse and an army reservist nursing officer paid a visit to Buckingham Palace in June 2018 to receive an award.

Partnership in Clinical Practice

A partnership between industry and our Stroke Team was awarded for the prestigious Medilink 2019 Acute Care Award for changing clinical practice for the prevention of VTE, also known as deep vein thrombosis, in the acute stroke pathway.

The award recognised our collaborative work with a UK based medical devices company, who, in partnership, explored the use of a trademark device for VTE prophylaxis, in the acute stroke pathway, when other VTE prevention strategies are impractical.

Priorities for Improvement

3.1 Our Quality Priorities and Objectives for 2019/20

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

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

Prioritising our quality improvement areas

We have continued our focus on quality improvement with our Patient Care Improvement Programme which is aligned to our Strategic Objectives and 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 April 2019, 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 2019/20 with a focus on continuing to improve the priorities set in 2018/19.

Our Overall Goal for 2019/20 is:

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

Aims

One: To further reduce patient harm

What we will do

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

We will achieve this by:

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

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

✓ **Recognise and respond to deteriorating patients**

- Providing strategic direction for the development, implementation and monitoring of safer care of the deteriorating patient, across the Trust.
- Reviewing national legislation and guidance and address local implications of such guidance and inform the Deteriorating Patient Steering Group of issues to be reviewed

- Maintaining an up to date and accurate risk register with associated improvement plans; progress against which will be monitored by the Deteriorating Patient Steering Group
- Reviewing outcomes of local reviews and where necessary, make recommendations to address any gaps identified
- Monitoring adverse incident reports and reflect any findings as part of the improvement plan
- Reviewing findings from audit projects and reflect any findings as part of the improvement plan
- Escalating any issues of concern to the Quality & Safety Forum
- Share best practice through Trust working groups, Risk management Panel and Quality & Safety Forum.
- Roll out of NEWS2 and VitalPak

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

✓ **Reduce by 10% patient falls resulting in moderate harm or above. We will achieve this by:**

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

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

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

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

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

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

What we will do

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

  We will achieve this by:

  - Undertaking further work at Board and Divisional level to share our vision and strategy, and progress on delivery throughout the year
  - Increasing 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
  - Responding to the Staff Survey results via the Divisional and corporate action plans
  - We will continue with our staff appreciation visits and recognition activities such as employee and team of the month awards.
  - Ensuring that the divisional people plans focus on engagement as a key objective during 2019/2020

  How we will measure our progress ?

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

  What forum we will report progress?

- Quality Assurance Committee

Three: To 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 will achieve this by:

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

How we will measure our progress?

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

What forum we will report progress

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

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

We will, by implementing the Trust's Digital Strategy, achieve this by number of key projects including:

- Migrating Electronic Referrals to the Electronic Patient Record
- Emergency Department implementation of VitalPak
- Implement the Integrated Care Record as part of the NHS Long Term Plan
- Implement the Electronic Prescribing & Medicines Administration system across the Trust
- Development of electronic Appointment Letters

How we will measure our progress?

- Progress and project reports will be monitored against key indicators for each project

What forum we will report progress

- IM&T Project Board
- Trust Executive Committee
- Trust Board

3.2 How we have performed against Quality KPIs during 2018/2019

Quality Indicator	Previous Period		Current Period	
The value of the Summary Hospital level Mortality Indicator (SHMI)	**October 2016 – September 2017** 1.04 (Band 2)		**October 2017 – September 2018** 1.06 (Band 2)	
The percentage of deaths with palliative care coded at either diagnosis and/or specialty level	39.5%		43.8%	
Patient Reported Outcome Measures scores* *(National Average)* Groin hernia surgery Varicose Vein Surgery Hip Replacement Primary Surgery Knee Replacement Primary Surgery **EQ-5D scores*	**Participation Rate 2016/17** 29.6% *(57.8%)* 2.2% *(35.0%)* 81.6% *(85.9%)* 89.5% *(94.6%)*	**Adjusted Health Gain 2016/17** 0.096 *(0.086)* - *(0.092)* 0446. *(0.445)* 0.328 *(0.324)*	**Participation Rate 2017/18** 6.5% *(49.6%)* 0.0% *(55.8%)* 67.3% *(67.0%)* 72.4% *(65.7%)*	**Adjusted Health Gain 2017/18** - *(0.089)* - *(0.096)* 0.443 *(0.468)* 0.309 *(0.338)*
Percentage of patients aged 0 to 15; and 16 and over Readmitted to a hospital which forms part of the Trust within 28 days of being discharged from hospital	**UHNS (2011/12)** 11.78% 11.89%		**No new data publication available from NHS Digital portal**	
The Trust's responsiveness to the personal needs of its patients	**2016/17 Survey** **65.1** *(England Average 68.1)*		**2017/18 Survey** **68.0** *(England average 68.6)*	
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)	**2017** **71%** *(England Average Acute Trusts 70%)*		**2018** **71.5%** *(England Average Acute Trusts 71.3%)*	
Percentage of patients who were admitted to hospital and who were risk assessed for Venous Thromboembolism (Acute Trusts) *(National Average)*	**2017/18** Q1 91.26% (95.11%) Q2 94.53% (95.21%) Q3 92.80% (95.30%) Q4 91.23% (95.89%)		**2018/19** Q1 93.4% (95.63%) Q2 94.27% (95.49%) Q3 95.34% (95.65%) 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] (Trust apportioned)	**2016/17** 19.9 *(England Average 13)* *(England Range 0 – 82.7)*		**2017/18** 15.5 *(England Average 13.7)* *(England Range 0.0 - 91.0)*	
The number and rate of patient safety incidents reported within the trust - Acute trusts (non specialist)	6244 (April – September 2017) 27.6 per 1000 bed days		*6322 (Oct 2017 – March 2018)* *26.0 per 1000 bed days*	
The number and percentage of such patient safety incidents that resulted in severe harm or death— acute (non specialist)	31 (April – September 2017) 0.5%		18 *(Oct 2017 – March 2018)* 0.4%	

[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 the Public Health England database.

Commissioning for Quality and Innovation (CQUIN) Indicators for 2018/19

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 2018/19, the targets for each scheme together with a forecast of the Trust's performance.

1.25% of income is dependent on the achievement of the CQUINs together with a further 1.25% available associated with STP support and engagement in local initiatives.

Performance against objectives

Ref no.	Indicator	Target for the Year	Performance
Main Contract CQUIN 2018/19			
	Supporting local areas: Sustainability and Transformation Partnerships (STPs)	Contribute and engage with the STP transformation initiatives. Enter into discussions with the STP on activities that will support the wider aim of integrated care and also consider local payment reform and introduction of local tariffs	*Achievement is subject to STP discussions*
1a	**HEALTH & WELLBEING – STAFF**	Achieve an improvement in 2 of the 3 NHS annual staff survey questions on health and wellbeing, MSK and stress	*Not achieved*
1b	**HEALTH & WELLBEING – FOOD**	**a) Maintain the changes introduced in 2016/17**: ban price promotions on sugary drinks and foods high in fat, sugar or salt (HFSS); ban advertisements on NHS premises of sugary drinks and foods HFSS; ban sugary drinks and foods HFFS from checkouts; ensure health options are available for staff working night shifts	*Achieved*
		b) Introduce 3 new changes: (i) Sign up to the national Sugar Sweetened Beverage (SSB) reduction scheme and SSBs sold account for 10% or less of all drinks sold; (ii) 80% of confectionery and sweets do not exceed 250kcal; (iii) at least 75% of pre-packed sandwiches and pre-packed meals contain 400kcal or less per serving	*Achieved*
1c	**HEALTH & WELLBEING – FLU**	Improve the uptake of flu vaccinations for front line clinical staff with a target to achieve 75% by the end of February 2018	*Achieved*
2a	**ANTIMICROBIAL (AMR) STEWARDSHIP: Timely identification of sepsis**	To achieve 90% of patients who met the criteria for sepsis screening were screened for sepsis	*Part achieved*
2b	**AMR STEWARDSHIP: Timely treatment of sepsis**	To achieve 90% of those patients who were found to have sepsis and received IV antibiotics within 1 hour of diagnosis	*Part achieved*
2c	**AMR STEWARDSHIP: Antibiotic review within 3 days**	To achieve 90% of patients with sepsis who are still inpatients at 72 hours following the review criteria have an assessment of a clinical antibiotic review between 24-72 hours of initiations including: ▪ The review was completed by an infection senior doctor, infection pharmacist or senior member of the clinical team ▪ There was a documented outcome of the review ▪ Clear documentation whether an IV to oral decision was made or if the patient remained on IV antibiotics including a rationale for not switching	*Achieved*
2d	**AMR STEWARDSHIP: Reduction in antibiotic consumption**	▪ Reduce the total antibiotic consumption by 2%	*Not achieved*
		▪ Reduce the total Carbapenem use by 2%	*Achieved*
		▪ Increase the proportion of AWaRe antibiotics by 1%	*Achieved*

4	IMPROVING SERVICES FOR PEOPLE WITH MENTAL HEALTH NEEDS WHO PRESENT TO A&E	▪ Maintain a 20% reduction for the 2017/18 cohort against the 2016/17 baseline	*Achieved*
		▪ Identify a new patient cohort and achieve a 20% reduction in their attendances to A&E in 2018/19	*Achieved*
		▪ Improve the Emergency Care Dataset data quality to 95% completeness for Chief Complaint, Diagnosis, and Injury Intent by the end of Q4	*Achieved*
6	ADVICE & GUIDANCE (A&G)	Develop and operate A&G services for non-urgent GP referrals, allowing GPs to access consultant advice prior to referring patients in to secondary care. Operationalise A&G services for specialties covering at least 75% of GP referrals by Quarter 4 2019	*Achieved*
		80% of A&G requests responded to within 2 days	*Achieved*
		95% of A&G requests responded to within 5 days	*Achieved*
9	PREVENTING ILL HEALTH BY RISKY BEHAVIOURS	a) Tobacco screening: 90% of patients screened	*Achieved*
		b) Tobacco brief advice: 90% of applicable patients given advice	*Part achieved*
		c) Tobacco referral and medication offer: 30% compliance	*Part achieved*
		d) Alcohol screening: 50% of patients screened	*Achieved*
		e) Alcohol brief advice or referral: 80% compliance	*Achieved*
Specialised Contract CQUIN 2018/19			
1	HAEMOPHILIA HAEMTRACK PATIENT HOME REPORTING	1) Faster adoption of prioritised best value Factor VIII products as they become available 2) Improving MDS data quality for Factor VIII products and reconciliation data 3) Improving data quality associated with outcome databases	*Achieved*
2	DOSE BANDING FOR ADULT INTRAVENOUS ANTICANCER THERAPY	Implementation of nationally standardised doses of SACT using the dose-banding principles and dosage tables published by NHS England	*Achieved*
3	SHARED DECISION MAKING (SDM)	**Renal** – to ensure all relevant treatment options are discussed with patients, to enable choices aligned to a patient's overall needs and values and clinical ability to benefit	*Achieved*
		Respiratory – continuation of SDM scheme from 2017/18 demonstrated through patient feedback	*Achieved*
		Cardiology – continuation of SDM scheme from 2017/18 demonstrated through patient feedback	*Achieved*
4	CYSTIC FIBROSIS PATIENT ADHERENCE (ADULT)	Improved adherence and self-management by patients, enabling better health outcomes and much less time off work and other life activities.	*Achieved*
5	COMPLEX DEVICE OPTIMISATION	Enhancement and maintenance of local governance systems to ensure compliance with national policies and specifications; development of sub-regional network policies to encourage best practice when determining device choice; ensure that referral pathways and robust MDT decision making processes are developed for complex and clinically unusual cases, revisions and lead extractions	*Achieved*
6	SPINAL SURGERY: NETWORKS, DATA, MDT OVERSIGHT	Establishment and operation of regional spinal surgery networks, data flows and MDT for surgery patients. The scheme aims to promote the better management of spinal surgery by creating and supporting a regional network of a hub centre and partner providers that will ensure data is collected to enable evaluation of practice effectiveness and that elective surgery only takes place following MDT review	*Achieved*
7	MEDICINES OPTIMISATION	Adoption of best value generic/biologic products of existing and new patients	*Achieved*
		Increased use of cost effective dispensing routes for outpatient medicines	*Achieved*
		Reporting of all NHSE excluded drugs dispensed data to the Trust pharmacy systems	*Achieved*
8	PAEDIATRIC NETWORKED CARE	Aligns to the national Paediatric Intensive Care service review and aims to gather information which allows the demand across the whole paediatric critical care pathway to be considered	*Achieved*

9	**ARMED FORCES**	Embedding the Armed Forces Covenant to support improved health outcomes for the Armed Forces Community	*Achieved*
10	**AAA SCREENING**	Identify and reduce local inequalities in abdominal aortic aneurysm screening	*Achieved*
11	**BREAST SCREENING**	Identify and reduce local inequalities in breast cancer screening	*Achieved*

To note, that the above is subject to final submission in April and review by Commissioners for agreement that the associated milestones have been met

For further information, please contact Trish Rowson, Associate Chief Nurse, Quality & Safety, on 01782 675679

4. Patient Story

4.1 Thank you to Maternity Services "Just keep doing what you're doing"

Our daughter, Emily, was born in February 2017. She was delivered at Royal Stoke Hospital under some very complicated circumstances and sadly, due to those complications Emily passed away shortly after she was born. Throughout the pregnancy we received the absolute highest standard of care, not just in a clinical sense but also a humanistic one. This continued to be the case during our five days staying in one of the forget-me-not rooms. We met some absolutely incredible people during those difficult 29 weeks; people we will never forget and people that we hold close in our hearts.

On returning home we spent a lot of the following months supporting various charities such as the North West Human Milk Bank, Aching Arms, 4Louis and University Hospitals of North Midlands. Then, to our delight, we received some fantastic news in early autumn that we were expecting again. The pregnancy was a nervous time however, with the care from our consultant, our community midwife and the rest of the hospital staff, we made it through to 38 weeks with no issues and far less anxiety than we had anticipated. Our previous consultant was an incredible man but unfortunately he wasn't able to consult on the pregnancy this time round. We were absolutely delighted when our son, Harry Alexander, was born (via C-section) on 24th May 2018 at 38 weeks and 1 day.

So why are we writing this letter to you? Well, it's very simple; we wanted you to know that the best day of our lives was made even more special by your absolutely incredible staff.

Throughout the pregnancy we were under the care of our consultant and the bereavement midwives. Even though we had since moved house it was arranged that we could also keep the same community midwife. They really looked after us, kept us at ease and whenever we needed to speak to someone, they were there.

Fast forward to May 24th, delivery day. It just so happened to be my birthday on that day as well as the birthdate of Harry. A lot of the staff that helped to deliver Emily had asked to help deliver Harry, it was a request that meant a great deal to us and one we were glad to accept.

It was also Helen's final day as a midwife at the hospital. She helped us massively through the previous complicated pregnancy with Emily; it was amazing to have her with us once more.

It felt like the operating theatre was filled with friends and people that had been with us on our journey over the last 12-18 months: the whole atmosphere was so positive and so relaxed. It was clear that everyone had made a real effort to make this a completely different surgical experience from our last one.

There was some background music being played in theatre. My wife, Tracy, was asked if she had any particular taste, to which Tracy answered: "Oasis". So a little bit of Oasis was played as Tracy was getting prepped. A member of the surgical staff, Kim, started to sing a little to some of the Oasis songs, it was lovely. As the surgery started she asked Tracy if she had any special requests. Tracy asked her if she knew the song

'Thousand Years' by Christina Perri as that was the song Tracy walked down the aisle to at our wedding. She didn't have the song at hand so instead she started to sing it...

Harry was actually born as Kim was singing the chorus to the song that meant the most to us, she sang loudly and she sang it brilliantly. It's a moment that neither Tracy nor I will ever forget, it was absolutely incredible. There were a lot of tears shed in that theatre at 09:16 on 24th May. Our anaesthesiologist commented that it was the most memorable C-Section he had ever experienced and that he had done over 5000 of them. Harry was put straight onto Tracy for skin to skin which is exactly what we wanted, I even got to cut the umbilical cord. Just before we were wheeled into recovery, all of the staff formed a semi-circle around us and sang happy birthday to Harry and I. Unexpected, but absolutely lovely.

In all honesty, I don't think my description of events has done it much justice. It was simply incredible and something that both Tracy and I will always hold close to us. We look forward to the day that we can tell Harry the story about his birth and the superb people that made it so memorable.

On a final note, a medical student was on ward 206 on the day we were discharged, she was looking for interesting cases to write up. She took a full history of everything that happened with Emily and Harry. Before she left, she asked if there was anything we could suggest to further improve the care we received. We both looked at her blankly, we simply could not suggest how the service could have been any better; we felt genuinely cared for and were treated wonderfully. All we could manage was:

"Just keep doing what you're doing"

We couldn't be more thankful for everything the staff at Royal Stoke (plus our community midwife) have done for us. We did try and thank everyone in person whilst we were there but if you could thank them yet again it would be greatly appreciated. The maternity unit at Royal Stoke has a fantastic reputation, it's obvious to the both of us that its reputation is well deserved.

4.2 Working together for the benefit of the patient and the carer

My wife had numerous health problems over the last few years of her life and I became her main carer. On the 14th February 2018 I helped her into bed as normal and when I turned around to get her eye drops she tried to stand and fell out of bed. She fell on top of me so I broke her fall but I noticed that she had burns on her feet from the carpet. When we woke the next morning her leg was very swollen so we came to County hospital and a fractured ankle was diagnosed. Her toes looked ok but the doctors wanted to be sure so they strapped her up and sent her to Royal Stoke to have the blood flow in her leg checked. They gave her a special boot and we came home under the care of the district nurse.
Unfortunately the friction burns on my wife's toe didn't heal and started to get worse. The GP prescribed pain killers but I was extremely worried so I phoned the hospital for advice. Donna in the plaster room asked me to bring her in the next day and she called the doctor as soon as she saw my wife's foot. The doctor was also very concerned and phoned Stoke immediately insisting that she was seen by a specialist. She was taken to Accident and Emergency, was seen immediately, and quickly moved onto Ward 105. My wife stayed in the Royal Stoke Hospital for a week but they couldn't operate as there was no room in theatre so she came home for a week and then returned to Ward 110 but they were still extremely busy so she had to wait for a few days. I remember she was in awful pain during this time. She was on very strong intravenous antibiotics but just couldn't fight the infection.

The doctors were not happy about the circulation in my wife's leg and told us she needed two stents, one in her tummy and one in her leg. They performed a washout and it was a relief to see her leg return to its normal colour. Sadly the stents started to leak and the poison went back into her body. The doctors told me that they would normally proceed to an amputation at this stage but they were extremely concerned as they didn't think that my wife would be strong enough to go through this.

We had good days and bad days. One day I thought we were going to be ok and she would get through this and then she would take a bad turn and I would fear the worse. I think my wife knew how poorly she was and she did ask to see a pastor. I know these visits offered her comfort as she was able to talk through a lot of things that were bothering her.
One day I popped home for a change of clothes and as soon as I stepped through the door I received a phone call from the nurse asking me to return as quickly as possible as my wife was screaming and they were very concerned about her. I was so tired that I had to ask a friend to drive me back. When I returned she was in such a state that it took me about 3 hours to calm her down but she eventually settled and we had a good day together. I knew from that day that I would need to remain with her constantly and the nurses supported this. They provided me with meals and a bed and we were both looked after so well.

A fortnight before my wife died she told me that her dad, mum and sister (who were all deceased) had told her that they wouldn't let her go as her time hadn't come yet. My wife was much calmer during this time as I was with her the whole time. I put her to bed and fed her each day. Everyone looked after her really well the whole time she was in hospital. Although no one actually told me she was going to die I was told that she was seriously ill so I suspected that she may not recover.

My wife did keep telling me what she wanted me to do. I was surprised when she asked to see her older brother as they didn't always get on but she promised me she would behave herself! The family were all allowed to visit but it was quite a frightening experience for them to see her so poorly. The gangrene was slowly moving up her leg and this was very upsetting to see.

A week before she died my wife was in a lot of pain. I tried my best to console and comfort her and she asked me if she could go. I told her it was ok, she could go, although I desperately wanted to keep her. We had been married for 28 years and she was the love of my life. I watched her die over the next few days, even the

nurses were in tears at the end. They really looked after both of us during this very difficult time. Everyone, even the cleaners treated us with the utmost respect, it was like home from home. I was told she had a place at Katherine house but I talked to the nurses and they agreed we could stay on the ward.

The feeling that we both mattered to the staff was very clear. On the day my wife died a member of staff helped me to carry all of the bags to my car as they said I looked worn out. They offered a driver to take me home but I said I would be ok to drive so they made me promise to call the ward as soon as I got in to let them know I was safe.

I was smiling all the way home in the car as I remembered all of the lovely, crazy antics we got up to. I knew I needed to sleep but I couldn't so I spent the morning ringing all of the relatives and hoped I had told everybody. Of course I did forget a couple of people so when I was trying to settle off to sleep the phone kept ringing! My wife was a bundle of fun and loved by many family and friends who attended the funeral.

We were together for 40 years as she turned down my proposals 5 times before finally agreeing to marry me. She had a lot of spirit, was very outgoing and loved life and I knew early on in our relationship that she was the person I wanted to spend the rest of my life with. We finally moved in together in 1989 and one day she said to me "what are you doing on 27th January? I have booked our wedding!"

I would like to thank all of the staff who helped us through this very difficult time with true care and compassion. You really did make a difference way beyond the call of duty and we couldn't have wished for better care or attention.

5. Statement of Assurances

5.1 Review of Services

Care Quality Commission

During March 2019, the Trust received the Routine Provider Information Request and submitted the requested information for analysis by the Care Quality Commission (CQC) on 26th March 2019. The Trust has not yet received formal notification of the next inspection.

The Trust was previously inspected October 2017; 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

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

As the CQC have found strong links between the quality of overall management of a trust and the quality of its services, an additional aspect has been added as part of the new inspection regime. During November the CQC spoke with members of the Board and Senior Management Team as part of the new 'well led' visit.
The CQC rates the Trust via the 5 domains (Safe, Effective, Caring, Responsive and Well-led) and by core service. The ratings are shown below.

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

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

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

Care Excellence Framework

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

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

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

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

In addition, the Commissioners, along with NHS Improvement and NHS England, have also undertaken a programme of announced visits to the Emergency Department throughout the 2018/19. The Commissioners have also completed a number of visits to the A&E Department during times of extreme pressure. The visits supported CCGs assurance in respect of both the services it commissioned and the quality of care/support delivered to patients and carers. As part of the visits patients, carers, and members of staff offered their views on the care received/delivered in A&E.

PLACE Inspection

The 2019 PLACE inspections will be held later in the year than usual due to a national review of the documentation and process which is anticipated would be concluded by the end of March 2019. Trusts are waiting for amended questionnaires and briefing information to be issued and once this is received the inspections can be arranged for Royal Stoke and County Hospitals. The date of publication of the results will also be later in 2019 than the usual August date due to the later inspections and data collection.

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 2018/19 - 51 National Clinical Audits and 9 - 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 2018/19 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
Non- Invasive Ventilation	Yes	Awaiting action plan
Cancer in Children, Teens and Young Adults	Yes	Awaiting action plan
Acute Heart Failure	Yes	Awaiting action plan
Perioperative Diabetes	Yes	Awaiting action plan
Chronic Neurodisability	Yes	Awaiting action plan
Young Peoples Mental health	Yes	Awaiting action plan
Bowel Obstruction	Yes	Data Collection
Pulmonary Embolism	Yes	Data Collection
Long Term Ventilation	Yes	Data Collection

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 2018/19 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
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%
Cardiac Rhythm Management (CRM)	Yes	100%
Case Mix Programme (CMP)	Yes	100%
Child Health Clinical Outcome Review Programme	Yes	100%
Congenital Heart Disease (CHD)	Yes	100%
Diabetes (Paediatric) (NPDA)	Yes	100%
Elective surgery (National PROMs Programme	Yes	100%
Falls and Fragility Fractures Audit Programme (FFFAP)	Yes	100%
Feverish Illness in Children (Care in Emergency Departments)	Yes	100%
Fracture Liaison Database	Yes	100%
Hip Fracture Database	Yes	100%
Inflammatory Bowel Disease (IBD) programme	Yes	100%
Lung cancer (NLCA)	Yes	100%
Major Trauma: The Trauma Audit & Research Network (TARN)	Yes	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)	Yes	100%
Mandatory Surveillance of Bloodstream and Infections and Clostridium Difficile Infection	Yes	100%
Myocardial Infarction National Audit Project (MINAP)	Yes	100%
National Adult Cardiac Surgery Audit	Yes	100%
National Adult Community Acquired Pneumonia Audit	Yes	100%

National Adult Non-Invasive Ventilation Audit	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	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 Percutaneous Coronary Interventions (PCI)	Yes	100%
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)	Yes	100%
National Bariatric Surgery Registry	Yes	100%
National Diabetes Inpatient Audit	Yes	100%
National Diabetes Footcare Audit	Yes	100%
National Diabetes Transition Audit	Yes	100%
National Pregnancy in Diabetes Audit	Yes	100%
National Cardiac Arrest Audit (NCAA)	No	0%
National Comparative Audit of Blood Transfusion programme	Yes	100%
National Emergency Laparotomy Audit (NELA)	Yes	100%
National Joint Registry (NJR)	Yes	100%
National Maternity and Perinatal Audit (NMPA)	Yes	100%
National Ophthalmology Audit	Yes	100%
National Prostate Cancer Audit	Yes	100%
National Vascular Registry	Yes	100%
Neonatal Intensive and Special Care (NNAP)	Yes	100%
Neurosurgical National Audit Programme	Yes	100%
Oesophago-gastric cancer (NAOGC)	Yes	100%
Paediatric Intensive Care Audit Network (PICANet)	Yes	100%
Sentinel Stroke National Audit Programme (SSNAP)	Yes	100%
UK Cystic Fibrosis Registry	Yes	100%
Vital signs in Children (care in emergency departments)	Yes	100%
VTE risk in lower limb immobilisation (care in emergency departments)	Yes	100%

Corporate and Local Clinical Audits

A total of 85 clinical audit projects were completed by Clinical Audit Staff and a further 254 clinician led audit projects were registered during 2018/19. 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 Deconditioning on the Elderly Care Wards

Action	Co-ordinator	Action Completed By
In order to ensure patients are encouraged:- a) To mobilise, b) Wear their own clothes c) To be independent in activities of daily living. A Deconditioning Care Bundle was developed and implemented. Staff initiate the bundle for all patients admitted to the Elderly Care Wards.	Elderly Care Consultant / Elderly Care CNS / Matron for Elderly Care	October 2018
In order to increase patient and relative awareness of Deconditioning, a Deconditioning Patient Information Leaflet was developed and is now incorporated into the admission folders on all Elderly Care Wards.	Elderly Care Consultant / Elderly Care CNS / Matron for Elderly Care	October 2018
In order to promote the principles of Deconditioning, a Deconditioning poster is displayed on all Elderly Care Wards.	Elderly Care Consultant / Elderly Care CNS / Matron for Elderly Care	October 2018
In order to improve staff knowledge around frailty and deconditioning a bespoke seminar has been introduced as part of the year 3 Medical Student teaching programme.	Elderly Care Consultant	October 2018
In order to highlight the results and to reiterate the importance of educating both staff and patients about Deconditioning the report will be disseminated throughout the Division.	Elderly Care Consultant / Elderly Care CNS / Matron for Elderly Care	October 2018
In order to improve patient experience and outcome, the good practice and learning from this audit will be highlighted across the Trust. A re-audit will be undertaken at a Trust wide level to ensure that all patients admitted to UHNM are managed according to the principals of Deconditioning	Clinical Audit Department	May 2019

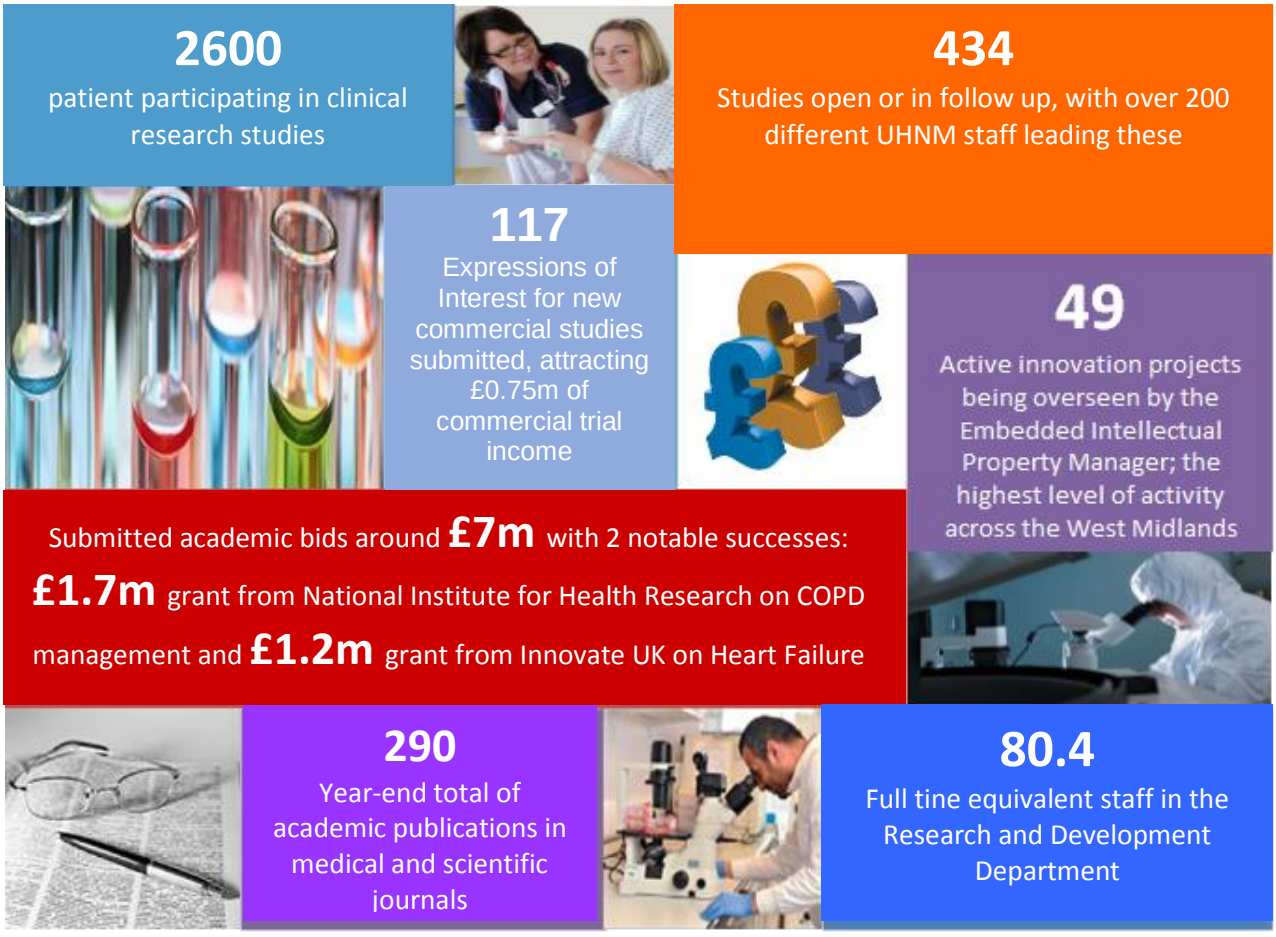
5.4 Participation in Clinical Research

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

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

- is inversely correlated with the likelihood of being in Special Measures
- 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.



5.5 Data Quality

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

A programme of regular data quality audits

- A number of data quality key performance indicators are monitored through the Trust's Data Quality Steering Group and regular updates are provided for assurance to the Executive Committee of the Trust
- An additional strategic Data Quality Programme Group has been implemented to provide assurance to the Recovery Programme Board on actions being taken to improve and maintain accuracy
- The Data Quality Strategy is supported by robust monitoring via the Trust's Data Quality Steering Group, providing an assurance framework to assist with feedback to the Executive Committee
- The Data Quality Policy has been refreshed and the strategy reviewed to include RTT data monitoring and management

2018/19 has been a productive year for the data quality team and we aim to build on this throughout 2019/20, 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 2018/19 and has maintained these results.

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

- 99.6% for admitted patient care; national performance is 99.4%
- 99.8% for outpatient care; national performance is 99.6%
- 98.0% for accident & emergency care; national performance is 97.6%

All of these results are higher than the national average.

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

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

All of these results are 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 2018/19, achieving an overall 'mandatory' rating in all areas of the audit and 'advisory' in 2 of the 4 areas audited. All recommendations from the 2017/18 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 2018/19.

The internal Staff Audit Programme has been expanded and updated for 2019/20.

The Trust now 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 2018/19, reporting less than 2% at most monthly submissions.

5.8 Information Governance Toolkit Attainment Levels

This year sees the launch of a new data security and protection toolkit. This is a self-assessment tool which the Trust must complete and submit to NHS Digital on the 31st March every year. The toolkit has been 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). A phased approach has been adopted in the implementation of the toolkit; 2018/2019 requires the completion of 32 assertions with the full 40 assertions being completed for the 2019/2020 submission.

The Trust submitted its self-assessment in line with the timeframe. All 32 assertions were achieved with 1 assertion requiring improvement: percentage of staff successfully completing the level 1data security awareness training. In line with NHS Digital guidance an improvement plan has been included as part of the self-assessment. This will be reviewed by NHS Digital and once accepted the Trust's rating will be classified as 'Standards not fully met (plan agreed)'. The Trust is currently awaiting confirmation from NHS Digital.

An improvement plan, with training trajectories, has been developed and shared across all Divisions. The improvement plan will be monitored via the Trust's Information Governance Steering Group with assurance provided at the Trust Quality Assurance Committee and Trust Board.

Part B: Review of Quality Performance

6. Quality Priorities 2018/19

In 2018/19, in partnership with our stakeholders we identified 4 specific priorities to focus on:

One: To keep our patients safe and free from harm

Two: To improve staff engagement, resilience, feeling valued

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

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

Priority 1:
To keep our patients safe and free from harm

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

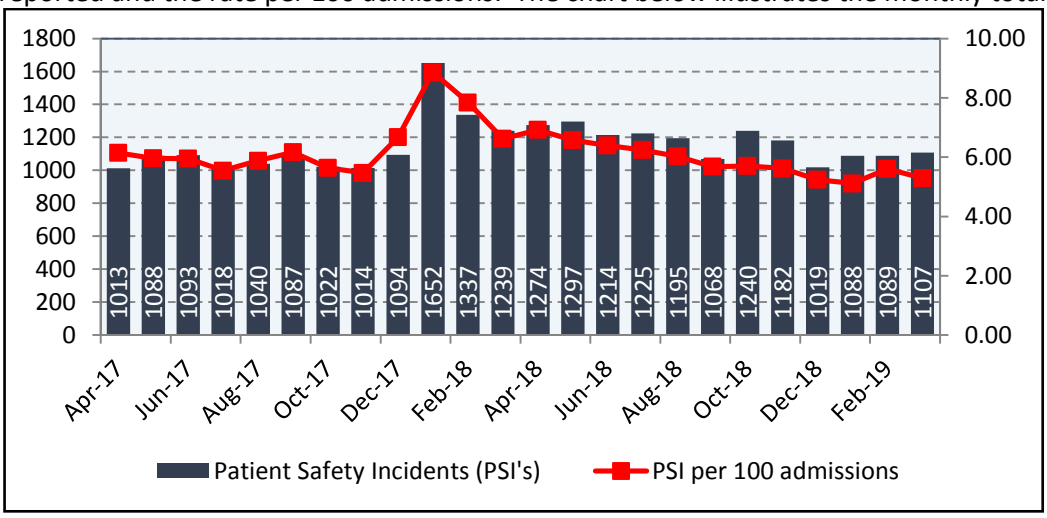
As an organization we stated that we would improve safety of our patients by

- ✓ **Improve timely recognition and treatment of Sepsis.**
- ✓ **Reduce harm from falls by 20%.**
- ✓ **Eliminate avoidable hospital acquired grade 4 pressure ulcers and reduce the incidence of avoidable grades 2 and 3 pressure ulcers by 5%. We will achieve this by:**
- ✓ **Improve the confidence of staff in the application of Mental Capacity Act assessments**

Performance against this priority and its aims has been monitored during 2018/19 using a range of key indicators. The following section provides a summary of the performance for these indicators and what these results mean for our patients.

Patient Safety Incidents

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

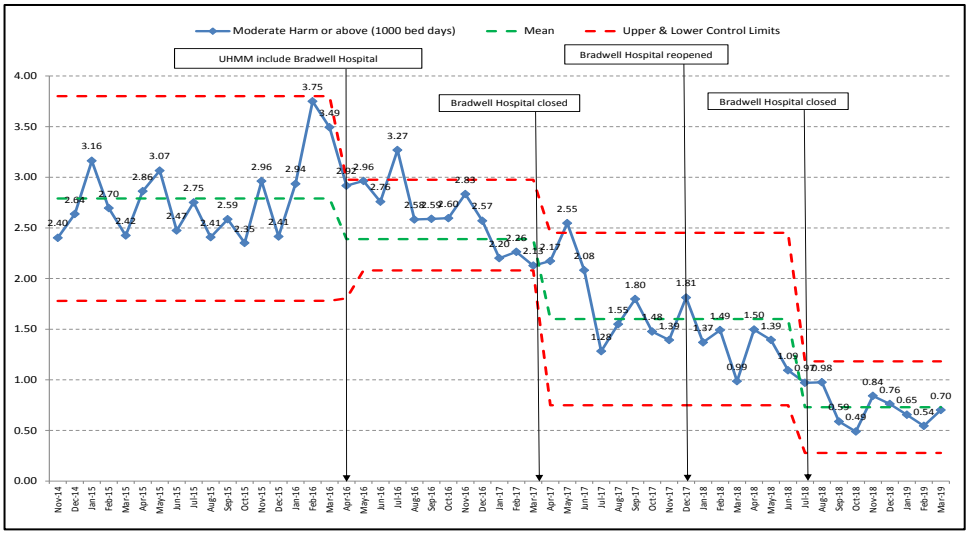


2% increase in total reported Patient Safety Incidents from 2017/18 to 2018/19

8% reduction in rate of Patient Safety Incidents per 100 admissions from 2017/18 to 2018/19

During 2018/19, UHNM has seen increase in the total number of patient safety incidents but the rate of patient safety incidents has reduced. This means that whilst UHNM has seen increased activity, the safety of our patients has continued to improve with less patients experiencing harm whilst receiving care at UHNM.

** Includes Patient Safety Incidents that are reported to NRLS*



Despite the increases in the number of total PSIs being reported, the level of harm as a direct result of the reported incidents is continuing to show improvements.

47.5% reduction in rate of incidents recorded with moderate harm or above

Never Events

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

6 reported Never Events during 2018/19

Retained foreign object post procedure - retained guidewire (x2)

2 separate incidents in NICU and PICU where guidewires used for the insertion of Central Venous Catheters were retained in error. Both guidewires were identified later and safely removed. Neither patients suffered any harm as a result of the retained guidewires.

Learning identified / Actions taken:

- Removed all CVC sets that contain 2 guidewires from unit so that all packs are standardised and staff aware that all CVSC sets only use 1 guidewire.
- Introduced safety checklist for invasive procedures (Local Safety Standards for Invasive Procedures) which includes a 2 person check and sign off on the guidewires pre and post procedure.

Transfusion of ABO incompatible blood component

Patient attended the Emergency Department having suffered a ruptured aneurysm associated with acute kidney injury. Patient was haemodynamically unstable and required life-saving surgery – which was successful. During resuscitation patient received 1 unit of ABO incompatible blood (pt group O donor group A)

Patient suffered no adverse consequences of this incident, recovered well and was discharged over a week later. Noted fast escalation of error by BMS involved

Learning identified / actions taken:

- New 2 person check to minimize future error and this is noted by staff as being sustainable process moving forwards. SOPs are in place and training is thorough.
- Key root cause relates to improving the IT system to allow the issuing of automated alerts in the case of attempted issue of incompatible blood products for patients who have no previous blood group recorded.

Retained foreign object post procedure – retained swab

Following a gynaecology procedure patient was discharged and pulled out swab at home. No harm caused to patient as result of alleged retained swab. Incident is still under review.

Wrong site surgery

Patient attended the Central Treatment Suite excision of lesion on tip of nose under local anaesthesia. Consent was obtained and incorrect lesion was marked to be removed. The Surgeon carrying out the procedure was told by the patient after completion that the wrong lesion was removed

Wrong implant / prosthesis

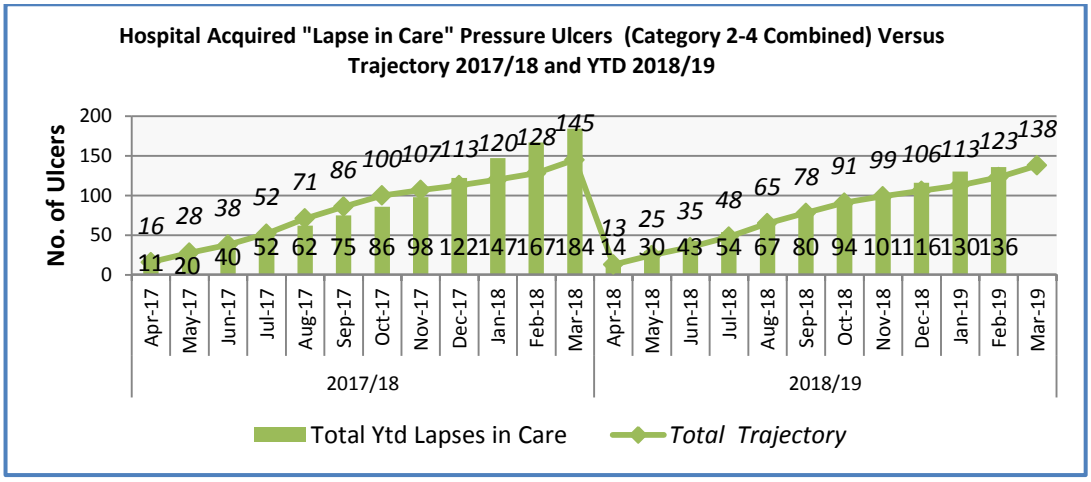
Patient attended the Poswillo Cataract Suite for a Left Phacoemulsification and intraocular lens implant. During the pre-operation round the left eye was marked and examined as planned. A lens based on the biometry for the right eye, instead of the left eye was selected for the operation. The incorrect lens was then inserted into the left eye. The lens implanted was 1 dioptre less than the correct lens that would have been used. The Consultant did not realise that the incorrect lens was inserted until the patient had been discharged. The patient was recalled and a conversation was had with the patient. Patient declined any further treatment and no harm to patient as result of the incident.

Learning identified / Actions taken:

- Adopted Ophthalmology specific WHO Surgical Safety Checklist
- Ophthalmology Service have adopted to use a sticker on Biometry sheet and integrate into process of WHO checks.
- Current biometry data sheet has been updated to reflect the change in manufacturer of the available lens.

Hospital Acquired Pressure Ulcers

We are currently slightly above trajectory to achieve 5% reduction of Hospital Acquired Avoidable Grade 2 to 4 pressure ulcers during 2018/19*



18.5% reduction in Hospital Acquired Pressure Ulcers with 'lapses in care' in 2018/19 compared to 2017/18*

0 Category 4 Hospital Acquired Pressure Ulcers during 2018/19*

*Current position as at 17/04/2019, awaiting final validation

Improvement in Sepsis Recognition and Treatment

During 2018/19, there has been continued improvement in both the sepsis screening results and anitibiotics being administered with 1 hour in Emergency Portals and Inpatient Areas from the sepsis audits undertaken.

SEPSIS Audit Quarterly Summary – 2018/19

			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		282	245	86.9%	151	113	74.8%
	Qtr 2		228	213	93.4%	102	85	83.3%
	Qtr 3		416	399	95.9%	130	117	90.0%
	Qtr 4		305	278	91.1%	130	117	90.0%
Emergency Portals Total			**1231**	**1135**	**92.2%**	**513**	**432**	**84.2%**
Inpatients	Qtr 1		171	114	66.7%	45	35	77.8%
	Qtr 2		163	150	92.0%	35	30	85.7%
	Qtr 3		219	209	95.4%	17	16	94.1%
	Qtr 4		166	151	91.0%	15	12	80.0%
Inpatients Total			**719**	**624**	**86.8%**	**112**	**93**	**83.0%**
Grand Total			**1950**	**1759**	**90.2%**	**625**	**525**	**84.0%**

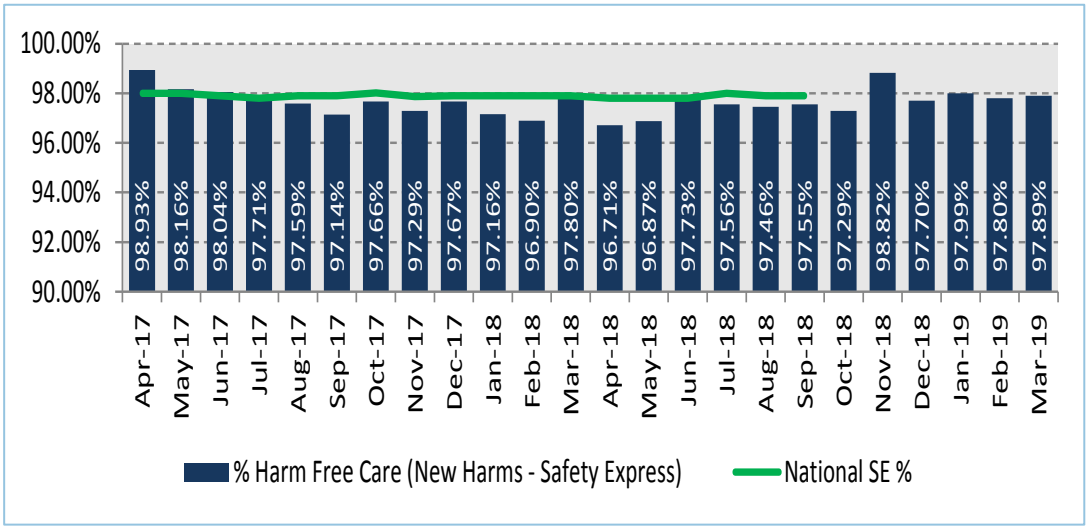
The UHNM Sepsis Team has continued to support and raise awareness to all levels of clinical/medical staff in emergency portals and in-patient areas at both sites to continue to embed the sepsis pathway and improve sepsis screening and antibiotic timeliness. These actions include:

- New band 5 staff, new band 4 staff and Trainee associate nurse and Nursing students receive sepsis training
- Robust action plans remain in place as well as working closely with front line staff have created a significant impact to our Sepsis CQUIN achievement; still on-going
- Regular sepsis update regarding compliance via divisional meeting/ MDT meeting
- Sepsis reinforcement continues during the winter period
- Sending Datix request to areas that are non-compliant with IVAB within the hour.
- Regular visit/ Sepsis audit in Emergency department – to ensure compliance is monitored
- Mandatory Sepsis education at induction of Junior doctors in both medical and surgical departments and Core medical, Foundation year trainee doctors (bi annual)
- Recruitment of sepsis champions within departments to enhance internal leadership
- Date for Sepsis champion's lunch meeting will be arranged following Sepsis Grand Rounds.
- The sepsis team is also working closely with Maternity senior team and clinical staff. Also involved in their Matneo Sepsis project with MDT (internal & external) and have been invited to London to support and show case the multi-disciplinary work on their project.
- Sepsis E-learning for all clinical/medical staff, available since November 2018. Compliance will be closely monitored by the sepsis team and the first 3 areas/wards that will achieve 90% compliance will be awarded and will receive certificate and prize from the team.
- Sepsis Grand Round will take place at County hospital on 12th April and at Royal Stoke on the 10th May which will include a patient experience.

The Sepsis team are currently working with the **Vitalpac** team for the Sepsis module and awaiting a release date for the system to be rolled out across UHNM.

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 2018/19 the final result is 97.61% (refer to chart below).



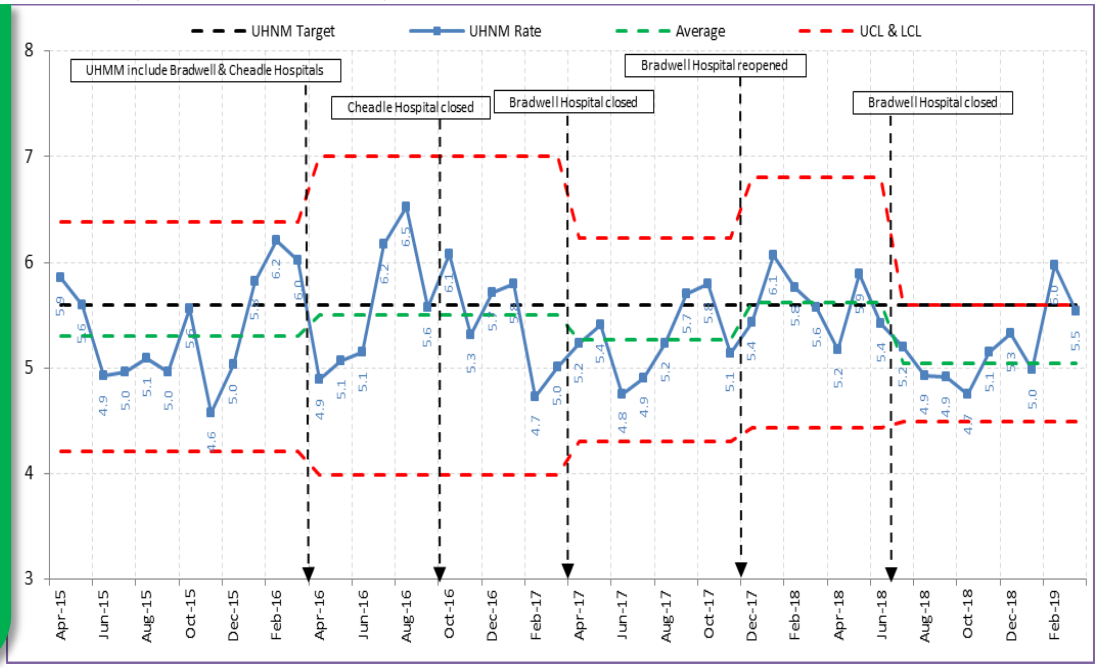
Exceeding the 95% National Target for Harm Free Care (New Harms) throughout 2018/19

Patient Falls

During 2018/19 there were 2581 patient falls reported compared to 2663 in 2017/18, 2788 in 2016/17, 2450 in 2015/16 and 2712 in 2014/15. During, 2018/19 Bradwell Hospital has been excluded since July 2018. What is important to note is that the Trust also reviews the rate of patient falls per 1000 bed days which allows for comparisons taking into account changes in activity. During 2018/19 the falls rate was 5.26 compared to 5.37 in 2017/18, 5.47 in 2016/17, 5.19 in 2015/16 and 5.54 in 2014/15.

3% Reduction in total patient falls reported and 2% reduction in overall rate of patient falls per 1000 bed days during 2018/19 compared to 2017/18

15% reduction in rate of harm to patients as result of falls rated as moderate harm or above per 1000 bed days in 2018/19 with 0.17 compared to 0.20 in 2017/18



Allied to the decrease in total falls and rate during 2018/19 compared to 2017/18, the level of harm reported for these incidents has decreased with 0.17 falls per 1000 bed days resulting in moderate harm or above compared to 0.20 in 2017/18. This is positive in the reduction of harm to our patients as a result of proactively managing patients, identifying risks and taking actions to minimize the risk, and impact, of any falls.

Mortality

Our mortality rate with current HSMR for 2018/19 year to date (April 2018 – December 2018) reported at 100.36. This means that UHNM's number of in hospital deaths is well within expected range based on the type of patients that have been treated. This compares to 103 for April 2017 - December 2017 reported in last year's Quality Account.

UHNM continues to compare well against peers during 2018/19 and remains within expected ranges

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 1.05. This is a rolling 12 month measure.

Why are the two measure different?

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

Learning from Deaths Mortality Reviews

1902 patient deaths (55% of all in hospital deaths during 2018/19) have been reviewed during 2018/19

During 2018/19, we continued to use our online Mortality Review Proforma to allow in hospital deaths to be electronically reported following review of the patient death and included the outcomes of these reviews within our quarterly Patient Safety Report which was presented at the public session of the Trust Board meetings. These reviews required reviewing clinicians to assess the care provided prior to death using the NCEPOD A-E categories. In addition, from December 2017, we adopted a more detailed review proforma based on the Royal College of Physicians Structured Joint Review form.*

During April 2018 – March 2019, the Trust have completed 1902 online proformas, accounting for 55% of all the hospital deaths recorded during 2018/19. 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 2018/19 that have also had completed reviews submitted by 31st March 2018. There are deaths that are still being reviewed as part of the Trust's local Mortality & Morbidity Review meetings but whilst the deaths may have occurred in 2018/19 the review will not have been completed within 2018/19 especially for deaths in Quarter 4 and Quarter 3.

	2018/19 Total		Q1		Q2		Q3		Q4	
Total Number of Deaths in reporting period	3486		880		786		833		987	
Total Number of Deaths in reporting period subject to review (% of total deaths)	1902	55%	620	70.5%	499	63.5%	482	57.9%	301	30.5%
Total Number of reviewed deaths with suboptimal care identified – NCEPOD grade E (% of reviews)	3	0.16%	1	0.16%	1	0.2%	1	0.2%	0	0%

* The RCP removed the scoring system on preventability following a national pilot. UHNM continue to use the NCEPOD classification system:
A: Good practice - a standard that you accept for yourself
B: Room for improvement - regarding clinical care
C: Room for improvement - regarding organisational care
D: Room for improvement - regarding clinical & organisational care
E: Less than satisfactory - several aspect of all of the above

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 SJR process that could be improved.

- Timely involvement of the Palliative Care Team and care given that met the patient's Advance Directive
- Clearer documentation and legibility in notes
- Multiple ward moves
- Inappropriate times of transfers between wards / sites
- Patient still on IV therapy despite syringe driver being used for medication
- Patient prescribed coamaxiclav which could have contributed to diarrhoea
- Delay in requesting CT scan for potential bowel perforation but delay not contribute to death
- Vancomycin levels were not checked/monitored as frequently as required

- Continued administration of medications when probably not needed
- Patient sent to Step Down but was not MFFD
- More timely referral to ITU
- Patient was taken to County Hospital instead of RSUH
- Improve communication and sharing of information – DNAR decision not well documented / communicated
- Good discussions and involvement with families and patients in discussing DNACPR decisions
- Incorrectly placed IV line in artery. Learning shared with SHO who placed line. Not contributory to death but learning point.

Hospital Acquired Infections

The Trust continues to strive to reduce the number of avoidable hospital associated infections. 2 of the key infection associated indicators that are used are Methicillin-resistant Staphylococcus aureus (MRSA) and Clostridium Difficile (C Diff). During 2018/19, we have seen reductions in like for like numbers compared to 2017/18 for C Diff and continue to see longer term improvements in reducing these infections associated with treatment received in UHNM. It is important to note that from 1st April 2019 the national definitions used for C Diff has changed, consequently there will be higher numbers expected, and the target will have increased to accommodate this change.

Indicator	2018/19 Target	2017/18	2018/19	Change
To reduce C Difficile infections	81	71	56	↓
To reduce MRSA infections	0	0	1	↑

Priority 2:
To improve staff engagement, resilience, feeling valued

What we will do

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

We will achieve this by:

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

How we will measure our progress ?

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

What forum we will report progress?

- Quality Assurance Committee

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

2018 NHS Staff Survey – The National Context and Trust Outcomes

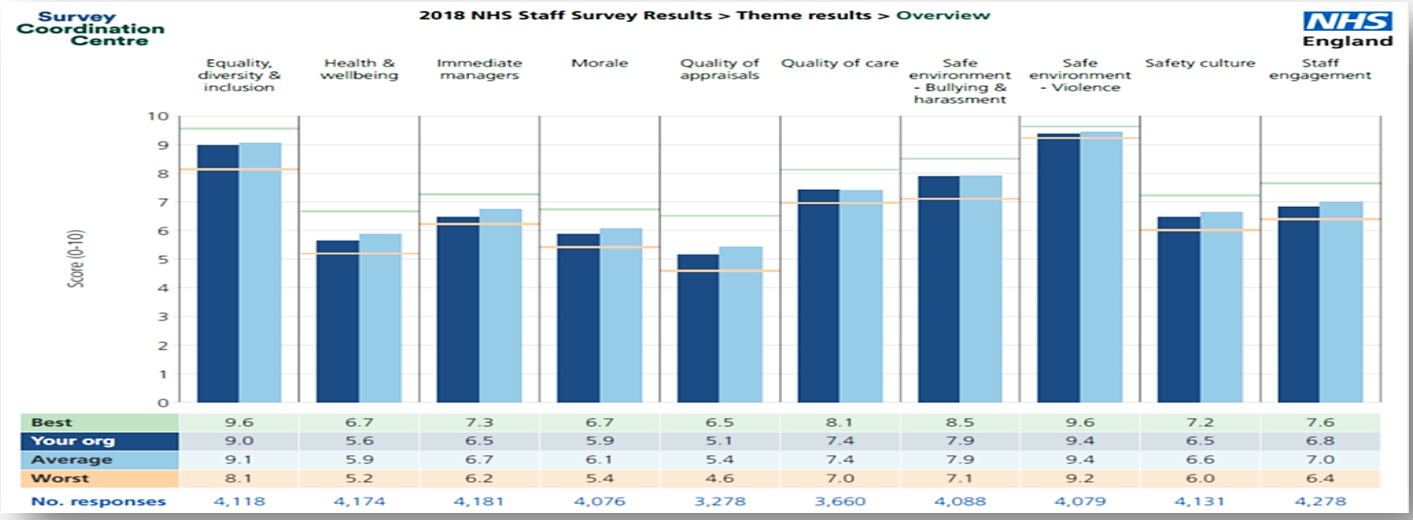
The 2018 NHS Annual Staff Survey was carried out between September and December 2018

The Annual NHS Staff Survey was open to all staff and 4307 staff took part. This was a response rate of 42%, just short of the national average for acute trusts (44%).

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.

Changes to the reporting of the 2018 Staff Survey results have seen 'Key Findings' replaced by themes. The themes cover ten areas of staff experience and present results in these areas in a clear and consistent way. All ten themes are scored on a 0-10 scale, where a higher score is more positive than a lower score. These changes mean that the theme results cannot be compared directly with the Key Finding results reported in previous years.

There were no statistically significant changes in the 2018 scores when compared to the previous year's data.



	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement
Best	9.6	6.7	7.3	6.7	6.5	8.1	8.5	9.6	7.2	7.6
Your org	9.0	5.6	6.5	5.9	5.1	7.4	7.9	9.4	6.5	6.8
Average	9.1	5.9	6.7	6.1	5.4	7.4	7.9	9.4	6.6	7.0
Worst	8.1	5.2	6.2	5.4	4.6	7.0	7.1	9.2	6.0	6.4
No. responses	4,118	4,174	4,181	4,076	3,278	3,660	4,088	4,079	4,131	4,278

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 9.1. The main issue for staff is their perception of fairness as regards career progression and/or promotion, with scores reducing from 81.6% to 80.9%
2. **Health and wellbeing** - There was a slight fall in staff perception of the Trust taking positive action on health and well-being. However, staff had an improved perception that, as an employer, the Trust does make adequate adjustment(s) to enable staff to carry out work.
3. **Immediate Managers** – Linked to the concerns about Health and Wellbeing, staff perception is that immediate managers do not appear to take a positive interest in staff health and well-being. However, there was an improvement in staff saying they received the support they wanted from immediate managers compared to the 2017 survey.
4. **Morale (a new theme this year)** - Staff have a perception that managers do not value their work; there is a lack of respect from colleagues, and that relationships are strained. Staff perception is that they want greater encouragement from managers.
5. **Quality of Appraisals** - Overall, there was no significant change in the quality of appraisals compared to 2017, although staff identified that the setting of clear objectives for their work needs improvement. Positively, there was an improvement in the percentage of staff saying their appraisal left them feeling that their work is valued by the organisation.
6. **Safety Culture** – There was no overall change in theme score, although there were small changes within specific questions:
   - There was a very slight reduction in staff feeling secure raising concerns (from 65.7% to 65.4%), and in confidence that the Trust would address and act on their concerns (from 52.7% to 52.6%)
   - There was improvement in the percentage of staff saying those involved in an error, near miss or incident are treated fairly (from 52.2% to 55.9%); and improvement in the feedback staff receive in response to reported incidents (from 53.9% to 57.6%).
7. **Staff engagement** – At 6.8, the staff engagement score is just below the acute trust average of 7.0. There were improvements in staff saying they look forward to going to work and are enthusiastic about their job. Staff

concerns are around career development opportunities via access to non-mandatory training, learning or development. There was however, an improvement in the percentage of staff who would recommend the Trust as a place to work (from 54.7% 57.2%).

8. As regards the care of patients, there was a small drop in staff feeling that the care of patients / service users is the organisation's top priority (from 71.7% to 69.3%). However, staff would still recommend the Trust as a place for treatment.

   Also, there was a positive improvement in staff saying they receive updates on patient / service user experience feedback and that this feedback is used to make informed decisions.

Next Steps

Improvement activities planned for 2019/20, aimed at creating an organisational culture where everyone is valued and is able to thrive at work, thus maximising the potential of our people to improve patient outcomes, include:

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

1. Implement the Empactis Absence System, to evidence line manager effectiveness in managing unplanned absences and to help target support and interventions.
2. Hold focus groups to gain a better understanding of what the term 'wellbeing' means to staff so that wellbeing offerings and staff support can be adjusted accordingly.

Towards improving equality and diversity, staff morale and a culture of safety:

3. We will maintain a focus on implementing the '*Just Culture'*; raising concerns, promoting diversity in the workplace and sustaining the call to action against bullying
4. Complete a culture assessment, based on the NHSI culture and leadership assessment tool, to establish the current versus desired culture state
5. We will work with Divisions to improve staff perceptions around career progression and promotion opportunities, initially by identifying and developing the organisation's high potential staff, ensuring that Succession Plans are in place across the Trust for critical roles at Band 7 upwards.

To improve the quality of Appraisals:

6. We aim to ensure all managers have the basic skills to manage effectively. Management and leadership training is being reviewed and work has commenced on setting out the top activities that managers need to perform brilliantly at this Trust. Training offerings will then be developed to deliver these activities.

Towards improving staff involvement and engagement:

7. The Service Improvement Champion approach will be re-invigorated by developing and deploying a well-supported and trained cohort of practitioners. Infrastructure will be put in place to facilitate two-way development of improvement "ideas" which read across to Transformation and Cost Improvement Plans (CIP) plans.
8. A leadership approach/strategy document will be developed, committing to a "collective leadership" approach which will be built into leadership development training.

Priority 3:
To ensure service users' experiences help to shape service developments and improvements at all levels of the organisation.

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 2018. A total of 1250 patients were sent a postal questionnaire asking them to feedback on their experience. The questionnaire consisted of 72 questions in total. 36% of patients responded.

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

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

Improvement initiatives include:

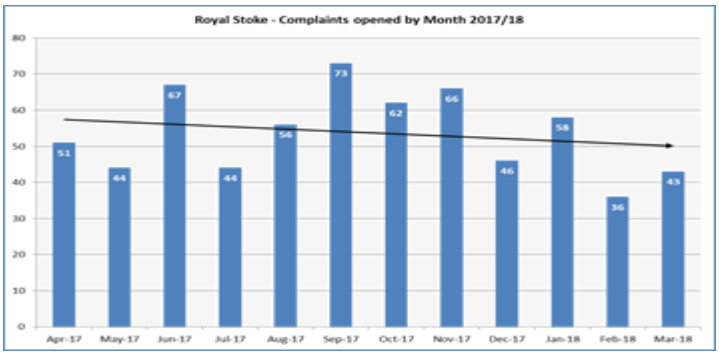
- "It's OK to ask" campaign: to encourage patients to ask the questions about their care and treatment that matter to them.
- "Top 20 wards" introduced to encourage staff to gain patient feedback about their experience of the Trust
- Redesign of patient information leaflets to promote patient awareness.
- Measurement of effectiveness of initiatives with 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 is 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.
- Outpatients achieved an Excellence Accreditation as a Health Literacy friendly department
- Production of a staff awareness video to support staff when caring for patients with hearing impairments.

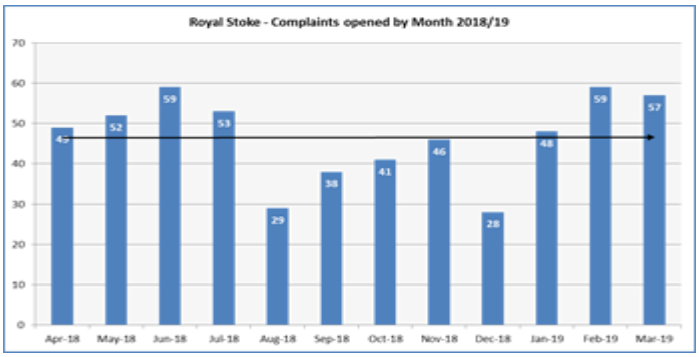
Complaints

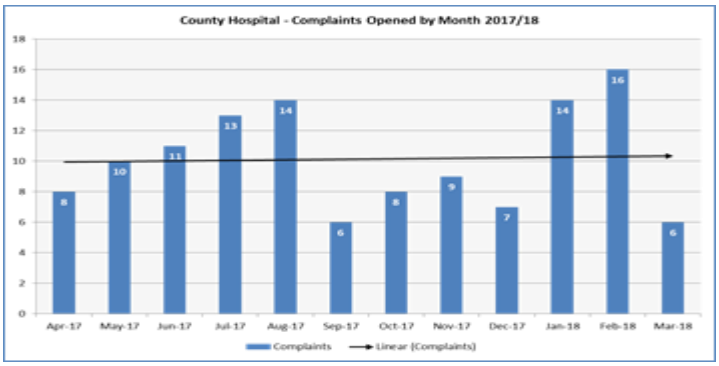
The total number of complaints opened at Royal Stoke University Hospital during 2018/19 is 559 which is a decrease of 14.7% over the same period in 2017/18 when 650 complaints were opened.
The total number of complaints opened at County Hospital was 108 in 2018/19, which is a 14.9% reduction from 2017/18 with 127 complaints received.

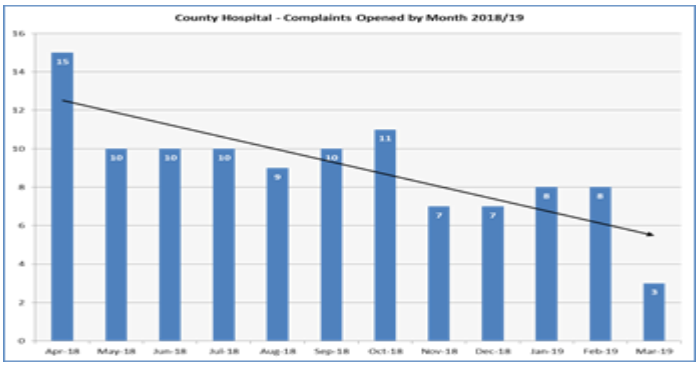
During 2018/19, the Complaints Team have achieved the following:

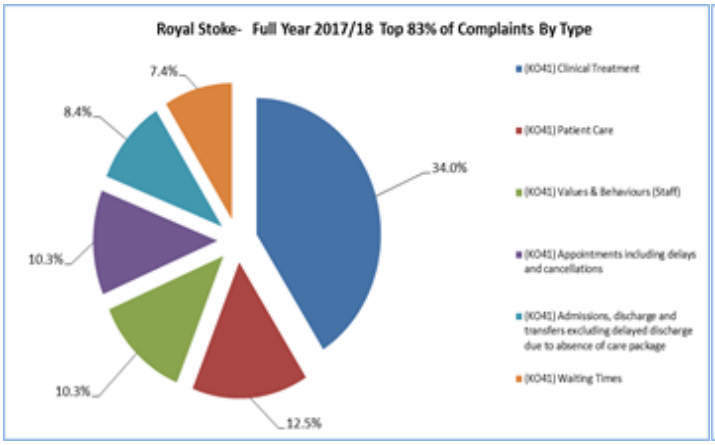
- Complaints are categorised to assist in analysing their trends and themes.
- Complaints processes have been aligned across UHNM sites so working practices are consistent
- On-going review of the current process to facilitate an improvement in the timeliness of responses from receipt of complaint to final response
- Improved consistency and quality of responses
- Average of 37.9 days during 2018/19 for complaints to be closed compared to 47.4 days in 2017/18 and 53.9 days in 2016/17
- Development of a Trust-wide Peer Review Programme which provides consistency of approach to reviewing complaints across both hospital sites and forms an integral part of the Trust's governance for evidencing the learning from complaints through a robust peer review programme.

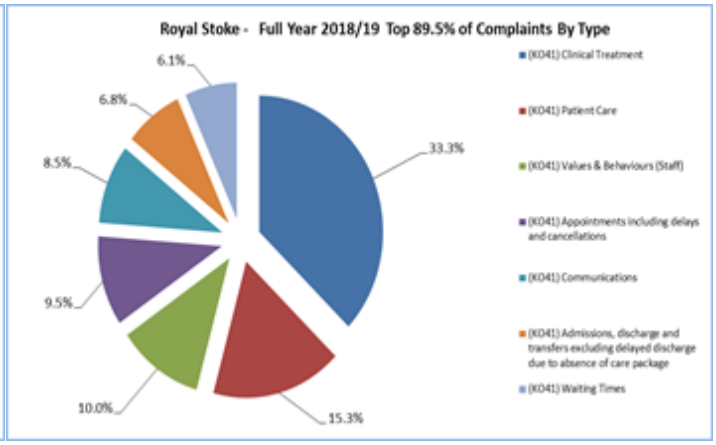

Royal Stoke - Complaints opened by Month 2017/18
Apr-17 May-17 Jun-17 Jul-17 Aug-17 Sep-17 Oct-17 Nov-17 Dec-17 Jan-18 Feb-18 Mar-18
51 44 67 44 56 73 62 66 46 58 36 43

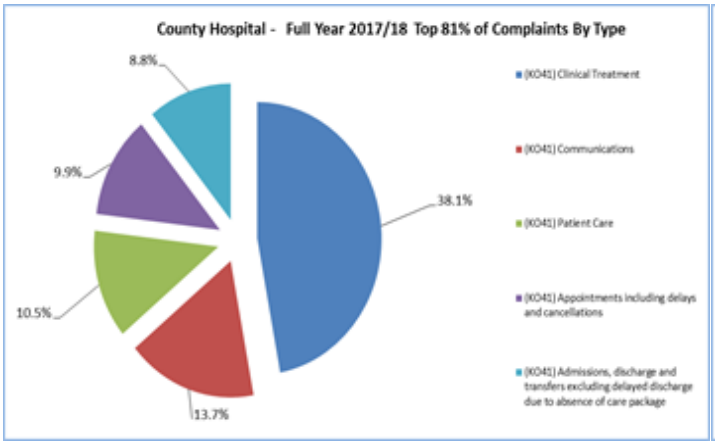

Royal Stoke - Complaints opened by Month 2018/19
Apr-18 May-18 Jun-18 Jul-18 Aug-18 Sep-18 Oct-18 Nov-18 Dec-18 Jan-19 Feb-19 Mar-19
49 52 59 53 29 38 41 46 28 48 59 57

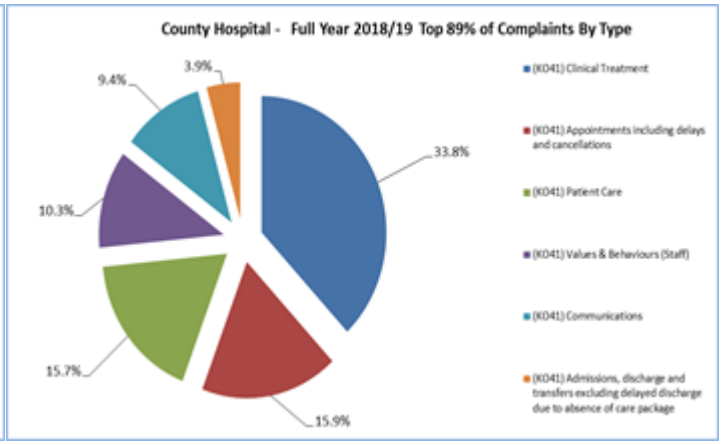

County Hospital - Complaints Opened by Month 2017/18
Apr-17 May-17 Jun-17 Jul-17 Aug-17 Sep-17 Oct-17 Nov-17 Dec-17 Jan-18 Feb-18 Mar-18
8 10 11 13 14 6 8 9 7 14 16 6
Complaints
Linear (Complaints)


County Hospital - Complaints Opened by Month 2018/19
Apr-18 May-18 Jun-18 Jul-18 Aug-18 Sep-18 Oct-18 Nov-18 Dec-18 Jan-19 Feb-19 Mar-19
15 10 10 10 9 10 11 7 7 8 8 3


Royal Stoke- Full Year 2017/18 Top 83% of Complaints By Type
7.4%
8.4%
34.0%
10.3%
10.3%
12.5%
(K041) Clinical Treatment
(K041) Patient Care
(K041) Values & Behaviours (Staff)
(K041) Appointments including delays and cancellations
(K041) Admissions, discharge and transfers excluding delayed discharge due to absence of care package
(K041) Waiting Times


Royal Stoke - Full Year 2018/19 Top 89.5% of Complaints By Type
6.1%
6.8%
33.3%
8.5%
9.5%
10.0%
15.3%
(K041) Clinical Treatment
(K041) Patient Care
(K041) Values & Behaviours (Staff)
(K041) Appointments including delays and cancellations
(K041) Communications
(K041) Admissions, discharge and transfers excluding delayed discharge due to absence of care package
(K041) Waiting Times


County Hospital - Full Year 2017/18 Top 81% of Complaints By Type
8.8%
9.9%
38.1%
10.5%
13.7%
(K041) Clinical Treatment
(K041) Communications
(K041) Patient Care
(K041) Appointments including delays and cancellations
(K041) Admissions, discharge and transfers excluding delayed discharge due to absence of care package


County Hospital - Full Year 2018/19 Top 89% of Complaints By Type
3.9%
9.4%
33.8%
10.3%
15.7%
15.9%
(K041) Clinical Treatment
(K041) Appointments including delays and cancellations
(K041) Patient Care
(K041) Values & Behaviours (Staff)
(K041) Communications
(K041) Admissions, discharge and transfers excluding delayed discharge due to absence of care package

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: As a family you were upset that your relative's nephrostomy tube was poorly managed causing her to be in unnecessary pain for the last 8 months of her life.

We did: The management of nephrostomy tubes has been raised as a clinical risk within the Trust. The risk has been included on the Trust Risk Register and there is currently a working group who are looking at ensuring a pathway is devised for patients who have nephrostomy tubes are appropriately managed

You said: You do not live in the area in fact several miles away, you attended for a scan, and were telephoned shortly afterwards and told that the scan had been carried out incorrectly and that you needed to return that evening for another scan to be performed.

We Did: The issue of using the incorrect lens has been discussed with the staff member involved and highlighted the responsibility they have to be observant when performing their role.

You said: You were unhappy that following surgery you got an infection in the wound

We did: As a result of your complaint, Senior Sister has composed a wound management advice leaflet which staff give to all patients on discharge.

You said: That you received bruising to your face during surgery

We did: The Consultant has started using soft padding to cover the face in long operations. He has also changed his practice now in long operations and he uses soft gel padding under the head, placed above the head ring

You said: You were unhappy with the delay in receiving results of your MRI

We Did: Clear instruction has been given to all reporting Radiologists, Specialist Registrars and Advanced Practitioners of the timeframes to be set, in order to ensure that all imaging events are captured, and formal reports are available to the patient's referring clinician in a timely manner

You said: You were disappointed that your follow up appointment will be over 20 weeks post-surgery

We did: The issue regarding lengthy waits for follow up appointments in the Gynaecology Clinic will be looked into and addressed in order to be able to increase clinic capacity and ensure that patients are seen in a timelier manner. Additionally all gynaecology secretaries have been spoken to and advised that when moving patient's follow-up appointments, this should be discussed with the relevant Consultant or senior management before doing so.

Part C: Statements from our key stakeholders

Healthwatch Stoke-on-Trent is once again pleased to comment on the Quality Account Statement for University Hospital of the North Midlands (UHNM) 2018/19.
The vital nature of the acute work undertaken by the Trust is recognised by everyone in Staffordshire and Stoke-on-Trent and at Healthwatch Stoke-on-Trent we continue to receive considerable feedback from members of the public, whether they be patients, family members, or carers. The overwhelming sentiment of this feedback continues to be complimentary, recognising that the medical staff all work extremely hard and provide care in a safe, secure manner, often in challenging circumstances.
In Stoke-on-Trent, we do, of course, hear complaints about the Royal Stoke site - for example, the 'hospital being too small' to handle the number of patients and the desperately inadequate car parking facilities. However, some complaints are of a more worrying nature, principally concerning falls and safe discharge.
When reading the latest Quality Account, we note that the Trust aims to become one of the top University Teaching Hospitals in the UK by 2025. While this is laudable, it is reassuring from the patient perspective to see the four Priority Quality Objectives set for 2019/20 set as:

- To further reduce patient harm, identifying specific areas such as sepsis, falls and pressure ulcers;
- Improve staff feeling of belonging – this hopefully will reduce staff turnover and mean a more stable workforce;
- To continue to increase involvement of patients, carers and the wider community with particular regard to planning and evaluation; and to
- Further promote use of technology to improve patient care.

These four objectives will continue to be the most important ones to consider in the eyes of patients and carers – an expert and committed workforce can bring improvements to patient safety and can reduce harm, using ever more effective practices, some of these involving technology. To also improve patient/carer voice in each area of care is to be commended.
It is also reassuring to see, at Section 5, the improved ratings given by the Care Quality Commission following its' original inspection undertaken in 2015. While some areas still 'require improvement' there has been a marked improvement in every area inspected. Healthwatch Stoke-on-Trent will continue to monitor progress in its' role of 'critical friend'.
As work on the Staffordshire and Stoke-on-Trent Sustainability and Transformation Partnership continues, Healthwatch Stoke-on-Trent would wish to see a greater push towards achieving better performance regarding safe, effective and timely discharge. We appreciate this requires far greater 'joined up' work between other Agencies working with UHNM (principally Stoke-on-Trent City Council and the Midlands Partnership Foundation Trust) but would urge this essential work be given the highest priority. We will continue to monitor the vital work undertaken by UHNM and trust its' endeavours to further improve will continue throughout next year.
We wish to publicly thank the Doctors, Consultants, Nurses and other medical staff who continue to provide a high level of safe healthcare to the public.

Healthwatch Stoke-on-Trent

21st May 2019

Statement for University Hospital of North Midlands NHS Trust Quality Account
Staffordshire & Stoke-on-Trent Clinical Commissioning Groups (CCGs) are pleased to comment on this Quality Account 2018/2019.

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 CCG 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 and listen to the views of patients and front line staff.

The CCGs were pleased to note the improvements made on the 2018/19 quality priorities; achievements include:

- 15% reduction in rate of harm to patients as a result of falls rated as moderate harm or above per 1000 bed days and a 3% reduction in the total number of falls reported.
- 18.5% reduction in Hospital Acquired Pressure Ulcers with 'lapses in care' in 2018/19 compared to 2017/18.
- Continued improvement in both the sepsis screening results and antibiotics being administered with 1 hour in Emergency Portals and Inpatient areas resulting in the Trust achieving the national sepsis CQUIN in Q4.
- Reduction in the number of Clostridium Difficile infections ending the year under the set threshold of 81 with 56 cases recorded.
- Improvement in uptake of the flu vaccination of frontline staff, achieving the national CQUIN standard with 75.4% frontline staff vaccinated.
- The Trust has continued to provide an open invite to commissioners, to participate in the Care Excellence Framework (CEF) visits at both Royal Stoke and County Sites. Commissioners value this opportunity to actively participate in the CEF as it is a robust quality and safety assurance system. In addition, we have also undertaken a programme of safety visits with the Trust to both Emergency Departments throughout the winter period. As part of these visits patients, carers and staff were spoken to regarding care received and delivered.

However, 2018/19 has not been without its challenges. Commissioners attended and contributed to the development of the Trust's Quality priorities for 2019/20 and have recognised the following areas as requiring further focused work to ensure that required standards are consistently achieved:

- Further Improving the Sepsis pathway,
- Recognising and responding to deteriorating patients
- During 2018/19 the Trust reported six Never Events and while this is disappointing the clinical teams involved have undertaken robust investigations which results in substantial learning and change to existing systems and processes.
- Whilst the Trust has made considerable progress in year, there is a continued focus to achieve Emergency Department 4 hour performance target.

- Continued reductions in pressure ulcers with identified learning.
- Continued improvement to sustain and improve achievement of the Constitutional Standards e.g. Cancer 62 day standard

Commissioners recognise that this year UHNM is commencing with changes to the Senior Leadership team with a new Chief Executive, Chief Operating Officer and Chief Nurse. The CCG look forward to developing new relationships and to seeing further improvements this year, building on previous work undertaken.

Commissioners note that the Trust continues to be an active partner within the Staffordshire Sustainability and Transformation Partnership. Overall the CCG recognise that significant improvements in quality and safety have been seen at the Trust during a challenging period locally but also in the wider NHS. We look forward to working together with the Trust to ensure continued improvement over the coming year.

The CCG 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

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

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

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

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

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

Introduction. We note that the document presents a clear vision, Trust values, achievements and purpose. The statement from the Board summarising the view and quality of NHS services is present. The signature of the CEO and the Chair are also present. The list of services provided is noted but more detail on any services sub contracted would have been helpful.

Priorities. The difference between the Trusts aims and priorities was not clear and could be confusing to the public. The Priorities do not contain measurable targets in order to access progress.

Links to the Care Quality Commission registration and recent inspection reports are listed along with an explanation of the Care Excellence Framework.

Regarding CQUIN income, it is noted that the 1.25% of potential income was dependent on achieving quality improvement and innovation goals agreed with the Commissioners through the CQUIN Framework, with a further 1.25% available with STP support and engagement in local initiatives. The achievements on 2018/19 priorities was not clear. Further information concerning conditions and income would also add value to the document. It was pleasing to see a link to STP initiatives.

Statements of Assurance. We note the supplementary text and relevance of the mandated information in relation to quality and services. In relation to improvement of communication with patients and stakeholders, the inclusion of the patient's stories provides a balanced account for the benefit of the reader.

We note the presence of information in respect of the participation in local and national audits and the rational applied to the process as a whole. We would suggest that the report would benefit from additional detail concerning positive outcomes and the number of patients taking part in each study.

Review of Quality Performance. Priority one and three do not contain information on how they will be achieved, measured, where they will be reported to or the next steps.

Information about specific services and specialities and what patients and public say is present. Indicators and evidence including complaints, patient and staff surveys are also included.

We note that we are commenting on a draft document; our comment is based on the information available with the expectation that the outstanding information be added before publication. On general presentation, a glossary of terms would have been useful as would a corporate logo and heading on the front of the report. Some of the text on the diagrams, for example complaint data, is so small it is difficult to read, even on line.

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

We have been engaged by the Board of Directors of University Hospitals of North Midlands NHS Trust to perform an independent assurance engagement in respect of University Hospitals of North Midlands NHS Trust's Quality Account for the year ended 31 March 2019 ("the Quality Account") and certain performance indicators contained therein as part of our work. NHS Trusts are required by section 8 of the Health Act 2009 to publish a Quality Account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010 and as subsequently amended in 2011, 2012, 2017 and 2018 ("the Regulations").

Scope and subject matter

The indicators for the year ended 31 March 2019 subject to the limited assurance engagement consist of the following indicators:

- percentage of patients risk-assessed for venous thromboembolism (VTE); and
- rate of clostridium difficile infections.

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

Respective responsibilities of the directors and Practitioner

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

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

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

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

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

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

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

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

- Board minutes for the period 1 April 2018 to 27 June 2019;
- papers relating to quality reported to the Board over the period 1 April 2018 to 27 June 2019;
- feedback from commissioners dated 21 May 2019;
- feedback from local Healthwatch organisations dated 21 May 2019;
- feedback from the Overview and Scrutiny Committee dated 17 May 2019;
- the Trust's complaints report published under regulation 18 of the Local Authority, Social Services and National Health Service Complaints (England) Regulations 2009, dated April 2019;
- the national patient survey dated 28 February 2019;
- the national staff survey dated 26 February 2019;
- the Head of Internal Audit's annual opinion over the Trust's control environment dated 24 May 2019;
- the annual governance statement dated 24 May 2019; and
- the Care Quality Commission's inspection report dated 2 February 2018.

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

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

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

Assurance work performed

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

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

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

Limitations

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

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

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

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

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

Basis for qualified conclusion

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

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

Conclusion

Based on the results of our procedures, as described in this report, except for the matter reported in the basis for qualified conclusion paragraph above, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2019:

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

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27 June 2019