## Public Trust Board

Meeting to be held on Tuesday 9th February 2016 from 1:30 pm to 3:30 pm
in the RAB Thomas Lecture Theatre, Post Graduate Medical Centre, County Hospital, Stafford

### AGENDA

<table>
<thead>
<tr>
<th>No.</th>
<th>Agenda Item</th>
<th>Purpose</th>
<th>Lead/s</th>
<th>Enclosure</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Chairs welcome and apologies</td>
<td>Information</td>
<td>Mr J MacDonald</td>
<td>Verbal</td>
</tr>
<tr>
<td>2.</td>
<td>Declarations of Interest</td>
<td>Information</td>
<td>Mr J MacDonald</td>
<td>Verbal</td>
</tr>
<tr>
<td>3.</td>
<td>Minutes of the meeting held on 12th January 2016</td>
<td>Approval</td>
<td>Mr J MacDonald</td>
<td>Enclosure</td>
</tr>
<tr>
<td>4.</td>
<td>Matters arising via the Post Meeting Action Log</td>
<td>Approval</td>
<td>Mr D Haycox</td>
<td>Enclosure</td>
</tr>
<tr>
<td>5.</td>
<td>Chairman’s Opening Comments</td>
<td>Information</td>
<td>Mr J MacDonald</td>
<td>Verbal</td>
</tr>
<tr>
<td>6.</td>
<td>Report from the Chief Executive</td>
<td>Information</td>
<td>Mr R Courteney-Harris</td>
<td>Enclosure</td>
</tr>
<tr>
<td>7.</td>
<td>Strategic Area of Focus: SO4 - Create an Integrated, Vibrant Trust and Develop Strategic Alliances with Neighbouring Trusts and Partners</td>
<td>Consideration</td>
<td>Mr A Butters</td>
<td>Presentation</td>
</tr>
<tr>
<td>8.</td>
<td>Quarterly Quality &amp; Safety Report</td>
<td>Consideration</td>
<td>Mrs L Rix</td>
<td>Enclosure</td>
</tr>
<tr>
<td>9.</td>
<td>Month 9 Performance Report</td>
<td>Consideration</td>
<td>Mrs H Lingham</td>
<td>Enclosure</td>
</tr>
<tr>
<td>10.</td>
<td>Month 9 Finance Report</td>
<td>Consideration</td>
<td>Mrs S Preston</td>
<td>Enclosure</td>
</tr>
<tr>
<td>11.</td>
<td>Emergency Care Improvement Programme Report</td>
<td>Consideration</td>
<td>Mrs H Lingham</td>
<td>Enclosure</td>
</tr>
<tr>
<td>12.</td>
<td>Strategic Objectives and Board Assurance Framework – Quarter 3</td>
<td>Approval</td>
<td>Mr D Haycox</td>
<td>Enclosure</td>
</tr>
<tr>
<td>13.</td>
<td>Monthly NTDA Compliance Return – December 2015</td>
<td>Approval</td>
<td>Mr D Haycox</td>
<td>Enclosure</td>
</tr>
<tr>
<td>14.</td>
<td>Committee Assurance Reports:</td>
<td>Information</td>
<td>Mr A Smith</td>
<td>Verbal</td>
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<td></td>
<td>• Quality Assurance Committee 21st January</td>
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<td>Mr R Courteney-Harris</td>
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<td></td>
<td>• Trust Executive Committee held 27th January</td>
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<td>Mr S Burgin</td>
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<td>• Finance &amp; Efficiency Committee held 29th January</td>
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<td>Mr Collins</td>
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<td>• Audit Committee 29th January</td>
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<td>15.</td>
<td>Questions from the Public</td>
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### DATE AND TIME OF NEXT MEETINGS

Tuesday 8th March 2016, 1:30 pm to 3:30 pm
Boardroom, Springfield, Royal Stoke University Hospital
Voting Members present:
Mr J MacDonald        JMc  Chair
Mr M Bostock          MB   Director of IT
Mr S Burgin           SB   Non-Executive Director
Professor A Garner    AG   Non-Executive Director
Mr J Marlor           JMa  Non-Executive Director
Mr A Smith            AS   Non-Executive Director
Mr N Young            NY   Non-Executive Director
Mr R Courteney-Harris RCH  Medical Director
Mr M Hackett          MH   Chief Executive
Mrs H Lingham         HL   Chief Operating Officer
Mrs S Preston         SP   Acting Director of Finance
Mrs E Rix             LR   Chief Nurse
Ms R Vaughan          RV   Director of Human Resources

Non-Voting Members of the Board present:
Mr J Simpson          JS   Director of Estates, Facilities and PFI
Mr D Haycox           DH   Associate Director of Corporate Affairs

Members of Staff In Attendance:
Mrs S Bailey          SB   Personal Assistant (minutes)

Apologies:
Mr A Butters          AB   Director of Business Development
Mr R Collins          RC   Non-Executive Director
Ms N Duggan           ND   Director of Communications
Mr D Simons           DS   Associate Non-Executive Director

In Attendance:
Members of the Public 8
Press                 2

<table>
<thead>
<tr>
<th>No.</th>
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<tbody>
<tr>
<td>1.</td>
<td>Chair’s Welcome and Apologies</td>
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<tr>
<td>001/2016</td>
<td>Mr MacDonald welcomed members of the Board, public and press to the Trust Board meeting. Apologies were received from Mr Bostock, Director of IT, Mr Butters, Director of Business Development, Mr Collins, Non-Executive Director, Ms Duggan, Director of Communications and Mr Simons, Non-Executive Director.</td>
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<td>2.</td>
<td>Declarations of Interest</td>
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<td>002/2016</td>
<td>There were no declarations of interest.</td>
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<td>3.</td>
<td>Minutes of the Meeting Held 4th December 2015</td>
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<td>003/2016</td>
<td>The minutes of the meeting held 4th December 2015 were approved as a true and accurate record.</td>
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<td>4.</td>
<td>Matters Arising via the Post Meeting Action Log</td>
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<td>004/2016</td>
<td>PTB/089 – Mrs Rix informed that the Trust were working with the HIVE which is an information network available to all members of the Service community and had been participating in many different events. Mr Hackett added that the Trust had appointed a number of military A&amp;E consultants in the last few months.</td>
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<td>5.</td>
<td>Chairman’s Opening Comments</td>
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<td>005/2016</td>
<td>Mr MacDonald noted that the timescales for recruitment of a new Non-Executive Director had been extended.</td>
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<td>005/2016</td>
<td>Mr MacDonald highlighted that the first meeting of the new Shadow Council of Governors had been successful and the next meeting was scheduled to take place on 18th January.</td>
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<td>005/2016</td>
<td>Mr MacDonald noted the junior strike which was taking place that day. Mr Courteney-Harris informed that 110 outpatient appointments had been cancelled as a result of the strike; however no surgery had been cancelled. He informed that members of the Board had visited the ward to ensure that services were being maintained and that there were junior doctors in attendance at A&amp;E, thankfully the strike had not resulted in much disruption to the Trust.</td>
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<td>6.</td>
<td>Report from the Chief Executive</td>
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<td>006/2016</td>
<td>Mr Hackett highlighted the following points from the Chief Executives report:</td>
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<td>006/2016</td>
<td>Plans have been improved in all areas to ensure the delivery of 62 day wait target in March 2016.</td>
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<td>006/2016</td>
<td>Large increase shown in cancer demand between 5-10% going to up to 20% in breast, this is partly due to campaigns and the Trust offering a one stop service.</td>
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<td>006/2016</td>
<td>Over £1m has been invested in colorectal to improve capacity for cancer care.</td>
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<td>006/2016</td>
<td>91.3% compliance with the 18 week pathway for cancer patients.</td>
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<td>006/2016</td>
<td>Update on length of stay – this has been reduced by 1 day in Medicine and has substantially improved in patients over 70 leaving the hospital earlier.</td>
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<td>006/2016</td>
<td>Continued rise in medically fit for discharge (MFFD) patients, partly due to the need to increase social domiciliary care services and out of hospital care. Trust partners are responding to this need but must be putting in extra capacity in the community. The Trust has also taken responsibility for step down beds at Bradwell, Cheadle and Leek from 1st December 2015, with a view to the Leek beds being closed from 31st March 2016.</td>
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<td>006/2016</td>
<td>The number of complaints continues to fall by over 10% in 12 months – testament to the Chief Operating Officer, Chief Nurse and Medical Director for this remarkable improvement.</td>
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<td>006/2016</td>
<td>Patient safety incidents continuing to fall, very close to the target for harm free care and substantially below the national average for falls on the County site. This best practice is being translated to Royal Stoke.</td>
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- The Trust is below the national agency cap by working hard to appoint more staff and using our own bank staff to cover any shortages.
- Trust achievements - Major progress in Thoracic surgery and the team had successfully secured expansion, demonstrated sustainable change and had recorded the highest targets across the West Midlands. Dr Sven Lehm and the TB team had successfully won the award for exemplar model in TB service for refugees.
- Modernisation of the County site continued, with £3.1m being spent on the new Renal Unit along with £1.9m investment in modern freezing catering facilities.
- 2025 vision – There had been a new Treatment Investigation Unit and second Orthopaedic laminar flow theatre has opened on the County site. The Surgical Ambulatory Care Unit has also opened successfully at Royal Stoke. The business case for a sixth MRI scanner has been approved. There were 52 substantive consultants appointed 2015. Achieved 98.8%, which was above the 75% target for flu vaccinations.

Mr Young queried, as the demand in breast care had not decreased since the campaign had ended, does the Trust have the funds to sustain this increased demand. Mr Hackett responded that the Trust try to intervene as early as possible to prevent waits increasing by putting in the capacity required. He added that the Chief Operating Officer has been asked to produce an Annual Cancer Plan and part of the Integrated Business Plan (IBP).

### 6b. Assurance: NHS Preparedness for Major Incident

**007/2016**

Mrs Lingham presented the paper and advised that the Trust had been contacted in December by Dame Barbara Hakin with a request to provide assurance to the Trust preparedness for a major incident. She stated that although there are on-going improvements to be made NHS England and Clinical Commissioning Groups awarded UHNM the highest level of assurance.

Mr Courteney-Harris commended Patrick Wilkinson, Senior Manager for Operations, for all his hard work and commitment to provide the assurance and also he has been part of the work with the junior doctor’s strike. Mr MacDonald requested that Mrs Lingham pass on thanks from the Board.

The Trust Board received the paper as assurance of UHNM preparedness for a major incident.

### DELIVERING QUALITY EXCELLENCE FOR PATIENTS

#### 7. Whistleblowing and Implementation of the Freedom to Speak Up Action Plan

**008/2016**

Mrs Vaughan presented the report and highlighted the following points:

- The policy has been update to include the Employee Support Advisors (ESA’s) and Freedom to Speak up Guardian.
- Role of Raising Concerns Manager has now been appointed and is in post.
- The Care Quality Commission (CQC) has appointed the new national freedom to speak up guardian for the NHS. Dame Eileen Sills DBE, Chief Nurse at Guys and St Thomas's Hospital NHS Foundation Trust.
- The national policy is currently out for consultation.
- There have been no formal whistleblowing matters raised during the quarter.
Mr Smith informed the Board that as the Whistleblowing Director he had attended a conference in London, following this it had been agreed that UHNM will meet with Whistleblowing Directors from other organisations to share best practice.

Mr Marlor queried how the Trust is measured on their performance for whistleblowing. Mrs Vaughan responded that there was not currently a benchmark standard and Mr Smith added that there may be something developed in the future by the Duty of Candour as organisations develop their processes and systems are put into place. Mr MacDonald stated that in part it is currently measured in the staff survey, and the Trust need to ensure that staff are aware of who they need to go to. Mrs Vaughan stated that there is an extensive training and development programme planned.

Mr Burgin queried when the national policy will be finalised. Mrs Vaughan responded that it is likely to be February/March. Mr Burgin also queried whether there are timescales set with regards to responses when whistleblowing matters are raised. Mr Smith assured that there are timescale guidelines included within the policy similar to the complaints process.

The Trust Board received and noted the report and supported the actions taken.

### 8. Month 8 Performance Report

009/2016 Mrs Lingham highlighted the following points from the performance report:

- Challenging month for diagnostic targets because our MRI scanners were not fully operational.
- Below target on 2 week cancer wait referrals due to increase in referrals particular from the South of Staffordshire.
- 62 day wait target pulled back on track for March 2016 delivery.
- RTT position – the Trust executed everything that had been planned within the winter planning including opening 3 more wards, strengthening the site team and working with partners on out of hospital capacity. The actions we all complete before the Christmas period. However, increased emergency admissions and increases in Medically Fit for Discharge patients and levels in the local health system plan had resulted in cancellations of elective surgery which impacted on December achieving the target which was missed by 1.9%.
- Discussion taking place on a daily basis with partners, regarding emergency demand.
- County performed as one of the strongest in the country for 4 hour waits in an acute setting hitting 93%, as of the 11th January this performance had been maintained.
- Increased demand at the County site, along with rising medically fit for discharge (MFFD) patients. The Trust is working with partners in the area to resolve this to ensure the Trust can deliver its annual plan targets.
- Royal stoke has seen a significant increase in ambulance demand. These levels of demand have not been seen before with a 24% increase in admissions compare to this quarter last year overall.
- Clinical engagement is excellent both internally in the Trust to deliver good care and this has been recognised by external bodies and partners.
- High number of 12 hour waits occurred early January 2016, no more cases since, these have been appropriately reported to the NTDA and the Trust very much regrets this around the impact on patients, however safety is being maintained.
- The Trust has been asked to speak nationally on safe care and overcrowding and is also the most improved Trust in cohort 1 for managing frail and elderly.
- Thanks given to the NTDA and emergency national team for their support in the programme of work for community and private care.

Mrs Rix highlighted on the quality and safety aspects of the report:
- Board assurance processes were put in place last year to ensure the safety of patients. Root Cause Analysis (RCAs) were carried out on all 12 hour waits and can assure the board that no harm was caused to the patient and they were all managed individually at the time.

Mr Courteney- Harris stated that County Hospital is very busy with a high turnover of beds and has been very challenging with staff working very hard to manage the demand there too.

Mrs Vaughan highlighted on the HR indicators within the report:
- Sickness rates have slightly improved but more focus need on this going forward
- Appraisal and Statutory and Mandatory training are at 92% and 95% for County. Congratulations were given to all the managers for their hard work by Trust Board.

Mr Burgin queried the significant increase in A&E attendance if there were reasons for this. Mrs Lingham responded that it was due to a number of issues, predominantly the increase in ambulance transfers and GP referrals, there are also different issues in different areas of Staffordshire with demand.

Mr Marlor queried whether there was a geographical link to the areas which significant increase in demand. Mrs Lingham responded that there are clearly defined areas within the city and Staffordshire and the team are concentrating to manage this and take further action. A more in-depth explanation to this will be brought back to the Board. Mr Marlor queried whether the catchment area had increased. Mrs Lingham advised that there had not been a significant increase in catchment area; the biggest challenge is to look at out of hospital care provisions, which is a system issue rather than a Trust issue.

Mr Smith stated that following a recent visit to the A&E department and seeing how busy the department is and how hard staff are working, has this had an impact on the recent cancer targets. Mrs Lingham assured the Board that there had not been any cancer work cancelled this year; this work has been protected as the most clinically urgent. Mr Smith queried, regarding the three patients being discharged with a cannula in situ which seems to be persistent each month, what is being done to prevent this. Mrs Rix stated that all emergency protocols focus on this area and the checklist should be completed at all times. On these occasions RCAs were carried out and there was no harm to the patient and the issues were rectified as soon as the Trust was made aware.

Mr Young queried whether there was any correlation to the lack of access to GP practices to the increase in hospital demand. Mrs Lingham stated that the Trust is aware of the pressures in primary care and that there needs to be some innovative solutions. She added that many initiatives were put in place to support winter pressures, of which the Trust met all the actions assigned, however primary care providers were under estimated. Mr Courteney-Harris added that work on long term conditions, of which the Trust are working on better management, would ease the
demand in the long-term. Mr Hackett stated that although there was a decrease in length of stay by a day the Trust didn’t see the benefit of this due to the increase in MFFD patients, the issue with capacity in intermediate care need to be address and discussed with partners.

Mr MacDonald concluded that the Trust is back on track with cancer targets. He expressed apologies to the patients who waited over 12 hours and did not receive the experience that the Trust would hope for, however looking back on performance last year following this demanding day, that the service managed to get back on track within two days and he recognised the effort and work by the Chief Operating Officer and her Divisional teams. Mrs Lingham added that the ECIP report had been received on Christmas Eve and had been circulated to the Chief Executive and Chairman along with members of the System Resilience Group, and action plan will be presented to the Board next time informing of the key actions for the system.

The Trust Board received and noted the report and:
1. Noted the performance in November 2015, with the key risks detailed in the report.
2. Noted the actions being taken against key risks areas are being delivered and are resulting in improvements.

DELIVERING OUR FINANCIAL OBLIGATIONS TO THE TAXPAYER

9. Month 8 Finance Report

010/2016 Mrs Preston highlighted the following points to the Board:
• At the end of November, the Trust had a deficit of £16.3m which was a £2.4m adverse variance to plan.
• The Trust had achieved savings of £15.4m to date in the CIP target.
• To date, the Trust has a cash holding of £46.7m.
• The Trust spent £30.8m on capital schemes which is £8.2m behind plan, but will catch up before the year end.
• Income is currently the main issue for the Trust.
• Struggling to mobilise and recruit staff as quickly as planned, however this is improving.
• Fines and penalties – these are levied by commissioners for the Trust not meeting their targets, there will be pressure on the Trust in this area until the end of the financial year.
• Included in other income are fines and penalties which have not yet been agreed relating to queries and challenges on our income from commissioners.
• Aiming to minimise deficit by the year end.

Mr Marlor queried, regarding cash holding, whether the Trust would incur a loss if this is not spent. Mrs Preston advised that this can happen, however the money has been identified and there is no risk.

Mr MacDonald queried the information in section 5.9 of the report, regarding transaction of capacity reserve and sought assurance from the Finance and Efficiency Committee Non-Executive Director members that they were satisfied with this. Mr Marlor and Mr Burgin assured Mr MacDonald accordingly.

The Trust Board received and noted the report.

GOVERNANCE

The Board received and approved the returns and agreed the actions to reduce risk to compliance which are summarised within the paper.

### Committee Assurance Reports

**012/2016**

**Trust Executive Committee (9th December 2015)**
Mr Hackett stated that he had nothing further to add.

**Shadow Council of Governors (11th December 2015)**
Mr MacDonald informed that a workshop was scheduled to take place on Tuesday 19th January and that the details of the governors would be displayed on the website soon.

**Finance and Efficiency Committee (21st December 2015)**
Mr Burgin highlighted that the fifth scanner had been approved by the Committee and in addition, the budget setting process and CIP process for 2016/17 had been reviewed.

### CLOSING MATTERS

### Questions from the Public

**013/2016**

Mr Wilson referred to issues with triaging patients in A&E, advised that a friend had waited 7 hours in A&E after others being seen before them who were there only for painkillers. He added that the information screen displayed in the waiting area of A&E is not clear on waiting times.

Mr MacDonald stated that waiting times and the reasons had been discussed earlier in the meeting and asked that Mrs Rix provide information regarding the processes of triage in A&E. Mrs Rix advised that the Trust are obliged to see any patient that attends A&E, however there are initiatives in place for the front of house staff to provide the patient with information of alternative places to attend. Mr MacDonald questioned as to whether this process was that same across other hospitals. Mrs Rix stated that yes all A&E departments work in this way. Mrs Lingham confirmed that best practice with rapid treatment and discharge is always the aim for each patient. She informed of a new “app” which is scheduled to be launched by the Trust and will be the first of its kind in the Country. The “app” will allow patients to view waiting times and will suggest the places available to attend for their specific problem, giving the patient a more informed choice. Mrs Lingham agreed that she would discuss the information board in the A&E department and discuss ways that this could be made clearer for patients.

Mr Wilson informed that he had been invited to attend the opening of the new MS Centre at UHNM and was advised that parking would be available on the 1st floor of the multi storey car park which is quite a distance away from the main building and is not at all suitable for patients with disabilities. Mr Simpson agreed that he would look into rectifying this issue.

Mr Syme raised the issues with integrated care and informed of his concerns that there did not seem to be any one taking a serious hold and looking at the issues in totality.

Mr Hackett informed that the decision was made by the Trust in January 2015 to take a much greater system leadership role in emergency care. The Trust also now has its own domiciliary care provider in Stoke-on-Trent, and has taken on a co-ordinating role on long term conditions as lead provider for local health economy to help improve
treatment of patients at home and in the community, as well as the direct lead provider role for community hospital and intermediate care services supporting hospital discharge. These responsibilities for long term conditions and “step-down” discharge services move to the Trust on 1st December 2015 a concept of integrated emergency care led by UHNMM. The Trust would welcome public members to advocate for this service. The Trust is currently working with capitated budget with partners. Significant progress had been made so far and there is on-going active dialogue with partners. Mr Syme agreed and stated that the public will need more information to understand what is required and added that primary care would play a key role in this project; however there is limited resources. Mr MacDonald agreed that there are gaps for capacity throughout the whole system and assured that the Trust had made many efforts to take on a more leading role in this and are heading in the right direction, however further progress needed to be made.

Mr Syme referred to the 2 week wait in breast cancer patients and stated that in October UHNMM were the fourth worst performing Trust in the Country and in addition to this performance dropped further to 11.2% in November. Mr Syme queried how and why this had happened.

Mrs Lingham responded that the 2 week wait is a standard for all Trusts however with the mix of demand the addition capacity which was put in place was not sufficient. The service is now back on track and patients are being seen within 14 days and the Trust must look at how demand is managed going forward. Patients are given the choice and are made aware of the waits. Mr Syme queried the figures for December 2015 and whether they were likely to be worse than November. Mrs Lingham informed that she was not able to provide the data for December as this had not yet been validated and that she accepted all points that Mr Syme had raised and would take all issues on board.

Press Questions:

Mr King referred to the breast cancer waiting list and questioned how many of the patients who had waited over the two weeks were seen within 15 days. Mrs Lingham responded that there was a large cohort of patients who had just tipped over the 14 day wait however she was unable to answer this specifically as she did not have the granular data available at the meeting and suggested that this information would be included within the performance report in the future. Mrs Lingham also added that referrals are prioritised clinically at all times.

Mr King referred to the specific areas within Staffordshire which currently have a higher A&E attendance rate to others, as discussed earlier, and queried where the areas of concern are. Mrs Lingham advised that she was not able to discuss this further at this point before discussing with the System Resilience Group and partners. Mr King questioned whether this information will be available in the future. Mrs Lingham assured that there would be no reason to hold the information.

Mr King queried the Trust's actions to deal with the increased number of ambulances attending A&E. Mrs Lingham advised that the Trust had agreed for the West Midland Ambulance Service (WMAS) to carry out an audit and added that the Trust will not hold an ambulance up from off-loading a patient, preventing them from getting to other patients. The Trust will always allow patients through and manage them once in A&E. Mr Courtene-Harris added that the Trust have a very positive relationship with WMAS. Mr King referred to the 41 patients who were waiting in A&E for over 12 hours and queried whether the Trust could provide assurance that this would not happen again. Mrs Lingham responded that the Trust micro-manage flow on a 24 hours basis and put plans and contingencies in place for winter however, she stated that it cannot be guaranteed that this will not happen again as demand cannot be
accurately predicted, it is clear that the system is very fragile and there is still a lot of work to be done.

Mr Blackhurst queried whether the 5 breast cancer patients reported to have waited over 28 days was due to patient choice. Mrs Lingham advised that she did not have the information to hand to confirm, however relevant information would be included within the reports to Board in the future. Mr Blackhurst questioned the queues in the clinical decisions unit and the reasons for this. Mrs Lingham informed that the Unit had been set up purposely for those patients staying for no longer than 24 hours with patient being treated by the emergency department doctors. It is a very small area which is within the foot print of the emergency department but not part of it. Mr Blackhurst questioned whether the beds scheduled to be closed at Leek will be taken on by SSOTP. Mrs Lingham informed that the future of the beds is still under discussion with SSOTP.

**DATE AND TIME OF NEXT MEETING**

Tuesday 9th February 2016, 1.30 pm
RAB Thomas Lecture Theatre, Post Graduate Medical Centre, County Hospital
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<tr>
<th>Ref</th>
<th>Meeting</th>
<th>Meeting Date</th>
<th>Subject (agenda item)</th>
<th>Action</th>
<th>Assigned to</th>
<th>Due Date</th>
<th>Done Date</th>
<th>Progress Report</th>
<th>RAG Status</th>
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<tr>
<td>PTB/088</td>
<td>Public Trust Board</td>
<td>06/11/2015</td>
<td>Questions from the Public</td>
<td>To further discuss the negative patient experience received within the AEC with Mrs Mawby.</td>
<td>Helen Lingham</td>
<td>09/11/2015</td>
<td>02/02/2016</td>
<td>Complete</td>
<td>Green</td>
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<td>PTB/089</td>
<td>Public Trust Board</td>
<td>04/12/2015</td>
<td>Report from the Chief Executive</td>
<td>To consider targetting the defence service in terms of recruiting staff for the ARTU.</td>
<td>Liz Rix</td>
<td>08/03/2016</td>
<td>These measures have been initiated recently and so effects are not yet apparent.</td>
<td>Yellow</td>
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<td>PTB/090</td>
<td>Public Trust Board</td>
<td>04/12/2015</td>
<td>Questions from the Public</td>
<td>To inform Mr Bastin of the current process in place to report duty of candour.</td>
<td>Rob Courteney-Harris</td>
<td>12/01/2016</td>
<td>02/02/2016</td>
<td>Complete</td>
<td>Green</td>
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<td>PTB/091</td>
<td>Public Trust Board</td>
<td>12/01/2016</td>
<td>Questions from the Public</td>
<td>To discuss with Mr Wilson the information board in the A&amp;E department and discuss ways that this could be made clearer for patients.</td>
<td>Helen Lingham</td>
<td>09/02/2016</td>
<td>02/02/2016</td>
<td>Discussed following the meeting and comments being taken on board.</td>
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<tr>
<td>PTB/092</td>
<td>Public Trust Board</td>
<td>12/01/2016</td>
<td>Questions from the Public</td>
<td>To discuss with Mr Wilson the distance of the parking from the main building which is offered to patients with a disability following a recent visit to the MS Centre</td>
<td>John Simpson</td>
<td>08/03/2016</td>
<td>Action not yet due.</td>
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<tr>
<td>PTB/093</td>
<td>Public Trust Board</td>
<td>12/01/2016</td>
<td>Questions from the Public</td>
<td>To provide information as to whether the 5 breast cancer patients reported to have waited over 28 days was due to patient choice.</td>
<td>Helen Lingham</td>
<td>09/02/2016</td>
<td>Update to be provided at February's meeting.</td>
<td>Yellow</td>
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**EXECUTIVE SUMMARY FRONT SHEET**

**Meeting:** Public Trust Board  
**Date:** 9th February 2016

<table>
<thead>
<tr>
<th>Title:</th>
<th>Chief Executive’s Report</th>
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<tr>
<td>Author:</td>
<td>Mark Hackett, Chief Executive</td>
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<td>Executive Lead:</td>
<td>Mark Hackett, Chief Executive</td>
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**Other meetings presented to:** Not applicable

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**Purpose**

To brief the Board on progress and achievement of the key targets in 2015/16 regarding operational performance, strategic management and quality and safety developments.

**Link to Strategic Objectives**

- Delivering quality excellence for patients ✓
- Delivering our financial obligations to the Taxpayer ✓
- To achieve excellence in education, training and research ✓
- Create an integrated vibrant Trust and develop strategic alliances with neighbouring trusts and partners ✓
- Create a resilient Urgent and Emergency Care System and Increase Integrated Healthcare Provision ✓

**Executive Summary**

This report includes summary updates regarding the following:

1. Contract Awards
2. Operational Performance
3. Staffing
4. Quality and Safety Performance
5. 2025Vision
6. Financial Performance
7. Conclusion

**Key Recommendations**

The Board is asked to receive the report for information.

**Corporate Impact Assessment (please tick any which are impacted on / relevant to this paper)**

<table>
<thead>
<tr>
<th>Quality Implications</th>
<th>✓ Financial Implications</th>
<th>✓ Legal Implications</th>
<th>✓ Workforce Implications</th>
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</table>
1. Contract Awards

Between 1st December 2015 to 31st January 2016, six new contracts were awarded:

- **Endoscopy Consumables** supplied by Boston, Cook, Diagmed for the duration of 1/1/2015-31/10/2017 at a total cost of £1,765,000 (annual value £882,500), generating savings of £134,000 approved by the Chairman 22/12/2015.

- **Contract for the Home Delivery of Recombinant Coagulation Factors for Hemophilia Patients** supplied by Healthcare at Home for the duration of 01/10/2014-30/06/2016 at a total cost of £1,605,000 (annual value £917,142) approved by the Chairman 21/12/2015.

- **Salary Sacrifice – Childcare Vouchers** supplied by Sodexo for the duration of 01/02/2016-31/01/2017 at a total cost of £780,000 (annual value £780,000), generating savings of £95,000 approved by the Chairman 22/12/2015.

- **Salary Sacrifice – Home Electronics** supplied by SME HCI for the duration of 11/06/2015-10/06/2017 at a total cost of £1,000,000 (annual value £500,000), generating savings of £68,000 approved by the Chairman 18/12/2015.

- **Heart Valves – Contract Extension** supplied by Edwards, Sorin, St.Jude and Medtronic for the duration of 01/12/2015-30/11/2017 at a total cost of £451,000 (annual value £225,500), generating savings of £30,000 approved by the Chairman 18/12/2015.

- **Provision to Rapid Response to Patient Social Care and Re-Enablement Needs** supplied to AMG Nursing for the duration of 01/11/2015-31/03/2016 at a total cost of £2,300,000 (annual value £2,300,000), approved by the Chairman 21/12/2015.

2. Operational Performance

The reports that will be considered later during the Board meeting reflect the position at 31st December 2015 and reflect that the Trust achieved a number of operational standards in diagnostics – patients waiting less than 6 weeks for a diagnostic test. This standard has been maintained since June 2015 and in December 2015 we will have reported only 25 patients out of 10,192 patients waiting who have exceeded 6 weeks, with the maximum being nine weeks. This is excellent news for Diagnostics. We forecast we will achieve 5 out of 8 national cancer standards and we are on track to deliver the 62 day cancer target for 1 March 2016.

The national standards the Trust under-achieved were in part as a result of the continued demand and capacity pressures, but also in not changing fast enough to meet patient needs. These were:

- A&E 4 hour wait standard – overall the standard was not achieved. UHNMs performance was 82.8% overall. Royal Stoke’s performance reached 80.5% - both a decrease on the previous month. 12 hour trolley waits in A&E – There was one breach of the 12hr trolley wait in December 2015. However, in early 2015 we saw 41 breaches during an unprecedented peak in demand where demand on the weekend after New Year was the highest ever.

- Cancelled operations not re-booked within 28 days – we reported four patients in this category for November 2015 (December’s data is unavailable until after the end of January 2016).

- The 18 week RTT incomplete pathway standard. We will unfortunately be reporting eight patients who, at the end of December 2015, will have waited over 52 weeks. Dates are being confirmed with the patients.

- 3 out of 8 cancer standards for: 2ww and 2ww for Breast symptomatic and 62 day GP referral Cancer Performance.

2.1 Cancer Targets

We continue not to meet the NHS Constitutional patient right to see and treat cancer patients within 62 days, despite this being one of our key priorities. The timely and sustainable delivery of cancer pathways needs to be a key focus for management and clinical teams.

As one of 19 trusts nationally that has under-achieved this target, the NTDA has accepted the Trust’s Cancer Standard Improvement Plan. In addition, each individual cancer site has produced an improvement plan and trajectory
for delivery of the 62 day standard and the associated forecast expects delivery from the end of December 2015 onwards. Delivery is dependent on:

• 2 week wait demand
• Delivery of the LHE 4 hour wait & winter capacity plans
• Delivery of the service plans for cancer in individual cancer sites and specialties

Increased demand for cancer services remains a key risk for delivery of the standards we are falling short of. During 2015/16 the demand for 2ww GP referrals has continued to increase. The increases are:

• Q1 5,393 2ww GP referrals,
• Q2 5,627 (increase of 234 outpatient appointments)
• Q3 5,798 (increase of 171 outpatient appointments)

2.2 18 Week pathways

Whilst specialty recovery plans were in place the emergency pressures the Trust experienced during December 2015 meant that some elective capacity was withdrawn/cancelled. The current position for December 2015 18 Weeks is 90.4%. At present the Trust has 2,930 patients waiting over 18 weeks, of which 50% are related to outpatient and 50% to inpatients. Whilst this is in excess of the Trust forecast it is a reduction in size (in July 2015 we had 3,200) due to the relentless focus the specialty teams have placed on this. The Trust is working on a revised the trajectory for the remainder of the year, in line with a request from the NTDA.

To address these shortfalls for our patients we need to respond differently. The clinical divisions are now implementing changes this month against this set of principles:

• There must be delivery of our elective and cancer targets in Q4 by using County Hospital and our partners in Leighton more.
• We need to resolve dramatically MFFD at County Hospital to support this from approximately 25 to 10-12 now and going forwards.
• The capacity released in surgery at Royal Stoke must be used for single capacity for both surgery and medicine.
• The increased receipt of intermediate trauma must cease now by working with providers and the ambulance service to free up to 10 beds.
• Improving productivity in theatre lists at County and Royal Stoke

The specific actions are:

• The delivery of four day case sessions at County rapidly.
• The released theatre sessions/time at Royal Stoke to focus on expanding emergency surgery for upper/lower GI, Urology. Upper and Lower GI cancer care.
• The reduction in bed capacity at Royal Stoke must be used for single capacity. We may need to transfer even more day case work to County to do this at scale and reconsider the full use of W6 for emergency.
• The delivery of more Orthopaedic elective work at County Hospital by taking out theatre sessions at Royal Stoke and transferring staff to release bed capacity.
• Increase elective cases for Orthopaedic operating at Leighton to reduce complex inpatient elective work.
• Increase use of Leighton for simple upper GI cases.
• Working with Stafford and Surrounds to drive MFFD down to stop use of W6 fully and reduce bed occupancy at CH existing beds.
• The cessation of intermediate trauma for Cannock areas, and elsewhere.
• Getting a greater list of productivity at linked to theatre devolution by SMART plans, which divisions set now.
• Investing in new domiciliary/intermediate care suppliers to shut Ward 81 and get back to 67 MFFD.

In 2016/17 we will be investing in substantial capital developments at County Hospital in beds, theatres and outpatients. To achieve this we will invest over £3m of capital developments for a new orthopaedic theatre, pre-assessment capacity and a central treatment suite.

2.3 Emergency Care

The LHE plan committed to a step change improvement in performance for 4 hour waits, which had been delivered successfully up to August 2015. However, in the final four months of 2015 performance deteriorated to below that of the agreed LHE trajectory. Trust total performance in December was 82.8%, with only one day over 90% achieved on during the month. Our Trust resilience plans are resulting in improvements. The Trust is becoming increasingly
effective at processing ambulance handovers, despite having the highest number of total conveyances in the WMAS region:

- Handovers >30-60 minutes – December 2015 has seen the lowest Trust total handovers of over 30 minutes since April 2014, with 53. This is a 91% (-538) reduction compared to December 2015.
- Handovers >60 minutes - The Trust had no handovers of over 60 minutes in December 2015 after having five in October and November 2015 combined.

There has been a 6% reduction in the number of NEL patients >70-years with a +10 day length of stay (daily average of 192 in Q2 versus 183 in Q3). More simple and timely discharge targets are being achieved. The weekday target was achieved in December 2015, with a daily discharge average of 138 Mon-Fri (target 122). The target has been achieved on 12 of the last 13 weeks (as @10/01/16). Finally there has been a reduction in medical outliers, which are negligible. An average of three per day during Q3, 50% less than the daily average of six in Q1.

The Local Health Economy (LHE) Resilience Plan schemes remain in place with agreement of the LHE System Resilience Group (SRG) that no bed capacity is to be reduced without SRG approval. The Trust has in place an Emergency and Urgent Care Improvement Programme Board to take forward the recommendations of the review undertaken by Dr Ian Sturgess, who continues to work with the Trust, and has expanded the scope of this meeting to include other improvement initiatives such as the exemplar programme. Medicine took on 18 beds on Ward 103 from 04/01/16. The Chief Operating Officer has been working with our community colleagues on a number of initiatives using different models of care that were introduced in December 2015.

The problems we face are:

- The admission demand for emergency care has risen over the last four months with increases between 4-15% for certain CCGs at Royal Stoke and County Hospital. The Local Health Economy was planning on a reduction in demand in Stoke and North Staffordshire of over 4,700 admissions and it has not happened/ Demand at County Hospital has grown significantly in the same period.
- The level of medically fit for discharge patients on both hospitals is significantly higher than planned at this time. Royal Stoke has over 150 patients when it planned on 67, and County Hospital has around 20-25, when it was planned to have 10. These directly relate to ‘bloated’ out of hospital services not being available to discharge patients into.
- The community hospital beds we have responsibility for in December 2015 are not reducing LoS to the levels needed.
- The community intermediate care, domiciliary care and nursing home/residential care services are not at the scale to support the patient discharge levels we need with no services to take them. This is partially a workforce contract, a lack of providers and a funding issue.

The actions we are taking to address the problems are:

- The exemplar front door elderly service will become operational in ED in February 2016.
- I have asked Helen Lingham and Gill Adamson to take direct management control of our step down bed management immediately to drive LoS improvements between now and March 2016.
- There will be revised demand and capacity modelling of the LHEs solution lead by ECIP
- The health and social commissioners have been asked by SRG to identify how they will fund more out of hospital capacity to meet community and hospital needs. This will report in January 2016.
- Capacity in AMG domiciliary care is being expanded to support the chronic problems in Stoke-on-Trent with capacity.
- The Stafford and Surrounds CCG are working to reduce medically fit for discharge patient below 10 asap.
- Dr Amit Arora is presenting to SRG our new frailty pathway. We are currently losing the war on resolving this as a service of health systems and we must now deliver a better battle plan to overcome the problems we face.

3. Staffing

The Employee of the Month for January 2016 is Helen Martin, a HCA in Home Therapies. Helen is an inspirational role model to new staff and an invaluable support to nursing and medical staff. She has been key in helping to manage the aAPD service, the UK’s largest in-house assisted dialysis service, working far above and beyond what is expected of her to help keep patients out of hospital and on dialysis at home. Her commitment extends far beyond the workplace, with Helen using her own time to work for the KPA, a charity organisation working to improve the life of patients with kidney disease. Here she took on the role as chairperson, as treasurer and then equipment officer using her own time to go out of her way to support patients.
The Team of the month for January 2016 is Phlebotomy. The team have a target to bleed 85% walk-in patients within 30 mins of arrival. This is a particularly challenging target considering the team have no control over patient numbers or arrival. In April 2015 phlebotomy repeated a 'perfect week' exercise when annual leave was restricted to ensure all available phlebotomy rooms at the three walk-in centres were fully staffed. The exercise improved morale within the team and the service is now in a more robust position.

Recent measures taken have resulted in a dramatically improved monthly performance and the KPI has been achieved and maintained at all three walk-in centres since May 2015 with an average of 92.5% patients waiting less than 30 minutes between then and November 2015. Pathology achieved a total of 17,503 patients bled across all walk-in locations in September 2015. Patient satisfaction with the service has always remained really high with an average of 97% of patients rating the service as good/excellent from April – November 2015.

I have given my CEO Award for January 2016 to staff across our Emergency Department at both sites. We know that the beginning of the year is a tough time for staff working in emergency medicine. This year they experienced a peak in demand beyond anything we have seen before. And although some patients did experience long waits, the feedback I have received is that the care was exemplary. In addition, the team’s hard work throughout the year meant that they were able to recover much quicker than we have previously, again helping patients. Seeing our staff in action in peak winter always reminds me how fortunate we are to have such a skilled and dedicated team in emergency medicine.

4. Quality and Safety Performance

Complaints have continued on the longer term trend of decreasing and the rate per 10,000 episodes. However, December 2015 has seen an in month rise of 20. YTD the rate of complaints is 44.16 per 10,000 episodes.

There continues to be an overall long term reduction in patient safety incidents reported across the Trust, although there has been an in month increase in December 2015. The total number of incidents is higher than December 2014 but the rate, which factors in increased activity, is lower. There were with 7.63 patient safety incidents per 100 admissions in December 2015 compared to 7.76 in December 2014.

We have continued to meet the national target rate of 95% for Harm Free Care (New Harms) and this continues the positive trend of improvement since April 2014. Total Falls have increased by 27 during December 2015 compared to November 2015, but there were 49 less when compared to December 2014. The target rate of 5.8 falls per 1,000 bed days has been met during December 2015. VTE Assessment continues to be achieved.

We have reported 26 hospital acquired pressure ulcers during December 2015, which is an increase, compared to previous months, with 20 Grade 2 and six Grade 3. These are still awaiting final validation and review as to whether they are avoidable/unavoidable. There have been no Grade 4 ulcers reported during December 2015. There were zero cases of MRSA Bacteraemia and seven Trust Apportioned Clostridium Difficile cases identified in December 2015.

The crude mortality trend shows that during recent months there has been reducing HSMR and crude mortality rates that are lower than November 2015 and December 2014.

The percentage of women who have seen a midwife or obstetrician for a health & social care assessment by 12 weeks 6 days of their pregnancy – we achieved 91.9% against the 91.5% standard.

5. 2025Vision

- The new £1.5m Poswillo Cataract Suite, which will treat patients with eye problems, is being opened at Royal Stoke later this month. The state-of-the-art suite will be used by clinicians to perform eye surgery on patients from across Stoke-on-Trent, Stafford and the wider local area. The centre, which includes a brand new microscope, will have the capacity to treat any patient requiring cataract surgery who is fit to do so under local anaesthetic. As well as improving the surroundings for patients, the new unit will be able to treat around 1,500 patients per year, which will result in reduced waiting times.
- Research patient recruitment has hit a new monthly record for the year with 283 patients recruited in December 2015, a significant achievement considering the festive break and the usual seasonal downturn in recruitment. This increase can be attributed to a number of new approaches to recruitment by the research teams. The total number of research studies now open or in follow-up at the Trust is 420.
I have been overwhelmed by the excellence shown Parakkal Raffeeq, Nick Savage and their colleagues in paediatrics, who are well on the way to being world class for their Paediatric Diabetes Care. They have been working on a reduction in the proportion of children in diabetic ketoacidosis (DKA) at diagnosis and a reduction in admissions for diabetes related acute complications (DKA and Hypoglycaemia). Well done all.

An innovative recruitment programme has used the bath clinics, where the research team provides extra support delivering the service, to identify and recruit patients and their families for the trial. The trial has now recruited a total of 229 compared to its original target of 25.

We have launched a Transitional Care Unit at the Royal Stoke Maternity Centre. Transitional care is where babies who need a little more nursing care and monitoring can stay with their mum rather than going to the Special Care Baby Unit. The Transitional Care Unit has six beds and is based alongside the maternity wards. My thanks to Alison Moore, Lynn Keilty-Woolcock and the team for launching this service. I was delighted to see we have increased our level of ITU care with over 1,900 days of intermediate care, up from 1,400 days two years ago.

A new MRI scanner will soon be opening adjacent to the Cancer Centre. This is another exciting development at the Trust and will help us to meet the growing needs of our local population. The centre will be called the Valley Centre and is operational next month.

More than 80 apprentices are being given the chance to kick-start a career with UHNM as a nursing assistant. The Trust has teamed up with Stoke on Trent College to deliver a new training opportunity over the next 12 months for those interested in a career in healthcare. From Monday 4 January 2016, those aged 18 and over will be able to apply for a nursing assistant apprenticeship or traineeship, depending on their past experience. This is a great opportunity for young people to come and work here.

The hugely popular fruit and veg stall has returned to Royal Stoke following the successful trial. I know many of you were disappointed that the pilot came to an end in September 2015. However, we now have a local company, Freshview Foods Limited, in place and we hope to return a stall to County Hospital once a company local to Stafford can be sourced to provide the service.

Seven day cover by the Paediatric Research Nurses to deliver the Pneumacare Bronch study has already ensured it is has already recruited 28 of its target 30 cases since starting the trial in November 2015. The research nurses have been working weekends to not only recruit patients, but to also perform follow-up scans.

In partnership with ARUPs, comprehensive Travel Plans have been produced for each hospital site and form a key component of the UHNM Car Parking Strategy. Travel Plans are a mandatory Planning Authority requirement, and provide a framework to deliver specific measures designed to minimise the impact of travel to the site. The Travel Plans aim to:

- Reduce traffic generation and its impact (congestion, air and noise pollution, accidents etc) and to develop and promote the widest possible travel choices
- Manage the number of single occupancy vehicles which visit to the site
- Promote increased use of public transport
- Promote active travel such as cycling and walking
- Promote integration between different transport modes
- Improve the accessibility of the site to non-car users and the disabled
- Provide clear information to staff and visitors on alternative modes of transport to and from the site

The Travel Plans support our sustainability agenda through the Trust's Sustainable Development Management Plan (SDMP): ‘Our 2020 Vision: Our Sustainable Future’.

EF&PFI have secured a £2k grant from Stoke-on-Trent Healthy Workplace Grant Fund (Staffs Chamber of Commerce) in order to establish a signposted circular walking route on the Royal Stoke site with installation of wooden benches. Partners are charity Living Streets and the local Prison, who make the benches. Estates, UHNM Wellbeing Group and the UHNM Charity were consulted and supported the application.

Over 20,000 men have now been screened for a potentially life-threatening condition at the Trust. Since launching the Abdominal Aortic Aneurysm (AAA) screening programme in 2012, the Trust has detected almost 400 aneurysms, 63 of which were potentially fatal, in men across the North Staffordshire region. The UHNM milestone comes at a time when the national screening programme celebrates screening its one millionth patient. My thanks to the Arun Pherwani and the AAA team.

The Combined Heat and Power Engine installation is now complete and in full operation providing heat and electricity to the Royal Stoke site. More works are planned for the Energy Centre over the next three months to provide even more efficiency to its operation and reduce energy costs by making more use of waste heat and minimising the amount of gas required to keep the boilers working at their optimum capacity.

Partnership working between the Trust and Keele University has been further consolidated with the appointment of a unique joint post. In what is the first joint role between the two organisations to support research partnership working, James Cook has taken up the newly-created position of Research Grant Facilitator. He will work across the two organisations, who are both funding the post, by supporting joint projects spanning clinical research on the Trust site and basic lab-based science conducted at Keele’s Guy Hilton Research Centre.

The Trust has been recognised as a model of best practice in the use of the specialist database management system, EDGE. It has been selected as an early adopter site within the West Midlands. The team is leading the
way regionally amongst other trusts who are now also adopting the system. We are now featured in a working

- The new catering arrangements at County site were launched in December 2015 to improve the service to
  patients.
- The County Hospital A&E refurbishment will run from March 2016 to November 2017.
- Burton Hospitals have agreed to two additional consultant cardiology posts working at Royal
  Stoke/Burton/Litchfield, which are now being implemented.
- An additional consultant neurologist has been appointed to work at Burton in January 2016.
- We are reuniting the breast screening program in Staffordshire. Over the next two to three years we will see
  screening services for Seisdon Peninsula CCG moving to RWT and the Burton population moving to Royal Derby.
- Additional clinics are being opened at County Hospital to support pain, cardiology and a number of other
  specialities.
- The RCP West Midlands visited UHNM and praised our implementation of the IT system, Nervecentre – the out
  of hours task system, which was implemented across the Medicine and Surgery divisions in April 2015, led by Zia
  Din and his out of hours team. This included praise for consultant presence and leadership. My thanks to Zia and
  his colleagues.
- A new £3.1m Renal Unit has opened at County Hospital in new facilities.
- The ward refurbishment has commenced at County, which will transform care for our patients. We are investing
  £14.9m in completely replacing the eight wards with five new modern ward environments between now and
  2017/18.
- I am committed to building a new AMU on the Ground Floor of the Trent Building, which will require relocation of
  the services currently in the building to elsewhere at Royal Stoke. I have worked with the project team to increase
  this and we have set aside £12m of capital resources to secure this and the relocation of all West Building wards
  to the Trent Building by 2018.

6. Financial Performance

The Trust’s financial performance to the end of Month 9 is a deficit of £18.1m, which is £4.1m worse than plan. To
date income is below the plan by £5.3m and non-pay is overspent by £6m. However, this is partially offset by under
spends on pay of £6m and depreciation of £1.3m. The Trust’s CIP target for 2015/16 is £36m. At the end of Month 9
the Trust achieved savings of £20.6m, though this is £3.4m behind the £24m of savings planned to the end of
December 2015.

The Trust has a cash holding of £31.4m at the end of December 2015, which is £20.6m better than planned due to
lower payroll costs, higher than planned receipt of SLA income and non-payment of 2014/15 provisions that have not
yet materialised.

The Trust has spent £33.5m on capital schemes to the end of Month 9, which is £10.6m behind the plan due to
slippage on a number of major capital schemes.

7. Conclusion

As expected, we kicked off the New Year with a huge demand for our services. In one day alone we had over 440
attendances to A&E at Royal Stoke and an incredible 220 via ambulance. These figures are simply staggering. This
led to 41 patients breaching the 12 hour target during an intense 36 hour period. Obviously this is disappointing, but
we need to put it into context against the 164 12 hour breaches we saw last year.

Furthermore, it shows the resilience in our health and care system is greatly improved this year and we were able to
contain the situation quickly. Our overall A&E performance is a vast improvement on 2014/15 when we experienced
regular multiple breaches from October 2014 onwards. Our ambulance turnaround time remains one of the best in the
West Midlands, allowing the ambulance crews to get back on the road and attend to 999 calls.

This resilience is a testament to the hard work of staff within the Trust and across our health and care partner
organisations in implementing the plans we put in place since last winter. There are still many weeks of winter
remaining, but clearly you are all doing your utmost to handle the pressures and this is reflected in the care patients
receive.

As we enter 2016/17 together there will be many challenges for all services. To deliver the 2025Vision we will have to
confront some fundamental issues around culture, service configuration, financial health demand for our services and
the use of both hospital sites as well as chasing the opportunities the responsibilities we now have for community
hospitals and long term conditions. In doing this we will stay true to our values.
The NHS we all cherish needs us to change faster. The national picture is far away from what we can create in our part of the NHS. We have an enormous responsibility to change our services for our families, friends and the public to continue to have faith in us.
# EXECUTIVE SUMMARY FRONT SHEET

**Agenda Item:** 8.

<table>
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<th>Public Trust Board</th>
<th>Date:</th>
<th>9(^{th}) February 2016</th>
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<td>Title:</td>
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<tr>
<td>Author:</td>
<td>Head of Quality, Safety &amp; Compliance</td>
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<td>Executive Lead:</td>
<td>Chief Nurse / Medical Director</td>
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<td>Other meetings</td>
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## Purpose

The purpose of the quarterly report is to provide a summary of the key quality indicators and where available use national and/or local benchmarking to provide comparison of performance. The report includes patient experience, patient safety, patient outcomes and effectiveness.

## Link to Strategic Objectives

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<th>Decision</th>
<th>Approval</th>
<th>Information</th>
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- Delivering quality excellence for patients
- Delivering our financial obligations to the Taxpayer
- To achieve excellence in education, training and research
- Create an integrated vibrant Trust and develop strategic alliances with neighbouring trusts and partners
- Create a resilient Urgent and Emergency Care System and Increase Integrated Healthcare Provision

## Executive Summary

The latest quarterly report provides a summary of the key patient safety targets with performance compared with previous quarters and the national/local targets. The report includes performance related to the following areas:

- Complaints
- Patient Experience
- Patient Safety Incidents
- Harm Free Care
- Pressure Ulcers
- Medication Incidents
- Patient Falls
- Serious Incidents & Never Events
- Mortality
- Patient Related Outcome Measures (PROMS)
- Clinical Audit
- NICE
- Information Governance

The report also provides summaries of some of the actions taken and lessons learned from various indicators.

The latest Quality Indicators for Quarter 3 2015/16 are generally showing a positive trend with improvements being made during October to December 2015 when compared to same period in 2014. The Trust is moving forward with reduction of harm and improvements in quality with consistent reporting and investigation of adverse incidents and the sharing of learning across both sites with the implementation of actions where applicable.
The quality indicators are available at local ward/departmental levels to allow for focused local review and analysis which is giving services greater ownership and understanding of the issues facing individual areas along with greater sharing of outcomes and learning. The indicators are used to triangulate any identified concerns/issues and inform the need for unannounced ward reviews as part of the Trust’s Clinical Assurance Framework programme which uses the same methodology as the current CQC Inspections.

Where performance is not meeting the required level within the Trust there are agreed actions and improvement plans being implemented to support the required improvements i.e. Information Governance Training compliance which implemented an improvement plan and during Quarter 2 has seen improvements in performance.

Complaints received have reduced during Quarter 3 2015/16 compared to same period in 2014/15 and the rate of complaints received based on activity has also reduced during Quarter 2.

Friends & Family Test results have shown improvement for Inpatients during Quarter 3 with over 97% of inpatients stating they would recommend the service but there has been a reduction for A&E patients with 72.1% recommending the service compared to 74.6% previously. Both continue to exceed the 70% national target.

Patient Safety Incidents rate per 100 admissions have decreased during Quarter 3. The reporting profile for adverse incidents and level harm is comparable to similar Trusts submitting information to the National Reporting and Learning System and the level harm identified at time of reporting the incident has remained relatively constant.

Harm Free Care (New Harms), via the monthly Safety Express, continue to meet the national 95% target rate with Quarter 3 averaging 97.9% which continues the long term improvement.

The Trust has reported 71 grade 2 and 3 pressure ulcers during Quarter 3 which is an increase compared to both Quarter 1 and Quarter 2. There has been a 14% decrease in the number of reported Grade 3 pressure ulcers when comparing same period in previous year. Over 40% of the pressure ulcers related to patients heels and the Trust held a Happy Heels campaign week in November 2015 to help focus attention and initiatives to reduce heel pressure.

The rate of patient falls per 1000 bed days have decreased during Quarter 3 compared to the same period in 2014/15. This reduction in rate of falls has occurred during a quarter when the compliance with Falls Care Bundle and Risk Assessments have improved.

The severity of falls are continuing to reduce with higher percentage of patients not suffering any significant harm following a fall due to better management of individual patients and falls reduction techniques being adopted as general practice across the Trust.

The number of serious incidents reported is lower than previous quarters with 24 reported in Quarter 3. The reduction of the reported SIs on STEIS is as a result of changes in the national SI reporting framework and agreement with the CCGs to only report Grade 3 pressure ulcer once confirmed that the damage was hospital acquired and avoidable.

The Trust has not reported any Never Events during Quarter 3.

Mortality is within expected ranges based on both the Hospital Standardised Mortality Ratio (HSMR) and the Summary Hospital-level Mortality Index (SHMI). HSMR has shown reducing trend for the past 6 months of available data.

There have been no new publications from the HSCIC relating to PROMS during Quarter 2.

The Trust’s Clinical Assurance Framework visits have continued to be rolled out and are providing the Trust and local areas with detailed information on improvements that are required and also where good practice...
can be shared.

### Key Recommendations

The Trust Board to note the following:

- To approve the new integrated Quarterly Quality & Safety Report (*Target date: 21st January 2016*)
- Quality, Safety & Compliance Department to work with directorates and divisions to continue to improve the IG Training compliance and work towards achieving 95% compliance (*Target date: March 2016*)
- To share the report within across the Trust to raise awareness of the Trust’s performance and to share learning across the organisation. (*Target Date: 10th February 2016*)
- Head of Quality, Safety & Compliance to include summary of learning and outcomes in the CEO Bulletin (*Target Date: 30th January 2016*)

### Corporate Impact Assessment (please tick any which are impacted on / relevant to this paper)

<table>
<thead>
<tr>
<th>Quality Implications</th>
<th>Financial Implications</th>
<th>Legal Implications</th>
<th>Workforce Implications</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓</td>
<td>✓</td>
<td></td>
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</tbody>
</table>
Title of Report: UHNH Quality & Safety Report (Quarter 3 2015-16)
Author: Head of Quality, Safety & Compliance
Executive Lead: Chief Nurse
# Contents

1 EXECUTIVE SUMMARY........................................................................................................................................3

2 PATIENT EXPERIENCE .........................................................................................................................................4

2.1 Patient Story ........................................................................................................................................................... 4

2.2 Complaints .............................................................................................................................................................. 5

2.2.1 Learning from Complaints .............................................................................................................................. 6

2.2.2 Actions as a result of patient feedback ........................................................................................................... 6

2.3 Friends & Family Test.............................................................................................................................................. 7

3 QUALITY & SAFETY INDICATORS .........................................................................................................................8

3.1 Incidents.................................................................................................................................................................. 8

3.1.1 Patient Safety Incidents .................................................................................................................................. 8

3.1.2 Harm Free Care ............................................................................................................................................... 9

3.1.3 Falls ............................................................................................................................................................... 10

3.1.4 Pressure Ulcers ............................................................................................................................................. 12

3.1.5 Medication Safety ............................................................................................................................................ 13

3.2 Serious Incidents................................................................................................................................................... 14

3.2.1 Duty of Candour ............................................................................................................................................ 15

3.2.2 Learning from Serious Incidents ................................................................................................................... 15

3.3 Never Events ......................................................................................................................................................... 16

4 CLINICAL EFFECTIVENESS .................................................................................................................................. 17

4.1 Mortality ............................................................................................................................................................... 17

4.1.1 Actions to date and future planning ............................................................................................................. 18

4.2 Patient Related Outcome Measures..................................................................................................................... 20

5 CLINICAL EFFECTIVENESS .................................................................................................................................. 21

5.1 Clinical Audit ......................................................................................................................................................... 21

5.2 NICE Compliance................................................................................................................................................... 24

5.3 Care Quality Commission........................................................................................................................................ 24

5.4 Clinical Assurance Framework.............................................................................................................................. 25

5.5 Information Governance....................................................................................................................................... 26
1 EXECUTIVE SUMMARY

Quality, safety and patient experience remains our number 1 priority. Our core vision continues to be a leading centre in health care, driven by excellence in patient experience, research, teaching and education, and our overall ambition is to equal or exceed the best performing Trusts in England. We will achieve our vision by setting challenging standards and placing quality, safety and patient experience at the heart of everything we do, ensuring we place the interests of patients ahead of individual or organisational ambition.

In delivering our ambition we have taken into account findings, recommendations and best practice guidance from the multitude of national publications, international research evidence and our local knowledge. Our strategy therefore is structured around the 5 domains described in The Keogh Report (July 2013) and the CQC outcome standards as described in the table below:

<table>
<thead>
<tr>
<th>Keogh Domain</th>
<th>CQC Outcome Standards</th>
</tr>
</thead>
</table>
| Safety       | **Outcome 7:** Safeguarding people who use services from abuse  
**Outcome 8:** Cleanliness and infection control  
**Outcome 10:** Safety and suitability of premises  
**Outcome 11:** Safety, availability and suitability of equipment |
| Effective    | **Outcome 2:** Consent to care and treatment  
**Outcome 5:** Meeting Nutritional needs  
**Outcome 9:** Management of medicines  
**Outcome 12:** Requirements relating to workers  
**Outcome 13:** Staffing  
**Outcome 14:** Supporting staff |
| Caring       | **Outcome 1:** Respecting and involving people who use services  
**Outcome 4:** Care and welfare of people who use services |
| Responsive   | **Outcome 6:** Co-operating with other providers  
**Outcome 17:** Complaints |
| Well Led     | **Outcome 16:** Assessing and monitoring the quality of service provision |

This report presents provides a summary of the patient experience, patient safety and effectiveness different indicators and outcomes along with actions taken. This report is supplemented by the monthly Quality Assurance Report which provides further information and trends for the quality & safety indicators at Trust level as well as separating results by Royal Stoke University Hospital and County Hospital site level.
2 PATIENT EXPERIENCE

2.1 Patient Story

4th August 2015 – I arrived for my appointment 15 minutes early as requested. The auto check-in system was very good and easy to use. I collected my ticket and found my way to the preadmission desk. The staff were very pleasant. I was checked in for 1pm and was seen by a very pleasant nursing assistant for a urine sample and ECG. There was a short wait then a Sister (no name badge) asked me about my medical history. I then went to see the anaesthetist who asked further questions about my medical history and the tablets I was taking. We had a very nice informal chat as he explained his role in my operation; possible problems and reactions to my endovascular aortic repair. Two students were present and they seemed very interested in my case. I was then given an MRSA kit to use daily and finally a blood test. All was finished at 3:15pm.

I was asked to have a blood test within 7 days of the operation. This was inconvenient as I had an 80 mile round trip – I thought we had the same blood group for life, but must follow orders.

11th August – Arrived to give blood test at 12pm. I checked in and was asked to wait but was done and dusted by 12:30pm and on my way home. Roll on Friday 14th – need the operation done so I can get on with my life.

14th August – Arrived at 7:30am and checked into Ward 105. Quite a large number of people about but staff on top of it and very soon I was in a bedside gown and ready to go to the operating theatre.

I came round in the post op room. Angie and her team were very busy bringing people round. It seemed like chaos at first but as time went on it was just very busy with all staff being directed with little fuss and clear goals. Later in the day I was moved to a bed in a side room on the Surgical Special Care Unit. I experienced strange temperature variations, one minute hot and then cold, throughout the night. There was a glitch which meant my clothes etc. were still down on Ward 105 and it was locked up for the night.

Only at my daughter-in-laws insistence were the keys found and I was finally reunited with my dentures and gloves.

Sister Nicky and her team checked me throughout the night even finding me a fan to cool me down due to the temperature problems in the room. Nurse Keeley was a little star as I have irregular heartbeats and she kept checking with the ECG in case it was the machine and not me giving the odd readings.

15th August - I was transferred to Ward 107. The food and drink was excellent – what was supposed to be hot was and what was supposed to be cold was. It was a great menu, as good as many in 4-star hotels I have stayed in. I liked the varied choice.

The water jugs appear to have a fault as the water doesn’t push open the spout, this makes it a 2-handed job or you have to take the lid off. The paper cups are rubbish. They are much too thin so everyone uses 2 or 3 inside one another – what a waste! All staff comment about this so it doesn’t appear that management are listening.

17th August – Physio came and checked my mobility and said it was OK for me to go home. Medication and further dressings were issued and the staff called my son to arrange my transport home.

I was very impressed with the cleaning on the wards. This seemed to go on around the clock and everywhere was spotless. All staff were keen to help and nothing was too much trouble. Over the years I have stayed in a number of hospitals and this one has been the most pleasant. The dedication and attention of the staff was wonderful and the food was excellent.
2.2 Complaints

The Trust are always seeking to improve the patient experience and the quality of the care and treatment we provide. A key way to inform the Trust and services is using the complaints received as a positive tool for improvement. In order to do this the Trust analyses the complaints received to understand where the complaints relate to and what the different reasons for the complaints are.

Chart 1: Complaints per Quarter by Site

What do these results tell us?

Complaints at UHNM have continued the longer term trend of decreasing in both actual numbers and the rate per 10,000 episodes.

Total complaints opened 2015/16 year to date as at December 2015 is 670. This is a decrease for the same period the previous year 2014/15 of 17.6% in which there were 814 complaints recorded.

Chart 2 shows that the numbers and rate of complaints for Quarter 3 (October to December 2015) have decreased compared to the same months in 2014 with 224 complaints received compared to 250. Quarter 3 has also received less complaints than Quarter 2.

The Quarterly rate of complaints averaged at 42.36 across UHNM compared to Quarter 2 rate of 46.43 and Quarter 3 rate of 2014/15 of 47.44 complaints per 10,000 episodes.

Chart 3 shows that the main reason for complaints being received is in relation to the treatment provided followed by Outpatient Appointment delays and or cancellations.
2.2.1 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 actions taken as a direct result of complaint investigations in Quarter 3.

**You said:** Your mother did not receive adequate oral hygiene whilst she was in our care.

**We did:** New oral hygiene equipment has been purchased for the ward and the majority of staff have received additional training on both mouth care technique and documentation of oral hygiene for those patients who are nil by mouth.

**You said:** You were unhappy with the long waiting time for your outpatient appointment

**We did:** The Trust has employed an additional Consultant Plastic Surgeon to deal with the increase in demand for this service. Initiatives include the provision of additional clinics and validation of waiting lists.

**You said:** You had to wait too long for your medication to take home

**We did:** Portering services have been reviewed so that all ward and department areas are visited at least every 50 minutes.

**You said:** You waited an excessive amount of time for your scan to be reviewed.

**We did:** The Imaging department are reviewing their reporting times for all investigations to ensure future patients receive timely results.

**You said:** You did not know where to access a wheelchair on your discharge home

**We did:** Staff now direct patients to the British Red Cross for the loan of a wheelchair where appropriate.

**You said:** There was an unacceptable delay in your discharge from County Hospital

**We did:** The Manager of the discharge lounge is currently looking at processes to help support the doctors in writing the discharge letters in a timely manner to improve this situation.

2.2.2 Actions as a result of patient feedback

As well as direct responses to complaints received, we have also taken actions following comments/suggestion and general patient feedback.

**You said:** You want to be more involved in your plan of care and discharge planning

**We did:** Consultants are encouraged to provide all patients with an estimated date of discharge and patients who are able are encouraged to attend Multi-disciplinary team meetings

**You said:** The height of the waiting room chairs in the Emergency Department is too low for some patients.

**We did:** We have purchased a number of raised chairs for the department.

**You said:** The paper cups are much too thin to use with patients and staff often having to put 2 or 3 inside one another.

**We did:** All of the new drink trollies at County Hospital have been supplied with rigid and heat insulated holders that must be used at all times when giving out hot drinks. Matron is currently reviewing the system at the Royal Stoke site to ensure only safe cups are used.

**You said:** You would appreciate a drink in the Emergency Department, particularly during a long wait, for both patients and their relatives/carers.

**We did:** We have increased the numbers of housekeepers in the Emergency Department and advertise the times that they will be undertaking drinks rounds for both patients and their escort.
2.3 Friends & Family Test

The following section provides a summary of the monthly performance against the Friends & Family Test and percentage of users that would promote inpatient or A&E services.

Chart 4: Friends & Family Results per month

<table>
<thead>
<tr>
<th>Inpatient</th>
<th>% Recommending Service - A&amp;E</th>
<th>% Recommending Service - Inpatient</th>
</tr>
</thead>
<tbody>
<tr>
<td>% promoting service</td>
<td>70</td>
<td>Q3</td>
</tr>
<tr>
<td>Response Target</td>
<td>25%</td>
<td>Q3</td>
</tr>
<tr>
<td>A&amp;E</td>
<td>Score Target</td>
<td>70</td>
</tr>
<tr>
<td>Response Target</td>
<td>25%</td>
<td>Q3</td>
</tr>
</tbody>
</table>

What do these results tell us?

UHNM continue to meet the target for % of responders recommending the service in both Inpatient and A&E. Quarter 3 returned an average of 97.3% for Inpatients (an increase from Quarter 2) and 72.1% for A&E (a decrease from Quarter 2). This shows that in general our patients are happy with the care and treatment they received. However, there is still room for improvement and these themes are identified as part of the National Surveys and the use of in year surveys linked to improving communications and medications.

During Quarter 3, the Trust has not met the 25% response target for Inpatient or A&E. However, the A&E response rate improved from 23.5% to 23.7% in A&E and the YTD rate for Inpatient is still achieving the target with 28.7% overall YTD response rate.
3 QUALITY & SAFETY INDICATORS

3.1 Incidents

A key indicator on the quality and safety of the care and services provided is the number and rate of patient safety related adverse incidents that are reported. The following section provides a summary of some of these key indicators and actions that have been taken to improve the quality and safety and reduce harm to our patients.

3.1.1 Patient Safety Incidents

During Quarter 3 there has been the continued trend of reducing patient safety incidents in actual numbers and rate per 100 admissions prior to November 2014 and since the establishment of UHNM on 1st November 2014.

The Trust’s continued focus on quality and safety for patients has led to reduced adverse incidents and levels of reported harm as a result of these incidents. The reporting profile of types of incidents and level of harm for UHNM to the National Reporting & Learning System (NRLS) continues to be comparable to the profile for all Large Acute Trusts and is with the background of staff feeling that they can and report incidents as noted by the recent CQC Inspection visit.

What do these results tell us?

UHNM has continued to see reductions in the numbers and rate of Patient Safety Incidents. Quarter 3 saw continued reductions in rate per 100 admissions with quarterly average of 6.92 which is lower than the 7.59 rate in Quarter 3 of 2014/15.

There have been months which have seen increases in the rate of PSIs per 100 admissions but these are all within normal variation as illustrated in Chart 6 opposite. Indeed, the current reductions are still normal variation but the longer term trend is showing reductions during 2015.

The level harm for all patient related incidents has seen the levels of harm remain relatively constant and is similar to all acute Trusts as reported in the national benchmarking NRLS reports.
3.1.2 Harm Free Care

The provision of harm free care continues to be a trust priority as measured by the Safety Thermometer and is used as a tool to measure local improvement and reduction in harms over time. It is essential that the care we provide for our patients is free from harm.

The Safety Thermometer allows the Trust to measure a snapshot (or prevalence) of harm and the proportion of patients that are ‘harm free’ in relation to Grade 2/3/4 pressure ulcers, Catheter associated urinary tract infections, falls and venous thrombo-embolism. The Safety Thermometer and harms data is collected for every patient in the Trust on the same day, with the exception of patients in Theatres, Emergency Departments and Outpatients.

The chart above shows the percentage of patients classified as being free of new harms (or hospital acquired) by month and indicates that the Trust has continued to exceed the target 95%. The Trust is continuing to show a longer term improvement in harm (new harms) free care with Quarter 3 averaging at 97.9 and this continues the in year improvement.

The chart also shows the national average for new harms measured via the Safety Thermometer.

What do these results tell us?
Since April 2014 our average reported hospital acquired harm rate has been below the reported national average for new harms and our harm free care (new harms) has continued to improve over the longer term.
3.1.3 Falls

Reducing the number and harm from patient falls is a key aim for the Trust as part of its Patient Care Improvement Programme. Overall the number of patient falls has started to reduce as illustrated in Chart 8 below.

Chart 9: Patient Falls per month

Following initial integration of RSUH and County Hospital there was an increase in the number of falls being reported and this led to changes in the SPC control limits. Since March 2015 there has been a decreasing trend of reported falls across the Trust. Quarter 3 2015/16 recorded 558 patient falls compared to 608 in 2014/15, equating to 8.2% reduction. In order to assess and compare the falls trends across UHNM, the Trust also measures the rate of falls per 1000 bed days which allows for differences in activity between months.

Chart 10: Falls rate per 1000 bed days

Chart 11: Falls Bundle Compliance and Falls Risk Assessment Completion
During 2015/16 there has been noted reductions in the level of harm from falls. During Quarters 1 to 3 there has been a reduction in moderate to severe harm as a result of a fall whilst in hospital and corresponding increase in patients not experiencing any harm as a direct result of the fall. The examples of the types of injuries categorised as these levels of harm are fractured Neck of femur (Hips), Fractured elbow, subdural haemorrhage. Quarter 1 had 5.15% of all patient falls being classified with Moderate Harm, Severe Harm or Death caused by the fall. Quarter 2 and Quarter 3 recorded 6.1% and 5.07% respectively.

The percentage of patients having a fall that resulted in no harm increased from 71.4% in Quarter 1 to 75.5% in Quarter 3.

What do these results tell us?

The average patient fall rate for Quarter 3 (October - December) is 4.74 (Quarter 2 was 4.81) which marks a reduction compared to previous quarterly averages. These reductions are following focussed work undertaken with wards and departments to ensure that patients are being fully risk assessed on admission to the wards and the Falls Care Bundles being implemented. The reduction of the rate of falls has been recorded as the Falls Bundle Compliance and Completed Risk Assessments have been improving during the past 12 months (see Chart 10).

The reduction in moderate to serious harm and the corresponding increase in no harm as a result of patient falls also shows that, whilst the Trust continue to work with patients and relatives to reduce the risk of a fall, the risk management and falls reduction strategies help minimise the actual impact / injury.

**Actions Taken**

- A Quality Improvement Facilitator has now been appointed as lead for falls reduction and is in the process of delivering update training to all falls key trainers.
- A robust RCA process is in place across both hospital sites to identify the level of harm and lessons learned. Duty of Candour is now an integral part of this process.
- The Trust falls reduction plan has been revised with an initial priority for promoting delivery of training in individual clinical areas by falls key trainers and further improving the compliance with the falls bundle.
- Quality Improvement Facilitator is currently developing individual improvement plans with the 5 highest reporting areas for patient falls.
- An integrated Trust Falls Policy has now been ratified across both hospital sites.
3.1.4 Pressure Ulcers

Reducing the number and harm from hospital acquired pressure ulcers is a key aim for the Trust as part of its Patient Care Improvement Programme. Overall the number of hospital acquired pressure ulcers has increased during Quarter 3 compared to Quarter 2 2015/16 but reduced compared to Quarter 1. The chart below shows the monthly total split by grade.

**Chart 13: Hospital acquired Pressure Ulcers per Month**

![Chart 13](chart.png)

What do these results tell us?
Quarter 3 has seen an increase with 71 in total compared to 50 in Q2, 69 in Q1 and Q4 previously.

Quarter 3 has continued to note reductions in Grade 3 Hospital Acquired Pressure Ulcers and increased reporting of Grade 2. Quarter 3 2015/16 has seen a 14% reduction in Hospital Acquired Grade 3 Pressure Ulcer when compared to Quarter 2014/15.

The number of new harms associated with pressure ulcers have remained the same as Quarter 2 during Quarter 3.

From analysis undertaken, over 40% of hospital acquired pressure ulcers are on patients’ heels.

**Actions Taken**

- A robust RCA process is in place across both hospital sites to identify the level of harm and lessons learned. Duty of Candour is now an integral part of this process.
- Over 40% of our hospital acquired pressure ulcers are on patient’s heels. A campaign entitled “Happy Heels” was launched w/23rd November
- Roll out UHNM SKIN bundle at County Hospital is now complete
- Quality Improvement Facilitator is currently developing individual improvement plans with the 5 highest reporting areas
3.1.5 Medication Safety

The following section summarises the trends for medication incidents and learning following review of these incidents at the Trust Safe Medication Committee.

The previously published NHS England/MHRA Patient Safety Alert Improving medication error incident reporting and learning highlighted the need for Trusts to increase the reporting of medication errors and ensure that lessons are learnt as a result and shared across the organisation. The target model should be an increase in reporting of low/no harm incidents, review of incidents for themes or potentially serious incidents, understanding the background to the incidents and development of a culture of learning from incidents to prevent more serious incidents occurring.

Chart 15: Medication Errors and Rate per Month

What do these results tell us?

Reporting of Medication related incidents has increased during Quarter 3 in both actual numbers and rate per 10,000 bed days. There was a rise during Quarter 3 compared to Quarters 1 and 2.

At UHNM the number of reported medication incidents with no or low harm for the year has increased which demonstrates an increased awareness of the importance of medication incident reporting amongst all staff along with a willingness / openness to report and learn from errors.

The number of moderate harm incidents has remained stable and the challenge is to reduce this figure. The themes in this group continue to include prescribing errors, often as a result of inaccurate drug history taking, failure to administer doses of medicines and problems affecting discharge medicines, either with the medicines themselves or inaccurate discharge letters.

Chart 16: Level of Harm per month

Actions Taken:

Following the investigation and review of the medication related incidents the following actions have been taken during Quarter 3 to share learning from medication incidents:

1. The Trust Medication Safety Officer continuing to meet monthly with Junior Doctors and the quality nurses to share learning from medication incidents and how medication errors could have been avoided. This should be taken back to their base wards to share with the nurses/midwives.
2. Learning from medication incidents built into Trust induction and mandatory training for all staff including consultants and junior doctors.
3. Deputy Chief Nurse for Quality and Safety is leading a focus group to review missed doses and reasons for these. Reports will be shared at the Trust’s Safe Medications Committee.
3.2 Serious Incidents

Chart 17 shows the number of serious incident reported each quarter on the Strategic Executive Information System (STEIS).

**Chart 17: Number of Serious Incidents reported per quarter**

What do these results tell us?

Following the establishment of UHNM in November 2014, there was a rise in the number of serious incidents reported which was a result of including the reporting of serious incidents at County Hospital as well as an increase in reported incidents relating to pressure ulcers. UHNM were logging any reported grade 3 pressure ulcers as SIs prior to validation and confirmation that these pressure ulcers are hospital acquired and avoidable. Quarter 1 saw a decrease in the numbers reported following agreement with CCGs on consistent reporting of pressure ulcers across local health economies. We now only report Grade 3 pressure ulcers that have been fully investigated and reviewed at the Trust Tissue Viability Review Panel, which has CCG representation, and confirmed as being an avoidable pressure ulcer (i.e. practice could have been improved). This new agreed reporting process is in line with the new NHS England framework for the reporting and management of serious incidents. This has also been discussed and agreed at the regional Serious Incident Network facilitated by NHS England.

During Quarter 3, UHNM has continued to note a reduction in the reported numbers of Serious Incidents and this current quarterly total is lower than the Q3 total in 2014/15 which was previously UHNS and did not include any of the activity associated with County Hospital.
3.2.1 Duty of Candour

The Trust has continued to roll out the training to all staff groups regarding our Duty of Candour during Quarter 3.

At the end of Quarter 3, 552 individual members of staff have attended the specific Duty of Candour training session. In addition to this bespoke training, Duty of Candour is also included in the Trust’s Statutory & Mandatory face-face training sessions and these sessions have resulted in 1500 staff receiving updates on the requirements of Duty of Candour and what would trigger the duty of candour along with staff members individual responsibilities.

The Trust’s new policy has been drafted and includes template letters to allow notification to patients / relatives.

Specialist forums within the Trust are taking a lead on ensuring that Duty of Candour has been met in relation to falls, infection control and pressure ulcers. The Trust’s Risk Management Panel continue to review the Root Cause Analyses for serious incidents and the Duty of Candour details are included in all completed Root Cause Analyses undertaken.

During Quarter 3 there have been 55 adverse incidents that have been reported as initially triggering the Duty of Candour requirement with moderate, harm, severe harm or death reported as a direct result of the adverse incident. All of these incidents have been discussed verbally with the patients and/or relatives as soon as practically possible after the incident was identified. It should be noted that not all of these, on review and investigation actually formally trigger the Duty of Candour i.e the adverse incident did not directly result in the harm to the patient.

What do these results tell us?
The Trust has continued to roll out the Duty of Candour requirement and provide training and education to all staff groups. Staff are aware of the reporting requirements. Further work is ongoing throughout the Trust, with the Divisions being supported by the Quality, Safety & Compliance Department, to ensure that Duty of Candour letters are uploaded to Datix system to allow for improved reporting on Duty of Candour follow up.

3.2.2 Learning from Serious Incidents

Once the investigation report has been reviewed and approved internally, the RCA is submitted to the CCG for formal sign off and closure on STEIS. During Quarter 3 the Quality, Safety & Compliance Team have worked closely with Stoke on Trent, North Staffordshire and Stafford & Surrounds CCGs to help facilitate the closure of Serious Incidents on STEIS. This work has also included the development of a robust process with the CCGs, as well as with Stoke and Staffordshire Partnership NHS Trust, for dealing with incidents raised by GPs and other community based healthcare services. These incidents in particular relate to discharge and transfer issues.

The main Serious Incidents reported are:
- Grade 3 Pressure Ulcers
- Healthcare associated Infections (including C Diff / MRSA / Ward Closures)
- Patient Falls
- Maternity related incidents
When reviewing the SIs to identify the learning and themes from the completed RCAs the main themes and action taken from the RCAs reviewed and closed during Quarter 2 are:

- Improving documentation of interventions and risk assessments in relation to Pressure Area damage and treatment. Pressure Ulcer are being reviewed and attributed as unavoidable due to lack of complete documentation.
- Staff escalation of concerns and deterioration in patients’ conditions
- Patients assessed as high risk of falling were cared for in areas where they were most observable
- Completion of Discharge Checklist and physical check of patient prior to discharge to reduce the number of Cannulas left in situ

As part of the Trust’s monthly monitoring and review of quality there are monthly ‘Proud to Care’ audits undertaken on every ward to identify the standard the care and documentation. The audit reviews the documentation related to 10 randomly selected patients on each ward and focuses on the issues that have been identified in adverse incidents. There are specific sections relating to completion and actions for:

- Tissue Viability,
- Nutrition
- Pain Management
- Medicines Management
- Observation/MEWS,
- Falls
- IV Care
- Privacy & Dignity
- Patient Experience and Personal Care
- Cleaning

By using these audits along with other information sources, such as complaints/incidents and Clinical Assurance Framework visits, the Trust is able to monitor the standard and quality of the care/treatment provided to patients. Where performance is not meeting the required standard then focussed support is provided via the Quality Improvement Team to assist the multi disciplinary teams to work together to improve care and treatment.

### 3.3 Never Events

There have no Never Events reported at UHN during October – December 2015.
4 CLINICAL EFFECTIVENESS

4.1 Mortality

The latest updated Dr Foster mortality information is up to September 2015. The chart below shows an overall HSMR of 96.81 for the period October 2014 – September 2015 and the HSMR for September 2015 is 82.96.

What do these results tell us?

UHN not only has mortality within expected ranges as illustrated by the HSMR and SHMI in Chart 17 to 19 but has also seen improving HSMR mortality trends. Both the rolling 12 months HSMR and the monthly trends are showing continued reductions in the Trust’s overall HSMR compared to same months / periods in previous years. This means that overall, based on the Trust’s casemix that there are more patients surviving than expected.

Current official SHMI is 1.04 and Band 2 = mortality as expected.

In addition, the Trust’s Mortality Review Group was observed by the TDA and provided observers with positive assurance that the Trust robustly reviews and discusses mortality to understand changes in performance and ensure that learning is shared.

The Trust has not received any Mortality Outlier Alerts from the Care Quality Commission relating to any specific diagnoses or procedures since April 2014.
4.1.1 Actions to date and future planning

As part of our commitment to reduce mortality rates, the Trust has recently updated its Mortality Reduction Action Plan which outlines the Trust objective of reducing mortality and avoidable deaths. The action plan identifies the key initiatives and actions required to help achieve the objective and the current position in relation to these key actions and completion targets. The delivery of the plan and associated actions is monitored at the Trust’s Mortality Review Group.

A number of these initiatives are to embed the use of recognised best practice in the treatment of particular diagnoses by utilising Care Bundles. These Care Bundles outline the actions required to assess and treat patients with these specific diagnoses which should lead to improved outcomes for patients. The trust has agreed to fully implement the following Care Bundles:

- Falls
- Sepsis
- Community Acquired Pneumonia (CAP)
- Acute Kidney Injury (AKI)
- Venous Thrombo-embolism (VTE)

Implementation and compliance with the these care bundles are to be monitored via audits of identified patients to identify where improvements can be made and to share the learning and good practice across the Trust. Mortality against these diagnoses and conditions is monitored on a monthly basis at the Trust’s Mortality Review Group and with Divisional Mortality Reports.

During Quarter 3, to provide assurance internally and externally regarding mortality, the Trust introduced its new ‘All Deaths’ Mortality review form and process. The new process was started at the start of December 2015.

Whilst emails will go to the named consultant and mortality leads, with initial review proposed to be undertaken by the consultant responsible, some specialties have agreed to coordinate the reviews and allocate independent consultants for the initial review to determine the CEPOD classification and any potential requirements for more in depth review. Thus far the response has been positive on the proforma and the process. 194 notifications have been circulated and 130 completed proformas have been submitted.

Chart 21 below shows the classifications of the completed mortality reviews. The deaths classified as B, C or D will be formally discussed and presented at the relevant specialty M&M Meetings to share the learning and escalate any concerns.

**Chart 21: Mortality Review Proforma Classifications**

![Chart 21: Mortality Review Proforma Classifications](image-url)
The Trust has recently updated the Trust Mortality Reduction Action Plan (see Appendix 1) which outlines the Trust objective of reducing mortality and avoidable deaths. The action plan identifies the key actions required to help achieve the objective and the current position in relation to these key actions and completion targets.
4.2 Patient Related Outcome Measures

During Quarter 3, there have not been any updates relating to UHNM from the HSCIC on the new year PROMS data for 2015/16.

The following charts show the Trust’s performance in relation to the 4 national PROMS programmes (Groin Hernia, Hip Replacement, Knee Replacement and Varicose Vein) based on the different scoring systems used to evaluate the health gain or patients’ reported improvement in their condition, using a pre and post operative questionnaire that were published during Quarter 2. The Average Health Gain for England is shown along with the Trust score.

![PROMS Adjusted Average Health Gain EQ-5D Index (April 2013-March 2014)](chart1)

![PROMS Adjusted Average Health Gain EQ-5D Index (April 2014 – March 2015)](chart2)

What do these results tell us?

During 2013-2014, The Trust adjusted average health gain using the EQ-5D Index (a combination of five key criteria concerning general health) following these procedures were lower than the English national average. The Trust had previously been identified as a risk within the CQC Intelligent Monitoring Report due to lower performance in Knee Replacement (Primary) adjusted health gain under EQ-5D.

The results for April 2014 – March 2015 show that there have been improvements in all 3 programmes where the Trust has submitted large enough numbers of questionnaires to calculate an average health gain. The Trust in the latest national analysis are no longer outliers, and this change should be reflected in future CQC Intelligent Monitoring Reports.

The improvement in these scores during 2014/15 are following the implementation of new UHN ‘Joint School’ for patients pre operatively, better education and information on potential outcomes and improvements in condition and increased follow up and rehabilitation post operatively for physiotherapy and occupational therapy provided by UHNM. As a result of these changes and improvements, UHNM have been asked to present at national PROMS Conference on how the use of PROMS have led to changes in service provision and commissioning changes.
5 CLINICAL EFFECTIVENESS

5.1 Clinical Audit

During Quarter 3 a total of 38 clinician led audits were registered in addition to the Clinical Audit Team’s formal programmes.

Participation in the National Clinical Audit (NCA) programme and the National Confidential Enquires in Patient Outcome and Death (NCEPOD) is mandated through the NHS contract and participation is reported annually within the Department of Health Quality Accounts. UHNM participate in the following National Audits:

**Medicine**
- Alcoholic Liver Disease
- Bowel Cancer
- Diabetes (Adult)
- Diabetes (Paediatric)
- Falls and Fragility Fractures
- Inflammatory Bowel Disease
- Lung Cancer
- Medical Clinical Outcome Review Programme
- Mental Health Care in ED
- National Audit of Dementia
- National Audit of Intermediate Care
- National COPD Audit
- National Vascular Registry
- Non Invasive Ventilation in Adults
- Pleural Procedure
- Renal Replacement Therapy
- Sepsis
- Moderate or Severe Asthma in Children
- VTE Risk in Lower Limb Immobilisation in ED
- Vital Signs in Children in ED

**Specialised**
- Acute MI and other ACS
- Adult CAP
- Adult Cardiac Surgery
- Cardiac Arrhythmia
- Congenital Heart Disease
- Coronary Angioplasty
- National Audit of Seizure Management
- National Heart Failure Audit
- National Joint Registry
- Pulmonary Hypertension
- Sentinel Stroke National Audit Programme
- Severe Trauma
- Lower Limb Amputation
- Sub-Arachnoid Haemorrhage
- National Cardiac Arrest Audit

**Children, Women and Diagnostics**
- BSUG Audit Database
- Epilepsy 12
- Maternal, New born and Infant Clinical Outcome Review Programme
- National Audit of the Accuracy of Interpretation of Emergency Abdominal CT
- National Comparative Audit of Blood Transfusion
- National Care of the Dying Audit
- Neonatal Intensive and Special Care
- Paediatric Intensive Care
- Paediatric Pneumonia

**Surgery**
- Adult Critical Care
- Elective Surgery
- Head and Neck Cancer
- Medical Clinical Outcome Review Programme
- National Bariatric Surgery Register
- National Emergency Laparotomy Audit
- Oesophago-gastric Cancer
- Prostate Cancer
- Tracheostomy
Published Audits

Re-Audit of Think Glucose at the Royal Stoke University Hospital

The Think Glucose initiative was implemented at the University Hospital of North Staffordshire (UHNS) in 2012 and the Trust undertook an initial audit post implementation to determine if the Think Glucose documentation was being completed in line with the Trust’s Standard Operating Procedure. Following the initial audit the Think Glucose Monitoring Chart was revised and this re-audit was prioritised in order to assess if there has been any improvement in the completion of the Think Glucose documentation and determine enhanced patient experience and outcome for diabetic patients being treated at the Royal Stoke University Hospital. The table below outlines the results and how these compare to the results from the previous audit.

<table>
<thead>
<tr>
<th>Standard</th>
<th>Number (%) of Cases</th>
<th>Variance (%) against previous audit</th>
</tr>
</thead>
<tbody>
<tr>
<td>A Think Glucose monitoring and assessment chart should be completed</td>
<td>96 (96%)</td>
<td>+13%</td>
</tr>
<tr>
<td>Daily referral assessments performed</td>
<td>0 (0%)</td>
<td>No change</td>
</tr>
<tr>
<td>HbA1c checked prior to admission (for elective patients)</td>
<td>24 (86%)</td>
<td>-14%</td>
</tr>
<tr>
<td>Think Glucose Assessment Chart available at the patient’s bed / bay</td>
<td>94 (99%)</td>
<td>+6%</td>
</tr>
<tr>
<td>Patient referred to Diabetic Specialist Nurses</td>
<td>16 (16%)</td>
<td>+16%</td>
</tr>
<tr>
<td>Blood glucose measurement taken at least four times daily</td>
<td>28 (29%)</td>
<td>-</td>
</tr>
<tr>
<td>Adherence to the algorithm for hypo management has improved from the first audit but remains disappointingly poor.</td>
<td>20 (69%) Not followed</td>
<td>6/18 not followed</td>
</tr>
</tbody>
</table>

A number of actions have been identified and are listed below.

Action

In order to ensure all relevant staff are informed of the results of the audit, the audit report will be disseminated via the following forums:-

- Hospital Study Day.
- Regular education sessions within the Trust including the management of hypoglycaemia.

In addition, Quality Nurses will be tasked with ensuring that all ward staff are made aware of key results in relation to the management of hypoglycaemic patients.

In order to ensure appropriate referrals to the Diabetic Specialist Nurse Team the Think Glucose Chart will be amended to incorporate a colour coded section that will track any ‘higns’ and ‘lows’ and trigger a referral when required.

To determine if improvements in practice have taken place a re-audit will be undertaken.
Re Audit of the Trust Policy (MM01) for Medicines Reconciliation at UHNM

The aim of medicines reconciliation is to ensure that the medicines which are prescribed when a patient is admitted to hospital correspond to the medicines that the patient was taking before being admitted. This re-audit was prioritised to ensure on-going compliance with University Hospitals of North Midlands Trust Policy MM01, around the Medicines Reconciliation of inpatients admitted to UHNS.

Since the last audit was performed in 2013 the following key actions have taken place:
- All pharmacy staff have been retrained on MM01;
- Orthopaedic pre-ams paperwork has been revamped;
- Summary Care Records are made available in all the Admissions Portals throughout UHNM.

From the latest results there have been a number of improvements against many of the audit standards and these includes:
- Level 1 medication history needs to be completed by admitting doctor, consultant nurse or advanced practitioner
- For each medication item the following should be identified:-
  - Generic name of the medicine
  - Dose
  - Frequency
- Once the medical history has been documented it should be accompanied by:-
  - Name
  - Signature
  - Contact Method
- Where the clinical plan involves intentional changes to existing medications or additional prescribing the prescriber is responsible for recording and dating, in both the patient’s notes and on the prescription chart, details of these changes.
- Contact Details on the pharmacy notes

Whilst there were overall improvements in the audit results compared to the results from the 2013 audit there are still areas that require further action to improve compliance and practice. Improvements are required in the following:
- All patients should have a Level 1 medication history documented within 24 hours of admission
- Any drug / other specific allergies should be documented in the medical notes and the prescription chart – this should be improved by the implementation of electronic prescribing.
- Recording the name of pharmacy staff completing the pharmacy note (often just signatures). Again resolved by electronic prescribing.

An action plan has been developed to address the above areas and is currently being implemented.
5.2 NICE Compliance

NICE consider that there is no single model for effective implementation, but suggest principles of implementation and require that the organisation’s approach to meeting these principles should be clearly stated in an implementation policy. This policy is in place with assurance on implementation of the guidance sought via the Trust NICE and External Publications Group (NICE & EP Group).

The following table provides a summary position of all guidance monitored via the Trust NICE and External Publications Group. Guidance that is being reviewed by the clinician has been categorised as ‘under review’ and guidance that has been presented at the Trust NICE & EP Group has been categorised as ‘being implemented.’

<table>
<thead>
<tr>
<th>Category</th>
<th>Archive</th>
<th>Under Review</th>
<th>Being Implemented</th>
<th>Audit Review</th>
<th>Complete</th>
<th>N/A</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Guidelines</td>
<td>39</td>
<td>41</td>
<td>23</td>
<td>13</td>
<td>5</td>
<td>13</td>
<td>134</td>
</tr>
<tr>
<td>Medical Technology Guidelines</td>
<td>0</td>
<td>10</td>
<td>5</td>
<td>0</td>
<td>2</td>
<td>9</td>
<td>26</td>
</tr>
<tr>
<td>Interventional Procedure Guidance</td>
<td>0</td>
<td>38</td>
<td>8</td>
<td>11</td>
<td>7</td>
<td>62</td>
<td>126</td>
</tr>
<tr>
<td>Public Health Guidance</td>
<td>0</td>
<td>10</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>11</td>
<td>24</td>
</tr>
<tr>
<td>Diagnostic Technology Guidance</td>
<td>0</td>
<td>3</td>
<td>5</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>14</td>
</tr>
<tr>
<td>Quality Standards</td>
<td>0</td>
<td>37</td>
<td>31</td>
<td>12</td>
<td>4</td>
<td>17</td>
<td>101</td>
</tr>
</tbody>
</table>

5.3 Care Quality Commission

The Care Quality Commission (CQC) inspected the Trust in April 2015 and the report was published 28th July 2015 with the CQC rating the Trust as ‘Requires Improvement’. In response, the Trust has developed an improvement plan to address all recommendations within the report and any other comments or observations where improvements can be made. Implementation of the improvement plan will be supported by local level monitoring with regular assurance given to the Trust Board. In addition, the Clinical Assurance Framework is being further developed to include the CQC’s recommendations to support the effective delivery of the requirement improvements. The Trust is seeking to not only meet the CQC recommendations but to improve its rating to Good/ Outstanding in 2016/17.
5.4 Clinical Assurance Framework

As part of the Trust’s drive to provide safe and effective care the Trust has implemented a robust assurance process which has developed a programme of Clinical Assurance visits to wards and departments which will allow the Trust to review each area using the approach adopted by CQC Inspection teams. These visits can focus on all the CQC domains or be a focussed visit on a particular domain.

During Quarter 3 there have been 11 Clinical Assurance Framework (CAF) visits undertaken. Following the CAF visit, each ward / department is provided with a detailed outcome report summarising the findings of the visit and the recommendations/issues which need to be addressed. Action plans are submitted and the implementation of these are monitored centrally via the Trust’s Compliance Steering Group, ensuring that all CAF visits are effectively improving quality.

Figure 1 details some of the actions implemented following CAF visits

Figure 1: Quarter 2 Summary of Actions following CAF Visits

<table>
<thead>
<tr>
<th>Estates undertaking a refurbishment of the ward to ensure the environment is in line with current health and safety and fire regulations</th>
<th>All non-essential clinical duties have now stopped during mealtimes to promote</th>
<th>New hearing loop system implemented</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pictorial menus to be sourced and introduced</td>
<td>Pictorial menus to be sourced and introduced</td>
<td>All staff undertaking information governance and medications training</td>
</tr>
<tr>
<td>All staff contacted and informed of their responsibilities in the documentation of estimated discharge dates</td>
<td>A review of security is currently underway to ensure that visitors are able to enter the ward securely</td>
<td>A bespoke quality board has been ordered</td>
</tr>
<tr>
<td>Quality Nurses to audit PEWS completion on a regular basis and action accordingly</td>
<td>Hot topics leaflet introduced to keep staff up to date on important issues</td>
<td>Monthly quality reports being developed and displayed to staff, patients and visitors</td>
</tr>
</tbody>
</table>
5.5 Information Governance

The IG toolkit (IGT) is a performance tool that the Trust must self-assess against to meet the criteria for all 45 requirements. If the Trust is unable to meet the criteria for any of the requirements the Trust is rated as “unsatisfactory”. The Trust was rated as unsatisfactory for the 2014/15 Toolkit submission, as the training requirement for 95% of staff to have received their information governance training was not achieved.

During Quarter 2, the Health and Social Care Information Centre (HSCIC) contacted the Trust to request a training plan detailing how the Trust will achieve the 95% requirement for information governance training.

Following their review of the training plan, the HSCIC have rated the Trust as “satisfactory with action plan” for the 2014/15 submission. The HSCIC will continue to follow the Trust’s progress against the delivery plan with the potential to downgrade the Trust to “unsatisfactory” if they feel improvement has been insufficient. This is a significant improvement and will allow the Trust, if performance continues to meet the agreed delivery plan, to achieve overall compliance with the IG Toolkit.

Training figures for the Trust overall are shown in the chart below:

![Chart 22: IG Training Performance 2015/16 per month](image)

No IG breaches have been submitted to the Information Commissioner’s Office during 2015/16 to date.

The number of Freedom of Information (FOI) requests received during quarter three 2015/16 are shown below. The same period for 2014/15 is shown for comparison:

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>FOI requests</td>
<td>47</td>
<td>38</td>
<td>53</td>
<td>60</td>
<td>27</td>
<td>36</td>
<td>127</td>
<td>134</td>
</tr>
<tr>
<td>Questions within FOI requests</td>
<td>451</td>
<td>292</td>
<td>409</td>
<td>757</td>
<td>988</td>
<td>540</td>
<td>1848</td>
<td>1589</td>
</tr>
</tbody>
</table>
## EXECUTIVE SUMMARY FRONT SHEET

### Meeting:
Public Trust Board

### Date:
9th February 2016

### Title:
Month 9 Performance Report

### Author:
Karan Allman, Deputy Head of Performance & Nicola Galley, Performance & Information Analyst

### Executive Lead:
Helen Lingham, Chief Operating Officer

### Other meetings presented to:
N/A

### Purpose
Provides a summary of the Trust performance at month 9 (December) against the key national standards and contractual standards agreed with CCGs for 2015/16.

### Decision Approval Information
- Link to Strategic Objectives
  - Delivering quality excellence for patients: ✓
  - Delivering our financial obligations to the Taxpayer: ✓
  - To achieve excellence in education, training and research: ✓
  - Create an integrated vibrant Trust and develop strategic alliances with neighboring trusts and partners: 
  - Create a resilient Urgent and Emergency Care System and Increase Integrated Healthcare Provision:

### Executive Summary
The attached board report provides an update on key areas including:

- NHS Constitution/NTDA Accountability Framework measures.
- Quality and patient experience.
- Local contractual requirements
- Organisation development

### Key Indicators

<table>
<thead>
<tr>
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<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>4 Hour wait</td>
<td>95%</td>
<td>80.1%</td>
<td>82.8%</td>
<td>89.0%</td>
<td>90.9%</td>
<td>93.3%</td>
<td>88.5%</td>
<td>85.3%</td>
<td>85.4%</td>
</tr>
<tr>
<td>RTT Incomplete</td>
<td>92%</td>
<td>89.7%</td>
<td>90.4%</td>
<td>90.6%</td>
<td>90.0%</td>
<td>89.8%</td>
<td>90.3%</td>
<td>90.8%</td>
<td>91.4%</td>
</tr>
<tr>
<td>Cancer 2ww</td>
<td>93%</td>
<td>93.8%</td>
<td>96.7%</td>
<td>93.4%</td>
<td>95.7%</td>
<td>94.3%</td>
<td>94.4%</td>
<td>92.5%</td>
<td>88.2%</td>
</tr>
<tr>
<td>Cancer 31 Day</td>
<td>96%</td>
<td>94.4%</td>
<td>92.8%</td>
<td>94.3%</td>
<td>94.3%</td>
<td>97.0%</td>
<td>96.1%</td>
<td>98.1%</td>
<td>96.8%</td>
</tr>
<tr>
<td>Cancer 62 Day</td>
<td>85%</td>
<td>71.4%</td>
<td>68.0%</td>
<td>79.8%</td>
<td>72.3%</td>
<td>80.1%</td>
<td>73.2%</td>
<td>73.0%</td>
<td>82.4%</td>
</tr>
</tbody>
</table>

- Attendances risen by 3.4% since Apr-15 and 7% since Dec-14
- The total backlog decreased from Sep-15, with a rise at the end of Dec.
- Cancer 2ww is largely influenced by the Breast symptomatic referrals which have increased by 5.6% since Apr-15
- Emergency admissions continue to rise with an 11% increase since October
December saw a rise in the number of attendances particularly for the first two weeks and then again after the Christmas period. In addition the RSUH daily average throughout of MFFD in December was 105 versus the target of 67. The number of emergency admissions at Royal Stoke also continues to rise with an 11% increase since October. A combination of these factors means that A&E performance has worsened. Although there was only one 12 hour trolley wait in December, this has risen to 42 in January. We also had to cancel planned operations in December to accommodate the emergency pressures. The impact on the RTT position is shown in the table above. Trauma and Orthopaedics suffered particularly and experienced a higher than average number of patients with fractured Neck of Femurs.

**Key Recommendations**

1. To note the performance in December 2015, with the key risks detailed in the report.
2. To be assured that the actions being taken against key risks areas are being delivered and are resulting in improvements.

**Corporate Impact Assessment (please tick any which are impacted on / relevant to this paper)**

<table>
<thead>
<tr>
<th>Quality Implications</th>
<th>Financial Implications</th>
<th>Legal Implications</th>
<th>Workforce Implications</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
</tbody>
</table>
1. Purpose of the Report

This report accompanies the Performance Report and outlines the Trust’s exceptions against key access and performance indicators for the month of December 2015. This new framework for the Board report has been revised to support changes in the NTDA Accountability Framework and local contract requirements.

2. Summary

Emergency and demand have impacted on the elective pathways and performance against some of the key national and contractual indicators. This is reflected in the dashboard with the following standards being below threshold in July.

3. NHS Constitution / NTDA Accountability Framework Measures

3.1 4 Hour Wait Standard, 12 Hour Trolley Waits and Ambulance Handover Delays:

- The Local Health Economy (LHE) improvement trajectory, sets out an expected step change improvement in performance based on LHE schemes of 90% delivery in August and 95% delivery in November:

<table>
<thead>
<tr>
<th>LHE 4 Hour Improvement Trajectory</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actual</td>
<td>80.1%</td>
<td>82.8%</td>
<td>89.0%</td>
<td>90.9%</td>
<td>93.3%</td>
<td>88.5%</td>
<td>85.3%</td>
<td>85.3%</td>
<td>82.8%</td>
<td>76.7%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- The step change improvement in performance of 90% by the end of July was successfully achieved by the Trust with July’s performance at 90.9%, and sustained throughout August with performance better than trajectory at 93.3%.
- Month on month improvement across both RSUH/CH sites for April to August until a steady downturn from September onwards. December has been the worst performing month since May.
- In addition the 95% standard has not been achieved at all in that time.

12 hour trolley waits – There were 13 in Q2 (all occurring on 1st July) and there was a single 12 hour trolley wait in Q3 on 16th December.
Ambulance handovers - In 2015/16 thus far there has been a significant improvement in ambulance handover delays.

>30-60 minutes
- December has seen the lowest trust total handovers of over 30 minutes since April 2014 with 53. This is a 91% (-538) reduction compared to December 2015.

Handovers >60 minutes
- The Trust had no handovers of over 60 minutes in December after having 5 in October and November combined.

Demand Headlines:
- Emergency admissions continue to rise. They were 15% higher in Q3 compared to Q2. This can mainly be attributed to December within which emergency admissions were 7% higher than October.
- Since the beginning of November 2015 the number of medically fit for discharge patients on the RSUH Site has not fallen below 100; target is 67. In addition to this, the number of MFFDs at County has risen from a planned level of 20 to in excess of 50 on occasion.
- The overall occupancy levels are set at 95% and in December was 92% overall. For Medicine the occupancy level was 96% and for T&O/ Neuro it was 102%
- Our performance on ambulance handover is much better than this time last year and continues to improve despite the growth in ambulance activity. The trust saw a 5% increase in ambulance conveyances in Q3 compared to the same period last year.
- We are focusing attention on improving flow through the NHS community services since we took responsibility for step down, community beds and intermediate care services from 1 December 2015.
- Working through detailed plans to strengthen community alternatives for the long term conditions of respiratory, diabetes and heart failure for which we now hold the contract.

Critical success factors:

<table>
<thead>
<tr>
<th>Strategic Objective: Create a resilient Urgent and Emergency Care System with Integrated Healthcare Provision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Success Factor</td>
</tr>
<tr>
<td>-------------------------</td>
</tr>
<tr>
<td>5.1 Deliver 92% Bed Occupancy or less</td>
</tr>
<tr>
<td>5.2 System Wide Demand &amp; Capacity Plan</td>
</tr>
<tr>
<td>5.3 High Quality Major Trauma Centre</td>
</tr>
<tr>
<td>5.4 Deliver the 95% 4 Hour Standard Sustainably</td>
</tr>
<tr>
<td>5.5 An integrated ‘Home First’ Culture</td>
</tr>
</tbody>
</table>

Average NEL length of stay is improving as a whole with all divisions experiencing a decrease. In Q1 2015/16 the Trust achieved its lowest quarterly total length of stay since Q1 2014/15. The overall length of stay has fallen from 3.79 in November to 3.75 in December.

Simple and timely discharge targets continue to be sustainably:
- The Trust continues to sustainably achieve these targets, with the targets achieved in 18 out of the last 18 weeks (19/07/15 – 02/01/16).
- The average number of discharges per week is 827 (average last 13 weeks) +63 in excess of the 764 target.
- 30% discharges before 1 pm – in Q3 the performance is 28.6%.
- Discharges pre 12pm for December was 21.3% - the national range is between 10% – 30%.
- Discharge to Assess (D2A) scheme – the proportion of pathway 1 and 2 patients being discharged within 24 hours of being listed reduced slightly in to December 78% compared to 81% in November, this was due to capacity issues.
- An integrated home first culture - the Trust is discharging 93.9% of all patients, and 83% of patients >70 years of age to their usual place of residence.

Key Emergency Care Improvement Programme (ECIP) recommendations for next 3 months:

1. Effective system leadership of the development of a whole system urgent care strategy
   i. Vision
   ii. Agreed priorities
   iii. Workforce development
      Measured by:
      - Sustainability tool
      - Stranded patient metric
      - 4 hour standard
      - Staff survey

2. SAFER care bundle/Exemplar wards implemented throughout the system(included community facilities)
   i. Senior Review
   ii. All patients have an EDD
   iii. Flow
   iv. Early discharge before 10am
   v. Review all patient every week over 7 days
   vi. Implement a Red and Green 'No Waits' process (include community facilities).
      Measured by:
      - Stranded patient metric
      - Number of patients discharged before 10 am/discharge profile
      - 4 hour standard
      - Audit of board/ward round

   a. Followed up with length of Stay review of all stranded patients over 7 days.
      Measured by:
      - LOS
      - Stranded patient metric
      - 4 hour standard
      - Internal waits audit
      - Reduction in DTOCs

4. Further Ambulatory Care Development
   i. Further links with ED
   ii. Further development of ‘default to ambulatory’ to include specialties
   iii. Further development of surgical ambulatory care process
   iv. Further access to hot clinics
      Measured by:
      - Zero length of stay metric
      - 4 hour standard
      - Conversion rate
      - Daily Capacity in assessment area

5. Frailty pathway development
   i. Development of front door services and early CGA
ii. Development of short stay pathway
iii. Involvement of primary and community care- step up and step down
iv. Review of the Hub particularly their role in step up and step down.

Measured by:
- 4 hour standard
- Conversion rates of over 75s
- LOS for over 75
- D2A

3.2 18 Weeks RTT

As noted in a previous Performance Report the 18 week RTT standard has become the sole measure of 18 week performance. The Trust's performance submitted for December was 90.6% versus the target of 92%.

Key Issue:
- Whilst specialty recovery plans were in place the emergency pressures the Trust experienced during December meant that some elective surgery was cancelled. In addition a growth in demand for Trust services and emergency/bed pressures continued. A&E experienced challenges in December which affected bed capacity resulting in reduction of the elective programme and increased cancelled operations. At present the Trust has 2,846 patients waiting over 18 weeks, of which 1221 is related to outpatients and 1625 to inpatients. Further information is provided below.

Performance:
- In light of the change in the national position and the agreement of a single indicator for 18 weeks performance, the Trust continues to focus on the treatment of long wait patients as a priority and reducing its 18 week backlog, which has been discussed and supported by the Local Health Economy Strategic Resilience Group (SRG).
- The Trust had completed a revised recovery trajectory in October and in light of the current pressures we are working on re forecasting a new trajectory for the remainder of the year. This numerically informs the forecast for incomplete pathways for the remainder of 2015/16.

<table>
<thead>
<tr>
<th>18 week Trust Improvement Trajectory</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actual</td>
<td>89.7%</td>
<td>90.4%</td>
<td>90.6%</td>
<td>90.0%</td>
<td>89.8%</td>
<td>90.3%</td>
<td>90.8%</td>
<td>91.4%</td>
<td>90.6%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>To be confirmed</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>91.3%</td>
<td>91.9%</td>
<td>90.3%</td>
<td>92.1%</td>
<td>92%</td>
<td>92%</td>
<td>92%</td>
<td>90.5%</td>
<td>91.2%</td>
<td>91.6%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- The volume of patients over 18 weeks is improving however the reduction has not been as rapid as originally forecast, and the Trust needs to reduce this number in order to achieve the 18 week incomplete 92% standard. There are 6 key risk specialities that have a backlog greater than the forecasts, and in the main are contributing to the numbers required to achieve the 92% incomplete target, these include: General Surgery, Oral Surgery, Dermatology, Plastics, T&O and Gastro.

Key Actions:
In addition to the individual specialty action plans, all specialties are:
- Micro-managing the incomplete position.
- Validating waiting lists and ensuring accuracy of data quality.
- Management of waiting lists to ensure the national guidance and the Trust Patient Access Policy is applied in full, ensuring wait in line principles are maintained.
- Written validation of the waiting list is being undertaken where appropriate.
- Additional treatment initiatives are being undertaken for both non-admitted and admitted waiting lists at both RSUH and County sites.
- Optimise utilisation of capacity across both sites.
3.3  +52 week breach patients

In December 8 Surgical patients (7 in general Surgery & one in Trauma and Orthopaedics) waited longer than 52 weeks for their inpatient treatment. RCAs have been undertaken for all patients and any lessons learned have been shared with the relevant staff members, the RCAs will be presented to our Trust Quality and Safety forum:

3.4  Cancelled operations not rescheduled within 28 dates

Total cancelled ops in December was 311 – these patients revert back to the WL

- Unexpected cancellation of outpatient’s sessions and Cath Lab activity in Cardiology – for a specific consultant / unexpected last minute leave
- Non-elective Trauma has hit T&O – with 55 operations cancelled end December and early January. Admitted 55 Fractured NOF (against the usual 20-30). T&O now have 105 more breaches than forecasted due to cancelled patients reverting back to the waiting list
- Urology have hit the 92% but have more breaches than forecasted – patients who have rolled over from 16/17 weeks
- General Surgery have had more breaches than forecasted and have not achieved the 92%. The Directorate will have suffered from cancelled operations in December. Total of 44 cancelled operations in December

3.5  Cancer 2ww Standard for Breast Symptomatic patients

As reported previously the demand for both the suspected cancer and symptomatic breast pathways continues to increase. The annual Breast Awareness Campaign in October put the service under further pressure. This increase in demand has continued.

All breast suspected cancer and symptomatic referrals are seen in a ‘one stop clinic’. This service provides patients with a consultant consultation and diagnostic tests. Nationally this type of service is seen as ‘gold standard’ and not all Trusts can deliver this service. The Breast team have delivered additional resource to deal with the demand however, as any additional clinics need cross directorate resources this is not always possible.

The teams have been working hard to meet demand however performance through August – December has not reached the required standard. In January additional ‘one stop’ clinics have been sourced at RSUH and County Hospital which will have to have a positive impact on performance in – January.

Since the start of September 18% of all breast referrals have been for patients under the age of 30. As a result an under 30 clinic has been set up. Patients are referred from this clinic for further tests if requires. It is expected that this clinic will support performance recovery.

The Trust is working with commissioners to review demand and a number of actions relating to this have been included in the joint LHE Cancer Improvement Plan and the Trust is continuing to work with Commissioners to implement these.

To further support the timely delivery of the service a bi weekly cross directorate working group has been established. The meetings are chaired by the Deputy AD for Surgery and Principle Radiographer, Imaging. Representatives from Outpatients, Breast Screening and Cancer Services also attend the meeting. Actions to mitigate patient delays include:

- capacity review across Stoke and County sites,
- full utilisation of the County capacity,
- application of IMAS capacity and demand model

Current breast position is as follows (2ww standard across the Trust has achieved over the 93% in January):

<table>
<thead>
<tr>
<th></th>
<th>Standard</th>
<th>Nov-15</th>
<th>Dec-15</th>
<th>Jan-16 (unvalidated)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2ww suspected cancer breast</td>
<td>93%</td>
<td>35.64%</td>
<td>38.74%</td>
<td>77.47%</td>
</tr>
<tr>
<td>2ww symptomatic breast</td>
<td>93%</td>
<td>30.04%</td>
<td>40.91%</td>
<td>77.59%</td>
</tr>
<tr>
<td>2ww suspected cancer total</td>
<td>93%</td>
<td>88.18%</td>
<td>88.52%</td>
<td>93.08%</td>
</tr>
<tr>
<td>62 day (2ww)</td>
<td>85%</td>
<td>75.00%</td>
<td>77.78%</td>
<td>70.59%</td>
</tr>
</tbody>
</table>
2ww Demand:
Referral Demand:
- Q1 average 2ww suspected cancer patients seen per month 1797 versus 1875 in Q2, a 4% increase in activity. Q3 average was 1932 per month; a 3% increase versus Q2.
- Q1 average breast symptomatic patients seen per month 228 verses 223 in Q2. Q3 average was 244 per month; a 9.6% increase versus Q2.

3.6 Cancer 31/62 Days

As previously noted the Trust, along with 19 other providers, has been required by the national regulators to submit an improvement plan and trajectory, and a self-assessment against the 8 high impact actions, identified by the national cancer waiting times taskforce.

The high impact actions have been extended to include a further 5 actions. These have been included in the LHE Cancer Improvement Plan.

The forecast of the cancer 62 day standard provided in second iteration of the plan demonstrates achievement of the 62 day standard from March 16 onwards. As noted in the letter from Regulators all Trusts are required to recover the standard as soon as possible, but at least by year end.

```
62 Day Trust Improvement Trajectory | Oct | Nov | Dec | Jan | Feb | Mar
-------------------------------------|-----|-----|-----|-----|-----|-----
62 Day Actual                       | 77.2%| 80.1%| 81.4%| 82.9%| 84.3%| 85.3%
```

62 day breach reasons

<table>
<thead>
<tr>
<th></th>
<th>Patient</th>
<th>Capacity</th>
<th>Medical</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nov-15</td>
<td>8 (30%)</td>
<td>13 (48%)</td>
<td>6 (22%)</td>
<td>27</td>
</tr>
<tr>
<td>Dec-15</td>
<td>9 (22%)</td>
<td>15 (37%)</td>
<td>17 (41%)</td>
<td>41</td>
</tr>
</tbody>
</table>

- % 62 day breaches in December are circa 37% due to Trust reason i.e. capacity, and 63% due to factors outside of the Trusts control including i.e. patient choice, complex/medical reasons.

62 day breach reasons (breast)
- Nov 15 – 1 patient choice, 2 capacity & 2 medical (5 total)
- Dec 15 – 1 patient choice, 1 capacity & 2 medical (4 total)
Cancer 62 Day performance by Cancer Site

- The key high risk specialities which are contributing to the Trusts overall underachievement of the standard are Urology & Colorectal. There have been improvements for Lung during Q2 which is continuing through Q3.
- A maximum level of breaches has been agreed with each cancer site to support the delivery of the target.
- The table below provides UHNM Q2 performance verses the national performance. There are 3 sites where UHNM have achieved a better performance to the national picture.

<table>
<thead>
<tr>
<th>62 Day Monthly Performance 2015</th>
<th>National % Meeting Standard</th>
<th>UHNM % Meeting Standard</th>
<th>UHNM Q2 breach volume</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Jul</td>
<td>Aug</td>
<td>Sept</td>
<td>Oct</td>
</tr>
<tr>
<td>Brain*</td>
<td>0.00%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Breast</td>
<td>72.7%</td>
<td>88.5%</td>
<td>89.3%</td>
<td>92.2%</td>
</tr>
<tr>
<td>Colorectal</td>
<td>56.2%</td>
<td>26.7%</td>
<td>44.8%</td>
<td>52.9%</td>
</tr>
<tr>
<td>Gynae</td>
<td>60.0%</td>
<td>88.9%</td>
<td>77.8%</td>
<td>76.0%</td>
</tr>
<tr>
<td>Haematology*</td>
<td>80.0%</td>
<td>86.9%</td>
<td>57.1%</td>
<td>54.5%</td>
</tr>
<tr>
<td>Head &amp; Neck</td>
<td>57.1%</td>
<td>100.0%</td>
<td>66.7%</td>
<td>62.5%</td>
</tr>
<tr>
<td>Lung</td>
<td>75.9%</td>
<td>77.4%</td>
<td>75.0%</td>
<td>66.7%</td>
</tr>
<tr>
<td>Other*</td>
<td>100.0%</td>
<td>0.0%</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Sarcoma*</td>
<td>0.0%</td>
<td>100.0%</td>
<td>85.1%</td>
<td>78.0%</td>
</tr>
<tr>
<td>Skin</td>
<td>90.0%</td>
<td>100.0%</td>
<td>85.1%</td>
<td>78.0%</td>
</tr>
<tr>
<td>Upper GI</td>
<td>76.0%</td>
<td>89.5%</td>
<td>83.3%</td>
<td>88.0%</td>
</tr>
<tr>
<td>Urology</td>
<td>64.4%</td>
<td>72.7%</td>
<td>66.7%</td>
<td>63.0%</td>
</tr>
<tr>
<td>Trust</td>
<td>72.0%</td>
<td>80.1%</td>
<td>73.5%</td>
<td>73.0%</td>
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</tbody>
</table>

*small volume pathways therefore if any breaches occur in these pathways it is difficult to achieve the 85% standard in those areas.

** Provisional data

Key Actions:

- Development of a LHE Cancer Improvement Plan and trajectory.
- All cancer sites have an action plan and trajectory in place which underpins the Trusts overarching cancer improvement plan.
- The Trust is continuing to work with the IST who are supporting the Trust 1 day a week with a focus on: Outpatient demand/capacity and processes, inter provider referrals, further review of the urology pathway and in particular the conversion rates.
- The IST, on behalf of the Trust, have facilitated Demand and Capacity workshop in September and October to support whole pathway planning at cancer site level.
- Robust performance information to support operational delivery, challenge and oversight by divisional, service line and MDT teams is in place.
- Trust governance structure in place to ensure weekly review/action of cancer performance through Divisional Access meetings, and the Trust Planned Care Group. In addition, escalated performance management arrangements are in place for the most challenged specialities.
- Weekly meetings between clinical and management teams to review performance and the patients over 62 day cohort of the PTLS, agreeing actions as required.
- Daily PTL meeting are in place to reduce delays in patient pathways –all specialities

3.7 Diagnostics:

The Trust achieved the diagnostic waiting time target for December with 0.7% of patients not being seen within the 6 week threshold against the target of 1%

4 Quality & Patient Experience

Harm Free Care - Harm Free Care (New Harms), via the monthly Safety Express, continue to meet the national 95% target rate averaging 97.9% which continues the long term improvement. Patient Safety Incidents rate per 100 admissions have decreased. The reporting profile for adverse incidents and level harm is comparable to similar Trusts submitting information to the National Reporting and Learning System and the level harm identified at time of reporting the incident has remained relatively constant.
C-Difficile:- There were 7 Trust apportioned cases of *C difficile* toxin infections (CDI) to report in December 2015. This means that UHNM is above trajectory (7 versus a target of 6) for the month of December and ahead of the year to date trajectory (68 versus 49 for the year to date). 85% of C-Diff are unavoidable i.e no lapses in care.

In all cases control measures are instigated immediately, and RCA’s are reviewed. Each in-patient is reviewed by the *C difficile* nurse at least 3 times a week, and forms part of a weekly multi-disciplinary review.

There was one clinical area that had more than one case of *C difficile* toxin to report within a 28 day period in December 2015.

There is an increase of cases in the wider health economy, and monthly C-Diff Short Life meetings continue, chaired by the CCGs, to have a Health Economy approach. There is an agreed action plan which is monitored and reported to the group and CQRM. A key action includes the antimicrobial prescribing in primary care amongst other measures.

A summit is scheduled for January which will include members from the TDA; NHS England; Local Providers and CCGs.

**MRSA** - There were no cases of MRSA bacteraemia in December 2015 at the UHNM.

The MRSA bacteraemia in November 2015 has been deemed unavoidable with no lapses in care identified for UHNM. This was a poorly 1 year old child with very complex multiple health problems, and has been an inpatient at several Children’s Hospitals, as well as 14 admissions at RSUH this year.

**HSMR** – Mortality is within expected ranges based on both the Hospital Standardised Mortality Ratio (HSMR) and the Summary Hospital-level Mortality Index (SHMI). HSMR has shown reducing trend for the past 6 months of available data, further detail is available in the Trust Quality Assurance Report.

### 5 Local Contractual Requirements

#### 5.1 All clinically inappropriate lines left in situ after discharge:

- 3 Retained Cannula during December 2016.
- All 3 were at RSUH.
- Incidents were reported in A Bay (ED), SAU and Ward 111 (ENT).

No harm came to any patient, and all cannulas were subsequently removed by Trust staff. RCAs are being completed for all patients and lessons learned shared with teams.

#### 5.2 Percentage of Looked-After Children (LAC) will have an initial health assessment undertaken and reported within the 15 working-day timeline of the 28-Day Pathway:

<table>
<thead>
<tr>
<th></th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contractual Standard</td>
<td>90%</td>
<td>95%</td>
<td>97%</td>
<td>100%</td>
</tr>
<tr>
<td>Actual Performance</td>
<td><strong>62.7%</strong></td>
<td><strong>65%</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The Trust has underachieved against the standard in both quarters, however performance was marginally improved in Q2 and there was a significant improvement in the month of September at 88%. The Directorate are forecasting an improvement against the standard in Q3 however November’s performance was 77.4% and this will still result in performance below the standard for Q3. Full achievement of the 100% standard is expected in Q4. At present the waiting time for assessment is <10 days, the key issue impacting on the target is reporting capacity.

**Key Mitigating Actions:**

- Release additional administration time for the clinical team to enable timely completion of the reports.
- Review and re-distribution of activity across the medical team to ensure equality of waiting times.
- Maximisation of middle grades to support LAC clinic reporting.
- Monitoring of consultant teams capacity to ensure there is adequate time to supervise middle grade reporting.
- Improve administrative data collection and inputting processes, to enabling effective coordination of appointments and completion of reports.
- Improved escalation processes have been put in place to ensure early identification and action of any patients who are at risk of breaching the standard.

6 Organisational Development

Sickness Absence Rate (days lost): Sickness absence increased from 4.19% in November to 4.25% in December.

Appraisal Rates: Overall performance improved in December to 94.28% (for staff other than consultants), just short of the 95% target.

Statutory and Mandatory Training: Compliance rates fell slightly from 91.9% to 91.7% in December.

Actions include:
- A Wellbeing coordinator post has been advertised.
- A portfolio of wellbeing/support offerings is being developed that can be rolled out across the organisation.
- A Leadership launch event in March 2016 will focus on compassionate leadership and engagement, which will support positive leadership approaches and wellbeing.
"We will be a leading centre in healthcare driven by excellence in patient experience, research, teaching and education."
## Trust Performance Dashboard: December 2015

### NHS CONSTITUTION/TDA ACCOUNTABILITY FRAMEWORK

<table>
<thead>
<tr>
<th>KPI</th>
<th>Target</th>
<th>Current Month</th>
<th>Previous Month</th>
<th>Current Month Last Year</th>
<th>Next Month Forecast</th>
<th>Quarter Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer (9 Standards)</td>
<td>9</td>
<td>5</td>
<td>3</td>
<td>9</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>18 Weeks (2 Standards)</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>% Waiting &lt;5 weeks from referral to diagnostic treatment</td>
<td>1%</td>
<td>0.78%</td>
<td>0.24%</td>
<td>1.96%</td>
<td>0.90%</td>
<td></td>
</tr>
<tr>
<td>Cancellation operations rebooked within 28 days (current month/unvalidated)</td>
<td>0</td>
<td>-</td>
<td>3</td>
<td>11</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgent operations cancelled for a second time</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>% of A&amp;E attendances admitted/ transferred/discharged within 4 hours</td>
<td>95%</td>
<td>97.81%</td>
<td>97.59%</td>
<td>97.04%</td>
<td>97.81%</td>
<td></td>
</tr>
<tr>
<td>Number of 12-Hour trolley waits in A&amp;E</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Ambulance clinical handovers &gt;60 mins</td>
<td>0</td>
<td>0</td>
<td>14</td>
<td>17</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Ambulance clinical handovers &gt;60 mins</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>9</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Mixed Sex Accommodation Breaches</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

### QUALITY & PATIENT EXPERIENCE

<table>
<thead>
<tr>
<th>KPI</th>
<th>Target</th>
<th>Current Month</th>
<th>Previous Month</th>
<th>Current Month Last Year</th>
<th>Next Month Forecast</th>
<th>Quarter Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>C. Difficile (PA)</td>
<td>74 PA</td>
<td>1</td>
<td>1</td>
<td>10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MRSA</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Never Events</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td>SHMI Band 2</td>
<td>Rand 2</td>
<td>Rand 2</td>
<td>Rand 2</td>
<td>Rand 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sickness Absence</td>
<td>3.39%</td>
<td>4.25%</td>
<td>4.19%</td>
<td>4.01%</td>
<td>4.01%</td>
<td></td>
</tr>
<tr>
<td>Staff Turnover (12 month rolling average)</td>
<td>11%</td>
<td>8.13%</td>
<td>8.36%</td>
<td>7.86%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appraisal Rates (12 month rolling average)</td>
<td>2</td>
<td>9%</td>
<td>11%</td>
<td>10%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Statutory &amp; Mandatory Training</td>
<td>95%</td>
<td>94%</td>
<td>94%</td>
<td>94%</td>
<td>94%</td>
<td></td>
</tr>
</tbody>
</table>

### MEETING OUR LOCAL CONTRACT PERFORMANCE-STANDARDS

<table>
<thead>
<tr>
<th>KPI</th>
<th>Target</th>
<th>Current Month</th>
<th>Previous Month</th>
<th>Current Month Last Year</th>
<th>Next Month Forecast</th>
<th>Quarter Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of women who have seen a misfit or obstetrician for a health &amp; sexual care assessment by 12 weeks 6 days of their pregnancy</td>
<td>95%</td>
<td>94.90%</td>
<td>91.90%</td>
<td>91.90%</td>
<td>95-94%</td>
<td></td>
</tr>
<tr>
<td>Patients admitted following a stroke spend at least 90% of their hospital stay on a stroke unit*</td>
<td>80%</td>
<td>87.80%</td>
<td>85.90%</td>
<td>85.90%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Falls from a trolley, theatre table, A&amp;E trolley or examination table resulting in a fracture, serious injury or death.</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Non-Obs Ultrasound: Results to GP &lt;5 working days from appointment</td>
<td>98%</td>
<td>99.60%</td>
<td>99.70%</td>
<td>99.7%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of Looked-After Children have an initial health assessment undertaken and reported within 15 working-days of admission</td>
<td>45%</td>
<td>Not available</td>
<td>Not available</td>
<td>45%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of CYP admitted to hospital with an acute exacerbation of asthma and discharged with an asthma plan in place</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

### STAFFING & ORGANISATIONAL DEVELOPMENT

<table>
<thead>
<tr>
<th>KPI</th>
<th>Target</th>
<th>Current Month</th>
<th>Previous Month</th>
<th>Current Month Last Year</th>
<th>Next Month Forecast</th>
<th>Quarter Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of Looked-After Children have an initial health assessment undertaken</td>
<td>95%</td>
<td>97.81%</td>
<td>97.59%</td>
<td>97.04%</td>
<td>97.81%</td>
<td></td>
</tr>
<tr>
<td>% of Looked-After Children have an initial health assessment undertaken and reported within 15 working-days of admission</td>
<td>45%</td>
<td>Not available</td>
<td>Not available</td>
<td>45%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Falls from a trolley, theatre table, A&amp;E trolley or examination table resulting in a fracture, serious injury or death.</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Non-Obs Ultrasound: Results to GP &lt;5 working days from appointment</td>
<td>98%</td>
<td>99.60%</td>
<td>99.70%</td>
<td>99.7%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### PRODUCTIVITY

<table>
<thead>
<tr>
<th>KPI</th>
<th>Target</th>
<th>Current Month</th>
<th>Previous Month</th>
<th>Current Month Last Year</th>
<th>Next Month Forecast</th>
<th>Quarter Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Length of Stay (EL)</td>
<td>New KPI</td>
<td>4.66</td>
<td>3.84</td>
<td>4.42</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average Length of Stay (NIL)</td>
<td>New KPI</td>
<td>5.75</td>
<td>3.79</td>
<td>4.59</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Theatre-Surgery Utilisation (Excludes Trauma)</td>
<td>&gt;76.8%</td>
<td>&gt;76.8%</td>
<td>&gt;76.8%</td>
<td>&gt;76.8%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Outliers (Month Average)</td>
<td>New KPI</td>
<td>6.45 (R Sts)</td>
<td>0.65</td>
<td>31</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bed Occupancy (Med &amp; Frail Elderly, surgery, T&amp;O)</td>
<td>New KPI</td>
<td>96.1% (R Sts)</td>
<td>94.2%</td>
<td>96%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### DEMAND

<table>
<thead>
<tr>
<th>KPI</th>
<th>Target</th>
<th>Current Month</th>
<th>Previous Month</th>
<th>Current Month Last Year</th>
<th>Next Month Forecast</th>
<th>Quarter Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Department Attendances</td>
<td>13,325</td>
<td>14,749</td>
<td>15,412</td>
<td>16,287</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elective (Inpatient &amp; Daycase)</td>
<td>8,184</td>
<td>7,686</td>
<td>7,014</td>
<td>8,365</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Elective</td>
<td>9,261</td>
<td>9,626</td>
<td>9,089</td>
<td>8,988</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatients New</td>
<td>17,971</td>
<td>17,354</td>
<td>18,132</td>
<td>16,589</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatients Follow-Up</td>
<td>36,660</td>
<td>34,716</td>
<td>33,177</td>
<td>32,285</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient Procedures</td>
<td>7,656</td>
<td>6,587</td>
<td>6,075</td>
<td>6,975</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**NB The information in this sheet shows a combination of Royal Stoke and County Hospital. Please see subsequent sheets for a split by site.**

**Cancelling Ops are reported one month in arrears to allow for validation.**

**The 2 targets are (1) Consultant Appraisals and (2) Trust Total (Excluding Consultant Appraisals).**

**Commissioning SUS Dataset***

- **Ambulance clinical handovers >60 mins**
  - 0
- **Ambulance clinical handovers >30 mins**
  - 0
- **Mixed Sex Accommodation Breaches**
  - 0

**Completion of valid NHS Number:**

- **Acute SUS Dataset***
  - 95% - 94.90%
  - 99.70%

***Nationally, these figures are reported a month in arrears, therefore the reporting month is not yet available.***
<table>
<thead>
<tr>
<th>KPI</th>
<th>Target</th>
<th>Current Month Royal Stoke</th>
<th>Current Month County</th>
<th>Current Month UHNM</th>
<th>Previous Month Royal Stoke</th>
<th>Previous Month County</th>
<th>Previous Month UHNM</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 Week-Wait - GP Referral to 1st Outpatient (Cancer)</td>
<td>93%</td>
<td>86.70%</td>
<td>95.80%</td>
<td>88.90%</td>
<td>86.30%</td>
<td>96.40%</td>
<td>88.20%</td>
<td></td>
</tr>
<tr>
<td>2 WW - GP Referral to 1st Outpatient (Breast Symptoms)</td>
<td>93%</td>
<td>23.90%</td>
<td>90.30%</td>
<td>39.80%</td>
<td>11.20%</td>
<td>81.00%</td>
<td>30.00%</td>
<td></td>
</tr>
<tr>
<td>31 Day - Diagnostic to 1st Treatment (Tumour)</td>
<td>96%</td>
<td>97.00%</td>
<td>100%</td>
<td>97.40%</td>
<td>96.40%</td>
<td>100%</td>
<td>96.90%</td>
<td></td>
</tr>
<tr>
<td>31 Day - 2nd or Subsequent Treatment (Surgery)</td>
<td>94%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>93.50%</td>
<td>75.00%</td>
<td>91.50%</td>
<td></td>
</tr>
<tr>
<td>31 Day - 2nd or Subsequent Treatment (Anti-Cancer Drugs)</td>
<td>98%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>31 Day - 2nd or Subsequent Treatment (Radiotherapy) Royal Stoke Only</td>
<td>94%</td>
<td>95.90%</td>
<td>95.90%</td>
<td>95.80%</td>
<td>95.80%</td>
<td>95.80%</td>
<td>95.80%</td>
<td></td>
</tr>
<tr>
<td>62 Day - Urgent GP Referral to Treatment</td>
<td>85%</td>
<td>74.20%</td>
<td>77.80%</td>
<td>74.60%</td>
<td>83.00%</td>
<td>78.90%</td>
<td>82.50%</td>
<td></td>
</tr>
<tr>
<td>62 Day - Urgent GP Referral to Treatment (Screening)</td>
<td>90%</td>
<td>92.00%</td>
<td>100.00%</td>
<td>94.1%</td>
<td>88.50%</td>
<td>100.00%</td>
<td>89.7%</td>
<td></td>
</tr>
<tr>
<td>62 Day - Urgent GP Referral to Treatment (Consultant Upgrade - Local Standard)</td>
<td>93%</td>
<td>88.30%</td>
<td>100.00%</td>
<td>90.80%</td>
<td>88.50%</td>
<td>96.60%</td>
<td>90.40%</td>
<td></td>
</tr>
<tr>
<td>Admitted (No longer National Standard)</td>
<td>N/A</td>
<td>82.00%</td>
<td>74.50%</td>
<td>81.30%</td>
<td>79.40%</td>
<td>76.40%</td>
<td>79.00%</td>
<td></td>
</tr>
<tr>
<td>Non-Admitted (No longer National Standard)</td>
<td>N/A</td>
<td>93.30%</td>
<td>97.00%</td>
<td>94.30%</td>
<td>92.60%</td>
<td>96.40%</td>
<td>93.60%</td>
<td></td>
</tr>
<tr>
<td>Incomplete Pathways</td>
<td>92%</td>
<td>89.90%</td>
<td>94.40%</td>
<td>90.60%</td>
<td>90.40%</td>
<td>96.50%</td>
<td>91.40%</td>
<td></td>
</tr>
<tr>
<td>Zero Tolerance to Waits more than 52 Weeks ('Incomplete Pathways' i.e. patients waiting at month-end)</td>
<td>0</td>
<td>0.56%</td>
<td>1.5%</td>
<td>0.78%</td>
<td>0.43%</td>
<td>0.18%</td>
<td>0.24%</td>
<td></td>
</tr>
<tr>
<td>Diagnostics</td>
<td>1%</td>
<td>0.56%</td>
<td>1.5%</td>
<td>0.78%</td>
<td>0.43%</td>
<td>0.18%</td>
<td>0.24%</td>
<td></td>
</tr>
<tr>
<td>Cancelled Operations</td>
<td>0</td>
<td>Reported one month in arrears</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>A&amp;E 4 hour wait</td>
<td>95%</td>
<td>80.49%</td>
<td>93.00%</td>
<td>82.81%</td>
<td>81.20%</td>
<td>94.80%</td>
<td>85.17%</td>
<td></td>
</tr>
<tr>
<td>Number of 12 hour trolley waits</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Handovers between ambulance &amp; A&amp;E within 15 minutes, none waiting over 30 minutes</td>
<td>0</td>
<td>46</td>
<td>0</td>
<td>46</td>
<td>75</td>
<td>1</td>
<td>74</td>
<td></td>
</tr>
<tr>
<td>Handovers between ambulance &amp; A&amp;E within 15 minutes, none waiting over 60 minutes</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>MSA</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>
### PRODUCTIVITY

<table>
<thead>
<tr>
<th>KPI</th>
<th>Target</th>
<th>Current Month</th>
<th>Previous Month</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Royal Stoke</td>
<td>County</td>
<td>UHN Total</td>
<td></td>
</tr>
<tr>
<td>Average Length of Stay (EL)</td>
<td>New KPI</td>
<td>4.48</td>
<td>4.46</td>
<td>4.09</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3.86</td>
<td>3.36</td>
<td>3.84</td>
</tr>
<tr>
<td>Average Length of Stay (NEL)</td>
<td>New KPI</td>
<td>3.48</td>
<td>7.67</td>
<td>3.75</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3.5</td>
<td>8.33</td>
<td>3.79</td>
</tr>
<tr>
<td>Theatre Session Utilisation (Excludes Trauma)</td>
<td>&gt;76.8%</td>
<td>73.66%</td>
<td>65.36%</td>
<td>72.53%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>80.22%</td>
<td>69.14%</td>
<td>78.60%</td>
</tr>
<tr>
<td>Medical Outliers (Month Average)</td>
<td>New KPI</td>
<td>6.45 (Royal Stoke Only)</td>
<td>0.63 (Royal Stoke Only)</td>
<td></td>
</tr>
<tr>
<td>Bed Occupancy (Medicine &amp; Frail Elderly)</td>
<td>New KPI</td>
<td>96.0% (Royal Stoke Only)</td>
<td>93.6% (Royal Stoke Only)</td>
<td></td>
</tr>
<tr>
<td>Bed Occupancy (Surgery)</td>
<td>New KPI</td>
<td>80.3% (Royal Stoke Only)</td>
<td>92.5% (Royal Stoke Only)</td>
<td></td>
</tr>
<tr>
<td>Bed Occupancy (Trauma &amp; Orthopaedics)</td>
<td>New KPI</td>
<td>101.6% (Royal Stoke Only)</td>
<td>101.9% (Royal Stoke Only)</td>
<td></td>
</tr>
<tr>
<td>Bed Occupancy (Medicine &amp; Frail Elderly, Surgery, T&amp;O)</td>
<td>New KPI</td>
<td>91.6% (Royal Stoke Only)</td>
<td>94.2% (Royal Stoke Only)</td>
<td></td>
</tr>
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</table>

### QUALITY & PATIENT EXPERIENCE

<table>
<thead>
<tr>
<th>KPI</th>
<th>Target</th>
<th>Current Month</th>
<th>Previous Month</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Royal Stoke</td>
<td>County</td>
<td>UHN Total</td>
<td></td>
</tr>
<tr>
<td>C-Difficile</td>
<td>74 PA</td>
<td>7</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>MRSA</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Never Events</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Hospital Standardised Mortality Ratio (HSMR)</td>
<td>&lt;100</td>
<td>96.81</td>
<td>97.39</td>
<td></td>
</tr>
<tr>
<td>Summary Hospital-Level Mortality Indicator (SHMI)</td>
<td>Band 2</td>
<td>(Band 2) UHN Total</td>
<td>(Band 2) UHN Total</td>
<td></td>
</tr>
<tr>
<td>KPI</td>
<td>Target</td>
<td>Current Month</td>
<td>Previous Month</td>
<td>Trend</td>
</tr>
<tr>
<td>----------------------------------------------------------</td>
<td>--------</td>
<td>--------------</td>
<td>---------------</td>
<td>-------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Royal Stoke</td>
<td>County</td>
<td>UHNM</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4.20%</td>
<td>5.09%</td>
<td>4.20%</td>
</tr>
<tr>
<td>Sickness absence rate (days lost)</td>
<td>3.39%</td>
<td>4.14%</td>
<td>5.09%</td>
<td>4.19%</td>
</tr>
<tr>
<td>Long-term sickness rate (30+ days absence)</td>
<td>2.60%</td>
<td>2.81%</td>
<td>3.95%</td>
<td>2.87%</td>
</tr>
<tr>
<td>Frequent sickness rates (4 or more episodes of absence)</td>
<td>3.35%</td>
<td>4.01%</td>
<td>3.22%</td>
<td>3.99%</td>
</tr>
<tr>
<td>Staff turnover (12 month rolling average)</td>
<td>11%</td>
<td>8.04%</td>
<td>10.97%</td>
<td>8.13%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>8.22%</td>
<td>10.20%</td>
<td>8.36%</td>
</tr>
<tr>
<td>Appraisal rates (12 month rolling average) - Consultant Medical Staff</td>
<td>95%</td>
<td>94.02%</td>
<td>97.76%</td>
<td>94.28%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>93.89%</td>
<td>97.76%</td>
<td>94.14%</td>
</tr>
<tr>
<td>Appraisal rates (12 month rolling average) - Trust (excl Consultant Medical Staff)</td>
<td>95%</td>
<td>91.51%</td>
<td>96.05%</td>
<td>91.92%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>91.87%</td>
<td>96.05%</td>
<td>92.19%</td>
</tr>
<tr>
<td>Appraisal Rates - Qualified Nursing Staff</td>
<td>95%</td>
<td>93.68%</td>
<td>100.00%</td>
<td>93.88%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>92.53%</td>
<td>100.00%</td>
<td>93.13%</td>
</tr>
<tr>
<td>Appraisal Rates - Add Prof Scientific and Technic; Allied Health Professionals; Healthcare Scientists</td>
<td>95%</td>
<td>95.89%</td>
<td>98.58%</td>
<td>96.09%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>96.30%</td>
<td>98.58%</td>
<td>96.50%</td>
</tr>
<tr>
<td>Appraisal Rates - Additional Clinical Services; Estates and Ancillary</td>
<td>95%</td>
<td>97.16%</td>
<td>100.00%</td>
<td>97.32%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>96.32%</td>
<td>100.00%</td>
<td>96.53%</td>
</tr>
<tr>
<td>Statutory and Mandatory Training</td>
<td>95%</td>
<td>66.50%</td>
<td>61.90%</td>
<td>Not available</td>
</tr>
<tr>
<td>Pay costs as a % of income</td>
<td>66.50%</td>
<td>61.90%</td>
<td>Not available</td>
<td>60.20%</td>
</tr>
<tr>
<td>NHS staff engagement (Target = 2015 National average for acute trusts)</td>
<td>3.74%</td>
<td>Measured Annually</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff Friends and Family Test - combined result from all questionnaires</td>
<td>=&gt;61%</td>
<td>62.00%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>Measured Annually</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of year 5 students, retained into F1 posts (excluding Stafford and Shrewsbury) (Annual Measure)</td>
<td>50.00%</td>
<td>41%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of F1 students retained into F2 Posts (Annual Measure)</td>
<td>50.00%</td>
<td>33%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>KPI</td>
<td>Current Month</td>
<td>Previous Month</td>
<td>Trend</td>
<td></td>
</tr>
<tr>
<td>---------------------</td>
<td>---------------</td>
<td>---------------</td>
<td>-------</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Royal Stoke</td>
<td>County Target</td>
<td>Total Target</td>
<td>Total Activity</td>
</tr>
<tr>
<td>Emergency Department</td>
<td>9,701</td>
<td>3,624</td>
<td>13,325</td>
<td>15,794</td>
</tr>
<tr>
<td>Daycase</td>
<td>5,536</td>
<td>1,098</td>
<td>6,634</td>
<td>6,565</td>
</tr>
<tr>
<td>Elective Inpatients</td>
<td>1,397</td>
<td>153</td>
<td>1,550</td>
<td>1,121</td>
</tr>
<tr>
<td>Regular Daycase</td>
<td>218</td>
<td>163</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Regular Overnight</td>
<td>245</td>
<td>163</td>
<td>245</td>
<td>290</td>
</tr>
<tr>
<td>Non-Elective</td>
<td>6,115</td>
<td>1,378</td>
<td>7,493</td>
<td>7,653</td>
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<tr>
<td>Non-Elective Non-Emergency</td>
<td>1,759</td>
<td>9</td>
<td>1,768</td>
<td>1,973</td>
</tr>
<tr>
<td>Elective Excess Bed Days</td>
<td>491</td>
<td>4</td>
<td>491</td>
<td>5,160</td>
</tr>
<tr>
<td>Non-Elective Non-Emergency Excess Bed Days</td>
<td>132</td>
<td>68</td>
<td>190</td>
<td>307</td>
</tr>
<tr>
<td>Non-Elective Excess Bed Days</td>
<td>2,579</td>
<td>14</td>
<td>2,593</td>
<td>1,878</td>
</tr>
<tr>
<td>Outpatient First Attendance</td>
<td>15,476</td>
<td>2,495</td>
<td>17,971</td>
<td>17,354</td>
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<tr>
<td>Outpatient Follow-Up Attendance</td>
<td>31,418</td>
<td>5,242</td>
<td>36,660</td>
<td>32,972</td>
</tr>
<tr>
<td>Outpatient Procedures</td>
<td>6,377</td>
<td>1,279</td>
<td>7,656</td>
<td>5,807</td>
</tr>
</tbody>
</table>

*RED = >10% variance in either direction*
<table>
<thead>
<tr>
<th>KPI</th>
<th>Target</th>
<th>Current Month</th>
<th>Previous Month</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of women who have seen a midwife or an obstetrician for health &amp; social care assessment of needs / risk by 12 weeks 6 days of their pregnancy</td>
<td>91.5%</td>
<td>94.90%</td>
<td>91.90%</td>
<td>91.5%</td>
</tr>
<tr>
<td>Patients admitted following a stroke spend at least 90% of their hospital stay on a stroke unit - Royal Stoke*</td>
<td>80%</td>
<td>72.20%</td>
<td>52.70%</td>
<td>80%</td>
</tr>
<tr>
<td>Plain film X-ray: Results to GP &lt;5 working days from appointment - Royal Stoke</td>
<td>90%</td>
<td>99.50%</td>
<td>97.50%</td>
<td>90%</td>
</tr>
<tr>
<td>Plain film X-ray: Results to GP &lt;5 working days from appointment - County</td>
<td>80%</td>
<td>99.90%</td>
<td>99.60%</td>
<td>80%</td>
</tr>
<tr>
<td>Non-Obs Ultrasound: Results to GP &lt;5 Working Days from Appointment</td>
<td>98%</td>
<td>99.50%</td>
<td>97.50%</td>
<td>98%</td>
</tr>
<tr>
<td>Percentage of Looked-After Children (LAC) will have an initial health assessment undertaken and reported within the 15 working-day timeline of the 28-Day Pathway</td>
<td>90%</td>
<td>99.50%</td>
<td>97.50%</td>
<td>90%</td>
</tr>
<tr>
<td>Percentage of CYP Admitted to Hospital with an Acute Exacerbation of Asthma will be discharged with an asthma plan (aged 16 year and under)</td>
<td>40%</td>
<td>Not available</td>
<td>94.90%</td>
<td>40%</td>
</tr>
<tr>
<td>Falls from trolley, resulting in a fracture, serious injury or death. Falls from theatre tables, A&amp;E trolleys or examination tables, resulting in a fracture, serious or a serious injury.</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Device that malfunctions or cannot be used when required due to the device not being serviced within required time that results in serious medical harm.</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>All clinically inappropriate lines left in situ where clinically inappropriate after discharge</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>VTE Risk Assessment all inpatient service users undergoing risk assessment for VTE</td>
<td>95%</td>
<td>98.54%</td>
<td>97.81%</td>
<td>95%</td>
</tr>
<tr>
<td>Completion of valid NHS Number: Acute SUS Dataset**</td>
<td>99%</td>
<td>99.80%</td>
<td>99.80%</td>
<td>99%</td>
</tr>
<tr>
<td>Completion of valid NHS Number: A&amp;E Commissioning SUS Dataset**</td>
<td>95%</td>
<td>98.50%</td>
<td>98.50%</td>
<td>95%</td>
</tr>
</tbody>
</table>

*Sentinel Stroke National Audit Programme (SSNAP) figures are reported a month in arrears. All acute strokes are seen at Royal Stoke and repatriated to County (where applicable) for rehabilitation only.
** SUS Data-Quality Dashboards have incorporated County into RJE figures, therefore it is not possible to separate this information by site. NB SUS figures are one month in arrears and are cumulative percentages.
**EXECUTIVE SUMMARY FRONT SHEET**

<table>
<thead>
<tr>
<th>Meeting:</th>
<th>Public Trust Board</th>
<th>Date:</th>
<th>9th February 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title:</td>
<td>Finance Report – Month 09 2015/16 - December 2015</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Author:</td>
<td>Dylan Davies – Deputy Director of Finance – Performance and Reporting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Executive Lead:</td>
<td>Sarah Preston – Acting Director of Finance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other meetings presented to:</td>
<td>Finance and Efficiency Committee, Trust Executive Committee</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Purpose**

The purpose of this report is to set out the Trust’s financial performance for the nine months ending 31st December 2015.

**Link to Strategic Objectives**

- Delivering quality excellence for patients
- Delivering our financial obligations to the Taxpayer
- To achieve excellence in education, training and research
- Create an integrated vibrant Trust and develop strategic alliances with neighbouring trusts and partners
- Create a resilient Urgent and Emergency Care System and Increase Integrated Healthcare Provision

**Executive Summary**

The Trust’s financial performance to the end of Month 9 is a deficit of £18.1m which is a £4.1m adverse variance to plan. Month 9 saw a negative variance to plan in month of £1.6m.

To date income is under recovered against the plan by £5.3m and non pay is overspent by £6m however this is partially offset by under spends on pay of £5.7m and depreciation £1.3m.

The Trust’s CIP target for 2015/16 is £36m. At the end of Month 9 the Trust has achieved savings of £20.6m, £3.4m behind the planned £24m savings.

The Trust has a cash holding of £31.4m at the end of Month 9 which is £20.6m better than planned due to lower payroll costs, higher than planned receipt of SLA income and non-payment of 2014/15 provisions which have not materialised. Cash holdings have reduced in month by £15.2m.

The Trust has spent £33.5m on capital schemes to the end of Month 9 which is £10.6m behind the plan.

**Key Recommendations**

The Trust Board is asked to note the content of the financial position to Month 09 2015/16.

**Corporate Impact Assessment (please tick any which are impacted on / relevant to this paper)**

<table>
<thead>
<tr>
<th>Quality Implications</th>
<th>Financial Implications</th>
<th>Legal Implications</th>
<th>Workforce Implications</th>
</tr>
</thead>
</table>
Being a place our families would choose.
<table>
<thead>
<tr>
<th>No.</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Introduction</td>
<td>4</td>
</tr>
<tr>
<td>2.</td>
<td>Summary</td>
<td>4</td>
</tr>
<tr>
<td>3.</td>
<td>Income &amp; Expenditure</td>
<td>5</td>
</tr>
<tr>
<td>4.</td>
<td>Activity &amp; Income</td>
<td>6</td>
</tr>
<tr>
<td>5.</td>
<td>Pay Expenditure</td>
<td>7</td>
</tr>
<tr>
<td>6.</td>
<td>Non Pay Expenditure</td>
<td>9</td>
</tr>
<tr>
<td>7.</td>
<td>Cost Improvement Programme</td>
<td>10</td>
</tr>
<tr>
<td>8.</td>
<td>Capital Programme</td>
<td>11</td>
</tr>
<tr>
<td>9.</td>
<td>Balance Sheet</td>
<td>13</td>
</tr>
<tr>
<td>10.</td>
<td>Cash</td>
<td>14</td>
</tr>
<tr>
<td>11.</td>
<td>Financial Risk Rating</td>
<td>15</td>
</tr>
<tr>
<td>12.</td>
<td>Conclusion</td>
<td>15</td>
</tr>
<tr>
<td>13.</td>
<td>Recommendations</td>
<td>16</td>
</tr>
</tbody>
</table>
1. Introduction

The purpose of this report is to set out the Trust’s financial performance for the 9 months ending 31 December 2015, including:

- Income and expenditure
- CIP savings and delivery
- Capital programme
- Balance sheet
- Cash flow
- Financial risks

2. Summary

The table below summarises the performance for the first 9 months of 2015/16 in relation to the approved financial plan and the Trust’s financial duties.

<table>
<thead>
<tr>
<th>Trust Financial Summary</th>
<th>Month 9 2015/16</th>
<th>Annual</th>
<th>In Month</th>
<th>YTD</th>
<th>RAG Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Plan £000s</td>
<td>Budget £000s</td>
<td>Actual £000s</td>
<td>Variance £000s</td>
</tr>
<tr>
<td>Income &amp; Expenditure Position</td>
<td>(16,823)</td>
<td>(113)</td>
<td>(1,720)</td>
<td>(1,607)</td>
<td>(14,017)</td>
</tr>
<tr>
<td>CIP Delivery</td>
<td>36,000</td>
<td>3,711</td>
<td>5,214</td>
<td>1,502</td>
<td>23,996</td>
</tr>
<tr>
<td>Capital Expenditure</td>
<td>(66,986)</td>
<td>(5,176)</td>
<td>(2,703)</td>
<td>2,473</td>
<td>(44,137)</td>
</tr>
<tr>
<td>Cash Holdings</td>
<td>9,745</td>
<td>(1,589)</td>
<td>(9,776)</td>
<td>(8,187)</td>
<td>10,882</td>
</tr>
<tr>
<td>IHSS PDC Capital Cash Funding</td>
<td>43,052</td>
<td>3,028</td>
<td>-</td>
<td>(3,028)</td>
<td>26,320</td>
</tr>
<tr>
<td>DoH PDC Revenue Cash Support</td>
<td>12,450</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Financial Sustainability Risk Rating</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>-</td>
<td></td>
</tr>
</tbody>
</table>

2.1 The Trust's plan for 2015/16 is a year-end Income & Expenditure financial deficit of £16.8m. At the end of month 9 the Trust has an actual deficit of £18.1m. This is an adverse variance to plan of £4.0m. The reasons for this variance are described in sections 4 to 6.

2.2 The Trust has delivered £20.6m of CIP savings to month 9. The trust has delivered £3.7m savings in month.

2.3 The Trust has spent £33.5m on capital schemes to month 9. The capital expenditure has slipped by £10.6m compared to the planned expenditure of £44.1m to month 9.

2.4 The Trust has £31.4m of cash at the end on month 9 which is significantly higher than the planned £10.9m. The Trust has drawn down £10.6m of IHSS PDC capital funding to month 9, this is £15.7m lower than planned due to delays in the capital programme and the TDA delaying the approval of PDC Capital cash funding due to the trusts current cash holding. The trust is forecasting to require an additional £12.5m cash support from the Department of Health in 2015/16.
3. Income and Expenditure to Month 9

3.1 The Trust’s financial performance is summarised in the table below. Further detail and performance at divisional level is provided at Appendix 1 and 2 respectively. The Trust’s income and expenditure position for the first 9 months of 2015/16 is a shortfall of income over expenditure of £18.1m against its plan of £14.0m. This is an adverse variance to plan of £4.1m. The in month position is a deficit of £1.7m against a planned in month deficit of £0.1m. This is an adverse variance to the in month plan of £1.6m.

<table>
<thead>
<tr>
<th></th>
<th>Annual</th>
<th>In Month</th>
<th>Year to Date</th>
<th>RAG Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Budget</td>
<td>Budget</td>
<td>Actual</td>
<td>Variance</td>
</tr>
<tr>
<td>Income from Activities</td>
<td>554,695</td>
<td>47,617</td>
<td>48,287</td>
<td>670</td>
</tr>
<tr>
<td>Other Operating Income</td>
<td>149,210</td>
<td>13,407</td>
<td>12,085</td>
<td>(1,322)</td>
</tr>
<tr>
<td>Total Income</td>
<td>703,905</td>
<td>61,024</td>
<td>60,372</td>
<td>(651)</td>
</tr>
<tr>
<td>Pay Expenditure</td>
<td>(435,744)</td>
<td>(37,226)</td>
<td>(36,999)</td>
<td>227</td>
</tr>
<tr>
<td>Non Pay Expenditure</td>
<td>(236,768)</td>
<td>(19,886)</td>
<td>(21,193)</td>
<td>(1,306)</td>
</tr>
<tr>
<td>EBITDA</td>
<td>31,393</td>
<td>3,911</td>
<td>2,180</td>
<td>(1,731)</td>
</tr>
<tr>
<td>Depreciation &amp; Amortisation</td>
<td>(26,663)</td>
<td>(2,228)</td>
<td>(2,128)</td>
<td>100</td>
</tr>
<tr>
<td>Interest Receivable</td>
<td>73</td>
<td>6</td>
<td>0</td>
<td>(6)</td>
</tr>
<tr>
<td>Finance Costs</td>
<td>(15,869)</td>
<td>(1,322)</td>
<td>(1,334)</td>
<td>(11)</td>
</tr>
<tr>
<td>PDC</td>
<td>(5,757)</td>
<td>(480)</td>
<td>(439)</td>
<td>41</td>
</tr>
<tr>
<td>(Gain)/Losses on Disposal of Assets</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Income &amp; Expenditure Position</td>
<td>(16,823)</td>
<td>(113)</td>
<td>(1,720)</td>
<td>(1,607)</td>
</tr>
</tbody>
</table>

3.2 Detailed analysis of the Income, Pay and Non pay are covered in sections 4 to 6.

3.3 Depreciation is £1.3m below the planned expenditure of £20.0m at month 9 due to the slippage in the capital programme.

3.4 The surplus/(shortfall) run rate, representing the difference between income and expenditure, is reflected in the graph below. The negative planned run rate currently shown is a consequence of the overall shortfall of income over expenditure. The graph compares on a monthly and cumulative basis the planned and actual run rates for the year. The graph demonstrates that the planned monthly deficits in the second half of the year are significant less than the planned and actual deficits in the first half of the year. This is a result of higher CIPs and higher levels of income in the second half of the year.

[Diagram of Run Rate 2015/16]
4. Activity and Income

4.1 Operating income for the first 9 months of the financial year was £522m, £5.3m adverse variance to plan. The table below summarises the year to date income position plus the current month position.

<table>
<thead>
<tr>
<th>Income to Month 9 2015/16</th>
<th>Annual</th>
<th>In Month</th>
<th>Year to Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Budget £000s</td>
<td>Budget £000s</td>
<td>Actual £000s</td>
</tr>
<tr>
<td>Comissioned Patient Income</td>
<td>545,911</td>
<td>47,641</td>
<td>47,369 (272)</td>
</tr>
<tr>
<td>Other Clinical Income</td>
<td>8,783</td>
<td>(24)</td>
<td>918</td>
</tr>
<tr>
<td>Income from Activities</td>
<td>554,695</td>
<td>47,617</td>
<td>48,287 (670)</td>
</tr>
<tr>
<td>Private Patients</td>
<td>1,357</td>
<td>113</td>
<td>70 (43)</td>
</tr>
<tr>
<td>Injury Cost Recovery</td>
<td>2,376</td>
<td>198</td>
<td>211</td>
</tr>
<tr>
<td>Education and Training</td>
<td>22,970</td>
<td>1,914</td>
<td>2,046 (132)</td>
</tr>
<tr>
<td>Research &amp; Development</td>
<td>5,577</td>
<td>470</td>
<td>543</td>
</tr>
<tr>
<td>Other CCG Revenue</td>
<td>161</td>
<td>13</td>
<td>6 (9)</td>
</tr>
<tr>
<td>Consultant Distinction Awards</td>
<td>1,100</td>
<td>92</td>
<td>79 (13)</td>
</tr>
<tr>
<td>Non patient Services</td>
<td>29,710</td>
<td>3,604</td>
<td>1,983 (1,621)</td>
</tr>
<tr>
<td>Commercial Income</td>
<td>3,662</td>
<td>305</td>
<td>264 (41)</td>
</tr>
<tr>
<td>IHSS Deficit and Transitional Support</td>
<td>76,019</td>
<td>6,335</td>
<td>6,335</td>
</tr>
<tr>
<td>Other Revenue</td>
<td>6,278</td>
<td>362</td>
<td>558</td>
</tr>
<tr>
<td>Total</td>
<td>703,905</td>
<td>61,024</td>
<td>60,372 (651)</td>
</tr>
</tbody>
</table>

4.2 Commissioned Patient Income

The position against the internally planned activity and income is summarised in the table below.

<table>
<thead>
<tr>
<th>Commissioned Income &amp; Activity to Month 9 2015/16</th>
<th>Annual Plan</th>
<th>Budget £000s</th>
<th>Actual £000s</th>
<th>Variance £000s</th>
<th>Budget £000s</th>
<th>Actual £000s</th>
<th>Variance £000s</th>
<th>RAG Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elective inpatient Spells</td>
<td>17,974</td>
<td>13,362</td>
<td>11,233 (2,129)</td>
<td>56,569</td>
<td>41,973</td>
<td>38,744 (3,229)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Day care Spells</td>
<td>80,756</td>
<td>60,062</td>
<td>61,533 1,081</td>
<td>56,085</td>
<td>41,405</td>
<td>40,922 (483)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non elective Emergency inpatient Spells</td>
<td>81,839</td>
<td>60,564</td>
<td>60,681 117</td>
<td>130,476</td>
<td>103,456</td>
<td>103,292 (164)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non elective Non Emergency inpatient Spells</td>
<td>22,568</td>
<td>16,929</td>
<td>20,057 3,128</td>
<td>24,125</td>
<td>18,039</td>
<td>20,099 2,560</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient Attendances &amp; Procedures</td>
<td>760,844</td>
<td>568,686</td>
<td>520,725 (47,961)</td>
<td>79,654</td>
<td>59,589</td>
<td>55,287 (4,302)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accident &amp; Emergency Attendances</td>
<td>162,186</td>
<td>123,028</td>
<td>114,308 11,522</td>
<td>16,992</td>
<td>12,887</td>
<td>14,075 (1,186)</td>
<td></td>
<td>1200</td>
</tr>
<tr>
<td>Critical care</td>
<td>38,232</td>
<td>28,791</td>
<td>30,667 1,876</td>
<td>39,914</td>
<td>30,062</td>
<td>30,343 (281)</td>
<td></td>
<td>1300</td>
</tr>
<tr>
<td>Direct care</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>13,863</td>
<td>10,249</td>
<td>11,285 1,086</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>270,015</td>
<td>203,905</td>
<td>270,308 66,403</td>
<td>84,100</td>
<td>62,652</td>
<td>61,078 (1,614)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PDR Excluded &amp; Chemotherapy Drugs (Pass through)</td>
<td>21,074</td>
<td>15,854</td>
<td>13,627 (2,227)</td>
<td>38,568</td>
<td>28,855</td>
<td>33,012 4,157</td>
<td></td>
<td>1200</td>
</tr>
<tr>
<td>Pass through drugs</td>
<td>9,336</td>
<td>7,416</td>
<td>9,250 2,410</td>
<td>11,977</td>
<td>8,901</td>
<td>9,215 333</td>
<td></td>
<td>1200</td>
</tr>
<tr>
<td>Fines &amp; Penalties</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>(2,300)</td>
<td>(1,725)</td>
<td>(4,219) 2,404</td>
<td></td>
<td>1200</td>
</tr>
<tr>
<td>Contractual RARs</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>(2,941)</td>
<td>(2,206)</td>
<td>(2,825) 626</td>
<td></td>
<td>1200</td>
</tr>
<tr>
<td>Emergency Threshold</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>(2,941)</td>
<td>(2,206)</td>
<td>(2,825) 626</td>
<td></td>
<td>1200</td>
</tr>
<tr>
<td>Total</td>
<td>1,465,923</td>
<td>1,098,597</td>
<td>1,131,257 34,660</td>
<td>554,694</td>
<td>414,178</td>
<td>409,027 (5,151)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4.3 The income plan is based on the expected levels of demand for acute care within UHNM and therefore in a number of services business cases are required to determine the staffing resources required to meet the increased demand. Currently a number of business cases have yet to be developed or are failing to deliver as planned which are contributing to failure of 18 weeks targets. This is resulting in under performance in particular in elective activity. The plan is also based on clearing the majority of outpatient follow up backlog and as yet the backlog remains at similar levels at the start of the year.

4.4 Main variances to date are –

Author: Dylan Davies, Deputy Director of Finance
Executive Lead: Sarah Preston, Acting Director of Finance
Title of Report: Finance Report – Month 09 2015/16
Version: 1
• Elective inpatient / daycase activity is £3.7m below plan as a result of insufficient theatre capacity, delivery of planned business case developments and winter pressures.
• Non Elective Non-Emergency income is £2.6m above plan. The over performance is due to additional activity in Specialised Surgery and AEC.
• Outpatient activity is 48k behind plan this is causing £4.3m under recovery of income. The activity is below plan due to the planned backlog clearance having not yet been implemented.
• High attendance volumes contribute to A&E activity being up against plan.
• Direct Access over performance of £1m can mainly be attributed to the radiology service over performance of £0.8m.
• Other activity includes the following main variances; £3.4m under performance can be accounted for by RAP’s of £1.8m and a coding challenge by commissioners regarding Daycase to Regular Attendees of £1.1m.
• Contractual fines and penalties incurred up to month 9 are £4.2m. In addition to penalties incurred there is also a further loss of £1.8m income in relation to failure of the agreed RAPs for delivery of the RTT incomplete target plus A&E delivery of the 4 hour target. Fines and Penalties include RTT targets (£1.7m) and A&E 95% target (£1.7m).
• Emergency Threshold is worse than plan, although it is impacted by the opening of the AEC and the increased emergency admission via this portal. Taking into account the emergency performance once all activity has been coded this will be subject to an emergency marginal rate adjustment of 30% for any SLAs that are over performing against the threshold rolled forward from 2014/15. The emergency threshold adjustment at the end of month 9 has been calculated as a reduction in income of £2.8m.

4.5 The commissioned patient income performance summary has un-coded activity estimated at point of delivery level. There is a high level of un-coded activity at month 9 valued at circa £5.8m, the level of un-coded activity has shown an increase compared to month 8.

4.6 Other Operating Income
The majority of Education and Training income over achievement relates to additional SIFT income in year. Commercial Income is below plan mainly due to an under achievement in Car Parking income of £0.5m.

4.7 The table below shows total income run rates against plan

- Contractual fines and penalties incurred up to month 9 are £4.2m. In addition to penalties incurred there is also a further loss of £1.8m income in relation to failure of the agreed RAPs for delivery of the RTT incomplete target plus A&E delivery of the 4 hour target. Fines and Penalties include RTT targets (£1.7m) and A&E 95% target (£1.7m).

5. Pay Expenditure

5.1 Actual pay expenditure is £322.9m at month 9 against a plan of £328.6m. This is a favourable variance of £5.7m at month 9.
5.2 The table below presents the pay expenditure by pay category:

<table>
<thead>
<tr>
<th>Pay Expenditure to Month 9 2015/16</th>
<th>Annual Budget £000s</th>
<th>In Month Budget £000s</th>
<th>Actual £000s</th>
<th>Variance £000s</th>
<th>Year to Date Budget £000s</th>
<th>Actual £000s</th>
<th>Variance £000s</th>
<th>RAG Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>(124,011)</td>
<td>(10,484)</td>
<td>(11,263)</td>
<td>(779)</td>
<td>(92,645)</td>
<td>(96,538)</td>
<td>(3,893)</td>
<td></td>
</tr>
<tr>
<td>Nursing</td>
<td>(135,476)</td>
<td>(12,659)</td>
<td>(11,546)</td>
<td>(1,112)</td>
<td>(101,233)</td>
<td>(99,812)</td>
<td>1,420</td>
<td></td>
</tr>
<tr>
<td>Other Clinical</td>
<td>(103,149)</td>
<td>(8,181)</td>
<td>(8,996)</td>
<td>(815)</td>
<td>(77,097)</td>
<td>(79,912)</td>
<td>(2,815)</td>
<td></td>
</tr>
<tr>
<td>Other Non Clinical</td>
<td>(69,993)</td>
<td>(5,838)</td>
<td>(5,194)</td>
<td>644</td>
<td>(52,716)</td>
<td>(46,670)</td>
<td>6,046</td>
<td></td>
</tr>
<tr>
<td>Unallocated CIP saving target</td>
<td>4,973</td>
<td>(871)</td>
<td>-</td>
<td>871</td>
<td>2,342</td>
<td>-</td>
<td>(2,342)</td>
<td></td>
</tr>
<tr>
<td>Reserves</td>
<td>(8,088)</td>
<td>807</td>
<td>-</td>
<td>(807)</td>
<td>(7,274)</td>
<td>-</td>
<td>7,274</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>(435,744)</td>
<td>(37,226)</td>
<td>(36,999)</td>
<td>227</td>
<td>(328,623)</td>
<td>(322,933)</td>
<td>5,690</td>
<td></td>
</tr>
</tbody>
</table>

5.3 Medical Staffing is overspent at month 9 by £3.9m. The Medical division has the greatest adverse variance to plan of £2.5m due to continued agency expenditure in Acute medicine, A&E, Respiratory and Frail Elderly.

5.4 Other Clinical costs are overspent by £2.8m at month 9. The theatres department is overspent by £1.5m on Other Clinical staff due to agency expenditure.

5.5 Nursing costs are £1.4m under spent year to date. Within the overall under spend there are areas of significant under and over spends.

- A&E Royal Stoke is overspent by £1.3m to month 9. This is due agency usage above the current vacancies.
- Critical Care is overspent by £1.3m to month 9 due to agency expenditure covering vacancies
- The overspend in A&E and Critical Care is off-set by underspends across many wards and departments including Community midwifery £0.4m, Maternity services £0.5m and Orthopaedics £0.4m

5.6 Other Non Clinical staff is underspent by £6.0m due to vacancies and establishment controls within the Central functions departments £3.4m, CWD £1.0m and Estates, Facilities and PFI £0.4m

5.7 Pay funding remaining in reserves relates to capacity requirements not yet drawn down to divisional budgets and County agency contingency reserves.

5.8 The trust has spent £32.2m on agency staffing to Month 9. A summary of agency spend by staff group is included in the table below.
5.9 The highest area of agency expenditure is in Medical and Nursing staff where 13% of the total staffing costs is agency expenditure.

5.10 The graph below shows the pay run rate costs against plan to Month 9 2015.

5.11 The planned reduction in pay costs for the last five months of the year is due to the increased CIP phased towards the second half of the year. The July actual expenditure is lower than the underlying run rate due to the release of provisions in month.

6. Non Pay Expenditure

6.1 Non pay expenditure is £182.5m at month 9 against a plan of £176.5m. This is an adverse variance of £6m. The table below details the expenditure by category.

<table>
<thead>
<tr>
<th>Non Pay Expenditure to Month 9 2015/16</th>
<th>Annual Budget £000s</th>
<th>In Month Budget £000s</th>
<th>Actual £000s</th>
<th>Variance £000s</th>
<th>Year to Date Budget £000s</th>
<th>Actual £000s</th>
<th>Variance £000s</th>
<th>RAG Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Services from Other NHS Bodies</td>
<td>(7,558)</td>
<td>(1,292)</td>
<td>(1,676)</td>
<td>(384)</td>
<td>(3,397)</td>
<td>(5,542)</td>
<td>(2,145)</td>
<td>Red</td>
</tr>
<tr>
<td>Purchase of Healthcare from Non NHS Bodies</td>
<td>(11,172)</td>
<td>(543)</td>
<td>(858)</td>
<td>(315)</td>
<td>(8,925)</td>
<td>(9,436)</td>
<td>(511)</td>
<td>Red</td>
</tr>
<tr>
<td>PBR Excluded &amp; Chemotherapy Drugs</td>
<td>(38,568)</td>
<td>(3,237)</td>
<td>(3,717)</td>
<td>(479)</td>
<td>(28,855)</td>
<td>(33,012)</td>
<td>(4,156)</td>
<td>Red</td>
</tr>
<tr>
<td>Other Drugs</td>
<td>(21,485)</td>
<td>(1,817)</td>
<td>(1,990)</td>
<td>(173)</td>
<td>(16,041)</td>
<td>(14,953)</td>
<td>1,088</td>
<td>Green</td>
</tr>
<tr>
<td>Suppliers &amp; Services - Clinical</td>
<td>(64,525)</td>
<td>(5,599)</td>
<td>(5,775)</td>
<td>(176)</td>
<td>(48,307)</td>
<td>(52,853)</td>
<td>(4,546)</td>
<td>Red</td>
</tr>
<tr>
<td>Supplies &amp; Services - General</td>
<td>(6,398)</td>
<td>(536)</td>
<td>(621)</td>
<td>(84)</td>
<td>(4,771)</td>
<td>(4,985)</td>
<td>(214)</td>
<td>Green</td>
</tr>
<tr>
<td>Establishment Expenses</td>
<td>(4,751)</td>
<td>(446)</td>
<td>(406)</td>
<td>40</td>
<td>(3,553)</td>
<td>(3,606)</td>
<td>(54)</td>
<td>Green</td>
</tr>
<tr>
<td>Transport Expenses</td>
<td>(2,776)</td>
<td>(231)</td>
<td>(227)</td>
<td>5</td>
<td>(2,082)</td>
<td>(2,158)</td>
<td>(76)</td>
<td>Green</td>
</tr>
<tr>
<td>Premises</td>
<td>(26,871)</td>
<td>(2,242)</td>
<td>(2,010)</td>
<td>232</td>
<td>(19,762)</td>
<td>(19,059)</td>
<td>703</td>
<td>Green</td>
</tr>
<tr>
<td>Education &amp; Training</td>
<td>(1,907)</td>
<td>(167)</td>
<td>(109)</td>
<td>58</td>
<td>(1,380)</td>
<td>(1,428)</td>
<td>(48)</td>
<td>Green</td>
</tr>
<tr>
<td>Clinical Negligence Premium</td>
<td>(11,632)</td>
<td>(969)</td>
<td>(969)</td>
<td>0</td>
<td>(8,724)</td>
<td>(8,724)</td>
<td>0</td>
<td>Green</td>
</tr>
<tr>
<td>Other Non Pay</td>
<td>(38,028)</td>
<td>(3,566)</td>
<td>(2,834)</td>
<td>732</td>
<td>(29,170)</td>
<td>(26,774)</td>
<td>2,396</td>
<td>Green</td>
</tr>
<tr>
<td>Unallocated CIP savings</td>
<td>7,233</td>
<td>(274)</td>
<td>-</td>
<td>274</td>
<td>4,618</td>
<td>-</td>
<td>(4,618)</td>
<td>Green</td>
</tr>
<tr>
<td>Reserves</td>
<td>(8,330)</td>
<td>1,035</td>
<td>(0)</td>
<td>(1,035)</td>
<td>(6,196)</td>
<td>(0)</td>
<td>6,196</td>
<td>Green</td>
</tr>
<tr>
<td>Total</td>
<td>(236,768)</td>
<td>(19,886)</td>
<td>(21,193)</td>
<td>(1,306)</td>
<td>(176,546)</td>
<td>(182,532)</td>
<td>(5,986)</td>
<td>Green</td>
</tr>
</tbody>
</table>

6.2 Supplies & Services – Clinical, are overspent by £4.5m year to date. Supplies & Services – Clinical over spend of £0.4m relates pass through devices which is matched by patient activity income, £1.7m relates to theatre non pay overspends, £0.9m relates to cardiology consumables as a result of increased activity. A further £1.2m relates to over spends in imaging and critical care.
6.3 PbR Excluded Drugs & Chemotherapy Drugs are overspent by £4.5m. As this is a pass through cost to commissioners this additional cost is offset by additional income.

6.4 The £2.1m over spend in Services from Other NHS bodies relates to Orthopaedic recharges to Wolverhampton of £0.9m and maternity pathway recharges of £0.9m.

6.5 Other non pay is £2.4m underspent year to date mainly due to release of £2.0m provisions. In addition there is a year to date underachievement against the non pay CIP target which is resulting in a £4.6m adverse variance. Reserves have been underutilised by £6.2m. The unused reserves relate to non pay inflation and capacity requirements not yet drawn down to divisional budgets.

6.6 Non pay run rate is shown in the graph below.

![Non Pay Run Rate Costs 2015/16](image)

7. Cost Improvement Programme

7.1 The trust has delivered £20.6m of savings to month 9. This is an adverse variance of £3.4m compared to the £24m target. All divisions have underperformed year to date, with the exception of Central Functions, Estates and Facilities and Medicine.

7.2 The following table gives an overview of the in-month and year to date performance for all divisions.

<table>
<thead>
<tr>
<th>Division</th>
<th>15/16 Target £000s</th>
<th>Month 9 Target £000s</th>
<th>Month 9 Actual £000s</th>
<th>Month 9 Variance £000s</th>
<th>YTD Target £000s</th>
<th>YTD Actual £000s</th>
<th>YTD Variance £000s</th>
<th>RAG Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central Functions</td>
<td>2,813</td>
<td>249</td>
<td>388</td>
<td>139</td>
<td>2,058</td>
<td>3,156</td>
<td>1,098</td>
<td>Green</td>
</tr>
<tr>
<td>County Medicine</td>
<td>2,093</td>
<td>227</td>
<td>102</td>
<td>(125)</td>
<td>1,365</td>
<td>1,309</td>
<td>(55)</td>
<td>Yellow</td>
</tr>
<tr>
<td>CWD</td>
<td>8,868</td>
<td>915</td>
<td>520</td>
<td>(394)</td>
<td>5,938</td>
<td>4,516</td>
<td>(1,422)</td>
<td>Red</td>
</tr>
<tr>
<td>Estates, Facilities &amp; PFI</td>
<td>3,041</td>
<td>282</td>
<td>339</td>
<td>57</td>
<td>2,256</td>
<td>2,439</td>
<td>183</td>
<td>Green</td>
</tr>
<tr>
<td>Medicine</td>
<td>6,730</td>
<td>782</td>
<td>3,074</td>
<td>2,292</td>
<td>4,325</td>
<td>4,426</td>
<td>102</td>
<td>Green</td>
</tr>
<tr>
<td>Specialised</td>
<td>4,369</td>
<td>388</td>
<td>460</td>
<td>71</td>
<td>3,190</td>
<td>3,018</td>
<td>(172)</td>
<td>Red</td>
</tr>
<tr>
<td>Surgery</td>
<td>8,085</td>
<td>870</td>
<td>332</td>
<td>(538)</td>
<td>4,865</td>
<td>1,175</td>
<td>(3,690)</td>
<td>Red</td>
</tr>
<tr>
<td>Trustwide Items</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>570</td>
<td>570</td>
<td>Orange</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>36,000</strong></td>
<td><strong>3,711</strong></td>
<td><strong>5,214</strong></td>
<td><strong>1,502</strong></td>
<td><strong>23,996</strong></td>
<td><strong>20,611</strong></td>
<td><strong>(3,386)</strong></td>
<td><strong>Green</strong></td>
</tr>
</tbody>
</table>
7.3 In month 9, savings of £5.2m were delivered against a target of £3.7m, giving a positive variance of £1.5m month 9. The positive variance in month is due medicine delivering £3.1m of savings for length of stay and occupancy savings.

7.4 The overall forecast position is £31.9m against a £36.0m target, giving a shortfall of £4.1m. Additionally, the recurrent full year effect is £26.3m attributable to a significant number of non-recurrent schemes in the Estates Facilities & PFI and CWD divisions.

7.5 The following graph provides an overview of the forecast position broken down by high, medium and low risk. It also shows the level of mitigation required to achieve the £36.0m target.

![Graph showing forecast position by risk level](image)

7.6 Whilst good progress has been made to mitigate risks within the programme, there remains £1.9m of high risk schemes and a further £3.8m medium risk schemes within the forecast position. These schemes relate predominantly to income growth and repatriation across the Surgery, Medicine and Specialised divisions. There are also a small proportion of high and medium risk schemes within the year-to-date position.

8. Capital Programme

8.1 The trusts Original Planned Capital Resource Limit for the year was £67m, this has been subsequently reduced to £58.7m to reflect the forecast reduced IHSS and PFI spend.

<table>
<thead>
<tr>
<th>Capital Resource Limit 2015/16</th>
<th>Original £000s</th>
<th>Revised £000s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Royal Stoke - Self Funded</td>
<td>11,455</td>
<td>12,870</td>
</tr>
<tr>
<td>Royal Stoke - PFI</td>
<td>4,466</td>
<td>3,000</td>
</tr>
<tr>
<td>IHSS - self funded</td>
<td>7,850</td>
<td>6,780</td>
</tr>
<tr>
<td>IHSS - PDC funded</td>
<td>43,053</td>
<td>35,795</td>
</tr>
<tr>
<td>Original CRL</td>
<td>66,824</td>
<td>58,445</td>
</tr>
<tr>
<td>Technology Fund</td>
<td>162</td>
<td>162</td>
</tr>
<tr>
<td>Updated CRL</td>
<td>66,986</td>
<td>58,607</td>
</tr>
</tbody>
</table>
The trust has spent £33.5m to month 9 compared to a planned expenditure of £44.1m. The table below provides a summary of the budget and expenditure to date.

<table>
<thead>
<tr>
<th>Capital Expenditure to Month 9 2015/16</th>
<th>Annual</th>
<th>In Month</th>
<th>Year to Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Budget £000s</td>
<td>Budget £000s</td>
<td>Actual £000s</td>
</tr>
<tr>
<td>Royal Stoke - Self Funded</td>
<td>(11,617)</td>
<td>(886)</td>
<td>(909)</td>
</tr>
<tr>
<td>Royal Stoke - PFI</td>
<td>(4,466)</td>
<td>(569)</td>
<td>(126)</td>
</tr>
<tr>
<td>IHSS - Self Funded &amp; PDC funded</td>
<td>(50,903)</td>
<td>(3,721)</td>
<td>(1,668)</td>
</tr>
<tr>
<td>Total</td>
<td>(66,986)</td>
<td>(5,176)</td>
<td>(2,703)</td>
</tr>
</tbody>
</table>

8.3 Royal Stoke – Self funded

The trust has spent £6.1m to month 9 compared to a planned expenditure of £9m. The ICT Infrastructure work stream is £1.7m behind plan. Expenditure is behind plan for Medical Equipment by £1.1m which is mainly due to slippage on a Haemodialysis machines of £250k due to an extended procurement process. Expenditure is behind plan for Estates Infrastructure by £815k which is mainly due to slippage on the Backlog Maintenance works £762k.

8.4 Royal Stoke – PFI

The trust has spent £1.2m to month 9 compared to a planned expenditure of £3.4m. PFI Lifecycle costs are being capitalised monthly in line with the plan but PACS expenditure is behind plan by £0.6m due to a review of the plan by the PACS team. Delays to the 5th MRI project have meant that there is slippage of £0.8m.

8.5 IHSS – Self funded & PDC funded

The trust has spent £26.2m to month 9 compared to a planned expenditure of £31.7m. The table below shows the expenditure by work stream.

<table>
<thead>
<tr>
<th>IHSS - Self funded &amp; PDC funded Capital Expenditure to Month 9 2015/16</th>
<th>Annual</th>
<th>In Month</th>
<th>Year to Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Budget £000s</td>
<td>Budget £000s</td>
<td>Actual £000s</td>
</tr>
<tr>
<td>ICT Infrastructure</td>
<td>(10,057)</td>
<td>(190)</td>
<td>(103)</td>
</tr>
<tr>
<td>Medical Equipment</td>
<td>(2,152)</td>
<td>(400)</td>
<td>(294)</td>
</tr>
<tr>
<td>Estates Infrastructure</td>
<td>(38,694)</td>
<td>(3,131)</td>
<td>(1,271)</td>
</tr>
<tr>
<td>Total</td>
<td>(50,903)</td>
<td>(3,721)</td>
<td>(1,668)</td>
</tr>
</tbody>
</table>

The trust has spent £6.1m on ICT Infrastructure to month 9 compared to a planned expenditure of £7.7m. The underspend year to date of £1.6m is mainly due to delays relating to the Infrastructure project. The trust has spent £1.5m on Medical Equipment to month 9 compared to a planned expenditure of £1.2m. The medical equipment programme is overspent by £0.3m at month 9 which mainly relates to additional costs of modular theatres equipment. This has been offset against an underspend on contingency. The trust has spent £18.6m on Estates Infrastructure to month 9 compared to a planned expenditure of £22.8m, an underspend of £4.2m year to date. The year to date under spend is mainly due to delays in the fire Safety and backlog maintenance.
9. Balance Sheet

9.1 The Trust’s Balance Sheet (Statement of Financial Position) at month 9 shows net assets of £179m.

<table>
<thead>
<tr>
<th>Balance Sheet as at 31st December 2015</th>
<th>31/03/2015</th>
<th>30/11/2015</th>
<th>31/12/2015</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual £000s</td>
<td>Actual £000s</td>
<td>Plan £000s</td>
</tr>
<tr>
<td>Property, Plant &amp; Equipment</td>
<td>497,497</td>
<td>510,223</td>
<td>507,933</td>
</tr>
<tr>
<td>Intangible Assets</td>
<td>13,301</td>
<td>13,207</td>
<td>10,503</td>
</tr>
<tr>
<td>Other Non Current Assets</td>
<td>-</td>
<td>286</td>
<td>215</td>
</tr>
<tr>
<td>Trade and other Receivables</td>
<td>1,127</td>
<td>617</td>
<td>1,387</td>
</tr>
<tr>
<td>Total Non Current Assets</td>
<td>511,925</td>
<td>524,333</td>
<td>520,038</td>
</tr>
<tr>
<td>Inventories</td>
<td>10,840</td>
<td>12,317</td>
<td>11,036</td>
</tr>
<tr>
<td>Trade and other Receivables</td>
<td>64,086</td>
<td>82,588</td>
<td>113,583</td>
</tr>
<tr>
<td>Other Current Assets</td>
<td>303</td>
<td>17</td>
<td>21</td>
</tr>
<tr>
<td>Cash and Cash Equivalents</td>
<td>9,758</td>
<td>46,667</td>
<td>10,882</td>
</tr>
<tr>
<td>Total Current Assets</td>
<td>84,987</td>
<td>141,589</td>
<td>135,522</td>
</tr>
<tr>
<td>Trade and other payables</td>
<td>(66,251)</td>
<td>(152,270)</td>
<td>(145,505)</td>
</tr>
<tr>
<td>Borrowings</td>
<td>(10,267)</td>
<td>(10,438)</td>
<td>(9,630)</td>
</tr>
<tr>
<td>Provisions</td>
<td>(11,645)</td>
<td>(8,674)</td>
<td>(6,233)</td>
</tr>
<tr>
<td>Total Current Liabilities</td>
<td>(88,163)</td>
<td>(171,382)</td>
<td>(161,368)</td>
</tr>
<tr>
<td>Borrowings</td>
<td>(319,190)</td>
<td>(312,350)</td>
<td>(315,851)</td>
</tr>
<tr>
<td>Provisions</td>
<td>(1,372)</td>
<td>(1,372)</td>
<td>(894)</td>
</tr>
<tr>
<td>Total Non Current Liabilities</td>
<td>(320,562)</td>
<td>(313,722)</td>
<td>(316,745)</td>
</tr>
<tr>
<td>Total Assets Employed</td>
<td>188,187</td>
<td>180,817</td>
<td>177,447</td>
</tr>
<tr>
<td>Financed By:</td>
<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public Dividend Capital</td>
<td>328,683</td>
<td>339,279</td>
<td>355,003</td>
</tr>
<tr>
<td>Retained Earnings</td>
<td>(245,636)</td>
<td>(263,597)</td>
<td>(262,612)</td>
</tr>
<tr>
<td>Revaluation Reserve</td>
<td>105,140</td>
<td>105,135</td>
<td>85,056</td>
</tr>
<tr>
<td>Total Taxpayers Equity</td>
<td>188,187</td>
<td>180,817</td>
<td>177,447</td>
</tr>
</tbody>
</table>

9.2 The Board should be note the following in relation to the Balance Sheet.

- The overall variance to plan of £1.6m is mainly due to plan figures being calculated using 2014/15 FOT closing figures and not final figures.
- Provisions relating to 2014/15 have not yet been fully utilised.
- PDC capital relating to IHSS has not been drawn down in line with the plan due to delays in the capital spend programme and delays in the drawdown process with the TDA due to the trusts current level of cash holdings.

9.3 Trade Receivables

The trust has a total of £67.6m debt outstanding as at 31st December 2015. Of this £45m relates to the January 2016 SLAs that were billed in advance to ensure payment was received by 15th of the following month. The trust has a target of having no more than 5% of its total debts over 90 days old. At the end of month 9, £9.7m (14%) of the trust debts were over 90 days (13% at month 8).

The profile of the aged debt is shown in the table below:-

- The profile of the aged debt is shown in the table below:-

1 Author: Dylan Davies, Deputy Director of Finance
   Executive Lead: Sarah Preston, Acting Director of Finance
   Title of Report: Finance Report – Month 09 2015/16
   Version: 1
9.4 Trade Payables

The trade payables balance at the end of December stood at £29.0m, an increase of £2.8m from November. In relation to the Trusts performance against the Better Payment Practice target of 95%, 84% of invoices in value were paid within target during the first 9 months of the year and 87% in terms of number of invoices were paid within target.

<table>
<thead>
<tr>
<th>Aged Debt Report as at Month 9 2015/16</th>
<th>NHS £000s</th>
<th>Non NHS £000s</th>
<th>Total £000s</th>
<th>Total last month £000s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 30 Days</td>
<td>55,200</td>
<td>678</td>
<td>55,878</td>
<td>51,942</td>
</tr>
<tr>
<td>31 to 60 Days</td>
<td>3,543</td>
<td>87</td>
<td>3,630</td>
<td>(3,945)</td>
</tr>
<tr>
<td>61 to 90 Days</td>
<td>(1,722)</td>
<td>93</td>
<td>(1,629)</td>
<td>2,784</td>
</tr>
<tr>
<td>91 to 180 Days</td>
<td>4,808</td>
<td>(190)</td>
<td>4,618</td>
<td>2,783</td>
</tr>
<tr>
<td>181 to 365 Days</td>
<td>2,951</td>
<td>1</td>
<td>2,952</td>
<td>3,061</td>
</tr>
<tr>
<td>366+ Days</td>
<td>1,772</td>
<td>364</td>
<td>2,136</td>
<td>1,872</td>
</tr>
<tr>
<td>Total</td>
<td>66,552</td>
<td>1,033</td>
<td>67,585</td>
<td>58,497</td>
</tr>
<tr>
<td>Debt greater than 90 days (% of total Debt)</td>
<td>14%</td>
<td>17%</td>
<td>14%</td>
<td>13%</td>
</tr>
</tbody>
</table>

10. Cash Flow

10.1 At the end of Month 9 the trust is holding £31.4m of cash this is £20.5m greater than the planned cash holding of £10.9m.

10.2 The graph below shows actual cash versus plan and a revised update to the cash position
10.3 The Trust has received more cash income than plan mainly due to receipts of £6.9m for SLA income relating to finalisation of 2015/16 contract values, a further £9.6m relating to 2014/15 transitional monies. Cash has been further reduced by £5m for non receipt of Q3 transitional monies from the DoH, this is expected to be received in January as is the outstanding education monies.

11. Financial Risk Rating

11.1 The financial sustainability risk framework aims to identify whether the financial position of a trust could place the delivery of its Commissioner Requested Services at risk and where there may be wider issues relating to financial efficiency.

The rating measures 4 metrics to calculate an overall rating. The year to date rating for the trust is detailed in the table below.

<table>
<thead>
<tr>
<th>Financial Sustainability Risk Rating at Month 8 2015/16</th>
<th>Weight</th>
<th>Year to Date</th>
<th>RAG Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continuity of Service</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Liquidity Ratio</td>
<td>25</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Capital Servicing Capacity</td>
<td>25</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Financial efficiency</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I&amp;E Margin Rating</td>
<td>25</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>I&amp;E Margin Variance from Plan</td>
<td>25</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Financial Sustainability Risk Rating</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>2</td>
<td>-</td>
</tr>
</tbody>
</table>

11.2 The trust has an overall rating of 2 which is in line with the planned rating. All metrics are in line with plan except for the I&E margin variance which has a rating of 3 compared to a planned rating of 4 due to the I&E position at month 9 showing an adverse variance to plan. The overall rating of 2 represents a material level of financial risk.

12. Conclusion

12.1 The Trust has an adverse I&E position for the first 9 months of its financial plan for 2015/16. An updated year end forecast has been submitted to the TDA and performance against the financial plan and the year end forecast will be reported to Trust Board in February.

12.2 Following the assessment of the trusts forecast at Q3 the actions below were identified to manage the trusts financial position.

- Operational performance being managed to ensure there is no deterioration on the realistic forecast position regards to contractual fines and penalties.
- Weekly meetings are being held with the CEO, DoF and COO to work with the divisions to ensure opportunities are identified and realised, plans remain on track and support is given where required.
- Any additional risks and opportunities continue to be identified with clear actions for realisation or mitigation in line with the process in place.
- Appointment of additional resource into the PMO function has been made to support delivery of CIP and productivity schemes.
- All CIP schemes will be continue to be developed through the existing process and savings maximised.
• The productivity issues around theatres will continue to be closely managed to ensure the maximum improvements to utilisation rates are achieved in year.

• Additional income opportunities relating to the utilisation of the County site will continue to be assessed to ensure that they are realised.

• A decision with regard to the funding issues requiring resolution by the TDA will continue to be pursued.

• The challenges to the commissioner will continue to be made to ensure that any fines and penalties are invested back in to the Trust.

• The risks and opportunities schedule will continue to be used to track and manage the delivery of the 2015/16 financial forecast. The longer term financial recovery plan will be incorporated with the IBP currently being developed.

• The implications of the 15/16 outturn position and impact of the recovery plan will be modelled through to 16/17 and beyond in conjunction with the IBP process.

13. Recommendations

13.1 The Board is asked:

• To receive the report and note that at month 9 the trust is behind plan.
• The continued endorsement of the management actions identified to increase the levels of assurance relating to the delivery of the optimum financial position.
Agenda Item: 11.

Meeting: Public Trust Board  
Date: 9th February 2016  
Title: Emergency Care Improvement Programme (ECIP) Report  
Author: Vivek Khashu, Deputy Chief Operating Officer  
Executive Lead: Helen Lingham, Chief Operating Officer  
Other meetings presented to: Trust Executive Committee

Purpose
The purpose of this report is to update the Board on the ECIP diagnostic review which was undertaken in Q3 2015/16 and to highlight the key themes and recommendations which were noted within the report.

Link to Strategic Objectives
Delivering quality excellence for patients
Delivering our financial obligations to the Taxpayer
To achieve excellence in education, training and research
Create an integrated vibrant Trust and develop strategic alliances with neighboring trusts and partners ✓
Create a resilient Urgent and Emergency Care System and Increase Integrated Healthcare Provision ✓

Executive Summary
The UHNM system was included within the cohort of 28 Trusts nationally to benefit from intensive support to urgent and emergency care improvement. The first step of this was for a week long diagnostic visit to be undertaken across the whole health system (including south Staffordshire and County Hospital). A report was presented back to the SRG Chair and UHNM on the 22nd December for review prior to final sign off. There was recognition of the improvements to process and practice within UHNM and the constituent sites which had led to benefits in patient flow. These included the Ambulatory Emergency Care Unit at Stoke, the exemplar ward programme and the approach to site management amongst others. The ECIP review team were asked to focus on the acute-community discharge interface and the opportunity to drive the ‘home first’ principle further. The review highlighted key areas for focus, these included the development of a system wide vision, that commitments were made across all disciplines to deliver the vision and finally that the system implemented a structured approach to recovery at the beginning of January (known nationally as a MADE event – Multi Agency Discharge Event). Additionally, the report highlighted a structure for taking forward the recommendations, principally that was to divide the improvement programme into three key ‘flow’ work streams.

A revised action plan, building on current work, but also taking the recommendations of the report has been developed with the support of the ECIP team and signed off by both the system wide Integrated Operational Group (IOG) and the SRG. The plan focuses UHNMs activities going forwards, both internally and with system partners. The delivery of the plan will be managed via the IOG, this is a whole system group which is Chaired by the UHNM Chief Operating Officer, with Director level membership from all system partners, including Local Authorities.

Since the report has been received, the system has proactively engaged with ECIP support across a number of fronts to progress the programme of work. Principally initiating work to implement discharge to assess in south Staffordshire, strengthening discharge to assess in the north Midlands and demand and capacity modelling for the system with regard to reviewing the current capacity model for this current year.
within the system.

As an ‘ECIP system’ the offer is around support, however, it is also about sharing good practice to support the improvement journey of other challenged systems. At the first ECIP launch event UHNM was invited to present on the exemplar ward programme, which is now being implemented in other organisations to good effect (Cambridge University Hospitals FT). On the second event, planned for February 3rd 2016, the mobile phone app developed by Karen McCracken, within the medical division will also be presented. The App gives patients and other health care practitioners real time information on waiting and journey times to respective services such as EDs and walk in centres. The intention is to help inform patients where they may choose to attend, with the added benefit of this app being that it is configured to be used nationally, rather than just within Staffordshire alone.

Key Recommendations

The Board are asked to note the report and its recommendations which have been accepted by the Staffordshire SRG.

Corporate Impact Assessment (please tick any which are impacted on / relevant to this paper)

<table>
<thead>
<tr>
<th>Quality Implications</th>
<th>✓ Financial Implications</th>
<th>✓ Legal Implications</th>
<th>Workforce Implications</th>
</tr>
</thead>
</table>

Emergency Care Improvement Programme (ECIP)

December 2015

Management in Confidence

By E-mail

Dr Andrew Bartlam
Clinical Accountable Officer and SRG Chairman
Stoke on Trent CCG

Dear Andrew,

Emergency Care Improvement programme (ECIP) – Whole System Diagnostic (16th – 20th November 2015)

Thank you for inviting the ECIP to review the urgent and emergency care (UEC) system between the 16th and the 20th of November 2015, where we had the opportunity to meet with leaders, professionals and managers working across the system.

This letter expands on the feedback which was presented at the whole system event on the 19th of November 2015 and offers a series of recommendations for you to consider. As agreed the report will concentrate on highlighting the key areas of priority, which the system should consider to deliver immediate, sustained improvements. We do hope the report can be of some assistance for future development.

Yours sincerely,

Steve Christian
Head of Improvement
Emergency Care Improvement Programme
Mobile: 07769 135279
E Mail: Steven.Christian@nhs.net

Claire Old
Intensive Support Manager
Emergency Care Improvement Programme
Mobile: 07769 726512
claire.old1@nhs.net
ECIP – Whole System Diagnostic - Staffordshire Local Health and Social Care Economy

Summary

A whole system review was undertaken on the 16th – 20th November 2015. The acute Trust that formed part of the whole system review is the University Hospitals of North Midlands NHS Trust (UHNM) incorporating the County Hospital (Staffordshire) and the Royal Stoke University Hospital (Stoke on Trent). The Trust was in full support of the review and the preparatory work leading up to our visit.

The University Hospitals of North Midlands NHS Trust operates from two sites; The Royal Stoke University Hospital and The County Hospital (formerly Stafford Hospital). The trust provides 1,508 beds consisting of 1,380 general and acute beds, 97 critical care beds and 91 maternity beds.

The trust provides general acute hospital services for approximately 700,000 people living in and around Staffordshire. The trust also provides specialised services, such as Trauma, for three million people in a wider area.

The hospital provides healthcare to the population served by six Clinical Commissioning Groups (CCGs):

1. Cannock Chase CCG
2. East Staffordshire CCG
3. North Staffordshire CCG
4. South East Staffordshire and Seisdon Peninsula CCG
5. Stafford and Surrounds CCG
6. Stoke-on-Trent CCG

Each CCG (and its providers) were invited to engage in the process. The SRG was responsible for setting up and arranging the visits against our initial proposal.

The community provider that also formed part of the initial ECIP visit was Staffordshire and Stoke on Trent Partnership NHS Trust (SSOTPT) which provides community health services and adult social care in Staffordshire and health services in Stoke on Trent. These services range from district nursing, health visiting, school nursing, running five community hospitals and managing health services in six prisons through to providing very specialist community care. The Partnership Trust is the biggest integrated health and social care provider in the UK and currently offers health and social care to adults living in Staffordshire (outside of Stoke-on-Trent) through integrated care locality
teams. The 32 teams give people access to a one-stop service for all their health and care needs. The trust serves a population of 1.1 million people and employs in the region of 6,000 staff. It is located within the geographical boundaries of Staffordshire County Council and Stoke-on-Trent City Council and contains a number of urban centres including Stoke-on-Trent, Leek, Burton-upon-Trent, Cannock, Lichfield, Stafford, Tamworth and Wombourne, although the geographic area is largely rural.

Staffordshire and Stoke on Trent Councils

Both Councils face considerable financial challenges and have already seen significant reductions in central government revenue funding in the last 5 years. Expenditure on externally procured long term residential, nursing and domiciliary care represents a considerable proportion of adult social care budgets and it is in this sector that pressures are likely to be most keenly felt. The two Councils do not feel these pressures in the same way with the Council experiencing more difficulty in procuring sustainable domiciliary care than the City Council. This is particularly acute in the rural part of the county.

There are also significantly different other pressures respectively facing the two Councils. Stoke is a discrete, largely urban council with access to a pool of available labour. Staffordshire displays all the characteristics of a dispersed and diverse rural area and the difficulties in access, both geographical and to local services. This, in turn, leads to restricted access to a pool of available labour, where competition from retail and tourism job opportunities create gaps in the provision of care and support.

One of the most important differences is that the County Council’s adult social care provision is delivered by the Staffordshire and Stoke on Trent Partnership Trust. This is an integrated health and social care provider which has been in existence since September 2011. The County Council retains its commissioning responsibility for this service but has no direct management of it. This is not the same for the City Council who retains their adult social care assessment and care management function. Thus their relationship with the hospital is more direct, through the provision of hospital social work teams managed directly by the Council. The relationship with the County Council is one step removed from this.

Although these differences need to be recognised and acknowledged, it is also the case that both Councils are committed to working much more closely particularly in relation to integrated discharge and discharge to assess. There have been some developments put in place by the acute trust that have had a direct impact on the ability of the Councils to facilitate market development and bring sustainability to the system which is explained below. There is recognition by both Councils that they need to be a stronger voice at the partnership table and, in the Council’s case, a stronger commissioner in its relationship with SSOTP. There is a good understanding that the SRG arrangements could be more effective and joint arrangements could be managed much more effectively. There is a perceived need to make sure that the SRGs focus on strategic issues rather than reacting to present problems. There has been a consolidation and clarification of Council attendance and role in SRG system and responses to escalation when required.

Recent staff changes at both Councils have led to progress in the partnership arena and a different and refreshed relationship with both the acute trust and SSOTP. There has been agreement with both SRGs that reporting on DTOCs is not compliant with the national guidance with two workshops
put in place to shift towards a national guidance compliance position. They have undertaken a
number of audits and have identified significant disparity in the reported position on delays due to
social care and the real position. A Social Care Workforce summit was held 20th Nov 2015 attended
by Chief Social Worker, Cabinet Lead, Interim DASS and Chief Executive of the County Council to
present a new vision for SCC adult social care and was attended by 350 social care practitioners.

A review of current partnership agreements with NHS across SSOTP and both mental health trusts
has been undertaken. An interim Principal Social Worker (PSW) for the County has been appointed
and there has been a multi-agency refresh led by SCC of the quality monitoring and intelligence
meetings for quality in the care market.

DASSs were keen highlight recent positive developments and to be able to build upon the
foundations that have recently been established with constructive and proportionate support.

The whole system review comprised of the following:

1. An acute walkthrough of the patient pathway across UHNMs urgent and emergency care
   systems in Stoke and Stafford, meeting with both clinical and managerial staff involved in
   running and working across the internal pathways.
2. Visits to Hayward Hospital, Bradwell Hospital and Cheadle Hospital, the Hub, intermediate
care/CIS at Brighton house, the social care team at Royal Stoke Hospital and Leek ILCT.
3. Structured interviews with GPs, providers and commissioners outside Acute Trust across
   health and social care.
4. Whole system event to present findings and initiate discussion to explore solutions.

Acknowledgements

We would like to thank the teams and individuals we met for their openness and willingness to be
challenged.

We accept, in view of the limited time available, that there may be some errors in the report, for
which we accept responsibility. Nonetheless the visit, with the co-operation of all the staff we met,
has allowed us to make a number of observations, which we have developed into priority
recommendations.

We wish to assure all concerned, in particular the teams we met, that in our evaluation we have
acted independently and trust that observations and recommendations will be viewed in a
constructive manner by all concerned.

The ECIP review was conducted by Dr Jack Hawkins (ECIP Clinical Lead), Liz Sargeant (Clinical Lead –
ECIP -Integration Health and Social Care), Steve Christian (ECIP Cluster Head of Improvement) and
Claire Old (ECIP Intensive Support Manager). Vivek Khashu, Head of Delivery and Development
NHS Trust Development Authority also joined the visit.

Local Context

There have been significant pressures on the Emergency Departments (ED) at UHNMs with crowding,
aggravated by difficulties in patient flow. The department has been operating at over 100%
occupancy levels for long periods, and as a consequence patients and staff experience an area that is
crowded and, at times, not resilient. The system has had a number of inputs from external sources in
the past, most recently from the CQC in July 2015 and from Dr Ian Sturgess in January 2015. The
emergency department at Royal Stoke has consistently and frequently failed the 4 hour waiting time target with the Trust running at around 81% achievement currently.

The pressures placed on the ED and its’ staff due to the constant heightened pressures is neither a sustainable nor safe way of working. As a result, UHNM and system partners must identify further alternative measures and strategies in the best interest of both the patients and the work force, and most importantly to ensure the systems future planning is robust, safe and fit for purpose.

Evidence Base – Case for Change

As a starting point it is essential that everyone across the system understands that poor patient flow leads to a reduction in high quality care, and therefore the requirement to make improvements at pace.

Research into poor patient flow (resulting in crowded Emergency Departments and high bed occupancy) has established links with a number of adverse patient outcomes and evidence suggests:

- For patients who are seen and discharged from an A&E, the longer they have waited to be seen, the higher the chance they will die during the following 7 days (Guttmann et al, 2013).
- The longer a patient spends in the Emergency Department (ED), the longer they stay in the hospital (Liew et al, 2003).
- 10 days in hospital leads to the equivalent of 10 years ageing in the muscles of people over 80 (Giles et al, 2004).
- Delays in transfer from ED to higher dependency unit’s increase mortality and length of stay (Chalfin et al, 2007).
- Once a hospital is over 90% bed occupancy it reaches a tipping point in its resilience (Forster et al, 2003).
- Lowering levels of bed occupancy is associated with decreased in hospital mortality and improved performance on the 4-hour target (Boden et al, 2015).

The national key factors associated with deterioration in 4 hour standard performance

The Economic Team at Monitor have completed analysis to determine the key factors at a national level for the deterioration in performance (figure 1).
The findings show that the most important cause of the decline was a reduction in hospital trusts’ ability to absorb an increase in admissions from EDs. This, in turn, was a result of trusts running at very high occupancy rates of 90% or above. The data indicates that factors potentially contributing to blockages at other stages in the patient pathway had either a minor or no impact on actual delays. Therefore measures taken by trusts to improve patient flow through hospital departments other than ED are likely to be highly effective in avoiding another sharp decline in 4 hour standard performance next winter.

Based on the findings from the analysis (national context) and our observations across the whole system review the report will detail process improvement recommendations that if delivered we believe will support the system resilience in achievement of the 4 hour standard. However, more importantly, improve patient experience and mitigate any potential harm factors arising from the known evidence based risk factors associated with poor patient flow and ED crowding.

**Recommendations**

As requested, the report will identify the priorities (by stream) for system opportunities to secure rapid and sustained improvement. The report has purposely kept the priorities to a manageable level and been specific on the areas that if delivered will provide the marginal gains required. It must be noted that we observed many aspects of good practice and hardworking, committed individuals. The report is focused on further opportunities to complement existing efforts.

Please note that we heard that the system had received numerous diagnostic visits and reports recently and you requested that we triangulated previous findings with our recommendations in order not to introduce new priorities, especially during the winter period. We have tried to do this as much as possible and in doing so recognised, as have many colleagues in the system who expressed intense frustration, that some actions remain outstanding from previous reports.

1. **Leadership**

Whilst recognising that the system still has challenges, there is a feeling from the system itself that there has been a significant positive change particularly in the operational leadership of the acute Trust over the last 12 months. Participants internally and externally to the Trust recognised the huge positive leadership influence from Helen Lingham as the Chief Operating Officer. There was a recognition that the sub-SRG Integrated Operating Group, chaired by Helen, was functioning to effect change, although there was some disquiet that some actions such as the acute trust commissioning of a more expensive domiciliary care provider to ensure swift discharge of patients, had unintended consequences on the domiciliary care market. There is always a balance to be sought between pragmatic action to solve problems and the long term consequences of that action. We find that where there is true integrated working, relationships and governance, the risk is mitigated as effectively as possible. There was still a feeling between
partners that the acute trust sometimes takes action without effective integrated consultation and we recommend that an effective mechanism is developed and accepted by all stakeholders.

It was reported by participants we interviewed that the presence of six CCGs (effectively two in the North and four in the South of the area) can cause some confusion as to the priorities for urgent care, particularly for providers. We were given the ‘North Staffordshire Urgent Care Strategy’ for the next five years, produced by the two north CCGs and we learnt that the four southern CCGs were keen to input into the document to ensure clarity of vision for urgent care. To date, the input has not been forthcoming from the other CCGs which is causing a confusion as to the strategy status and sign-up to the vision. We recommend that leaders work together to develop a clear vision and strategy for urgent and emergency care. The Ian Sturgess report of the 16th of January 2015 describes that “system level leadership requires significant further development. This needs to be aligned to a credible clinical vision with a clear set of impact metrics”. We agree with this recommendation and suggest that it is prioritised

Priority recommendations:

- Development of system wide vision for UEC and delivery of an effective communication strategy to cascade to all staff by the SRG
- Ensure clinical leads and middle managers set out ‘commitments’ to deliver and work towards the achievement of the vision.
- System leaders to run a Safer Start campaign in the first week in January to support system resilience and assist maintaining the current ‘positive’ culture across system in continuous improvement.

At the feedback session we suggested a concentration on actions in three areas:

- Assess to Admit
- Do Todays Work Today
- Home First/Discharge to Assess

Simply put, this gives a framework to only treat people in hospital who need to receive that care in hospital. Senior multidisciplinary assessment early in the pathway ensures care alternatives can be sought.

If the patient needs hospital care, using the SAFER flow bundle to proactively manage today's work today ensuring a ‘no waits’ philosophy, the implementation of a frailty model and the management of ‘red and green days’ avoids decompensation particularly of elderly patients.

A ‘home first’ aim ensures simple discharges are expedited, again to avoid decompensation. Where home first requires supporting services to be wrapped around the patient, these must be available without delay e.g. within half a working day.

For those more complex patients who may need enablement in a residential or nursing environment, care plans must be clear to ensure that a bedded environment is necessary, as many patients can have enablement at home. A baseline of ‘no patient is assessed for long term care in an acute environment’ ensures that the assessment can be carried out when the patient has achieved their potential, outside the acute trust (ideally at home), within an actively managed environment after receiving appropriate therapeutic input.

2. **Assess to Admit**

(i) **The Ambulance Service**
Although we did not meet managerial ambulance colleagues during this visit, we heard of excellent joint working in admissions avoidance, particularly using the Hub.

Triangulation with the Sturgess Report: WMAS now directly convey patients to the Haywood Hospital Walk-In centre. We support this pathway however it was felt that the service is not being maximised and we recommend that the system evaluates this initiatives to develop and build on current successes.

(ii) Primary Care

We talked to a number of GPs in Stoke on Trent and staff in their practices. We also spoke to GP trainees. It is recognised that we need to talk to GPs in the south to get an impression of primary care before making detailed recommendations.

The major challenge for GPs in the north are high levels of vacancies for all staff in primary care, particularly doctors and advanced nurse practitioners. Out of the 88 practices in the north, 12 practices are at high risk for sustainability going forward and there is a risk of closure if the position deteriorates. (Please refer to section 7- workforce challenges) It was reported that because no additional winter monies have been made available this year, proactive services have not been commissioned as yet for the winter. There is a perception that local general practitioners were not engaging with the new OOH provider in the North which may put the OOH service at risk.

It was reported that there was significant variation in general practice referral rates to the acute trust and the attendance rates at ED. Primary care data sets were produced with a quality visiting programme of all general practices in place. Capacity challenges had made this less frequent and effective, the quality visits were now only performed annually.

GP have formed a Federation and some are very keen on working to improve the urgent care agenda. There is work on collaborative commissioning models in primary care involving GPs in the ‘Year of Care’ agenda but there were questions about who was driving the urgency for change? GPs bemoaned the fragmentation of services and they recommended:

- that the Federation needed to work at a faster pace to effect change.
- that primary care and out of hours in the north were ‘broken’.
- that there needed to be a clearer vision on long term conditions management.
- that the Sturgess report recommendations needed to be further embedded in UHN M.
- that junior doctors needed to be educated and empowered to educate patients about not attending ED without fear of recourse from complaints.
- UHNS frequent flyers needed coordinated management

We recommend that it becomes a standard for all GPs to visit the patient before admission except in life threatening situations to ‘assess to admit’.

(iii) 111

We did not review the 111 service in our WSD visit, but at the feedback session, you expressed that this was causing some challenges to the system therefore we are willing to conduct a review of the service using one of our expert colleagues once the data is presented to support this.
(iv) Ambulatory Emergency Care

Royal Stoke Hospital

The medical ambulatory care unit takes all calls from GPs between 9 and 5 and after these calls go through to the admissions unit. The ambulatory care unit is open for 12 hours led by three ANPs trained to masters’ level with prescribing skills. Staff described medical recruitment as a barrier to extending medical hours in the ambulatory care unit. Staff outlined a ‘pull’ of patients undertaken by ANPs to the ambulatory care unit at 8am from ED and AMU, and that there still needed to be further buy-in from specialist medical staff to use an ambulatory model. They described positive changes in culture and behaviours, although confidence in the model was still developing. However the staff we met felt that trust were now bought into the concept of ambulatory care and “it now feels very different”, but they recognised that a further step change was needed in the behaviour of the specialists to discharge earlier and use ambulatory care. The unit was large, well planned and well run, with staff that were passionate about the possibilities of ambulatory care.

The surgical ambulatory care unit had recently been developed. The model was still being expanded and seemed to be in the ‘proof of concept’ stage. That said, the staff were extremely enthusiastic and desperate to develop the model further. We recommend contacting the SAU team in Bath who have been running their SAU for a number of years and are happy to share their new protocols.

Priority recommendations:

• To continue to develop both the medical and surgical ambulatory care units and increase the number of emergency patients being referred to AEC, prior to decision to admit into hospital.
• All patients referred as an emergency should be considered for AEC management as a first line unless they are clinically unstable.
• The time frames for initial assessment and medical review in the AEC facility should be similar to those in the main ED. This should be monitored and reported.
• The AEC service should be available for a minimum of 12 hours per day 7 days per week, including telephone advice to ‘assess to admit’

Triangulation with the Sturgess Report:

Dr Sturgess recommended ambulatory care and a short stay flow stream which the Trust has developed very well on the Stoke Royal site.

County Hospital

There are some services to prevent admission at the front door, we would recommend that the model is reviewed and linked to the development of a frailty team to allow immediate capture of collateral functional information on admission by therapists or assistant practitioners. If the person is admitted to a base ward this should follow them onto the ward and be used as the information on which their discharge is planned. Any reduction in function is likely to have been caused by deconditioning due to long periods in bed, rehabilitation/reablement may be required and this should be undertaken back at home.
once the person is medically optimised and has no acute nursing needs. Further assessment should be undertaken once the person is at home, this will require rapid response from community teams and ability to put in short term support if required while they recover.

To achieve this requires a tier of intermediate support that is flexible and always able to respond in a timely manner. It appeared to us that although there are services to support people at home, there are a range of different services, governed by criteria that prevent people being able to access the support and care they need in a timely way.

The AEC unit at County Hospital requires development to increase the number of emergency patients being referred to AEC, prior to decision to admit into hospital.

Priority Recommendations:

• As per recommendation for the Royal Stoke Hospital, all patients referred as an emergency (from GP and ED) should be considered for AEC management as a first line unless they are clinically unstable. The number of patients being directly referred to AEC from ED and GP needs to form part of the daily performance reports that are accessible to all clinical and managerial leads. The aim should be to deliver a process were the AEC facility is accommodating at least 35% of the current medical take.
• The time frames for initial assessment and medical review in the AEC facility should be similar to those in the main ED. This should be monitored and reported internally.
• On the day of the visit the unit had been open overnight for patients with a ‘Decision to Admit’. This should be avoided as it prevents the effectiveness of the model and its resources the following day.

(v) ‘Step up’

‘The Hub’

We visited The Hub and staff outlined some of their current challenges as:

• A perceived risk aversion/lack of understanding from the acute trust to enable risk to be managed in people’s own homes. Community staff felt that there could be more use of the ‘two week trial’ model where services wrapped around patients to enable them to try to live at home.
• A shortage of GPs.
• A public expectation of hospital and a bed.
• Challenged intermediate care capacity
• The development of confidence in community support services for GPs to keep patients at home.
• No whole system real culture of ‘home first’.
• “We have more community beds than the whole of the Christian World”
• Delays in the provision of packages of domiciliary care- with over 1000 hours of need in Stoke currently unmet.
• Challenges in the nursing and residential market- particularly around issues with CQC registration.
• Payments to care staff were reported to be different in the two LA areas, with it outlined that Stoke had made a decision to pay the ‘living wage’ but Staffordshire had not yet taken its decision on how it will manage this issue.
• “We want integration of teams at the shop floor level, the ingredients are here, but we haven’t got hearts and minds yet and key people are not convinced”
The Hub has been in place since 2010 and has recently the operating model was reviewed. We observed a committed group of passionate professionals with shared frustrations about the lack of ability to redirect patients to non-bedded alternatives and ‘step-up’ facilities. When we asked if, when there was a lack of a capacity in the intermediate care teams, priority would be given to ‘step up’ or ‘step down’ patients, we received the answer that it would be “step up- because the person who was in a hospital bed was in a place of safety”. We also observed a ‘simple’ redirection of a DVT pathway taking at least 45 minutes and several phone calls with changes in decisions to resolve the issue. Whilst we understood that the service had been moved temporarily recently and this had caused some confusion, we also heard of some GPs not using the Hub at all, if they find the service difficult to navigate, even the staff in the Hub admitted that they may resort to admission. In triangulating the usefulness of the Hub for admissions avoidance with stakeholders, some GPs thought it was excellent, and they always used it to avoid admission and felt it was effective. We did have a report from the walk-in centre to say “if I discuss 10 patients with the Hub, they would not be able to access any alternatives for 9 patients”.

The Hub is currently housed in a very poor environment and we wondered if there was a chance that placing it in the new ambulatory care unit in the Royal Stoke may raise the profile, link with ambulatory teams and care of the elderly teams, to truly enhance the recommendation and referral to the step up and step down role?

There was a perception from many people in the system that we met, that the intermediate care service required review to ensure that the model was fit for purpose.

We heard an interesting comment- “if UHNM Consultants gave the same level of confidence to the community teams as they gave to their own hospital at home service we would love it”. We would recommend that a discharge workshop with both teams and the Consultants would help to develop a community model which had the confidence of all stakeholders, and the economies of scale in the deployment of scarce staff resource.

The Hub took an average of 60 calls per day from GPs and used a two page trusted assessment document. The Hub also took calls from nursing homes and residential homes as part of a pilot, and accessed an advanced practitioner for a 2-4 hour response service which is said to be evaluating well for admission avoidance. There seemed to be a lack of clarity and potential duplication of this service with the GPs providing cover to these homes, but we recommend that this potential is evaluated. The capacity in both the South and North ICT teams was unclear. We heard that demand and capacity modelling had not been carried out, and we recommend that when you are clear about your model, you create a model based on true demand.

The Hub operates in north Staffordshire. In the south the ambulance service deliver a ‘Telemed’ service with similar provision. We were pleased to see that staff attended each other’s centres to ensure that there was shared training in assess to admit of both systems; it was reported that ambulance crews often telephoned the Hub for South Staffordshire patients. Staff asked if there were economies of scale by combining the two units?

Hub staff recognised the level of escalation in the hospital as a result of twice daily escalation emails and reinforced the message of admission avoidance as a result.

Priority Recommendations:

- Staff recommended that the provision of night sitting could increase the admission avoidance opportunities. The voluntary sector could support this.
- To address the workforce challenges across both systems, we recommend a workshop to explore solutions. We believe that innovative solutions can be developed which protect the
system from losing valuable staff to each other with the consequence of reducing system resilience. This was described to us all over your system, but most poignantly in primary care, where excellent ANPs were being lost, reducing capacity, and a risk of increased ED attendances.

- Staff recommended that patient education on the alternatives to admission should be developed.
- Staff also felt that there were still GPs not using the Hub. We would suggest that the Primary Care Strategy could be more explicit about the use of assess to admit pathways. Staff also suggested marketing the Hub to GPs.

Triangulation with the Sturgess Report:
Dr Sturgess recommended that all GP urgent care referrals that cannot be managed through effective alternative care pathways from the Hub must have a senior clinical discussion between the GP and the appropriate Consultant.
**We do not believe that this is happening as yet.**

Dr Sturgess recommended a care home model which avoided admissions, this is now in place.

Whilst the Hub did encourage integrated management of common acute presentations, given what we observed, **this still requires more work.**

3. **Today’s work Today**

(i) **Emergency Department**

Given the thoroughness of the Sturgess Report, you asked us not to review the ED again; however it would be remiss of us not to mention that the major problem for the ED and assessment units at the Trust is ‘outflow’. The 4 hour standard should be seen as a ‘barometer’ for the system, however, the key solutions do not lie within the ED. We saw, and heard, during the visit that ED had changed their SOP to ensure the consistent delivery of early senior assessment and made changes to improve patient care and improve flow within the department. Without improved out flow of patients awaiting admission, waiting times will remain too high.

In the Paediatric ED concerns were raised during the visit. It was extremely busy and attendances were described to be rising. We were informed that the CCGs were ‘unhappy’ with the rise in attendances and have sought to re-commission the service. When we visited Primary Care, they described ‘being on their knees’ and unable to cope with any further demand. The specialist paediatric staff were worried that unless alternatives were commissioned effectively supported by an adequate workforce to meet demand, the service would be decommissioned without a safe alternative in place. Whilst we are sure that commissioners would not allow this to happen, the uncertainty around the future is causing serious concerns for staff. We would advise that any re-commissioning seeks to engage the experts and has a very careful communication programme to ensure that there are no unintended consequences to the re-provision.

Triangulation with the Sturgess Report:

The ED has consistent delivery of early senior assessment.

The interface between ED and the Intermediate Care services is perceived to be much improved but the adoption of a front end care of the elderly model would enhance this further.
Until the feedback session, mental health was not mentioned at all as an issue; liaison services were seen to be much improved. Commissioners still felt it was a problem, but it was, unusually, not mentioned as an issue in the acute trust.

(ii) Acute Medicine

The Royal Hospital

Acute medicine is about assessment, short stay (SS) medicine, ambulatory emergency care (AEC), speciality streaming and ‘pulling’ of patients who need ongoing care. These elements are all present, with opportunities for improvement. It is important for the whole team delivering this care, doctors, nurses, therapists and managers to understand ‘this is how we work here’. The vision needs to be clear, shared, owned and communicated with all involved in the patient’s journey.

The County Hospital

The take is relatively small and therefore a small number of breaches can result in failure to achieve the 4 hour standard. There are about 18 admissions a day with attendances of 120/130.

Priority Recommendations:

- The adoption of the vision has moved a long way but there is more to do to reduce variation and, as outlined above, more ‘buy-in’ needed for the ambulatory care model from clinicians to prevent admission and increase discharge to the care of the ambulatory team.
- A drive to create spaces on AMU every morning is essential to enable flow. This obviously requires downstream pull into deep inpatient wards.
- Staff felt that there was an understanding in the system of the front end of the urgent and emergency care pathway, but still felt that downstream deep inpatient ward staff did not appreciate the pressure on the front door.

(iii) Exemplar Wards

Implementation of the SAFER patient flow bundle across every bed based location in system.

Wards had been invited to create an exemplar model and on the participating general medical ward we reviewed, the team had certainly embraced the elements of the SAFER care bundle. Services had become responsive to the patient, such as phlebotomy at 6am to allow decisions to be made at the board round, and early discharges were happening. Radiology was reported to be very responsive, with services starting at 7.15am. There still seemed to be a delay waiting for the reports.

Staff reported the biggest issue was liaising with other specialists, reporting ‘specialty Ping-Pong’ resulting in refusals to accept referred patients. It was also reported that there was no urgency to pull from the AMU into the specialties.

We heard that many frail patients were ending up on the deep inpatient medical wards even when the frail elderly assessment unit had accepted the patient. Our recommendations for the development of a full acute frailty model are outlined below.
Staff reported low confidence levels between the acute and community teams in the trusted assessor model.

On the exemplar ward we observed, patients and relatives involved in decision making around EDDs. Nurses re-engaged with the patients after the roving board round to discuss next steps with patients and their relatives as a matter of routine.

The clinical leads forum had become a monthly event and was starting to influence change, but clinicians reported that it was still not as effective as it could be.

Priority Recommendations:

- Whilst it was accepted that exemplar wards are moving forward we recommend that you need to implement SAFER at scale to enhance the exemplar model. A good approach to managing complexity as you are aware is to develop and use simple rules. We would encourage a focused effort in the implementation of the national SAFER patient flow bundle. All the principles must be adhered too in a consistent manner to deliver good outcomes for patients. The successful implementation of a patient flow bundle approach requires ‘buy-in’ at all levels, including all members of the executive team and specialist teams. We have helped a number of Trusts implement the SAFER patient flow bundle and believe this is an area of focus that the Trust and system must prioritise and support.

- We would recommend that every month, each specialty tries to phone their own service to test how easy it is. We did hear that four specialties had agreed to receive their referrals via ‘ordercom’ which would allow visibility of referrals waiting, but we also heard that some were resistant. We recommend a standardised referral model is put in place.

- We recommend the implementation of ‘No Patient Delays’ philosophy by introducing monitoring of red/ green days and highlighting the days when patients are in an acute bed where no action occurs for that day (e.g. waiting for diagnostics, external assessments planned didn’t take place). This goes hand in hand with the internal professional standards, which seem to be a particular challenge at the moment.

Triangulation with the Sturgess Report:

“Assertive use of EDD and clinical criteria for Discharge”. As explained above this is much improved in the acute trust, but needs further embedding to avoid variation. We were not convinced that it has been as consistently applied in community facilities to enable clear management and goals to be communicated in community facilities. This is particularly important for effective working with social care.

“Sick ‘mono-organ’ specialty admissions” Specialty medicine were required to deliver effective consultant led, twice daily input to the acute medical unit and patients identified by the AMU Physicians for a medical specialty should become the responsibility of that specialty. Participants reported that this was an area where more work was required.

(iv) Frailty Model

Royal Stoke

We visited the 20 bedded frailty assessment unit. This unit takes patients directly from ED and the GPs but, we were told, not from the acute admission unit.
The nurses in-reach into ED and assess patients for suitability using the ‘Bournemouth criteria’. Staff explained that they had a ‘silver phone’ for specialist admissions avoidance advice. It was not known how many patients could not access the unit due to capacity issues. Once assessed, patients are transferred to deep inpatient wards as there is no short stay facility for frailty.

The County Hospital.

There have been significant changes at the County site over the last two to three years. The number of wards has reduced significantly since the changes to ED. The hospital appears to have a high level of older people who are increasingly frail within their bed base. There was a challenge to us in relation to our view that 60% should be managed in 2 midnights or less and 80% within 7 days may not apply as their take is skewed towards fail older people many with dementia. However, most sites report similar challenges and those areas with the highest numbers of older people have shorter lengths of stay and reduced use of social care. We would say that these are the very people with mild to moderate illness that should not be staying in hospital for sustained periods. The highly complex patients with a need for longer lengths of stay are likely to be going as specialist cases to the North Staffs site. We are happy to debate this further.

There is an urgent need to develop a frailty team to ensure that older people receive appropriate care to prevent admission wherever possible. If admission is required the aim should be to ensure that the patient is in hospital as short a time as possible with return to their own home/usual place of residence within 72 hours wherever possible and within a week at most.

A large number of patients that form part of the medical take meet the frailty markers. It is felt that the key area of priority for improvement across the County Hospital is to review the front door frailty service arrangements.

Priority recommendations:

- The ‘front door’ therapy process is a key element of Acute Frailty. Early assessment of baseline is imperative. Also, as outlined above, 10 days in hospital adds the equivalent of 10 years ageing to muscles, hence the need to mobilise patients (not just physiotherapy) in the first 12 hours and to return people to their usual place of residence (home if possible) as soon as they no longer need acute medical care. We heard that the early CGA in ED will start with a consultant, nurse, therapist and social worker imminently.
- The team have been members of the Frailty Network for two months now. The components of an excellent frailty model will be shared and should be implemented as soon as possible. Proactive management of patients at the beginning of the pathway should free up the time of the 8 Consultants who run a Consultant of the Week model for the assessment unit. This should support the development of the short stay frailty unit model.
- Challenges in discharging patients with confusion continue to be an issue resulting in the most vulnerable patients having extended lengths of stay. There is apparently only one facility which is ‘Harplands’ with 15 ‘time to think’ beds but the waiting list is too long. **We recommend that this is reviewed.**
Triangulation with the Sturgess Report:
There has been a large amount of work done on the improvement of this pathway and, as outlined, there is more to do across the whole system.

4. **Discharge to Assess**

**Royal Stoke**

(i) **The Discharge Lounge**

The discharge lounge was an excellent environment with an extremely passionate nursing leader. There were 30 chairs and 7 trollies available 7 days a week. The nurses gave last dose IVs and other appropriate treatment, arranged TTOs and were managing up to 60 discharges per day. We were told that the presence of pharmacy support was missing. **We recommend** that this is reviewed given the potential to expedite discharge. The nurse leader also felt that transport commissioning could be reviewed to enable more predictable, swifter, more flexible, discharge/transfer.

(ii) **Discharge to Assess (D2A)**

**Service linked to The Royal Hospital**

The Hub has a role in directing patients into Step Down (seen to be D2A) currently and uses the same trusted assessment as the Step Up form. The forms go to the Intermediate Care Teams (ICT) and a qualified nurse will go in and assess the patient on the same day. This is not a ‘trusted assessment’. There are still assessments being done in the acute trust. The hospital social care team seem perform a similar role.

We met the social care team in the Royal Stoke Hospital. The team link the two complex discharge systems. It was interesting to note that we heard several times that “South Staffordshire is managing to trim point”. The inference is that an acute patient will not be moved into a home or D2A (Step Down) environment until they have reached the trim point in their acute episode. This could mean that patients are deliberately being kept in hospital when they are medically fit to be transferred elsewhere. **Given all that is written about the decompensation potential, particularly for frail older people, of patients being kept in acute hospital beds when they are medical fit for discharge, we strongly recommend that this practice ceases. Commissioning solutions should be negotiated quickly and patients should not be kept unnecessarily in an acute environment.**

We were told that the ‘step down’ provision for Stoke and North Staffordshire will be transferred to the acute Trust. SOPs are being reviewed in preparation for this transfer.

In this system, it seems that D2A started a year ago, but there was a lack of clarity as to how enablement and assessment were accessed for patients (although we did hear a ‘Home First’ model gaining momentum). “LIS”, “CIS” and “ICT” are services that were available but were not readily understood with referral requiring multiple steps and duplication.

In other areas, for D2A, a shared purpose had been agreed at the beginning of the process with a principle that ‘no patient is assessed for long term care from an acute bed’. The motivation for the change in model had also been clear from all organisations involved:
• A reduction in length of stay for the acute and community trusts to enable elective and emergency care patients to be accommodated.

• For the Council, a reduction in the placement of patients in long term care.

• For the CCG, the ability for all patients to receive a period of enablement to result in a step down from Continuing Healthcare.

It wasn’t clear that the above had been agreed in this system before commencement, and that any evaluation would be based on this as an achievement.

In other systems there are three pathways:

Pathway 1

This is the home based pathway for those patients who require enablement prior to assessment at home. This is the pathway that has the most room for capacity development, particularly given the acute shortage of available care hours.

Pathway 2

Pathway 2 is a bed based model which can be in residential/nursing homes or community hospital facilities for patients who need a maximum of six weeks re-enablement to step down dependency to aim for home if possible, but if not possible, a step down from nursing to residential home provision.

In Staffordshire, this care is called ‘Step Down’ and is based in the community hospitals and in Nursing Homes, such as Brighton House. The pathway approach for enablement differs in each facility- as does the medical cover to support it.

We were told that there was a shortfall of beds in the south, compared with the North of the patch. This may be an advantage in working towards a model where the aim is to ensure that people spend as little time as possible away from their own home.

Pathway 3

In this pathway, patients who very complex and are at the end of their acute phase are not assessed until they have had the chance to receive care and enablement in a non-acute facility (D2A). These patients are called ‘Step Down’ in Staffordshire. The Acute Trust is now taking on the Step Down provision.

There are 200 people on the complex discharge list in the hospital, which is a huge number of patients. **We would recommend** that a Length of Stay review is conducted to see what all these patients are waiting for, in order, for the system to develop an accurate view on the development of alternative services.

Priority recommendations:

• **We would recommend a root and branch review** of the scale, pace and principles of D2A.
A key focus is the clinical behaviour to develop a ‘think home first’ system wide approach – which is currently heavily reliant on bed based solutions. This will require commissioners to be brave in the redistribution of resources to home based care, and Consultants to learn that home care models can be ‘safe’, even if their own teams of ‘Hospital at Home’ are not caring for them.

The model of enablement in community hospital facilities needs to be systematic and consistent. Medical leadership/engagement is essential in this model.

Given the new model of ‘step down’ management **we recommend** that the time would be right for a review of all step down care. There needs to be more clarity about the available services which would help people in the system to understand what was appropriate for each patient.

**Triangulation with the Sturgess Report:**

**This work needs to be prioritised.**

**Services linked to The County Hospital**

In the hospital there is an integrated team of nurses and social workers. The social care staff have been integrated into the community trust for some time and we had some concerns about their connection to Adult Social Care leadership within the County Council.

The team appeared to be comparatively large for a hospital the size that The County now is, with only three medical wards, the Emergency Department and Assessment areas and some elective wards which should not require massive amounts of social care input. Although based in the same area the team does not have joint leadership of the team and they appear to work in parallel rather than being truly integrated.

The head of the social care team said that they required large numbers of staff because of the amount of information that has to be entered onto ‘Care Direct’ in part we were told to ensure that providers are paid. If the system is the reason that the team needs to be so large we would **recommend** a review to ensure that the service is working as efficiently as possible.

We did not review the community services in this patch however the team leader/manager of the hospital social services team said that he also managed the services outside the hospital. We did not look at these in depth but there seemed to be a distinct lack of capacity in these teams to respond to the needs of people leaving the hospital. There are very few permanent community beds in the South Staffordshire system compared with the North. This is not a negative feature as large numbers of community beds can have a negative impact on flow requiring resources that could otherwise be spent on community services to support people at home. We did not look in depth at the services outside the acute trust within this system and would like to offer to the CCG and other partners that we could undertake a wider system review in the South if this would be helpful.

The processes to support complex discharge on the wards seemed unnecessarily complicated, with significant amounts of paperwork, despite a discharge facilitator on every ward. There appeared to be an appropriate number of therapists for the case mix, however we would recommend that there
is a shift of focus particularly of the OTs, from capturing the functional information at the point of admission to having a follow through approach for patients on the wards. We are happy to work with the trust on developing this model for which we have evidence reduces length of stay and potential deconditioning that can occur from extended stays in hospital.

We met some excellent staff and while they understand and accept that they are part of a larger organisation, they feel their ability to influence change is limited. It may be that some of the solutions that work on the UHNM site will not be appropriate at The County. There may be potential to develop some different workforce models by developing Advance Practitioners and Assistant Practitioner roles. There is a perception that roles such as the discharge facilitators have been imposed and this has resulted in a lack of role clarity between ward staff and the discharge facilitators resulting in duplication of tasks.

We were told that the Red Cross and Age UK services to support discharge are being decommissioned. Nationally there is evidence that these schemes really work effectively. There is an expectation that CCGs will commission more of these services not less. We are aware that we did not meet people from this CCG and are very happy to meet to understand their perspective on their system.

Priority recommendations:

- Develop an acute frailty pathway on this site potentially testing some innovative workforce models linked to a front loaded therapy model as discussed with the Head of Therapies on the visit.
- If a patient is admitted to a ward, the exemplar (SAFER) principles must be delivered in a consistent manner—we felt at this stage the processes were still varied in application and need to be reviewed
- Review the current integrated discharge team to consider how true integration can be achieved to reduce duplication. The models for discharge planning and discharge teams that are in place in UHNM may not be the model that is required for the County site. The principles listed above should be achieved on both sites with models that suit the specific patient populations on each site.

5. **Family Choice**

Patient family choice was not highlighted as an issue within the acute trust. We saw that clear expectations were being set with families early in the admission; however the urgency to move patients from community facilities did not seem to be as well managed which created bottlenecks.

- We would recommend clear executive leadership of the patient choice policy from all organisations that introduce patient information at the beginning of the acute episode, and a comprehensive communication with all staff regarding the choice policy. In many sites staff we have seen a positive effect in using welcome cards, ticket home or patient passport concepts to inform the patient and family of next steps, and we know that these are available in some parts of your pathway.
6. Capacity and Escalation

We would recommend that the system reviews the overarching escalation plan and processes to manage any increase in levels. Many areas are struggling with escalation given that operating at a red/black level has been normalised. Whilst the system is apparently operating a ‘full capacity protocol’, we would advise looking at the system that Barking, Having and Redbridge have implemented recently to manage risk created in ED.

There is a need to calibrate the system in order to introduce an effective system wide escalation. We recognise that perfect week has been used in this system previously but we would recommend when your revised plan is drafted and a further similar ‘system wide’ exercise is undertaken to test out the plan and also reset the health and social care economy.

We do have examples of plans which have been developed in other areas which we can share. It is important to set clear triggers which link across partners and take into account the impact that carrying out a certain action will have on others. Many acute trusts are developing both emergency department and organisation trigger tools which quantify when to escalate with different responses. This requires real-time data to be available, measuring by hour attendances & discharges for example from all departments. Both Ipswich and South Tyneside have excellent examples of this operating and would be happy to share information.

As with any escalation this operates best when there is clarity of the requests. Leadership, accountability and roles need to be defined within the escalation plan. Training needs to be provided to ensure leaders are competent to manage escalation either within the organisation or at a system level. Along with this, clear lines of communication need to be agreed, defined agendas for any calls established and defined information required to inform the calls. We did hear that there was a degree of ‘pragmatic response’ to escalation at times, rather than following the plan, particularly in out of hours’ periods.

7. Workforce recommendations

As with many other areas, City Council reported their biggest challenge to be commissioning domiciliary care packages. Again, as with other areas, the challenge is the competition for the same lower paid workforce within the area. We also heard about the workforce challenges in Primary Care (outlined in the Primary Care Section). **We recommend that** the system look at holding a workforce event where innovative solutions could be sought to this whole system problem to prevent the loss of workers between public and private services. Other areas have successfully developed skills escalator career pathways which enable workers to experience development opportunities which lead to progression and retention. **The system should seek to aim to create a workforce strategy that anticipates the likely demands for different types of worker in the future and sets out a roadmap for securing that resource.**

8. Conclusion and Next Steps

An enormous amount of work has been carried out in this system over the past year; however, there are opportunities for further significant improvement. Please can we formally thank all of the doctors, nurses, staff and managers for their hard work on improving the system. Your enthusiasm, hard work and adhesion to an aim which is based on improving patient care is to be congratulated.
We recognise that there is more work to do to bring this system closer to partnership working and the focus needs to be on down-stream flow. We look forward to supporting you. To aid your progression, we would like to suggest the following as your priorities for the next three months:

1. Effective system leadership of the development of a whole system urgent care strategy
   i. Vision
   ii. Agreed priorities
   iii. Workforce development
       Measured by:
       - Sustainability tool
       - Stranded patient metric
       - 4 hour standard
       - Staff survey

2. SAFER care bundle/Exemplar wards implemented throughout the system (included community facilities)
   i. Senior Review
   ii. All patients have an EDD
   iii. Flow
   iv. Early discharge before 10am
   v. Review all patient every week over 7 days
   vi. Implement a Red and Green ‘No Waits’ process (include community facilities).
       Measured by:
       - Stranded patient metric
       - Number of patients discharged before 10 am/discharge profile
       - 4 hour standard
       - Audit of board/ward round

   a. Followed up with length of Stay review of all stranded patients over 7 days.
       Measured by:
       - LOS
       - Stranded patient metric
       - 4 hour standard
       - Internal waits audit
       - Reduction in DTOCs

4. Further Ambulatory Care Development
   i. Further links with ED
   ii. Further development of ‘default to ambulatory’ to include specialties
   iii. Further development of surgical ambulatory care process
   iv. Further access to hot clinics
       Measured by
       - Zero length of stay metric
       - 4 hour standard
       - Conversion rate
       - Daily Capacity in assessment area
5. Frailty pathway development
   i. Development of front door services and early CGA
   ii. Development of short stay pathway
   iii. Involvement of primary and community care- step up and step down
   iv. Review of the Hub particularly their role in step up and step down.

   Measured by:
   • 4 hour standard
   • Conversion rates of over 75s
   • LOS for over 75
   • D2A

We hope that this report has been useful. We welcome any feedback on the content/accuracy.

When you have confirmed that you are happy with the factual accuracy of this report, we would respectfully ask that it is shared with all members of the SRG & other stakeholders.

We would like to formally thank those involved in our visit for their time and constructive discussions.

**Future Support**

As you are aware, we have assigned Claire Old to be your ECIP support. She has already met with staff during December to discuss the help and support available from all members of our team to assist with your system improvement.

Yours Sincerely,

Steve Christian
Intensive Support Manager
Emergency Care Intensive Support Team
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E-Mail: Steven.Christian@nhs.net

Claire Old
Intensive Support Manager
Emergency Care Improvement Programme
Mobile: 07900248634
E-Mail Claire.Old1@nhs.net

C.c. Helen Lingham, IOG Chair
Vision to Recover our National Target - 95% of Patients within 4 hours

1. PURPOSE

The local health and social care economy aims to “deliver an urgent care system that ensures high quality care in the right setting by the right professional in a timely manner 7 days a week”.

The purpose of this paper is to outline our plan to recover our A&E target of seeing 95% of patients within 4 hours.

The projects outlined in this document focus specifically on three key priorities for system partners to achieve an improvement in the system’s ability to meet our performance targets. The following are the key priorities,

- Assess before admission
- Doing todays work today
- Discharge to Assess (D2A)

2. BACKGROUND AND EXPLANATION FOR THE CURRENT A&E PERFORMANCE

The delivery of whole system urgent care across Northern Staffordshire presents a significant challenge to all stakeholder organisations. The urgent care system has consistently failed to achieve the national target of seeing 95% of patients within 4 hours, with a significant number of 12 hour trolley breaches.

There have been a number of diagnostics undertaken within the health economy to understand the reasons for the challenges within the urgent and emergency care system. These resulted in the system A&E Recovery Plan which has had many iterations.

As the A&E trajectory had not been achieved further diagnostics on the system have been undertaken by Dr Ian Sturgess. This resulted in the development of high impact interventions designed to resolve the issues identified in the economy. More recently a system diagnostic by the Emergency Care Improvement Programme (ECIP) has resulted in the following six key priorities being identified:

- Leadership
- MADE
- Ambulatory care
- SAFER
- Therapies
- Frailty and D2A

Working with ECIP all existing plans have therefore been rationalised and a framework developed to deliver improvement across the urgent and emergency care system.
3. **VISION**

In order to develop the plan to deliver the improvement in performance the system vision for the medical pathway has been defined on the advice of ECIP. This is shown in Figure 1.

**Figure 1: Vision for the Medical Pathway**

The vision delivers in the 3 areas of Assess for Admission, Todays Work Today and D2A. The vision has been further translated into the key programme areas to deliver the required improvement. Aims, objectives and benefits have been defined for each programme area. This is attached in Appendix 1.

For each programme area, a milestone and detailed programme plan has been developed (Appendix 2- critical success factor plan). Progress and monitoring of this plan is through the System Resilience Group dashboard (Appendix 3) which has the advantage of providing a one page high level view of system performance but enables detailed metrics for each project to be built into the dashboard. These project key performance indicators ultimately link back to achievement of the overall objective. Existing dashboards have been aligned within this one dashboard against the ECIP diagnostics and vision.

4. **GOVERNANCE FOR THE PLAN**

The governance of the plan will be enacted at three tiers. The strategic oversight of the plan will be undertaken by the Northern Delivery Group/SRG, the tactical by the Integrated Operational Group and operational by the Delivery Groups.
The delivery of the vision requires minimal change to the current agreed Governance Structure. Notably the JOG and Unscheduled Care Group will be redefined into one group. Within the delivery groups the key priority areas of assess before admission, today's work today and D2A will be considered, rather than managed through separate sub-groups.

The full structure is attached in Appendix 4.

5. PROGRAMME MANAGEMENT STRUCTURE

The programme management office will oversee the delivery of the programme. The current programme management office is hosted by the Clinical Commissioning Groups (CCG). The PMO co-ordinates the programme on behalf of the System Resilience Group but also has an internal CCG function. IOG have proposed the PMO structure is strengthened through contribution by all organisations within the health economy so that each of the three core work-streams of Unscheduled Care, Primary care and Planned care have a senior manager to drive forward the improvement and transformation required, working under the remit of the current PMO lead. Whilst project support from the PMO is currently provided for some work streams such as Frail Elderly, further consideration will also be required in strengthening the project support function. Consideration will also need to be given to strengthening the current Business Intelligence function within the PMO.

In order to drive the transformation required the health economy has recognised the need for cultural and behavioural changes. A senior leader has been recruited in to the health economy (Rob Cragg) to drive the development, transformation and leadership required.

The Organisational Development initiatives coming on-line in quarter 4 2015-16 and quarter 1 2016-17 hope to improve the systems leadership literacy of our managers and clinicians, as well as offering them leadership development programmes to both learn and practice the behaviours conducive for systems success. Systems leadership masterclasses are running through February and March with the ‘Advancing Talent’ leadership programme commencing in April.

To help pinpoint the cultural improvements the health economy need to make a system wide diagnostic is currently being finalised. This will show the engagement deficits which exist in our services that we can then prioritise interventions to resolve. The 30 question survey also enables us to track the enactment of our behavioural concordat, enabling us to see if we need to improve adherence to the behaviours we wish to see. This survey will be initiated quarterly so progress can be tracked and will be launched in February. The compassion recognition scheme goes live in March amongst the majority of North Staffordshire providers acting to bolster appreciation and moral.

6. CONCLUSION

The urgent care system has consistently failed to achieve the national target of seeing 95% of patients within 4 hours, with a significant number of 12 hour trolley breaches. The projects outlined in this document focus specifically on three key areas and six key priorities that partners are confident will achieve the recovery against the 4 hour, 95% system target.
Appendix 1

7 Day Services

Assess before Admission

Exemplar Front Door
Frailty
Step Up
Ambulatory Pathway

Aims: To develop a model of care for adult patients who require urgent assessment and possible intervention, which facilitates rapid assessment and decision making at the appropriate stage in the patients' journey, rather than defaulting to an emergency admission. Provide immediate assessment intervention from expert team for frailty. Embed and expand emergency ambulatory pathways designed to avoid admission. Right care, right time by right person with right skills in right place.

Outcomes: Enhanced patient experience. Seamless pathways which avoid hospital admission. Improved care coordination across all settings supporting right care, right place, right person. Development and enhancement of existing 24/7 initiatives. Improved patient flow. Improved discharges. Increased transfer to ambulatory pathways. Hot Clinic Provision


Today's Work Today

Review of cross economy bed based Services

SAFER
Therapies

Aims: All patient to have a Consultant Review before midday. All patient will have an EOG based on medically suitable for discharge status agreed by clinical teams. To increase the flow of patients at the earlier opportunity. 33% of patients will be discharged from base impatient wards before midday. Weekly systematic review of patients with extended lengths of stay.

Outcomes: Structure to the days to day running of the ward. Consistent organised and disciplined approach. Efficient use of time and resources. Care coordinated appropriately. Required capacity created for incoming patients.

Benefits: Improved care coordination and standardisation of approach. Well planned, informed and timely discharge. Less Outliers. Patients will be less likely to be cared for in crowded wards and departments.

Discharge to Assess

Home First
Step Down

Aims: Discharge to assess with Home First principles. Reduced impact on independence and future quality of life. Decrease in the number of patients admitted to long term care. Active intervention and reablement reduce decompensation and maximise independence.

Benefits: Reduction in NH/RII home placements needed. Reduction in the hours of Dom Care needed. Reduced reliance on bed based services. Increased patient satisfaction. Redirection to lower level of care. Contribute to A&E 4 hour target.


Escalation Planning

Workforce Development and OD

ICT Enabling schemes

Capacity and Demand Modelling

Communications and Demand Engagement

These projects will help with admission avoidance
These projects will help with bed based services sustainability
These projects will help with hospital flow

KL/GA Vision to Recover our National Target - 95% of patients within 4 hours. 19/1/16
## Assess before Admission

<table>
<thead>
<tr>
<th>Scheme</th>
<th>Critical Success Factors</th>
<th>Accountable Lead</th>
<th>Operational Lead</th>
<th>Short / Medium / Long Term</th>
<th>The Metrics</th>
<th>RAG Time</th>
<th>RAG (Impact)</th>
<th>RAG (Risk)</th>
</tr>
</thead>
</table>
| Exemplar Front Door | Extend the SPEED Team | Helen Lingham | Gill Adamson | Short Term - 01.03.16 | • Reduction of 7 avoided admissions per day from 01.12.15  
• Reduction of 10 avoided admissions per day from 31.03.16 | TBC | TBC | TBC |
| Increase the number of patients conveyed by WMAS to FOH | Paul Jolley | Natalie Cotton | Short Term - 01.03.16 | • Delivery of 40 net divert to FOH/UCC per day. Attainment of ED SLA, on a monthly basis. | TBC | TBC | TBC |
| Direct booking in to UCC from the NHS 111 service | Paul Jolley | Tim Jones | Short Term - 01.03.16 | • Delivery of 40 net divert to FOH/UCC per day. Attainment of ED SLA, on a monthly basis. | TBC | TBC | TBC |
| Development of Liaison Psychiatry to 24/7 at RSUH | Sandra Chadwick | Jane Barnes / Ron Daley | Medium Term - 30.01.16 | • 24 hour access to specialist MH assessment in ED and Acute wards  
• Effective MH interventions in ED and Acute  
• AMU transitions direct to Elderly Care Wards  
• Increased capacity in the ED by 0.5%  
• 2% reduction in AMU occupancy | TBC | TBC | TBC |
| Frailty | Improve patient experience by changing the pathway for care of the Frail Elderly patients presenting at UHNM | Helen Lingham | Gill Adamson | Short Term - 01.12.15 | • AMU transitions direct to Elderly Care Wards  
• Increased capacity in the ED by 0.5%  
• 2% reduction in AMU occupancy | TBC | TBC | TBC |
| Re-specify the FEAS to provide in-reach to portals | Sandra Chadwick | Dave Sanzeri | Short Term - 11.01.16 | • 10% reduction in NEL admission for over 75’s Pan Staffordshire (5% for Northern Staffordshire - already delivering some impact) | TBC | TBC | TBC |
| Re-specify the FEAS to provide GP with a same day / next day service | Helen Lingham | Rob Royce | Short Term - 03.10.15 | • Pan Staffordshire this equates to 5976 NEL reduction (Northern Staffordshire impact 794 and contribute to the avoidance of 4771 NEL) | TBC | TBC | TBC |
| Re-specify the FEAS to provide GP support for anticipatory planning including Comprehensive Geriatric Assessment (CGA) | Helen Lingham | Rob Royce | Short Term - 30.01.16 | • Increased capacity of the FOH/UCC (quantitative KPIs to be determined) | TBC | TBC | TBC |
| Step up | Further increase the clinical portfolio of the FOH/UCC | Paul Jolley | Natalie Cotton | Long Term - 01.02.16 | • Increased capacity of the FOH/UCC (quantitative KPIs to be determined) | TBC | TBC | TBC |
| Implement the specialist Integrated Long-Term Condition Pilot, to establish UHNM as the lead for the community-based integrated Long-Term Conditions service delivered by Specialist nurses under clinical governance of the UHNM consultants | Helen Lingham | Dave Sanzeri | Medium / Long Term - 24.12.15 | • Reduction of 1300 NEL admission in 2015/16 | TBC | TBC | TBC |
| Expand the Nursing Home project | Sandra Chadwick | Dave Sanzeri | Short Term - 30.12.15 | • Reduction in NEL by 520 per year FYE over 38 Nursing Homes | TBC | TBC | TBC |
| Increase capacity for Step up Intermediate Care | Becky Scullion | Christine Wheeler | Short Term - 30.12.15 | • 3009 step up Intermediate Care Packages available FYE in 16/17. Overall step-up/step-down case load increased to 113 by December 2015 continual review and promotion of service to GPs and Nursing Homes | TBC | TBC | TBC |
| Reduce the number of High Volume Users (Frequent Attendees) | Paul Jolley | Leanne Sheppard | Medium Term - 31.03.16 | • Reduction in NEL admissions per month / per practice | TBC | TBC | TBC |
| Implement a clinical reappraisal mechanism for green ambulance and ED disposition, from the NHS 111 Service | Paul Jolley | Tim Jones | Medium Term - 01.09.14 | • Delivery of 84 diversions per week (as reported via the NHS 111 Sitrep)  
• ED and ambulance dispositions to be maintained at or below the national average on a monthly basis | TBC | TBC | TBC |
<p>| Maximise utilisation of the Walk in Centres | Mandy Donald | Cath Skerritt | Short Term - 31.12.15 | • Divert 2 - 3 patients each day to walk in centres | TBC | TBC | TBC |
| Maximise utilisation of step up beds | Kieron Murphy | Lisa Mulme | Short Term - 31.12.15 | • Increase referral to step up | TBC | TBC | TBC |
| Ambulatory Pathway | AEC Model &amp; Short Stay | Rob Royce | Rob Royce | Short Term - 19.02.16 | | TBC | TBC | TBC |</p>
<table>
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<th>RAG (Risk)</th>
</tr>
</thead>
</table>
| Cross Economy bed based services | Roll-out Exemplar Ward (safer bundle) principles to identify blocks to effective patient flow for patient with complex discharge needs in Acute Hospitals | Helen Linham     | Judith Earl      | Short Term - 30.11.15    | • 50% improvement productive patient days caused by internal delays  
• Reduction in the number of stranded patients over 70 years 10+ days  
• Increase in the number of discharges to pre admission place of residence  
• Achieve 30% of patients discharged before 12:00. Achieve 35% of patients discharged before 13:00 | TBC     | TBC          | TBC        |
|                 | Roll-out Exemplar Ward (safer bundle) principles to identify blocks to effective patient flow for patient with complex discharge needs in Community Hospital | Mandy Donald     | Lisa Hulme       | Short Term - 30.11.15    | • 50% improvement productive patient days caused by internal delays  
• Reduction in the number of stranded patients over 70 years 10+ days  
• Increase in the number of discharges to pre admission place of residence  
• Achieve 10% of patients discharged before 13:00 from identified benchmark | TBC     | TBC          | TBC        |
|                 | Roll-out Exemplar Ward (safer bundle) principles, where appropriate, in the Mental Health Trust | Andy Rogers      | Jane Munton-Davies | Short Term - 30.12.15  | • To reduce the number of stranded patients over 70 years 10+ days.  
• To increase the number of discharges to pre-admission place of residence  
• To increase the number of earlier in the day discharges | TBC     | TBC          | TBC        |
<p>| Therapies       | Review of Therapy service to be undertaken                                               | TBC              | TBC              | TBC                       |                                                                                                                                                                                                            | TBC     | TBC          | TBC        |
|                 | Plan for improvement to Therapy Service’s to be developed                               | TBC              | TBC              | TBC                       |                                                                                                                                                                                                            | TBC     | TBC          | TBC        |</p>
<table>
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<th>RAG (Risk)</th>
</tr>
</thead>
</table>
| Home First | Align and Improve discharge processes for South Staffordshire patients treated at Royal Stoke | Rob Lusuardi / Claire Mackirdy | Alex Bennett / Nicky Cooke | Short Term - 30.01.16 | • Monitor Progress and Delivery through DOG and SRG  
• Pathway Implemented  
• CIS support in place  
• Reduction in MFFD and DTOC | TBC | TBC | TBC |
| Medical Ownership of Speciality Outlier | Rob Royce | John Oxtoby | Short Term - 30.09.15 | TBC | TBC | TBC | TBC |
| Plan for Discharge within 48 hours for emergency admissions | Helen Lingham | Gill Adamson | Short Term - 18.01.16 | TBC | TBC | TBC | TBC |
| To have accurate and timely information related to discharge of patients with complex needs and use it to forward plan | Gill Adamson | Carla Bickley | Short Term - 21.12.15 | TBC | TBC | TBC | TBC |
| Establish a multi agency discharge Team | Gill Adamson | Carla Bickley | Short Term - 01.12.15 | TBC | TBC | TBC | TBC |
| Develop 'without prejudice' agreements between health and social care to enable patients to move in to a care home placement for assessment | Dave Sanzeni | Bev Jocelyn | Medium Term - 30.01.16 | TBC | TBC | TBC | TBC |
| Work with Care Homes to assess previous residents within 24 hours | Helen Trousdale | Becky Bowley / Bev Jocelyn | Short / Medium Term | TBC | TBC | TBC | TBC |
| Roll out of Trusted Assessor model across the health and social care economy | Helen Lingham | Judith Earl | Short / Medium Term - 27.02.16 | TBC | TBC | TBC | TBC |
| Develop a Single Health and Social Care Direction of Choice Policy | Sandra Chadwick | Sharon Maguire | Short / Medium Term - 31.01.16 | TBC | TBC | TBC | TBC |
| UHNM will operate 3 community hospitals for step down and the management of patients from Admission to final destination | Helen Lingham | Gill Adamson | Short / Medium Term - 31.03.16 | TBC | TBC | TBC | TBC |
| Increase supply of domiciliary care within North Staffs through the | Helen Trousdale | Bev Jocelyn / Rosanne Corran | Short Term - 14.12.15 | TBC | TBC | TBC | TBC |
| Reduce the amount of time taken for residential and nursing care homes to undertake assessments to enable people to be discharged | Helen Trousdale | Bev Jocelyn / Rosanne Corran | Short Term - 14.12.15 | TBC | TBC | TBC | TBC |
| Increase capacity in Domiciliary Care | Simon Robson | Becky Bowley | Short / Medium / Long Term - 01.11.15 | TBC | TBC | TBC | TBC |
### Strategic AIM 1: Strive for 4 week performance

#### Key Outcomes/Process Measures

<table>
<thead>
<tr>
<th>High level Outcome</th>
<th>Standard/Target</th>
<th>4 Week Performance</th>
<th>26 Week Average</th>
<th>13 Month Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Achieve national standards and local improvement metrics</td>
<td>Achieve 4 hour 95% Standard (UHNM only)</td>
<td>&gt;= 95%</td>
<td>82.4%</td>
<td>87.4%</td>
</tr>
<tr>
<td></td>
<td>Achieve 4 hour 95% Standard (County only)</td>
<td>&gt;= 95%</td>
<td>92.8%</td>
<td>95.5%</td>
</tr>
<tr>
<td></td>
<td>Achieve Zero tolerance 12 hour trolley wait target</td>
<td>0</td>
<td>67</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>Reduction in Non-Election Admissions</td>
<td>To Plan</td>
<td>62.6%</td>
<td>58.1%</td>
</tr>
<tr>
<td></td>
<td>Home First - discharge back to usual residence age &gt;70</td>
<td>90%</td>
<td>85.0%</td>
<td>84.7%</td>
</tr>
<tr>
<td></td>
<td>Reduction in Stranded Patients (PE &amp; LoS &gt;30 days)</td>
<td>150</td>
<td>195</td>
<td>189</td>
</tr>
<tr>
<td></td>
<td>Achieve 92% occupancy - UHNM</td>
<td>&lt;= 92%</td>
<td>93.1%</td>
<td>94.2%</td>
</tr>
<tr>
<td></td>
<td>Achieve 92% Occupancy - Community Hospitals</td>
<td>&lt;= 92%</td>
<td>94.0%</td>
<td>93.0%</td>
</tr>
</tbody>
</table>

#### 4 Week Performance

- 46 trolley wait on the 46 recorded between 4th & 5th January

#### 26 Week Average

- Reduction in A&E attendances (post-FoH) 9,068 10,284 9,050
- Increase of Front of House activity to average 7% (to re-look)
- Increase HLS-15% non-ED dispositions
- Increase Intermediate care step-down referrals (SSOTP) 160 149 123
- Reduce WMAH-hospital-Conversion rate
- Reduce A&E Time to initial assessment
- Reduce Median time to treatment
- Reduce proportion of discharges before 12pm
- UAT = 4 hours for 30% of admitted patients (Emergency admission)
- UAT = 2 days for 60% of admitted patients (Emergency admission)
- Reduce Attendance to Admission Rate
- Reduce WMAH to target
- UAT = 17 days for 80% of admitted patients (Emergency admissions)
- UAT = 10 days for 90% of admitted patients (Emergency admissions)
- Increase step-down/intmediate care referrals (SSOTP) 70 82 73
- Increase step-down/community hospital admissions (SSOTP) 260 145 160
- Reduce community hospital length of stay - AHS-wards (SSOTP) 36.3 25.6 25.9
- Reduce days core referrals (Date LA)
- SSOTP DTOC Patient Numbers 12 30 28

#### 13 Month Trend

- Target consistently within 24% below LHE trajectory for the week (W/E 10/1/2016)
- Target consistently within 4 week performance
- Target consistently within 95% standard (County only)
- Target consistently within 95% standard (UHNM only)
- Drop back to 95% standard as far back as end of March
- Target consistently within 12 hour trolley wait target
- Target consistently within 12 week f/u for discharged patients
- Target consistently within 12 week f/u for discharged patients
- Target consistently within 12 week f/u for discharged patients
- Target consistently within 12 week f/u for discharged patients
- Target consistently within 12 week f/u for discharged patients
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KL/GA Vision to Recover our National Target- 95% of patients within 4 hours, 19/1/16
Assess before Admission

Todays work today

Discharge 2 Assess

Clinical lead – Senior Lead for each stream
11 January 2016

Dr Andrew Bartlam
Clinical Accountable Officer and SRG Chairman
Stoke on Trent CCG

Cc:
Helen Lingham, Chief Operating Officer, University Hospitals of North Midlands NHS Trust and IOG Chair (sub group of SRG)
Sandra Chadwick, Accountable Officer, Stoke CCG

Dear Andrew,

Re: Emergency Care Improvement Programme (ECIP) – Concordat Agreement

The diagnostic visit has now been completed for your system under cluster one.

The diagnostic visit included:

- An acute walkthrough of the patient pathway across each hospital site, meeting with both clinical and managerial staff involved in running and working across the internal pathways
- Structured interviews with providers and commissioners across the system.
- Visiting a range of community services.
- A Chief Officers feedback session to present findings and initiate discussion to explore solutions.

The structured and comprehensive programme provided the team full access and exposure which significantly helped triangulate our findings to shape the ‘high impact’ priority areas for your system to utilise the ECIP support.

We would like to thank all individuals involved in the planning leading up to the visit. Since the visit we have provided a formal report detailing our findings and highlighted recommendations along with good practice principles and guidance, which builds upon the feedback to Chief Officers.

We have purposely kept the ‘high impact’ priority areas to a manageable level and been specific on the areas that if delivered we believe will provide the marginal gains required to improve UEC performance. It must be noted that we observed many aspects of good practice and hardworking, committed individuals, and the ECIP support is focused on further opportunities to complement existing efforts.

We are writing to set out a formal proposal of support from the ECIP. This proposal, with your agreement, sets out a clear plan that will form a “concordat of agreement” across the system. The concordat will be signed by leaders from each part of the system and the regional tripartite to demonstrate the overall commitment to the objectives set out.
As you are aware, we have assigned Claire Old, Intensive Support Manager, to be your ECIP lead going forward and Claire has commenced work with the system to assist with delivery against the ‘high impact’ priority areas.

The ‘high impact’ priority areas we have are in line with evidence based good practice. We can offer practical and specialist support across each area. Whilst we can offer support and constructive challenge the successful implementation and sustainability of the improvement required will be reliant on the capability of the system.

Our diagnostic report covered a number of observations / recommendations and the concordat does not suggest that these recommendations can’t be taken forward with / without our support. The below are the key ‘high impact’ priorities we believe need to be focused upon to maintain, and improve, the systems urgent and emergency care pathway. If the system has a particular drive to move forward on a particular recommendations outlined in the ECIP system diagnostic report however it is not identified under the ‘high impact’ priorities, the ECIP would be happy to assist and support the system to develop.

The ‘high impact’ priority areas we have suggested and commenced work with the system are as follows:

1. **Effective system leadership of the development of a whole system urgent care strategy**
   - i. Vision
   - ii. Agreed priorities
   - iii. Workforce development

2. **SAFER care bundle/Exemplar wards implemented throughout the system (included community facilities)**
   - i. Senior Review
   - ii. All patients have an EDD
   - iii. Left shift discharge profile across day
   - iv. Review all patient every week over 7 days
   - v. Implement a Red and Green ‘No Waits’ process

3. **Introduce MADE accelerated discharge event-across both the acute and community hospitals (system wide) starting 1st week of January 2016 and to be considered as a regular exercise throughout Q4 to develop interface processes.**

4. **Ambulatory Care Development**
   - i. Further links with ED
   - ii. Further development of ‘default to ambulatory’ to include specialties
   - iii. Further development of surgical ambulatory care process
   - iv. Further access to hot clinics
5. The acute Trust has commissioned a therapies review externally. ECIP to support and provide constructive specialist support to ensure models of care are sustainable and effective for the future.

6. Frailty / Discharge to Assess pathway development
   i. Development of front door services and early CGA
   ii. Development of short stay pathway
   iii. Involvement of primary and community care- step up and step down
   iv. Review of the Hub particularly their role in step up and step down.
   v. Review of the supply of care for EMI.
   vi. Provide ECIP social care support to review Domiciliary care position

It is our view that focusing on these areas will help Stoke and Staffordshire SRG best improve the performance of their urgent and emergency care pathways and so improve outcomes for patients in their system.

ECIP will provide support for the priority areas from the date of agreement of this concordat to 31st March 2016. Claire Old is underway in planning the support to each area and we would like to attend the February 2016 SRG to review our collective progress / partnership.

ECIP expects that the system should define its own goals for these improvement metrics and the ways it will gather and monitor the information by 22nd January 2016.

To monitor improvement of the ‘high impact’ priority areas ECIP propose the following metrics should be considered with SMART aims to deliver continual improvement against current performance up to 31 March 2015. The ECIP can support the system if required.

- 4 hour standard
- Time to Treatment
- Conversion rate
- Admissions
- Bed Occupancy G&A
- Beds Occupied by Stranded Patient
- Bed used by DToC
- Percentile performance in length of stay

Support to develop and implement the ‘high impact’ priority areas will be undertaken over the period to 31st March 2016 through a structured programme commencing from the date of this agreement. This will include on-site visits from the team specified in Table 1 above. These may reduce in intensity over the 120 day period as the workstreams and projects mature.

We would also suggest that a formal review of progress with ECIP and the SRG be undertaken on a monthly basis to ensure we track progress and ensure delivery. To ensure accelerated delivery of the support programme, we would also suggest that key members of the SRG meet ECIP weekly in the first instance to regularly establish progress against agreed actions, issues and next steps. This should be coordinated through your ECIP lead.
In line with the programme objective, please note we will be publishing quarterly data in February and April relating to systems participating in the programme and will ensure all systems have first sight and time to prepare for the data release.

In summary, we would like to thank you for engaging with the ECIP and inviting us to provide a more detailed review of the internal clinical processes within your system which has been the main focus of this proposal document.

I hope this proposal and the diagnostic report meets with your expectations and that the support offered by the ECIP is of value to your organisation and health community.

Yours sincerely,

Steven Christian
Head of Improvement
ECIP

Vincent Connolly
Medical Director
ECIP

Glen Burley
Senior Responsible Officer
ECIP

Claire Old
Intensive Support Manager
ECIP

Approved by:

Regional Tripartite Leads
NHS England
NHS TDA
Monitor

Stoke & Staffordshire CCG
EXECUTIVE SUMMARY FRONT SHEET

Meeting:  Public Trust Board
Title:  Strategic Objectives and Board Assurance Framework – Quarter 3
Author:  David Haycox, Associate Director of Corporate Affairs
Executive Lead:  Mark Hackett, Chief Executive and Other Executive Directors as assigned to each Strategic Objective and Risk
Other meetings presented to:  Executive Risk Oversight Group on 5 February 2016

Purpose
The purpose of the Strategic Objectives and Board Assurance Framework for quarter 3 is two-fold:

- To provide the Board with a summary of progress and status against the delivery of each of the five strategic objectives agreed by the Board as part of the Annual Plan for 2015/16 (first attachment); and
- To consider the position of the progress of mitigating against each of the 21 strategic risks, also agreed as part of Annual Plan for 2015/16 (second attachment).

Decision
Approval ✓
Information

Link to Strategic Objectives
- Delivering quality excellence for patients ✓
- Delivering our financial obligations to the Taxpayer ✓
- To achieve excellence in education, training and research ✓
- Create an integrated vibrant Trust and develop strategic alliances with neighbouring trusts and partners ✓
- Create a resilient Urgent and Emergency Care System and Increase Integrated Healthcare Provision ✓

Executive Summary

Following the recommendations made by Professor Georges Selim in his review of Governance which reported in February 2015 and the subsequent review and development of Strategic Objectives and Critical Success Factors, progress continues in providing improved reporting relating to the delivery of strategic objectives, with progress considered against each of the Critical Success Factors and against each of the strategic risks.

In addition, following the consideration by the Executive Risk Oversight Group of the further review of Risk Management and the subsequent agreement of a detailed plan to progress with improvements with the management of risks throughout the organisation, continued progress has been made as follows.

Risk workshops were held in November and December 2015 led jointly by Corporate Affairs and Quality, Safety and Compliance that included representatives from each Division concluding with agreement of a number of changes to the approach for practically using the risk system which would support Divisions in managing their respective risks and in providing a framework for the delivery of specific risk training to key representatives within each Division, including consultants and nursing staff in addition to managers and administrative support staff.
Training sessions commenced in December 2015 and continued through January 2016, delivered by Quality, Safety and Compliance Department. Interaction during these sessions and feedback has been positive. Further training sessions are scheduled to take place through until March 2016 with the aim that all relevant clinical and non-clinical staff will have received appropriate training by that time.

From the new financial year there will be dedicated central support regarding risk management, from existing resources, which will support Divisions in their consideration of risk as a vehicle for managing the operational and planning of delivery of services.

Planned changes to Executive Risk Oversight Group meeting commenced in January 2016 with each Division providing a status view as to the progress in mitigation against each of the extreme operational risks for their respective Division. Appropriate challenge was made by the Executive Directors present in the meeting and an acknowledgement of how these risks may impact upon each of the strategic risks of the Trust.

Plans for fully meeting recommendations to enhance the reporting of progress against strategic objectives and in mitigating strategic risks will continue, including the provision of an Integrated Board Assurance Framework report capturing key issues of delivery of objectives and managing risks, for reporting the 2015/16 end of year position at quarter four and using for the monitoring of strategic objectives and risks in 2016/17. This will include reporting to the Committees of Board regarding respective objectives and risks and the consideration of the appropriateness of assurance at Audit Committee in advance of Trust Board.

The reporting of a summary position of the status of strategic objectives and risks will remain quarterly and, in accordance with good practice, will incorporate progress in the delivery of mitigating actions to enhance the levels of controls and assurance together with further planned actions and timescales. However, additionally the monthly performance reports for quality, operational, human resources and finance will continue to address the specific matters that the overarching quarterly reports refer to.

The reports attached provide details regarding the position against each strategic objective and the position of each strategic risk as at quarter three.

**Key Recommendations**

The Board is asked to receive this report, noting the progress in improving risk management processes, the further planned improvements and to challenge Executive Directors with regards to the status of respective strategic objectives and risks at quarter three.

**Corporate Impact Assessment (please tick any which are impacted on / relevant to this paper)**

<p>| Quality Implications | ✔ | Financial Implications | ✔ | Legal Implications | ✔ | Workforce Implications | ✔ |</p>
<table>
<thead>
<tr>
<th>Strategic Objective</th>
<th>Exec Lead</th>
<th>Critical Success Factor</th>
<th>Link to Other SO's</th>
<th>Risk No.</th>
<th>Strategic Risk</th>
<th>Target Risk Score</th>
<th>Q1 Risk Score</th>
<th>Q2 Risk Score</th>
<th>Q3 Risk Score</th>
<th>Risk Score Change</th>
<th>Key Sources of Actual Assurance Relevant to this Quarter</th>
<th>Primary Assurance Committee</th>
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<tbody>
<tr>
<td>SO1: Delivering Quality Excellence for Patients</td>
<td>Liz Rix, Chief Nurse</td>
<td>1.1 Patient experience will be in the top 20% of all NHS hospitals by 16/17.</td>
<td>SO1 SO2 SO3 SO4 SO5</td>
<td>1</td>
<td>Failure to deliver effective clinical leadership across the Trust to secure patient experience, clinical safety, financial results and service transformation.</td>
<td>HIGH9</td>
<td>HIGH12</td>
<td>HIGH9</td>
<td>HIGH8</td>
<td></td>
<td>Q3 Quality and Safety Report to Trust Board UHNM Mortality Report to QAC. 2015/16 Mortality Reduction Plan Internal patient survey.</td>
<td>Quality Assurance Committee</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1.2 Reduce avoidable patient harm by a further 20% by 2018.</td>
<td>SO1 SO2 SO3</td>
<td>2</td>
<td>Failure to achieve faster improvement in patient experience, safety and outcomes nationally greater than UHNM.</td>
<td>HIGH9</td>
<td>HIGH12</td>
<td>HIGH9</td>
<td>HIGH8</td>
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<td></td>
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<td>1.3 HSMR and SHMI is 80 by 17/18.</td>
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<tr>
<td>SO2: Delivering our Obligations to the Taxpayer</td>
<td>Sarah Preston, Acting Director of Finance</td>
<td>2.1 Achievement of I&amp;E plans set over 3 years - income and expenditure.</td>
<td>SO1 SO2 SO3</td>
<td>3</td>
<td>Failure to deliver / implement capital schemes to support I&amp;E / capacity strategy / plan and the environmental estate.</td>
<td>HIGH9</td>
<td>EXT16</td>
<td>EXT16</td>
<td>EXT16</td>
<td></td>
<td>M9 Finance Reports and Q3 Forecast and associated process to Board, FEC &amp; TEC Integrated Business Plan / LTFM Finance Risk Register, Income and contracting report, Workforce and Finance Reports to FEC. The capital programme is reported monthly to FEC which identifies issues relating to the delivery of the Capital plan. The progress on development of 15/16 and 16/17 CIP's is reported in the monthly CIP report to FEC. Proposed solution to be discussed with the TDA re the future financing of the deficit included within the Addendum Business Case submitted to the TDA in October 2014. Joint Transition Board for Staffordshire.</td>
<td>Finance and Efficiency Committee</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2.2 Delivering the CIP of £85m by 17/18.</td>
<td>SO1 SO2 SO3 SO4</td>
<td>4</td>
<td>Failure to deliver Staffordshire review on time to secure Trust I&amp;E sustainability.</td>
<td>EXT20</td>
<td>EXT25</td>
<td>EXT25</td>
<td>EXT25</td>
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<td></td>
<td>2.3 Achieve continuity of service liquidity risk rating.</td>
<td>SO1 SO2</td>
<td>5</td>
<td>Failure to define CIP / productivity savings of £85m across 2015/16 to 2017/18.</td>
<td>HIGH8</td>
<td>EXT20</td>
<td>EXT20</td>
<td>EXT20</td>
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<td>2.4 Delivery of the £100m Capital Programme to time and cost over 3 years.</td>
<td>SO1 SO2 SO3 SO4 SO5</td>
<td>6</td>
<td>Inability to achieve income targets due to commissioner affordability, tariff changes, poor quality or capacity constraints.</td>
<td>HIGH12</td>
<td>EXT20</td>
<td>EXT15</td>
<td>EXT15</td>
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<tr>
<td>SO3: Achieve Excellence in Education, Training and Research</td>
<td>Ro Vaughan, Acting Director of HR (with Rob Guthrey Harris, Medical Director)</td>
<td>3.1 To deliver £5 million grant income by 2018/19.</td>
<td>SO1 SO2 SO3</td>
<td>9</td>
<td>Failure to deliver Research Strategy affects academic development because we cannot recruit high calibre people and the resource infrastructure.</td>
<td>HIGH9</td>
<td>HIGH9</td>
<td>MOD6</td>
<td>MOD6</td>
<td></td>
<td>Monthly Finance Report to Board, FEC and TEC Monthly Annual Plan review meetings Annual Plan Report to FEC Workforce Report to FEC HR Performance Metrics to FEC Refine the Workforce Demand and Supply model to facilitate the tracking of changes and to monitor progress.</td>
<td>Quality Assurance Committee</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3.2 To deliver £5 million commercial trial income by 2018/19.</td>
<td>SO1 SO2 SO3 SO4 SO5</td>
<td>10</td>
<td>Failure to recruit and retain workforce to deliver teaching, research and service requirements.</td>
<td>HIGH9</td>
<td>HIGH9</td>
<td>MOD6</td>
<td>MOD6</td>
<td></td>
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<td>3.3 To be rated in The Guardian Undergraduate Training Survey in the top 5 for 2014/15 to 2018/19.</td>
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<td>3.4 To be seen by Health Education England, Keele University as the top performing postgraduate medical teaching and undergraduate teaching organisation by 2017/18.</td>
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<td>3.5 80% staff rate their teaching and education as excellent by 2016/17.</td>
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</table>
### BOARD ASSURANCE FRAMEWORK (BAF)
#### Quarter 3 - January 2016

<table>
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<th>Strategic Objective</th>
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<tr>
<td><strong>SO4: Create an Integrated Trust and Develop Strategic Alliances with Neighbouring Trusts</strong></td>
<td>Andrew Butters, Acting Director of Planning</td>
<td>4.1 Full delivery of TSA model by 2017/18</td>
<td>SO1 SO2 SO5</td>
<td>11</td>
<td>Lack of capacity to deliver TSA model for Orthopaedics.</td>
<td>HIGH12</td>
<td>EXT20</td>
<td>EXT16</td>
<td>EXT16</td>
<td>➔</td>
<td>Progress report on phase 1 of integration of services at County and RSUH to Board complete (Risk 11)</td>
<td>Transformation Programme Board</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4.2 Increase number of staff recommending the Trust as a place to work</td>
<td>SO2 SO4 SO5</td>
<td>12</td>
<td>Provider / professional resistance to new service models or organisational plans prevents integrated care happening fast enough.</td>
<td>EXT16</td>
<td>EXT16</td>
<td>HIGH12</td>
<td>HIGH9</td>
<td>➔</td>
<td>LTC discussions taking place within formal Project Structure (Risk 12 and 13)</td>
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<td></td>
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<td>4.3 Single management structure by 2015/16</td>
<td>SO2 SO5</td>
<td>13</td>
<td>Inability of clinical and non-clinical teams to deliver service transformation to meet CSF's.</td>
<td>HIGH9</td>
<td>EXT16</td>
<td>HIGH12</td>
<td>HIGH9</td>
<td>➔</td>
<td>Engagement Champions and OD Plans in place; Divisions engaging; cultural audit report and action plan to future Board - lined to OD Strategy (see below) (Risk 14)</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>4.4 Integrated governance system by 2015/16</td>
<td>SO2 SO5</td>
<td>14</td>
<td>Failure to deliver service transformation plans on time.</td>
<td>HIGH9</td>
<td>EXT16</td>
<td>EXT16</td>
<td>HIGH12</td>
<td>➔</td>
<td>ICT Governance Arrangements reconfigured to increase assurance and scrutiny (approved by FEC) (Risk 16)</td>
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<td></td>
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<td>4.5 Marketing strategy to grow local elective share by 2% per annum and overall market share in our specialist catchment area by 2% per annum.</td>
<td>SO1 SO2 SO4 SO5</td>
<td>15</td>
<td>Failure to deliver innovative open focussed culture in the Trust impacts on service and financial performance and Vision.</td>
<td>HIGH8</td>
<td>HIGH12</td>
<td>HIGH12</td>
<td>HIGH9</td>
<td>➔</td>
<td>An Organisational Development Strategy has been produced and critiqued by all the key stakeholders and will be cascaded throughout the operation as an adopted strategy and will shape all on-going work in the OD field across the organisation</td>
<td></td>
</tr>
<tr>
<td><strong>SO5: Create a resilient Urgent and Emergency Care System and Increase Integrated Healthcare Provision</strong></td>
<td>Helen Lingham, Chief Operating Officer</td>
<td>5.1 Deliver 92% bed occupancy or less</td>
<td>SO1 SO2 SO5</td>
<td>17</td>
<td>Inability to deliver admissions reduction plan and discharge levels increases bed occupancy.</td>
<td>HIGH8</td>
<td>EXT16</td>
<td>EXT16</td>
<td>EXT16</td>
<td>➔</td>
<td>Regular Trajectory and Plan to Achieve 4 Hour Compliance to Board</td>
<td>Quality Assurance Committee</td>
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<tr>
<td></td>
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<td>5.2 Develop admissions reduction programme to reduce level of non-elective activity by 7000 admissions by 2017/18</td>
<td>SO4 SO5</td>
<td>19</td>
<td>Commissioner reconfigurations create slow pace of change.</td>
<td>MOD6</td>
<td>HIGH12</td>
<td>HIGH12</td>
<td>HIGH12</td>
<td>➔</td>
<td>Compliance to Board Final Annual Plan 2015/16 to Board, TEC &amp; FEC</td>
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<td></td>
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<td>5.3 Develop and implement intermediate acute care and step down care achieved by acute hospital</td>
<td>SO1 SO4 SO5</td>
<td>20</td>
<td>Failure to agree and implement with commissioners an integrated care strategy and plan.</td>
<td>MOD6</td>
<td>HIGH12</td>
<td>HIGH12</td>
<td>MOD6</td>
<td>➔</td>
<td>Monthly Performance Report to Board &amp; FEC</td>
<td></td>
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<td></td>
<td></td>
<td>5.4 Establish system demand and capacity plan</td>
<td>SO1 SO2 SO3 SO4 SO5</td>
<td>21</td>
<td>Inability to secure management capacity, rigour and capability to secure strategy and plans and create a patient centred culture.</td>
<td>LOW4</td>
<td>HIGH8</td>
<td>MOD6</td>
<td>HIGH12</td>
<td>➔</td>
<td>Monthly Annual Plan review meetings SRG Monthly Reporting</td>
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<td>5.5 Integrated workforce plan with partners</td>
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<td>5.6 Integrated 'home first' culture.</td>
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</table>
### Strategic Objectives, Critical Success Factors and Strategic Risks

**Quarter 3 Performance Review**

<table>
<thead>
<tr>
<th>Executive Lead</th>
<th>SD No.</th>
<th>Strategic Objective</th>
<th>Critical Success Factors</th>
<th>Key Delivery Mechanisms (Strategies/Plans)</th>
<th>Baseline Figure</th>
<th>Q3 2015/16 Performance</th>
<th>Q4 2015/16 Forecast</th>
<th>Measurements</th>
<th>Assurance Source</th>
<th>Interdependence of SO’s</th>
<th>Strategic Risks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Liz Rix, Chief Nurse</td>
<td>SO1</td>
<td>Delivering Quality Excellence for patients</td>
<td>1.1 Patient experience will in the top 20% of all NHS hospitals by 16/17</td>
<td>UHNMs continue to meet the target for % of responders recommending the service and quarter 3 returned an average of 97.3% for inpatients</td>
<td>Top 40%</td>
<td>Top 30%</td>
<td>Top 20%</td>
<td>Top 10%</td>
<td>National Patient Survey 2014/15</td>
<td></td>
<td>Failure to deliver effective clinical leadership across the Trust to secure patient experience, clinical safety, financial results and service transformation.</td>
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<td>1.2 Reduce avoidable patient harm by a further 20% by 2018</td>
<td>Patient Care Improvement Plan (PCIP) Proud to Care Programme Sign up to Safety Programme</td>
<td>97%</td>
<td>UHNMs has continued to see reductions in the numbers and rate of Patient Safety Incidents and quarter 3 saw continued reductions in rate per 100 admissions with quarterly average of 6.92 which is lower than the 7.59 rate in quarter 3 of 2014/15</td>
<td>5% reduction</td>
<td>5% reduction</td>
<td>10% reduction</td>
<td>20% reduction</td>
<td>Patient Safety Report</td>
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<td>1.3 HSMR and SHMI is 90 by 17/18</td>
<td></td>
<td></td>
<td></td>
<td>97</td>
<td>HSMR 95</td>
<td>HSMR 90</td>
<td></td>
<td>HSMR and SHMI</td>
</tr>
</tbody>
</table>

**Executive Lead:** Liz Rix, Chief Nurse

**SD No.:** SO1

**Strategic Objective:** Delivering Quality Excellence for patients

**Critical Success Factors:**
1.1 Patient experience will in the top 20% of all NHS hospitals by 16/17
1.2 Reduce avoidable patient harm by a further 20% by 2018
1.3 HSMR and SHMI is 90 by 17/18
### Strategic Objectives, Critical Success Factors and Strategic Risks

#### Quarter 3 Performance Review

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</table>
| **SO2**        |        | SO2                 | Achieving I&E plans over 3 years to secure breakeven - income and expenditure. | Integrated Business Plan (IBP)  
Annual Plan  
Marketing Strategy  
Capacity Plan  
Commissioning Intentions Provider Relationships | £20m deficit | At the end of Q3 we are £4.1m adverse variance to plan. The year end forecast stands at a deficit of £23.9m. Significant pressures and challenges remain within that forecast. | £23.9m deficit | £16.9m deficit | £5.3m surplus | £7.7m surplus | IBP  
Annual Plan  
Financial Recovery Plan | **SO2, SO1, SO4**  
Failure to deliver / implement capital schemes to support I&E capacity strategy / plan and the environmental estate. |
| **SO4**        |        | SO4                 | Delivering the CIP Programme of £85m by 17/18 | Cost Improvement Programme (CIP)  
Service Transformation Plan  
Commercial Strategy  
Procurement Strategy  
People Strategy | £85 m | At the end of Q3 we are £3.4m adverse variance to plan. | £28m | £36m | £31.6m | £30.5m | CIP Programme  
3 Year Strategy  
IBP | **SO4, SO5, SO2**  
Failure to deliver Staffordshire review on time to secure Trust I&E sustainability. |
| **SO1**        |        | SO1                 | Achieving continuity of service liquidity risk rating of 3 | Liquidity Strategy | 2 | The Liquidity rating remains on plan at a level 2 for 15/16 | 2 | 2 | 3 | 3 | Liquidity Ratio Continuity of service ratings | **SO1, SO2, SO4, SO5**  
Inability to achieve income targets due to commissioner affordability, tariff changes, poor quality or capacity constraints. |
| **SO2**        |        | SO2                 | Delivery of the £100m capital programme to time and cost over 3 years | Capital Strategy | N/A | The capital programme has slipped by £10.6m compared to the plan at Q3. | £57m | £50.9m | £26.8m | £0 | 3 Year Capital Programme | **SO2**  
Failure to develop and secure a deliverable liquidity plan. |
### Strategic Objectives, Critical Success Factors and Strategic Risks

#### Quarter 3 Performance Review

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<th>Critical Success Factors</th>
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<th>Baseline</th>
<th>Q3 2015/16 Performance</th>
<th>Q4 2015/16 Forecast</th>
<th>Measurement</th>
<th>Assurance Source</th>
<th>Interdependency of SO’s</th>
<th>Strategic Risks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rob Vaughan, Director of HR and Rob Courtney-Harris, Medical Director</td>
<td>S03</td>
<td></td>
<td></td>
<td></td>
<td>2014/15 target: £0.54M</td>
<td>£0.93k (April- Dec 2015)</td>
<td>£1.18M</td>
<td>£1.4M</td>
<td>£2.3M</td>
<td>£3.5M</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>3.1</td>
<td>To deliver £5 million grant income by 2018/19.</td>
<td></td>
<td>2014/15 target: £2.1M</td>
<td>£0.99M</td>
<td>£2.1M</td>
<td>£3.0M</td>
<td>£4.4M</td>
<td>Quarterly R&amp;D Reports</td>
<td>S03</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3.2</td>
<td>To deliver £5 million commercial trial income by 2018/19.</td>
<td>Research Strategy</td>
<td>2014/15 target: £2.1M</td>
<td>£0.99M</td>
<td>£2.1M</td>
<td>£3.0M</td>
<td>£4.4M</td>
<td>Quarterly R&amp;D Reports</td>
<td>S01, S02, S03, S04</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3.3</td>
<td>To be rated in The Guardian Undergraduate Training Survey in the top 5 for 2014/15 to 2018/19.</td>
<td>Kelee has been ranked</td>
<td>4</td>
<td>2nd Overall for Student Satisfaction</td>
<td>Within top 5</td>
<td>Within top 5</td>
<td>Within top 5</td>
<td>Times and Sunday Times University League Tables for 2016</td>
<td>S01, S02, S03, S04, S05</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3.4</td>
<td>To be seen by Health Education England, Keele University as the top performing postgraduate medical teaching and undergraduate teaching organisation by 2017/18.</td>
<td>1st (Student Satisfaction National Student Survey 2015)</td>
<td>2nd</td>
<td>1st (Student Satisfaction National Student Survey 2015)</td>
<td>Within top 3</td>
<td>Within top 3</td>
<td>Within top 3</td>
<td>National Students Survey QA Visits</td>
<td>S01, S02, S03, S04, S05</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3.5</td>
<td>80% staff rate their teaching and education as excellent by 2016/17.</td>
<td>78%</td>
<td>National Student Survey 2015 = 95% satisfaction rating</td>
<td>95% National Students Survey (reported August 2015) Average 80%</td>
<td>70%</td>
<td>80%</td>
<td>80%</td>
<td>National Students Survey August 15</td>
<td>S01, S02, S03, S04, S05</td>
</tr>
</tbody>
</table>
### STRATEGIC OBJECTIVES, CRITICAL SUCCESS FACTORS AND STRATEGIC RISKS
#### Quarter 3 Performance Review

<table>
<thead>
<tr>
<th>Executive Lead</th>
<th>SD No.</th>
<th>Strategic Objective</th>
<th>Critical Success Factors</th>
<th>Key Delivery Mechanisms (Strategies / Plans)</th>
<th>Baseline Figure</th>
<th>Q3 2015/16 Performance</th>
<th>Q4 2015/16 Forecast</th>
<th>Measurement</th>
<th>Assurance Source</th>
<th>Interdependence of SO’s</th>
<th>Strategic Risks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Andrew Butters, Acting Director of Planning</td>
<td>4.1</td>
<td>Full delivery and sustainability of TSA model by 2017/18.</td>
<td>Service Transition Plan</td>
<td>N/A</td>
<td>Implementation of TSA model continues to be implemented</td>
<td>62% for Nov 15</td>
<td>65%</td>
<td>n/a</td>
<td>TSA model</td>
<td>SO1, SO2, SO5</td>
<td>Lack of capacity to deliver TSA model for Orthopaedics.</td>
</tr>
<tr>
<td></td>
<td>4.2</td>
<td>Increase number of staff recommending the Trust as a place to work</td>
<td>People Strategy Annual HR Plan</td>
<td>57%</td>
<td></td>
<td>65%</td>
<td>70%</td>
<td>80%</td>
<td>Staff survey</td>
<td>SO2, SO4, SO5</td>
<td>Provider / professional resistance to new service models or organisational plans prevents integrated care happening fast enough.</td>
</tr>
<tr>
<td></td>
<td>4.3</td>
<td>Sustainable vision for a thriving County Hospital.</td>
<td>LHE Planning Group</td>
<td></td>
<td>Part of IBP and Staffordshire Strategic Transformation Review</td>
<td>IBP to include plans for County Hospital and to be approved by Board</td>
<td>IBP to include plans for County Hospital and approved by Board</td>
<td>Commence implementation of agreed plan.</td>
<td>IBP</td>
<td>SO2, SO5</td>
<td>Inability of clinical and non-clinical teams to deliver service transformation to meet CSF’s.</td>
</tr>
<tr>
<td></td>
<td>4.4</td>
<td>Marketing strategy to grow local elective share by 2% per annum and overall market share in our specialist catchment area by 2% per annum.</td>
<td>IBP Marketing strategy Annual Plan</td>
<td></td>
<td>Local Elective - 1% growth at Q2</td>
<td>1.2% growth</td>
<td>2% growth</td>
<td>2% growth</td>
<td>Total market share SOT/NS CCG all specialities</td>
<td>SO2, SO5</td>
<td>Failure to deliver service transformation plans on time.</td>
</tr>
</tbody>
</table>

* a) The Royal Stoke Hospital currently provides 52% of the local elective surgery for the Local Health Economy (i.e. North and South Staffordshire)
* b) The County Hospital currently provides 16% of the local elective surgery for the LHE
* c) The Trust currently provides 53% of the specialist elective care for the specialist catchment of Staffordshire, South Cheshire, and Shropshire
<table>
<thead>
<tr>
<th>Executive Lead</th>
<th>SD No.</th>
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<th>Q3 2015/16 Performance</th>
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<th>2015/16</th>
<th>2016/17</th>
<th>2017/18</th>
<th>Assurance Source</th>
<th>Interdependence of SO’s</th>
<th>Strategic Risks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Helen Lingham, Chief Operating Officer</td>
<td>SO5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.1</td>
<td></td>
<td></td>
<td></td>
<td>Deliver 92% bed occupancy or less</td>
<td>102%</td>
<td>Actual bed occupancy in Nov 15 was 96.1%</td>
<td>95%</td>
<td>95%</td>
<td>93%</td>
<td>92%</td>
<td>Weekly data set Peer review</td>
<td>SO1, SO2, SO5</td>
<td>Inability to deliver admissions reduction plan and discharge levels increases bed occupancy.</td>
</tr>
<tr>
<td>5.2</td>
<td></td>
<td>System wide demand and capacity plan.</td>
<td>Ambulatory Care Strategy, Orthopaedic Strategy, Clinical Leadership Strategy</td>
<td>Length of stay reduction plan, Admissions reduction plan, System-wide demand and capacity plan by 2015/16 - 2017/18</td>
<td>TBC (following system-wide review)</td>
<td>System-wide independent review by ECIP agreed to be undertaken</td>
<td>TBC</td>
<td>TBC</td>
<td>TBC</td>
<td>TBC</td>
<td></td>
<td>SO1, SO2, SO5</td>
<td>Trust fails to recruit staff in key shortage areas, e.g. theatres, nursing, critical care, therapies to deliver new service models or planned capacity.</td>
</tr>
<tr>
<td>5.3</td>
<td></td>
<td>High quality Major Trauma Centre.</td>
<td>Sturgess Report 6 measures (in hospital), Deliver 6 OOH Sturgess recommendations</td>
<td>Good</td>
<td>Excellent</td>
<td>Excellent</td>
<td>Good</td>
<td>Good</td>
<td>Excellent</td>
<td>Peer review</td>
<td></td>
<td>SO1, SO4, SO5</td>
<td>Commissioner reconfigurations create slow pace of change.</td>
</tr>
<tr>
<td>5.4</td>
<td></td>
<td>Deliver the 95% 4 hour standard sustainably.</td>
<td></td>
<td>78.80%</td>
<td>Actual achieved in Dec 15 was 85.4%, and a misalignment of capacity and demand post New Year has not supported delivery of the target</td>
<td>87%</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
<td>National benchmarking Site reports</td>
<td>SO1, SO2, SO3, SO4, SO5</td>
<td>Inability to secure management capacity, rigour and capability to secure strategy and plans and create a patient centred culture.</td>
<td></td>
</tr>
<tr>
<td>5.5</td>
<td></td>
<td>An integrated ‘home first’ culture.</td>
<td></td>
<td>N/A</td>
<td>93%</td>
<td>93%</td>
<td>90%</td>
<td>90%</td>
<td>90%</td>
<td>Staff survey Patient survey</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**STRATEGIC OBJECTIVES, CRITICAL SUCCESS FACTORS AND STRATEGIC RISKS**
Quarter 3 Performance Review
**EXECUTIVE SUMMARY FRONT SHEET**

**Meeting:** Public Trust Board  
**Date:** 9th February 2016  
**Title:** NTDA Monthly Self Certification Returns – December 2015  
**Author:** David Haycox, Associate Director of Corporate Affairs  
**Executive Lead:** Mark Hackett, Chief Executive  
**Other meetings presented to:** n/a

### Purpose

The enclosed document set out the Boards declaration of compliance against the governance requirements which are monitored by the NTDA. The information relates to December 2015.

### Link to Strategic Objectives

- Delivering quality excellence for patients  
- Delivering our financial obligations to the Taxpayer  
- To achieve excellence in education, training and research  
- Create an integrated vibrant Trust and develop strategic alliances with neighbouring trusts and partners  
- Create a resilient Urgent and Emergency Care System and Increase Integrated Healthcare Provision

### Executive Summary

The NTDA has established an oversight model which requires non-Foundation Trusts to submit a monthly self-certification declaration which is signed off by the Board. Within the enclosed declaration, there are some risks to compliance which have been identified. These relate to:

- **Finance**
- **Governance**
  - 4 Hour Wait Standard  
  - Trolley waits >12 hour:  
  - Cancer 62 Day Standard  
  - 18 Weeks  
  - Diagnostic 6 Week Standard  
- **IG Toolkit** (although declared as satisfactory)

Full details of the issues associated with these areas of risk are provided within the enclosed summary which has been submitted to the NTDA. Against each area of risk is a summary of the current position and actions being undertaken to recover the position.

### Key Recommendations

The Board is asked to approve the returns and agree the actions to reduce risk to compliance which are summarised above.

### Corporate Impact Assessment (please tick any which are impacted on / relevant to this paper)

<table>
<thead>
<tr>
<th>Quality Implications</th>
<th>Financial Implications</th>
<th>Legal Implications</th>
<th>Workforce Implications</th>
</tr>
</thead>
</table>
Delivering for Patients: the 2015/16 Accountability Framework for NHS trust boards

Monthly self-certification requirements
<table>
<thead>
<tr>
<th>Licence Condition</th>
<th>Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Condition G4 – Fit and proper persons as Governors and Directors (also applicable to those performing equivalent or similar functions)</td>
<td>Compliant</td>
</tr>
<tr>
<td>2 Condition G5 – Having regard to monitor Guidance</td>
<td>Compliant</td>
</tr>
<tr>
<td>3 Condition G7 – Registration with the Care Quality Commission</td>
<td>Compliant</td>
</tr>
<tr>
<td>4 Condition G8 – Patient eligibility and selection criteria</td>
<td>Compliant</td>
</tr>
<tr>
<td>5 Condition P1 – Recording of information</td>
<td>Compliant</td>
</tr>
<tr>
<td>6 Condition P2 – Provision of information</td>
<td>Compliant</td>
</tr>
<tr>
<td>7 Condition P3 – Assurance report on submissions to Monitor</td>
<td>Compliant</td>
</tr>
<tr>
<td>8 Condition P4 – Compliance with the National Tariff</td>
<td>Compliant</td>
</tr>
<tr>
<td>9 Condition P5 – Constructive engagement concerning local tariff modifications</td>
<td>Compliant</td>
</tr>
<tr>
<td>10 Condition C1 – The right of patients to make choices</td>
<td>Compliant</td>
</tr>
<tr>
<td>11 Condition C2 – Competition oversight</td>
<td>Compliant</td>
</tr>
<tr>
<td>12 Condition IC1 – Provision of integrated care</td>
<td>Compliant</td>
</tr>
</tbody>
</table>
### Board statements – December 2015

For each statement the Board is asked to confirm the following:

<table>
<thead>
<tr>
<th>For CLINICAL QUALITY, that</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>The Board is satisfied that, to the best of its knowledge and using its own processes and having had regard to the TDA’s oversight (supported by Care Quality Commission information, its own information on serious incidents, patterns of complaints, and including any further metrics it chooses to adopt), the trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients.</td>
</tr>
<tr>
<td>2</td>
<td>The board is satisfied that plans in place are sufficient to ensure ongoing compliance with the Care Quality Commission’s registration requirements.</td>
</tr>
<tr>
<td>3</td>
<td>The board is satisfied that processes and procedures are in place to ensure all medical practitioners providing care on behalf of the trust have met the relevant registration and revalidation requirements.</td>
</tr>
</tbody>
</table>

For FINANCE, that

| Response |
The board is satisfied that the trust shall at all times remain a going concern, as defined by relevant accounting standards in force from time to time.

Risk

The Board is satisfied that the Trust is currently a going concern in line with standard definitions, although this remains contingent upon continuing cash support arrangements in line with the financial recovery plan trajectories previously agreed with the TDA. The Trust has received confirmation that cash support requirements will continue to be met in 2015/16 as part of its assurance to the External Auditors that the Trust can be considered a going concern on this basis. In addition the Trust has assurance relating to funding support for the costs identified in the IHSS transaction to the end of 2016/17 through the approval of the revised acquisition business case and the incorporation of the funding agreements within the transfer agreement.

Currently, anticipated cash support requires the Trust to deliver its forecast outturn in 2015/16 and return to its financial recovery plan trajectory in 2016/17. At present the Trust is unable to forecast delivery of plan in 2015/16 and have reported this position to the NTDA. The 2016/17 financial plan will be informed by the development of the Integrated Business Plan currently being prepared. 2015/16 Cash support submission is being made in time for the TDA February ITFF in order that the cash can be received in March 2016.

For GOVERNANCE, that

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>5</td>
<td>The board will ensure that the trust remains at all times compliant with the NTDA accountability framework and shows regard to the NHS Constitution at all times.</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>6</td>
<td>All current key risks to compliance with the NTDA's Accountability Framework have been identified (raised either internally or by external audit and assessment bodies) and addressed – or there are appropriate action plans in place to address the issues in a timely manner.</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>7</td>
<td>The board has considered all likely future risks to compliance with the NTDA Accountability Framework and has reviewed appropriate evidence regarding the level of severity, likelihood of a breach occurring and the plans for mitigation of these risks to ensure continued compliance</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>The necessary planning, performance management and corporate and clinical risk management processes and mitigation plans are in place to deliver the annual operating plan, including that all audit committee recommendations accepted by the board are implemented satisfactorily.</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td></td>
<td>An Annual Governance Statement is in place, and the trust is compliant with the risk management and assurance framework requirements that support the Statement pursuant to the most up to date guidance from HM Treasury (<a href="http://www.hm-treasury.gov.uk">www.hm-treasury.gov.uk</a>).</td>
</tr>
</tbody>
</table>
The board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets (after the application of thresholds) as set out in the relevant GRR; and a commitment to comply with all known targets going forwards.

**Risk**

The Board is committed to compliance with all known targets, however key risks relate to sustainable delivery of:

**4 Hour Wait Standard**

The below table demonstrates an improving month on month position throughout Q1 and up to August against the 4 hour standard. However, the following four months saw performance fall to levels previously seen earlier in the summer. The Trust continues to experience sporadic days where emergency pressures are significant and on the 16th December 1 >12 hour trolley wait occurred.

The LHE plan committed to a step change improvement in performance which has been delivered successfully up to August. However, in the last four months performance has declined to below that of the agreed LHE trajectory:

- Performance in November was over 90% on 4 days in the month, with no single day achieving over 95%.
- Performance in December was over 90% on 1 day in the month.
- Total performance for the month of December was 82.8% against the trajectory of 95.4%

### Weekly performance

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total performance</td>
<td>80.1%</td>
<td>82.8%</td>
<td>89.0%</td>
<td>90.9%</td>
<td>93.3%</td>
<td>88.5%</td>
<td>85.3%</td>
<td>85.3%</td>
<td>82.1%</td>
<td>84.7%</td>
<td>81.3%</td>
<td>84.2%</td>
<td>79.9%</td>
<td>71.9%</td>
<td></td>
</tr>
</tbody>
</table>

### Monthly Performance:

<table>
<thead>
<tr>
<th></th>
<th>Q1 14/15</th>
<th>Q2 14/15</th>
<th>Q3 14/15</th>
<th>Q4 14/15</th>
<th>April</th>
<th>May</th>
<th>June</th>
<th>July</th>
<th>August</th>
<th>September</th>
<th>October</th>
<th>November</th>
<th>December</th>
</tr>
</thead>
<tbody>
<tr>
<td>RSUII</td>
<td>87.7%</td>
<td>85.5%</td>
<td>79.1%</td>
<td>75.1%</td>
<td>77.6%</td>
<td>81.0%</td>
<td>87.7%</td>
<td>83.4%</td>
<td>91.3%</td>
<td>86.9%</td>
<td>83.1%</td>
<td>83.1%</td>
<td>80.5%</td>
</tr>
<tr>
<td>County</td>
<td>87.4%</td>
<td>92.7%</td>
<td>91.1%</td>
<td>91.2%</td>
<td>95.1%</td>
<td>97.6%</td>
<td>95.5%</td>
<td>95.4%</td>
<td>95.0%</td>
<td>94.8%</td>
<td>93.1%</td>
<td>93.1%</td>
<td>91.1%</td>
</tr>
<tr>
<td>UHNM</td>
<td>80.1%</td>
<td>79.2%</td>
<td>80.1%</td>
<td>82.3%</td>
<td>85.0%</td>
<td>90.9%</td>
<td>95.3%</td>
<td>88.5%</td>
<td>85.3%</td>
<td>85.3%</td>
<td>82.8%</td>
<td>93.1%</td>
<td>91.1%</td>
</tr>
</tbody>
</table>

### Trolley waits >12 hour:

<table>
<thead>
<tr>
<th></th>
<th>Q1 14/15</th>
<th>Q2 14/15</th>
<th>Q3 14/15</th>
<th>Q4 14/15</th>
<th>April</th>
<th>May</th>
<th>June</th>
<th>July</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
</tr>
</thead>
<tbody>
<tr>
<td>14/15</td>
<td>2</td>
<td>16</td>
<td>180</td>
<td>948</td>
<td>724</td>
<td>4</td>
<td>6</td>
<td>15</td>
<td>13</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>
Key factors impacting on performance have been:

- Continued high numbers of A&E attendances (3.4% increase in Q3 2015/16 actual compared to Q2 2015/16 actual) and a 13.7% increase in NEL actual admissions in Q3 2015/16 compared to Q2 2015/16.

- Trust occupancy rate – 92% overall in December 2015

<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Medicine &amp; Frail Elderly</td>
<td>97%</td>
<td>95%</td>
<td>93%</td>
<td>93%</td>
<td>92%</td>
<td>93%</td>
<td>92%</td>
<td>94%</td>
<td>96%</td>
</tr>
<tr>
<td>Surgery</td>
<td>92%</td>
<td>90%</td>
<td>92%</td>
<td>91%</td>
<td>88%</td>
<td>87%</td>
<td>94%</td>
<td>93%</td>
<td>80%</td>
</tr>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td>98%</td>
<td>103%</td>
<td>109%</td>
<td>103%</td>
<td>101%</td>
<td>101%</td>
<td>110%</td>
<td>102%</td>
<td>102%</td>
</tr>
<tr>
<td>Total</td>
<td>95%</td>
<td>95%</td>
<td>94%</td>
<td>94%</td>
<td>92%</td>
<td>92%</td>
<td>95%</td>
<td>94%</td>
<td>92%</td>
</tr>
</tbody>
</table>

- Medically fit for discharge patients continue to be in excess of the LHE target of 67, with an average of 105 per day in December.

Delivery of the 4 Hour Wait Standard:

- The Local Health Economy (LHE) Resilience Plan schemes remain in place with agreement of the LHE System Resilience Group (SRG) that no bed capacity is to be reduced without SRG approval and alternative offers in place.

- LHE 15/16 programme plan and project management arrangements in place.

- Revised LHE trajectory was submitted to NHSE at the beginning of June, the trajectory forecasts:
  - >=95% delivery of the standard for all A&E Types for the month of December. Actual was 82.8%
  - The Trust has in place an Emergency and Urgent Care Improvement Programme Board to take forward the recommendations of the review undertaken by Dr Ian Sturgess, who continues to work with the Trust, and has expanded the scope of this meeting to include other improvement initiatives such as the exemplar programme.

The Trust resilience plans are resulting in improvements including:

- 6% reduction in the number of NEL patients >70-years with a +10 day length of stay (daily average of 192 in Q2 versus 183 in Q3).

- Reduction in medical outliers. Average of 3 per day during Q3, 50% less than the daily average of 6 in Q1.

Simple and timely discharge targets are being achieved

- The weekday target was achieved in December with a daily discharge average of 138 Mon-Fri...
The target has been achieved on 12 of the last 13 weeks (@10/01/16).
The opening of the new expanded discharge lounge, combined with exemplar wards programme and length of stay plans is supporting both the improvement of flow and timeliness of discharges.

Key plans over the forthcoming months

- Agreement with SRG to concentrate on the 15 minute handover of patients as a key measure to ensure that there is swift handover of those patients who clinically require it
- Review and invest in medical staffing at key peak times of the day
- Review of the Trauma demand as not in line and excessive to that of TSA model
- Present and implement Medically Fit For Discharge programme
- Improvement of step down/ social care – additional posts and audit of use
- Implementation of new model for surge capacity

South Staffordshire / County Hospital Actions being taken:

The critical success factors that need to be achieved, to deliver and sustain the 95% 4 hour quality indicator are outlined below:

1. Maximise the function of the “admission portals” – AAU / CDU
   - The ambulatory stream of patients continues along with the appropriate medical take from A&E for triage directly to AAU. Patients are either discharged, streamed to short stay or to specialty wards
   - A defined cohort of patients under the care of ED are streamed to CDU for a maximum stay of 23 hours whereby provision of response are alternatives to admission e.g. hot clinics, community assessment, access to out of hospital schemes

2. Ward based discharges; inclusive of Exemplar Ward model and D2A model
   - Agreed internal professional standards to reflect how key roles operationally work on a daily basis including structured ward rounds, EDD, criteria led discharges, ward processes, weekend planning, and long stay are being rolled out, with all wards included in this programme.

3. D2A – currently scoping the various elements of the model including workforce, patient profiling, demand and capacity and integrated working pathways

4. Governance process remains in place including the County Medical Programme Board and the UHNMM Urgent and Emergency Care Improvement Board to oversee performance against the emergency pathway and delivery of the actions.
Cancer 62 Day Standard

Performance:
- UHNM has been identified as 1 of 19 Trusts nationally that has underachieved the 62 day target and has been required by the national regulators to submit improvement plans and trajectory, and a completed self-assessment against the 8 high impact actions identified by the national cancer waiting times taskforce.
- The overall Trust improvement plan has been transferred into the required template, and will be underpinned by cancer site specific improvement plans and forecasts. Delivery of the specialty plans is reviewed fortnightly by the AD of Surgery.
- Forecast of the cancer 62 day standard shared with the NTDA demonstrates achievement of the 62D standard from the end of December 15 onwards. As noted in the letter dated 30/07/15 from Regulators all Trusts are required to recover the standard as soon as possible, but at least by year end.

Actual performance against the revised trajectory for Royal Stoke, County Hospital and UHNM:

<table>
<thead>
<tr>
<th></th>
<th>Q1</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Q2</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
</tr>
</thead>
<tbody>
<tr>
<td>RSUH - Actual</td>
<td>73.40%</td>
<td>73.40%</td>
<td>81.62%</td>
<td>74.51%</td>
<td>76.05%</td>
<td>74.29%</td>
<td>82.75%</td>
<td>74.62%</td>
</tr>
<tr>
<td>CH – Actual</td>
<td>76.40%</td>
<td>76.40%</td>
<td>71.43%</td>
<td>60.00%</td>
<td>68.52%</td>
<td>55.00%</td>
<td>76.47%</td>
<td>77.78%</td>
</tr>
<tr>
<td>UHNM Actual</td>
<td>73.60%</td>
<td>73.60%</td>
<td>80.06%</td>
<td>73.21%</td>
<td>75.21%</td>
<td>73.00%</td>
<td>82.01%</td>
<td>75.00%</td>
</tr>
</tbody>
</table>
*Provisional

Key Issues:
- Q1 average 2ww suspected cancer patients seen per month 1797 verses 1875 in Q2, a 4% increase in activity. Q3 average was 1932 per month; a 3% increase verses Q2.
- Q1 average breast symptomatic patients seen per month 228 verses 223 in Q2, a slight reduction in activity. Q3 average was 244 per month; a 9.6% increase verses Q2.
- On average the proportion of breaches on the 62 day pathway in November are circa 48% due to Trust capacity, and 52% due to factors outside of the Trusts control including i.e. patient choice, medical reasons. Theatre plans include increased capacity which is workforce dependent and in addition patient choice management.

Key Actions:
- Robust performance information to support operational delivery, challenge and oversight by divisional, service line and MDT teams is in place.
- Trust governance structure is in place to ensure weekly review/action of cancer performance through Divisional Access meetings, and the Trust Planned Care Group.
• Escalation policy is in place to support the pulling of patients through the pathway in line with Trust internally set standards.
• Escalated performance management arrangements are in place for the most challenged specialties, chaired by the AD of surgery.
• Daily PTL meetings are to commence in January ’16. In attendance will be the specialty management teams and representative from Imaging and Pathology to review performance and the PTLs, agreeing actions as required.
• The Trust is working with the Intensive Support Team (IST) to review challenged pathways in line with IST recommendations.
• The IST and UHNMC Cancer Services Manager have complied a Cancer Delivery and Sustainability Plan, which includes the IST recommendations.
• A live demand and capacity tool for 2 week wait referrals have been in place for over a year.
• The Trust is working with the IST 1 day per day week to improve performance. In January ’16 the IST will be doing further work with the Trust’s specialty teams to develop their capacity and demand models for 2ww referrals and diagnostics tests.

18 Weeks

December Performance:
• The Trust under-achieved all 18 week standards in December, with the Incomplete performance at 90.6%.

Key Issue:
• Due to unforeseen pressures in December, some of specialties recovery plans these were not able to be implemented or completed.
• At the end of March the Trust total backlog (admitted/non-admitted/County/Royal Stoke) was circa 2500, and at the end of August this had reached 3056. This has slightly increased to 2756 in December and with continued focus the backlog should reduce to below 2500 in January, currently 1575 are admitted and 1181 are non-admitted.

Key Actions:
• In light of the change in the national position and the agreement of a single indicator for 18 weeks performance, the Trust continues to focus on the treatment of long wait patients as a priority and reducing its 18 week backlog, which has been discussed and supported by the LHE SRG.
• The Trust had undertaken a revised forecast for incomplete pathways for the remainder of 2015/16. However, due to underachievement and at the request of the TDA, re-modelling of the forecast is underway underpinned by detailed action plans. This will be shared with the NTDA Delivery and Development Manager. The specialty teams will be closely monitoring their plans and assumptions put forward to deliver the forecast. It is expected, however that two specialities will continue to be challenged (General Surgery and T&O).
Diagnostic 6 Week Standard – The diagnostic standard has now been achieved in consecutive months with December performance at 0.9%. The Trust is expecting to maintain the standard, although there are some expected risks for January regarding equipment that are outside the Trusts control.

HSCIC have declared the Trust as satisfactory

On 31st March 2015 the Trust submitted an IG Toolkit score of 85% for 2014/15. One requirement was declared at level 1 and therefore the overall submission is deemed as "not satisfactory". This requirement related to information governance mandatory training.

A target of 95% of staff having received IG training within each 12 month period is required as part of the toolkit submission.

As outlined in the previous submission the HSCIC contacted the Information Governance Manager (August 2015) to discuss the option of upgrading the Trust's overall position from 'unsatisfactory' to 'satisfactory' if HSCIC could be assured that a robust training plan was in place. The delivery plan was submitted and accepted, on the basis that HSCIC will continue to review the Trust's position. The HSCIC has subsequently changed the Trust's public IGT score from red/unsatisfactory to green/satisfactory. The IGT score is available via the HSCIC website.

As at the end of December the training figure was 72%. This is in line with the delivery plan submitted to HSCIC.

In order to successfully achieve training compliance and to fulfill the training plan, the IG team will continue to RAG rate all Trust staff according to their IG training status. Individuals will be notified to alert them to the IG training status. Lower compliance departments continue to be targeted first.

Divisions and Directorates continue to receive a monthly breakdown of compliance, with staff listed individually along with their compliance status. The Trust's IG training position is presented at the Trust's Information Governance Steering Group.
|   | The board will ensure that the trust will at all times operate effectively. This includes maintaining its register of interests, ensuring that there are no material conflicts of interest in the board of directors; and that all board positions are filled, or plans are in place to fill any vacancies. | Yes |
|---|---|
| 13 | The board is satisfied that all executive and non-executive directors have the appropriate qualifications, experience and skills to discharge their functions effectively, including setting strategy, monitoring and managing performance and risks, and ensuring management capacity and | Yes |
| 14 | The board is satisfied that: the management team has the capacity, capability and experience necessary to deliver the annual operating plan; and the management structure in place is adequate to deliver the annual operating plan. | Yes |

<table>
<thead>
<tr>
<th>Signed on behalf of the Trust:</th>
<th>Print Name</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CEO</td>
<td>Mark Hackett, Chief Executive, University Hospitals of North Midlands NHS Trust</td>
<td>29/01/16</td>
</tr>
<tr>
<td>Chair</td>
<td>John MacDonald, Chairman, University Hospitals of North Midlands NHS Trust</td>
<td>29/01/16</td>
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