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Staffordshire County Council

Staffordshire & Stoke-on-Trent Joint Health Overview and Scrutiny Committee
Wednesday, 18 November 2026 at 10.00 am
Civic Centre, Glebe Street, Stoke-on-Trent, ST4 1HH

Membership

Stoke-on-Trent City Council	**Staffordshire County Council**
Councillor Laura Carter	Councillor Antonia Orlandi-Fantini
Councillor Dave Evans	Councillor Mike Broom
Councillor Chandra Kanneganti	Councillor Adam Griffiths
Councillor Daniella Santoro	Councillor Jill Hood
Councillor Alastair Watson	Councillor Rhys Mandry

Agenda

1. **Welcome & Introduction**
2. **Apologies for Absence**
3. **Election of Chair**
4. **Election of Vice-Chair**
5. **Disclosure of Interests**
6. **Ambulance Wait Times Report** (Pages 1 - 24)

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Agenda Item 6

Joint Staffordshire and Stoke-on-Trent Health Overview and Scrutiny Committee
18 November 2026

Open

Ambulance Wait Times

Report of the Acting Chief Executive and Chief Operating Officer

University Hospitals of North Midlands

Purpose of Report

To explain ambulance waiting times at Royal Stoke University Hospital, performance against key performance indicators (KPIs)—the measures used to assess waiting times—and the reasons for delays. The report also describes trends, risks and actions to improve care.

Glossary

Acronym	Meaning
CQC	The **Care Quality Commission (CQC)** is the independent regulator of all health and adult social care services in England, including NHS hospitals, GP practices, dentists, care homes, and home care agencies.
ED	An Emergency Department (ED) commonly known as **Accident and Emergency (A&E)** is a hospital department that provides 24-hour, 365-day emergency care for serious injuries and life-threatening conditions.
EEMAC	Extended Emergency Medicine Ambulatory Care is a dedicated care pathway and physical area for adult Emergency Department (ED) patients who require more than 4 hours of ongoing assessment, diagnostics, or treatment, but have a high likelihood of being discharged home rather than admitted to a hospital bed (typically within an 8-hour window in the unit, or up to 12 hours total)
GIRFT	Getting It Right First Time - a national program within NHS England designed to improve patient care and treatment by reducing unwarranted clinical and operational variation
HOSC	Health Overview and Scrutiny Committee
KPIs	Key Performance Indicators - Is a quantifiable, measurable value used to track how effectively a hospital, trust, or service is achieving its core clinical, operational, and financial goals
NHS	National Health Service
SDEC	Same Day Emergency Care - It is a service that assesses, diagnoses, and treats patients with urgent, non-life-threatening conditions on the same day they arrive, allowing them to go home without an overnight hospital stay.
SDM	Shared Decision Making - It is a collaborative process where healthcare professionals and patients work together to make clinical decisions. The goal is to ensure you are fully informed and have an active voice in your own healthcare journey
SPoA	Single Point of Access

	Is a centralized service, team, or digital gateway that streamlines how patients, GPs, and healthcare professionals connect to community, urgent, mental health, or specialist care
TES	Temporary Escalation Space - A non-designated clinical area used to care for patients temporarily during severe hospital capacity pressures.
UEC	Urgent and Emergency Care - covers a spectrum of health services designed to handle everything from minor, non-life-threatening health issues to critical, life-saving emergencies.
UHNM	University Hospitals of North Midlands NHS Trust
UTC	Urgent Treatment Centre - This provides medical help for urgent, non-life-threatening conditions that cannot wait for a standard GP appointment, but do not require a visit to a major Accident & Emergency (A&E) department

1.0 Recommendations

1.1 The Committee is asked to receive and note the actions underway to improve ambulance handover times through the UHNM Winter Plan and over the medium term.

2.0 Background and Introduction

Introduction

2.1 This report covers urgent and emergency care (UEC): services for people who need prompt assessment or treatment. It focuses on the transfer of care from ambulance crews to hospital staff, known as ambulance handover, and waits in the Emergency Department (ED), where patients receive emergency assessment and treatment. Waiting-time performance remains below the required standards. The Trust remains in Tier 1 national oversight, meaning that its improvement work is subject to close national monitoring and support. Waiting times indicate pressure on services; they do not, on their own, establish whether a patient has been harmed.

2.2 The Trust has an improvement plan, refreshed as part of its Annual Delivery Plan for the current year. Recent changes are intended to support winter services and improve care over the longer term.

Background

2.3 The programme followed a review by NHS England in January 2025 of how patients are assessed, treated and moved through services. Progress is monitored at the Trust's Urgent and Emergency Care Recovery and Oversight Meeting. The Getting It Right First Time (GIRFT) team also supports the work. GIRFT is a national NHS England programme that uses clinical reviews, data and comparisons between services to identify improvements in care. Its role here is supportive and intended to benefit patients by helping reduce delays.

2.4 Performance has varied over the period shown in the charts, with earlier improvements followed by deterioration. The latest November 2026 points show markedly shorter ambulance handover times, improved four-hour performance and fewer patients spending 12 hours or longer in the Emergency Department. These are encouraging early results, but November figures will continue to change as the month progresses. The priority is to maintain improvement throughout winter and demonstrate that shorter waits are accompanied by safe care and a better patient experience.

2.5 The information presented suggests that delays in moving patients through the hospital are an important barrier to faster ambulance handover. When beds remain occupied and patients leave hospital later in the day, people waiting in the Emergency Department cannot move to a ward promptly. This limits space for patients arriving by ambulance. The improvement programme therefore focuses on safe, earlier discharge, avoiding admissions where another service can safely meet a patient's needs, and providing assessment and treatment without an overnight stay where appropriate.

3.0 Report Details

3.1 Performance improved steadily up to April but worsened after the additional winter capacity closed following Easter. It improved again in July, moving back towards earlier levels, but became less consistent in August. In September, ambulance handovers were consistently delayed, patients waited longer in the Emergency Department (ED), and more patients were waiting to be admitted to hospital.

3.2 The report describes broadly stable attendance numbers since last winter, with occasional increases in attendances and ambulance arrivals during August. Good handover performance was achieved on some busy days, suggesting that the number of arrivals alone does not explain the delays. However, attendance totals do not show how unwell patients were, when they arrived or how many needed admissions. These factors, staffing, available beds and discharge delays all impact on delays.

3.3 The data demonstrates better waiting-time performance on days when more patients leave hospital before midday and 4 pm, and when fewer than 93% of beds are occupied by early afternoon. These conditions are associated with:

- faster movement to the next stage of care for patients whose assessment or treatment is complete;
- a reduction in ED length of stay; and
- an increase of around 12 percentage points in ambulance handovers completed within 45 minutes. This measures the change in the proportion completed within that time, not a reduction in waiting time.

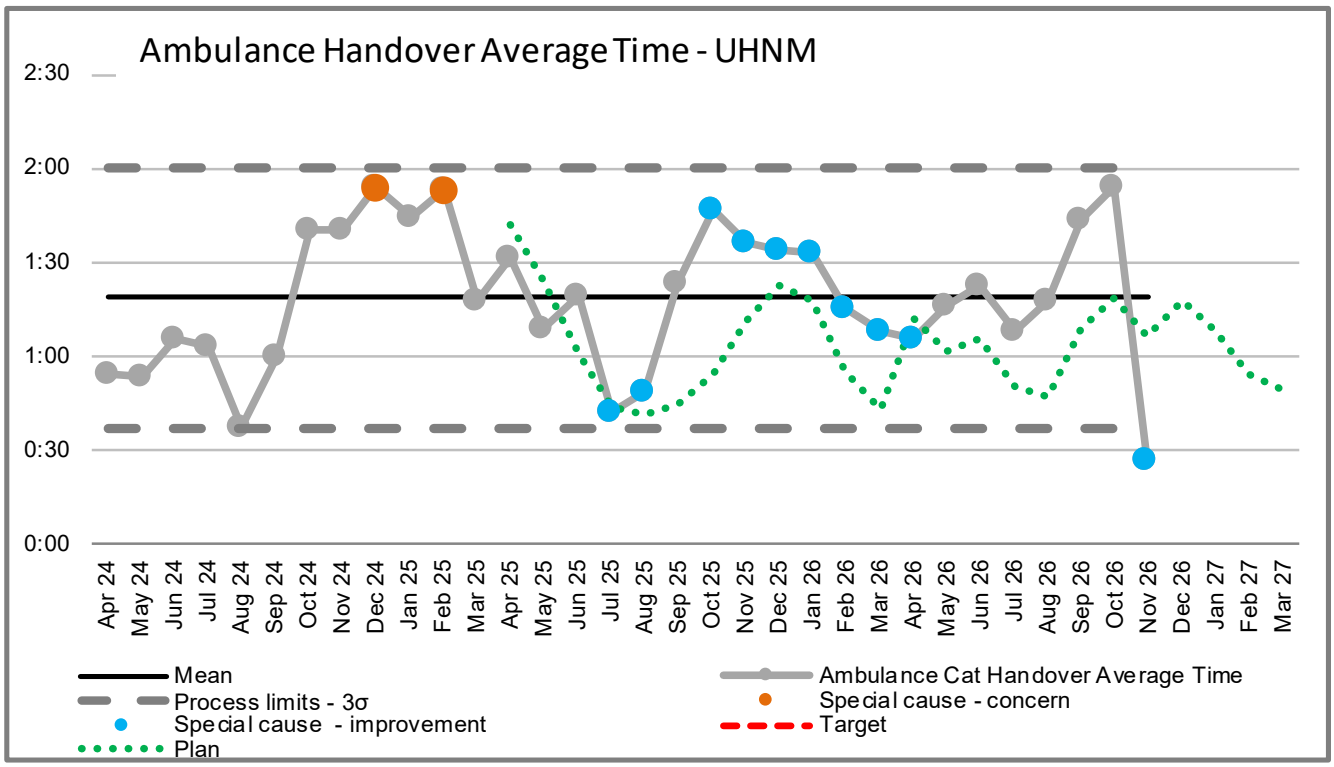
These findings suggest that making beds available earlier helps reduce waits.

3.4 Beds are not becoming available early enough on a consistent basis. The report reports fewer discharges, particularly before 4 pm, during September, high and changing bed occupancy, and more patients waiting for admission. Extra temporary spaces on wards remain in use.

3.5 Following an unannounced inspection by the Care Quality Commission (CQC), the independent regulator of health and care services in England, 15 corridor spaces in the Emergency Department were closed. This reduced the spaces available for care. Temporary additional community beds were provided but had returned to normal levels ahead of winter arrangements. Other actions included longer opening hours for Same Day Emergency Care (SDEC), which assesses and treats suitable patients without an overnight stay; greater use of the discharge lounge, where patients can wait after leaving a ward; and discharge against agreed clinical criteria, so suitable patients can leave when those conditions are met. Work also continues to reduce unnecessarily long hospital stays

3.6 The Trust is also reviewing admission criteria because benchmarking indicates that its admission rate is higher than comparable organisations.

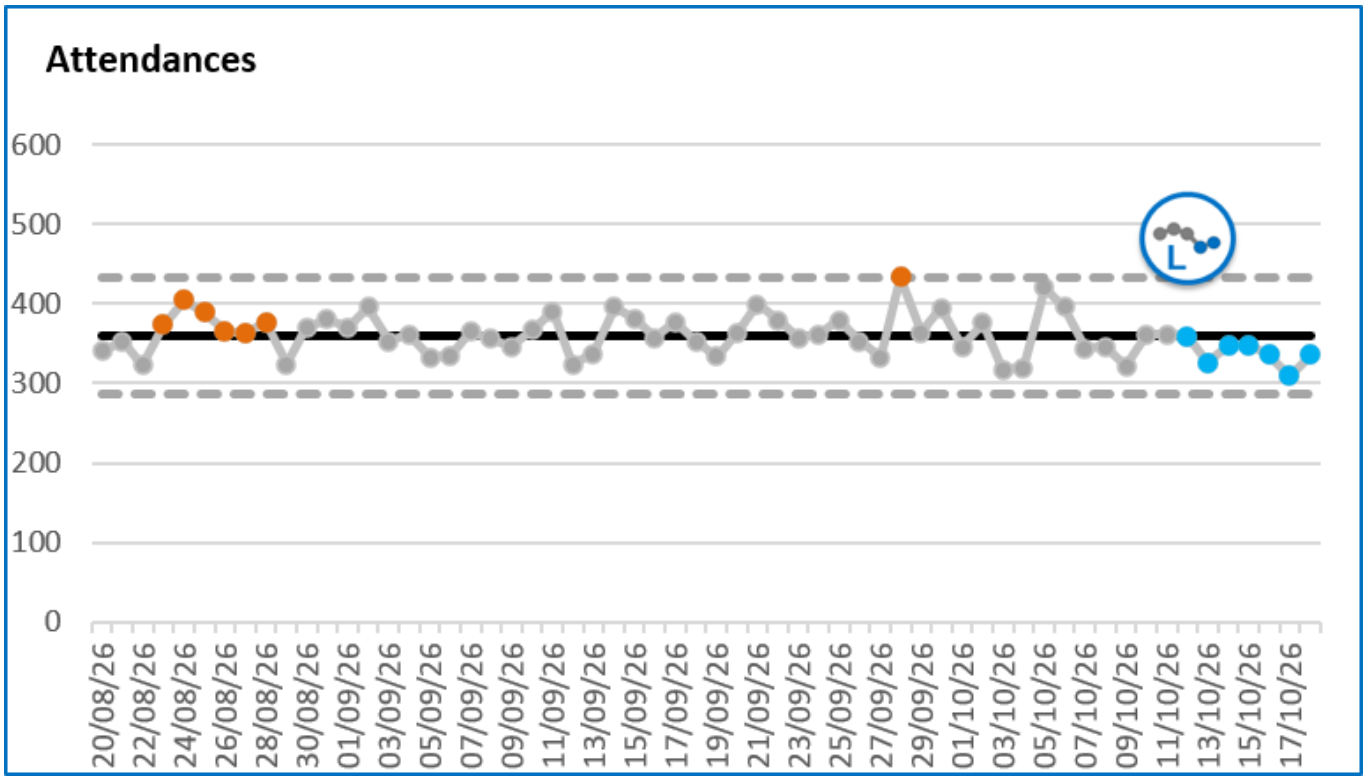
3.7 **Ambulance Handover Average Time - UHNM**

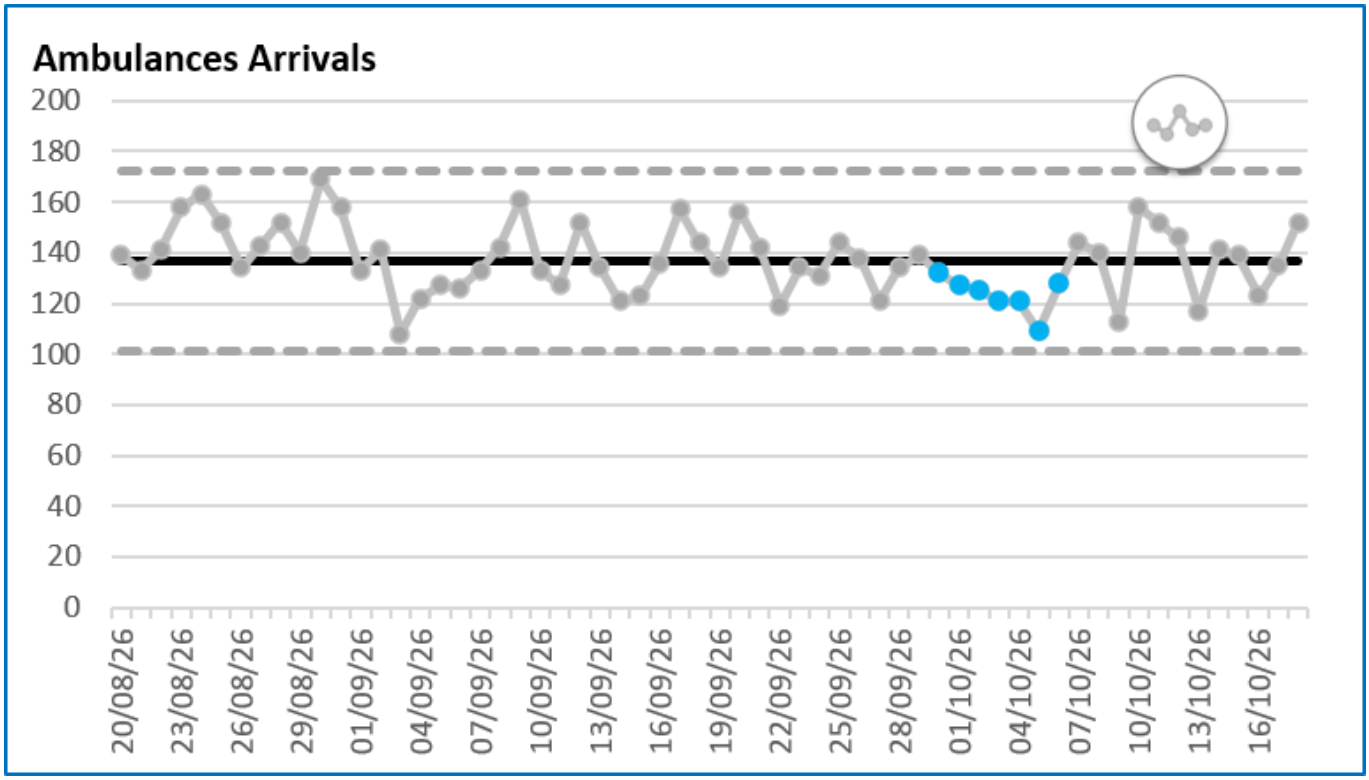


The chart shows average ambulance handover times for University Hospitals of North Midlands, rather than a separately identified Royal Stoke measure. Times are shown in hours and minutes; lower values mean shorter waits for the transfer of care from ambulance crews to hospital staff. Performance has varied considerably since April 2024. Average waits rose to around 1 hour 40 minutes to 1 hour 55 minutes in late 2024 and early 2025, before falling to around 40–45 minutes in June and July 2025. This improvement was not sustained: waits increased again in autumn 2025. During much of 2026, average waits were around an hour or more, rising to nearly two hours in October. The latest point, labelled November 2026, shows a sharp reduction to approximately 27 minutes. This is encouraging, but a single monthly point does not demonstrate sustained recovery.

As the report is being prepared during November, this number may move based on the rest of the months performance. The green dotted line represents the plan, not actual performance; its future values should not be read as achieved results. Overall, the chart shows that shorter waits have been achieved during November now need to be maintained. Reducing handover times supports earlier transfer into hospital care and releases ambulance crews to respond to other calls.

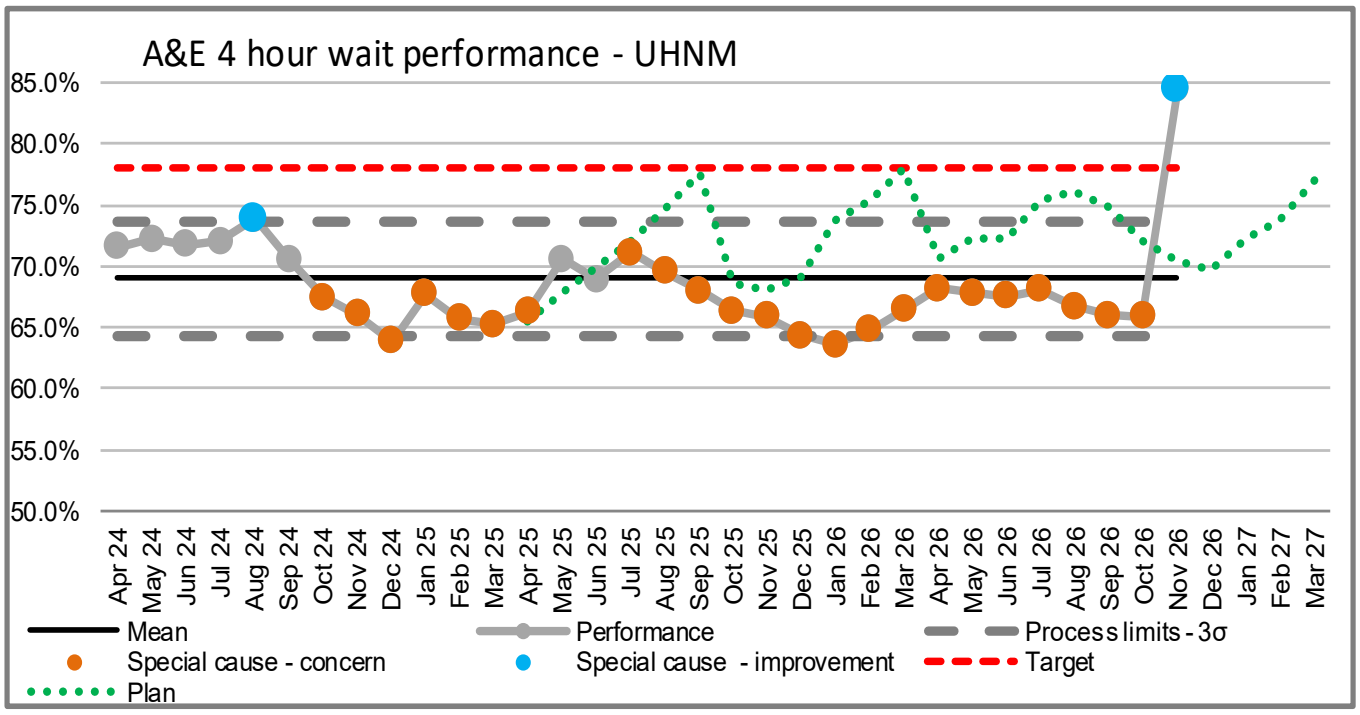
3.8 **Attendances**





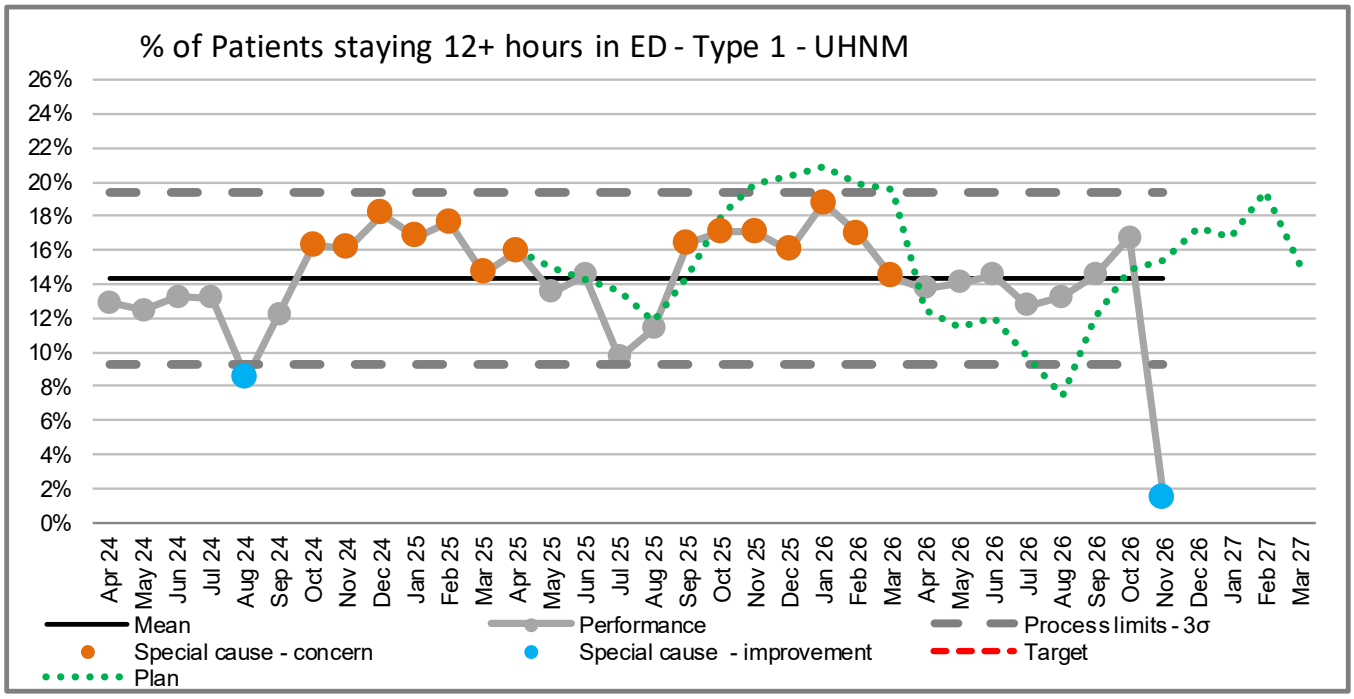
3.9 The report describes the overall number of Emergency Department attendances as broadly stable since last winter. If confirmed, this suggests that rising attendance totals alone do not explain the worsening waits. It does not rule out pressure from concentrated arrival times or patients needing more complex treatment.

3.10 **Time in the Emergency Department**



3.11 The charts show waiting-time performance for University Hospitals of North Midlands as a whole. The first shows the proportion of patients admitted, transferred or discharged within four hours of arrival; a higher percentage means better performance. Results were around 72–74% in spring and summer 2024, but were generally around 64–71% from autumn 2024 to October 2026, below the 78% target shown by the red dashed line. The latest point, labelled November 2026, rises sharply to approximately 85%, exceeding the displayed target and improving on around 66% in October. This is also higher than the approximately 68% recorded in November 2025.

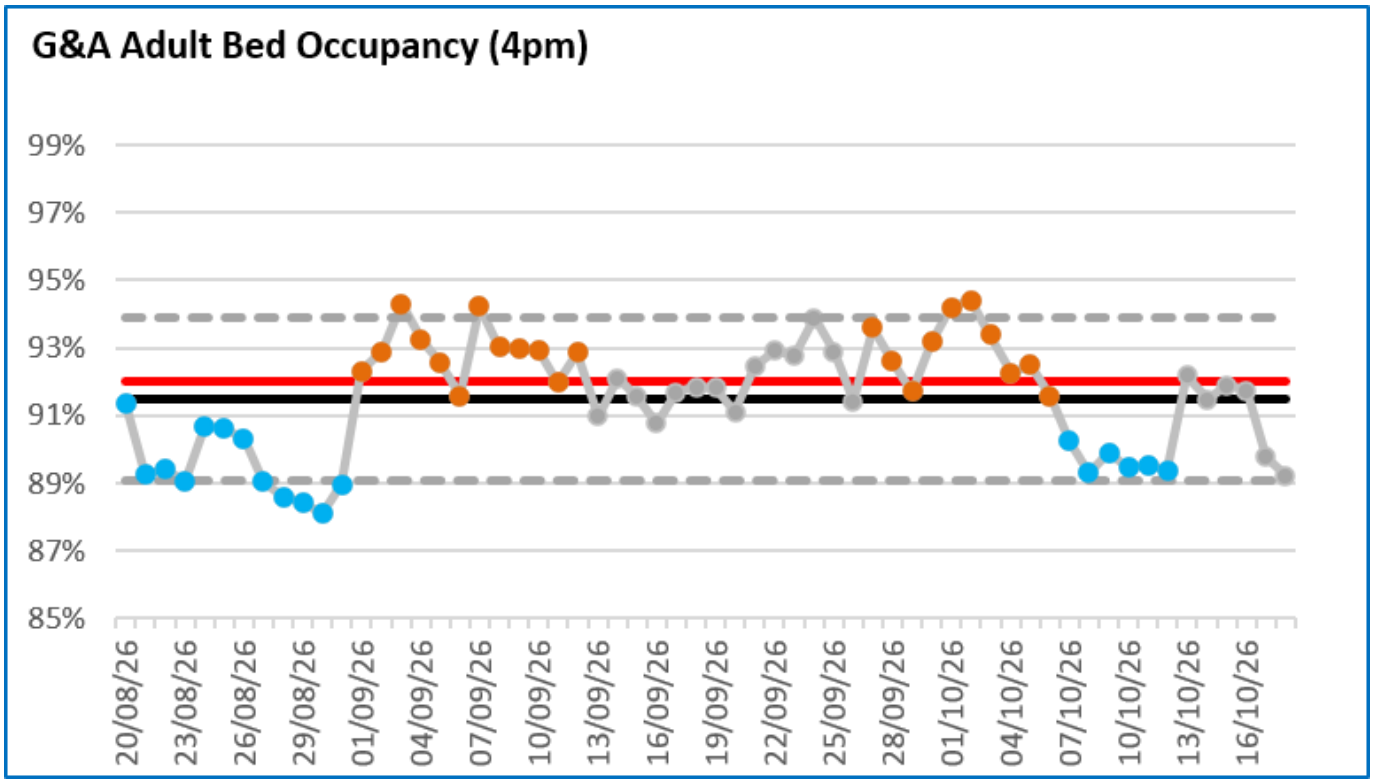
3.12

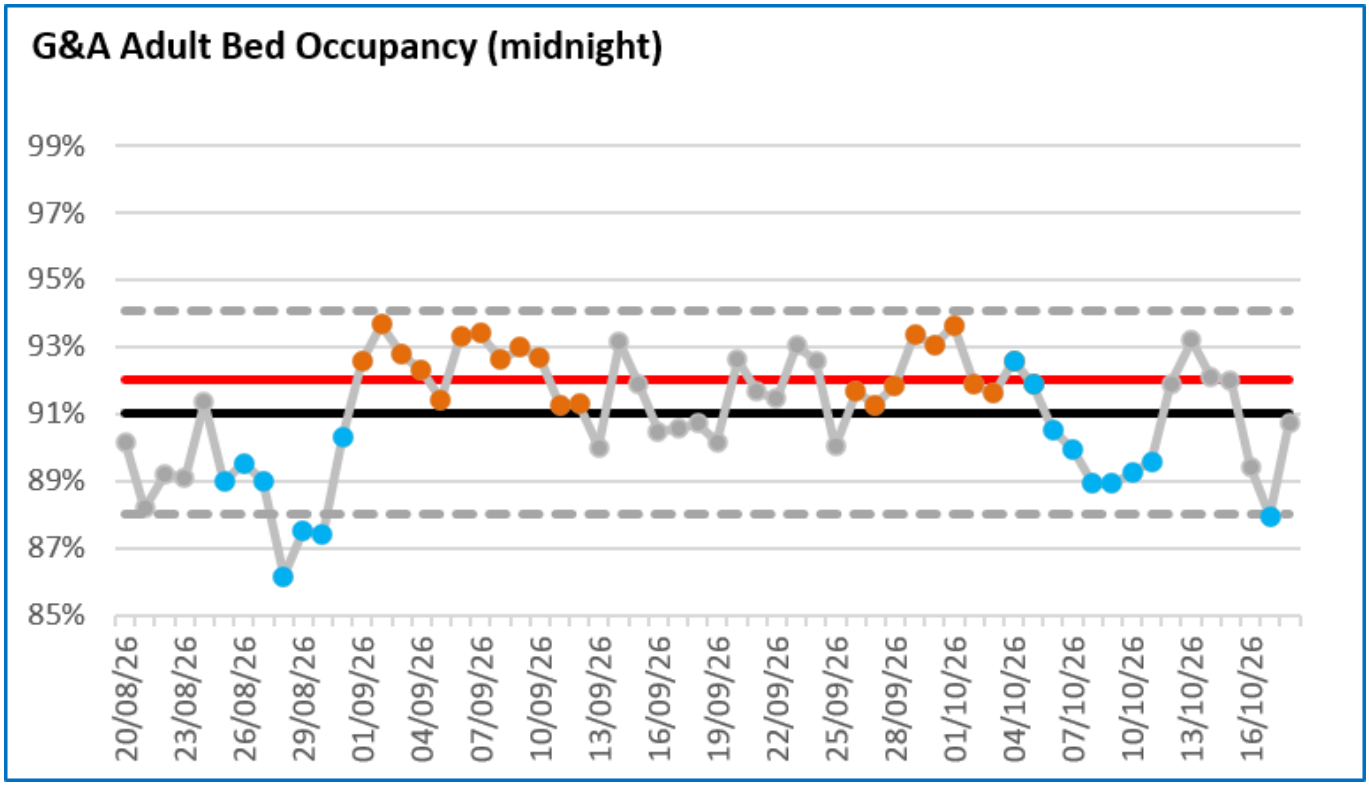


3.13 This chart shows the percentage of patients spending 12 hours or longer in a Type 1 Emergency Department—a consultant-led department providing a full emergency service. A lower percentage means fewer patients experiencing these long stays. The proportion reached around 18–19% during the winters of 2024/25 and 2025/26. It fell to around 13–14% during summer 2026, before rising to approximately 17% in October. The November 2026 point shows a marked reduction to around 1–2%, compared with approximately 17% in November 2025. These are percentages, not patient numbers, and describe total time in the department rather than time spent waiting after a decision to admit. As November data is incomplete this month's data will change as the month continues and demonstrates a requirement to maintain performance.

3.14 Taken together, the latest points indicate substantially fewer prolonged stays and more patients completing their Emergency Department visit within four hours. Both are marked as improvements outside the charts' expected range of variation. This is encouraging and consistent with the latest improvement in ambulance handover times described in section 3.7, but does not establish that one caused the other or that recovery is sustained. As the report is being prepared during November, therefore this performance needs to be sustained in order to continue this improvement.

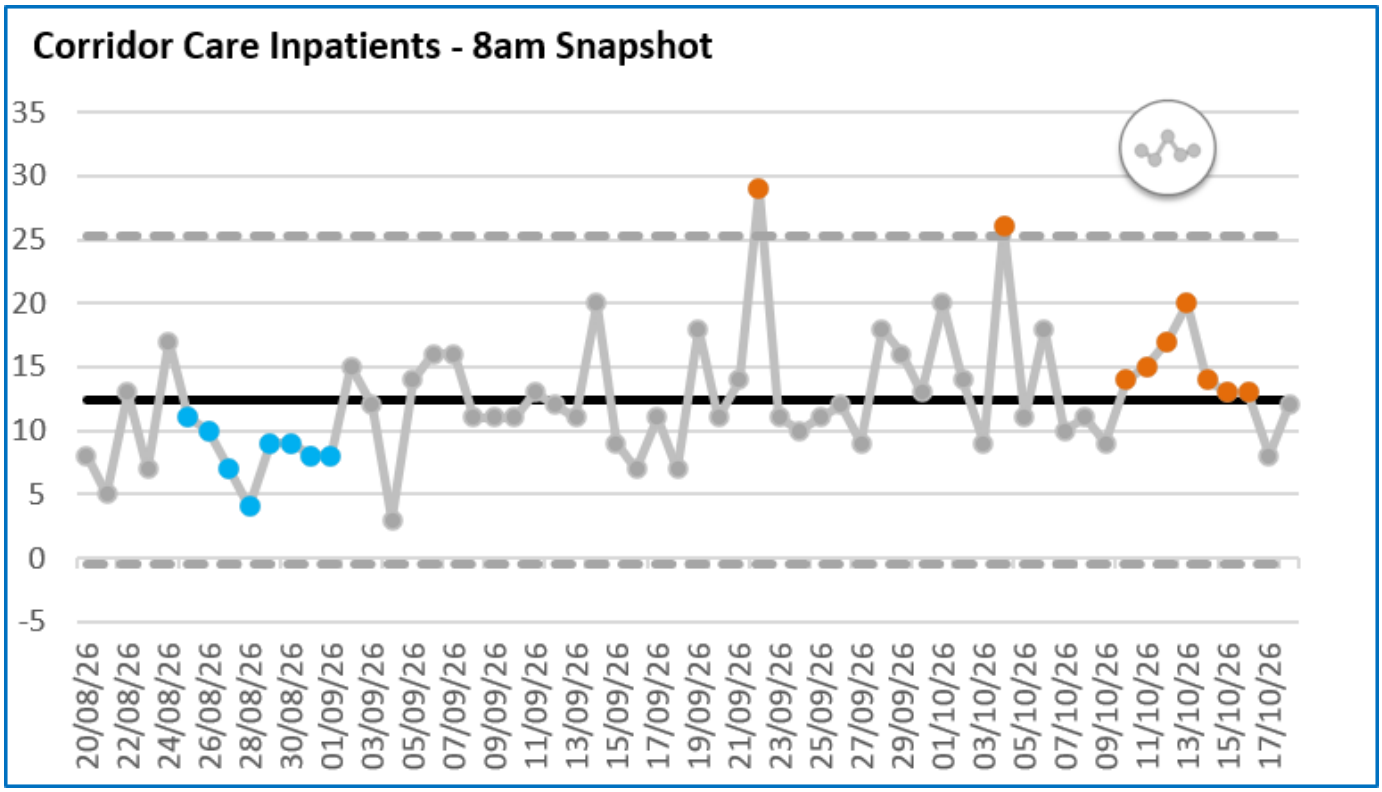
3.15 **Bed Occupancy**





3.16 Bed occupancy is the percentage of available beds in use. The report describes it as high and variable, with some improvement in October. When few staffed beds are available, patients may wait longer to move from the Emergency Department to a ward. The reported association with occupancy below 93% in section 3.3 is a local observation, not an established national target or proof of a safe level.

3.17 **Use of Escalation Space (Temporary Escalation Space - TES)**

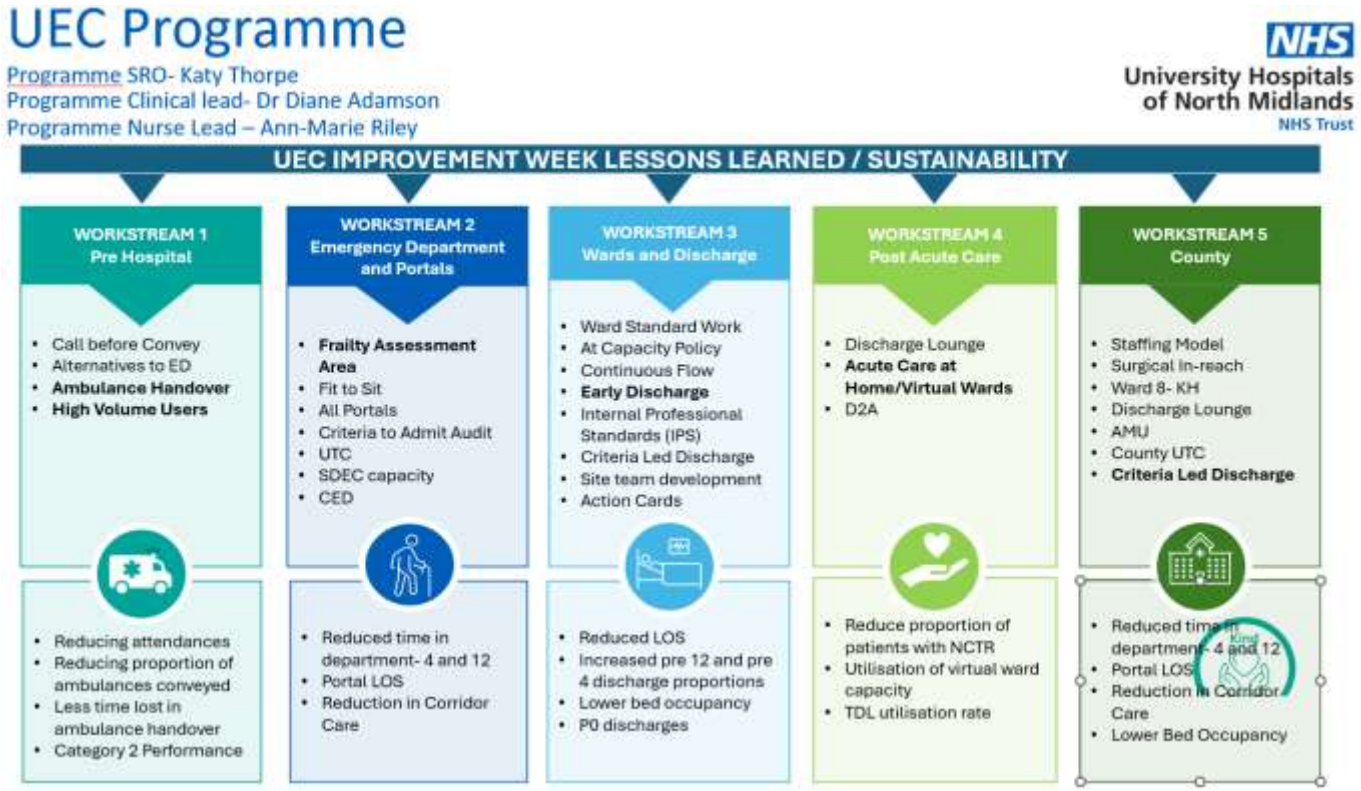


3.18 Temporary Escalation Space (TES) means additional space used to care for patients when normal ward capacity is insufficient. The report indicates that these ward spaces remain in use. The Emergency Department corridor has remained closed since August 2026 and is not included in the ward-space measure. Continued use demonstrates pressure on normal capacity, but the measure alone does not establish the quality or safety of care in those spaces.

3.19 **Urgent and Emergency Care (UEC) Improvement Programme**

The improvement programme followed the January 2025 NHS England review described in section 2.3. The Trust's Urgent and Emergency Care Recovery and Oversight Meeting monitors delivery, with support from the Getting It Right First Time (GIRFT) team.

The programme is reviewed weekly so that teams can assess progress and respond to problems.



3.20 The Trust has made a number of changes to how services are organised and run in recent weeks – including the streamlining of its emergency portals. The intention of the UEC improvement programme for the coming months is to allow the recent changes to be embedded, before any further changes are made

3.21 To date, the programme has delivered the following:

3.22 The Urgent Treatment Centre, which provides care for suitable urgent problems outside the main Emergency Department service, opened on 7 September 2026.

3.23 Changes to emergency assessment services were completed on 8 October 2026. Medical Same Day Emergency Care, which assesses and treats suitable medical patients without an overnight admission, operates 24 hours a day, seven days a week. Capacity also increased in Frailty Same Day Emergency Care.

3.24 An Extended Emergency Medicine Ambulatory Care (EEMAC) pilot took place in September. Ambulatory care means assessment and treatment without an overnight hospital stay for suitable patients.

3.25 A Single Point of Access (SPoA) Shared Decision Making (SDM) model has been introduced. This is intended to provide a coordinated route for advice and decisions about the most appropriate care, including alternatives to hospital admission where suitable.

3.26 Use of the discharge lounge has increased, and the report reports improvement in simple and timely discharge. Moving suitable patients to the lounge can release ward beds while they wait to leave hospital.

3.27 A revised ambulance escalation process began on 2 November 2026, supporting handover within 45 minutes. This is intended to reduce prolonged ambulance waits and release crews to respond to other calls. The timing coincides with November's improvement, but does not establish that the process alone caused it.

3.28 The Getting It Right First Time (GIRFT) team continues to support the Trust. It has reviewed ambulance journeys bringing patients to hospital and possible missed opportunities to use other appropriate care. Formal feedback was awaited when the report was written. This support is intended to have a positive effect on care and waiting times.

3.29 The Hospital Buildings Maintenance Programme ended on the 25 October. This gives us access to a ward used temporarily while maintenance takes place elsewhere as part of our winter capacity.

3.30 **Quality of care, patient safety and incidents at Royal Stoke**

In September a Rapid Quality Review took place for Royal Stoke following the Emergency Department corridor closed on 12 August 2026, with patients moved to appropriate clinical areas. Following inspection concerns, the Trust reviewed medicines arrangements, recognition of deterioration, emergency response, clinical competencies and resuscitation equipment. Matron oversight and daily auditing of temporary escalation spaces were reinforced. In the Acute Medical Unit, where patients receive assessment and early treatment, a weekly audit programme was established covering documentation, risk assessment and the security of patient records.

3.31 **Incidents and learning:** the Rapid Quality Review confirmed that specific patient incidents identified by the Care Quality Commission were reviewed by senior clinical leads, with learning and actions identified. Findings were being incorporated into training, clinical practice and emergency-response arrangements.

4 Conclusion

4.1 Urgent and emergency care performance remains below the standard we expect for our patients. September was particularly challenging, although October has brought early signs of improvement in ambulance handovers and bed occupancy. The data continues to show that demand alone is not driving performance; the principal constraint is inconsistent “patient flow” (this is how patients move through assessment, treatment and discharge through the hospital), reflected in high bed occupancy, later discharges and increased numbers awaiting admission.

4.2 We understand the operational conditions required to improve performance and have demonstrated that creating capacity earlier in the day improves ambulance handovers and time spent in the Emergency Department. The early improvements seen in October now need to become consistent daily delivery. Our immediate priorities remain strengthening ward processes, increasing timely discharge, reducing avoidable admissions and accelerating the movement of patients who are clinically ready to proceed.

4.3 The UEC transformation programme provides a clear framework for recovery, with robust executive oversight and continued support from NHS England and GIRFT. Delivery to date—including the UTC, portal reconfiguration, expanded same-day emergency care, the EEMAC pilot, the SPOA shared decision-making model and increased use of the discharge lounge—provides a stronger platform for winter. However, sustained improvement will depend on embedding these changes reliably across the organisation and translating them into measurable gains in patient flow, outcomes and experience. The current position remains unacceptable, and our focus is on pace, accountability and consistent delivery.

4.4 The Trust has implemented significant service and safety changes, while partners are supporting discharge and alternatives to hospital attendance. The provisional November results show markedly shorter ambulance waits, improved four-hour performance and fewer prolonged Emergency Department stays. These early results are encouraging, but they must be maintained throughout winter.

5 Implications

5.21 Financial Implications

The programme has many financial implications relating to workforce, extended service hours and winter capacity. Improved patient flow and reduced avoidable admissions may deliver efficiency benefits; however, the report does not quantify costs, savings or funding requirements.

5.22 Legal Implications

No specific legal implications are identified in the report. However, ongoing patient safety and regulatory concerns are highlighted, including delayed ambulance handovers, prolonged ED stays, the closure of ED corridor spaces following a CQC inspection, and continued Tier 1 national oversight

6 Other Implications

6.21 Human Resources

6.21.1 Not required for this report.

6.22 Equalities Impact (Equality Act 2010)

6.22.1 An Equality Impact Assessment is not required for this report.

6.23 Social Inequalities Impact

6.23.1 The proposals set out in this report do not impact on social inequalities, including issues relating to poverty, social exclusion or health.

6.24 Environmental Impact

6.24.1 The proposals set out in this report will not impact on the environment.

Report Information

Wards affected: All wards and areas with UHNM

Links to Council Priorities - Our City, Our Wellbeing

N/A: This report is required to ensure statutory compliance.

Type of Decision: Scrutiny Discussion Item

Background Papers: None

Appendices: Health Overview and Scrutiny Committee UHNM Report 18.11.26.

University Hospitals of North Midlands NHS Trust

Joint Staffordshire & Stoke-on-Trent Health Overview and Scrutiny Committee

18 November 2026



Kind Excellent Together

University Hospitals of North Midlands NHS Trust

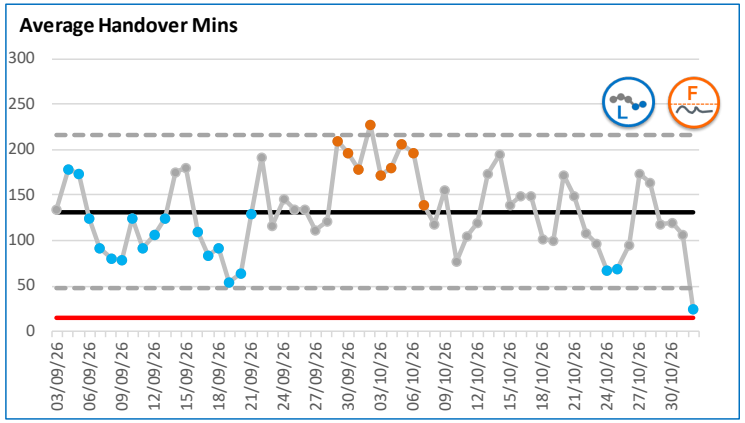
Urgent and Emergency Care

Kind Excellent Together

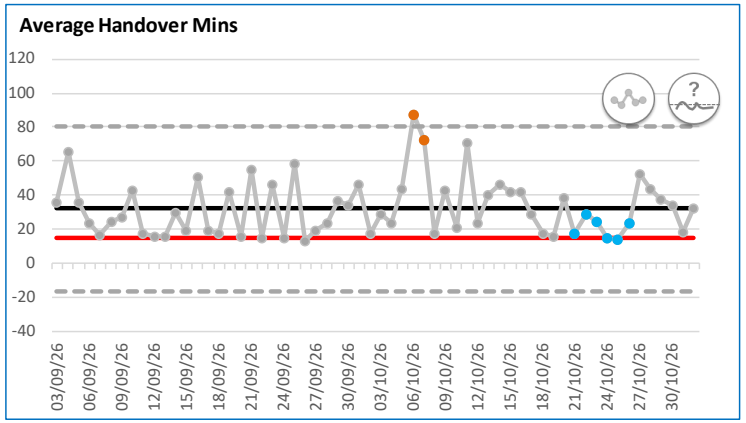
Urgent and Emergency Care – Ambulance Handover Delays

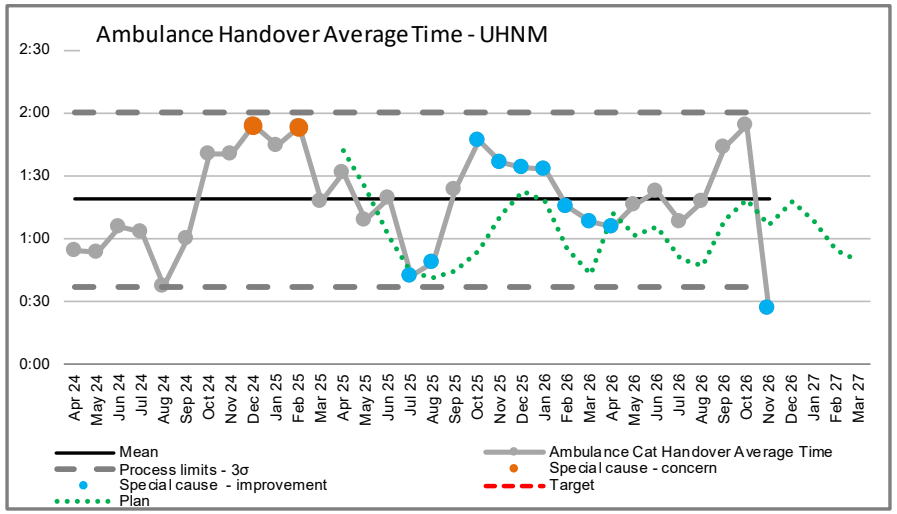
University Hospitals of North Midlands NHS Trust

Royal Stoke Hospital



County Hospital





Current month is MTD

Operational Narrative:

- Average ambulance Handover Time in October was 1hr 54 mins across both sites, which is 35 mins behind plan.
- Ambulance arrivals at **Royal Stoke** last week were 929 a reduction of 36 from the previous week at 965.
  > To note; average handover time also reduced to 113 mins, against a weekly trajectory of 49 mins.
- Ambulance arrivals at **County** last week were 235, an increase of 42 from the previous week at 193.
- > To note; Average handover time increased to 36 mins, from 23 the previous week..

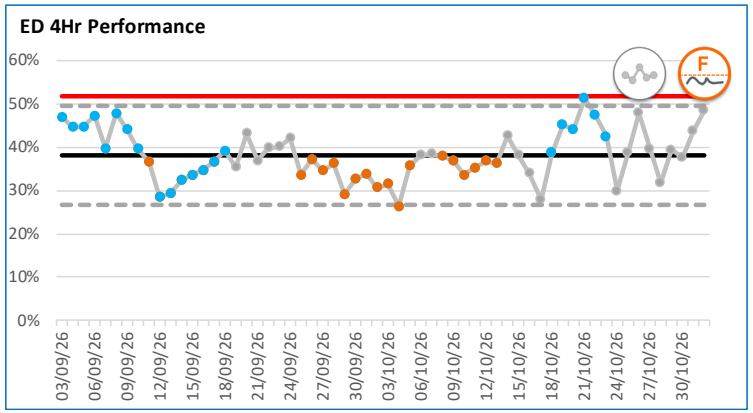
Lost Hours

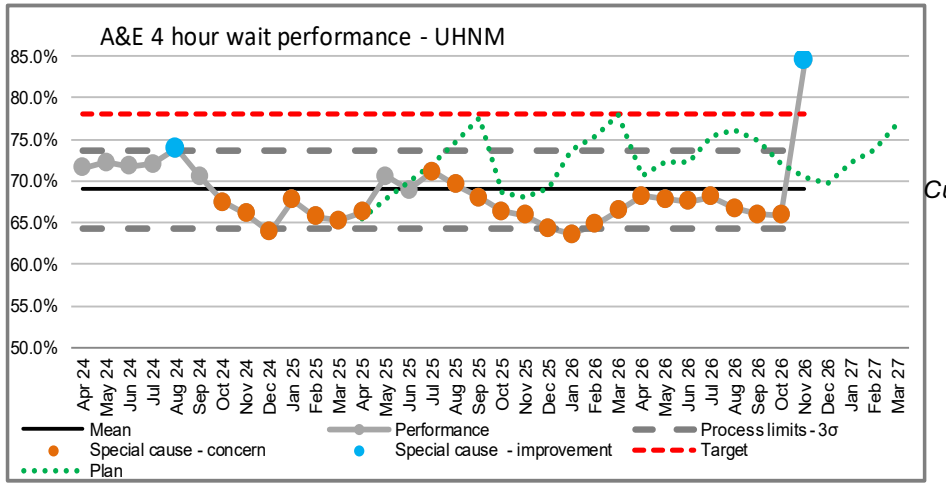
- West Midlands Ambulance Service Lost Hours (>30 mins) was 1374 last week, with RS remaining similar to the previous week at 1322 and County increasing slightly to 52.

Urgent and Emergency Care – 4hr Performance

University Hospitals of North Midlands NHS Trust

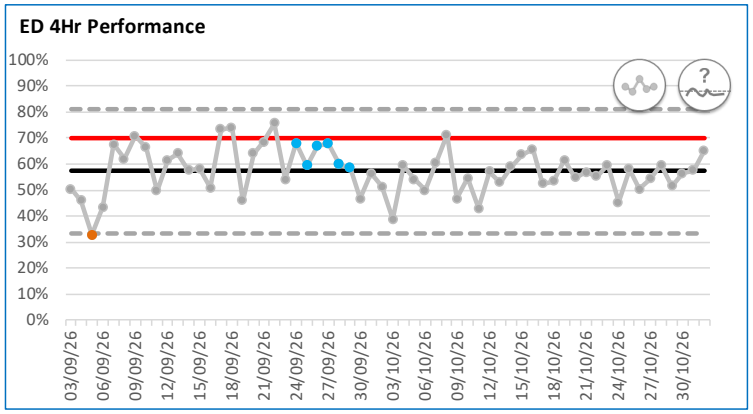
Royal Stoke Hospital





Current month is MTD

County Hospital



Last week

Site/Location	Attends	Breaches	Performance	12Hr Breach
Type 1	**3,309**	**1,791**	**45.9%**	**15.5%**
Royal Stoke	2,275	1,335	41.3%	19.0%
County	1,034	456	55.9%	7.8%
Type 2	**108**	**0**	**100.0%**	**0.0%**
Eye Clinic	108	0	100.0%	0.0%
Type 3	**2,022**	**18**	**99.1%**	**0.0%**
UTC	634	18	97.2%	0.0%
Haywood	1,121	0	100.0%	0.0%
Leek MIU	267	0	100.0%	0.0%
Total	**5,439**	**1,809**	**66.7%**	**9.5%**

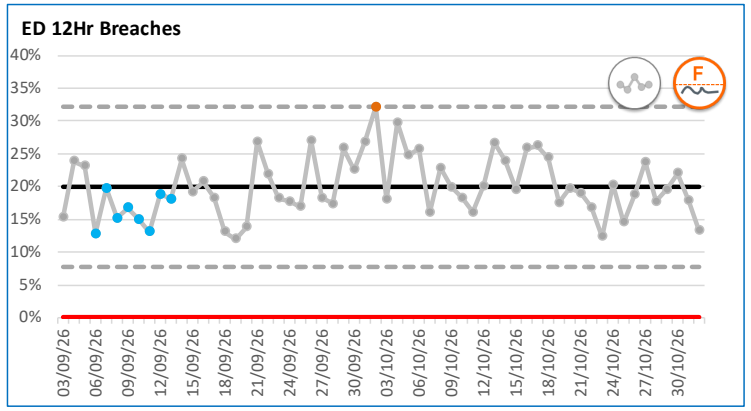
Operational Narrative:

- A&E 4hr performance in October was 65.9%, 6.2% behind October plan of 72.1%.
- Overall attendances all types were 5,439 last week, down by 333 from the previous week, performance deteriorated marginally to 66.7%, (November plan is 70.4%).
- Royal Stoke attendances were slightly lower than the previous week, with similar performance at 41.3%, likewise County performance remained similar to the previous week at 55.9%.

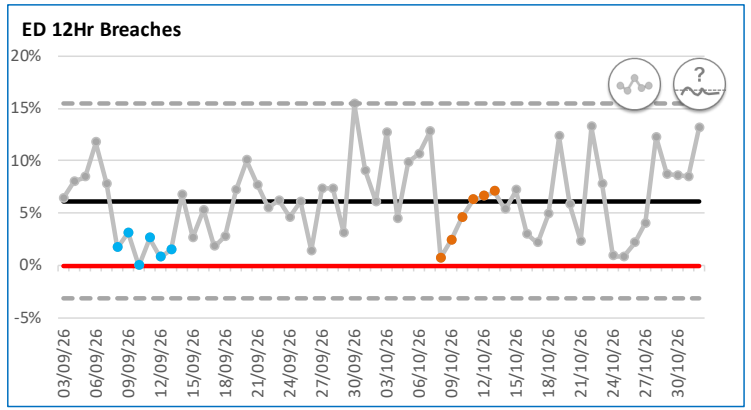
Urgent and Emergency Care – A&E 12hr Performance

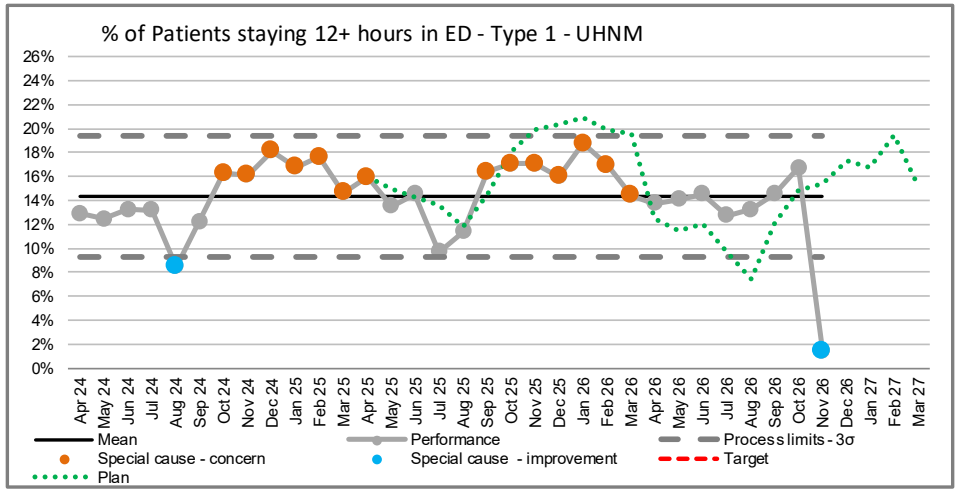
University Hospitals of North Midlands NHS Trust

Royal Stoke Hospital



County Hospital



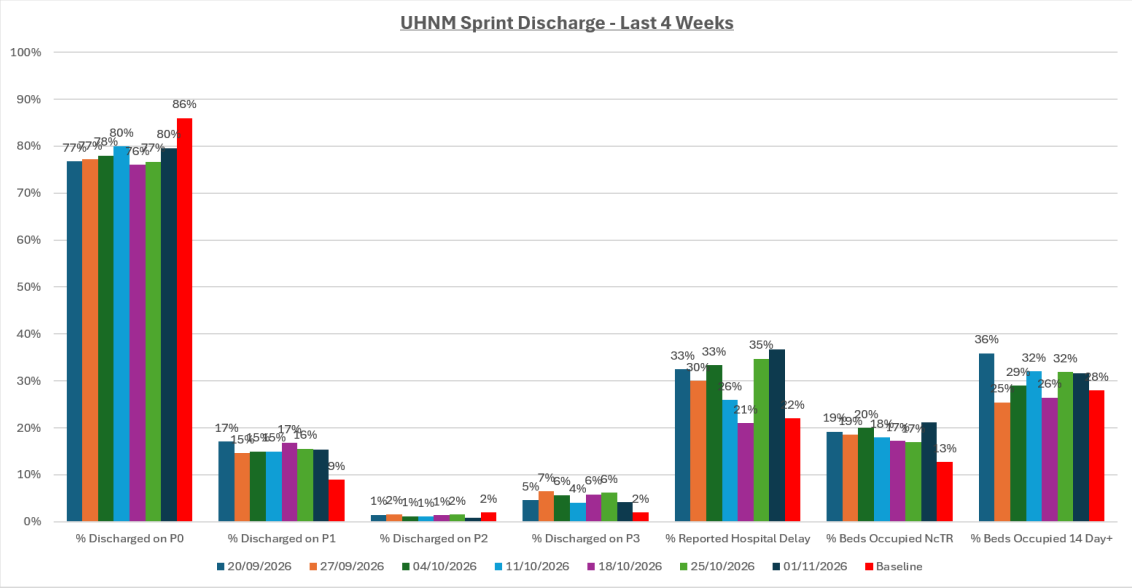


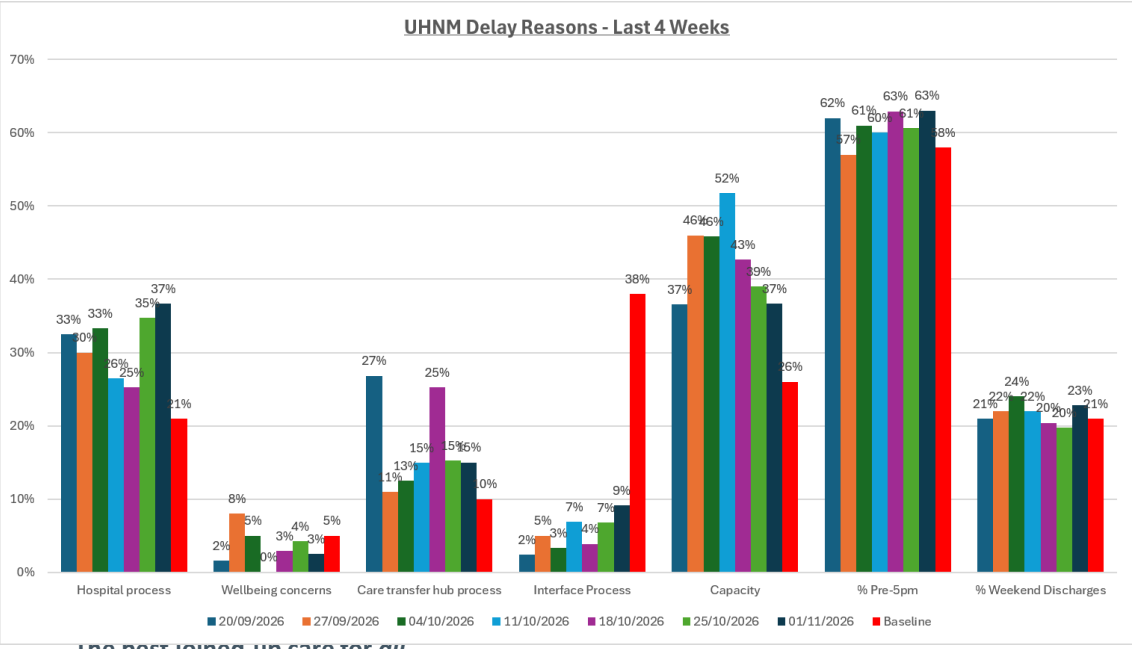
Current month is MTD

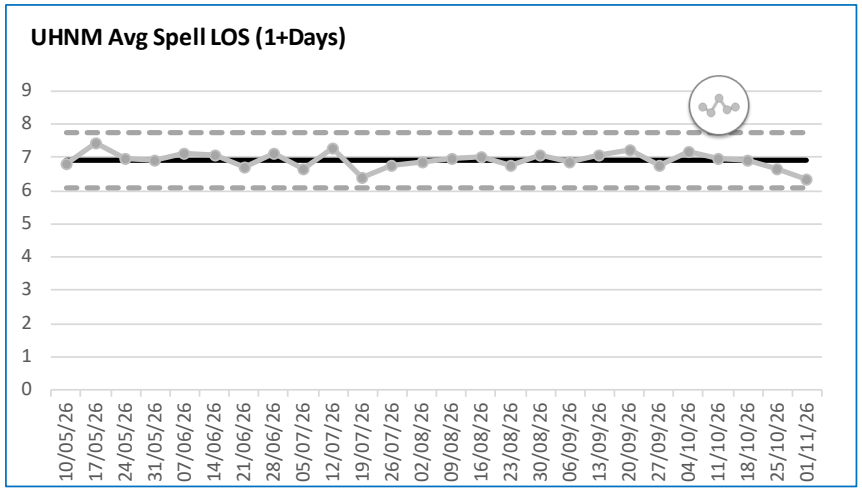
Operational Narrative:

- A&E Type 1 12hr performance in October was 16.8%, 2.0% off the 14.8% plan
- A&E Type 1 12hr performance for last week was 9.5%, an increase of 1.4%pts on the previous week.
  > This increase was seen at Royal Stoke and County, up by 1.5% and 1.2% respectively

UHNM – Discharges







University Hospitals of North Midlands NHS Trust

Operational Narrative:

The percentage of patients reported as a hospital delay saw a reduction last week from 36% to 22%, with those patients having "no Criteria to Reside" also reducing to 13% last week.

Delayed reasons for discharged through hospital processes reduced to 22% last week from 37% the previous week.

Last week, 58% of patients being discharged happened before 5pm, a decrease of 5%pts form the previous weeks.

Delayed reasons relating to Interface processes saw a significant increase to 38% last week where previous weeks averaged at 7%.

Average LOS+1 over the last five weeks has seen a positive reduction.

Urgent and Emergency Care Improvement Actions

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- Urgent and Emergency Care Improvement plan - Simplification of the plan to embed changes
  - 3.3k patients through Urgent Treatment Centre in October (increase of 64% on August) with 94.7% under 4hr performance
  - Portal Reconfiguration completed 8 October 2026. MSDEC and FSDEC both treating increased volume of patients, contributing to lower Emergency Department occupancy
  - Extended Emergency Medicine Ambulatory Care criteria altered, accommodating a wider range of stable patients
  - New escalation process agreed with a move to 45 min handover. Started 2nd Nov
- Getting it Right First Time - Audits of ambulance conveyances and missed opportunities completed in October
- Private Finance Initiative (PFI) Maintenance Programme - Now complete
- Winter plan – Ward 80 to open imminently
- Emergency Department corridor remains closed
- "Inpatient corridor care" reduced following fire risk assessments with increased escalation and monitoring of patients over 2 hours.

Winter Plan on a Page | Winter Plan 26/27

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Context

- Challenged UEC performance across 26/27 to date
  - 68.1% 4-hour in July, behind plan and last year
- Winter 25/26 lessons learnt, with improved performance compared to previous year over the winter months
- UEC Improvement Plan in progress with key improvements due prewinter (eg UTC, portal reconfiguration)
- Risk to financial challenge and funding of additional capacity
- Winter plan in draft form at this stage, so subject to Board approval

Headline targets 26/27 (operational plan)

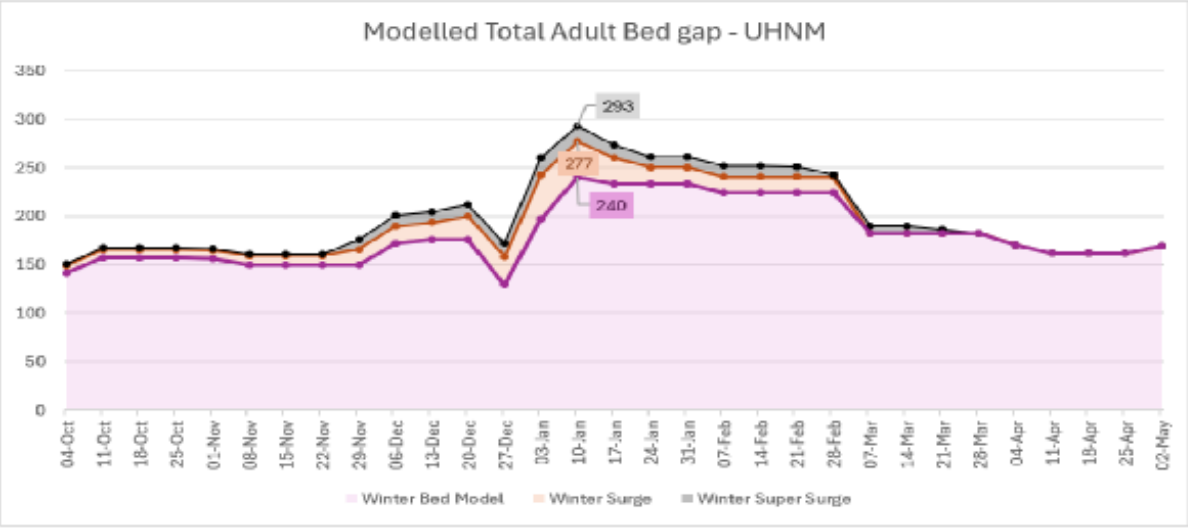
- ✓ **A&E 4-hour performance** >70% winter average
- ✓ **12-hour breach rate** <17%
- ✓ **Ambulance handover delays** <1hr 15m across winter

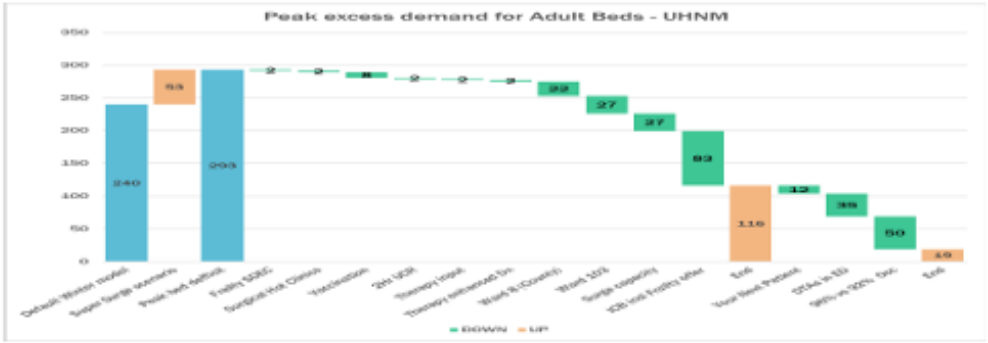
Priorities

Admission and Attendance Avoidance - Reduced LOS - Increased Capacity

Capacity Mitigations

-Frailty In reach and FSDEC extended opening hours
-SDEC / Surgical Hot Clinics increased capacity
-Vaccination
-Increased capacity to deliver 2 Hr UCR response
-Increased therapy input
-Therapy Enhanced Discharge Pathway - County (6-month Pilot)
-Ward 8 at County to Unplanned Care – inc. support services
-Ward 103 at RSUH to UPC
-Surge ward for 1 month post Xmas TBC
-Reopen - West Building ward
*All subject to Board approval





University Hospitals of North Midlands NHS Trust

Additional Requested Information



End of Life Palliative Care

University Hospitals of North Midlands NHS Trust

Admissions numbers

At UHNM, approximately 3,310 patients identified as having palliative and end of life care needs are admitted from the Emergency Department each year (identified and extrapolated from audit data)

This figure is based on patients identified through the High Risk of Deterioration (HRD) tool which identifies patients who are recorded on the Gold Standards framework in Primary Care. This number is likely to underestimate the total number of palliative and frail patients admitted annually. Approximately 10% of patients attending A&E Majors each day have palliative care needs.

In addition, the UHNM Specialist Palliative Care Team received 4,224 referrals during 2024/25, an increase from 3,502 referrals three years earlier, demonstrating growing demand for specialist palliative care support.

Referrals to the Specialist Palliative Care Team have increased by more than 20% over the last three years, rising from 3,502 in 2022/23 to 4,224 in 2024/25. (a good thing – providing qualitative specialist support and access to care pathways)
The Trust's work through the HRD tool has also identified a larger cohort of patients who may benefit from earlier palliative intervention. A pilot was undertaken to identify patients via the HRD tool (criteria – patients recorded on the Gold Standard Framework in Primary Care).

During the first eight months of the pilot, Emergency Department referrals to the Specialist Palliative Care Team doubled from 350 to 700 patients, indicative of improved identification rather than increased demand alone

End of Life Palliative Care

University Hospitals of North Midlands NHS Trust

The Trust's approach is centred on providing care that reflects a person's wishes, values and preferences, with a strong focus on quality of life, dignity and comfort.

To support this there has been ICB investment to implement a new **Front Door Specialist Palliative Care Service** in partnership with **Marie Curie**, supported by the HRD tool. The plan is to go live in December 2026.

This will enable Marie Curie specialist palliative care review in the Emergency Department (Royal Stoke initially and then County Hospital – 7 days per week), helping ensure that patients receive personalised care based on their wishes.

Through the HRD tool, patients with palliative or end of life needs are identified much earlier in their hospital journey. Specialist palliative care clinicians are then able to:

- Undertake earlier assessment.
- Support patients and families with advance care planning.
- Complete or review ReSPECT plans and ceilings of treatment.
- Improve symptom control.
- Work with hospice and community teams to support care closer to home where appropriate.

End of Life Palliative Care

University Hospitals of North Midlands NHS Trust

Discharge pathways

The Trust works collaboratively with health, social care, marie curie, hospice and system partners to support timely discharge for frail and end of life patients.

A significant development is the partnership between UHNM and Marie Curie and collaborative working with MPFT and Staffordshire's four hospices (Dougie Mac, Katharine House, St Giles and Compton Care) to provide the following:

- A Front Door Palliative Care Service within UHNM.
- Rapid Response services in the community.
- Hospice-led Virtual Wards.
- Enhanced specialist advice available 24/7 for professionals, patients and their carers / families
- Earlier discharge and "step-down" support from hospital to home or care home.

The proposed hospice-led Virtual Ward, once fully established, will support up to **80 patients at any one time** and aims to reduce avoidable admissions, improve symptom control and help more people remain in their preferred place of care.