NHS

Worcestershire Acute Hospitals

NHS Trust

Quality Account 2016/2017

Taking PRIDE in our health care service

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Overview of the 2016/17 Quality Account

About the Trust

Worcestershire Acute Hospitals NHS Trust provides hospital-based services to a population of more than 560,000 people in Worcestershire as well as caring for patients from surrounding counties and further afield. Our three main sites are:

- Alexandra Hospital in Redditch;
- Kidderminster Hospital and Treatment Centre;
- Worcestershire Royal Hospital, Worcester.

We provide a wide range of NHS services, employ more than 5,500 people and have an annual turnover of over £360 million.

What is a Quality Account and why is it important?

Providers of NHS healthcare are required to produce an annual Quality Account — a report that regularly informs the public about the quality of NHS services being delivered. Quality Accounts help Trusts to demonstrate their achievements and commitment to quality improvement for patients and their carers and families. Worcestershire Acute Hospitals NHS Trust's report for 2016/17 includes statutory statements required within a quality account and goes on to describe:

- Our quality priorities for the coming year, 2017/18.
- How we have performed against the priorities we set out at the beginning of 2016/17.
- What other organisations think about our quality priorities.

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Part 1: Statement from our Chief Executive

Michelle McKay
Chief Executive

Thank you for your interest in our Trust's Quality Account for 2016/17. Since my arrival in March 2017, I have devoted time to assessing the Trust's staff and services.

Over the past 12 months, the Trust has had challenges across the spectrum of quality, service provision, performance against KPIs, financial sustainability and culture. This situation is largely the result of, and exacerbating difficulties in, recruitment of medical and nursing staff, alongside significant instability within the Executive leadership team. Joined in the Executive team by other, newly appointed colleagues, we are determined to support our staff to recover performance. Our Quality Account for 2016/17 candidly describes the Trust's delivery of quality priorities during the year as well as actions we are implementing during 2017/18. These demonstrate a firm commitment to improve. Some crucial issues to get right include:

1.1 Key concern: Emergency Access Standards

The local emergency care system has been particularly constrained at several times during the year. This has led to significant pressures in our Emergency Departments and, at times, a sub-optimal experience for our patients. Delivery of care in line with NHS Emergency Access Standards remains a challenge. Acknowledging growing numbers of attendances over the years since it was built, the Emergency Department at Worcestershire Royal Hospital has been expanded in 2016/17, giving us dedicated space for minor injuries and illness and for high care areas in the department. However, discharging patients from our wards as soon as they are well enough to go home remains key to improving all aspects of our service, county-wide.

We have taken steps to ensure our hospitals at Kidderminster and Redditch are sufficiently robust to continue to provide emergency and urgent care for their local people. For example, in September 2016, we had to suspend in-patient services for children and young people at the Alexandra Hospital. This change was made to ensure a reliably safe service could

be provided for paediatric patients who need admission to hospital, across the county of Worcestershire. The Alexandra Hospital's Emergency Department continues to look after children who do not need admission.

There is more detail about our urgent care work during 2016/17 in Part 3 of this account.

1.2 Key concern: Our regulator's requirements

Reflecting concerns about quality of service provision, the Trust has been under the 'special measures' regime since November 2015. The subsequent visit from the Care Quality Commission (CQC) in November 2016 resulted in the Trust receiving a section 29A warning notice in January 2017. This required the Trust to demonstrate significant improvement to the quality of healthcare by 10 March 2017. In addition to concerns about patient safety, the notice also raised considerable concerns about governance and risk management, with the specific comment that 'The board cannot rely on the processes in place or the information they are receiving in order to take assurance that risks are identified and actions taken to reduce the risks to patients'.

A series of unannounced and announced visits by the CQC during April 2017, while recognising some improvements, has not satisfied the CQC that significant improvement has occurred. Additionally, there has been deterioration in patient experience, as measured in the annual inpatient survey. In terms of KPIs, the Trust has not met the Emergency Access Standard (EAS), Referral to Treatment (RTT), Diagnostic or Cancer targets for the entire year and, in some cases, longer periods. When compared to peer Trusts, the Trust ranks consistently in the lower performing three or four in respective peer groups of approximately 30 Trusts. Plans to address the quality impact of this position are set out in Part 2 of this account.

1.3 Key concern: Consistent leadership

The introduction of a permanent Executive leadership team early in 2017 brings the stability the Trust needs. The final permanent appointment, a substantive Medical Director, will be in place in May 2017. The team will lead on an improvement programme that embeds 'getting good and getting better'; refocuses on fundamental standards; and, in time, embeds a culture in which every member of staff is proud to make their unique contribution to improving quality and safety within the Trust. The new leadership team will get to grips with delivering healthcare consistently across all Trust sites and services and will strengthen recording and reviewing of clinical care, so that the Trust can demonstrate where care is up to standard and learn from those areas where care is less consistent.

1.4 Key concern: Workforce and culture

Though the Trust met its financial control total for 2016/17, it has a significant, underlying deficit going forward. One of the prime drivers of this is premium costs for agency and locum staff, due to significant medical and nursing vacancies. While considerable focus has been placed on recruitment during the last year, there are 153 medical vacancies out of an establishment of 705. There has also been deterioration in this vacancy rate during 2016/17. Within the nursing stream, there are 164 vacancies in a 1837 establishment. The turnover rate for nursing staff has been

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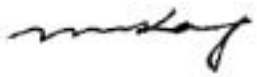
consistent at approximately 14% over the last year. In terms of staff culture, the Trust has seen deterioration through the national annual staff survey. The 2016 result indicated only 48% of staff considered the Trust a good place to work against the average of all acute Trusts of 62%. This was a deterioration on the 2015 result. Furthermore only 56% of staff would be happy with the standard of care should a friend or relative require treatment against the average of all Trusts of 70%.

The Trust will begin to address these workforce pressures during 2017/18 and, as these improve, we will see improvement in the quality of care we provide. There are many engaged, motivated and skilled staff within the Trust. In some areas, there is excellent work underway. There is also strong support from a number of stakeholders and regulators to assist the Trust to succeed. However, there is a clear view from those who are experienced in challenged Trusts that the depth of distress of the Trust is marked and that, while there is optimism that success is achievable, it will require significant time, focus and resource.

In summary, the Trust's challenges will take time and significant effort to resolve.

There is considerable goodwill in the local health economy and from our communities around the county. Building on these, the Trust's board has endorsed a plan that will give clear focus on deliverables and accountabilities in essential areas, including the delivery of quality improvement plans outlined in this document.

I hope you find this quality account answers your questions about the Trust's quality improvement programme. Please contact me if there is anything further I can help with.



Michelle McKay, Chief Executive

Part 2: Our Quality Priorities for 2017/18

Improving quality in 2017/18 is centred on making sure the Trust provides consistently good standards of care across all its services and departments.

In this way, we can be sure that we have a firm baseline to build upon in providing our patients with safe, effective care that they experience positively, each time they encounter our services. To gain consistency, we will focus on re-iterating care standards and monitoring their delivery, providing training and support where necessary and creating accountability where this is lacking. To demonstrate that improved reliability, we will also focus on care systems and processes, so that our care is clearly documented and action is taken on those communications and reports as necessary.

Our quality priorities for 2017/18 are therefore covered under three main headings in this section:

- Embedding the fundamentals of care in everybody's practice, every day.
- Answering the specific requirements of our regulator.
- Creating a quality management system that focuses on assurance of standards and improvement.

2.1
Fundamental Quality Priorities

In addition to answering the issues raised by regulators and inspections, (see following section), the Trust's new Executive management team has identified, through early learning from incidents and complaints, a recurrent theme within the Trust's services, of inconsistent compliance with care standards.

In recognition of this issue's central importance, during 2017/18, the Trust will consolidate practice to achieve good care standards across the Trust in all domains of quality, across all services. 2017/18 will be a year in which building confidence that fundamental safety and quality practice is employed reliably across the Trust, is our first priority.

The Trust therefore has the following quality priorities for 2017/18, which are shown overleaf.

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2.2
Quality Priorities 2017/18

Our aim is to deliver safe, high quality, compassionate care to all patients.

Quality Domain	CQC Domain	Priority	Measures
Safety	Safe	We will embed and assure the revised ward to board governance structures and processes and improve the identification and management of risk.	• 90% compliance with the serious incident investigation timescales by Divisions, including completion and delivery of action plans from September 2017. • All risk registers reviewed and updated monthly from July 2017. • Eliminate back-log of open incidents by December 2017. • NEWS/PEWS documentation completed and appropriate escalation from June 2017. • Mortality reviews completed within agreed timeframes by December 2017.
Clinical Effectiveness	Well led, Effective	We will address the quality and safety concerns identified by the CQC.	• 100% compliance by all wards with Red2Green by March 2018. • All staff engaged in a culture change programme by March 2018. • 20% reduction in complex complaints (red rated) by March 2018. • 50% reduction in mixed sex breaches in 2017/18 against 2016/17 by March 2018. • Zero MRSA bacteraemia by March 2018.
Patient Experience	Caring, Responsive	We will develop a robust improvement, quality and safety culture across the Trust, including learning when things go wrong.	• 80% of relevant patients receiving sepsis screening in 1 hour by December 2017. • 90% of patients who have a positive sepsis screen receive antibiotics with one hour by March 2018. • 95% of patients will receive a VTE assessment within 24 hours of admission by September 2017. • Zero grade 3 and 4 hospital acquired pressure ulcers by March 2018. • All #NOF patients fit for surgery have operation within 36 hours by August 2017. • More than 90% of patients would recommend us to their friends and family as a place to receive care and treatment by March 2018.

2.3 Quality Improvement Plan

In January 2017, the Trust received a warning notice under section 29A of the Health and Social Care Act 2008, from the CQC, requiring it to make progress with issues identified at its most recent CQC inspection in November 2016.

The concerns focused around three areas of operation:

- Urgent care and patient flow though the hospital
- Safe and effective care
- Governance and risk management

The Quality Improvement Plan (QIP) arising from this warning notice is specifically designed to address the concerns raised in that notice, which can be found at: http://bit.ly/2qHBqWJ

The Trust's answering Quality Improvement Plan can be found at: http://bit.ly/2qN860c

2.4 Quality Management - plans and ambitions

It is acknowledged that since 2015 the Trust has primarily functioned in a reactive manner, responding to feedback from the CQC by developing action plans and being driven almost exclusively by these. While this approach has delivered improvements, some of these had not been sustained and processes have been imperfect. There has also been insufficient focus on risk and assurance.

The Trust recognises that to ensure improvements to quality and safety are sustained, and built on further, we must be less 'action plan driven' taking a more proactive approach and building in prospective review processes that are aligned to the CQC's fundamental standards. We will therefore be taking the issues from the Section 29A notice, pulling out the themes, and aligning them to existing assurance processes. This will embed the delivery of improvements into normal business, rather than treating it as something quite separate.

There will be a greater focus on:

- Ensuring that all risks are fully assessed, added to the risk register and escalated to the corporate risk register in line with the Risk Management Strategy.
- Identifying and recording the impact of any risks on the fundamental standards.
- Availability of assurance, ensuring that assurance is evidence-based, closely scrutinised and robust.

The framework for developing assurance is shown overleaf.

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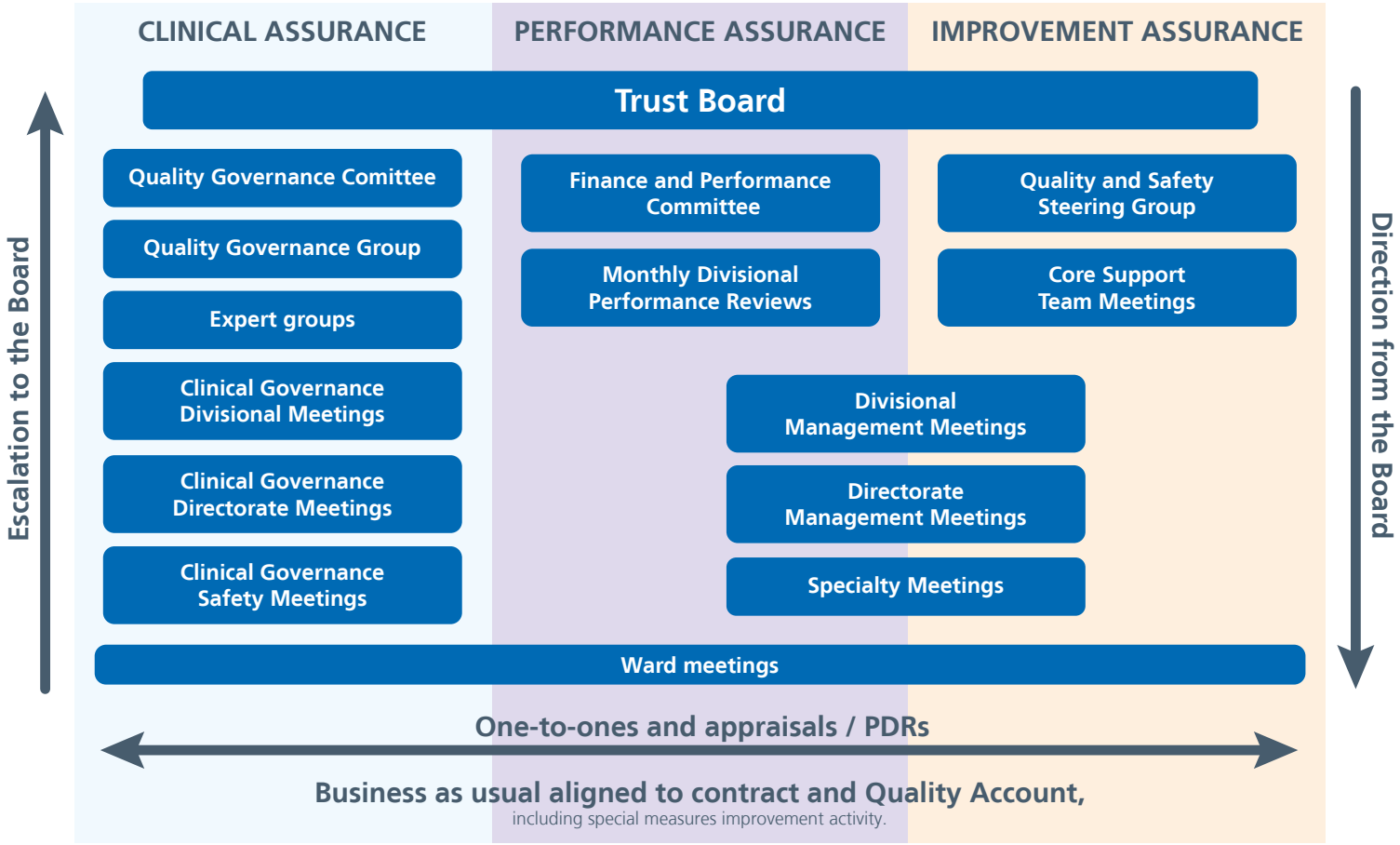
Assurance from ward to Board



Part 3a: How did we do in 2016/17?

This section in our Quality Account reflects on:

- The progress of priorities set for 2016/17.
- CQC visits and their quality requirements.
- The in-year impact of the Future of Acute Hospital Services in Worcestershire (FoAHSW) review on the quality of our services.

It also includes statements of assurance from the Trust Board and other statutory information.

3.1 Delivery of the year's quality priorities

For 2016/17, we set three overarching priorities for quality improvement. We set these priorities because our stakeholders and our staff told us these things needed to be improved. Our stakeholders include: patients and their carers and friends, the public, the Care Quality Commission, local Health-watch and our commissioners. Our priorities were also aligned to national NHS priorities. Each priority was matched to changes we wanted to make to deliver them. Each change was part of a work programme, broken down into workstreams, delegated to a senior team member to deliver and designed to support provision of high quality care for our patients. Many of these were aligned to commissioners' priorities for Worcestershire's health services, through CQUIN schemes, described in detail at the end of Part 3 of this account.

Quality Priorities 2016/17 (from Quality Account 2015/16)		
Quality element	***CQC Domains***	***Priority***
1. Patient Safety	Safe	Improve patient safety through optimising patient flow and developing effective systems for early senior review.
2. Clinical Effectiveness	Effective and well-led	Ensure learning from incidents and other harm reviews, identifying and addressing the causes of avoidable harm including pre-emptively through the adoption of early warning tools and best practice care bundles.
3. Patient Experience	Caring and responsive	Develop a greater quality and safety culture across the organisation through engagement, training and staff development from Ward to Board.

Priority 1:
Improve patient safety through optimising patient flow and developing effective systems for early senior review.

3.2
Priority 1: Patient Safety

During 2016/17 there continued to be an increased demand for emergency care, together with an increase in the acuity of patients needing emergency care. These service pressures were manifest nationally, across the NHS, and continued to prove challenging for the Trust throughout the year. Against this backdrop, our patient safety priority was addressed through four workstreams:

Workstream 1: SAFER Care Bundle

The SAFER Care Bundle is a set of simple rules for adult inpatient wards, followed to improve patient flow and prevent unnecessary waiting for patients. When we routinely undertake all the elements of the SAFER patient flow bundle, we improve the journey our patients experience when they are admitted to our hospital.

Why is this important?
A good flow of patients through the hospital ensures that patients are in the right place at the right time and receive the care they need when they need it. This makes sure they are in hospital no longer than necessary.

How have we done?
One of the measures we set ourselves was the % of patients discharged before 12midday. Whilst the Trust has placed a significant focus on this measure, it has proved difficult to deliver on the ambition set. The Trust has generally maintained a rate of approximately 16% of discharges taking place prior to 12 midday, against a target rate of 33%.

The SAFER workstream was boosted during January 2017 to improve the rate of discharge before midday. This work will carry forward into 2017/18.

Percentage of patients discharged before 12 midday

2016									2017		
Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17%	18%	17%	16%	16%	14%	14%	16%	15%	16%	15%	21%

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Workstream 2: Frailty pathway

This piece of work introduced a pathway of care in which timely assessment of elderly care patients is paramount, avoiding admission whenever possible and avoiding deterioration in health status if a patient is already in hospital.

Why is this important?
This is important because there is evidence[1] that long and/or frequent stays in hospital can reduce independence for people who are frail and elderly.

How have we done?
The Trust has fewer than average older people's physicians and it has been difficult to sustain a frailty pathway in the face of acute bed pressures. The service model is being refreshed as part of the Urgent Care and Patient Flow workstream and will be carried forward to 2017/18.

Workstream 3: Acute Care Model

Development of the Trust's acute care model focused on:

a. Improving emergency response time to improve quality and flow, together with
b. Establishing an acute medical service to support flow.

Why is this important?
Improving patient flow is recognised as critical to increasing patient safety by supporting the patient to receive the right care, in the right place, at the right time. An acute medicine service helps to maintain flow by quickly assessing people who present to hospital, carrying out appropriate, initial diagnostic tests and examinations and ensuring care is planned, whether they are to be treated in hospital or to be discharged.

How have we done?
To ensure that people do not suffer harm as a result of waiting during times of very high demand, the Trust has put in place a number of systems and processes, including care reviews, which ensure patients are assessed, observed, reviewed and treated in a timely way, despite the queues. Although these care processes are sometimes unable to optimise patients' privacy and dignity, the Trust has invested to be sure its overflow spaces, which in normal operation are circulation space, are equipped as far as possible with screens and other facilities.

The Trust has implemented ambulatory (i.e. capable of walking) emergency care as an alternative way of caring for some patients presenting to hospital who would traditionally be admitted. These mobile patients are not cared for in a bed but are treated and discharged on the same day as they arrive.

[1]Professor Finbarr C Martin, President, British Geriatrics Society and Consultant Physician for Older People in Continuity of care for older hospital patient: A call for action, The King's Fund 2012. Available at: http://bit.ly/2ozf3pC

Workstream 4: Patient Flow Centre Evaluation

The Patient Flow Centre (PFC) coordinates the transfer of patients who need additional support on discharge, from acute hospitals to home or to community hospitals and other intermediate care settings.

Why is it important?
The PFC provides a vital outflow route from Worcestershire's acute hospitals. The free flow of patients to other care settings arranged by the PFC directly links to the acute Trust's ability to manage patients through emergency departments.

How have we done?
Evaluation of the PFC identified shortfalls in the availability of suitable support for patients requiring: homecare; community hospital beds; community rehabilitation and residential or nursing home accommodation. A pathway review to rebalance demand and capacity within the PFC's pathways was recommended. This work will be ongoing into 2017/18, led by the Worcestershire Health and Care Trust and accountable to the Worcestershire Urgent Care Board, which operates across the health system.

At the end of 2016/17, the Trust had neared its target of reducing the numbers of patients who are medically fit for discharge but who cannot yet go home, reaching a reduction in numbers "stranded" of 42.4% against a target of 45%. This target is heavily reliant on all member organisations within the pathway aligning their policies, procedures and capacity. The Trust takes an active part with partners in managing the local health economy's capacity.

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Priority 2:
Ensure learning from incidents and other harm reviews, identifying and addressing the causes of avoidable harm including pre-emptively through the adoption of early warning tools and best practice care.

3.3
Priority 2: Clinical Effectiveness

As a whole, the NHS has prioritised reduction of avoidable harm and, by 2020, Trusts should be able to show measurable improvement.

The CQC report of care at Worcestershire Acute Hospitals NHS Trust, published 2 December 2015, indicated that the Hospital Standardised Mortality Indicator (HSMR) for the 12month period July 2013 – June 2014 was higher than expected. This indicator measures whether the number of in-patient hospital deaths is higher or lower than expected, though data is computed nationally and is often published as much as six months later than other datasets.

Additionally, the report also reflected that the Summary Hospital-Level Mortality Indicator (SHMI) covering the 12month period January 2014 to December 2014 was within the expected range. SHMI is a nationally agreed trust-wide mortality indicator which measures whether the number of deaths both in hospital and within thirty days of discharge is higher or lower than expected.

To improve consistency of care and ensure that both indicators reflect improving performance to 2020, the Trust has placed major emphasis on this priority. We have assimilated actions from our *Sign up to Safety* plan, launched in 2015 and described in last year's Quality Account, into this workstream. The Trust is not corporately a member of the *Sign up to Safety* initiative, though certain members of the quality team have maintained individual membership and use some of the tools and techniques disseminated by this national campaign.

Four workstreams were identified to support the delivery of priority 2.

Workstream 1: Mortality Reviews

This workstream focuses on establishing effective governance processes to review all patient deaths.

Why is this important?
Recent findings of the Care Quality Commission's (CQC) report, *Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England*, found that learning from deaths was not always being given sufficient priority and, consequently, valuable opportunities for improvements were being missed.

Our clinicians are committed to learning all they can from reviews of deaths that occur whilst patients are in our care. This workstream is dedicated to creating routine and systematic ways for them to do so.

How have we done?
Initially, a system to enable primary reviews of deaths to take place was designed and implemented in 2015/16.

For 2016/17, the Trust set a target of reviewing 50% of all deaths within 14 days of date of death. This is a milestone on a trajectory that will eventually see all deaths screened against national criteria being reviewed for lessons to be learned within 14 days of date of death. Whilst performance against this target has fallen short, averaging 19% per month across the year, the overall review rate achieved was 62.5%.

The Trust has re-designed the system and introduced an electronic form, pre-populated with patient data, which guides and systematises the review process. The report mentioned above signals a nationally recommended process for mortality review which Worcestershire Acute Hospitals NHS Trust (WAHT) will incorporate into its process, ensuring best practice is built into our policy. This priority will carry forward to the Trust's 2017/18 improvement plans.

Workstream 2: Sepsis Six Bundle

This workstream focuses on the implementation and systematic use of the sepsis six care bundle for early detection and screening of patients with suspected sepsis, together with the commencement of antibiotic therapy within one hour of presentation.

Why is this important?
Research by the York Health Economics Consortium (YHEC) and commissioned by the UK Sepsis Trust – reported on 20 February 2017 - found that there are at least 260,000 cases of sepsis in the UK each year, with more than 44,000 deaths from septicaemia across the country each year. The Chief Executive of the UK Sepsis Trust said the findings unveil a 'shocking new indication of the gravity and sheer scale of the problem'. There is an ongoing national campaign to raise awareness and improve clinical practice.

How have we done?
The Trust's HSMR for sepsis is 128 for the 12 months for December 2016 and has been higher than the English NHS average for 8 months. To identify actions required to improve consistent use of sepsis screening and timely treatment for those found to be septic, ward audits of sepsis care have been introduced at the Alexandra Hospital and at Worcester Royal Hospital during the fourth quarter 2016/17. The audit results have fed into improvement planning for 2017/18

Workstream 3: Fractured Neck of Femur – access to theatres within 36 hours of a patient presenting with a fractured hip

Hip fractures are associated with increased mortality together with temporary (and sometimes permanent) reduction in the quality of life. The Trust has set a target of 85% of patients undergoing surgery for fractured neck of femur within thirty-six hours of admission.

Why is it important?
This workstream focuses on the timeliness of access to surgery following a fractured hip. Evidence demonstrates that earlier surgery is associated with better outcomes, lower rates of complication and mortality.

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Trust hip fracture HSMR

Site/Year	HSMR	Deaths	'Expected' deaths	Number discharged
AGH 2015	128	21	15	248
AGH 2016	137	25	20	315
WRH 2015	105	28	27	427
WRH 2016	123	35	28	411

Earlier surgery reduces the amount of time a person is confined to bed rest pre-surgery which can help to prevent DVT, pressure sores and urinary tract infections. Worcestershire Acute Hospitals NHS Trust participates in the national hip fracture database which is a clinically led audit of hip fracture care. NICE guideline CG124 recommends that hip fracture surgery is undertaken on the day of, or the day after admission.

How have we done?

WAHT's hip fracture HSMR (data from January to November 2016) is higher than that for the same period in 2015 for both the Alexandra Hospital (AGH) and Worcestershire Royal Hospital (WRH), as shown in the table above.

An improvement plan in place during 2016/17 resulted in sixty per cent of patients who needed surgery reaching theatre within thirty-six hours of admission, against a target of eighty-five per cent. The target is set at this level to allow for patients who are admitted for hip surgery but not fit enough to undergo a procedure within thirty-six hours. The Orthopaedic department has reviewed its pathway and plans for patients with a fractured hip and early signs show that performance is increasingly progressing towards target. This priority is carried forward to the Trust's plans for 2017/18.

Workstream 4: National Early Warning Score (NEWS) – Introducing the best practice approach to the management of deteriorating patient

This workstream focuses on the implementation of NEWS across all clinical areas and demonstrating compliance with its use.

Why is it important?
The NEWS tool:

- Enables the sickest patients to be identified quickly and admitted to intensive care more promptly than at present so they can have a greater chance of a better outcome.
- Helps staff to recognise patients whose condition is deteriorating on the wards earlier than at present so they can have the benefit of being treated in time to prevent their admission to intensive care.
- Helps identify post-operative patients whose condition is deteriorating on the wards earlier than at present so they can have the benefit of being treated in time to prevent their admission to intensive care.
- Responds to the latest National Confidential Enquiry into Patient Outcome and Death (NCEPOD) report on CPR where poor monitoring was an issue.

How have we done?
The critical care outreach team has led introduction of the NEWS chart across adult care. A paediatric version (PEWS) has been introduced for children. Training and awareness was provided during June and July, including drop-in sessions, display boards and walk-about sessions by the critical care team. In addition, a detailed implementation programme was undertaken in which an identified link nurse on each ward supported the training programme. E-learning was also available and each clinical area was responsible for ensuring the training and development of their staff. To support ongoing learning and development, NEWS awareness is provided at Trust induction and at annual mandatory training for all clinical staff.

The Trust developed a clinical guideline '*Recognising and responding to early signs of deterioration in adult hospital patients using NEWS*'. This was approved by the Trust in August 2016.

The Trust also has a robust programme of audit in place - 10 sets of clinical documentation are audited monthly in each clinical area - to monitor compliance with the clinical guideline and to ensure that staff are scoring accurately and escalating appropriately. Audits are discussed with the clinical areas and at the *'preventing deterioration'* expert forum which is chaired by the Associate Medical Director for Clinical Effectiveness.

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Priority 3:
Develop a greater quality and safety culture across the organisation through engagement, training and staff development from ward to Board.

3.4
Priority 3: Patient experience

Major workstreams were dedicated during 2016/17 to improving the Trust's quality and safety culture through improved staff experience. However, the Trust is proud of a number of developments which also directly improved patients' experience. These included: introduction of a therapy dog 'ward round'; a new dementia strategy, joint awareness raising and other improvements developed with the Alzheimer's Society; more extensive use of volunteers; re-launch of dedicated carers' rooms at the Alexandra Hospital, introduction of a regular programme of carer awareness briefings for staff; new and improved contracts for interpreters and translation services; creating a better experience for those with learning disability in partnership with Worcestershire Health and Care Trust; introduction of a new complaints and concerns policy and related procedure designed in consultation with patients and families who highlighted issues in 2015-16; and a survey of users of the Trust's complaints process to learn lessons from their experience.

To address patient experience through staff experience, the Trust embraced the well-evidenced principle that high staff satisfaction[2] is predictive of high patient satisfaction. Since 2014, the Trust's annual staff satisfaction surveys have shown lower than average satisfaction in a variety of key measures. These results prompted the Trust to establish five workstreams designed to improve quality and safety awareness through better staff engagement, training and development at all levels of the Trust from Ward to Board.

Workstream 1: Leadership development to develop effective leaders

This work focuses on continuing development of leadership at all levels across the Trust.

Why is it important?
There is research[3] to demonstrate that staff views of their leaders are strongly related to the patients' perceptions of the quality of care delivered.

How have we done?
After completing diagnostic activities during 2016/17, WAHT has specified an extensive leadership development programme, recognising that the quality and behaviour of leaders impacts on the performance and engagement of staff, which in turn affects the patient experience.

[2] Michael West, Developing collective leadership for health care, The King's Fund, Cavendish Square, London W1G 0AN, May 2014

[3] http://bit.ly/2qy6OJH

In February 2017 the Trust launched a leadership programme, in conjunction with the Chartered Management Institute. The programme includes Board Development, Band 8 managers' Development, Band 7 Ward Managers' Development, and Consultant Development across a key range of organisational and individual performance management and staff engagement topics.

Workstream 2: Culture improvement and safety

This work focuses on the continual development of a culture in which employees are committed to safe, compassionate care and maximising productivity.

Why is it important?
Work undertaken by Michael West and colleagues *(op.cit.)* has demonstrated conclusively that caring, compassionate leadership is the key determinant of positive and compassionate cultures of care. Furthermore, the degree to which staff are engaged with the organisation is a key success criterion in meeting the Trust's objectives and in ensuring the knowledge, skills, experience and innovation of teams and individuals is used to greatest effect. It is widely recognised that a workforce that is engaged, empowered and well-led will provide better care and a more positive experience for patients and services users.

How have we done?
Recognising a need to address the Trust's quality culture, in 2016/17, the Trust launched a new Human Resources and Organisational Development Strategy underpinned by a Staff Engagement Plan. The engagement plan incorporates a number of ongoing communications, leadership, and health and wellbeing actions, including:

- Staff Engagement Group
- 'Big Conversation' events
- Executive briefings
- Staff newsletters
- Quarterly pulse surveys
- Progressing the recommendations from Listening into Action (LiA)

Workstream 3: Workforce – recruitment and retention of staff

Why is it important?
The Trust has renewed its strategies for recruitment and retention, leadership, staff communication and engagement and staff health and well-being, aiming to rebuild its organisational culture so that it is built on shared values and common goals. This begins with the recruitment process and 'values based recruitment'.

How have we done?

Recruitment
Worcestershire Acute Hospitals NHS Trust employs just under 6,000 staff across all professions and disciplines. The Trust's annual expenditure on pay is approximately seventy per cent of its total budget.

Throughout 2016/17 the substantive workforce capacity has remained relatively stable following an increase of 138.26 full-time equivalents (FTE) in the previous year due to radiotherapy development.

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However, there is a shortfall against the budgeted establishment of 501.63 FTE, as at January 2017, despite active recruitment.

We have held active recruitment campaigns across many main staff groups, with the introduction of assessment centres for band 5 nurses and health care assistants (HCAs), to support values based recruitment. However, as a consequence of continued retention issues in key areas such as middle grade doctors, surgical nursing, diagnostic radiography and theatre staff, recruitment is not keeping pace with turnover. Shortfalls in capacity are being partially met through continued use of bank and agency staffing.

There is no single 'quick fix' solution to these continuing shortages, but actions to address the key issues affecting the Trust's ability to attract, recruit and retain high quality staff in sufficient numbers include analysis of direct feedback from staff via local and national surveys, the Friends and Family Test, and exit interviews.

Current initiatives, which will carry forward to 2017/18, include:

- Launch of a new internal staff bank, in partnership with NHS Professionals.
- Improved bank rates and an incentive scheme for those undertaking 10 bank shifts.
- A 10% over-recruitment target in key areas (namely medicine and surgery).
- Agreement with Worcester University to increase numbers of student placements from 2016 intake.
- Recruitment events and careers fairs.
- Introduction of a simplified internal transfer process to retain staff.
- Band 5 and HCA assessment centres scheduled throughout the year.
- Business case for another round of international recruitment.
- Return to Practice Campaign.
- Introduction of a recruitment and retention premium in theatres.
- Widening participation – development of more Band 4 Assistant Practitioner posts.
- Active recruitment campaigns have continued during 2016/17 including staff nurse recruitment days. In addition, the Trust has promoted a return to nursing course in affiliation with Worcester University to encourage nurses to re-enter the profession and has reviewed pay rates for bank staff to ensure they are competitive in the local market.

Retention

Within the context of staff recruitment and retention, the term 'turnover' is used to refer to the totality of leavers from the organisation. The current overall turnover rate of 13.77% demonstrates a generally elevated rate seen in the last two years. To help to reduce turnover, the Trust has introduced new staff benefits, including health benefits, and, more widely, is addressing issues related to staff engagement and staff satisfaction – see workstreams 1,2 and 5.

Workstream 4: New roles and skills development

This workstream augments the objectives in our recruitment strategy above. Nationally, a number of new healthcare roles have been developed as key contributors to the multidisciplinary workforce and some have been implemented by the Trust.

Why is this important?
Introducing these roles helps to complement the existing NHS workforce, particularly in areas of service where professional staff are in short supply. It also widens access to a career in healthcare. This benefits recruitment and retention of staff across the Trust.

How have we done?
The Trust has introduced the following roles;

- Physicians associates.
- Nursing associates/Band 4 nursing roles.
- Ward administrators/housekeepers.
- Apprentices (business, administrative and healthcare).

Workstream 5: Policies and standards – development of a clear set of policies for bullying and harassment and raising concerns

The Trust has clear policies in place to deal with any issues relating to bullying and harassment in the workplace.

Why is it important?
The Trust encountered allegations of bullying and harassment from a small group of staff during 2015. Whilst no allegations were proven, the Good Governance Institute was asked to investigate the culture of the Trust. Their report recommended a review of policies to ensure they are clear and accessible to all.

How have we done?
Policies have been reviewed and re-launched. Sustainable implementation of these improved policies, including guidance for 'whistle blowing', is being monitored and reported to the Trust board through the Workforce Assurance Group.

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3.5
Staff Survey 2016

Illustrating some of the issues this priority addresses, the 2016 Staff survey results were published on 7th March 2017. The table identifies the key indicators related to this priority, compared to the previous year's survey.

The table's indicators in bold type are those prescribed for inclusion in Quality Accounts. Additional indicators are shown to illustrate a broader context. The Trust's complete staff survey report is available at http://bit.ly/2qX6o0N

Indicator identifier	Indicator description	Change since 2015 survey	Ranking, compared with all acute trusts in 2016
Violence, harassment and bullying			
KF22	% experiencing physical violence from patients, relatives or the public in last 12 months	Decrease (better than 15)	Above (worse than) average
KF23	% experiencing physical violence from staff in last 12 months	No change	Below (better than) average
KF24	% reporting most recent experience of violence	No change	No change
KF25	% experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	Decrease (better than 15%)	Highest (worst) 20%
KF26	**% experiencing harassment, bullying or abuse from staff in last 12 months**	**No change**	**Highest (worst) 20%**
KF27	% reporting most recent experience of harassment, bullying or abuse	Increase (better than 15)	Average
Equality and Diversity			
KF20	% experiencing discrimination at work in last 12 months	No change	Below (better than) average
KF21	**% believing the organisation provides equal opportunities for career progression / promotion**	**No change**	**Lowest (worst) 20%**

3.6
Addressing the Care Quality Commission's (CQC) requirements in 2016/17

The CQC inspects healthcare providers to ensure they are delivering services in accordance with the terms of their license and that those services are of sufficient quality. Since March 2015, the Trust has had the following conditions and warning notices placed upon its license, which remain in place at 31st March 2017.

Special Measures

The regulator NHS Improvement often places hospitals in special measures when the CQC's routine inspection rates the provider as Inadequate. This is likely to be because the provider is not delivering quality care consistently in all areas. NHS Improvement provides additional help for Trusts in special measures and the CQC continues to monitor the quality of care provided. The Trust began 2016/17 in special measures, with a rating of inadequate, having been placed in this regime on 2nd December 2015 after a CQC inspection in July 2015.

Conditions / Warning Notices / Ratings	Area	Site	Date Notice / Report Received
Section 31 condition placed on registration (requirement to report 15-minute triage breaches and Harm Reviews)	Emergency Department	WRH	26th March 2015
Section 29 Warning Notice Regulation 15	Emergency Department Security	WRH/Alex	30th March 2015
Section 29 Warning Notice Regulation 16	Emergency Department Equipment	WRH	30th March 2015
Section 29 Warning Notice Regulation 22	Emergency Department Staffing	WRH	30th March 2015
Section 31 Condition	Radiology	Trust wide	16th August 2016
Section 29A Warning Notice	• Patient safety – urgent care pathway; • Quality governance systems in the organisation (how do you know patients are safe); and • Inconsistency of compliance in clinical wards and services with local/national policies and procedures or standards, together with issues such as mandatory training compliance.	Trust wide	27th January 2017

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Radiology

CQC carried out an unannounced inspection at WRH on 27th July 2016. The purpose was to look at specific aspects of the care provided by radiology services at WAHT. Following this, WAHT was required to take appropriate steps to resolve the backlog of radiology reporting. Based in the findings of this inspection a Section 31 Condition was placed on Trust, requiring the Trust to report progress in resolving the backlog to CQC on a weekly basis.

Patient Care Improvement Plan

After the Trust was placed in special measures, a patient care improvement plan (PCIP) was developed to record and track progress of quality improvement. The PCIP was in place through most of 2016/17. Its major strands of work were:

- Urgent care and patient flow improvement.
- Governance improvement.
- Maternity and Neonatal care.
- Infection control procedures.

The Patient Care Improvement Programme sought to reinvigorate the Trust's focus on many of its priorities and teams were monitored to ensure that effective systems were in place to deliver these priorities. However, whilst there was significant work undertaken throughout the year on the improvement priorities described above, faced with changes in key personnel and increasing operational pressures, delivery of these priorities was inconsistent.

Following the CQC re-inspection in November 2016 and two subsequent risk summits, the Trust's Executive team re-prioritised the Patient Care Improvement Plan. A summary of these refreshed priorities is overleaf.

Further to setting these priorities, and in response to a further CQC warning notice received in January 2017 (see paragraph re Section 29A notice below), the Trust developed a Quality Improvement Plan (QIP), responding specifically to issues raised within the CQC's Section 29A notice. As these will largely be implemented during 2017/18, they are described in detail in Part 2 of this account. The QIP is supported by a robust programme governance structure.

Events leading to the QIP - Section 29A notice requiring significant improvement

Between 22nd and 25th November 2016, the CQC carried out a scheduled, formal inspection, in consequence of the Trust's *Inadequate* rating, with unannounced inspection visits on 7th, 8th and 15th December 2016. These visits resulted in the Trust receiving a Section 29A letter from the CQC, raising concerns regarding:

- Patient safety – urgent care pathway;
- Quality governance systems in the organization – "how do you know patients are safe?"; and
- Inconsistent compliance with local/national policies and procedures or standards, in some clinical wards and services together with issues such as mandatory training compliance.

Immediate action was taken to address safety concerns raised by CQC and the QIP, addressing all other issues raised, was submitted to CQC by 10th March 2017.

Trust Priority Improvement Programme

KEY ENABLERS

Leadership
Roll out agreed leadership development programmes focussing initially on existing and aspiring clinical leaders and middle managers.

Governance
Embed new, more robust governance processes around quality, safety and risk.

Performance management
Strengthen and improve performance management systems and processes.

OPERATIONAL IMPROVEMENT

SAFER Discharge Bundle
Rapid (8 week) deployment of SAFER bundle across 22 acute ward areas.

Front Door Streaming
Integrate GP in ED and OPAL and to develop alternative ambulatory pathways for medical patients attending ED.

Medical Assessment
Develop and consistently deliver medical assessment fundtion in MAU.

Stranded Patients
Weekly multi-agency discharge events focussing on long stay patients.

Clinical Capacity Management
Including tools for patient tracking and task management.

Clinical Service Planning
Robust demand and capacity planning to support operational delivery in 2017/18.

QUALITY AND SAFETY IMPROVEMENT

Avoidable Mortality
- Improved mortality oversight and mortality reviews.
- Trust wide rollout of SEPSIS bundle
- Improved recognistion and management of acute kidney injury
- Effective deployment of national early warning score system (NEWS).

Harm Free Care
Compliance with national safety standards for interventional procedures (NATSSIPs).

Focus on: VTE, pressure ulcers, falls, hydration and nutrition, IPC basics, medicines storage and administration.

Care Standards
Focus on: safe staffing, core competencies, 'care and comfort', documentation, audit, MCA/DoLS and safeguarding.

CRITCIAL TASKS: Medical recruitment, medical engagement

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As discussed in Part 2 above, fundamental quality improvement priorities remain a focus of the Trust's quality management system and are carried forward, together with the QIP's objectives, to the Trust's quality goals for 2017/18.

3.7 Future of Acute Hospital Services in Worcestershire (FoAHSW)

During 2016/17, the Trust employed emergency powers to centralise in-patient paediatric services, maternity and emergency abdominal surgery at Worcestershire Royal Hospital on safety grounds. The need for these changes arose from an increasing inability to meet national safe standards for medical staffing whilst providing dual site services at both the Worcestershire Royal Hospital and the Alexandra Hospital. Locum and temporary staff were being relied upon too frequently to fill roster gaps, resulting in an unacceptably high risk of variability of clinical care and patient dissatisfaction. The changes are part of a recent consultation with the public about the future of acute services in Worcestershire and more detail can be found at the *Future of Acute Hospital Services in Worcestershire website:* www.worcsfuturehospitals.co.uk

Whilst the Trust regrets the need to make these changes, they have brought considerable improvements to patients.

Emergency bowel surgery

- Patient outcomes have been improved.
- The number of complications after surgery has fallen.

Maternity

- Cover by dedicated resident senior doctors on the labour ward has increased to 77 hours every week, meaning more women have immediate access to a senior doctor when they are in labour.
- Caesarean section rates have fallen from 32.6% to under 25% of all births, benefiting more than 400 women a year.
- Most women across the county have chosen Worcestershire Royal Hospital to give birth. All the additional births have been accommodated at Worcestershire Royal Hospital.
- Patient satisfaction levels remain high.

Children's in-patient services

- All children are assessed by a senior children's doctor who decides whether they need to be admitted to the Worcestershire Royal Hospital.
- GPs in the north of the county can refer children to specialist clinics at the Alexandra Hospital.
- Fewer children are being admitted to hospital – we've seen a 17% fall in admissions since the emergency changes.
- Individual plans have been put in place to ensure children with 'open access' to the Alexandra Hospital, because of long-term problems, can have the same access to the Worcestershire Royal Hospital and individual transport plans to enable them to travel to and from Worcester Paediatric services.

3.8 Implementing the Duty of Candour

The introduction of a Duty of Candour owed to service users by health professionals and health organisations was a direct response to recommendations of the Francis Inquiry report into Mid Staffordshire NHS Foundation Trust[4], which recommended that a statutory Duty of Candour be introduced for health and care providers.

In essence, professionals and organisations must ensure that patients, and where appropriate their families, are told openly, honestly and truthfully when unanticipated errors occur which cause, or may cause in future, significant harm.

The duty was statutorily enacted in 2014. It applies to all health and social care organisations registered with the Care Quality Commission (CQC) in England and is aligned to health professionals' regulatory bodies' registration requirements.

The Trust's *Duty of Candour policy* requires that incidents that meet criteria described in the CQC's regulation 20 should be discussed by a registered health professional with the affected service user or their representative as soon as reasonably practical after the incident comes to light. This conversation should be conducted with honesty, include an apology and should describe next steps planned to follow up on the incident that has occurred. It should be documented and reported to the Trust according to the Trust's Incident Reporting Policy.

In 2016/17, the Trust recorded 162 incidents that met the threshold for Duty of Candour. Analysis of these has identified that the initial conversation regarding the incident occurred (or did not occur despite extensive efforts to do so, with reasons fully documented) in 148 (92%) of cases. A follow up letter or leaflet was sent to the patient and/or relative in 78% of cases.

96 investigations/incident reviews have been finally approved and 51 (53%) cases have either received or declined the final report to be shared with the family. 43 (45%) are still pending the final report to be shared.

The analysis has identified that the Trust is achieving over 90% of initial discussions taking place. Formally following these discussions up in writing needs to be improved, as does ensuring the final report is shared with the patient and/or family. Currently, a fortnightly report is provided to the Trust's divisions in the Serious Incident Review and Learning Group, to highlight and provide assurance that the initial Duty of Candour conversation has taken place.

Action to be carried forward to 2017/2018

- Provision and accessibility of staff training has been reviewed. An e-learning package is currently being devised and will be rolled out in Q2.
- More widely, availability of training to ensure staff are aware of the Duty of Candour regulations and that they feel confident and empowered to hold difficult conversations and to break bad news will be increased.

[4] http://bit.ly/2pvPLsm

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- An annual report, providing more detailed analysis and an action plan will be written at the end of Q1 and presented at Trust Board so that there is oversight of where improvements will be targeted.
- More regular reporting to divisions will be provided to allow improved monitoring of training take-up and performance against the policy, so that prompt improvement action can be taken.
- Areas of non-compliance will be shared with divisional directors, and where necessary with the Executive team to ensure there are clear lines of accountability.

3.9 Infection Prevention

Hand hygiene

The Care Quality Commission in the announced and unannounced inspection visits observed hand hygiene that was not always in compliance with the World Health Organisation's recognised *5 moments of hand hygiene* standard for washing or gelling hands. The Trust has responded by undertaking hand hygiene audits and spot checks Trust wide and has updated its hand hygiene policy to include an escalation procedure for any staff found to be non-compliant; with accountability leading to the Chief Medical Officer and Chief Nurse.

The Trust has also launched an awareness campaign including a revised hand hygiene video shown at all staff induction days and mandatory training updates and has asked ward staff to sign a pledge, committing them to provide a safe environment for patients by complying with the '5 moments of hand hygiene' and wearing appropriate personal protective equipment.

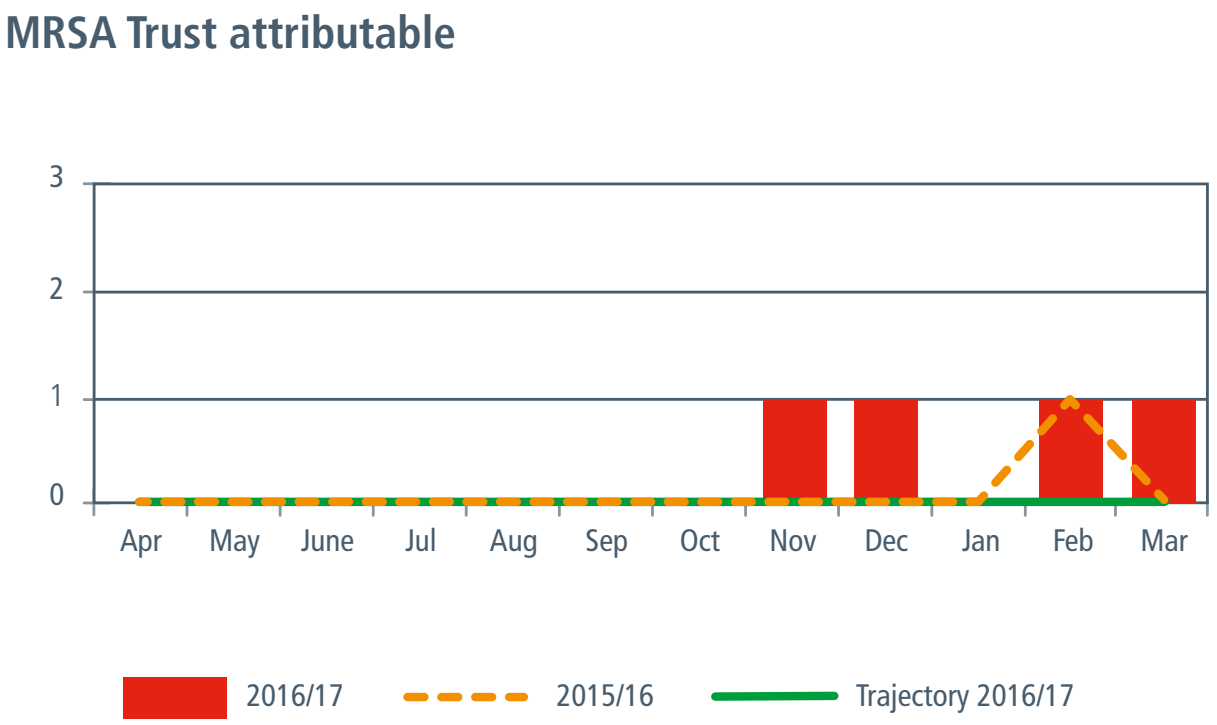
New poster to raise hand hygiene awareness

Screenshot from our revised hand hygiene video shown at staff induction

MRSA bacteraemia

A national zero tolerance of Meticillin resistant *Staphylococcus aureus* (MRSA) bacteraemia continues and therefore a trajectory of zero cases is set for all Trusts. Unfortunately, there have been 4 cases of MRSA bacteraemia that have been attributed to the Trust during 2016-17, comparing to one case during 2015-16. Of these cases, 3 occurred in patients at the Alexandra Hospital and one case at Worcestershire Royal Hospital. The first of these cases at the Alexandra Hospital was classified as a contaminant in the blood culture, which means it was not a true bacteraemia. However, the other 3 cases were deemed true blood stream infections.

There have been 3 other cases of MRSA bacteraemia that were not attributed to the Trust, in patients where blood culture was taken within 48 hours of admission to hospital.



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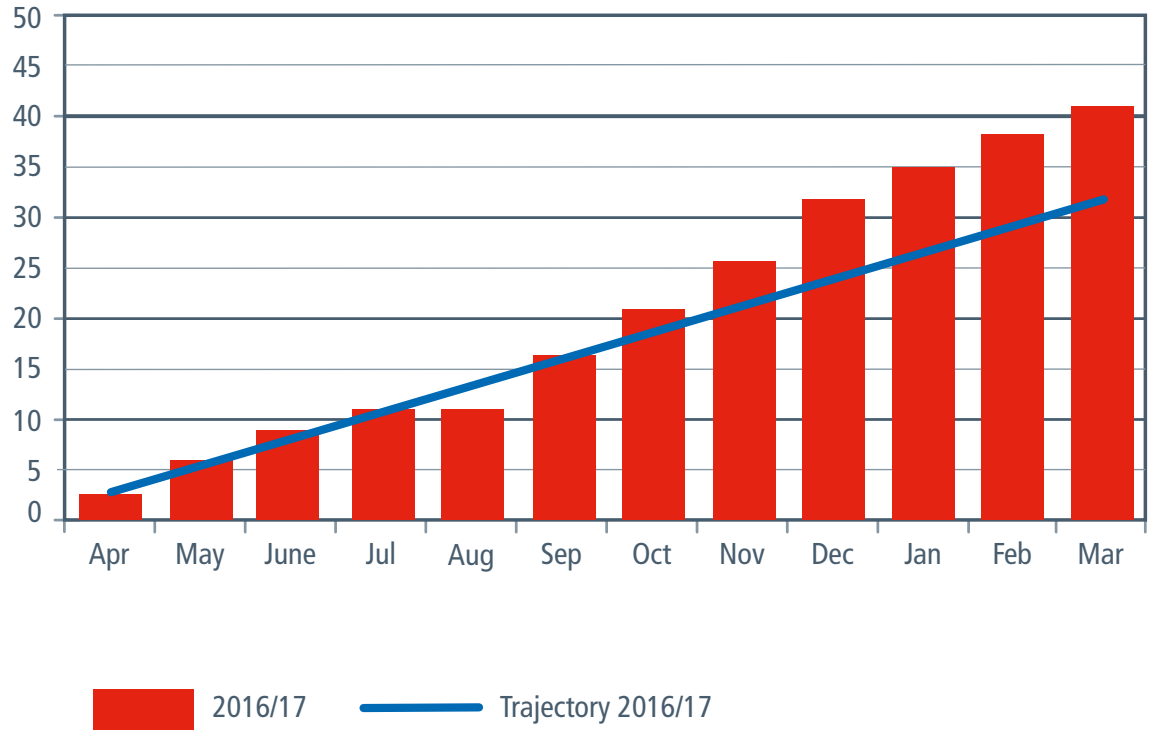
C.difficile

There were 41 cases of *C.difficile* (toxin positive) reported during 2016-17. This is above the target set by NHS England of no more than 32 cases and represents an increase on the 29 cases seen during 2015-16.

One of the main factors that triggers *C.difficile* is the use of antibiotics which while necessary to treat patients, also can have the effect of triggering *C.difficile* infection. 2017-18 will see a concerted effort to audit and review prescribing of antibiotics in accordance with revised Antimicrobial Stewardship Guidelines; and a renewed focus on spot checks of cleanliness.

An annual trajectory for *C.difficile* has been set for 2017-18; again no more than 32 cases.

CDI Trust attributable cumulative



MSSA and E.coli bacteraemia surveillance

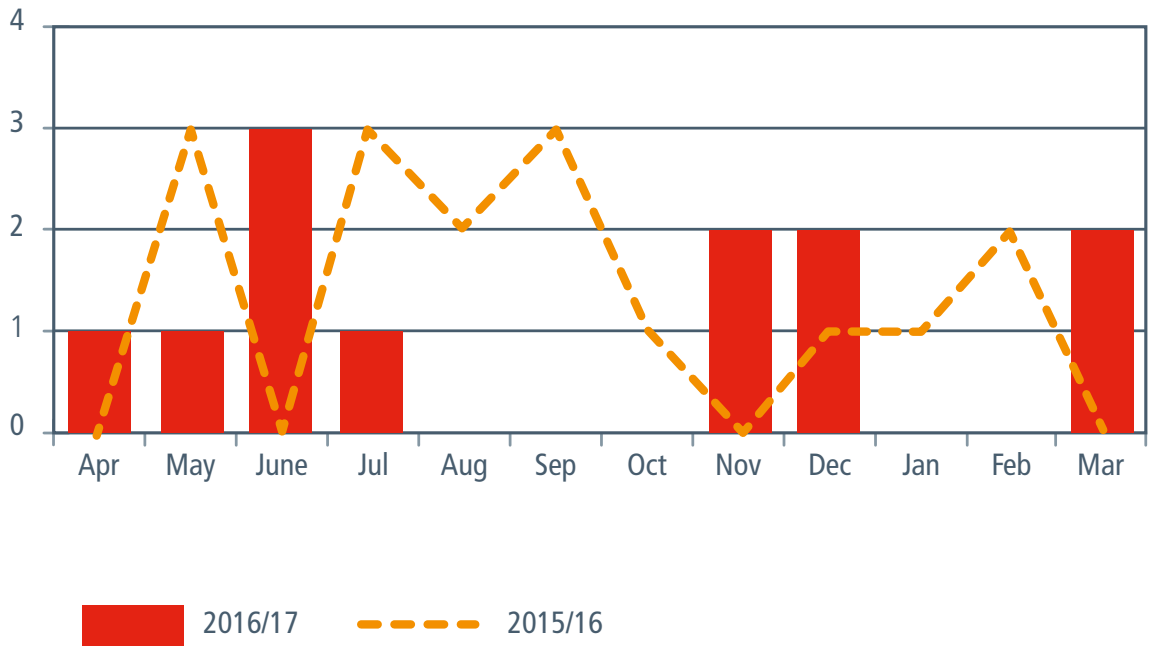
There were 12 cases of Trust-attributable Meticillin sensitive *Staphylococcus aureus* (from blood cultures taken 48 hours after admission to hospital) during 2016-17 comparing to 19 during 2015-16. However, analysis has shown no particular trends or themes in cases.

Public Health England is introducing enhanced surveillance for both MSSA and *E.coli* bacteraemia for 2017-18 and this will mean there will be an increased focus on understanding any causative reasons for each case in order to try and reduce overall cases.

Blood culture contamination rate

The blood culture contamination rate for adult blood culture specimens is 2.5%, which is an indicator of good practice as it is below the national average of 3%.

MRSA Trust attributable



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3.10 Safeguarding

The Care Quality Commission (CQC) defines safeguarding as:

Protecting people's health, wellbeing and human rights, and enabling them to live free from harm, abuse and neglect.[1]

The Trust agrees with the CQC's assertion that safeguarding is fundamental to high-quality health and social care. Our safeguarding policies strive to protect and promote the welfare of children, young people and adults. Robust and effective practice relies on a knowledgeable, skilled workforce, dealing confidently with fundamental process and procedures when concerns related to patient safety arise.

The safeguarding team has implemented sound safeguarding systems, processes and practice for children, young people and adults across the Trust and has set objectives to deliver a safe environment in which statutory functions and CQC requirements are met. Expert advice, support and guidance in relation to safeguarding are available to all staff, Trust-wide, sustained by training tailored to individual roles and responsibilities. Together, these elements facilitate all staff's awareness of safeguarding responsibilities and obligations.

During 2016/17, the safeguarding team has assessed the Trust's current safeguarding pathways and policies and reviewed governance arrangements which monitor and review safeguarding practice. The resultant action plans form key objectives for 2017/18. In addition, the team is developing closer working relationships with partner agencies and safeguarding boards within the county to improve understanding and delivery of the Trust's role in joint operation of policies and statutory obligations. (CA 1983, Sec.11 and Care Act 2014).

The safeguarding team will also review any health actions incorporated in the forthcoming recommendations of the OFSTED inspection into Worcestershire Children's Social Care and the Worcestershire Safeguarding Children's Board and integrate recommendations to the Trust's work plan for 2017/18 as necessary.

[5]http://www.cqc.org.uk/content/safeguarding-people

Part 3b: Statements of assurance from the Board and other statutory information

The wording in the following statements is required by the Department of Health and is common to all quality accounts. These statements offer assurance to the public in relation to:

- Performing to essential standards (such as CQC registration).
- Measuring clinical processes and performance (for example through participation in national clinical audits).
- Involvement in projects and initiatives aimed at improving quality.

3.11 Review of services

During 2016/17, the Worcestershire Acute Hospitals NHS Trust provided and/or subcontracted 46 NHS services. The Trust has reviewed all the data available to them on the quality of care in these services. The income generated by the NHS services reviewed in 2016/17 represents one hundred per cent of the total income generated from the provision of NHS services by the Worcestershire Acute Hospitals NHS Trust for 2016/17.

3.12 Registration with the Care Quality Commission (CQC)

The Trust is required to register with the CQC and its current registration status is registered with conditions in regard to diagnostic and screening procedures. Details of the Trust's registration can be found at: www.cqc.org.uk/provider/RWP/registration-info and in appendix 2

3.13 Trust's core indicators for 2016/17

The quality indicators overleaf are reviewed monthly by the Trust's Board of Directors.

3.14 NHS Outcomes Framework Core Quality Account Indicators

The framework comprises high-level outcomes which the NHS is aiming nationally to improve. Though these data are required within Quality Accounts, they are not always available for the most recent financial year at the time the Quality Account is compiled. Further, only some outcome framework indicators record worst and best providers across the NHS.

For simplicity, the table *(see page 41)* is restricted to those outcome indicators relevant to the care provided by our Trust.

Trust Board's quality dashboard

Area	Indicator type	Indicator		Current YTD	2016/17 Tolerances			Data Quality Kitemark
					On target	Of concern	Action required	
Incidents and never events	Local	QPS3.3	Incidents - SIs open > 60 days (Awaiting closure - WAHT)	38	0	-	>0	●
	National	QPS4.1	Never Events	2	0	-	>0	●
	Local	QPS6.6	Falls: Total falls resulting in Serious Harm (in month)	23	<=1	-	>=2	●
	Contractual	QPS7.5	Pressure ulcers: New Patients with Hospital Acquired Grade 3 Avoidable (monthly)	18	0	1-3	>=4	●
	Contractual	QPS7.7	Pressure ulcers: New Patients with Hospital Acquired Grade 4 Avoidable (monthly)	0	0	-	>=1	●
Mortality	National	QPS9.1	Mortality: SHMI (HED tool) Inc. deaths 30 days post discharge - rolling 12 months.	108	<100	>=100 to UCL	> UCL	●
	National	QPS9.81	Mortality: HSMR - All diagnostic groups - rolling 12 months	108	<100	>=100 to UCL	> UCL	●
	National	QPS9.21	% primary mortality reviews completed*	60%	>=60		<60	●
	National	QPS9.22	% secondary mortality reviews completed*	10%	>=20		<20	●
Safety Thermometer	National	QPS10.1	Safety Thermometer - Harm Free Care Score	92.60%	>=95%	90% - 94%	<90%	●
VTE	National	QPS11.1	VTE Risk Assessment**	94.27%	>=95%	94% - 94.9%	<94%	●
Infection Control	National	QPS12.1	Clostridium Difficile (Monthly)	41	15/16 Threshold <=33 16/17 Threshold <=32			●
	National	QPS12.4	MRSA Bacteremia - Hospital attributable (monthly)	4	0	-	>0	●
	National	QPS12.131	MRSA patients screened (high risk wards only) - elective	95.40%	>=95%	-	<95%	●

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Patient Experience

Area	Indicator type	Indicator		Current YTD	2016/17 Tolerances			Data Quality Kitemark
					On target	Of concern	Action required	
Complaints and Compliments	Local	QEX1.1	Complaints - Numbers (in month)	724	-	-	-	●
	Local	QEX1.3	Complaints - Number per 10,000 Bed Days (YTD)	25.06	-	-	-	●
	Local	QEX1.14	Complaints - % of Category 2 complaints responded within complainant deadline (WAHT) - NEW	63.0%	>=90%	80-90%	<79%	●
Friends and Family	National	QEX2.1	Friends and Family - A&E (score)	70.2	>=71	67-<71	<67	●
	National	QEX2.61	Friends and Family - Acute Wards (score)	80.0	>=71	67-<71	<67	●
	National	QEX2.7	Friends and Family - Maternity (score)	84.0	>=71	67-<71	<67	●
EMSA	National	QEX3.1	EMSA - Eliminating Mixed Sex Accommodation	64	0	-	>0	●

Effectiveness of Care

Area	Indicator type	Indicator		Current YTD	2016/17 Tolerances			Data Quality Kitemark
					On target	Of concern	Action required	
Hip Fracture***	National	QEF3.1	Hip Fracture - Time to Theatre <=36 hrs (%)	60.0%	>=85%	-	<85%	●
	Local	QEF3.1i	Hip Fracture - Time to Theatre <=36 hrs (%) - WRH	55.7%	>=85%	-	>=85%	●
	Local	QEF3.1ii	Hip Fracture - Time to Theatre <=36 hrs (%) - ALX	67.2%	>=85%	-	>=85%	●
	National	QEF3.2	Hip Fracture - Time to Theatre <=36 hrs (%) - Excluding unfit/non-Operative patients	70.2%	>=85%	-	<85%	●

NHS Outcomes Framework Core Quality Account Indicators

Domain	Indicator	16/17 value	National average value	Where applicable		Trust statement	Previous values (where data is available)		
				Best NHS performer	Worst NHS performer		15/16	14/15	13/14
Preventing people from dying prematurely	SHMI value and banding	108.6 Rolling 12 months to Sep 16 Banding 2	n/a	68.97 Rolling 12 months to Sep 16	116.38 Rolling 12 months to Sep 16	*Worcestershire Acute Hospitals NHS Trust (WAHT) considers that this data is as described for the following reasons:* Improvements in timely care for patients whose condition deteriorates is demonstrated by reducing SHMI. *WAHT intends to take the following actions to improve this number and so the quality of its services by:* See quality account priorities.	110 Banding 2	113.04 Banding 1	
	% patient deaths with pallative care coded (Oct 2015 -Sept 2016)	(15/16 data) 28.4%	n/a	56.3%	0.4%	*Worcestershire Acute Hospitals NHS Trust (WAHT) considers that this data is as described for the following reasons:* Data quality is good but there is room for improvement. *WAHT intends to take the following actions to improve this number and so the quality of its services by: The Trust will aim to improve this performance during 2017/18.*		28.6% (Oct 14 - Sep 15)	
Helping people to recover from episodes of ill-health or injury	Patient reported outcome score for groin hernia surgery	63.2% Apr-Sep 2016	50.9% (EQ-5D provisional Apr - Dec 2016)	Data not published as at May 2017		*Worcestershire Acute Hospitals NHS Trust (WAHT) considers that this data is as described for the following reasons:* The Trust has continued to improve and has exceeded the national average. *WAHT intends to take the following actions to improve this number and so the quality of its services by: Further planned improvements will sustain this performance.*	52.8%	46.3%	48.9%

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Domain	Indicator	16/17 value	National average value	Where applicable		Trust statement	Previous values (where data is available)		
				Best NHS performer	Worst NHS performer		15/16	14/15	13/14
Helping people to recover from episodes of ill-health or injury continued...	Patient reported outcome score for varicose vein surgery	52% Apr-Sep 2016	51.9% (EQ-5D provisional Apr - Dec 2016)	Data not published as at May 2017.		*Worcestershire Acute Hospitals NHS Trust (WAHT) considers that this data is as described for the following reasons:* A small number of procedures are undertaken and performance has been maintained. *WAHT intends to take the following actions to improve this number and so the quality of its services by: Further planned improvements will sustain this performance, though small numbers of procedures mean this data is susceptible to patient variation.*	49.6%	25.0%	
	Patient reported outcome score for hip replacement surgery	94.6% Apr - Sep 2016	89.4% (EQ-5D provisional Apr-Dec 2016	Data not published as at May 2017.		*Worcestershire Acute Hospitals NHS Trust (WAHT) considers that this data is as described for the following reasons:* Outcomes are slowly improving and are above the national average. *WAHT intends to take the following actions to improve this number and so the quality of its services by: See Quality Account priorities - plans to improve access to theatre aim to create further improvement.*	91.3%	94.9%	89.2%

Part 3b: Statements of assurance from the Board and other statutory information

Domain	Indicator	16/17 value	National average value	Where applicable		Trust statement	Previous values (where data is available)		
				Best NHS performer	Worst NHS performer		15/16	14/15	13/14
Helping people to recover from episodes of ill-health or injury continued...	Patient reported outcome score for knee replacement surgery	72% Apr - Sep 2016	81.61% (EQ-5D provisional Apr-Dec 2016	Data not published as at May 2017.		*Worcestershire Acute Hospitals NHS Trust (WAHT) considers that this data is as described for the following reasons:* Planned knee surgery has been impacted by reduced theatre access arising from difficulties with patient flow. *WAHT intends to take the following actions to improve this number and so the quality of its services by: Improving flow so improving timeliness of treatment and avoiding pain or deterioration for waiting patients.*	81.3%	80.4%	80.6%
	28 day readmission rate for patients aged 0-15	0% 0-15yrs	Data not published as at May 2017			*Worcestershire Acute Hospitals NHS Trust (WAHT) considers that this data is as described for the following reasons:* Children's services in all specialties strive to ensure readmissions are avoided to avoid disruption to children and families. *WAHT intends to take the following actions to improve this number and so the quality of its services by: Ensuring this performance is maintained.*	0%		

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Domain	Indicator	16/17 value	National average value	Where applicable		Trust statement	Previous values (where data is available)		
				Best NHS performer	Worst NHS performer		15/16	14/15	13/14
Helping people to recover from episodes of ill-health or injury continued...	28 day readmission for patients aged over 15 years	3.8%	Data not published as at May 2017			*Worcestershire Acute Hospitals NHS Trust (WAHT) considers that this data is as described for the following reasons:* Despite bed pressures, the Trust ensures patients are fit enough to cope at home where possible. *WAHT intends to take the following actions to improve this number and so the quality of its services by:* *Maintaining safe discharge practice.*	3.4%		
Ensuring that people have a positive experience of care	Responsiveness to inpatients' personal needs - CQC national inpatient survey score	To be published in August 2017				*Worcestershire Acute Hospitals NHS Trust (WAHT) considers that this data is as described for the following reasons:* The Trust strives to maintain all elements of patient experience, despite acute bed pressures. *WAHT intends to take the following actions to improve this number and so the quality of its services by:* *Improvements to patient flow described in Quality Account priorities.*	75.0	76.2	75.8
	Percentage of staff who would recommend the provider to friends and family needing care	56%	70%	100% Date Q2 2016/2017	44% Data Q2 2016/2017	*Worcestershire Acute Hospitals NHS Trust (WAHT) considers that this data is as described for the following reasons:* Staff engagement has remained static this year and is the lowest quartile for the NHS. *WAHT intends to take the following actions to improve this number and so the quality of its services by:* *See Quality Account.*	56%	51%	

Part 3b: Statements of assurance from the Board and other statutory information

Domain	Indicator	16/17 value	National average value	Where applicable		Trust statement	Previous values (where data is available)		
				Best NHS performer	Worst NHS performer		15/16	14/15	13/14
Ensuring that people have a positive experience of care continued...	Inpatient Friends and Family Test	Score - 80 Responses - 15.7%	Data not published as at May 2017			*Worcestershire Acute Hospitals NHS Trust (WAHT) considers that this data is as described for the following reasons:* This score is consistent with recent inspection results in which the Trust's highest score reflected compassionate care. *WAHT intends to take the following actions to improve this number and so the quality of its services by: See actions in Quality Account.*	Score - 76 Response - 15.7%	Score - N/A Response - 22%	
	A&E Friends and Family Test	Score - 70 Responses - 5.5%	Data not published as at May 2017			*Worcestershire Acute Hospitals NHS Trust (WAHT) considers that this data is as described for the following reasons:* The Trust is working hard to improve response rates in ED. *WAHT intends to take the following actions to improve this number and so the quality of its services by: Action to improve patient flow - see Quality Account - will improve patient experience in ED and encourage staff to support work to improve response rates.*	Score - 71 Response - 15.1%	Score - N/A Response - 17.2%	
Treating and caring for people in a safe environment and protecting them from harm	% of patients risk-assessed for Venous Thrombo-embolism	94.27%	95.64% Q3 2016/2017 Data	100% Q3 2016/2017 Data	76.48% Q3 2016/2017 Data	*Worcestershire Acute Hospitals NHS Trust (WAHT) considers that this data is as described for the following reasons:* VTE assessment rates have dropped below the national average. *WAHT intends to take the following actions to improve this number and so the quality of its services by: See Quality Account priorities.*	95.00%	95.01%	

Domain	Indicator	16/17 value	National average value	Where applicable		Trust statement	Previous values (where data is available)		
				Best NHS performer	Worst NHS performer		15/16	14/15	13/14
Treating and caring for people in a safe environment and protecting them from harm	Rate of C.Difficile per 100,000 days	15.17	14.9 2015/16 Data - 2016/17 data due Jul 2017	0.0 2015/16 Data	66.0 2015/16 Data	*Worcestershire Acute Hospitals NHS Trust (WAHT) considers that this data is as described for the following reasons:* The Trust has re-emphasised simple control of infection measures, particularly at times of extreme bed pressures. *WAHT intends to take the following actions to improve this number and so the quality of its services by: See Quality Account priorities.*	10.4	14.0	14.8
	Rate of patient safety incidents per 1,000 bed days	39.1 Data - Apr - Sep 2016				*Worcestershire Acute Hospitals NHS Trust (WAHT) considers that this data is as described for the following reasons:* The Trust has continued to focus on improvements to safety review processes. *WAHT intends to take the following actions to improve this number and so the quality of its services by: Improvement plans described in Quality Account priorities.*	40.1 (Oct 15 - Mar 16)	42.0 (Oct 14 - Mar 15)	
	Rate of patient safety incidents that resulted in severe harm of death per 1,000 bed days	0.09 Data - Apr - Sept 2016				*Worcestershire Acute Hospitals NHS Trust (WAHT) considers that this data is as described for the following reasons:* The Trust has continued to focus on improvements to safety review processes. *WAHT intends to take the following actions to improve this number and so the quality of its services by: Improvement plans described in Quality Account priorities.*	0.10 (Oct 15 - Mar 16)	0.23 (Oct 14 - Mar 15)	

3.15 Explanatory notes about the NHS Outcomes Framework

Domain: preventing people from dying prematurely

The Standardised Hospital Level Mortality Indicator (SHMI) is a measure of mortality developed by the Department of Health, which compares our actual number of deaths with our predicted number of deaths. Each hospital is placed into a band based upon their SHMI.

Domain: helping people to recover from episodes of ill health or following injury

Patient reported outcome scores

A patient reported outcome measure is a series of questions that patients are asked in order to gauge their views on their own health. In the examples of groin hernia, knee replacement, hip replacement and varicose vein surgery, patients are asked to score their health before and after surgery. We are then able to understand whether patients see a 'health gain' following surgery. The data provided gives the average difference between the first score (pre-surgery) and second score (post-surgery) that patients give themselves. In all procedures where data is available there are improvements in the average score. However, it is important to note that the sample size for all patient reported outcome scores is very small which may impact upon the meaningfulness of the data. This is rectified when the full year data is provided.

Domain: ensuring that people have a positive experience of care

Responsiveness to inpatients' personal needs

This indicator provides a measure of quality, based on the Care Quality Commission's National Inpatient Survey. The score is calculated by averaging the answers to five questions in the inpatient survey. The highest score achievable is 100 .

Domain: Treating and caring for people in a safe environment and protecting them from avoidable harm

Risk assessing inpatients for venous thromboembolism (VTE) is important in reducing hospital acquired VTE.

Domain: Treating and caring for people in a safe environment and protecting them from avoidable harm

Patient safety incidents are reported to NHS England. Organisations that report more incidents usually have a better and more effective safety culture. We believe you cannot learn and improve if you do not know what the problems are. WAHT will continue to encourage a culture of open reporting in order to learn and improve.

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3.16
Participation in Clinical Audit

During 2016/17, forty national clinical audits and six national confidential enquiries covered relevant health services that Worcestershire Acute Hospitals NHS Trust provides. Also, in 2016/17 we undertook three hundred and seventy-nine registered local clinical audits.

During that period, Worcestershire Acute Hospitals NHS Trust participated in ninety per cent of national clinical audits and one hundred per cent national confidential enquiries that it was eligible to participate in.

Appendix 1 contains a list of national audits, national confidential enquiries and local audits that Worcestershire Acute Hospitals NHS Trust participated in during 2016/17. Appendix 1 also describes the actions we have taken or are planning to take to improve our services in response to insights from these audits.

3.17
Participation in Clinical Research

The number of patients receiving NHS services provided or sub-contracted by Worcestershire Acute Hospitals NHS Trust in 2016/17 that were recruited during that period to participate in research approved by a Research Ethics Committee was 1340. Worcestershire Acute Hospitals NHS Trust recruited patients to 90 clinical research studies across 19 different clinical specialties. 40 new studies were opened during the year.

These recruitment figures represent a 25% overall increase in the level of participation in clinical research since 2015/6. The number of patients recruited to cancer studies has increased by 85%. Worcestershire Acute Hospitals NHS Trust is committed to expanding access to clinical research in all specialties. We believe that through clinical research, we will improve the quality of care we offer our patients and also help our staff achieve their full potential.

3.18
Data Quality

Clinicians, managers and staff rely upon good quality information to support delivery of patient care and accurate and effective service planning.

In common with all NHS Trusts and most health providers internationally, summary information about the Trust's provision of care is coded from clinical records of patients' diagnoses and treatments, by the Clinical Coding Department, in accordance with the International Classification of Diseases and the OPCS Classification of Interventions and Procedures. This coded information is submitted for external use, through the NHS's Secondary Uses Service, and is used locally by clinicians and managers to review and improve care provided. It is also used in transacting with the Trust's commissioners. In support of these requirements, the Trust is committed to pursuing a high standard of accuracy, completeness and timeliness within all aspects of data collection, in accordance with NHS Data Standards.

All staff are accountable for recording data accurately and are supported by training, guidance and feedback on an ad hoc basis and via internal and external audits. Regular monitoring of key data is undertaken and issues are addressed promptly. The Trust liaises closely with local CCGs on any data quality concerns they may have arising from their commissioner role or raised by GPs.

The Trust has a Data Quality Steering Group (DQSG), chaired by a Clinical Lead for Data Quality. The Trust's executive data quality lead is the Chief Medical Officer. The DQSG maintains a strategic overview of data quality issues within the Trust and facilitates better data quality from Ward to Board.

Worcestershire Acute Hospitals NHS Trust submitted the following number of records during 2016/17 to the Secondary Uses Service for inclusion in England's Hospital Episode Statistics.

- A&E records – 149,321
- Inpatient records – 178,294
- Outpatients records – 840,762

These are included in latest published national data. The accuracy and completeness of submitted data are reflected in key measures of the Trust's published data shown below:

Patient's NHS number was valid for:

- admitted patient care in 99.7% of records.
- outpatient care in 99.7% of records.
- accident and emergency care in 97.3% of records.

Patient's GP was valid for:

- admitted patient care in 100% of records.
- outpatient care in 100% of records.
- accident and emergency care in 100% of records.

Inpatient ethnic origin was valid for:

- admitted patient care in 95.8% of records

Whilst these figures are extremely encouraging, the Trust acknowledges that there is significant work remaining to ensure that data is complete and accurate.

Information Governance (IG) toolkit attainment

Each NHS Trust is required to assess the quality of the data it maintains and provides. Measured against the relevant standards contained in the NHS's Information Governance (IG) toolkit, the Trust achieved an overall score of 68%, remaining at a *satisfactory* level. The score against each standard equated to a minimum of level 2[6].

[6]https://www.igt.hscic.gov.uk/RequirementFullDetailsPrint.aspx?tk=399524890099532&lnv=6&cb=19%3A41%3A16&sAssId=9212&reqid=1510

3.19 Actions to maintain and improve data quality

Data Quality Steering Group (DQSG)

The DQSG monitors strategic data quality concerns, keeps a log of data quality issues and supports action arising from the data assurance element of the Information Governance (IG) toolkit assessments.

The Data Quality Steering Group is clinically led and is currently expanding its membership to include further clinicians, divisional leads and operational staff. There has been a substantive appointment to the post of Clinical Lead for Data Quality who chairs the group, and meetings are arranged bimonthly during 2017. The DQSG reports to the Information Governance Steering Group which, in turn, reports to the Trust Management Group, a Trust committee constituted within the Trust's governance framework. The Trust has recently appointed a dedicated data quality manager whose primary purpose is to lead delivery of the Trusts' operational and strategic data quality agenda.

Data Quality Kitemark

During 2015/16 the Trust introduced a quality kitemark to assure the quality of information used in its indicator sets. The kitemark awards one of three levels, Exemplary, sufficient or not sufficient, to six measures of data quality for any indicator. The kitemark records scores for granularity, timeliness, completeness, validation, source status and audit status. In 2016/17, the kitemarking assessment was rolled out to all Trust Board indicators and there is an ongoing programme to incorporate it in other, divisional dashboards. In this way, the Trust transparently demonstrates its degree of confidence in published data and assures the Trust board of information quality.

Data quality audits

A range of audits has been carried out by external auditors on behalf of the Trust to provide assurance regarding the accuracy and timeliness of its data. These include:

- *IG standard 506:* a continuous audit cycle. To meet the requirements of the IG toolkit standard 506, an auditor was employed by the Trust to conduct a continuous process of auditing electronic case notes against the Trust's patient administration system. This process is documented in the Data Quality Policy and reports are included as a standing agenda item for the Information Governance meeting. The findings are reported back to the Trust's clinical divisions as part of the IG reporting system.
- *IG standard 505:* Clinical Coding /IG audit. To meet the requirements of the IG toolkit's standard 505, a coding audit which included auditing 200 sets of case notes, was undertaken by an external coding auditor and the Trust's qualified coding auditor in January 2017. The table below shows the overall percentages of correct coding.

Coded data item	Percentage correctly coded
Primary diagnosis	91.2%
Secondary diagnosis	93.3%
Primary procedure	92.9%
Secondary procedure	94.2%

These percentages result in attainment of Level 2 of the IG toolkit for standard 505. This is an improvement on the results of the 2015 audit.

- *Internal audits of clinical coding.* A schedule of internal coding audits is in place and the coding auditor has conducted several clinical and staff audits.

Clinical involvement in improving coding quality is essential. The Clinical Coding Department is involved in the financial recovery programme, actively supported by a programme of clinical engagement. Additionally, over 200 key performance coding indicators (KPIs) have been introduced, ensuring a representative selection across a large range of diagnoses and treatments, and further indicators are to be put in place to assure the accuracy of patient data.

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3.20
Commissioning for Quality and Innovation (CQUIN) goals

Each year, the Trust is asked by commissioners to prioritise elements from a designated Commissioning for Quality and Innovation (CQUIN) framework, which is designed to promote improvement by linking a proportion of the Trust's income to the delivery of agreed quality goals. There are a number of national CQUIN schemes and a number of locally agreed CQUIN schemes. The content of local schemes is agreed between the Trust and the Clinical Commissioning Groups (CCGs) prior to the start of the financial year. These are then embedded in the Trust's contract.

In 2016/17, the Trust delivered CQUIN commitments as follows:

CQUIN Type	CQUIN		Aim	Year end expected performance
National	NHS staff and well- being	Induction of health and well-being initiatives	Improving staff health and well-being by introducing a range of physical activity and mental health initiative schemes, and improving access to physiotherapy services.	Achieved
		Healthy food for NHS staff, visitors and patients	Improve the health of the food offered on the premises.	Achieved
		Improving uptake of Flu vaccinations for front line staff	Achieving an uptake of flu vaccinations by front line clinical staff of 75%.	Achieved
	Timely identification and management of sepsis		Aimed at improving systematic screening for sepsis of appropriate patients in emergency departments (EDs) and in acute inpatient hospital services together with, where sepsis is identified, timely and appropriate treatment and cessation of treatment.	Not achieved
	Antimicrobial resistance and stewardship		Aimed at reducing total antibiotic consumption as well as to obtain evidence of antibiotic review within 72 hours of commencing an antibiotic.	Not achieved

CQUIN Type	CQUIN	Aim	Year end expected performance
Local Clinical Commissioning Group	Patient Flow - Implementation of AEC	To improve the use of AEC and increase the number of patients discharged home on the same day through greater understanding and resolving of the delays contributing to same day discharge.	Partially achieved
	Patient Flow - GP Assessment	Improve the assessment and review of GP patients accessing non-elective care.	Partially achieved
	Implementation of SAFER Bundle	Improving care co-ordination and standardisation of approach. Well-planned, informed and timely discharge thus supporting reduction of 'stranded patients'.	Not achieved
	Emergency Department Triage and Assessment	To improve the assessment, senior review and timely admission or discharge of patients accessing A&E.	Partially achieved
	Eating Disorder Pathway development	Developing an integrated eating disorders pathway and liaison protocol document, to be appended to the children's urgent mental health care protocol, and implemented.	Achieved
Specialised Commissioning Team	Adult Critical Care Timely Discharge £160,000	Reduce delayed discharges from ACC to ward level care by improving bed management in ward based care, thus removing delays in improving flow.	Not achieved
	Neonatal Unit Admissions £197,541	Reduce separation of mothers and babies and reduce demand on neonatal services by improving learning from avoidable term admissions into neonatal units.	Achieved
Local Area Team	CQUIN Baseline Data Collection	Establish reasons for participation and/or non-participation in a screening programme, through direct engagement with patients and the general public.	Achieved
	Promotion of Screening Programme	Encourage active promotion of screening programme.	Achieved
	Increasing access to screening for specific groups	Working with eligible people in specified priority group to improve access to screening.	Achieved
	Managed Clinical Networks (MCN)	Active involvement of secondary care clinical in their specialty MCN to review and improve pathways and outcomes for patients.	Achieved
	Secondary care clinical attachment in oral surgery	Develop and deliver a clinical attachment programme in oral surgery	Achieved

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3.21
2017/18 CQUIN Programme

The CQUIN framework for 2017/18 has been wholly nationally determined. Our programme has launched and leads are progressing with their plans for achieving the desired changes. Most CQUINs originated for the 2017/18 year extend over two years, encouraging attention to sustainable practice change. Progress will be closely monitored over the first quarter, allowing the Project Management Office (PMO) to provide early further support where needed and to escalate risks in good time if necessary.

CQUIN TYPE	CQUIN		Aim
National	Improving staff health and well-being	Improvement of health and well-being of NHS staff	Achieving a 5 percentage point improvement in two of the three NHS annual staff survey questions on health and well-being, MSK and stress.
		Healthy food for NHS staff, visitors and patients	Improving the health of food provided by increasing the percentage of sugar free drinks, decreasing the percentage of high calorie confectionery and decreasing the calorie and fat content of pre-packed sandwiches.
		Improving the uptake of flu vaccinations for front line staff within providers	Achieving an uptake of flu vaccinations by frontline clinical staff of 70%.
	Reducing the impact of serious infection	Timely identification of sepsis in emergency departments and acute inpatient setting	To embed a systemic approach towards the prompt identification and appropriate treatment of life-threatening infections.
		Antibiotic review	Reducing the chance of antibiotic-resistant strains of bacteria developing.
		Reduction in antibiotic consumption per 1000 admissions	
	Improving services for people with mental health needs who present to A&E		Reduce by 20% the number of attendances to A&E for those within a selected cohort of frequent attenders who would benefit from mental health and psychosocial interventions, and establish improved services to ensure this reduction is sustainable.

Part 3b: Statements of assurance from the Board and other statutory information

CQUIN TYPE	CQUIN		Aim
National continued...	Offering advice and guidance (A&G)		Set up and operate A&G services for non-urgent GP referrals, allowing GPs to access consultant advice prior to referring patients in to secondary care.
	NHS e-Referrals		Providers to publish ALL GP referrals to consultant-led 1st outpatient services and make ALL of their First Outpatient Appointment slots available on NHS e-Referral Service.
	Supporting proactive and safe discharge - Acute providers		Increasing proportion of patients admitted via non-elective route discharged from acute hospitals to their usual place of residence within 7 days of admission by 2.5% points.
Local Area Team	Screening	AAA Screening	Reducing socioeconomic gradient of uptake and ensuring equity of delivery for AAA screening.
		Bowel Screening	Increasing Bowel Cancer Screening uptake within priority groups, to include prisoner screening AND increase GP engagement in low uptake practices.
	Secondary Care Clinical Attachment in Oral Surgery		Decrease inappropriate referrals to secondary care providers of oral surgery services.
Specialised Commissioning Team	Hospital pharmacy transformation and medicines optimisation		Procedural and cultural changes required to fully optimise use of medicines commissioned by specialised services.
	Neonatal critical care community outreach		Improve community support and to take other steps to expedite discharge, pre-empt readmissions, and otherwise improve and care such as reduce demand for critical care beds and to enable reduction in occupancy levels.
	Paediatric Networked care		Alignment to the national PIC service review. It aims to gather information which allows the demand across the whole paediatric critical care pathway to be considered.

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3.22.
How we keep everyone informed

There are a number of communications channels used by WAHT to ensure colleagues based at our hospitals and out in the community are kept up to date on all the latest news and developments. The methods of reaching our staff include:

- the weekly e-bulletin
- GP bulletin
- the intranet
- screensavers, which are particularly useful for alerting staff to new initiatives or patient safety messages.

The Trust engages with members of the public and other organisations via its Worcestershire Acute Twitter feed and its Facebook page, sharing news of achievements with all followers. We publish a monthly newspaper, Worcestershire Way, for patients and carers, staff, visitors and volunteers and this is a great way to publicise upcoming events as well as to showcase and celebrate our staff and services.

A desktop wallpaper giving staff information about sepsis.

The front cover of our monthly newspaper

3.23
Statement of Directors' Responsibilities

The directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended by the National Health Service (Quality Accounts) Amendment Regulations 2012).

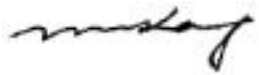
In preparing the Quality Account, directors are required to take steps to satisfy themselves that:

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

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

Caragh Merrick, Chairman

June 2017



Michelle McKay, Chief Executive

June 2017

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Appendix 1: Clinical Audit – participation details

National Confidential Enquiry into Patient Outcome and Death (NCEPOD)

Worcestershire Acute Hospitals NHS Trust participated in 100% of national enquiries for which it was eligible. The national confidential enquiries that Worcestershire Acute Hospitals NHS Trust participated in, and for which data collection was completed during 2016/17, are listed below alongside the number of cases submitted to each enquiry as a percentage of the number of registered cases required by the terms of that enquiry.

In addition the Trust has a robust clinical effectiveness work plan which incorporates an annual audit plan. The Trust is committed to undertaking local clinical audit and 379 local clinical audits were undertaken during 2016/17.

National Confidential Enquiry into patient Outcome and Death (NCEPOD)	% of cases returned
Mental Health	60%
Acute Pancreatitis	30%
Acute Non Invasive Ventilation	67%
Chronic Neurodisability	67%
Young People Mental Health	86%
Cancer in Children, Teens and Young Adults	No eligible cases

National Audits

The national audits that the Trust was eligible to participate in, together with participation status, are outlined below.

Eligible National Audits	Participation	Reason for non-participation
Acute coronary syndrome or acute myocardial infarction (MINAP)	Yes	
Adult Asthma	Yes	
Asthma (Paediatric and adult) care in emergency departments	Yes	
Bowel Cancer (NBOCAP)	Yes	
Cardiac Rhythm Management (CRM)	Yes	
Case Mix Programme (CMP)	Yes	
Coronary Angioplasty/National Audit of Percutaneous Coronary Interventions (PCI)	Yes	

Appendix 1: Clinical Audit - participation details

Eligible National Audits	Participation	Reason for non-participation
Diabetes (Paediatric) (NPDA)	Yes	
Elective Surgery (National PROMs Programme)	Yes	
Endocrine and Thyroid National Audit	Yes	
Falls and Fragility Fractures Audit Programme (FFFAP) - FLSD	No	The Trust does not have a fracture liaison database & is currently unable to participate in the audit.
Falls and Fragility Fractures Audit Programme (FFFAP) - NHFD	Yes	
Head and Neck Cancer Audit	Yes	
Inflammatory Bowel Disease (IBD) Programme	No	Unable to participate due to a lack of resource.
Learning Disability Mortality Review Programme (LeDer Programme)	N/A	Not yet rolled out to Worcestershire Acute NHS Trust.
Major Trauma Audit	Yes	
Maternal, Newborn and Infant Clinical Outcome Review Programme	Yes	
National Audit of Dementia	Yes	
National Cardiac Arrest Audit (NCAA)	Yes	
National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme	No	Unable to participate due to lack of available IT support. The Trust is exploring how this can be managed so that participation may re-commence.
National Comparative Audit of Blood Transfusion - Audit of Patient Blood Management in Scheduled Surgery	Yes	
National Diabetes Audit - Adults	Yes	
National Emergency Laparotomy Audit (NELA)	Yes	
National Heart Failure Audit	Yes	

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Eligible National Audits	Participation	Reason for non-participation
National Joint Registry (NJR)	Yes	
National Lung Cancer Audit (NLCA)	Yes	
National Ophthalmology Audit	No	Unable to participate due to lack of an IT system to collect data. Anticipate system will be in place and participation will commence late 2017/18.
National Prostate Cancer Audit	Yes	
National Vascular Registry	Yes	
Neonatal Intensive and Special Care (NNAP)	Yes	
Nephrectomy Audit	Yes	
Oseophago-gastric Cancer (NAOGC)	Yes	
Paediatric pneumonia	Yes	
Percutaneous Nephrolithotomy (PCNL)	Yes	
Radical Prostatectomy Audit	Yes	
Sentinel Stroke National Audit Programme (SSNAP)	Yes	
Severe Sepsis and Septic Shock - Care in Emergency Departments	Yes	
Specialist rehabilitation for patients with complex needs	N/A	The national team has confirmed Worcestershire Acute Hospitals NHS Trust is not required to participate as all data is already submitted to the Major Trauma Audit.
Stress and Urinary Incontinence Audit	Yes	
UK Cystic Fibrosis Registry	Yes	

Appendix 1: Clinical Audit - participation details

Note: We are developing a process for 2017/18 that will allow us to provide the % of cases submitted for national audits compared to the number of cases required by the terms of the audit. This information is unavailable for 2016/17.

There was no data collection from the National Audit teams during 2016/17 for the following audit;

- Rheumatoid and Early Inflammatory Arthritis

Worcestershire Acute Hospitals NHS Trust was not eligible to participate in the following national audits.

Ineligible national audits	Reason WAHT is ineligible
Adult Cardiac Surgery	Specialist Audit
Chronic Kidney Disease in Primary Care	Audit applies only to primary care.
Congenital Heart Disease (CHD)	Specialist Audit
Mental Health Clinical Outcome Review Programme	Specialist Audit
National Audit of Pulmonary Hypertension	Specialist Audit
Paediatric Intensive Care (PICA Net)	Specialist Audit
Prescribing Observatory for Mental Health (POMH-UK)	Specialist Audit
Renal Replacement Therapy (Renal Registry)	Specialist Audit

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The following have been selected as examples how services use the outcomes of clinical audit to improve the quality of services delivered.

Actions from National Audits that Worcestershire Acute Hospitals NHS Trust has taken or intends to take:

Audit Year	Title of National Audit	Action/ Improvement
2015/16	ID 153 NELA (National Emergency Laparotomy Audit)	Emergency Laparotomy Care pathway is now established and in use.
2016/17	Cardiac Rhythm Management (CRM)	Review data submission process to ensure completeness and accuracy.
2015/16	ID 618 National Heart Failure Audit	Ensure patients are seen within required timescales by appropriate specialist.
2015/16	ID 617 Coronary Angioplasty/National Audit of Percutaneous Coronary Interventions (PCI)	Compliant with standards.
2016/17	Coronary Angioplasty/National Audit of Percutaneous Coronary Interventions (PCI)	Standards met. No actions identified.
2015/16	ID 621 CORP Acute Pancreatitis	There has been now been established a nutrition ward round on which patients with pancreatitis may be assessed. NEWS is used Trust-wide and all patients presenting with pancreatitis are assessed using a severity scoring system (Glasgow). There is a "pure" gastroenterology service, to which referrals can be made for clinical input regarding inpatients.
2016/17	Bowel Cancer (NBOCAP)	Action plan in development.
2015/16	ID 395 Vital Signs in Children	Teaching sessions to ensure children presenting with medical illnesses have a full set of vital signs taken and documented within 15 minutes of arrival or triage. Also, those children with abnormal vital signs should have a further complete set taken and documented within 60 minutes.

Appendix 1: Clinical Audit - participation details

Audit Year	Title of National Audit	Action/ Improvement
2015/16	ID 417 VTE Risk in lower Limb Immobilization in Plaster Cast	Teaching sessions to ensure VTE assessments are completed.
2015/16	ID 654 VTE Risk in lower Limb Immobilization in Plaster Cast	Poster displayed in plaster room.
2015/16	ID 615 Diabetes - National Inpatient Audit	Training developed in safe prescribing for FY1 & 2 doctors. Update current insulin charts and in-house posters. Training nursing staff on high-strength insulins and training of ward diabetes link nurses.
2016/17	Falls and Fragility Fractures Audit Programme (FFFAP) - Falls Audit	Designate a board member to be responsible for falls prevention. Increase and maintain falls training Review bed rails assessment Establish Falls Prevention Group.
2015/16	National Comparative Audit of Blood Transfusion - Audit of Patient Blood Management in Scheduled Surgery	Worcestershire Acute Trust's performance was in the top third of hospitals in comparison with other participating hospitals.
2016/17	Neonatal Intensive and Special Care (NNAP)	The Trust's results were very good and better than the national average, except giving mother's milk at discharge. Actions include encouraging mothers about breastfeeding/EBM in the neonatal unit, and considering giving EBM up to discharge to babies who are on EBM in the neonatal unit.
2015/16	ID 627 UK Parkinson's Audit	Development of evidence based documents library. Update of Parkinson's outcome measures folder and staff training.
2016/17	MBRRACE-UK (Mothers and Babies - Reducing Rick through audits and Confidential Enquiries Across the UK)	Action plan in development.
2015/16	ID 160 Diabetes Paediatrics (NPDA)	We have improved our data capture and our care processes this year again. We are able to dedicate more time to newly diagnosed patients.

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Audit Year	Title of National Audit	Action/ Improvement
2015/16	ID 570 BTS Paediatric Asthma Audit 2015	Steroids within a 60 minute timeframe Standard refers to severe / life threatening episodes receiving steroids within 60. Clearly achieving this. Good practice that, if indicated, the majority of steroids are given within a timely manner Discharge with asthma plan and inhaler technique checked. Improvement needed on documentation, especially removing the phrase "reducing dose regime". Good inhaler technique and knowledge of asthma plan being seen in Outpatients. Updated asthma stamp with discharge information to be reintroduced on ward following audit.
2015/16	ID 755 End of Life Care Audit 2015 NCAPOP	End of Life Care working group to be established SAGE & THYME training provided.
2015/16	ID 99 BTS National Emergency Oxygen Audit	Oxygen education training is to be included in mandatory training days. NEW charts to be reviewed with addition of a space for target saturations Explore options for oxygen prescription changes.
2015/16	ID 608 COPD - Pulmonary Rehab	Waiting list reviews completed monthly. Assessment process reviewed.
2015/16	ID 624 National Cardiac Arrest Audit	Reviewed 'unexpected non-survivors' at Resuscitation Committee.
2016/17	National Prostate Cancer Audit	Action plan in development.

Local Clinical Audits

During 2016/17 Worcestershire Acute Hospitals NHS Trust undertook 379 local clinical audits.

The table below shows the actions from Local Clinical Audits that Worcestershire Acute Hospitals NHS Trust has taken to improve the quality of healthcare provided for the 57 audits that were completed during 2016/17. 'Completed' is defined as audit completed and all actions closed.

ID No	Audit Title	Division	Actions/Improvements
1137	Audit of feedback received from social care following a referral being made	Corporate	New Family Front Door referral process developed and training updated.
1225	Vital Signs in Children in WRH ED	Medicine	Better SHO awareness of the guidelines and best practice Education of nurses regarding the importance of vital signs in paediatric patients.
1202	Monitoring Glucose in NSTEMI and STEMI patients	Medicine	Posters placed on ward to increase awareness of need to obtain glucose results. Previous poster campaign achieved positive results.

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ID No	Audit Title	Division	Actions/Improvements
1179	Severe sepsis and septic shock	Medicine	Triage nurse training – complete observations must be recorded upon arrival Further training of doctors in ED – reiterate importance of full documentation of their grade and timings (especially of blood cultures) Continued induction for new doctors at changeover periods. Improve awareness of sepsis – posters in department, departmental teaching session with focus upon urine output measurement and senior review. Continued emphasis on sepsis proforma use trust-wide and use of NEWS escalation stickers. Further nursing training re: accurate NEWS calculation and reassessment. Increase frequency of NEWS reassessment (e.g. patients awaiting a cubicle in ED) to avoid sepsis developing and delays in antibiotic administration. Further teaching on urine output measurement/fluid balance – include fluid balance charts within ED notes and that these are accurately completed. Encourage earlier senior review and referral (e.g. to medical on-call team).
1120	Safeguarding of Children - Re-audit	Medicine	Audit results cascaded and ongoing monitoring taking place with a twice-yearly re-audit in place.
1111	TIA- are we following the NICE guidelines?	Medicine	Awareness-raising of the use of the TIA proforma, with doctors.
1109	Safe Guarding of Children Re-audit	Medicine	Audit results cascaded and ongoing monitoring taking place with a twice-yearly re-audit in place.
1051	Statin use among HIV-positive patients at Worcestershire Royal Hospital	Medicine	Review of patients missing a statin, who qualify, to HIV Multidisciplinary meeting.
981	Re-Audit of Nasogastric Tube Insertion and Safety Record	Medicine	Develop teaching for Junior Doctors.

Appendix 1: Clinical Audit - participation details

ID No	Audit Title	Division	Actions/Improvements
970	BHIVA Audit Re Late Diagnosis	Medicine	Standard achieved 100%. No actions identified.
888	BTS Audit on smoking cessation	Medicine	Smoking cessation service no longer in place.
862	Anticoagulation after stroke due to Atrial Fibrillation/Atrial flutter - Re-Audit	Medicine	Add to Bluespier a compulsory field to explain the secondary stroke prevention strategy selected.
777	Coronary Angioplasty/National Audit of Percutaneous Coronary Interventions (PCI) - Re-Audit	Medicine	Standards met. No actions identified.
1319	Appropriate Group and Screen requests for elective Urology patients - Re-Audit	SCSD	Potential saving to trust £20,000 per year plus staff time, patient time, comfort. No harm demonstrated from change.
1265	Is Tocilizumab for People with Rheumatoid Arthritis being used in accordance with NICE TAG375	SCSD	All patients with RA receiving Tocilizumab to be registered on Blueteq to provide assurance and safeguard against delayed clinical response reviews.
1221	Audit into the utilisation of RSI checklists for intubations outside theatres at WRH and ALX	SCSD	Improvement in patient safety, ensuring correct equipment and procedure for out-of-theatre intubations, and help guide trainees who find themselves in an unfamiliar environment.
1164	Obstetric Anaesthetic Complications and Practice Audit	SCSD	Implement protocol for PDPH F/U – info leaflet, phone call, clinic appointment, standard GP letter.
1149	Audit of Haematology 2 week waits	SCSD	Dissemination of audit results to enable review of referrals from all specialties.
1131	Re-audit of time to trauma CT in ED	SCSD	Implement blood tracker to enable greater audit trail.
1128	Prevention of retention of nasopharyngeal packs: Re-audit of Trust Policy - Re-Audit	SCSD	Audit shows full compliance with Trust throat pack policy ensuring patient safety.
1110	An audit of the anaesthetic pre-operative visiting for elective surgical patients	SCSD	Patients generally find anaesthetic service excellent, with privacy being the weakest aspect in the opinion of those surveyed.
1085	National Comparative Audit of Blood Transfusion - Audit of Patient Blood Management in Scheduled Surgery - Re-Audit.	SCSD	Worcestershire Acute Trust's performance was in the top third of hospitals in comparison with other participating hospitals.

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ID No	Audit Title	Division	Actions/Improvements
1076	Audit of CEPOD theatre utilisation times	SCSD	Communicated to surgeons and theatre staff involved with booking CEPOD cases that documenting urgency and ASA status is mandatory. Discuss with IT whether 'Urgency' can be made a mandatory field when booking a case.
1020	Audit of thyroid fine needle aspiration: diagnostic accuracy	SCSD	Compliance met. Re-audit.
1006	Electronic Anaesthetic Chart Availability Audit	SCSD	Encourage anaesthetists to report occasions where they are unable to find previous anaesthetic charts on EZ Notes - via QIM and follow up. Request that midwives file observations' anaesthetics charts in patient Obstetric notes folder before returning patient to ward. Liaise with IT to create QR code for Obstetric Anaesthetic charts. Print new charts with QR code included and distribute. Encourage anaesthetists to only use charts with QR code, destroy any old charts.
917	Audit of compliance with Adult Acute Pain Guideline regarding removal of epidural catheters	SCSD	The Trust has demonstrated a clear improvement in removing epidural catheters as per the guidance. Therefore the Trust will continue to use the new dressing for the foreseeable future.
916	Bone Marrow Trephine Audit	SCSD	No concerns regarding trephine processing but ongoing monitoring to take place.
914	Prostate Cancer: Utilisation of MRI in Diagnostic Pathway, New NICE 2014	SCSD	Audit results confirmed compliance with standards.
853	Outcomes for new prep for iodine allergic patients	SCSD	Implementation of the use of Ophthalmic Chlorhexadine Gluconate 0.02% for iodine allergic patients.
790	Re-audit of adequacy of post discharge tonsillectomy pain relief	SCSD	Anaesthetists to continue prescribing paracetamol and ibuprofen 10mg/kg tds for all patients without contra-indication. Reassure parents every time regarding safety and effectiveness of oramorph.
771	ED Airway equipment on the WRH Site	SCSD	Standardise stock so that bougie brand matches across the trust.
760	National Clinical Audit of Rheumatoid and Early Inflammatory Arthritis - Re-Audit	SCSD	Since 16th June 2016 a specialist EIA clinic has been running on a Thursday morning at WRH as per the service specification. A CNS clinic was established on the 7th July and runs in parallel with the consultant clinic. Currently the clinic is run by a single consultant with ST doctor support. A designated EIA referral proforma has been disseminated to the South Worcestershire GPs and embedded in the EMIS system. Referral is currently by FAX. A database has been established collecting outcome data for the new EIA clinic.

Appendix 1: Clinical Audit - participation details

ID No	Audit Title	Division	Actions/Improvements
671	An Audit of Anaesthetic Equipment Availability	SCSD	Necessary equipment for patient safety now present, bringing department up to ACSA standards. Equipment standardised across Trust and will therefore be more familiar to anaesthetists and in line with local and national teaching for the emergency management of failed intubations.
670	An Audit of Anaesthetic Equipment Checks	SCSD	Increased awareness of importance of machine checks and documentation Greater awareness of guideline and confirmation of machine readiness for afternoon list.
581	Retrospective audit of the departmental use of plain abdominal radiographs in the clinical setting of abdominal pathology	SCSD	Potential reduction in the number of plain abdominal radiographs done in the setting of acute abdominal presentations.
533	A Retrospective Study of the Identification of Tumour Position in Correct Segment Within the Bowel Cancer Screening Programme	SCSD	Re-audit scheduled to re-assess compliance.
1211	Electronic Filing of PSA Results	Surgery	Ensure Duty of Candour met.
1167	Trust Phototherapy Department Annual Audit	Surgery	Grade referrals as urgent and standard. Referrals within 3 weeks to start treatment. Continue to work with E-consenting team to achieve E-consenting for all referrals. Signs up in phototherapy areas advising patients to wear footwear at all times and such advice to appear on E-consenting forms. Two timers to be used to time patients soaking in bath psoralen.
1140	Surgical Notes Documentation	Surgery	Sticker has been amended and implemented.
1126	Readmission in Urology	Surgery	Schedule re-audit.
1037	BAUS Ureteroscopic stone surgery Audit - Re-Audit	Surgery	Results demonstrated that there is a generally good compliance to BAUS standards of surgical outcome comparatively. Accordingly, WAHT are performing more Flexible Ureteroscopy for larger and more complex renal stones.
1011	Evaluating the adequacy of Consenting Operative Orthopaedic Patients	Surgery	Improvements made as a result of the audit is that staff are more aware of the gaps in the consenting process, and a poster with the key points has been mounted in the orthopaedic doctors' room.

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ID No	Audit Title	Division	Actions/Improvements
1009	Mitomycin C after TURBT	Surgery	Re-audit to take place.
710	Impact of ICE Electronic Results in Urology	Surgery	Cyto/Histopathology request needs to be made electronic.
681	Outcomes and complications of TURP	Surgery	Standards met. No action identified.
598	Outcome of Patients with Pathological Nodal Involvement following Radical Prostatectomy	Surgery	Participation in national mandatory audit.
126	BAUS Nephrectomy Audit	Surgery	Good compliance. Continue participation in national audit and monitor compliance.
1312	Do we write enough information about a procedure in the surgical operation note - Is it satisfactory to the standards of the Royal College of Surgeons?	Surgery	Better communication with staff post-operatively after an operation.
1127	Check X-Ray adequacy following total hip replacements and hemiarthroplasty	Surgery	We have improved the adequacy of post-operative check x-rays from 81% of patients have adequate x-rays (against the British orthopaedic guidelines) to 93% of patients.
859	Prescription of Intravenous Fluids in adult patients	Surgery	NICE guidance as printed sheets on all inpatient IV fluid prescription charts. Mandatory Teaching session to Junior doctors at induction.
1242	Post-partum voiding problems	Women & Children	Better postnatal and bladder care for women, and increase compliance with NICE guideline.
1216	SBAR Handover	Women & Children	Better use and documentation of SBAR.
835	Screening Audit	Women & Children	To commence a yearly rolling audit for screening documentation.
708	Elective caesareans at Worcestershire Royal Hospital	Women & Children	Standards met. No actions identified.
553	IUGR Audit	Women & Children	Standards met. No actions identified.

Appendix 1: Clinical Audit - participation details

ID No	Audit Title	Division	Actions/Improvements
508	Management of Jaundice in Neonate	Women & Children	Phototherapy is being started and stopped according to NICE guidelines and babies are being treated according to NICE guidelines
112	Re- audit of 3rd and 4th degree tears	Women & Children	Ongoing improvement and reduction of 3rd/4th degree tears overall.

Appendix 2: Detailed CQC ratings for Worcestershire Acute Hospitals NHS Trust

These ratings were issued in December 2015. Plans to improve can be found in Part 2 of this document.

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall Trust	Inadequate	Requires improvement	Good	Requires improvement	Inadequate	Inadequate

Ratings for Worcestershire Royal Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and Emergency Services	Inadequate	Good	Good	Requires improvement	Requires improvement	Requires improvement
Medical Care	Requires improvement	Requires improvement	Good	Requires improvement	Inadequate	Requires improvement
Surgery	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Critical Care	Good	Good	Good	Requires improvement	Good	Good
Maternity and Gynaecology	Inadequate	Requires improvement	★ Outstanding ★	Requires improvement	Inadequate	Inadequate
Services for children and young people	Inadequate	Requires improvement	Good	Good	Inadequate	Inadequate
End of life care	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Requires improvement	Not rated	Good	Requires improvement	Inadequate	Requires improvement
Overall	Inadequate	Requires improvement	Good	Requires improvement	Inadequate	Inadequate

Appendix 2: Detailed CQC ratings for Worcestershire Acute Hospitals NHS Trust

Ratings for Alexandra Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and Emergency Services	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Medical Care	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Surgery	Inadequate	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Critical Care	Good	Good	Good	Requires improvement	Good	Good
Maternity and Gynaecology	Inadequate	Requires improvement	★ Outstanding ★	Requires improvement	Inadequate	Inadequate
Services for children and young people	Inadequate	Requires improvement	Good	Good	Inadequate	Inadequate
End of life care	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Inadequate	Not rated	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Inadequate	Requires improvement	Good	Requires improvement	Inadequate	Inadequate

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Ratings for Kidderminster Hospital and Treatment Centre

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and Emergency Services	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Medical Care	Good	Good	Good	Good	Good	Good
Surgery	Good	Good	Good	Requires improvement	Good	Good
Maternity and Gynaecology	Good	Not rated	Good	Requires improvement	Requires improvement	Requires improvement
Services for children and young people	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Outpatients and diagnostic imaging	Requires improvement	Not rated	Good	Requires improvement	Inadequate	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Ratings for Evesham Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging						
Overall	Good	Good	Good	Good	Good	Good

Appendix 3: External opinions - what others say about this quality account

Worcestershire Health Overview and Scrutiny Committee (HOSC) and Worcestershire Health and Wellbeing board have not submitted comments due to general election purdah.

Worcestershire CCGs

The response detailed below is a collective response from the three Clinical Commissioning Groups (CCGs) in Worcestershire. (NHS South Worcestershire CCG, NHS Wyre Forest CCG and NHS Redditch & Bromsgrove CCG). All three CCGs welcome the opportunity to comment on the 2016/17 Quality Account for Worcestershire Acute Hospitals NHS Trust.

During 2016/2017 the Trust has faced a number of significant challenges which have impacted upon their ability to make and sustain quality improvements across the organisation. It is acknowledged that the Trust is working to address these issues however progress has been slow which is reflected throughout the Quality Account and demonstrated by the Trust's failure to fully achieve any of the quality priorities that were set for 2016/17. It is also acknowledged that despite the work undertaken, performance across a number of specialties including stroke, cancer and dermatology has been unacceptable and significant concerns still remain in relation to the performance and sustainability of some services, workforce capacity and patient flow through the Trust.

The CCGs acknowledge the frank and honest appraisal made by the new Chief Executive Officer within the Quality Account, particularly in relation to the key concerns and challenges the Trust faces. The CCGs also concurs with her observation that whilst there is reason to be optimistic about making the prerequisite changes to improve quality that this is not guaranteed and will require significant time, focus and resource to achieve.

Commissioners support and welcome the specific priorities for 2017/18 to improve on patient safety, patient experience and clinical effectiveness which the Trust has highlighted in the Quality Account. All are appropriate areas to target for continued improvement and build on the achievements in 2016/2017. However given the limited progress seen against the targets set in 2016/17 the Trust should consider how they intend to ensure the monitoring processes are more robust this year in order to prevent a recurrence.

Our view is that the Quality Account is largely presented in a clear and easy to read format. It includes all essential elements, incorporates national presentation guidance and to the best of our knowledge appears to be factually accurate. The Quality Account is intended to help the general public understand how their local health services are performing. With that in mind it is recommended that the Trust reviews the Quality Account in relation to grammatical accuracy and whether some of the sections are written in plain English which can be understood by the general public.

The CCGs will continue to work collaboratively with the Trust monitoring quality improvements on a monthly basis, through the Clinical Quality Review Meetings. The CCGs will also continue to undertake Quality Assurance visits to enable the Trust to showcase improvements and identify areas on which to focus improvements and embed learning Trust wide.

Overall Commissioners are happy to accept this Quality Account as an accurate and fair reflection of the Trusts quality profile. The

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CCGs look forward to continuing to work in partnership with the newly appointed Executive team during 2017/18, and developing relationships to support the Trust in their vision of providing safe, high quality compassionate care to all patients.

Healthwatch Worcestershire

Does the draft Quality Account reflect people's real experiences as told to local Healthwatch by service users and their families and carers over the past year?

The Quality Account reflects the patient experience that has been told to, and observed by Healthwatch Worcestershire during the past year. During the course of the year both the interim Chair and new permanent Chair have acknowledged the poor performance of the Trust and expressed their personal commitment to address safety and quality issues that have been identified by the Care Quality Commission to improve patients experiences.

Whilst the focus is necessarily on improvement it must be acknowledged that many patients report very positive experiences, such as those associated with experience of the temporary arrangements for maternity which were introduced for safety reasons have attracted praise and appear to have been well received.

From what people have told local Healthwatch, is there evidence that any of the basic things are not being done by the provider?

The Trust has been in Special measures since the CQC reported on its inspection of the Trust in 2015. The reports that people have made to Healthwatch during the year under review have supported the CQC's judgement of the Trust.

In February and March 2017, in response to reports of patients experiences of being cared for in the corridors of the Trust's Accident and Emergency Departments, Healthwatch Worcestershire made unannounced visits to those departments to speak to patients about their experiences of being cared for in a corridor. The report, with 38 recommendations has been shared with the Trust will be published in June 2017. The report evidences basic things that are not being done by the Trust in the A&E Department at the Worcester Royal Hospital.

The Quality Account appears to provide an honest assessment of the situation and establishes a bench mark for improvement.

Is it clear from the draft Quality Account that there is a learning culture within the provider organisation that allows peoples real experience to be captured and used to enable the provider to get better at what it does year on year?

Since the Trust was placed in special measures there is evidence of the Trust seeking to put in place arrangements for continuous learning. This has included a number of iterations of a Patient Care Improvement Plan which have not delivered the planned outcomes. Healthwatch notes the Chief Executive's plans to pursue a culture change program across the Trust.

As Healthwatch identified in our response to the Trusts 2015/16 Quality Account there is still limited evidence that any learning culture extends to learning from patient experience. There is an opportunity for the Trust to involve and engage with public, patients, carers and service users in a much more co-produced and co-designed way. Healthwatch therefore welcome the recent commitment to

revising the arrangements for public/patient involvement across the Trust and will be monitoring progress in 2017/18.

Are the priorities for improvement challenging enough to drive improvement and is it clear how improvement has been measured in the past and how it will be measured in the future?

Healthwatch Worcestershire, as the independent public/patients champion has been given oversight of the arrangements that have been put in place to monitor the quality and safety of services and their improvement.

These arrangements bring together a number of organisations including NHS Improvement, NHS England, Worcestershire's Clinical Commissioning Groups and the Care Quality Commission to support improvement.

The Quality Account sets out challenging priorities for improvements in quality which the public expect to be delivered at pace.

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Independent Auditor's Limited Assurance Report to the Directors of Worcestershire Acute Hospitals NHS Trust on the Annual Quality Account

We are required to perform an independent assurance engagement in respect of Worcestershire Acute Hospitals NHS Trust's Quality Account for the year ended 31 March 2017 ("the Quality Account") and certain performance indicators contained therein as part of our work. NHS trusts are required by section 8 of the Health Act 2009 to publish a quality account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010, the National Health Service (Quality Account) Amendment Regulations 2011 and the National Health Service (Quality Account) Amendment Regulations 2012 ("the Regulations").

Scope and subject matter

The indicators for the year ended 31 March 2017 subject to limited assurance consist of the following indicators:

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

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

Respective responsibilities of directors and auditors

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

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

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

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

Appendix 3: External opinions - what others say about this Quality Account

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

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

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

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

- Board minutes for the period 1 April 2016 to 30 June 2017;
- papers relating to quality reported to the Board over the period 1 April 2016 to 30 June 2017;
- feedback from the Commissioners dated 16/06/2017;
- feedback from Local Healthwatch dated 28/06/2017;
- the Trust's complaints report published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009, dated 09/06/2017;
- the latest national patient survey dated 31/05/2017;
- the latest national staff survey dated 07/03/2017;
- the Head of Internal Audit's annual opinion over the Trust's control environment dated 26/05/2017;
- the annual governance statement dated 26/05/2017; and
- the Care Quality Commission inspection report dated 20/06/2017.

We did not test the consistency of the Quality Account with feedback from the local overview and scrutiny committee involved in the sign off of the Quality Account as the draft Quality Account was sent to them for comment, in accordance with the timetable specified in the Regulations, but no response has been received at the time the quality accounts were signed. We have considered the consistency with the other specified documents and are satisfied that there is no material risk of misstatement arising from this omission.

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

This report, including the conclusion, is made solely to the Board of Directors of Worcestershire Acute Hospitals NHS Trust.

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

Assurance work performed

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

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

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

Limitations

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

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

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

In addition, the scope of our assurance work has not included governance over quality or nonmandated indicators which have been determined locally by Worcestershire Acute Hospitals NHS Trust.

Basis for qualified conclusion

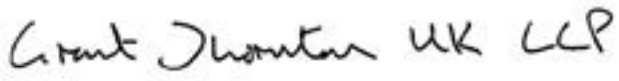
The indicator reporting the "percentage of patients risk-assessed for VTE" did not meet the six dimensions of data quality in the following respects:

- Accuracy and Validity: in our testing of 40 admissions we identified four cases where there was no evidence that a VTE assessment had been completed, although the Trust had reported it as being undertaken.

Qualified conclusion

Based on the results of our procedures, with the exception of the matter reported in the basis for qualified conclusion paragraph above, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2017:

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



Grant Thornton UK LLP
The Colmore Building, 20 Colmore Circus,
Birmingham, B4 AT.
30 June 2017

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Acknowledgements and feedback

Acknowledgements

Worcestershire Acute Hospitals NHS Trust wishes to thank its entire staff, the contributors to this Quality Account and our external stakeholders who have provided commentaries on it.

Feedback

Readers can provide feedback on the report and make suggestions for the content of future reports to the Communications Department.

Communications
Worcestershire Acute Hospitals NHS Trust
3 Kings Court
Charles Hastings Way
Worcester
WR5 IDD
01905 760 453
wah-tr.Communications@nhs.net

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