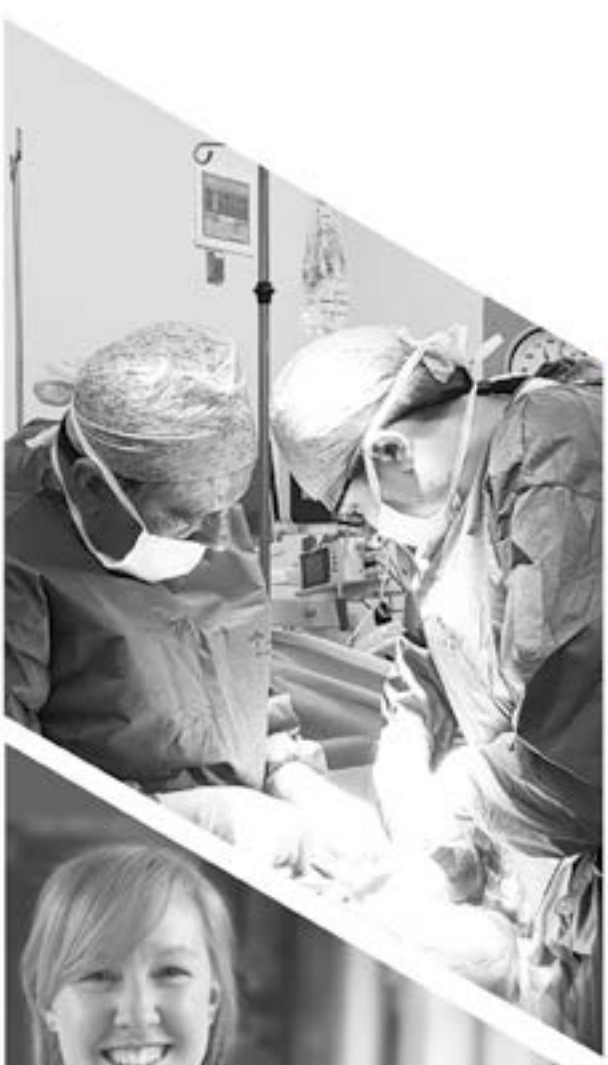
NHS

Worcestershire Acute Hospitals

NHS Trust



Quality Account

2018/2019

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 760453
wah-tr.Communications@nhs.net

Contents

Part 1: Welcome from our Chief Executive

Of the many documents our Trust is required to publish each year, this Quality Account is one of the most important and most relevant.

Our aim is to ensure that we work together across the Trust, in partnership across our health and care system and hand in hand with our patients and carers as we strive to continuously improve the quality, safety and sustainability of the services we provide.

This report provides a valuable opportunity to look back on the past year, reflect on our successes and progress and make a frank assessment of where we need to focus our efforts through the year ahead, and the major challenges we continue to face.

The need for the Trust to continue its journey of quality improvement, as well as sustaining improvements that have been made, have been an overarching priority throughout 2018/19.

Though, at the time of writing this Quality Account, the Trust remains in 'special measures', through our Quality Improvement Strategy and People and Culture Strategy we have started to see real progress on delivering both quality and culture change improvements across our hospitals.

Of particular note is the progress we have made to reduce hospital acquired pressure ulcers, the number of falls resulting in serious harm, and mortality of patients with sepsis. We've also seen a reduction in the number of medicines incidents, made significant improvements to maintain patient privacy and dignity and have met our targets for responding to and learning from complaints.

But better never stops.

Areas for continued focus in the months ahead to ensure we provide care that is safe, clinically effective and provides a positive experience for

Matthew Hopkins
Chief Executive

our patients and their carers includes improving sepsis screening, and ensuring patients and their families are fully involved in their discharge and understand their condition, treatment and pain management options – as well, of course, as continuing our improvement journey in the areas where we have seen progress.

A number of significant service changes – including the transfer of our frailty service to the Alexandra Hospital, and the opening up of additional beds - have had a positive impact on the quality of care we have been able to provide for our patients. We've also committed to, and seen, an improvement in our data quality, to ensure we have good, timely, reliable and easily accessible information that can provide insights into the safety, quality, efficiency and effectiveness of our services.

Our urgent care pathway has been, and remains, challenging but robust recovery plans are in

place to ensure we improve our performance on the Emergency Access Standard and ambulance handover figures.

We would like to put on record our thanks to all our staff and volunteers for their continued commitment and professionalism, and assure our partners, inspection and regulatory bodies, and wider communities of our commitment to our improvement journey and achieving our purpose of Putting Patients First.

Matthew Hopkins
Chief Executive

1.1

About this account

Every year all NHS hospitals in England must write an account for the public about the quality of their services. This is called a quality account. A quality account makes Worcestershire Acute Trust more accountable to you, the public, and drives improvement in the quality of our services.

Quality in our health care is made up of three dimensions:

- Care that is safe
- Care that is clinically effective
- Care that is a positive experience for our patients, their carers and the community we serve.

This account informs you how well we did against the quality priorities and goals we set ourselves for 2018/19 (last year). It sets out the priorities we have agreed for 2019/20 (this year), and how we plan to achieve them. It also contains an overview of our quality performance based on mandated and locally chosen indicators.

1.2

Who we are and what we do

Worcestershire Acute Hospitals NHS Trust (WAHT) was formed on 1 April 2000 following the merger of Worcester Royal Infirmary NHS Trust, Kidderminster Healthcare NHS Trust, and Alexandra Healthcare NHS Trust. Facilities are distributed across the three sites:

- Alexandra General Hospital, Redditch
- Kidderminster Hospital and Treatment Centre, Kidderminster
- Worcestershire Royal Hospital, Worcester

In addition, it operates services from three Community Hospitals Princess of Wales Community Hospital, Evesham Community Hospital and Malvern Community Hospital. The Trust has 954 beds, nearly 6,000 employees and has an annual income of over £400 million.

The Trust provides a range of acute services for the people of Worcestershire. This includes general surgery, general medicine, emergency care and women and children's services. There are a range of support services as well, including diagnostics and pharmacy.

The Trust predominantly serves the population of the county of Worcestershire with a current population of almost 580,000, providing a comprehensive range of surgical, medical and rehabilitation services. This figure is expected to rise to 594,000 by 2021; taken as a whole, the Trust's catchment population is both growing and ageing. Both the male and female population shows a projected increase from 2014 to 2025 in the older 70 plus age groups. This is especially apparent in the 75-79 age range, although proportionally the projected rise in the 90 plus age range is higher. The forecast increase in numbers of older people is due to increased life expectancy resulting in greater numbers of older people, particularly females, surviving to very old age (ONS, 2010). We note from national statistical data that the number

of older people with dementia is expected to double in the next 20 years. Of note, the rate of population growth is greatest in the very old age groups who present the greatest requirements for 'substantial and critical' care. Worcestershire has proportionally a greater number of older people than the nation in general.

The Trust's catchment population extends beyond Worcestershire itself, as patients are also attracted from neighbouring areas including South Birmingham, Warwickshire, Shropshire, Herefordshire, Gloucestershire and South Staffordshire. This results in a catchment population which varies between 420,000 and 800,000 depending on the service type. Referrals from GP practices outside of Worcestershire currently represent some 13% of the Trust's market share.

The majority of services are commissioned by three local Clinical Commissioning Groups (CCG):

- South Worcestershire CCG
- Redditch and Bromsgrove CCG
- Wyre Forest CCG

In addition, some specialist services are commissioned regionally by Specialised Commissioners accounting for 15% of income.

We work in partnership with a wide range of organisations for the delivery and planning of health services. The main statutory bodies include:

- Worcestershire Health and Care Trust
- West Midlands Ambulance Service
- Voluntary organisations such as The Haven, Age Concern
- Worcestershire County Council
- University Hospitals Coventry and Warwickshire NHS Trust

In 2018/19 we provided care to more than 231,448 different Worcestershire patients – that is 40% of the Worcestershire population received care at one of our hospitals.

A YEAR IN NUMBERS 2018/2019

143,429
Walk-in patients (A&E)

51,619
Patients arriving by ambulance

152,712
Inpatients

641,486
Outpatients

5,261
Births

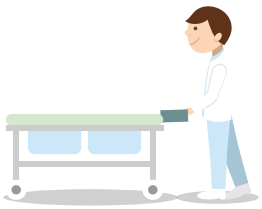
4,120
Emergency Operations

24,242
Elective Operations

1,848
Trauma Operations

6.7 days
Average length of stay

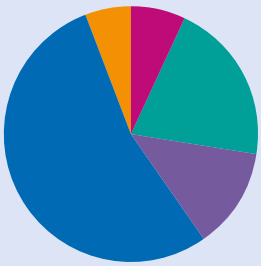
522,615
Number of meals served



2,505,646
Number of sheets laundered

£47m
Value of prescriptions issued

Diagnostics



- MRI scans - **23,278**
- Non-obstetric ultrasound scans - **72,443**
- CT scans - **50,204**
- Plain film X-Rays - **218,729**
- Endoscopies - **28,660**

Staff

Total Staff
5,283

Nurses
1,464

Doctors
324

Consultants
283

Allied Health Professionals
364

Midwives and Midwifery Support Workers
253

Other Support Staff*
2,595

Volunteers
436

*includes Scientists, professional and technical, estates and ancillary, student nurses and admin and clerical

State-of-the-art technology transforms Cardiac procedures at Worcestershire's hospitals

Patients suffering heart rhythm conditions in Worcestershire are benefitting from new state of the art technology which can rapidly map their heart's structure, allowing cardiologist to pinpoint problems quicker and more accurately.

Patients with heart rhythm disturbance benefit from catheter ablation procedures, which involve inserting thin wire catheters into the groin and up to the heart. Electrodes on the catheters help to identify the cause of the heart rhythm problem. Once identified, the doctor can place one of the catheters at the location of the problem and remove the undesirable tissue. This type of procedure is widely performed using X-ray.

The Carto® 3 imaging system newly in use at Worcestershire Acute Hospitals NHS Trust utilises electromagnetic fields to create three-dimensional images of patients' cardiac structures. With the use of this new system cardiologists can rapidly create a map of the heart to ensure accurate, real-time visualisation of the heart and wire catheters inside.

It allows a much more detailed view, allowing cardiologists to pinpoint the exact location and orientation of catheters in the heart. As a result, there is an increased success rate following the procedure and lower radiation dose for both patient and operator.

Pictured: Consultant Cardiologist and Electrophysiologist, Dr Bashar Aldhoon, team and patient Isobelle Batkin

Part 2: Our commitment to quality

The essence of our Trust is to provide compassionate, high-quality patient care and support for carers and families.

Worcestershire Acute Hospital NHS Trust's mission is to ensure we provide a high-quality health service that exhibits three key components of patient safety, clinical effectiveness and patient and carer experience. All three are achieved through our ability to exhibit a caring culture and professional commitment with strong leadership, services that are organised to meet patient need and that a positive staff experience.

2.1

Registration with the CQC

The Care Quality Commission (CQC) is the independent regulator of all health and social care services in England. Its job is to make sure that care provided by hospitals, dentists, ambulances, care homes and services in people's own homes and elsewhere meets government standards of quality and safety.

Since July 2015, there have been nine announced inspections undertaken of Worcestershire Acute Hospitals Trust; a number of unannounced Core Service inspections and two focused 'Is it Safe' inspections of our Urgent Care Services. At the time of drafting this Quality Account, the overall rating for the Trust remains as 'inadequate' as per the most recent 'Trust-wide' report issued in June 2018.

Between 23 January and 22 March 2018, the CQC visited the Trust to inspect six core services; Urgent Care (including Minor Injuries Unit), Surgery, Maternity, Children and Young People, Outpatient and Diagnostics. A review of the 'Well-led' Domain was also conducted. The inspection report published in June 2018 identified the following as outstanding:

- The Meadow Birth Centre won the MaMa 2017 national birth centre of the year award, in recognition of its outstanding health care environment. Feedback from women who had had their baby in the birth centre was overwhelmingly positive, and staff were often described as having gone "the extra mile".

- The service was especially caring and responsive to parents who had suffered a pregnancy loss, such as miscarriage, stillbirth or neonatal death. They were committed to continually improving the care and services they provided for bereaved parents and had recently raised over £50,000 in charitable donations for a second bereavement suite.

- All healthcare support workers in the MIU were enrolled on a Care Certificate course. This is a course that covers 15 standards of care in health and social care.

In addition to the above, the inspection report identified the following as areas of improvement:

- Management of incidents – urgent and emergency care
- Nurse staffing levels urgent and emergency care
- Generally, care and treatment based on national guidance
- Compassionate care
- Complaints are taken seriously, are investigated and lessons learnt
- Improvement in a backlog of x-rays
- Engagement with public and partners
- 4ward cultural change programme
- Stable executive team

The June 2018 inspection report recognised the stability of our executive team and the improvements made at a Trust level, increasing our overall rating for Well-Led from 'inadequate' to 'requires improvement'.

Overall, the Trust continues to be rated 'Good' in the Caring domain, 'Requires Improvement' in the Effective and Well-led domain and 'Inadequate' in the Safe and Responsive domain.

The following Conditions and Warning Notices were removed during 2018. The Trust does not currently have any Conditions or Warning notices placed on it by the CQC.

Worcestershire Acute Hospitals Trust - Conditions/Warning Notices withdrawn in 2018:

Conditions/ Warning Notices	Area	Site	Date Received	Withdrawn 2018
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	Various	Trust-wide	27th January 2017	✓
Section 29A	Various	Trust-wide	11th July 2017	✓

As well as a summary of findings, which included areas of outstanding and improved practice, the June 2018 inspection report outlined a list of regulated activity action the CQC require the Trust to focus on. These are referred to as Must and Should Dos. Must Dos are issues that the Trust must take action on to bring services into line with legal requirements. Should Dos are issues that the Trust should take action either to comply with minor breaches that did not justify regulatory action, to avoid breaching a legal requirement in future, or to improve services.

To ensure detailed focus on the Must and Should Dos, the Trust devised a tool - 'Regulatory Activity Improvement Tool' (RAIT) - and process that would allow for local monitoring of progress made in support of improvements. RAIT allowed the core services to understand where they were required to focus and facilitate the collation of assurance and evidence. The process allowed for detailed testing of the evidence by the Executive Team, at monthly meetings. During the monthly meetings, the Divisional Management Team and supporting Governance teams demonstrate their current ratings and progress and live link to evidence collated to support assurance.

The tool and process have received positive feedback from the Trust, partners and CQC and was actively used to support requests for evidence following the CQC's most recent 'Is it Safe' Inspection of Urgent Care in January 2019.

Due to the success of the Regulated Activity Improvement Tool, the Trust has recently

developed local tools to support core services in their measurement against the CQC's Key Lines of Enquiries (KLOEs). Essentially, the tool will work to the same process as that of the RAIT tool, however, the KLOE tool will support and encourage the core services to assess their processes and systems continuously and prior to inspection, which will allow the Trust to better understand our areas of outstanding performance, areas of improvement and any areas for focus.

2.2

Our Key Strategies

The need for the Trust to continue its journey of quality improvement, as well as sustaining improvements that have been made have been an overarching priority throughout 2018/19. It is one that our staff have taken on with passion and commitment, with many saying they are not only proud to be an employee of the Trust but also happy to be patients.

We have two key strategies;

Quality Improvement Strategy

We launched our Quality Improvement Strategy 2018-21 in April 2018. This strategy has been the driver which has supported a focus on delivering quality improvement plans at ward level, through our clinical divisions and to those Trust wide. The aim of the Quality Improvement Strategy was to move from reacting to the quality improvement requirements highlighted by our regulators, to one of proactively planning and prioritising the quality improvements, reducing variation and improving the outcomes of care for our patients. Throughout 2018 we have seen this developing, with staff focusing on developing their plans and showcasing their approaches. The Strategy has been our guide and focused the Trust to create a culture of continuous improvement and learning which has been both patient-centred and safety focused.

People and Culture Strategy

This year we have been committed to embedding our cultural change programme. The programme has helped our staff to be more positive and supportive, but also challenge where needed.

It has driven a sense of commitment and, importantly, has encouraged our staff to showcase their successes and, in turn, celebrate their achievement. The programme has provided staff with the core foundations for taking forward their own quality improvement programme.

Our focus has been twofold; to transform our culture whilst at the same time improving our performance across the whole of Trust, particularly around our wide-ranging quality improvement programme, improving the flow for patients who attend our Emergency Departments, and our efforts to achieve financial stability.

At the heart of 4ward are four signature behaviours. Our aim is to have all our staff positively demonstrating these behaviours and working together to achieve our shared goals.

The behaviours are:

- Do what we say we will do
- No delays, every day
- We listen, we learn, we lead
- Work together, celebrate together.

Making the Trust a better place for our staff, our patients and our local community is the ultimate goal of 4ward, so we want everyone to focus on how we behave, what we deliver and create a culture we can all be proud of.

What has 4ward helped us to achieve so far?

Our 4ward showcases: There have been numerous achievement in this year linked to our cultural change programme; including:

- The continued strong link between 4ward and Quality Improvement
- National award winning staff Facebook page set up under our 4ward behaviour 'work together, celebrate together' with over 3000 staff and community members engaging
- Asked to speak at a national HR conference regarding culture change
- 4ward increasingly referenced by job applicants as a reason to work at WAHT including consultants
- Oncology Team introducing a walking football team
- Successful team working ensuring smooth junior doctor August changeover
- Occupational Health Team re-accreditation
- Audiology Team improved patient experience in partnership with Deaf Direct with hearing aid boxes to store devices securely for inpatients
- Neurophysiology launch 4ward patient experience survey
- Clinical Systems E-learning rolled out to junior doctors by IT
- New appointment reminder service helping achieve 'no delay, every day'
- British sign language courses rolled out for staff
- Clinical research team awards evening
- Bladder Cancer support group set up for patients
- 4Ward used to improve service re-design i.e. Stoma Care Nurses designing a Saturday service
- Dedicated child-friendly theatre list at Kidderminster Hospital
- Kidderminster Outpatients Department successful pilot of the Student Coaching In Practice (SCIP) programme which has supported student nurses on placement
- Increased partnership working between Medical Assessment Unit and Medical Short-Stay Unit
- Staff feel empowered to make cost savings on the renal dialysis unit
- Lesbian, Gay, Bisexual and Transgender (LGBT) history week celebrated for the first time
- Quality Hub, Business Intelligence and Information work together to create a Senior Nurse Quality Check app
- We have developed a scheme we know as #ThankyouThursday where staff are encouraged to present a thank you card to any member of staff for achievement or actions undertaken.

Staff at Worcestershire Royal Hospital receive their BSL Level 2 certificates.

Hospital staff complete level 1 British Sign Language course to improve patient experience

A successful initiative to teach sign language to hospital staff has seen 90 hospital staff complete the level 1 British Sign Language (BSL) course across Worcestershire's hospitals.

Carol Silvester, Chair of the Friends of Worcestershire Royal (centre) with Porter, Steve Hartman (left) and Hospital Chaplain, Rev David Southall (right).

British Sign Language (BSL) is used by 50,000 people in the UK and our Worcestershire hospitals see frequent visits from deaf patients for whom BSL is their first language

The 10 week course enables staff to have simple, but vital, conversations with deaf patients and relatives.

It was set up following an idea by Chaplain, Rev. David Southall, and Porter, Steve Hartman, a British Sign Language tutor who himself became deaf 16 years ago due to a virus.

Rev. David Southall said: *"The course has proved to be highly popular. I myself have been learning sign language and it has been so rewarding. I think we can make a real difference to the life of our deaf patients and relatives by learning this language and being as inclusive as possible."*

BSL tutor and hospital porter Stephen Hartman said: *"I am passionate about teaching sign language to NHS staff. This course is at beginner's level but will allow staff to be able to have simple conversations with Deaf patients & relatives. The most important thing is that Deaf patients can know that we take their hearing issues seriously and want to be as inclusive as possible. I want our hospitals in Worcestershire to be Deaf-friendly places."*

Clinical Services Strategy

The Trust Board agreed a new five year vision and strategic objectives towards the end of 2018/19. This sets the direction for the Trust from 19/20 onwards and importantly provides a framework for a new Clinical Services Strategy for the Trust. This clinically led strategy will be developed bottom up with each of the Trust clinical specialties, taking account of the direction set by the Trust Board and the local and national context. Following a process of engagement and development, the Trust Clinical Servics Strategy will be published in early autumn 2019 and will feed into the Trust and Herefordshire and Worcestershire STP business planning cycle for 2020/21 and beyond.

Monitoring quality

We work closely with our commissioners (local and NHS England) throughout the year to monitor our performance in all areas of quality management. We monitor progress with the delivery of the Quality Improvement Strategy and work collaboratively to develop the annual Quality Account, acute quality schedule and priorities for the next year through the clinical quality group. This ensures that our quality agenda aligns with local and national priorities.

The clinical governance group (CGG) is our monthly forum attended by our staff and our commissioners and is a key part of our governance structure.

The governance arrangements in the Trust are jointly led by the Chief Medical Officer and Chief Nursing Officer who have executive responsibility for Quality. Progress with our quality goals, targets and priorities are reported through this framework, to the Trust Executive Management Group and Quality Governance Committee to enable monitoring from ward to board.

Part 3: Our commitment to data quality

It is essential for all NHS Trusts to have good quality, timely, reliable and easily accessible information that provides insights into the safety, quality, efficiency and effectiveness of its services. The provision of good quality information should be a by-product of the day-to-day clinical and administrative processes.

The Trust has always had a small resource of staff looking at Data Quality within demographic information, but in 2018/19 recruited a Data Quality Manager to work alongside the clinical lead for Data Quality and widen the remit. The Data Quality team is integrated within the Information Department and considers any data across the Trust that may impact patient safety or care, the effectiveness of our services and financial sustainability.

The Data Quality team do not only consider the immediate resolution of data but more in-depth investigations into the root cause and working with others to put in robust and sustainable processes or changes to prevent further data quality issues from occurring.

In 2018/19 the Data Quality Manager has targeted 'Getting it right, first-time' data entry by engaging with ward clerks who capture a vast amount of data about the patient journey. The ward clerks are not centrally managed and as such do not have a consistent approach to training and application of processes, so a ward clerk forum was set up monthly to ensure a consistent approach.

Another area of improvement in 2018/19 relates to the data shared externally with our primary care colleagues. The Trust has liaised closely with the CCG and GP Practices to ensure that they have timely and accurate access to data that improve pre and post-acute service care. Although data exchange was previously in place, it had not been reviewed for many years and was not sufficient enough to support the changing approach to more holistic patient care.

The support for improving data quality across the Trust means that more issues are being identified now than previously; with more staff more aware of its importance. All data quality issues are recorded, reviewed and prioritised with the clinical lead for Data Quality.

The launch of the Data Quality Policy was in May 2018 and we have been allocating a Data Quality kite mark to core datasets to ensure that any strategic decision making fully considers the impact of using data with low confidence levels. During 2019/20 the Data Quality kitemark will be adjusted so that it is less complex and easier for anyone to understand, this change is being made following feedback that has been received.

Worcestershire Acute Hospitals NHS Trust submitted the following number of records during 2018/19 (Apr-Jan) to the Secondary Uses Service (SU) for inclusion in England's Hospital Episode Statistics:

- A&E records – 166,045
- Inpatient records – 146,765
- Outpatients records – 671,046

These are included in the latest published national data. The accuracy and completeness of submitted data have been steadily improving from 92.8% to 94.3% however this was consistently below the national average.

The robustness of data quality is variable across the Trust with some areas being better than others, but overall, data quality across the Trust is improving. Now that the foundations have been put in place for data quality; focus in 2019/20 will be on moving the Trust towards a higher level of data quality maturity and reducing the variation of data quality across different datasets.

The first patient to be transferred to the new ward via the bridge

New ward and bridge opened at Worcestershire Royal

A new £3m link bridge, joining Worcestershire Royal Hospital to Aconbury East, was officially opened in January, along with a 28-bed ward. These developments formed part of the wider Winter Plan which was put in place to improve patient flow through our hospitals and saw a total of 83 additional beds opened at both the Worcestershire Royal Hospital and Alexandra Hospital.

The bridge development brings the ward capacity in the Aconbury buildings (Aconbury East, Aconbury West and Aconbury North) under one roof with the main hospital building, facilitating much more rapid and convenient transfer of patients and allowing patients with more complex needs to be managed in the Aconbury ward areas.

3.1
Safety and Quality Information Dashboard (SQuID)

After the launch of SQuID in 2017, the Trust has seen this dashboard being embedded into the Trust culture and seen as a valued tool. 2018/19 has seen a refreshed version of SQuID which has developed into a tool that monitors the key indicators as highlighted in the Quality Improvement Strategy that provides a single source of information, with improved functionality to assist reporting.

2019/20 will see the launch of the Path to Platinum Ward Accreditation programme. This has been created to recognise individual teams that distinguish themselves by improving every element of patient care activity. As teams strive for improvement, they can progress through four levels of accreditation - Bronze, Silver, Gold and Platinum - in recognition of significant milestones along their journey to excellence. For our patients and their families and carers, the accreditation programme signifies the journey to exceptional care through improved outcomes and greater overall experience and satisfaction.

Part 4: Overview of the 2018/19 Quality Account

This section of our Quality Account provides a look back over the 2018/19 quality priorities at the Trust.

We developed quality improvement plans at ward, directorate and divisional level and Trust wide for each of the priorities and our performance has been monitored throughout the year by our clinical teams and hospital committees. We have implemented a number of important quality checks, leadership walkabouts, senior executive walkabouts, and safety walkabouts which have included patients and members of the public. These approaches have provided a 'fresh eyes approach' and our performance has been monitored throughout the year by our clinician's with support offered in real time.

Senior Nursing Quality Audits

- Focus on environment and risk assessment documentation July 2017

Listening into Handovers, Safety Huddles and Safety Walkabouts

- Executive/Non-Executive Director, Patient Public Forum and Partners.

Back to the Floor

- Senior Nurses and Professionals engaged in approach to working along side front line teams in wards and departments.

Key Line of Enquiry Checks

- Divisional Directors engaged with areas and walk through bespoke checklists with staff.

Quality Improvement Strategy Reviews:

- Confirm and challenge style
- Review of actuals, targets and revised trajectories
- Review combined with CQC Regulatory Activity improvements.

To further support our commitment to quality assurance, improvement and improved patient care, safety and experience, we introduced the following:

The Quality Hub

The Quality Hub is a team of staff who support our clinical colleagues. The team provides quality assurance support to the Trust in a number of areas such as:

- Quality agenda
- Quality Improvement Strategy
- CQC Regulated health care standards, regulated activity requirements and registration
- Process flow and improved documentation to external bodies
- Support staff in providing a suite of Quality Audits and tools
- Construct divisional direct level monitoring tools to allow detailed testing of assurance and evidence
- Path to Platinum Accreditation Programme support
- Regulator and partner inspection and assurance visit logistics
- Communication of improvements

"Our Quality Improvement Strategy is driving improvements through the Divisional, Directorate and Ward Quality Improvement Plans."

Freedom to Speak Up Guardian

We believe that if our staff witness or are the subject to any form of unacceptable behaviour, they should report this immediately so that action can be taken to remedy the concern. We firmly consider that any form of unacceptable behaviour has potential implications for our care for our patients, even if it is not directed at a patient. Therefore we need to address such issues by understanding the cause and supporting managers and staff to create the most appropriate remedy. In order to enable this to happen, we appointed an independent Freedom to Speak Up Guardian who reports directly to the Chief Executive and the Board. He is supported by 30 Freedom to Speak Up champions who all have substantive roles spread across all of our three main sites. We have a clear vision for Freedom to Speak Up which has been approved by the Board and is being implemented in every ward and department in the Trust.

Our vision is to have every member of staff having the courage to speak up if they see any form of unacceptable behaviour and for our managers to deal with such issues promptly and with compassion and care.

Our Freedom to Speak Up Guardian, Bryan McGinty (pictured above), has the role of supporting and encouraging colleagues to 'speak up' if they have concerns about safety, quality and issues that have Trustwide impact and may jeopardise patient or staff safety.

Delivering our **Quality Improvement Strategy**

Quality Improvement Strategy

Our Signature Behaviours

- Do what we say we will do
- No delays, every day
- We listen, we learn, we lead
- Work together, celebrate together

Care that is safe

We will give every patient consistently safe, high quality and compassionate care.

We will protect every patient from unintended or unexpected harm.

We will improve care by learning from our mistakes.

Our staff will be taught the clinical and improvement skills required to provide high quality care. We will work together to achieve excellence.

Care that is clinically effective

We will do the right thing for patients by ensuring decisions about healthcare are based on the best available, current, valid and reliable evidence.

We will work in the right way by developing a workforce that is skilled and competent to deliver the care required.

We will provide treatment at the point of need in a timely manner.

We will ensure patients have the right outcome to ensure maximum health gain for their clinical circumstances.

Care that is a positive experience for patients and their carers

We will develop a culture where patients, and their carers are at the forefront of all we do.

To develop a culture of person centred and family centred care.

To develop a culture that supports continuous improvement by delivering services to the patient, their carers and the community that is responsive to the information they are telling us.

We will include patients, their carers and our community partners in our Patient Experience Strategy and Engagement Plan that will achieve a cultural transformation, promoting a genuine shift in power and control.

Quality Improvement Faculty

- Quality Hub to triangulate learning
- Quality Informatics and Quality Improvement Training to support teams
- Ward Accreditation

State-of-the-art simulation ward opens at Kidderminster Hospital and Treatment Centre

A brand new state-of-the-art simulation ward has been officially opened at Kidderminster Hospital, ensuring nurses and other health professionals across the county and beyond have access to the most up-to-date and comprehensive training opportunities.

The simulation ward, which has been created in a former ward area, is designed to provide a diverse practical teaching area for nurses, midwives, Allied Health Professionals and other registered and non-registered healthcare professionals and simulate 'real life scenarios'.

The simulation ward includes four lifelike 'manikins' from Lifecast, which have been designed to be used alongside Advanced Life Support technology to create outstanding simulated clinical training. The manikins have been chosen to reflect the ethnic diversity of the population we serve and will support our staff to learn skills and competencies including catheter and nasogastric tube insertion.

The Simulation ward will bring together a variety of teaching styles to refresh the training programmes already provided by the Professional Development Team at Worcestershire Acute Hospitals NHS Trust, including preceptorships, care certificate training, venepuncture, cannulation and IV therapy as well as training students from all disciplines.

Pictured: Members of the Professional Development Team with one of the state-of-the-art 'manikins' in use in the new simulation ward.

Progress against the quality priorities 2018/19

We have made significant progress from last year's quality improvement plan. This year we over achieved on six of our indicators, made partial improvements on five and did not meet one indicator out of the twelve. We will carry over a number of indicators into next year's priorities to ensure we achieve further on all areas of quality.

Priority 1: Safe Care

Quality Indicator	Target	Evaluation	Outcome
Quality indicator 1 We said we would reduce the number of avoidable hospital-acquired pressure ulcerations (HAPU)	Grade 2-HAPU from a baseline of 84 to <80 (10% reduction)	Reduction of 47%	We have significantly reduced Avoidable Category 3 and 2 Hospital Acquired Pressure Ulcerations (HAPU) and have had no Grade 4s.
	Grade 3 HAPU and deep upgradable; from a baseline of 17 to <15 (12% reduction) HAPU	Reduction of 35%	
	Grade 4 HAPU from a baseline position of 0, we aimed to maintain this performance	None	
Quality indicator 2 We said we would reduce the number of patients who have a fall that causes them harm under our care	A baseline position of 0.08 falls per 1,000 bed days (22), to 0.07 falls per 1,000 bed days (20) = 10% improvement	There have been 14 serious incident falls (0.05 per 1,000 bed days) in 2018/19 achieving a 36% improvement compared to 17/18.	We have significantly reduced the number of falls which resulted in serious harm for our patients whilst under our care. We are below the Royal College of Physicians national benchmark of 0.19 serious incident falls per 1000 bed days.

Quality Indicator	Target	Evaluation	Outcome
Quality indicator 3 We said we would improve the identification and escalation of sepsis screening	Increase sepsis screening for patients in the emergency department baseline position of 83% to >85%	Sepsis screening in the emergency department has improved significantly and consistently with >90% of patients who require screening are screened for sepsis. 93.80%	Mortality for patients with sepsis has shown a significant improvement which has been maintained for more than 12 months. We did not meet our targets for sepsis screening and compliance with the sepsis 6 bundle, however, have improved on our performance from last year. Administration of antibiotics with one hour has significantly increased. Improvement in all aspects of the diagnosis and management of sepsis will be a key priority for us for next year as we know there is so much more we can do.
	Increase sepsis screening for patients in wards. Baseline position of 67% to >75%	Compliance with a screening of adult patients. 77.13%	
	Increase compliance with the sepsis 6 bundle in the emergency department. Baseline position of 50% to >60%	Compliance with sepsis 6 continues to remain disappointingly around 50% but there is an enhanced level of scrutiny and focus to ensure all patients receive the whole of the sepsis 6 bundle. 53.44%	
	Increase compliance with sepsis 6 bundle onwards. Baseline position of 80% to >85%.	Improvements have been seen in in-patients. More than 70% of patients who require screening for sepsis are screened. The most recent data available (Q3 18/19 shows levels are >75%). 47.94%	

Quality Indicator	Target	Evaluation	Outcome
Quality Indicator 4 We will prescribe, administer and supply the right medicine at the right time for the right patient. We wanted to evidence the benefit of this for our patients by four sub-indicators.	Increase the reporting of medicine near misses and incidents. Baseline position 3.52 per 1000 bed days to 4.47 per 1000 bed days.	We have achieved 4.47 per 1000 bed days which was the target set for 2018/19. With the exception of one month, the reporting has exceeded the base-line for the previous year.	We have met the targets for two indicators.
	Reduce the percentage of medicine incidents causing harm. Baseline position of 19.53% to 15.62%.	We have met the target of 15.62% by achieving 15.48% and have reduced the percentage of medicine incidents causing harm in 2018/19.	

Priority 2 - Care that is clinically effective

Quality Indicator	Target	Evaluation	Outcome
Quality indicator 1 We said we would monitor and seek to reduce mortality for patients whilst under our care	From a baseline position of a rolling average of HSMR ~102, we said we would achieve HSMR~100 consistently throughout the year	There has been a deterioration over 2018 to a level of 112.54 with the most recent data indicating that this is plateauing. Our rolling HSMR is one of three mortality indicators we monitor. The actual number of patients who have died in the Trust is the lowest it has been for the last two years and our other indicator for mortality, SHMI, shows that our mortality is as expected. At present approximately 80% of all patients who die, have their care reviewed. However, we aim to review the deaths of all patients so that any lessons can be learned and shared across the Trust. Responding and learning when patients die will continue to be a key priority for us in 2019/20 and fits with the national priority. We are committed to improving how we learn from deaths to further improve safety and care.	We did not meet our target.

Quality Indicator	Target	Evaluation	Outcome
Quality Indicator 2 We said we would improve our time to theatre for patients with fractured neck of femur (broken hip)	Baseline position of 85% of patients going to theatre within 36 hours with fractured neck of femur (broken hip) for 5 out of 12 months to 85% for 8 out of 12 months	We maintained our baseline position of 85% of patients with a fractured neck of femur going to theatre within 36 hours for 5 out of 12 months; we did not achieve the anticipated improvement to 8 months out of the year. However, our average time to get patients to the theatre is less than 30 hours and consistently better than the national average of 33 hours.	We have maintained our performance throughout the year.
Quality Indicator 3 We said we would implement clinical standards for seven – day hospital service	We said we would assess ourselves against the 4 of the 10 clinical standards for seven-day services and measure ourselves on patient experience and our provision for consultant review. We will improve our position of non-compliance in 4 standards and be compliant in 2 out of 4	Our baseline position on 31st March 2018 was that we were compliant (>90%) in 1 of 4 Seven Day Priority Standards. At the end of 2018/19, we were also compliant in 1 of 4 Seven Day Priority Standards against a trajectory of 2/4 standards. Our compliance for each priority standard on 31st March 2019, compared with the previous period was as follows; ▶ Clinical Standard 2 - Time to first consultant review within 14 hours (from 65% in 2017/18 to 74% in 2018/19. ▶ Clinical Standard 5 - Access to diagnostics (from 84% in 2017/18 to 97% in 2018/19). ▶ Clinical Standard 6 – Access to consultant directed interventions (from 94% in 2017/18 to 89% in 2018/19. ▶ Clinical Standard 8 - Ongoing consultant review (from 69% in 2017/18 to 92% in 2018/19).	We have improved our level of compliance in clinical standards 2, 5 and 8.

Quality Indicator	Target	Evaluation	Outcome
Quality Indicator 4 We said we would complete an annual program of local clinical audits.	We said we would complete an annual program of local clinical audits. This we aimed to do by the Better outcomes for patients (BOPP) approach which supports an objective within the Clinical Effectiveness plan 'to complete an annual programme of local clinical audit'.	Completion of the Better Outcomes for Patients Programme (BOPP) during 2018-19 demonstrated a significant improvement in comparison to 2017-18 with an increase of 42% in the completion of the BOPP, leading to a year-end BOPP completion of 74% against a trajectory of 60%.	We achieved the target we set.

Priority 3 - Care that is a positive experience for patients and their carers

Quality Indicator	Target	Evaluation	Outcome
Quality Indicator 1 We said we would improve our complaints performance and we will learn from our complaints	Complaints responded to within 25 working days - Baseline position of 78% to 80% for 12 months	We have responded to complaints in a timely manner with an end of year position of 85.71%.	We have met our targets for complaints.
	Reduce the number of complaints returned from those who are unhappy with the response. Baseline position of 35% to 10%.	Of all cases received in 2018/2019, 16.4% were reopened with further concerns. Between April and August 2018 the trajectory of returned responses rose steadily to 29% of cases reopened. Since this point, the percentage has reduced on a downward trajectory month on month to 9% of December complaints reopened. The figure rose in February to 13.7%. The figure for 2018-2019 at year end was 16.4%.	
	Implement the Sage and Thyme communication skills workshops	We have refreshed the training programme for communication skills known as the Sage and Thyme. Staff have attended core training sessions to equip with key skills in the delivery of our programme for 2019/20.	

Quality Indicator	Target	Evaluation	Outcome
Quality Indicator 2 We said we would maintain the patient's privacy and dignity throughout their time with us	We said we would adopt and roll out the campaign #end PJ paralysis. We will audit the number of patients who are up and dressed each day from a baseline position of 0.	A Quality Check Audit feedback audit tracker was implemented in December 2018. "If the patient is able to have they been encouraged to get up and dressed?". Nurses complete this audit on a daily basis. The results show that between Dec 2018 – 12th April = 94% of patients were encouraged at Worcestershire Royal Hospital to get up and get dressed and 96% were encouraged at the Alexandra Hospital. Of the patients who have experienced a stroke 95% of patients were up and dressed if able.	We have made significant improvement but recognise we have more to do.
	We said we would evaluate the patient/carer experience of mixed-sex accommodation to ensure privacy and dignity needs are being met. Baseline position of inpatient Picker survey question 17% to be in line with the national average (based on previous Picker scoring).	The NHS Inpatient Picker 2017 results determined that 83% of patients did not share mix sex accommodation. This improved to 88% in 2018. This is an improvement of 5%. The national average is 91% and the Trust average is 88%, which determines a deficit percentage of 3%.	
	We said we would improve patient experience of privacy in the emergency department. Baseline position in inpatient picker survey questions 33% to be in line with the national average (based on previous Picker scoring).	The 2017 Inpatient Picker survey results demonstrated 93% of patients reported that they had enough privacy and dignity when being examined or treated in the emergency departments. This figure remained the same in 2018 at 93%. The national average is 98% which determines a difference of 5%.	

Quality Indicator	Target	Evaluation	Outcome
Quality Indicator 2 continued… We said we would maintain the patient's privacy and dignity throughout their time with us	We said we would improve on the indicator on inpatient Picker survey for "not always treated with respect or dignity". Baseline position of 20% to be in line national average (based on previous Picker scoring).	The survey results for the Picker Inpatient's survey for "Overall treated with respect and dignity" 2017 gives a percentage of 97% and in 2018 this decreased to 96%. This is below the national average of 98% by 2%, however, it is to be noted that on separating site scores, the Alexandra scored 99% of patients treated with respect or dignity.	We have made significant improvement but recognise we have more to do.
Quality Indicator 3 We said we would ensure patients and their families are fully involved and aware of their discharge so they are confident they have everything they need to continue their treatment or recovery including rehabilitation.	Improve on the national Inpatient Picker Survey on whether patients are told of side effects of medications when discharged. Baseline position 69% to be in line with the national average	The 2017 Inpatient survey results reported that 57% were told the side-effects of medicines, whereas, in 2018, 51% shared that they were told. This gives the Trust an average of 51% as compared to the national average of 57%.	We have made significant improvement but recognise we have more to do.
	Improve on the national Inpatient Picker Survey indicator on whether on "discharge patients are informed of the danger signs". Baseline position of 64% to be in line with the national average.	The 2017 Inpatient survey results demonstrated that 59% of patients were told of the danger signals. In 2018 this dropped to 57%. The national average is 64% and the Trust average is 57%	We have made improvements but we recognise we have more to do.
Quality Indicator 4 We said we would ensure patients understand their condition, treatment and pain management options.	Pain Management: Improve on the indicator in the national inpatient Picker Survey of "not enough or too much information given on their condition". Baseline position of 26% to be in line with the national average(based on previous Picker scoring).	Picker Survey for 2017 saw that 26% of patients felt that they did not have the right amount of information. With a change in Picker scoring, 74% felt that they did have the right amount of information in 2018. The performance was maintained (2017 scores equated to 74%). The national average is 80%.	We have made significant improvement but recognise we have more to do.

Child-friendly surgery service at Kidderminster Hospital expands number of procedures

Worcestershire youngsters are now able to undergo more surgery closer to home in a friendly and welcoming environment tailored just for them, thanks to the expansion of children's surgery at Kidderminster Hospital and Treatment Centre.

Worcestershire Acute Hospitals NHS Trust, which has been gradually increasing the amount of children's surgery it can perform at the hospital since 2016 – most recently adding Ear, Nose and Throat surgery – such as tonsillectomies and adenoidectomies.

The Hospital has also introduced a dedicated all day children's operating list – one of the only hospitals in the Midlands which does this.

On these days the four operating theatres are converted into an exclusively paediatric environment; with child friendly screens, toys and play equipment and theatre staff even wear child friendly theatre hats. The theatre team along with children's nurses, play specialists and medical specialists all work together to provide specialist paediatric services and support.

Pictured: The theatre team at Kidderminster with patient, Leo Leverett-Hawes

Part 5: Our quality priorities for 2019/20

In choosing our quality priorities for the coming year, we consulted widely with our staff and with representatives of the community which included Healthwatch and the Health Overview Scrutiny Committee. We sought input from our staff through the Clinical Governance Committee and Patient Experience Committee which is also attended by our patient public representatives.

This was in order to ensure, going forward, we build on the successes of last year, further challenge ourselves for even greater improvements and ensure we are focusing on the qualities that are important for our patients, their carers, the community we serve and our staff.

In identifying our quality priorities we consulted and engaged with our patients, their carers and the public throughout November 2018 across three hospital sites asking them "what does quality mean to you?" A total of 61 people gave us their opinions and commented on our services. These comments, alongside those we gathered from Friends and Family Tests, complaints, cards of thanks, opinions left on NHS Choices, Care Opinion etc, have all been the bedrock for each and every priority.

An overwhelming 99% of people we spoke with confirmed that they had experienced 'good care' and welcomed the opportunity to discuss their experiences and ideas.

They defined 'good care' as:

- Determining what is wrong in order to remedy it so it can be fixed
- Being treated with dignity and respect as an equal.

The majority of people reported their care to be safe. Comments included *"it has really picked up here in the last year in every sense"*. Staff were described as being *"friendly, helpful and person-centred"*, and "it was a prompt and professional service". These are in line with those received on NHS Choices.

Building on from our engagement with patients, carers and the community, we have taken two additional approaches in determining our quality priorities for 2019/20:

1. We have evaluated the quality priorities from 2018/19, what we have done well, and where we want to do better.

2. Evaluated where we have done well and where we wish to do better from our Care Quality Commission reports from 2018.

From the triangulation of our information sources, we have set our three quality priorities for 2019/20.

Our three quality priorities for 2019/20

Priority 1
Care that is Safe

We will reduce avoidable harm to patient's through seven key quality indicators which will support required improvements as outlined in the Quality Improvement Strategy.

Key quality indicators are:

- Medicines safety
- Hospital acquired pressure ulcers
- Falls resulting in harm
- Infection prevention and control
- Sepsis
- Venous thromboembolism
- Improve permanent staffing levels

Priority 2
Care that is clinically effective

We will ensure our care is based upon sound evidence which is made up of three indicators which underpin by our principles of:

Key quality indicators are:

- Reduce mortality rates
- Implement clinical standards for seven-day hospital services
- Complete an annual programme of local clinical audits

Priority 3
Care that is a positive experience for patients and their carers

We will ensure that - by developing a culture that supports continuous quality improvement and by delivering services that are responsive to the needs of our patients, carers and their families - we will build on our person and family-centred approach. We can assess in "real-time" our patients and their carers' experiences of care and how effective they see this care to be. We will do this through two key quality indicators and a focus on three subindicators.

Key quality indicators are:

- Maintain our complaint performance and continue to respond within 25 working days of receipt and ensure we create learning from the themes from complaints
- Maintain the percentage of inpatients who would recommend our Trust to friends and family to 94% or above and will achieve recommended national response rates for inpatients = >30%, maternity services = >30%, emergency outpatient = >20% and emergency services >10%.

We will improve patient's and carer experience in the sub indicator areas of:

- Privacy and dignity
- Information provided at discharge
- Communication

Priority 1
Care that is Safe

QUALITY INDICATOR 1
We will reduce the percentage of medicine incidents causing harm across the Trust.

Our position for 2018/19 was 15.48%	Our Target for 2019/20 is a reduction to 11.71%

QUALITY INDICATOR 2
We will reduce the number of patients who have a fall with harm whilst under our care.

Our position for 2018/19 was 14	Our Target for 2019/20 is no more than 12

QUALITY INDICATOR 3
We will continue to improve on progress achieved in reducing the number of avoidable hospital-acquired pressure ulcers (HAPU) .

Our position for 2018/19 was 287 (all categories)	Our Target for 2019/20 a reduction of 5%

As of April 2019 the Trust will be compliant with the new NHSI Pressure ulcers: revised definition and measurement framework. This means that all Hospital Acquired Pressure Ulcers above a category 2 will be investigated to understand causative and contributory factors affecting why this incident has occurred. We will then be able to identify what changes need to occur in order to prevent further incidents in the future and this will be shared/disseminated with the whole MDT via the Tissue Viability newsletter.

QUALITY INDICATOR 4
We will achieve excellent infection prevention practices, and our rates of infection will improve in order to improve the safety and experience of our patients.

The specific areas we will focus upon are:

Clostridioides difficile
Please note: there is been an international name change, with Clostridium difficile now called Clostridioides difficile.

Our position for 2018/19 was 43 cases	Our Target for 2019/20 is no more than 53

There are revised national definitions of Trust-attributable cases from April 2019, which now includes patient developing infection within 28-days of discharge from our hospitals including those readmitted with Clostridioides difficile within that time period. The estimated impact on us is an additional 9-12 cases per annum. Our 2019-20 national target has been set at 53 cases to take account of this change (an increase from the target in 2018-19).

E coli Bacteraemia

Our position for 2018/19 was 72 cases	Our target for 2019/20 is no more than 29 cases

The CCG notified us in May 2019 of a change to the national target for E coli bacteraemia reduction, with a 50% reduction from baseline now due by 2024, rather than 2021.

MSSA Bacteraemia

Our position for 2018/19 was 24 cases	Our target for 2019/20 is no more than 10 cases

MRSA Bacteraemia

Our position for 2018/19 was 0 cases.	Our target for 2019/20 will remain at 0 cases

Hand Hygiene

Our position for 2018/20 was 97%.	Our target for 2019/20 is above 97%

**NHS Improvement has issued revised guidance on the definitions which will be used to attribute infections to Trusts in 2019-20. The guidance identifies 4 categories including infections with onset within 2 days of admission where there the person has been an in-patient in the Trust within the previous 4 weeks. From April 2019 these cases will be attributed to the Trust. The national targets have been increased to take account of this change.*

QUALITY INDICATOR 5

We will further improve the identification and treatment of sepsis.

Baseline position for screening in the emergency department 2018/19 of 93.80%	Target for 2019/20 is >90%
Baseline position for sepsis screening inpatients wards- for 2018/19 was 77.13%	Target for 2019/20 is >85%
Baseline position for implementing the sepsis six bundle - Emergency Department was 53.44%	Target for 2019/20 is >70%
Baseline position for implementing the sepsis six bundle - Inpatients wards was 47.94%	Target for 2019/20 is >90%

QUALITY INDICATOR 6

We will improve further our compliance with screening for venous thromboembolism (VTE) .

Baseline position for 2018/19 for inpatients of 18 years old and above was 94.89%	Target improvement for 2019/20 for an initial assessment for inpatients of patients >16 years old is 95%

QUALITY INDICATOR 7

We will improve permanent staffing levels.

Baseline Position for Nursing and Midwifery for 2018/19 was 10.43%, Doctors; 13.02%	Our Target position for 2019/20 is Nursing and Midwifery: 9.43%, Doctors 10%

Priority two
Care that is clinically effective

QUALITY INDICATOR 1

We will monitor and seek to reduce mortality rates for patients whilst under our care.

Baseline Hospital Standardised Mortality Rate for 2018/19 was 112.57	Target position for 2019/20 is 105.0

QUALITY INDICATOR 2

We will implement clinical standards for seven-day hospital services.

Baseline position of compliant >90% in 1 of 4 seven day priority standards against a trajectory 2/4 target and how we will do this for 2019/20 is:	All patients being reviewed with 14 hours of coming into our care All our patients have improved access to diagnostics All our patients have access to a consultant for direct interventions All our patients have ongoing consultant review

QUALITY INDICATOR 3

We will complete an annual programme of local clinical audits.

Our baseline position for 2018/19 was 32%	Our target position for 2019/20 is 80%

Priority 3
Care that is a positive experience for patients and their carers

QUALITY INDICATOR 1
We will respond to complaints within 25 working days of receipt and ensure we create learning from the themes from complaints.

Our Baseline Position for 2018/19 was 85.71%	Our target position for 2019/20 is 80%

QUALITY INDICATOR 2
We will maintain the percentage of inpatients who would recommend our Trust to friends and family to 94% or above and will achieve recommended national response rates for emergency departments, inpatients, outpatient and maternity services.

Baseline position for 2018/19 was 94.94%	Target for 2019/20 is 95%

We will specifically focus upon:
Ensure we maximize and maintain privacy and dignity throughout a patient's time with us.

We will do this by:
- Continue to raise awareness amongst staff on the importance of privacy and dignity for all our patients. We will do this by developing a range of educational aids which will be rolled out Trust wide and will ensure that all newly inducted staff receives this message on their first day at induction.
- This work be supported further through implementation and monitoring within the Pathway to Platinum ward accreditation programme.

We will specifically focus upon:
Ensure patients and their families are fully involved and aware of their discharge so that they are confident they have everything they need to continue their treatment or recovery including rehabilitation.

We will do this by:
- Implementation of our programme SAFER standards that will focus specifically on multidisciplinary/multi-agency review of all patients with a stay >21days.
- Providing patients and their relatives are aware of their expected date of discharge with written information on progress made through their discharge planning in line with the Trust accommodation policy.
- This will be supported further through implementation and monitoring within the Pathway to Platinum ward accreditation programme.

We will specifically focus upon:
Ensuring patients and their carers feel listened too and have clear lines of communication with staff about their condition, treatment and care

We will do this by:
- We will implement training programmes on customer care and communication.
- We will develop our volunteer's strategy and patients experience champions scheme to support our capacity of responding when patients raise concerns, offer ideas and give compliments.
- Take forward our #togtherwearepatientexperience campaign.
- This work will be supported further through implementation and monitoring within the Pathway to Platinum ward accreditation programme.

PATH TO PLATINUM
ACCREDITATION PROGRAMME

Ward Accreditation – Pathway to Platinum

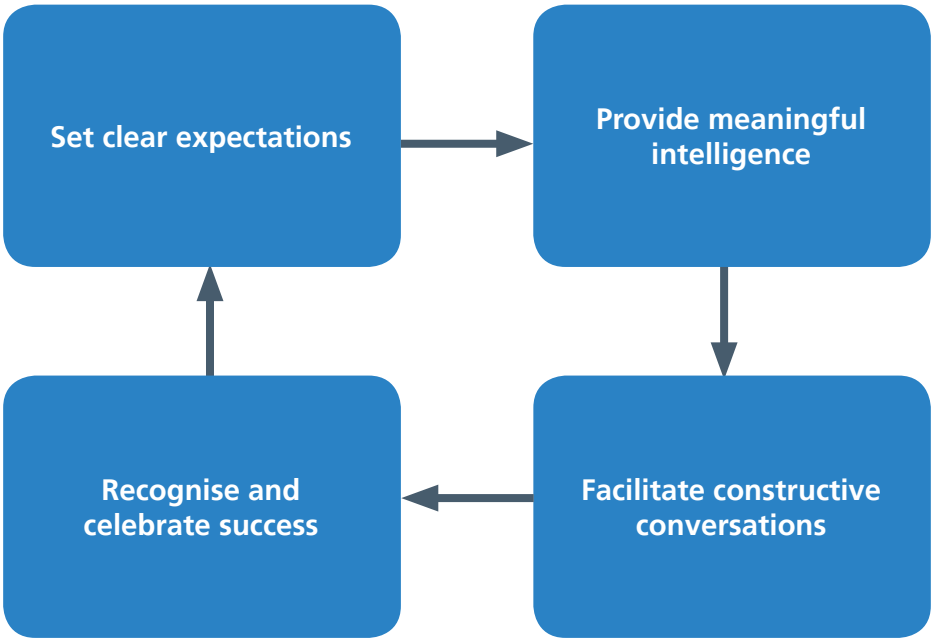
From April 2019 we will launch a Trust-wide programme of ward accreditation. Excellence is the sum of many complex parts on our hospital wards and in departments. Our Accreditation Programme has been created to recognise individual teams that distinguish themselves by improving every element of patient care activity. As teams strive for improvement, they can progress through four levels of accreditation – Bronze, Silver, Gold and Platinum – in recognition of significant milestones along their journey to excellence.

For our patients and their families and carers, the Accreditation Programme signifies the journey to exceptional care through improved outcomes and greater overall experience and satisfaction.

"Achieving this requires clear objectives, clinical leadership, effective team working, a focus on established best practice and a determination to deliver improvements for the good of our patients.

Our Path to Platinum Accreditation Programme aims to deliver just that."

Matthew Hopkins, Chief Executive
Worcestershire Acute Hospitals Trust



For our clinical staff, the Accreditation Programme means providing a positive and supportive work environment with greater collaboration between colleagues and leaders leading to higher morale and a lower turnover of staff. The programme provides a road map and tools to assist wards and departments on their journey to providing excellent care.

The ward accreditation programme has been piloted on five wards during 2018/19 which has produced an approach where wards, going forward, will produce a portfolio of evidence relating to:

- Culture of Continuous Improvement - leadership, team culture, evidence-based practice
- Environment of care - including infection prevention and control, accessibility and safety standards
- Communication about and with patients - including team communication, documentation and patient feedback
- Care process
- Staff/teams achievement/success.

Wards will receive a dashboard each month that informs them on how they are doing against this range of quality priorities.

Each ward is required to undertake a quality improvement project of their choice. They are supported in doing this through our quality improvement training programme and will be offered coaching and support where required.

We have appointed a new post 'Quality Improvement Matron'. This post will provide bespoke support for staff in clinical areas to ensure the delivery of improvement programmes which, in turn, will improve patient, carer, relative and staff experience of our care.

QUALITY IMPROVEMENT

*"**Quality Improvement** needs to be front and centre of what we are doing.*

*It's the **number one** of my top three priorities."*

Matthew Hopkins, Chief Executive
Worcestershire Acute Hospitals Trust

Our onward journey for Quality Improvement (QI)

We know that our staff and patients are best placed to recognise, create and deliver the improvements required to ensure quality care: clinical effectiveness, patient safety and positive patient experiences. Therefore, with the right tools and support, the staff will be better informed and empowered to do this. We will commence a programme of training staff from April 2019 with plans to progress to training and including patient and public leaders in improvement projects.

We have joined with partner organisations in Worcestershire and Herefordshire and agreed on a programme of Quality Improvement training. This training is a recommended programme designed by the NHS Improvement team. To ensure that we achieve our quality improvement aims, and other delivery plans, it is important that everyone has the skills to do this so we have created a tiered approach to Quality Improvement training. This is important for our patients, families and carers to provide assurance that all our staff knows how to make improvements for better care and safer care.

There are three levels of training that we have called Bronze, Silver and Gold. Bronze training is being delivered by our Improvement Team and is an introduction to Quality Improvement tools. This training will be helpful for all staff of any role and responsibility to help them identify solutions to problems so that they can progress to make improvements: small or large. The Silver Training will be for staff who want to undertake a larger Quality Improvement project with additional support from the organisational development team with coaching. The Gold Training is affiliated with partner organisations so that we can all work closely to ensure there are improved clinical pathways across the systems. Currently, we have three staff members that are soon to complete the Gold standard training. The Bronze training has commenced and training dates established for 2019/20 with additional bespoke sessions taken and taking place; for example Ward Manager Development Days.

There will also be online electronic-learning for individuals with a preference for self-directed learning. This is available on the Trust's website for Quality Improvement called the QI Faculty. The Faculty is a single space for staff to go to: for all that is a Quality improvement. It will evolve and develop over time; initially, it will be a place to explore the importance of Quality Improvement and importantly what impact it can have on improving patient care and experiences. It will also be a space for staff to share improvement projects and celebrate the quality improvements made to patient care.

Quality Improvement training "Human Factors"

For our clinical staff, there has been a programme of training on Human Factors. We recognise the importance of the impact of human factors; it is helping staff think about things differently to better understand things like the impact of relationships, or the environment they work in. This means that staff will be more aware of the impact of human factor influences. For patients, changes can be made that will result in a reduction of human error and higher quality care and patient safety. Using Human Factors has been beneficial to understand when there has been an error and help teams get to the heart of what went wrong and what can be done to prevent them in the future.

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.

Award-Winning Staff

The Nursing Times Award, awarded to the Professional Development Team at Worcestershire Acute Hospitals were awarded the **Nursing Times Workforce Team of the Year Award** in October, recognising and rewarding excellent work which supports the nursing and midwifery workforce.

Caitlin Wilson, Consultant Midwife, received **international recognition** after presenting her research findings at a birthing conference in Michigan, USA. Caitlin was invited to attend the International Normal Labour and Birth Research Conference at the University of Michigan in Ann Arbor, after submitting two pieces of original research on maternity roles in the UK.

Chief Radiographer, David Hill, was named **Radiographer of the Year** for the whole Midlands region.

Anaesthetists at Worcestershire Acute Hospitals NHS Trust were recognised for providing the highest quality care to their patients. The prestigious **Anaesthesia Clinical Services Accreditation (ACSA)** from the Royal College of Anaesthetists (RCoA) was presented at a ceremony on 9 January.

The University of Worcester's first cohort of Nursing Associate students were honoured in a special ceremony to mark the end of their journey, paving the way for others to follow.

A **Nursing Associate Celebration Event**, held at the University of Worcester Arena, saw 12 trainee Nursing Associates from Worcestershire Acute Hospitals given a commemorative pin badge as they completed their two years of study.

Radiographer Julia Rhodes was awarded the prestigious **Society of Radiographers' Silver Medal**.

The Silver Medal is the highest annual award given out by the Society, and is awarded to recognise individuals for outstanding dedication and contribution to the profession of Radiography.

Dr Ashim Lahiri was awarded the annual **Frank Farr Award** by the regional West Midlands Association of Radiologists, in recognition of his 'exemplary commitment and contribution to training Radiologists in the West Midlands'.

Midwives and maternity professionals in the Wyre Forest won the **Innovation Award** at the Midlands Maternity and Midwifery Festival Awards in April.

The Awards recognise outstanding achievement and commitments by maternity staff. The Innovation Award was awarded to the Wyre Forest Maternity Hub – a 'one stop shop' antenatal and postnatal service based at Kidderminster Hospital and Treatment Centre.

Part 6: Trust Board's Quality Dashboard

NHS Outcomes Framework Core Quality Account Indicators

Domain	Indicator	Current Performance	National average value	Where applicable		Trust statement	Previous values (where data available)		
				Best NHS performer	Worst NHS performer				
Preventing people from dying prematurely	SHMI value and banding Oct 17 to Sep 18	1.1132 Banding 2 – 'as expected'	—	0.6917	1.2681	*Worcestershire Acute Hospitals NHS Trust considers that this data is as described for the following reasons:* Improvements in timely care for patients whose condition deteriorates is demonstrated by a reducing SHMI. *Worcestershire Acute Hospitals NHS Trust intends to take the following actions to improve this number and so the quality of its services, by:* See quality account priorities.	1.0584 Banding 2 – 'as expected' (Apr 17 – Mar 18)	1.0667 Banding 2 – 'as expected' (Apr 16 – Mar 17)	1.1001 Banding 2 – 'as expected' (Apr 15 – Mar 16)
	% of deaths with either palliative care specialty or diagnosis coding Oct 17 to Sep 18	30.15%	33.56%	59.55%	14.29%	*Worcestershire Acute Hospitals NHS Trust considers that this data is as described for the following reasons:* Data quality is good but there is room for improvement. *Worcestershire Acute Hospitals NHS Trust 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 2018/19.	28.50% (Apr 17 – Mar 18)	28.47% (Apr 16 – Mar 17)	28.18% (Apr 15 – Mar 16)

Domain	Indicator	Current Performance	National average value	Where applicable		Trust statement	Previous values (where data available)		
				Best NHS performer	Worst NHS performer				
Preventing people from dying prematurely	Patient-reported outcome score for hip replacement surgery – adjusted average health gain (Oxford Hip Score) April 2017 to March 2018 (final)	22.965 Not an outlier	22.00	—	—	*Worcestershire Acute Hospitals NHS Trust considers that this data is as described for the following reasons:* Outcomes are slowly improving and are above the national average. *Worcestershire Acute Hospitals NHS Trust 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.	21.508 Not an outlier (16/17)	20.754 Not an outlier (15/16)	21.681 Not an outlier (14/15)
	Patient-reported outcome score for knee replacement surgery – adjusted average health gain (Oxford Knee Score) April 2017 to March 2018 (final)	17.022 Not an outlier	16.87	—	—	*Worcestershire Acute Hospitals NHS Trust considers that this data is as described for the following reasons:* Planned knee surgery has improved as patient flow to the theatre has been addressed. *Worcestershire Acute Hospitals NHS Trust intends to take the following actions to improve this number and so the quality of its services, by:* Improving flow so improving the timeliness of treatment and avoiding pain or deterioration for waiting patients.	16.413 Not an outlier (16/17)	16.087 Not an outlier (15/16)	16.052 Not an outlier (14/15)

Domain	Indicator	Current Performance	National average value	Where applicable		Trust statement	Previous values (where data available)		
				Best NHS performer	Worst NHS performer				
Preventing people from dying prematurely	28-day readmission rate for patients aged 0 -15 April 2018 to February 2019	0.00%	National publications of this data were suspended in 2013			*Worcestershire Acute Hospitals NHS Trust 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. *Worcestershire Acute Hospitals NHS Trust intends to take the following actions to improve this number and so the quality of its services, by:* Ensuring this performance is maintained.	0.02% (17/18)	0.00% (16/17)	0.02% (15/16)
	28-day readmission rate for patients aged over 15 years April 2018 to February 2019	10.80%	National publications of this data were suspended in 2013			*Worcestershire Acute Hospitals NHS Trust 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 wherever possible. *Worcestershire Acute Hospitals NHS Trust intends to take the following actions to improve this number and so the quality of its services, by:* Maintaining safe discharge practice.	9.62% (17/18)	9.53% (16/17)	9.15% (15/16)

Domain	Indicator	Current Performance	National average value	Where applicable		Trust statement	Previous values (where data available)		
				Best NHS performer	Worst NHS performer				
Ensuring that people have a positive experience of care	Responsiveness to inpatients' personal needs – CQC national inpatient survey score 2017/18	66.2	68.6	85.0	60.5	*Worcestershire Acute Hospitals NHS Trust 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. *Worcestershire Acute Hospitals NHS Trust intends to take the following actions to improve this number and so the quality of its services, by:* Improvements to the patient flow described in Quality Account priorities.	65.2 (16/17)	66.5 (15/16)	69.6 (14/15)
	The percentage of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends. 2018	58.3%	70.9%	94.7%	41.1%	*Worcestershire Acute Hospitals NHS Trust considers that this data is as described for the following reasons:* Staff engagement has remained static this year and is in the lowest quartile for the NHS. *Worcestershire Acute Hospitals NHS Trust intends to take the following actions to improve this number and so the quality of its services, by:* See Quality Account.	56.8% (2017)	55.9% (2016)	55.5% (2015)

Domain	Indicator		Current Performance	National average value	Where applicable: Best NHS performer	Where applicable: Worst NHS performer	Trust statement	Previous values (where data available)		
Ensuring that people have a positive experience of care	Inpatient Friends & Family test January 2019	% Recom-mend	94.09%	95.41%	100.00%	76.67%	*Worcestershire Acute Hospitals NHS Trust 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. *Worcestershire Acute Hospitals NHS Trust intends to take the following actions to improve this number and so the quality of its services, by:* See actions in Quality Account.	93.58% (Mar 18)	95.05% (Mar 17)	95.22% (Mar 16)
		Response Rate	18.63%	23.74%	100.00%	1.84%		5.65% (Mar 18)	11.25% (Mar 17)	14.96% (Mar 16)
	A&E Friends and Family test January 2018	% Recom-mend	82.02%	86.03%	100.00%	59.67%	*Worcestershire Acute Hospitals NHS Trust considers that this data is as described for the following reasons:* The Trust is working hard to improve response rates in ED. *Worcestershire Acute Hospitals NHS Trust 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.	73.75% (Mar 18)	97.59% (Mar 17)	90.00% (Mar 16)
	A&E Friends and Family test January 2018	Response Rate	5.87%	11.91%	31.09%	0.00%	*Worcestershire Acute Hospitals NHS Trust considers that this data is as described for the following reasons:* Action to improve patient flow – see Quality Account – will improve patient experience in ED and encourage staff to support work to improve response rates.	3.59% (Mar 18)	4.15% (Mar 17)	5.77% (Mar 16)

Domain	Indicator	Current Performance	National average value	Where applicable		Trust statement	Previous values (where data available)		
				Best NHS performer	Worst NHS performer				
Treating and caring for people in a safe environment and protecting them from harm	% of patients risk-assessed for venous thromboembolism Quarter 3 2018/2019	94.45%	95.65%	100.00%	54.86%	*Worcestershire Acute Hospitals NHS Trust considers that this data is as described for the following reasons:* VTE assessment rates remain below the national average. *Worcestershire Acute Hospitals NHS Trust intends to take the following actions to improve this number and so the quality of its services, by:* See Quality Account priorities.	92.26% (Q4 17/18)	93.75% (Q4 16/17)	93.55% (Q4 15/16)
	Rate of C.difficile per 100,000 bed days April 2017 to March 2018	12.7	13.7	0.0	91.0	*Worcestershire Acute Hospitals NHS Trust 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. *Worcestershire Acute Hospitals NHS Trust intends to take the following actions to improve this number and so the quality of its services, by:* See Quality Account priorities.	15.7 (Apr 16 to Mar 17)	10.3 (Apr 15 to Mar 16)	14.0 (Apr 14 to Mar 15)

Domain	Indicator	Current Performance	National average value	Where applicable		Trust statement	Previous values (where data available)		
				Best NHS performer	Worst NHS performer				
Treating and caring for people in a safe environment and protecting them from harm	Rate of patient safety incidents per 1,000 bed days October 2017 to March 2018	37.0		14.9	158.3	*Worcestershire Acute Hospitals NHS Trust considers that this data is as described for the following reasons:* The Trust has continued to focus on improvements to safety review processes. *Worcestershire Acute Hospitals NHS Trust 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.	42.0 (Oct 16 to Mar 17)	40.4 (Oct 15 to Mar 16)	42.0 (Oct 14 to Mar 15)
	Rate of patient safety incidents that resulted in severe harm or death per 1,000 bed days October 2017 to March 2018	0.5		0.00	4.34	*Worcestershire Acute Hospitals NHS Trust considers that this data is as described for the following reasons:* The Trust has continued to focus on improvements to safety review processes. *Worcestershire Acute Hospitals NHS Trust 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.	0.21 (Oct 16 to Mar 17)	0.10 (Oct 15 to Mar 16)	0.23 (Oct 14 to Mar 15)

Explanatory notes about the NHS Outcomes Framework

The NHS Outcomes Framework (NHSOF) indicators provide national level accountability for the outcomes the NHS delivers; they drive transparency, quality improvement and outcome measurement through the NHS.

The Framework sets out the national outcome goals that the Secretary of State uses to monitor the progress of NHS England. It does not set out how these outcomes should be delivered, it is for NHS England to determine how best to deliver improvements by working with Clinical Commissioning Groups (CCGs) to make use of the tools at their disposal.

Indicators in the NHSOF are grouped around five domains, which set out the high-level national outcomes that the NHS should be aiming to improve. They focus on improving health and reducing health inequalities:

- **Domain 1:** Preventing people from dying prematurely
- **Domain 2:** Enhancing quality of life for people with long-term conditions
- **Domain 3:** Helping people to recover from episodes of ill health or following injury
- **Domain 4:** Ensuring that people have a positive experience of care
- **Domain 5:** Treating and caring for people in a safe environment and protecting them from avoidable harm.

Clinical Audit 2018/19

During 2018/19 59 national clinical audits and 5 national confidential enquiries covered relevant health services that Worcestershire Acute Hospitals NHS Trust provides. Also, in 2018/19 we undertook 392 registered local clinical audits.

During that period Worcestershire Acute Hospitals NHS Trust participated in 95% of the national clinical audits and 80% of the 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 2018/19. 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.

Participation in Clinical Research

Clinical research continues to be a driver of quality and effectiveness across the Trust, offering the opportunity to develop new treatments and providing the evidence of safety and effectiveness for better health and care.

During 2018/19, 1127 patients, carers and staff were entered into 64 research studies, across 15 different clinical specialties. This reflects an increase in activity from 17/18 in line with the Research and Development Strategy. 22 new studies were opened during the year, including three commercial studies across three specialty areas. 254 patients were entered into randomised clinical trials, across the following clinical areas:

Anaesthesia, Perioperative Medicine and Pain Management	9
Cancer	112
Cardiovascular Disease	56
Critical care	6
Haematology	21
Injuries and Emergencies	2
Musculoskeletal disorders	1
Reproductive Health and Childbirth	9
Respiratory Disorders	2
Surgery	36

The Trust will continue to try to increase research activity for the benefit of patients, staff and the NHS.

Commissioning for Quality and Innovation (CQUIN)

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 2018/19 the Trust's CQUIN commitments were as follows:

CQUIN Type	CQUIN	Aim	Year End Performance
National	**Improving Staff Health and Well-being 1a**	Achieving a 5 percentage point improvement in two of the three NHS annual staff survey questions on health and well-being, MSK and stress.	Expected to partially achieve
	Improving Staff Health and Well-being 1b	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. A further shift in percentages is required in 2018/19.	Expected to fully achieve
	Improving Staff Health and Well-being 1c	Achieving an uptake of flu vaccinations by frontline clinical staff of 75%.	Expected to fully achieve
	Reducing the impact of serious infections (Sepsis)	To embed a systemic approach towards the prompt identification and appropriate treatment of life-threatening infections.	Expected to partially achieve
	Reducing the impact of serious infections (Antimicrobial Resistance)	Reducing the chance of antibiotic-resistant strains of bacteria developing.	Expected to partially achieve
	Improving services for people with mental health needs who present to A&E	10% reduction in A&E attendances of patients with a primary mental health diagnosis in Q4 of 2018/19 as compared to a baseline set in Q4 2017/18. Ensure reduction of A&E attendances of the selected cohort (Year 2017/18) is sustainable.	Expected to fully achieve
	Offering advice and guidance	Set up and operate A&G services for non-urgent GP referrals, allowing GPs to access consultant advice prior to referring patients into secondary care. Increase the A&G services available. Sustain % of asynchronous responses provided within 2 working days.	Expected to partially achieve
	Reducing ill health by risky behaviours - Alcohol screening and interventions	Outlines the need for the NHS to take action to address risky behaviours, with a focus on alcohol consumption. Equip staff to conduct alcohol screening and deliver brief advice and/or referral through updated processes. Increase the number of people receiving interventions appropriate to their risk category.	Expected to fully achieve

CQUIN Type	CQUIN	Aim	Year End Performance
Local Area Team	**AAA Screening**	Reducing socioeconomic gradient of uptake and ensuring equity of delivery for AAA screening.	Expected to fully achieve
	Bowel Screening	Increasing Bowel Cancer Screening uptake within priority groups, to include prisoner screening AND increase GP engagement in low uptake practices.	Expected to fully achieve
	Breast Screening	Reduce Breast Cancer mortality rates by increasing awareness through various promotional activities; encourage screening uptake within priority groups and increase GP engagement.	Expected to fully achieve
	Oral Surgery	Deliver gains in service efficiency and quality by undertaking a trial of a one-stop pathway in a range of sessions, supported by suitably trained clinic staff. Optimise the benefits gained from DERMs.	Expected to fully achieve
Specialised Commissioning Team	**Hospital Pharmacy Transformation and Medicines Optimisation**	Procedural and cultural changes required to fully optimise the use of medicines commissioned by specialised services.	Expected to fully achieve
	Neonatal 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 a reduction in occupancy levels.	Expected to fully achieve
	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.	Expected to fully achieve

2019/20 CQUIN Programme

We are pleased to see that CQUINs 19/20 have been given a renewed focus on clinical achievement for improving quality. This year's CQUINs prioritise simplicity and deliverability and are based upon achieving goals for each intervention with clinical staff leading the projects.

The CQUINs are also aligned to 4 key areas that support the NHS Long Term Plan:

1. Prevention of ill health
2. Mental Health
3. Best Practice Pathways and
4. Patient Safety.

We have some reoccurring CQUINS and new initiatives:

- Antimicrobial Resistance – Lower Urinary Tract Infections in Older People and Antibiotic Prophylaxis in Colorectal Surgery
- Staff Flu Vaccinations
- Alcohol and Tobacco – Screening and Brief Advice
- Three High Impact Actions to Prevent Hospital Falls
- Same Day Emergency Care – Pulmonary Embolus/Tachycardia/ Community-Acquired Pneumonia
- There are many benefits to be achieved, expected to be patient safer care, improved patient experience and improved clinical pathways.

Appendix 1: Clinical Audit participation details

National Confidential Enquiry into Patient Outcome and Death (NCEPOD)

Worcestershire Acute Hospitals NHS Trust participated in 80% 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 2018/19, 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.

National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	% of cases returned
Cancer in Children, Teens and Young Adults *	No eligible cases
Perioperative Diabetes	N/A – not part of the study
Pulmonary Embolism	100%
Acute Bowel Obstruction	100%
Long Term Ventilation	No eligible cases

* Cancer in Children, Teens and Young Adults – we were eligible to participate in this audit, but did not do so due to an internal communications issue. We did not have any eligible cases in 2018/19.

National Audits

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

Eligible National Audits	Participation	% or Numbers of cases submitted	Comments
BAUS - Cystectomy	Yes	100%	
BAUS - Female Stress Urinary Incontinence	Yes	N/A	Audit removed nationally due to safety warning
BAUS - Nephrectomy	Yes	** Data not available	Ongoing data entry
BAUS - Percutaneous Nephrolithotomy	Yes	100%	
BAUS - Radical Prostatectomy	Yes	** Data not available	Ongoing data entry
BTS - Adult Community-Acquired Pneumonia	Yes	** Data not available	Data collection closes 31/5/19

Eligible National Audits	Participation	% or Numbers of cases submitted	Comments
BTS - Non-Invasive Ventilation - Adults	Yes	** Data not available	Data collection closes 30/6/19
CEM - Feverish Children	Yes	100%	
CEM - Vital Signs in Adults	Yes	100%	
CEM - VTE Risk in Lower Limb Immobilisation	Yes	100%	
EPILEPSY 12 - National Audit of Seizures and Epilepsies in Children and Young People	Yes	100%	
FFFAP - National Hip Fracture Database (NHFD)	Yes	n264	
ICNARC - Case Mix Programme	Yes	100%	
LeDeR - Learning Disability Mortality Review Programme	Yes	** Data not available	Final figures are unavailable.
Mandatory Surveillance of Bloodstream Infections and Clostridium Difficile Infection	Yes	100%	
MBRRACE - Maternal, Newborn and Infant Clinical Outcome Review Programme	Yes	100%	
NABCOP - National Audit of Breast Cancer in Older People	Yes	100%	
NACAP - Pulmonary rehabilitation	Yes	100%	
NACAP - Secondary Care - Adult Asthma	Yes	100%	
NACAP - Secondary Care - COPD	Yes	100%	
NACEL - National Audit of Care at the End of Life	Yes	100%	
NACR - National Audit of Cardiac Rehabilitation	Yes	100%	
NAOGC - National Oesophago-gastric Cancer Audit	Yes	100%	
NAD - National Audit of Dementia	Yes	100%	
National Mortality Case Record Review Programme	Yes	** Data not available	Unknown - data not available
NBOCA - National Bowel Cancer Audit	Yes	100%	
NBSR - National Bariatric Surgery Registry	Yes	n26	
NCAA - National Cardiac Arrest Audit	Yes	100%	
NCABT - Management of massive haemorrhage	Yes	100%	
NCAP - Cardiac Rhythm Management (CRM)	Yes	** Data not available	Data entry until May/June 19
NCAP - Myocardial Ischaemia National Audit Project (MINAP)	Yes	** Data not available	Data entry until May/June 19
NCAP - National Audit of Percutaneous Coronary Interventions (PCI)	Yes	** Data not available	Data entry until May/June 19
NCAP - National Heart Failure Audit	Yes	** Data not available	Data entry until May/June 19

Eligible National Audits	Participation	% or Numbers of cases submitted	Comments
NCAREIA - National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis	Yes	100%	
NDA - Adults - National Core Diabetes Audit	Yes	100%	
NDA - Adults - National Diabetes Foot Care Audit	Yes	100%	
NDA - National Diabetes Inpatient Audit	Yes	100%	
NDA - Adults - National Pregnancy in Diabetes Audit	Yes	100%	
NELA - National Emergency Laparotomy Audit	Yes	96%	
NJR - National Joint Registry	Yes	96% Consent rate	
NLCA - National Lung Cancer Audit	Yes	100%	
NMPA - National Maternity and Perinatal Audit	Yes	100%	
NNAP - National Neonatal Audit Programme	Yes	100%	
NPCA - National Prostate Cancer Audit	Yes	100%	
NPDA - National Paediatric Diabetes Audit	Yes	100%	
NVR - National Vascular Registry	Yes	100%	
PROMS - Elective Surgery	Yes	100%	
Reducing the Impact of Serious Infections (Antimicrobial Resistance and Sepsis) - Antibiotic Consumption	Yes	N/A	No patient cases, but antimicrobial consumption data is uploaded quarterly by Stewardship Pharmacist.
Reducing the Impact of Serious Infections (Antimicrobial Resistance and Sepsis) - Antimicrobial Stewardship	Yes	100%	
SHOT - Serious Hazards of Transfusion: UK National Haemovigilance	Yes	100%	
SSNAP - Sentinel Stroke National Audit Programme	Yes	100%	
Surgical Site Infection Surveillance Service	Yes	100%	
TARN - Major Trauma Audit	Yes	100%	
NDA - National Diabetes Harm Review	Yes	100%	
NDA - National Diabetes Transition Audit	Yes	100%	
FFFAP - (NAIF) National Audit of Inpatient Falls	Yes	100%	
FFFAP - Fracture Liaison Service Database (FLSD)	No	N/A	Unable to participate due to a lack of identified resources. Seeking to resolve during 2019/20.

Eligible National Audits	Participation	% or Numbers of cases submitted	Comments
IBD - Inflammatory Bowel Disease Programme/ IBD Registry	No	N/A	Unable to participate due to lack of resources. Progress has been made during 2018/19 to begin the development of the database required to enable participation. This will continue into 2019/20.
National Ophthalmology Audit	No	N/A	Unable to participate due to lack of resources. Seeking to resolve during 2019/20.

There was no data collection from the National Audit teams during 2018/19 for the following audits;

- National Asthma and COPD Audit Programme - Paediatric Asthma

Worcestershire Acute Hospitals NHS Trust was not eligible to participate in the following national audits because we do not provide the services within the scope of the audit;

Ineligible National Audits	Scope
Adult Cardiac Surgery	Specialist Audit
National Audit of Anxiety and Depression	Audit applies to Mental Health
National Audit of Intermediate Care	Specialist Audit
National Audit of Pulmonary Hypertension (COPD)	Specialist Audit
National Clinical Audit of Psychosis	Specialist Audit
National Clinical Audit of Specialist Rehabilitation for Patients with Complex needs following Major Injury (NCASRI)	Specialist Audit
National Comparative Audit of Blood Transfusion Programme - Use of Fresh Frozen Plasma and Cryoprecipitate in neonates and children	Do not provide this service/ low numbers of patients
National Congenital Heart Disease	Specialist Audit
Neurosurgical National Audit Programme	Specialist Audit
Paediatric Intensive Care (PICANet)	Specialist Audit
Prescribing Observatory for Mental Health (POMH-UK)	Audit applies to Mental Health
UK Cystic Fibrosis Registry	Specialist Audit

A total of 47 National Clinical Audit reports have been published in 2018/19 for national audits that the Trust either participated in or was eligible to participate in. These reports were reviewed in 2018/19 and the table below presents a selection of actions Worcestershire Acute Hospitals NHS Trust intends to take to improve the quality of healthcare provided.

National Audit	Date Published	Specialty	Actions/Improvements
NACAP - Pulmonary rehabilitation National Report 2018 Clinical and Organisational	12/04/2018	Respiratory	▶ Reduce waiting times for enrolment to PR (from receipt of referral) with an achievement target of 85% of patients being enrolled within 90 days for each PR programme. ▶ Each PR service should ensure that all exercise assessments are performed to recommended technical standards. ▶ PR programmes should achieve patient completion rates of 70% or more following assessment for PR. ▶ Patients who complete PR should receive a written discharge exercise plan. ▶ Hospital discharge teams should ensure that local discharge care bundles include the offer of early post-discharge PR, accompanied by information about the benefits of PR. ▶ The COPD team should review individual patient exacerbation prevention measures across in-reach, community and PR services.
NACAP - Secondary Care - COPD - Organisational Audit Report	12/04/2018	Respiratory	▶ Improve access to smoking cessation services. ▶ More COPD patients cared for on respiratory wards. ▶ Access respiratory specialist care within 24hrs. ▶ Implementation of a discharge bundle.
CEM - Pain in Children - Report 2017 ALX	24/05/2018	Emergency Department	▶ All patients should have a pain score recorded at triage. ▶ Re-evaluation of pain score post administration of analgesia with repeat obs.
CEM Fractured Neck of Femur - Report 2017 ALX	24/05/2018	Emergency Department	▶ Teaching on use of fascia iliaca block. ▶ The teaching of on re-evaluation of pain score to nursing staff.
CEM - Procedural Sedation in Adults - Report 2017 ALX	24/05/2018	Emergency Department	▶ Teaching regarding the use of checklist and proforma.
CEM - Pain in Children - Report 2017 WRH	24/05/2018	Emergency Department	▶ Aide memoirs in assessment areas to aid pain scoring. ▶ Effective handover message of the week. ▶ Re-evaluation of an hourly checklist.

National Audit	Date Published	Specialty	Actions/Improvements
CEM Fractured Neck of Femur - Report 2017 WRH	24/05/2018	Emergency Department	▶ Reassessment of pain scores in effective handover aid aide memoirs for pain in triage areas. ▶ Discussion with T&O hip improvement group for streaming options including pre-hospital alerts. ▶ Amendment of the hourly checklist and re-launch. ▶ Hip fracture lead for the Emergency Department.
ICNARC - Case Mix Programme 2017-18 Q4	01/06/2018	Critical Care / ITU	▶ Rapid access to ward beds for patients fit for step down from critical care within the target 8 hours to meet best practice standards.
NCABT - 2017 National Comparative Audit of Transfusion Associated Circulatory Overload (TACO)	03/06/2018	Haematology	▶ Implement a TACO checklist into the prescription for transfusion. ▶ Add patient weight on the prescription for transfusion. ▶ Implement Patient Blood management measures- indication codes. ▶ Implement Patient Blood management measures – Launch a single unit campaign. ▶ Educate doctors on the risk of TACO, including the need for patient review pre and post-transfusion. ▶ Include indication and consent for transfusion on the documentation for transfusion. ▶ Present audit at the Transfusion committee meeting.
SHOT - Serious Hazards of Transfusion UK National Haemovigilance	12/07/2018	Haematology	▶ Amend the competency assessments to include ABO and Rh groups ▶ Implement an Electronic Blood management system - Write Business case and case for change.
NPDA - National Paediatric Diabetes Audit	12/07/2018	Paediatrics	▶ Increase patient engagement and consistently implementing high HbA1c policy. ▶ Inform CYP and their carers of current DNA rates via the newsletter and sending out a copy of our mission statement with the next newsletter.

National Audit	Date Published	Specialty	Actions/Improvements
NDA - Assessment of delirium in hospital for people with dementia spotlight audit	09/08/2018	Neonatal	▶ Review and update the Dementia/Delirium Assessment Tool. ▶ Develop a delirium e-learning package. ▶ Develop Comfort Intervention Chart (to monitor changes in behaviour). ▶ Develop Dementia/Delirium Core Competency Training.
NJR - National Joint Registry 15th Annual Report 2018	01/09/2018	Trauma & Orthopaedics	▶ Robust data quality is key "supporting data quality strategy" – Review of data quality and level of input. ▶ BOA and NHS improvement endorsement on monitoring Surgeon engagement and reflection on their own practice and performance data – Link NJR to surgeons appraisal. ▶ Benchmark pricing for orthopaedic implants to achieve the best national prices – Implant benchmarking. ▶ Support Getting it Right First Time project by British Orthopaedic Association – Monitor Trust performance.
NAOGC - National Oesophago-gastric Cancer Audit Annual Report 2018 (NAOGC)	13/09/2018	Upper GI	▶ Increase case discussion of HGD cases. ▶ Monitor use of chemoradiotherapy. ▶ Case ascertainment >90%.
MBRRACE - Saving Lives, Improving Mothers Care	01/11/2018	Obstetrics	▶ Dissemination of findings from MBRRACE report 2018 to the wider team with Multi-Disciplinary Team input. ▶ Review and Amendment of Guidelines as per MBRRACE recommendations. ▶ New guideline/ Pathway for pregnancy care in vulnerable women. ▶ Cascade the recommendations to the Oncology team and primary care to improve the care of women with malignancy. ▶ MBRRACE Audit plan- on the 5 clinical conditions discussed in the report- To be included in the Directorate Audit Forward plan.

National Audit	Date Published	Specialty	Actions/Improvements
FFFAP - National Hip Fracture Database (NHFD) Annual Report 2018	15/11/2018	Trauma & Orthopaedics	▶ Review data quality › Hip fracture nurse appointed. › Confirmation of ASA for patients not having surgery. ▶ Daily senior ward rounds › Now incorporated into Consultant's job plans. › Audited at weekly Harm Review meeting for patients who breach 36-hour BPT. ▶ Golden patient initiative › Standard practice at WRH. › Being rolled out to the Alex. › Monitored/managed by the Hip Fracture Nurse Specialist. ▶ Hip fracture care pathway documentation › Developed and in use by all clinicians. ▶ Monthly Harm Review meetings › Weekly meetings take place to review actions/ issues arising. › Common themes and learning are shared at monthly directorate meetings. ▶ Combined weekend on-call rota in place from August 2018. ▶ Reduction in the number of T&O Consultants that can be on annual leave at any one time (maximum 40%). ▶ Mortality reviews › Reviews for patients continue to take place › Additional review of deaths during August 2017 to identify issues/learning. ▶ Hip fracture pathway audit. ▶ Visit other units that have had previous issues with excess mortality but have improved through changed management processes. ▶ British Orthopaedic Association peer review – has been confirmed for 4-5 June 2019.

National Audit	Date Published	Specialty	Actions/Improvements
National Cardiac Audit Programme (NCAP) Annual report for 2016/17 - MINAP Results	22/11/2018	Cardiology	▶ To improve direct access to Cardiology wards for ACS patients (not via AMU) at the Alexandra Hospital. ▶ To improve access to Specialist care and key disease-modifying drugs for in patients with Heart Failure. ▶ Complete Service Specification for Cardiac Rehab to include care of Heart Failure patients. ▶ Acute Heart Failure Nurses to provide capacity for early follow-up.
NVR - National Vascular Registry Annual Report 2018	28/11/2018	Vascular	▶ To investigate and support Interventional Radiology developing daycase lower-limb angioplasty/stenting capacity at the WRH (hub) site, plus investigation/ development of low-risk daycase angioplasty options at appropriate 'spoke' hospitals. ▶ To support Interventional Radiology in recruitment/ retention of Consultants, IR Nurses and IR Radiographers such that a 24/7 IR service may be implemented. ▶ Audit of major lower limb amputations (risk-adjusted survival below the national average, but within acceptable standard deviation range as per published data to assess for opportunities to improve in this metric) and implementation of findings.
NDA - National Diabetes Transition Audit 2011-2017	10/01/2019	Paediatrics	▶ The introduction of a clinic proforma for paediatric clinics. ▶ The introduction of an effective paediatric diabetes database. ▶ The introduction of a young adult diabetes clinic.

Local Clinical Audits

The reports of 309 local clinical audits were reviewed by Worcestershire Acute Hospitals NHS Trust in 2018/19 and the table below provides a selection of actions the provider intends to take or has taken to improve the quality of healthcare provided.

Audit Title	Specialty	Actions/Improvements
ID 10031 Deprivation of liberty safeguards	Corporate	▶ Workshops to be provided to address the 'how to' complete a DoLS application - to include a knowledge check and background information in respect of the assessment of mental Capacity and application of the 'acid test'. ▶ Training provision in relation to DoLS to be made available to medical staff - workshop provision will be promoted via mandatory training and senior clinical programmes. ▶ Band 5 applications (Senior Staff Nurse) to be scrutinised by band 6 or above to ensure compliance with legal and statutory requirements and Trust Policy.
ID 10080 Documentation audit 2018	Corporate	▶ Self-inking identification stamps to be rolled out to all registered medical, nursing, AHP staff. ▶ Re-audit of MAU, SCDU, Surgical Ward and Urology 2 following the rollout of the stamps. ▶ Revisions to be made to the audit tool regarding Q18.
ID 10085 16A Temperature monitoring and management of hypothermia during anaesthesia	Anaesthetics	▶ Improve documentation and active warming. ▶ Alternative warming devices. ▶ Alternative temperature monitoring device.
ID 10017 16D Patients cancelled "unfit" day of surgery	Anaesthetics	▶ Ask POAC staff to reinforce to patients importance of contacting the hospital if acutely unwell and how to do this. ▶ Investigate the possibility of text message reminders to try and reduce DNA's for surgery as well as action in case of acute illness.
ID 1038 Sepsis requiring critical care admission: Initial diagnosis and management	Critical Care / ITU	▶ Education around Sepsis Six - early identification using a structured screening tool with early treatment and antibiotic review and appropriate timely escalation. ▶ Encourage staff to use new sepsis tool.
ID 1674 17B Delirium on the ICU: Knowledge, attitudes and prevention	Critical Care / ITU	▶ Teaching Program on Delirium for all staff and review current delirium guidelines. ▶ Laminated CAMICU chart inpatient file. ▶ Consultant lead to check scoring twice daily as part of FASTHUG. ▶ Use Action sticker in response to positive CAMICU.

Audit Title	Specialty	Actions/Improvements
ID 10061 18B Therapeutic OGD audit as per BSG quality and safety indicators 2016	Endoscopy	▶ Raise awareness of audit results to all nursing and medical teams. ▶ 2 stage consent process to be followed by all Endoscopists. ▶ The correct consent form to be utilised.
ID 1564 An audit of compliance with the BCSH guidelines for the management of diffuse large B-cell lymphoma (DLBCL)	Haematology	▶ Add boxes of Prognostic score and EOT PET to be filled on MDT sheet. ▶ To circulate an email to consultants. ▶ EOT PET to be done as routine practice, if clinically relevant.
ID 10127 Discharge and follow-up of transplant patients	Haematology	▶ Document in notes upon admission to Laurel 3 timing of follow-up appointment. ▶ Copy of clinic letter to be sent to Transplant Consultant at UHB and BMT Co-ordinator to be copied in to forward to UHB Data Manager. ▶ Determine feasibility of nurse-led post-transplant clinic to ensure patients are seen within.
ID 693 Audit report on intravenous antibiotic treatment of suspected neutropenic sepsis - 2017 Q2	Oncology	▶ Improve Door to needle time adherence. ▶ Revise documentation for Just in Case Pack and rename to Emergency Sepsis Antibiotic Prescription. ▶ Teaching within A&E & MAU departments. ▶ Meet with A&E and MAU Clinical Leads and agree on the pathway for improvement. ▶ Collection of data on why patients missed the 1 hour target time. Weekly review with A&E.
ID 10327 Audit of mortality rates following palliative radiotherapy in 2018	Oncology	▶ Schedule repeat audit for January 2020 in Qpulse. ▶ Review data for any deaths within 14 days of completion of radiotherapy.
ID 10314 Audit to ensure all radiotherapy patient are receiving the new general radiotherapy patient info leaflet in all outpatient clinics at the time of consent	Oncology	▶ Review Radiotherapy Patient Experience Survey to include a question to check patients are receiving the booklet as intended. ▶ Inform all consultants of audit results and advise to carry a small supply of booklets with them for private patients.
ID 1558 Glaucoma diagnosis and DVLA advice	Ophthalmology	▶ To use an Audit Day presentation to raise the awareness of clinicians of the need to (A) advise patients with notifiable glaucoma that they need to notify the DVLA, and (B) improve clinical documentation of patients' driving status and of any advice given regarding notifying the DVLA.

Audit Title	Specialty	Actions/Improvements
ID 10181 19B A review of patients supported with the AMBER care bundle	Palliative Care	▶ Devise and plan new teaching sessions to update teams on AMBER and inform new members of staff of its use. ▶ Support the use of the AMBER Care Bundle earlier in the patient's journey – at the 'front door'. – make contact with A&E, MAU and support and facilitate the role in these departments. ▶ Raise the profile of AMBER in the trust – Communication pieces, twitter, keeping regular contact on wards. ▶ Networking with ward teams and support key relationships – patient flow centre, discharge team. ▶ Support and facilitate teams to have honest conversations with patients surrounding preferences for place of care and death through training to improve knowledge and confidence. ▶ Undertake SAGE & THYME communication training to disseminate learning to others. ▶ Re-audit AMBER Care Bundle and 1-year post-employment of AMBER Care Bundle Support Nurse.
ID 1355 Compliance with surgical antimicrobial prophylaxis guidelines within vascular and orthopaedic surgery at a single acute general hospital	Pharmacy	▶ Review Antimicrobial Prescribing Guidelines. ▶ Remove outdated guideline information from clinical areas. ▶ Easy access to up-to-date antimicrobial prescribing guidelines.
ID 1417 An audit of antibiotic review in general surgical inpatients from intravenous to the oral route of administration in accordance with local and national guidance	Pharmacy	▶ Design review form to prompt and guide review of IV antibiotics 48 to 72 hours after initiation and guide documentation of decision. This is to be used across all specialties for all inpatients. ▶ Redesign antibiotic prescribing section on inpatient drug chart to prompt early antibiotic review after 48 hours.
ID 1521 Neck/thyroid fine needle aspiration: Adequacy of samples	Radiology	▶ Check histology results of all FNA samples. ▶ Continuous monitoring of results after every 25 patients.
ID 1629 25B Emergency equipment audit (resuscitation trolleys) re-audit	Resuscitation	▶ Areas that generated DATIX reports will be re-audited within 1 month. ▶ Audit summary to be presented to the Resuscitation Committee.

Audit Title	Specialty	Actions/Improvements
ID 10296 25A DNACPR audit and respect form survey	Resuscitation	▶ Post-take ward round consultants to review recently implemented ReSPECT/ DNACPR quicker e.g. routine. ▶ Nurse-in-charge/ ward staff to flag up to consultant patients who may need DNACPR. ▶ Encouragement of HCP to document mental capacity assessments as well as highlighting capacity status. ▶ Next audit to focus on proper completion of ReSPECT forms with additional qualitative information regarding HCP attitudes towards ReSPECT.
ID 1247 Audit of British Society for Rheumatology guidelines for the management of ANCA associated vasculitis in adults 2013	Rheumatology	▶ Feedback of audit results to the department. ▶ Review of current rheumatology cyclophosphamide protocol.
ID 10079 27E WHO audit	Theatres	▶ Improve engagement with sign in. ▶ Increase audit sample numbers. ▶ Improve team brief and debrief engagement. ▶ Focus on the silent cockpit. ▶ Maintain larger audit sample numbers.
ID 1362 Pain management during cardiac implantable electronic devices	Cardiology	▶ Record accurate patient weight prior to device. ▶ Use lidocaine as per weight/maximum dosage. ▶ Clear documentation of medications used during procedures. ▶ Interventions targeted at reducing pre and peri-implant anxiety may potentially help reduce patient reported pain during CIED implantation.
ID 1644 Effect of additional Saturday cathlist on patient turnover times and comparison with NICE standard for IP coronary	Cardiology	▶ Continue with Saturday cath lists long term. ▶ Arrangement for echocardiograms over weekends to facilitate discharges/patient flow.
ID 10132 Management of severe hyperlipidaemia in ACS patients: re-audit	Cardiology	▶ To continue raising awareness in checking lipids and monitor them amongst the multidisciplinary team. ▶ Discussion with the cardiac rehabilitation team to help with repeat lipids level in 3 months. ▶ Discussion with Lipid team for further follow up / assessment of patients at risk.

Audit Title	Specialty	Actions/Improvements
ID 10251 DKA management compliance	Endocrinology	▶ Ensure DKA leaflets are available to be distributed to new DKA patients on all wards or on the intranet. ▶ Provide diabetes teaching and a lecture on DKA management once annually at least. ▶ Emphasise the adjustment to FRIII insulin infusion rate on the current trust guidelines and DKA presentation.
ID 1706 Were PEGs discussed at MDT prior to insertion? A re-audit	Gastroenter-ology	▶ PEG MDT to be continued as the audit data suggesting improving PEG patient selection and outcomes.
ID 10108 Frailty proforma completion - Ward 12	Geriatric Medicine	▶ Introduction of 'mini' frailty proforma to be completed for patients admitted to ward 12 without full Frailty Proforma from FAU.
ID 10122 The use of the term confusion in the assessment of patients with delirium	Geriatric Medicine	▶ The use of the term 'confusion' in the assessment of patients with delirium. ▶ Education to nurses about the requirement to document the assessment of patients with recent changes or fluctuations in behaviour. ▶ Create a poster of different behaviours and circulate to wards.
ID 10322 Appropriateness of antibiotic treatment in UTIs re-audit	Geriatric Medicine	▶ Presentation to junior doctors in the geriatric team for learning to improve on medical practice. ▶ Create awareness at trust level to abide by guidelines. It will help to learn about the underlying issue of not vigorously using the broad spectrum antibiotics.
ID 10304 Falls risk assessment with the STOPP/START tool	Geriatric Medicine	▶ Create awareness of Falls Risk Assessment + STOPP/START Tool Kit via presentations. ▶ Follow up on inputting "For STOPP/START Review" in Clerking booklet. ▶ Create mini cards with "STOPP/START Review" on them and make available in the hospital environment.
ID 1364 An Audit of treatment outcomes in a cohort of HIV patients co-infected with chronic hepatitis C in the semi-rural community of Worcestershire	Infectious Diseases	▶ To continue an audit on treatment outcomes in a cohort of HIV co-infected patients with chronic hepatitis.
ID 1299 Analysis of HES data for WAHT in multiple sclerosis	Neurology	▶ Recognition of the need for more MDT capacity. ▶ Alemtuzumab patients prioritised. ▶ Proforma introduced by QEHB.

Audit Title	Specialty	Actions/Improvements
ID 1633 Carpal tunnel syndrome test assessment (West Midlands)	Neurophysi-ology	▶ Introduction of very severe category in CTS. ▶ Use of thermometer in NCS.
ID 1508 12D Retrospective audit of patients with end-stage renal disease who commenced dialysis during 2016-October 2017	Renal Medicine	▶ Consistent use of diagnosis box in renal letters. ▶ Meet with QEH partners to review dialysis starters.
ID 1697 Renal biopsy	Renal Medicine	▶ To create new renal biopsy proforma.
ID 1318 Oxygen prescription audit	Respiratory	▶ Reminder to both doctors and nurses. ▶ Pharmacist colleagues to check oxygen has been signed. ▶ Consider oxygen wrist band in the future. ▶ Put up laminated notice.
ID 1603 Thromboprophylaxis, NIHSS and Co-morbidity form completion for patients admitted to Acute Stroke Unit	Stroke	▶ Trial discharge Sticker.
ID 10043 Occupational therapy documentation audit	Therapies	▶ Feedback of results to staff. ▶ Provide training to staff re documentation & SOAP notes. ▶ Provide individual team results for feedback.
ID 10212 The implementation of the malnutrition Re-audit	Therapies	▶ Streamline nursing documentation for MUST by combining assessment and action plan on one sheet. ▶ To improve accurate assessment for MUST by ensuring laminated charts are ordered from XEROX. ▶ To offer training to nurses at WRH & AH on use of MUST and correct documentation on the action plan. ▶ To facilitate patient's height being measured on admission via the use of laminated MUAC measuring tapes.

Audit Title	Specialty	Actions/Improvements
ID 10171 28B Health equity audit for the newborn hearing screen programme	Audiology	▶ Further training to be undertaken by the screeners, NHSP A&C, Audiology A&C on the KPI-NH2 standard. ▶ Look at clinic availability and locations for diagnostic ABR have and ensure it is flexible and as efficient as possible. Look at reducing ABR appointment time to 1 hour with the introduction of Chirps as standard. ▶ Ensure the A& C staff book into the most convenient location for the diagnostic ABR. ▶ Book the diagnostic ABR appointment face to face at the time of the screen whenever possible. Provide laptops on the ward so that screeners can access Audit base to do this. ▶ Ensure all Senior Clinical Audiologists call parents that DNA a diagnostic ABR appointment. Document the reasons why in the journal of Auditbase and rebook another appointment over the telephone at a time and date that is convenient for the parents whenever possible. ▶ Send DNA letter to GP surgery when an appointment is not attended.
ID 1454 Use of antibiotics and implant loss rate at WAHT	Breast	▶ Audit presented in directorate meeting. Antibiotic guidelines discussed and agreed - induction dose and 3 post-op doses for implant reconstructions. Therapeutic mammoplasties, wire localised procedures, patients post chemotherapy and high-risk (diabetic, immunocompromised, obese) to get an induction dose only.
ID 674 National audit of non-melanoma skin cancer (NMSC) excision and completeness of histopathological reporting	Dermatology	▶ Highlight the availability of the surgical logbook to Dermatologists.
ID 10195 32B Epistaxis review by a consultant within 24 hours	Ear, Nose and Throat	▶ Senior clinician/Consultant review at second pack removal. ▶ Failed second pack removal results in listing for SPA. ▶ Re-audit with actions above implemented.
ID 10130 IV fluid audit	General Surgery	▶ Teaching on fluid management and awareness of NICE guidance (Junior Doctors and Nurse Practitioners).
ID 1367 An audit of pre-assessment of patients listed for oral surgery under IV sedation	Oral & Maxillo-facial, Orthodontics and Orthognathic	▶ Educate team members on the importance of assessing and recording physiological parameters. ▶ Aim to update departmental guidelines to aid in the assessment and listing of patients for IV sedation. ▶ Consider prospective study to confirm findings.

Audit Title	Specialty	Actions/Improvements
ID 10140 34C Compliance with eye observations on the ward following reduction of zygomatic complex fractures or orbital floor repair	Oral & Maxillo-facial, Orthodontics and Orthognathic	▶ Production of a suitable chart that will allow for reliable documentation - this has been produced and is in use.
ID 1473 Fascia iliaca compartment block in neck of femur patients	Trauma & Orthopaedics	▶ Present the findings of the audit to all junior doctors during the Thursday journal club. ▶ Ensure junior doctors are able to observe blocks in the emergency department and understand the anatomy of the fascia iliaca compartment. ▶ Inform doctors of the result of the audit during the board round. Highlight what areas need improvement. ▶ Highlight analgesia to all Clinicians.
ID 1345 Pain management and the consideration of nerve blocks in patients admitted to A&E at Worcestershire Royal Hospital with neck of femur fractures	Trauma & Orthopaedics	▶ Present audit at a departmental meeting. ▶ A poster to highlight the importance of assessing pain scores and following the guidelines of pain management. ▶ Teaching session on how to perform an FI block.
ID 10247 NOF and AKI	Trauma & Orthopaedics	▶ AKI Sticker – to check whether the patient has had: IV fluids prescribed, fluid balance checked.
ID 10174 Outcomes and complication audit of transperineal template prostate biopsy	Urology	▶ To clarify the role of MRI PIRADS in stratifying patients for prostate biopsy.
ID 1647 Outcomes of emergency thrombembolectomy of patients presenting with acute limb ischaemia at WRH from Jan 2016 - Dec 2017	Vascular	▶ For viable limbs (Category I ALI), revascularization should be performed on an urgent basis within 6–24 hours. ▶ Revascularization should be performed within 6 hours for patients with clinically threatened limbs. ▶ All patients should have TROPONIN T levels on admission. ▶ Risks of amputations associated with thromboembolectomy to be discussed prior to operation. ▶ Risks of mortality associated with thromboembolectomy to be discussed prior to operation. ▶ Re audit [Commenced Jan '19, for completion 31/8/19]
ID 1346 A Retrospective analysis of common iliac artery aneurysms (CIAA) at Worcestershire Royal Hospital	Vascular	▶ This study has been presented nationally and written up as a paper which is pending publication. The results have the potential to change national surveillance practices for CIAA.

Audit Title	Specialty	Actions/Improvements
ID 1538 Acute ambulatory care, outcomes and safety - Re-audit	Acute Medicine	▶ Improve documentation of date and time patient seen both first time. ▶ Improve the percentage of patients seen for the first time within 15 minutes from arrival. ▶ Improve the percentage of patients seen by a consultant within 4 hours from arrival.
ID 1686 Documentation of lumbar punctures in ambulatory patients	Acute Medicine	▶ Present results to junior doctors in the department. ▶ Design proforma for lumbar puncture documentation.
ID 10152 Medical short stay. Is it working?	Acute Medicine	▶ Share results with acute medical team outcome. ▶ Develop a proforma for better streaming of patients.
ID 1584 - 2B Management of primary spontaneous pneumothorax in the Emergency Department - are we getting it right?	Emergency Department	▶ Present audit findings and educate doctors. ▶ To upload the new guidelines orientated flow chart for A+E staff members to use in A+E when someone presents with PSP.
ID 10112 Re-audit of colles fracture manipulation in ED	Emergency Department	▶ Review # clinic practices. ▶ Encourage the use of advice sheets. ▶ Plaster techs to give support and learning to ED staff who plaster.
ID 1701 Renal colic	Emergency Department	▶ Feedback of good results. ▶ Improve HCG documentation - Staff message to relay the importance of documenting HCG for women of childbearing age. ▶ Pain management - ED to review hourly checklist and how best to implement it - current staffing levels, training and overcrowding are currently making this very difficult for the ED to achieve.
ID 10155 Management of uncomplicated stable supraventricular tachycardia in the emergency department	Emergency Department	▶ A weekly message to inform to ask first before bloods for simple SVT patients ▶ Continuing education around the benefit of valsalva manoeuvre as 1st line treatment for SVT.
ID 10124 CT scan (requests from A&E)	Emergency Department	▶ Shared learning and findings with radiology. ▶ A weekly message to include 'urgent CT's i.e. time critical must be discussed with the on-call radiologist to ensure they happen promptly.
ID 10303 Sepsis screening tool in the paediatric unit and A&E Department	Emergency Department	▶ Develop a paediatric sepsis tool. ▶ Staff education.

Audit Title	Specialty	Actions/Improvements
ID 10199 2C Re-audit of management of fracture neck of the femur within the emergency department at Redditch Alexandra Hospital	Emergency Department	▶ Teaching to Doctors and nurses to ensure that all patient with suspected # NOF should receive. Analgesia , if in the corridor should receive oromorph. ▶ Teaching to Senior Doctors to remind the need for all patients with fracture NOF should receive Facia illaca block. ▶ All patients with fracture NOF should have a record of pain score with a set of obs.
ID 1230 Audit of national standards in colposcopy - Re-audit	Gynaecology	▶ All colposcopists should meet the required number of New patients seen within 12 months. ▶ All colposcopists should endeavour to ensure a depth of greater than 7mm is achieved when treating. ▶ Women who have HGCIN/CGIN on biopsy should be treated within 28 days of the report being received. ▶ Standard of women with LG cytology treated at first visit with HG disease on histology to be monitored.
ID 10159 39C BSUG outcome audit	Gynaecology	▶ Assess the impact of the suspension of TVT on incontinence surgery uptake and procedure types.
ID 10167 40B Treatment of neonatal jaundice at WRH	Neonatal	▶ Continue education for clinical staff. ▶ Include use of phototherapy charts in junior doctors and nurses induction. ▶ Consider tweaking the current phototherapy charts.
ID 10185 40C Newborn pulse oximetry screening audit	Neonatal	▶ Present data and findings to the paediatric junior doctors who carry out the majority of NIPE. ▶ Visible poster of pulse oximetry flow diagram placed in the paediatric junior doctors' office.
ID 1615 Maternity domestic abuse	Obstetrics	▶ Standardised practice in relation to undertaking the routine enquiry across the community midwifery team. ▶ DA Link Midwife to liaise with Perinatal Institute to see if DA section can be added into post-natal. ▶ DASH risk assessment training roll out to Specialist Midwives. ▶ Named Midwife to Liaise with Matron Postnatal ward re promoting opportunities. ▶ Training.
ID 10001 41B Maternity sepsis audit	Obstetrics	▶ Increase awareness of maternal sepsis audit tool. ▶ Sepsis audit tool staff reminder. ▶ Document on K2 whether sepsis six has been undertaken.
ID 1580 Management of sepsis	Paediatrics	▶ Trust paediatric sepsis proforma – to be initiated into Riverbank Ward and A+E. ▶ Staff education.

Audit Title	Specialty	Actions/Improvements
ID 1665 42D Management of sepsis in children admitted to Riverbank Ward	Paediatrics	▶ Sepsis management new sepsis guidelines. ▶ To circulate the audit findings to the paediatric team to remind all to fill in the senior review part of the clerking sheet.
ID 1623 USS abdomen in suspected appendicitis in paediatrics	Paediatrics	▶ Pain abdomen - flow chart creation. ▶ To adapt pain abdomen guidelines from PIP.
ID 10121 42A Management of UTI in children (CG54)	Paediatrics	▶ To remind nurses and doctors to document the result of urine dipstick before sending for culture.

Examples of how Clinical Audit has been used to Drive Improvement

Paediatric Oncology Shared Care Unit

The Paediatric Oncology Shared Care Unit provides Level 2 Care for children and young people with cancer. Worcestershire Acute Hospitals NHS Trust cares for children and young people with cancer in the region, with patients having 24-hour Open Access to the Riverbank Ward at Worcestershire Royal Hospital.

Neutropenia sepsis is the most common life-threatening complication of treatment in children with cancer. Our annual audits previously showed that we were not giving a high number of patients antibiotics within 1 hour of admission.

A focus on placing patients immediately on the Neutropenic Sepsis Pathway has led to us achieving outstanding 'door-to-antibiotic' times for patients with fever and suspected neutropenia.

Last year there were 74 admission episodes of patients at risk of neutropenia who presented with fever. In 69 out of these 74 episodes (93%), patients received intravenous antibiotics within 60 minutes of arrival.

Out of the 5 episodes when patients did not receive antibiotics within 60 minutes: 2 patients had no central venous line (CVL) and needed a peripheral cannula, 2 patients had a blocked CVL, and 1 patient had difficult vascuport access. In 4 out of these 5 episodes, patients received antibiotics within 2 hours.

Our average door to needle time was 37 minutes. The CCLG 2017 winter audit revealed 66% of paediatric oncology patients received intravenous antibiotics within 60 minutes.

Further plans to continue improvement include;

- Nurses to receive training in cannulation skills
- Nurses to obtain NMP certificate
- Continued education for nursing and medical staff
- Continued positive feedback for excellent performance.
- Sharing of practice with other PTC/POSCU at Paediatric Oncology Study Days and conferences.

A number of clinical audits have been presented outside of the Trust and some have won awards, for example;

Breast

- An audit of the use of chemotherapy in patients over 80 years of age is being published **– ID 10286**

Urology

- An audit on thyroid shield usage was presented regionally and internationally and won Best Presentation Award in the Royal College of Surgeons (Ed) Quality Improvement Meeting **– ID 1486**

- A template prostate biopsy audit won the Peter Ryan Prize at the Midland Urology Club **– ID 10174**

- The Flexible URS vs PCNL audit was presented regionally and internationally, including at the World Congress of Endourology **– ID 1533**

Oral and Maxillofacial Surgery

- The audit of Assessing adherence to NICE guidance for urgent suspected skin cancer referrals following the implementation of a new 2-week wait NDT (OMFS. Dermatology) clinical audit was accepted for presentation at the British Association of Oral and Maxillofacial Surgeons **– ID 10176**

Appendix 2: Care Quality Commission (CQC) Inspections and Ratings 2018

Date	Services Inspected
23rd - 26th January	Maternity, Children & Young People, Outpatients, Diagnostics & Minor Injuries Unit
13th - 15th February	Surgery, Outpatients & Maternity
26th - 28th February	Well-Led Inspection
20th - 21st March	Urgent Care (Focused 'Is it Safe' Inspection)

CQC Inspection Report published: 5th June 2018

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Inadequate	Requires improvement	Good	Inadequate	Requires improvement	Inadequate
June 2018	June 2018	June 2018	June 2018	June 2018	June 2018

The rating for well-led is based on our inspection at Trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Ratings for the acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Worcestershire Royal Hospital	Inadequate June 2018	Requires improvement June 2018	Good June 2018	Inadequate June 2018	Inadequate June 2018	Inadequate June 2018
Alexandra Hospital	Inadequate June 2018	Requires improvement June 2018	Good June 2018	Inadequate June 2018	Inadequate June 2018	Inadequate June 2018
Kidderminster Hospital and Treatment Centre	Inadequate June 2018	Requires improvement June 2018	Good June 2018	Inadequate June 2018	Inadequate June 2018	Inadequate June 2018
Evesham Community Hospital	Good Dec 2015	Good Dec 2015	Good Dec 2015	Good Dec 2015	Good Dec 2015	Good Dec 2015
Overall trust	Inadequate June 2018	Requires improvement June 2018	Good June 2018	Inadequate June 2018	Requires improvement June 2018	Inadequate June 2018

Ratings for the trust are from combining ratings for hospitals. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Ratings for Worcestershire Royal Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement June 2018	Good January 2018	Requires improvement June 2018	Inadequate January 2018	Inadequate January 2018	Inadequate June 2018
Medical care (including older people's care)	Requires improvement January 2018	Requires improvement January 2018	Good January 2018	Requires improvement January 2018	Requires improvement January 2018	Requires improvement January 2018
Surgery	Inadequate June 2018	Requires improvement June 2018	Good June 2018	Inadequate June 2018	Inadequate June 2018	Inadequate June 2018
Critical care	Requires improvement June 2017	Good June 2017	Good June 2017	Requires improvement June 2017	Requires improvement June 2017	Requires improvement June 2017
Maternity	Requires improvement June 2018	Good June 2018	Good June 2018	Good June 2018	Good June 2018	Good June 2018
Services for children and young people	Requires improvement June 2018	Requires improvement June 2018	Good June 2018	Good June 2018	Requires improvement June 2018	Requires improvement June 2018
End of life care	Good June 2017	Good June 2017	Good June 2017	Good June 2017	Good June 2017	Good June 2017

	Safe	Effective	Caring	Responsive	Well-led	Overall
Outpatients	Inadequate June 2018	N/A	Good June 2018	Inadequate June 2018	Inadequate June 2018	Inadequate June 2018
Diagnostic imaging	Requires improvement June 2018	N/A	Good June 2018	Requires improvement June 2018	Requires improvement June 2018	Requires improvement June 2018
Overall*	Inadequate June 2018	Requires improvement June 2018	Good June 2018	Inadequate June 2018	Inadequate June 2018	Inadequate June 2018

Ratings for Kidderminster Hospital and Treatment Centre

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement June 2018	Inadequate June 2018	Good June 2018	Good June 2018	Inadequate June 2018	Inadequate June 2018
Medical care (including older people's care)	Requires improvement January 2018	Requires improvement January 2018	Good January 2018	Good January 2018	Requires improvement January 2018	Requires improvement January 2018
Surgery	Inadequate June 2018	Requires improvement June 2018	Good June 2018	Inadequate June 2017	Inadequate June 2018	Inadequate June 2018

	Safe	Effective	Caring	Responsive	Well-led	Overall
Services for children and young people	Requires improvement June 2018	Requires improvement June 2018	Good June 2018	Requires improvement June 2018	Requires improvement June 2017	Requires improvement June 2018
End of life care	Good June 2017	Good June 2017	Good June 2017	Good June 2017	Good June 2017	Good June 2017
Outpatients	Inadequate June 2018	N/A	Good June 2018	Inadequate June 2018	Inadequate June 2018	Inadequate June 2018
Diagnostic imaging	Requires improvement June 2018	N/A	Good June 2018	Requires improvement June 2018	Requires improvement June 2018	Requires improvement June 2018
Maternity and gynaecology	Requires improvement June 2017	Requires improvement June 2017	Good June 2017	Good June 2017	Requires improvement June 2017	Requires improvement June 2017
Overall*	Inadequate June 2018	Requires improvement June 2018	Good June 2018	Inadequate June 2018	Inadequate June 2018	Inadequate June 2018

Ratings for Alexandra Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement June 2018	Requires improvement January 2018	Good January 2018	Requires improvement January 2018	Inadequate January 2018	Requires improvement June 2018
Medical care (including older people's care)	Requires improvement January 2018	Requires improvement January 2018	Good January 2018	Requires improvement January 2018	Requires improvement January 2018	Requires improvement January 2018
Surgery	Inadequate June 2018	Requires improvement June 2018	Good June 2018	Inadequate June 2018	Inadequate June 2018	Inadequate June 2018
Critical care	Good June 2017	Good June 2017	Good June 2017	Good June 2017	Good June 2017	Good June 2017
Services for children and young people	Requires improvement June 2018	Requires improvement June 2018	Good June 2018	Requires improvement June 2018	Requires improvement June 2018	Requires improvement June 2018
End of life care	Good June 2017	Good June 2017	Good June 2017	Good June 2017	Good June 2017	Good June 2017
Outpatients	Inadequate June 2018	N/A	Good June 2018	Inadequate June 2018	Inadequate June 2018	Inadequate June 2018

	Safe	Effective	Caring	Responsive	Well-led	Overall
Diagnostic imaging	Requires improvement June 2018	N/A	Good June 2018	Requires improvement June 2018	Requires improvement June 2018	Requires improvement June 2018
Maternity and gynaecology	Requires improvement June 2017	Requires improvement June 2017	Good June 2017	Good June 2017	Requires improvement June 2016	Requires improvement June 2017
Overall*	Inadequate June 2018	Requires improvement June 2018	Good June 2018	Inadequate June 2018	Inadequate June 2018	Inadequate June 2018

Ratings for Evesham Community Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Critical care	Good July 2015	Good July 2015	Good July 2015	Good July 2015	Good July 2015	Good July 2015
Overall*	Good July 2015	Good July 2015	Good July 2015	Good July 2015	Good July 2015	Good July 2015

Care Quality Commission (CQC) Inspections and ratings 2019

Date	Services Inspected
14th January	Urgent Care at both the Alexandra Hospital and the Worcestershire Royal Hospital. (Focused 'Is it Safe' review)

Date CQC Inspection Report published: 8th February 2019

This inspection was intentionally 'unrated'.

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

Clinical Commissioning Groups

The response detailed below represents a collective review 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 provide comments on the Quality Account prepared by Worcestershire Acute Hospitals NHS Trust (WAHT) for 2018/19.

The Trust Quality Account is a clearly written document which highlights how the Trust performed against the agreed quality priorities it set itself to achieve for 2018/19 as well as the revised priorities for 2019/20. The Account includes all nationally mandated elements and incorporates the prerequisite national guidance and to the best of our knowledge is factually accurate.

The CCGs note the positive progress made against some of last year's quality priorities such as pressure ulcer prevention, falls and responding to complaints in a timely manner. However, the CCGs also note that there are a significant number of areas where the quality requirements were not fully attained during 2018/19. In some cases, this represents the third consecutive year where similar quality requirements have not been achieved which is concerning. The CCGs are particularly disappointed with the lack of progress made in relation to undertaking timely mortality reviews and implementing effective processes for disseminating learning across the Trust. Given the limited progress seen against some of the targets set in 2018/19 the Trust is advised to consider carefully how they intend to ensure the targets set for 2019/20 are fully achieved. It is anticipated that the improvements made during the year which include strengthening and streamlining the Executive Leadership Team and improving corporate governance functions will be instrumental in enabling the Trust to demonstrate improvements during 2019/20.

Commissioners support and welcome the specific quality priorities identified for 2019/20. All are appropriate areas to target for continued improvement and build upon the achievements in 2018/19. The CCGs are particularly pleased to see that staffing, mortality, seven-day service and infection prevention practice have been prioritised for improvement this year. The CCGs also recognise and support the Trusts emphasis within the revised quality priorities on the importance of engaging with staff to ensure ward to board commitment and accountability for improving quality.

Despite the positive work identified above the CCGs would like to highlight the ongoing quality concerns resulting from challenged performance across several specialties. These include urgent care, stroke and cancer care and the CCG will continue to work in partnership with the trust to deliver the agreed improvements. However, the CCGs main concern relates to the potential patient safety and patient experience impact of the waiting times for access to urgent care at the trust and will continue to work in collaboration with the trust to drive delivery of the urgent care and patient flow priority actions, which include a range of same day emergency care initiatives and streaming of appropriate patients to these services. The CCG will also continue to work with system partners to appropriately reduce acute trust demand and to further enhance the improvements seen in recent years related to complex discharge from hospital.

Overall Commissioners are happy to accept this Quality Account as an accurate and fair reflection of the Trusts quality profile. 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 upon which to focus improvements and embed learning Trust wide.

Worcestershire Health Overview and Scrutiny Committee (HOSC)

The Worcestershire Health Overview and Scrutiny Committee welcomes receipt of the draft 2018-19 Quality Account for Worcestershire Acute Hospitals NHS Trust and through the routine work of HOSC, and the activities of individual Members, we hope that the scrutiny process continues to add value to the development of healthcare across all health economy partners in Worcestershire. The draft Quality Account is positive about the significant work taking place. Nonetheless, through its regular public scrutiny of the Acute Trust's performance, the Committee has expressed its concern that the Trust remains in special measures and has another new Chief Executive. The Committee will continue to monitor performance and hopes to see a dramatic and consistent improvement in quality and that the latest CQC visit will demonstrate this is happening at last.

healthwatch Worcestershire

Healthwatch Worcestershire

Healthwatch Worcestershire [HWW] has a statutory role as the champion for those who use publicly funded health and care services in the county. Healthwatch Worcestershire welcomes the opportunity to comment on the Worcestershire Acute Hospitals NHS Trust Quality Account [QA] for 2018/19. Healthwatch Worcestershire's principal concern is that patients who live or work in Worcestershire receive safe and quality services from the Trust.

We have used national Healthwatch England guidance to form the response below to the draft Quality Account 2018-2019 for the Worcestershire Acute Hospitals NHS Trust.

1. **Do the priorities of the provider reflect the priorities of the local population?**

We are pleased to see that the Trust has used a triangulation approach to identify the Quality Priorities, and in particular that there has been engagement with patients to inform the priorities.

The three priorities of the Quality Improvement Plan: Care that is Safe, Care that is Clinically Effective and Care that is a Positive Experience are likely to reflect the priorities of the local population.

We particularly welcome the inclusion of Priority 3, Quality Indicator 5 'We will support patients and carers to feel more involved and supported in taking ownership of the decisions about their care to ensure there are positive co-production and involvement approach'. The commitment by the Trust to 'increase diversity on existing patient forum groups' and to 'increase involvement from the public and patient representatives across

our Trust in our meetings, on our committees and groups' are approaches Healthwatch Worcestershire supports and we look forward to seeing progress in this area.

2. Are there any important issues missed?

The triangulation of information using patient consultation, the SQUID and the CQC inspection 'Must Dos' should be an effective method of ensuring that important issues are not missed. The priorities do reflect the concerns of the patients raised in the consultation, issues raised by the Safety and Quality information Dashboard and the CQC 'Must Dos'. However, we do have some concerns as to whether there are challenging, and measurable targets attached to all of the priorities and consequently that future evaluation may prove difficult.

PRIORITY 1: CARE THAT IS SAFE

Quality Indicator 2:
We will reduce the number of patients who have a fall with harm whilst under our care.

The Trusts position for 18/19 was 14, yet the target for 19/20 has increased to no more than 18. At face value it looks as though the target is being relaxed and therefore it is difficult to see how it will drive improvement.

Quality Indicator 4:
We will achieve excellent infection prevention practices, and our rates of infection will improve in order to improve the safety and experience of our patients.

Some of the targets for infection case numbers have increased, however an explanation has been provided. Although, it is unclear why the target for Hand Hygiene has decreased from 97% for 18/19 to above 95% for 19/20. Given the infection prevention Quality Indicator we would expect this target to be increased or at least an explanation for the decrease provided.

PRIORITY 2: CARE THAT IS CLINICALLY EFFECTIVE

Whilst the three quality indicators attached to this priority should drive improvements in clinical effectiveness, they are not necessarily the issues that are raised with us by the public who in general are more concerned with waiting times to access services and the quality of services when they are accessed.

Quality Indicator 2:
We will implement clinical standards for seven-day hospital services.

Whilst we welcome the inclusion of this indicator there are no clear targets attached to the Quality Indicator, therefore it not clear how progress will be measured and evaluated by the Trust.

PRIORITY 3: CARE THAT IS A POSITIVE EXPERIENCE FOR PATIENTS AND THEIR CARERS

Quality Indicator 6:
We will maintain the percentage of inpatients who would recommend our Trust to friends and family to 94% or above and will achieve recommended national response rates for emergency departments, inpatients, outpatient and maternity services.

HWW consider that it would be useful to have included the national response rates and the current rates achieved by the WAHT mentioned in the QI so that progress can be measured.

3. Has the provider demonstrated that they have involved patients and the public in the production of the Quality Account?

We welcome the continuation of the patient and public consultation around 'What does Quality mean to you?' and the involvement of the Patient Experience Committee in the discussions around the Quality Priorities for 2019/20.

4. Is the Quality Account clearly presented for patients and the public?

There is a challenge to producing a Quality Account with the detailed information required by NHS England and ensuring that they are clearly presented for patients and the public. However, we made suggestions in our response to the 2017/18 Quality Account around the presentation of information including the possibility that the Trust could highlight achievements against previous years Quality Indicators by using a "Traffic Light" approach and shading the lines in the table's green/amber/red according to performance.

Healthwatch Worcestershire also suggested that the Trust should produce a summary of the Quality Account in an accessible format specifically for patients and the public.

Worcestershire Acute Hospitals NHS Trust's Patient and Public Forum's response to the Trust's 2018/19 Quality Account .

Worcestershire Acute Hospitals NHS Trust's Patient and Public Forum

The Patient and Public Forum of Worcestershire Acute Hospitals Trust [WAHT] welcomes the opportunity to comment on the draft 2018-19 Quality Account for WAHT.

We have seen the impact of the new Quality Improvement Strategy during our visits to wards. It is visibly driving improvements and innovations.

Likewise, the Patient and Culture Strategy in the form of the 4ward programme has driven many innovations. As well as the actions listed in the Quality Account, we were impressed how the audit team, using the tenets of 4ward, have engaged with staff to greatly improve participation in audit as we feel the effect of this will be to drive improvements in quality thus enhancing patient experience.

On Quality priorities for 2018-19, we commend the Trust for its hard work in reducing the number of hospital acquired ulcerations and reducing the number patients who have a fall. However, we are disappointed that the Trust did not meet its target for reducing mortality for our patients but we understand the Trust is actively working with its health partners on this and we hope that continued vigilance will see an improvement next year.

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

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

Scope and subject matter

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

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

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

Respective responsibilities of the directors and Practitioner

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

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

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

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

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

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

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

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

- Board minutes for the period 1 April 2018 to 27 June 2019;
- papers relating to quality reported to the Board over the period 1 April 2018 to 27 June 2019;
- feedback from the three Clinical Commissioning Groups in Worcestershire dated 10 June 2019;
- feedback from Healthwatch Worcestershire dated 14 June 2019;
- feedback from the Worcestershire Health Overview and Scrutiny Committee dated 6 June 2019;
- feedback from the Patient and Public Forum of Worcestershire Acute Hospitals Trust dated 13 June 2019;
- the Trust's complaints report published under regulation 18 of the Local Authority, Social Services and National Health Service Complaints (England) Regulations 2009, dated 21 June 2018;
- the national patient survey dated 20 June 2019;
- the national staff survey dated 26 February 2019;
- the Head of Internal Audit's annual opinion over the Trust's control environment dated 22 May 2019;
- the annual governance statement dated 22 May 2019; and
- the Care Quality Commission's inspection report dated 5 June 2018.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with these documents (collectively the "documents").

Our responsibilities do not extend to any other information.

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

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

Assurance work performed

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

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

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

Limitations

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

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques that can result in materially different measurements and can affect comparability.

The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the Quality Account in the context of the criteria set out in the Regulations.

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

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

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

Basis for qualified conclusion

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

- Accuracy and validity: in our testing of 40 cases we identified two cases where there was evidence in the patient record that a VTE risk assessment had been completed within 24 hours of admission, but the Trust had reported the cases as not being compliant with the VTE standard. We also identified two cases where the patient's VTE risk assessment had not been updated since the patients were booked in for antenatal services. A VTE risk assessment should have been completed on admission for postpartum services but had not been and the cases were thus not compliant with the VTE standard.

Conclusion

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

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;

- the Quality Account is not consistent in all material respects with the sources specified in the Guidance; and

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

Grant Thornton UK LLP

Grant Thornton UK LLP
Chartered Accountants
Birmingham

27 June 2019

Appendix 4: Mortality Data

Hospital mortality rates – or death rates as they are known commonly – can sometimes be presented in rather an alarmist way by the media. The resulting coverage often seems to forget that despite all the new technology and medical breakthroughs of recent years, people do die in hospital every day. Most of the time, these deaths are unavoidable – the consequences of major trauma such as road traffic accidents, as well as other serious conditions like heart attacks. Some people die because their illness is incurable; yet others have just come to the end of their natural life and the most important thing is that they have a dignified and respectful death, ideally at home surrounded by their loved ones.

Why do hospitals measure mortality rates?

Not only do they help us better understand the risks of hospital treatments for individual patients, changes in patterns over time can pinpoint where improvements may need to be made. They can also help those people wishing to make a choice about the hospital where they may want to have their treatment. When it comes to measuring mortality rates, there are three main statistics used:

Crude mortality rate (produced by the Trust)

A hospital's crude mortality rate looks at the number of deaths that occur in a hospital in any given year and then compares that against the amount of people admitted for care in that hospital for the same time period. The crude mortality rate can then be set as the number of deaths for every 100 patients admitted. What it tells you is how a hospital or Trust's mortality rate changes over time.

Hospital standardised mortality ratio (published nationally by Dr Foster Intelligence)

While crude mortality rates are important, it is very hard to use this information to compare and contrast what's happening between hospitals. This is because every hospital is different, both in the treatments and operations that it offers and the make-up of its local population.

A hospital that carries out higher-risk operations, such as organ transplants or see more patients who are elderly and/or come from areas of greater poverty, will have a crude mortality rate that is very different from one that doesn't provide such higher-risk operations and/or whose local population is generally younger and more affluent.

Several years ago statisticians interested in comparing mortality rates between hospitals sought to find a new statistical way to allow them to do just that. The one now used most commonly is called the hospital standardised mortality ratio – or HSMR for short – which is published nationally by Dr Foster Intelligence.

The HSMR scoring system works by taking a hospital's crude mortality rate and adjusting it for a variety of factors – population size, age profile, level of poverty, range of treatments and operations provided, etc. The idea is that by taking these factors in to account for each hospital, it is possible to calculate two scores – the mortality rate that would be expected for any given hospital and its actual observed rate. It is the difference between these two rates that is important when it comes to HSMR. Nationally the expected HSMR score for such hospitals is set as being 100.

This figure does not represent deaths or percentages – it is a baseline number that statisticians use against which to compare observed performances. Through the combination

of the complexity of the data being measured, along with natural random variation that occurs, HSMR scores, are never absolute figures. Indeed the experts behind the HSMR system suggest that any individual score could vary by as much as +/- 7%.

So statically speaking, a NHS trust with a HMSR score of 94 could well have an identical performance to one with a score of 106 and vice versa. Scores well above 100 suggest that there may be a need to investigate whether or not there is an underlying clinical problem that needs to be addressed.

This does not mean that people can or should assume that a real problem exists at all. It could just be that the data on which the calculation was based wasn't as accurate as it should have been. But there again, it could point to a specific clinical issue that needs attention. Until investigated thoroughly, it is often impossible for anyone to tell what the true reason is behind a lower or higher than expected HSMR score.

Summary Hospital-level Mortality Indicator (published nationally by NHS Digital)

The Summary Hospital-level Mortality Indicator (SHMI) reports on mortality at trust level across the NHS in England using a standard and transparent methodology. It is produced and published monthly as a National Statistic by NHS Digital.

The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.

In essence, therefore, SHMI is trying to do the same things as HSMR – it's just that different variable factors are taken in to account in calculating the scores. The principle one of these is that SHMI includes deaths following a patient's discharge (within 30 days).

www.worcsacute.nhs.uk

WorcsAcuteNHS

WorcestershireAcute

Published: June 2019