Trust Board
There will be a meeting of the Trust Board on **Thursday 9 June 2022** at 10:00am. It will be held virtually and live streamed on You Tube.

Sir David Nicholson
Chair

Item		Assurance	Action	Enc	Time
037/22	**Welcome and apologies for absence:**				**10:00**
038/22	**Patient Story**				**10:05**
039/22	**Items of Any Other Business** To declare any business to be taken under this agenda item				**10.30**
040/22	**Declarations of Interest** To declare any interest members may have in connection with the agenda and any further interest(s) acquired since the previous meeting.				
041/22	**Minutes of the previous meeting** *To approve the Minutes of the meeting held on 12 May 2022*		*For approval*	**Enc A** **Page 3**	**10:30**
042/22	**Action Log**		*For noting*	**Enc B** **Page 12**	**10:35**
043/22	**Chair's Report**		*For approval*	**Enc C1** **Page 14**	**10:40**
044/22	**Chief Executive's Report**		*For noting*	**Enc C2** **Page 16**	**10:45**
	Best Services for Local People				
045/22	**Communications and Engagement Report** Director of Communications and Engagement	TBA	*For assurance*	**Enc D** **Page 20**	**10:50**
046/22	**Quality Account** Chief Nursing Officer	Level 6	*For approval*	**Enc E** **Page 26**	**11:00**
047/22	**2022/23 Annual Plan Priorities** Director of Strategy and Planning	Level 5	*For approval*	**Enc F** **Page 88**	**11:10**
048/22	**Ockenden Final Report and Gap Analysis** Director of Midwifery	Level 5	*For noting*	**Enc G** **Page 93**	**11:20**

049/22	**Board Assurance Framework & Risk Appetite Statement** Company Secretary	Level 5	*For approval*	**Enc H** **Page 97**	**11:35**
	Best Experience of Care and Outcomes for our Patients				
050/22	**Integrated Performance Report** Executive Directors	Level 4	*For assurance*	**Enc I** **Page 106**	**11:45**
051/22	**Committee Assurance Reports** Committee Chairs		*For assurance*	**Page 188**	
	Best People				
052/22	**Safest Staffing Report** Chief Nursing Officer/Director of Midwifery		*For assurance*	**Enc J**	**12:00**
	a) Adult/Nursing **b) Midwifery**	Level 5 Level 4		**Page 195** **Page 201**	
	Governance				
053/22	**Trust Management Executive Report** Chief Executive		*For assurance*	**Enc K** **Page 210**	**12:15**
054/22	**Any Other Business** *as previously notified*				**12:25**
	Close				

Reading Room:

- Enc C1 – Contract governance awards
- Enc F – Annual Plan Priorities
- Enc G – Ockenden Appendix
- Enc H – full BAF detail

MINUTES OF THE PUBLIC TRUST BOARD MEETING HELD ON THURSDAY 12 MAY 2022 AT 10:00 AM HELD VIRTUALLY

Present:		
Chair:	Sir David Nicholson	
Board members: (voting)	Paul Brennan	Chief Operating Officer
	Anita Day	Vice Chair, Non-Executive Director
	Matthew Hopkins	Chief Executive
	Colin Horwath	Non-Executive Director
	Paula Gardner	Chief Nursing Officer
	Dame Julie Moore	Non-Executive Director
	Simon Murphy	Non-Executive Director
	Robert Toole	Chief Finance Officer
Board members: (non-voting)	Richard Haynes	Director of Communications and Engagement
	Vikki Lewis	Chief Digital Information Officer
	Jo Newton	Director of Strategy and Planning
	Rebecca O'Connor	Company Secretary
	Tina Ricketts	Director of People and Culture
	Sue Sinclair	Associate Non-Executive Director
In attendance	Justine Jeffery	Director of Midwifery
	Jo Ringshall	Healthwatch
	Jo Wells	Deputy Company Secretary
	Louise Pearson	Lead Nurse for Workforce & Education
	Kate Knight	Lead Nurse for Professional Development &
	Anna Sterckx	International Nurse Recruitment
		Head of Patient, Carer & Public Engagement
	Jules Walton	Deputy Chief Medical Officer
Public		Via YouTube
Apologies	Richard Oosterom	Associate Non-Executive Director
	Sharon Thompson	Associate Non-Executive Director
	Waqar Azmi	Non-Executive Director
	Christine Blanshard	Chief Medical Officer

020/22 **WELCOME**

Sir David welcomed everyone to the meeting, including the public viewing via YouTube observers and staff members who had joined.

Sir David informed that International Day of the Midwife was last week and gave thanks to the work they do. Today marked International Nurses day and the Trust had an exceptional nursing workforce and thanks were extended to them all.

021/22 **PATIENT STORY**

Ms Gardner advised that as well as International Nurses Day, it was also Florence Nightingale's birthday and to mark the day, the story would focus on the International Nurses programme.

Ms Knight shared the following summary:

- The Trust welcomed the first recruits in August 219 and they still remained at the Trust. Retention at the Trust was above the national average.
- The Trust worked in partnership with the Global Learners Programme and since December 2019, with NHSP International.
- 256 international nurses had been welcomed to the Trust since the start of the programme and there was a typical intake of 6-12 recruits per month.
- The Trust currently managed 9 properties, providing new recruits with accommodation for 3 months.
- Information and advice was provided along with 24/7 support. Nurses were met upon their arrival, assisted with food shopping, transport arranged and assistance provided with a residency permit. Professional development support was in place and networks created with Facebook and WhatsApp groups.
- Prior to exams, a celebration was held for them.

A video was shared depicting international recruits sharing their experiences. Each reported the excellent support given and training in place.

Ms Day commended the programme and the teams involved to the real care and support shown to help new recruits adapt. Ms Day added that experience had shown that issues or concerns are not always known and queried whether international nurses felt whether they could speak up. Ms Knight replied that improvements could always be made. 2 band 6 nurses had been employed to support the team as some aspects did require development. Additional transitional courses from classroom to ward were being looked at.

Ms Sinclair advised that she had some of the nurses who had settled in really well. The retention rate is extraordinary and congratulations were extended to the teams.

Ms Gardner added that Ms Knight, Ms Pearson and the team were doing an amazing job and expressed her thanks.

Sir David stated that it must be difficult for the nurses to travel and leave their families and the support in place for them was exemplary. The Trust really did need them, and thanks were extended to all.

022/22 **ANY OTHER BUSINESS**
There were no items of any other business.

023/22 **DECLARATIONS OF INTERESTS**
There were no additional declarations pertinent to the agenda. The full list of declarations of interest is on the Trust's website.

024/22 **MINUTES OF THE PUBLIC TRUST BOARD MEETING HELD ON 7 APRIL 2022**
There being no amendments noted, the minutes were approved.

RESOLVED THAT subject to the above the Minutes of the public meeting held on 7 April 2022 confirmed as a correct record and signed by the Chair.

025/22 **ACTION SCHEDULE**
Ms O'Connor presented the action log noting the updates as set out in the paper. All other actions were either closed as per the log, or not due for update at this meeting.

026/22 **CHAIR'S REPORT**

Sir David advised that the previous day was Staff Networks Day and encouraged supporting each other. A joint Board meeting was held with the Health & Care Trust last week, which was a positive step forward to develop joint working with services across Worcestershire.

RESOLVED THAT: the Chair's update be noted

027/22 **CHIEF EXECUTIVE'S REPORT**

Mr Hopkins presented his report which was taken as read. The following key points were highlighted:

- International Nurses Day was acknowledged and thanks were extended to the teams with keeping patients safe.
- Components of the Health and Care Act received royal ascent last week, moving towards Integrated Care Board establishment from 1st July. A representative would be nominated to represent Worcestershire.
- The Board to Board was a useful exercise for members of both organisations and in agreeing next steps in working together.
- Fantastic work was highlighted by the Palliative Care Team and the opening of the Peony room.

Sir David noted that nominations for the ICB Board were due by 13th May and proposed that both Chief Executives were nominated (Matthew Hopkins and Sarah Duggan).

Ms Day suggested that a section in the report was included to focus on where the Trust was supporting system partners and what was happening as a system.

RESOLVED THAT: the report be noted

RESOLVED THAT: The Trust Board nominated Matthew Hopkins and Sarah Duggan as partner representatives on the ICB Board

Best Services for Local People

028/22 **2022/23 ANNUAL PLAN**

Ms Newton presented the Annual Plan which was submitted on 28 April. The following key points were highlighted:

- Activity targets would be achieved subject to the follow up rule being removed. The 104 week wait excluded Orthodontics.
- There were risks around the achievement of the Productivity and Efficiency Plans (PEP) target. Reviews were taking place at divisional Performance Review Meetings (PRM) and discussion was focused on closing the gap and testing maturity of PEPs.
- Risks identified in the plan included the Elective Recovery Fund (ERF) and conversations were taking place at a national level.
- Priorities had been grouped into delivering on quality, investment around infrastructure, digital infrastructure with electronic records and cyber security.
- There needed to be a tight grip on reporting and progress would be monitored at Trust Management Executive (TME) and Finance and Performance Committee (FPC).

Mr Hopkins advised that the system plan submitted has a financial gap and the Trust was working with regional teams to find ways to close it. Teams were looking for a further £3m in relation to the existing cost reduction plan which was ambitious, but opportunities were being reviewed. There remained no clarity of the application of the ERF and this would be subject to further discussion at FPC.

Mr Horwath would have liked to have seen a longer term financial strategy with indication of the 3-year plan to assess progress. Mr Horwath asked whether there was indication from the system of their view of overall strategy.

Mr Murphy referred to the FPC report which detailed over programming on PEP to plan to deliver more on the basis of slippage. A debate took place around the investment required to deliver the changes needed. Mr Murphy queried how assurance would be given that performance was on track to achieve.

Ms Day observed the major caveats to the plan were in relation to outpatient follow up conversion, noting if it is not agreed, the Trust cannot achieve ERF. Monitoring and tracking would be key and the PRMs were a central role in that, however there was no visibility or assurance of the strength of the PRM model to hold people to account and lead to remedial action.

Ms Newton replied that in terms of PRMs and achieving, elements of the plan had been included in divisional budgets to ensure they are measurable. The IPR dashboard was being refreshed to reflect elements feeding through the plan.

Mr Brennan advised that there is not an agreement with the region on the new follow up removal and that discussions were ongoing. The Orthodontic position is moving and the Trust was working with Specialist Commissioning and the CCG. Work done to date has reduced the risk from 88 down to 66 with collaborating working had reduced those numbers down from over 300 patients. Mr Brennan added that the PRMs were clear on their role and divisional teams were clear about membership and were involving clinical directors. TME and FPC will review clear trajectories on activity levels and performance on key long waits detailing what must be achieved month by month.

Mr Toole clarified that the plan did not include costs for the Pathways Decision Unit, however equal and opposite funding was included in the final submission.

Mr Hopkins advised that the 3-year plan would start to be built and would expect a draft to be available before the end of June. Discussions with regional teams would be reopened; it was recognised that there was a sizable gap at national level in this year's plan and the only support likely would be in relation to inflation pressures. Years 2-3 of the plan are open to debate and the Trust would work with the ICB team and the region. The key headline metrics were around run rate, elective delivery, clear tracking of productivity and efficiency in theatres and formulating a plan that complements the PRMs.

Sir David observed the risks but that it was possible to deliver the plan. There needed to be high level measures as to progress delivery and high level indicators to make decisions. Sir David thanked the teams for the work done to date and encouraged work to continue to improve services for patients.

RESOLVED THAT: the 2022/23 Annual Plan was noted.

029/22 **INTEGRATED PERFORMANCE REPORT**

Mrs Lewis presented the report for month 12, which had an overall assurance level of 4 and highlighted the following key points:

- The full position had not yet been validated. A review had taken place at TME and FPC.
- Key issues were COVID-19 as a presenting condition and the allocating of beds has changed.
- Good news stories were reported as: Workforce had consistently performed with sickness absence rate. Recovery and restoration of services in H1 and H2 has over achieved against plan. Finance year end position was better than predicted, reporting a £1.4 deficit rather than £1.9m.
- There was an 11% demand increase in emergency care in comparison to the previous year.
- Cancer referrals hit an all-time high during March with high demand across all pathways.
- IPC were challenged with c-diff.

Mr Horwath referred to the planning assumptions and the impact of increased demand throughout the reports, asking if it was a permanent step change or a backlog from COVID-19. Mr Brennan replied that the increase in referrals was likely to be seen throughout the year. Breast, skin and Colorectal services in particular had seen sharp increases. There did need to be better engagement with primary care colleagues and improvement to the triage mechanisms. A new Clinical Director for the cancer service had been appointed who would start a review. Mr Brennan added that though the Trust was seeing a growth in referrals, there had not been the equivalent in cancer diagnosis.

Ms Day observed the rise in cancer referrals and advised that revisiting the pathways is imperative. Ms Day queried if any work had started with the pathways, if timelines were recognised as a system and how progress was continuing with the IPC targets as 4 out of 5 had achieved. Mr Brennan replied that work was underway and was recognised by system partners. Some internal arrangements may need to change. Discussion was taking place with the cancer alliance and whether their funding can support an increase in clinical nurse specialists in colorectal to support the increase. Ms Gardner informed that there were target related issues with c-diff. There had been issues with the cleaning within Aconbury where radiator covers had to be removed and issues with a cleaner who has received extra training. NHSI/E visited in March to review cleanliness and IPC to ensure post infection reviews of outstanding c-diff cases had been completed. A table top exercise was conducted in early May and the Trust were awarded a green status for IPC in the areas they visited.

Mr Murphy referenced discharges and asked whether any innovations had been introduced to make improvements along with system partners assistance. Mr Brennan responded that significant challenges remained. The Trust was seeing more admissions than discharges on a daily basis. The biggest issue is the profile of when clinical colleagues say patients need to be admitted and the time of discharges are out of kilter. There needed to be a consistent input into the incident cell in order to assist in the management of discharges. System colleagues are all working together.

Mr Hopkins informed that ambulance delays peaked in March with the number of patients waiting. It was a worrying situation and is problematic for the ambulance service. Teams needed to ensure that patients who can be taken to other areas are. There is a capacity

gap in beds and there was a requirement to refocus on what else could be done in order to improve.

Ms Sinclair observed the impression that patients are being admitted with c-diff due to the lack of face to face GP appointments. Ms Gardner advised that there had been transmission in the hospital as well as in the community.

Sir David was pleased to see some good areas of performance such as staff sickness, the year-end financial position, progress on restoration work and the external inspection of IPC. Issues did remain however, particularly within cancer services and would like a further discussion to take place in 2-3 months' time to review progress. Patients needed to be diagnosed timely. Urgent and emergency care also remained problematic.

Ms Lewis advised that there would be high level monitoring of the plan: improvement plan, PEP trajectories, run rate and agency spend will be included within future report by a balanced scorecard/dashboard. Clear trajectories would be provided on a monthly basis and more visibility to benchmarking positions.

RESOLVED THAT: the report be noted for assurance.

030/22 **COMMITTEE ASSURANCE REPORTS**

The following points were highlighted by Committee Chairs:

- F&P: Mr Horwath updated that the 22/23 Annual Plan was the main item for discussion and the Committee raised concerns around achievement. An item recommended for approval was included on the Private Trust Board agenda.
- QGC: Ms Sinclair informed that the Committee discussed IPC and welcomed the new Health & Safety Officer's report.

RESOLVED THAT: The Committee reports be noted for assurance.

031/22 **OCKENDEN FINAL REPORT APRIL 2022**

Ms Jeffrey presented the final report for noting and to acknowledge the publication of the Ockenden final report. The following key points were highlighted:

- There were some sad and tragic events detailed within the report and lots of lessons can be learnt such as informed choice, Freedom to Speak Up and the involvement of families.
- Progress continued against compliance rates.
- A gap analysis was being created and would be available in June. 2 areas of focus were continuity of carer and newly qualified midwives. Further discussion would take place at Private Trust Board.
- A full report would be available in June.

Mr Murphy informed that the report was a holding document and that consultations had been held with staff regarding continuity of care.

Mr Hopkins updated that regional discussions had taken place and would feature on the agenda for a system perspective for the next few months to ensure alignment with system partners. Relationships with Wye Valley as a local provider are going well.

Sir David encouraged all to read the report if they hadn't already and that reports such as these did generate a large number of recommendations. The key was making sure that when women give birth, they are in the safest possible environment with full staffing and motivated midwives who have the opportunity to speak out. The service should embrace the attitude of patients and we do what they say. Thanks were given for the enormous amount of work that the team is doing. Sir David recognised that it was a very difficult time for maternity staff.

RESOLVED THAT: the report was noted.

Best Use of Resources

032/22 **CHIEF FINANCE OFFICER'S REPORT – MONTH 12**

Mr Toole presented the report which outlined a positive outcome in the month 12 and highlighted the following:

- The Trust stayed within the capital limit. There was a significant capital programme last year of £53m and there was still work in progress such as the community diagnostic hub.
- A good cash balance was reported.
- Focus now is on this year and managing the capital as well as delivering the challenging plan.

Sir David commended the delivery of an improved financial outturn and expected the same next year.

RESOLVED THAT: the report was noted for assurance

Best People

033/22 **SAFEST STAFFING REPORT**

a) Adult/Nursing and Quality Impact Assessment (QIA)
b) Midwifery

Adult/Nursing
Ms Gardner reported an assurance level of 5.

- HCA vacancies had reduced to 9.7% and initiatives were being created in order to retain them.
- 15 minor harm incident were reported. There was no significant hard to any patients as a result.
- Staffing gaps were being filled with bank and agency.

Mr Hopkins observed that good support had been put place from a nursing perspective. It was recognised that many of the issues raised by staff related to getting paid and parking. Getting those issues right were meaningful to staff.

Nursing vacancy challenges were discussed at the Board to Board meeting and there was an opportunity to help the Health & Care Trust with the positive things the Trust were doing. Ms Gardner advised that the Trust was working with the new Nursing Director at the Health & Care Trust and looking at options such as rotating staff to offer a different way of working and the potential of including Wye Valley. The Trust was working with the council on pathways 1 and 2.

Ms Day observed a good retention rate of international nurses and asked if there was clear visibility of the retention rate 12 months after the recruitment of nurses and how that benchmark against others. Ms Gardner reported a 92% retention rate across nursing and the Trust did benchmark. The HCA vacancy rate (regionally and nationally) required more work to ensure they are retained, noting that they did undertake a challenging role.
Sir David encouraged the support of HCAs, a major part of winter planning is workforce as a whole.

Midwifery
Ms Jeffrey reported an assurance level of 4.

- There was reduced activity during March.
- Acuity was met 55% of the time before any mitigations.
- Acuity tool completion was performing better than previous months.
- Sickness remained high at 9.84% with stress and anxiety as the highest theme.
- COVID-19 staff absence had improved between 4-8%.
- Turnover was 16%
- Vacancy rate is 9% with the majority of vacancies in inpatient areas.
- 1 red flag was reported but maintained supernumerary status in month.
- Minimum safe staffing was not met on all shifts but mitigations were in place.

Sir David noted a high turnover and asked if it was consistent. Ms Jeffrey replied that it was not consistent. There was a peak during one quarter within a community team due to a number retiring. The Trust had recruited from a neighbouring Trust but many had returned back to their previous Trust.

Mr Horwath noted the supernumerary status of shift leaders and that it generated a red flag, which needed to be mitigated as much as possible.

RESOLVED THAT: The Trust Board Noted the report for assurance

Governance

034/22 **REVIEW OF CONDITIONS FT4 and G6**

Ms O'Connor presented the report for approval of the publication of the self-certification. Backing documents were attached for information.

The Trust was declaring a non-complaint position against the two conditions. Trust Management Board, Quality Governance Committee and Audit & Assurance Committee had reviewed the conditions. The position remained the same is was last year as a result of the underlying financial position of the Trust and the Trust was in-year subject to section 31 conditions, which have since been removed, however the legal undertakings remain.

RESOLVED THAT: the Review of Conditions FT4 and G6 were approved.

035/22 **TERMS OF REFERENCE**

Finance & Performance & Quality Governance

Ms O'Conner presented the updated Terms of Reference which had been reviewed by the Committees and included a refreshed approach of the Non-Executive Director Champion roles. Part of the annual review was reviewing national guidance and amendments were highlighted.

Ms Day observed a lack of oversight of responsibility of tackling heath inequalities and suggested a governance discussion as part of the priorities at a future Board meeting. Sir David suggested that an update regarding cancer diagnosis was considered at the same time.

ACTION: Health inequalities and cancer diagnosis to be discussed at a future meeting/Board Development.

RESOLVED THAT: the terms of reference be APPROVED with the caveat to reflect further on how to apply the lens of heath and inequalities.

036/22 **ANY OTHER BUSINESS**

There was no further business raised.

DATE OF NEXT MEETING

The next Public Trust Board meeting will be held virtually on Thursday 9 June 2022 at 10:00am.

The meeting closed.

Signed _____ **Date** _____

Sir David Nicholson, Chair

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

PUBLIC TRUST BOARD ACTION SCHEDULE

RAG Rating Key:

Completion Status	
	Overdue
	Scheduled for this meeting
	Scheduled beyond date of this meeting
	Action completed

Meeting Date	Agenda Item	Minute Number (Ref)	Action Point	Owner	Agreed Due Date	Revised Due Date	Comments/Update	RAG rating
13.01.22	Charter	158/21	Mrs Ricketts and Mr Hopkins to continue the conversation regarding meaningful action and outcome measures and report back to Board in two months	MH/TR	March 2022	May 2022 (P&C)	Task and Finish Group established to oversee implementation of charter. Outcome measures being developed through this group. Update to be provided to People & Culture Committee 31st May 2022	
10.03.22	CEO Report	186/21	LGBTQ+ relaunch to be presented to Trust Board	TR	TBC	June 2022	Date to be agreed for network to present. ROC having a broader discussion to ensure all networks are scheduled.	
9.12.21	Board Assurance Framework	141/21	Ms O'Connor to share the Board analysis and bring a paper to Board following the next quarter's review	ROC	Feb 2022	July 2022	Annual review prepared and meeting with Chair to review scheduled for June. Paper to follow to Board in July 2022	
13.01.22	Minutes	154/21	Communications Report to reflect upon how could they engage better with communities and diversify our approach.	RH	May 2022	June 2022	Report due to Trust Board in June 2022	

13.01.22	Charter	158/21	Mrs Rickets to circulate to Board Members information on the work of the IDEA Committee and the EDI agenda within the Trust.	TR	March 2022	TBC	To be scheduled for a board development session. Board development plan circulated to Board members. Action closed	
10.03.22	CEO Report	186/21	Ms Gardner to obtain more information regarding the distribution of the quality of life survey and feed back to the next meeting.	PG	April 2022		Information circulated 13 May 22. Action closed.	
10.03.22	Communications & Engagement Report	187/21	Mrs Ricketts to circulate an update regarding the Behaviour Charter.	TR	April 2022		Update scheduled to the next People & Culture Committee in May via the Integrated P&C report. On the Board agenda. Action closed.	
15.05.22	Terms of Reference	035/22	Health inequalities/cancer to be discussed at a future meeting/Board development	ROC	July 2022		Included on board development plan. Action closed	
10.3.22	Action Schedule	184/21	Decisions regarding increases of staff to be documented including source of funding, whether this is recurrent/non recurrent and reported to Finance and Performance Committee	TR/RT/JN	May 2022	June 2022	Action plan considered by CETM in April. Being taken forward through Annual Planning Group.	

Worcestershire Acute Hospitals NHS Trust

Meeting	Trust Board
Date of meeting	9 June 2022
Paper number	Enc C1

Chair's Report

For approval:	X	For discussion:		For assurance:		To note:	

Accountable Director	Sir David Nicholson Chair		
Presented by	Sir David Nicholson Chair	**Author /s**	Rebecca O'Connor Company Secretary

Alignment to the Trust's strategic objectives (x)							
Best services for local people		Best experience of care and outcomes for our patients		Best use of resources	X	Best people	

Report previously reviewed by		
Committee/Group	Date	Outcome

Recommendations	The Trust Board are requested to ratify the action undertaken on the Chair's behalf since the last Trust Board meeting in May 2022.

Executive summary	The Chair, undertook a Chair's Action in accordance with Section 24.2 of the Trust Standing Orders to: 1. approve a two-year contract and tender waiver for Rotapro and Consumables via Boston Scientific (contract C53066) in accordance with the Contract Governance Award (CAG) Report. 2. Approve a 6-month contract extension of InHealth mobile endoscopy unit at Kidderminster Treatment Centre in accordance with the CAG report The relevant CAG reports are available for Trust Board members in the Reading Room

Risk			
Which key red risks does this report address?		**What BAF risk does this report address?**	*BAF 7, 4, 18*

Assurance Level (x)	0		1		2		3		4	X	5		6		7		N/A	
Financial Risk																		

Action						
Is there an action plan in place to deliver the desired improvement outcomes?	Y		N		N/A	X
Are the actions identified starting to or are delivering the desired outcomes?	Y		N			

Worcestershire Acute Hospitals NHS Trust

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If no has the action plan been revised/ enhanced	Y		N		
Timescales to achieve next level of assurance					

NHS
Worcestershire
Acute Hospitals
NHS Trust

Meeting	Trust Board
Date of meeting	9 May 2022
Paper number	Enc C2

Chief Executive Officer's Report

For approval:		For discussion:		For assurance:		To note:	X

Accountable Director	Matthew Hopkins Chief Executive Officer		
Presented by	Matthew Hopkins Chief Executive Officer	**Author /s**	Rebecca O'Connor Company Secretary

Alignment to the Trust's strategic objectives (x)							
Best services for local people	X	Best experience of care and outcomes for our patients	X	Best use of resources	X	Best people	X

Report previously reviewed by		
Committee/Group	Date	Outcome
N/A		

Recommendations	The Trust Board is requested to • Note this report.

HS	This report is to brief the Board on various local and national issues. Items within this report are as follows: • Integrated Care Board Appointments • MPs Briefing • Tara Donnelly virtual visit • Worcestershire Leaders' meeting • Lord Lieutenant's Garden Party • NHSE Maternity insight visit

Risk			
Which key red risks does this report address?	N/A	**What BAF risk does this report address?**	N/A

Assurance Level (x)	0		1		2		3		4		5		6		7		N/A	X
Financial Risk	None directly arising as a result of this report.																	

Action						
Is there an action plan in place to deliver the desired improvement outcomes?	Y		N		N/A	X
Are the actions identified starting to or are delivering the desired outcomes?	Y		N			
If no has the action plan been revised/ enhanced	Y		N			
Timescales to achieve next level of assurance						

Worcestershire Acute Hospitals NHS Trust

Meeting	Trust Board
Date of meeting	9 May 2022
Paper number	Enc C2

Introduction/Background

This report gives members an update on various local, regional and national issues.

Issues and options

Herefordshire and Worcestershire Integrated Care Board (ICB) Appointments
The Integrated Care Board is set to take over from NHS Herefordshire and Worcestershire Clinical Commissioning Group (CCG) on 1 July 2022. It will be part of the Herefordshire and Worcestershire Integrated Care System and will be responsible for improving health outcomes for our local population, reducing health inequalities, and supporting broader social and economic development.

The new Board membership comprises of:

Chair
- Crishni Waring

The Chair is responsible for the effective leadership of the Board, working closely with the leaders and chairs of all partner organisations

Non-Executive Members
- Dr Sarah Raistrick | Non-Executive Member for Health Inequalities and Engagement
- David Wightman | Non-Executive Member for Appointments and Remuneration

Non-Executive Members act as independent members of the Board, helping to shape the long-term plan for the local NHS as well as collectively hold the Executive Team to account for planning and delivery

In addition to the roles described above, we are currently formalising the appointment of the Non-Executive Member for Audit and Governance.

Executive Members
- Simon Trickett | Chief Executive
- Dr Kathryn Cobain | Chief Nursing Officer
- Dr Will Taylor | Chief Medical Officer
- Mark Dutton | Chief Finance Officer

Executive Members are responsible for providing effective leadership to the organisation, and for delivery against the long-term plan

Partner Members
- Dr Nikki Burger | Primary Care
- Dr Nigel Fraser | Primary Care
- Sarah Dugan | NHS Trust
- Matthew Hopkins | NHS Trust
- Jane Ives | NHS Trust
- Paul Robinson | Local Authority
- Paul Walker | Local Authority

Partner members bring the perspective of primary, secondary, and social care from across Herefordshire and Worcestershire

MPs Briefing
Our Chair and I hosted the latest in our regular series of MPs briefings on Friday 20 May (as a virtual meeting) when we were able to share with them updates on some of the exciting service developments under way across our Trust, including progress on bringing robotic assisted surgery to Worcestershire, our plans to build a new operating theatre complex at the Alexandra, the community diagnostic hub at Kidderminster and the urgent and emergency care development at Worcestershire Royal.

We were also able to answer their questions on other issues of interest and concern, with the continuing pressure on our urgent and emergency care services being a major discussion point, as expected. These briefings are an important way of keeping our local MPs informed of the progress we are making as well as hearing directly from them the issues that their constituents are raising.

Worcestershire Leaders' Meeting
Some of the issues covered in our MPs brief were also among the topics covered when I attended this meeting which brings together the Leaders and Chief Executives of our county and district councils.

I was also able to share with our local authority partners some reflections on another 12 months of responding to the challenges of the Covid pandemic as well as some of our success stories from the last year, including our overseas nurse recruitment programme. I also highlighted to them our positive progress across a wide range of important quality and safety indicators as reflected in our Quality Account for 2021/22, including our work to make sure that patients and their carers feel listened to and have clear lines of communication with staff about their condition, treatment and care, and the improvements we have made to the care we provide for patients nearing the end of their lives.

Lord Lieutenant's Garden Party
A number of colleagues from across our Trust were among the invited guests at a Platinum Jubilee Garden Party, hosted by the Lord Lieutenant of Worcestershire. The event, at Hartlebury Castle, provided an opportunity for the county to say thank you to people from across the public, private and voluntary sectors who had made a particularly valuable contribution to Worcestershire.

Each member of our staff attending the event, on Monday 30 May, had been nominated by a member of our senior leadership team for going above and beyond in their role with the Trust. Between them they represented a wide cross section of our services, with many taking other colleagues with them as their 'plus one.' Fortunately for all involved, after some dismal weather earlier in the day, the sun came out for the event and they had a well-deserved very enjoyable afternoon.

Tara Donnelly virtual visit
I was joined by Vikki Lewis, Chief Digital Information Officer and Mike Emery, Director of Digital for the ICS to host a virtual meeting with Tara Donnelly Director of Digital Care models at NHS England and Deputy Director Breid O'Brien.

Worcestershire Acute Hospitals NHS Trust

Meeting	Trust Board
Date of meeting	9 May 2022
Paper number	Enc C2

The purpose of the meeting was to introduce Tara to the work that we have underway aligned to our digital strategy with a focus on digital innovation to support clinical pathways and emerging clinical models that span organisational boundaries. We have a close working relationship with the ICS digital director and this was evident in the work we showcased to Tara and promotes close working across the ICS.

I was delighted to be able to share with Tara the progress on our patient pathways including those for Chronic Obstructive Pulmonary Disease and Dermatology, as well as the pre operative digital application and the improved patient experience this offered. A very brief outline and illustrations of the latest innovation pilots that are currently being worked on across the Trust and wider ICS was well received.

A particular highlight was sharing of images from the Digital Innovation space now located at the Kidderminster Treatment Centre *the Co Lab* and its purpose with an invitation extended for Tara to come in person to see the space and meet our clinical digital champions and new Chief Clinical Information Officer Jon Hughes and Matthew Little, Chief Nursing Information Officer.

NHSE Maternity insight visit

There is a national requirement to conduct insight visits to all maternity trusts in the Midlands to gain assurance with implementation of the Ockenden report. The visit is led by the Midlands Perinatal Team and seeks to also to demonstrate that the Perinatal Surveillance model is embedded at provider, system and regional levels. The visit was collaborative with the Local Maternity and Neonatal System (LMNS), with the expectation these will be carried out quarterly.

Our visit was conducted on Tuesday 31st May led by Janet Driver, Regional Chief Midwife. There will be a report that follows the visit and will provide a RAG rating for progress.

Recommendations

The Trust Board is requested to

- Note this report.

Appendices - None

NHS
Worcestershire Acute Hospitals NHS Trust

Assurance levels Nov 2020

Meeting	Trust Board
Date of meeting	9 June 2022
Paper number	Enc D

Communications and Engagement Update

For approval:		For discussion:		For assurance:	x	To note:	

Accountable Director	Richard Haynes, Director of Communications and Engagement		
Presented by	Richard Haynes	**Author /s**	Richard Haynes

Alignment to the Trust's strategic objectives (x)							
Best services for local people	X	Best experience of care and outcomes for our patients	X	Best use of resources	X	Best people	X

Report previously reviewed by		
Committee/Group	Date	Outcome

Recommendations	Board members are asked to note the report

Executive summary	This report provides Board members with examples of significant communications and engagement activities which have taken place recently as well as looking ahead to key communications events/milestones in coming months. In the spirit of our 4ward behaviour of work together, celebrate together, this report includes recent examples of our more successful proactive media and social media work which help to showcase our commitment to putting patients first, and further improve the profile and reputation of our Trust.

Risk			
Which key red risks does this report address?		**What BAF risk does this report address?**	BAF Risk 12: If we have a poor reputation then we will be unable to recruit or retain staff, resulting in loss of public confidence in the trust, lack of support of key stakeholders and system partners and a negative impact on patient care

Assurance Level (x)	0		1		2		3		4		5	x	6		7		N/A		
Financial Risk	Related activities carried out within the existing communications budget or covered by the budgets of supported projects or programmes.																		

Action

Worcestershire Acute Hospitals NHS Trust

Assurance levels Nov 2020

Meeting	Trust Board
Date of meeting	9 June 2022
Paper number	Enc D

Is there an action plan in place to deliver the desired improvement outcomes?	Y		N	X	N/A	
Are the actions identified starting to or are delivering the desired outcomes?	Y	X	N			
If no has the action plan been revised/ enhanced	Y		N	X		
Timescales to achieve next level of assurance	**Communications and engagement priorities for 22/23 are aligned with Trust planning priorities and timelines in ways which are consistent with our Communications Strategy, subject to capacity constraints. Progress and issues will be reflected in future Board updates**					

Worcestershire Acute Hospitals NHS Trust

Assurance levels Nov 2020

Meeting	Trust Board
Date of meeting	9 June 2022
Paper number	Enc D

Introduction/Background

This report provides Board members with examples of significant communications and engagement activities which have taken place recently as well as looking ahead to key communications events/milestones in coming months.

In the spirit of our 4ward behaviour of work together, celebrate together, this report includes recent examples of our more successful proactive media and social media work which help to showcase our commitment to putting patients first, and further improve the profile and reputation of our Trust as well as supporting the wellbeing of our staff.

This report also looks at some highlights of the partnership working between our communications teams and colleagues in the Worcestershire Acute Hospitals Charity.

Issues and options

Positive proactive media and social media

A number of our media releases about service developments have generated significant positive media and social media coverage and comment, including our release announcing the Board's approval of the business case to bring robotic assisted surgery to the Alexandra Hospital, the opening of our new Peony Room at Worcestershire Royal and progress on the new Community Diagnostic Hub at Kidderminster.

Positive stories about our patients and staff also continue to generate interest and positive comment (locally, nationally and often internationally) – notable recent examples including our story of two brothers whose partners gave birth on the same day at Worcestershire Royal Hospital.

Staff Recognition Awards

At the end of May, in partnership with Worcestershire Acute Hospitals Charity we launched our 2022 Staff Recognition Awards which are being widely publicised internally and externally as we encourage nominations across a wide range of categories to celebrate the extraordinary work our teams do every day to put our patients first.

Following the relaunch of the awards last year with a virtual event, for 2022 we are planning a live awards ceremony which is due to take place in November.

Worcestershire Acute Hospitals NHS Trust

Assurance levels Nov 2020

Meeting	Trust Board
Date of meeting	9 June 2022
Paper number	Enc D

MyWorcsAcute – Staff App

We launched our new Staff App **'MyWorcsAcute'** to staff across the Trust at the end of March. In the two months between then and the time of writing this report, it has been downloaded onto more than 2,000 different phones, with more than 18,000 different opens/visits, demonstrating a good engagement/return rate.

The App contains a wealth of handy information and useful resources including: Staff Health and Wellbeing offer, Staff Benefits offer, Trust Vision and Values, latest Trust news, a link to 'Raise a Concern' from anywhere via the Freedom to Speak Up portal, and useful links straight to Lateral Flow Test reporting, ESR, e-Rostering and the Staff Facebook Group.

The App also has a built-in notification system, which allows us to issue 'Push Notifications' to colleagues who have downloaded the App notifying them to their personal device with a short message of any topic of importance. We trialled this for the first time at the end of May to promote the Rainbow Badge Staff Survey (see item below)

Rainbow Badge Staff Survey/Pride Month

We have been working with members of our LGBTQ+ Network to promote the recently launched Rainbow Badge Staff Survey, with posters, screensavers, video messages, social media and internal communications messages as well as an expanded intranet site for the network.

The start of Pride month at the beginning of June offered a further opportunity for a weekly message 'takeover' by Network Chair Dr Luke Simonds, which will be followed over the course of the month by personal 'lived experience' stories from other members of the Network.

Working with our BAME Network Colleagues

To widen the reach of our Big Quality Conversation, using insights from public health partners and with the support of our BAME network we produced a series of short videos for sharing through our social media channels in some of the languages other than English most commonly spoken in Worcestershire.

A special 'thank you' to colleagues Tariq Mahmood (Punjabi and Urdu), Rashida Bashir (Urdu) and Dorota Amator Bueno (Polish) for their help in making this possible.

Thank you also to Dr Munir Ahmed, one of our Consultant Paediatricians, who shared his thoughts on how to support colleagues and patients in a special Trustwide message to mark the start of Ramadan.

Meeting	Trust Board
Date of meeting	9 June 2022
Paper number	Enc D

As part of the work to seek wider recognition for our Networks which was covered in the last communications update to Board (March 2022), I am pleased to be able to share with Board members that Jas Cartwright has been shortlisted in the Compassionate and Inclusive Leader category of the National BAME Health & Care Awards for her work as the first Chair of our BAME Network.

The winners are due to be announced on the evening of Thursday 9 June.

There is, of course, always more that could be done to engage more effectively with diverse audiences – whether that is our staff or people in the communities we care for.

This is one of the areas where there are significant opportunities for partnership working at Place and/or system/ICS level.

Place/System Working

The Worcestershire 'Place' Communications Cell, which I currently chair, is now established and meeting monthly, bringing together communications and information colleagues from our Trust together with colleagues from across our local health system, as well as the county council – and (a new addition for the June meeting) the voluntary sector. Areas of focus include urgent and emergency care, including support for the Rapid Improvement Cell initiative (see below)

Rapid Improvement Cell

The Trust communications team have produced weekly internal communications packages in support of this multi-agency Worcestershire-wide initiative which aims to ease pressure on local urgent and emergency care services, reduce waiting times, support more timely discharge and improve ambulance handovers.

The packages include information on each week's theme, success stories from the previous week, pictures and videos. They are featured in our Worcestershire Weekly each week and shared with Place communications colleagues for cascade through their own internal communications channels.

4ward Improvement System

Communications support for the roll out of our 4ward Improvement System has included the addition of a new section to the induction programme added to the 4ward section from May onwards, giving our new colleagues an introduction to the 4ward Improvement System and how it aligns with and supports our wider work to further improve organisational culture.

We are also developing a range of presentation and display materials and at the time of writing preparations were being finalised for Leading 4ward – a showcase and learning event for senior leaders from across the Trust.

Worcestershire Acute Hospitals NHS Trust

Assurance levels Nov 2020

Meeting	Trust Board
Date of meeting	9 June 2022
Paper number	Enc D

Digital Care Record

In partnership with colleagues in our digital team we supported a series of Sunrise Electronic Patient Record (EPR) launch events across our three sites, offering demonstrations on how the system will work and how it will benefit colleagues and our patients. The sessions were well attended, with a great deal of interest and positive feedback.

Other issues attracting significant interest

Pressures on our urgent care services continues to generate a significant amount of media and social media attention, with multiple requests received every week for comments on general challenges and specific incidents.

The major flooding incident at Worcestershire Royal Hospital which has previously been reported to Board members required a period of intensive communications support (internal and external) over a period of several days.

The Trust's ongoing response to the Covid pandemic continues to require a significant level of communication support. Our regular Coronavirus Staff Briefing - keeping colleagues up-to-date with the latest news, guidance and clinical advice – reached its 334th edition at the end of May.

For patients and the public we have used a wide range of channels to provide up to date information on issues such as infection prevention and control requirements when visiting our hospitals.

Conclusion
Demand for communications and engagement support continues to grow rapidly and with finite capacity we are trying to focus our time and skills on those areas which will provide most value to the Trust's wider strategic and operational priorities.

Recommendations
Board members are asked to note the report

Worcestershire Acute Hospitals NHS Trust

Assurance levels Nov 2020

Meeting	Trust Board
Date of meeting	9 June 2022
Paper number	Enc E

2022/23 DRAFT Quality account

For approval:	x	For discussion:		For assurance:		To note:	

Accountable Director	Chief Nursing Officer		
Presented by	Deputy Chief Nursing Officer	**Author /s**	Associate Director of Governance, Safety and Risk

Alignment to the Trust's strategic objectives (x)							
Best services for local people	x	Best experience of care and outcomes for our patients	x	Best use of resources	x	Best people	x

Report previously reviewed by		
Committee/Group	Date	Outcome
QGG	03/05/2022	Approved
TME	18/05/2022	Approved
QGC	26/05/2022	Approved
Trust Board	09/06/2022	

Recommendations	Trust Board are requested to • Review the content of the 2021/2022 quality account. • Approved in support to the agreement for onward production.

Executive summary	The Department of Health and Social Care requires providers to submit their final Quality Account to the Secretary of State by uploading it to the NHS website by June 30 each year. This requirement is set out in the Health Act 2009. 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. The Quality Account makes Worcestershire Acute Hospitals NHS Trust more accountable to the public. The purpose of the Quality Account is to enable, patients and their carers to make better informed choices about their healthcare providers to hold NHS providers to account for the quality of the healthcare services they provide. The production of this year's quality account is running on very tight timescales in order that we can meet our commitments and submit to the Secretary of state by June 30th 2022. Please note that within the draft document, there are some data elements that are yet to be provided, and will be validated at month end (May), at which point the quality account will be updated.

Risk

Worcestershire Acute Hospitals NHS Trust

Meeting	Trust Board
Date of meeting	9 June 2022
Paper number	Enc E

Which key red risks does this report address?		**What BAF risk does this report address?**	

Assurance Level (x)	0		1		2		3		4		5		6	x	7		N/A	

Financial Risk	*State the full year revenue cost/saving/capital cost, whether a budget already exists, or how it is proposed that the resources will be managed.*

Action						
Is there an action plan in place to deliver the desired improvement outcomes?	Y		N		N/A	x
Are the actions identified starting to or are delivering the desired outcomes?	Y		N			
If no has the action plan been revised/ enhanced	Y		N			
Timescales to achieve next level of assurance	**30th June 2022**					

Meeting	Trust Board
Date of meeting	9 June 2022
Paper number	Enc E

Introduction/Background
•
Issues and options
• There are two stakeholder reports requested that are outstanding prior to production. • The Communications team will make ready the document for publication and will add in positive examples of service improvement that have occurred in the year and will add in the Graphics and illustrations.
Conclusion
• The development of this year's Quality Account has been made possible through the input of clinical quality priority leads, the Quality Hub, Associate Director of Governance, safety and Risk and stakeholder services representing patients, their carers and the public Worcestershire Acute Trust services. • It is a reflection of areas we the Trust has exceled and celebrated the positive improvement achieved in patient safety and quality of care and where we continue on the journey of quality improvement.
Recommendations
Trust Board are requested to • Review the content of the 2021/2022 quality account. • Approved in support to the agreement for onward production.
Appendices Quality Account final draft prior to publication

Worcestershire Acute Hospitals NHS Trust Quality Account 2021/22

Contents: **Page number:**

Welcome and Introduction

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.**

The Quality Account makes Worcestershire Acute Hospitals NHS Trust more accountable to you, the public. The purpose of a Quality Account is to enable:

- Patients and their families and carers to make better informed choices about their healthcare providers
- Boards of providers to focus on improving quality
- The public to hold NHS providers to account for the quality of the healthcare services they provide

It is our pleasure to showcase the work undertaken over the last 12 months to continuously improve the quality of the services we provide.

Quality in our healthcare is made up of three key 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 Quality Account provides information about how well we did against the quality priorities we set ourselves last year in our 2020/21 Quality Account. It sets out our priorities for 2022/23 (this year), which we have agreed with our patients, carers, staff and stakeholders, and outlines how we plan to achieve those targets. It also contains an overview of our quality performance, based on locally chosen indicators, and a report of the key national indicators from the NHS Outcomes Framework.

We will also share with you the comments we have received in relation to the Quality Account from our Commissioners, Healthwatch, Worcestershire Health Overview and Scrutiny Committee, and our Patient and Public Forum.

About Worcestershire Acute Hospitals NHS Trust

We serve a population of more than 592,000. This figure is projected to rise by 4.5% over the next 10 years. The age groups with the highest forecasted population growth are amongst our very elderly population. Worcestershire experienced slightly fewer COVID-19 deaths versus the national average per 100,000 populations.

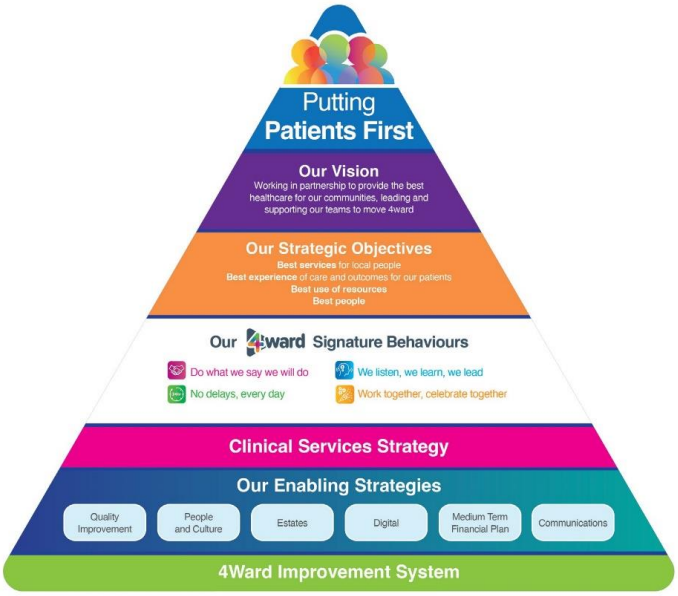
We operate services from:

- Alexandra Hospital, Redditch
- Kidderminster Hospital and Treatment Centre, Kidderminster
- Worcestershire Royal Hospital, Worcester
- Princess of Wales Community Hospital, Bromsgrove
- Evesham Community Hospital, Evesham
- Malvern Community Hospital, Malvern

We provide a broad range of acute services:

- General surgery
- General medicine
- Acute care
- Cancer care
- Intensive care
- Women's and Children's services

We have a range of support services, including diagnostics and pharmacy.



Our Strategic Pyramid

Putting Patients First

Better never stops, and our vision, as set out in our strategic pyramid, is *to ensure that we work in partnership to provide the best healthcare for our communities, and lead and support our teams in moving 4ward.*

Our purpose and vision shape our objectives:

- **Best Services for Local People**: We will develop and design our services with patients, for patients. We will work actively with our partners to build the best sustainable services, which enable people in the communities we care for to enjoy the highest standards of health and wellbeing.
- **Best experience of care and best outcomes for our patients**: We will ensure that the care our patients receive is safe, clinically excellent, compassionate and an exemplar of positive patient experience. We will drive the transformation and continuous improvement of our care systems and processes through clinically-led innovation and best use of technology.
- **Best use of resources**: We will ensure that services – now and in the future – meet the highest possible standards within available resources for the benefit of our patients and the wider health and care system.
- **Best people**: We will invest in our people to ensure that we recruit, retain and develop the right staff with the right skills who care about, and take pride in, putting patients first.

These objectives are underpinned by our 4ward behaviours which we will all strive to model as positively as we can, as often as we can:

- Do What We Say We Will Do
- Listen, Learn, Lead
- No Delays, Every Day
- Work Together, Celebrate Together

Improvement & Innovation
4ward Improvement System

Key to making all of this happen, and making sure that our teams are empowered and equipped with the skills, tools, techniques and mind-set to drive continuous improvement in every part of our Trust, is our single improvement methodology – the 4ward Improvement System.

Initially working with our chosen partner, the Virginia Mason Institute, but with an increasing focus on building our own capacity and capability, our 4ward Improvement System will give us:

- A shared method for identifying and seizing every opportunity to improve the quality and safety of care we provide.
- A common language to describe those improvements.
- Robust ways of measuring the improvements we have made and the benefits that have delivered in terms of patient experience and outcomes; staff morale; efficiency and waste reduction; organisational reputation and our contribution to leading improvement not just in our Trust but across our local health and care system.
- Hope for a better future and a clear road map to help us move 4ward to that better future together.

A Welcome from our Chief Executive and Chair

At Worcestershire Acute Hospitals NHS Trust, we are committed to providing compassionate, safe and high quality care by ensuring that our services consistently exhibit the three key components of quality – patient safety, clinical effectiveness and patient and carer experience.

We aim to continue to achieve these by fostering a culture across all services that fulfils our purpose of putting patients first - ensuring patient-centred care that is tailored to each person's needs and guarantees their dignity and respect, and by empowering our staff to make improvements in their own areas.

In 2021/22, in spite of the continuing challenges that the Covid-19 pandemic has continued to present us with, a collective team effort from our Trust staff, our partners across the health and care system, the voluntary sector, and our wider communities has meant we can celebrate successes in a number of areas.

This report provides a valuable opportunity to look back on that past year, reflect on those 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.

Of particular note is the progress we have made to meet our targets in continuing to reduce medicine incidents causing harm, reduce falls with harm, reduce the number of pressure ulcers and continue to increase hand hygiene compliance. Results from our Friends and Family Test also show that more than 96% of inpatients would recommend our hospitals.

Areas for continued focus in the months ahead to ensure we provide care that is safe, clinically effective and provides a positive experience for our patients and their carers include a reduction in prescribing of antibiotics, and a focus on reducing the number of C-Difficile, E-Coli and MSSA infections. We are pleased that our target to eliminate MRSA infections in 2021/22 was met.

We are also making good progress on the continued implementation of the actions in our Maternity Improvement Plan which sets out how we will continue to work on national and local improvement plans to continually improve the service we offer to women and families in Worcestershire. The development of our Quality Strategy 2022-2025 – in partnership with our patients, stakeholders, and partners - will bring together the requirements of local and national strategies, with a refreshed commitment to quality and patient safety.

Of course, alongside these, and, as we continue to emerge from the challenges of the pandemic the Trust, and the NHS as a whole, is also continuing to focus efforts on the recovery of services.

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 across the Herefordshire and Worcestershire Integrated Care System, inspection and regulatory bodies, and wider communities of our commitment to our improvement journey and achieving our purpose of Putting Patients First.

Sir David Nicholson
Chair

Matthew Hopkins
Chief Executive

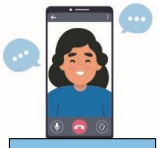
A YEAR IN NUMBERS 21/22

2,033
COVID INPATIENTS

9.47
DAYS IN HOSPITAL (FOR COVID PATIENTS)

Covid 1741
PATIENTS DISCHARGED

361,681
OUTPATIENTS (FACE TO FACE)



140,904
OUTPATIENTS (VIRTUAL AND TELEPHONE)

113,266
WALK-IN PATIENTS (A&E)

53,638
PATIENTS ARRIVING BY AMBULANCE

151,357*
INPATIENTS

5,010
BIRTHS

4,267
EMERGENCY OPERATIONS

18,093
ELECTIVE OPERATIONS

2,169
TRAUMA OPERATIONS

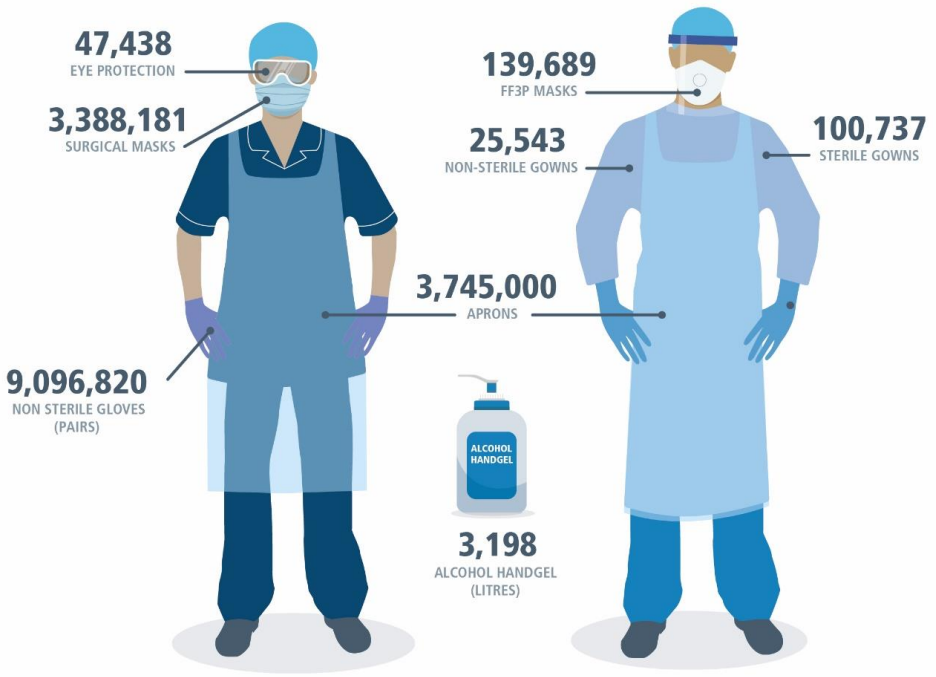
5.8 days
AVERAGE LENGTH OF STAY

770,285
NUMBER OF MEALS SERVED

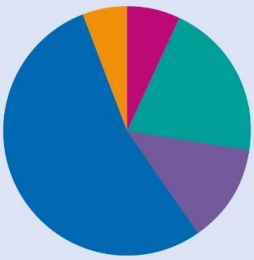
878,149
NUMBER OF SHEETS LAUNDERED

£53.2m
VALUE OF PRESCRIPTIONS ISSUED

* PROVISIONAL DATA TO BE UPDATED AT THE END OF MAY



Diagnostics



- MRI scans - **18,704**
- Non-obstetric ultrasound scans - **65,547**
- CT scans - **63,745**
- Plain film X-Rays - **181,472**
- Endoscopies - **18,347**

Staff

Registered Nurses and Midwives

2241

Total Staff

6806

Doctors and Consultants

728

HCAs, Helpers and Assistants

1291

OTHER CLINICAL STAFF AND ALLIED HEALTH PROFESSIONALS

859

OTHER NON-CLINICAL SUPPORT STAFF

1687

VOLUNTEERS

Our Commitment to Quality

In this section of this Quality Account, we review the progress we have made against the priorities we set ourselves in the 2021/22 Quality Account, and we will outline our quality improvement priorities for the next 12 months (2022/23). In addition, we will provide a statement from the Board on mandated items.

At Worcestershire Acute Hospitals NHS Trust, we are committed to providing compassionate, safe and high quality care by ensuring that our services consistently exhibit the three key components of quality – patient safety, clinical effectiveness and patient and carer experience. We aim to continue to achieve these components by fostering a culture across all services that ensures patient-centred care that is tailored to each person's needs and guarantees their dignity and respect, and by empowering our staff to make improvements in their own areas.

Registration with the Care Quality Commission (CQC)

Following an inspection of the Trust's Emergency Departments as part of CQC's focused winter programme in December 2019, the CQC issued Section 31 Conditions Notices for the Worcestershire Royal Hospital and Alexandra Hospital Emergency Departments.

Safety, quality, risk assessments and assurance tools and processes have been implemented and embedded across the service, in partnership with NHSI/E, CCG and WMAS, and oversight of the continuous improvement has been monitored via the Trust's internal governance structure and the Home first Worcestershire Board.

The Trust continued to satisfy the conditions, submitting fortnightly reports to the CQC. The Trust submitted applications for the Section 31 Conditions to be removed from the Emergency Departments in February 2021, and in April 2021, the CQC formally confirmed that all conditions had been removed from both Emergency Departments.

Throughout 2021/22, in response to the COVID-19 requirements, CQC have focused their formal inspection activity on areas of high risk, and implemented a Transitional Monitoring Approach to ensure continued engagement, oversight and assurance.

During 2021/22, the Trust has remained proactively engaged with the CQC, and facilitated a number of monitoring calls such as:

- Transitional Monitoring Approach – Well-led
- Transitional Monitoring Approach – Critical Care

In May 2021, the CQC announced '*A new strategy for the changing world of health and social care - Our Strategy from 2021'*. In support of the new ways of CQC working alongside the

Trust, a 2-day (onsite & remote) engagement event took place in November 2021, which included:

- Opening session with the Executive Team.
- CQC meeting with the clinical teams in areas such as the Emergency Departments, Critical Care, Maternity and Outpatients at both Worcestershire Royal and the Alexandra Hospitals
  - Virtual engagement sessions with Respiratory Teams, Ward 1 (KTC), Radiology, End of Life Care, Clinical Research, Outpatients, International Nurses, Roster Team, #CallMe, Freedom to Speak Up.
- Open staff engagement sessions.

A further one day (on-site) engagement event was held in February 2022 at Worcestershire Royal Hospital which included visits to:

- Emergency Department and tour of new Urgent Care Village construction site.
- Surgical Same Day Emergency Care (SDEC) Unit
- Critical Care
- Maternity
- Speciality Medicine - Avon 4 ward

Informal feedback from the CQC following both engagement sessions was positive, with many examples of high quality patient care and good leadership. The CQC expressed their gratitude for the welcome they received, the openness and honesty of the colleagues they spoke to and shared their profound admiration for everything that our staff had achieved and are achieving.

It is important to note that CQC are still developing the framework for inspection under their new strategy.

The Trust has maintained its overall quality rating of “Requires Improvement”. The Trust continues to be rated positively “Good” in the “Effective” and “Caring” domains, and “Requires Improvement” in the “Safe”, “Responsive” and “Well-Led” domains.

Ratings for the Whole Trust at 2019						
	Safe	**Effective**	**Caring**	**Responsive**	**Well-Led**	**Overall**
Overall Trust	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement	Requires Improvement

Ratings for the acute services/acute Trust at 2019						
	Safe	Effective	Caring	Responsive	Well-Led	Overall
Worcestershire Royal Hospital	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement	Requires Improvement
Alexandra Hospital	Requires Improvement	Requires Improvement	Good	Requires Improvement	Good	Requires Improvement
Kidderminster Hospital and Treatment Centre	Good	Good	Good	Requires Improvement	Good	Good
Evesham Community Hospital	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement	Requires Improvement

Data Quality

We remain committed to ensuring that all data is accurate, valid, reliable, timely, relevant and complete, and have a number of appropriate systems in place to ensure data quality. Where any risks to data quality are identified, relevant mitigation measures are included within the Trust's risk register.

The Trust submitted the following number of records during 2021/22 to the Secondary Uses Service (SUS) for inclusion in England's Hospital Episode Statistics:

- A&E Records XXXXXX
- Inpatient Records XXXXXX
- Outpatient Records XXXXXX

Review of Quality Priorities for 2021/22

Care that is Safe			
Quality Indicator	**Target for 2021/22**	**Outcome**	**Evaluation**
1. We will reduce the percentage of medicine incidents causing harm across the Trust	Less than 11.71%	2.92% a further reduction from 2021 figures at 3.21%	We met our target
2. We will reduce the number of patients who have a fall with harm whilst under our care	<6	5	We met our target
3. We will continue to improve on progress in reducing the number of pressure ulcers	No more than 247; a reduction of 10% on all pressure ulcers (Total 4 Serious Incident pressure ulcers)	220 total pressure ulcers 1 Serious Incident pressure ulcer	We met our target
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.			
• Clostridium difficile Infection	No more than 61	90	We did not achieve our target
• E coli Bacteraemia	No more than 30 (Local target) *(National target of 128)*	36 achieved the national target <128	We met our target
• MSSA Bacteraemia	No more than 10 *(No national target provided)*	23	We did not achieve our target
• MRSA Bacteraemia	0 cases	0	We met our target
• Hand Hygiene	98% and above	Compliance: 99.68% Participation: 93.49%	We met our target
5. We will further improve the identification and treatment of sepsis	Baseline position for screening in the emergency department: >95%	98.79% (Apr-21 to Feb-22)	We met our target
	Baseline position for screening in inpatient wards: >95%	81.46% (Apr-21 to Feb-22)	We did not achieve our target
	Baseline position for implementing the sepsis six bundle in the emergency department: >80%	74.69% (Apr-21 to Feb-22)	We did not achieve our target
	Baseline position for implementing the sepsis	54.19% (Apr-21 to Feb-22)	We did not achieve our target

	six bundle in inpatient wards: >95%		
6. We will further improve our compliance with screening for venous thromboembolism (VTE)	>95%	96.34%	We met our target
7. We will ensure that the nutrition and hydration needs of patients in hospital are met	100% of patients will have an assessment and documentation of their nutritional and hydration needs	**Adult** **97.36% had an** • Has the MUST action plan been completed correctly? • If the score is less than 2, has appropriate action been taken? 97.51% • If the score is 2 or higher, has the patient been referred to dietetics? 86.91% • Has the care and comfort round documentation been completed? 99.07% **Day case** • Has the correct section on the MUST action plan been completed correctly? 99.35% • If the score is less than 2, has appropriate action been taken? 99.28% • If the score is 2 or higher, has the patient been referred to dietetics? 0% (based on 1 patient)	We did not achieve our target
	>90% of patients, who in their care plans are identified as requiring this to meet their care needs, will have a fluid balance chart and food diary	**Adult** • If on A Fluid Balance Chart, are the totals correctly calculated and recorded within the last 12/24 hours? 94.39% • If patient is on a Fluid Balance Chart, is the positive/negative daily fluid balance recorded? 94.51% **Day case** • If appropriate, has a fluid balance chart been commenced? 100%	We met our target
8. ESR Frailty Essential Training for Clinical Staff (incorporates HAFD) % eligible trained	Measured through a subset of indicators from the Homefirst Frailty / HAFD Dashboard:		
	New priority for second half of Year 3+1, 2021/22		
	Corporate	100%	
	Digital	87.07%	
	SCSD	87.76%	
	Specialty Medicine	83.85%	
	Surgery	79.19%	
	Urgent Care	59.42%	
	Women and Children's	59.42%	
	Trust wide total	83.66%	

	Home First Frailty Dashboard - Total time in A&E 95th percentile Trust daily	WRH (19.7)	Alex (10.2)	Trust wide (15.3)	
	% Emergency admissions 75+	WRH (27.2%)	Alex (42.5%)	Trust wide (31.8%)	
	% of patients 75+ discharged with Length of Stay (LOS) 0 days	WRH (18.8%)	Alex (25.3%)	Trust wide (21.8%)	
	% of patients 75+ discharged with LOS 1 – 2 days	WRH (19.6%)	Alex (26.9%)	Trust wide (23.1%)	
	% of patients 75+ discharged with LOS 3+ days	WRH (61.6%)	Alex (47.7%)	Trust wide (55%)	
	Number of patients 75+ with LLOS 7+ days	WRH (78)	Alex (51)	Trust wide (129)	

Care that is Clinically Effective			
Quality Indicator	**Target for 2021/22**	**Outcome**	**Evaluation**
1. We will monitor and seek to reduce mortality rates for patients whilst under our care	HSMR of below 100	Rolling 12 months to Jan 22 | 102.72 HSMR relies on a second cut of SUS and this tends to lead to some volatility in the measure. As our HSMR is as much reliant on the coding and submission of SUS by other trusts as it is our own, this means that the latest HSMR on HED should be taken with caution.	This remains well within expected range and is below the combined Midlands trusts value (105.41)
2. We will implement clinical standards for Seven Day Hospital Services	All patients are reviewed within 14 hours of coming into our care	• The clinical audit programme for regular monitoring of performance against 7DS clinical standards 2 & 8 is now in place supported by clinical divisions and the Clinical Effectiveness team. • Performance against clinical standard 2 has increased, by 22% since October 2021, to 74% in November '21 being reviewed by a consultant within 14 hours of admission to hospital. • Weekday performance improved from 45% in October '21 to 64% in November '21 • Weekend performance improved from 59% in October '21 to 87% in November '21 • 7-day consultant cover now in place in Acute Medicine. • 7-day consultant cover now in place on approx. 60% of inpatient medical wards, and 6-day cover on all other wards • Documentation improvements on both sites, and increased recruitment to acute medicine consultant posts.	We met this standard. 7 day services ceased March 2022

3. We will complete an annual programme of local clinical audits	80%	At 31st March 2022 24% of the 2021/22 annual programme of clinical audits was complete, with a further 20% in progress. Due to the rolling nature of clinical audit projects, which extend across years, we monitor progress on a rolling 2-year basis, which gives a clearer indication of audits completed. In addition to annual programme audits 118 ad-hoc (non-programme) clinical audits had been completed at 31st March 2022.	We did not meet our target

Care that is a Positive Experience for Patients and their Carers			
Quality Indicator	**Target for 2021/22**	**Outcome**	**Evaluation**
1. We will respond to complaints within 25 working days of receipt and ensure we create learning from the themes from complaints	80%	80.62% of complaints were responded to within 25 working days	We met our target
2. We will reduce the number of complaints returned from those who are not satisfied with the response	10%	16.6% of complaints received in year and closed have been reopened at the time of writing.	We did not meet our target
3. We will maintain the percentage of inpatients and all visitors to our hospitals who would recommend our Trust to friends and family to 95% and we will maintain our baseline response rates for emergency departments, inpatients, outpatients, paediatrics and maternity services. We will specifically focus on ensuring that the public is encouraged and aware of how they can feedback to us and we will demonstrate that we are listening and	95%	Inpatients Recommend – 96.09% Outpatients Recommend – 92.61% ED Recommend – 76.58% Maternity Recommend – 93.08%	We met the target for inpatients, however, we did not meet our target for Outpatients, ED and Maternity

sharing what we are being told			
4. We will ensure patients with Dementia and their carers feel they have received care that positively improves their outcomes, as reported within the national dementia audit, through implementing consistently the Dementia bundle with every patient admitted under our care	80% training completion	• 10 of 12 actions from RCP National Audit of Dementia Recommendations completed (2 outstanding actions to be completed via Trust annual account report). • Dementia & Delirium Assessment performance dashboard available via WREN. • Dementia Awareness e-learning live as essential training from October 2020, 89.9% eligible staff have completed at end March 2022 (standard is 90%). • Agreed questions for dementia care included in safety huddles. • Quality Audit questions revised and finalised to include 2 questions related to dementia/delirium identification and action for patients aged 65+. • Deep dive questions based on dementia/delirium care bundle agreed for digital upload to GAP/WREN (currently on hold). • Condensed "What Matters to Me" document (based on "About Me" document to aid person-centred care during COVID visiting restrictions.	We met our target
5. Ensuring patients and their carers feel listened to and have clear lines of communication with staff about their condition, treatment and care	Creation of a Front of House PALS service	The number of people contacting the PALS service has risen sharply throughout the year to previously unseen levels which have been sustained and continued to rise. Measures have been introduced in response to this, to support efficiency within the PALS team. It has not been possible to move to a front of house service with the sustained high level of telephone calls and increased emails.	Expected to be met in 2022
	Ease of sharing feedback and increasing visibility	There has been progress with the Trust's "Commitment to Carers which has resulted in an integrated approach and partnership with Worcestershire Association of Carers. Underpinning this is the Trust's active engagement in the Carer's Partnership Network. Initiatives this year include: ➢ Joint delivery of a social media campaign for Carer's Right's day ➢ Development of a series of measures to gain Carer feedback to assess how Carers are listened to and included in information about care	Good practice examples and integrated approaches Expected to be met in 2022

		➢ Inclusion of specific Carer questions in the Big Quality Conversation 2021-22 ➢ Integrated communication approaches including engagement with the Trust's Poet in Residence to acknowledge Carers "After Care/r" We created a variety of ways for the public to share feedback about services and experiences through The Big Quality Conversation – through QR code posters and a survey available in different languages across our hospitals, to a social media campaign, videos and face to face conversations. Engagement with stakeholders in the local D/deaf community supported a mini tender carousel competition to award a contract for Sign language at the Trust – we engaged with the community to design an approach for 2022-23 which will include a focus on feedback and quality improvement. The local D/deaf community engaged with 'The Big Quality Conversation' to share their experiences of care, creating a British sign language (BSL) video and interpreted café session to support active engagement. We increased our networking throughout the year across the Integrated Care Services locally to amplify our messaging and strengthen our partnerships and approaches. We have extended the opportunity to meet and work with us in a variety of ways to local organisations including Healthwatch to continue conversations of joint interest and provide a variety of ways to "feed-back. We met with patients directly where services affected them, during our face to face pre-engagement consultation on a cancer service based at Kidderminster Treatment Centre. We invited our volunteers to feed back to us after each volunteering session, so that we could understand what is working well and where we can improve. Feedback was overwhelmingly positive and ensured that we continued to deliver responsive and positive experiences for our local community.	
	"You Said We are Listening" – underpin initiatives with Path to Platinum	How divisions are "listening" to and acting on patient feedback has been reported into and discussed at bi-monthly-quarterly Patient, Carer and Public Engagement steering group meetings which include Patient Representatives, The Worcestershire Association of Carers and Healthwatch. Examples of how we have listened include: • The approach taken to engage with D/deaf patients and engage a contractor	We met our target

		that meets need (responding directly to feedback/concerns/complaints from members of the D/deaf community) • The Garden Suite pre-consultation in response to public concerns and feedback (This was an informal consultation, and engagement approach (informal conversations based on survey questions) with patients to understand experiences of using the temporarily relocated suite. • Ongoing Patient and Public Forum quality projects • #CallMe was launched in Patient Experience Week: #ExpoOfCare in June 2021 and won the British Medical Journal Award for Digital Innovation Team of the Year award – created in response to feedback the initiative supports every patient to be called by their preferred name New volunteer roles developed to support patient experience include Discharge/Pharmacy roles, new Wayfinder roles at both hospitals, Patient Parcel small gift delivery service and Patient Experience roles in the Emergency Department.	
	Appoint a Lead for Equality and Diversity and improve accessibility across our services	Through human resource department lead for Equality and Diversity we have: • We launched Accessible Guides through a partnership with “AccessAble”. Stakeholders have been involved throughout the process to ensure that the Guides created are as accessible as possible. ➢ Patient Stories have been shared in a variety of ways at the Trust Board monthly meetings to support across the equality, accessibility and inclusion agenda ➢ We asked specific questions in The Big Quality Conversation to help us to understand and monitor equality, diversity and equal opportunity monitoring – to inform us about how we can continue to diversify how we engage and continue to improve accessibility to our approaches and services. ➢ We have invited patients, carers and Patient Representatives to committees and meetings to have conversations about how we can continue to develop and improve accessibility and co-produce solutions together, this includes working together at The Patient, Carer and Public Engagement Committee, Clinical Governance Group and Quality Governance Committee. We have explored new ways of doing this which	

		includes commissioning a poem "Made of Stories" which was read at the Dementia Steering group, working with local students and school children to bring art and creativity into a clinical environment and working with volunteers who are registered blind.	
	Devise new ways to share compliments within and outside our trust	Compliments are reported into and discussed at the bi-monthly-quarterly Patient, Carer and Public Engagement steering group. Reports are shared with the Patient and Public Forum and Clinical Governance Group. Next steps include with support of the digital infrastructure to input compliments for both divisional and trust wide real-time views.	Expected to be met in 2022
	Implement training Programmes on customer care designed through feedback from patient services and FFT	As we continue to explore our patient feedback, we will explore how training opportunities can be introduced to support improvement and share best practice.	Expected to be met in 2022
	Continue to develop our #TogetherWeArePatientExperience campaign supporting Patient Experience Champions	Our teams have been supported to ensure that patient experience is a focus through a variety of other measures which include *#CallMe* and associated training, regular divisional reporting and ongoing Ward Accreditation	We met our target
6. We will engage with and understand the needs of patients who are receiving care at the end of their lives, and will offer services to meet their physical, psychological, social and spiritual needs and will ensure that they are involved in and have control over decisions about their care.	Increase in engagement in advanced care planning including the update of ReSPECT and AMBER Care Bundle for those with uncertain recovery	1050 patients were supported with the AMBER Care Bundle in 2021/22 (718 at WRH & 332 at ALX), compared with 634 in 2020/21 (326 at WRH & 308 at ALX). This demonstrates a significant increase in usage at WRH. ReSPECT training: Awareness – 89% Authorship – 76%	We met our target
	Compliance with the use of the Individualised Last Days of Life for Adults care plan, for those identified as being in the last days of life	Last audited in March 2020 – results: 95% compliance (95% of expected deaths had a LDOL care plan in place). Previous audit result was 90% compliance, therefore an improvement Re-audit planned for Summer 2022.	We met our target
	Constructive participation in local and national End of Life audits	Participation in National Audit for Care at the End of Life (NACEL) – final results of round 3 awaited. Registered to take part in round 4 during summer 2022. Local audit programme in place as part of BOPP	We met our target

<table>
<tr><td rowspan="3"></td><td>Positive feedback from patients and those important to them</td><td>VOICES bereavement survey currently under review. Aiming to relaunch in Spring/Summer 2022.

NACEL Round 3 also included feedback from bereaved relatives – final results awaited</td><td>We met our target</td></tr>
<tr><td>Reduction in End of Life Care related complaints</td><td>In 2020/21 percentage of total complaints with EOLC component = 2.1%
In 2021/22 percentage of total complaints with EOLC component = 1.8%
Demonstrating slight improvement as a whole trust, despite a slight increase in number of EOLC complaints at WRH.

<table>
<tr><th></th><th>Total</th><th>Formal complaints with EoLC component.</th><th>% complaints with an EoLC component</th></tr>
<tr><td>WRH</td><td></td><td></td><td></td></tr>
<tr><td>2011-2012</td><td>364</td><td>7</td><td>1.9%</td></tr>
<tr><td>2012-2013</td><td>407</td><td>11</td><td>2.7%</td></tr>
<tr><td>2013-2014</td><td>330</td><td>12</td><td>3.6%</td></tr>
<tr><td>2014-2015</td><td>325</td><td>9</td><td>2.8%</td></tr>
<tr><td>2015-2016</td><td>397</td><td>16</td><td>4%</td></tr>
<tr><td>2016-2017</td><td>479</td><td>11</td><td>2.3%</td></tr>
<tr><td>2017-2018</td><td>354</td><td>7</td><td>2%</td></tr>
<tr><td>2018-2019</td><td>314</td><td>7</td><td>2.2%</td></tr>
<tr><td>2019-2020</td><td>345</td><td>5</td><td>1.4%</td></tr>
<tr><td>2020-2021</td><td>276</td><td>4</td><td>1.4%</td></tr>
<tr><td>2021-2022</td><td>341</td><td>6</td><td>1.8%</td></tr>
<tr><td>Alex</td><td></td><td></td><td></td></tr>
<tr><td>2011-2012</td><td>272</td><td>8</td><td>2.9%</td></tr>
<tr><td>2012-2013</td><td>244</td><td>9</td><td>3.7%</td></tr>
<tr><td>2013-2014</td><td>204</td><td>5</td><td>2.5%</td></tr>
<tr><td>2014-2015</td><td>144</td><td>1</td><td>0.7%</td></tr>
<tr><td>2015-2016</td><td>171</td><td>6</td><td>3.5%</td></tr>
<tr><td>2016-2017</td><td>176</td><td>4</td><td>2.3%</td></tr>
<tr><td>2017-2018</td><td>151</td><td>2</td><td>1.32%</td></tr>
<tr><td>2018-2019</td><td>171</td><td>2</td><td>1.16%</td></tr>
<tr><td>2019-2020</td><td>146</td><td>3</td><td>2%</td></tr>
<tr><td>2020-2021</td><td>104</td><td>4</td><td>3.8%</td></tr>
<tr><td>2021-2022</td><td>151</td><td>3</td><td>2%</td></tr>
</table>
</td><td>We met our target</td></tr>
<tr><td>Engagement and increased uptake in End of Life education and training amongst healthcare professionals</td><td>The below is the total percentage of staff who have undertaken the EOLC e-learning since it was introduced in Spring 2021.

A wide range of palliative & EOL Care education is delivered throughout the year.</td><td>We met our target</td></tr>
</table>

		<table><tr><th>Division</th><th>Eligible Headcount</th><th>No. of Staff Completed as at 31/03/22</th><th>% of Staff Completed as at 31/03/22</th></tr><tr><td>365 Corporate</td><td>102</td><td>67</td><td>65.69%</td></tr><tr><td>365 Specialised Clinical Services Division</td><td>1248</td><td>1118</td><td>89.58%</td></tr><tr><td>365 Specialty Medicine</td><td>958</td><td>843</td><td>88.00%</td></tr><tr><td>365 Surgery</td><td>700</td><td>596</td><td>85.14%</td></tr><tr><td>365 Urgent Care</td><td>495</td><td>406</td><td>82.02%</td></tr><tr><td>365 Women & Children</td><td>130</td><td>91</td><td>70.00%</td></tr><tr><td>Grand Total</td><td>3633</td><td>3121</td><td>85.91%</td></tr></table>	

Our Quality Priorities and Key Indicators for 2022/23

During 2021/22, the Trust has been required to continue its clinical focus on the COVID-19 pandemic response, and focusing on how we can restore our services.

Over the last 12 months, we have consulted with our stakeholders, partners and patients to construct our Quality Strategy 2022 – 2025, which will bring together the requirements of local and national strategies, with a refreshed commitment to quality and patient safety.

For Year 1 of our strategy – 2022/23 – our priorities have been formulated through ongoing engagement throughout 2020/21 and 2021/22, and action focused refinement with:

- Staff, including Divisional Directors, via Quality Strategy socialising sessions
- Patients, via the Big Quality Conversation, compliments, complaints, Friends and Family feedback
- System Partners, through engagement with the annual accounting process and monthly quality forums:
    - Herefordshire and Worcestershire Clinical Commissioning Group
    - Worcestershire Health Overview and Scrutiny Committee
    - Healthwatch Worcestershire
    - Integrated Care System
- Patient and Public Forum, Volunteers, Youth Forum through assurance processes/reviews and engagement via forums
- Students via engagement sessions.

We conducted our second Big Quality Conversation online survey, and asked patients, carers and the public to provide feedback on the quality and safety of services they have experienced during 2021/22.

The survey was viewed over 2152 times, with over 585 either full (345) or partial (240) responses representing a 23% increase on 2021 figures. Of those completing the survey:

- 30.64% (110) male respondents
- 63.79% (229) Female respondents
- Of 352 responses, 311 are recorded as White: English/Welsh/British

% of responses and associated clinical areas:

- WRH 81.45%
- Alex 23.64%
- Kidderminster Hospital and Treatment Centre 14.73%
- Evesham community hospital (Burlingham Endoscopy ward only) 2.36%

Our quality statements are laid out under the three dimensions of quality, with priority areas under each quality statement.

- Care that is **Safe:**
- Care that is **Clinically Effective:**
- Care that is a **Positive Experience** for Patients and their Carers:

Respondents to the survey told us that the following areas are important to them and are addressed throughout this quality account:

•Infection Prevention and Control
- Personnel Protective equipment (PPE)
- Cleanliness
- Social Distancing

•Communication
- British Sign Language
- Interpreters
- Clear Communication
- Being Kept Informed
- Keeping in touch with family

•Staffing
- Competent staff
- Visibility of Staff
- Enough Staff
- Staff Attitudes
- Caring Staff

•Responsive
- Waiting times
- Quick Treatment
- Regular Monitoring

•Effective
- High Standard of Care
- Quick Treatment

Care that is Safe: **These year's survey findings tell us that 70.49% of 454 responses reported feeling "extremely safe or very safe" and 19.82% reported feeling "somewhat safe". This shows an increase in response and satisfaction rate from 227 (2021) responses to 454 (2022) responses, with an overall satisfaction increase of 0.45%.**

Quality Statements:

- Our patients will continue to receive the highest levels of Infection Prevention and Control (IPC) excellence, reducing the risk of nosocomial (healthcare acquired) infections in hospital
- Our patients will be represented in our governance processes, in particular by ensuring Patient Safety Partners are involved in the implementation of the National Patient Safety Strategy
- Our patients' nutrition and hydration needs will be met during their time in our hospitals
- Our patients will experience safe and timely discharges from hospital and transfers between services
- Our patients will continue to receive timely identification and treatment of sepsis
- Digital Care Record

Priorities for 2022/23

Care that is Safe

Our patients will continue to receive the highest levels of Infection Prevention and Control (IPC) excellence, reducing the risk of nosocomial (healthcare acquired) infections in hospital

Care that is Clinically Effective: **These year's survey findings tell us that 70.55% of 420 responses reported that staff worked together "Extremely well or very well" and 19.29% felt that staff worked together "Somewhat well". This shows an increase in response and satisfaction rate from 225 (2021) responses to 420 (2022) responses, with an overall increase of 0.55%.**

Quality Statements:

- We will commit to continuous learning from deaths and monitor and seek to reduce mortality rates for patients whilst under our care
- Our patients will experience better health outcomes due to a regular programme of clinical audit and subsequent quality improvement projects
- Our patients will receive timely treatment and care through improved waiting times, seven day services and a focus on reducing backlog
- Develop new Research and Development Strategy

Reducing Clostridium difficile	**Our target for 2022/23 is: 61**
We will do this by: • Achieving the standards set out in the 2022-23 *Key Standards to Prevent Infection* • Participating in regional Clostridium difficile collaborative • Divisions will focus on improving detection and management of patients with diarrhoea, based on learning from cases in 2021-22. Fewer cases will have these issues detected as an "amber" lapse in care. • Recognising patients with previous Clostridium Difficile Infection on admission, so that prescribing can take account of previous infection and reduce the risk of recurrence. • Ensuring a proactive programme of deep cleaning beds and trollies will be established on both sites. • Ensuring a programme of deep cleaning Emergency Departments and admission areas. • Meeting the national standards in all areas for cleanliness minimum standard: nursing and estates as well as cleaning services.	

Antimicrobial stewardship	**Our targets for 2022/23 are:** 1. Achieve a cumulative reduction of 4.5% for prescribing of antibiotics in "Watch" and "Reserve" groups compared to 2018 baseline. 2. Commissioning for Quality and Innovation (CQUIN) target: Achieving 60% of all antibiotic prescriptions for UTI in patients aged 16+ years that meet NICE guidance for diagnosis and treatment.
We will do this by: • Target 1 will be achieved by – undertaking and completing review of treatment guidelines for antimicrobial prescribing taking into account the following; national treatment guidance (i.e. National institute for Care and Excellence (NICE) guidelines), local resistance patterns, rationalising empirical guidance for broad spectrum antibiotics (i.e. co-amoxiclav) and monitoring compliance to prescribing guidelines via quarterly point prevalence surveys reported via Antimicrobial Stewardship steering Group (ASG). • Target 2 will be achieved by – establishing an Multi-Disciplinary team task and finish group to monitor and action CQUIN progress, updating local antimicrobial treatment guidelines for the diagnosis and treatment of Urinary Tract Infections producing education and training materials and delivering ad-hoc education and training sessions with feedback and progress updates for directorates.	

Our patients will be represented in our governance processes, in particular by ensuring Patient Safety Partners are involved in the implementation of the National Patient Safety Strategy

Transition to the Patient Safety Incident Response Framework	Our target for 2022/23 is to fully implement and transition to the new Patient Safety Incident Response Framework (PSIRF)
We will do this by: We will review changes to the PSIRF following feedback from the early adopter sites. This program is scheduled to be incrementally delivered as and when National documentation has been approved. We will start to roll out the PSIRF throughout 2022 and will review bi-annually to ensure progress against national targets.	

Improvement of the quality of investigation reports, including implementation of the new Patient Safety Investigation standards	Our target for 2022/23 is 35% of all patient safety investigations will be conducted according to the new investigation standards
We will do this by: We will transition to the new PSIRF during 2022 and will be implementing the new investigation standards. The aim in the first year will be to demonstrate that 35% of all patient safety investigations are conducted utilizing the new investigation approach. This percentage will be increased yearly.	

Our patients' nutrition and hydration needs will be met during their time in our hospitals

Nutrition and hydration assessments	Our target for 2022/23 is 100%
We will do this by: • Assessing and evaluating all our patients as clinically appropriate • Monitoring compliance against these standards through senior nurse audits, with an improvement approach to support areas of non-achievement • Ongoing training available to support staff in evidence based completion of assessments	

Food diaries and fluid balance charts	Our target for 2022/23 is 100%
We will do this by: • All patients that require a fluid balance chart will have one, and the documentation will be up to date, contemporaneous and used to support clinical decision making • Monitoring compliance against these standards through senior nurse audits, with an improvement approach to support areas of non-achievement • Ongoing training available to support staff in evidence based completion of assessments	

Our patients will experience safe and timely discharges from hospital and transfers between services

Rollout of Discharge Production Boards (DPBs) on all inpatient ward areas	Our target for 2022/23 is >95%

We will do this by: • Ward to Board roll out of the DPB model • Monitoring of key discharge metrics to demonstrate improvement

Our patients will continue to receive timely identification and treatment of sepsis

Baseline position for screening in the emergency department	**Our target for 2022/23 is >95%**
We will do this by: • Continuous monitoring of use of the Sepsis Six bundle within our Emergency Departments through governance processes and audit. • Implementation of the Digital Care Record.	

Baseline position for screening in inpatient wards	**Our target for 2022/23 is >95%**
We will do this by: • Continuous monitoring of use of the Sepsis Six bundle within our Emergency Departments through governance processes and audit. • Implementation of the Digital Care Record.	

Baseline position for implementing the sepsis six bundle in the emergency department	**Our target for 2022/23 is >85%**
We will do this by: • Trust Sepsis Lead to work with Divisions to increase the use of the sepsis six bundle. • Implementation of the Digital Care Record.	

Baseline position for implementing the sepsis six bundle in inpatient wards	**Our target for 2022/23 is >85%**
We will do this by: • Trust Sepsis Lead to work with Divisions to increase the use of the sepsis six bundle. • Implementation of the Digital Care Record.	

Digital Care Record

The Digital Care Record (DCR) is a high-tech electronic patient record system which will modernize and improve the way we deliver patient care across the Trust.

Introducing a DCR system will mean that all patient information will be available electronically, on screen, at any hospital location at any time. It will transform the way we admit, treat and discharge our patients. It will improve referral management, reducing the

number of cancellations and rescheduled appointments. It is the first step to allow us ultimately to share patient records with other appropriate NHS organisations.

Phase 1 documentation roll-out		
We will do this by: • "Phase 1" is scheduled to go live at the end of 2022, and will contain the most common Medical and Nursing documents used for recording care or assessing risk for adults receiving care in an inpatient setting, for example:		
• Adult Acute Medical Admission Document • Adult Acute Medical Daily Review Document • Surgical Admission Assessment • Adult Surgical Daily Review Document • Comorbidities • Biographical Details • Inpatient Risk Assessment for VTE • Nursing Admission • Assessment of Nursing Care Needs • Patient Property - Disclaimer Form • Dementia Assessment Tool	• Falls Prevention Assessment and Intervention • Falls Risk Assessment Care Plan Inpatient • Bedrails Assessment and Implementation Plan • Mobility Assessment • Adult MUST Assessment Action Plan • Pressure Ulcer Prevention Care Plan • Water low Chart • Oral Care Assessment and Recording Tool • Alcohol Consumption and Smoking Screening Tool • Patient Admission Assessment for Risk of Infection	• Stool Charts • Wound assessment • Urinary Catheter • Oral Care Assessment and Recording Tool • Alcohol Consumption and Smoking Screening Tool • PVD Form • Intentional Care and Comfort Record • New2 Observation and Pain Management Chart • Glasgow Observation Chart • Sepsis Screening Tool • Fluid Balance Sheets • Discharge Checklist • Rockwood Assessment

Care that is Clinically Effective

We will commit to continuous learning from deaths and monitor and seek to reduce mortality rates for patients whilst under our care

Relatives contacted by medical examiner team and invited to raise concerns	**Our target for 2022/23 is 90%**
We will do this by: • Recruitment to Medical Examiner and Medical Examiner Officer posts.	

- Setting up systems to ensure all deaths are reviewed and family discussions occurring before MCCD's (Medical certificate for cause of death) are forwarded to the registrar.
- All concerns logged and issues passed on through appropriate escalation pathways.

Outcomes of mortality reviews will be reported and improvement actions developed	**Our target for 2022/23 is 90%**

We will do this by:

- Ensuring standard templates to report output from clinical team mortality meetings and divisional governance meetings with the focus primarily on quality improvement activity arising as a result of mortality reviews.
- Reporting overseen at Learning from deaths group where sharing of learning and improvement initiatives occurs.
- Presenting a quarterly learning from deaths report to Quality Governance Committee.

Reducing SHMI to remain within the "as expected" range

We will do this by:

- Monitoring for and review of any high relative risk of death diagnostic groups to ensure best practice in clinical care and coding are provided.

Our patients will experience better health outcomes due to a regular programme of clinical audit and subsequent quality improvement projects

Participating in a programme of national audits for which we are eligible	**Our target for 2022/23 is >95% of national audits for which we are eligible**

We will do this by:

- Continuing to participate in all national audits that we are eligible to participate in.
- Ensuring that baseline assessments are carried out for all new national audits, seeking to overcome any obstacles to participation where necessary.

Outcomes of national audits will be reported and improvement actions will be generated and monitored	**Our target for 2022/23 is 90% of relevant* national audits will have a baseline audit/ progress update, with actions generated and monitored, via the National Clinical Audit Module.** **relevant – excludes some national audits that are registries*

We will do this by:

- Launching the National Clinical Audit Module on Clinical Audit Tool (CATs) (estimated June 2022), to facilitate reporting of national audits, recording of actions and monitoring, with regular reports being provided to Divisions and Clinical Governance Group by the Clinical Audit Team.

Our patients will receive timely treatment and care through improved waiting times, seven day services and a focus on reducing backlog

Eliminating 104 week waits for elective treatment in 2022/23	**Our target for 2022/23 is 0 104 week waits**
We will do this by: • Increasing throughput at Kidderminster Hospital and Treatment Centre. • Implementing new theatre capacity at the Alexandra Hospital.	

Restoring diagnostic and treatment activity to pre-covid levels	**Our target for 2022/23 is 104%**
We will do this by: • Increasing throughput at Kidderminster Hospital and Treatment Centre, including development of Community Diagnostic Hub. • Implementing new theatre capacity at the Alexandra Hospital.	

Develop new Research and Development Strategy

Develop new Research and Development Strategy
We will do this by: The new Research and Development Strategy has been approved by the Trust Board in April 2022. We will implement the strategy and report progress to Quality Governance Committee.

Work with educational partners to improve the training for our staff

Work with educational partners to improve the training for our staff during 2022/23,
we will do this by: **Medical staffing:** • Ensuring alignment with Health Education England education contract **Medical Education:** • Adopting Midlands Charter across all aspects of medical education • Continuing to pursue relationship with Worcester University – Three Counties Medical School; Birmingham University and Warwick University • Approving new build Simulation Centre

Care that is a Positive Experience for Patients and their Carers

Our patients will experience better access to our services, particularly for our patients and their carers who live with health inequalities. This includes members of Ethnic Minority communities, the LGBT+ community and people who live with disabilities or vulnerabilities.

Implementing a real-time accessibility information service that supports access to our facilities	**Our targets for 2022/23 are:** • Friends and Family Test: Achieve 95% Recommended rate in A and E, Inpatients/Day case, Maternity and Outpatients.

We will do this by:

- We will ensure that patients, carers, family and friends are offered a variety of ways to feedback about services across our hospitals – by providing and making available cards, text message and iPad “every day” and throughout a patients’ journey. We will explore ways to maximise on the visibility and ensure that our patients are aware that we invite them to feedback about the quality of their care.
- Public feedback will be displayed in ward/clinic areas in a standardised and consistent way – clearly demonstrating actions and improvements from comments. ‘You said – we listened’ - ward areas will display positive comments and update their boards monthly.
- Divisions will present action plans at governance meetings in response to Care Quality Commission (CQC) patient Experience surveys and provide headlines and progress at the Patient, Carer and Public Engagement steering group to ensure a standardised approach to action and improvement.
- Carer’s Conversation Cafes in partnership with the Worcestershire Association of Carers will offer an additional mechanism to engage directly with carers and provide opportunity to feedback about experiences. Themes will be presented to the Patient, Carer and Public Engagement Group and reported into Clinical Governance Group.
- Engagement events with the D/deaf community will raise awareness of how the community can feedback about their experiences which will directly inform developments for sign language provision at the Trust. Themes and actions will be reported into the Patient, Carer and Public Engagement Group and Clinical Governance Group.
- We will develop a Patient Advice and Liaison service (PALS) Front of House Service at Worcestershire Royal Hospital to provide an additional support mechanism for the public to feedback concerns, compliments and issues.
- Wards will consistently offer Learning Disability patients the Easy Read Friends and Family Test which is available within the Learning Disability Resource pack

Strengthening pathways for patients with Learning Disabilities (LD)
We will do this by:

- Sharing of key messages, actions, learning, improvements, patient stories and incidents for People with a Learning Disability and autistic people (LeDeR) through the LD Steering Group.
- Re-establishing LD Champions, holding training events to share skills, supporting wards with embedding the use of the LD Traffic Light Symbol to highlight there maybe additional needs/reasonable adjustments – monthly audits by LD Team to monitor.
- Introduce New National Training Programmes as they become available (Summer 2022)
- LD National Survey – Review results and make SMART actions for improvements, working with Divisions to make improvements, monitoring actions through LD Steering Group and reporting to CGG. (To check with Claire this is correct forum)
- Resource Packs to be printed and made available for each ward area to support teams with LD appropriate resources.
- Quarterly LD Bulletins to be shared with teams – showcasing good practice, patient stories, key messages and news.

Developing diagnostic access with community hubs and implement care in new, purpose built facilities to meet patient needs	**Our target for 2022/23 is to open one Diagnostic Hub**
We will do this by: • Working with partners to develop facilities and pathways	

Our patients and their carers will be provided with a variety of methods for providing feedback on their experiences of our services, to ensure learning and improvements can be prioritised.

Implementing a digital solution that enables patients to provide feedback in real-time	**Our targets for 2022/23 are** • 4star rating from patients and carers. • Friends and Family Test: Achieve 95% Recommended rate in A and E, Inpatients/Day case, Maternity and Outpatients.
We will do this by: • We will explore a whole-system web based IT solution to capturing and monitoring feedback: this will include further ways for the public to feedback and strengthen our messaging that we are a listening Trust. • To support this, we will explore creating a greater visibility of the importance of giving feedback in the main entrances of our hospitals. • We will bring in new ways to understand the patient feedback journey which will provide a new management interface, tableau dashboards and an internal and public launch	

Greater engagement with patients and carers through the annual Big Quality	**Our target for 2022/23 is** (increase by 10%)

Conversation, feeding into yearly priorities	
We will do this by: • We will deliver targeted engagement with staff, patients, carers and the wider community. • We will do this through a poster campaign and through local community groups, developing staff webinars, working with our volunteers and engaging with community networks. • We will engage using a mixed mode approach of face to face conversations and workshops and harnessing digital technology	

Increasing Compliments and recommendation rates	Our target for 2022/23 is increase compliments by 15%
We will do this by: • We will update the Datix Reporting system to provide a mechanism for any member of staff to upload and register a compliment at the Trust. • We will maximise awareness with staff through our internal Communications and we will monitor improvement through the Patient, Carer and Public Engagement steering group. • We will report on progress with our target into the Clinical Governance Committee	

Reducing the number of complaints returned from those who are not satisfied with the response	Our target for 2022/23 is 15%
We will do this by: • Explore the roll out of surveying patients and carers to gain feedback on the quality of the process and identify areas for improvement • Explore Business Case against benchmarking from other Trusts to expand Complaints Team and service function (if required) to meet National Complaints Standards Framework. • Produce regular thematic reports on reopened complaints to identify reasons and areas for action/need for additional training.	

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 the 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 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 the Department of Health guidance

Quality Dashboard – NHS Outcomes Framework

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 Published: 12th May 2022	1.0410 Banding 2 'as expected' (Jan-21 – Dec-21)	N/A	0.7127	1.1897	*Worcestershire Acute Hospitals NHS Trust considers that this data is as described for the following reasons:* An improvement 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	1.0321 Banding 2 'as expected' (Apr-20 – Mar-21)	1.0428 Banding 2 'as expected' (Apr-19 – Mar-20)	1.1440 Banding 1 'higher than expected' (Apr-18 – Mar-19)
	% of deaths with either palliative care specialty or diagnosis coding Published: 12th May 2022	34% (Jan-21 – Dec-21)	39%	11%	64%	*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 continue to improve this performance during 2020/21	34.11% (Apr-20 – Mar-21)	34.75% (Apr-19 – Mar-20)	33.63% (Apr-18 – Mar-19)

Domain	Indicator	Current Performance	National average value	Where applicable: Best NHS performer	Where applicable: Worst NHS performer	Trust statement	Previous values (where data available)		
	Patient-reported outcome score for hip replacement surgery – adjusted average health gain (Oxford Hip Score)	COVID-19 note In order to respond to the challenges posed by the coronavirus pandemic, NHS hospitals in England were instructed to suspend all non-urgent elective surgery for patients for parts of the 2020/21 reporting period. This has directly impacted upon reported volumes of activity pertaining to Hip & Knee replacements reported in PROMs. In addition it is possible that behaviours around activities relating to the completion, return and processing of pre and post-operative questionnaires may have also been impacted when compared to earlier years data where behaviours and processes related to managing the current pandemic were not in place.				*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	22.754 Not an outlier (19/20 Final)	22.532 Not an outlier (18/19 Final)	22.965 Not an outlier (17/18 Final)
	Patient-reported outcome score for knee replacement surgery – adjusted average health gain (Oxford Knee Score)					*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	17.342 Not an outlier (19/20 Final)	18.049 Not an outlier (18/19 Final)	17.022 Not an outlier (17/18 Final)

Domain	Indicator	Current Performance	National average value	Where applicable: Best NHS performer	Where applicable: Worst NHS performer	Trust statement	Previous values (where data available)		
	28-day readmission rate for patients aged 0 -15	Nationally now reporting "Emergency readmissions within 30 days of discharge from hospital" – however only published as part of Outcomes framework so is at CCG or LA level not Trust.	National publication of this data have been suspended			*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% (18/19)	0.02% (17/18)	0.00% (16/17)
	28-day readmission rate for patients aged over 15 years		National publication of this data have been suspended			*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	10.80% (18/19)	9.62% (17/18)	9.53% (16/17)
Ensuring that people have a positive experience of care	Responsiveness to inpatients' personal needs scored from the National Inpatient Survey Hospital stay: 01/11/2020 to 30/11/2020 Survey collected 01/01/2021 to 31/05/2021	73.4	74.5	85.4	67.3	*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:*	66.3 (19/20)	64.3 (18/19)	66.2 (17/18)

Domain	Indicator		Current Performance	National average value	Where applicable: Best NHS performer	Where applicable: Worst NHS performer	Trust statement	Previous values (where data available)		
	Published: 17th March 2022						Improvements to the patient flow described in Quality Account priorities			
	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. *NHS Staff Survey 2021*		60.7%	66.9%	89.5%	43.6%	*Worcestershire Acute Hospitals NHS Trust considers that this data is as described for the following reasons:* Staff engagement has improved this year but remains in the lowest quartile for Acute Trusts *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	68.6% (2020)	63.3% (2019)	57.9% (2018)
	Inpatient Friends and Family test **Mar-22**	**% Positive**	**97%**	**93%**	**100%**	**66%**	*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*	**96%** **(Mar-21)**	**94%** **(Mar-19)**	**94%** **(Mar-18)**
	Published: 12th May 2022	**Response Rate**	**30%**	**18%**	**100%**	**1%**	*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*	**33%** **(Mar-21)**	**18%** **(Mar-19)**	**6%** **(Mar-18)**
	A&E Friends and Family test **Mar-22**	**% Positive**	**78%**	**73%**	**100%**	**49%**	*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	**86%** **(Mar-21)**	**82%** **(Mar-19)**	**74%** **(Mar-18)**

Domain	Indicator		Current Performance	National average value	Where applicable: Best NHS performer	Where applicable: Worst NHS performer	Trust statement	Previous values (where data available)		
	Published: 12th May 2022	**Response Rate**	**17%**	**10%**	**41%**	**1%**	*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.	**19%** **(Mar-21)**	**6%** **(Mar-19)**	**4%** **(Mar-18)**
Treating and caring for people in a safe environment and protecting them from harm	% of patients risk-assessed for venous thromboembolism		The VTE data collection and publication is still suspended to release capacity in providers and commissioners to manage the COVID-19 pandemic.				*Worcestershire Acute Hospitals NHS Trust considers that this data is as described for the following reasons:* VTE assessment rates are now 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	94.45% (Q4 18/19)	92.26% (Q4 17/18)	93.75% (Q4 16/17)
	Rate of C. difficile per 100,000 bed days Published 15th September 2021		61.7 (Apr-20 to Mar-21)	22.2	0.0	140.5	*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	39.4 (Apr-19 to Mar-20)	50.0 (Apr-18 to Mar-19)	36.8 (Apr-17 to Mar-18)
	Rate of patient safety incidents per 1,000 bed days		52.8 (Apr-20 to Mar-21)	N/A	27.2	118.7	*Worcestershire Acute Hospitals NHS Trust considers that this data is as described for the following reasons:*	53.1 'No evidence for potential	52.90 'No evidence for potential	43.77 'No evidence for potential

Domain	Indicator	Current Performance	National average value	Where applicable		Trust statement	Previous values (where data available)		
				Best NHS performer	Worst NHS performer				
	Published: 29th September 2021 Transition to annual reporting					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	under-reporting' (Oct-19 to Mar-20)	under-reporting' (Apr-19 to Sep-19)	under-reporting' (Apr-18 to Sep-18)
	Percentage of patient safety incidents that resulted in severe harm or death Published: 29th September 2021	0.36%	0.44%	0.03%	2.80%	*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	0.26% (Oct-19 to Mar-20)	0.32% (Apr-19 to Sep-19)	0.29% (Apr-18 to Sep-18)

Clinical Audit 2021/22

During 2021/22 44 national clinical audits and 2 national confidential enquiries covered relevant health services that Worcestershire Acute Hospitals NHS Trust provides. We also undertook 142 registered local clinical audits during 2021/22.

During this period Worcestershire Acute Hospitals NHS Trust participated in 100% of the national clinical audits and 100% 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 2021/22. 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 is a driver of quality and effectiveness across the Trust. We prioritise the delivery of national high-quality studies adopted by the National Institute for Health Research (NIHR), which benefit patients and the NHS.

At the outset of the pandemic, the Government made it clear that research was pivotal to the pandemic response. As such, most research was paused to prioritise studies to increase our understanding of the new virus and develop effective treatments.

As a result, the Trust was able to recruit 11.8% of all COVID-19 admissions into the RECOVERY trial, a phenomenal achievement and has been recognised regionally and nationally for its outstanding contribution. In just three months the study recruited 10,000 patients in the UK, and identified that dexamethasone, a cheap and widely available drug could reduce deaths by a third. This changed practice globally overnight.

Despite these challenges, recruitment of patients, carers and staff into studies was increased to 1469. This included 465 patients who were recruited into interventional studies, of which 374 were in REMAP CAP and RECOVERY, the two interventional COVID-19 studies.
We recruited into 24 studies across 10 different clinical specialties, the recruitment for which is shown below. 3 of these studies were commercial. 11 new studies were opened during 2020/21.

Participation in Clinical Research	
Cancer and haematology	26
Cardiology	92
Critical Care	160

Health Services Research	2
Infection	1042
Mental Health	33
Musculoskeletal disorders	10
Renal Disorders	6
Reproductive Health and Midwifery	85
Surgery	13

The Clinical Research and Innovation strategy is one of the building blocks of our Trust vision of putting patients first. Being delivered in accordance with our 4ward signature behaviour's will contribute to our strategic objectives of providing the best services for local people, delivered by the best people.

Our research participants will have the best experience of care, and we will ensure that our research team makes the best use of the resources we are provided with from the NIHR, research funders and charitable funding.

This strategy will raise awareness of and engagement with research and innovation at the Board and throughout the Trust and will result in:

- Increased participation in Clinical Research
- Increased income and improved efficiency
- Increased awareness of Clinical Research and Innovation across the Trust
- Enhanced reputation externally
- Successful clinical recruitment too hard to recruit to areas
- Opportunities to create new roles within the Trust's workforce to support delivery of the Clinical Strategy

The strategy was approved by the Trust Board in March 2022 and implementation will be the focus of 2022/23.

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.

During 2021/22, CQUINS were paused at a national level. However, these have been reintroduced for 2022/23. There are a number of national CQUIN schemes, one locally agreed CQUIN and Specialised CQUIN scheme: the content of the local scheme was agreed

between the Trust and the Clinical Commissioning Groups (CCGs) prior to the start of the financial year.

For 2022/23, the Trust's CQUIN commitments have been agreed as follows:

CCG	CQUIN
CCG1	Achieving 90% uptake of flu vaccinations for staff with patient contact.
CCG2	Achieving 60% of all antibiotic prescriptions for UTI in patients aged 16+ years that meet NICE guidance for diagnosis and treatment.
CCG3	Achieving 60% of all unplanned critical care unit admissions from non-critical care wards of patients aged 18+, having a NEWS2 score, time of escalation (T0) and time of clinical response (T1) recorded.
CCG8	Ensuring that 70% of surgical inpatients are supported to drink, eat and mobilise within 24 hours of surgery ending
CCG9	Achieving 35% inpatients (with at least 1-night stay) with a diagnosis of alcohol dependence who have an order or referral for a test to diagnose cirrhosis or advanced liver fibrosis.
Specialised Services	**CQUIN**
PSS1	To reduce the delays in assessment, investigation, and revascularisation in patients with chronic limb threatening ischaemia and in turn reduce length of stay, in-hospital mortality rates, readmissions and amputation rates
PSS2	Achieving high quality shared decision making conversations to support patients to make informed decisions based on available evidence and their personal values and preferences and knowledge of the risks, benefits and consequences of the options available to them with regard to both their clinical condition and the consequences of the current pandemic.
PSS3	Achieving priority categorisation of patients within selected surgery and treatment pathways according to clinical guidelines

Appendix 1: Clinical Audit Participation Details, including examples of how clinical audit has been used to drive improvement

National Confidential Enquiry into Patient Outcome and Death (NCEPOD)

Worcestershire Acute Hospitals NHS Trust participated in 100% of national enquiries for which it was eligible.

The national confidential enquiries that Worcestershire Acute Hospitals NHS Trust participated in, and for which data collection was completed during 2021/22, 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.

NB: both of the below studies are studies that were scheduled to have closed during 2021/22. However, the national deadline has been extended due to the number of cases still outstanding. The figures below are accurate at the time of this report.

National Confidential Enquiry into patient Outcome and Death (NCEPOD)	% of cases returned
Transition from child to adult health services: Clinician questionnaire	50%
Epilepsy: Hospital attendance	17%

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 No's cases submitted	Comments
EPILEPSY 12 - National Audit of Seizures and Epilepsies in Children and Young People	Yes	100%	
FFFAP - National Hip Fracture Database (NHFD)	Yes	ALX – n430 WRH – n478	
IBD - Inflammatory Bowel Disease Programme/IBD Registry	Yes	100%	
ICNARC - Case Mix Programme	Yes	100%	

Eligible National Audits	Participation	% or No's cases submitted	Comments
LeDeR -Learning from Lives and Deaths of People with learning disability and autistic people (Previously known as Learning Disability Mortality Review Programme)	Yes	Managed to get a number last year	1/4/21 – 31/3/22
MBRRACE - Maternal, New-born and Infant Clinical Outcome Review Programme	Yes	100%	
NABCOP - National Audit of Breast Cancer in Older People	Yes	100%	
NACAP - Pulmonary rehabilitation Organisational and Clinical audit	Yes	Cohort 1 – 100% Cohort 2 – ** data not available	Cohort 1 – 1 April 2021 to 30 September 2021 Cohort 2 – 1 October 2021 to 28 February 2022 submission deadline 8th July 2022
NACAP - Secondary Care - Adult Asthma	Yes	Cohort 1 – n24 Cohort 2 – ** data not available	Cohort 1 – 1 April to 30 September 2021 Cohort 2 – 1 October 2021 to 31 March 2022 submission deadline 13 May 2022
NACAP - Secondary Care – COPD	Yes	** data not available	Submission deadline 13 May 2022
NACR - National Audit of Cardiac Rehabilitation	Yes	** data not available	Submission deadline 30 June 2022
NOGCA - National Oesophago-gastric Cancer Audit	Yes	100%	
National Audit of Dementia (NAD) - Care in General Hospitals	Yes	N/A	There was no national data collection for hospitals in the 2021/22 financial year
NBOCA - National Bowel Cancer Audit	Yes	** data not available	Submission deadline is by July 2022
NCAA - National Cardiac Arrest Audit	Yes	ALX Q1 – 5 Q2 – 6	Q4 data not available until mid-April 2022

Eligible National Audits	Participation	% or No's cases submitted	Comments
		Q3 – 2 WRH Q1 – 14 Q2 – 13 Q3 – 12	
NCAP - Cardiac Rhythm Management (CRM)	Yes	100%	
NCAP - Myocardial Ischaemia National Audit Project (MINAP)	Yes	100%	
NCAP - National Audit of Percutaneous Coronary Interventions (PCI)	Yes	100%	
NCAP - National Heart Failure Audit	Yes	100%	
NEIAA - National Early Inflammatory Arthritis Audit	Yes	n87	
NDA - Adults - National Diabetes Foot Care Audit	Yes	** Data not available	Submission deadline Friday 17 June 2022
NDA - Adults - National Pregnancy in Diabetes Audit	Yes	100%	
NDA - Adults - National Core Diabetes Audit	Yes	** Data not available	Submission deadline June 2022
NELA - National Emergency Laparotomy Audit	Yes	Q1 n32 Q2 n38	1/12/21 – 30/11/22 1/12/22 – 30/11/23
NJR - National Joint Registry	Yes	100%	
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%	

Eligible National Audits	Participation	% or No's cases submitted	Comments
NPDA - National Paediatric Diabetes Audit	Yes	** Data not available	Submission deadline 27th May 2022
NVR - National Vascular Registry	Yes	Q1 – n129 Q2 – n138 Q3 – n121	Q4 not available until mid-April 2022
PROMS - Elective Surgery	Yes	100%	
SHOT - Serious Hazards of Transfusion: UK National Haemovigilance	Yes	100%	
SSNAP - Sentinel Stroke National Audit Programme	Yes	100%	
TARN - Major Trauma Audit	Yes	** Data not available	TARN has not processed all recent submissions. Submission deadline 8th July 2022
FFFAP - (NAIF) National Audit of Inpatient Falls	Yes	** Data not available	Deadline of 8th April for checking data entries
CEM - Pain in Children	Yes	** Data not available	Data collection deadline 03/10/22
Society for Acute Medicine's Benchmarking Audit (SAMBA)	Yes	WRH – 100% ALX – 0%	ALX - particularly severe staffing issues around that time
NDA - National Diabetes Harm Review NaDIA	Yes	100%	
NACAP - Paediatric Asthma	Yes	Cohort 1 – 100% Cohort 2 – ** data not available	Cohort 1 – 1st April 2021 to 30th September 2021 Cohort 2 – 1 October 2021 to 31 March 2022 -Submission deadline 13 May 2022
Chronic Kidney Disease Registry	Yes	100%	
National Perinatal Mortality Review Tool	Yes	100%	
National Outpatient Management of Pulmonary Embolism	Yes	WRH n15 ALX n13	
BAUS Management of the Lower Ureter	Yes	n32	

Eligible National Audits	Participation	% or No's cases submitted	Comments
in Nephroureterectomy Audit			
NACEL - National Audit of Care at the End of Life	Yes	Case note review n40 Staff survey n43 Quality survey n23	

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
Mental Health Clinical Outcome Review Programme	Audit applies to Mental Health
National Audit of Pulmonary Hypertension (COPD)	Specialist Audit
National Clinical Audit of Psychosis	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
FFFAP - Fracture Liaison Service Database (FLSD) SCSD/ Rheumatology - Professor. Rai	The Trust does not provide this service. It was de-commissioned 31/08/19
Cleft Registry and Audit Network (CRANE)	Specialist audit
National Congenital Heart Disease (CHD) - NCAP	Specialist audit
Out-of-Hospital Cardiac Arrest Outcomes (OHCAO) Registry	Applies to primary care and ambulance Trusts
National Adult Cardiac Surgery Audit - NCAP	Specialist audit
National Child Mortality Database	Sole providers of data are Child death overview panels (CDOP) Does not apply to the Trust
National Audit of Cardiovascular Disease Prevention	Primary Care
Transurethral Resection and Single Instillation Mitomycin C Evaluation in Bladder Cancer Treatment	Mitomycin C is not given - this is not our standard practice
National Smoking Cessation 2021 Audit	Trust does not provide this service.

Worcestershire Acute Hospitals NHS Trust was eligible to participate in the following national audits, however the below audits were removed from the Quality Account list and did not take place nationally during 2021/22;

- BAUS Cytoreductive Radical Nephrectomy Audit
- CEM - Severe Sepsis and Septic Shock

- National Comparative Audit of Blood Transfusion programme - 2021 Audit of the perioperative management of anaemia in children undergoing elective surgery

A total of 35 National Clinical Audit reports have been published and reviewed in 2021/22 for national audits that the Trust either participated in or was eligible to participate in. These reports were reviewed in 2021/22 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 Report Published	Specialty	Actions/Improvements
Mental Health - Care in the ED WRH	15/04/2021	Urgent Care	• An appropriate area of the ED should be available in which patients with mental health problems may be observed. This should be both safe and as calm and quiet as possible – move to new department • An appropriate programme should be in place for to train ED nurses, health care assistants, and doctors in mental health and mental capacity issues. • Promotion of mental health triage documentation in the ED
Mental Health - Care in the ED ALX	15/04/2021	Urgent Care	• Educating on triage
SSNAP Quarterly results Jan - March 2021	02/06/2021	Stroke	• Develop a 24/7 CNS model to contribute to early assessment and subsequent flow of patients that may impact on an improvement in the performance in terms of Thrombectomy. • Medical Workforce Recruitment – Rolled over from Q3 AP • Stroke Scanning Pathway • Stroke Specific Clerking Paperwork • Quarterly meeting with data analyst, data in-putter and lead practitioner for stroke to ascertain areas for improvement and sustaining improvement by early identification of areas not performing well. • Weekly data review meetings to ensure data accuracy. • Daily completion of exception reports to identify any areas where targets are not maintained to identify common themes in order to work towards possible solutions. • Working with the health and care trust daily to coordinate the flow of patients to rehab beds and to the Community Stroke team, further enhanced by weekly in-reach from the community.

National Audit	Date Report Published	Specialty	Actions/Improvements
			• Working with the H&C trust by providing input into the Job description and jointly interviewing for a full time coordinator to work across the stroke pathway to facilitate patient flow.
NACAP - Secondary Care - COPD	10/06/2021	Respiratory	• Implementation of a discharge bundle • Business Case for COPD • Best Practice Tariff submitted to increase COPD team support for discharge bundle implementation. • Current Rask Finish working group has reviewed COPD pathways. • Appropriate oxygen prescription and target saturations • Smokers are identified, offered and prescribed smoking cessation pharmacotherapy • Ensure spirometry results available for all patients admitted • Ensure that all patients requiring NIV on presentation receive it within 120 minutes of arrival. • Ensure that all current smokers are identified, offered, and if they accept, prescribed smoking cessation pharmacotherapy. • Educate on smoking cessation effectiveness from health care professionals. Review prescribing policy with pharmacy. Currently no smoking cessation services available within county • Implementation of a discharge bundle • Access respiratory specialist care within 24hrs • Deep-dive case review of COPD mortality and readmissions
NPDA - National Paediatric Diabetes Audit	10/06/2021	Paediatrics	• The introduction of a young adult diabetes clinic. • Improving the care of patients with a HbA1c between 69 and 80 mmol/mol managed at Kidderminster Hospital and the care of patients with a HbA1c >80 mmol/mol at Worcester Hospital and the Alexandra Hospital. • Children and carers to receive more information on managing illness. • To redesign vacant clinical psychology post to help with recruitment and retainment. • To address clinics being age appropriate with our Trust's youth forum.
NABCOP - National Audit of Breast Cancer in Older Patients	03/08/2021	Breast	• Review completeness of pathology data capture and reporting • Audit patterns of surgery, WLE vs mastectomy; chemo; by age grouping < or > 75

National Audit	Date Report Published	Specialty	Actions/Improvements
2021 Annual Report			

Local Clinical Audits

A total of 146 local clinical audits were reviewed by Worcestershire Acute Hospitals NHS Trust in 2021/22 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 11022 HIV Testing in Tuberculosis	Infectious Diseases	• No actions required - compliance 100%
ID 10949 Postmenopausal pathway audit	Gynaecology	• Implementation of registrar PMB clinic to run alongside consultant hysteroscopy clinic. • Change practice where ET 5-8mm for pipelle biopsy and ET >8mm for hysteroscopy.
ID 10941 VTE prophylaxis prescribing in Trauma and Orthopaedics	T&O	• Presentation and key findings and recommendation circulated to other doctors via email to highlight what can be done to increase standard of care. • Compulsory for all patients to have the VTE prophylaxis form completed and Clexane prescribed correctly based on their weight and renal function. • Ask or estimate patient's weight or weigh patient if able on admission to ensure adequate dose prescribed. • Review patient's renal function on admission and review regularly as their renal function can change throughout inpatient stay and may require lower dose of Clexane or Unfractioned heparin.
ID 10633 Pre-procedure Antibiotic therapy in Urology	Urology	• Improvements in sepsis risk after implementation of new ATB guidelines.
ID 11081 Mental Health Matrix and Overdose Proforma	A&E	• Encourage triage nurses to print overdose proforma and mental health matrix as soon as patients with intentional OD are triaged. • Awareness should be made on the various proformas used in mental health during the orientation program for junior doctors.
ID 10938 AMT recording (Re-audit)	Acute Medicine	• Poster about recording AMT and its importance and stick on MAU doctor's office walls and gallery. • Speak to acute medicine consultants - to remind juniors on post take regarding importance of AMT recording.
ID 10857 Audit of completion of dementia screening tool	Geriatric Medicine	• Redesign screening tool to be more streamlined. • Promulgation of audit results to doctors by presentation at grand round.
ID 10974 Opioid prescribing at the end of life	Palliative Care	• Present audit findings to hospital palliative care team. • Launch of Version 4 of Individualised last days of life care plan and anticipatory medications. • F1 doctor teaching. • 'Essentials in palliative care' ward teaching programme. • Liaison with intensive care consultants. • Present audit findings to pharmacy team. • Junior doctor induction.

ID 11071 25G Re-audit of appropriateness of clinical indications of Brain MRI performed in Worcestershire Acute Hospitals NHS Trust, requested by the Primary care physicians	Radiology	• Presentation in the County Radiologist Meeting. • Audit discussion at the Neurology / CCG meeting.
ID 11086 1B Use of broad spectrum antibiotics in acute medicine at Worcester Royal Hospital.	Acute Medicine	• Inform clinical governance for further advice and input. • Inform antibiotic stewardship for further advice and suggestions. • To develop/review clinical guidelines in the use of this group of antibiotics.
ID 11135 Re-Audit on appropriate Documentations	A&E	• Presentation to be done and emphasis put on need to document date, time and name. Also emphasis on completion on back of PAS card. • Reminder to receptionists to flag receipt of blank documentation for scanning. • Email to be sent out emphasising need to document date, time name and completion on back of PAS card.
ID 11124 Management of Neonatal Jaundice (CG98) Re-Audit	Paediatrics	• Changes to Neonatal bilirubin charts for ease of use. • Education of how to use charts for new SHOs. • Education to nursing and midwifery team via newsletter. • Review of harm moving patient up a chart based on gestation. • Investigate option of adding box on ICE request for SBR that allows date and time of birth to be inputted. Time from birth could be included in SBR reports to produce plotting errors.
ID 11095 27B Re-audit of Giant Cell Arteritis Fast Track Clinic against BSR 2020 Guidelines	Rheumatology	• Present audit findings to Rheumatology department and circulate to Vascular team. • Increase number of weekly clinic slots designated to GCA from 3 to 5. • Circulate reminder to primary care physicians of required GCA blood tests via 'Member Practice Update'.
ID 11084 AKI management in orthopaedic inpatients re-audit	T&O	• Presentation of re-audit results to local NHS trust T&O/Vascular surgery Clinical Governance Audit Meeting. • Printed AKI checklist on wards. • Junior Doctor education on AKI management at induction.
ID 11073 Audit of EEG performed from time of referral against NICE Guidance	Neurophysiology	• To ensure data is entered and coded correctly on to oasis, ensures all dates and referral sources are accurate. • Rebook and restart of patients into all available EEG appointment slots. • Validation of all referrals to ensure appropriate referrals are on the waiting list – therefore ensuring improvement with NICE compliance. • Scientist staff working in flexible approach to reduce backlog and therefore increase compliance with standard. • Ensure cancelations are filled promptly. • Calling of patients to reduce DNA's.

ID 10850 2A Handover In Emergency Department Alexandra Hospital - Re Audit	A&E	• Handover should be in writing every day at 08:00,13:00 and 22:00hrs • All handover sheets should be completed and left in handover box in Doctor's Office. • 15 minutes to be allocated to all senior Doctors for handover to take place safely and appropriately in the seminar room. • If senior Doctors coming on shift are late, wait ten minutes and do handover with team – record absence of senior on handover sheet. • 0800hrs – night registrar to handover to morning registrar in seminar room with day SHO present. • 2000hrs registrar leaving at 2300hrs will do handover with night team. • New Doctors to have importance of handover re-iterated in their induction. • All Doctors on shop floor to be present in board round/handover at 1200hrs.

Examples of how Clinical Audit has been used to Drive Improvement

Clinical Audit, in addition to providing assurance on the extent to which standards are met, is a valuable quality improvement tool. When used effectively clinical audit drives improvement and the projects below are examples of where clinical audit has played an important role in delivering improvements for our patients.

- **The use of stent with - versus without string through pandemic: 2 PDSA cycles**

This audit saw the use of QI methodology where the lead undertook 2 PDSA cycles. It highlighted that the Trust is 100% compliant with stent insertion post uteteroscopy and that the Trust has evolved to increase its use to stent-with-string since the pandemic. The Trust also has more nurse led stent-with-string removals following successful training and the new stent techniques reduced the rate of accidental removal, and is now standard practice.

- **Re-Audit to assess the Compliance of Pre-Operative Antibiotic prescribing in Vascular Surgery patients**

This audit was undertaken following a discussion regarding antibiotic stewardship at a clinical governance meeting in 2020. It led to the revision of the Trust guidelines and the vascular induction booklet was updated.

- **Audit of assessment of COVID clinical compliance in patient flow management in the SHO 'hot' clinic**

This audit highlighted that there was no provision for a 'HOT' sheet and that there was no shared drive access which caused limitations. Following the completion of the audit, access to shared drives are now up and running along with the implementation of a 'HOT' sheet which since going live has improved communication between staff.

- **ID 10857 Audit of completion of dementia screening tool**

The lead undertook 2 PDSA cycles, implementing small step changes after the 1st PDSA cycle. It's clear from the findings that the changes that were made following the 1st PDSA cycle, to include education and awareness of the dementia screening tool, were sustainable as the

compliance increased in 5/6 areas that were audited. The Clinical Audit Team put a poster together for dissemination in the speciality as an opportunity for shared learning to demonstrate the positive impact of the audit and the benefits of using QI methodology.

- **10909 Quality improvement project to enhance patients' awareness of their current hospital admission**

Following the 1st PDSA cycle, a checklist was introduced in the patient notes which prompted clinicians to tick the three-point checklist. In case of confused or delirious patients they can give a reason and sign the checklist. Following the analysis of the 2nd PDSA cycle, it is clear that the introduction of this checklist means that patients have more awareness with regards to their hospital admission.

- **11014 Is there a significant difference to prescribed CPAP pressure using the Oxford CPAP algorithm when using AHI vs ODI**

This audit showed good use of QI tools in the use of 2 PDSA cycles. Whilst compliance is good at with an increased standardisation of care, the audit led to create a new Trust policy which is to be put forward for approval.

- **ID 11119 Platelet Usage for Line insertion in Haematology patients**

Since completing this audit, a Vascular Access Steering Group with key stakeholders has been created which will review the booking and timely insertion of lines, and to enable the correct line to be placed in each patient. This audit has provided evidence that an improvement in this service will be extremely beneficial for patients.

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

Worcestershire Royal Hospital

	Safe	Effective	Caring	Responsive	Well-Led
Urgent and Emergency Services	Inadequate Feb 2020	Good Sept 2019	Requires Improvement Sept 2019	Inadequate Feb 2020	Inadequate Feb 2020
Medical care (Including older people's care)	Requires Improvement Sept 2019	Requires Improvement Sept 2019	Good Sept 2019	Requires Improvement Sept 2019	Good Sept 2019
Surgery	Requires Improvement Sept 2019	Good Sept 2019	Good Sept 2019	Requires Improvement Sept 2019	Good Sept 2019
Critical Care	Requires Improvement Jun 2017	Good Jun 2017	Good Jun 2017	Requires Improvement Jun 2017	Requires Improvement Jun 2017
Maternity	Requires Improvement Feb 2021	Good Feb 2021	Good Jun 2018	Good Jun 2018	Requires Improvement Feb 2021
Services for Children & Young People	Good Sept 2019	Good Sept 2019	Good Sept 2019	Good Sept 2019	Good Sept 2019
End Of Life	Good Jun 2017	Good Jun 2017	Good Jun 2017	Good Jun 2017	Good Jun 2017
Outpatients	Requires Improvement Sept 2019	N/A	Good Sept 2019	Requires Improvement Sept 2019	Good Sept 2019
Diagnostic Imaging	Requires Improvement Sept 2019	N/A	Good Sept 2019	Good Sept 2019	Requires Improvement Sept 2019

Alexandra Hospital

	Safe	Effective	Caring	Responsive	Well-Led
Urgent and Emergency Services	Inadequate Feb 2020	Requires Improvement Sept 2019	Good Sept 2019	Inadequate Feb 2020	Inadequate Feb 2020

Medical care (Including older people's care)	Requires Improvement Sept 2019	Requires Improvement Sept 2019	Good Sept 2019	Good Sept 2019	Good Sept 2019
Surgery	Requires Improvement Sept 2019	Good Sept 2019	Good Sept 2019	Requires Improvement Sept 2019	Good Sept 2019
Critical Care	Good Jun 2017	Good Jun 2017	Good Jun 2017	Good Jun 2017	Good Jun 2017
End Of Life	Good Jun 2017	Good Jun 2017	Good Jun 2017	Good Jun 2017	Good Jun 2017
Outpatients	Good Sept 2019	N/A	Good Sept 2019	Requires Improvement Sept 2019	Good Sept 2019
Diagnostic Imaging	Requires Improvement Sept 2019	N/A	Outstanding Sept 2019	Good Sept 2019	Requires Improvement Sept 2019

Kidderminster Hospital and Treatment Centre

	Safe	Effective	Caring	Responsive	Well-led
Urgent and Emergency Services	Requires Improvement Sept 2019	Requires Improvement Sept 2019	Good Sept 2019	Good Sept 2019	Requires Improvement Sept 2019
Medical care (Including older people's care)	Good Sept 2019	Good Sept 2019	Good Sept 2019	Good Sept 2019	Good Sept 2019
Surgery	Good Sept 2019	Good Sept 2019	Good Sept 2019	Requires Improvement Sept 2019	Good Sept 2019
End Of Life	Good Jun 2017	Good Jun 2017	Good Jun 2017	Good Jun 2017	Good Jun 2017
Outpatients	Good Sept 2019	N/A	Good Sept 2019	Requires Improvement Sept 2019	Good Sept 2019
Diagnostic Imaging	Good Sept 2019	N/A	Good Sept 2019	Good Sept 2019	Good Sept 2019

Appendix 3: External Opinions – what others say about this Quality Account

- **Herefordshire and Worcestershire Clinical Commissioning Group/Integrated Care Board**
  Note: Check – usually we request this section from Rachel Dunne (Associate Director of Nursing and Quality, CCG), but CCG has taken on the role of the ICB
- **Healthwatch Worcestershire**
  Note: Simon Adams will provide this
- **Worcestershire Acute Hospitals NHS Trust's Patient and Public Forum**

Considering the continuing pressures on the Trust from the ongoing pandemic and increasing pressures on patient flow, it is rewarding to see that several targets were met and that innovation continued.

We congratulate the Trust on initiating the "call me" facility which is already having a positive impact for patients as well as the Trust receiving an award for the initiative.

We welcome the development of PALS front of house at Worcester Royal Hospital, the Research and Development Strategy, the roll out of the Digital Care Record and the new Worcester Urgent Care Department later this year.

We also welcome the Trust becoming more inclusive with the development of the LGBT and disability networks.

Increasing methods of obtaining patient feedback and working more closely with Carers' organisations and the deaf community are also welcomed.

It was good to note that volunteers are beginning to come back on site and look forward to this being fully implemented.

Sepsis is still an area the PPF would like to see improving as well as learning from deaths and complaints [our concerns from last year].

We were disappointed to see there were no targets for stroke for next year as we feel this should be a priority.

We would also like to see better liaison between the Trust and primary care to ensure the patient has seamless transition between them.

Rosemary Smart

Chair of Patient and Public Forum

- **Worcestershire Health Overview and Scrutiny Committee (HOSC)**

The Worcestershire Health Overview and Scrutiny Committee (HOSC) welcomes receipt of the 2021-22 Quality Account for Worcestershire Acute Hospitals NHS Trust in its draft format, although it is disappointing that some data and figures are not yet available.

Members of the Committee have appreciated the support the Trust has given to the scrutiny process during the year and the Members look forward to working with the Trust in the future. Through the routine work of HOSC, we hope that the scrutiny process continues to add value to the development of healthcare across all health economy partners in Worcestershire.

Councillor Brandon Clayton
Chairman of Worcestershire Health Overview and Scrutiny Committee

Glossary of Terms:

Word	Definition
4ward	The Trust's culture change programme, launched in 2018.
LDOL	Last days of life care plan
ELOC	End of life care
LGBT	Lesbian, Gay, Bisexual and Transgender
CQUIN	The Commissioning for Quality and Innovation (CQUIN) payment framework
MCCD	Medical certificate for cause of death
LeDeR	Learning disability mortality review
LDALN	Learning disability additional learning needs
VTE	Venous thromboembolism (VTE)
MBRRACF	Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK
PROMS	Patient reported outcome measures
SSNAP	The Sentinel Stroke National Audit Programme (SSNAP)
COPD	Chronic obstructive pulmonary disease (COPD)

NHS
Worcestershire
Acute Hospitals
NHS Trust

Assurance levels Nov 2020

Meeting	Trust Board
Date of meeting	9 June 2022
Paper number	Enc F

2022/23 Annual Priorities

For approval:	x	For discussion:		For assurance:		To note:	

Accountable Director	Jo Newton, Director of Strategy, Improvement and Planning		
Presented by	Jo Newton, Director of Strategy, Improvement and Planning	**Author/s**	Jo Newton, Director of Strategy, Improvement and Planning Lisa Peaty, Deputy Director of Strategy and Planning

Alignment to the Trust's strategic objectives (x)							
Best services for local people	x	Best experience of care and outcomes for our patients	x	Best use of resources	x	Best people	x

Report previously reviewed by		
Committee/Group	Date	Outcome
Trust Board	12th May 2022	Noted
Finance and Performance Committee	25th May 2022	Noted with minor amendments
Quality Governance Committee	26th May 2022	Noted

Recommendations	It is recommended that Trust Board: • Approve the Trust's annual priorities for 22/23 • Note the risks and opportunities to be addressed

Executive summary	The purpose of this paper is to set out the draft annual priorities for 2022/23 which, following the May Board meeting, have been considered by Finance and Performance Committee and Quality Governance Committee. Our refreshed priorities and actions for the year ahead as well as the risks to delivery are presented. The priorities support the delivery of the operational plan submitted to NHSE/I and aim to further improve the quality, safety and sustainability of our services, as well as operational and financial performance. The priorities have been developed following a review of last year's priorities which were agreed by Board in July 2021. Current strategic transformation programmes and key strategic risks outlined in the board assurance framework have also been considered. The priorities build on our successes in 2021/22 and address areas where progress remains challenged. The priorities are also set within the context of national priorities and those of the Herefordshire and Worcestershire Integrated Care System (ICS).

NHS
Worcestershire
Acute Hospitals
NHS Trust

Assurance levels Nov 2020

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Risk			
Which key red risks does this report address?		**What BAF risk does this report address?**	*7, 8, 9, 11, 14, 18, 19*

Assurance Level (x)	0		1		2		3		4		5	x	6		7		N/A	
Financial Risk																		

The annual priorities contribute to the mitigation of the risks above. It will continue to be reviewed in light of delivery of the operational plan and in light of future potential impacts of COVID-19.

Action						
Is there an action plan in place to deliver the desired improvement outcomes?	Y	X	N		N/A	
Are the actions identified starting to or are delivering the desired outcomes?	Y	X	N			
If no has the action plan been revised/ enhanced	Y		N			
Timescales to achieve next level of assurance						

Introduction/Background

The trust's annual priorities for 2022/23 are set out in Appendix One which can be found in the reading room. They have been developed in light of the work to date on the 3 year plan, and following a review of last year's priorities which were approved by Trust Board in July 2021; current strategic transformation programmes and key strategic risks outlined in the board assurance framework.

The 2022/23 priorities support the delivery of the operational plan submitted to NHSE/I by the ICS on 28th April 2022, particularly the requirements to reduce the backlog of patients which has arisen as a result of COVID-19 and to meet operational performance standards.

Issues and options

The annual priorities set out in Appendix One are ambitious, yet reflect the Trust's key areas of work for the year ahead.

They focus on quality, improving access, and supporting healthier lives for our communities and staff, underpinned by financial stability and are consistent with the national long-term plan and policy. Our priorities for 2022/23 also reflect current strategic transformation programmes and key strategic risks outlined in the board assurance framework. The delivery of the actions and measures support the delivery of the operational plan submitted to NHSE/I by the ICS on 28th April 2022, particularly requirements to address the backlog of patients as a consequence of COVID-19 and to meet operational performance standards. Their delivery will depend on progress with addressing the backlog of patients as a consequence of COVID-19; pressures associated with the demand for emergency and urgent care; the future trajectory of the COVID-19 pandemic and success of our Targeted Investment Fund bid for rebuilding the theatres at the Alexandra Hospital. Investment in our 4ward improvement system to challenge and change our ways of working plays an underpinning role as part of our strategic pyramid to deliver the change required.

There is also a golden thread between our 22/23 priorities and those set at a national level and of the Herefordshire and Worcestershire Integrated Care System (ICS). As the ICS evolves over the next 12 months, we will review our priorities to ensure that they continue to align with those of the ICS.

1 Our Priorities

Whilst our annual plan priorities are structured under the Trust's four strategic objectives (Appendix One), the priorities can be grouped under four headings: quality; improving access; supporting healthier lives for our communities and staff and delivering value.

i) Quality

As we progress towards our aspiration of outstanding as rated by CQC, we will implement our 4ward Improvement system to improve quality by:

- **Delivering care that is safe**: a refreshed Quality & Safety Strategy, including a focus on maternity improvement, infection prevention & control
- **Investing and delivering improved infrastructure** in estates, including opening a new Urgent and Emergency centre, delivering the Acute Services Review and further investments in diagnostics; and digital infrastructure (electronic patient record and cybersecurity)
- **Focusing on getting the basics right** as a platform for future development; reducing waste to release more time to care and reinvestment of cashable and non-cashable benefits

ii) Improving access

- **Elective recovery and reset**: focus on reducing the time patients have to wait for procedures; working with system partners to deliver transformational change including outpatient's transformation and embedding delivery of elective hubs for inpatients at the Alexandra hospital and day case (Kidderminster)
- **Flow and discharge**: improve flow by working in partnership with all system partners at place through the Homefirst programme
- **Work with partners** to deliver high quality seamless care: service sustainability, lead provider voice at place, demonstrate corporate social responsibility as an anchor institution.

iii) Healthier lives

To improve wellbeing of our staff and our communities:

- **An empowered, well led workforce** that delivers better outcomes and performance: workforce development infrastructure.
- The **right sized, cost-effective workforce** that is organized for success: substitute bank & agency for permanent staff.

- **Adjust, learning and innovative culture** built on respect for our people: develop organisational culture using the 4ward Improvement system.
- A people function that is organised around the optimum employee journey: **workforce resilience and wellbeing.**
- **Addressing health inequalities** by supporting population health management to prevent ill health: optimising health of those on our waiting lists, supporting smoking cessation
- **Promoting long-term health** by implementing the Trust's Green plan: substitution anaesthetic gases; reducing energy use; location by vocation

iv) <u>Delivering value</u>

- Driving **financial stability** through development of the 3 year plan, delivery of our productivity and efficiency programme and improving benefits realisation
- Delivering better value for the same cost through **implementation of the GiRFT programme and by reducing waste**

Performance against these priorities will be monitored via the Trust's internal and ICS governance processes. Work to further develop our Integrated Performance Report is underway and this will ensure that performance metrics associated with delivery of the annual priorities are evident in the monthly report.

2 Plan governance

The priorities will be reviewed by TME on a quarterly basis which will also provide an opportunity to review ongoing progress of the ICS operational plan and for the development of the Herefordshire and Worcestershire ICS to be triangulated with and reflected appropriately in our priorities.

3 Top 3 risks

Risk	Mitigation
Future COVID surges and other operational pressures limit capacity to deliver our 22/23 priorities	• Agree and implement revised accountability framework • Continue to monitor any significant shifts in delivery of priorities and develop and deliver rectification plans
Pace of ICS development hampers progress of our 22/23 priorities	• Ensure Trust is fully engaged in ICS/place development and is represented at ICS meetings/workshops • Seek alignment of ICS/place and Trust priorities and undertake leadership role in their delivery where possible
Workforce availability impacts delivery of 22/23 priorities	• Delivery of Best People Programme work streams • Implementation of staff wellbeing initiatives

Meeting	Trust Board
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- Ensure appropriate blend of operational and support roles in delivery of transformation priorities

Conclusion

Our 22/23 plan is ambitious, but despite the challenges, we continue to invest in our workforce and infrastructure, underpinned by the 4ward improvement system, to deliver our strategic objectives and vision to put patients first. We will continue to work with our partners to support development of the ICS and delivery of the priorities we share with our partners.

Recommendations

It is recommended that Trust Board:

- Approve the Trust's annual priorities for 22/23
- Note the risks and opportunities to be addressed

Appendices

Appendix One: draft annual priorities 2022/23

Worcestershire Acute Hospitals NHS Trust

Assurance levels Nov 2020

Meeting	Trust Board
Date of meeting	9 June 2022
Paper number	Enc G

Ockenden Final Report Gap analysis May 2022

For approval:		For discussion:	x	For assurance:	x	To note:	

Accountable Director	Paula Gardner, Chief Nursing Officer		
Presented by	Justine Jeffery, Director of Midwifery	**Author /s**	Justine Jeffery, Director of Midwifery

Alignment to the Trust's strategic objectives (x)							
Best services for local people	x	Best experience of care and outcomes for our patients	x	Best use of resources	x	Best people	x

Report previously reviewed by		
Committee/Group	Date	Outcome
Maternity Governance	May 2022	
Quality Governance Committee	26th May 2022	Assured

Recommendations	The Board is asked to note the publication of the final Ockenden report published on March 30th 2022 and consider the maternity services positon against the essential actions as outlined in the report.

Executive summary	The final Ockenden report was published on 30th March 2022 following an independent review of maternity services at Shrewsbury and Telford Hospital NHS Trust. The report contains 105 essential actions for all Trusts to review and implement. The maternity service is able to demonstrate full compliance with 57 actions and has collated robust evidence to support this position. There are 40 essential actions noted as amber; to demonstrate full compliance existing guidance and local SoPs will need review and strengthening and then monitoring to ensure implementation through audit. There are 8 areas of non-compliance were focused work is required. There are a number of areas for the maternity directorate to focus upon and there are some areas of good practice to celebrate. An update will be provided quarterly to ensure progress with actions identified.

Risk			
Which key red risks does this report address?		**What BAF risk does this report address?**	

Assurance Level (x)	0		1		2		3		4		5	x	6		7		N/A	

Worcestershire Acute Hospitals NHS Trust

Assurance levels Nov 2020

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Financial Risk	*State the full year revenue cost/saving/capital cost, whether a budget already exists, or how it is proposed that the resources will be managed.*

Action						
Is there an action plan in place to deliver the desired improvement outcomes?	Y	x	N		N/A	
Are the actions identified starting to or are delivering the desired outcomes?	Y	x	N			
If no has the action plan been revised/ enhanced	Y		N			
Timescales to achieve next level of assurance	End of Q2					

Worcestershire Acute Hospitals NHS Trust

Assurance levels Nov 2020

Meeting	Trust Board
Date of meeting	9 June 2022
Paper number	Enc G

Introduction/Background

In December 2020 the first independent review into maternity services at Shrewsbury and Telford NHS Trust was published (Appendix 1) and a number of immediate and essential actions (IEA) were outlined within the report. Over the last 12 months the maternity team have provided evidence to the NHS England & Improvement regional team on two occasions to demonstrate current compliance against the IEAs. Overall the Trust can demonstrate compliance for 92% of all IEAs in the first Ockenden report. Some of this evidence was reviewed by the Local Maternity & Neonatal System on 3rd May 2022; there were no suggested amendments to our current compliance. A further regional visit is planned for 31st May 2022. The required funding to complete the final actions from this report has been identified and it is expected that these actions will be completed over the next 6 months.

On 30th March the second and final Ockenden report was published. Within the report there are a further 105 essential actions for each Trust to review and make improvements if actions are not already in place. There are a further 3 actions outlined in the report that are not for Trusts or systems to implement.

Issues and options

The maternity directorate team have reviewed the report and have completed a gap analysis (Appendix 2), collated evidence and have started to prepare an action plan to support the monitor of ongoing improvement against the 105 essential actions.

Current position

The maternity service is able to demonstrate full compliance with 57 actions and has collated robust evidence to support this position. There are 40 essential actions noted as amber; to demonstrate full compliance the team will strengthen existing guidance and local SoPs and then monitor the implementation and embedding of this through audit and quality improvement. There are 8 areas of non-compliance were focused work is required.

The areas requiring most improvement are:

- multi-disciplinary training,
- obstetric anaesthesia,
- training and provision of HDU care
- investment in the time available for medical staff to engage in the governance agenda.

The areas were scores were highest are:

- Financing a safe maternity workforce
- Preterm care
- Neonatal care
- Bereavement Care
- Supporting families

Conclusion

Worcestershire Acute Hospitals NHS Trust

Assurance levels Nov 2020

Meeting	Trust Board
Date of meeting	9 June 2022
Paper number	Enc G

The final Ockenden report was published on March 30th 2022 following an independent review into maternity services at Shrewsbury and Telford Hospital NHS Trust.

The maternity team have reviewed the report and have completed a gap analysis (Appendix 2), collated evidence and have started to prepare an action plan to support ongoing improvement against the 105 essential actions. The current positon is:
57 greens, 40 ambers and 8 reds.

There are a number of areas that the maternity directorate need to focus upon and there are some areas of good practice to celebrate. A quarterly update will be provided.

Recommendations

The Board is asked to note the publication of the final Ockenden report published on March 30th 2022 and consider the maternity services positon against the essential actions as outlined in the report. The Board is asked to support the delivery of ongoing improvement in maternity services.

Appendices

1. Ockenden Final report

https://www.gov.uk/government/publications/final-report-of-the-ockenden-review

2.

20220425
Ockenden 15 IEAs b

NHS
Worcestershire Acute Hospitals NHS Trust

Meeting	Trust Board
Date of meeting	9 June 2022
Paper number	Enc H

Board Assurance Framework

For approval:	X	For discussion:		For assurance:	X	To note:	

Accountable Director	Chief Nursing Officer, Paula Gardner		
Presented by	Rebecca O'Connor, Company Secretary	**Author /s**	Rebecca O'Connor, Company Secretary

Alignment to the Trust's strategic objectives (x)							
Best services for local people	X	Best experience of care and outcomes for our patients	X	Best use of resources	X	Best people	X

Report previously reviewed by		
Committee/Group	Date	Outcome
TME	18 May 2022	Endorsed
Quality Governance	26 May 2022	Endorsed
Finance and Performance	25 May 2022	Endorsed
People and Culture	31 May 2022	

Recommendations	To review and approve the Board Assurance Framework on a confirm or challenge basis and approve the Risk Appetite Statement

Executive summary	This report sets out the full Board Assurance Framework (BAF) following a process of review by Executives. The output will be considered during the February Committee cycle and the BAF reported to Trust Board • The full BAF (at the current point of review) is enclosed within the reading room • There have been three changes in BAF score since the last report to Trust Board in March 2022. • BAF 9 workforce has decreased from 15 to 12; BAF 17 from 16 to 12; BAF 18 from 25 to 20. • There has been one change in level of assurance; BAF risk 8 having decreased to level 3 assurance. • Supporting detail and control measures for all risks have been reviewed and updated. The Risk Appetite Statement has been reviewed and updated. This is attached for reference. Clarity has been given to the context of the statement and the supporting risk scores have been adjusted to more accurately reflect the tolerated level of risk.

Risk			
Which key red risks does this report address?		**What BAF risk does this report address?**	*All BAF risks as outlined in this report.*

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Worcestershire Acute Hospitals NHS Trust

Meeting	Trust Board
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Assurance Level (x)	0		1		2		3		4		5	X	6		7		N/A				
Financial Risk	*If the Trust does not have a robust BAF and system of monitoring in place there is the risk that the strategic objectives will not be achieved, which could have regulatory, reputation and financial implications and could impact on the quality of care that is provided. Specific risks relate to financial balance and capital. Individual risks and associated controls and or mitigating actions may have financial implications.*																				

Action						
Is there an action plan in place to deliver the desired improvement outcomes?	Y	X	N		N/A	
Are the actions identified starting to or are delivering the desired outcomes?	Y		N		As per report	
If no has the action plan been revised/ enhanced	Y		N		As per report	
Timescales to achieve next level of assurance	As outlined for each risk					

Introduction/Background

The Trust Board is responsible for identifying and monitoring the risks to the achievement of the Trust's strategic objectives. This is achieved through the development of a BAF, which is monitored by the Trust Board and its Committees for areas of their authority.

The Audit and Assurance Committee also has oversight of the BAF to inform the annual programme of internal audit activity and to allow the Committee to discharge its duties in terms of providing assurance around the robustness of the overall system of internal control, of which the BAF is an integral component. Strategic risks on the BAF are those which are of such importance, that failure to control the same, may cause the Trust to fail to deliver its strategic objectives.

This report provides assurance as to the management of strategic risks which are presented on a confirm or challenge basis.

Issues and options

BAF Summary

A summary of the risk position is as follows:

	Number	**Comment**
New Risks opened	0	
Risks Closed	0	
Risks Escalating	0	
Risks De-escalating	3	BAF 9 decreased from risk score 15 to 12 BAF 17 decreased from risk score 16 to 12 BAF 18 decreased from risk score 25 to 20
Total risks identified	17	
Level of assurance changes	1	BAF 8 – decreased to level 3

A summary of the Trust's risk exposure is below. This shows that whilst the mitigations put in place are slightly reducing the overall risk exposure, this remains very high.

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	Extreme	High	Moderate	Low
Current risk score	9	8	-	-
Initial risk score	13	4		

BAF Updates

BAF risks have been reviewed and updated, the following changes have been endorsed by Committees as follows:

- **Risks Opened/Closed:**

None

- **Risk Escalating/ De-escalating:**

BAF 9 – risk score has decreased from 15 to 12 as a result of the mitigations in place.
BAF 17 - has decreased from risk score 16 to 12 following executive review
BAF 18 - has decreased from risk score 25 to 20 as a result of overachievement of the activity plan, however this remains the joint highest risk faced by the Trust

- **Risk Narrative Updates**

Reviews of all risks have taken place and updates made to all current BAF risks in respect of the actions, controls and mitigations. The latest full BAF is enclosed in the reading room and the high level summary is appended.

Level of Assurance

The level of assurance is mapped as follows. The graph shows the number of risks and their risk score mapped against the level of assurance; the majority of risks (8) having a level 4 assurance. Of the 17 risks, 13 provide level 4 assurance or above.

Tracking of assurance levels demonstrates the improvement made in assurance of the BAF risks, this is shown by movement to the right of the graph.

NHS Worcestershire Acute Hospitals NHS Trust

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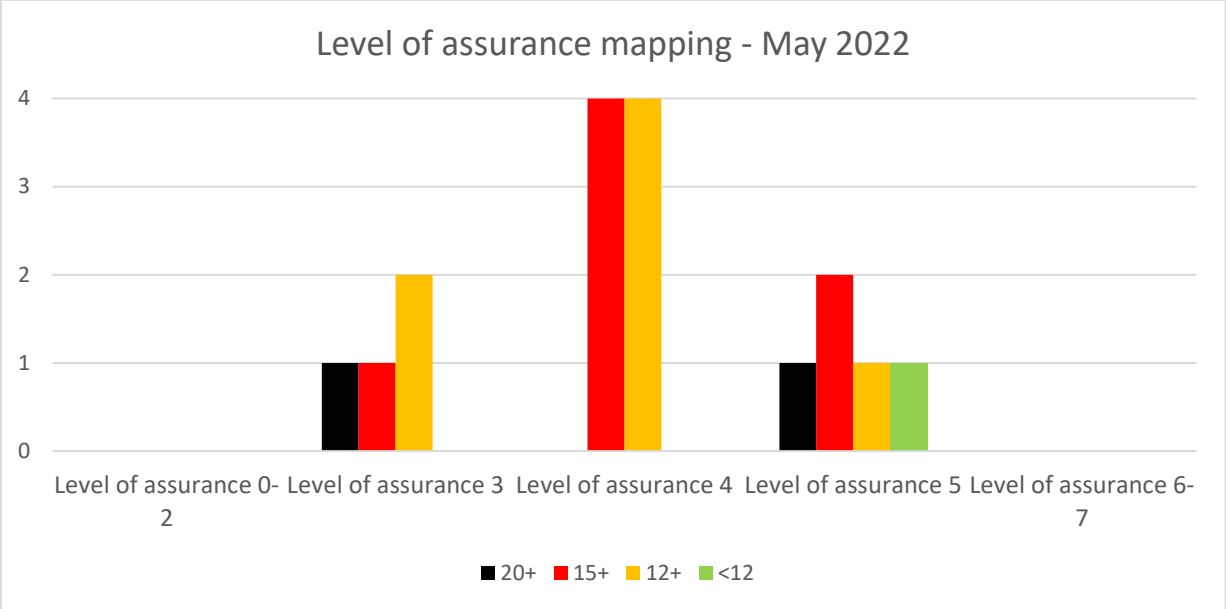


The change in levels of assurance can be tracked in the following table which will be added to throughout the year:

	No. of Risks Dec 21	No. of Risks Feb 22	No Risks May 22	Change from last Board report
Level of assurance 0-2	-	-	-	-
Level of assurance 3	4	3	4	+1
Level of assurance 4	10	10	8	-2
Level of assurance 5	3	5	5	No change
Level of assurance 6-7	-	-		-

Mapping of Strategic Risks Against Strategic Objectives

The table below shows a mapping of the Trust's strategic objectives and goals against the risks identified in the assurance framework. All strategic objectives and goals are covered by a range of risks.

		BAF 2	BAF 3	BAF 4	BAF 7	BAF 8	BAF 9	BAF 10	BAF 11	BAF 13	BAF 14	BAF 15	BAF 16	BAF 17	BAF 18	BAF 19	BAF 20	BAF 21
Strategic Objective	Best services for local people	X							X	X			X	X	X			X
	Best experience of care & outcomes for our patients		X	X					X							X	X	
	Best use of resources				X	X			X									
	Best people						x	x	X		X	X		X				

Goal	**Goal – strategy**	X							X	X		X	X	X	X			X
	Goal – quality		X	X					X							X	X	
	Goal - finance				X	X			X									
	Goal – workforce and culture						X	X	x		X	X						

- **Risk Exposure**

The Trust's risk exposure is slightly decreasing from the last report, but is expected to be increase in general over the medium term. This is due to a number of factors including the ongoing impact of Covid, its impact on restoration and recovery and urgent and emergency care pressures etc alongside broader uncertainty in the wider financial environment.

Mitigating activity, controls and assurance are identified for all risks and detailed within the reading room. The intention being the mitigations in place demonstrate a reduction in risk exposure from the initial to residual risk scores. However, there are times where despite there being control measures in place, these are not yet sufficiently effective, nor embedded to enable a reduction in the current risk score. It is not within the Trust's risk appetite to accept risks with no control measures in place.

- **Risk Appetite**

The Trust's risk appetite is not necessarily static, but all risks are expected to have controls and mitigations in place, which aim to reduce the risk exposure to a tolerable level. The Trust's updated Risk Appetite Statement is attached as an appendix to this report.

The Trust Board may vary the amount of risk that it is prepared to tolerate depending on the circumstances at the time. Committees review the BAF and can makes recommendations to the Trust Board regarding the adequacy of the outlined mitigations and control measures. If the Trust Board is unwilling to accept the level of risk to which it is currently exposed, it is invited to consider further mitigating actions or challenge those already identified.

Conclusion

The Trust has a Board Assurance Framework in place which is operational and effective. The Trust's risk exposure is static from the last report and mitigating actions are as outlined in this report.

Recommendations

To review and approve the Board Assurance Framework on a confirm or challenge basis and approve the Risk Appetite Statement

Appendices

High level BAF risk summary
Risk Appetite Statement
Full BAF within the reading room

BOARD ASSURANCE FRAMEWORK
JUNE 2022

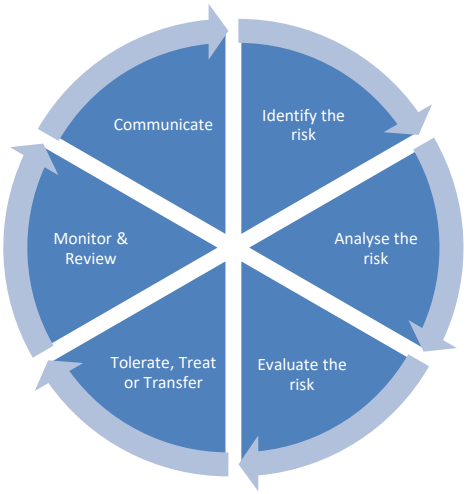
Worcestershire Acute Hospitals NHS Trust

Risk Number	Theme	Risk Description	Exec Lead	Responsible Committee	Current Risk Score			Change	Previous Risk Score	Initial Risk Score	Risk appetite	Level of Assurance	Change
					Likelihood	Consequence	Risk Score						
Sort	*Sort*	*Sort*	*Sort*	*Sort*	*Sort*	*Sort*	*Sort*	*Sort*	*Sort*	*Sort*	*Sort*	*Sort*	*Sort*
18	Activity	If we are unable to increase elective activity, remove long waits and reduce waiting list size in a timely and cost effective manner, then patient outcomes will suffer, patient care will be compromised and/or costs will increase	COO	QGC/F&P	4	5	20	↓	25	25	Low	5	→
7	Finance	If we fail to address the drivers of the underlying deficit and fail to respond effectively to the new financial regime (post COVID-19), then we will not achieve financial sustainability (as measured through achievement of the structural level of deficit [to be fully determined]) resulting in the potential inability to transform the way in which services operate, and putting the Trust at risk of being placed into financial special measures.	Chief Finance Officer	F&P	5	4	20	→	20	15	Low	3	→
13	Cyber	If we do not have assurance on the technology estate lifecycle maintenance and asset management then we could be open to a cybersecurity attack or technology failure resulting in possible loss of service.	Chief Digital Officer	F&P	4	4	16	→	16	20	Low	3	→
16	Digital	If we do not make best use of technology and information to support the delivery of patient care and supporting services, then the Trust will not be able to deliver the best possible patient care in the most efficient and effective way	Chief Digital Officer	F&P	4	4	16	→	16	20	Low	5	→
19	System working	If we do not have effective system wide working to enhance patient flow and to ensure patients are managed in the most appropriate environment, then we will not be able to manage the level of urgent care activity and patient experience for patients who are clinically ready for discharge, but have not been, will suffer	COO	QGC/F&P	4	4	16	→	16	16	Low	4	→
20	Urgent care	If we do not ensure that all actions are in place to enable discharge at the point of being ready for clinical discharge then we will adversely impact patient experience and inhibit flow	COO	QGC/F&P	4	4	16	→	16	16	Low	4	→
3	Clinical Services	If we do not implement the Clinical Services Strategy then we will not be able to realise the benefits of the proposed service changes in full, causing reputational damage and impacting on patient experience and patient outcomes.	CMO/Dir of S&P	QGC	4	4	16	→	16	15	Low	4	→
17	Engagement with staff	If we fail to effectively involve our staff and learn lessons from the management of change and redesign / transformation of services, then it will adversely affect the success of the implementation of our Clinical Services Strategy resulting in missed opportunity to fully capitalise on the benefits of change and adversely impact staff engagement, morale and performance	COO/Dir P&C	QGC/P&C	4	4	16	→	16	12	Low	5	→
11	Reputation	If we have a poor reputation this will result in loss of public confidence in the Trust, lack of support of key stakeholders and system partners and a negative impact on patient care.	Director of C&E	QGC	4	4	16	→	16	12	Moderate	4	→
2	Engagement with patients, public and partners	If we fail to effectively engage and involve our patients, the public and other key stakeholders in the redesign and transformation of services then it will adversely affect implementation of our Clinical Services Strategy in full resulting in a detrimental impact on patient experience and a loss of public and regulatory confidence in the Trust.	Director of C&E/CNO	QGC	3	4	12	↓	16	12	Moderate	4	→
9	Workforce	If we do not have a right sized, sustainable and flexible workforce, we will not be able to provide safe and effective services resulting in poor patient and staff experience and premium staffing costs.	Director of People & Culture	P&C/Trust Board	3	4	12	↓	15	15	Moderate	4	→
4	Quality	If we do not have in place robust systems and processes to ensure improvement of quality and safety and to meet the national patient safety strategy, then we may fail to deliver high quality safe care resulting in negative impact on patient experience and outcomes.	CMO/CMO	QGC	3	4	12	→	12	20	Low	4	→
21	ICS	If the Trust fails to capitalise on the benefits of integrated care at Place, System or intra System level then this will result in missed opportunities to improve quality of care, patient experience, efficiency or financial sustainability	Director of Strategy	Trust Board	3	4	12	→	12	16	Low	3	→
8	Infrastructure	If we are not able to secure financing then we will not be able, to address critical infrastructure risks as well as maintain and modernise our estate, infrastructure, and facilities; equipment and digital technology resulting in a risk of business continuity and delivery of safe, effective and efficient care.	Chief Finance Officer	F&P	3	4	12	→	12	15	Moderate	3	↓
15	Leadership	If we do not have a comprehensive leadership model and plan in place then we may not have the right leadership capability and capacity to deliver our strategic objectives and priorities	Director of People & Culture	Trust Board	3	4	12	→	12	12	Moderate	4	→
10	Culture	If we fail to sustain the positive change in organisational culture, then we may fail to have the best people which will impede the delivery of safe, effective high quality compassionate treatment and care.	Director of People & Culture	People and Culture/Trust Board	2	5	10	→	10	15	Moderate	5	→
14	Health and Wellbeing	If we do not have the capacity and capacity to implement, or staff do not access, health and wellbeing support then we may be unable to maintain safe staffing levels due to higher rates of absence and staff turnover	Director of People & Culture	P&C	2	5	10	→	10	15	Moderate	5	→

1. Introduction

1.1 Effective risk management arrangements are integral to the success of organisations and the delivery of strategic objectives.

1.2 There are many good practice models available and all commonly break down the risk management process into key steps as shown in the diagram below:



2. Risk Appetite

2.1 Risk appetite is the level of risk the Trust Board is willing to tolerate, based on the types of risks faced and the environment in which the Trust operates. The Trust will measure, monitor and adjust as necessary, the actual risk position of individual risks against the agreed risk appetite.

2.2 Using the Good Governance Institute risk appetite matrix, the Trust Board has adopted a risk appetite statement, setting out the level of risk it is willing to accept in seeking to achieve its purpose and strategic objectives:

- Best Services for Local People
- Best Experience of Care and Outcomes for Our Patients
- Best Use of Resources
- Best People

3. Risk Appetite Statement

3.1 The Trust's overarching risk appetite statement is as follows:

Worcestershire Acute Hospitals NHS Trust (WAHT) recognises that long term sustainability depends upon:

- a focus on our purpose of Putting Patients First,
- the delivery of our four strategic objectives and
- building confidence in the quality, safety and efficiency of our services with our patients, carers, staff, partners and the public.

The Trust will not accept risks that have a materially negative impact on service quality, patient safety or the sustainability of services.

4. Risk Appetite against the Trust's Strategic Objectives

4.1 As well as the overall risk appetite statement, separate statements are provided for each risk category in the table below, with links to the strategic objective to which they are most relevant.

Strategic Objective	Risk Category	Risk Appetite	Target Risk Score
Best Services for Local People	Clinical Innovation	**MODERATE** risk appetite for clinical innovation that does not compromise the quality of safety care.	8-12
Best Services for Local People	Compliance /Regulatory	**LOW** risk appetite for non-compliance or regulatory risks which may compromise the Trusts compliance with statutory duties and/or regulatory requirements. The Trust sees regulatory compliance as important in optimising service quality and financial sustainability. The Trust Board will take a cautious approach to risks in this area.	4-6
Best services for Local People	Partnerships	**HIGH** risk appetite for partnerships which may support and benefit the people we serve.	12-15
Best Experience of Care and Outcomes for our Patients	Safety/ Quality/ Outcomes	**LOW** risk appetite for any clinical practice, actions or decisions which may compromise the delivery of outcomes for our service users. The quality of our staff is measured by clinical outcomes, patient safety and patient experience which is paramount. We are strongly averse to risks that could result in poor quality patient care or unacceptable clinical risk, non-compliance with standards or poor clinical or professional practice.	4-6
Best Use of Resources	Financial/ Value for money	**LOW** risk appetite for financial/VFM in that we will strive to deliver our services within budgets modelled in our financial plans and will only consider exceeding these constraints if there is an associated risk to patient safety or quality of care. All such financial responses will be undertaken ensuring optimal value for money in the utilisation of public funds.	4-6
Best Use of Resources	Reputation	**MODERATE** risk appetite for actions and decisions which may adversely impact on the reputation of the organisation initially, provided those decisions are taken in the interest of improving safety, quality or sustainability of services.	8-12
Best People	Workforce	**MODERATE** risk appetite for any decisions or service changes which may have a detrimental impact on Trust ability to recruit and retain staff.	8-12

5. Recommendation

a) To review and recommend approval of the Board Assurance Framework
b) To review and recommend approval of the Risk Appetite Statement

NHS
Worcestershire Acute Hospitals NHS Trust

Meeting	Trust Board
Date of meeting	9 June 2022
Paper number	Enc I

Integrated Performance Report – Month 1 2022/23

For approval:		For discussion:		For assurance:	X	To note:	

Accountable Directors	Paul Brennan – Chief Operating Officer, Paula Gardner – Chief Nursing Officer, Christine Blanshard - Chief Medical Officer, Tina Rickets – Director of People & Culture, Robert Toole – Chief Finance Officer		
Presented by	Vikki Lewis – Chief Digital Information Officer	**Author /s**	Steven Price – Senior Performance Manager

Alignment to the Trust's strategic objectives (x)							
Best services for local people	X	Best experience of care and outcomes for our patients	X	Best use of resources	X	Best people	X

Report previously reviewed by		
Committee/Group	Date	Outcome
TME	18th May 2022	Approved
Finance and Performance	25th May 2022	Assured
Quality Governance	26th May 2022	Assured
People and Culture	31st May 2022	Assured

Recommendations	The Board is asked to ▪ note this report for assurance

Key Issues	**Cancer** Cancer referrals saw a significant reduction in Apr-22; the second lowest in the last 12 months. Improvements in the timeliness of patients being seen within two weeks by Breast Services continued with performance above the 93% waiting times standard (for both 2WW and Breast Symptomatic). However, overall 2WW performance was offset by significant demand on Lower GI and Skin with only 10% of patients being seen in time. We continue not to achieve the 28-day faster diagnosis standard and the on-going delays at the start of patient cancer pathways impact our opportunity to improve. 62-day pathway delays also continue with only skin and gynaecology achieving the standard in Apr-22. The trend of 90% of first treatments within one month of the decision to treat has continued. Our backlog of cancer patients waiting 63+ days remains significant at 400 and of those, 144 have been waiting 104+ days. **Urgent and Emergency Care** Like many NHS organisations, our services continue to operate under sustained pressure. In April, we saw the highest levels of Covid-19 positive patients in the year to date with an average of 140 patients per day and 177 at its peak. There has been a sustained decline in Covid-19 positive over the course of May-22 as community prevalence decreases. Non-elective pressures have resulted in crowding in our Emergency

Worcestershire Acute Hospitals NHS Trust

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Departments; this has impacted on our ambulance handover performance with over 1,000 60 minute delays for the second month. The high demand and long delays means that providing timely access to urgent and emergency care services is an ongoing challenge and patient flow challenges have resulted in a high number of 12-hour trolley waits even with fewer patients attending in Apr-22.

There were an average of 60 long stay patients (21+ days) in our beds over the course of the month, and 24 were deeded medically fit for discharge. In total, 1,388 patients were still on our wards 24 hours after becoming medically fit.

Infection Prevent and Control

Following an onsite visit 09-03-22 and subsequent follow-up review of C.difficile learning and our action plan from 21-22, NHSEI have written to confirm that we have achieved a GREEN rating. Their letter confirms significant improvements in governance and assurance, leadership and antimicrobial prescribing. They will meet quarterly with us commencing July 22, to monitor our progress with reducing C.difficile during 22-23.

Tracking of our Carbapenem consumption confirms we are no longer an outlier following changes to policy and practice in 21-22, resulting in significantly lower levels of prescribing.

National targets for key infections have been issued for 2022-23; our C.difficile reduction target is 79, and internal trajectories are being re-calculated for this target.

Targeted action within the Aconbury building is in place to address issues relating to the environment. As of 30-05-22; there remains 1 active covid outbreak.

Fractured Neck of Femur (#NOF):

There were 74 #NOF admissions in April-22 and a total of 29 breaches. 48% of the breaches were due to the patient being medically unfit or were under non-operative management and 28% were due to theatre capacity – breach reasons are being reviewed with the clinical teams to ensure they are recorded accurately.

Our Crude Death Rate for #NOF is 15.3%. Nationally, we have the 8th highest rate and the 2nd highest rate in the Midlands. Our average LOS is 10.4 days, which is the second lowest nationally and the lowest in the Midlands.

Risk																									
Which key red risks does this report address?			**What BAF risk does this report address?**		2, 3, 4, 5, 7, 8 ,9, 10, 11, 13, 14, 15, 16, 17, 18, 19, 20																				
Assurance Level (x)	0		1		2		3		4	X	5		6		7		N/A								
Financial Risk	*N/A*																								
Action																									
Is there an action plan in place to deliver the desired											**Y**		**N**		**N/A**	**X**									

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improvement outcomes?						
Are the actions identified starting to or are delivering the desired outcomes?	**Y**		**N**			
If no has the action plan been revised/ enhanced	**Y**		**N**			
Timescales to achieve next level of assurance						

Recommendations
The Board is asked to ▪ note this report for assurance
Appendices
▪ Trust Board Integrated Performance Report (up to Apr-22 data) ▪ WAHT April 2022 in Numbers Infographic ▪ Committee Assurance Statements (May-22 meetings)

Integrated Performance Report

NHS Worcestershire Acute Hospitals NHS Trust

Trust Board

9th June 2022

Best services for local people, Best experience of care and Best outcomes for our patients, Best use of resources, Best people

Operational Performance

Summary Performance Table | Month 1 [April] 2022-23

	Performance Metrics	Latest Month	Measure	Target	Performance	Assurance	Mean	Lower process limit	Upper process Limit
EAS	Percentage of Ambulance handover within 15 minutes	Apr-22	38%	-	L	-	61%	47%	75%
EAS	Time to Initial Assessment - % within 15 minutes	Apr-22	64%	-	L	-	82%	75%	90%
EAS	Average time in Dept for Non Admitted Patients	Apr-22	284	-	H	-	211	184	238
EAS	Average time in Dept for Admitted Patients	Apr-22	777	-	H	-	471	364	579
EAS	% Patients spending more than 12 hours in A&E	Apr-22	14%	-	H	-	6.25%	2.64%	9.85%
EAS	Number of Patient spending more than 12 hours in A&E	Apr-22	1584	-	H	-	715	335	1096
RTT	Incomplete (<18 wks)	Apr-22	48%	92%	L	F	69%	65%	73%
RTT	52+ weeks waiting	Apr-22	6,490	0	H	F	2204	1,614	2,795
RTT	104+ weeks waiting	Apr-22	254	0	H	F	71	26	116
CANCER	2WW All	Apr-22	51%	93%	L	?	80%	66%	93%
CANCER	2WW Breast Symptomatic	Apr-22	98%	93%	H	F	45%	-2%	91%
CANCER	28 Day Faster Diagnosis	Apr-22	58%	75%		?	67%	49%	84%
CANCER	62 Day All	Apr-22	50%	85%	L	F	68%	55%	80%
CANCER	104 day waits	Apr-22	144	0	H	F	63	30	95
CANCER	31 Day First Treatment	Apr-22	93%	96%	L	?	96%	92%	101%
CANCER	31 Day Surgery	Apr-22	97%	94%		?	87%	64%	110%
CANCER	31 Day Drugs	Apr-22	93%	98%		?	97%	87%	107%
CANCER	31 Day Radiotherapy	Apr-22	100%	94%		?	99%	93%	106%
CANCER	62 Day Screening	Apr-22	65%	90%		?	72%	35%	110%
CANCER	62 Day Upgrade	Apr-22	100%	90%	H	?	85%	65%	106%

	Performance Metrics	Latest Month	Measure	Target	Performance	Assurance	Mean	Lower process limit	Upper process Limit
	Diagnostics (DM01 only)	Apr-22	68%	99%	H	F	51%	39%	64%
STROKE	CT Scan within 60 minutes	Mar-22	40%	80%		F	45%	21%	68%
STROKE	Seen in TIA clinic within 24hrs	Mar-22	96%	70%		?	85%	51%	119%
STROKE	Direct Admission	Mar-22	38%	90%	L	F	40%	18%	62%
STROKE	90% time on a Stroke Ward	Mar-22	68%	80%	L	?	72%	56%	89%

Operational Performance Report - Headlines

Operational Performance	Comments
Urgent and Emergency Care (validated)	• In Apr-22, the Trust saw 11,946 patients attend our type 1 sites – a decrease compared to the 12,552 seen in Mar-22 but still higher than the 19/20 average of 11,123. • The trend of special cause concern for our front door metrics continues as the pressure to admit to our hospitals hasn't changed resulting in patients spending time on our corridors and in our ED's whilst they wait for a bed. The average time that a patient was waiting on an ambulance at WRH was 171 minutes; the fifth consecutive month above 100 minutes.
Patient Flow and Capacity (validated)	• The pressure remains on both hospital sites to manage bed capacity and patient flow, particularly to discharge patients before midday and support our long length of stay and medically fit for discharge patients to leave the hospital when they no longer need an acute hospital bed. Admissions, to alleviate patients waiting in our EDs, have been hindered by reduced bed availability driven by increasing numbers of covid patients, infection outbreaks and staffing pressures. • The number of long length of stay patients increased from 56 on the last day of March to 60 on the last day of April; 21 of the 60 were identified as MFFD.
Cancer (unvalidated)	• **Long Waits:** The backlog of patients waiting over 62 days has increased from 335 to 400 and those waiting over 104 days has increased from 144 to 145, with urology contributing the most patients to this cohort of our longest waiters (60%). • Cancer referrals in Apr-22 decreased for all specialties; however Lower GI demand remains the biggest risk to achieving the waiting times standards with referrals still higher than pre-pandemic. • Despite the improvement in 2WW cancer for breast, the overall waiting time standard has not been achieved and only 3 specialties achieved at least 93%. • The 28 Day Faster Diagnosis standard has not been achieved and remains at risk with referred patients not being seen by a specialist within 14 days. • The 62 day standard has not been achieved and less than 50% of patients started treatment within 62 days due to delays in the 2WW and diagnostics elements of the pathway in Apr-22. • The delays are impacting the 31 day standard of treatment from decision to treat which continues to show special cause concern and below the 96% standard.
RTT Waiting List (validated)	• **Long Waits:** Our 6,490 patients waiting over a year for treatment can be broken down as follows; between 52 and 78 weeks (4,912), between 78 and 104 weeks (1,324) and those waiting over 104 weeks (254). Of the 254 patients waiting over 104 weeks, 201 are waiting for orthodontic treatment and 53 are associated with other treatment specialties. This cohort continues to decrease. • The RTT Incomplete waiting list was reviewed as it is now over 60,000 but it was found to be a genuine increase.
Outpatients (Second SUS submission)	• **Long Waits:** There are 34,222 RTT patients waiting for their first appointment and 23% of them have been dated. • Based on our second SUS submission (and adjusted for reclassification), Apr-22 saw 41,944 outpatient attendances take place (consultant and non-consultant led). Albeit unvalidated, 22/23 annual plan OP targets have not been achieved for Apr-22, an activity gap which needs to be addressed in the remainder of the year as well as how do we reduce the number of follow-up appointments. • The annual plan wanted Trusts to reduced the number of follow-up appointments in 22/23. This was, against the plan, not achieved in Apr-22 i.e. we undertook more appointments than we planned to.
Theatres (validated)	• Based on our second SUS submission, we have not achieved our 22/23 annual plan targets for total elective spells in the month with both elective inpatient and day case falling short. • 10 eligible patients who had their operation cancelled were not rebooked within 28 days in Apr-22; however 13 patients (56%) were.
Diagnostics (validated)	• **Long Waits:** 3,112 patients are waiting over 6 weeks for their diagnostic test and of the total number of breaches, 879 have been waiting over 13 weeks with 47% of our longest waiters attributable to DEXA and Echocardiography. • DM01 performance is at 32.36% with 6+ week breaches having increased, CT breaches are now down to 47 but non-obstetric ultrasound has increase from 388 to 806. • Activity in Apr-22 was 15,121 tests. Only CT and echocardiography achieved their Apr-22 annual plan activity targets with non-obstetrics ultrasound the further away from target (-1,378) due to sickness in the staffing group.