NHS
Worcestershire
Acute Hospitals
NHS Trust

Date of meeting	14th September 2017
Paper number	Enclosure I1

Report provided:							
For approval:	√	For assurance:	√	To note:		For information:	

Infection Prevention & Control annual report 2016-17 and annual plan 2017-18

Accountable Director	Vicky Morris, Chief Nurse / Director Infection Prevention & Control
Presented by	Vicky Morris, Chief Nurse
Author	David Shakespeare, Associate Chief Nurse Infection Control

Alignment to the Trust's strategic priorities (√)	Deliver safe, high quality, compassionate patient care	√	Design healthcare around the needs of our patients, with our partners	√
	Invest and realise the full potential of our staff to provide compassionate and personalised care	√	Ensure the Trust is financially viable and makes the best use of resources for our patients	√
	Develop and sustain our business	√		

Alignment to the Single Oversight Framework (√)	Leadership and Improvement Capability		Operational Performance	
	Quality of Care	√	Finance and use of resources	
	Strategic Change		Stakeholders	

Report previously reviewed by		
Committee/Group	Date	Outcome
Quality Governance Committee	24th August 2017	Approved
Trust Infection Prevention & Control Committee	18th August 2017	Revised version approved following comments from QGC
Quality Governance Committee	27th July 2017	Amendments requested
Trust Infection Prevention & Control Committee	6th July 2007	Approved

Assurance: Does this report provide assurance in respect of the Board Assurance Framework strategic risks?	Y	BAF number(s)	2902

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Level of assurance and trend (up/down/level) Current:		
	Limited / up	

Purpose of report	The purpose of the report is for the Board to receive the Infection Prevention & Control Annual Report 2016-17 and Annual Plan 2017-18.
Summary of key issues	• The Trust reported 41 cases of hospital attributable *Clostridium difficile* infection against an NHS England set trajectory of no more than 32. • The Trust experienced 4 cases of Trust attributable MRSA bacteraemia during the year 2016-17. This means the Trust exceeded the nationally set target of zero tolerance. • The Care Quality Commission in their unannounced visits during November and December 2016 observed some none compliance with hand hygiene, 'bare below elbow' and correct use of personal protective equipment. • The Trust continues to participate in a Worcestershire health economy approach to minimising risk from HCAI and meets bi-monthly to monitor progress against the agreed health economy strategy.
Recommendations	The Board is asked to receive for approval and assurance the Annual Infection Prevention & Control Report for 2016-17 and annual plan for 2017-18.

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WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

INFECTION CONTROL ANNUAL REPORT AND PLAN

1 Introduction

Minimising risk from Healthcare Associated Infection remains an essential component of maintaining patient safety and is specifically encompassed by Regulation 12 – safe care and treatment; and regulation 15 – premises and equipment; and key lines of enquiry S1.8 – S1.12 as a minimum requirement of compliance.

2 Background

The annual Infection Prevention & Control report 2016-17 and annual plan 2017-18 provides information to our patients, staff, the Trust Board, Commissioners and the public on infection prevention activity at the Trust and outlines how key themes are embedded into priorities for improvement during 2017-18.

3 Current situation

The Trust has experienced a challenging year with 41 cases of hospital attributable *Clostridium difficile* infection against an NHS England set trajectory of no more than 32. Lessons being implemented include improvements in the provision of assurance of cleanliness and the strengthening of antimicrobial stewardship.

The Trust also experienced 4 MRSA bacteraemia during the year. Key lessons were around improvements in wound management and associated documentation and completeness of MRSA screening and checks on admission of previous history of MRSA.

The unannounced visits by the Care Quality Commission in November and December 2016 highlighted observations that staff did not always comply with appropriate hand hygiene and some medical staff were not always bare below elbow; and that incorrect use of personal protective equipment had been noted.

The Trust has responded to this outcome with a range of actions as detailed in the annual report including a revised hand hygiene policy with escalation process for continued non-compliant staff leading to the Medical and Nurse Directors; and letters form the Medical Director to Medical staff requiring compliance with the hand hygiene policy. The profile of hand hygiene has been raised by means of regular audits and fostering a culture of challenge to non-compliance and by increasing the profile via the infection prevention link staff and a range of communications.

Whilst not the subject of the period of the annual report; a peer review of infection prevention practice was invited and arranged at the Trust on 27th July. The outcome was broadly positive with observations of good compliance with infection prevention practice and hand hygiene. This has resulted in de-escalation from a red to amber for Infection Prevention & Control by NHS Improvement. Next steps include learning from other Trust's Quality Assurance work in this area and to work with the National Institute for Health and Care Excellence on further Quality Improvement initiatives.

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4 Implications

The board are asked to approve that the annual Infection Prevention & Control report 2016-17 and annual plan 2017-18 can be placed on the Trust external website.

5 Recommendations

The Board is asked to receive for approval and assurance the Annual Infection Prevention & Control Report for 2016-17 and annual plan for 2017-18.

Full implementation of the Infection Prevention & Control annual plan 2017-18 will provide moderate assurance for the organisation of compliance with the Hygiene Code and a robust internal system of control for infection prevention. The risk rating is currently 2 subject to full implementation of the plan.

Compiled by
David Shakespeare,
Associate Chief Nurse Infection Control

Director
Vicky Morris
Chief Nurse / Director Infection Prevention & Control

Pull Together to Prevent Infection

Worcestershire Acute Hospitals NHS Trust

Infection Prevention and Control Annual Report 2016-17

And Infection Prevention Plan 2017-18

Vicky Morris
Chief Nursing Officer / Director Infection Prevention & Control

David Shakespeare
Associate Chief Nurse – Infection Prevention & Control

Patients | Respect | Improve and innovate | Dependable | Empower

Taking **PRIDE** in our healthcare services

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Foreword

Having joined the Trust in mid March 2017, I am presenting an Infection Prevention & Control Annual Report for 2016-17, which provides a helpful context for the future improvements we will be taking forward in the plan for 2017-18.

Prevention of Healthcare Associated Infection (HCAI) remains a cornerstone of patient safety both in terms of cleanliness of the environment and in clinical practice.

Infection Prevention at the Trust experienced a challenging year as cases of *Clostridium difficile* exceeded the trajectory set by NHS England of no more than 32 cases with a total of 41 cases reported. This number was also above the 29 cases reported during 2015-16. In addition the Trust has reported 4 MRSA bacteraemia during the year against a national zero tolerance and a background of one case during 2015-16.

The inspection of the Care Quality Commission during November and December 2016 also highlighted problems of non compliance with hand hygiene and use of personal protective equipment during their visits, to which a comprehensive response has been put in place. The Trust however, has seen some success, with almost 76% of front line staff receiving their influenza vaccination.

We will be working comprehensively with the clinical and non clinical teams across the Trust and our stakeholders to ensure the learning from analysis of these cases and from the Care Quality Commission's observations is embedded, so that practice can be improved.

Vicky Morris
Chief Nursing Officer and Director Infection Prevention & Control

1. Executive Summary

- The Trust has reported 41 cases of hospital attributable *Clostridium difficile* infection against an NHS England set trajectory of no more than 32.

- The Trust experienced 4 cases of trust attributable MRSA bacteraemia during the year 2016-17. This means the Trust exceeded the nationally set target of zero tolerance.

- The Trust continues to participate in a Worcestershire health economy approach to minimising risk from HCAI and meets bi-monthly to monitor progress against the agreed health economy strategy.

2 Introduction

This is the annual report from the Director of Infection Prevention and Control (DIPC) providing information on infection prevention and control (IPC) activity across the organisation. The Director of Infection Prevention & Control during 2016-17 was Jan Stevens CBE until March 2017 when Vicky Morris took up the role.

The purpose of this report is to provide detail to our patients, public, staff, Trust Board and Commissioners on the IPC agenda.

This report covers the period from April 2016 to March 2017 and provides information that includes:

Reporting arrangements for IPC
Clostridium difficile infection rates and analysis of cases
Meticillin Resistant *Staphylococcus aureus* (MRSA) bacteraemia figures and description of lessons identified
Key work undertaken to strengthen water and ventilation governance
A summary of education & training for IPC undertaken in year
A summary of audits undertaken in year
A plan of key objectives for 2017/18

Cases of *C.difficile* infection have increased during 2016-17 with 41 cases against a trajectory of no more than 32 cases. These are cases where the sample has been taken beyond day of admission to hospital plus two days. This represents an increase on the 29 cases reported during 2016-17 and the 36 cases reported during 2014-15.

Four cases of hospital attributable MRSA bacteraemia (blood stream infection) are also disappointing given the position of national zero tolerance. This represents a deterioration on the position during 2015-16 when one case was reported.

3. Reporting arrangements

The *Trust Board* recognises and agrees their collective responsibility for minimising the risks of infection and agrees and supports the means by which these risks are controlled. The responsibility for Infection Prevention and Control lies with the Director of Infection Prevention & Control (DIPC) who is the *Chief Nurse*. The Chief Nurse is supported in this respect by an Associate Chief Nurse Infection Control, by the Consultant Microbiologists and the Infection Prevention & Control Nurse Team (IPCT). The *Chief Executive* accepts on behalf of the Trust Board responsibility for all aspects of Infection Prevention & Control within the Trust. This responsibility is delegated to the Chief Nurse as the DIPC. The Chief Nurse reports directly to the Chief Executive and the Board and chairs the Trust Infection Prevention & Control Committee.

The *Consultant Microbiologists* provide expert microbiological and infection prevention advice and provide support for the wider IPCT and fulfil the *Infection Control Doctor* function.

The *Associate Chief Nurse Infection Prevention & Control* provides strategic direction and leadership for the IPCT. The Associate Chief Nurse reports professionally to the Chief Nurse / DIPC and works closely with the Consultant Microbiologists to interpret and incorporate national guidance into local practice. While part of the IPCT, the Associate Chief Nurse works with Divisional leaders to ensure best practice is embedded across the Trust.

The Lead Nurse IPC is a source of expert clinical advice and is operationally responsible for the development of policies, guidance, infection prevention practice; and education and training for infection prevention Trust wide.

The *Trust Infection Prevention & Control Committee* (TIPCC) is the main forum for discussion and monitoring of action around IPC practice at the Trust. The membership of TIPCC includes representation from all Divisions at the Trust, plus the Clinical Commissioning Group IPC Lead Nurse and is chaired by the Chief Nurse. The committee meets bi-monthly. The Chief Nurse takes a report from the committee to the Clinical Governance Committee and then the Quality Governance Committee, which is a subcommittee of the Trust Board.

Infection Control *Link Practitioners* are a cornerstone of the IPC infrastructure at Worcestershire Acute Hospitals NHS Trust (WAHT) and are the champions of infection prevention in clinical areas. Study days are held at least quarterly to ensure Link Practitioners remain involved in IPC activity and are equipped to follow national best practice guidance. There is also a well attended annual Link Practitioner study day.

In terms of *Estates*, the Trust receives a monthly report for the Worcestershire Royal Hospital site from the Private Finance Initiative Funder (Special Purposes Company) and monthly reports from service providers Engie with respect to the estate and building fabric; Siemens with respect to equipment management; and ISS comprising chiefly of Housekeeping, Catering, Portering and Security arrangements. For the Alexandra Hospital and Kidderminster Treatment Centre sites a monthly report is received from the Trust Estates and Facilities Team on the above services; where Housekeeping, Catering,

Portering and Security arrangements are also considered at the Trust Patient Environmental Operational Group.

Patient representation is present in Infection Prevention & Control at the Trust via monthly and annual Patient Led Assessments of the Care Environment, otherwise known as PLACE audits. Patient representatives are primarily drawn from the Trust Patient Forum, League of Friends and Worcestershire Health watch.

Reporting of HCAI: WAHT continues to participate in mandatory surveillance of Meticillin Resistant *Staphylococcus aureus* (MRSA) blood stream infections (BSI), Meticillin Sensitive *Staphylococcus aureus* (MSSA) BSI, *Escherichia coli (ECO)* BSI, Glycopeptide (or Vancomycin) resistant *Enterococci* (GRE/VRE) and *Clostridium difficile* infections. MRSA, MSSA and *E.coli* BSIs and laboratory detected *Clostridium difficile* toxins are reported monthly via the Public Health England HCAI data capture system. This is signed off on behalf of the Chief Executive and reported to TIPCC. Enhanced surveillance of MSSA and *E.coli* has also commenced from April 2017.

Infection Prevention & Control Team Nurse and administrative (IPCT) establishment

The IPCT whole time equivalent (WTE) establishment is:

1.0 WTE Associate Chief Nurse (Band 8C)
1.0 WTE Lead Nurse (Band 8a)
1.0 WTE Senior IPC Nurse (Band 7)
4.3 WTE IPC Nurse Advisors (Band 6)
1.9 WTE IPC Staff Nurse (Band 5)
1.0 WTE Healthcare Support Worker (Band 3)
0.8 WTE Data Analyst (Band 4)
0.9 WTE Administrative Support Officer (Band 4)
0.8 WTE MRSA Screening Co-ordinator (Band 3)

The team has nurses and administrative staff who are based at and circulate between the Worcestershire Royal and Alexandra Hospital sites. The team also provide a service to Kidderminster Treatment centre and other Acute Trust services based at Evesham Community Hospital and Princess of Wales Community Hospital, Bromsgrove.

Members of the IPCT attend and participate in the following groups / committees:
TIPCC
Health Economy HCAI Steering Group
Water Safety Committee
Decontamination Committee
Ventilation Safety Group
Antimicrobial Stewardship Group
Medical Devices Committee
Senior Nurse Meeting
Patient Environment Operational Group
Winter preparedness Groups
Occupational Health meetings including for staff influenza vaccination
Estates liaison meetings for environmental cleaning and building planning

The Assurance Framework for IPC

Reporting arrangements for IPC at WAHT are outlined in the policy for 'The Management of Infection Prevention & Control' CG-043.

The Assurance Framework for IPC and reporting arrangements for TIPCC are as follows:

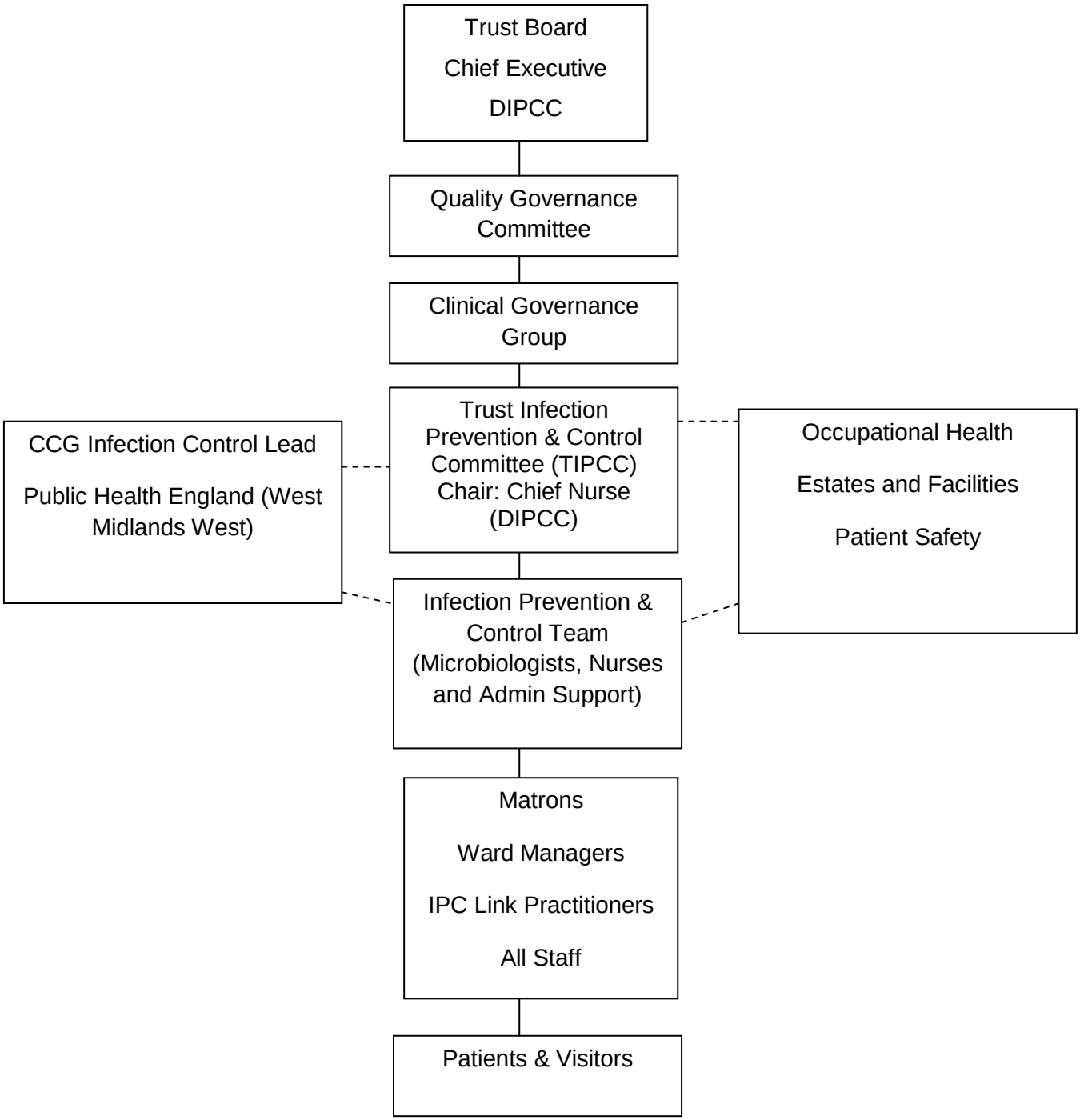

Figure 1: Assurance framework for IPC at WAHT

4. Compliance with the Hygiene Code

The Trust is required to demonstrate compliance with The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance (The Hygiene Code). The Trust declares compliance with the Hygiene Code during 2016-17, but accepts challenges to compliance following the findings of the Care Quality Commission during their inspection visits November and December 2016.

The Trust collates and continually updates evidence of compliance against the 10 criteria of the Hygiene Code. Evidence is continually collated in an electronic folder of evidence with hyperlinks to the specific documents, which are available for regulators to access.

This includes, but is not limited to:

Criterion one: Systems to manage and monitor the prevention & control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them.
Trust Infection Prevention & Control Committee Terms of Reference Sample cleaning schedules Sample water safety group minutes Diarrhoea and vomiting risk assessment tool Infection Prevention & Control local risk register IPC Annual Report IPC serious incident investigation reports Mandatory update presentations and attendance figures Sample discharge letter for Norovirus affected areas Infection Prevention & Control audit tools and results Management of Infection Prevention & Control Policy Hand Hygiene policy High Impact Interventions audits and results Waste Management policy Food Hygiene policy Linen policy Infection Control and Bed Management policy
Criterion two: Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
Sample environmental cleaning schedules and checking process Sample cleanliness scores Sample nurse cleaning schedules and ward cleanliness handover records Sample IPC audit tool Decontamination policies Sample Patient Environmental Operational Group report General Decontamination policy Trust Cleaning policy

Criterion three: Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.
Trust Antimicrobial Prescribing Guidelines Antimicrobial Stewardship Group Terms of Reference and minutes *C.difficile* management quick guide Sample Consultant Microbiologist on call rota
Criterion four: Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing / medical care in a timely fashion.
Norovirus patient information leaflet *C.difficile* patient information leaflet VRE patient information leaflet Meticillin resistant S*taphylococcus aureus* (MRSA) patient information leaflet Hand hygiene leaflet for staff patients and visitors Close ward poster (in event of Norovirus outbreak). Chief Nurse (DIPC) and Chief Medical Offer posters Protocol for the management of MRSA MRSA screening – protocol for admissions screening MRSA including elective, non-elective, orthopaedic Multi-resistant Gram negative bacteria including Extended spectrum beta lactamase (ESBL) producing organisms; Vancomycin resistant E*nterococci* (VRE) and Carbapenemase producing *Enterobacteriaceae* (CPE) – policy for the management and prevention of spread.
Criterion five: Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.
ICNET surveillance system to identify alert and other organisms Isolation policy Sample outbreak agenda Sample outbreak circulation list HCAI case analysis for *C.difficile* and MRSA Notifiable diseases – policy for notification Policy for presumed outbreaks of viral diarrhoea and vomiting Policy for the management of *C.difficile* and prevention of spread Flu quick guide 2016-17 IPC protocol for seasonal influenza Screening for MRSA Screening as required in response to potential or actual outbreak of specific organism

Criterion six: Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.
IPC training records for contractors Sample estates project IPC sign off Compliance with attendance at IPC mandatory training Standards of dress policy Sample of job descriptions with IPC element Standard precautions poster Management of Infection Prevention & Control Policy
Criterion seven: Provide or secure adequate isolation facilities.
IPC risk assessment tool for prioritisation of side rooms Ventilation Committee Terms of Reference Patient admission assessment for risk of infection Isolation Policy Ward Environmental Risk Assessment tool Site based profile of available isolation rooms
Criterion eight: Secure adequate access to laboratory support as appropriate.
Laboratory United Kingdom Accreditation Service (UKAS) accreditation certificate Laboratory standard operating procedures
Criterion nine: Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.
Full range of IPC policies (with policy review process) required by the code including: Control of outbreaks Safe handling and disposal of sharps Aseptic technique
Criterion ten: Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.
Occupational Health policies including: Seasonal influenza policy (for staff vaccination) Vaccination and management of Measles, Mumps and Rubella in healthcare and related workers Vaccination and management of Varicella zoster virus in healthcare workers Vaccination and management of Hepatitis B in healthcare and related workers The management of HIV in healthcare and related workers Occupational Health Reports to Trust Infection Prevention & Control Committee Minutes of Trust Infection Prevention & Control Committee for Occupational Health issues

The Trust Infection Prevention & Control Committee received assurance during 2016-17 of compliance to the Hygiene Code. During 2017-18 The Trust Infection Prevention & Control Committee will review 2 criterion of the Hygiene Code at bi monthly meetings to ensure all criteria are formally reviewed to assess the level of assurance on compliance.

5. Care Quality Commission Visits

The Care Quality Commission (CQC) undertook unannounced visits at the Trust during November and December 2016 and a report on these visits was published during June 2017.

What did CQC say about cleanliness and infection prevention?

The CQC summarised:

'Wards and clinical areas were visibly clean and ward-cleaning schedules were in place in most areas'

'All equipment in use appeared clean and 'I am clean' stickers were in place...staff were observed cleaning equipment after use'.

However, the report also cited that:

'Staff did not always clean their hands between caring for patients, there was incorrect use of personal protective equipment and some doctors were not 'arms are below the elbow'.

How has the Trust responded?

The Trust has responded to these concerns with a comprehensive programme which has included the following:

- Letter from Medical Director to all medical staff requiring their compliance with hand hygiene (January 2017). While outside the period of this annual report, this was reinforced again by the new substantive Medical Director in July 2017 when a further letter to medical staff was issued requiring continued compliance and requesting challenge to any non-compliance observed.
- Infection Control Team Newsletter including focus on hand hygiene and personal protective equipment (January 2017).
- Link Practitioner focus on hand hygiene at quarterly meeting (March 2017) and subsequently at annual study day (May 2017).
- Revised hand hygiene policy with escalation procedure for non-compliance leading to Medical and Nurse Directors – applicable to all staff groups (March 2017).
- Extensive hand hygiene audits including immediate feedback where non compliance is observed.
- Increasing Trust Infection Control Committee to monthly for 2017-18 to increase scrutiny and profile on infection prevention.
- Increased walkabouts by Infection Control Nurse Team and senior nurses to check for hand hygiene and compliance with correct use of personal protective equipment and cleanliness.
- Ward pledges displayed in clinical areas – these are displayed statements signed by staff members committing to a clutter free and clean environment and compliance with hand hygiene and correct use of personal protective equipment.

- A screensaver developed to be utilised periodically to reinforce hand hygiene message:

- Use of the Trust newspaper 'Worcestershire Way' during March 2017 to reinforce the message around the requirement for clinical staff to be bare below the elbow:

- A new 'how to' hand hygiene video made within the Trust now shown at Trust Induction and all mandatory updates to explain why hand hygiene is so important and the required technique.

In addition the Infection Control Nurses have been working alongside Divisional teams to address the concerns raised and the issues will continue to be monitored at the Trust Infection Prevention Committee where improvements and remaining challenges will be measured and scrutinised. During 2017-18 the Infection Control Nurses will continue to work closely with matrons, ward sisters and departmental heads to ensure they understand their responsibilities for infection prevention. A new cleanliness escalation framework will also be developed to ensure that all staff know who is responsible for environmental cleanliness in their areas and how to escalate and resolve any concerns raised. In addition there will also be an increased frequency of checks by the infection control nurses and senior nurses to ensure the environment and medical devices are clean and that infection control practices are as expected in line with Trust policy.

6. Clostridium difficile

The end of financial year 2016-17 position for *C.difficile* infections (CDI) is 41 reported cases against a trajectory of no more than 32. This represents a deterioration on the 29 cases reported during 2015-16 and the 36 cases reported during 2014-15.

Figure 2 below summarises cases of trust attributable CDI against a monthly trajectory agreed with the Clinical Commissioning Group for the financial year 2016-17.

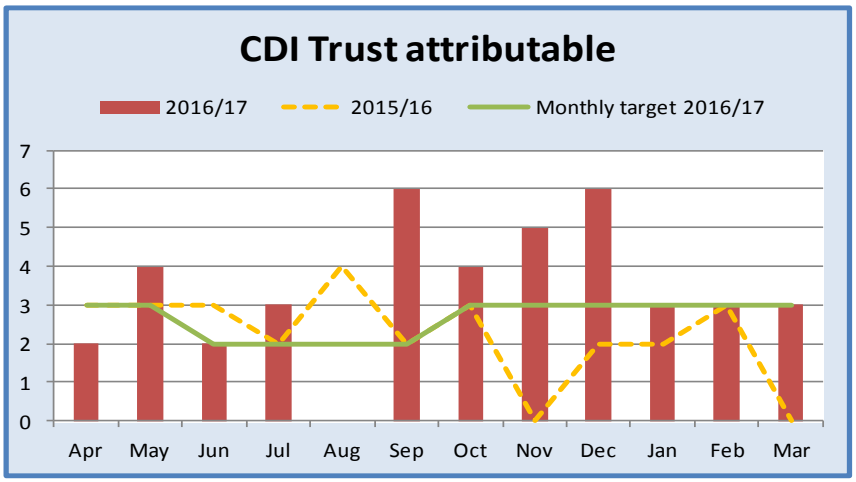

Figure 2: Trust attributable *C.difficile* infections shown monthly for 2016-17 with 2015-16 cases for comparison.

Figure 3 shows cumulative cases against the annual trajectory of no more than 32 cases, showing the end of year above trajectory position.

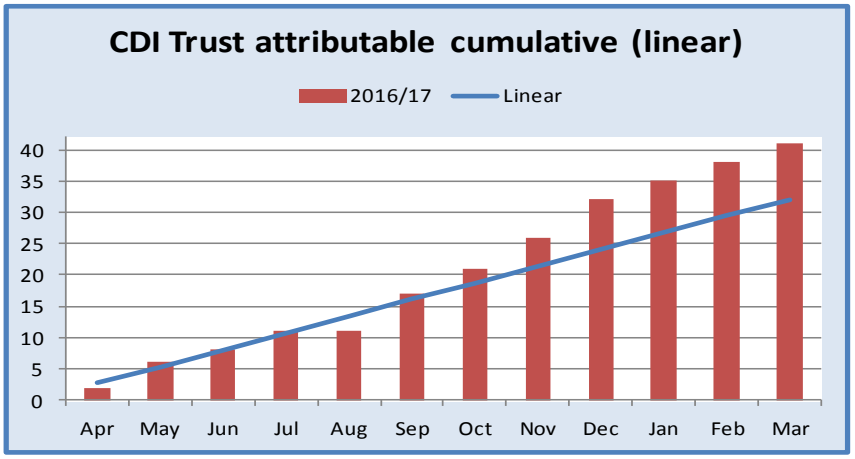

Figure 3: Cumulative trust attributable cases of *C.difficile* infection against linear distribution of trajectory 2016-17.

Figure 4 shows CDI by month and site. Of the 41 reported cases, 35 were from specimens taken at Worcestershire Royal Hospital, 6 at the Alexandra hospital and none at Kidderminster Treatment Centre. All cases are investigated to ascertain if there are lessons to apply to future case prevention.

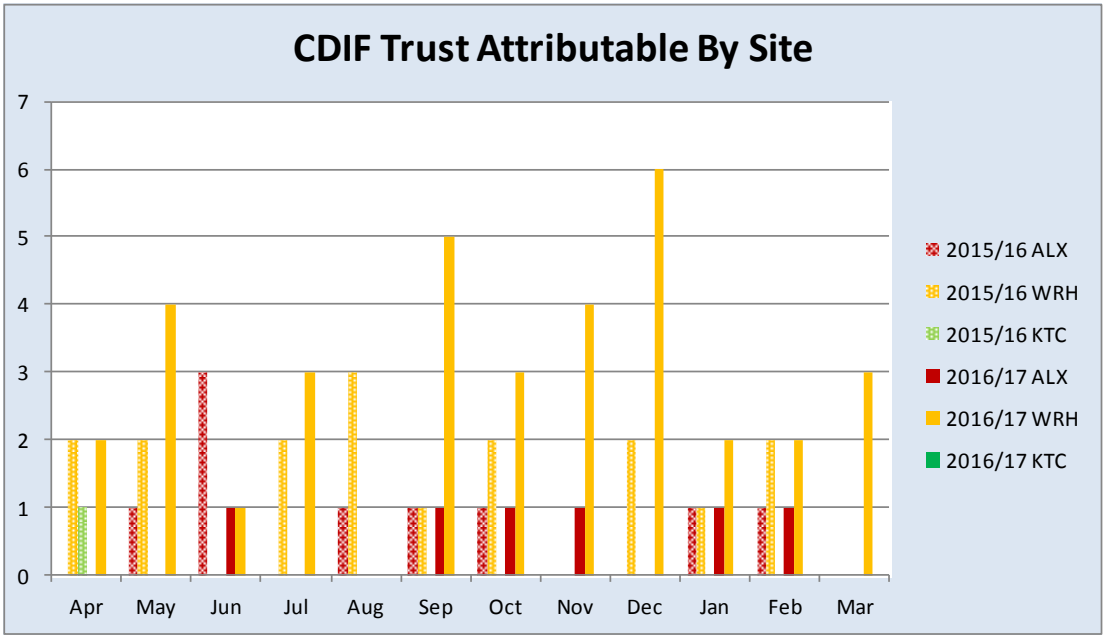

Figure 4: *C.difficile* infections by month and site

Analysis of cases

Definitions, agreed with the Clinical Commissioning Groups in Worcestershire are used primarily to support clinical case reviews being based on harm reduction and prevention and cases are assigned a Red/Amber/Green rating:

Lapse in care contributing to acquisition of CDI	Lapse in care not contributing to acquisition	No lapse in care

A review of each of the 41 cases has been undertaken and considers specific risk factors for acquisition of CDI and then looks at the management of the patient including antimicrobial use prior to onset of symptoms, compliance with the CDI protocol and also considers the presence of concurrent cases, environmental cleanliness and hand hygiene. Figure 5 shows a summary of identified lapses in care 2016-17.

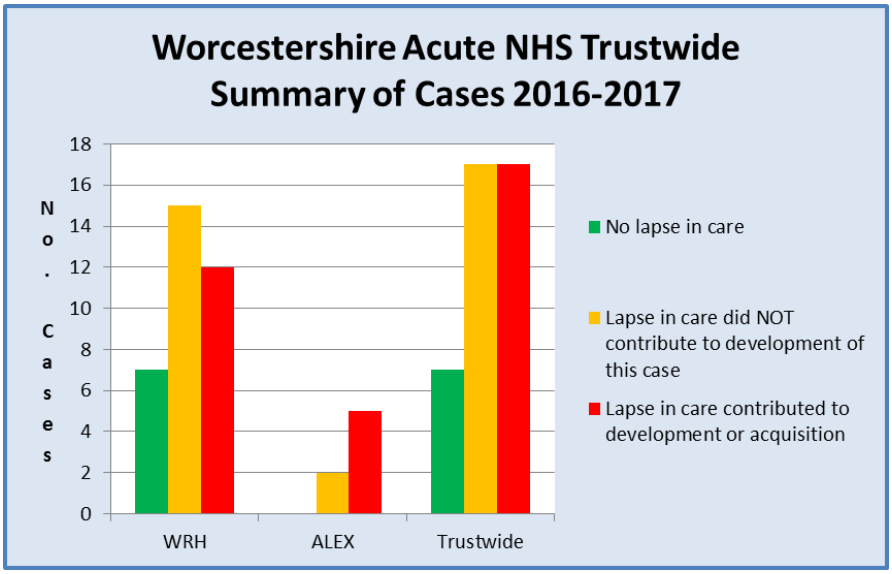

Figure 5: Summary of cases by lapse in care 2016-17

Findings:

- 83% (34/41) cases were found to demonstrate a lapse in care
- 41.5% (17/41) of all cases were red lapses in care contributing to the development or acquisition of CDI.
- 29% (5/17) of red lapse cases were reported at the Alexandra Hospital site and 71% (12/17) were reported at the Royal Worcestershire Hospital site.
- 41.5% (17/41) of all cases were amber lapses in the care, not contributing to development or acquisition of CDI. 12% (2/17) of amber lapses were at the Alexandra site and 88% (15/17) were at the Royal Worcestershire Hospital site.
- 17% (7/41) of all cases were green (no lapse in care) and were all at the Royal Worcestershire Hospital site.

Key risk factors identified:

- The highest risk factor for acquisition of CDI is antibiotic usage in the three month period prior to confirmation and occurred in 97.5% of cases (40/41). However, antimicrobial therapy was almost always required but was also the trigger for CDI development.
- This was closely followed by concurrent CDI cases on the ward (66% cases), which may not be the same ribotype, though is thought to increase the likelihood of environmental loading with *Clostridium difficile* (Spores of *C.difficile* contaminating and remaining in the ward environment).
- The third highest risk factor was use of laxatives or anti-emetics related to previous hospital admission in the three month period prior to acquisition (61% cases).
- The fourth was previous admission in the last 3 months (56% cases).
- Co-amoxiclav was found to be the antimicrobial agent most likely to trigger CDI with 68% (28/41) cases having received treatment with this agent before developing CDI.

The age range of patients was between 58 and 96 years and 40 of the 41 patients affected were over the age of 65 years. 95% (39/41) of cases were emergency admissions.
Some good practice was noted in the management of CDI cases notably:

- 97.5% (40/41) cases were monitored through use of a stool chart.
- Proton Pump Inhibitor (a class of drugs also known to trigger CDI) review had taken place in 93% (38/41) cases.
- Antibiotic review had taken place in 85% (35/41) cases.

However, some deficiencies were noted including:

- Sampling was delayed in 56% (23/41) cases with only 44% (18/41) sampled the same day as onset of symptoms.
- There were delays in isolation with 71% (29/41) cases not isolated on the day they developed symptoms.
- There were delays in empirical treatment being commenced with only 17% (7/41) of all patients receiving empirical treatment before a diagnosis was confirmed.
- There were delays in commencing full treatment with 73% (30/41) receiving timely treatment the same day once a diagnosis of CDI was confirmed.

In response to these findings key actions to be undertaken during 2017-18 include:

- Ratification and launch of revised antimicrobial prescribing policy and programme of antimicrobial prescribing audits and feedback to prescribers to be fully in place before end of September 2017.
- Launch of antimicrobial prescribing smart phone App for prescribers to be in place before end of September 2017.
- Letter to prescribers reminding them of appropriate alternatives to the use of Co-amoxiclav in order to help reduce consumption (July 2017).
- Further ongoing education and training opportunities around antimicrobial stewardship, hand hygiene and other IPC practice and completion of IPC documentation.
- Zero tolerance of non compliance with hydrogen peroxide vapour treatment for single rooms for high risk infections.
- Review and refinement of the policy for management of *Clostridium difficile* prior to re-approval before end of September 2017.
- Initial case review undertaken within 3 days of the case being identified.
- Reminder for clinical staff to obtain a sample as soon as possible after symptoms have developed included in mandatory training and via link practitioners.

Clostridium difficile infection 30 day all-cause mortality

Clostridium difficile 30 day all-cause mortality is defined as death occurring within 30 days of a specimen testing positive for *C.difficile*. It is important to remember that this is 'all-cause' mortality where a death may have occurred due to a range of co-morbidities and

does not mean that *C.difficile* is the cause of death. In addition, these figures are calculated from trust attributable cases only and reflect only when a sample has been taken beyond day of admission plus two.

A separate calculation is also made for deaths where *C.difficile* is cited as the cause of death on part 1a of a death certificate (the *C.difficile* attributable death rate). Where this happens, such cases are recorded and investigated as serious incidents.

Figure 6 below shows the Trust's *C.difficile* 30 day all-cause mortality for 2016-17. The all cause *C.difficile* mortality for 2016-17 is 15 of 41 cases equating to 36.5%. This is higher than expected as the Department of Health (2008) guide '*Clostridium difficile* infection: How to deal with the problem' identified action is required if the 30 day mortality rate approaches 20%. A further analysis of these cases will therefore be undertaken during July 2017 in order to assure the Trust Infection Prevention & Control Committee if there any further lessons not already understood from the analysis of cases for 2016-17; and this report will be received at the Trust Infection Prevention & Control Committee in August 2017.

The *C.difficile* attributable death rate (where *C.difficile* has been cited on part 1a of the death certificate) is 1 of 41 cases equating to 2.4%.

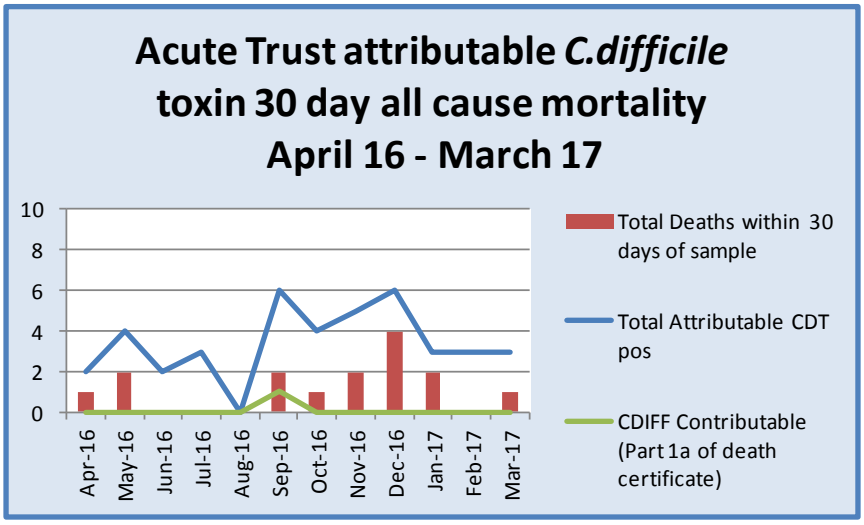

Figure 6: *C.difficile* all-cause mortality 2016-17.

Clostridium difficile infection trajectory for 2016-17

The trajectory for 2017-18 for the Trust has been set by NHS England, at no more than 32 trust attributable cases which is consistent with the 2016-17 target.

C.difficile PCR

C.difficile PCR is also monitored in accordance with the three step algorithm. The Trust follows Department of Health 2012) guidance on diagnosis and reporting of *C.difficile and* uses a three step process of glutamate dehydrogenase (GDH), toxin enzyme

immunoassays (EIA) and toxin gene (PCR) testing. This means the Trust is compliant with national guidance with regard to laboratory testing for *C.difficile*.

In addition to externally reportable toxin positive cases as described above, PCR testing is also undertaken. This testing is able to identify toxin negative patients but PCR positive, where a patient is carrying *C.difficile* with the potential capability of making toxin. It is therefore important to monitor these patients and assess risk e.g. if symptomatic to ensure isolation precautions ensue and treatment is instigated.

Figure 7 shows PCR by location and Figure 8 shows PCR and toxin by location. The IPCT monitors these to ascertain if there is any action that could be taken to prevent further toxin positive cases.

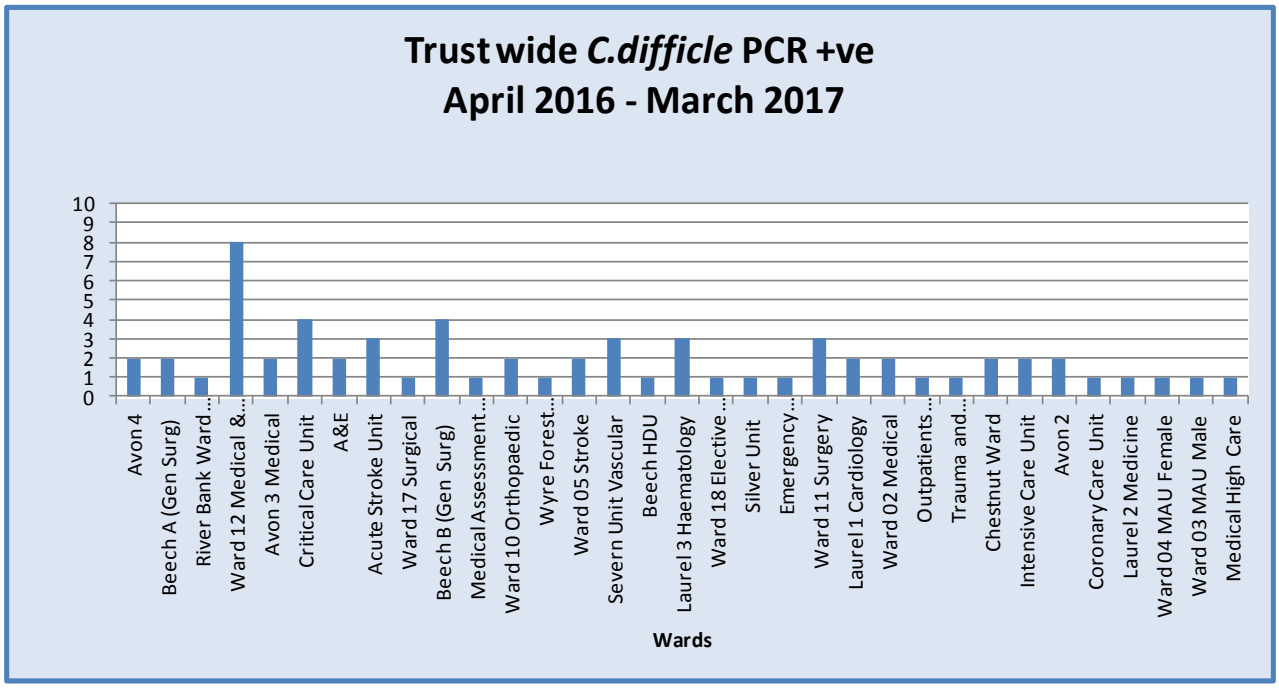

Figure 7: *Clostridium difficile* PCR by location 2016-17 (Tot: 65, WRH 38, Alex 26, KTC 1)

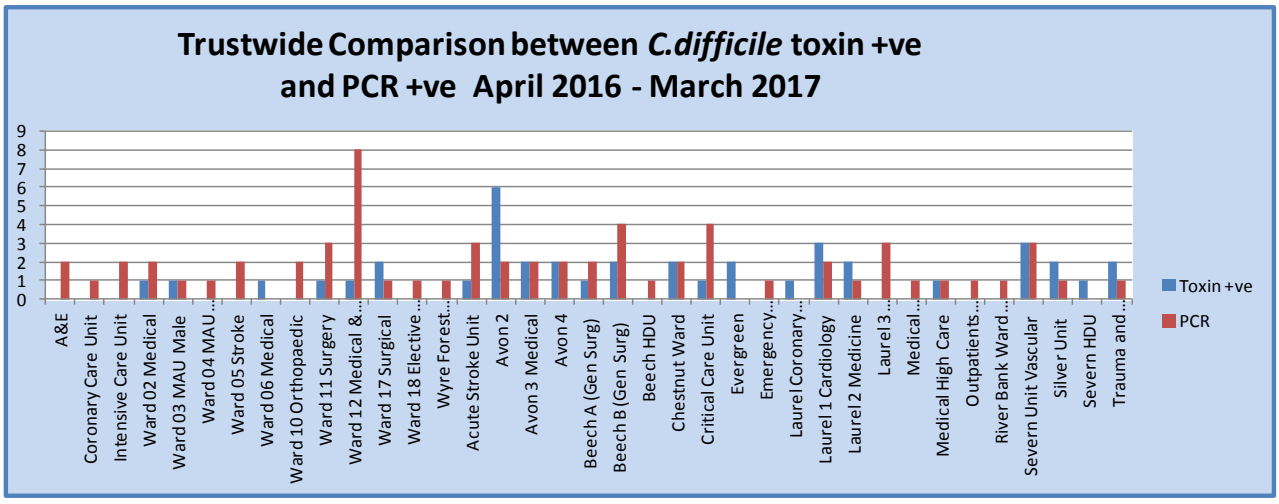

Figure 8: *Clostridium difficile* toxin and PCR by location 2016-17

7. Meticillin resistant *Staphylococcus aureus* (MRSA) bacteraemia

During 2016-17 a total of 7 MRSA bacteraemia (blood stream infections) were reported. Of these cases, 4 were attributed on post infection review to the Trust. This represents a breach of the national zero tolerance of hospital attributable MRSA bacteraemia; and is worse than the one case reported during 2015-16, as reflected in Figure 9 below.

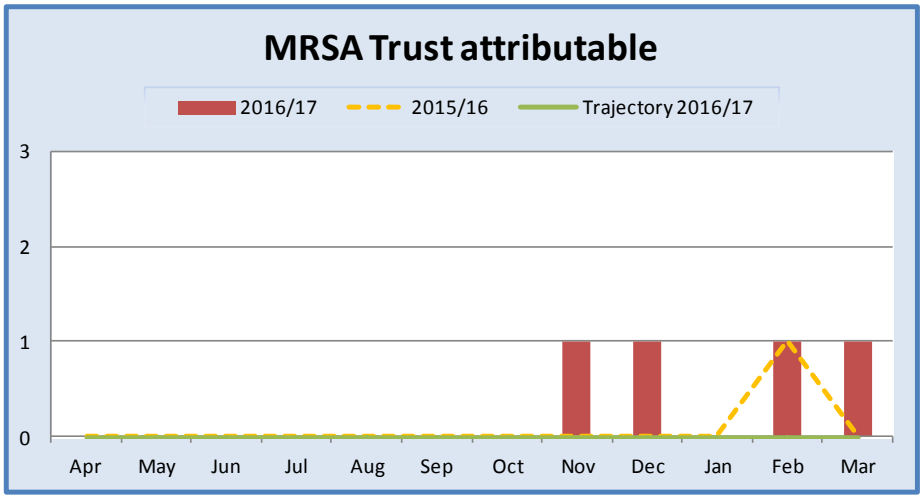

Figure 9: Trust attributable MRSA BSI 2016-17; also showing the 2015-16 case

The Trust attributable cases were reported as three at the Alexandra site in November 2016 and January and March 2017; and one at the Worcestershire Royal Hospital site in December 2016. The 2015-16 cases is also shown, having occurred at the Worcestershire Royal Hospital site in February 2016 (Figure 10).

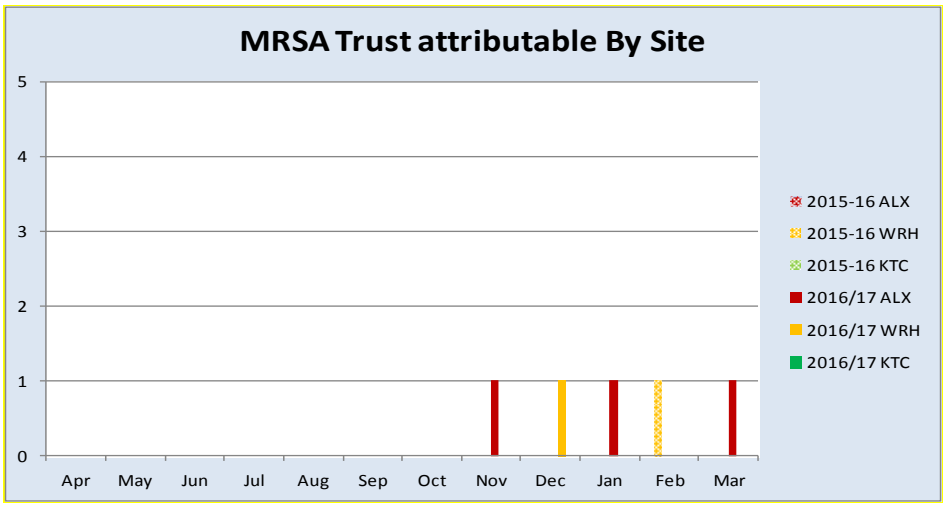

Figure 10: Trust attributable MRSA by site 2016-17 and 2015-16 for comparison.

Trust attributable cases:

Case	Sample date	Location	Outcome
1	22/11/16	Ward 2, Alexandra Hospital	Contaminant – Trust attributable
2	22/12/16	T&O Ward, Worcestershire Royal Hospital	Acute attributable
3	07/02/17	Ward 12, Alexandra Hospital	Acute attributable
4	19/03/17	Ward 11, Alexandra Hospital	Acute attributable

Summary of cases

Case 1 occurred in a gentleman > 80 years admitted from sheltered housing with a previous history of MRSA. While not reported as a serious incident, the case as a contaminant is attributed to the Trust.

Case 2 occurred in a gentleman > 80 years with no previous history of MRSA. The investigation found that the likely portal of entry for the MRSA was via a wound.

Case 3 occurred in a gentleman > 80 years with no previous history of MRSA. The investigation found that the likely portal of entry for the MRSA was also via a wound.

Case 4 occurred in a lady > 80 years who had a previous history of MRSA. The investigation found that the likely cause was related to an existing medical condition of the patient.

Cases 2-4 were reported by the Trust as serious incidents and further detail and key lessons from these cases is outlined in section12 of this report: 'Infection Prevention & Control Serious Incidents and outbreaks of infection'.

The figures for the previous full year 2015-16 were 5 MRSA bacteraemia of which 4 were non attributable cases and 1 attributable case.

For purposes of comparison, published figures by Public Health England indicate that for the financial year 2016-17, of 17 acute trusts covered by Public Health England in the West Midlands area, there has been one Trust with 7 hospital attributable MRSA bacteraemia; one other Trust with 4 cases; one trust with 3 cases; and four Trusts reporting one case.

MRSA screening

During 2016-17 the Information Team and IPCT have worked closely to further refine data quality around MRSA screening compliance figures, leading to improvements that now more accurately reflect the vigilance placed on MRSA screening by the Pre-operative Assessment Team.

A definition of high risk has been taken from Department of Health (2014) modified MRSA screening guidance. This includes: Vascular, renal/dialysis, neurosurgery, cardiothoracic surgery, haematology/oncology/bone marrow transplant, orthopaedics/trauma, all intensive care units (Adult/paediatric/Neonatal), High Dependency Units, Coronary Care Units and the Neonatal Unit at Worcester Royal Hospital.

Figure 11 shows MRSA screening compliance of high risk elective patients against a target of 95%.

Date 2016-17	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
High Risk MRSA Elective Screening %	94.4%	94.7%	95.5%	95.9%	95.9%	92.3%	97.1%	96.3%	93.8%	97.1%	96.2%	95.5%
Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%

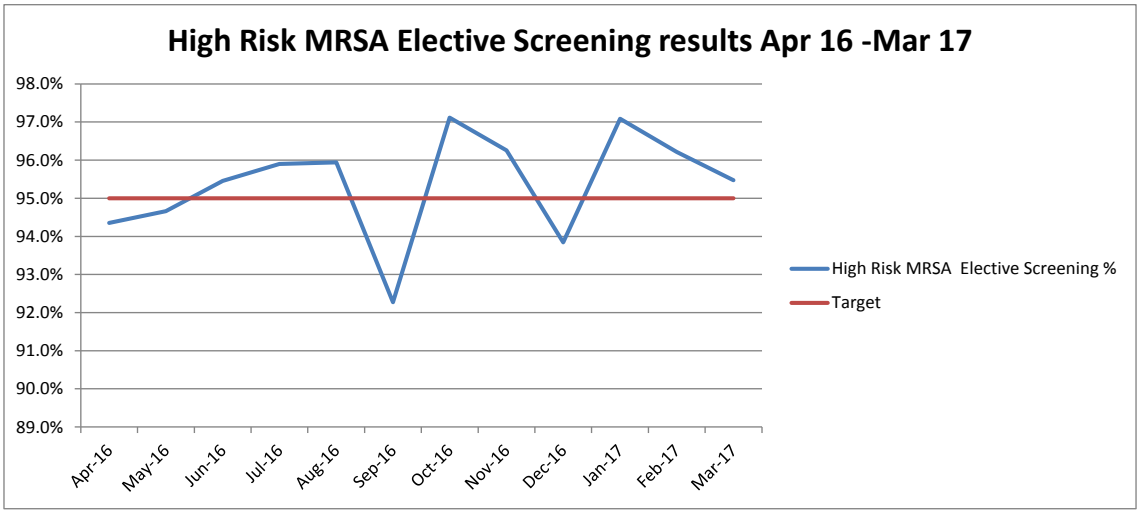

Figure 11: MRSA high risk Elective screening compliance against 95% target

For any incidence of screening non-compliance reported, the information is forwarded to the Division for them to assess if the patient should have been screened and to do so at the earliest next opportunity, or assess if the patient did not in fact require screening.

Work around MRSA screening will continue in 2017-18 to further refine data quality for MRSA screening of emergency admissions.

Despite publishing MRSA screening compliance in accordance with the definition of 'high risk' above, the Trust continues to screen all emergency admissions to the Trust as part of a continued policy of universal screening; and almost all elective admissions are screened with some low risk procedures exempt from MRSA screening in line with Department of Health guidance.

Re–screening for longer term in-patients is undertaken one month post admission. Compliance with this has remained at 100% for 10 months of the year with two dips though these remained at 96% for June 2016 and 95% for August 2016. (Figure 12).

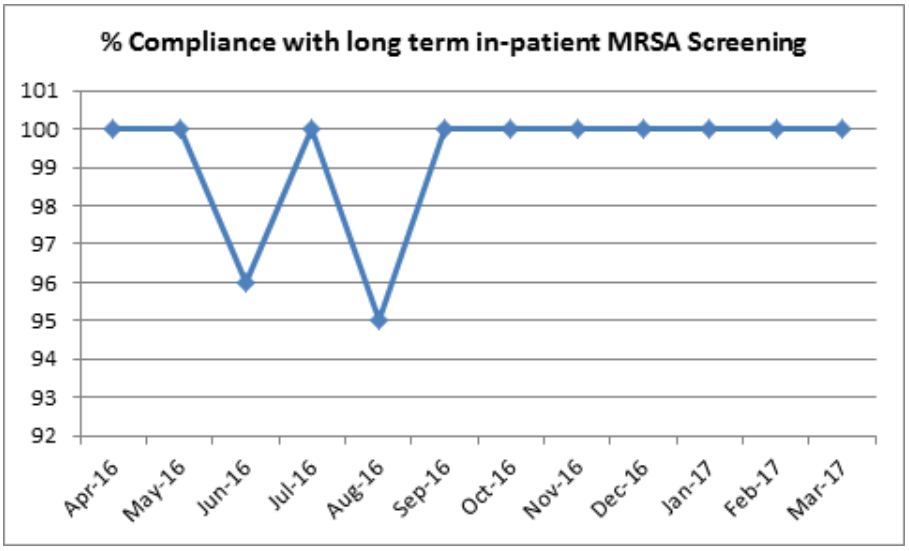

Figure 12: Long term inpatient MRSA re- screening 2016-17

8. Meticillin sensitive *Staphylococcus aureus* (MSSA) bacteraemia

Bloodstream infections due to Meticillin sensitive *Staphylococcus aureus* became subject to mandatory reporting in April 2011. During 2016-17 the trust has recorded 71 MSSA BSI, of which 12 occurred in patients beyond the first post-admission day and were therefore classified as hospital attributable for national reporting purposes.

Figure 13 below shows the 12 Trust attributable MSSA BSI reported during 2016-17 and comparison with the 16 cases reported during 2015-16. Of the 12 cases reported 2016-17, 7 were reported in blood cultures from Worcestershire Royal Hospital and 5 from the Alexandra Hospital.

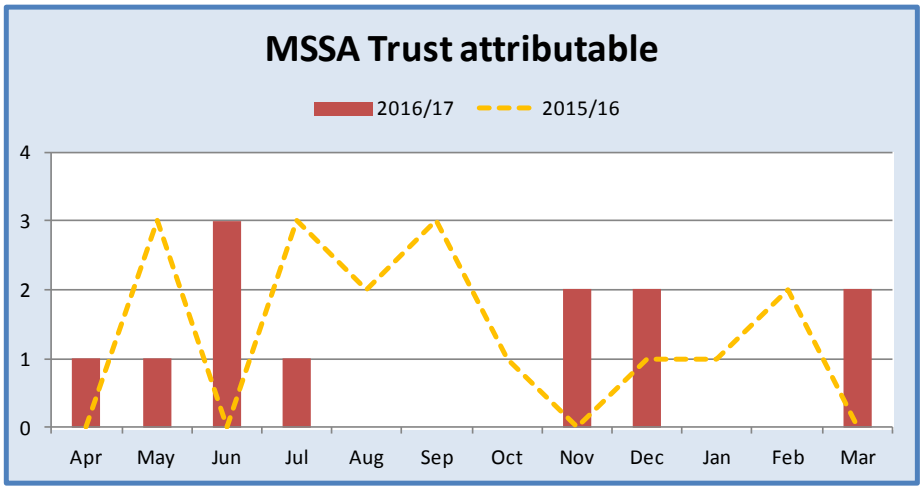

Figure 13: Trust attributable Meticillin sensitive *Staphylococcus aureus* (MSSA) BSI 2016-17.

While each case is reviewed, there were no clear key themes in the cases relating to causative factors. However, it was noted that there was some non-compliance with completion of peripheral vascular device (PVD) monitoring forms and this has been highlighted to IPC link practitioners to observe and encourage improvements in completion in their ward areas. This area of practice is also highlighted as a priority for improvement during 2017-18.

There continues to be no local or national mandatory reporting trajectories for MSSA. It is not anticipated that there will be any national trajectories introduced during 2017/18.

9. *E.coli bacteraemia*

During 2016-17 the Trust recorded 372 *E.coli* bacteraemia of which 67 were classified as trust attributable, having been detected in patients beyond the first post admission day. This compares with 49 trust attributable cases during 2015-16 and 61 during 2014-15. Of the 67 cases, 50 were reported in blood cultures from Worcestershire Royal Hospital, 17 from the Alexandra Hospital and 0 from Kidderminster Treatment Centre. The most significant cause group appears to be urosepsis.

Figure 14 shows trust attributable *E.coli* bacteraemia during 2016-17 with 2015-16 for comparison. *E.coli* bacteraemia has been included in the mandatory reporting process since June 2011. There are no national or local trajectories set for *E.coli* bacteraemia.

However, as part of arrangements for the Clinical Commissioning Group Quality Premium scheme for 2017-18, a target 10% reduction has been set with actions to achieve this set around improved antimicrobial stewardship; a focus on reducing catheter related urinary tract infection (CAUTI), ensuring asepsis for intravascular device insertion and their improved effective management by means of education on the issue and improved management of hydration.

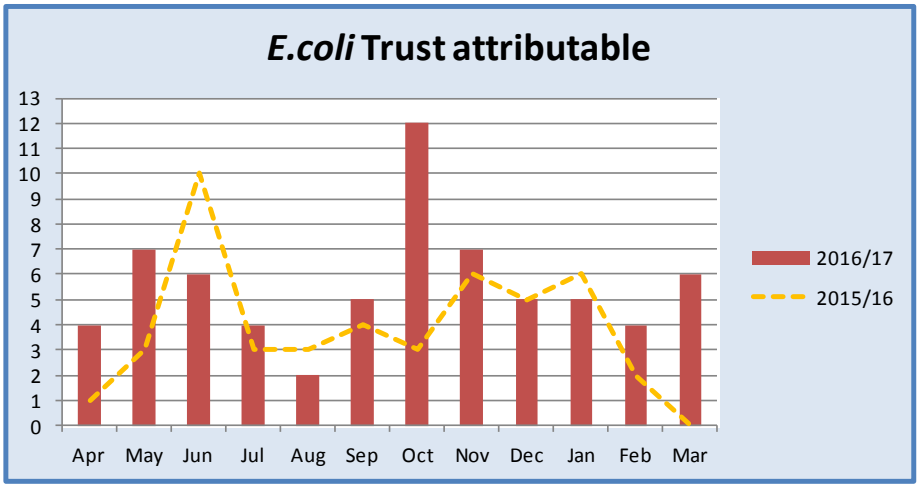

Figure 14: trust attributable *E.coli* bacteraemia 2016-17.

A breakdown by site is as follows for 2016-17 with 2015-16 for comparison (Figure 15)

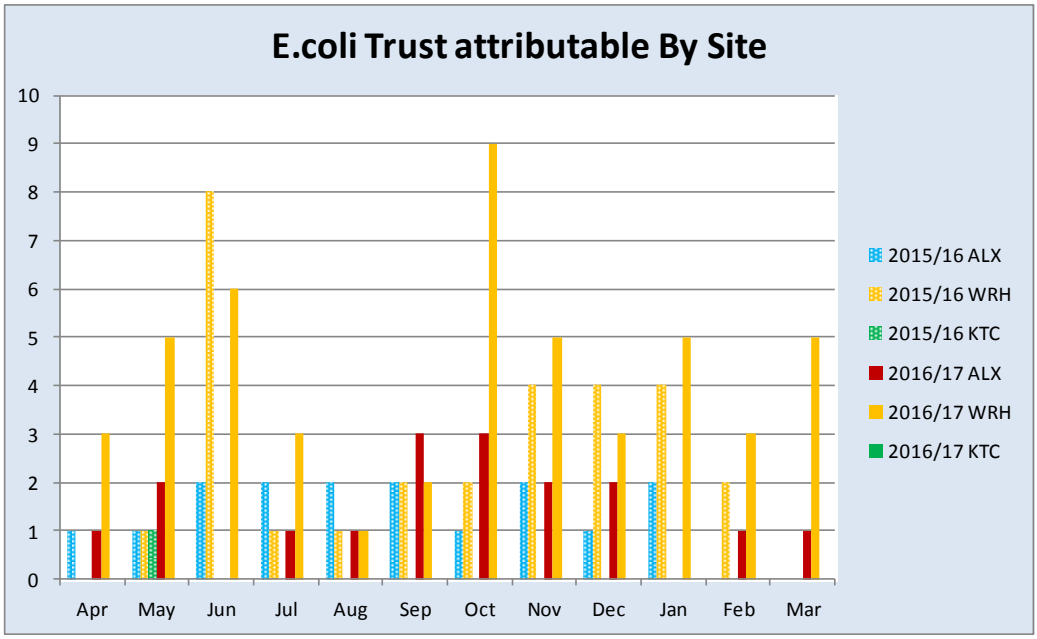

Figure 15: *E.coli* Trust attributable bacteraemia by site at WAHT 2016-17 with 2015-16 comparison

10. Blood culture contamination rates

The blood culture is an important tool used by health care professionals in order to detect the presence of potentially harmful pathogens in the bloodstream. A positive blood culture can suggest a definitive diagnosis which enables targeted therapy against the specific organism identified. A contamination occurs when organisms that are not present in the blood stream are grown in the culture. With all blood culture results a decision is made as to whether the identified infection is clinically significant. Contaminated cultures may occur as a result of sub optimal practice of the healthcare professional taking the culture or may be related to the patient's physiology should it prove difficult to obtain a sample, or if there is a heavy presence of a particular organism on the skin.

The rate of blood culture contamination for adult patients at WAHT is 2.54% against a national average of 3% indicating that the rate for WAHT is within expected parameters. (Figure 16).

	Total number of non-paediatric blood cultures received	Total number contaminated	Percentage contamination rate (non-paediatric patients)	Number of blood cultures received from paediatric patients	Number contaminated	Percentage contamination rate (paediatric patients)
Apr-16	1037	30	2.89%	130	4	3.08%
May-16	1204	21	1.74%	112	0	0.00%
Jun-16	1026	19	1.85%	123	4	3.25%
Jul-16	984	26	2.64%	142	1	0.70%
Aug-16	1024	27	2.64%	120	2	1.67%
Sep-16	1054	23	2.18%	129	3	2.33%
Oct-16	1166	32	2.74%	98	0	0.00%
Nov-16	1119	32	2.86%	116	2	1.72%
Dec-16	1261	36	2.85%	119	0	0.00%
Jan-17	1206	30	2.49%	125	3	2.40%
Feb-17	1028	29	2.82%	126	1	0.79%
Mar-17	1039	30	2.89%	188	3	1.60%
Total	**13148**	**335**	**2.54%**	**1528**	**23**	**1.50%**

Figure 16: Blood culture contamination rates WAHT 2016-17.

11. Antimicrobial Stewardship

Antimicrobial stewardship is a systematic effort to stem the overuse of antimicrobials and retard the development of antimicrobial resistance in micro-organisms.

The departments of microbiology and Infection Prevention and Control continued to implement the recommendations of the “Start Smart then Focus” national campaign for the financial year 2016-17. Existing antimicrobial stewardship activities such as, *C. difficile* post-infection review meetings, daily intensive care unit ward rounds, weekly *C. difficile* ward rounds and selective reporting of antimicrobial susceptibilities were maintained through the year. Antimicrobial stewardship training was provided to senior clinical staff, junior doctors as part of their mandatory training sessions and at an Infection Prevention and Control link nurse study day. A workshop at a Medicines Management Link nurse study day was also held. The secondary care Paediatric Antimicrobial Prescribing Guidelines were reviewed and published in December 2016. The secondary care Adult Antimicrobial Prescribing guidelines were extensively reviewed, updated and expanded and will be launched in the new financial year following approval by the Trust’s Medicines Optimisation Expert forum. Funding for MicroGuide, which enables publication of the prescribing guidelines via smart portable electronic devices (tablets and smart phones) and the Trust intranet in the new financial year, has been secured.

Antimicrobial Usage Trend

Overall antibiotic consumption for the Trust continued to increase to 16 372 DDD/1000 admissions for the financial year. This was increased by 31% compared to consumption in 2015-16 (12 439 DDD/1000 admissions) and by 35% to that of 2014/2015 (12 098 DDD/ 1000 admissions). Details of consumption by selected broad-spectrum antimicrobials detailed are displayed in 17-21 below. Piperacillin with Tazobactam use was decreased markedly due to a manufacturing problem of the injection. This led to an increase in Co-Amoxiclav consumption and, more so, in carbapenem consumption. There was a marked increase in cephalosporin consumption in quarter 1 of 2016-17, likely due to an increase in OPAT use for the management of cellulitis. However this decreased to below previous year’s use for the remainder of the year.

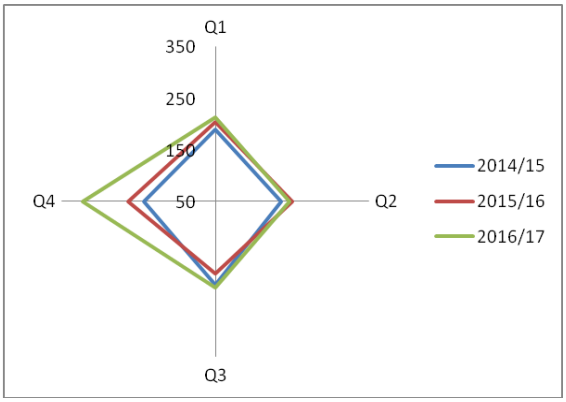

Figure 17 WAHT Carbapenem Usage (DDD/1000 admissions)

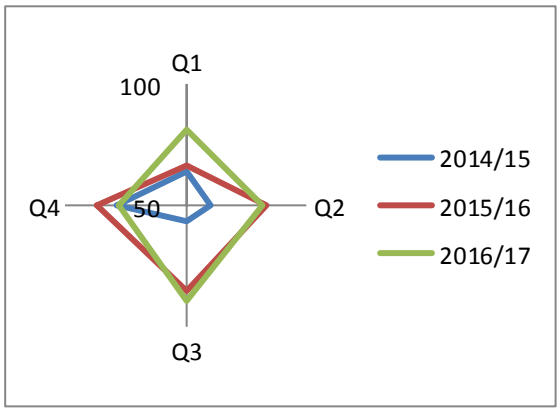

Figure 18 WAHT Cephalosporin Usage (DDD/1000 admissions)

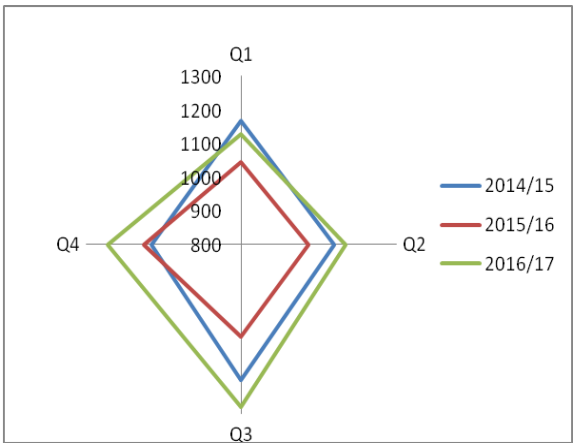

Figure 19 WAHT Co-Amoxiclav Usage (DDD/1000 admissions)

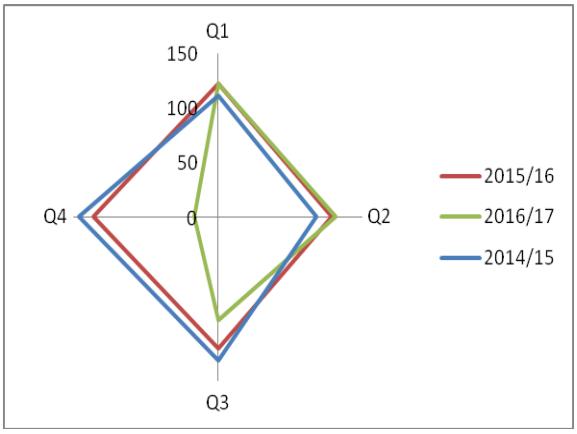

Figure 20 WAHT Piperacillin with Tazobactam Usage (DDD/1000 admissions)

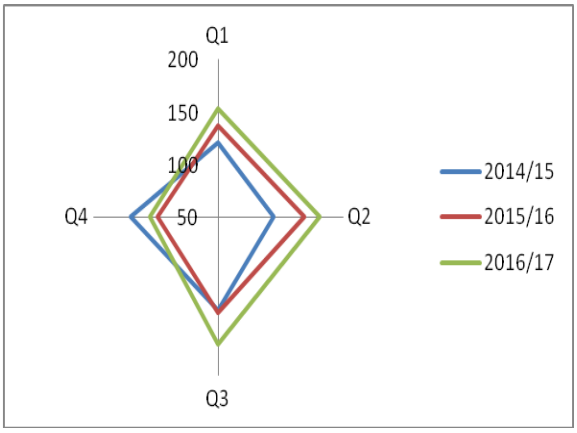

Figure 21 WAHT Quinolone Usage (DDD/1000 admissions)

Ongoing contributing factors for the increase in overall antimicrobials include:

- An increasingly frail, elderly population with multiple co-morbid conditions and high susceptibility to bacterial infection.
- An increasing rate of infection with multi-drug resistant Gram-negative pathogens (an increased laboratory isolation rate of ESBL-producing Enterobacteriaceae has been noted from surveillance).
- Increasing awareness of sepsis, due to high-profile national campaigns and a lower threshold to prescribe broad-spectrum antimicrobials in response.
- Inadequate time, confidence or training of medical practitioners resulting in inadequate initial assessment of a patient to determine the likely focus of infection and hence over-reliance on broad spectrum agents to manage sepsis rather than narrow spectrum “site-specific” therapy.
- Limited antimicrobial prescribing guidance available to practitioners at the point of prescribing.
- Failure to de-escalate to a narrower spectrum agent upon receipt of culture and sensitivity data.

- Continuation of antimicrobial therapy post-operatively as 'extended prophylaxis', in opposition to the trust's guidelines (demonstrated from an audit of surgical patients).
- Lack of a dedicated, full-time antimicrobial pharmacist or whole-time equivalent to support stewardship activity
- Strained resources for medical microbiologists limiting the expansion of Stewardship Rounds for targeted review of carbapenem prescriptions and high risk patients to clinical areas.
- Increasing numbers of oncology patients being cared for in Worcestershire and, hence, increased numbers of patients with febrile neutropenia presenting to hospital. First-line agents for febrile neutropenia are Piperacillin with Tazobactam or if penicillin-allergic or a haematology/oncology patient, meropenem.

Plans for a dedicated, full-time antimicrobial pharmacist were approved during the financial year and the post was filled end of November 2016.

Commissioning for Quality and Innovation (CQUIN) – Antimicrobial Stewardship 2016-17

The Antimicrobial Stewardship CQUIN was introduced for the 2016-17 financial year. For part A of the CQUIN the Trust was required to reduce the consumption of total antimicrobials, piperacillin with tazobactam and carbapenems (i.e. ertapenem and meropenem) by 1% each of the baseline value (consumption in the financial year 2013-14); the indicator weighting was 0.20%. This meant a target 7.5% reduction on current consumption, which was not achieved. Part B of the CQUIN (indicator weighting 0.05%) required evidence showing that up to 90% of prescriptions have been reviewed within 72-hours of initiation of antimicrobial therapy.

Both, antibiotic usage and review data were submitted to PHE ESPAUR programme in a timely manner. Whilst reduction in total antibiotic consumption (Figure 22) and carbapenem consumption (Figure 23) were below CQUIN target, the reduction in total piperacillin with tazobactam consumption achieved CQUIN target (Figure 24).

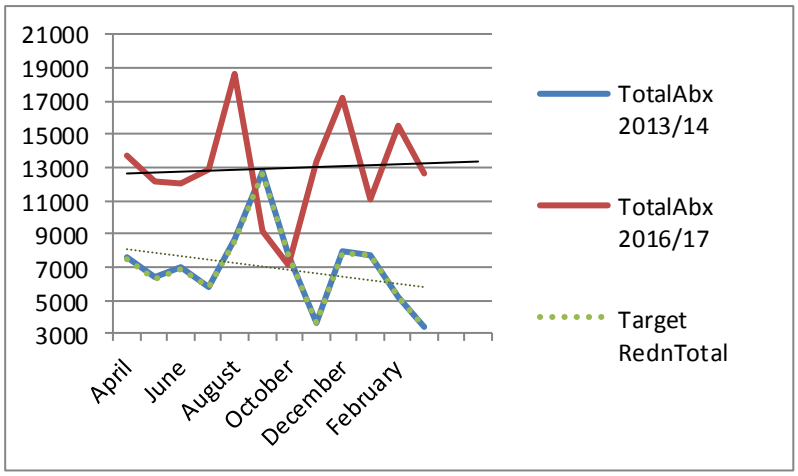

Figure 22 Total antibiotic usage 2016-17 vs 2013/14 (DDD/1000 admissions)

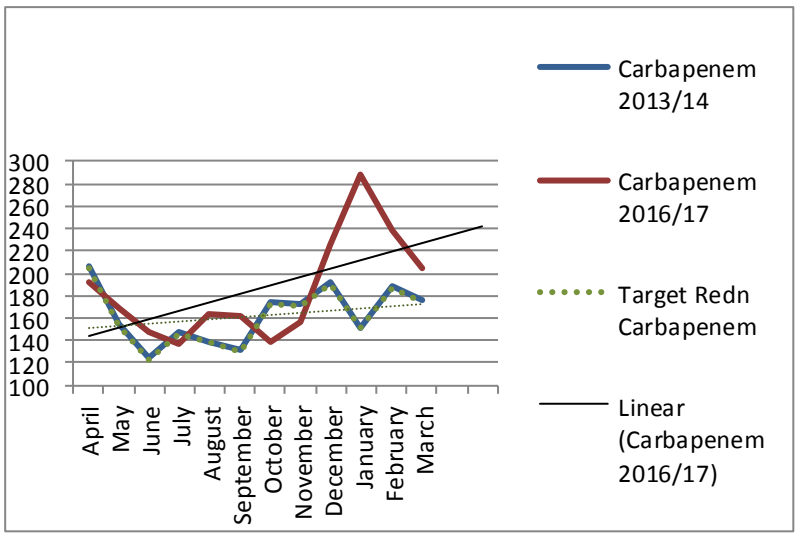

Figure 23 Carbapenem usage 2016-17 vs 2013/14 (DDD/1000 admissions)

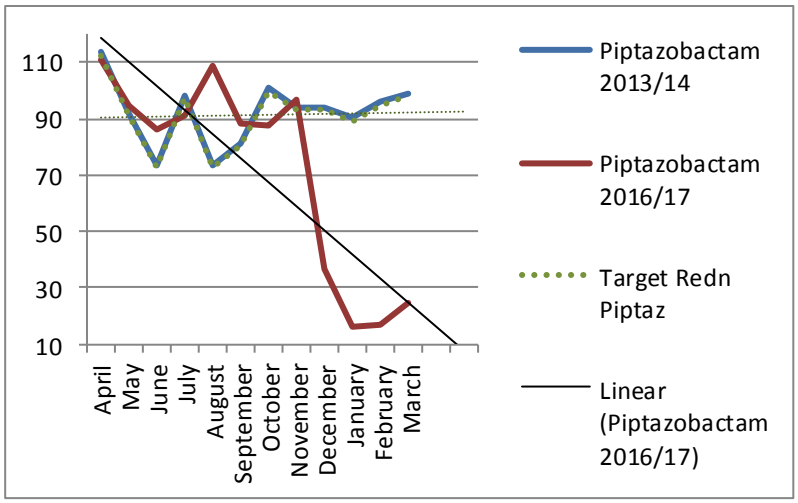

Figure 24 Piperacilin with Tazobactam usage 2016-17vs 2013/14 (DDD/1000 admissions)

Performance for timely antibiotic review achieved CQUIN target for Q1-Q3; the target for Q4 was narrowly missed. Improvements are required in clinical areas when reviewing prescribed antimicrobial treatment, particularly those started empirically. Monthly audits demonstrated that the majority of prescriptions have unspecific plan following review and showed low intravenous to oral switch rates (Figure 25).

Results for audit of antibiotic review (quarters 3 and 4)

Criteria	Q 3	Q 4
Number of prescriptions audited	204	339
Number of prescriptions reviewed within 72 hours	191 (93.6%)	303 (89.4%)
Number of prescriptions not reviewed within72 hours	13 (6.4%)	36 (10.6%)
Number of prescriptions for IV antibiotics at start of therapy	164 (80.4%)	258 (76%)
Number of prescriptions stopped within 72 hours	35 (17.2%)	35 (10%)
Number of prescriptions continued at review	69 (33.8%)	204 (60.2%)
Number of prescriptions where therapy was escalated following review	70 (34.3%)	18 (5%)
Number of prescriptions where therapy was de-escalated following review	10 (4.9%)	11 (3%)
Number of prescriptions where therapy was switched to oral therapy at review	11 (5.4%)	32 (9%)
number of prescriptions where microbiology/ID advice was followed	103 (50.5%)	no data
number of prescriptions that complied with Trust Antibiotic prescribing guidelines	152 (74.5%)	309 (91%)

Figure 25: Results for audit of antibiotic review (quarters 3 and 4)

For financial years 2017-19 the AMS CQUIN and Sepsis CQUIN have been combined in the Reducing the Impact of Serious Infections CQUIN with the aim to timely identify and treat sepsis and reduce clinically inappropriate antibiotic prescription and consumption. The CQUIN will target a reduction in total antibiotic, carbapenem and piperacillin with tazobactam consumption reduced by1 or 2% compared to baseline (antibiotic consumption January to December 2016).

Glossary (Antimicrobial prescribing)

Abx	antibiotics
AMS	Antimicrobial Stewardship
CQUIN	Commissioning for Quality and Innovation
DDD	Defined Daily Dose
OPAT	Outpatient Antimicrobial Therapy
PHE ESPAUR	Public Health England English Surveillance Programme for Antimicrobial Utilisation and Resistance
WAHT	Worcestershire Acute Hospitals NHS Trust

12. Infection Prevention & Control Serious Incidents and outbreaks of infection

Outbreaks of infection, including MRSA bacteraemia or death from *Clostridium difficile* recorded on part 1a on a death certificate, or significant incidents involving other organisms are classified as serious incidents and are reported via the serious incident reporting system STEIS in accordance with the Serious Incident Management Policy and Procedure. Figure 26 below lists the 6 HCAI related serious incidents reported during 2016-17.

Incident date	Site	Summary
08/07/16	Worcestershire Royal Hospital	Outbreak of VRE – two linked bacteraemia
09/07/16	Worcestershire Royal Hospital	Period of increased incidence *C.difficile* Severn Suite
09/09/16	Alexandra Hospital	*C.difficile* death part 1 of death certificate Ward 17
22/12/16	Worcestershire Royal Hospital	MRSA bacteraemia T&O ward
07/02/17	Alexandra Hospital	MRSA bacteraemia Ward 12
19/03/17	Alexandra Hospital	MRSA bacteraemia Ward 11

Figure 26: HCAI serious incidents reported 2016-17

Summary of each of the SIs

Outbreak of VRE – two linked bacteraemia

Two bacteraemia (Blood stream infections) caused by Vancomycin resistant Enterococci (VRE) were identified in patients linked to the same ward (Laurel 3) on 7th and 14th June 2016. The incident let to deep cleaning of the environment using chlorine based agents and hydrogen peroxide fogging. Subsequent environmental testing revealed negative results.

In response to this incident the Trust instigated for 2 months routine patient VRE screening on Laurel 3 and Intensive Care Units as a precaution and to help inform antimicrobial prescribing in patients where the VRE screen was positive. Screening of patients on Laurel 3 then discontinued but environmental screening continues as a means of measuring the risk posed by VRE in this area with any positive sample resulting in additional cleaning. Routine VRE screening in Intensive Care Unit continues.

Period of increased incidence *C.difficile* Severn Suite

A period of increased incidence of *Clostridium difficile* toxin was detected on 9th July 2016, when a second toxin positive case was confirmed on a patient on Severn Suite within a 28 day period following a first case on 7th July 2016. However, typing of the two cases confirmed differing strains and therefore there was no direct evidence of cross infection between the cases. However, the investigation felt that a lapse in care had occurred owing to the percentages scored in cleaning audits around this time and the

areas affected on the ward were treated with chlorine releasing agents and hydrogen peroxide fogging.

C.difficile death part 1 of death certificate Ward 17

A patient was admitted following a fall during August 2016. Following surgery the patient was declared medically fit for discharge. However, deterioration in clinical condition was then observed. Type 7 stools led to a diagnosis of severe *C.difficile* disease. The investigation found that opportunities to recognise the onset of *C.difficile* disease were missed and this delay led to fulminant disease and the death of the patient.

Key learning points in this case included:

The importance of completion of the D&V risk assessment.
Addressing of gaps in medical and nursing knowledge concerning the prescribing and administration of Vancomycin.
The need for audits of antimicrobial prescribing audits for surgical prophylaxis.
Medical education around recognition of *C.difficile* disease leading to pan-colitis.

MRSA bacteraemia T&O ward

A gentleman > 80 years was admitted from a care home with non specific deterioration during December 2016. Sepsis of unknown origin was managed with intravenous antibiotics. Following a septic episode in which urinary tract infection was initially suspected; blood cultures confirmed the presence of MRSA.

The investigation found that the national early warning score (NEWS) chart was not adequately completed leading to the patient not being escalated for timely medical review. The gentleman had no previous history of MRSA and therefore a failure of infection prevention practice may have led to the transmission of the infection which the investigation found is likely to have entered the body via a wound. The case was therefore felt to be avoidable.

MRSA bacteraemia Ward 12

A gentleman > 80 years was admitted to the Alexandra Hospital during January 2017 and was treated for a chest infection. There was no previous history of MRSA. The investigation found that the likely portal of entry was a wound resulting from previous surgery. The investigation found that there had been failures in the management of the wound and an MRSA screen of the wound had not been undertaken. The case was therefore felt to have been avoidable.

The key lesson from this case was around re-enforcement of the protocol for MRSA screening and a further learning point was noted with regard to monitoring of peripheral vascular devices and completion of charts.

MRSA bacteraemia Ward 11

A lady > 80 years was admitted to the Alexandra hospital during March 2017 with adnominal pain and a moisture lesion to her sacrum. The lady had a previous history of MRSA though this admission the initial screen was negative. However, the previous history of MRSA had not been checked on admission. The Infection Control Team informed the ward of the patient's previous history of MRSA and advised commencement of body washes for MRSA. However, a communication failure meant that the washes did not commence. This was the first of two missed opportunities to prevent the bacteraemia in this case. The second occurred when the patient developed suspected hospital acquired pneumonia. Had the previous history of MRSA been acknowledged by the medical team, an intravenous antimicrobial effective against MRSA could have been chosen. The investigation found that the most likely portal of entry for the MRSA was felt to be related to an existing condition of the patient. The case was therefore felt to have been avoidable. In response to the case the Trust is now introducing a policy of 3 post admission screens in the event of a previous history of MRSA in order to negate the risk of a false negative screen on admission.

Note the MRSA bacteraemia in November 2016 recorded as a contaminant was not required to be recorded as a serious incident.

Outbreaks of infection

Outbreaks of infection are not always reported as serious incidents if the response to them is as expected in line with trust policy.

The Trust has a standard response to Norovirus outbreaks which includes daily review by the Infection Prevention & Control Team of affected patients, an increase in the frequency of environmental cleaning using a chlorine releasing product and restriction of staff movement in order to prevent spread. Outbreak meetings are held which receive an overview of the wider community prevalence of Norovirus. This means that where Care Homes are affected, this information is relayed to admitting areas in the Trust to ensure that patients from affected locations in the community can be placed in isolation on admission.

Cases of flu are also managed by via outbreak meetings, in particular if there is evidence of spread within the hospital and cases are managed using personal protective equipment including full face piece (FFP3) masks when an aerosol generating procedure is to be performed. A quick flu guide is used to provide staff with practical information to support managing cases in their ward areas.

Figures 27 and 28 show known or suspected Norovirus and influenza cases during 2016-17. When a positive Norovirus case is identified in a ward area, further testing is not always undertaken as patients who are symptomatic are treated as positive in order to prevent spread to other areas. Any patient suspected of being involved in an outbreak or is a contact of a known or symptomatic case is also monitored and assessed for any clinical symptoms as part of preventing further spread.

MONTH	ALEXANDRA SITE & number wards affected	Norovirus No. patients affected (de-duplicated)	No. Patients Norovirus positive	Influenza No. Patients affected (de-duplicated)	No. Patients + Staff Influenza Positive
April 2016	1 ward	12	0	40	10
May 2016	5 wards	53	9	13	3
June 2016	2 wards	9	0	2	1
July 2016	Nil	9	0	2	1
August 2016	Nil	5	0	1	1
September 2016	1 ward	10	0	0	0
October 2016	1 ward	6	0	0	0
November 2016	2 wards	20	3	1	0
December 2016	8 wards	118	8 + 2 staff	15	9
January 2017	4 wards	22	1 + 2 staff	19	8
February 2017	8 wards	91	19 + 3 staff	34	7 + 1 staff
March 2017	Nil	12	24 + 2 staff	5	1

Figure 27: Norovirus and flu cases and patient affected Alexandra site

MONTH	WORCESTER SITE number wards & affected	Norovirus No. patients affected (de-duplicated)	No. Patients + Staff Norovirus positive	Influenza No. patients affected (de-duplicated)	No. Patients + Staff Influenza Positive (Zero staff positive)
April 2016	7 wards	58	8 + 3 staff	11	27
May 2016	3 wards	14	0 + 8 staff	44	12
June 2016	3 wards	27	0 + 2 staff	19	3
July 2016	Nil	29	0	1	0
August 2016	Nil	14	0 + 1 staff	2	0
September 2016	2 wards	18	0	1	0
October 2016	2 wards	18	0 + 1 staff	2	0
November 2016	6 wards	32	2 + 9 staff	3	1
December 2016	2 wards	52	5 + 7 staff	53	14
January 2017	4 wards	39	3 + 1 staff	65	17
February 2017	10 wards	63	10 + 8 staff	26	8
March 2017	10 wards	63	18 + 2 staff	12	4

Figure 28: Norovirus and flu cases and patient affected Worcestershire Royal site.

13. Tuberculosis (TB) and other Mycobacterial infections.

Worcestershire continues to be a low incidence area for tuberculosis with an incidence below the national average. Most cases of TB are community based but occasionally admission to hospital is required. Cases are managed by the TB lead physicians, predominantly on an outpatient basis, and supported by the county wide TB nursing team who also screen contacts of each case. If admission to hospital is required, cases of suspected or confirmed pulmonary tuberculosis are admitted to isolation rooms, preferably with negative pressure ventilation.

Occasionally patients are admitted to hospital and a diagnosis of pulmonary TB comes to light after a few days into an admission. In this scenario contacts of such a case are identified and offered advice and screening where appropriate. Between April 2016 and March 2017 there have been no such TB exposure incidents at the Trust.

Whilst TB has decreased in the UK other Mycobacterial infections are on the increase both nationally and internationally. Some Mycobacterial infections such as *Mycobacterium avium–intracellulare* are seen in patients with chronic lung conditions, such as bronchiectasis and COPD, and are becoming increasingly common but complex infections to treat. New evidence based management guidelines are expected from the British Thoracic Society in 2017 and the recommendations will be reviewed locally.

Mycobacterium chimaera is a non-tuberculous Mycobacterium which has been linked to heater-cooler systems used in cardiac bypass surgery. There has been an internationally recognised outbreak linked to these by-pass machines which the MHRA and Public Health England have been investigating. Patients who have had these procedures and deemed to have been possibly at risk of this infection have been contacted by the cardiac surgical units in other Trusts where their surgery was undertaken to inform them of their potential exposure. Some patients in Worcestershire have received such letters and those with symptoms that may indicate infection are being investigated appropriately.

14. Staff influenza vaccination campaign

The Trust can report a successful staff influenza campaign for the 2016-17 influenza season with 75.95% of frontline staff being vaccinated. Figure 29 below also details uptake by frontline staff groups. This also meant achievement of the Commissioning for Quality and innovation (CQUIN) target of vaccinating 75% of frontline staff. The successful strategy included flu hubs for a 4 week period in visible locations at the Worcestershire Royal and Alexandra Hospital sites and regular pop up hubs in other Trust locations. There were also planned visits to clinical areas including during the evening and at weekends in order to maximise the update of the vaccine. The target for 2017-18 winter season will be 70% of staff.

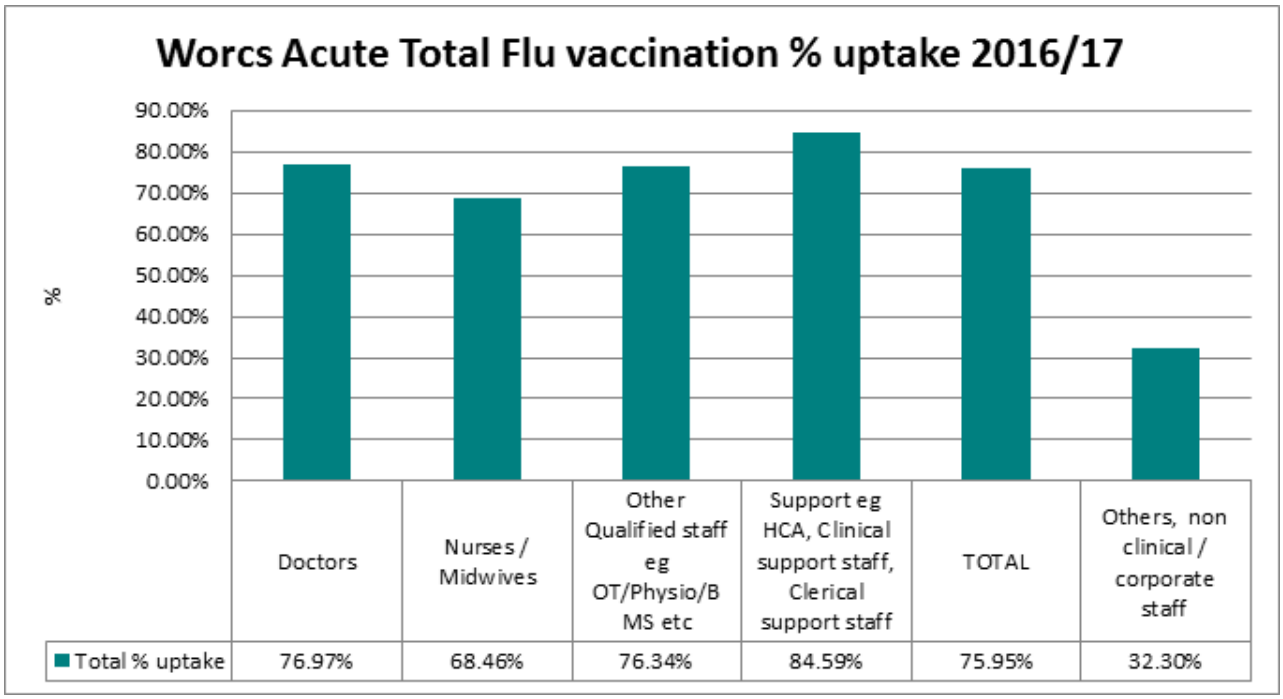

Figure 29: Staff influenza vaccine uptake 2016-17

15. Surgical Site Surveillance

In 2004 it became a mandatory requirement for all trusts undertaking orthopaedic surgery to conduct surveillance of surgical site infections, using the Surgical Site Infection (SSI) Surveillance Service of Public Health England (PHE). The data set collected as part of the surveillance is forwarded to PHE for analysis and reporting. Surveillance is divided into quarters (Jan-Mar, Apr-Jun, July-Sept and Oct-Dec) and each Trust site is required to participate in at least one surveillance period every 12 Months in at least one orthopaedic category. During 2016 the Trust participated in modules for total hip replacement, total knee replacement and fractured neck of femur repair during April to June and July to September.

The data collection is overseen by the IPCT on the Alexandra site with trained surveillance nurses collecting and inputting data on ward 1 at Kidderminster Treatment Centre, T&O ward at Worcester Royal Hospital and wards 16 & 17 at the Alexandra Hospital. During the surveillance period, all patients undergoing total hip replacements, total knee replacement or repair of fracture neck of femur must be included and the appropriate data set gathered, including post discharge surveillance, which extends for 30 days. Infections are defined according to a robust case definition. Any infections that are reported using the SSISS data base are investigated by the Orthopaedic team, surveillance nurses, ward manager and infection prevention and control team to identify any issues / practices for improvement.

Surveillance for wound infection is continued for 30 days in the immediate post-operative phase and is required for up to one year post procedure for joint prosthesis surgery. Cases of surgical site infection identified are considered at review meetings to ascertain if any lessons can be learned for future practice. Figures for SSI as published by Public Health England for total hip repair (THR), total knee replacement (TKR), and repair of fractured neck of femur (NOF), for the three sites where this surgery is performed with comparative England average are shown in Figure 30. Figures are for the last available published data showing July – September 2016 and the previous 4 periods published.

Site	Procedure	July – September 2016	No procedures	Last 4 periods	No procedures	England Average
Worcestershire Royal Hospital	THR	0.0%	21	1.0%	96	1.1%
	NOF	1.0%	103	0.3%	385	1.4%
Alexandra Hospital	THR	0.0%	98	0.5%	379	1.1%
	TKR	0.0%	110	0.7%	418	1.5%
	NOF	0.0%	56	2.3%	217	1.4%
Kidderminster Treatment Centre	THR	0.0%	10	0.0%	66	1.1%
	TKR	0.0%	15	0.0%	71	1.5%

Figure 30: Wound infection rates in hip and knee replacement and fractured neck of femur repair

16. Water governance

The Water Safety Group (WSG) continues to work to raise awareness of water safety issues throughout the Trust and continues to take steps to improve arrangements for water safety and governance:

Monthly WSG meetings are on-going. Prior to each meeting a monthly Water Report to a standard format is circulated to all members of the WSG and other stakeholders, which with the expanded agenda forms the basis of meeting discussions. Standardised reporting across all 3 sites has resulted in improved quality and consistency of reports. Non-microbiology clinical engagement however remains poor with not all clinical areas regularly represented. Better clinical representation is needed to effectively assess and respond to risks to patient safety and translate the work of the WSG to the clinical environment. The WSG has invited the Divisional Directors of Nursing to attend the meeting, or send a deputy, to ensure adequate clinical representation and engagement.

Flushing on all three Trust sites is now firmly established, with improved compliance now seen. This is a huge achievement. In an effort to reduce the associated administration and data storage burden the Estates department initiated a successful trial of a software based solution to record flushing. This will improve the ease with which clinical staff can record flushing in real time. The new system will not only create compliance reports but will also escalate non-compliance through a pre-determined electronic cascade system.

The Trust is currently working to a draft Water Safety Plan (WSP) which satisfies the requirements of HTM 04-01 addendum. The plan covers all existing buildings currently owned or occupied by Trust and new builds / refurbishments. It provides clear recommendations for the management and maintenance of existing water systems and associated equipment in addition to recommendations for the design, build, commissioning and hand over of new projects. Additional resources and clinical input are needed to move this WSP into a final format.

The new water testing protocol, agreed jointly by the Authorising Engineer, Trust Microbiologist and Principal Engineer have been in place for nearly a year. This is working well and the enhanced testing has identified hitherto unknown potential problem areas and has enabled corrective work to be undertaken to ensure continued water quality.

Over the reporting period the Estates department experienced on-going problems with two external water hygiene contractors at the Kidderminster and Redditch sites. To overcome this Estates are developing a business case for employing staff to deliver the work in house. The team believe this will improve the quality and timeliness of work and will also deliver financial savings. In Parallel to this, the 'Water hygiene' contract has been put out to a competitive tender. The work is currently being delivered by two agency staff who are performing very well.

An annual review of the Trust Legionella and Pseudomonas risk assessments has taken place, good progress has been made on resolving remedial actions and additional work is being planned with this year's capital budget. Progress against risk assessment actions will be added to WSG monthly reports.

17. Ventilation governance

A Ventilation Validation Group has been established to oversee the clinical governance around critical ventilation systems. The aim of the group is to ensure that these systems are inspected, tested, maintained and operated safely across all 3 sites, but also to ensure that the clinical staff are aware of any risks these systems may pose to clinical activity.

To improve the governance, a Trust Ventilation Policy has been written and an Authorising Engineer – Ventilation (AE) has been appointed The AE has audited the site ventilation systems in June and will produce a compliance report in due course. Two authorised persons (APs) have been trained and have been appointed by the AE. Engie, the PFI hard services provider have their own AE and APs. The duty of the APs is to ensure safe day to day operation of Trust's critical ventilation systems and to appoint and supervise suitable competent persons (CPs) to maintain and test the ventilation systems.

The Estates department reviewed all the Trust critical ventilation systems verification reports and a number of longstanding compliance issues were identified. These issues have now been addressed as far as is practicable and where issues would take time to address e.g. Air changes in sterile pack room and AHR theatre recovery, they were discussed with the department and infection control and suitable controls were identified to maintain patient safety.

In order to maintain patient and staff safety a new 'permit to work' and 'hand back' documents have been developed to ensure that staff who work with critical ventilation systems are clearly informed of the work that has taken place and are assured that the systems are safe to operate.

A ventilation issue that remains outstanding relates to the treatment rooms across all three WAHT sites. HTM 03-01 Appendix 2 (Recommended air-change rates), requires that treatment rooms have 10 air changes an hour supplied by mechanical ventilation through an S7 filter. This is required, in order to achieve sufficient dilution of the airborne contamination and reduce infection risk. The Estates team, with infection control, carried out a survey of all the rooms in the hospitals where invasive procedures were being undertaken. During 2017-18 further work will be undertaken to provide assurance that the air changes per hour (ACH) are compatible with the procedures being undertaken and if necessary to re-locate any procedures to locations with higher ACH.

18. Education and training

The IPCT continue to support a variety of educational opportunities across the Trust sites ranging from formal teaching sessions to ward based group and individual training. Sessions include Trust Induction, Mandatory Core Skills update programme for clinical and non-clinical staff. Following a change to the clinical skills core programme we are exploring alternative methods of delivery of some content such as antimicrobial stewardship. The IPCT also provide nursing, medical student and doctors induction formal sessions incorporating maintaining asepsis, peripheral cannulation, central vascular device management, blood culture sampling and phlebotomy.

In addition core skills and competency check sessions are run for FFP3 mask fit testing, commode cleaning and hand hygiene. We have been fortunate to work with our new media developer in communications department and Tissue Viability colleagues to produce two training videos on hand hygiene and aseptic technique.

The team have also responded to requests to provide wrap around support for specific wards or individual staff development.

Link Practitioner Study Days

Our link practitioner programme continues to thrive. During 2016-17 we held 9IPC study days including the Annual Link Practitioner Study Day when 132 staff attended. This was the first year we had used an external venue for our annual study day. Being off site posed several IT challenges and the venue was disappointing but we will continue to explore this option in the future. Figure 31 below shows the date, sites; number of attendees and topics discussed:

Date	Site	Number attended	Topics covered
02/04/16	Annual Worcester Rugby Club	132	An overview of the previous year UV light technologies Influenza infection and management VRE infection on ITU case study *C difficile* and Faecal transplant Health Economy IPC strategy for 2016-17 including *C difficile* summary

Date	Site	Number attended	Topics covered continued
23/06/16	Alex	36	Site wide static mattress audit, Hand hygiene principles and competency training refresher, Clinisafe® cardboard waste system roll out, IPCN and Link Practitioner Meeting
24/06/16	WRH	39	
21/09/16	WRH	32	Hand hygiene peer audit and PVD pack stock check, CPE infection and management, CQC visit preparation, CQUIN – what are they and why do they matter? Winter preparedness including Norovirus and Influenza IPCN and Link Practitioner meeting
22/09/16	Alex	35	
21/11/16	WRH	38	Audit of IPC admission assessment documentation, IPCN and Link Practitioner meeting, IV therapy update, NEWS scoring recognising the sick patient/sepsis, Urinary catheter drainage bag change of suppliers
28/11/16	Alex	29	
17/02/17	WRH	22	Hand hygiene peer audits using SNAP; hand hygiene 'train the trainer' session, MRSA decolonisation, IPC risks related to cadaver preparation, new end of life documentation and last offices, IPCN and Link Practitioner meeting including CQC Section 29a letter, Procurement Savings and change of IPC related products Urinary catheter audit
20/03/17	Alex	15	

Figure 31: Link staff study days 2016-17

Attendance at IPC Mandatory Training

Figure 32 below demonstrates the number of staff who attended infection prevention training either through an induction or mandatory core skills update session between April 2016 and March 2017. Attendance overall is at 89% with clinical staff achieving 91% attendance in the period and non-clinical staff achieving 83%; against a Trust target of 90%. Training sessions have been reviewed following the cessation of the senior risk update programme and introduction of a more flexible training pathway for all subjects.

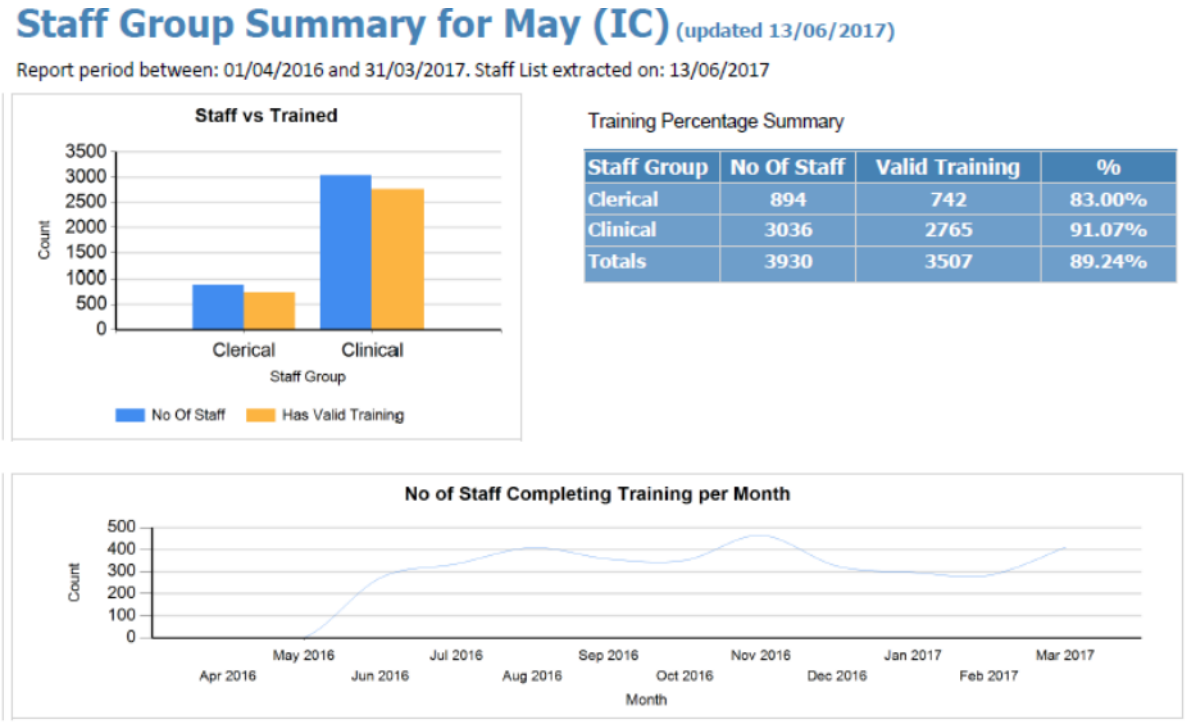

Figure 32: Attendance of IPC induction or mandatory training in year

Mandatory training includes hand hygiene theory. Practical assessment is undertaken at ward level by members of the Infection Prevention & Control Team or other staff members trained to undertake hand hygiene competency assessment. Clinical staff need to refresh their competency every two years and non-clinical staff every three years. Other information available for staff includes an induction information booklet, staff leaflet summarising standard infection prevention precautions and a ward based hard copy resource folder holding all IPC related documentation and information posters. The IPC team are currently exploring other methods of delivery of training including use of smart phone apps, video vignettes and online e-Learning.

Further Training

In addition to the above the team also provide reactive training following practice audits and bespoke training for departments where it is difficult for staff to attend regular core skills updates and the training needs to be more reflective of their role within the Trust e.g. housekeeping and portering staff.

A workshop is held for all FY1 and FY2 medical staff joining the Trust in August each year. This is to ensure they are aware of and skilled in the use of equipment provided to facilitate effective IPC practices. The workshop includes an element of theory and work station based practical skills on blood culture collection technique, safety medical devices, faecal management system insertion and management, use of peripheral vascular device insertion packs and needle free connectors, intravenous dressing application and safe removal, skin disinfection and standard IPC practices including use of Personal Protective Equipment (PPE) and hand hygiene competency assessment.

19. Infection Control audits and key findings

In 2015-16 IPC Nurses were allocated to divisions with a view to undertaking practice audits in these areas and developing a deeper relationship and knowledge of their allocated wards and departments. There are a total of 148 areas that require auditing, which includes 23 corporate areas; this is obviously a labour intensive process. Undertaking an audit requires preparation to check for previous issues that need revisiting, attendance to undertake the audit (can be 2 to 3 hours), immediate feedback and rectification actions, preparation and distribution of the report, any follow up or support activity required in subsequent weeks and a re-audit if score below 84%.

Following our CQC inspection in November 2016 the requirement to focus on hand hygiene and use of PPE disrupted the divisional audit programme, requiring the team to take a fresh approach. It was agreed all IPC Nurses would focus on auditing a specific division during a particular month and during the following month the audit programme is latent to allow for follow up of any areas with an audit score less than 84% (Fail). The audit scoring mechanism is in line with the PLACE cleaning audit scores where a Fail is <84%, a qualified pass is 85 – 94% and a pass is 95% and above.

We have also seen the development of new electronic audit tools via the SNAP audit system in an attempt to automate the audit process for hand hygiene and IPC clinical practice.

Audit Schedule amendments

Type of audit	2016-17 plan	2017/18 plan
Wards and inpatient areas	4 monthly	Every 6 months
Priority departments e.g. theatres	3 – 6 monthly	Every 6 months
Departments e.g. outpatients	6 monthly	Every 6 months
Annual duty of care audits – waste, laundry and catering	Annual	Annual

Key for Audit Scores		
	Fail	<84%
	Qualified Pass	85 – 94%
	Pass	95% and above

Division	Audit Activity	Outcome	Key themes from failed areas
Specialised Clinical Services (SCSD)	A total of 31 audits across 24 of the 44 areas were audited	Score ranged between 54% and 100% A total of 8 areas failed the audit (3 at the Alexandra, 4 at WRH and 1 at KTC)	• Condition and appearance including sticky tape residue, ceiling tiles soiled /need replacing and damaged work surface edges • High and low dust evident • Storage of items on floor/ inappropriate areas (insufficient) • Cleaning of observation machines or white boards (access to wipes) • Clean utility room cleanliness and clutter

Medicine	A total of 91 audits across 39 of the 40 areas were audited	Score ranged between 47% and 100% A total of 20 areas failed the audit (6 at Alexandra, 14 at WRH and nil at KTC)	• Condition and appearance of environment, fixtures and fittings including sticky tape residue, ceiling tiles soiled /need replacing and damaged work surface edges • High and low dust evident • Storage of items on floor/ inappropriate areas (insufficient) • Cleaning of observation machines or white boards (access to wipes) • Clean utility room cleanliness and clutter • Computers/ office equipment dusty • Sharps containers temporary closure use and storage • Personal Protective Equipment (PPE) use and disposal inappropriate • Beverage trolley cleanliness and lime scale plus sink taps
Surgery	A total of 57 audits across 22 of the 23 areas were audited	Score ranged between 61% and 100% A total of 13 areas failed the audit (5 at the Alexandra, 8 at WRH and nil at KTC)	• Condition and appearance of environment, fixtures and fittings including sticky tape residue, ceiling tiles soiled /need replacing and damaged work surface edges • High and low dust evident • Storage of items on floor/ inappropriate areas (insufficient) • Cleaning of observation machines or white boards (access to wipes) • Computers/ office equipment dusty • Sharps containers temporary closure use and storage • Personal Protective Equipment (PPE) use and disposal inappropriate • Beverage trolley cleanliness and lime scale plus sink taps

Women and Children's	A total of 34 audits across 17 of the 18 areas were audited	Score ranged between 56% and 100% A total of 10 areas failed the audits (4 at the Alexandra, 6 at WRH and nil at KTC)	• High and low dust evident • Storage of items on floor/ inappropriate areas (insufficient) • Cleaning of observation machines or white boards (access to wipes) • Dressing trollies are dusty • Inappropriate items stored in sluice • Gel dispensers requiring drip trays

It is clear from this summary the trust has not been able to resolve all the issues regarding condition and appearance of the environment in areas where the estate is aged and requires financial investment. Plans are in place at the Alexandra site to upgrade patient bathrooms and sluice areas. Storage remains a key issue which could be partially resolved by the implementation of equipment stores on each site, though this would require a business case. The issues regarding high and low level dust are concerning and reflect the issues raised with our PFI colleagues and trust cleaning teams. Capacity at the WRH site has also challenged access to areas, especially for high dusting, as this cannot be done if the patient bed is occupied; therefore closer working between service providers and trust staff is required to ensure co-operative working and facilitation of cleaning.

Results of audits are fed back to the ward manager or department head, matron and relevant cleaning teams for their actions. Failures are also followed up by the Infection Prevention & Control Team.

Other practice audits undertaken in 2016-17

Audit	Findings	Lessons Learnt/ Action Required
Urinary catheter point prevalence audit all inpatient areas	19 – 21% patients are catheterised post admission (previous audit 2014-15 was the same)	CAUTI (Catheter Associated Urinary Tract Infection) rates are difficult to calculate as this requires pre insertion and post removal microbiological sampling (no longer best practice). Instead the national Safety Thermometer tool is used that bases the diagnosis of CAUTI on any patient who is catheterised who is actively being treated with antibiotics for urinary tract infection (UTI). Evidence suggests that CAUTI rates can be reduced by minimising the use of urinary catheters and good hydration. The focus in the Trust has therefore been on reducing use of catheters post admission, introduction of a care bundle insertion pack to promote best practice at insertion, use of pre-connected urinary catheters to negate the risk of contamination of the system at insertion and removal of urinary catheters at the earliest opportunity with effective documentation and management. A health economy urinary catheter passport is due to be launched in July 2017. Both a Trust working group and a health economy urinary catheter group are in place.
IPC Admission Assessment Documentation Audit (CPE Assessment Question)	Of the areas audited documentation was present in; 81% of cases in Medicine; 88% of cases in Surgery; 100% cases in Women and Childrens (one area). The CPE assessment question was completed in; 58% of cases in Medicine; 75% of cases in Surgery 100% of cases in Women and Childrens	Whilst there is scope for improvement, this is a marked improvement on previous audits. The assessment tool has been re-launched via IPC Link Practitioners in November 2016 following the audit. A repeat audit of compliance will be undertaken at the September 2017 link study day.

The purpose of the Department of Health Saving Lives High Impact Intervention (HII) Audits is to support practitioners in preventing device related infections through monitoring clinical practices and identifying any deviance from best practice. If audit scores deteriorate this prompts the ward manager to identify which elements of practice have deteriorated and take remedial action to improve practices. Audits relevant to the area of practice are undertaken by wards on a monthly basis. Scores and a rolling 12 month history of scores are sent to ward managers and matrons on a monthly basis so they can identify trends in performance and address any practice deficits raised.

Wards and departments undertake weekly hand hygiene audits using the National Patient Safety Agency (NPSA) 20 minute observation tool to observe compliance with the World Health Organisation (WHO) Five Moments of Hand Hygiene.

The facilities monitoring team, ward manager and matrons undertake monthly cleaning monit visits that use the 50 elements of the DH PAS 5748 2011 Specification for the Planning, Application and Measurement of Cleanliness Services in Hospitals. The Alexandra and Kidderminster sites use the Credits 4 Cleaning (C4C) system and ISS Housekeeping at the Worcestershire Royal site use Service Trac®; an equivalent system. Facilities monitoring team also undertake additional peer audits checking on cleanliness, waste and catering feeding back to ward managers and matrons.

20. Policy reviews

Infection Prevention Policies reviewed during the year 2016-17

WAHT-CG-494 – Cleaning Policy

WAHT-INF-026 – Cleaning, Decontamination & Validation of Endoscopes

WAHT-INF-033 Infection Prevention and Control Protocol for Seasonal Influenza

WAHT-INF-033 Influenza Quick Guide

Policy for the Management of Linen and Laundry Services

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Acknowledgements:

Dr H Morton, Consultant Microbiologist and Astrid Gerard, Antimicrobial Pharmacist: Antimicrobial Stewardship.
Dr T Gee, Consultant Microbiologist: Tuberculosis.
Dr M Ashcroft, Consultant Microbiologist and Simon Noon, Principal Engineer: Water governance.
Simon Noon, Principal Engineer: Ventilation Safety.
Heather Gentry, Lead Nurse Infection Prevention & Control: Audit and training summaries, policy reviews.
Vicki Shayler, Data Analyst: HCAI data and graphs.

23: Annual Plan 2017-18 (To be monitored at Infection Prevention & Control Committee)

Key work streams 2017-18	Lead Officers
Demonstrate continuous improvement in and hygiene compliance and use of personal protective equipment	
Ensuring all staff are compliant to 5 moments of hand hygiene and using PPE as per Trust policy with desired outcome of 90% compliance in hand hygiene audits trust wide: • Continue with high profile for hand hygiene and undertake monthly hand hygiene audits • Continue with high profile for use of PPE and undertake spot checks	**Lead Nurse Infection Control**
Antimicrobial stewardship	
Achieving compliance and providing assurance around antimicrobial prescribing with desired outcome of reducing overall consumption at the Trust including reduced use of carbapenems: • Revision, ratification and launch of antimicrobial prescribing guidelines and launch of smart phone App for prescribers by September 2017. • Achievement of 2017-18 antimicrobial prescribing CQUIN including reduction in overall antimicrobial prescribing. • Reduction in consumption of Co-amoxiclav.	**Director of Pharmacy** **Consultant Microbiologist** **Antimicrobial Pharmacist**
Improvements in surveillance of urinary catheter associated urinary tract infection (CAUTI) and reduction in cases during 2017-18	
Improving surveillance of urinary catheter use and reducing unnecessary usage with desired outcome of reducing catheter associated urinary tract infection by 10%. • Review and refine definition for CAUTI and data collection • Undertake baseline audit of urinary catheter usage and CAUTI and repeat in year to achieve a 10% reduction in each category.	**Associate Chief Nurse Infection Control** **Lead Nurse Infection Control**

Water Safety – further strengthening governance	
Achieving improved assurance of water quality and safety for the Trust with desired outcomes to: • Complete and ratify revised Trust water safety plan • Improve the outlet flushing regime to provide assurance of compliance to water safety plan	**Principal Engineer Water Safety** **Consultant Microbiologist**
Ventilation - further strengthening governance	
Achieving improved assurance of ventilation in accordance with HTM 04-01 with desired outcome to: • Complete process of assessing ventilation in rooms and risk assessment of procedures undertaken; and provide assurance thereof of compliance to HTM 04-01	**Principal Engineer Water Safety** **Consultant Microbiologist**
Gram negative organisms – improving management	
Achieving improved assurance on management of Gram negative organisms including for *E.coli* bacteraemia, with desired outcome of 10% reduction in *E.coli* bacteraemia; and improved assurance on management of infection or colonisation with Carbapenemase Producing *Enterobacteriaceae* (CPE) • Introduction of case reviews for *E.coli* bacteraemia as part of Public Health England extended surveillance and to achieve a Care Commissioning Group target of a 10% reduction in 2017-18 • Introduction of extended surveillance for *Pseudomonas* and *Klebsiella* bacteraemia • Re launch of CPE screening guidance and patient management of cases at the Trust	**Consultant Microbiologist** **Lead Nurse Infection Control**
Strengthening governance around cleanliness	
Enhancing the governance around cleanliness in order to identify and rectify any environmental cleanliness failures at the earliest opportunity. • A new cleanliness escalation pathway to ensure all staff know who is responsible for cleaning and how to contact them in order to report and rectify any deficiencies. • Increasing the frequency of cleanliness 'walkabouts' with senior nurses and members of the Infection Control Nurse Team and to rectify any deficiencies identified.	**Associate Chief Nurse Infection Control** **Head of Facilities**

Surgical Site Infection – improving surveillance and learning lessons	
Revitalising the approach to monitoring surgical site infection with the desired outcome to ensure SSI rates comparable or below national averages when benchmarked against other Trusts. • Revitalising the surgical site infection data collection and review process • Strengthening the review of identified infection by increasing clinician engagement • Implementing lessons from SSI investigation.	**Associate Chief Nurse Infection Control** **Lead Nurse Infection Control** **Divisional Director of Nursing for Surgery**
Recovery Plan for *C.difficile*	
Achieving within trajectory position for 2017-18 of no more than 32 cases: • *C.difficile* action plan following analysis of cases 2016-17 including introduction of rapid review of cases within 3 days of confirmation and monitoring both cases and rate of 30 day all cause mortality against trajectory at Trust Infection Prevention & Control Committee	**Associate Chief Nurse Infection Control** **Lead Nurse Infection Control** **Consultant Microbiologist**
Recovery plan for MRSA bacteraemia	
Achieving zero tolerance of MRSA bacteraemia • Completion and implementation of action plans from MRSA bacteraemia investigations 2016-17 including a focus on improving wound management and care of peripheral vascular devices	**Associate Chief Nurse Infection Control** **Lead Nurse Infection Control** **Consultant Microbiologist**

24: Trust Infection Prevention & Control Committee 2017-18

Dates of the Trust Infection Prevention & Control Committee 2017-18:

Date	Time	Location
Monday 8th May	13-00 – 15.00	Seminar Room A, Charles Hastings Education Centre
Thursday 6th July	11.00 – 13.00	Pathology Seminar Room, Worcestershire Royal Hospital
Friday 18th August	14.00 – 16.00	Pathology Seminar Room, Worcestershire Royal Hospital
Thursday 7th September	11.00 - 13.00	Northwick/Claines Meeting Room, Kings Court, Worcestershire Royal Hospital
Friday 13th October	14.30 – 16.30	Pathology Seminar Room, Worcestershire Royal Hospital
Thursday 9th November	12.00 – 13.30	Pathology Seminar Room, Worcestershire Royal Hospital
Wednesday 20th December	09.30 – 11.30	Video conference between Sky 2, Worcestershire Royal Hospital and GMMR, Alexandra Hospital
Wednesday 17th January	09.00 – 11.00	Video conference between Sky 2, Worcestershire Royal Hospital and GMMR, Alexandra Hospital
Wednesday 14th February	09.00 – 11.00	Northwick/Claines Meeting Room, Kings Court, Worcestershire Royal Hospital
Wednesday 14th March	09.00 – 11.00	Video conference between Sky 2, Worcestershire Royal Hospital and GMMR, Alexandra Hospital

NHS
Worcestershire
Acute Hospitals
NHS Trust

Date of meeting	14 September 2017
Paper number	Enclosure I2

Report provided:							
For approval:	√	For assurance:		To note:		For information:	

Safeguarding Adults & Children Annual Report April 2016 – March 2017

Accountable Director	Vicky Morris Chief Nursing Officer
Presented by	Vicky Morris Chief Nursing Officer
Author	Christina Rogers Head of Safeguarding

Alignment to the Trust's strategic priorities (√)	Deliver safe, high quality, compassionate patient care	√	Design healthcare around the needs of our patients, with our partners	√
	Invest and realise the full potential of our staff to provide compassionate and personalised care	√	Ensure the Trust is financially viable and makes the best use of resources for our patients	
	Develop and sustain our business			

Alignment to the Single Oversight Framework (√)	Leadership and Improvement Capability		Operational Performance	
	Quality of Care	√	Finance and use of resources	
	Strategic Change		Stakeholders	√

Report previously reviewed by		
Committee/Group	Date	Outcome
Clinical Governance Group	July 2017	Approved
Quality Governance Committee	July 2017	Amendments requested
Quality Governance Committee	August 2017	Approved

Assurance: Does this report provide assurance in respect of the Board Assurance Framework strategic risks?	N	BAF number(s)	
Level of assurance and trend not assessed			

NHS
Worcestershire
Acute Hospitals
NHS Trust

Date of meeting	14 September 2017
Paper number	Enclosure I2

Purpose of report	This report provides the annual update to the Trust Board on service developments in relation to safeguarding adults and children. This report provides assurance to the Board that WAHT is fulfilling its statutory responsibilities in relation to safeguarding adults and children who access services from the Trust.
Summary of key issues	There are a number of local influences in addition to the national context which continue to drive focus and demand for The Safeguarding Agenda within WAHT. These encompass: • Growth in demand (with an increasing aged population/ greater awareness/ higher levels of scrutiny) • Continued emphasis upon 'voice of the child-young person' and 'making safeguarding personal' • An extension of the categories of abuse for Safeguarding Adults to now include self-neglect and modern slavery • Continued drive and focus on radicalisation and the PREVENT agenda • Increase in / number of Serious Case Reviews / children (SCR), Serious Adult Reviews (SAR) and Domestic Homicide Reviews (DHR) • Increase in the number of safeguarding referrals for children and adults –received between November 2016 and February 2017, 12% were from Health • Increase in 'Position of Trust' referrals – 35 informal enquiries and 7 formal enquiries for 2016-17 • Increase in children subject to Statutory Social Care Involvement compared to previous year: ▪ 2016-17: Child Protection Plans (CPP 486), Child in Need Plans (CIN 734) and Looked After Children (LAC 746). ▪ 2015-16: Child Protection Plans (CPP 400) and Looked After Children (LAC 686). CIN data only available from 2016 onwards (new metric). *Please note that appendices are available on request*
Recommendation	The Board is asked to approve the Safeguarding annual report 2016-17 and the forward plan for 2017/18.

Glossary:

CQC – Care Quality Commission
CCG –Clinical Commissioning Group
DOLS –Deprivation of Liberty Safeguards
MASH –Multi Agency Safeguarding Hub
WAHT – Worcester Acute Hospitals NHS Trust
WSAB –Worcestershire Safeguarding Adult Board
WSCB –Worcestershire Safeguarding Children Board
SAR – Serious Adult Review
SCR- Serious Case Review
DHR – Domestic Homicide Review
LAC – Looked after Child
CIN – Child in Need
CPP – Child Protection Plan
NHSE – NHS England
WCC – Worcestershire County Council

NHS
Worcestershire
Acute Hospitals
NHS Trust

Date of meeting	14 September 2017
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WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

ANNUAL SAFEGUARDING REPORT 2016/17
FORWARD WORK PLAN FOR 2017/18

1 Introduction

This report provides the annual update to the Trust Board on service developments in relation to safeguarding adults and children.

This report provides assurance to the Board that WAHT is fulfilling its statutory responsibilities in relation to safeguarding adults and children who access services from the Trust.

Safeguarding activity across WAHT continues to intensify in volume and complexity which is reflected both nationally and regionally, the Trust is committed to ensuring the provision of an integrated and highly robust safeguarding service for all ages.

Key findings from CQC Inspection 22nd to 25th November 2016 and 7th, 8th and 15th December 2016, publication date 20.06.2017 identified areas of improvements were required by the trust for:

- Safeguarding training in the areas of children and young people, Mental Capacity and Deprivation of Liberty, female genital mutilation (FGM), child sexual exploitation. (CSE)
- Accessibility by staff of safeguarding checks for children and young people at risk
- Mapping of Safeguarding training needs analysis trust wide, and divisions to provide training improvement trajectory and ensure an improvement of mandatory training figures to 90%. Focus within trajectory of those high risk, priority areas children's, obstetrics, emergency department

1.1 Summary - Key Issues and improvements

There are a number of local influences in addition to the national context which continue to drive focus and demand for the Safeguarding Agenda within WAHT. These encompass:

- Growth in demand (with an increasing aged population/ greater awareness/ higher levels of scrutiny)
- Continued emphasis upon 'voice of the child-young person' and 'making safeguarding personal'
- An extension of the categories of abuse for Safeguarding Adults to now include self-neglect and modern slavery
- Continued drive and focus on radicalisation and the PREVENT agenda
- Increase in / number of Serious Case Reviews / children (SCR), Serious Adult Reviews (SAR) and Domestic Homicide Reviews (DHR)
- Increase in the number of safeguarding referrals for children and adults – received between November 2016 and February 2017, 12% were from Health
- Increase in 'Position of Trust' referrals – 35 informal enquiries and 7 formal enquiries for 2016-17

- Increase in children subject to Statutory Social Care Involvement compared to previous year:
  - 2016-17: Child Protection Plans (CPP 486), Child in Need Plans (CIN 734) and Looked After Children (LAC 746).
  - 2015-16: Child Protection Plans (CPP 400) and Looked After Children (LAC 686). CIN data only available from 2016 onwards (new metric).

Key Improvements

- Restructure and development of The Safeguarding Team with an amalgamation of the Adult and Children Safeguarding Committee
- Robust review to enhance and improve governance processes
  - Safeguarding information only shared on a need to know basis with all information stored electronically within a secure shared drive
  - Internal Safeguarding Audit processes reviewed and enhanced
- Development and review of all Safeguarding training provision by levels of 1-5, to ensure compliance with Intercollegiate Safeguarding Children and Young people: roles and competencies for health care staff (2015) alignment of all Trust staff roles to respective level of safeguarding training required (Royal College of Paediatrics and Child Health 2014 and NHS England 2016)
- Increased awareness of FGM and CSE, all levels of training now incorporate identification, response, recognition and reporting/referral.
- Development of a 'Training Strategy' and 'Training Passport'
- Review and revision of existing policies and guidelines with formulation of an electronic 'Safeguarding Pathway' available via the trust intranet homepage
- Introduction of a 'Snippets' newsletter to provide key safeguarding messages Trust Wide – this is produced on a three-monthly basis and is cascaded via the Safeguarding Committee and disseminated via communications Trust wide (Appendix 1)
- Further development and review of existing electronic flagging utilised to identify adults and children at risk with particular focus upon the Care Quality Commission (CQC) Section 29a Warning Notice
- Developments within Safeguarding Supervision, including an increase in trained Safeguarding Supervisors and meeting mandatory provision requirements.

2 Background

Effective safeguarding and promotion of the welfare of adults and children/young people relies upon joint working and constructive relationships that are conducive to good multi-agency partnership working. This can only be effective when all staff are knowledgeable, confident and equipped with the skills to deal with process and procedures when concerns arise relating to patient safety.

The Trust received a further CQC Inspection from 22 to 25 November 2016, with unannounced inspections at Worcestershire Royal Hospital, the Alexandra Hospital and Kidderminster Hospital and Treatment Centre on 7, 8 and 15 December 2016. This inspection followed from the previous one in December 2015 due to

Inadequate rating and received an inadequate rating also.

On 27 January 2017, the CQC issued a section 29A warning notice to the trust requiring significant improvements in the trusts governance arrangements for identifying and mitigating risks to patients. This had particular emphasis in respect to checking of Child Protection Plan electronic flags within Emergency Departments.

The purpose of this Annual Report is to provide assurance to the Board by highlighting those areas requiring focus and development and to inform of any intervention and change that has been made to strengthen the safeguarding processes within WAHT, including any safeguarding references within the CQC Report following its publication.

3.1 Appointment of new staff

The safeguarding team has expanded to meet needs of capacity increases, a Named Nurse for Safeguarding was appointed in January 2017 and a Safeguarding Administrator was appointed in November 2016. Both posts are part time. It is recognised that safeguarding is a continuously evolving specialism with work stream demands collaborative endeavour increasing which then has resource and capacity implications. Further developments are planned within this area with the recruitment to a Full Time Band 6 Associate Nurse role to support both the Adult and Children's Safeguarding agenda, with specific focus in supporting the Safeguarding Training agenda.

3.2 **Governance**

The Chief Nurse is the executive lead for safeguarding. Following a realignment of the Trust governance structure at the end of 2016, The Safeguarding Committee was restructured to a 'Safeguarding Expert Forum' and became a group of the newly formulated 'Clinical Governance Group' (Appendix 2). New Terms of Reference, Agenda and standing member list was reviewed in accordance to this new structure. The Clinical Governance Group is a subcommittee to The Quality Governance Committee (QGC) gaining assurance on behalf of the Trust Board that its legal and statutory duties are met in respect of the safeguarding of adults and children.

The Safeguarding Expert Forum acts as a conduit for the following agendas and has representatives from the health economy, including, the designated Nurse for Safeguarding, Worcestershire:

- Safeguarding adults – including compliance with the Mental Capacity Act (2005), Deprivation of Liberty Safeguards (DOLS), and the Mental Health Act (MHA).
- Response to the Trusts duties as part of the PREVENT strategy, working with partner agencies across the health economy.
- Safeguarding children – including child sexual exploitation and female genital mutilation
- Gaining assurance from the Divisions that responses to external or internal inspection reports are met and that risks are managed and mitigated accordingly
- The Trust upholds its reputation and meets its responsibilities in relation to

the Worcestershire Safeguarding Adult and Children's Boards and associated sub-groups.

Since the restructure, attendance of standing key members has reduced. Membership is recorded and reported at each meeting. The newly formed governance structure remains under review and progress on this will be provided within the next Annual Report 2017-18.

3.3 **Risk Register**

The Corporate risk register incorporates the risks formally managed by the Safeguarding Expert Forum.

A newly added risk relates to the findings of the CQC Inspection and the resultant Section 29a letter pertaining to appropriate safeguarding checks of children subject to a Child Protection Plan within the Emergency Department. Electronic flags are inputted electronically by The Safeguarding Team on receipt of the list from Children's Social Care, no paper documentation is utilised. A relating Standard Operating Practice was devised by The Safeguarding Team to support this process (Appendix 3).

The current high risks are:

- Safeguarding Training
- Lack of Responsible Clinician
- Administration of Mental Health Act
- Flags / Electronic Alerts

The Trust electronic flagging system is currently being reviewed with developments planned in relation to incorporation of a Trust Wide policy and a review of all existing flags. This is being led by Governance and Patient Experience as a Working Group; Safeguarding is one of the key members.

3.4 **Training**

Safeguarding Adult and Safeguarding Children training is mandatory for all Trust staff (NHSE 2014 and RCPCH 2014) and is monitored as part of the safeguarding assurance process. Extensive work has been invested in matching job roles to required level of training and there have been extensive challenges pertaining to collation of data by Informatics and Learning and Development Team. The Trust training attainment target remains at 90% across all Levels.

The Safeguarding Team has focused upon training as a key priority and furthermore, significant developments include, all training provision reviewed in line with RCPCH (2014), NHSE (2016), WSCB and WSAB requirements. Training provision increased and scheduled for a year in advance. Additional options of access to multiagency free training by CCG and WSCB for Safeguarding Children in place and bespoke training sessions facilitated by the Safeguarding Team to high priority areas, further increasing availability to trust staff. Another development encompasses the provision of a Training Strategy and accompanying training passport in December 2016 to aid staff understanding, provide clarity and impart clear messages pertaining to roles and responsibilities (Appendix 4). It is envisaged

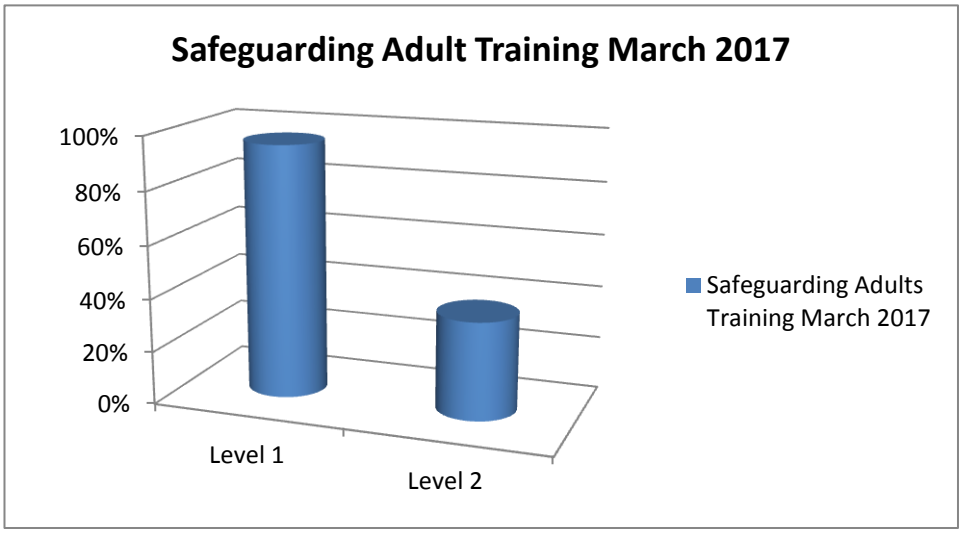
that the Training Passport can be transferred and utilised across region supporting continuity of training.

3.5 **Safeguarding Adults Training**

All adult training packages have been revised and brought into line with local and national guidelines for Safeguarding Adults (WSAB Competency Framework 2016 and NHSE 2016). The NHSE (2016) guidelines 'Safeguarding Adults Training, entitled: 'Safeguarding Adults: Roles and Competencies for health care staff – Intercollegiate document', stipulate that Level 3 is not indicated for acute Trust staff and therefore this level of training is not provided and hence not reported on. The NHSE guidelines are currently under review and all training will be revised in line with any amendments produced.

Safeguarding Adults Training Level 1 and Level 2

Based upon Trust target compliance 90%



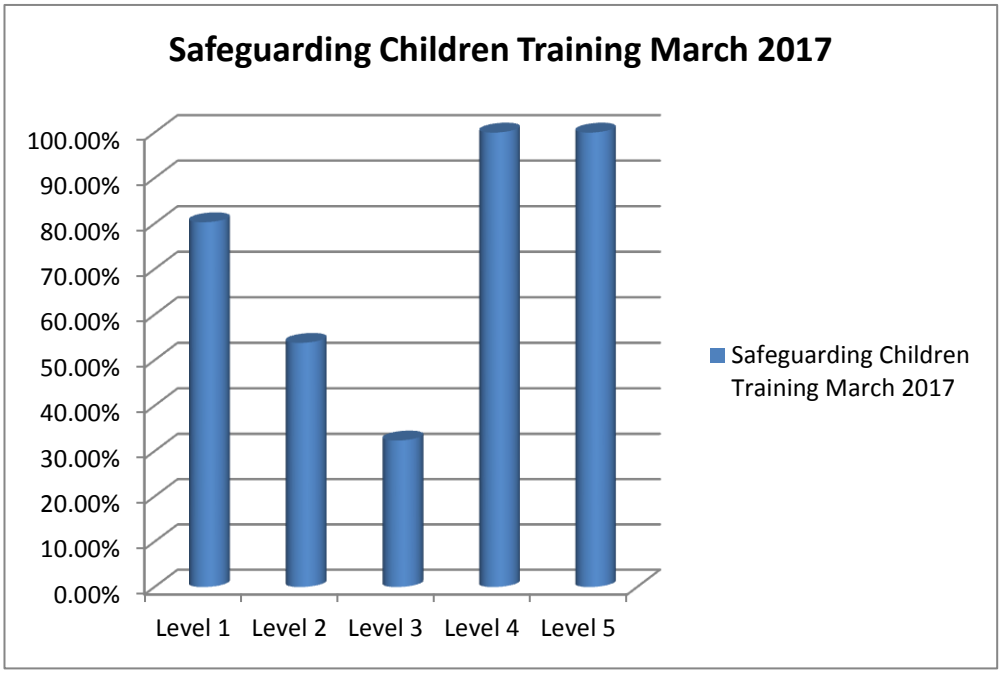
Level 1 remains compliant with Trust Target at 95.56%
Level 2 is currently 40.06%
Training specifically by level commenced in August 2016 in line with the new mandatory requirements of Adult Safeguarding Training to be provided by level.

3.6 Safeguarding Children Training

During 2016/17 data collection challenges have impacted upon the accuracy of previous Safeguarding Children Training figures provided. There was initially a significant delay in training figures being presented by Level; however, data presentation commenced during December 2016. The introduction of the 'Safeguarding Dashboard' in March 2017 will support the Safeguarding Team to target high risk areas, which include Paediatrics, Emergency Department, Maternity and Out-Patients. The Safeguarding Dashboard is anticipated to provide specific data, incorporating training figures by division and ward area with a non-compliance staff list. This will enable Line Managers and Divisional Leads to monitor training data within their teams. The Safeguarding Team will continue to work in collaboration with Informatics and Learning and Development to strengthen existing

processes. Furthermore, working with divisional leadership teams to ensure that attendance and training records are aligned.

Safeguarding Children Training March 2017
Based upon Trust target compliance 90%



Level 1: 80.31%, Level 2: 53.82% and Level 3: 32.37% - are below trust target compliance of 90%. Level 4 and 5 is 100%, which is above trust target compliance. Safeguarding Children training was reviewed at the end of August 2016 to ensure all training was aligned to the Intercollegiate Guidelines (RCPCH 2014) and all staff groups have been reviewed to align to appropriate level of training provided. Training figures have been provided by level since the introduction of the Safeguarding Dashboard in March 2017.

3.7 PREVENT / WRAP

PREVENT awareness training continues to be delivered on induction and all mandatory training programmes with an extended workshop to raise awareness of prevent (WRAP) delivered on clinical and senior mandatory training sessions.

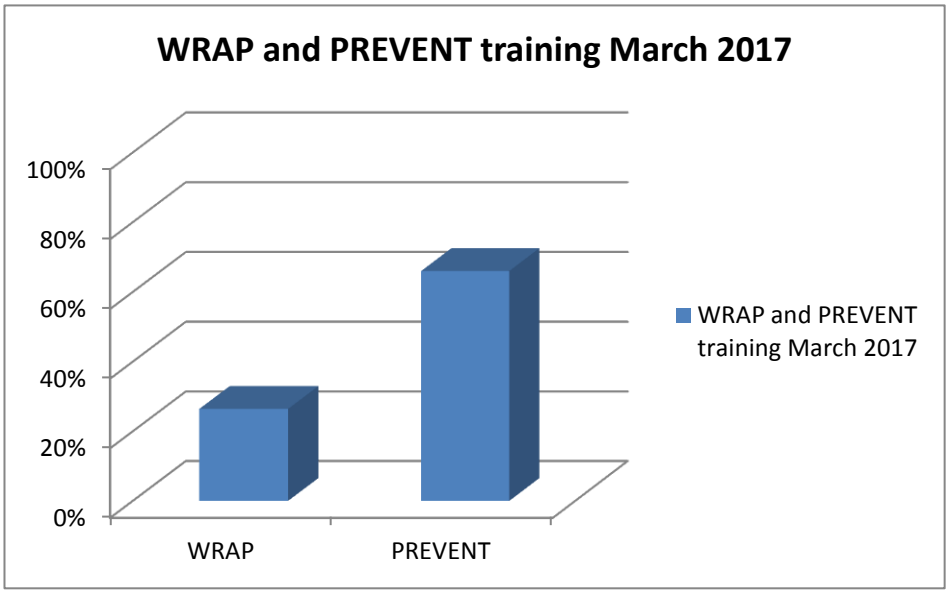
Of the 4093-staff requiring WRAP training – 60% (2466) staff have completed. This is on trajectory for the 3-year delivery plan by the end of 2018 – the compliance target to be achieved is a minimum of 85%. The Trust is on Trajectory to achieve this target.

The Trust provides a quarterly report to the CCG to monitor compliance with the Governments counter terrorism PREVENT strategy. This data is also reported internally within Clinical Governance Group and Quality Governance Committee. The Trust is represented at both local and regional PREVENT forums. The Home Office is currently in the process of reviewing all training materials for PREVENT /

WRAP and Trust training packages will need to be reviewed in accordance with this.

Training Trajectory WRAP / PREVENT
National training trajectory target three-year delivery plan, compliance of 85% required by March 2018 (NHSE- Prevent Training and Competencies Framework February 2015)

March 2017



WRAP training: 26.44%
PREVENT Training: 66%

Key findings from CQC inspection November 7-8th, 15th December 2016.

- The level of safeguarding children's training that staff in certain roles undertook was not compliant with the intercollegiate document "Safeguarding Children and Young People: Roles and competencies for Health Care Staff (March 2014) or the Royal College of Paediatric and Child Health guidelines. Therefore, it could not be assured that staff had sufficient knowledge and skills to safeguard children. Mandatory training below trust target of 90% - Ensure staff complete the required level of safeguarding training, including safeguarding children and ensure staff compliance with mandatory training meets trust target of 90% Not all staff had a good understanding of their obligations under the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). As at August 2016 MCA training has been completed by 37% of staff trust wide against a target of 90%. DoLS training compliance was just below the trust target at 85%.

Actions that the Trust must take to improve:

- Ensure staff complete the required level of safeguarding training, including safeguarding children.
- Ensure staff compliance with mandatory training meets trust target of 90%.

Key areas of action taken:

- The training framework utilised has been reviewed and revised by Chief Nurse, Head of Safeguarding, Human resources and education 29.08.2016 to ensure compliance with the requirements contained in the Intercollegiate safeguarding Children and Young people: roles and competencies for health care staff (2014, 2016)and that alignment with WSCB and WSAB competency guidance is followed.
- All training across each respective level incorporates FGM and CSE training; this includes identification, response, recognition and reporting.
- A Training Strategy and Training Passport has been developed with the aim of providing guidance for managers and staff on the level of training required, how often staff must attend and recording of all safeguarding training. It is recognised that all staff groups will have different training needs to fulfil their duty depending on their level of contact with children, young people and adults.
- The introduction of a trust wide MCA / DoLS reference card, which has been provided to all staff to carry with them at all times whilst on duty Safeguarding Training is a high priority for the trust has been supported by a Trust wide communication strategy to ensure all staff are appraised of the level of safeguarding training they require, training provision available, how to access this and of the significance of its utilisation.
- The provision of fortnightly compliance reports has been established and this will enable stringent monitoring and assurance of compliance figures. Stringent monitoring of training compliance is essential to ensure non-compliance is identified in a timely manner and actioned accordingly.
- The staff eligibility matrix has been reviewed to ensure staff are aligned to the correct level of safeguarding training and will provide clarity for staff at clinical level.
- There has been Increased provision for face to face training with the implementation of additional level 3 safeguarding children trainers.
- E Learning training provision has been strengthened for Level 1 and Level 2 safeguarding children and adult training, and this has been communicated via communication strategy.
- Bespoke Safeguarding training is being provided and targeted to high priority areas, including ED, maternity, paediatrics and out-patients.
- Additionally, training sessions focusing upon on MCA and DoLS is being facilitated with further sessions pertaining to bespoke targeted training for high priority areas, including Avon and Silver. Training sessions are being delivered by the safeguarding team and have been scheduled in advance for the forthcoming year.
- Level 1 will be delivered on Trust Induction. Level of awareness has been raised through the provision of Trust wide mandatory leaflet attached to all payslip in July 2017.
- Level 2 safeguarding training will be delivered via E-Learning or a taught teaching session
- Level 3, delivered via a taught teaching session, both are accessed internally. These are provided by The Safeguarding Team or externally, via CCG or WSCB. This offers support for staff to access training and afford them with flexibility in its approach. The taught sessions will incorporate a

multidisciplinary learning environment; ensuring intercollegiate guidance is adhered to. Early evaluation of training has proved positive and trust uptake of WSCB training has increased since the training review and robust communication dissemination trust wide.

3.8 Female Genital Mutilation (FGM)

The Trust continues to have three leads for FGM, Named Midwife Safeguarding, Consultant Obstetrician and Consultant Paediatrician. The Trust wide pathway for FGM is now in place. This pathway includes information relating to the national data set. Safeguarding Training for both Adults and Children incorporates FGM and focuses upon recognition and reporting.

There have been no identified / reported cases of FGM within the timeframe of this report.

Key findings from CQC inspection November 7-8th, 15th December 2016.

- Staff had poor awareness of female genital mutilation and reported not receiving any training in the identification of this - Need to establish identification of female genital mutilation and child sexual exploitation training that is to be completed by all staff working in children and young people's services.

Actions that the Trust must take to improve:

- Establish identification of female genital mutilation and child sexual exploitation training that is to be completed by all staff working in children and young people's services.

Key areas of action taken

- All training across each respective level incorporates FGM and CSE training; this includes identification, response, recognition and reporting.

3.9 Child Sexual Exploitation (CSE)

Regional data collated by Worcestershire Children's Social Care between 2016 and February 2017, reports that the number of missing children incidents average at 80 per month and 45% of all missing incidents were associated with CSE. In 2017 there was a monthly average of 36 referrals in relation to CSE, current overall number of children recorded as suffering from CSE is 21, and the overall number recorded as vulnerable to CSE is 295.

The Named Midwife Safeguarding remains as the Trust lead for CSE and attend the WSCB operational working group. The Safeguarding team do not attend CSE daily Triage which is led by Children's Social Care and Police. The Triage is attended by Worcestershire Health and Care Trust. At present data in respect to children who are at risk of CSE is not provided to WAHT and health information is not requested from WAHT. This has been escalated to Children's Social Care as a risk and added to the safeguarding risk register. Children who are known to be at risk of CSE are required to be Flagged via the Trust electronic flagging system.

3.10 Domestic Abuse

Tackling domestic abuse remains a strategic priority for the Safer Communities Board and the wider partnership in recognition that Domestic Abuse affects both adults and children. Worcestershire Children's Social Care receives on average 580 domestic abuse incidents per month within which children have been exposed to Domestic Abuse. Furthermore, Domestic Abuse daily triage numbers are high averaging 20-30 cases per day and Multi Agency Risk Assessment Conference (MARAC) averages between 30-50 cases on a fortnightly basis. Subsequently, health referrals received by Worcestershire Adult Social Care are predominantly due to Domestic Abuse concerns.

A criminal offence of coercive and controlling behaviour became law on the 29th December 2015 under Section 76 –the Serious Crime Act. This key legislation has placed an ardent renewed focus on the recognition and reporting of Domestic abuse which heightens the consideration required by professionals.

The Trust is working with partner agencies to develop a single Domestic Abuse pathway for the health economy which will incorporate the recent National Institute for Clinical Excellence (NICE) guidance around domestic abuse (NICE Domestic Violence and Abuse Quality Standard February 2016). A further update upon this will be provided within the next Annual report 2017-18. The Trust now actively participates in the Multi Agency Risk Assessment Conference (MARAC) process, with both Named Midwife and Named Nurse alternating their attendance. Robust health information gathering is initiated for each MARAC case which incorporates victim, perpetrator and any associated children. A Domestic abuse electronic flagging system is used to support the MARAC process. The Safeguarding Team provide Domestic Abuse training as part of Mandatory Safeguarding Children and Safeguarding Adult training. Trust Staff are also encouraged to attend external training and bespoke teaching sessions in accordance to learning need. Additionally, The Trust adopts a proactive approach in supporting Worcestershire's Domestic Abuse Strategy; this was demonstrated in its active participation in the 'White Ribbon' campaign aimed at increasing awareness of Domestic Abuse.

3.11 Children with vulnerabilities

3.11.1 Looked after Children (LAC), Child Protection Plan (CPP) and Child In Need Plan (CIN)

As of February 2017, regional data provided by Worcestershire Children's Social Care;

- 746 children subject to LAC arrangements (Sec 21 / 31 CA 1989)
- 734 children subject to a CIN plan (Sec 17 CA 1989)
- 486 children with a CPP (Sec 47 CA 1989)
- The % of CPP's broken down by category is: Neglect 49%, Emotional Abuse 44%, Sexual Abuse 4% and Physical Abuse 3%.
- Children with Disabilities (CWD) - There are over 400 children supported by the CWD team less than 3% are on a CP plan and 7% are LAC

The Trust has an electronic flagging system in place to identify vulnerable children who are subject to CPP. Work is progressing with Worcestershire Children's Social Care to gain LAC and CIN information in order to inform the Trust's Electronic Flagging System to identify such children.

Child Protection - Information Sharing (CP-IS) is a nationwide system that enables child protection information to be shared securely between local authorities and NHS trusts across England. CP-IS connects local authority children's social care systems with those used by NHS unscheduled care settings, such as Accident and Emergency, walk-in centres and maternity units. It ensures that health and care professionals are notified when a child or unborn baby with a child protection plan (CPP) or looked after child status (LAC) is treated at an unscheduled care setting. CP-IS is a secure system with clear rules governing access.

The Child Protection Information System (CP-IS) has been introduced within The Trust priority paediatric areas. The current challenge in achieving effective implementation of this pertains to IT establishment difficulties for Worcestershire County Council (WCC). WCC are reviewing their organisational position with regards to completing the Information Governance Tool Kit on the 16th June 2017 with their Corporate Information Governance Group. Following the outcome of that review WCC will be forming a meeting between WCC representatives and NHS representatives to agree a plan and proposed timeline for implementing CP-IS. NHS England is aware of these challenges and has extended the date to 2018. This is currently monitored and under review via the Trust Corporate Risk Register.

Key finding from CQC inspection November 7-8th, 15th December 2016.

- Ensure safeguarding checks are made consistently by ensuring that information relating to the children at risk register is accessible.

Actions that the Trust must take to improve:

- Ensure safeguarding checks are made consistently. Ensure information relating to the children at risk register is accessible.

Key areas of action taken

- An electronic alert system to flag children who are vulnerable is in place, to provide access for clinicians in order to provide fast and efficient patient care.
- This provides a focus for those who are subject to a Child Protection Plan and have a named social worker working within the family. The following alerts are added to OASIS and are now live on the system:
  - Current Vulnerable Child
  - Historic Vulnerable Child
  - Vulnerable Unborn Baby
- The alert is recorded in Oasis and linked through to Patient First [ED/Minor Injury Unit system], Bluespier and the Clinical Portal (Evolve).
- A weekly audit is in place in Ed to assure nurse is carrying out the checks. 95% of compliance has been maintained. All staff who are found not to have carried out the check now receive a letter of improvement required and further training.

3.12 Allegations made against People in Position of Trust

Within Worcestershire region, there has been over a 20% increase in Initial and Follow up strategy meetings, now averaging 27 per month. 90% of cases are closed

within 5 days of these meetings.

- 50% of all closed cases are unsubstantiated.
- % Allegations against working groups in regard to initial strategy meetings are: Foster Carers 34%, Education Staff 26%, Taxi/Coach Drivers 7%, Residential 5%, Youth Organisations 5%, others 23%.
- The Trust has received 4 referrals during the time frame of the report

The Trust now has dedicated policy 'Allegations made against People in Position of Trust' – this is transcribed further within subheading: Policy Development. The Trust works closely with the Local Designated Officer within Children's Social Care in respect to all referrals receive.

3.13 Quality Assurance - Audits

A review of existing internal audit activity within The Safeguarding Team has been reviewed and quality assurance activity has increased and will incorporate:

- Referrals made to Children's Social Care and Adults' Social Care
- Court Statements
- Initial and Review Case Conference reports
- Maternity Alert Completed Templates

This will be reported within the next Annual Report 2017-18.

Both Safeguarding Boards under statutory and legislative frameworks (CA 1989, CA 12014) have a duty to ensure all organisations are adhering to safe and robust safeguarding practice and as such request WSCB Section 11 Audit and WSAB self-assurance processes are adhered to. The last WSCB Section 11 audit (February 2014) was rated as 'good' in all areas. The next audit is due March 2018. The WSAB self-assessment audit was recently completed and has identified areas requiring improvement pertaining to staff understanding of Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) and embedding of sound practice. This is identified within our Key Objectives further on in the report.

3.14 Mental Health Act / Mental Capacity Act Statutory Duties

3.14.1 Mental Capacity Act 2005

A crib prompt card has been developed and provided to all Trust staff in March 2017, outlining the key principles of the Mental Capacity Act 2005 and considerations for assessing Mental Capacity.

Examples of Mental Capacity assessments and best Interest decision making are included on all training pertaining to the Mental Capacity Act delivered within the Trust. These examples have also been uploaded to the Trust intranet for ease of staff reference.

Further development is planned pertaining to training with commissioning for a period of 6 months (April to September 2017) to provide additional training sessions for clinical staff whom require level 2 training. This is expected to afford Trust staff with wider availability of training sessions. This will be reported upon in the next Annual Report 2017-18.

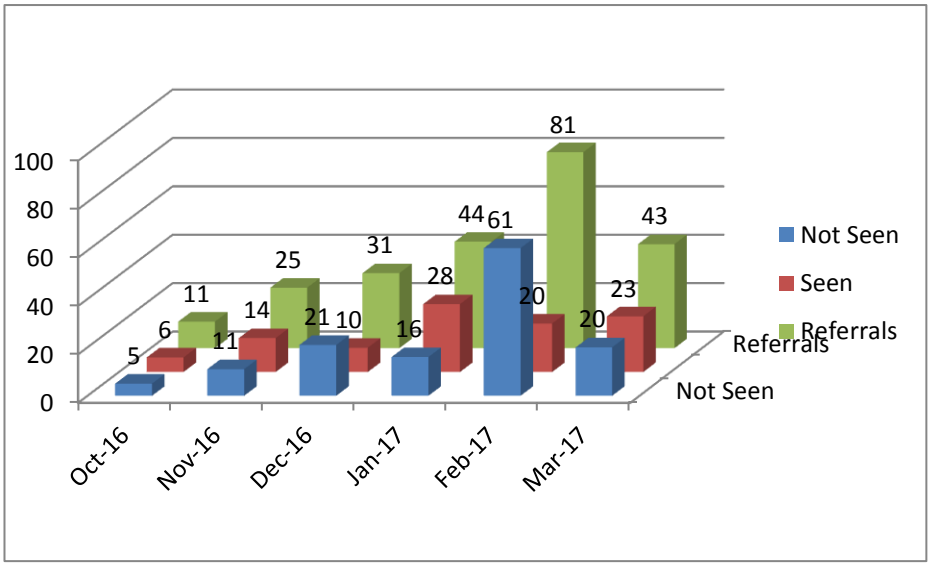
Mental Capacity training is delivered on Trust induction at Level 1 (awareness). Clinical staff are expected to undertake Level 2 training within 3 months of their start date with the Trust. This is monitored via an individual's mandatory training requirements as each role within the Trust has been assigned the level of Safeguarding training required in alignment to their job role

3.15 Mental Health Act Administration

The Lead Nurse Safeguarding Adults attended a 2-day Mental Health Act Administrator course in order to improve the scrutiny of detention papers in order for the Trust to meet its mandatory and legal duties in the absence of formal Mental Health Act Administration arrangements which remains a Corporate risk and is on the Risk Register.

There have been 12 detentions under the Mental Health Act within the Trust over the last year.

The Safeguarding Team continue to work in collaboration, attending the Mental Health Act working Group and Mental Health Crisis Concordat Meetings. There continues to be challenges in accessing timely support with patients who have mental health illnesses whilst they are patients within the Trust. The multi-agency mental health crisis care concordat is reviewing all pathways for people presenting with acute mental health problems. A pilot out of hour's assessment service is being established in the Elgar unit to prevent high risk patients having to wait in ED overnight. This pilot is in its infancy and referrals are only being accepted from the ambulance service, police and GP's, from February 2017 the next phase will include Accident and Emergency referrals. An update of this Pilot has been received from Worcestershire Health and Care Trust in respect to 'Crisis Assessment Suite – CAS':



A Simple guide has been produced by the clinical lead of CAS to support staff with managing challenges in the CAS unit. This has been written to compliment the operational protocol and addresses some of the difficulties experienced by staff.

Agreement to invite an ED representative to the forthcoming CAS Monitoring meeting on the 10th April. This is to facilitate a discussion about improving referral arrangements.

3.16 NHS Information centre KP90 return.

The Trust are required to submit a national return to collate data in respect to Mental Health Act Detentions within the Trust. The KP90 return has been replaced with the Strategic Data Collection Service (SDCS) with effect from January 2017 and this data will be reported on in the next Annual Report. Mental Health Act detentions continue to be monitored via the Datix incident reporting system.

3.17 Deprivation of Liberty Safeguards (DoLS)

Between 01.04.2016 and 31.03.2017 – 177 DoLS applications were made by Trust staff. DoLS applications are increasing both nationally and regionally. Of those 177 referrals across a number of local authorities, the Trust received 90 acknowledgment letters from WCC. There are currently no notification arrangements into The Safeguarding Team when a DoLS referral is made to another Authority but this is a work in progress.

Of all of the 11 statutory assessments completed by the DoLS team local authority over this period - only 2 were not granted. This provides significant assurance that the referrals are appropriate when assessed by the Local Authority.

From Monday 3 April 2017, the Coroners and Justice Act 2009 will be amended so that people subject to authorisations under DoLS will no longer be considered to be 'otherwise in state detention' for the purposes of Section 1 of the Coroners and Justice Act 2009. This means that coroners will no longer be under a duty to investigate a death solely because a DoLS authorisation was in place. Such deaths will only be reported to the coroner if the cause of death is unknown, or where there are concerns that the death was violent or unnatural. This effectively brings the position in line with deaths which do not involve DoLS, and the circumstances where a jury will now be required will be rare. The practical effect of this change will be to reduce the number of referrals to the coroner, and the number of associated witness statements and inquests. The Safeguarding Team have devised a DoLS tracker to monitor DoLS applications and their outcomes with any conditions imposed upon the Trust. Existing Mandatory Safeguarding training has been revised to reflect this and message disseminated to staff to align with publication date of 3rd April 2017.

3.18 Policy Development

The Electronic Safeguarding Pathway for both adults and children was commenced in January 2017; this continues to be regularly reviewed by the Safeguarding Team with improvements based on staff feedback implemented. The Trust has a key document lead who continues to support with conversion of all the policies into a pathway. The newly structured 'Family Front Door' process and change in the Safeguarding Children's Referral process has been supported by the Safeguarding Team and cascaded within the Safeguarding Committee, in addition to various communications methods and provision of a Standard Operating Practice (Appendix 5). The process was led by Worcestershire Children's Social Care and launched in July 2016 with key agencies including health, invited to attend briefing sessions.

The Trust wide pathway for FGM is in place following consultation in December 2016 and this is available within the Safeguarding Pathway on the Intranet.

The policy 'Allegations against a Person in a Position of Trust' was devised by the Head of Safeguarding in joint consultation with senior HR staff. This was approved in November 2016 (Appendix 6). The policy was launched effectively with trust wide communication methods and a bespoke multiagency teaching session was commissioned by the CCG to support its implementation. A further teaching session will be scheduled for this coming year.

Developments for the forthcoming year will focus upon revision of The Safeguarding Children Policy and Safeguarding Supervision Policy.

Development of a generic health economy domestic abuse pathway is progressing. This is being led by the Public Health Practitioner for Domestic Abuse and Sexual Violence – regional board with support from key members of the health economy. This will then report into WSCB.

Two policies due for renewal have had their renewal date extended to enable work to be completed to move policies into pathways.

The Control and Restraint Policy has been revised to bring it into line with Positive and Proactive Care: reducing the need for restrictive interventions (Department of Health, April 2014) and the 'Positive and Safe' initiative. This will now include a post incident review process. This is in the approval process.

A further development within Safeguarding Adults encompasses improving the quality of referrals made by Trust staff and is in recognition of feedback received from WCC. A flowchart has been devised to support decision making pertaining to pressure ulcers and tissue viability and whether a referral into Adult Social Care is indicated. This is currently in the approval process. (Appendix 7) and supports adherence to Care Act 2014 and WSAB Guidelines. The outcome anticipated will be a reduction in inappropriate referrals to WCC.

3.19 Serious Adult Reviews (SAR) and Domestic Homicide Reviews (DHR) – Safeguarding Adults

The Trust has participated in one combined DHR and SAR, four SAR's and one DHR. All Trust actions completed in respect to these, with one SAR remaining in progress. We are awaiting WSAB publication of these and will disseminate learning accordingly and implement into Safeguarding Adults Training. The Trust has implemented a notification process for any adult patient who fails to attend any appointment for which a 'did not attend' code is entered.

Training continues to emphasise the key messages in relation to utilising opportunities to assess and review patients on their own and the associated language used when considering safeguarding and asking relevant questions proportionate to individual need e.g. learning disability.

3.20 Serious Case Reviews (SCR) – Safeguarding Children

There have been no serious case reviews in the timescale of this report. However, there has been a reflective learning event in July 2016, whereby all agencies, including health were invited to participate. Furthermore, the learning from this event was cascaded by The Safeguarding Committee and appropriate communication via WSCB newsletter; furthermore, Safeguarding Children Training has incorporated the learning.

WSCB has recently identified one case to commence as an SCR and a further possible case is due to be scoped in July 2017. This will be further reported on in the next Annual Report.

3.21 Safeguarding Supervision

Since the last Annual Report, significant improvement has continued within Safeguarding Supervision. The trust has trained a further two members of staff to be Safeguarding Supervisors and both are members of The Safeguarding Team. In addition, all four Specialist Midwives are now Safeguarding Supervisors with the latter two having successfully completed their training in 2016.

Community Midwives were highlighted as a priority to receive Safeguarding Supervision and are mandated to do so (RCPCH 2014). Since September 2016, all 80 Community Midwives and four Specialist Midwives have received Safeguarding Supervision or are scheduled to receive in accordance with the three-monthly requirement. Reallocation of Supervisees in recognition of the new pool of Safeguarding Supervisors completed in May 2017, which each Supervisor being allocated a geographical area. In addition, at the request of Redditch and WRH Antenatal Clinic staff group supervision is also provided on a three-monthly basis.

All Supervisors will be required to contribute to monthly data collation of all supervision sessions provided; this will be managed by The Safeguarding Team who will then input onto electronically onto the Shared Drive and relevant Spreadsheet. This will facilitate effective governance processes and ensure supervision is undertaken in a timely and robust manner. Progress will be reported in respect to this.

Further developments and improvements in this area will incorporate the identification of key staffing groups whom may require this, for example Paediatric Physiotherapy and Epilepsy Specialist Nurses. The team will be undertaking a scoping exercise to identify key groups and offering group Safeguarding Supervision. Furthermore, review of existing Safeguarding Supervision Policy is scheduled in 2017.

3.22 Objectives 2017/18

3.22.1 Adult Safeguarding

- Review of Policy / training packages based upon the outcome of the Law Commission review (March 2017) in relation to Deprivation of Liberty Safeguards.
- Review and embed training materials once DoH review of PREVENT / WRAP training complete this year

- Await NHSE review of the Adult Intercollegiate Document and amend / add any training packages accordingly
- New WSAB Training Strategy due April 2018 – ensure all current training aligns with this guidance
- Deliver mandatory training in line with Trust trajectory to achieve 90% compliance in accordance with WSAB Competency Frameworks
- Key findings from CQC inspection November 7-8th, 15th December 2016 and actions required, will be monitored via the Safeguarding Committee and appointed Leads.

3.22.2 Safeguarding Children

- Safeguarding Children's Training – commission an external training provider to provide additional training for Levels 2 and 3 to increase availability of teaching sessions for trust staff and increase overall trust compliance to 90% in line with Trust targets. Continue to offer bespoke teaching sessions to areas of high priority.
- To schedule further 'Position of Trust' training to support and further embed policy 'Allegations made against people in positions of trust'
- To continue to work with Children's Social Care and WSCB to support Ofsted Service Improvement Plan
- Continue to further develop existing audit work plan to incorporate any areas requiring improvement and to identify good and outstanding practice. This includes: WSCB Section 11 Audit due March 2018. working with Identify audit programme
- Work with NHSE and CCG to ensure WCC IT is progressing to implement the National Child Protection Information System [CP-IS]
- Review and develop existing policies:
  - Safeguarding Children Policy
  - Safeguarding Supervision Policy
- Key findings from CQC inspection November 7-8th, 15th December 2016 and actions required, will be monitored via the Safeguarding Committee and appointed Leads.

4 Implications

Safeguarding is covered in the following Acts/guidance

- Working Together to Safeguard Children (2015)
- PREVENT duty guidance (2015)
- Counter Terrorism and Security Act (2015)
- The Care Act (2014)
- Intercollegiate Document (2014) -
- safeguarding children & young people: roles and competencies for healthcare staff
- Safeguarding Adults: Intercollegiate Document (2016) -
- roles and competencies for healthcare staff
- Deprivation of Liberty Safeguards (2009)
- Health & Social Care Act (2008)
- Mental Capacity Act (2005)
- Mental Health Act (1983)
- CQC Fundamental Standards
- Statement on CQC's roles and responsibilities for safeguarding children and adults (June 2015)

- Serious Crime Act (2015)
- Children Acts (1989) and (2004)
- Female Genital Mutilation Act (2003), FGM enhanced data set (2015)
- WSAB Competency Framework for Adults: MCA / DOLS and Safeguarding Adults (2016)

5 Recommendation

The Board is asked to approve the Safeguarding annual report 2016-17 and the forward plan for 2017/18.

Compiled by
Christina Rogers
Safeguarding Lead

Director
Vicky Morris
Chief Nurse

NHS
Worcestershire
Acute Hospitals
NHS Trust

Date of meeting	14 September 2017
Paper number	Enclosure I3

Report provided:							
For approval:		For assurance:	✓	To note:		For information:	

Annual Health & Safety Report 2017

Accountable Director	Jim O'Connell Interim Chief Operating Officer
Presented by	Jim O'Connell Interim Chief Operating Officer
Author	Paul Graham Health & Safety Manager

Alignment to the Trust's strategic priorities (√)	Deliver safe, high quality, compassionate patient care	✓	Design healthcare around the needs of our patients, with our partners	
	Invest and realise the full potential of our staff to provide compassionate and personalised care		Ensure the Trust is financially viable and makes the best use of resources for our patients	
	Develop and sustain our business			

Alignment to the Single Oversight Framework (√)	Leadership and Improvement Capability		Operational Performance	
	Quality of Care	✓	Finance and use of resources	
	Strategic Change		Stakeholders	

Report previously reviewed by		
Health & Safety Committee	18th July 2017	Approved
Trust Leadership Group	16th August 2017	Approved

Assurance: Does this report provide assurance in respect of the Board Assurance Framework strategic risks?	N	BAF number(s)	
Level of assurance and trend not assessed			
Significant	Limited	None	

NHS
Worcestershire
Acute Hospitals
NHS Trust

Date of meeting	14 September 2017
Paper number	Enclosure I3

Purpose of report	This annual report has been produced to inform the Trust Board of the health and safety management activities that have occurred during the period 1st April 2016 – 31st March 2017. These activities were based upon meeting the key objectives within the Health and Strategy 2016. A series of graphs generated by the DATIX Risk Management System have been included to illustrate the numbers of accidents and near miss incidents reported during the above period. The report also includes details of the health and safety risks that are currently on the Trust's Risk Register.
Summary of key issues	• There are currently a large number of outstanding non-clinical accidents and incidents on the Datix system that require actions. Divisions must monitor and close out accidents and incidents in accordance with the timeframes set out in the Trust's Incident Reporting Policy • Staffing levels in clinical areas continues to be reported as an issue. The Trust needs to closely monitor staffing levels as a shortage can have an impact on the frequency and severity of accidents in the workplace. • The Trust currently lacks a robust system to identify health & safety risks. An 'in house' training programme has been developed to provide managers with the necessary knowledge and skills to be able to carry out risk assessments and audits within their respective work areas. Divisional Directors of Operations are also currently developing H&S Audit programmes for the 2017/18 period.
Recommendations	The Board is asked to note the contents of this report for assurance purposes

Date of meeting	14 September 2017
Paper number	Enclosure I3

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

ANNUAL HEALTH & SAFETY REPORT 2017

1 Introduction

This report contains details of the recent health and safety activities and the health and safety risks that the Trust is currently exposed to. The report shows some encouraging results following the excellent work put in by managers and staff to avoid workplace hazards and where appropriate report accidents and near miss incidents.

2 Background

The Trust provides an Annual Health & Safety Report for the Board. The report has been submitted to the Health & Safety Committee and the Trust Leadership Group. Following a couple of amendments it was approved to be submitted to the Board.

3 Current situation

During 2016 the Trust aimed to meet the objectives set out in the revised 2016 Health and Safety Strategy. Progress was closely monitored by the Trust Health and Safety Committee. The following information provides evidence of meeting the respective strategic objectives:

Objective 1

To ensure an effective, co-operative and integrated approach to health and safety management across all three hospital sites.

- The Trust Health & Safety Committee met in April, July and October 2016 and in March 2017. Attendance has improved over the last 12 months however there has been an inconsistency in providing a suitable chairperson for the meetings.

- The Committee discussed the following topics:
  - Workplace Stress
  - COSHH (Control of Substances Hazardous to Health) Environmental Monitoring
  - Bariatric Ski pads
  - H&S Training for managers
  - Manual Handling in Theatres
  - Mortuary Fridges
  - Amp snap safety devices
  - Endoscopy Department AH – upgrade
  - Baby security system at WRH
  - Dental chairs in Hawthorn Suite
  - Divisional H&S Audit Programme
  - CQC Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Compliance with Regulation 15: Premises and equipment.

Objective 2

To ensure effective compliance with all relevant health & safety legislation and any quality and safety standards that includes the 5 Care Quality Commission (CQC) Domains.

- The H&S policies were not updated during 2016 due to their review dates being extended for a further 12 months. The policy review process recommenced in March 2017 with the Latex, Display Screen Equipment and Manual Handling policies. Each document is now consulted on by the Policy Working Group and Health & Safety Committee before being presented to the JNCC for final approval.

- The Trust has continued to assess its level of compliance with the CQC Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in particular Regulation 15 which relates to Premises and Equipment.

- The Trust continues to regularly distribute medical device alerts issued by the Medicines and Healthcare products Regulatory Agency (MHRA), NHS Improvement and the Department of Health. The information sheets received from the Central Alerting System (CAS) identify particular hazards and risks that may need to be addressed.

- The Trust met the deadlines of all Central Alert System (CAS) alerts received during 2016/17.

- The Patient Safety Team manages the patient safety alerts issued by NHS England. The only outstanding alert to date is

    - **NHS/PSA/RE/2015/008:** *Supporting the introduction of the National Safety Standards for invasive procedures.*

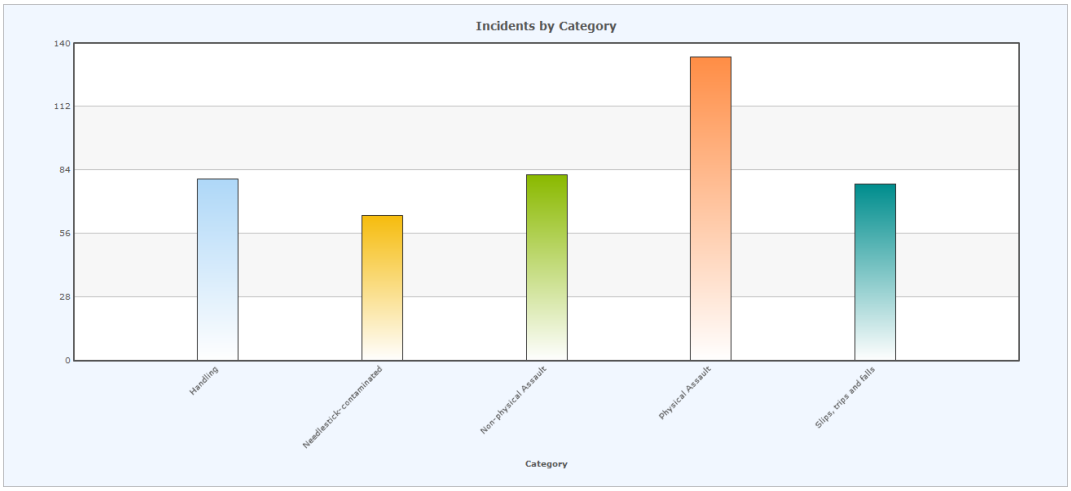
Objective 3

To increase staff involvement in health and safety management by encouraging them to participate in the risk assessment process, reporting and investigating accidents and incidents.

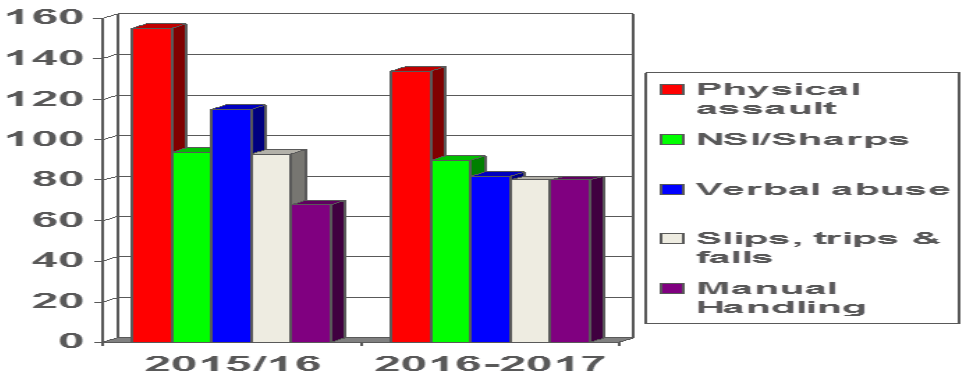
- The Trust continues to make use of the Datix electronic Incident Reporting process which is available to all staff via the intranet. The system currently has 40 non-clinical incidents in the holding area awaiting review, 175 under review and 40 incidents awaiting final approval. Of the total 255 incidents, 153 are currently overdue for action. A number of these events have occurred in general access areas of the Trust or in other areas which are not under the direct responsibility of any manager. The H&S Manager is working through many of these to help close them out. The H&S Committee receives quarterly Divisional Reports which identify any outstanding actions and learning points from their accidents

and incidents. The Divisions themselves also regularly monitor the closure of all events in terms of meeting the timescales stated within the Incident Reporting Policy.

- The Bar chart below indicates the main causes of H&S accidents/ incidents reported during the last 12 months. Overall violence and aggression continues to be a problem. Staff continue to be informed about the administrative sanctions that are available and can, in certain cases, be applied to patients who display verbal abuse and /or physical aggression. When sanctions cannot be applied due to capacity issues staff need to consider whether or not the care environment is appropriate for a particular patient or whether that patient requires 1:1 care.



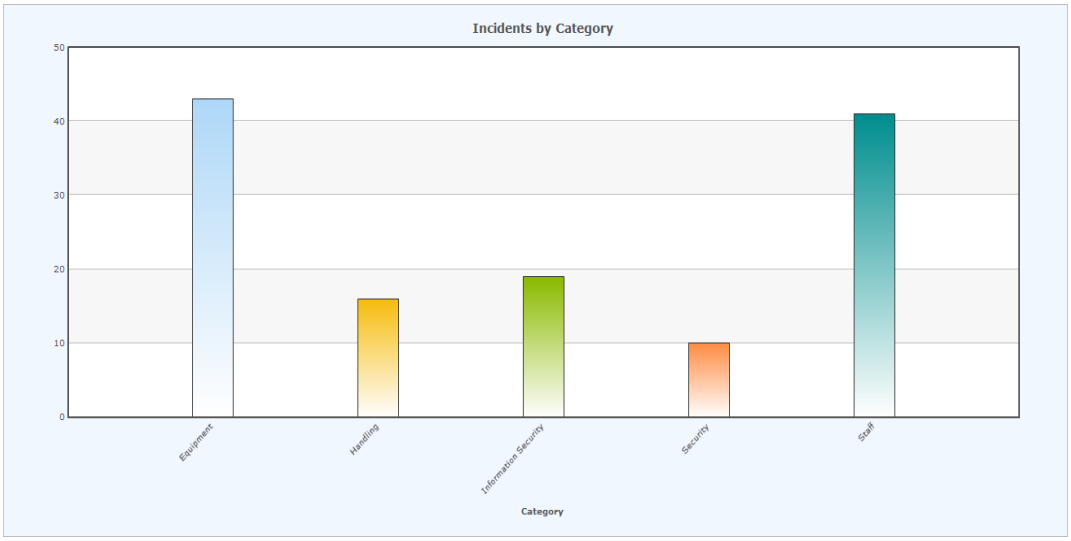
- The graph below compares the numbers of accidents/incidents reported in 2015/16 with those reported in 2016/17.



Although it remains the Trusts highest non-clinical risk in terms of causing harm to staff the overall numbers associated with incidents of violence and aggression have reduced over the last 12 months. The numbers of contaminated needle-stick and sharps injuries have reduced from 94 in

2015 to 90 in 2016. The Trust continues to consider safer technology when purchasing equipment that may potentially cause sharps type injuries. Slips trips and falls events have also reduced however the number of manual handling accidents has increased from 63 to 80. All manual handling injuries are reported to the Manual Handling team for investigation purposes. The level of manual handling training for staff currently sits at 87.7%.

- The Bar Chart below shows the most frequently occurring 'near miss' incidents that were reported during 2016. The majority of the equipment incidents can be further categorised under the sub-categories of failure or broken. All incidents relating to medical devices were reported to the Medical Devices Group and followed up with the local work area and where necessary reported to the Medicines Healthcare products Regulatory Agency (MHRA). The numbers of reports concerning staffing levels continues to rise however this is being closeley monitored by the Divisional nursing teams. All information incidents were reported to and investigated by the Information Governance Manager.



- The Trust also uses the Datix system to record all of its health, safety and security risks. The system currently has 31 open health & safety risks and 4 security risk recorded on the Risk Register. Of these 35 risks, 1 risk is graded as High, 11 as Moderate, 19 as Low and 4 as Very Low.

- The following risk is currently recorded s **High**:

    - **Due to the lack of adequate control there is a risk to patients and staff caused by the possible unauthorised access to the MRI scan room at WRH.** – The Director of Asset Management and ICT has been informed of this risk and the work required to reduce the risk is currently sitting with Engie for costing purposes.

- The following are the current **Moderate** risks recorded on the system:

    - Manual handling – general risk to staff employed to carry out manual handling tasks (Trust wide).
    - Exposure of staff to the potential risk of sustaining a needle-stick injury (Trust wide).
    - Staff at risk of violence & aggression from patients (Medicine Division)
    - Exposure of staff, visitors & contractors to slip trip & fall hazards (Trust wide).
    - Risk of non-compliance with National waste guidance and potential incorrect segregation of waste (Trust wide).
    - Reception desk in Radiology at AH unfit for purpose (SCS Division)
    - Risk of exposure to high risk organisms in Pathology (SCS Division).
    - Increased risk of neonatal abduction due to an insufficient number of baby security tags (W&C Division).
    - Trust lacks an efficient system of identifying its health & safety risks (Trust wide).
    - Potential risk to quality of care in OPD – relating to ineffective ventilation and overcrowding or work area (SCS Division).
    - Violence & aggression of service users at Minor Injuries Unit at KTC – staff and others may be injured (Medicine Division).

- The following Moderate risks appeared on the register during 2015/16 but have subsequently been closed due to either re-assessment or the implementation of suitable and effective control measures:

    - Design of dirty utility area endoscopy too small leading to potential manual handling risks.
    - Holding limbs of anaesthetised patients during skin prepping in Theatres may lead to staff injuries.

- Regular audits continue to be undertaken by the Infection Control team which contribute to the overall health & safety management programme.

- Divisional Directors of Operations are currently developing H&S Audit programmes for the 2017/18 period.

Objective 4

To provide appropriate training and guidance for managers and staff that enables them to safely undertake their work activities.

- In 2017/18 the Trust is to provide managers with health & safety training. This will consist of a one day course to include both theory and practical skills in risk assessment and accident investigation. It will be aimed at Band 6/7's who have been identified by the DOP's as the individuals responsible for managing health & safety at a local level i.e. wards/departments.

- All staff continues to attend a three yearly refresher risk management training day which includes an update on health, safety and security issues.

- Attendance figures at mandatory training currently show that the Trust is achieving an 87% level of compliance with Health & Safety and 83% with Violence & Aggression (Conflict Resolution Training).

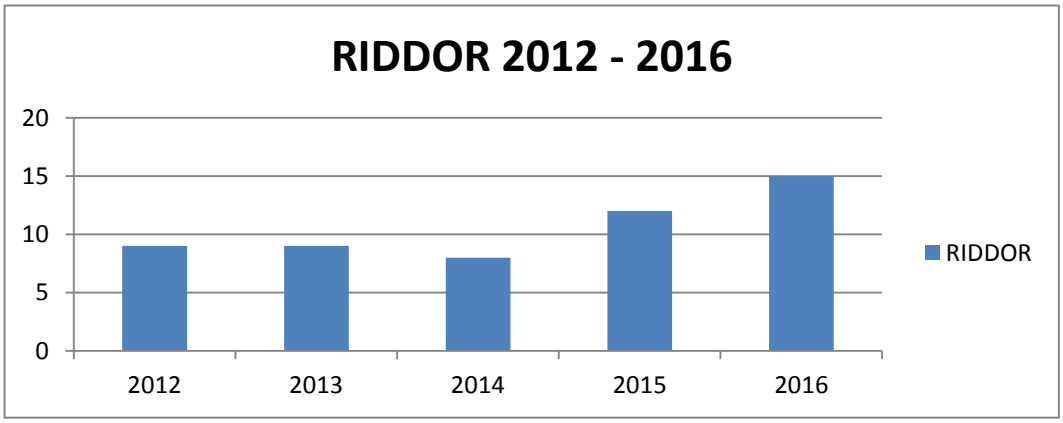
Objective 5

To reduce the number of accidents reportable under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995. (RIDDOR).

- Datix has been used to record and regularly report on performance in terms of reducing the numbers of accidents across the Trust. These reports have been provided to various committees and included as part of the Trusts overall performance review.

- The H&S Manager has continued to review each RIDDOR case with the relevant managers and staff-side members in order to help identify the root causes and determine what lessons can be learnt to prevent any similar reoccurrences. The H&S Committee has received copies of the relevant Case Reviews.

- The overall number of RIDDOR cases (see chart below) has slowly increased over the last 2 years.



- Of the 15 cases reported during 2016/17:

    - 8 involved slips trips & falls which resulted in fractures. (2 of the injured were patients being cared for where the level of care had a direct impact on causation)
    - 4 involved members of staff who sustained ‘over 7 day’ injuries resulting from 1 collision with an item of equipment, 3 physical assaults committed by patients and 2 manual handling tasks involving patients.

- 2 involved members of staff who slipped and fell and sustained fractures - one to her ribs the other to her wrist.
- 1 involved a member of staff who was overcome by Xylene fumes whilst working the Histology Department. It was discovered that the LEV system had shut down. The area was monitored for xylene levels and the problem reported immediately to the Estates Team for repair.

Each case was followed up and fully investigated by the H&S Manager and where appropriate the manager of the work area. The following learning points were identified and shared as part of the investigation process:

Learning Points:

- *Staff must follow the handling assessment either detailed in the patients care plan or following a dynamic assessment of the task to be carried out. (Included in manual handling training)*
- *An environment contractor has now been asked to provide the Trust with a monthly report of the state of repair of its car park areas re: trip hazards.*
- *The Trust must continue looking at ways it can prevent staff having to carry out hazardous manual handling tasks.*
- *Staff must be made aware of potential hazards within the work place.(Environmental Assessments are undertaken but these need to be shared with staff)*
- *Potentially aggressive patients must be suitably assessed to identify any control measures that can be implemented to help reduce the risk of violence against staff (Refer to Management of Violence & Aggression Policy).*
- *Where necessary falls assessments of patient must be carried out and any falls prevention techniques implemented accordingly. These must also be suitably recorded in the patients care plans/medical records.(Shared with members of Serious Incident Group)*
- *The requirements for planned preventative maintenance of essential items of equipment must be identified and implemented as required. (Shared with Engie PFI Estates providers)*

Objective 6

To effectively manage any security issues that are identified as part of the Trust's risk assessment process.

- The Trust has been informed that NHS Protect is to be de-commissioned on the 3rd July 2017. It will no longer provide security support to the Trusts' Local Security Management Specialists (LSMS) and the requirements for the Trust to report to the Security Incident Reporting System (SIRS) will no longer be necessary. It remains however a requirement to have an LSMS in post and for the Trust to provide evidence to our Commissioners that we are meeting the requirements of the NHS Security Management Standards which are part of the NHS Standard Contract. Work around fraud will continue but under the management of a new body called the NHS Counter Fraud Authority.

- The Trust will continue to monitor compliance with the NHS Security Management Standards which will enable us to give assurance to our commissioners that we are identifying and addressing any security risks that may apply to the acute setting.

Objective 7

To ensure that all food service areas of the Trust including the PFI, that are inspected by their relevant Local Authority Environmental Health Food Safety Inspectors, achieve a minimum Food Hygiene Rating level of 4 Stars.

- The food hygiene and waste management standards and any associated risks continue to be monitored by the Catering and Portering & Transport Manager respectively. No significant risks have been reported through to the Trust H&S Committee.
- In 2016 the Alexandra and Kidderminster Hospital's Catering Departments achieved an excellent 5 Star Food Hygiene Rating.

Objective 8

To achieve an acceptable standard of fire safety in accordance with statutory requirements and Department of Health guidance, thereby minimizing the incidence and impact of fire.

- Please refer to the Trust Annual Fire Safety Report 2016/17 to find details of the Trusts fire risks and the on-going work that is being undertaken to improve control.
- The Occupational Health Department has been tasked to ensure that, where a member of staff declares any form of disability which may impact on their ability to recognise or react to a fire alarm situation and/or safely evacuate from a work area, these individuals are made known to their responsible manager so that they in turn can suitably assess the individual using a Personal Emergency Evacuation Plan (PEEP). Once completed this document will be used to inform the member of staff as to the safe means of escape and a copy retained within their personal file.

4 Implications

None

5 Recommendations

The Board is asked to note the contents of this report for assurance purposes

Compiled by
Paul Graham
Health & Safety Manager
Director
Jim O'Connell
Interim Chief Operating Officer

NHS
Worcestershire
Acute Hospitals
NHS Trust

Date of meeting	14 September 2017
Paper number	Enclosure I4

Report provided: ()							
For approval:	√	For assurance:		To note:		For information:	

Equality and Diversity Annual Report

Accountable Director	Michelle McKay Chief Executive
Presented by	Michelle McKay Chief Executive
Author	Debbie Drew Head of Human Resources

Alignment to the Trust's strategic priorities (√)	Deliver safe, high quality, compassionate patient care		Design healthcare around the needs of our patients, with our partners	
	Invest and realise the full potential of our staff to provide compassionate and personalised care	√	Ensure the Trust is financially viable and makes the best use of resources for our patients	
	Develop and sustain our business			

Alignment to the Single Oversight Framework (√)	Leadership and Improvement Capability	√	Operational Performance	
	Quality of Care		Finance and use of resources	
	Strategic Change		Stakeholders	

Report previously reviewed by		
Committee/Group	Date	Outcome
People and Culture	24 August 2017	Approved for presentation at Trust board

Assurance: Does this report provide assurance in respect of the Board Assurance Framework strategic risks?	Y	BAF number(s)	P3.2
Level of assurance and trend not assessed			

NHS
Worcestershire
Acute Hospitals
NHS Trust

Date of meeting	14 September 2017
Paper number	Enclosure I4

Purpose of report	This the fifth annual Equality and Diversity report of the Worcestershire Acute Hospitals NHS Trust. This report brings together the various strands of our equality agenda for both patients and staff including reports, audits, data analysis, and service improvements.
Summary of key issues	The purpose of this report is to demonstrate our progress in 2016/17 and identify our key priorities for 2017/18 and future years. This shapes our action plan for the forthcoming year to enable us to transform our services by understanding the diverse communities we serve. Our key aims are to: • eliminate discrimination, harassment, victimisation and any other conduct that is prohibited under the Equalities Act; • advance equality of opportunity between patients and staff who share a relevant protected characteristic and those who do not share it; and Foster good relations between groups who share a relevant protected characteristic and those who do not share it.
Recommendations	To note and endorse the Equality & Diversity Annual Report for 2016-2017 and build the actions into the overall Trust Cultural Improvement Programme.

EQUALITY INFORMATION

Annual Report for 2016/17

Debbie Drew and David Southall – Equality Leads for Staff
Tessa Mitchell and Linda Price – Equality Leads for Patients

Contents

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Contents (continued)

Foreword by the Executive Leads

This the fifth annual Equality and Diversity report of the Worcestershire Acute Hospitals NHS Trust. This report brings together the various strands of our equality agenda for both patients and staff including reports, audits, data analysis, and service improvements.

The Trust has joint Equality Leads covering the separate patient and staff strands as we feel that this is the most effective way of covering the whole of the Equalities agenda. This report has been compiled by our operational leads – **Tessa Mitchell** (Associate Director of Patient Experience) and **Linda Price** (Patient Experience Lead); and **Debbie Drew** (Head of Human Resources) and **David Southall** (Chaplaincy and Staff Equalities Engagement Lead)

The Executive Lead role for Equality and Diversity is shared between **Vicky Morris** (Chief Nursing Officer) for patient related issues; and **Denise Harnin** (Director of Human Resources and Organisational Development) for staff related areas.

The purpose of this report is to demonstrate our progress in 2016/17 and identify our key priorities for 2017/18 and future years. This shapes our action plan for the forthcoming year to enable us to transform our services by understanding the diverse communities we serve.

Our key aims are to:

- **eliminate discrimination, harassment, victimisation** and any other conduct that is prohibited under the Equalities Act;
- **advance equality of opportunity** between patients and staff who share a relevant protected characteristic and those who do not share it; and
- **foster good relations** between groups who share a relevant protected characteristic and those who do not share it.

We aim to plan and deliver services that take account of the diverse needs of our patients, and create an organisational culture where our staff feel valued and respected.

We are actively engaged with people who use our services, families, carers, our staff, voluntary and partner organisations and communities to deliver improved services and working environments.

We are committed to ensuring that equality, diversity and inclusion are at the centre of everything that we do, both for our patients and staff.

Vicky Morris
Chief Nursing Officer

Sandra Berry
Deputy Director of HR and OD

1. Summary

The link between how organisations treat their staff and patient experience is widely publicised. As an NHS organisation we aim to engage with our staff and patients to get feedback on their experience of our services, and to learn from errors and omissions to improve in our role as a provider or care, and as an employer.

Equality for Patients

Patients and their families still experience differences in NHS services both in terms of access, and their treatment and outcomes.

Our aim as a Trust is to improve the patient experience for everyone, regardless of any protected characteristic. We work with advocates and independent organisations to review our patient pathways and to make changes where they are needed.

We welcome the introduction of, and are working towards, the Accessible Information Standard which will set minimum requirements for all public sector services.

Equality in our Workforce

Our staff are our most expensive, and most important resource. Fully engaged staff will provide the best possible care to our patients. During 2016/17 the Trust has been challenged by a poor CQC inspection, increased capacity issues, and unfavourable media publicity which has in turn impacted on the morale of our staff. We recognise that we have a lot of work to do to improve the reputation of the Trust so that we are seen as one of the best employers in the area.

We welcomed the introduction of the Workforce Race Equality Standard (WRES) and pleased that this is to be extended to cover Disability Equality Standard (DES) in 2018.We were concerned that our 2015 staff survey indicated issues for our BME workforce and took the decision to run a full staff survey in 2016 to enable further investigation. Our WRES assessment for 2016/17 based on our 2016 staff survey results is included as **Appendix C**.

As part of its OD plan the Trust launched a Staff Engagement Group, Listening into Action, and pulse surveys, as well as a Staff Equalities Social Media forum in 2016 to understand what more can be done to improve staff experience at work. This is a step towards developing a Staff Equalities Network (including a BME network which has been difficult to establish due to lack of interest despite previous attempts).

Our future priorities

We have developed a number of equality objectives that will help us to achieve the necessary changes in the Trust. These are based around the key headings of the EDS:

Equality Objectives:

1. **Implement data verification systems to improve recording of ethnicity (for both patients and staff)**
2. **Establish systems to collect, monitor and provide analysis of data across the 9 protected characteristics (for patients and staff)**
3. **Publish Equality information and objectives on website and intranet**

2. Introduction

We use the NHS Equality and Delivery System (EDS) as our tool for measuring our performance against the duties of the Equality Act 2010. This report has been set out to explain our progress against each of the 9 protected characteristics laid down in the Act. This includes:

- How people from across the 'protected characteristics' are involved and engaged in decisions
- How we have integrated equality considerations into our mainstream business processes
- Where we think we can improve equality in this area, and the plans we have in place to achieve this.

3. About the Trust

Worcestershire Acute Hospitals NHS Trust was established in 2000 and operates across three main hospital sites: The Worcestershire Royal Hospital, The Alexandra Hospital and The Kidderminster Treatment Centre. In 2011 a number of services transferred into the Trust under Transferring Community Services (TCS). These services operate from Community Hospitals at Evesham, Tenbury, Princess of Wales (Bromsgrove) and Malvern. The Trust has a workforce of over 5,900 and an annual turnover of over £349 million. A typical year could on average present the Trust with around 90,000 operations, 130,000 in Emergency Department, 6,300 births, and 500,000 out-patients appointments

Worcestershire's health services serve an increasing population of approximately 576,000 providing a comprehensive range of surgical, medical and rehabilitation services. This figure is expected to rise to 607,000 by 2020. Taken as a whole, the Trust's catchment population is both growing and ageing. Life expectancy continues to rise above the national average and contributes towards the forecast growth in activity due to the increase in over 75's in the local population.

Information from the last Census in 2011, found that ethnic minorities are relatively small in Worcestershire; with just over 92% of people living in the county classed as White British compared to almost 80% in the whole of England. However, statistics show that Black and Minority Ethnic groups in Worcestershire have risen from 24,700 (4.6%) in 2001 to around 43,000 (7.6%) in 2011, with the vast majority residing in the district of Redditch (12.6%).

4. Equality Data and the Public Sector Duty

The Equality Act 2010 replaced previous anti-discrimination laws with a single Act, strengthened the law and brought forward new measures to help tackle discrimination and inequality. The Act includes a general duty on the public sector to:

- eliminate discrimination, harassment, victimisation and any other conduct that is prohibited under the Act;
- advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it; and
- foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

The aim of the general equality duties is to encourage public bodies to consider how they could positively contribute to the advancement of equality and good relations. They require equality considerations to be reflected in the design of policies and the delivery of services, including internal policies and review of those policies. The specific requirements under the act are:

Requirement	Our Progress
Publish information to show our compliance with the Equality Duty, at least annually	We publish staff equality dashboard information quarterly on our intranet and web pages; and patient and staff reports, surveys and audits periodically.
Set and publish equality objectives, at least every four years	We published our Equality Objectives in the form of our 4 year EDS Action Plan by April 2012. This has been revised to take account of EDS2 with a new 4 year action plan from 2015.

5. The Equality Delivery System (EDS)

The EDS is a tool that was developed in 2011/12 by the NHS for use by organisations that commission and provide NHS services. We use the EDS in partnership with patients, the public and staff to review our equality performance and to identify future priorities and actions. A revision (EDS2) was made in 2013/14 and we have amended our action plan and self- assessment to reflect these changes.

The EDS2 consists of four goals:

1. Better health outcomes for all
2. Improved patient access and experience
3. Empowered, engaged and included staff
4. Inclusive leadership at all levels

The goals are underpinned by 18 outcomes that the Trust initially self-assessed itself against in 2011/12 and has revised its assessment in 2013/14, and June 2015. The aim is to achieve equality in these outcomes across the nine characteristics protected by the Equality Act:

- Age
- Disability
- Gender reassignment
- Pregnancy/ maternity
- Marriage/ civil partnership
- Religion/ belief
- Race
- Gender
- Sexual orientation.

Our EDS2 Action Plan (as at 31st March 2017) is attached as **Appendix A**

6. Our Equality Committee Structure

Our Equality and Diversity Committee agrees and monitors a comprehensive action plan based around the EDS2. It agrees direction, considers issues and feedback, and monitors progress.

The full committee meets every quarter and is chaired by the Head of Human Resources. Through 2016/17 the committee has met monthly to cover key E&D topics such as preparation for Equality and Diversity Week, and launch of the Accessible Information Standard. Membership of the committee is drawn from across the Trust and includes the Patient and Staff Equality Leads, divisional managers and staff side, and aims to increase representatives to cover the nine protected characteristics. The work of the Equality and Diversity Committee is reported to Workforce Assurance Group on behalf of the Trust Board.

7. Looking back - what we achieved in 2016/17

7.1 The 2016/17 Trust equality objectives detailed in our 4 year EDS Action plan were:

Objective	Progress
Implement data verification systems to improve recording of ethnicity (for both patients and staff)	Completed with on-going monitoring
Establish systems to collect, monitor and provide analysis of data (where appropriate) across the 9 protected groups across services (for patients and staff)	Completed
Publish Equality information and objectives on website and intranet	Completed and ongoing

The Trust has made good progress in identifying a number of key issues relating to equality and diversity over the previous year. A substantial amount of work has been completed, the key successes being:

- Submission of Workforce Race Equality Standard (WRES) to commissioners and NHS England.
- Inclusion of data from a greater number of protected characteristics giving confidence that conclusions are valid and more meaningful.
- Preparation for roll out of ESR Employee Self Service which will enable staff to update their equalities data themselves thus improving data quality.
- Significant progress made in improving services for patients with learning disabilities, dementia and hearing and visual impairments.
- Progress made with providing improved services for carers.
- Full review of Mandatory Training programme to enable more staff to access topics in a flexible way.
- Full review of Induction programme to incorporate key messages and learning points from CQC
- Launch of Management Know Leadership Development Programme
- Revision of key policies around bullying and harassment, whistleblowing, and Equality, Diversity and Inclusion

- Continuation of bespoke kNOw Bullying training and skills training for managers involving actors demonstrating scenarios with user participation.
- Appointment of dedicated Staff Equalities Engagement lead
- Launch of Staff Equalities forum through social media
- Staff Health and Wellbeing days on each of the three sites including Equality and Diversity awareness
- New contract for Translation services launched from March 2017

7.2 Equality Data

This year we have extended our data to include all the protected characteristics except civil partnership which is currently being included to our hospital pre/admission documents. All of our feedback from patients and surveys that we do include the 9 protected characteristics.

We have reviewed the data that is available to us which suggests that the numbers of people using us as an inpatient, day case and outpatient services are broadly consistent with the age, sex and ethnicity distribution in the local population.

Responsibility for commissioning of health services for people in Worcestershire rests with Worcestershire CCG's. As a Trust we work with colleagues in the CCG's and the Worcestershire Health and Care Trust to identify where the scope or model of services may impact on the ability of people with some, but not all of the protected characteristics. The public consultation exercises that the Trust has been involved in relating to the Joint Services Review (Future of Acute Hospital Services in Worcestershire) involved staff and public from the protected characteristics. There are three clinical sub-groups: Women's and Children's, Emergency Care, and Planned Care who completed their work with involvement from patients, public, stakeholders and advisory boards.

7.3 Equality and Diversity – Good Practice Toolkit

The Trust launched its Equality and Diversity Good Practice Toolkit in 2014/15 to ensure staff have the effective tools to communicate with patients and visitors to enable greater interaction with a modern, diverse society. The aim was to help staff to understand cultural, age related and religious differences of patients, visitors and colleagues.

Communication with employees, patients and the public takes many forms. The language we use should give employees and the communities we serve a clear message that we value diversity and respect individual differences. The toolkit includes guidance on communicating with different groups, appropriate language and customs and cultures.

We recognise and value difference and aim to create a working culture and practices that recognise, respect, value and harness difference for the benefit of the organisation and the individual.

7.4 Plans for Equality and Diversity Week – May 2017

The Staff Equalities Engagement Lead has worked with the Equality and Diversity Committee and external networks to plan for Equality and Diversity Days on each of the three main sites for Equality and Diversity Weeks. This would include patient and staff equalities information to raise the profile and provide useful contacts and information.

8. Equality Information for Patients in 2016/17

During the past year we have continued to work with our patients, carers and wider communities to enhance patient experience across our services and to take account of feedback to continuously improve what we do.

We have taken part in 2 National Surveys covering inpatients, and Accident and Emergency Services.

Key improvements have included:

- Commissioning of new interpreting and translation services alongside roll out awareness briefings
- Significant improvement project within outpatients departments including: environment changes (including dementia clocks and signage and chairs); introduction of text messaging appointment reminders; introduction of standard codes of behaviour and expectations of staff for all clinics and a review of clinical scheduling to increase efficiency.
- Introduction of Hearing Loops across all sites and training sessions for staff on using these
- Launch of Trust wide Dementia Strategy
- Carer Awareness Training delivered in partnership with Worcestershire Association of Carers to over 70 staff
- Introduction of new end to end and user led Concerns and Complaints Policy and Process informed by users responses to our 2015-16 survey
- Introduction of monthly 'Learning from Complaints' presentations
- Maternity Services successfully reaccredited under UNICEFS 'Baby Friendly Initiative' in June 2016
- Participation in the Kings Fund 'Collaborative Pairs Programme' to develop patient leadership and better collaborative working across the Trust
- Successful Quality Improvement Project in Radiotherapy Department
- A&E department expansion at WRH including improved disability access
- Over 60,000 hours of voluntary activity recorded to support our services across all 3 sites
- Greater collaborative working with Healthwatch and other partners including Worcestershire Association of Carers and SpeakEasy Now.
- Recruitment of new Learning Disability Nurse and ongoing joint work with the Health & Care Trust to provide better services for patients and their families
- New Trust wide patient information leaflet templates introduced
- Revisions to Governance structures across the Trust to provide a greater focus on patient experience
- Draft Accessible Information Policy developed and start of working party to improve trust alerts system to support this
- Accessible information now on all TV loops in waiting areas
- New standard back page for patient information leaflets developed promoting that information is available in different formats and languages
- Development of new signage across Trust to assist patients and visitors to find their way
- 146 patients and families have used the Stephen Bayley, end of life care room at the Alexandra Hospital
- Development of a Trust wide pathway for Female Genital Mutilation

- Development of a prompt card for staff re Mental capacity act
- Ongoing roll out and support for PREVENT Training

8.1 Patient Experience Surveys

The Trust has undertaken a variety of in depth patient surveys during the year including those commissioned through Picker which have covered: inpatients and Accident and Emergency and maternity services.

8.1.1 National Inpatient Survey

National Inpatient Survey – Conducted by Picker – July 2016

- Survey of 83 Trusts - Response rate 44% compared with average of 41%
- Trust has deteriorated to 'below average' compared to other Trusts

8 areas where our performance significantly deteriorated	14 problem areas where we scored over 50%, of which 7 related to discharge	3 year trend analysis
• Admission: had to wait a long time to get a bed on a ward • Hospital: sharing sleeping areas with opposite sex • Hospital: using bath / shower area shared with opposite sex • Nurses: Talked in front of patient as if not there • Care: Wanted to be more involved in decisions • Care: Did not always have confidence in decisions made • Care: Did not always have enough privacy & dignity • Discharge: did not feel involved in decisions about discharge	• Discharge: not given enough notice when discharge; family not given enough information; not feeling involved in decisions regarding discharge; not always knowing what would happen next after leaving hospital; not fully told of danger signals to look for; not fully told of danger signals; discharge delayed by 1 hour or more. • Admission: Had to wait too long for a bed • Planned Admissions: no choice of hospitals • Care: wanted to be more involved in decisions; could not always find staff member to discuss concerns with • Nurses: did not always know which nurse was in charge • Overall: not asked to give views on quality of care; not given any information explaining how to complain	**Improving :** • Planned admission- should have been admitted sooner **Deteriorating:** • Not given enough privacy and dignity within A&E • Shared sleeping area with opposite sex • Not enough information on condition / treatment • Not enough emotional support from staff • Not enough privacy when being examined / treated • Not told of danger signals to look out for • Staff did not discuss need for further health of social care services • Not treated with dignity & respect • Rated experience less than 7/10

Our patients and their families have raised a number of issues over recent years which require targeted and sustained improvement activity. Working with staff we have developed a Trust wide Action Plan to tackle the areas. These actions include:

- Focus on delivery and embedding of SAFER which is premised on effective communication with patients & carers and better flow throughout our hospitals
- Updating of discharge information to include information patients are repeatedly telling us they do not receive
- Requiring all wards / departments to have staff who have attended Carer Awareness Briefings which emphasises need to communicate with relatives and involve them in care, treatment and discharge as

well as signposting carers to appropriate support. • Improved information on Trust website • Revision of FFT implementation and how we use data • Privacy & Dignity Awareness Raising across Trust • Patient Experience to be standard element of Junior Doctors training
What we achieved following last year's survey: • Sage & Thyme training available to all staff to help develop communication skills – 177 trained during last year • Carer Awareness Training for staff to ensure carers are seen as expert care partners – 70 staff members trained • Ongoing revisions and review patient information across our services • Monthly learning presentations introduced to share learning from complaints and concerns along with good practice • SAFER launched in June 2016 • Introduction of new interpreting contract and standard template for leaflets including information on how to obtain information in alternative languages and formats g

Key information about the 531 patients who responded:

Gender: 48.2% were male and 51.8% were female.
Age: 1% under 20**;** 3% 20-39; 18.5% 40-59; 21% 60-69; 30.5% 70-79 ; 23.4% 80+
Disability: Hearing impairment 14.5%; Visual impairment 5.3%;longstanding physical condition 28.7%; learning disability 1.8%; mental health issue 6.4%; longstanding chronic illness 33.4%
Religion/ belief: 81.3% Christian; **13.8**% no religion; 2.1% prefer not to say; other 1.4%; Muslim 0.8%; Buddhist 0.4%
Ethnicity: 97% British; Pakistani 0.8%; Any other White 0.6%; Irish 0.4%; Indian 0.4%; White & Black Caribbean; 0.2%; White & Black African 0.2%; Any other Asian background 0.2%; Arab 0.2%
Sexual orientation: 95.8%heterosexual; 3.4% prefer not to say; 0.4% other; 0.4%Gay / Lesbian;
Gender reassignment - the survey does not ask this
Pregnancy/ maternity – the survey does not ask this
Marriage/ civil partnership - the survey does not include this question

8.1.2 Accident and Emergency

Accident and Emergency Survey – Conducted by Picker		
• Survey of 75 Trusts - Response rate 32.5% compared with national average of 26% • Average performer relative to other trusts but deteriorating picture with scores declining in 24 of the 35 questions		
3 Questions scoring significantly better than the Picker average	**3 Questions scoring significantly worse than the Picker average**	**Worst absolute scores affecting most patients**
• Drs / nurses talking in front of patients as if not there • Feeling threatened by other patients / visitors	• Waiting over 4 hours • Not enough privacy when examined • Waited more than 15 minutes to get pain relief	• Waiting: Not told how long would have to wait to be examined • Leaving: Family or home situation not taken into account • Leaving: Not fully told when to resume normal activities • Pain: Waited more than 15mins to get pain relief medication • Leaving: Not fully told about medical side effects • Care: Not reassured by staff if distressed • Leaving: Not fully told about danger signals to look for • Waiting: Overall, visit to emergency department more than 4 hours • Arrival: Not enough privacy when discussing condition with receptionist • Care: Not always able to get help from Staff when needed • Doctors/ nurses: Did not fully discuss patient anxieties or fears
What we have done / are doing: • Reconfigured and expanded the WRH A&E waiting area • Introduced additional consulting capacity cubicles to improve privacy and dignity • Reduced numbers who can gain access through to A&E corridor and introduced screens, buzzers and additional volunteers to support patients and families • Introduced a relatives room in the Medical Admissions Unit • Launched SAFER across our hospitals to improve patient flow		

Key characteristics of the 383 people completing the survey:

Gender – 45.8% male and 54.2% female
Age: 3.5% under 20; 22.9% 20-49; 14.4% 50-59; 18.1% 60-69; 21.8% 70-79; 19.4% 80+
Disability: 12% Hearing Impairment; 3.4% Visual Impairment; 22.6% Longstanding Physical Condition; 1.4% Learning Disability; 4.5% Mental Health Condition; 2% Dementia
21.2% longstanding illness

Ethnicity: White British 96.5%; any other white background 2.7%; White Irish 0.3%; any other mixed / multiple ethnic group 0.3%; any other Asian background 0.3%
Religion: 75.8% Christian; 20.5% No religion; Prefer not to say 2.1%; 0.8% Buddhist; 0.4% other
Sexual Orientation: 91.7% Heterosexual; 4.3% Prefer not to say; 1.9% other; 1.6% Gay / Lesbian; 0.5% Bisexual;
Gender reassignment – survey does not ask this question
Pregnancy / Maternity – survey does not ask this question
Marriage / civil partnership- survey does not ask this question

8.1.3 Hospedia Surveys

Hospedia is the bedside entertainment system which is available in ward areas across the Redditch and the Worcester sites (with the exception of Aconbury wards). As well as providing entertainment options it also provides hospital information and is used to capture near real time patient feedback.

The following surveys are available via Hospedia:

- Friends and Family Test (started 16/10/14)
- Carer Survey (started 19/06/13)
- Learning Disability Survey (started 08/07/13)
- Patient Satisfaction (started 01/07/13)
- Cleanliness Poll (started 05/02/14)

The information obtained from these surveys is triangulated with information obtained from our other feedback sources and used to inform improvement activities.

8.1.4 Carers Survey

Hospedia Survey	Key findings	Actions
Carer Survey - 135 carers completed this survey during 2016-17	• Welcomed to ward 79% • Staff introduced themselves 70% • Medicines explained 61% • Given helpful information about the hospital 70% • Involved in discharge 48% Given information about carer services / support 29% • Given opportunity to discuss caring role 34% • Felt experience as carer recognised by staff 42% • Asked if a carer 32%	The findings provide a mixed picture with deterioration in some areas such as staff introducing themselves and being informed of carers services while improvements have been recorded in; being asked if they are a carer; being recognised as a carer and given the opportunity to discuss their caring role. We have continued to promote carers involvement and recognition through our Carer Awareness Briefings. Over the past year we have held 6 individual sessions attended by some 70 staff. These have been run jointly with Worcestershire Carers Association, who also ran information stalls at all 3 of our sites during Carers Week in June 2016. These provided information on carer's services to patients, visitors and staff. We also relaunched our Carers Rooms at the Alexandra Hospital in February to mark National dignity day.

		 Involving and valuing carers is now a key message in all our patient experience training sessions and our champions are promoting carer involvement on wards and in departments throughout the Trust. This is also central to the effective implementation of SAFER. The Trust remains an active member of the Worcestershire Carers Partnership and we continue to work closely with our fellow members. We have signed up to Johns Campaign, as part of our Dementia Strategy to reinforce our commitment to involving carers. We also intend to introduce Carers Cards in the near future for all carers so that they can more easily be present at ward rounds and outside standard visiting times to provide support to their loved ones.

8.1.5 Learning Disability Survey

Hospedia Survey	Key findings	Actions
Learning Disability 356 learning disability patients seen by the Link Nurses at the Acute over the past year. 75% of those referred. The impact of their work is reflected in the results from our 2016-17 Survey - 143 were completed during the year.	• 81% were admitted as emergencies • 87% found the hospital staff friendly and helpful • 77% felt staff explained things in a helpful way • 78% felt staff involved them in their care • 73% said staff involved their carer • 44% who had a 'Hospital Passport booklet felt this helped staff look after them	There have been some key improvements recorded this year in these findings not least an increase in numbers stating that their carers have been involved in their care, up from 47% last year to 73% this year. No doubt the regular Carers Briefings and ongoing work of our Learning Disability Link Nurses have helped with this. The LD Nurses are employed by the Health & Care Trust, and have a community role alongside that of their work with the Trust. They provide on-going support to our patients and their families and regular training updates for our staff, including LD Champions. Some 783 staff have had some learning disability training input over the past year which greatly enhances understanding and patient experience. They have also supported the Patient Experience Team to deliver Carer Awareness Briefings. The team has experienced some changes

		during the year with the retirement of a longstanding nurse and recruitment of a new team member who started in March 2017. Our Associate Director of Patient Experience was part of this recruitment panel alongside our H&CT colleagues. The team have also relocated within the Acute Trust and are now located alongside the Patient Experience Team at Kings Court. **Key achievements**: Introduction of new Hospital Passport to replace the previous About Me booklet Introduction of transition folder into A&E to support the transition from children's to adult services for those with complex needs. 90% of patients seen by the LD Nurses had a six point assessment completed which covers: - Level of learning disability, capacity - Communication, - Carers - Risks - Reasonable adjustments - Hospital passport. Team ran stalls across all 3 sites during Learning Disability Week in May promoting the Mencap 'Hear my Voice' campaign to raise awareness of the experiences of those living with a learning disability. One measure of the effectiveness of the team and the support they give patients and their families is that we have received no complaints from service users during the last year. Our plans to make the LD Survey on Hospedia an Easy Read survey was unfortunately thwarted by the limitations of the system. However an accompanying hard copy has been developed to support completions and has been circulated across our wards. The Trust continues to be an active member of the Worcestershire Learning Disabilities Partnership Board and contributor to the Staying Healthy Sub Group.

8.1.6 Patient Satisfaction Survey

Hospedia Survey	Key findings	Actions
Patient Satisfaction Survey 896 completed during the year	• Staff listened to my concerns 84% • Staff were friendly and approachable 89% • I was involved as much as I wanted to be in decisions about my care and treatment 72% • I was given enough information 71% • I understood the information given 85% • I was given enough privacy when discussing my condition 81% • I was bothered by noise at night 48% • The food was good / very good 76% • I was treated with dignity and respect 86% • The care I received was excellent / good 89%	Results in this survey are very similar to those recorded in 2015-16 with some slight deterioration in areas relating to privacy, dignity & respect and involvement which are also reflected in our National Inpatients Survey. The Action Plan and improvement activity targeted at those findings should also impact upon these results for 2017-18.

8.1.7 The Friends and Family Test

The Friends and Family Test (F&FT), introduced in 2012 is a national initiative designed to help service users, commissioners and practitioner ensure services measure patient experience. Since April 2012, we have been asking our patients whether they would recommend hospital wards to their friends and family if they needed similar care or treatment. This provides a simple way for every patient to give feedback on the quality of the care they receive and helps us improve our services.

Friends and Family gives us an indication of whether our services are meeting patient needs and whether they are being delivered in an acceptable way. This is supplemented by a number of other more detailed surveys based on specific service areas. The F&F forms are given out by staff and volunteers.

All of this feedback is being taken forward in various initiatives during the forthcoming year regarding improving discharge arrangements and improving communication skills for all staff via our ACE with Pace programme.

Friends & Family Response Rates 2016-17

	Target	YTD	RAG
Wards	30%	12.84%	
A&E WRH	20%	7.27%	
A&E ALX	20%	3.79%	
Maternity	30%	26.73%	

Friends & Family Scores 2016-17

	Target	YTD	RAG
Wards	75	79.68	
A&E WRH	75	61.13	
A&E ALX	75	83.08	
Maternity	75	84.09	

FFT response rates have continued to prove challenging throughout the year. Improvement work has focussed on:

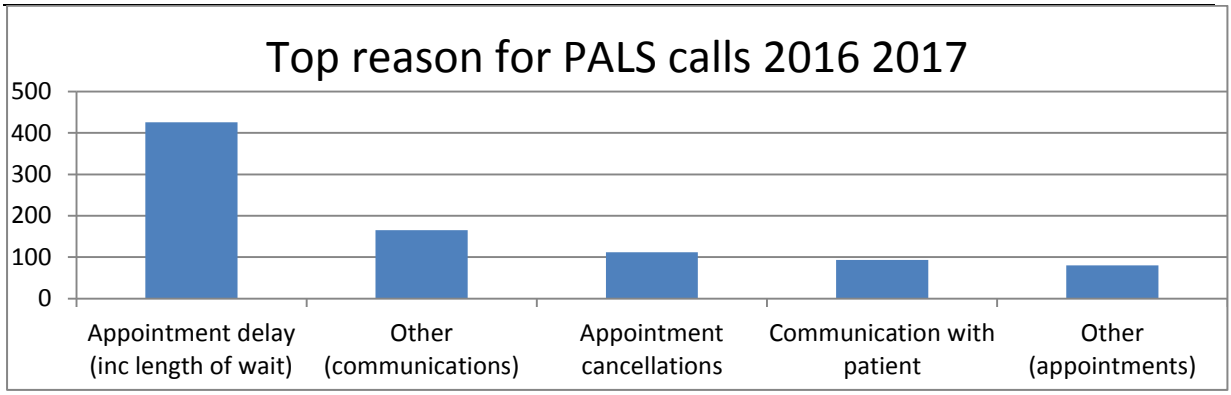
- Updating posters and collection boxes throughout our hospitals and added promotional videos to the TV loop in waiting areas.
- Considering whether to outsource FFT or develop further in house. The PE Team visited other hospitals and met with a number of external providers to review this. By the start of 2017-18 however the decision was made to continue to develop in house and develop much more accessible reporting.
- The development of the trusts new SQUID dashboard has started this process
- Work is ongoing with informatics to develop a new FFT app and enable completions on our website. We aim to go live with this in summer 2017.
- Alongside this our Patient Experience Lead has continued to support staff within A&E and ward areas to improve response rates through raising awareness and sharing scores and completion rates, engaging more volunteers to assist with completions and installing new FFT boxes and posters in the waiting areas and cubicles.
- We are also planning monthly FFT Stars Awards to highlight areas who have used their feedback effectively.

More information on the NHS Friends and Family Test can be found at: http://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2013/07/Publication-Guidance.pdf

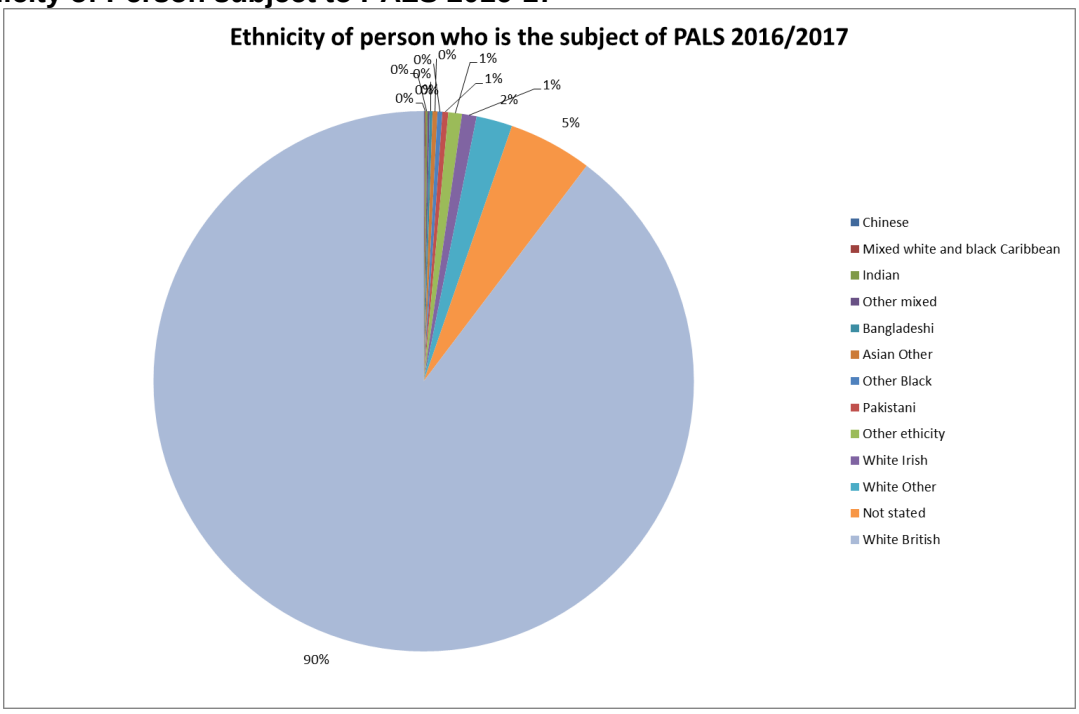
8.2 Patient and Advice Liaison Service (PALS)

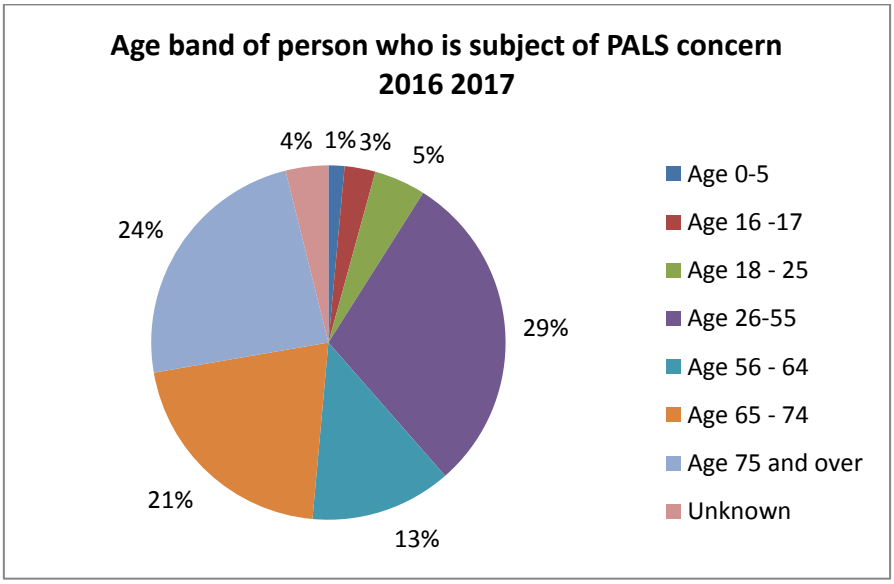
The Patient Advice and Liaison Service continued to have a significant workload during the past year with 2561 enquiries compared to 2562 in 2015-16 and 1833 in 2014-15.

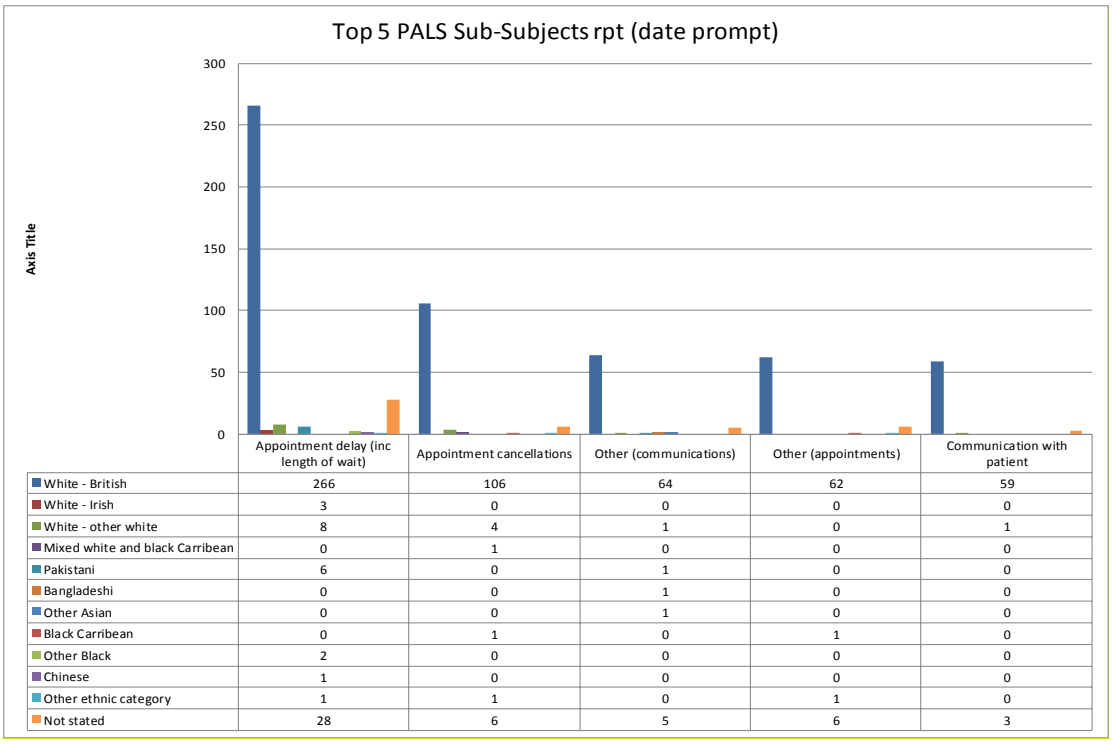
The PALS Officer works primarily with matrons to ensure that callers concerns are addressed within 24 hours, thus reducing anxiety and distress. They also follow up calls to ensure that contact has been made and that the caller is satisfied. The main themes of our PALS calls during the past year have been as follows:



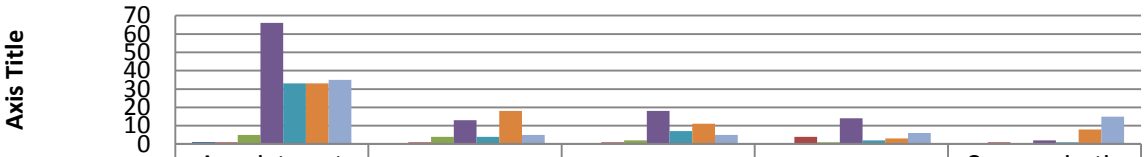
Ethnicity of Person subject to PALS 2016-17







	Appointment delay (inc length of wait)	Appointment cancellations	Other (communications)	Other (appointments)	Communication with patient
White - British	266	106	64	62	59
White - Irish	3	0	0	0	0
White - other white	8	4	1	0	1
Mixed white and black Carribean	0	1	0	0	0
Pakistani	6	0	1	0	0
Bangladeshi	0	0	1	0	0
Other Asian	0	0	1	0	0
Black Carribean	0	1	0	1	0
Other Black	2	0	0	0	0
Chinese	1	0	0	0	0
Other ethnic category	1	1	0	1	0
Not stated	28	6	5	6	3



	Appointment delay (inc length of wait)	Appointment cancellations	Communication with patient	Other (appointments)	Communication with relatives/carers
0-5	1	0	0	0	0
6-17	1	1	1	4	1
18-25	5	4	2	1	0
26-55	66	13	18	14	2
56-64	33	4	7	2	1
65-74	33	18	11	3	8
75 and over	35	5	5	6	15

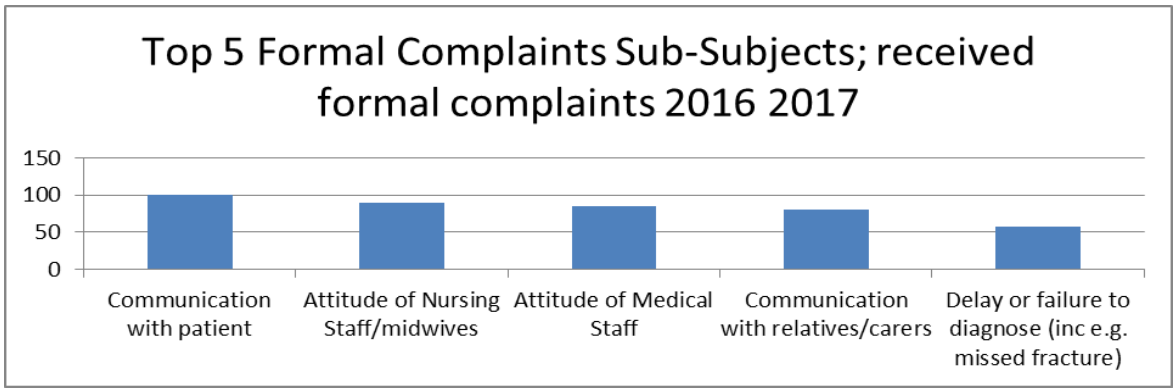
PALS provides a much valued service enabling patient concerns to be dealt with at source, quickly and effectively. The effectiveness of PALS is demonstrated in the fact that only 1.3% of cases which started as PALS enquiries went on to become formal complaints during the past year. Any peaks / themes are also highlighted immediately to enable any corrective action to be taken and monthly Divisional reports are also collated.

We remain acutely aware that we are not currently resourced to deliver a front of house PALS service across our three sites but despite this we continue to deliver an accessible and increasingly well used service to patients and their families

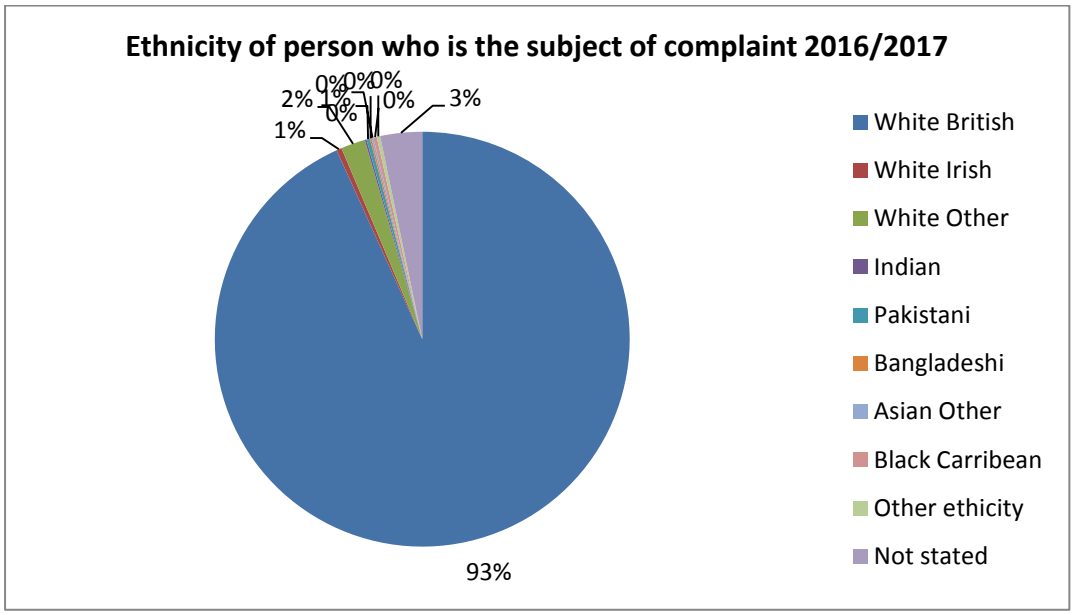
8.3Learning from Complaints

Over the past year we have seen a 12% rise in complaints, from 658 in 2015-16 to 742 in 2016-17. Many of these have been related to the issues we have experienced in A&E. Our response times also dropped during this period from 66% to 63%.

The top 5 concerns raised by patients are:

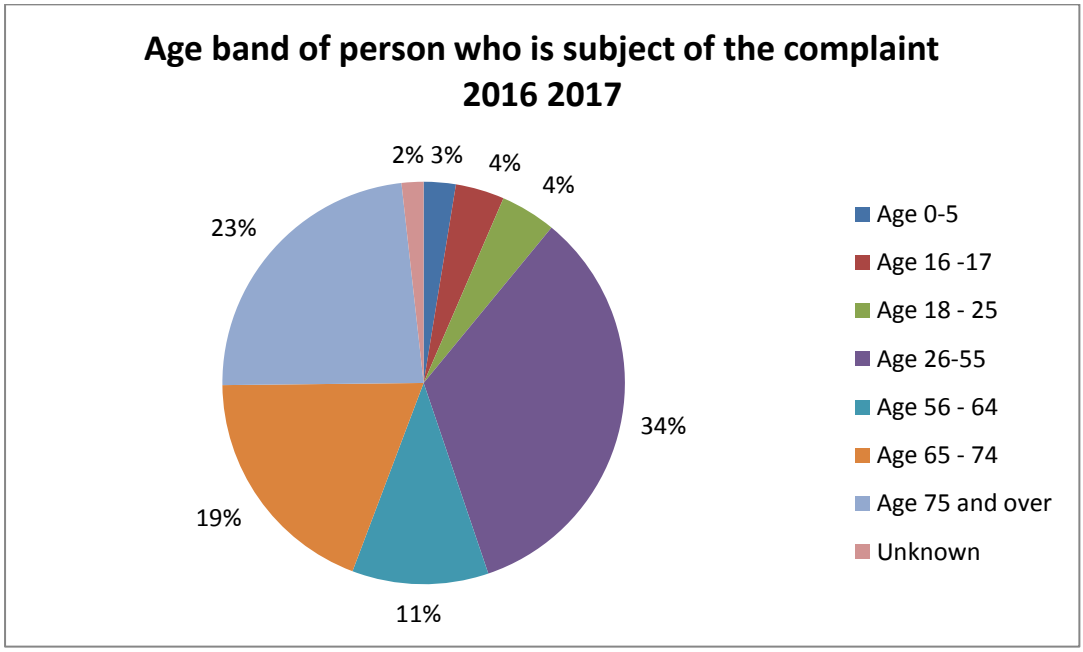


8.3.1 Ethnicity of Complainants

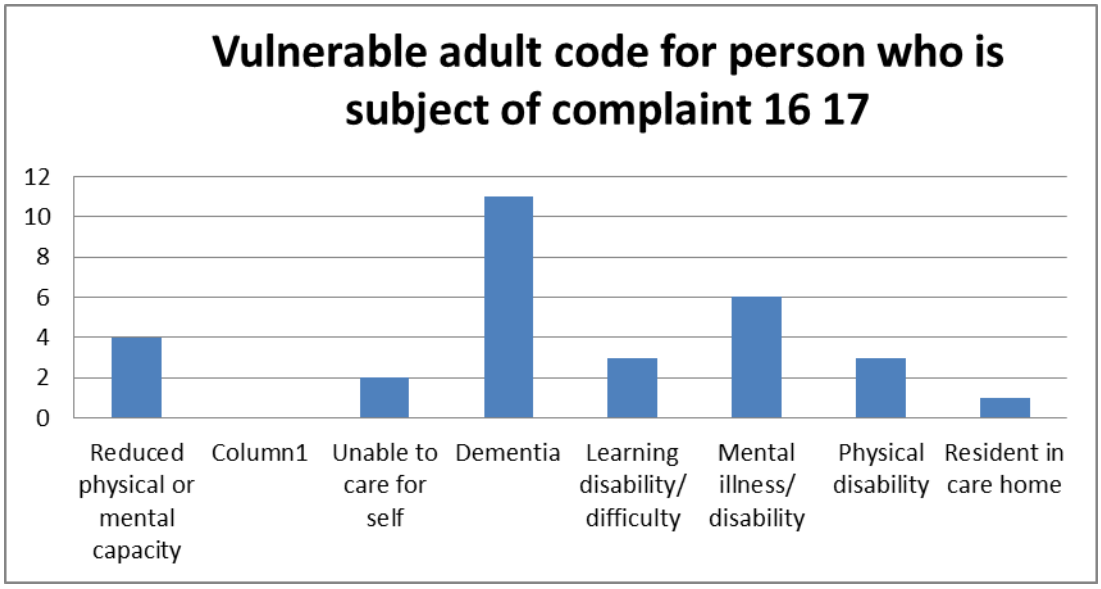


The majority of people making a complaint were white (93%) reflecting the county's demographic profile. 3% were Indian and 2% White Other. In reviewing these complaints the overarching reason for the complaints were communication issues, attitude and delays in treatment which reflects the general trend across all complaints.

8.3.2 Age



8.3.3 Vulnerable Adults



Complaint information is captured regarding vulnerable adults which and reported to the Safeguarding Committee.

8.3.3 Top 5 areas for complaints by site

Site	Number of complaints	Main Service Areas for complaints	Number of complaints
WRH	**477**	A&E	85
		General OP/clinics	57
		Beech B	14
		MAU	14
		Trauma Unit	12
ALX	**177**	A&E	38
		General OP/clinics	29
		Ward 5	9
		Ward 17	8
		Ward 3/ Ward 11	7
KTC	**58**	General OP/clinics	10
		MIU	8
		Day Surgery Unit	5
		Day Hospital/Ward 1	2
Other	**30**	POWCH	6
		Trust wide	5
		ECH	4
Total	**742**		511 (69% of total complaints)

Communication remains our key concern both in complaints and in our national surveys. We continue to roll out 'Sage and Thyme' communication training to improve communication skills across the organisation and patient experience training which incorporates this is included in our Care Certificate and preceptorship training. It will also be included on junior doctors training from autumn 2017

8.3.5 Learning from Complaints

One of the most important aspects of monitoring complaints is to ensure that the Trust learns from them and takes action to ensure that the situation that led to the complaint in the first place is not repeated. To support this, the Divisions are working closely with the Complaints Team to improve action planning and shared learning. The new investigation template includes action planning and monthly Divisional Audits are now taking place which enables us to with the Quality Governance Leads, patient representatives and our CCG colleagues are being scheduled as part the quality assurance process.

Some examples of learning from complaints in the past year have been:

Complaint	Action	Learning
Communication with patient		
Poor communication with a patient whose first language was not English. This led to the patient making a complaint that they did not realise that part of their finger would be amputated.	Ward Manager has been asked to remind her nursing staff about how important it is to ensure patient understands what we are saying and we should use an independent translator for patients who do not speak English as their first language.	If a translator had been used, rather than the patient's sister, there would not have been this level of misunderstanding.
A lot of medical jargon was used and the patient did not understand it. Patient is not aware what is wrong with them.	The consultant has been advised about the importance of explaining the terms that are used in a consultation.	Patients may not understand what they are being told so explanations need to be clear.
Attitude of nurses/midwives		
Staff' communication with each other about their frustrations with some processes caused the patient's son to become concerned about the care his mother was receiving.	Staff attended 'Sage and Thyme' communication training.	How staff communicate with each other can affect the patient experience.
Attitude of medical staff		
The patient did not feel listened to by the consultant or his colleagues.	Discussed in the specialty and the consultants have agreed to ensure talking to patients and relatives is part of their ward rounds. To allow this to happen a suitable area has been identified where private conversations can take place. There is now a weekly multidisciplinary ward round. The Directorate review all complaints, in confidence, at their Clinical Governance meeting; comments about staff attitude have been shared with the relevant teams at this meeting and this will be monitored.	It is important to keep patients informed of their care and treatment at all times, particularly when multiple specialties are involved
Concern about missed diagnosis and doctor's attitude.	Concern about doctor raised in departmental clinical governance meeting; teaching sessions arranged with junior and senior doctors to avoid such an issue in future.	With the benefit of hindsight the mechanism of injury and the laceration on head could have raised suspicion of an underlying fracture and triggered a request for a CT scan of head. There is always a learning point for us from patients' feedback.
Communication with relatives and carers		
Family have raised concerns about several inpatient admissions, diagnosis, subsequent care pathways, communication with patient and family. Mix-up with appointments and another hospital and lack of any clear treatment or diagnosis. Patient subsequently passed away	Discussed at team meeting that staff should approach each request in a way that is helpful and supportive, offering alternative options. Ward manager has also had one to one meetings with her staff to improve the consistency of care and documentation on the ward. A newly appointed Neurology Nurse Specialist has been appointed to improve communication and coordination between clinicians, particularly	Better communication is needed with patients and their relatives.

Complaint	Action	Learning
	those working in different hospitals. The team has been reminded about the use, and sharing of, appropriate leaflets and information so that this further information can be accessible for friends and family.	

8.3.6 Revisions to our Complaints Processes

Using feedback from our annual complaints users survey 2015-16 and guidance contained in the Parliamentary and Health Service Ombudsman Guidance 'My Expectations' we totally revised our complaints policy and processes last year and launched these in December 2016. This has introduced and supported the following:

- Focus on resolving matters quickly and informally at source
- Expectation investigating officer will contact complainant within 5 working days
- Deregistration of formal complaints if matter can be resolved to complainants satisfaction without the need for an investigation and complainant agrees to deregistration
- Datix is the tool for management of all complaints across the Trust
- Quality Governance Leads have key role in assuring quality of responses and ensuring actions and learning shared
- Weekly sitrep, introduced in July 2016 includes complaints and gives weekly updates on numbers and trajectories for closure
- The Complaints Team presented their work to the National Complaint Managers Conference in London in March
- 4 sessions of Modern Gov Complaints Response Writing Training have been held and attended by over 80- staff
- A new Complaints Audit Tool was developed by the Clinical Governance Forum and monthly audits of 10% of complaints will commence in April 2017.
- Introduction of a complaints monthly learning presentation from November 2016 which is shared with Divisions
- Phase 3 of new SQUID dashboard incorporated complaints data which can be drilled down to ward .
- Trust taking part in pilot of new NHS England Complaints Survey for 2016-17
- All Complex (Category 3) complaints reported to the Patient & Carer Experience Expert Forum.
- Dissemination of new Policy & Process through attendance at range of Divisional meetings, Comms Briefings and discussions with staff

All of this has been about using what patients / carers have been telling us and simplifying our processes and procedures and ensuring that they have a single point of contact to help them through the complaint.

8.4 Patient / Public Engagement

8.4.1 Volunteers

Our volunteers are overseen by a variety of Friends Groups and other agencies such as Macmillan and the RVS. Over the past year we have worked closely with our partners to promote and grow our volunteers and development a new Volunteer Policy.

In April 2015 we started recording volunteer hours for the first time and this has given us the opportunity to understand and recognise the huge contribution that volunteers make to our hospitals. An incredible 55,000 hours were recorded during that first year and this rose to over 60,000 this year.

As part of our Patient Experience CQUIN we introduced a Volunteer Survey onto Hospedia to understand the impact and perception of volunteering across our Trust. Key findings:

Volunteer Survey 2016-17	
I think the volunteers improve the patient experience for patients and carers	62% Yes 12% No
I always knew who was a volunteer and who wasn't	39% Yes 41% No
I found volunteers friendly and approachable	50% Yes 20% No
The volunteers provide services that the trust would not otherwise provide	51% Yes 16% No
Involving volunteers helps the trust to show it cares as an organisation	61% Yes 15% No
Volunteers provide a good way of involving the local community in our community	65% Yes 9% No
Volunteers provide a good way for the trust to listen to patients and the public	60% Yes 13% No

Volunteers are clearly felt to enhance patient experience, provide a positive way of involving the local community, provide a good method of engagement, support services which otherwise could not be provided and show that the Trust is a caring organisation.

A new recruit to our volunteers in the past year has been our therapy dog Aero and his owner Lesley Farage. Lesley volunteers for the charity Therapy Dogs Nationwide. Aero has been visiting patients regularly at WRH since summer 2016.

We were thrilled that Aero won 'Volunteer of the Year' at Crufts in March and since them he has accompanied Lesley on a number of interviews on local radio raising awareness of the work that he does and encouraging others to join the charity. We will be expanding the visiting service in 2017-18 to include Redditch. We are also focussing on expanding ward and department based volunteering opportunities across all our sites.

8.4.2 Patient Public Forum

The Trust has a very committed Patient and Public Forum, a group of patients who volunteer their time to help us with a variety of improvement and quality assurance activities aimed at improving patient experience and services across all our sites. These activities include ward and clinic visits, contributing to specific areas of work such as reviewing documents and sitting on a range of Trust Committees. Over the past year the group has been significantly depleted due to sickness and departures and has also been reviewing with the Trust how we can maximise their impact. This has included reviewing their Terms of Reference, Role Specification and linking them more closely with our Divisions.

Key activities over the past year have included:

- Supporting Patient Led Assessment Care Environment (PLACE) and Mini PLACE, Quality Reviews and Clinical Fridays.
- Developing links with Medicine and Surgery and starting to work with them on their respective priorities including: A&E expansion and impact on patient experience; Complaints; FFT; SAFER roll out and patient information
- Scheduling a number of joint visits for the year.
- Reviewing a range of patient leaflets and information
- Representing patients on a range of Trust Committees and patient groups

Key themes and improvement activities:

- Noise at night - development of 'Noise at Night Protocol' – to be launched early in summer 2017-18
- Buzzers and phones not answered promptly – highlighted with Matrons and included in Inpatients Action Plan
- Issues regarding discharge – communication and delays – Discharge Leaflet introduced
- Assistance in developing a new standard template for Trust leaflets and helping review and improve a wide range of patient information ensuring that it meets patients' needs and is understandable
- Ongoing support to check and ensure our sites are dementia friendly

We are aiming to increase our involvement opportunities over the forthcoming year and to broaden the breadth and diversity of those who work with us to better reflect the patient groups within Worcestershire. To do this we need to continue to work closely with Healthwatch and the Health and Care Trusts Youth Engagement Board as well as a range of other local groups and networks.

8.4.3 Web based Feedback

The Trust collects feedback from NHS Choices and Patient Opinion. Over the past year 172 comments were made during the past year of which 72% were positive. The Patient Experience Team oversee this feedback, sharing it as it comes in with the areas concerned and asking patients to contact us directly to follow up any specific concerns. Monthly Divisional reports are also collated and shared.

8.4.4 Patient Stories

Patient stories are regularly shared throughout the Trust at Board and ward level. We plan to develop these further during the forthcoming year utilising patient pathways and audio and video feedback to help new patients prepare for their stays in our hospitals. One such story has been:

Mrs A wrote to the Trust following her and her husband's experiences regarding his admission to Worcestershire Royal Hospital in November 2016. Mrs A is 81 and her husband 83.

Mr A, was admitted to WRH on the 12th November with knee problems and confusion. He becomes a patient on Avon 3. His 81 year old wife and primary carer visited him regularly and attended on one day to find that he wasn't there. On enquiring at the nurse's station she found that the staff she asked had no idea and no passwords for the computer system. They rang 5/6 other wards before eventually tracking him down via Theatre Assessment to Medical Short Stay.

On arriving at the ward, Mrs A found her husband tearful and distressed as he thought he had been put into a wheelchair to be taken home. No one had communicated with him regarding the move or with Mrs A.

Later that evening Mrs A rang Medical Short Stay to check that her husband was ok. The Sister who answered the phone said she had not heard of him and suggested that Mrs A rang A&E- he had already been in the hospital at this time for over a week.

The following day Mrs A discovered that her husband had been moved again, this time to Evergreen; as she visited by bus knowing this in advance would have saved her a considerable walk. Ongoing up in the lift to the ward Mrs A met another visitor who like her had arrived to find her husband moved and had spent over 2 hours trying to find him. She was very upset and angry about the experience she had had.

Mrs A found that her husband was again distressed by the move. She spent some time with him and was joined by a friend. At about 3.00pm a man arrived at the foot of the bed with a wheelchair. Mrs A said, surely her husband was not being moved again to be told yes he was and would now be going to another hospital. He was then whisked away leaving Mrs A and their friend to clear out his locker.

Mrs A concluded her letter by saying 'It is the 21st century and as a porter has to be instructed to fetch and move him elsewhere the patient and next of kin should be informed. We are not objects being moved around in a warehouse but human beings. I sincerely hope that these practices will be put right. I am very aware that you all work extremely hard and hope you can just spend 2 minutes to put this matter right'.

Our surveys and complaints regularly highlight that we must involve patients and carers more in their care and in discharge.

8.4.5 Organisational Learning

- Impact of numerous patient moves on patients and relatives
- Importance of communicating reasons for moves with patients and relatives
- Importance in discussing discharge / rehabilitation plans with patients and relatives

What we are doing:

- The Trust is part of the Worcestershire Carers Partnership and works closely with Worcestershire Association of Carers.
- WAC jointly present our Carers Awareness Briefings which are now part of a regular training programme for staff aimed at involving carers in patient care and supporting them through information and signposting. We also promote carer awareness in Trust
- Induction, Preceptorship and Care Certificate training sessions.
- The Trust has signed up to John's Campaign which although focussed on dementia is committed to flexible visiting for carers.
- The PE Lead visits ward areas to discuss with staff and promote better involvement of carers in patient care and greater empathy and understanding.
- Our Director of Comms met with Mrs A, who used her 3 hours respite from her caring responsibilities to come and discuss her experiences. This will now be followed up by Comms and the PE Team to make a video / audio case study which can be used for staff training.

These stories are extremely powerful in ensuring patients experiences remain firmly at the heart of everything we do and by sharing these it helps all staff remember why we do the work we do and the impact that we each have individually on those that we treat and their families.

8.5 Safeguarding

8.5.1 Structural Changes and CQC Recommendations

Effective safeguarding and promotion of the welfare of adults and children/ young people relies upon joint working and constructive relationships that are conducive to good multi - agency partnership working. This can only be effective when all staff are knowledgeable, confident and equipped with the skills to deal with process and procedures when concerns arise relating to patient safety.

A second CQC Inspection took place from 22 to 25 November 2016, with unannounced inspections at Worcestershire Royal Hospital, the Alexandra Hospital and Kidderminster Hospital and Treatment Centre on 7, 8 and 15 December 2016. This inspection followed from the previous one in December 2015 due to our Inadequate rating and this follow up inspection gave us the same.

On 27 January 2017 the CQC issued a section 29A warning notice to the trust requiring significant improvements in the Trusts governance arrangements for identifying and mitigating risks to patients. This had particular emphasis in respect to checking of Child Protection Plan electronic flags within Emergency Department. Considerable work has continued to address these recommendations.

8.5.2 Staff Training

Safeguarding adult and children training is mandatory for all Trust staff and is monitored as part of the safeguarding assurance process. Extensive work has been invested in matching job roles to required level of training but there remain extensive challenges pertaining to collation of data which are continuing to be addressed by Informatics. The Trust training attainment target remains at 90% across all Levels. Training provision has been increased and scheduled for a year in advance. Additional options of access to multiagency free

training has also been promoted to staff. A leaflet covering Level 1 Safeguarding information will be distributed to all staff with wage slips in the Spring.

8.5.3 Prevent

PREVENT awareness training continues to be delivered on induction and all mandatory training programmes with an extended workshop to raise awareness of prevent (WRAP) delivered on clinical and senior mandatory training sessions.

Of the 4093 staff requiring WRAP training – 60% (2466) staff have completed. This is on trajectory for the 3 year delivery plan by the end of 2018 – the compliance target to be achieved is a minimum of 85%. The Trust is on Trajectory to achieve this target.

The Trust provides a quarterly report to the CCG to monitor compliance with the Governments counter terrorism PREVENT strategy. This data is also reported internally within Clinical Governance Group and Quality Governance Committee. The Trust is represented at both local and regional PREVENT forums.

8.5.4 Female Genital Mutilation (FGM)

The Trust now has 3 leads for FGM, Named Midwife Safeguarding, Consultant Obstetrician and Consultant Paediatrician. The Trust wide pathway for FGM is now in place. This pathway includes information relating to the national data set. Safeguarding Training for both Adults and Children incorporates FGM and focuses upon recognition and reporting. There have been no identified / reported cases of FGM within the last year.

8.5.5 Child Sexual Exploitation (CSE)

Regional data collated by Worcestershire Children's Social Care between 2016 and February 2017, reports that the number of missing children incidents average at 80 per month and 45% of all missing incidents were associated with CSE. In 2017 there was a monthly average of 36 referrals in relation to CSE, current overall number of children recorded as suffering from CSE is 21, and the overall number recorded as vulnerable to CSE is 295.

The Named Midwife Safeguarding remains as the Trust lead for CSE and attend the WSCB operational working group. The Safeguarding team do not attend CSE daily Triage which is led by Children's Social Care and Police. The Triage is attended by Worcestershire Health and Care Trust. At present data in respect to children who are at risk of CSE is not provided to WAHT and health information is not requested from WAHT. This has been escalated to Children's Social Care as a risk and added to the safeguarding risk register. Children who are known to be at risk of CSE are required to be Flagged via the Trust electronic flagging system.

8.5.6 Mental Health Act - NHS Information centre KP90 return

The Trust are required to submit a national return to collate data in respect to Mental Health Act Detentions within the Trust which is monitored via Datix. The KP90 return has been replaced with the Strategic Data Collection Service (SDCS) with effect from January 2017.

8.5.7 Mental Capacity

A crib prompt card has been developed and provided to all Trust staff in March 2017, outlining the key principles of the Mental Capacity Act 2005 and considerations for assessing Mental Capacity. Examples of Mental Capacity assessments and best Interest decision making are included on all training pertaining to the Mental Capacity Act delivered within the Trust.

8.5.8 Deprivation of Liberty Safeguards (DoLS)

Between 01.04.2016 and 31.03.2017 – 177 DoLS applications were made by Trust staff. DoLS applications are increasing both nationally and regionally. Of those 177 referrals across a number of local authorities, the Trust received 90 acknowledgment letters from WCC. There are currently no notification arrangements into The Safeguarding Team when a DoLS referral is made to another Authority and work is taking place to address this.

Of all of the 11 statutory assessments completed by the DoLS team local authority over this period - only 2 were not granted. This provides significant assurance that the referrals are appropriate when assessed by the Local Authority.

From Monday 3 April 2017 the Coroners and Justice Act 2009 will be amended so that people subject to authorisations under DoLS will no longer be considered to be 'otherwise in state detention' for the purposes of Section 1 of the Coroners and Justice Act 2009. This means that coroners will no longer be under a duty to investigate a death solely because a DoLS authorisation was in place. This effectively brings the position in line with deaths which do not involve DoLS, and the circumstances where a jury will now be required will be rare. The Safeguarding Team have devised a DoLS tracker to monitor DoLS applications and their outcomes with any conditions imposed upon the Trust. Existing Mandatory Safeguarding training has been revised to reflect this and message disseminated to staff.

8.5.9 Domestic Violence

Worcestershire Children's Social Care receives on average 580 domestic abuse incidents per month within which children have been exposed to Domestic Abuse. The Trust is working with partner agencies to develop a single Domestic Abuse pathway for the health economy which will incorporate the recent National Institute for Clinical Excellence (NICE) guidance around domestic abuse (NICE Domestic Violence and Abuse Quality Standard February 2016). The Trust now actively participates in the Multi Agency Risk Assessment Conference (MARAC) process, with both Named Midwife and Named Nurse alternating their attendance. Robust health information gathering is initiated for each MARAC case which incorporates victim, perpetrator and any associated children. A Domestic abuse electronic flagging system is used to support the MARAC process. The Safeguarding Team provide Domestic Abuse training as part of Mandatory Safeguarding Children and Safeguarding Adult training.

8.5.10 Serious Case Reviews (SCR) – Safeguarding Children

There have been no serious case reviews in the timescale of this report. However, there has been a reflective learning event in July 2016, whereby all agencies, including health were invited to participate. Furthermore, the learning from this event was cascaded by The Safeguarding Committee and appropriate communication via WSCB newsletter.

8.5.11 Serious Adult Reviews (SAR) and Domestic Homicide Reviews (DHR) – Safeguarding Adults

The Trust has participated in one combined DHR and SAR, four SAR's and one DHR. All Trust actions completed in respect to these, with one SAR remaining in progress. We are awaiting WSAB publication of these and will disseminate learning accordingly and implement into Safeguarding adults Training. The Trust has implemented a notification process for any adult patient who fails to attend any appointment for which a 'did not attend' code is entered.

8.6 Age

8.6.1 Dementia

The Trust has a dedicated Dementia Team who undertake a wide range of work to promote dementia awareness and ensure the best possible experience for patients and carers. A key development over the last year has been the launch of our new Dementia Strategy in

February. Interim Deputy Chief Nurse Dilly Wilkinson addressed our partners from Worcestershire Health & Care Trust, the Alzheimer's Society, CCG's as well as patients, carers and staff of the Trust. The strategy has been developed by the Trust's dementia team, in partnership with the Alzheimer's Society and our patients. The strategy commits us to:

- Deliver person-centred care which supports people living with dementia
- Modernise communication links with people living with dementia and their carers.
- Develop a dementia friendly environment
- Developing a skilled and effective workforce
- Promote a collaborative approach to care delivery

Our dedicated Dementia Team are central to this and undertake a wide range of work to promote dementia awareness and ensure the best possible experience for patients and carers. A key part of this is Dementia Training. 1047 staff have received dementia awareness training during the past year and we also have a network of 67 Dementia Champions who help drive improvement and excellence in dementia care within their clinical areas. Regular Dementia Champion events are held and we are encouraging staff to become Dementia Friends.

We are compliant with national standards for the early identification of dementia and delirium achieving a 90% screening rate of all patients over 75 requiring screening over the past year. We have introduced our new dementia and delirium pathway which includes the use of the Forget Me Knot Flower to enable staff to recognise if a patient has dementia and the Abbey Pain Toolkit to ensure patients with dementia are accurately assessed for pain control.

Environmental improvements have been made across all wards with the introduction of dementia friendly clocks and toilet signs We have also changed the colour of trays used in some wards to help provide a better contrast between crockery and the tray. Digital reminiscence kits have also introduced across 6 wards at the Alexandra Hospital and Worcestershire Royal sites.

Twiddle muffs have continued to prove highly beneficial for patients, helping calm and reduce agitation exacerbated by being in an unfamiliar environment and a change of routine. The Dementia Team are also planning to introduce new activity boxes onto wards to provide additional activities for patients and assist with promoting conversations.

The Side by Side project run in conjunction with The Alzheimer's Society was established to provide support to patients with dementia and their carers during hospital stay and to reduce the distress and anxiety that often accompanies such stays due to lack of familiarity and the hustle and bustle associated with hospital wards which can be very unsettling. A new project manager commenced in August and the project has gone from strength to strength. 602 patients and their carers have been involved with the project over the past year.
28 volunteers giving some 1090 hours of voluntary hours have been involved in providing support and activities. Activities have included kitting; games and discussion groups which have all helped with patient confidence and wellbeing and enabled carers to understand additional sources of support available to them. Great links have been established with Worcestershire College who have enabled a number of students who are interested in health and social care careers to volunteer with the scheme to get an insight into working within a hospital environment.

Students from Worcester College with their Certificates of Achievement in recognition of their support for the Side by Side Project at Worcestershire Royal Hospital

We were delighted that after the very successful pilot of this scheme at Worcestershire Royal Hospital this is now going to become a national scheme and part of the Alzheimer Societies portfolio nationally. The Alzheimer's' Society have also introduced regular information stalls across our sites to promote their services and raise awareness of Dementia amongst staff and the public.

Side by Side volunteers have also used our new Digital Reminiscence Therapy (DRT) equipment to run music groups for patients on Avon 4. This has provided stimulus and entertainment patients, enabling them to listen to music and play along: it also meant patients were able to be away from their bed space (with staff support to mobilise), and were able to chat with volunteers and each other. Observation (by Side by Side coordinator) suggested this was an enjoyable experience for all concerned: both volunteers and ward staff confirmed that people had interacted well, and felt valued.
Side by Side works very closely with the Trusts Dementia Team and when the team flagged up that a person living with dementia had been admitted to a ward on which Side by Side did not operate and was very distressed and upset about a procedure which was required their volunteers were able to go to the ward in question and provide companionship and reassurance. This flexibility and good partnership working helps maximise the positive outcomes for patients and their relatives.

8.6.2 Children and Young People

We introduced the FFT for Children and Young People in 2014/15 and have used this to continue to collect their feedback. The opening of the Meadow Birth Centre in April 2015 has been met with extremely positive feedback from families. This facility has provided additional choice for low risk women in deciding where to have their babies within the county and 830 new babies were born there this year. Our Maternity Services were also successfully reaccredited under UNICEFS 'Baby Friendly Initiative' in June 2016. Inspectors stated:

"The staff at Worcestershire Acute Hospitals NHS Trust are commended for their hard work over the last two years in continuing to support mothers. It was clear to the assessment team, that …pregnant women and new mothers received a high standard of care. Staff knowledge and skills in supporting infant feeding were exceptional"

A new patient experience lead within children's services is being appointed and we look forward to working alongside her to continue to develop initiatives with young service users going forward. One area that always comes up is the provision of patient Wi-Fi and this remains an area we hope to develop during the new year once funding is secured.

8.7 Disability

The Trust undertakes a range of work to enhance patient experience for patients who have a disability. All our sites comply with accessibility requirements and we are working on improving our data collection regarding physical disability.

8.7.1 Learning Disability

The Trust continues to works in partnership with the Health and Care Trust who manage our two Acute Liaison Learning Disability Link Nurses. The hospital admission system alerts them by email and text when someone known to have a learning disability is admitted. Of 473 admissions recorded during the year 356 were seen by the link nurses; 75% of all admissions. This was down on the 90% for 2015-16 because of capacity; due to retirement and recruitment issues which meant that the service could not be fully resourced for a number of weeks. Our new liaison nurse commenced in March 2017.

The four main reasons for admission excluding planned elective surgery and planned investigations are:

- Chest infection/pneumonia, aspiration
- Epilepsy
- Bowel obstruction/constipation
- Diabetes
- Urinary tract infection

The Link Nurses continue to provide a range of training to Trust staff with 784 staff and trainees undertaking some form of learning disability training in the past year including a Learning Disability Champion Event. The recruitment of learning disability champions continues and they provide valuable ward/department based support to patients supplementing the work of the link nurses. E-learning is also available to all acute staff on ESR. They have also worked closely with A&E staff to roll out blue boxes which contain some basic information to assist A&E staff to work effectively and sensitively with patients with learning disabilities.

The Trust celebrated Learning Disability Week, 16th -20th May 2016 with stands across all three hospital sites promoting the work of the Link Nurses and the 'Hear my Voice' campaign.

The team have also been involved in work to embed the use of the hospital Passport and in ensuring easy read information is available and used. Unfortunately we were unable to get the Easy Read version of the LD Survey onto Hhspedia as the system cannot accommodate it but we are now looking at developing an alternative app moving forward.

Throughout the year the Trust has been an active contributor to the Worcestershire Learning Disability Partnership Board and has contributed to the achievement of the strategic objectives contained within the My Worcestershire Health Plan. This work will continue into 2017-18.

8.7.2 Physical Disability

The Trust is compliant with relevant legislation and environmental considerations are regularly reviewed as part of PLACE and other regular inspections. Waiting areas have space for wheelchairs and chairs of differing heights and with and without arms. We do not currently record physical disability as a data set for patients. This is something we will address in 2017-18.

8.7.3 Sensory Impairments

The Trust has an alert system for patients with sensory impairments. Information can be made available in a range of formats including braille, audio and large print. We have revised the back of all patient leaflets to make this clearer.

The Trust have an interpreter service agreement with a local provider, Deaf Direct to provide British Sign Language interpretation. Over the past year 51 patients have been supported by Deaf Direct. The main areas for these were: Trauma & Orthopaedics (36); Maternity (28) and Diabetes (27) and Radiology(26).

The ethnicity and disability status of service users are as follows:

Client Ethnicity		Client Disability	
British - Pakistani	2	Deaf BSL User	46
British - Black	0	Deaf Blind BSL user	3
Romany	1	Deaf with Learning Disability	1
White British	42	Other	1
White Other	4		
Unknown	2		

Service user age range are as follows:

Client Age Range	
Under 18	2
18 to 24	2
25 to 34	9
34 to 44	14
45 to 54	6
55 to 64	7
65 +	3
75 +	0
85 +	1

Hearing loops have been introduced Trust wide along with staff training on how to use these. We are fortunate in having a very constructive relationship with Deaf Direct who contact us if any difficulties are occurring. We have had a few occasions this year where interpreters have not been arranged and because we have been informed we can follow up directly with staff concerned and improve awareness and understanding.

8.7.4 Accessible Information

We have undertaken considerable work on this over the past year working with The Health & Care Trust, Healthwatch and Worcestershire County Council. A draft Accessible Information

Policy has been developed incorporating our revised Interpreters and Translations Policy. However during this process it became very apparent that a key element of this is an effective patient alert system. The Trusts system has a number of problems and a Task and Finish Group covering a wide range of teams including IT, Informatics, clinicians and Patient Experience are working on improving and updating the entire alerts system. This is a complex piece of work and will continue into 2017-18.

We have put information regarding accessible information on the TV loops in waiting areas and developed a new standard back page for all trust leaflets promoting that information is available in different formats. The Patient Experience Team will also be arranging some training sessions with Reception staff to ensure they ask patients about their communication preferences when signing them in and that there are regular updates of this information

8.7.4 Privacy and Dignity and Bereavement

Feedback relating to privacy and dignity issues arising from surveys, visits, PALS and complaints are reviewed at the Patient and Carer Expert Forum and will be incorporated in both the inpatients and A&E Survey Action Plans. On-going pressures in A&E have highlighted areas of concern with patients waiting in corridors we have continued to remain vigilant and raise awareness to ensure that we continue to improve privacy and dignity for patients in our care. Improvements this year have been the redesign of the Worcester reception area to improve confidentiality and plans to introduce designated assessment areas within the A&E dept. MAU have also introduced a relative's room where private conversations can be undertaken. Age UK and the RVS have recruited a number of Dignity Champion volunteers to support patients Dignity champions staff or volunteers help ensure that patients are consistently treated with dignity and respect; a basic human right.

The Stephen Bailey End of Life Care suite continues to be a much used and appreciated facility at Redditch with 146 patients and families using the room over the past year. In 2015 and 2016 the CQC inspection reports rated End of Life Care as Good for all 5 domains and we are very pleased that our EOLC services have been chosen as one of 10 Trusts to participate in the 'Building on the Best' quality improvement initiative.

8.8 Gender Reassignment

The Trust has not undertaken any key areas of work around gender reassignment other than ensuring there is guidance in the policy for Same Sex Accommodation for those who are gender reassigned.

8.9 Pregnancy/ Maternity

8.9.1 Friends and Family Test – Maternity

The FFT has been extended to cover Maternity Services from 1st October 2013.

Women are surveyed at three times during their pregnancy with an expected response rate of 15%:

- When they are 36 weeks pregnant
- Birth and care on the postnatal ward 10 days after birth

8.10 Marriage and Civil Partnership

There has been no specific work around this protected characteristic in 2016/17.

8.11 Religion/ Belief

Spiritual and Pastoral Care

The Spiritual & pastoral Care Team consists of 4 Chaplains (2.8 wte) and a service level agreement with the Roman Catholic priests who cover the 3 sites of the Acute Trust and provide a 24/7 on call cover to patients, relatives and staff of all faiths and none. Each hospital has a prayer room (equipped for all faiths) along with the appropriate religious texts and suitable equipment. There is also a *Wudu* (ritual washing facilities for Muslims) at Worcester Royal and The Alexandra. The employed team is augmented by 94 volunteers across the Trust who provide a variety of roles, as well as a database of other faith leaders who give their time voluntarily and can be contacted for emergency situations. There is also a Chaplains Blog (www.revdavidsouthall.com) which was initiated by Rev. Dr. David Southall in March 2013. The Chaplaincy Team and volunteers are seen as instrumental in promoting the E&D agenda within the Trust and are part of establishing Staff Engagement Groups for various protected characteristics.

The team is embedded within the three hospital sites and has particular links with the Palliative Care Team and Maternity Services (with respect to baby loss). Chaplains take approximately 100 baby funerals and 25 adult funerals per year and also provides regular religious services for the Christian and Muslim faiths, and opportunity for private prayers.

Spiritual and Pastoral Care also provides a strategic role within the delivery of care on the Equality and Diversity Group, and the Dignity, Privacy and Bereavement Group, and has good relationships with the Executive Team. They also have a role in staff wellbeing, offering support to staff in times of crisis and new initiatives which will include th provision of mindfulness for staff.

During the next year the Team plan to:

- Continue to develop a “Mindfulness” provision for staff and patients to aid emotional resilience by working with the Education Team at the Trust.
- Examine the possibility of being involved in creating a culture of compassion by implementing “Compassion Circles”
- Continue to develop the use of social media to enhance patient’s spiritual care within the Trust and NHS.

8.12 Race

8.12.1 Translation and Interpretation Services

As a Trust we are committed to providing high quality, equitable, effective healthcare services that are responsive to the needs of all patients. Effective communication is essential and this year we agreed two new contracts for interpreting services, one for British Sign Language and one for language and written translations. The language one was due to commence in April 2017 but our existing providers went into liquidation before this and we were very grateful to our new providers. AA Global, for stepping into the breach and ensuring our patients continue to receive a good service which meets their needs.

845 language interpreting sessions were arranged during the year with our most requested languages being : Polish; Urdhu and Romanian.

The implementation of our new interpreting and translation service was accompanied by awareness briefings held by AA Global across all 3 of our sites and a Comms campaign. We have also added information regarding Accessible Information to the TV loops in waiting areas and incorporated this on the back of the new standard leaflet template.

The top 3 areas for interpreting services remain: Maternity; Outpatients and Cancer Services (93).

We have revised our patient experience dashboard to include interpreters and have also continued to promote the Trust's Equality and Diversity Toolkit which is designed to increase staff awareness and understanding of cultural, age related and religious differences of patients, visitors and colleagues.

8.13 Gender

We have not undertaken any specific work around this protected characteristic in 2016/17

8.14 Sexual Orientation

We have not undertaken any specific work in relation to sexual orientation in 2016/17.

8.15 Developments during the Forthcoming Year

We are committed to enhancing our patient data collection to help us understand their specific needs and to using this more effectively to identify and address any issues of concern or improvement needed. Activities during 2017-18 will include:

- Equality & Diversity week to be held across all sites involving local partners
- Increase awareness of diversity across all staff groups through the introduction of a diversity calendar and desk top wall papers
- Revise E&D training for all staff
- Expanding and strengthening our public engagement to reflect the diversity of our patients and ensure better collaboration and co-production.
- Develop an app to host the easy read Learning Disability Survey
- Developing work streams aligned to our new Dementia Strategy
- Revision of Trust alerts process
- Launch of Accessible Information Standard Policy

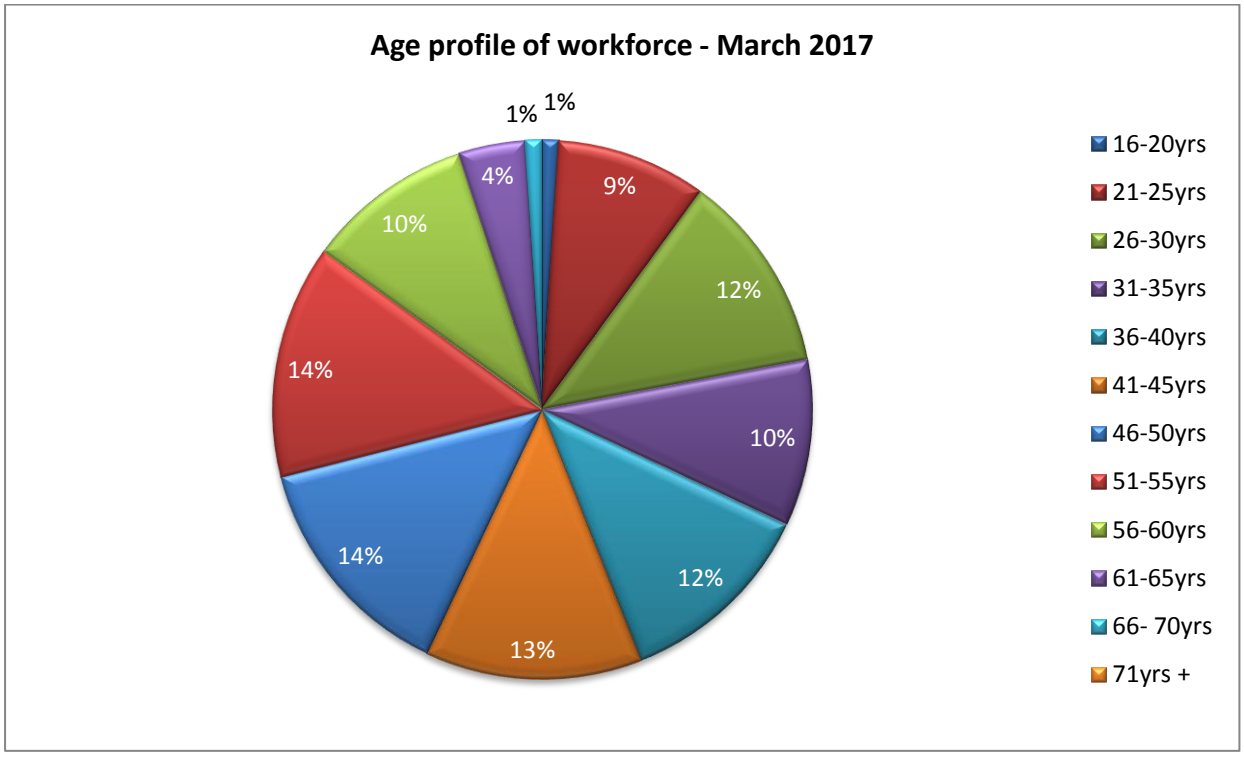
9. Equality for our Workforce in 2016/17

We have compared our data to determine whether there are any statistically significant differences in gender, age and ethnicity between the Trust workforce and the population of Worcestershire and England. We do not have population data to carry out statistical analysis for the other protected characteristics. Comparisons are taken from the data published by the Office of National Statistics (ONS) and NHS Employers (infographics)

The 2016 Staff Opinion Survey showed an improvement of 2% to 83% of respondents who felt the Trust acts fairly with regard to career progression and promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age. This is against the national average of 86%. We have compared our responses from the annual Staff Opinion Survey with other Acute Trusts, or the NHS overall to indicate whether there are any areas of concern.

9.1 Age

The age profile of the workforce is interesting and shows that the removal of the default retirement age has led to staff working longer. We have 324 (5%) of our staff age 61 or over (increased by 17 from last year), with 56 of these (1%) over the previous default retirement age of 65, and 2 over 71, which makes retirement planning more difficult as we cannot accurately predict when staff will leave.



1459 of our staff (25%) are between the ages of 51 and 60 and therefore could potentially retire within the next 5 or 10 years. This group has increased by 24 in the past year and by 50 in the past 2 years.

Our staff numbers in the 16-20 age group has increased in recent years directly due to the introduction of successfully Apprenticeship Programmes in business admin and health care

assistant roles. We have 65 staff in this age range as at March 2017 which although only 1%, is an improvement of 10 from last year.

The proportion of people under 25 who work for the Trust has improved from 7.64% in 2012/13, to 9.16%, 9.15%, 9.69%. and now 9.91% this year. This is significantly better than national NHS figures of 6% under 25. However, the number of leavers between the ages 21-35 increased from 45.4% in 2015/16 to 48.3% in 2016/17.

The proportion of staff aged over 45 is currently 43.8% which has marginally improved from 44.29% last year. This is comparable to the NHS workforce as a whole which has 47% in this age group (source: NHSE infographic) The Trust continues to have a problem with an ageing workforce and further monitoring needs to be undertaken of the age profile of new recruits to ensure that we are able to attract and retain younger workers. A recruitment campaign launched through social media has had a positive response which we expect to appeal to younger candidates.

2% of the staff surveyed in our 2016 Staff Opinion Survey said that they felt that they had been discriminated against due to their age. This is the same as last year and is the same as national average.

We have continued to run our successful Apprenticeship and Work placement Schemes in 2016/17 to increase the numbers of younger staff in our workforce with 198 placements. We also offer flexible retirement options to encourage the older worker to remain in employment and phase down in preparation for retirement. In the 12 month period ending 31st March 2017, there were 13 members of staff who retired and returned under our flexible retirement scheme.

The introduction of the Apprenticeship Levy in 2017 has focussed attention throughout the Trust on any opportunities to develop new apprenticeships.

9.2 Disability

We continue to have a significant number of staff recorded in the 'undefined' or 'not declared' box when which means that workforce disability data is not complete. There is a plan to roll out ESR Employee Self Service by the end of 2017/18 which will enable staff to update their own personal data in real time which should improve data quality.

We currently have only 1.1% of staff who declare themselves to be disabled which is in line with the NHS average of 1% (based on ONS, 2011 data). We recognise that many people would choose not to describe themselves as disabled and therefore we do not feel that conducting a full census of the workforce is helpful. We will continue to monitor through NHS Jobs for new applicants and record the monitoring data on ESR for all new staff. Any staff who declare a disability or have any restrictions at work have this recorded on their Occupational Health records, as well as their personal file.

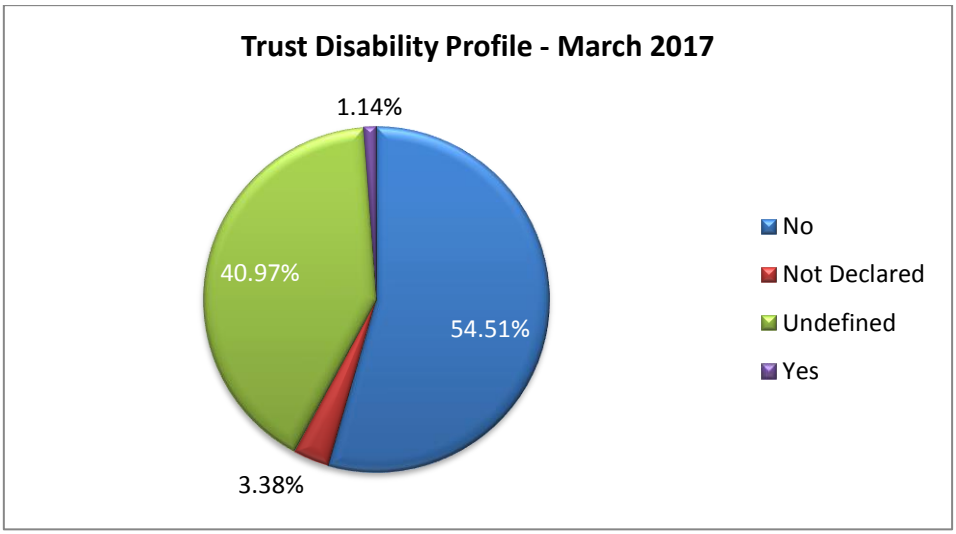
We can also monitor disability through the annual staff opinion survey which indicates that 14% of respondents in 2016 declared themselves to have a disability, long term health problem or longstanding illness. This is 1% lower than last year and 2% lower than the national acute trust average of 16%. We can also use qualitative information from our contacts with staff who become disabled and through our recruitment analysis. 69% of these respondents felt that the Trust made adequate adjustments to enable them to carry out their work, compared to 74% nationally.

The Trust is approved to use the "Disability Confident" employer logo. The Trust does offer support to staff with disabilities during recruitment with a guaranteed interview for all applicants who declare themselves to have a disability (provided they meet the essential criteria in the person specification). We also provide support through Occupational Health and modified duties/redeployment for staff who become disabled during their working life.

We have recruited 4.9% of applicants who declared they had a disability in 2016/17 which is an increase from 1.8% on the previous year. 46.7% of applicants who declare they have a disability were shortlisted for the post applied for. This indicates that the two ticks guaranteed interview scheme is working; we have had no claims of disability discrimination from any applicants.

Due to the high level of non-recording of disability for existing staff, it is not possible to undertake any meaningful analysis of whether having a disability is a bar to promotion within the Trust. We are hopeful that staff will update their personal data when they have access to ESR Employee Self Service.

In the 2016 Staff Opinion Survey 1% of our staff reported that they felt they had been discriminated against due to their disability (which is the same as the national average for acute trusts) and is unchanged from the previous year.



9.3 Gender Reassignment

At present the Trust does not collect data for gender reassignment and this is not an area that we intend including as a matter of course in our recruitment or survey questionnaires. We do need to obtain a better understanding of the needs of transgendered members of staff. However, it is likely that this will be addressed through the offer of Support Networks using qualitative rather than quantitative data as NHS jobs 2 (the national recruitment database) does not include gender reassignment as a category for applicants and we do not feel it is appropriate to ask existing staff to declare their status. We are looking to roll out ESR Employee on-line at the end of 2017 which will enable staff to update their personal information themselves if they wish to update.

9.4 Pregnancy and Maternity

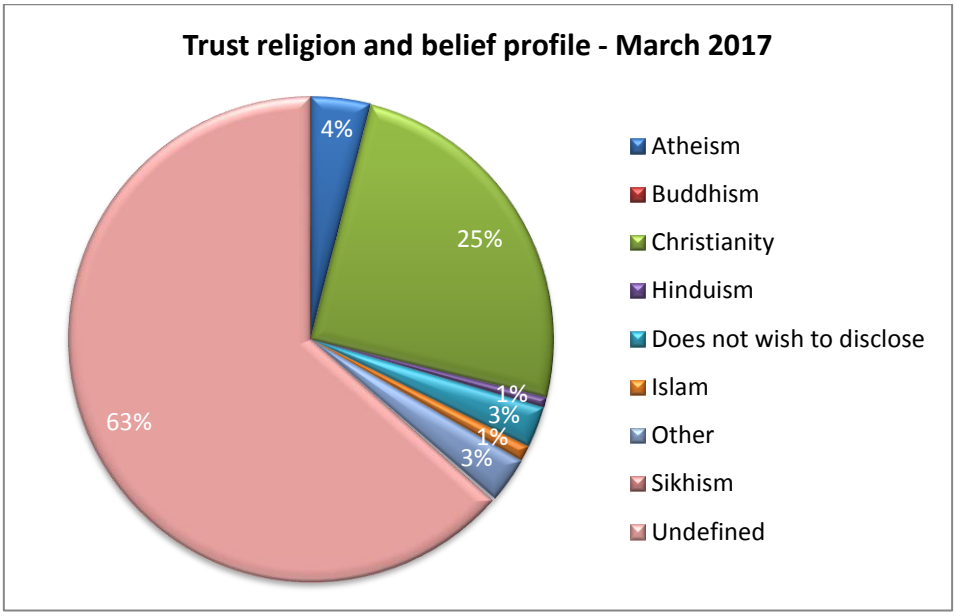
We do monitor the number of staff who are on maternity leave on a monthly basis in our Trust Board Dashboard. There were 138 members of staff on maternity leave as at the end of March 2017 which is a reduction of 18 on the previous year. The Trust generally ranges from 109 to 129 staff on maternity leave per month so this is recognised as a higher level than normal which does put pressures on the service for cover. We have had no complaints of less favourable treatment from staff who are pregnant, or recently returned from maternity leave, during 2016/17.Staff are able to use the flexible working policy to assist with their family care needs.

9.5 Marriage/Civil Partnership Status

We have added this status into our standard reports in order to identify trends. Our recruitment records for 2016/17 show that the majority of our applicants (51.2%) are single, followed by 36.9% married and 5.2% divorced or legally separated and 0.9% widowed. 326 applicants (2.3%) declared themselves to be in a civil partnership and only 2.5% failed to disclose which is a positive trend for our future analysis. We have had no complaints of discrimination in any of these areas.

9.6 Religion and Belief

From the snapshot of the workforce religion and belief data below, it demonstrates that the majority of the workforce (3,779 headcount) are undefined with a further 164 saying that they do not wish to disclose their religion, and 181 stating “other”. 1,476 describe themselves as Christian which is a reduction of 87 from last year. 234 staff describe themselves as Atheist, 41 Hindu, 63 Islamic, and 10 Sikh.



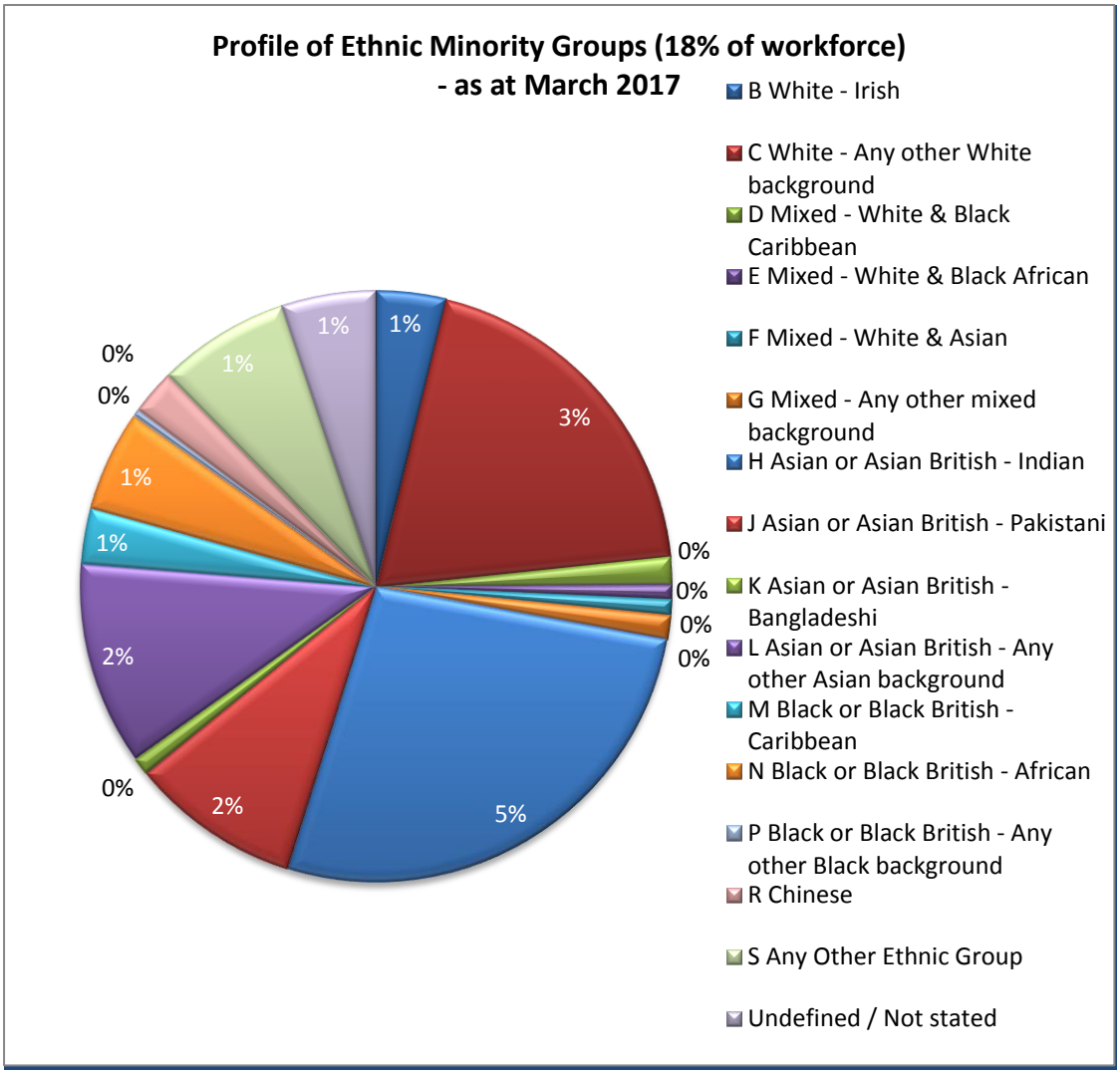
None of the respondents in the 2016 Staff Opinion Survey said that they had been discriminated against on the grounds of their religion which corresponds with the national response. This is a reduction of 1% on the last three years results. We continue to work with the Hospital Chaplains to understand the religious and pastoral needs of our workforce. This includes a nationally recognised Chaplains blog, multi-faith facilities, and a Hospital Choir which provide forums for people to network. We developed our Chaplaincy Team to include a new Lead Chaplain and Staff Equalities Engagement role which has been active in setting up Social Networking and Equalities initiatives including plans for Equality and Diversity Week. We will expand these networking opportunities where there is an interest from staff.

Our contracted multi-faith Chaplains and 40 Chaplaincy volunteers are actively involved in our E&D Committee, Staff Engagement Group and our Health and Wellbeing agenda.

9.7 Race

The introduction of the Workforce Race Equalities Standard (WRES) in 2016 enabled us to benchmark our equalities data for Race against other Trusts. We were 106 out of 235 in the nationally published data with 6.4% of our senior managers from BME backgrounds. The WRES results were disappointing for us in 2015 as they were based on 2015 staff survey which was only sent out to a random sample of 850 staff which appeared to have skewed the results. The 2016 staff opinion survey was an all staff survey which has improved our position. The Trust will continue to undertake full staff surveys to enable accurate analysis of results in terms of WRES.

The chart below depicts the breakdown of the Trust's 18% ethnic minority workforce as at 31st March 2017 by ethnic group. 82% of our workforce described themselves as White British, compared to 87% of the UK workforce, and 78% in the NHS (source: NHS E Infographic 2017).

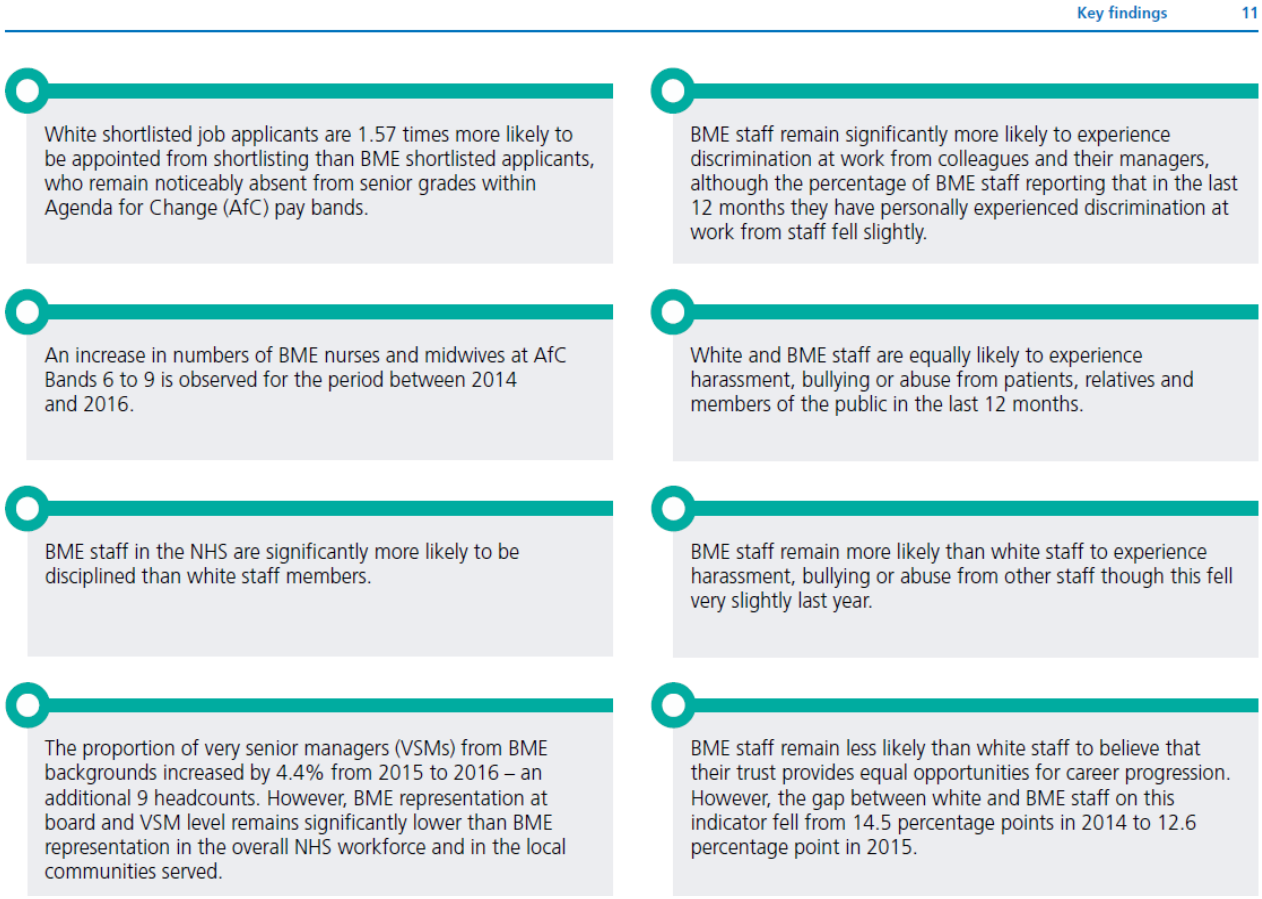


In 2016/17 we received 13,918 applications with 63.4% being white British, 8.1% Asian British (Indian), 6.4% other white background, 5.2% Black African, 4.3% Asian British (Pakistani), and 2.8% Asian British – any other ethnic background.

3% of the respondents to the 2016 National Staff Opinion Survey said that they had experienced discrimination from patients/service user/public in the last 12 months due to their race/ethnic origin. This is a 1% improvement from last year and is better than the Acute Trust average of 4%.

WRES

The introduction of the Workforce Race Equalities Standard (WRES) in 2015 enabled us to benchmark our equalities data for Race against other Trusts. We do not stand out as an outlier in the nationally published data although there is clearly still work to do. Our responses were not out of line with the national findings and this will form the basis of future WRES action plans. The national findings are as follows:



Key findings 11

White shortlisted job applicants are 1.57 times more likely to be appointed from shortlisting than BME shortlisted applicants, who remain noticeably absent from senior grades within Agenda for Change (AfC) pay bands.

BME staff remain significantly more likely to experience discrimination at work from colleagues and their managers, although the percentage of BME staff reporting that in the last 12 months they have personally experienced discrimination at work from staff fell slightly.

An increase in numbers of BME nurses and midwives at AfC Bands 6 to 9 is observed for the period between 2014 and 2016.

White and BME staff are equally likely to experience harassment, bullying or abuse from patients, relatives and members of the public in the last 12 months.

BME staff in the NHS are significantly more likely to be disciplined than white staff members.

BME staff remain more likely than white staff to experience harassment, bullying or abuse from other staff though this fell very slightly last year.

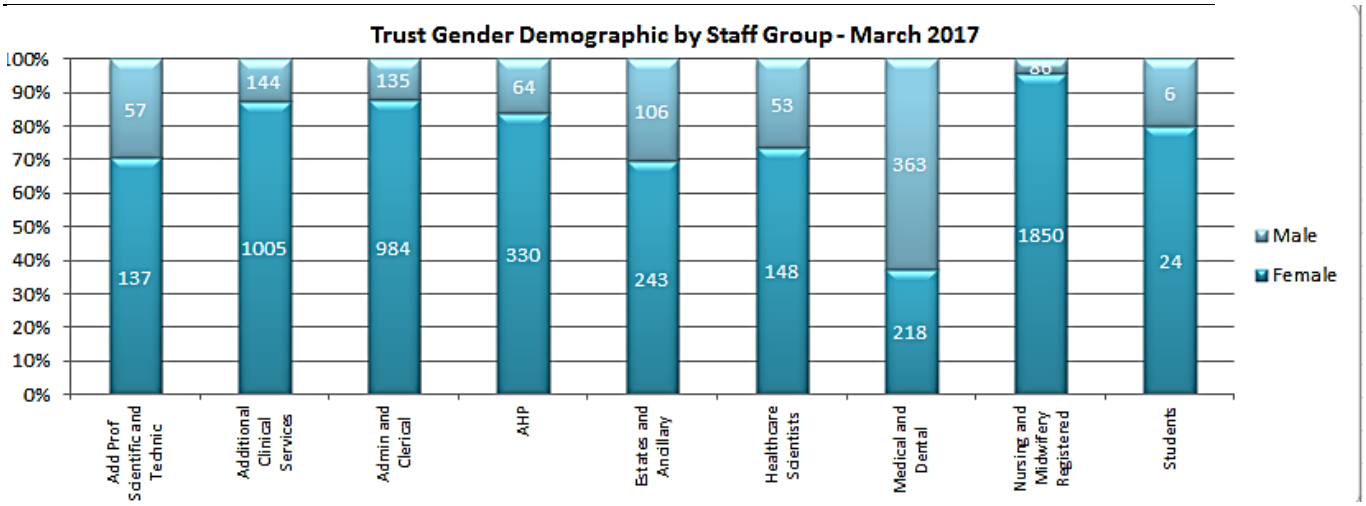
The proportion of very senior managers (VSMs) from BME backgrounds increased by 4.4% from 2015 to 2016 – an additional 9 headcounts. However, BME representation at board and VSM level remains significantly lower than BME representation in the overall NHS workforce and in the local communities served.

BME staff remain less likely than white staff to believe that their trust provides equal opportunities for career progression. However, the gap between white and BME staff on this indicator fell from 14.5 percentage points in 2014 to 12.6 percentage point in 2015.

9.8 Gender

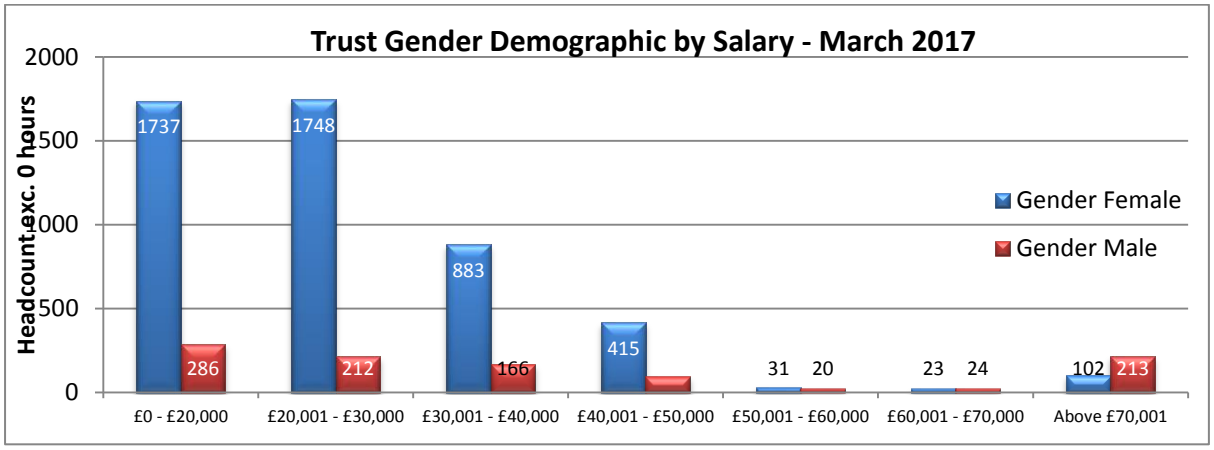
83% of the workforce were female on 31st March 2017 as shown in the chart below which is higher than the national NHS figure of 77%. The UK workforce is made up of only 47% women (source: NHSE Infographic 2017). This Trust therefore employs significantly more women and a high percentage of part-time workers or staff working flexible contracts.

During 2016/17 the Trust recruited 1055 new staff with 73% of them being female which would indicate that this trend is gradually moving closer to the NHS average.



Although the vast majority of our staff are female these tend to be concentrated in the lower level pay bands. Only 2% of our female workforce have an annual salary of £70,001 or above compared to 21% of our male workforce. We also have less than 1% of females earning between £60k and £70k compared to 2% males, and only 1% females between £50k and £60k compare to 2% males.

Further analysis is required to identify whether this is because women choose not to apply, or are not being recruited or promoted to senior posts. It is worth remembering that a high percentage of the higher graded posts are medical and dental which is traditionally a male dominated workforce.



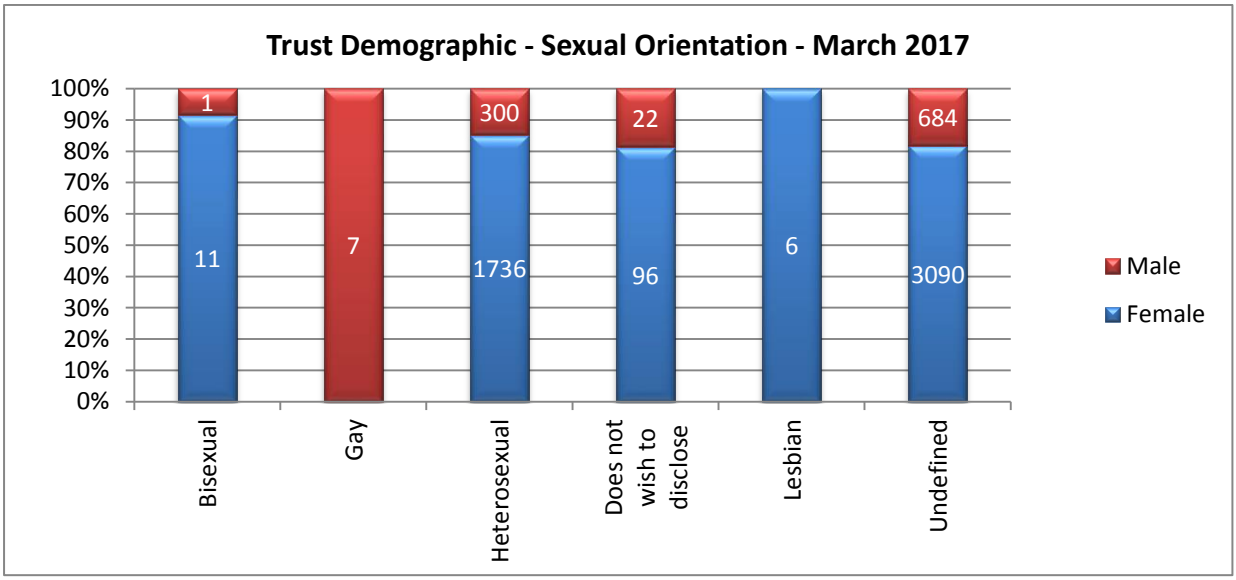
1% of respondents to the 2016 Staff Opinion Survey said that they had been discriminated against in the last year in respect of their gender which is a 1% improvement from last year and is 1% better than national average for acute trusts.

9.8.1 Gender Pay Gap reporting

The Trust will be required to report nationally on its Gender Pay Gap by April 2018. Preparatory work is underway through the regional streamlining group with IBM tasked with producing standard reports through ESR.

9.9 Sexual Orientation

The chart below illustrates the workforce broken down by sexual orientation. It is clear to see that there a similar issue as with the disability data, where 2% of staff say that they do not wish to disclose their sexual orientation, and 63% are undefined/not recorded. The Trust has set up a Staff Engagement Group and is continuing to encourage the staff Networks which will include sexual orientation which should hopefully afford staff a voice and create a more open culture. At the present time no meaningful analysis can be undertaken of whether someone's sexual orientation has any bearing on them being recruited to, leaving or being promoted within the Trust. It is hoped that the launch of ESR Self Service will improve data collection.



Analysis of our 2016 Staff Opinion Survey does not provide more insight into this protected characteristic due to the low numbers. Nobody said that they were gay or lesbian in the survey, 1% declared themselves to be bi-sexual and 1% other. 91% of those surveyed said that they were heterosexual compared to 94% last year, and the national average of 92%. 7% said they preferred not to say.

We have not received complaints from staff in relation to being treated differently, and our 2016 staff survey indicates that 1% of those surveyed felt that they had been discriminated against on the grounds of their sexuality.

9.10 Equality and Diversity Training Progress

In order to promote equal opportunities, it is important that all staff receive equality and diversity training. The training will help staff to meet their career and personal development requirements, as well as improve behaviours and communication with patients, colleagues and the general public. This is seen as a key part of our culture change programme.

From 2016/17 Equality and Diversity training became mandatory for all staff to undertake every three years which should over time improve the take-up of training, although as expected, reduced our compliance rate initially. Our take up of E&D training in the last 3 years as at March 2016 was 42.80%, and by March 2017 this had increased to 69%.

Since 2010 we have included Equality and Diversity modules in our Leadership Programmes for managers e.g. Recruitment and Selection, performance management, as well as for all new staff through our Induction programme. We have also launched online E&D training modules which improved compliance. Due to ongoing IT compatibility issues with our e-

learning modules we plan to include E&D in our instructor led Mandatory Training programme from 2018 which should enable us to get much nearer to the Trust target of 90%.

Our approach to equality and diversity is to win over the hearts and minds of the organisation by helping them to see things from another person's shoes. This will embed behavioural change and cultural tolerance rather than simply ticking a box. Over the past 5 years this has included Deaf Awareness training by a speaker with hearing loss, complimented by **"patient stories"** including one from a service user with learning disabilities. Through 2016/17 a number of bespoke sessions were run for various departments relating to social media and the fine line between "banter" and discrimination/bullying. Current training programmes being offered that include E&D modules are:

- **kNOw Bullying course**
- **Bespoke 1 hour E&D updates for departments "The Fine Line"**
- **Basic Equality & Diversity Awareness on Induction for all staff**
- **Equality and Diversity (full day course)**
- **Equality & Diversity E Learning Modules**
- **Deaf and Disability Awareness Training – Deaf-eating Barriers**
- **Conflict Management and Conflict Resolution**
- **Dignity in Care Workshop**
- **Dignity Link Nurse Training**
- **PDR training for Reviewers**
- **Recruitment & Selection Training**
- **Being Absence Minded – sickness absence training for managers**

9.11 Access to Training and Development

We continue to support our staff with excellent training programmes recognising the importance of supporting staff and managers to become good role models and leaders, and help them develop resilience to cope with the demands of an ever-changing NHS. Our talent management strategy supports the transformation agenda and supports developing the workforce for the future.

The trust provides a comprehensive induction programme for new employees and mandatory training updates in 12 mandatory topics plus local topics, for existing staff using a variety of teaching methods and assessment. In addition our in house Customer Care with Pride programme has carried on from the "Ace with Pace" programme to support our staff in providing excellent customer service and help them deal with difficult situations.

The trust provides accredited and bespoke **leadership programmes** for all levels of staff including coaching skills for managers.

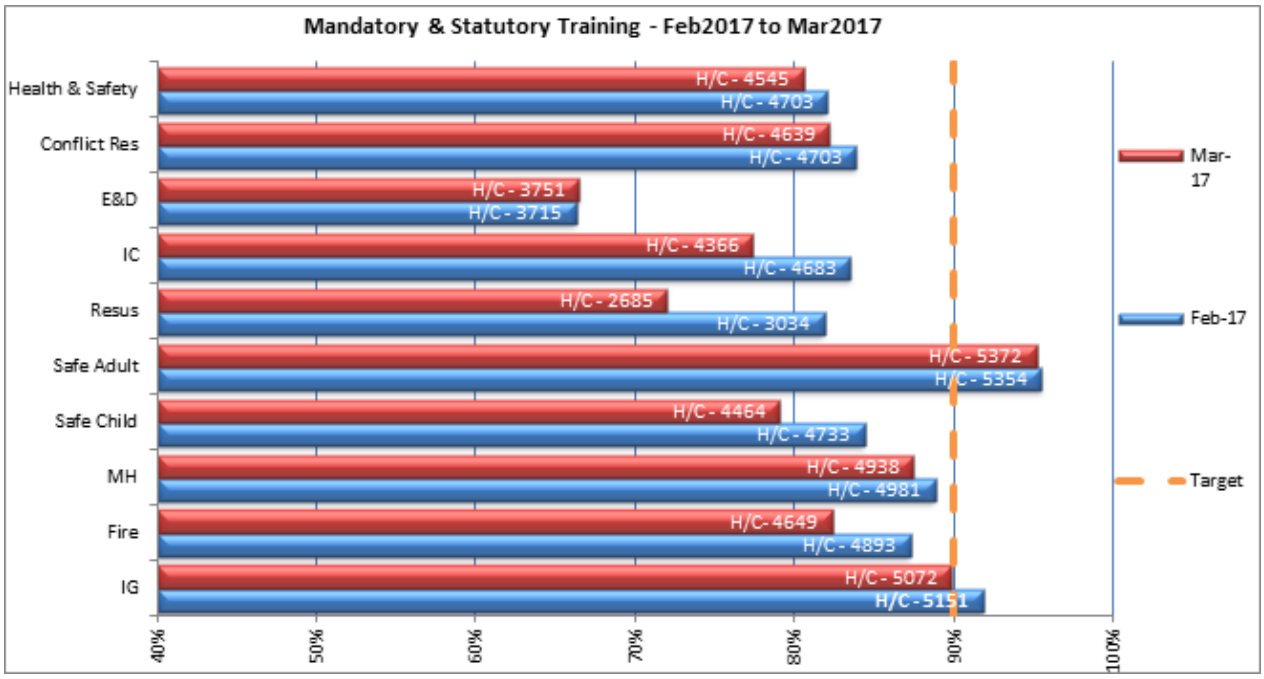
During 2016/17, 198 young people completed **work experience placements** and the trust supported 93 new **apprenticeship programmes** in both business administration and health and social care.

To recognise the hard work and dedication of our staff the trust hosts an **annual long service awards** and an annual **Staff Recognition award** event where staff receive awards that they had been nominated for by their colleagues and patients.

We monitor access to Training and Development through the Workforce Assurance Group. Each manager receives monthly performance reports in respect of their percentage rates for

all mandatory training and appraisal. The performance rates are included monthly in Trust Board Workforce Dashboard which includes Divisional workforce performance.

As at the end of March 2017 our performance against our **Mandatory Training targets** was as follows:



We have not had any complaints from staff regarding being treated unfairly in respect to access to training, and our 2016 SOS results showed that 72% of our staff said they have received job related training which is the same as national average, and a 1% improvement on last year.

9.12 Staff Experience

9.12.1 Staff Opinion Survey Results 2016

We were disappointed that the results of the Staff Opinion survey in 2015 showed deteriorating results in respect of E&D compared to other Trusts and this resulted in the Trust Board developing an Improvement Plan that focusses on staff engagement and culture.

Our WRES results in 2015 were based on 2015 staff survey which was only sent out to a random sample of 850 staff which appeared to have skewed the results. The 2016 staff opinion survey was an “all staff” survey which has significantly improved our position.

The key E&D questions from the 2016 staff opinion survey which will populate the WRES are as follows:

5. Workforce Race Equality Standard (WRES)

The scores presented below are the un-weighted question level score for question Q17b and un-weighted scores for Key Findings 25, 26, and 21, split between White and Black and Minority Ethnic (BME) staff, as required for the Workforce Race Equality Standard.

In order to preserve the anonymity of individual staff, a score is replaced with a dash if the staff group in question contributed fewer than 11 responses to that score.

			Your Trust in 2016	Average (median) for acute trusts	Your Trust in 2015
KF25	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	White	32% ↑	27%	39%
		BME	25% ↑	26%	64%
KF26	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	White	31% ↓	24%	28%
		BME	32% ↑	27%	56%
KF21	Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	White	84% ↑	88%	82%
		BME	74% ↑	76%	69%
Q17b	In the 12 last months have you personally experienced discrimination at work from manager/team leader or other colleagues?	White	6% ↓	6%	5%
		BME	17% ↑	14%	24%

Key:		
	↑	improved from last year
	↓	deteriorated from last year

We have improved in all areas compared to the 2015 WRES in terms of BME staff. This is primarily due to the fact that 2016 was a full staff survey rather than a sample. There is a deteriorating position for white staff in terms of them experiencing bullying and harassment from staff in last 12 months. There is a slight deterioration for white staff in terms of discrimination from managers although this is still the same as national average. Although there is an improvement in this area in respect of BME staff this is still worse than average so requires further action.

.

In June 2014 we launched the **Staff Friends and Families Test (SFFT)** which was open to all staff at least once a year, with selected divisions each quarter to supplement the Staff Opinion Survey. The SFFT focuses on two principal mandatory questions which are fed back to NHSE:

- Would you recommend this Trust as a place for treatment?
- Would you recommend this Trust as a place of employment?

In 2016 we launched a number of initiatives to improve the staff experience and culture of the organisation. These included:

LiA – Listening into Action
ChatBack – staff pulse survey (incorporating SFFT)
Staff Engagement Group
HR and OD Strategy and Action Plan
Health and Wellbeing Strategy

Substantive recruitment into Executive positions in early 2017 has enabled the Trust to refresh its plans for improving the culture of the organisation.

Our plans for 2017/18 include the launch of an "intentional culture" programme called Pulse based on an Australian model. This will be supplemented by a structured CMI Leadership Programme for Senior Managers based around an assessment tool and programmes for improving Performance Management and Accountability, and Engaging staff.

9.13 Staff Networks and Forums

The Trust has appointed David Southall into a new role as Chaplaincy and Staff Engagement Lead. David is perfectly placed with his team of 3 Chaplains and 40 Chaplaincy volunteers to enage with staff and encourage greater dialogue around the equality and diversity agenda.

Since commencing in the new role in early 2017 David has established a Staff Engagement network, a social media platform and planned Equality and Diversity events to raise the profile within the Trust, to coincide with Equality and Diversity Week in May 2017.

9.14 Disciplinary Hearings, Investigations and Grievances Progress

Our HR Consultancy Team maintains an anonymous record of all casework. Overall patterns and numbers of cases are reported to the Workforce Assurance Group on a quarterly basis and to the JNCC on a monthly basis. Any patterns relating to Equality and Diversity would be discussed at Equality and Diversity Committee. Although it is recognised that case numbers are very low so it would be difficult to ascertain a pattern, there have been the following themes in 2016/17:

> From a total of 57 cases (including all formal investigation processes associated with disciplinary, dignity at work, sickness, grievance, safeguarding, flexible working), 4 cases in total were related to race discrimination. Appropriate action was taken in all cases.

10. Policies and Programmes in place to address equality issues

There are a number of policies that establish the Trust's framework for ensuring equality, diversity and inclusivity for both patients and staff. These explain what should be done if breaches of the policies occur.

The Trust is committed to ensuring that all staff and patients are treated fairly and equitably. All policies are published on the Trust's intranet site. We review these policies every two years to check that they are still fit for purpose. The current key **Workforce policies** as regards the equality agenda are:

> **Equality, Diversity and Inclusion Policy** (revised April 2017)
> **Dignity at Work (Bullying and Harassment) Policy** (February 2016)
> **Whistleblowing - Raising Concerns Policy** (July 2015)
> **Recruitment and Selection Policy** (September 2015)
> **Mandatory Training Policy** (May 2015)
> **Sickness Absence Health and Wellbeing Policy** (June 2015)
> **Disciplinary Policy** (June 2015)
> **Grievance Policy** (revised July 2015)

All other policies include an Equalities Impact Assessment to consider whether their implementation has an adverse effect on any particular protected groups.

Patient policies as regards the equalities agenda include:

Carers Policy
Chaperones Policy
Provision of Same Sex Accommodation for patients' policy
Privacy and Dignity Policy
Deprivation of Liberty Safeguards (DOLS) Policy
Safeguarding Adults Policy
Safeguarding Children Policy
Supporting People with Learning Disabilities when accessing
Acute Hospital Services policy
Assessing Mental Capacity and complying with the Mental Capacity Act 2005 policy
Interpreters and Translation Policy

11. Equality Impact Assessments/Equality Analysis

Equality Impact Assessments (EqIA's) are a practical and systematic approach to establishing whether Trust functions, policies, strategies and projects have a negative or adverse impact on different groups. All policies include a basic Equalities Impact Assessment. Where issues are identified a full EqIA is required and these will be reviewed by the Equality and Diversity Committee if complex.

12. Procurement

The buying of goods and / or services is an important tool in embedding equalities across the organisation. The Trust has various contracts with other private, voluntary and statutory organisations for goods, works, services and employment services. Procurement is a key way for the Trust to exercise its influence in the community and to discharge its public duties to promote equality.

This Trust will take steps to ensure that its equality and diversity commitments are carried out by organisations that are engaged through a contract or service level agreement. An equality compliance clause is written in into all our contracts. Legally we are required to do this for all our contracts. Through the Trusts Procurement Group we will ensure compliance with equality legislation and identify where positive action can be taken to promote equality. This will be reflected in the Trust's Procurement Strategy.

For existing contracts, equality clauses should be introduced when contracts are formally reviewed or in the event of significant change to the contract terms & conditions. This may be reviewed if there is evidence of inequality in relation to the contract e.g. from complaints, public concern or equality monitoring information.

12. Next Steps

The 2015/17 Trust equality objectives are attached as Appendix A with an update of progress as at August 2016.

The key aim for the year to come will be to ensure the essential messages are cascaded throughout the organisation, combining new initiatives with patient experience and leadership developments. This will form part of the staff engagement agenda and patient and carer experience strategy. Work will take place in the coming year to improve action

planning and shared learning around complaints. The primary objective going into the 2017/18 is around cultural change which will include equality and diversity issues.

13. Key challenges

Our EDS2 action plan for 2015-2018 is monitored through the Equality and Diversity Committee and Workforce Assurance Group. This has been supplemented by a WRES Action Plan from 2016/17.

The key challenges are:

- Gaps in data for staff – which will be addressed through the launch of ESR Employee Self Service
- Analysis of WRES data and taking appropriate action to improve the experience of BME staff
- Establishing effective BME and Staff Equalities networks as we have repeatedly had very low interest
- Providing appropriate skills training across a large, complex organisation which will be partly addressed by including E&D in the corporate Mandatory Training programme.
- Making clearer links, both for our staff, our patients and their families, between the issues identified, the actions taken and the outcomes achieved.

Appendix A – EDS2 Equality Objectives
Appendix B - WRES Submission March 2017
Appendix C – WRES Action Plan 2017/18

Appendix A

EDS Equality Objectives 2015 – 2017

EDS2 Goal	EDS2 Outcome:	Proposed Actions	Timescale and Lead	Progress as at August 2016
1. Better Health outcomes for all	1.1 Services are commissioned, procured and delivered to meet the health needs of local communities	Establish Divisional Equalities Leads who will be responsible for reporting progress and challenges to PEC and Equality and Diversity Committee	One Lead per Division – to be nominated by 31st July 2015	Leads established and invited to E&D Committee
		Establish a list of the main community and voluntary sector leads for each of the protected characteristics	Linda Price/Tessa Mitchell November 2015	Ongoing
		Add civil partnership and transgender to Oasis and to the patient assessment documents	Tessa Mitchell/Jas Cartwright March 2016	Update required from TM
	1.2 individual peoples health needs are assessed and met in appropriate and effective ways	We already have unannounced review of services and departments by the following groups: Patient Public Forum, Health-checkers (LD expert group). Invite leads from voluntary sector organisations to take part in our quality reviews e.g. age concern, maternity forum, LGBT engagement lead, Deaf Direct, Sight Concern	Rani Virk/Tessa Mitchell December 2015	Complete and on-going – TM to confirm
		Identify our top five languages accessed by our community and translate essential patient information on elective surgery, maternity delivery and out-patients leaflets – key leaflets identified by divisions.	TM/Divisional Equality Leads – as part of Accessible Information Standard Plan December 2016	Accessible Information Standard Plan in development
	1.3 transitions from one service to another for people on care pathways, are made smoothly with everyone well informed	To be embedded into the "Well Connected" programme. To improve our discharge and transfer processes for patients and carers To capture transition of care from child to adult services	Well Connected lead Urgent Care Pathway review lead LD lead	Included in Well Connected programme and will be in STP – timescales are led by CCG's but the Trust is actively involved in programmes.

	1.4 when people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse	To be embedded into the Patient Safety Committee agenda Monitoring incidents related to the 9 protected characteristics to ensure we provide a safe environment for all patients e.g. SUIs, complaints, safety thermometer, safeguarding incidents.	Chris Rawlings to advise TM December 2016	Update required from TM/CR
		Baseline audit of violence and aggression incidents from patients	Datix report – Chris Rawlings – December 2016	Update required from CR
	1.5 screening, vaccination and other health promotion services reach and benefit all local communities.	Ask the leads to identify whether any of the protected characteristics are excluded from our screening programmes: • Breast screening • Cervical screening • Antenatal and postnatal screening • Outbreaks screening based on outbreaks (Measles, TB and flu)	TM in liaison with David Burrell/Cathy Garlick/Heather Gentry/Barbara Todd – December 2016	Update required from TM on patient related screening. OH confirm that no staff are excluded in terms of outbreak screening.
2.0 Improve Patient Access and Experience	2.1 people, carers and communities can readily access hospital, community health or primary health care services and should not be denied access on unreasonable grounds	Review complaints to identify if any patient has declared that they have been denied access to services We need to invite leads from voluntary sector organisations to report on whether their community have experienced access issues: e.g migrant workers, age concern, maternity forum, LGBT engagement lead, Deaf Direct, Sight Concern	Pauline Spenceley March 2016 Voluntary leads through Linda Price/Tessa Mitchell December 2016	Complaints reviewed on an ongoing basis for Patient Experience Forum Update required from TM
	2.2 People are informed and supported to be as involved as they wished to be in decisions about their care	Review Picker/CQC surveys (inpatient, outpatient, maternity, childrens and neonates, day case) to identify whether any groups are saying that they are not informed or involved in decisions about their care and treatment.	Linda Price/Tessa Mitchell December 2016	Update required from TM
	2.3 People report positive experiences of the NHS	Review of Friends and Family Test; monitor patient experiences via PEC	Divisions/TM March 2016	SFFT rolled out and ongoing
	2.4 peoples complaints about services are	Identify the top 5 key concerns from patients in respect of protected characteristics	Tessa Mitchell/Pauline	Update required from TM

EDS Equality Objectives 2015 – 2017

	handles respectfully and efficiently		Spenceley December 2016	
3.0 Empowered, Engaged and Well-support staff	3.1 Fair NHS recruitment and selection processes lead to a more representative workforce at all level	Continue to monitor recruitment data and workforce KPI's to determine whether this is representative. Reports to E&DC and WAG and E&D Annual report.	Debbie Drew Ongoing	Complete and on-going. Data is published on the intranet on a quarterly basis.
	3.2 the NHS is committed to Equal Pay for work of Equal Value and expects employers to use Equal Pay Audits to help fulfil their legal obligations	Commission an Equal Pay Audit	Debbie Drew December 2016	McKesson have confirmed that they are working on an ESR report for this – monitor progress
	3.3 Training and development opportunities are taken up and positively evaluated by the staff	Review E&D Training for 2015/16. Expand external speakers to include Age, Migrant Workers, Travellers and LGBT. Promote on-line E&D training	Debbie Drew/Sandra Berry December 2016	Training reviewed, funding identified, update training provided. External Speakers still to be invited in.
		Evaluate staff leadership programme	Sandra Berry December 2016	Review underway as part of OD Strategy
	3.4 when at work, staff are free from abuse, harassment, bullying and violence from any source	Utilise the information from the 2015 Staff Opinion Survey and identify actions for each division. Review of Dignity at Work cases – GGI report and share learning	Debbie Drew/Sandra Berry/Julie Stupart March 2016	SOS 2015 analysed and circulated to divisions, presented to Trust Board and WAG. Dignity at work cases and policy reviewed.
	3.5 flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives	Monitor complaints in line with the Flexible Working policy to identify whether there are any issues relating to protected characteristics	Julie Stupart/Diane Pugh March 2016	1 complaint in relation to protected characteristics (Sex Discrimination) in last 3 years. Cases are recorded in caselog and monitored through WAG

EDS Equality Objectives 2015 – 2017

Worcestershire NHS
Acute Hospitals NHS Trust

	3.6 Staff report positive experiences of membership of the workforce	Review of SOS and SFFT data. Are we in line with national trends.	Debbie Drew On-going	Analysis completed. Actions incorporated into OD plan
4.0 inclusive leadership at all levels	4.1 Board and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations	Ensure that Board Development includes Equality and inclusion issues	Sandra Berry Ongoing	E&D issues discussed at Board Development Day in February as part of the SOS 2015 feedback
	4.2 Papers that come before the Board and other major commitments identify equality related impacts including risks, and say how these risks are to be managed	All policies have an EqIA attached to them. Check whether other Board Papers and Business Plans include Equality Risks in the template.	Kimara Sharpe December 2016	Template includes EqIA's. More work to be done around review of these by E&D Committee.
	4.3 middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination.	Devise a training programme for managers on culturally competent behaviours in the workplace, tie into launch of Cultural Good Practice Toolkit	Sandra Berry/Debbie Drew December 2016	Design commenced

WRES UNIFY Submission for March 2017 – Appendix B

Unify2 Upload Template

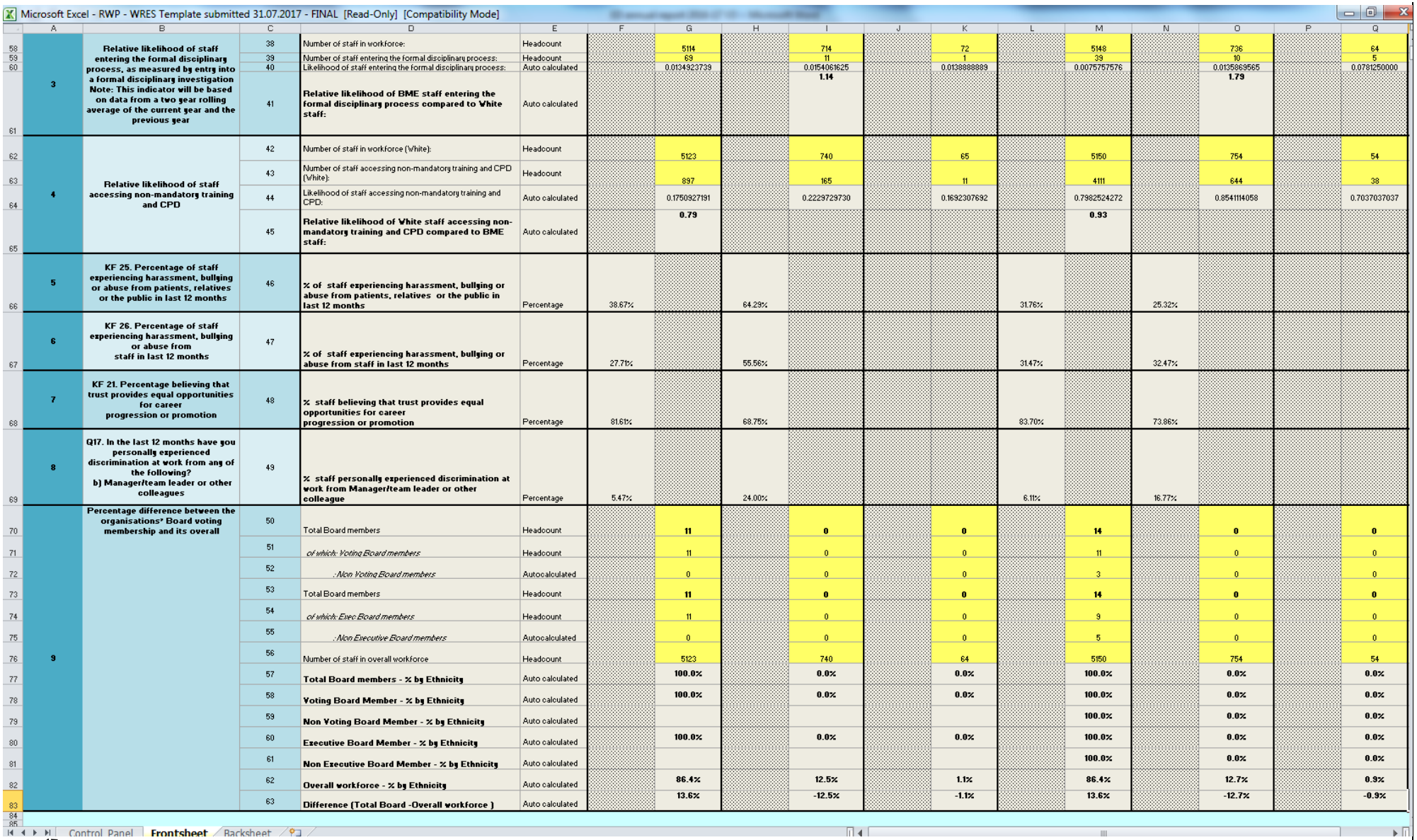
Workforce Race Equality Standards 2017/18 template

Organisation: RWP Worcestershire Acute Hospitals NHS Trust

INDICATOR	DATA ITEM		MEASURE	31st MARCH 2016 WHITE Prepopulated figures	31st MARCH 2016 WHITE Verified figures	31st MARCH 2016 BME Prepopulated figures	31st MARCH 2016 BME Verified figures	31st MARCH 2016 ETHNICITY UNKNOWN/NULL Prepopulated figures	31st MARCH 2016 ETHNICITY UNKNOWN/NULL Verified figures	31st MARCH 2017 WHITE Prepopulated figures	31st MARCH 2017 WHITE Verified figures	31st MARCH 2017 BME Prepopulated figures	31st MARCH 2017 BME Verified figures	31st MARCH 2017 ETHNICITY UNKNOWN/NULL Prepopulated figures	31st MARCH 2017 ETHNICITY UNKNOWN/NULL Verified figures
1 Percentage of staff in each of the AfC Bands 1-9 OR Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce		**1a) Non Clinical workforce**													
	1	Under Band 1	Headcount	0	17	0	2	0	0	0	17	0	5	0	0
	2	Band 1	Headcount	192	190	6	6	1	1	189	188	3	3	1	1
	3	Band 2	Headcount	136	135	3	3	6	6	139	135	3	3	6	6
	4	Band 3	Headcount	292	282	11	11	4	4	305	296	13	13	2	2
	5	Band 4	Headcount	301	296	7	7	5	5	307	305	5	5	4	4
	6	Band 5	Headcount	72	71	7	7	1	1	76	76	6	6	1	1
	7	Band 6	Headcount	61	62	3	3	0	0	60	61	6	6	0	0
	8	Band 7	Headcount	58	57	4	4	1	1	67	65	3	3	0	0
	9	Band 8A	Headcount	12	12	2	2	1	1	17	17	2	2	1	1
	10	Band 8B	Headcount	14	16	2	2	0	0	17	17	1	1	0	0
	11	Band 8C	Headcount	23	22	2	2	0	0	18	18	2	2	0	0
	12	Band 8D	Headcount	4	4	0	0	0	0	9	7	0	0	0	0
	13	Band 9	Headcount	0	0	1	1	0	0	0	0	0	0	0	0
	14	VSM	Headcount	3	11	0	0	1	0	4	19	0	1	1	1
		1b) Clinical workforce													
		of which Non Medical													
	15	Under Band 1	Headcount	0	9	0	0	0	0	0	0	0	0	0	0
	16	Band 1	Headcount	35	35	2	2	0	0	33	33	3	3	0	0
	17	Band 2	Headcount	861	850	98	99	5	5	870	856	105	105	3	3
	18	Band 3	Headcount	264	263	14	14	4	4	273	270	17	17	2	2
	19	Band 4	Headcount	65	64	1	1	2	2	74	72	4	4	1	1
	20	Band 5	Headcount	982	975	237	237	8	8	957	950	226	226	7	7
	21	Band 6	Headcount	848	829	69	69	8	8	852	834	84	83	8	8
	22	Band 7	Headcount	432	426	21	21	13	13	457	446	21	21	12	12
	23	Band 8A	Headcount	89	89	2	2	1	0	92	91	7	7	1	1
	24	Band 8B	Headcount	23	20	3	3	0	0	23	22	3	3	0	0
	25	Band 8C	Headcount	9	9	0	0	0	0	9	10	0	0	0	0
	26	Band 8D	Headcount	1	1	0	0	0	0	1	0	0	0	0	0
	27	Band 9	Headcount	2	2	0	0	0	0	1	1	0	0	0	0
	28	VSM	Headcount	1	0	0	0	0	0	2	2	0	0	0	0
		Of which Medical & Dental													
	29	Consultants	Headcount	180	183	94	95	1	1	183	181	100	97	0	0
	30	*of which Senior medical manager*	Headcount		21		11		0						
	31	Non-consultant career grade	Headcount	33	33	30	25	2	2	34	44	27	35	1	2
	32	Trainee grades	Headcount	157	160	114	122	2	2	103	117	80	103	3	2
	33	Other	Headcount	0	0	0	0	0	0	24	0	28	0	0	0
2 Relative likelihood of staff being appointed from shortlisting across all posts	34	Number of shortlisted applicants:	Headcount		4354		1290		76		4083		1180		71
	35	Number appointed from shortlisting:	Headcount		413		66		4		354		58		5
	36	Relative likelihood of shortlisting/appointed:	Auto calculated		0.0948553055		0.0511627907		0.0526315789		0.0867009552		0.0491525424		**0.0704225352**
	37	**Relative likelihood of White staff being appointed from shortlisting compared to BME staff:**	Auto calculated		**1.85**						**1.76**				
Relative likelihood of staff entering the formal disciplinary	38	Number of staff in workforce:	Headcount		5114		714		72		5148		736		64
	39	Number of staff entering the formal disciplinary process:	Headcount		69		11		1		39		10		5

Control Panel | Frontsheet | Backsheet

Patients Respect Improve and Innovate Dependable Empower



Microsoft Excel - RWP - WRES Template submitted 31.07.2017 - FINAL [Read-Only] [Compatibility Mode]

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q
58	3	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation Note: This indicator will be based on data from a two year rolling average of the current year and the previous year	38	Number of staff in workforce:	Headcount		5114		714		72		5148		736		64
59			39	Number of staff entering the formal disciplinary process:	Headcount		69		11		1		39		10		5
60			40	Likelihood of staff entering the formal disciplinary process:	Auto calculated		0.0134923739		0.0154061625		0.0138888889		0.0075757576		0.0135869565		0.0781250000
61			41	**Relative likelihood of BME staff entering the formal disciplinary process compared to White staff:**	Auto calculated				**1.14**						**1.79**		
62	4	Relative likelihood of staff accessing non-mandatory training and CPD	42	Number of staff in workforce (White):	Headcount		5123		740		65		5150		754		54
63			43	Number of staff accessing non-mandatory training and CPD (White):	Headcount		897		165		11		4111		644		38
64			44	Likelihood of staff accessing non-mandatory training and CPD:	Auto calculated		0.1750927191		0.2229729730		0.1692307692		0.7982524272		0.8541114058		0.7037037037
65			45	**Relative likelihood of White staff accessing non-mandatory training and CPD compared to BME staff:**	Auto calculated		**0.79**						**0.93**				
66	5	KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	46	**% of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months**	Percentage	38.67%		64.29%				31.76%		25.32%			
67	6	KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	47	**% of staff experiencing harassment, bullying or abuse from staff in last 12 months**	Percentage	27.71%		55.56%				31.47%		32.47%			
68	7	KF 21. Percentage believing that trust provides equal opportunities for career progression or promotion	48	**% staff believing that trust provides equal opportunities for career progression or promotion**	Percentage	81.61%		68.75%				83.70%		73.86%			
69	8	Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues	49	**% staff personally experienced discrimination at work from Manager/team leader or other colleague**	Percentage	5.47%		24.00%				6.11%		16.77%			
70	9	Percentage difference between the organisations' Board voting membership and its overall	50	Total Board members	Headcount		**11**		**0**		**0**		**14**		**0**		**0**
71			51	*of which: Voting Board members*	Headcount		11		0		0		11		0		0
72			52	*: Non Voting Board members*	Autocalculated		0		0		0		3		0		0
73			53	Total Board members	Headcount		**11**		**0**		**0**		**14**		**0**		**0**
74			54	*of which: Exec Board members*	Headcount		11		0		0		9		0		0
75			55	*: Non Executive Board members*	Autocalculated		0		0		0		5		0		0
76			56	Number of staff in overall workforce	Headcount		5123		740		64		5150		754		54
77			57	**Total Board members - % by Ethnicity**	Auto calculated		**100.0%**		**0.0%**		**0.0%**		**100.0%**		**0.0%**		**0.0%**
78			58	**Voting Board Member - % by Ethnicity**	Auto calculated		**100.0%**		**0.0%**		**0.0%**		**100.0%**		**0.0%**		**0.0%**
79			59	**Non Voting Board Member - % by Ethnicity**	Auto calculated								**100.0%**		**0.0%**		**0.0%**
80			60	**Executive Board Member - % by Ethnicity**	Auto calculated		**100.0%**		**0.0%**		**0.0%**		**100.0%**		**0.0%**		**0.0%**
81			61	**Non Executive Board Member - % by Ethnicity**	Auto calculated								**100.0%**		**0.0%**		**0.0%**
82			62	**Overall workforce - % by Ethnicity**	Auto calculated		**86.4%**		**12.5%**		**1.1%**		**86.4%**		**12.7%**		**0.9%**
83			63	**Difference (Total Board -Overall workforce)**	Auto calculated		**13.6%**		**-12.5%**		**-1.1%**		**13.6%**		**-12.7%**		**-0.9%**
84																	
85																	

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Appendix C

Worcestershire NHS
Acute Hospitals NHS Trust

WORKFORCE RACE EQUALITIES STANDARD – ACTION PLAN 2017/18

WRES INDICATOR	NATIONAL POSITION	HOW OUR TRUST COMPARES TO NATIONAL POSITION (AS AT 31 MARCH 2017)	HOW OUR TRUST COMPARES WITH IT'S OWN POSITION ON 31 MARCH 2016	ACTION – BY WHOM AND TIMESCALE	PROGRESS AS AT JULY 2017 (RAG RATED) KEY: COMPLETE	PROGRESS MADE	NO PROGRESS
1. % of BME staff in Bands 8-9, VSM (including executive Board members) compared to % of BME staff in the workforce	Nationally shows decline	We have 7.2% BME managers (excluding M&D) compared to 12.7% of workforce.	Percentage of BME managers has improved marginally, previously 6.1%.				
2. Relative likelihood of BME staff being appointed from shortlisting compared to that of white staff	Nationally white applicants are 1.74 times more likely to be appointed than BME	We are broadly the same as national at 1.76 times more likely	Slight improvement from 1.85 times more likely	Analyse whether this is in particular staff groups, grades, or departments.			
3. Relative likelihood of BME staff entering the formal disciplinary process, compared to that of white staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation	Nationally BME staff are twice as likely to enter disciplinary process and more likely to be disciplined	Our BME staff are 1.79 times more likely to enter disciplinary process than white staff which his better than national position.	Marginal Decline from 2016 position which was 1.5 times more likely.	Monitor – aim to be equal numbers of BME and white entering process.			
4. **Relative likelihood of BME staff accessing non-mandatory training and CPD compared** to white staff	**Nationally BME nurses are less likely to access non-mandatory training**	Our BME staff are MORE likely to access training which is better than national position (0.93). The improvement may be a consequence of not included non-mandatory training in 2016 figure.	The position has improved since 2015/16 (0.79) and demonstrates greater equality with regards to non-mandatory training & CPD.	**Monitor but unlikely to require additional action at this point.**			

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WORKFORCE RACE EQUALITIES STANDARD – ACTION PLAN 2017/18

WRES INDICATOR	NATIONAL POSITION	HOW OUR TRUST COMPARES TO NATIONAL POSITION (AS AT 31 MARCH 2017)	HOW OUR TRUST COMPARES WITH IT'S OWN POSITION ON 31 MARCH 2016	ACTION – BY WHOM AND TIMESCALE	PROGRESS AS AT DECEMBER 2016 KEY: COMPLETE	PROGRESS MADE	NO PROGRESS
5. **% of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months**	**Nationally 28% for BME staff and 28% for white staff**	Our BME staff reported 25% compared to 64% in 2015, white reported 32% compared to 39% in 2015. This demonstrates that the 2015 results were skewed by a sample survey of 850 staff. Full survey has corrected this and BME staff are now less likely to be harassed than white staff. Better than national position	Reverted to previous position where our BME staff reported they were less likely than white staff to experience this	Continue with full SOS survey Drill this data down to identify problem departments or staff groups. *Debbie Drew – September 2017* Set up Staff Engagement Forum with a view to BME network longer term – *David Southall – September 2017*			
6. % of staff experiencing harassment bullying or abuse from staff in last 12 months	Nationally 28% for BME and 25% for white	Our BME has improved from 56% in 2015 to 32% in 2016. White has deteriorated from 28% for white to 31%. Both are higher than national position.	Full SOS has brought BME staff almost equal to white staff. However still higher than national position.	Full SOS survey next year and set up BME network David Southall – September 2017			
7. **% believing that trust provides equal opportunities for career progression or promotion**	**Nationally 75% for BME and 89% for white staff**	Our response has improved from 69%in 2015 for BME to 74% in 2016 due to full staff survey. For white staff position has improved slightly from 82% in 2015 to 84% in 2016.	Improved but still worse than national for white staff, BME is same as national	BME group needs to be established to understand why staff feel this way, and what support we need to give. E&D Committee to take a lead.			

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					KEY: COMPLETE	PROGRESS MADE	NO PROGRESS
8. In last 12 months % personally experienced discrimination at work from manager, team leader or other colleagues	Nationally 13% for BME and 6% white	Our BME staff has reduced from 24% in 2015 to 17% in 2016 due to full staff survey. However this is still worse than national position. For white staff there is little change with 5% in 2015 and 6% in 2016 which is the same as national position.	Improved for BME and stayed the same for white	BME group needed to understand why and to support staff to voice concerns *D Drew/Lisa Thomson – Sept 2016*			
9. Boards are expected to be broadly representative of the population they serve	Nationally there has been a decrease in BME Board members	We are 0% against Worcs BME population of 7.6%	Remained at 0% as still interims as at 31st March.	Appointed1 BME post to board which will give us 7% representation from May 2017.			

Debbie Drew – Head of HR August 2017 Page 3 of 3