Quality Account

2015/16

Overview of the 2015/16 Quality Account

We have compiled this document to provide readers with information about Worcestershire Acute Hospitals NHS Trust.

About the Trust

Worcestershire Acute Hospitals NHS Trust provides hospital-based services from three main sites - the Alexandra Hospital in Redditch, Kidderminster Hospital and Treatment Centre, and Worcestershire Royal Hospital in Worcester.

- We provide a wide range of services to a population of more than 550,000 people in Worcestershire as well as caring for patients from surrounding counties and further afield.
- The Trust employs more than 5,500 people and have an annual turnover of over £360 million.

What is the quality account and why is it important to you?

Worcestershire Acute Hospitals NHS Trust is committed to improving the quality of our services we provide to our patients, their families and carers.

Our 2015/16 quality account is an annual report of:

- How we have performed over the last year against the priorities which we set out in last years' quality account.
- Statements about quality of the NHS services provided.
- How we have engaged staff, patients, commissioners, governors, Healthwatch and local Overview and Scrutiny Committees (OSCs) in deciding our priorities for the year.
- Statements about quality provided by our commissioners, governors, OSCs, Healthwatch and Trust directors.
- Our priorities setting out clearly how we are going to improve in the coming year (2016/17).

As you read this report we hope that it will explain what we believe that great care looks like and what you can expect if you need use your local NHS services.

If you would like to know more about the quality of services that are delivered at the Trust or any of our hospitals further information is available on our website www.worcsacute.nhs.uk/

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WAHT is committed to continuous improvement of data quality. The Trust supports a culture of valuing high quality data and strives to ensure all data is accurate, valid, reliable, timely, relevant and complete. This data quality agenda presents an on-going challenge from ward to Board.

Identified risks and relevant mitigation measures are included in the WAHT risk register.

This report is the most complete and accurate position available.

Work continues to ensure the completeness and validity of data entry, analysis and reporting.

Worcestershire Acute Hospitals NHS Trust :QUALITY ACCOUNT 2015/16

Statement from the Chief Executive

Worcestershire Acute Hospitals NHS Trust remains committed to delivering compassionate care for our patients.

The Quality Account forms part of our annual report to the public about the quality of our services. It describes our key achievements during 2015/16 and our priorities for quality improvement during the forthcoming year. In developing our Quality Account we have identified and shared information across the Trust with our doctors, nurses, therapists and management teams, as well as our service users and those who commission services from us.

Challenges and focus

2015/16 was a very challenging year for the Trust, which started with unannounced visits to our Emergency Departments (ED) by the Care Quality Commission (CQC), following concerns about safety and performance due to overcrowding.

Early in the year, the Trust also experienced a considerable change in personnel at Board level, and it is noteworthy that significant operational stability was restored rapidly.

As for many NHS organisations, our quality improvement plans are set against a background of continued pressure on services and an absolute commitment to deliver safe services for the people we serve.

Providing care within national waiting time standards has continued to be difficult for us, with particular challenges in emergency inpatient services, diagnostic services, some areas of planned surgery and waits for first cancer treatment.

Continued pressure on our inpatient services for people needing urgent care, as well as the rise in ambulances arriving at our A&E departments, has meant that we have not met the national standard for seeing, treating, admitting or discharging our emergency departments within four hours. This is an issue which many hospitals are facing. Despite a very busy winter, year-on-year we are seeing improvements, but we are by no means complacent and are committed to ensuring that all of our patients are seen and treated as quickly as possible.

Patient flow is a key issue for our hospitals as we regularly see the levels of bed occupancy reach 100%. As part of our on-going improvement journey we are continuing to work with the NHS Emergency Care Intensive Support Team to develop our services so that we can provide the urgent care people need quickly whilst minimising the use of hospital beds.

We have commenced work to expand our Emergency Department at Worcestershire Royal Hospital and have recently introduced an ambulatory care system which means that those needing to see a consultant specialist can be seen quickly without having to be admitted to a hospital bed. This is especially beneficial to frail elderly patients and those with complex needs as it delivers high quality care and prevents unnecessary admissions to a hospital bed. We have a high number of patients remaining in hospital after their acute episode has finished and we will continue to work with our healthcare partners to address this.

In much of 2015/16, the national standard for treating patients who are referred by their GP with suspected cancer within 62 days was not met. Changes in patient pathways and on-going issues with high levels of demand are being addressed, including additional consultant staffing and theatre realignment.

Patients referred for planned care have also waited longer than the '18 week referral to treat' national standards during the year, however month-on-month improvements have been made with at the end of the year the standard being affected …

We continue to control the rate of C.difficile infections, with fewer cases (29) in 2015/16 than the year before (36), or than our 2015/16 target (33).

Particular pressures have been faced in specialist surgery and we are continuing to work closely with those specialties experiencing high levels of demand for their services including dermatology and thoracic medicine.

Over the year we have focused on patients who have had symptoms of breast cancer and referred under the 2 week wait system for assessment and although the overall year performance is below the national standard, we achieved the standard in the last two months of the year. During the year we were able to appoint to two new registrars and this has further helped in us being able to provide more clinics for our patients.

Throughout the year we have continued to assess our compliance on nursing numbers and how we perform with regard to the numbers of shifts filled.

Engaging stakeholders to transform services

In 2015, 'Risk Summits' were held with patients, clinicians and our commissioners to develop and improve our services specifically around urgent care and maternity services. Following concerns raised by clinicians over patient safety we made the difficult decision, in consultation with our commissioners, to make temporary emergency changes to maternity, neonatal and gynaecology services in Worcestershire.

These were decisions we did not take lightly but our focus has always to be on patient safety. NHS England, the NHS Trust Development Authority and the county's three Clinical Commissioning Groups have all agreed that, despite extensive recruitment campaigns, staffing levels have not improved sufficiently to allow these temporary emergency changes to be reversed.

I recognise that many people will be disappointed that we are still not in a position to reverse these temporary emergency changes but safety of patients has to be our primary concern. There are simply not enough staff to safely run services across the two sites on a 24/7 basis. The current shortage of specialist staff, which is a national problem, means it would be unsafe to reverse these emergency arrangements.

This year we were extremely pleased to be part of the system-wide proposed Clinical Model for the Future of Acute Hospital Services in Worcestershire. Agreed by clinicians from across the county, along with the three Clinical Commissioning Groups (CCGs), we now look forward to the proposals going through the West Midlands Clinical Senate's assurance process. In the proposed model, emergency gynaecology, neonatal and consultant-led births in the county are all to be centralised at Worcestershire Royal Hospital. The CCGs are committed to consulting on the possibility of introducing a midwife-led birth centre in the north of the county for low-risk births. The proposed clinical model will be put to public consultation before any permanent changes are made, and under the current timetable this will take place later in 2016.

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Our regulators

The Care Quality Commission (CQC) conducted a full inspection of the Trust's three sites in July 2015, producing their report in December 2015. In this we were recognised as a very caring organisation and of the 115 domains they reviewed, 54 were rated as good, 46 require improvement, 13 were inadequate and 2 domains were outstanding. All services were rated as good or outstanding for care and the CQC also commended the Trust's leadership team for the level of understanding and commitment shown over recent months.

Our overall rating of inadequate was very disappointing and was due largely to concerns over the risks about our maternity and paediatrics services, services that we and our commissioners had already recognised as needing change. Therefore, the CQC report is helpful in endorsing the actions we had already taken. For example, the enhanced leadership and governance support provided to maternity and paediatric services since July, coupled with the decision to temporarily suspend birthing services at the Alexandra Hospital, has significantly reduced the risk profile of the services.

At the time of inspection, the CQC recommended that we required an enhanced level of support to continue our improvement journey. Following its report the CQC recommended that we should be put into 'Special Measures' which in the NHS means that we are provided with additional support to assist in a programme of further improvement. With an Improvement Director already in place and support being received from ECIP we also were able to access further support from a neighbouring trust to support our maternity and paediatric improvements and a nationally recognised trust to assist on governance.

Our people

Our people are our greatest asset. Engagement of staff from ward to Board is fundamental to improving the quality and safety of care across all Trust sites. It is testament to staff that despite the challenges the Trust has faced; the CQC found the staff approach to caring for patients to be good and in some cases outstanding, and the Trust must build on this going forward, especially in light of the disappointing results for the Trust from the recently published 2015/16 National Staff Survey.

Listening into Action

Our open and 'Big Conversation' approach which we started in October last year will be further supported in 2016/17 as we launch Listening into Action (LiA). This is a tried and tested programme called which has already led to increased engagement and morale of staff in other NHS trusts, and supports an important aim of our strategy – to listen to what frustrates staff at work, what they would like to see improve and change, and how leaders can support, enable and 'unblock the way' for staff to make that change happen. Our LiA journey over the initial 12 months will include a high profile round of LiA Staff Conversations to create an clear view of 'what matters to staff', a series of 'big impact' actions in response, and support for the first 10 and then next 20 teams 'on the ground' to adopt LiA as a vehicle for change.

The key Trust priorities for 2016/17 are:

1. **Delivering better performance and flow,** by supporting the Medicine Division to:
   - Create a sustainable countywide strategy
   - Deliver ambulatory care to avoid admission
   - Reduce the number of stranded patients
2. **Improving safety** by:
   - Learning from incidents and harm reviews in a 'no blame' culture
   - Reconfiguring fragile services
   - Reducing overcrowding and occupancy levels
   - Making data transparent to expose variability
3. **Investing in our staff** to:
   - Find solutions through teamwork
   - Develop new roles, improve recruitment and retention and to reduce reliance on agency staff
   - Become our ambassadors and to promote our organisation
4. **Stabilise our finances** by:
   - Delivering priorities 1-3
   - Managing to budget and delivering better value for money

The Trust enters 2016/17 with a major challenge around its financial position. Major progress was made in the later part of 2015/16 but this still leaves us with the challenge of continuing to improve quality and reduce our overall deficit. Primarily our position is a result of on-going issues with patient flow and bed occupancy and the need to open and staff additional non-elective bed capacity, leading in turn to a reliance on premium rate temporary staffing. This also impacts negatively on the delivery of the elective programme and on income levels. We are committed to delivering against this challenge.

Our teams are focused on our forthcoming CQC inspection and delivering against our programme of patient care improvement. This will enable us to ensure that we head towards being out of special measures by the end of the year and are able to demonstrate to our Regulators the significant improvements we have made to key areas highlighted including learning from mistakes and reporting of incidents.

We are focused on building on our success in attracting great people to come and work at the Trust as well as developing new roles with the support of Worcester University. Through LiA we will be looking to improve staff engagement and focus on quality improvements for our patients. This will be further supported by the progress of the Future of Acute Hospital Services as this enables clarity of the services on each site to be delivered.

In short it will be another very busy year for the Trust, set against a very complex and changing NHS. We are totally focused on delivering the highest quality, safe and sustainable care for the whole of Worcestershire and to achieve this will be working even closer with our healthcare colleagues from across the county throughout the year. I would like to put on record my sincere thanks to all of the staff working at the Trust who have gone the extra mile during a very difficult year and have taken up the challenge of improving services for the benefit of the patients we serve.

I am pleased therefore, to present our Quality Account for 2015/16 to you which I believe to be a fair and accurate report of our standards of care across the Trust.

Chris Tidman
Interim Chief Executive

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Looking back: progress on quality priorities for 2015/16

This section of the report describes our quality improvement priorities for 2015/16 and the progress we made during the year. Some of the work will roll over into next year.

Quality Priorities 2015/16	Quality domains			Additional CQC quality domains	
	Patient safety	Clinical effectiveness	Patient experience	Responsive	Well-led
1. Restore operational performance with a specific focus on Emergency Departments	✓			✓	
2. 'Sign up to Safety' campaign	✓				✓
3. Improve outcomes and experience for patients with a fractured hip	✓	✓	✓		
4. Improve mortality surveillance	✓				✓
5. Reducing variation in mortality between weekday and weekend working	✓	✓			
6. Reducing harm from medicines incidents	✓				✓

1. Restore operational performance with a specific focus on Emergency Departments — Not met

Overview of achievement:

- The CQC condition required the Trust to ensure that every patient attending the Emergency Department at Worcestershire Royal Hospital to have an initial clinical assessment within 15 minutes of arrival. This has not been met consistently through 2015/16
- The 4 hour access standard has not been met for the year of 2015/16
- Building work to increase capacity at the Worcestershire Royal Hospital Emergency Department has commenced
- In the Trust's 2015/16 operational plan, the System Resilience Group (SRG) agreed £1m funding for sub-acute capacity, which translates into one additional ward for six months. In reality, as a result of the high levels of bed occupancy and bed days associated with poor patient flow, the Trust has utilised additional capacity throughout the year with at its peak, three additional wards open and multiple medical patients outlying on surgical wards, which has in turn impacted on the delivery of the planned elective programme.
- Worcestershire as a health and social care economy is part of the Emergency Care Improvement Programme (ECIP) and from Q4 2015/16 onwards has been receiving support with the implementation of the SAFER patient flow bundle, review of the system-led patient flow centre and the development of more ambulatory emergency care including frailty assessment. High levels of bed occupancy in itself leads to delays and inefficiencies as patients are often not able to access the right bed first time.

Taking it forward:

- In light of the ECIP concordat, the Trust will work intensively with partners to address the issues with patient flow and to develop a trajectory for a reduction in the number of stranded patients at the Trust. This work is embedded in the Patient Care Improvement Plan and this must be delivered early in 2016/17. The Trust will reframe budgets in the second half of the year to reflect any realignment of capacity.
- Through the 2016/17 contract negotiations, the Trust will seek to ensure funded capacity to manage emergency surge pressures and will develop surge workforce plans aligned with this.
- In addition to these immediate capacity problems, the Trust has worked with partners in health and social care to develop an agreed longer term bed model for the county based on a shared set of demand assumptions. This model has identified under a range of planning scenarios, an underlying shortfall in the number of acute beds at the Worcestershire Royal Hospital site.

2. Sign Up to Safety Campaign — Partially met

Overview of achievement:

Sign up to Safety is a national initiative to help NHS organisations and their staff achieve their patient safety aspirations and care for their patients in the safest way possible. Launched by the Secretary of State in 2014, the ambition is to halve avoidable harm in the NHS over the next three years, and save 6,000 lives as a result. The Trust has signed up to campaign.

We have established our 'sign up to safety' plan using the driver diagram below. We have identified that in terms of the primary drivers, Nos. 1 (clinical care is delivered a intended by adherence to established guidance), 2 (care is delivered using reliable systems) and 3 (leaders are adequately skilled and committed to social change) are comprehensively covered within the PCIP however we need to create an additional action plan to address deficiencies identified in respect of 4. Documentation is complete and fit for purpose, and this action is in train.

Taking it forward:

Integrate drivers within the Trust's improvement programmes developed during 2015/16 – create an additional plan for health records.

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The Sign up to Safety Driver Diagram:

3. Improve outcomes and experience for patients with a fractured hip	Not met
Overview of achievement: A range of actions taken to improve the access of patients with a fractured hip to theatre within 36 hours of presentation have had some positive impact but the 95% target has not been met for the financial year. Actions taken: • Prioritisation of patients with fractured hips to be done first on the afternoon Trauma Theatre Sessions • Hip Fracture Escalation Policy implementation supported with daily reporting of achievement of the target • Trauma Nurse Practitioners & Clinical Teams are reviewing and escalating daily trauma issues • Theatre maintenance sessions have been rescheduled to not interfere with theatre availability **Taking it forward:** • A business case has been developed for additional weekend Trauma Theatre Sessions for both The Alexandra and Worcester Sites. • The Surgical Division will continue to take action to improve performance in 2016/17.	✖

4. Improve mortality surveillance	Partially met
Overview of achievement: There has been progress with this priority but we intend to continue the work as one of the improvement programmes in 2016/17. • Surveillance process has improved and awareness and engagement have improved. We identify deaths, provide primary review forms and primary reviews are provided with gradings for the care/concerns identified. Secondary reviews of concerns are undertaken and will generate more learning. • Targeted case note reviews of diagnostic groups (patients/procedures) are identified from review of mortality data and undertaken by clinical teams. **Taking it forward:** • Carried forward into the improvement programme	–

5. Reducing variation in mortality between week days and weekend working	Partially met
Overview of achievement: • In line with the commitment to achieving seven day services, the Trust has convened a Medical Workforce Assurance Group and is developing a progressive medical workforce plan and reviewing all of its Consultant job plans. The Trust has experienced chronic recruitment difficulties in some key clinical specialities in particular in Medicine. There is an emergency vision for the countywide acute medical service that is key to unlocking some of this • Investment in development of roles such as Physician's Associate and Associate Nurse Practitioners agreed and recruitment under way • Hospital at Night being launched in summer 2016 • There are already some enhanced and innovative services in place to maintain patient flow seven days a week, including diagnostic support services extending into the evenings and at weekends, the weekend pharmacy service and the nationally recognised pharmacist in A&E initiative **Taking it forward:** • Carried forward into the Organisational Development improvement programme • 7 day services will be scoped during 2016/17 in line with national development and will be implemented incrementally concentrating on non-elective admissions and the Emergency Departments	–

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6. Reducing harm from medicines incidents	Partially met
Overview of achievement: • EPMA – we have produced a draft clinical specification for electronic prescribing at WAYHT, through the EPMA team working with a development partner, which reflects the improvement in functionality across the market • Target higher risk medications – the drug chart has been designed to focus on higher risk medicines (as identified by a review of all medicines incidents) – insulin, anticoagulants, antibiotics, analgesics • Restructure the governance of medicines optimisation through a Medicines Optimisation Committee (MOC), reporting to Quality Governance Committee. MOC is supported by sub groups focusing on safe medicines practice, policy, PGDs and procedures and medicines assurance. This programme of work is driven through the Divisions by governance leads. This structure will also deliver CQC, CCG and professional reporting requirements	–
Taking it forward: • EPMA – A revised outline business case including the specification will be presented to TMC in May 2016 • Higher risk medications – continue to review incidents and patient safety alerts to identify high risk medicines – ensuring that communication, training, and policy revision reflects learning • Governance – continue to drive a safe medicines culture and improve reporting to reduce harm. Deliver the annual action plan for medicines optimisation through the MOC	

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Looking forward: quality account priorities for 2016/17

This section of the report describes a selection of quality priorities for the coming year. They are part of a wider work plan designed to deliver high quality care to our patients.

One of the key drivers has been to respond to the results of the CQC inspection in July 2015. Our Trust Improvement Plan (TIP) contains all the "must do" and "should do" elements, and progress is closely monitored by our quality governance and management committees. Other drivers include national NHS priorities, as well as feedback from our local Healthwatch, service users and stakeholders in the wider health economy.

Domain	CQC domain	Quality priorities for the Trust
Patient safety	Safe	Improve patient safety through optimising patient flow and developing effective systems for early senior review
Clinical effectiveness	Effective	Ensure that we are learning from incidents and other harm reviews (including mortality reviews) and identifying and addressing the causes of avoidable harm to patients in our care; including pre-emptively through the adoption of early warning tools and best practice care bundles.
Patient experience	Caring	Develop a greater quality and safety culture across the organisation through engagement, training and staff development from ward to Board

Patient safety

Priority 1: Improve patient safety through optimising patient flow and developing effective systems for early senior review	
Why this is a priority	Emergency demand and the increased acuity of patients, the lack of available capacity and flow within the Trust and within the health and social care system, have been significant challenges in 2015/16 and have been major limiting factors for the Trust achieving optimal operating performance and quality of care. A good flow of patients through the hospital ensures that patients are in the right place at the right time and get the care they require when they need it. Poor patient flow creates difficulties throughout the hospital, most noticeably in the Emergency Department, but interferes with the provision of good care and patient experience. Patient who stay in hospital longer than the acute phase of their condition requires, continue to deteriorate.
How we will deliver the improvement	Four workstreams have been identified from review of systems and performance to support the delivery of this improvement aim: • Safer care bundle: Reduce length of stay through implementing best practice ward rounds and reduction in stranded patients • Frailty pathway: establish admission avoidance and rapid assessment of elderly care patients • Acute care model: a. Improve Emergency Department response time to improve quality and flow b. Establish acute medical service to support flow • Patient Flow Centre Evaluation: improve responsiveness to support flow and patient needs

Priority 1: Improve patient safety through optimising patient flow and developing effective systems for early senior review	
Measures	A range of measures will be used includeing: • % discharges before 12 midday • Less than 45% of over 75 year old patients who are stranded (Length of stay over 7 days) • Time to initial assessment in the Emergency Department (ED) 95% seen within 15 minutes. • % of patients spending more than 12 hours in the ED
Targets	• 33% of discharges before 12am • Less than 45% of over 75 year old patients who are stranded (Length of stay over 7 days) • Time to initial assessment in the Emergency Department (ED) 95% seen within 15 minutes. • Less than 3.7% of patients spending more than 12 hours in the ED
Reporting route	An Urgent Care Programme Board has been established to monitor progress in meeting these goals and take action where necessary to meet them. This reports to the Executive Improvement Board, which in turn reports to the Trust Board.
Responsible Officer	Chief Operating Officer

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Clinical Effectiveness

Priority 2: Ensure that we are learning from incidents and other harm reviews (including mortality reviews) and identifying and addressing the causes of avoidable harm to patients in our care; including pre-emptively through the adoption of early warning tools and best practice care bundles.	
Why this is a priority	The Trust's mortality ratio is higher than expected. We need to understand the factors that may contribute to this and direct our efforts to improvements that will increase the quality of care and reduce the mortality ratio to within its expected range.
How we will deliver the improvement	Four workstreams have been identified from review of systems and performance to support the delivery of this improvement aim: • Mortality reviews – Establish effective review of all patient deaths • Sepsis bundle – implement Sepsis Six for early detection and screening of patients with suspected sepsis and antibiotic therapy commenced within 1 hour of presentation • Fractured neck of femur – access to theatre within 36 hours of a patient presenting with a fractured hip • National Early Warning Score (NEWS) – introducing the best practice approach to management of the deteriorating patient. This replaces our current system.
Measures	• SHMI (Summary Hospital Mortality Indicator) • HSMR (Hospital Standard Mortality Ration) • % of patients with completed early warning score • Sepsis bundle compliance • HSMR Sepsis • % of primary review forms received within 10 working days from dispatch • % of secondary review forms completed and presented within 60 days of request • Cardiac arrests per 1000 admissions • Proportion of clinical areas to which NEWS (National Early Warning System) has been rolled out against plan • % of patients admitted with a fractured hip undergoing surgery within 36 hours of admission

Priority 2: Ensure that we are learning from incidents and other harm reviews (including mortality reviews) and identifying and addressing the causes of avoidable harm to patients in our care; including pre-emptively through the adoption of early warning tools and best practice care bundles.	
Targets	• National targets for HSMR and SHMI • Graduated and increasing targets for completion of primary and secondary mortality reviews throughout the year • 90% of patients undergo surgery for fractured neck of femur within 36 hours
Reporting route	An Avoidable Mortality Review and Improvement Board has been established to oversee the workstreams. This reports to the Executive Improvement Board which in turn reports to the Trust Board.
Responsible Officer	Chief Medical Officer

Patient experience

Priority 3: Develop a greater quality and safety culture across the organisation through engagement, training and staff development from ward to Board	
Why this is a priority	There is a strong relationship between how a workforce feels and safe, effective care with a good patient experience. The Good Governance Institute's report in 2015 identified a number of issues that the Board are striving to address.
How we will deliver the improvement	Six workstreams have been established to support the delivery of this programme: • Leadership development to develop effective leaders • Culture improvement and safety – to develop a culture where employees are committed to safe, compassionate care and maximising productivity • Workforce plans – to support recruitment and retention of staff • Policies and standard – developing a clear set of policies for bullying and harassment and raising concerns • New roles and skills development – to meet current and future requirements
Measures	• Staff turnover • Number of comments related to poor leadership at exit interviews • Staff opinion survey - key questions related to staff, including: bullying and harassment, support from their manager; feeling valued; confidence to report unsafe practice and incidents; working additional hours • HR case work – number of bullying and harassment cases • Occupational Health Referrals – Number of work - related stress referrals • Vacancies • Number of new roles created for Physicians Associates; Band 4 nurses; Ward Administrators or Ward Housekeepers • Number of compliant rotas – medical and dental

Priority 3: Develop a greater quality and safety culture across the organisation through engagement, training and staff development from ward to Board	
Targets	• Staff turnover – 10% • Number of comments related to poor leadership at exit interviews - zero • Staff opinion survey - key questions related to staff, including: bullying and harassment, support from their manager; feeling valued; confidence to report unsafe practice and incidents; working additional hours – comparison with national average • HR case work– number of bullying and harassment cases- 0 • Occupational Health Referrals – Number of work - related stress referrals – 10 • Vacancies • Number of new roles created for Physicians Associates (12); Band 4 nurses (42); Ward Administrator or Ward Housekeepers (59) • Number of compliant rotas – Medical and Dental - 100%
Reporting route	An Organisational Development Board has been established to oversee these workstreams. This reports to the Executive Improvement Board, which in turn reports to the Trust Board
Responsible Officer	Director of HR

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Review of other quality performance 2015/16

Patient safety

The safety of patients in our care and the prevention of avoidable harm is our highest priority. The rating from the 2015 CQC inspection for Safety was 'inadequate'.

The headlines from the inspection report included the issues below and some of the key work we have undertaken to improve since that time is also described. A Governance and Safety Improvement Plan was developed to target actions at the issues raised and a wider review of our governance arrangements was undertaken. This is now supported by our partner, Oxford University Hospitals NHS Foundation Trust:

- The environment was generally well maintained as was equipment. Action was taken at the time for the Alexandra Hospital Early Pregnancy Assessment Unit.
- The trust lacked a systematic approach to the reporting, management and analysis of incidents, which were not always reported or investigated in a timely manner, and feedback was not always provided on reported incidents leading to a lack of subsequent learning taking place.
  - We have an electronic incident reporting system, Datix, and we are regularly in the top 25% of highest reporters nationally. We had a backlog of unviewed incidents at the time of the inspection for which a plan was already in place with weekly monitoring reports. There is daily review of incidents by the Divisional Governance Teams and virtually all incidents are now reviewed within 7 days of being reported.
  - The large number of outstanding incidents in Maternity were addressed at the time of the inspection
  - Feedback on learning from incidents has been improved and is something we continue to work on. The 'Lesson of the Month' has been supported with feedback from the weekly serious incident review meetings. Datix has also been configured to email members of staff who report incidents the results of the review when it has been closed. System learning also takes place through changes made to policy or guidance which is implemented through training and changes in equipment, such as replacement of nasogastric tubes following an incident.
- We will continue to train staff in investigation techniques to improve the quality of the investigation, its findings and recommendations. We know that if we understand the cause, we can design actions to address them and make care safer and more reliable. We already follow through relevant actions from serious incidents through to their completion and will take further measures to improve this and cover all incidents.
- The understanding of the categorisation of incidents was variable
  - There are several ways in which we categorise incidents – where they take place, the type of incident and a range of subcategories. Incidents are reviewed following reporting and corrections made but we are providing direct feedback to reporters who have mis-categorised incidents. We also categorise incidents by the level of harm that we cause. This is sometimes confused by the outcome for the patient and is something we – and other Trusts – are working to correct.
- There was a lack of understanding of Duty of Candour in some areas.
  - We use the guidelines from the National Reporting and Learning System to categorise incidents by harm. We changed to this in 2014 because the Duty of Candour is triggered by significant harm incidents. Our work with the Duty of Candour is described in a section below.
- Some identified risks were not being reviewed or managed appropriately
  - This was the case for some risks. We had a two-year programme to improve risk management across the Trust supported by an expert risk officer. A clear process for identifying risks, checking with staff that the risk register reflects their concerns, their approval and development of actions to improve control is in place. Training is provided for managers to achieve this and risks are monitored for the timeliness of their review and completion of actions within the required timescales. This is reviewed within the Divisional Management meetings, performance reviews and at Trust committees with necessary action taken. This work will now be extended.

Other issues raised in the CQC inspection report concerning safety are covered in other sections of the Quality Account, including:

- Staffing and reliance on temporary staff in some areas
- Emergency Department consultant cover and overcrowding
- Attendance at mandatory training

Harm-free care

We established a new Harm Free Care Group in February 2016, chaired by the Deputy Chief Nursing Officer, to manage the improvements in care across these areas. This one meeting will replace separate meetings regarding these incidents to bring together the common themes, re-energise and motivate staff and to improve attendance.

The NHS Safety Thermometer allows teams to measure harm and the proportion of patients that are 'harm free' from pressure ulcers, falls, urine infections (in patients with a catheter) and venous thromboembolism during their working day, for example at shift handover or during ward rounds.

The Safety Thermometer is a point of care survey that is carried out on 100% of patients on one day each month.

The Harm Free target is 95 %. The Trust consistently has an overall score of between 92-95.1%. September 2015 saw the lowest score recorded since April 2014. The position has remained relatively consistent with Harm free scores around 94%.

	2015									2016		
Month	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
No. surveys	816	840	805	800	748	742	781	707	728	672	728	674
No. harm free	764	800	771	746	708	689	727	665	676	633	676	632
% harm free	93.55	93.63	95.12	95.78	93.25	94.65	92.86	93.09	92.49	94.28	94.82	93.77

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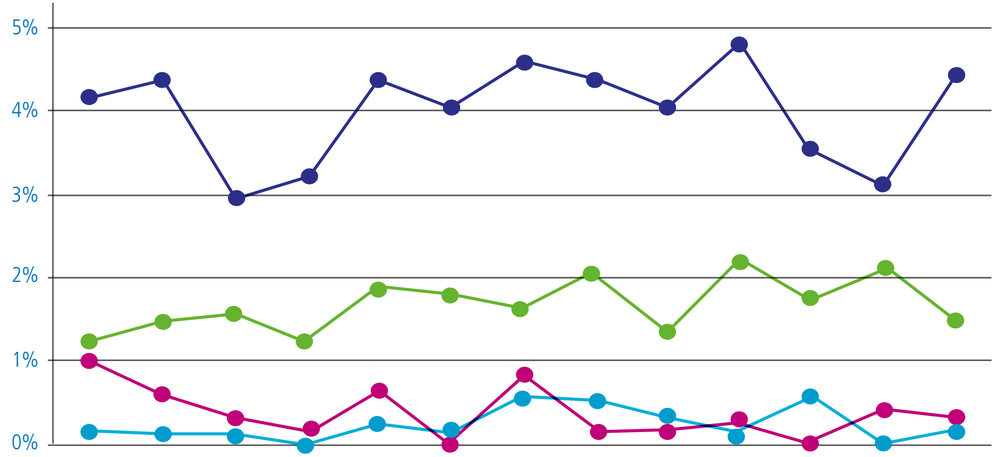
Safety Thermometer results 2015/16 – percentage harm



	Mar15	Apr15	May15	Jun15	Jul15	Aug15	Sept15	Oct15	Nov15	Dec15	Jan16	Feb16	Mar16
Pressue Ulcers	4.17	4.41	2.98	3.32	4.38	4.08	4.58	4.35	4.02	4.81	3.54	3.08	4.45
Falls	0.13	0.12	0.12	0	0.25	0.14	0.54	0.51	0.3	0.14	0.54	0	0.15
Catheter & UTI	1.26	1.47	1.55	1.24	1.88	1.77	1.62	2.05	1.34	2.2	1.77	2.1	1.48
New VTE	1.01	0.61	0.24	0.12	0.62	0	0.81	0.13	0.15	0.27	0	0.42	0.3
Patients	791	816	840	805	800	736	742	781	672	728	734	714	674

Patient falls

Falls remained consistently within the 95% target. The Safety Thermometer data is consistent with the overall patterns of patient falls across the Trust each month. The national average for falls per 1000 bed days (Royal College of Physicians Audit 2015) is 6.63. The average for the Trust is 5.03 for 2015/16.

Targeted interventions in the areas that saw increased numbers of patient falls has been undertaken and a number of issues have been identified in relation to the prevention of a number of these falls. These included:

- The number of patients with dementia or other mental health issues which pose challenges in an acute ward environment
- The Trust bank staff unable to meet the number of additional staff for 'specialing' or to provide specialist mental health trained staff
- Patients with mental health issues who could be discharged as no longer requiring acute care but suitable alternative placements cannot be found
- Patients whose care needs could be better met outside an acute environment requiring ongoing interventions which cannot be provided in secondary care e.g. IV antibiotics three times day
- Patients who are prone to seizures due to their medical condition

A number of actions were put in place to support these areas.

- The Professional Development Team visiting or phoning daily to offer support and advice to staff
- Weekly audits of falls success measures instigated (normally monthly)
- Documentation audited to ensure risk assessments and falls care plans are being completed appropriately
- Ensuring medication reviews are completed in a timely manner
- Further training on the use of alarms and other falls prevention equipment

The professional development team continues to work across the county on falls prevention strategies, and sharing documentation and good practice.

Pressure ulcers

The national target is for zero avoidable grade 3 and 4 pressure ulcers. We had 117 patients develop avoidable grade 2, 3 or 4 pressure ulcers during 2015/15. 13 of these were Grade 3 or 4.

Every pressure ulcer developed in hospital is reported as an incident and investigated. Accountability meetings are held for grade 3 or 4 pressure ulcers which are also reported as serious incidents.

Themes from pressure ulcer incidents have been identified and local and system wide actions being taken including:

- Targeting additional training in areas where pressure ulcer incidence has increased
- Providing heel pads for patients waiting on trolleys in the Emergency Department
- Changing the format of accountability meeting to include ward staff on duty at the time the grade 3 or 4 pressure ulcer developed. This has had a positive impact

Venous Thromboembolism (VTE)

VTE (the formation of blood clots within the veins) is a condition that contributes to an estimated 25,000 deaths amongst patients in hospital each year, some of which could be avoided. VTE risk assessment and prophylaxis (preventative measures) have been national priorities since 2010. NICE guidance states that 95% of all adult inpatients should be VTE risk assessed (weighing their chance of developing a clot against their risk of bleeding) and given preventative therapy.

We have consistently achieved the 95% VTE assessment rate and did so again for the whole of 2015/16. However, performance fell below 95% in the last half of the year.

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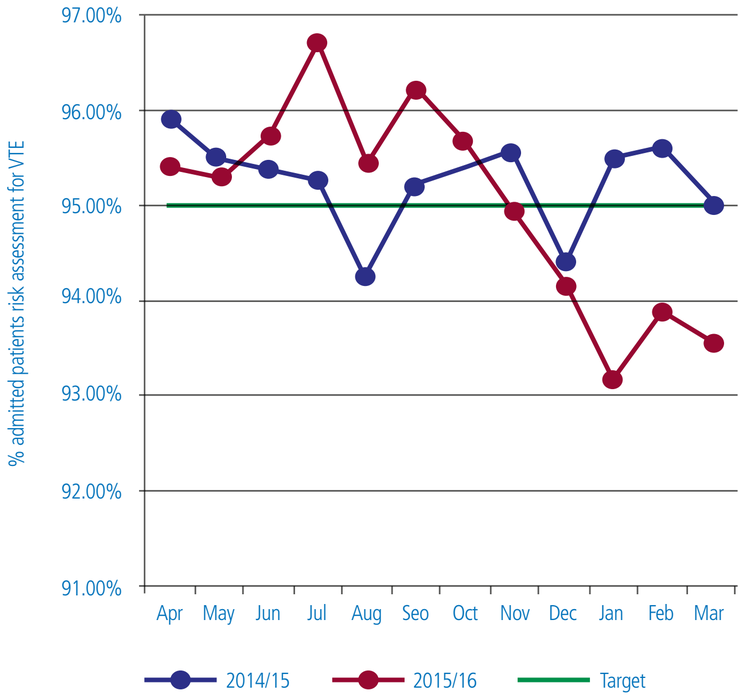
VTE assessment – comparison of 2014/15 with 2015/16



A range of actions have been taken to improve the assessment rate including:

- Introduction of a new VTE assessment form developed with the input of junior doctors to make it easier to use
- Communication to staff to encourage VTE assessment
- Requiring Ward Clerks to monitor the assessment of patients

Note: The data for this section is provided in the Performance Target section of this report.

Incident reporting and investigation

A high level of incident reporting reflects a good reporting culture and is an aim in the NHS Outcomes Framework. Our reporting rate slightly increased during the financial year from 36.0 incidents per 1000 bed days in 2014/15 to 38.74 in 2015/16. The total number of incidents and near misses also increased to 11255.

Severity of incidents

Severity	2013/14	2014/15	2015/16
No harm / insignificant	6540	7483	8163
Minor harm	3353	2417	2819
Moderate harm	521	298	222
Severe harm	47	21	19
Death	14	8	32*
Totals:	**10475**	**10227**	**11255**

*(*the number of incidents rated as 'death' are subject to amendment following investigation and will reduce)*

Patient safety incidents April 2013 to March 2016	2013/14	2014/15	2015/16
Number of patient safety incidents	10475	10227	11252
Number of patient safety incidents that resulted in severe harm or death	61	29	51
Percentage of patient safety incidents that resulted in severe harm or death	0.6%	0.3%	0.5%

The first annual 'Learning from Mistakes League' was published in March 2015 by NHS Improvement. This Trust was rated 219 out of 230 Trusts and placed in the 'poor' reporting culture category. While we are a high reporter of patient safety incidents, as the National Reporting and Learning System data shows, the inclusion of questions from the annual Staff Survey listed below brought the score down as we rated in the lowest 20% of Trusts for each of these questions:

- Key Finding 30: Fairness and effectiveness of procedures for reporting errors, near misses and incidents
- Key Finding 31: Staff confidence and security in reporting unsafe clinical practice
- Key Finding 7: Percentage of staff able to contribute towards improvements at work.
- Key Finding 26: Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months

Our response to the Staff Survey results is described in the Mandatory Indicators section of this report and our improvement priorities for 2016/17 focus on the areas covered by these questions.

A selection of the learning we have obtained and shared from review and investigation of incidents includes:

- Escalation of the deteriorating patient to senior medical care or outreach teams
- Check patient details when requesting radiological imaging
- Check that emergency trolleys are fully equipped and in date – and check another areas when you visit
- Risk management principles and escalation
- Causes of incidents include: human factors; system failure; clinical complexity – individuals are rarely the cause
- Following a patient fall – look for contributory factors including medication, blood pressure, and perform neurological observations if the fall wasn't witnessed or the patient hit their head
- Discharge letters – check that the GPs address is accurate when patients attend clinics or appointments
- Communicate clearly in health records – use the Situation Background Assessment Recommendation (SBAR) approach
- Penicillin allergy incidents – check the patient's allergy status and the drug prescribed to avoid administering penicillin to an allergic patient
- Nasogastric tubes - confirming correct placement by testing the pH value of stomach aspirate and then x-ray if unsure.
- Senior Medical Review of high-care patients must happen on a daily basis, including weekends and bank holidays
- Diagnostic test – if you request a test: follow up and act on it
- Always get a suitably qualified colleague to check before you inject drugs
- 1ml syringes – don't make the mistake of using the wrong syringe (for insulin)
- Make sure your patients have had a VTE assessment
- Use the Delirium Pathway correctly
- Blood Transfusion – make sure you follow the correct procedure to safeguard patients
- Don't continue to use equipment if you think it isn't functioning correctly
- Don't give warfarin without an INR – always check
- Identifying rare, life threatening conditions
- A rare diagnosis was missed for a patient with acute chest pain. Consider whether there may be a rare cause that requires further investigation – ask a senior colleague

Serious incidents requiring investigation (SIRI)

Every serious incident is investigated. We introduced an Initial Case Review in November 2015 to provide a summary of the event within 3 working days of the incident occurring. These are reviewed at a weekly meeting and assist in determining the severity of the incident, the level of investigation required, the key lines of enquiry and any immediate action that need to be take and shared across the Trust to minimise risk of further incidents occurring. The investigations generate reports which are approved at an Executive Director chaired meeting and actions are followed through to completion.

A total of 111 patient safety incidents were reported as serious incidents to the CCG within the following categories.

Category	No
Tissue viability	29
Patient fall	26
Obstetric speciality specific	14
Diagnosis	11
Treatment	8
Bed management	6
Infection control	6
Radiology triggers	5
Medication/Drugs	2
Documentation (clinical)/Patient records	1
Neonatal specialty specific	1
Pathology	1
Staff	1
Totals:	**111**

This is 21 fewer serious incidents than 2014/15 when 132 were reported to the CCG, which included:

- 53 tissue viability
- 24 falls
- 14 obstetric specific incidents

Learning from 'Never Events'

A 'Never Event' is described as a serious, largely preventable patient safety incident that should not occur if the available preventative measures have been implemented by healthcare providers. There are 14 types of incidents categorised as such by NHS England.

Incidents are considered to be 'Never Events' if:

- There is evidence that the 'Never Event' has occurred in the past and is a known source of risk
- There is existing national guidance or safety recommendations which, if followed, would have prevented this type of incident from happening
- Occurrence of the 'Never Event' can be easily identified, defined and measured on an ongoing basis

In 2015/16 we reported two such incidents that met these criteria. An investigation team gathered evidence and determined root causes and contributory factors for each event. Neither event caused significant harm to the patient involved. Action plans have been devised and reviewed with our commissioners and closely monitored by our Safe Patient Group.

1. Overdose of insulin due to abbreviations or incorrect device. The learning and actions arising from this incident were:

- Supervision will be provided to new starters until competence has been demonstrated
- The Nurse training programme will include a focus on 'high risk' medicines
- The staffing of the ward will be adequate to facilitate:
  - Nurse in Charge without clinical commitment
  - Provision of capacity to deliver preceptorship programme
- The insulin prescription chart will:
  - Provide direction regarding two nurse checking
  - Enable the recording of 'dose delivered' for variable dose prescriptions
- 1ml syringes have been removed from ward areas to prevent future confusion for insulin delivery.
- Improving the recognition of 'Never Events' amongst governance staff and senior staff.
- Staff requiring supervised practice will not be left to care for patients alone.
- Handover of all patients between in-charge nurses will be improved as this severely restricts their ability to manage the shift or focus supervision where needed.

2. Wrong implant/prosthesis
The recommendations and actions arising from this incident were identified as:

- The five steps to safer surgery WHO checklist was completed satisfactorily in this case but is not designed to identify variables in prosthetic implants. Before implanting any prosthesis the formal 'STOP' moment in proceedings to allow all variables relating to the implant to be checked will be enforced.
- All theatre staff across all sites of the Trust must be made aware of any new product information and any new surgical technique that they may be exposed to.

We have published and distributed information to help staff recognise when suspected 'Never Events' occur and remind them to report the incident to senior staff without delay. The Divisional Governance Teams screen incidents reported in Datix to ensure that we do not fail to recognise and respond to 'Never Events'.

Duty of Candour

We are committed to delivering safe, high quality care. However, mistakes occasionally happen. Although there are numerous safety checks to ensure that these do not affect patients, sometimes these systems break down and patients may be harmed whilst in our care.

When this happens, we strive to be open and honest in telling the patient or their family. We share our understanding of why it happened and offer to involve the patient or their family in how we plan to reduce the chances of the same mistake happening again.

The Duty of Candour became law in 2014. It reinforces the Being Open principles and means that healthcare providers must ensure that patients, and where appropriate their families, are told openly and honestly when unanticipated errors occur which cause significant harm. Medical and nursing staff also have a professional duty of candour that they must adhere to.

Being open involves:

- Saying sorry, explaining what went wrong and why
- Investigating why the incident happened and reassuring patients, their families and carers that lessons learnt will help to stop it happening again
- Hospital staff providing support to the patient and others involved or affected by the incident

The duty is triggered when a patient suffers significant harm (moderate harm, severe harm or death) that is caused through our error or omission, not as a natural progression of their disease or condition.

We continue to develop our systems to record and ensure that the Duty of Candour is triggered and the process described in our policy is met. New patient safety incidents are reviewed by the Divisional Governance Teams. Any incidents where significant harm is suspected are reviewed at a weekly meeting where an Initial Case Review is presented. The application of the duty is tested at this meeting. When investigation reports for serious incidents are reviewed, the application of the duty is again tested, including who will be offering a copy of the investigation report to the patient or family to discuss its findings.

We have provided a range of materials and awareness training for clinical teams to help them understand their responsibilities and awareness of when the Duty of Candour is triggered. Our incident reporting system contains prompts for staff when they report an incident and access to this information. We have developed a means of recording whether the duty has been followed, which we will roll out in the coming year, and we will be auditing the quality of the communication with patients and families. Further training will also be provided to ensure all clinical staff are aware and to support the overseeing roles of the corporate and Divisional Governance Teams in identifying significant harm incidents and ensuring that the duty is met effectively.

The Duty of Candour has challenged Trusts. Improving awareness of the Duty of Candour was a 'should do' action from our CQC inspection.

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The spirit and aims of it are well understood and fully supported but the guidance provided by professional bodies, the Care Quality Commission and the NHS Contract is all subtly different and we are developing our own understanding of how to meet both the spirit and process of the duty. Our processes will evolve and mature as we invest in them and use our connections with other Trusts to share and learn what works well.

Safeguarding

The Trust's Safeguarding Adult and Children's teams were integrated into one team in January 2016. The structure of this integrated safeguarding team has been reviewed and a new Head of Safeguarding appointed to lead on safeguarding within the Trust.

The Trust is a virtual member of the adult Multi Agency Safeguarding Hub (MASH) and has attended for both adult and child cases.

The Worcestershire Safeguarding Adult Board (WSAB) has recently published a training competency framework which the Trust is currently in the process of reviewing - this will involve matching competency to job role to level of training – the trust has met its contractual training figure for adults of 95% - year end training for adults being 96.2%.

The Trust is represented on the sub groups of WSAB and actively participates in work streams and serious case reviews upon request.

Clinical Effectiveness (Outcomes)

The rating from the 2015 CQC inspection for Effectiveness was 'requires improvement'. The headlines included the issues below and some of the work we have undertaken is also described:

- Mortality ratios were higher than those in similar Trusts
  - Our work to improve this is described in the section below
- Most specialties provided care in line with Royal College and NICE (National Institute for Health and Care Excellence) guidelines
  - We have a system that requires checking compliance with NICE guidance
- There were good examples of multi-disciplinary working
- We took part in most national clinical audits but outcomes were not always positive and evidence that areas of no-compliance were being addressed was inconsistent
  - We did in fact take part in all national clinical audits
  - This year we have introduced an on-line Clinical Audit Management System (CAMS) that provides registration and management of audits but also records actions arising from audits and allows them to be followed through to completion and re-audit.
- Nutrition and hydration was not always effectively managed or patients risk assessed
  - New documentation has been devised and introduced alongside staff training to improve the recording of nutrition and hydration
  - A new 'Harm Free Group', chaired by the Deputy Chief Nursing Officer, has been established to ensure that this work and the aspects of care included in the Safety Thermometer are effective.

Preventing people dying prematurely

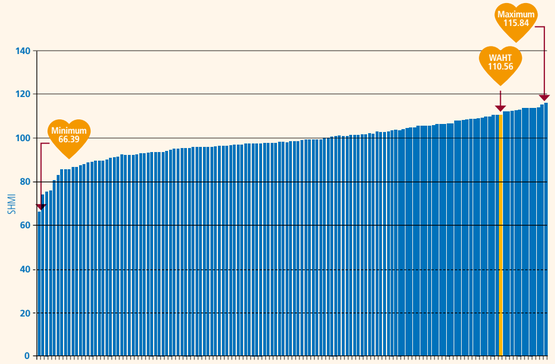
Summary Hospital Mortality Indicator (SHMI)

Hospital mortality indicators provide a ratio between the actual number of patients who die following hospitalisation at the Trust and the number that would be expected to die on the basis of the characteristics of the patients treated there.

The SHMI covers all reported deaths of patients who were admitted to non-specialist acute Trusts in England and either die while in hospital or within 30 days of discharge.

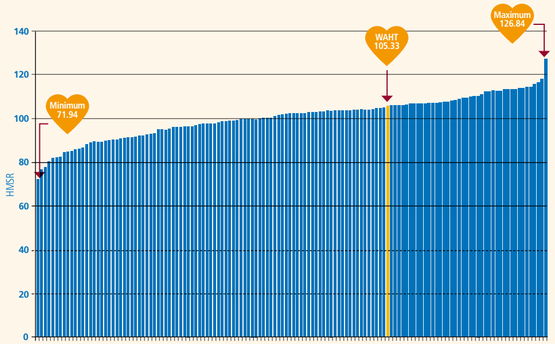
The SHMI value for the 12 months of 2015 was 110.56 (local data)

WAHT SHMI in comparison with English Acute Hospital Trusts (Jan 2015 - Dec 2015)



The SHMI value for the 12 month rolling period to December 2015 (latest 12 month period for which data is available) is 109. The Trust is a significant outlier for this metric. The 12 month rolling figures demonstrate a plateauing in value rather than any sustained reduction.

WAHT HSMR in comparison with English Acute Hospital Trusts (Jan 2015 - Dec 2015)



HSMR

The Hospital Standardised Mortality Ratio (HSMR) is similar to the SHMI but includes only those patients who die in hospital. The HSMR value for the whole of 2015 is 105.33. (local data)

The HSMR value for the rolling 12 months to January 2016 (the most recent period for which data is available) is 105. The comparable peer group figure is 100.

There is month-on-month variation. To identify a sustained trend the rolling 12 month figures are used. There does appear to be an improvement trend from a peak in the May 2014 – April 2015 period.

The Trust has embarked on four work streams to identify and address avoidable lapses in care that would be expected to impact on avoidable mortality as part of the overall Trust Improvement Programme.

- Stream 1: Routine review of the care of those dying whilst an in-patient
- Stream 2: Reduction in avoidable cardiac arrests
- Stream 3: Ensuring patients with sepsis are identified and treated within an hour of presentation
- Steam 4: Ensuring all patients presenting with a fractured neck of femur (hip) receive rapid treatment, specifically surgery within 36 hours of arriving at hospital.

Recovering from ill health and injury

Note: The data for this section is provided in the Performance Target section of this report.

Patient Reported Outcome Measures (PROMs)

Patient Reported Outcome Measures (PROMs) assess the quality of care delivered to NHS patients from the patient perspective. Currently covering four clinical procedures, PROMs calculate the health gains after surgical treatment using pre- and post-operative surveys. We have taken action to improve the completion of the survey forms in 2015/16.

The health gain for the four procedures is:

- Hip replacements – better than the national average
- Knee replacements – no results available for this year
- Groin hernia – just below the national average
- Varicose veins – below the national average but the questionnaire completion rate is very low

Emergency readmissions within 28 days of discharge from hospital

These emergency readmission indicators provide information to help the NHS monitor success in avoiding (or reducing to a minimum) readmission following discharge from hospital.

Not all emergency readmissions are likely to be part of the originally planned treatment and some may be potentially avoidable. The NHS may be helped to prevent potentially avoidable readmissions by seeing comparative figures and learning lessons from organisations with low readmission rates.

There are five emergency readmissions indicators: fractured proximal femur; hip replacement surgery; hysterectomy; stroke and 'all readmissions'

For 2015/16 our readmission rates are in terms of percentages for patients aged:

0 to 14	0.0%
15 or over 3.9%	3.9%

Healthcare acquired infections

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MRSA bacteraemia

A national zero tolerance of MRSA bacteraemia continues and therefore a trajectory of zero cases is set for this and all other Trusts.

There has been one case of MRSA bacteraemia within the Trust during 2015-16. This was recorded in a patient who had a previous history of MRSA colonisation on the Acute Stroke Unit during February 2016.

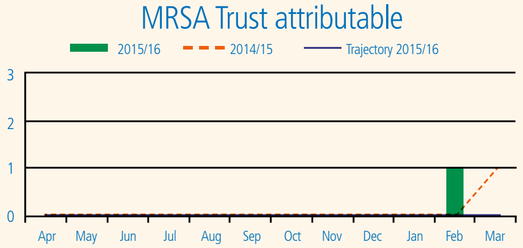
There were four other cases of MRSA bacteraemia during the year. These were in patients where blood culture was taken within 48 hours of admission to hospital. These cases were assigned to organisations other than the Trust.

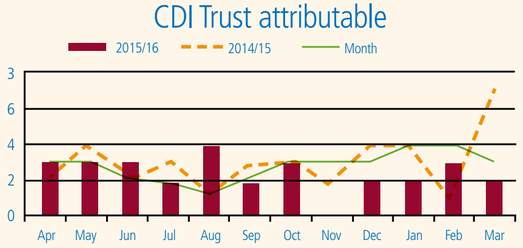
Clostridium difficile

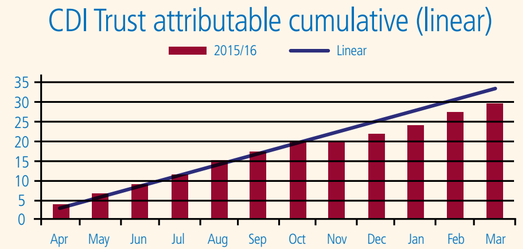
There were 29 cases of C.difficile (toxin positive) reported during the year 2015-16. This is against an NHS England set target of no more than 33 cases. There were between zero (November) and 4 (August) cases per month. The Trust has therefore successfully remained within the annual target set for the year.

The Trust has an Antimicrobial Stewardship Group reporting to the Medicines Optimisation Committee and a ward focused antimicrobial team. Evidence based antimicrobial prescribing guidelines were also updated and launched during the year. However, the key action for 2016-17 will be to continually strengthen and enhance antimicrobial stewardship and improve provision for a dedicated antimicrobial pharmacist. The Trust takes a health economy wide approach to C.difficile and during 2016-17 actions will be identified e.g. in relation to antimicrobial prescribing or other intervention to further reduce the possibility of new cases.

An annual trajectory of no more than 32 cases has been set by NHS England for 2016-7.







Engaging our staff to improve quality

Quality Review Visits

Since 2014 we have used unannounced Quality Review Visits to wards and department to provide an independent check on the standards of care and environment. This year we have refreshed our approach to improve the use of performance information to target the focus of the review and continue to use colleagues from across the professions and staff groups to undertake multi-disciplinary reviews.

The findings from the visits are used to identify areas that can be improved with follow through and checking by management teams to check that they have been completed and have had the desired impact.

Quality Champions

In early 2015 we formed a group of volunteer staff into 'CQC Champions'. The aim was to use this group to spread key messages about the inspection to wards and departments but to also listen to their feedback from colleagues. This worked well and was recognised at a celebrations event with the Chief Executive. Now called 'Quality Champions' this

group continues its work and will again help us to connect with teams across the Trust and prepare for the CQC re-inspection.

Patient experience

Our Trust values

- The rating from the 2015 CQC inspection for Caring was 'good'. The headlines included:
- Maternity and gynaecology services and elements of care on Avon 4 ward were regarded as outstanding
- People were supported, treated with dignity and respect, and were involved as partners in their care
- Good communication between staff, patients and their families was observed.
- Patients, their families and carers were involved in decisions about their care and treatment in most areas

Complaints are covered under the Responsive element of the CQC inspection report. This was rated as 'requiring improvement'. The relevant concerns raised were:

- Patients told the CQC that they received a slow or unsatisfactory response to concerns raised
- The response to patient's complaints within 25 working days did not meet our own standards

Our response to improve our management of patient complaints is described in the section to the right.

As a Trust we are committed to working with our patients and their families/carers to ensure that they are engaged in all aspects of their care, that their experiences are as positive as possible and that their feedback informs continuous service improvements. With the arrival of a new Associate Director in January 2015 the Trust brought together its patient experience, complaints, Patient Advice and Liaison Services (PALS) and volunteering services. This development has supported us in achieving the objectives in our 2013-17 Patient, Public and Carer Experience Strategy and during the past year we have focused on improving our systems and processes for overseeing and delivering patient experience initiatives. This formed the basis of our 2015/16 Work Plan.

Patient experience covers all aspects of the work that we do and is central to our values. To deliver this we need to ensure that we have a robust framework and delivery plan in place. This has required us to develop new ways of working, better data analysis and sharing of feedback to make us more responsive and effective, enabling us to drive forward service improvements.

Our achievements:

- Introduction of a Patient Experience Dashboard to monitor performance and delivery
- Improvements to our complaints processes to improve investigation, timeliness of responses and sharing of learning (reinforced from our CQC Inspection and Internal Audit)
- Introduction of monthly complaints, PALS and patient experience newsletters to share good practice and learning
- Introduction of new ward patient information boards throughout our hospitals
- Delivery of the 'Small Things Matter' patient experience CQUIN
- Review our use of surveys and how we benchmark and share data
- Update our Carers Policy and re-launch Carers Champions across the Trust
- Use the TDA Patient Experience Self-Assessment Tool to review and benchmark our Trust
- Introduce an Annual Patient Experience Report
- Review and improve Patient Experience Information
- Comprehensive review of our Volunteer Services to improve consistency and ensure compliance with the Lampard Report recommendations
- Increase our methods of engagement with patients/carers
- Work with Healthcheckers on reviewing our hospitals and improving accessibility and service delivery for patients with learning disabilities

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Progress on all areas of patient experience is regularly reported to the Trust's Patient and Carer Experience Committee, which in turn reports to the Quality Governance Committee and Trust Board. Significant progress has been made in most areas and where there is still work to be done this is being regularly monitored and reviewed.

How we handle complaints

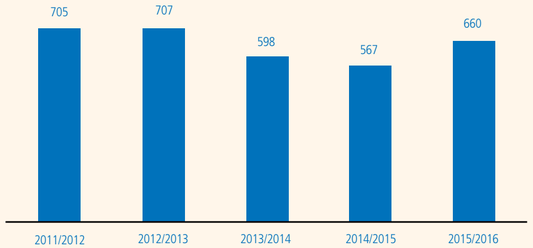
Over the past year we have seen a rise in complaints to 658. Category 2 complaints responses closed within 25 working days were 66% of the total, the same as last year.

Against activity our number of complaints annually is low. We receive 0.22 complaints per 100 bed days.

Four complaints referred to the Parliamentary and Health Services Ombudsman (PHSO) were partially upheld. The CQC Inspection and an internal audit both identified areas for improvement with regards to our processes and adherence to them.

A comprehensive Action Plan has been implemented which is incorporated within our Patient Care Improvement Plan (PCIP).

Number of formal complaints reveived, by the year, for the last 5 years



Key actions include:

- A new Complaints Investigation Template launched in February 2016 to standardise the investigation process and provide an audit trail for quality assurance. It mirrors our Serious Incident process.
- Complaints policy is being re-developed using the Trust Development Authority (TDA) Complaints Framework, the Parliamentary Health Service Ombudsman (PHSO) 'My Expectations For Raising a Complaint' and Patient Association Charter,
- New DATIX Complaint reporting launched in February 2016 to provide instantly accessible information.
- All Category 3 complaints are reported to the Patient and Carer Experience Committee
- A new Complaints and PALS Newsletter introduced for staff in February 2016 to share themes and trends and organisational learning.
- Phase 3 of the Ward Dashboard implementation will incorporate complaints and PALS. This will be reviewed with ward staff during regular schedule of visits by the Patient Experience Lead.
- A programme of complaints letter writing training has been undertaken during the past year by the Patient relations Manager. We are now reviewing this and future complaints training to incorporate the PHSO "My Expectations" report and the Patients Association Charter.
- A revised annual complaints survey has been developed and sent to 290 complainants asking for their feedback on our complaints process.

Complaints are allocated to one of three categories to ensure a proportionate response.

Category 1 complaints are those that can be resolved quickly, and we aim to respond within five working days.

Category 2 complaints are the vast majority, and we aim to reply within 25 working days.

Category 3 complaints are more serious matters which may involve a serious incident investigation and as such response time is negotiated with the complainant.

Categories of complaints received in 2015/2016	Total
Category 1	2
Category 2	630
Category 3	26
Total:	**658**

The key themes and trends identified from Complaints and PALS calls during 2015-16

Theme/trend/issue	Evidence	Actions proposed/completed
Communication – with patients and with their relatives or carers	92 mentions of complaints about communication with relatives or carer; 100 mentions of communication with the patient 68 PALS calls about communication with relatives and carers. 76 about communication with the patient	• Issues with communication discussed with Divisional Management Team as part of Quality Governance Meetings • Separate specific report will be sent to the relevant management team detailing their complaints themes. • New Patient Information leaflets developed with patient input and 'Approved by Patients' logo • Carer Awareness Training rolled out across Trust from March 16
Attitude of staff – nursing and medical	81 mentions of attitude of medical staff in complaints 80 mentions of attitude of nursing/midwifery staff 27 PALS contacts about attitude of nursing/ midwifery staff, 42 about attitude of medical staff	• Issues with attitude discussed with Divisional Management Teams – additional training and support have been provided, area specific training and where necessary internal HR processes activated. • The Trust continuing to roll out ACE with PACE customer service training to staff and is launching Sage and Thyme communication training in Spring 2016 • Separate detailed report will be sent to the relevant senior management team • Patient Experience slot included on trust Induction from January 2016

Compliments

The Trust receives far more compliments than complaints with 5600 received during the past year, including 107 via the NHS Choices/Patient Opinion websites. Positive feedback is regularly shared with teams to reinforce good practice and positive patient experience including:

Well done A&E

'I went to A&E at Redditch on Sunday afternoon suffering with chest pains. I was immediately taken to be assessed and was seen by a number of staff who were both friendly and professional. I was impressed at the extent to which the medical personnel investigated my illness until they sure it was not anything more sinister. In addition to the professionalism, the staff constantly checked to see if I would like a drink or something to eat. A follow-up appointment was arranged to ensure that there are no further underlying issues and I was allowed to go home. People are often quick to criticise so I thought it important to give my thanks for the fantastic care I received.'

Eye problem sorted

'Was sent to Kidderminster opthamology department a day after visiting my optician and mentioning to them that I had got a slight problem with floaters in my vision. Can't believe how promptly I was dealt with and had laser treatment straight away! The consultant was brilliant and put me at my ease. I don't think I could have had better treatment if I had been paying for it'

Nine hours in A&E

'I was unfortunate to have to spend 9 hours in A&E with chest pain. I would like to thank all the staff, they were brilliant. Although they were extremely busy they still looked after me very well. Many thanks'

Learning from patients/carers

Patient stories are a very important way of sharing best practice and learning from mistakes. These are shared from 'ward to Board' and are included regularly in our new Patient Experience Newsletter. One lady contacted us to say how the treatment received helped her family:

Patient story – delighted daughter gets her mum back!

"My mum was slowly losing interest in general life over the past 12 months. This was distressing for me, her grandchildren and her sister. During this time I did broach the topic of her lack of interest/depression. My mum said she was just tired.

"Mums appointment came through for her cataract op and from start to finish she could not speak highly enough of the team. I accompanied my mum on the day of the op and for her last check-up. The team came over as very caring not only about the patients and relatives but also about each other.

"The day of the op had been a trying day for the team who apologised for our wait as there had been an emergency. This was fine for us, we had had a good chat and enjoyed people listening/watching, As staff were going home they were thanking each other for the way they had worked, this was lovely to hear and really showed the care they took of each other. My mum was treated with dignity, respect and compassion on all visits.

"The best outcome has been the major improvement in my mum's sight which has brought about a wonderful lift in her spirit and desire to experience life.

"She asked me some four weeks after her op at what point had her eyebrows disappeared! Informing me the lady was coming later that day to shape and colour her eyebrows. I had tears in my eyes at this point as we had our mum/granny back.

Cataract ops may be very routine but please never underestimate the impact your team has on patients their friends and relatives."

This is such a wonderful story of the care given by the Ophthalmology Department at Kidderminster Hospital, not just for the patients and their families but to each other as well. This is so important. Unless we can be kind and compassionate to one another we cannot possibly care for our patients in this way. It embodies the 6C's, our Trust values and vision in a powerful way.

The CQC Report highlighted that we were 'good' for caring and this story epitomises this.

How we get feedback

Feedback from patients, families and carers is really important to us and we get this from a variety of places.

How we receive feedback	How we use this feedback
Local and national surveys	To develop trend analysis and focus on particular themes/concerns
PALS concerns	This provides a barometer of how the Trust is performing and enables concerns in particular areas to be highlighted in real time, allowing us to raise any issues with individual areas
Complaints	Themes and trends are regularly compiled and shared with wards/departments. The new DATIX Complaints Report provides instant access to Divisions on their complaints and outcomes/learning
Compliments	These are shared across wards/departments to highlight good practice and the impact on patients
NHS Choices/ Patient opinion	Each comment is responded to by the Patient Experience Team. Additional information is requested if we need to follow concerns up. Comments are shared with the relevant areas as they come in and a monthly report is shared with the Divisions

Friends and Family Test

The Friends and Family Test (FFT), introduced in 2012, is a national initiative designed to help service users, commissioners and practitioners 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.

Feedback from patients, families and carers is really important to us and we get this from a variety of places.

Friends and Family Test completions

	Target	Achievement
Wards	30%	15.7%
A&E Worcestershire Royal Hospital	20%	17.25%
A&E Alexandra Hospital	20%	11.76%
Maternity	30%	26.3%

Friends and Family Test scores

	Target	Achievement
Wards	75	76
A&E Worcestershire Royal Hospital	75	61.52
A&E Alexandra Hospital	75	85.34
Maternity	75	84

Completion of the Friends and Family test by patients has been disappointing low across the Trust, but our scores have been generally high. We are planning a relaunch of FFT early in 2016-17. We have new cards and posters being developed and a new film encouraging completion in our waiting areas. Our new Patient Experience Lead will be visiting wards and areas regularly to discuss completions and scores with staff.

More information on the NHS Friends and Family Test can be found here.

Worcestershire Acute Hospitals NHS Trust :QUALITY ACCOUNT 2015/16

National Patient Surveys

The Trust has participated in a variety of national patient surveys during the year covering: inpatients; outpatients and Accident and Emergency services with further local surveys conducted using the Hospedia patient 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. In all surveys the trust has come in as 'average' compared to other Trusts.

National Inpatients Survey 2015-16

National Inpatient Survey – Conducted by Picker – July 2015

- Survey of 81 Trusts - Response rate 46% compared with average of 45%
- Rated as 'average' compared to other Trusts

National Outpatients Survey 2015-16

Outpatient Survey – Conducted by Picker - 2015

- Response rate 48% compared with national average of 45%
- No significant improvement since 2011 survey (of 71 questions, improved in 2, no change on 69)
- Average performer relative to other Trusts (of 71 questions, better in 1, worse in 1 and average in 69)

National A&E Survey 2015-16

A&E Survey – Conducted by Picker – 2015

- Response rate 30.5% compared with national average of 32%
- Average performer relative to other Trusts (better in 6, worse in 2 and average in the rest)
- Slight deterioration since 2014 survey (of 32 questions, up in none, down in 6 no change on 26)

The results of these audits have been used to inform our patient improvement priorities and workplan for 2016/17

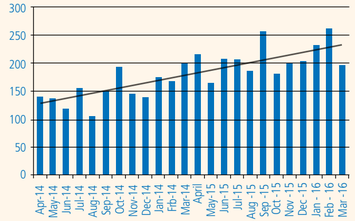
Local surveys

In addition to these national surveys we also undertake a range of local surveys on the Hospedia patient entertainment system covering carers, learning disabilities, patient satisfaction, cleanliness and volunteers. We continually review our questionnaires to ensure that they reflect patient concerns and national priorities.

Patient Advice and Liaison Service (PALS)

The Trust has one PALS Officer covering our three sites, making it effectively a telephone helpline. The number of enquiries continues to rise with 2562 calls being dealt with during the financial past year compared to 1833 in 2014/15.

Number of PALS calls by month 2014-16



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:

Top 5 subject matter of PALS calls in 2015/16	Total
PALS providing information or sign posting	619
Appointments delay	335
Appointment cancelled	153
Other (communication)	106
Other (clinical treatment)	80

Review of other quality performance for 2015/16

Core Indicators for 2015/16 Year to Date

All figures taken from the Board Report - Quality & Outcomes

	Readmissions	YTD	NHS Average*	Data Quality Kite Mark
QEFR1.1	Emergency Readmissions (Within 28 days of Elect. Discharge) – WAHT	0.4%	3.7%	
QEFR1.2	Emergency Readmissions (Within 28 days of Emerg. Discharge) – WAHT	8.0%	8.0%	
QEFR1.3	Emergency Readmissions (Within 28 days of All. Discharge) – WAHT	3.3%	7.5%	

Source : Board Report – Quality & Outcomes (Based on Apr 15 – Mar 16)

	Friends and Family	YTD	Target	NHS Avg Feb 2016	Data Quality Kite mark
QEX2.1	Friends & Family – A&E (Score)	71	>=71	85	
QEX2.2	Friends & Family – (Response Rate%)	15.1%	>=20%	13.3	
QEX2.61	Friends & Family – Acute Wards (Score)	76	>=71	95	
QEX2.62	Friends & Family – Acute Wards (Response Rate%)	15.7%	>=30%	24.1	
QEX2.2	Friends & Family – Maternity (Score)	84	>=71	92	
QEX2.3	Friends & Family – Maternity (Response Rate%)	26.3%	>=30%	6.3	

(Based on Apr 15 – Mar 16) Data source: NHS England

Caveat: In Feb 2016 there has been a change to the reporting definitions to ensure that the Trust is compliant with national guidance.

	VTE Risk Assessment	YTD	Target	NHS Average*	Data Quality Kite mark
QSVT1.0	VTE Risk Assessment	95.00%	95%	95.8%	

Based on Apr 15 – Mar 16)

	Infection Control	YTD	Target	Data Quality Kite mark
QPS12.5	Number of MRSA Cases	1	0	
QSIC1.3	Number of C.Difficile cases	29	33	

(Based on Apr 15 – Mar 16)

	Cancelled Operations	YTD	NHS Average	Data Quality Kite mark
PEL4.1	Cancellations (Patients)	698		
PEL4.0	Cancellations as a % of Admissions (inc Daycase)	0.9%	0.9%	

(Based on Apr 15 – Mar 16) Data source: QMCO return Jan – Dec 2015

Caveat: Cancelled Operations is based on the 2011 definition. For 16_17 the Trust will be moving to current national definition.

	Dementia	YTD	Target	NHS Average	Data Quality Kite Mark
PCQ3.1	Dementia: Find, Assess, Investigate and Refer (Pt 1)	96.50%	>=90%	95.8%	
PCQ3.3	Dementia: Find, Assess, Investigate and Refer (Pt 2)	97.10%	>=90%	95.0%	

(Based on Apr 15 – Mar 16)

	Stroke and TIA	YTD	Target	NHS Average**	Data Quality Kite mark
CST1.0	Stroke Patients to send 90% of LOS on Stroke Ward – based on Apr 15 – Feb 16	81.50%	>=80%	95.8%	
CST2.0	Stroke Patients admissted directly to a Stroke Ward (via A&E) – based on Apr 15 – Feb 16	75.30%	>=70%	95.0%	
CST3.0	TIA – based on Apr 15 – Feb 16	64.80%	>=60%	**Based on SSNAP Q3 2015/16	

Caveat: These metrics are based on local interpretation of the national definition. For 16/17 we will be ensuring national definitions are followed.

Waiting Times and RTT	YTD	Target	NHS Avg Feb 2016	Data sourced from HSCIC
% of Patients Referred and treated within 18 weeks – incomplete – based on Apr 15 - Feb 16	91.50%	92.0%	91.9%	
% of A&E Patients Being Seen, Admitted, Discharged or Transferred within 4 hours of Presentation to Ed (inc.MIU) – based on Apr 15 – Feb 16	87.90%	95.0%	87.8%	
% of Patients having their first treatment within 62 days from urgent GP referral for suspected cancer – based on Apr 15 0 Feb 16	81.40%	85.0%	81.02%	
% of Patients having their first treatment within 62 days from NHS Cancer Screening Service Referral – based on Apr 15 – Feb 16	96.90%	90.0%	90.03%	
% of Patients having their second or subsequent treatment within 31 days for surgery – based on Apr 15- Feb 16	91.70%	94.0%	95.77%	
% of Patients having their second or subsequent treatment within 31 days for anti-cancer drug treatments – based on Apr 15-Feb 16	99.50%	98.0%	99.60%	
% of Patients having their first treatment within 31 days from diagnosis – based on Apr 15 - Feb 16	97.60%	96.0%	97.70%	
% of Patients seen within 2 weeks for all urgent referrals – based on Apr 15 – Feb 16	86.40%	93.0%	95.41%	
% of Patients seen within 2 weeks for symptomatic breast patients – based on Apr 15 – Feb 16	80.10%	93.0%	94.51%	
6 Week Wait Diagnostics (% Waiting > 6 weeks) – based on Apr 15 – Feb 16	1.05%	<1%	1.3%	

Note: March Cancer data is not finalised until early May 2016 Data sourced from HSCIC

Source: Board Report – Quality & Outcomes (Based on Apr 15 – Feb 16)

Worcestershire Acute Hospitals NHS Trust :QUALITY ACCOUNT 2015/16

Mandatory Indicators

All Trusts are required by the Department of Health to provide a core set of indicators relevant to the services they provide, using a standardised statement.

The eight indicators relevant to Worcestershire Acute Hospitals NHS Trust are provided below using information from the Health and Social Care Information Centre and cover the last two reporting periods where data is available. They are set out under the NHS Outcomes Framework domains.

NHS Outcomes Framework – domain 1

Title	Indicator	2014/15	2015/16	National average	Highest and lowest NHS Trust and Foundation Trust scores for the reporting period
Summary Hospital Mortality Indicator (SHMI)	a) the value and banding of the summary hospital-level mortality indicator (SHMI) for the Trust for the reporting period;	113.04 Banding 1	106.00 Banding 3 (Quarter 3 figure used – different to 12 month rolling average)	95.11	64.74 110.29
	b) the percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the Trust for the reporting period.	1.78%	1.68% (Q1-Q3 2015/16)	1.44% (Q1-Q3 2015/16)	0.0% 1.9% (Q1 – Q3 2015/16)
	Worcestershire Acute Hospitals NHS Trust considers that this data is as described for the following reasons:		The results are based on nationally collected data. **The figures used in this section are locally available and produced in advance of the national report** Clinical Coding is of a generally good standard, but it was recognised that a reduction in the percentage for primary diagnosis and primary procedure needs to be addressed.		
	Worcestershire Acute Hospitals NHS Trust has taken the following actions to improve this number, and so the quality of its services, by:		See text in the Quality Account		

NHS Outcomes Framework – domain 3

Title	Indicator PROMs casemix-adjusted scores	2014/15 Adjusted average health gain	2015/16 (provisional data -) Adjusted average health gain	National average (provisional data - Adjusted average health gain	Upper and lower 95% control limit for the Trust (provisional data)Health Gain
Patient Recorded Outcome Measures (PROMS)	(i) groin hernia surgery	0.092	0.077	0.088	Not available
	(ii) varicose vein surgery	NR	0.037	0.104	Not available
	(iii) hip replacement surgery	0.460	0.487	0.454	Not available
	(iv) knee replacement surgery	0.321	NR	0.334	Not available
	Worcestershire Acute Hospitals NHS Trust considers that this data is as described for the following reasons:		• The Trust is performing marginally above national average for groin hernia surgery, hip replacement surgery and knee replacement surgery • Participation rates where too low to calculate health gains data for varicose vein surgery		
	Worcestershire Acute Hospitals NHS Trust has taken the following actions to improve this number, and so the quality of its services, by		• Development of an in-house database to monitor participations rates in an effort towards providing statistically significant data • Conduct analysis of health gains data to present to Clinical leads with the aim to optimise data use and improve clinical outcomes • Review possibility of undertaking training with Quality Health to improve participation rates • Undertake discussions with Quality Health to share good practice for implementation in-house		

Title	Indicator	2014/15	2015/16	National average	Highest and lowest NHS Trust and Foundation Trust scores for the reporting period
Readmission rates	The percentage of patients aged: (i) 0 to 14; and (ii) 15 or over, readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period.	0.0% 4.1%	0.0% 3.9%	Not available in required bands	Not available
Readmission rates	**Worcestershire Acute Hospitals NHS Trust considers that this data is as described for the following reasons:**	This indicator is currently being quality assured internally but the data used is that which is nationally available.			
	Worcestershire Acute Hospitals NHS Trust has taken the following actions to improve this number, and so the quality of its services, by:	See text in the Quality Account.			

NHS Outcomes Framework – domain 4

Title	Indicator	2014/15	2015/16	National average	Highest and lowest NHS Trust and Foundation Trust scores for the reporting period
Patient Survey – Responsiveness to patient's needs	The Trust's responsiveness to the personal needs of its patients during the reporting period	76.2 (Range: 59.0 to 88.2)	n/a	n/a	n/a
	Worcestershire Acute Hospitals NHS Trust considers that this data is as described for the following reasons:	• This information is not available on the HSCIC website at this time – the 2015/16 data will be released in August 2016			
	Worcestershire Acute Hospitals NHS Trust has taken the following actions to improve this number, and so the quality of its services, by:	• See text in the Quality Account			

NHS Outcomes Framework – domain 4

Title	Indicator	2014/15	2015/16	National average	Highest and lowest NHS Trust and Foundation Trust scores for the reporting period
Staff recommending the trust as a provider of care	The percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends	67%	56%	70%	Not available
	Worcestershire Acute Hospitals NHS Trust considers that this data is as described for the following reasons:	• The results are provided from the national staff survey and internal surveys show a similar pattern.			
	Worcestershire Acute Hospitals NHS Trust has taken the following actions to improve this number, and so the quality of its services, by:	• An Organisational Development strategy has been developed. • Patient flow through the Trust is critical to safe and effective care and the effective operation of the hospitals. Improving this is one of our key improvement programmes for 2016/17.			

(There is not a statutory requirement to report this indicator)

Title	Indicator	2014/15	2015/16	National average	Highest and lowest NHS Trust and Foundation Trust scores for the reporting period
Patients who would recommend the Trust to their family or friends	The Trust's score from a single question survey which asks patients whether they would recommend the NHS service they have received to friends and family who need similar treatment or care	Wards: 81.3 A&E Alx: 80.9 A&E WRH: 65.3 Combined A&E: 72 Maternity: 80.2	Wards: 76 A&E Alx: 85.3 A&E WRH 61.5 Combined A&E: 70.2 Maternity: 84.0	Not available	Not available
	Worcestershire Acute Hospitals NHS Trust considers that this data is as described for the following reasons:	• Data errors have been discovered and corrected in the financial year.			
	Worcestershire Acute Hospitals NHS Trust has taken the following actions to improve this number, and so the quality of its services, by:	• See text in the Quality Account			

Worcestershire Acute Hospitals NHS Trust :QUALITY ACCOUNT 2015/16

NHS Outcomes Framework – domain 5

Title	Indicator	2014/15	2015/16	National average	Highest and lowest NHS Trust and Foundation Trust scores for the reporting period
Venous thromboembolism risk assessments	The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period	95.2%	95.0%	95.8%	85.7% 100% (Full year 2015)
	Worcestershire Acute Hospitals NHS Trust considers that this data is as described for the following reasons:	• This indicator has been tested and found to have inaccuracies as described in the External Audit opinion.			
	Worcestershire Acute Hospitals NHS Trust has taken the following actions to improve this number, and so the quality of its services, by:	• A task group has been established to review each step of the process that generates this indicator and make necessary improvements to ensure that it is effective and improves data quality.			

Title	Indicator	2014/15	2015/16	National average	Highest and lowest NHS Trust and Foundation Trust scores for the reporting period
C.difficile infection	The rate per 100,000 bed days of cases of C.difficile infection reported within the Trust amongst patients aged 2 or over during the reporting period	12.66	9.89	14.9 (Q3 2015/16)	Not available
	Worcestershire Acute Hospitals NHS Trust considers that this data is as described for the following reasons:	• This indicator has been tested and found to have inaccuracies as described in the External Audit opinion.			
	Worcestershire Acute Hospitals NHS Trust has taken the following actions to improve this rate, and so the quality of its services, by:	• Antimicrobial Stewardship Group reporting to Medicines Optimisation Committee • Health economy strategy for C.difficile			

NHS Outcomes Framework – domain 5

Title	Indicator	2014/15	2015/16	National average	Highest and lowest NHS Trust and Foundation Trust scores for the reporting period
Incidents	The number and, where available, rate of patient safety incidents reported within the Trust during the reporting period	Number of incident reports: Apr 14 - Sep 14 4536 Oct 14 - Mar 15 5534 Rate of patient safety incidents: Apr 14 - Sep 14 36.21 per 1,000 bed days Oct 14 - Mar 15 42 per 1,000 bed days	Number of Incident reports: 5640 Rate of patient safety incidents: 41.57 per 1,000 bed days	Average number of incident reports 4647 The median reporting rate for this cluster is 38.25 per 1,000 bed days	For the cluster used by the NRLS (136 organisations) Highest number = 12,080 Highest rate = 74.67 Lowest number = 1559 Lowest rate = 18.07
	The number and percentage of such patient safety incidents that resulted in severe harm or death	Apr 14 - Sep 14 Number: • 18 severe harm • 9 deaths Percentage: • 0.4 severe harm • 0.2 deaths Oct 14 - Mar 15 Number: • 14 severe harm • 16 deaths Percentage: • 0.3 severe harm • 0.3 deaths	Number = 18 • 10 severe harm • 8 deaths Percentage: • 0.2 severe harm • 0.1 death	Number (average) = • 15.08 severe harm • 4.88 deaths Percentage: • 0.3 severe harm • 0.1 deaths	Severe harm (number) Highest = 89 Lowest = 0 Deaths (number) Highest = 22 Lowest = 0 Severe harm (percentage) Highest = 2.0 Lowest = 0 Deaths (percentages) Highest = 0.7 Lowest = 0
	Worcestershire Acute Hospitals NHS Trust considers that this data is as described for the following reasons:	• The data is provided from the National Learning and Reporting System • The incident reports are checked for accuracy by the Trust before they are exported to the NRLS.			
	Worcestershire Acute Hospitals NHS Trust has taken the following actions to improve this rate (for incident reporting) and number (of incidents that result in severe harm or death) and so the quality of its services, by:	• Actions are as described in the Quality Account.			

Worcestershire Acute Hospitals NHS Trust :QUALITY ACCOUNT 2015/16

Mandatory statement of assurance from the Board

Review of services

During 2015/16 the Worcestershire Acute Hospitals NHS Trust provided and/or subcontracted 46 NHS services. The Trust has reviewed all the data available to them on the quality of care in these services.

The income generated by the NHS services reviewed in 2015/16 represents 100% of the total income generated from the provision of NHS services by the Worcestershire Acute Hospitals NHS Trust for 2015/16.

Participation in clinical audits

During 2015/16, 43 national clinical audits and 4 national confidential enquiries covered relevant NHS services that Worcestershire Acute Hospitals NHS Trust provides.

During that period the Trust participated in 98% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in. Also in 2015/16 we undertook 281 registered local clinical audits.

There was no data collection for 5 national audits.

Appendix 1 contains a list of national clinical audits, national confidential enquiries and local clinical audits and describes the actions we have taken or are planning to take to improve our services in response to insights from these audits.

Information on research

1047 patients receiving NHS services provided or sub-contracted by Worcestershire Acute Hospitals NHS Trust in 2015/16 were recruited during that period to participate in research approved by a research ethics committee.

This increasing level of participation in clinical research demonstrates the Trust's commitment to improving the quality of care we offer and to making our contribution to wider health improvement.

Worcestershire Acute Hospitals NHS Trust was involved in conducting 114 clinical research studies across 15 different specialties. The Trust used national systems to manage the studies in proportion to risk. Of the 46 studies given permission to start, 92% were given permission by an authorised person less than 30 days from receipt of a valid complete application.

Goals agreed with commissioners

A proportion of Worcestershire Acute Hospitals NHS Trust income in 2015/16 was conditional on achieving quality improvement and innovation goals agreed between the Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation (CQUIN) payment framework.

We had nine CQUIN targets agreed with our main commissioners, NHS Worcestershire, in 2015/16. Further CQUINs were agreed through the Specialised Commissioning Team, National Team and Local Area Teams. They covered one or more of the quality domains as shown in the table below, along with our performance against each goal:

Further details of the agreed goals for 2015/16 and for the following 12 month period are available on request from the Director of Resources.

Title	Indicator	2014/15
Acute kidney failure (add brief description)	Completion of the Electronic Discharge Summary to inform GPs of the patient's condition is still inconsistent.	Not met
Sepsis	This will be a revised CQUIN in 2016/17	Not met
Dementia		Met
Urgent and emergency care	Data collected but admission avoidance process is not yet in place.	Partially met
Local CQUIN		
Prevention of falls for patients on the delirium pathway		Met
Patient Experience – 'small things matter'		Met
Improving safety culture – human factors training		Met
Midwifery led care		Met
Patient flow a) discharge lounge		Met
Patient flow b) best practice ward rounds		Met
Specialised Commissioning CQUIN		
Clinical utilisation review		Met
Right Care Right Place: outpatient follow up		Met
HIV: reducing unnecessary CD4 monitoring		Met
NICE DG10 compliance test – oncotype DX	Breast cancer test	Met
Local Area Team Commissioners		
Screening (AAA, bowel, breast)		Met

Worcestershire Acute Hospitals NHS Trust :QUALITY ACCOUNT 2015/16

Title	Indicator
National	1A Introduction of health and wellbeing initiatives
National	1B Healthy food for NHS staff, visitors and patients
National	1C Improving uptake of Flu vaccinations for front line clinical staff
National	2A Timely identification and treatment of sepsis in emergency departments
National	2B Timely identification and treatment of sepsis in acute inpatient settings
National	5A Reduction in antibiotic consumption per 1000 admissions
National	5B Empiric review of antibiotic prescriptions
National	Patient flow – Ambulatory Emergency Care
Local	Patient flow – GP referred attendances to assessment units
Local	Patient flow – SAFER
Local	Optimal devices
Specialised	Adult critical care timely discharge
Specialised	eGFR monitoring system
Specialised	Neonatal unit admissions
Specialised	Activation system for patients with long term conditions
Specialised	Local information collection on reasons for non-participation in screening amongst the general population
Local Area Team	Promotion of screening programme
Local Area Team	Working with eligible people in a specified priority group to improve access to screening
Local Area Team	Managed clinical networks (MCN)
Local Area Team	Secondary care clinical attachment in oral surgery
Local Area Team	Patient Flow – Emergency Department
Local Area Team	Eating disorder pathway – children and young people

Care Quality Commission (CQC)

Worcestershire Acute Hospitals NHS Trust is required to register with the Care Quality Commission (CQC) and its current status is 'registered with conditions'. The Trust has the following conditions on registration:

Usual conditions: the regulated activates that Worcestershire Acute Hospitals NHS Trust has registered for may only be undertaken on our registered premises.

Following an unannounced inspection of the Emergency Department at Worcestershire Royal Hospital on 24 March 2015, the CQC placed a Section 31 condition on the Trust's registration, which has remained in place throughout 2015/16.

The condition required the Trust to ensure that every patient attending the Emergency Department at Worcestershire Royal Hospital to have an initial clinical assessment within 15 minutes of arrival. Furthermore, the Trust is required to report breaches of this standard to the CQC each week, and on a monthly basis, to provide a report of any incidences of harm caused by delays in initial assessment, together with a root cause analysis for 10% of breaches and details of action taken to prevent recurrence. The Trust has complied with all reporting conditions.

The CQC has taken enforcement action against Worcestershire Acute Hospitals NHS Trust during 2015/16.

The Trust was inspected by the CQC between 14 and 17 July 2015 as part of their scheduled inspection programme. The CQC acknowledged the significant improvements that had been made within the Emergency Department since the March 2015 inspection.

Following the July 2015 scheduled inspection the Trust was rated as 'inadequate' overall and consequently entered special measures.

Special measures apply to NHS Trusts and Foundations Trusts that have serious failures in quality of care and where there are concerns that existing management cannot make the necessary improvements without support.

An overall rating of 'inadequate' was applied to the Alexandra Hospital and Worcestershire Royal Hospital. An overall rating of 'requires improvement' was applied to Kidderminster Hospital and Treatment Centre and a rating of 'good' was applied to the surgical services provided by the Trust at Evesham Community Hospital.

The Trust was rated as 'good' overall for how caring our services are.

Of the 115 domains rated by the CQC, the Trust received ratings of 'outstanding' in 2, 'good' in 54, with 13 'inadequate' and the rest 'requiring improvement'.

The overall ratings for the Trust are provided as Appendix 2.

Worcestershire Acute Hospitals NHS Trust intends to take the following action to address the points made in the CQC's assessment.

Immediately after the inspection, and following the informal feedback at the end of the inspection week, the Trust developed a follow-up action plan based on the key improvement requirements communicated at that stage. 31 out of 33 actions have been completed. One of the remaining actions will be implemented in spring 2016, while the other has been risk assessed and is being managed through the Trust's risk management process.

Following publication of the inspection report an action plan to address the 'must do's' and key 'should do's' was developed. Progress against the action plan has been, and continues to be, reported monthly to the Trust Management Committee, the Trust Board and the Trust Development Authority Quality Oversight Review Group.

Worcestershire Acute Hospitals NHS Trust has made the following progress by 31 March 2016:

Progress with many of the actions has been reported in the sections of this report covering 'safe', 'effective' and experience and is also referred to in the Chief Executive's statement.

- Surgical High Dependency Units (HDU) – We are reviewing the capacity requirements for HDU facilities in surgery and ensuring that they meet the required standards.
- Ensuring that surgical patients receive safe and timely care – up to date information to follow
- Sufficient staffing – up to date information to follow

The Trust has actively engaged in 'buddying' arrangements with other hospital Trusts. For example, with Birmingham Women's and Birmingham Children's NHS FT's around reviewing its current improvement plan and extending this to ensure that the Trust is following best practice across its maternity, neonatal and paediatric services. There has already been an external governance review in maternity and the Trust has also engaged with Oxford University Hospitals NHS Trust to provide support for the development of Trust - wide governance arrangements and processes. The Trust also plans to use the Medical Engagement Survey and to seek support around an organisational development framework that could be rapidly deployed to develop the capacity and capability to improve. The TDA, through the Improvement Director, has been supporting the Trust.

Worcestershire Acute Hospitals NHS Trust has participated in special reviews or investigations by the Care Quality Commission during 2015/16:

Review of health services for looked after children (LAC) and safeguarding

The Care Quality Commission (CQC) undertook a review of health services for looked after children and safeguarding in Worcestershire from 14 to 18 September 2015. The review was conducted under Section 48 of the Health and Social Care Act 2008, which permits the CQC to review the provision of healthcare and the exercise of functions of NHS England and Clinical Commissioning Groups.

The findings from the review were published on 14 December 2015, concluding that services across Worcestershire were 'inadequate' to safeguard children and young people. The full report can be read at this link: **www.cqc.org.uk/sites/default/files/20151214_CLAS_Worcestershire_Final_Report.pdf**

- The review explored the effectiveness of health services for looked after children and the effectiveness of safeguarding arrangements within health for all children
- The focus was on the experiences of looked after children, and children and their families who receive safeguarding services

In total, the experiences of 123 children were reviewed.

The report highlighted some good practice within the Trust, but there were also areas where improvement was required, including keeping babies and children safe within maternity services and the Emergency Department, the safeguarding reporting pathway, safeguarding supervision and training for staff and the lack of capacity within the safeguarding team, including not having a Named Midwife in post. The recommendations have been formulated into an action plan, which is monitored internally via the Trust Safeguarding Committee, and externally via the Clinical Commissioning Groups.

All actions, except the business plan to extend the Maternity K2 system, have been commenced by 31 March, and in several cases are complete. Some examples are:

- Named Midwife coming into post in November 2015
- Issues within the Emergency Department being resolved except for the installation of CCTV at WRH (part of the current refurbishment work)
- Safeguarding supervision pilot commenced
- Safeguarding training for health staff clarified with Worcestershire Safeguarding Child Board Training Officer
- Safeguarding governance restructure completed
- Integration and planned expansion of the adult and children safeguarding team

Data quality

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

The Trust is committed to pursuing a high standard of accuracy, completeness and timeliness within all aspects of data collection in accordance with NHS Data Standards.

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

There is a clinically led Data Quality Steering Group in place, chaired by a Consultant. The Trust strategic Data Quality Lead is the Chief Medical Officer. The DQSG maintain a strategic overview of data quality issues within the Trust, and support the enablement of better data quality from ward to Board.

Worcestershire Acute Hospitals NHS Trust submitted the following number of records during 2015/16 to Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data:

- A&E records **150981**
- Inpatient records **171991**
- Outpatients **746482**

The percentage of records in the published data are below:

Patient's valid NHS number was:

- For admitted patient care **99.6%**
- For outpatient care **99.7%**
- For accident and emergency care **97.5%**

Patient's valid GP was:

- For admitted patient care **100%**
- For outpatient care **100%**
- For accident and emergency care **100%**

Inpatient valid Ethnic Origin was:

- For admitted patient care **96.7%**

Whilst these figures are extremely encouraging, the Trust acknowledges that there is significant work remaining to ensure that data are not only present, but also accurate.

Information Governance Toolkit Attainment

The Trust achieved an overall score of 71% and has remained as an overall satisfactory level, with all of the standards achieving a minimum of a level 2. The overall score has decreased by 5% due to the changes in the requirements in Version 13 of the toolkit. However the Trust has a recovery plan in place to increase the score back to at least 76% for 2017. A recent external audit of the Toolkit included an in-depth review of the evidence for 9 standards and of the 5 actions only 2 are outstanding with actions in place to address any further evidence required.

Worcestershire Acute Hospitals NHS Trust has taken the following actions to maintain and improve data quality in the Trust

Data Steering Quality Group

There is a clinically led Data Quality Steering Group in place which includes fellow clinicians, divisional leads and operational staff. The Group has been operational since September 2015, and has met 4 times so far. It reports into the Trust Committee structure via the Quality Governance Committee. The Group monitors strategic data quality concerns, keeps a log of data quality issues, and will also support the data assurance element of the Information Governance (IG) toolkit.

Data Quality Kitemark

During 2015/16 the Trust introduced a Data Quality Kitemark to support the transparency of any data quality concerns identified by the Trust. This has been rolled out to the Trust level dashboard, and can be seen against all key performance indicators in Board papers.

NHS Number

One of the elements of IG and national standards is completeness of the NHS number. Our NHS number compliance averages 99%.

Board assurance around data quality is received through the Audit and Assurance Committee. Papers giving an overview of monitoring and improvement of data quality were presented to the Audit and assurance Committee in November 2015 and updates reported to the Quality Governance Committee in February 2016.

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

- Continuous audit cycle – in order to meet the requirements of the IG toolkit 506 standard, an auditor was employed by the Trust to conduct a continuous process of auditing case notes against the Trusts PAS. This process is documented in the Data Quality Policy and reports are included as a standing agenda item for the Information Governance meeting. The findings are reported back to the Divisions as part of the IG reporting system.
- Clinical Coding/IG audit – in order to meet the IG Toolkit 505 requirements; an audit of 200 case notes was conducted in November 2015.
- Internal coding audits – a coding internal audit schedule is in place and the coding auditor has conducted several clinical and staff audits.

Clinical Coding Error Rate

In line with the requirements of the IG toolkit standard 505, a coding audit which included auditing 200 sets of case notes, was undertaken by an external coding auditor and the Trusts qualified coding auditor.

The table below shows the overall percentage of correct coding.

Primary diagnosis	77.5%
Secondary diagnosis	91.2%
Primary procedure	88.8%
Secondary procedure	81.7%

The Clinical Coding is of a generally good standard, but it was recognised that a reduction in the percentage for primary diagnosis and primary procedure needs to be addressed. The lower percentage in the primary diagnosis was attributed to histology results either being late or not filed correctly for coders to record. The lower primary procedure was due to some incorrect recording of the 4th digit, which means the procedure is correct however the depth if coding is not accurate. There is an action plan in place to address the required actions.

Staff

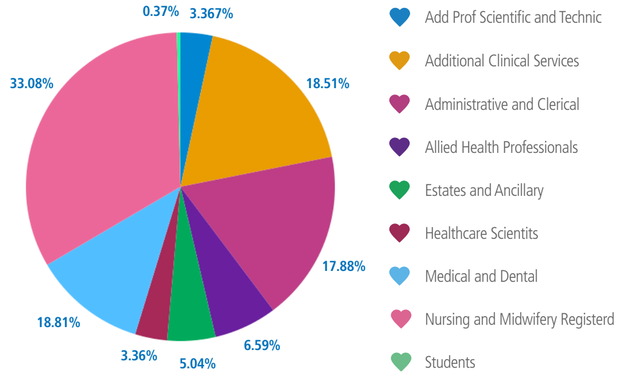
Workforce profile

Worcestershire Acute Hospitals NHS Trust employs just under 6,000 staff across all professions and disciplines. The Trust's annual expenditure on pay is approximately 70% of the total budget.

The largest single staff group is nursing and midwifery, which accounts for over 32% of the workforce, with medical and dental staff comprising just under 12%. The relative size of all staff groups within the Trust is shown in the diagram to the right.

Over 45% of our staff are within the 26 to 45 age group, whilst over 44% are 46 and over which means that the Trust is reviewing its retirement profile and planning for replacement.

The workforce is predominately female, with only 19% male. The Trust offers a range of flexible working practices which is demonstrated by the fact that we have over 35% of staff on part-time or flexible contracts.



Recruitment and retention

Throughout 2015/16 the substantive workforce capacity has remained relatively stable following an increase of 138.26 full-time equivalent (FTE) in the previous year due to radiotherapy development. However, we still have a shortfall against the budgeted establishment of 378.98 FTE as of February 2016 despite active recruitment.

Within the context of staff recruitment and retention, the term 'turnover' is used to refer to the totality of leavers from the organisation. The current overall turnover rate of 12.71% is an upward trend over the past financial year, which can in part be attributed to uncertainty over planned reconfiguration of services in Worcestershire, and the impact of negative press reports following a poor CQC report.

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

There is no single 'quick fix' solution but actions are being taken which aim to address the key issues affecting the Trust's ability to attract, recruit and retain high quality staff in sufficient numbers. This includes the analysis of direct feedback from staff via local and national surveys, the Friends and Family Test, and exit interviews. Current initiatives include:

- A 10% over-recruitment target in key areas (namely medicine and surgery)
- Agreement with Worcester University to increase numbers of student placements from 2016 intake
- Recruitment events
- Development of an internal transfer process to retain staff
- Band 5 and HCA assessment centres scheduled throughout the year
- Business case for another round of international recruitment
- Development of internal banks in some departments

- Return to Practice Campaign
- Introduction of a Recruitment and Retention Premia in theatres
- Widening participation – development of more B4 Assistant Practitioner posts
- Creating and sustaining the right culture and environment

Within the context of significant national staff shortages, which are predicted to continue for the foreseeable future, and additional pressures of the Trust's rural catchment area and uncertainty surrounding the Future of Acute Hospital Services in Worcestershire review, we anticipate recruitment and retention of staff to be challenging. Competition for staff is exacerbated by the pull to larger teaching Trusts which are easily commutable from Worcestershire.

Engagement

The degree to which staff are effectively engaged with the organisation is a key success criterion in meeting the Trust's objectives and in ensuring the knowledge, skills, experience and innovation of teams and individuals is utilised to the greatest effect. It is widely recognised that a workforce that is engaged, empowered and well-led will provide better care and a more positive experience for patients and services users.

Effective staff engagement is achieved in a variety of ways but the principal enabler is establishing and maintaining an organisational culture which is built on shared values and common goals. This begins with the recruitment process and 'values based recruitment'.

The Trust recognises that it is imperative to improve staff engagement, and therefore the quality of its services, by:

- Launching a new HR and OD Strategy underpinned by an OD Staff Engagement Plan which is supported by a myriad of communications, leadership, and health and wellbeing actions.
- Staff Engagement Group (SEG)
- Big Conversation
- Quarterly Pulse surveys
- Listening into Action (LiA) which is applied as a conversation tool at local and corporate levels, enabling teams to become more directly involved in making change happen in their areas. LiA events are to be launched in 2016.

NHS Staff Survey

The NHS Staff Survey is primarily intended for use by Trusts to consider feedback from staff regarding their experiences in the workplace. The findings of the annual survey are used in several ways, namely:

As a measure of staff engagement, informing the trust at organisation level on what is being done and where to focus attention for improvement

At a directorate and divisional level to provide data on staff experience alongside indicators such as patient surveys, complaints and compliments to inform and shape integrated plans to improve quality and patient experience.

As a benchmark with other acute Trusts

In total 372 staff at Worcestershire Acute Hospitals NHS Trust took part in the 2015 survey. This is a response rate of 44% which is average for acute trusts in England, and compares with a response rate of 38% in this Trust in the 2014 survey.

In summary the results of the national 2015 staff survey show no improvement and in many areas a decline against the Trust's 2014 position and the national average score for acute trusts. The Trust was in the bottom 20% of acute trusts for 23 of the 32 key findings and was worse than average in 4; average in 4 key findings and better than average in 1. At the time the survey in October – December 2015, the Trust was taking part in CQC and TDA reviews and the temporary move of birthing services from the Alexandra to Worcestershire Royal took place.

The results provide an indication that:

- There is evidence of a healthy reporting culture
- The results are statistically similar to last year

Three areas that have deteriorated specifically:

- KF22 – physical violence from patient/public increased from 14% to 22%
- KF6 – good communication between senior managers and staff deteriorated from 28% to 19%
- KF21 – agree that equal opportunities to career progression/promotion deteriorated from 90% to 80%

This position is being addressed with urgency as employee engagement is seen as fundamental to the Trust's improvement journey.

Staff Friends & Family Test

The degree to which staff are willing to recommend the trust both a place for their friends and families to be treated, and as a place to work, are strong indicators of staff engagement and motivation. These key areas of staff advocacy are tested quarterly through the annual staff opinion survey and the staff friends and families test which was first introduced in 2014. The results, including fee text comments are reported at the Workforce Assurance Group and to the Divisional management teams.

With respect to the two key advocacy questions in the annual staff survey compared with the national scores the Trust's performance has been as follows:

Staff who would recommend the Trust as a place for treatment

WAHT scores in national staff survey			Average Acute Trusts
2013	2014	2015	2015
62%	67%	56%	70%

Staff who would recommend the Trust as an employer

WAHT scores in national staff survey			Average Acute Trusts
2013	2014	2015	2015
59%	58%	56%	70%

Equality and diversity

The Trust complies with the Equality Act 2010 public sector equality duties and uses the Equality Delivery System (EDS2) developed within the NHS as a means by which to review and improve its equality performance. During 2015/16 the Trust has revised its Dignity at Work Policy and processes and Raising Concerns (Whistleblowing) Policy. It has developed its Staff Engagement and OD plan which aligns with the EDS2 and the Workforce Race Equality Standard (WRES).

All Trust workforce policies and procedures include an Equalities Impact Assessment (EIA) to ensure that any implications relating to diversity or inclusivity are considered. This is overseen by the Equality and Diversity Committee and the Workforce Assurance Group and any corrective action is taken.

The Trusts holds the "two ticks" disability symbol employer status. This accreditation recognises commitment to good practice in employing people with disabilities both in terms of recruitment and adjustments for those who become disabled during their career.

The Trust has recently extended its mandatory training matrix to include equality and diversity training. As at the end of March 2016 x% of staff had received this training. The vision and values are included in all mandatory and management development training sessions and x% staff have attended Ace with Pace (customer care) training. Dignity at Work and "kNow Bullying" training sessions have been held on the three main sites.

We have x Staff Support Advisers who are able to offer informal support any staff who feel that they are experiencing inappropriate behaviour by colleagues or patients.

Staff health and wellbeing

A focused programme of sustainable initiatives was delivered in 2015/16 overseen by the OH and Wellbeing team. Our aim is to promote healthier lifestyle choices for all staff including physical activity using discounted gym and leisure facilities. The Trust achieved Level 1 accreditation in "Worcestershire Works Well" which is an initiative developed with the government, public, private, and voluntary sector to set a recognised standard for employers in respect of their staff health and wellbeing.

We are committed to improving mental health and wellbeing and provide resilience training and self care programmes as well as counselling and support. The OH and wellbeing team also provide roadshows and health promotion events including lifestyle advice, information and signposting to external organisations.

Sickness absence management

The Trusts sickness absence rate is in line with other acute trusts in the NHS but is higher than the local stretch target of 3.5%. Over the past year there has been an increased focus on supporting managers in dealing with long term sickness absence, and in widening access to counselling through the OH service to include personal stress as well as work related stress

This was in recognition of a spike in staff being absent with stress in December 2014. Around £30k was invested in additional counselling sessions for staff who were off sick with stress or anxiety with x% being due to personal/home related stress which was exacerbated by the failure of GP's to provide timely access to counselling. We have seen our work related stress in the annual Staff Survey drop from 39% to 36% in 2015 which we believe to be in part related to our investment in counselling for home related stress

Sickness rate for past 3 years

Worcestershire Acute Trust Cumulative 12 month Sickness Rate		Acute Trust Benchmark (Cumulative % rate taken from HSCIC website)
April 2015 – Feb 2016	4.33% (4.28% as at November 2015)	4.28% (as at November 2015 which is the most up to date information published)
Apr 2014 – Mar 2015	4.09%	4.03%
Apr 2013 – Mar 2014	3.87%	3.84%
Apr 2012 – Mar 2013	3.87%	4.01%

In the winter of 2015 we saw our highest levels of sickness in the past 4 years. However, this was in line with other acute Trusts in England at 4.28% as at November 2015.

Appendix 1: List of clinical audits

The national clinical audits and national confidential enquiries respectively which Worcestershire Acute NHS Trust was eligible to participate in during 2015/16, are as follows:

Eligible National Audits	Participation	% or No's cases submitted
Peri and Neonatal		
National Intensive and Special Care (NNAP)	Yes	100%
Children		
Diabetes (Paediatric) (NPDA)	Yes	100%
Paediatric Asthma	Yes	WRH - 26 ALX - 22
Acute Care		
Case Mix Programme (CMP)	Yes	WRH - 489 ALX - 293
National Cardiac Arrest Audit (NCAA)	Yes	WRH - 107 ALX - 61
National Emergency laparotomy Audit (NELA)	Yes	259
Vital signs in children (Care in emergency Department)	Yes	WRH - 50 ALX - 50
Procedural sedation (Care in emergency Department)	Yes	WRH - 50 ALX - 50
VTE in lower limb immobilisation (Care in Emergency Department)	Yes	WRH - 50 ALX - 50
Emergency Oxygen	Yes	WRH - 26 ALX - 9
National Complicated Diverticulitis Audit (CAD)	Yes	>10
UK Parkinson's Audit	Yes	46
UK Cystic Fibrosis Registry	N/A	Included in Birmingham Childrens Hospital Data
Long Term Conditions		
Inflammatory Bowel Disease IBD (Programme) Biological Therapies	No	Insufficient resources to participate in data collection.
National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme - Pulmonary rehabilitation	Yes	73
National Vascular Registry	Yes	100%
Rheumatoid and inflammatory Arthritis	Yes	ALX - 56 KTC - 91 WRH - 69

Worcestershire Acute Hospitals NHS Trust :QUALITY ACCOUNT 2015/16

National Diabetes Programme		
National Inpatient audit Diabetes (Adult)	Yes	119
National Foot care audit	Yes	21
National Pregnancy in diabetes	Yes	WRH - 10 ALX - 13
Cardiovascular Disease		
Cardiac Rhythm Management (CRM)	Yes	>10
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	Yes	700
Coronary Angioplasty/National Audit of PCI	Yes	1069
National Heart Failure Audit	Yes	394
Sentinel Stroke National Audit Programme (SSNAP)	Yes	90%+
Cancer		
Bowel Cancer (NBOCAP)	No	>100%
Lung Cancer (NLCA)	Yes	0
National Prostate Cancer Audit	Yes	100%
Oesophago- Gastric Cancer (NAOGC)	Yes	>90%
Trauma		
Major Trauma- The Trauma & Audit Research Network (TARN)	Yes	WRH – 278 ALX - 152
National Joint Registry (NJR) - Hips	Yes	ALX – 348 ALX - 122 KTC - 67
National Joint Registry (NJR) - Knees	Yes	ALX – 370 WRH – 56 KTC - 71
Falls and Fragility Fractures Audit Programme (FFFAP)		
Fracture Liaison Database	Yes	Took part in feasibility study
Inpatient Falls	Yes	30
National Hip Fracture database	Yes	ALX – 298 WRH - 418
Blood Transfusion		
National Comparative Audit of Blood Transfusion Programme - Audit of blood management in scheduled surgery	Yes	47
National Comparative Audit of Blood Transfusion Programme – Use of blood in haematology	Yes	30
National Comparative Audit of Blood Transfusion Programme - Audit of the use of blood in Lower GI bleeding	Yes	30

Appendix 1: List of clinical audits

National Confidential Enquiry into patient Outcome and Death (NCEPOD)					
Name of Study	Cases included	Clinical Q Returned	Case notes returned	Sites Participating	Org Q returned
Mental Health General	10	4	9	3	2
Acute Pancreatitis	10	3	10	2	2
Sepsis	6	3	6	3	3
Gastrointestinal Hemorrhage	9	5	8	3	2

There was no data collection during 2015/16 for the following audits:

Audits
Paediatric Pneumonia
Non Invasive Ventilation (NIV)
Adult Asthma
National Audit of Ophthalmology
Secondary Care National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme

Worcestershire Acute NHS Trust was not eligible to participate in the following national audits:	
Chronic Kidney Disease in primary care	Audit applies only to Primary Care
Adult Cardiac Surgery	Specialist Audit
Congenital Heart Failure (CHD)	Specialist Audit
National Audit of Intermediate Care	Specialist Audit
National Audit of Pulmonary Hypertension	Specialist Audit
Paediatric Intensive Care (PICANET)	Specialist Audit
Prescribing Observatory for Mental health (POMH)	Audit only applies to mental health
CORP – Mental Health	Audit only applies to mental health
Renal Replacement Therapy (Renal Registry)	Specialist Audit

Worcestershire Acute Hospitals NHS Trust :QUALITY ACCOUNT 2015/16

Title of National Audit	Summary from report – best practice and actions
National Intensive and Special Care (NNAP)	The individual unit results show that data entry has improved significantly in a number of key areas from 2013 to 2014. In particular areas such as administration of antenatal steroids, ROP screening, and parent consultation.
Case Mix Programme (CMP)	The Trusts QI value is "better than expected than by chance alone" which is below 3SD category.
National Emergency laparotomy Audit (NELA)	The Trust has a case ascertainment rate of over 80% of estimated case load entered which therefore is a green rating. A pathway is being developed for all emergency laparotomy patients.
UK Cystic Fibrosis Registry	This service is shared care with Birmingham Childrens Hospital including joint clinics. The data is collected January – January and a report will be available in July.
National Inpatient audit Diabetes (Adult)	Report published action plan being developed.
National Diabetes Foot-care audit	This is a joint project with the Health & Care Trust nurses. No report has been published.
National Pregnancy in diabetes	New proforma specifically for DKA – available on the intranet Education of junior doctors in Trust Introduction of ketone monitors – in place Alex and WRH in A&E and MAU
Inflammatory Bowel Disease IBD (Programme) Biological Therapies	The Trust is currently purchasing the IBD Registry Patient Management System (PMS), a computerised information system that feeds data automatically into the IBD Registry, and in future, the UK IBD Audit.
Pulmonary rehabilitation National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme	Patients who received their initial assessment and had a primary diagnosis of COPD were invited to consent to take part in the audit. 73 patients were consented across the county.
National Vascular Registry	We are 100% compliant with the registries and are currently retrospectively inputting 3 years' worth of data onto the system.
Rheumatoid and inflammatory Arthritis	The Trust was an outlier in meeting Nice Quality Standard 2. People with suspected persistent synovitis are assessed in a rheumatology service within 3 weeks of referral. The Trust is assessing the waiting times and developing an EIA service
Cardiac Rhythm Management (CRM)	Practice is in line with the rest of the UK
Coronary Angioplasty/National Audit of PCI	• 118 PCI Centres – WRH in top 18 performing 950+ procedures • All clinicians on call same number of days whether weekend or week • Clinicians exceeding 100 procedures national average 75 • All of the fields data completeness 99-100% (Only 18 achieved 100%) • 33% of procedures all elective • Complication rates Femoral 1.3% Radial 0.3% • Call to balloon <150 min 79% • Door to balloon <90 min 90% • Mortality to discharge 1.7% • In hospital mortality 4.78%
National Heart Failure Audit	The audit has identified that a Specialist heart failure nurse is needed and therefore a business case has been produced. Worcestershire Acute Hospitals are in line with other Trusts in England against the standards.

Title of National Audit	Summary from report – best practice and actions
Sentinel Stroke National Audit Programme (SSNAP)	The SSNAP summary report published in March which details the October to December 2015 showed that the Trust had moved to an overall banding of D for SSNAP, which is an improvement from the previous quarter (July-September 2015) in which the band overall was E. The improvements made over the quarter have included the response times to the thrombolysis standards and processes and the increased effectiveness of the discharge process. Worcester has also increased our general SSNAP reporting process which has increased the case attainment which effects the overall scoring. The trust continues to be very challenged with the direct admission to the stroke unit which under SSNAP standards is measured from the point of ambulance crew handover to the stroke unit within 4 hours. This standard is in a bundle which the scoring of that bundle can then not be recovered / improved and has consistently seen the Trust banded at E. The Trusts capacity issues and the downstream flow have had, and continue to have, a detrimental effect on the SSNAP scoring. A large percentage of the patients are moved directly to ASU as their first ward but do not achieve the 4 hour standard. There is an action plan for the improvements required regarding the SSNAP standards for with the ability to improve upon (not capacity related). • Speech and language therapy have now recruited extra staff following the success of their business case and these staff are now in post. They have previously been banded at E due to the response times, but would be looking at an improvement to Band A/B on the reporting quarter that covers April to June 2016 as the service will be fully staffed. There may be a part quarter improvement in the next report. The new staff have also allowed the Trust to start to provide a robust plan of training nursing staff across stroke, ED and MAU on swallow assessments which will also increase the timely response and quality of patients swallow and nutritional assessments. • Continence assessment (part of a larger bundle) has been addressed with staff education and followed up with ward based Matron spot audit to ensure the process is embedded. The paperwork has also been uploaded to EZ notes to ensure a consistent approach across the pathway. • Assessment of mood and cognition: the assessment process has been modified to report on the AMT as a cognitive assessment which reducing repetition and is in line with standards and the dementia targets, and the mood assessments are now being routinely completed by the OT department. The trust would expect to see a next quarter increase in this target. • Completion and follow up of NIHSS scores: a best practice ward round checklist has been developed and is now in use with this standard included amongst others. The Trust would expect to see an increase in the scoring of this standard in the next reportable quarter. The stroke team has monthly speciality meetings to discuss the service, patient pathway and governance issues. The SSNAP standards and the audit improvement tool are discuss as a monthly agenda item
Bowel Cancer (NBOCAP)	The report demonstrates that Worcestershire Acute Hospitals NHS Trust is one of the largest resection centres in the country with index measures such as length of stay, proportion of surgery undertaken by laparoscopic surgery and 90 day post-surgery mortality rates being amongst the best currently being achieved in the UK. The report does document a higher than national average 18 month post-surgery stoma rate which appears to be related to historic data entry.
Lung Cancer (NLCA)	Lung cancer data was not uploaded to LUCADA last year and that resulted in Worcester being excluded from the 2014/2015 national report? The reason being LUCADA is no longer the platform for submitting the lung cancer audit data and as per guidance from the NCRS all audit data has been submitted on a regular monthly basis through the COSD dataset. Trusts in England have been offered a one-time opportunity to refresh lung cancer data for the first five months of 2015. Worcester submitted before the deadline of 7/1/16 and will be included in the appendices due in May 2016.

Title of National Audit	Summary from report – best practice and actions
National Prostate Cancer Audit	It is clear that the trust has done very well in this audit. However, we need to speed up our robotic project to be able to sustain our position
Oesophago- Gastric Cancer (NAOGC)	All of Worcestershire Acute hospitals gastric cancer patients have a management plan that has been agreed by the MDT team and referred to a specialist centre
Major Trauma- The Trauma & Audit Research Network (TARN)	This is a registry of on-going data collection; If the Trust was to become an outlier against any of the standards measured it would receive notification from the provider of the audit. The Trust would then tackle the issue in the form of an action plan.
National Joint Registry (NJR)	This is a registry of on-going data collection; If the Trust was to become an outlier against any of the standards measured it would receive notification from the provider of the audit. The Trust would then tackle the issue in the form of an action plan
Fracture Liaison Database	Obtaining resources to fulfil the requirements of this audit
Inpatient Falls	Action plan has been develop to incorporate national recommendations
National Hip Fracture database	The Trust regularly inputs data into the National Hip Fracture database and improves services based on the results.
Audit of blood management in scheduled surgery (National Comparative Audit of |Blood Transfusion Programme	Pathways being developed, communication package being developed

Local Clinical Audits

During 2015/16 WAHT undertook 281 local Clinical Audits.

The below table demonstrates the 34 completed clinical audits, their actions and any improvements that have been made. 'Completed' audits are classified as those that have been finalised, including closure of all outstanding actions. In addition to these completed audits there are a further 69 audits that have been completed and have actions that are being actively managed to closure.

ID No	Audit Title	Division	Actions/Improvements
1	**Review of Photic Stimulation Protocol**	Medicine/Neurology	A review of the departmental policy was undertaken as a result of the audit and based on BSCN/ANS standards.
5	**Audit of consent for clinical photography**	Surgery/Oral & Max Fax	Continue to follow local Trust policy or aim to achieve national best practice guidance as per the British Orthodontic Society.
15	**Percentage Compliance for Glucose Blood Test Results for NSTEMI Patients**	Medicine/Cardiology	To continue to improve compliance with obtaining Glucose results and will remind all staff in clinical areas of the importance of obtaining bloods for risk assessment. Continue to adhere to Trust Policies and NICE Guidance regarding care of ACS patients
18	**Complex cardiac device implantations, our experience so far**	Medicine/Cardiology	• Formal MDT discussion for all complex device implants • Implant letter for all procedures carried out • Uf plasmablade and or diathermy for patients on antiplatelets
22	**Use Of Endocrine Blockade For Men Diagnosed With ER+ Breast Cancer**	Surgery/Breast	The audit has highlighted that the Trust is non-compliant with the NICE guidance, however a high percentage are having adjuvant treatment
36	**Prevention of retention of nasopharyngeal packs: Reaudit of Trust Policy**	TACO/Anaesthetics	Policy on throat packs introduced Jan 2014, available via Anaesthesia Guidelines on the intranet. Since introduction there have been no instances recorded. It is now a Never Event
38	**Management of patients post Thyroidectomy for Grave's disease**	Surgery/Upper GI	The benefits of using a harmonic Scalpel for Graves' disease is Less operative time, Less haematoma, Less hypocalcaemia.
41	**Audit of CT whole body trauma times from patients attending the Emergency department at WRH**	Clinical Support/ Radiology	The actions highlighted and completed as a result of this audit are: • A pathway has been developed to provide earlier CT requesting from A&E. The department has decided not to wait for creatinine results to provide a CT due to the delay in SIP • Strategies been developed for optimising times by prioritising trauma reports over other scans from wards and A&E • Finally a written proforma has been agreed in line with RCR guidance to provide a primary report immediately
46	**ID 46 Re-excision rates after Breast Conservation Surgery**	Surgery/Breast	For patient undergoing BCS, the unit has achieved a 100% target for no residual disease at radial margins following 3 or less operations. The Trust needs to maintain the high standard level of care as per NICE and the literature guidelines. This information will be used when discussing treatment with patients.

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ID No	Audit Title	Division	Actions/Improvements
53	**ID 53 Standards for the Treatment of Chronic Immune (idiopathic) Thrombocytopenic Purpura**	Haematology/Clinical Support/TACO	Re-audit NICE guidance for use of Eltrombopag & Romiplostim (TA 221 & 293) in chronic Immune Thrombocytopenia. This is required to confirm on-going compliance with this NICE guidance with particular reference to standard 1 which requires clear documentation in the medical notes or clinic letter of the reasons a patient may not be suitable for splenectomy.
59	**ID 59 Surveillance Mammography after DCIS and Breast Cancer Treatment**	Surgery/Breast	• Perform annual mammography's • As a team to consider and discuss enrolling patients in the mammo 50 study (A study of mammographic surveillance in women older than 50 at the time of treatment) conducted by Warwick Medical School.
67	**ID 67 Appropriateness of usage of CTPA and isotope perfusion scans in the investigation of suspected pulmonary embolism in pregnancy.**	Clinical Support/ Radiology	The results against the standards were 95% and above, The only action identified was the Algorithm for the investigation and initial management of PE in pregnancy to be displayed in reporting rooms and CT control rooms on both sites
80	**ID 80 Annual Phototherapy Audit**	Surgery/Dermatology	When comparing to 'minimum standards for phototherapy services' most points are met and those that are not currently are being address as detailed in the action plan.
82	**Head Injury**	Medicine/Emergency Department	The audit identified the department was failing to triage patients within 15mins and highlighted a need for a Triage nurse this has now been addressed. There was an issue with receptionists not checking demographics when booking in the patients. A training session was delivered and the matter has been addressed.
96	**Risk Stratification in patients with Pulmonary Embolism**	Acute Medicine	The audit highlighted that PESI or sPESI are not used, therefore cardiology cannot stratify patients into the intermediate high or intermediate low risk categories according to ESC guidelines, we therefore do not know which patients should be 'monitored for early detection of haemodynamic decompensation. A PE proforma is currently being developed.
109	**Anticoagulation after stroke due to Atrial Fibrillation/Atrial flutter**	Medicine/Stroke	• To use a sticker for CVA patients with AF • To develop a stroke handbook for junior doctors and re-audit in the future
116	**Child Safety**	Medicine/Emergency Department	• Further training of the triage nurses • Reminder in the weekly update
140	**Regional audit into the use and effectiveness of investigations performed on in-patients**	Medicine/ Neurophysiology	The results are regional and the following recommendations were suggested. Results are thoroughly questioned prior to the investigation being performed, Know the specific question that needs answering prior to performing the test. Check the patient's actual state before the test.
80	**Recording of Adult Vital Signs and Actions Taken in the Major Areas of the Emergency Department**	Medicine/Emergency Department	90% Compliance was not reached for any of the criteria audited against, education will be cascaded using weekly brief and nurse and doctor teaching sessions.

ID No	Audit Title	Division	Actions/Improvements
144	**Pain In Children**	Medicine/Emergency Department	• Use of the observation sheet or second observation line • Use of the declined/offered box on the front clerking sheet (even if it by the doctor clerking not at triage) • Possibly include an additional box next to the NAI questions to put in a pain score, time and action • More awareness of appropriate analgesia for moderate and severe pain
146	**Emergency management of hyperkalaemia**	Medicine/Emergency Department	The audit shows good compliance against the NICE guidance, and identified that all patients with severe hyperkalaemia received Insulin/Dextrose but not all Salbutamol
170	**Asthma Audit 2014**	Women's and Children's/Paediatrics	The audit highlighted that we are administering Steroids within a 60 minute timeframe. The improvements completed are an asthma stamp to be used as a checklist, updated clinical guidelines and a management plan for asthma.
178	**The role of breast MRI in altering pre-planned treatment in elderly women with lobular cancer**	Surgery/Breast	We conclude that MRI was efficacious in evaluating the extent of disease and in changing the surgical plan towards a more radical operation and hence it is a useful (but expensive) tool in the evaluation of elderly women with ILC.
396	**Compliance of Asking Safeguarding Questionnaire**	Medicine/Emergency Department	The emergency department are not 100% compliant with the NICE guideline standards. Not all members of staff are aware of which designated professional to seek help from regarding child protection. The emergency department does have the NICE guideline available, but it is not being read during child protection training
399	**Management of Renal Colic Pain**	Medicine/Emergency Department	• Awareness among nursing and junior staff regarding prompt analgesia and re evaluation • Teaching session of junior and senior doctors for documentation and re-evaluation of analgesia • Explore and address the reason for more than 4hrs stay
400	**Acute kidney injury (AKI) CQUIN 2015 – FY doctor audit**	Medicine/Renal	• Staff members are aware of the AKI CQUIN and need to document the AKI CQUIN targets • Staff members are now prompted to fill in AKI details for GP according to CQUIN standards. • Staff members have been made aware of AKI CQUIN and need to document specific data for standards. • Bluespier has been modified to prompt staff to fill in specific data required
419	**Re Audit Airway Alert Follow Up**	TACO/Anaesthetics	The audit highlighted a need to change practice to ensure the patients could retain the information given. The anaesthetist has initial discussion with patient, the form is completed and the doctor contacts the patient for discussion. A credit card size document has been produced and a re-audit will take place in Oct 2016.
432	**Audit of the Hysterosalpingogram service provided at the Alexandra Hospital**	Clinical Support/ Radiology	• Work to reduce screening times • Work to reduce dose • Re-audit

ID No	Audit Title	Division	Actions/Improvements
441	**Hand Injury Management in the Emergency Department**	Medicine/Emergency Department	Documentation needs to be improved especially pain scores. Due to the sample size it will need to be re-audited with a larger sample for meaningful results
452	**VTE Risk Assessment**	Haematology/Clinical Support/TACO	Results showed non-compliance against the VTE policy and education is needed for all staff to highlight the need for VTE assessment and prevention. This will be a regular audit from April 2016.
474	**Re-audit of management of fracture neck of femur within the Emergency Department at Redditch Alexandra Hospital**	Medicine/Emergency Department	Re audit shows we are not doing well in managing the pain in patients with neck of femur fracture as compared to our previous audit, especially in recording the pain score, initial analgesia and re-evaluation of pain. We did improve CEM standard for radiology investigations. Overall admission rate under4 hours gone worse from 83% to 54%, this is mainly due to bed situation in trust.
483	**A Retrospective Clinical Audit of Falls at Timberdine Nursing and Rehabilitation Centre**	Medicine/Geriatric Medicine	The nursing staff are now able to perform the neurological examination
523	**RCPCH guideline about managing admitted children**	Women's and Children's/Paediatrics	Better compliance with RCPCH standards in re- audit
647	**Audit of viscosupplementation injections for Osteoarthritis of the Knee**	Surgery/T&O	Validate local protocol with the rest of the department

Appendix 2: Care Quality Commission Ratings

Worcestershire Acute Hospitals NHS Trust :QUALITY ACCOUNT 2015/16

Overall ratings for Worcestershire Acute Hospitals NHS Trust

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

Ratings for Worcestershire Royal Hospital

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

Ratings for Alexandra Hospital

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

Ratings for Kidderminster Hospital & Treatment Centre

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

Ratings for Evesham Hospital

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

Worcestershire Acute Hospitals NHS Trust :QUALITY ACCOUNT 2015/16

Appendix 3: Statements

Statement of Directors' responsibilities in respect of the Quality Account

The directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (in line with requirements set out in Quality Accounts legislation).

In preparing their Quality account, directors should take steps to assure themselves that:

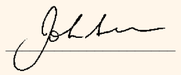
- The Quality Account presents a balanced picture of the trust's performance over the reporting period
- The performance information reported in the Quality Account is reliableand accurate
- There are proper internal controls over the collection and reporting of the measures of performance included in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

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

By order of the Board

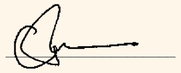
NB: sign and date in any colour ink except black

John Burbeck Chairman



Date: **8/06/16**

Chris Tidman Interim Chief Executive



Date: **8/06/16**

External review statements

Worcestershire Health Overview and Scrutiny Committee (HOSC)

Worcestershire HOSC regrets that it is unable to provide a commentary on the 2015/16 Quality Account due to changes in its committee membership.

Worcester CCGs

The response detailed below is a collective response from the three Clinical Commissioning Groups (CCG) in Worcestershire. (NHS South Worcestershire CCG, NHS Wyre Forest CCG and NHS Redditch & Bromsgrove CCG). All three CCGs welcome the opportunity to comment on the 2015/16 Quality Account for Worcestershire Acute Hospitals NHS Trust.

Commissioners recognise that this has been a particularly challenging year for the Trust during which it has managed a significant programme of transition and transformation of its services. This includes the redesign of the Emergency Department at the Worcester Acute Hospital site and the temporary relocating onto one site of the Maternity and Neonatal Services. This year has also seen the Trust placed into 'special measures' following its Care Quality Commission (CQC) Inspection in July 2015. Throughout, the Trust has been open and transparent regarding the challenges and concerns they face and the CCGs would like to acknowledge this.

During 2015/2016 the Worcestershire healthcare economy has faced a number of significant challenges which have impacted upon the Trusts ability to make and sustain quality improvements across the organisation. It is acknowledged that the Trust is working hard to address these issues however progress has been slow which is reflected throughout the Quality Account and demonstrated by the Trusts failure to fully achieve any of the quality priorities that were set for 2015/16. It is also acknowledged that despite the work undertaken significant concerns still remain in relation to the performance and sustainability of some services, workforce capacity and patient flow through the Trust.

The CCG recognises the capacity and demand challenges faced by the Trust and welcomes the Trusts commitment to prioritising improvements through the work they are undertaking with the Emergency Care Improvement Programme (ECIP). This will also be strengthened by the implementation of the 2016/2017 local CQUIN programme which has been developed with a specific focus on improving patient flow and reducing the number of avoidable Hospital admissions.

Despite the challenges faced by the Trust the CCGs would like to acknowledge some positive quality initiatives/outcomes achieved in relation to attaining the national Clostridium Difficile Infection (CDI) trajectory. Also the work undertaken, following the CQC inspection, to strengthen both corporate and local governance arrangements in relation to the reporting of quality concerns, management of Serious Incidents and complaints. These initiatives are still in the process of being fully implemented and there remains work to do in terms of embedding learning across the organisation. Nevertheless they demonstrate a commitment by the Trust to improving and sustaining quality and safety across the organisation. In relation to mortality reviews the CCGs support the implementation of the Trusts improvement programme and will continue to monitor the metrics to ensure improvements in avoidable mortality.

Commissioners support and welcome the specific priorities for 2016/17 to improve on patient safety, patient experience and effectiveness which the Trust has highlighted in the Quality Account. All are appropriate areas to target for continued improvement and build on the achievements in 2015/2016.However given the limited progress seen against the targets set in 2015/16 the Trust should consider how they intend to ensure the monitoring processes are more robust this year in order to prevent a recurrence.

Our view is that the Quality Account is largely presented in a clear and easy to read format.

Worcestershire Acute Hospitals NHS Trust :QUALITY ACCOUNT 2015/16

It includes all essential elements and incorporates the NHS England's 2015/16 presentation guidance and to the best of our knowledge appears to be factually correct. The Quality Accounts are intended to help the general public understand how their local health services are performing. With that in mind it is strongly recommended that the Trust reviews some sections in relation to the use of unqualified acronyms, grammar and whether some of the sections are written in plain English which can be understood by the general public.

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

Overall Commissioners are happy to accept this Quality Account as an accurate and fair reflection of the Trusts quality profile with a balance of positive and negative results. The CCGs look forward to continuing to work in partnership with the Trust during 2016/17 developing relationships to help deliver the Trust's vision of providing safe, effective, personalised and integrated care for local people, delivered consistently across all services by skilled and compassionate staff.

Healthwatch Worcestershire Response

Healthwatch Worcestershire has a statutory role as the champion for those who use publicly funded health and care services in the county. This involves ensuring that the experiences and views of patients, carers and the public are used to influence how NHS organisations, such as Worcestershire Acute Hospitals NHS Trust provide services.

We have used national Healthwatch England guidance to form the response below to the draft

Quality Account 2015-2016 for the Worcestershire Acute Hospitals NHS Trust

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

During the year under review, patients have related their experiences of services provided by the Trust to Healthwatch Worcestershire. These experiences have covered concerns about issues such as delays in appointments, waiting times for operations, 'trolley waits' in the Accident & Emergency Department and concerns about staff attitude.

Therefore as those experiences can be seen in the Trust's challenge to achieve against the relevant performance targets that is reported in the Quality Account it can be seen to reflect what people have told Healthwatch Worcestershire.

Those patients or their families who contact Healthwa tch have in the majority already contacted the Trust's Patient Advisory Liaison Service before they contact Healthwatch Worcestershire or will have been advised to do so to ensure the Trust was aware of their concerns.

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

The majority of issues referred to above that patients have reported to Healthwatch Worcestershire were identified during the CQC inspection, the result of which saw the Trust being placed in 'Special Measures'.

During 2015-16 Healthwatch Worcestershire surveyed the experiences of patients who had used adult mental health services and the experiences of parents of children under 5. The mental health survey identified patients' concerns about the attitude of staff working in the Trust's Accident & Emergency Department. Although the survey of parents under 5 identified compliments about the Trust's maternity services [including compliments from mothers who would have given birth in Redditch but did so in Worcester following the temporary closure at the Alexandra site], concerns were also identified about the level of support offered to mothers immediately after they had delivered.

Both of these concerns were shared with the Trust in March 2016 and neither are referred to in the Quality Account.

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

Since the CQC inspection, it is clear the Trust is implementing a learning culture although there is limited evidence this extends to learning from patient experience which is reflected in the Quality Account.

The draft Quality Account does not appear to detail how the Trust fulfils its statutory obligation to engage and involve patients and carers in the design and delivery of services. Whilst Healthwatch Worcestershire acknowledges that Trust has a Public and Patient Forum in place Healthwatch Worcestershire believes there is an opportunity for the Trust to improve its services by developing its approach to co-production as a matter of urgency.

Healthwatch Worcestershire welcomed the willingness of the Trust's senior leadership team to work with Healthwatch, and the invitation of the Trust to attend its Patient Public Forum where the focus appeared to have been on participation in management inspections. Healthwatch Worcestershire is willing to work with the Forum to develop co-production.

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

In March 2015 the Trust introduced the Patient Care Improvement Plan which was in place at the time of the CQC inspection and has been used to drive its search for improved performance that still alludes the Trust. Over the last 12 months the Trust has reorganised Maternity Services and whilst there was public concern in Redditch and Bromsgrove enquiries suggest where mothers have used services they have been pleased with the experience.

On page 4 there is specific reference to the 2016/17 priorities with no evidence of public involvement in co-producing them. The majority appear to have been identified by internal management and national performance data requirements or as a requirement of regulatory bodies. Much of these priorities, understandably, have been shaped and driven by the findings of the Care Quality Commission report in July 2015.

Is the draft Quality Account clearly presented for patients and the public?

The draft Quality Account document is very long and therefore may be difficult for many patients and members of the public to easily read and understand. Some parts are more of a technical performance report. It would therefore be helpful to have a summary or produce a shorter leaflet for patients explaining what feedback people have given the Trust about their services and what they are going to do as a result of this to change and improve.

Response to HealthWatch

The Trust would like to thank Healthwatch for their response and helpful comments. The Trust has a dedicated Patient Experience Team who triangulate and utilise the wide range of data given to us by patients including: surveys; FFT; complaints; PALS; Quality Review Visits; PLACE and other inspections. These rich sources of data from patients and carers underpin the Trust's improvement work across a range of patient experience initiatives and service developments. More detail pertaining to these outcomes over the past year will be included in our Annual Patient Experience Report but include the development of projects such as our Side by Side Dementia Project with the Alzheimer's Society and the introduction of the Parent Passport and improved communication initiatives within our neonatal team. We also introduced the 'Approved by Patients' logo when we revised our 'Your Stay in Hospital' booklet which is now available for all patient information reviewed and updated in conjunction with our patients.

In February we held a Patient Experience event with staff and patients to look at achievements and prioritise the areas our patients have highlighted as areas for improvement during the forthcoming year. This includes:

- Outpatients Strategy – to standardise clinics and information with improved reputation and better coms
- Roll out of Sage & Thyme training for staff to improve communication skills
- Improved discharge processes and introduction of SAFER Patient Flow Bundle
- New Communications Strategy

The Trust has an active, if currently small, Patient Public Forum and we are working on a new Community Engagement & Volunteer Strategy to increase the recruitment, diversity and skills mix of our involved patients. We have appreciated working more closely with Healthwatch and look forward to developing this relationship further during the forthcoming year as well as continuing to work alongside our patients / partners to ensure we continue to provide the best possible patient experience going forward.

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

We are required to perform an independent assurance engagement in respect of Worcestershire Acute Hospitals NHS Trust's Quality Account for the year ended 31March 2016 ("the Quality Account") and certain performance indicators contained therein as part of our work. NHS trusts are required by section 8 of the Health Act 2009 to publish a quality account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010, the National Health Service (Quality Account) Amendment Regulations 2011and the National Health Service (Quality Account) Amendment Regulations 2012 ("the Regulations'').

Scope and subject matter

The indicators for the year ended 31March 2016 subject to limited assurance consist of the following indicators:

- Percentage of patients risk-assessed for venous thromboembolism (VTE)
- Rate of Clostridium Difficile infections.

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

Respective responsibilities of directors and auditors

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

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

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

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

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

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

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

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

- Board minutes for the period April 2015 to June 2016;
- papers relating to quality reported to the Board over the period April 2015 to June 2016;
- feedback from the Commissioners dated 23/05/2016;
- feedback from Local Health.watch dated 07/06/2016;
- the Trust's complaints report published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009, dated 20/05/2016;
- the latest national patient survey dated 08/06/2016;
- the latest national staff survey dated 23/02/2016;
- the Head of Internal Audit's annual opinion over the Trust's control environment dated April 2016;
- the annual governance statement dated 01/06/2016; and
- the Care Quality Commission's Intelligent Monitoring Report dated 01/05/2015.

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

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

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

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

Assurance work performed

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

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- testing key management controls;
- analytical procedures;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content of the Quality Account to the requirements of the Regulations; and
- reading the documents.
- A limited assurance engagement is narrower in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Worcestershire Acute Hospitals NHS Trust :QUALITY ACCOUNT 2015/16

Limitations

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

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

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

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

Basis for qualified conclusion

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

- Accuracy and Validity: in our testing of 36 admissions we identified:

three cases where there was no evidence that a VTE assessment had been completed, although the Trust had reported it as being undertaken; and

one case where a VTE assessment had been completed but where the Trust had categorised the admission as 'unknown'.

Qualified conclusion

Based on the results of our procedures, with the exception of the matter reported in the basis for qualified conclusion paragraph above, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2016:

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

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Acknowledgements and feedback

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Feedback

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

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