NHS
Worcestershire Acute Hospitals
NHS Trust

70 YEARS OF THE NHS 1948 - 2018

Quality Account
2017/2018

4ward

Contents

Part 1: Welcome from our Chief Executive

Of the many documents our Trust is required to publish each year, this Quality Account is one of the most important and most relevant. Thank you for taking the time to read this report.

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

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

The Trust remains in 'special measures', since November 2015 and has received subsequent visits from the Care Quality Commission (CQC) in April and November 2017, and January, February and March 2018.

The CQC's reports from the above inspections, published in January 2018 and June 2018, show improved ratings for our Women and Children's Services, and in the well-led domain. The Section 31 regulation relating to our diagnostic imaging service was also lifted. Areas where further improvements were identified for the Trust, include patient flow, waiting lists, and privacy and dignity in the Emergency Department, surgical and outpatient services. We recognise the work that needs to be done to continue on our improvement journey and a comprehensive action plan is in place as part of our Quality Improvement Strategy.

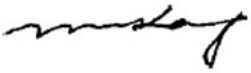
Michelle McKay
Chief Executive

Full details of the June 2018 report will be included in the 2018/19 Quality Account.

Our Quality Account has been put together with significant input from clinical and management teams across our Trust and enhanced by contributions from a number of our key stakeholders. I would like to thank all of them for their efforts.

I hope that what you find is a wealth of interesting, relevant and accessible data about the quality of our services.

I believe you will also see an emerging picture of an organisation which is by no means perfect but has a clear sense of purpose and a determination to do the right thing by our patients, carers, staff and our wider community.



Michelle McKay
Chief Executive

1.1
Introduction

Quality Accounts are annual reports for the public from NHS providers about the quality of the services provided. The Quality Account sets out where the Trust is doing well, where improvements in quality can be made and the priorities for the coming year. It also provides an overview of the progress made against the 2017/18 quality priorities.

1.2
Who we are and what we do

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

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

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

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

The Trust predominantly serves the population of the county of Worcestershire with a current population of almost 580,000, providing a comprehensive range of surgical, medical and rehabilitation services. This figure is expected to rise to 594,000 by 2021; taken as a whole, the Trust's catchment population is both growing and ageing. Both the male and female population shows a projected increase from 2014 to 2025 in the older 70 plus age groups. This is especially apparent in the 75-79 age range, although proportionally the projected rise in the 90 plus age range is higher. The forecast increase in numbers of older people is due to increased life expectancy resulting in greater numbers of older people, particularly females, surviving to very old age (ONS, 2010). We note from national statistical data that the number of older people with dementia is expected to double in the next 20 years. Of note the rate of population growth is greatest in the very old age groups who present the greatest requirements for 'substantial and critical' care. Worcestershire has proportionally a greater number of older people than the nation in general.

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

The majority of services are commissioned by three local commissioning groups (CCG):

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

We work in partnership with a wide range of organisations for the delivery and planning of health services.

The main statutory bodies include:

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

Patients at the Alexandra Hospital benefit from improved MRI scanning service

A new and improved £1million MRI scanner at the Alexandra Hospital in Redditch is providing a more relaxed experience for patients, thanks to its innovative ambient technology.

This ambient experience - generously funded thanks to a £36,000 donation from the Alexandra's League of Friends – is only available in a handful of NHS hospitals nationwide. It means patients can choose from a range of lighting effects and images which they can view whilst in the scanner. Situated in a newly refurbished building, it will bring numerous benefits to the thousands of patients who attend for MRI scans each year at the Alexandra Hospital.

Dr Rob Johnson, consultant radiologist said: *"An MRI scan can sometimes be an anxious experience for patients, particularly those who suffer from claustrophobia. The state-of-the-art ambient technology means patients attending MRI scans benefit from the new technology which provides a more relaxing and visual distraction during the scan. Feedback from patients has been extremely positive."*

Alex Wingrove, MRI Radiographer said: *"We are delighted to offer patients this enhanced lighting, sound and visual technology, and we are grateful for the additional funding which was provided by the League of Friends. It has made a real difference to patient experience."*

Pictured: Alex Wingrove, MRI Radiographer; Christine Phillips, League of Friends; Rachel Maclean MP, John Uren, Lead Radiologist; Dr Rob Johnson, Consultant Radiologist and Alison Harrison, Acting Divisional Director of Nursing.

Part 2: Our commitment to quality

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

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

2.1 Registration with the Care Quality Commission (CQC)

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

From July 2015 to February 2018 there have been nine announced inspections undertaken and a number of unannounced inspections. At the time of drafting this Quality Account, the overall rating for the Trust remains as 'inadequate' as per the most recent Trust-wide report issued in November 2016. The Trust continues to be rated positively in the caring domain, with safety, responsive and leadership found to be 'inadequate' and with effectiveness 'requiring improvement'. Their findings were reported in terms of 'must dos' and 'should dos' and categorised into the areas of Improving Patient Outcomes, Patient Experience and Engagement, Safe Care, Governance, Operational Flow and Culture and Workforce. This provided the basis for the 2017/18 Quality Improvement Plan which was generated by the new Executive Leadership Team in the first Quarter of 2017/18 following the Care Quality Commission (CQC) ratings of services.

Following the Trust-wide report issued in November 2016, the Trust was issued with a Section 29A due to not being able to demonstrate significant improvement in all of the areas required. An additional Section 29A was issued following a subsequent Trust-wide review in April 2017 and the Trust was tasked with providing a further detailed action plan to outline how significant improvement would be delivered.

In November 2017, the CQC visited the Trust to perform an unannounced inspection which focused on Urgent and Medical Care and found that improvements were made, including:

- Significant improvement in patients waiting more than 12 hours to be admitted and completed risk assessments.
- Improvements in pain relief, staff appraisals, hand hygiene, local leadership, sepsis guidelines, ambulatory care and frailty pathways, and patient flow.
- Improved VTE assessment, management of patient safety incidents and shared learning, supported staff, clear treatment plans documented and collaboration with partner organisations.

Areas of outstanding practice were also identified in holistic care provided on Evergreen Ward; improved mental health care for patient through alcohol detox therapy; and the liaison group with the local prison which reduced prisoner attendance and improved services for mental health patients.

Worcestershire Acute Hospitals NHS Trust - Conditions/Warning Notices in place at March 2018			
Conditions/ Warning Notices	**Area**	**Site**	**Date Received**
Section 31 Condition placed on registration (requirement to report 15 minute triage breaches and Harm Reviews)	Emergency Department	WRH	26 March 2015
Section 29 Warning Notice - Regulation 15	Emergency Department - **Security**	WRH/Alex	30 March 2015
Section 29 Warning Notice - Regulation 16	Emergency Department - **Equipment**	WRH	30 March 2015
Section 29 Warning Notice - Regulation 22	Emergency Department - **Staffing**	WRH	30 March 2015
Section 31 Condition	Radiology	Trust-wide	16 August 2016
Section 29A	Various	Trust-wide	27 January 2017
Section 29A	Various	Trust-wide	11 July 2017

Award-winning maternity services…

Maternity services across the county have been recognised nationally for their award-winning services.

The Meadow Birth Centre at Worcestershire Royal Hospital was awarded the title of national Birth Centre of the Year at the MaMa Awards 2017.

Midwives and maternity professionals in the Wyre Forest are also celebrating success after winning the Innovation Award at the Midlands Maternity and Midwifery Festival Awards.

The Meadow Birth Centre gives women more choice over where their baby is born and offers a comfortable environment where birth is treated as a 'normal' process rather than a medical one. The four self-contained rooms have seen over 2,000 babies born since opening to expectant mums in April 2015.

Meadow Birth Centre midwife team leader, Louise Turbutt said: *"We're so proud of what we've achieved so far and winning this award is very special for all of the team on the unit. It's a testament to the whole team and how hard everyone has worked to give mothers to have the best possible birth experience they can in a relaxing and homely environment."*

The Innovation Award was awarded to the Wyre Forest Maternity Hub – a 'one stop shop' antenatal and postnatal service based at Kidderminster Hospital and Treatment Centre.

The Hub – bringing community and hospital services together under one roof for the first time – is the first of its kind in the country. It has proved so successful other areas now looking to develop similar models of care.

Having community and hospital services together means pregnant women can access and receive any care they need - throughout their pregnancy and afterwards - quicker and easier.

Karen Chapman, Maternity Hub Team Leader, said: *"It is great to be recognised for the work that we are doing to really make a positive difference to pregnant women and new mums in Wyre Forest."*

Pictured: Meadow Birth Centre staff: Lesley Rose, Maternity Support Worker; Kate Humphries, Midwife; Lorraine Grummett, Midwife; Julie Cooper, Midwife; Louise Turbutt, Team Leader and Kathy Dewhurst, Midwife.

Part 3: Our commitment to data quality

Information and data lies at the heart of improving quality and safety within the Trust. From nationally mandated standards and levels of compliance, to local Trust agreed metrics; raw data is triangulated with qualitative evidence to provide intelligence about quality and safety priorities in the Trust. Information is used to ensure that everyone in the Trust can be held to account, consistently, for the work that we do. The Trust can proactively identify trends, track improvements, and identify hotspots for focus.

A broad range of quality Key Performance Indicators (KPIs) are monitored, as relevant, throughout the Trust Board's Assurance Framework (BAF), including all expert groups and the Trust Board's Quality Governance Committee. To improve the clarity and the depth of assurance, the Trust continues to develop a hierarchy of indicators in line with the new Quality Improvement Strategy and supporting plans, so that the elements of a balanced scorecard can be viewed and triangulated, in appropriate detail, at different levels within the framework from Ward to Board. This will reduce the number of indicators routinely viewed by the Trust Board, whilst ensuring greater visibility when key indicators raise concern.

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

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

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

In 2017/18 the Trust recruited a dedicated Data Quality Manager. The Data Quality Manager has worked alongside clinical and non-clinical teams to identify the root cause for a specific data quality issue and

take responsibility for putting together plans for improvement. The general improvements are usually related to a lack of knowledge and understanding by those who create, record and use the data and system configuration, or related to processes that are not robust.

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

- A&E records – 187,425
- Inpatient records – 163,710
- Outpatients records – 847,083

These are included in latest published national data. The accuracy and completeness of submitted data was consistently over 95% although this was, on average, a percentage point below the national average.

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

Safety and Quality Information Dashboard (SQUID)

A Board to Ward Safety and Quality Information Dashboard was launched in early 2017. Known as SQUID, the dashboard is open access to all and provides the Trust with a user friendly electronic assurance system giving ward to board sight of key quality and safety information. It also provides a single source of the truth for quality and safety information.

SQUID supports organisational hierarchy with escalation and assurance running from Ward to Board, and direction and steer running Board to Ward.

Areas of good and poor performance are highlighted, and the system encourages real time feedback. SQUID is supported operationally by DATIX - web-based patient safety software which is used within the Trust to manage incidents, complaints and risk. Operational real time dashboards are available through DATIX. SQUID will continue to be used to monitor, challenge, manage and report progress on the Trust's Quality Strategy.

Ward-based Patient Quality Checks were rolled out across the Trust in July 2017. Questions relate to key areas for development as highlighted from previous CQC inspections under the key lines of enquiry. Three weekly audits of patient notes on each ward are undertaken by Matrons and the development of a league table has driven improvement of the quality of care for patients. The development of a Ward-based Accreditation Programme and an earned autonomy from sustained performance on quality indicators is currently in development.

Worcestershire's hospitals given patient safety award for joint surgery data

All three of Worcestershire's acute hospitals have received a top patient safety award from the National Joint Registry (NJR).

The award recognises the high standards of patient safety achieved for orthopaedic surgery on hips, knees, ankles, elbows and shoulders at the county's hospitals.

Worcestershire Acute Hospitals NHS Trust completed local data audits and met six targets relating to patient safety to be awarded as a 'Quality Data Provider'.

The NJR is a national health watchdog that monitors the performance of hip, knee, ankle, elbow and shoulder joint replacement operations in hospitals across the country in order to improve clinical outcomes for the benefit of patients.

Data is collected on these surgeries in order to ensure quality, evidence and standards for joint replacement surgery are as effective and safe as possible. The National Joint Registry is currently the largest registry of its kind in the world.

Charles Docker, Clinical Lead Trauma and Orthopaedics said: *"Good data is essential for patient safety as it means patients can be confident in the outcomes of surgery at the hospital and so this unique award demonstrates the high standards we are meeting in our hospitals.*

"The award is also a good story for patients as it gives an opportunity to inform patients of how we use data from their surgery to protect them and our future patients".

Dr Suneil Kapadia, Chief Medical Officer for Worcestershire's acute hospitals said: *"Improving patient safety is of the utmost importance and something we all take very seriously, so we are very proud that our efforts have been recognised with this award.*

"These awards demonstrate that we are collecting the most complete and accurate information possible which helps the NJR make many of their decisions regarding quality of care and patient safety as well as overall cost-effectiveness of joint replacement surgery."

Pictured: The presentations of the Quality Data Provider certificate at each of Worcestershire's three acute hospitals in Redditch, Worcester and Kidderminster

Part 4: Overview of the Quality Account

The need for the Trust to provide the best quality of care consistently for our patients and their carers across all the services and departments was an overarching aim for the Trust throughout 2017/18.

Our quality improvement plan addressed the necessary improvements generated following the CQC's nine inspections undertaken between July 2015 and February 2018.

The work undertaken in 2017/18 has provided a clear baseline for the next few years and a list of priorities for improvement. The Trust, however, agreed the need to develop a three year Quality Improvement Strategy. The aim of this is to move from reacting to the quality improvement requirements highlighted by our regulators, to one of proactively planning and prioritising the quality improvements, reducing variation and improving the outcomes of care for our patients. This Strategy will guide and focus the Trust to create a culture of continuous improvement and learning which is both patient-centered and safety focused.

Quality Improvement Plan poster

Priority 1: **Safe Care**

We said we would embed and assure the revised Ward to Board governance structures and processes, and improve the identification and management of risks.

Target	Evaluation
90% compliance with the Serious Incident investigation timescales by Divisions, including completion and delivery of action plans from September 2017	We have achieved this. We achieved 96% compliance by the end of Quarter 4 of 2017/18 (January-March) and we are now sustaining the compliance with timescales. Whilst completion and delivery of action plans has improved, there remains a backlog of outstanding action plans with senior management teams, which are being addressed.
Corporate senior management team review risk registers on a monthly basis	What we have achieved so far: The process whereby the risks for patient care and treatment or service delivery, as identified by staff, is registered and reviewed has improved significantly. The Executive Team and Divisional leads now meet quarterly to discuss and review risk registers and agree actions required so that risks are reduced as much as possible. The Trust also agreed a Risk Management Strategy so that there is clear guidance for staff to follow based on best practice. What we still need to do: There are now monthly governance meetings where the risk owners are responsible for reviewing and updating their risks and report on progress. In addition the Clinical risk and Governance lead now meets with the Divisional Management Team each quarter to review their moderate and high risks. This process is ongoing and in place. DATIX, the risk register electronic system, now has the functionality to inform risk owners when a risk is overdue.
To eliminate back-log of open incidents by December 2017	We did not achieve this by December 2017, however the following progress has been made: We have a process of prioritising the investigation of incidents reported by staff members that are the most concerning and could potentially cause harm to patients. We are working towards reviewing all open incidents reported by our staff within 20 working days. We have focused on significantly improving the Serious Incident investigation process and timeliness (as reported above). This priority has not been progressed as much as we had hoped. We will continue our work in this area in 2018/19 to ensure that all incidents are not just investigated, but all actions are completed, and we are able to demonstrate our learning from the outcomes.

Target	Evaluation
NEWS (National Early Warning Score) and PEWS (Paediatric Early Warning Score) documentation completed and appropriate escalation from June 2017.	We did achieve this. In July 2017, a programme of quality checks commenced on all wards across the Trust. One of the key measures was completion and escalation of NEWS/PEWS and also included WOW (Worcestershire Obstetric Warning, the maternity early warning score). The data from these audits indicates the significant improvements that have been made and sustained in both the completion and escalation required when patients are unwell. This has improved with 95-100% completion over a 6 month period.
Mortality Reviews completed within agreed timeframes by December 2017	We have yet to achieve this. Since the last QA, the timeframes and process for mortality reviews have changed considerably making it difficult to compare directly. There are new nationally mandated metrics about the avoidability of death in hospital, we have developed an electronic system to facilitate reviews, introduced medical examiners and structured judgement reviews. The data shows that approximately 60% of deaths were being reviewed within 30 days with the expectation for this to improve further.

Priority 2: **Care that is clinically effective**

We said we would address the quality and safety concerns identified by the CQC.

Target	Evaluation
100% compliance by all wards with Red2Green by March 2018. **Sometimes patients spend days in hospital that do not directly contribute to their discharge (red days). The Red2Green approach is a visual management system to assist in the identification of wasted time in a patient's journey. The approach is used to reduce internal and external delays as part of the SAFER patient flow bundle.**	We had yet to achieve this but have made the following progress: Delivering care in line with NHS emergency access standards has been particularly challenging for the Trust particularly in March 2018 with a significant increase in the numbers of very unwell patients needing treatment, care and admission to hospital. We have made progress in helping the flow of patients requiring assessment and care outside of an emergency department with the opening of an Ambulatory Emergency Care facility that adjoins the Emergency Department in November 2017. **We held two workshops with staff in October** where they identified the need to introduce a set of internal professional standards which have been supported by the introduction of the Trust's wide cultural change programme - 4 Ward signature behaviours.
All staff engaged in a culture change programme by March 2018. **4ward is a long-tern, far-reaching initiative which aims to help colleagues across the Trust collectively work together. At the heart are four behaviours which all staff are asked to demonstrate.**	What we have achieved so far: The Trust-wide 4ward programme was launched in October 2017, with all staff encouraged to take part. The aim of the programme is to use evidence-based methodology to deliver a sustainable culture change, establishing what we describe as an "intentional culture" where colleagues work together to achieve a safer, mutually supportive, more productive and happier working environment for the benefit of their patients and themselves. The 4ward programme is built around four behaviours, developed in partnership with our staff: ▶ Do what we say we will do ▶ No delays, every day ▶ We listen, we learn, we lead ▶ Work together, celebrate together Every four months, all staff are encouraged to take part in a confidential checkpoint survey which gives them an opportunity to evaluate how they, and the colleagues they work most closely with. Two checkpoints were carried out in the period covered by this report – one in October 2017 and one in February 2018.

Continued… **All staff engaged in a culture change programme by March 2018.** **4ward is a long-tern, far-reaching initiative which aims to help colleagues across the Trust collectively work together. At the heart are four behaviours which all staff are asked to demonstrate.**	Evidence of real progress can be seen in the percentage of staff taking part in the Checkpoint which improved from 26% in October 2017 to 45% in February 2018 and in the "net culture score" generated which improved from 28% in October 2017 to 55% in February 2018. Although we have not yet (and may never) achieve 100% participation, it is worth noting that the February 2018 Checkpoint had the best response rate of any staff engagement exercise in the Trust's history. The 4ward Signature Behaviours and the supporting "Process Flow" methodology have also been widely adopted by colleagues to deliver a raft of service quality improvements, many of which are featured elsewhere in this Quality Account as well as informing the development of our Quality Improvement Strategy and supporting plans. We have not yet achieved this. We recognise that we remain in the bottom 20% of acute trusts in the 2017 staff survey. However, there has been slight improvement in two thirds of the questions when compared to the 2016 results. The overall staff engagement score has improved from 3.66 (2016) to 3.70 but is lower than the national average of 3.79[1]. The Trust is in the top 20% of acute trusts for reporting errors, near misses or incidents witnessed in the last month. Other areas of improvement since the 2016 survey include: ▶ Support from immediate managers ▶ Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months ▶ Recognition and value of staff by managers and the organization ▶ Organization and management interest in and action on health and wellbeing ▶ The fairness and effectiveness of procedures for reporting errors The three key findings which have deteriorated since the 2016 survey are: ▶ The number of staff reporting the most recent experience of violence ▶ The number of staff reporting the most recent experience of harassment, bullying or abuse ▶ The number of staff appraised in the last 12 months

[1] This score is made up of Key findings 1,4 and 7 – staff recommending the Trust as a place to work or receive treatment, staff motivation at work and staff ability to contribute towards improvement at work

20% reduction in complex complaints by March 2018.	We have not yet achieved this, however we did achieve the following: Overall, we have made significant improvement in both responding to complaints in a timely manner and ensuring complaint responses meet the complainant's satisfaction. We have **reduced the backlog of overdue complaint responses** from 160 in May 2017 to 17 by March 2018 with 78% of complainants receiving a response to their complaint within 25 days of receipt. This is against a target of 80% response within 25 days. However, the Trust received more complex complaints in 2017/18 than in 2016/17. These complex complaints were often cross specialties and occasionally require input from external expert review leading to a lengthened timeframe for resolution. In the financial year 2016/17, we had eighteen complex complaints. In 2017/18, we had twenty four complex complaints, an increase of 33%.
50% reduction in mixed sex breaches in 2017/18 against Q1 2017/18 by March 2018.	We have not yet achieved this. The Trust has faced particular challenges during the winter months in reducing the number patients who were placed in mixed sex breach accommodation. This is due to significant pressures on the availability of beds on the wards. This has had an impact mainly on patients who are waiting for a ward bed from intensive care areas. We have ensured that staff members have a good understanding of the policy and when patients are better and no longer need monitoring but have not yet been allocated a single sex bed on the main wards, we ensure that patient privacy and dignity needs are addressed. Our Patient and Public Forum representatives have carried out independent audits to ensure patient needs are being met whilst awaiting a ward bed.
Zero MRSA bacteraemia by March 2018.	We have achieved this. There have been no cases of hospital-attributable Meticillin Resistant Staphylococcus Aureus (MRSA) bacteraemia (blood stream infection) in line with a national zero tolerance. This is an improvement on the four cases seen during 2016-17. There have been three other cases of MRSA bacteraemia which were not attributed to the Trust, in patients where blood culture was taken within 48 hours of admission to hospital.

Innovative new test for meningitis transforms diagnosis

An innovative, rapid test for meningitis is now being used in Worcestershire's hospitals which speeds up diagnosis and saves lives by producing accurate results within an hour.

Meningitis is a life-threatening infection of the membranes surrounding the brain which can develop quickly and can kill within hours. Until now, the tests used to identify this infection took up to two days to get a result. The tests to identify encephalitis – an infection of the brain itself - took even longer to diagnose, usually up to four days.

The new technology, the Biofire FilmArray®, rapidly analyses samples and produces accurate results in just one hour. It allows the laboratory at Worcestershire Royal Hospital to inform doctors of a positive result much faster, leading to targeted treatment and reassurance for patients and their families.

The rapid test also means negative results are identified much quicker, reducing inappropriate treatments and unnecessary hospital stays. The Biofire FilmArray® works by analysing a patient's spinal fluid for up to 14 different bacteria and viruses.

Consultant Microbiologist, Dr Mary Ashcroft said: *"Meningitis can develop very quickly and can kill within hours. Whilst treating immediately because of suspicion of meningitis is the most important aspect of managing suspected cases, having early, accurate diagnosis that allows prompt and targeted treatment is essential for improving outcomes for patients. This new test has transformed the way we diagnose these dangerous infections."*

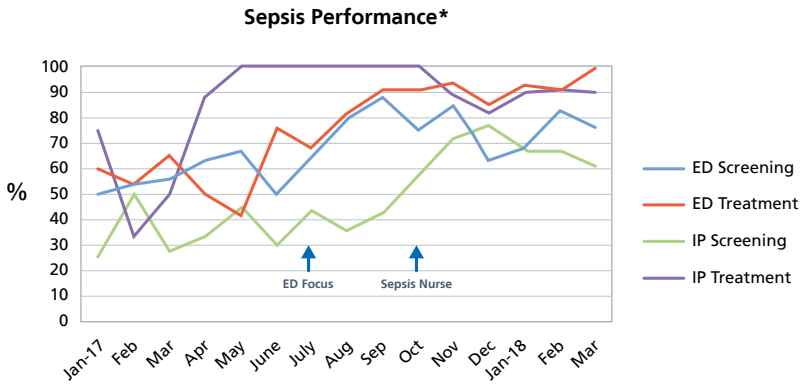
Worcestershire Acute Hospitals NHS Trust was one of the first hospital Trusts in the country to extensively trial this new technology.

The Biofire FilmArray® testing is now being carried out as a part of routine laboratory testing and is available seven days a week at Worcestershire Royal Hospital.

Pictured: The Microbiology Team at Worcestershire Royal Hospital.

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

We said we would develop a robust improvement, quality and safety culture across the Trust, including learning when things go wrong.

Target	Evaluation
80% of relevant patients receiving sepsis screening in 1 hour by December 2017.	We have achieved this. There has been a focus on our recognition and treatment of patients with sepsis. This has been led by a Trust-wide sepsis improvement group. The appointment of a sepsis lead nurse has been pivotal in improving screening through education and training. Mortality associated with sepsis has remained within "normal limits" since Quarter 1 2017/18. Prior to this, our mortality rate for patients with sepsis was above average. Treatment (Antibiotics) for Sepsis **in ED** Within 1 Hour 
90% of patients who have a positive sepsis screen receive antibiotics with one hour by March 2018.	What we have achieved: The data shows that in emergency areas 90% of patients identified as being at risk of sepsis are treated within 1 hour with antibiotics. For inpatients on the main wards, this had improved to over 75% by the end of 2017 but has since fallen since to 60%. The introduction of a nurse with a special interest in sepsis has led to significant improvements and we expect this to continue during 2018/19.

95% of patients will receive a VTE assessment within 24 hours of admission by September 2017. **Venous Thromboembolism (VTE), commonly known as blood clots, is a significant international patient safety issue. The first step in preventing death and disability from VTE is to identify those at risk so that preventative treatments can be used.**	What we have achieved: Positive change in the behaviours and practices by staff is apparent in many clinical areas; however, improvements in other areas are still needed. Efforts will now be focusing on addressing these issues and areas with poor compliance figures. Following discussions between the Trust and the CCG, it was agreed that from August 2017 there would only be a single reporting source for VTE assessment compliance. Previously there were two sources, which confused the issue. At the time of discussion, it was also reported that this would initially cause a dip in the compliance figures. However, performance was initially above the trajectory since the data source change but has decreased to around 92% for 2018. The support of the VTE nursing team (which commenced in April 2018) is expected to improve the compliance with VTE assessment.
Zero Grade 3 and 4 hospital acquired pressure ulcers (PU) by March 2018. **Grade 3: Full thickness skin loss involving damage to cutaneous tissue that may extend to, but not through, the underlying fascia.** **Grade 4: Full thickness skin loss involving muscle, bone or supporting structures.**	Grade 4 PU We have achieved this Grade 3 PU We have yet to achieve this reduction Whilst recognizing that we had fifteen Grade 3 pressure ulcers in 2017/18 and no Grade 4s, the Trust has: ▶ Engaged with NHS Improvement PU Collaboration. A national programme to support and encourage culture of safety, continuous learning and improvement across the health and care system; ▶ Introduced new mattresses appropriate for patients who are assessed as Very High Risk of developing pressure damage. The mattresses help to distribute pressure and relieve and support the prevention strategies discussed with patients when admitted to hospital; ▶ Introduced the 'React to Red' strategy. Ward and department staff observe patients' skin regularly throughout their stay and if the skin is becoming red - one of the first signs of early pressure damage - then a strategy for repositioning more frequently is implemented; ▶ Promoted 'Right Dressing, Right Wound, Right Time'. We have a Wound Dressing Selection (a formulary) which ensures the dressing is appropriate for the wound it is being used on, is available at the right time within the Ward/Department areas and is clinically and cost effective.

All patients with a fractured Neck of Femur (NOF) that are fit for surgery will have an operation within 36 hours by August 2017.	We have yet to achieve this. However, improvements in performance were seen. Whilst the service has not achieved 85% every month YTD, it has shown a consistent improvement over previous performance and compared to national performance, now sits in the top quartile. The Surgical directorate implemented an improvement programme in March 2017 to address the poor performance against the 36 hour 85% target for patients with a fractured NOF to receive their surgery. Weekly meetings with the Trauma Multi-Disciplinary Team and input from the Divisional Triumvirate and the Executive Team provided the governance and focus for improvement. A weekly harm review process of all patients who failed the standard commenced in April and continues. The reduced wait for surgery has resulted in an improved mortality rate which increased in Quarters 3 and 4 of 2016/7 but has reduced in Quarter 1 of 2017/8 and continues to be monitored.
More than 90% of patients would recommend us to their friends and family as a place to receive care and treatment by March 2018	What we have achieved so far: The methodology for calculating the Friends and Family Test (FFT) score was updated locally in August 2017 to match the national scoring (moved from a score to a percentage). The recommended target for the Trust is 90% which is mostly achieved for Inpatients and Women and Children. We have developed an FFT app. This is hosted on the Trust's intranet pages, can be downloaded onto Trust iPads and is also on the Trust website. We have redesigned FFT cards for each area including the addition of bespoke questions that reflect areas where improvement is required.

Worcestershire's hospitals dramatically improve survival rates for patients with Sepsis

The number of patients surviving from Sepsis in Worcestershire has dramatically increased after a successful project in Worcestershire's acute hospitals.

Sepsis, also known as blood poisoning, is the life-threatening reaction to an infection, in which the body attacks its own organs and tissues.

After the Trust made improving the survival rates of patients identified as having Sepsis a top clinical priority, the death rate from the condition have been significantly reduced to better than the national average.

The project in Worcestershire's hospitals has ensured more patients are screened for Sepsis, with those found to have the condition being treated much more quickly. A new dedicated Sepsis nursing role has also been created to oversee clinical advice and staff training about the condition.

Over 1,000 clinical members of staff across the county have been trained on specifically identifying the condition in patients, which has helped to detect and treat those with the condition more quickly.

Specialist IT improvements have also helped staff more easily and quickly report patients who have been identified as having Sepsis, and patient information leaflets were produced to provide Sepsis survivors and those more at risk of developing Sepsis with information about the condition and its treatment as well as their rehabilitation and recovery.

Dr Mike McAlindon, Clinical Lead for the Sepsis Quality Improvement Project at the Trust, said: *"Thanks to the hard work of staff across our Trust we've managed to dramatically reduce the mortality from Sepsis over the past year.This is good news for patients as now they can be assured that if they come to hospital with Sepsis, they will receive a good level of care, giving them a better chance at survival."*

Pictured: Hospital staff raising awareness of Sepsis.

Part 5: Our quality priorities for 2018/19

How we chose our quality priorities 2018/19

Staff have worked collectively to effectively achieve a number of improvements during 2017/18; however, we also needed to consider which aspects of patient care still require improvement. The Trust Board agreed during Quarter 3 of 2017/18 that there was a need for a three-year Quality Improvement Strategy, so that we can be clear about our improvement goals and how we will support our staff to deliver those improvements for our patients.

During January 2018, we revisited the quality priorities set for 2017/18 in partnership with our staff and patients as, in order for us to provide the highest possible standards we need to understand what is important to patients, their carers and our staff.

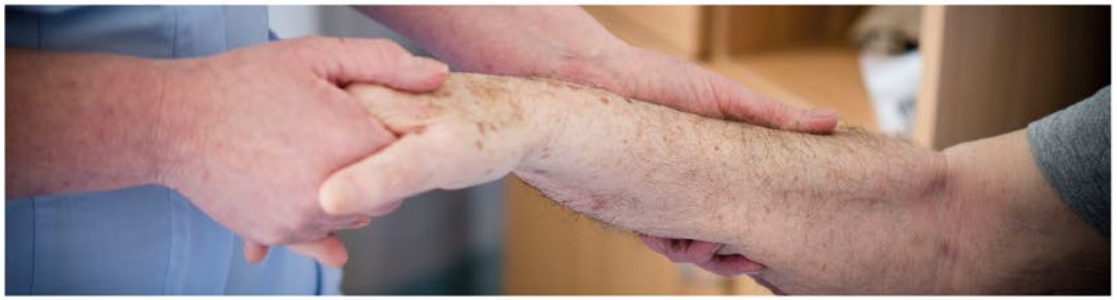
Throughout 2017/18, we have reported to our Board, our staff and our commissioners on progress against our quality priorities. We held events on each hospital site inviting patients, visitors and staff to tell us what was important to them and how they would define quality.

Working alongside patients, their carers, the community and our staff we have developed a Quality Improvement Strategy 2018-2021. This was approved by the Trust Board in March 2018 and will provide a basis for our reporting in future years through the Quality Account. Examples of quotes below were:

Delivering our **Quality Improvement Strategy**

NHS
Worcestershire Acute Hospitals
NHS Trust

Quality Improvement Strategy



Our Signature Behaviours

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

Care that is safe

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

We will protect every patient from unintended or unexpected harm.

We will improve care by learning from our mistakes.

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

Care that is clinically effective

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

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

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

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

Care that is a positive experience for patients and their carers

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

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

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

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

Quality Improvement Faculty

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

Published May 2018

National award-winning nurses…

Two county nurses have won national awards this year for the outstanding care they give to patients.

Sarah Mills, a Heart Failure Nurse Specialist who works in Bromsgrove as part of the specialist Heart Failure nursing team at Worcestershire Acute Hospitals NHS Trust, received a 'You're Simply Marvellous' award from Pumping Marvellous – the UK's patient-led Heart Failure charity. She was one of only three health care professionals chosen to receive the award.

Bernice Kent, colorectal clinical nurse specialist, was awarded with the Gary Logue Colorectal Nurse Award at the National Colorectal Cancer Nurses Network conference, run by charity Beating Bowel Cancer.

Bernice received the award after a nomination from a patient who described the fantastic support, encouragement, professionalism and dedication she gave to all her patients.

Sarah, who undertakes clinics and visits patients in their homes, to provide treatment, advice and support on their heart condition, said: *"I am very humbled to receive this award and very incredibly touched. It feels very special to have been nomination by a patient – thank you."*

Bernice said: *"As a colorectal clinical nurse specialist helping patients through their bowel cancer diagnosis and the trials that comes with this is not always easy, but the people I am fortunate enough to meet inspire and surprise me in so many ways.*

"The nominations I have received have really touched me from the bottom of my heart, what an honour and privilege to know I have been able to make people feel safe and supported in some way when they are going through such a devastating and life-changing period."

Pictured left to right: Sarah Mills, Heart Failure Nurse Specialist and winner of the 'You're Simply Marvellous' award from Pumping Marvellous; Bernice Kent, Colorectal Clinical Nurse Specialist, with her Gary Logue Colorectal Nurse award.

Our quality priorities for 2018/19 influenced by our staff and patients

1. Care that is safe

- We will reduce the number of avoidable hospital acquired pressure ulcers (HAPU)
- We will reduce the number of patients who have a fall whilst under our care
- We will improve identification and escalation of sepsis screening
- We will reduce the percentage of medicine incidents causing harm across the Trust

2. Care that is clinically effective

- We will monitor and seek to reduce mortality rates for patients whilst under our care
- We will improve our time to theatre for patients with fractured neck of femur
- We will Implement clinical standards for seven day hospital services
- We will complete an annual programme of local clinical audits

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

- We will respond to complaints within 25 days of receipt
- We will ensure maximise and maintain patients' privacy and dignity throughout their time with us
- We will ensure patients and their families are fully involved and aware of their discharge so that they are confident they have everything they need to continue their treatment or recovery including rehabilitation
- We will ensure patients understand their condition, treatment and pain management options

Priority 1: Care that is safe

Quality Indicator 1:
We will reduce the number of avoidable Grade 2-3 hospital acquired pressure ulcers (HAPU) and sustain zero Grade 4 pressure ulcers.

Why have we chosen this indicator?

We have heard from our patients the importance to them of reducing avoidable harm. From our comprehensive reviews of all pressure ulcers grade 2 and 3 that occurred during 2017/18, we feel it is vital we focus our intention on implementing what we have learnt from our analysis and learning. It is also an important pledge for us in our Quality Improvement Strategy 2018-21 to protect every patient from unintended or unexpected harm.

How we will evidence success?

We will reduce the number of avoidable hospital acquired pressure ulcers from our baseline position of:

- Grade 2; from 84 to <80 (10% reduction);
- Grade 3 and deep and ungradable; from our baseline position of 17 to <15 (12%);
- Grade 4; baseline position 0, we will maintain this performance.

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

Why have we chosen this indicator?

Whilst we were aware we were not an outlying hospital for the number of patients who experience a fall with harm, in 2017/18 there was an increasingly frail elderly population within Worcestershire who needed a stay in hospital. We were concerned and aware from our assessment of care and outcomes received for those patients who had had a fall in 2017/18 that we could do more.

How will we evidence success?

We will evidence the benefit for our patients by reducing the number of patients who experience a fall that results in harm per 1000 bed days from our baseline position of 0.07 falls per 1000 bed days (21), to 0.06 falls per 1000 bed days - representing an improvement of 10%. This will ensure we remain below the national average of 0.19 falls with harm per 1000 bed days.

Quality Indicator 3: We will improve identification and escalation of sepsis screening.

Why have we chosen this indicator?

We know that we could do better to improve the outcomes for our patients in line with National Institute for Health and Care Excellence (NICE) standards published September 2017. Supporting our staff to be very aware of early recognition of sepsis through assessment and starting treatment quickly will improve people's lives and reduce the number of deaths associated with sepsis.

How we will evidence success?

We will evidence the benefits for our patients by 5 sub-indicators:

- We will increase sepsis screening for patients in Emergency Department from our baseline position of 83% to >85%;
- We will increase sepsis screening for patients in wards from our baseline position of 67% to >75%;
- We will increase compliance with the sepsis 6 bundle in Emergency Department from a baseline position of 50% to >60%;
- We will increase compliance with the sepsis 6 bundle on wards from a baseline position of 80% to >85%;
- We will increase VTE compliance with screening from a baseline position of 92% to >95%.

Quality Indicator 4: We will prescribe, administer and supply the right medicines at the right time for the right patient.

Why have we chosen this indicator?

We know almost all patients have medicines as part of their stay with us. It is important that our staff are competent with up-to-date knowledge and skills, and that we have safe systems to prevent the occurrence of a medicine being prescribed and administered in error to keep patients safe and prevent harm.

How we will evidence success?

We will evidence the benefits for our patients with four sub-indicators:

- We will increase the reporting of medicines near misses and incidents from a baseline position 3.52 reported incidents per 1000 bed days to 4.47 reported incidents per 1000 bed days;
- We will reduce the percentage of medicine incidents causing harm across the Trust from a baseline position of 19.53% to 15.62%;
- We will implement a nursing and midwifery staff medicine e-competency assurance programme to ensure they can competently administer medicines safely. This is from a baseline position of inclusion of training at induction of all staff to 30% of all staff completing an e-competency assurance programme;
- We will implement an E-prescribing and Administration System (EPMA) system Trust-wide to reduce prescribing and administration errors. This will be evidenced by securing funding and completing the tendering process.

Priority 2: Care that is clinically effective

Quality Indicator 1: We will monitor and seek to reduce mortality for patients whilst under our care.

Why have we chosen this indicator?

Reducing the numbers of deaths in hospital is seen as one of many key indicators of the quality of our service and, as such, vitally important to our patients and their families.

How will we evidence success?

There are several metrics to monitor mortality; we will use the widely measured Hospital Standardised Mortality Ratio (HSMR) data. From a baseline position of a rolling average of HSMR ~102 we will achieve a HSMR ~100 consistently throughout the year.

Quality Indicator 2: We will improve our time to theatre for patients with fractured neck of femur.

Why have we chosen this indicator?

We know that fractured neck of femur is one of the most serious consequences of a fall among our older population with a significant mortality and loss of mobility. Worcestershire's growing population of people over 80 years of age makes this an essential quality indicator.

How will we evidence success?

We will evidence an improvement in our time to theatre for patients with a fractured neck of femur, improving from a baseline position of 85% of patients going to theatre within 36 hours for 5 out of 12 months, to 85% for 8 out of 12 months.

Quality Indicator 3: We will implement clinical standards for seven-day hospital services.

Why have we chosen this indicator?

We are committed to providing high standards of quality care and treatments but we know that we need to improve on the ability of our patients to have 24/7 services when they need them. We know that giving patients admitted as an emergency high quality consistent care - whatever day they enter the hospital - improves their experience and outcome of care, therefore we have made this a key priority.

How will we evidence success?

We will assess ourselves against the 10 clinical standards for seven day services in hospitals, developed in 2013 through the Seven Day Services Forum, chaired by Sir Bruce Keogh and involving a range of clinicians and patients. The standards were founded on published evidence and on the position of the Academy of Medical Royal Colleges (AoMRC) on consultant-delivered acute care. These standards define what seven day services should achieve, no matter when or where patients are admitted.

The four main standards are 2, 5, 6 and 8. In addition we are also measured on patient experience and our provision for consultant review. We will improve on our position of non-compliant in the 4 standards and will be compliant in 2 out of 4.

Patient Experience
Patients, and where appropriate families and carers, must be actively involved in shared decision making and supported by clear information from health and social care professionals to make fully informed choices about investigations, treatment and on-going care that reflect what is important to them. This should happen consistently, seven days a week.

Provision for Consultant review
To determine the provision for consultant review within the Trust, particularly for patients in specialities for which the Trust makes no acute provision. Does consultant job planning in the Trust make provision for a consultant-led ward round on every ward every day of the week?

Clinical Standard 2 – First Consultant review
All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but within 14 hours from the time of admission to hospital at the latest.

Clinical Standard 5 – Access to Consultant directed diagnostics
Hospital inpatients must have scheduled seven-day access to diagnostic services, typically ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, and microbiology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week.

- Within 1 hour for critical patients
- Within 12 hours for urgent patients

Clinical Standard 6 – Consultant directed interventions
Hospital inpatients must have timely 24-hour access, seven days a week, to key consultant-directed interventions that meet the relevant speciality guidelines, either on-site or through formally agreed networked arrangements with clear written protocols. These interventions would typically be:

- Critical Care
- Interventional radiology
- Interventional endoscopy
- Emergency general surgery
- Emergency renal replacement therapy
- Urgent radiotherapy
- Stroke thrombolysis
- Percutaneous coronary intervention
- Cardiac pacing (either temporary via internal wire or permanent)

Clinical Standard 8 – Ongoing review
All patients with high dependency needs should be seen and reviewed by a consultant twice daily (including all acutely ill patients directly transferred and others who deteriorate). Once a clear pathway of care has been established, patients should be reviewed by a consultant at least once every 24 hours, seven days a week, unless it has been determined that this would not affect the patient's care pathway.

Quality Indicator 4: We will complete an annual programme of local clinical audits.

Why have we chosen this indicator?

We know that examining and sharing the results of our clinical audits lets our patients, their carers and the public know how well we are doing and where we could do better. Therefore we have made this a key priority as it is the foundation for our Quality Improvement Strategy.

How will we evidence success?

We will improve on our baseline position of 47% and develop an achievable audit programme that meets local guidance, where 60% of audits have been completed.

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

Quality Indicator 1: We will respond to 80% of complaints within 25 days of receipt and we will learn from them.

Why have we chosen this indicator?

It is fundamental that we listen to our patients and learn from their experiences. Therefore, we want to make this an explicit priority this year. We know that responding to a complainant in a timely manner is important to them. Communication is one of the top three themes from our complaints and this will be a focus for our nursing and medical staff.

How will we evaluate success?

We have made significant progress in improving the response to complaints within a 25-day period, but we know we need to further improve. We want to ensure we maintain this performance throughout the year, as we have not always been consistent.

- We will improve on our baseline position of 78% to 80% for 12 months;
- We will reduce the numbers of complaints returned from dissatisfied members of the public from a baseline position of 35% to 10%;
- The Trust implemented the Sage and Thyme Communication Skills Workshop in 2016, which is a recognised skills programme. These workshops are about improving skills in listening to people who are worried. We know that we need to revisit the workshops and support staff further in the skills of active listening and communicating with our patients and their loved ones.

Quality Indicator 2: We will ensure that we maintain a patient's privacy and dignity throughout their time with us.

Why have we chosen this indicator?

- We are committed to providing excellent standards of care for all patients/carers. For those patients who are vulnerable particularly, ensuring their privacy and dignity whilst receiving care is a fundamental right. The National Picker Inpatient Satisfaction Survey tells us we could do better. Picker is an international charity dedicated to ensuring the highest quality health and social care for all. They carry out annual patient surveys and make the results of these surveys available to healthcare providers;
- Privacy when being examined in Emergency Department remains a challenge for the Trust;
- We need to reduce the number of mixed sex accommodation breaches across the Trust.

How will we evaluate success?

- We will adopt and roll out the 70 day challenge to #endpjparalysis to get our patients up, dressed and moving around across our hospital wards and will evaluate through patient surveys, staff surveys and audit the numbers of patients up and dressed each day from a baseline position of 0%;
- We will evaluate every patient/carer who has experienced a mixed sex accommodation breach to ensure meeting their privacy and dignity needs. We will improve from our baseline position of 17% in the National Picker Inpatient Satisfaction Survey for 'shared sleeping arrangements with opposite sex' to be in line with the 2018 national average;
- We will improve from our baseline position of 33% on the indicator for 'patients' privacy being maintained when being examined in emergency department' in the National Picker Inpatient Satisfaction Survey from a Trust position, to be in line with the 2018 national average;
- We will improve from our baseline position of 20% on the indicator for 'not always treated with respect or dignity' in the national Picker Inpatient Satisfaction Survey, to the 2018 national average.

Quality Indicator 3: We will ensure patients and their families are fully involved and aware of their discharge so that they are confident they have everything they need to continue their treatment or recovery including rehabilitation.

Patients who need on-going care and treatment after they have left have told us that their carers are not always fully involved and aware of their discharge and that this significantly impacts on how safe they feel in managing their care and treatment when at home. We know that we can improve this and are committed to doing more.

How will we evaluate success?

- We will improve how quickly we send patient and GP letters, working towards the contractual standard of 10 days;
- Whilst we were above the national average in the national Picker Inpatient Satisfaction Survey at 39% against a national average of 45% (the lower the score, the better the position), we know from our complaints and feedback from patients/carers that we could do better;
- We will improve the number of patients who are told of the side effects of medications when discharged from a baseline position of 69% to be in line with national average;
- We will improve on the indicator for National Picker Inpatient Satisfaction Survey that when discharged patients/carers are informed of danger signals to look for from a baseline position of 64% to be in line with 2018 national average.

Quality Indicator 4: We will ensure patients understand their condition, treatment and pain management options.

We know from our complaints and the outcomes of patient satisfaction surveys that understanding their condition or treatment is important to patients' overall health, well-being and ability to get better or live with their illness in a better way. Involving and empowering patients/ carers in their care and treatment is a fundamental requirement for us to ensure we give high standard quality care and we want to get this right.

How will we evaluate success?

We will improve on the indicator within the National Inpatient Picker Survey of 'not enough or too much information given on their condition' from a baseline position of 26%, to be in line with 2018 national average.

New nurses improve care for patients with learning disabilities and mental health problems

Worcestershire's hospitals are leading the way nationally in improving patient care thanks to the innovative introduction of learning disability and mental health registered nurses.

Nine new Learning Disability and Mental Health Nurses, who will work across wards at the Alexandra Hospital in Redditch and Worcestershire Royal Hospital, joined Worcestershire Acute Hospitals NHS Trust in September 2017.

The roles have traditionally been based in community NHS organisations, providing additional support to hospital patients and colleagues when needed. By integrating the nurses as part of the ward based teams, the care and experience of patients with learning disabilities and mental health illness will be improved.

Sarah Needham, Lead Nurse for Education and Workforce, said: *"Many of our patients experience chronic mental health illnesses and Worcestershire has a higher than average prevalence of patients with Learning Disabilities, therefore we are thrilled to be leading the way in improving care in this area, to ensure that our patients are signposted to appropriate community services on discharge.*

"As well as providing holistic support to our patients, the new nurses will also share their expertise with members of the multidisciplinary team, giving them additional skills in caring for patients with additional needs. Once patients are ready to leave our care, the transfer in to community services should also be improved."

The nine new nurses received an intensive education programme to support them in developing the skills and knowledge needed to care for patients within an acute hospital, followed by a tailored 12 months of mentoring and rotation opportunities across the Trust.

Pictured: The Trust's Learning Disability and Mental Health Nurses with the Professional Development Team.

Our Quality Improvement Strategy 2018/21

Our Quality Improvement Plan developed in the early part of 2017/18 was in direct response to the improvements highlighted by the Care Quality Commission and an essential part of our improvement journey. Staff across the Trust have worked hard to ensure a range of improvements have been delivered by clinical teams during 2017/18.

Our model for improvement 2018/21

The model which will drive our quality improvement is that promoted by the Institute for Healthcare Improvement. It focuses on answering three questions to define our improvement aims, measure our improvement and select the right changes to ensure success. Plan Do Study Act (PDSA) cycle enables changes to be tested before fully implemented, thus making sure that the changes we select have a positive impact.

Our journey for improvement

Our staff and patients are best placed to identify, create and deliver the improvements that are required for our services. It is the ambition to create a culture of learning, openness and transparency. Supporting staff with the training and development needed to support the delivery of care for our patients and their carers.

Our journey for 2018/19 will be achieved through working with our partners for improvement. These include the University of Worcester, West Midlands Academic Science Network and West Midlands Quality Review Service. Partners that will work with us that assess our services for accreditation will support the improvements we need to make such as Joint Advisory Group (JAG) in Gastrointestinal (GI) Endoscopy, International Standards Organization (ISO), Health and Safety and our regulators.

Expanding the principles and practice of Human Factors

In 2018/19 we are fully committed to further developing our programme across the Trust to roll out the principles and practices of Human Factors. The approach will provide a focus on reducing medical errors and its consequences on patient safety. It offers an integrated, evidenced, coherent approach through enhancing individual staff and team performance.

Statement of Directors' Responsibilities

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

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

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

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

Part 6: Trust Board's Quality Dashboard

NHS Outcomes Framework Core Quality Account Indicators

Domain	Indicator	Current Performance	National average value	Where applicable		Trust statement	Previous values (where data available):		
				Best NHS performer	Worst NHS performer		16/17	15/16	14/15
Preventing people from dying prematurely	SHMI value and banding Oct-16 and Sep-17	104.53 Banding 2 - 'as expected'		72.70	124.73	*Worcestershire Acute Hospitals NHS Trust considers that this data is as described for the following reasons:* Improvements in timely care for patients whose condition deteriorates is demonstrated by a reducing SHMI. *Worcestershire Acute Hospitals NHS Trust intends to take the following actions to improve this number and so the quality of its services, by:* See quality account priorities.	106.67 Banding 2 - 'as expected'	110.00 Banding 2 - 'as expected'	110.00 Banding 1 - 'higher than expected'

Domain	Indicator	Current Performance	National average value	Where applicable		Trust statement	Previous values (where data available):		
				Best NHS performer	Worst NHS performer		16/17	15/16	14/15
Preventing people from dying prematurely	% of deaths with either palliative care specialty or diagnosis coding Oct-16 to Sep-17	27.86%	31.50%	59.77%	11.52%	*Worcestershire Acute Hospitals NHS Trust considers that this data is as described for the following reasons:* Data quality is good but three is room for improvement. *Worcestershire Acute Hospitals NHS Trust intends to take the following actions to improve this number and so the quality of its services, by:* The Trust will aim to improve performance during 2017/18.	28.50%	28.18%	29.39%
	Patient reported outcome score for hip replace-ment surgery April 2016 - March 2017 (provisional)	87.2%	88.8%			*Worcestershire Acute Hospitals NHS Trust considers that this data is as described for the following reasons:* Outcomes are slowly improving and are above the national average. *Worcestershire Acute Hospitals NHS Trust intends to take the following actions to improve this number and so the quality of its services, by:* See Quality Account priorities – plans to improve access to theatre aim to create further improvement.		91.3%	94.9%

Domain	Indicator	Current Performance	National average value	Where applicable		Trust statement	Previous values (where data available):		
				Best NHS performer	Worst NHS performer		16/17	15/16	14/15
Preventing people from dying prematurely	Patient reported outcome score for knee replacement surgery April 2016 - March 2017 (provisional)	80.5%	80.9%			*Worcestershire Acute Hospitals NHS Trust considers that this data is as described for the following reasons:* Planned knee surgery has been impacted by reduced theatres access arising from difficulties with patient flow. *Worcestershire Acute Hospitals NHS Trust intends to take the following actions to improve this number and so the quality of its services, by:* Improving flow so improving timeliness of treatment and avoiding pain or deterioration for waiting times.		81.3%	80.4%

Domain	Indicator	Current Performance	National average value	Where applicable		Trust statement	Previous values (where data available):		
				Best NHS performer	Worst NHS performer		16/17	15/16	14/15
Preventing people from dying prematurely	28 day readmission rate for patients aged 0 -15 Feb-18	0.01% 0-15 yrs	National publications of this data were suspended in 2013			*Worcestershire Acute Hospitals NHS Trust considers that this data is as described for the following reasons:* Children's services in all specialties strive to ensure readmissions are avoided to avoid disruption to children and families. *Worcestershire Acute Hospitals NHS Trust intends to take the following actions to improve this number and so the quality of its services, by:* Ensuring this performance is maintained.	0%	0%	

Domain	Indicator	Current Performance	National average value	Where applicable		Trust statement	Previous values (where data available):		
				Best NHS performer	Worst NHS performer		16/17	15/16	14/15
Preventing people from dying prematurely	28 day readmission rate for patients aged over 15 years Feb-18	3.72%	National publications of this data were suspended in 2013			*Worcestershire Acute Hospitals NHS Trust considers that this data is as described for the following reasons:* Despite bed pressures, the Trust ensures patients are fit enough to cope at home wherever possible. *Worcestershire Acute Hospitals NHS Trust intends to take the following actions to improve this number and so the quality of its services, by:* Maintaining safe discharge practice.	3.67%	3.78%	

Domain	Indicator	Current Performance	National average value	Where applicable		Trust statement	Previous values (where data available):		
				Best NHS performer	Worst NHS performer		16/17	15/16	14/15
Ensuring that people have a positive experience of care	Responsiveness to inpatients' personal needs – CQC national inpatient survey score	To be published in August 2018				*Worcestershire Acute Hospitals NHS Trust considers that this data is as described for the following reasons:* The Trust strives to maintain all elements of patient experience, despite acute bed pressures *Worcestershire Acute Hospitals NHS Trust intends to take the following actions to improve this number and so the quality of its services, by:* Improvements to patient flow described in Quality Account priorities	65.2	66.5	69.6

Domain	Indicator		Current Performance	National average value	Where applicable		Trust statement	Previous values (where data available):		
					Best NHS performer	Worst NHS performer		16/17	15/16	14/15
Ensuring that people have a positive experience of care	Percentage of staff who would recommend the provider to friends or family needing care Quarter 2 17/18		57%	70%	100%	44%	*Worcestershire Acute Hospitals NHS Trust considers that this data is as described for the following reasons:* Staff engagement has remained static this year and is in the lowest quartile for the NHS. *Worcestershire Acute Hospitals NHS Trust intends to take the following actions to improve this number and so the quality of its services, by:* See Quality Account.	56%	56%	67%
	Inpatient Friends and Family Test Jan 2018	% recommend	95.21%	95.50%	100.00%	75.09%	*Worcestershire Acute Hospitals NHS Trust considers that this data is as described for the following reasons:* This score is consistent with recent inspection results in which the Trust's highest score reflected compassionate care. *Worcestershire Acute Hospitals NHS Trust intends to take the following actions to improve this number and so the quality of its services, by:* See actions in Quality Account.	95.05%	95.22%	97.24%
		Response rate	6.79%	22.74%	55.73%	3.03%		11.25%	14.96%	34.18%

Domain	Indicator		Current Performance	National average value	Where applicable		Trust statement	Previous values (where data available):		
					Best NHS performer	Worst NHS performer		16/17	15/16	14/15
Ensuring that people have a positive experience of care	A&E Friends and Family Test Jan 2018	% recommend	78.95%	86.42%	100.00%	65.51%	*Worcestershire Acute Hospitals NHS Trust considers that this data is as described for the following reasons:* The Trust is working hard to improve response rates in ED. *Worcestershire Acute Hospitals NHS Trust intends to take the following actions to improve this number and so the quality of its services, by:* Action to improve patient flow – see Quality Account – will improve patient experience in ED and encourage staff to support work to improve response rates.	97.59%	90.00%	94.83%
		Response rate	1.27%	12.16%	49.12%	0.21%		4.15%	5.77%	21.63%

Domain	Indicator	Current Performance	National average value	Where applicable		Trust statement	Previous values (where data available):		
				Best NHS performer	Worst NHS performer		16/17	15/16	14/15
Treating and caring for people in a safe environment and protecting them from harm	% of patients risk-assessed for venous thrombo-embolism Quarter 3 17/18	92.84%	95.30%	100.00%	76.08%	*Worcestershire Acute Hospitals NHS Trust considers that this data is as described for the following reasons:* VTE assessment rates have dropped below national average. *Worcestershire Acute Hospitals NHS Trust intends to take the following actions to improve this number and so the quality of its services, by:* See Quality Account priorities.	93.75%	93.55%	95.43%
	Rate of C.difficile per 100,000 bed days	11.5	13.0	0.0	82.7	*Worcestershire Acute Hospitals NHS Trust considers that this data is as described for the following reasons:* The Trust has re-emphasised simple control of infection measures, particularly at times of extreme bed pressures. *Worcestershire Acute Hospitals NHS Trust intends to take the following actions to improve this number and so the quality of its services, by:* See Quality Account priorities.	15.6	10.3	14.0

Domain	Indicator	Current Performance	National average value	Where applicable		Trust statement	Previous values (where data available):		
				Best NHS performer	Worst NHS performer		16/17	15/16	14/15
Treating and caring for people in a safe environment and protecting them from harm	Rate of patient safety incidents per 1,000 bed days Oct 16 to Mar 17	42.0				*Worcestershire Acute Hospitals NHS Trust considers that this data is as described for the following reasons:* The Trust has continued to focus on improvements to safety review processes. *Worcestershire Acute Hospitals NHS Trust intends to take the following actions to improve this number and so the quality of its services, by:* Improvement plans described in Quality Account priorities.	40.4	42.0	7.8
	Rate of patient safety incidents that resulted in severe harm or death per 1,000 bed days Oct 16 to Mar 17	0.21				*Worcestershire Acute Hospitals NHS Trust considers that this data is as described for the following reasons:* The Trust has continued to focus on improvements to safety review processes. *Worcestershire Acute Hospitals NHS Trust intends to take the following actions to improve this number and so the quality of its services, by:* Improvement plans described in Quality Account priorities.	0.10	0.23	0.03

Inside the new Ambulatory Emergency Care (AEC) Unit.

Worcestershire Royal Emergency Department improvements open to patients

A £920,000 redevelopment of the Emergency Department at Worcestershire Royal Hospital opened in November 2017, improving the experience of patients throughout the hospital.

A new, expanded Ambulatory Emergency Care (AEC) unit - which adjoins the current A&E department – allows appropriate patients to be seen and treated more quickly, as well as helping to free-up space in the main A&E department.

The expanded unit was funded by NHS England and formed a central part of a comprehensive winter plan put in place for the local NHS and County Council to deliver safe, high-quality patient care throughout the busy winter period.

Patients who are referred to the AEC have their individual needs assessed by a specialist team - including a Consultant, Nurse Practitioner, Nurse and Health Care Assistant - and a plan of care put in place. The unit takes some patients who would previously have needed to be admitted from A&E to a hospital bed to have their treatment, as well patients who have been referred by their GP.

The main aim of the unit - which can treat up to 16 patients at a time - is to see, assess and discharge patients more safely and promptly. By discharging appropriate patients back home on the same day they arrive, unnecessary overnight admissions can be avoided which helps ensure hospital beds are available for those who need them most.

Consultant in Acute Medicine for the unit, Dr Aruna Maharaj said: *"The expanded unit allows us to offer more efficient treatment to our patients and discharge within one day where possible. This helps patients as it shortens their patient journey and provides them with an overall better experience."*

Pictured: The AEC Unit Team.

Explanatory notes about the NHS Outcomes Framework

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

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

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

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

Quality Accounts information for Clinical Audit

During 2017/18, 51 national clinical audits and 3 national confidential enquiries covered relevant health services that Worcestershire Acute Hospitals NHS Trust provides. We also undertook 276 registered local clinical audits in 2017/18.

During that period, Worcestershire Acute Hospitals NHS Trust participated in 92.1% national clinical audits and 100% national confidential enquiries that it was eligible to participate in.

Appendix 1 contains a list of national audits, national confidential enquiries and local audits that Worcestershire Acute Hospitals NHS Trust participated in during 2017/18. Appendix 1 also describes the actions we have taken or are planning to take to improve our services in response to insights from these audits.

Participation in Clinical Research

The number of patients receiving NHS services provided or sub-contracted by Worcestershire Acute Hospitals NHS Trust in 2017/18 that were recruited during that period to participate in research approved by a Research Ethics Committee on the National Institute for Health Research Portfolio was 840.

Worcestershire Acute Hospitals NHS Trust recruited patients to 53 clinical research studies across 16 different clinical specialties. 29 new studies were opened during the year. This included 7 commercial studies across 3 specialty areas.

Although overall recruitment is reduced from 2016/2017 due to some large observational studies closing and internal capacity issues, 6 speciality areas actually included more patients in studies than the previous year and 3 new specialities opened studies in their areas.

For 2018/2019, the Trust is launching a new R&D Strategy, integrated into the Quality Improvement Strategy. This, combined with the investment of an internal R&D Department with clearer lines of accountability, means more patients will benefit from clinical research. Crucially, the following actions shall ensure that through clinical research, we shall improve the quality of care we offer our patients and help our staff achieve their full potential.

- Divisional reporting of Trust research activity will expand access to clinical research in all specialties;
- The establishment of the Herefordshire and Worcestershire Consortium will see closer working with NHS and external partners, resulting in improved performance and increased activity;
- Key appointments including a new Associate Medical Director for Research and Development, a Lead Research Nurse and a Research Operations Lead will help to drive forward the Trust strategy, create flexibility in the workforce to support more clinical specialties and ultimately increase access to clinical research for patients and staff.

Commissioning for Quality and Innovation (CQUIN)

Each year, the Trust is asked by commissioners to prioritise elements from a designated Commissioning for Quality and Innovation (CQUIN) framework, which is designed to promote improvement by linking a proportion of the Trust's income to the delivery of agreed quality goals.

There are a number of national CQUIN schemes and a number of locally agreed CQUIN schemes.

The content of local schemes is agreed between the Trust and the Clinical Commissioning Groups (CCGs) prior to the start of the financial year. These are then embedded in the Trust's contract.

In 2017/18, the Trust's CQUIN commitments were as follows:

CQUIN Type	CQUIN	Aim	Year End Performance
National	Improving Staff Health and Well-being 1a	Achieving a 5 percentage point improvement in two of the three NHS annual staff survey questions on health and well-being, MSK and stress.	Partially achieved
	Improving Staff Health and Well-being 1b	Improving the health of food provided by increasing the percentage of sugar free drinks, decreasing the percentage of high calorie confectionery and decreasing the calorie and fat content of pre-packed sandwiches.	Achieved
	Improving Staff Health and Well-being 1c	Achieving an uptake of flu vaccinations by frontline clinical staff of 70%.	Achieved
	Reducing the impact of serious infections (Sepsis)	To embed a systemic approach towards the prompt identification and appropriate treatment of life-threatening infections.	Partially achieved
	Reducing the impact of serious infections (Antimicrobial Resistance).	Reducing the chance of antibiotic-resistant strains of bacteria developing.	Achieved
	Improving services for people with mental health needs who present to A&E	Reduce by 20% the number of attendances to A&E for those within a selected cohort of frequent attenders who would benefit from mental health and psychosocial interventions, and establish improved services to ensure this reduction is sustainable.	Achieved

CQUIN Type	CQUIN	Aim	Year End Performance
	Offering advice and guidance	Set up and operate A&G services for non-urgent GP referrals, allowing GPs to access consultant advice prior to referring patients in to secondary care.	Partially achieved
	NHS E-Referrals	Providers to publish ALL GP referrals to consultant-led 1st outpatient services and make ALL of their First Outpatient Appointment slots available on NHS e-Referral Service.	Achieved
	Supporting Safe and Proactive Discharge	Increasing proportion of patients admitted via non-elective route discharged from acute hospitals to their usual place of residence within 7 days of admission by 2.5% points.	Achieved
Local Area Team	AAA Screening	Reducing socioeconomic gradient of uptake and ensuring equity of delivery for AAA screening.	Achieved
	Bowel Screening	Increasing Bowel Cancer Screening uptake within priority groups, to include prisoner screening AND increase GP engagement in low uptake practices.	Achieved
	Secondary Care Clinical Attachment in Oral Surgery	To equip General Dental Practitioners with the training necessary in order to provide an enhanced level of care to patients at primary level.	Achieved
Specialised Commissioning Team	Hospital Pharmacy Transformation and Medicines Optimisation	Procedural and cultural changes required to fully optimise use of medicines commissioned by specialised services.	Achieved
	Neonatal Community Outreach	Improve community support and to take other steps to expedite discharge, pre-empt readmissions, and otherwise improve and care such as reduce demand for critical care beds and to enable reduction in occupancy levels.	Achieved
	Paediatric Networked Care	Alignment to the national PIC service review. It aims to gather information which allows the demand across the whole paediatric critical care pathway to be considered.	Achieved

2018/19 CQUIN Programme

CQUIN Type	CQUIN	Aim
National	Improving Staff Health and Well-being 1a	Achieving a 5 percentage point improvement in two of the three NHS annual staff survey questions on health and well-being, MSK and stress.
	Improving Staff Health and Well-being 1b	Improving the health of food provided by increasing the percentage of sugar free drinks, decreasing the percentage of high calorie confectionery and decreasing the calorie and fat content of pre-packed sandwiches. A further shift in percentages will be required in 2018/19.
	Improving Staff Health and Well-being 1c	Achieving an uptake of flu vaccinations by frontline clinical staff of 75%.
	Reducing the impact of serious infections (Sepsis)	To embed a systemic approach towards the prompt identification and appropriate treatment of life-threatening infections.
	Reducing the impact of serious infections (Antimicrobial Resistance).	Reducing the chance of antibiotic-resistant strains of bacteria developing.
	Improving services for people with mental health needs who present to A&E	10% reduction in A&E attendances of patients with a primary mental health diagnosis in Q4 of 2018/19 as compared to baseline set in Q4 2017/18. Ensure reduction of A&E attendances of the selected cohort (Year 2017/18) is sustainable.
	Offering advice and guidance	Increase A&G services available. Sustain % of asynchronous responses provided within 2 working days.
	Reducing ill health by risky behaviours - Alcohol and Tobacco	Outlines the need for the NHS to take action to address risky behaviours, with a focus on alcohol consumption and smoking.
Local Area Team	AAA Screening	Reducing socioeconomic gradient of uptake and ensuring equity of delivery for AAA screening.
	Bowel Screening	Increasing Bowel Cancer Screening uptake within priority groups, to include prisoner screening AND increase GP engagement in low uptake practices.
	Breast Screening	Develop and implement 'Two Year Action Plan' to address health inequalities and target actions to increase uptake of Breast Screening.
	Secondary Care Clinical Attachment in Oral Surgery	TBA

Specialised Commissioning Team	Hospital Pharmacy Transformation and Medicines Optimisation	Procedural and cultural changes required to fully optimise use of medicines commissioned by specialised services.
	Neonatal Community Outreach	Improve community support and to take other steps to expedite discharge, pre-empt readmissions, and otherwise improve and care such as reduce demand for critical care beds and to enable reduction in occupancy levels.
	Paediatric Networked Care	Alignment to the national PIC service review. Sustain information collection which allows the demand across the whole paediatric critical care pathway to be considered.

Appendix 1: Clinical Audit participation details

National Confidential Enquiry into Patient Outcome and Death (NCEPOD)

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

The national confidential enquiries that the Trust participated in, and for which data collection was completed during 2017/18, are listed below alongside the number of cases submitted to each enquiry as a percentage of the number of registered cases required by the terms of that enquiry.

National Confidential Enquiry into patient Outcome and Death (NCEPOD)	% of cases returned
Chronic Neurodisability	50%
Young People's Mental Health	100%
Acute Heart Failure	100%
Cancer in Children, Teens and Young Adults	No eligible cases
Perioperative Diabetes	No eligible cases

National Audits

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

Eligible National Audits	Participation	% or No's cases submitted	Comments
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	Yes	100%	
*BAUS Urology Audits: Cystectomy	Yes	n1	
*BAUS Urology Audits: Female Stress Urinary Incontinence	Yes	n3	
*BAUS Urology Audits: Nephrectomy	Yes	n39	
*BAUS Urology Audits: Percutaneous Nephrolithotomy	Yes	n8	
*BAUS Urology Audits: Radical Prostatectomy	Yes	n100	
Bowel Cancer (NBOCAP)	Yes	100%	
Cardiac Rhythm Management (CRM)	Yes	100%	
Case Mix Programme (CMP)	Yes	100%	
Coronary Angioplasty/ National Audit of Percutaneous Coronary Interventions (PCI)	Yes	100%	

Eligible National Audits	Participation	% or No's cases submitted	Comments
Diabetes (Paediatric) (NPDA)	Yes	100%	
Elective Surgery (National PROMs Programme)	Yes	**Data not available	
Endocrine and Thyroid National Audit	Yes	**Data not available	
Falls and Fragility Fractures Audit Programme (FFFAP) - Inpatient Falls	Yes	100%	
Falls and Fragility Fractures Audit Programme (FFFAP) - National Hip Fracture Database	Yes	100%	
Falls and Fragility Fractures Audit Programme (FFFAP) - Physiotherapy Hip Fracture Sprint Audit	Yes	**Data not available	
Fractured Neck of Femur	Yes	100%	
Head and Neck Cancer Audit (HANA)	Yes	100%	
Learning disability Mortality Review Programme (LeDeR)	Yes	**Data not available	
Major Trauma Audit	Yes	95% (n355)	
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE)	Yes	100%	
National Audit of Breast Cancer in Older Patients (NABCOP)	Yes	100%	
National Audit of Dementia	Yes	100%	
National Bariatric Surgery Registry (NBSR)	Yes	100%	
National Cardiac Arrest Audit (NCAA)	Yes	100%	
National Chronic Obstructive Pulmonary Disease Audit Programme (COPD) - Pulmonary Rehabilitation	Yes	**Data not available	
National Chronic Obstructive Pulmonary Disease Audit Programme (COPD) - Secondary Care	Yes	**Data not available	
National Comparative Audit of Blood Transfusion Programme - 2017 National Comparative Audit of Transfusion Associated Circulatory Overload (TACO)	Yes	**Data not available	
National Comparative Audit of Blood Transfusion Programme - Re-audit of the 2016 audit of red cell and platelet transfusion in adult haematology patients	Yes	100%	
National Diabetes Audit - Adults - National Core Diabetes Audit	Yes	100%	
National Diabetes Audit - Adults - National Diabetes Inpatient Audit (NaDia)	Yes	100%	

Eligible National Audits	Participation	% or No's cases submitted	Comments
National Diabetes Audit - Adults - National Diabetes Transition	Yes	100%	
National Diabetes Audit - Adults - National Pregnancy in Diabetes Audit	Yes	**Data not available	
National Emergency Laparotomy Audit (NELA)	Yes	100%	
National Heart Failure Audit	Yes	100%	
National Joint Registry (NJR)	Yes	99%	
National Lung Cancer Audit (NLCA)	Yes	100%	
National Maternity and Perinatal Audit	Yes	100%	
National Neonatal Audit Programme (NNAP) (Neonatal Intensive and Special Care)	Yes	**Data not available	
National Vascular Registry	Yes	99%	
Oesophago-gastric Cancer (NAOGC)	Yes	n77	
Pain in Children	Yes	100%	
Procedural Sedation in Adults (Care in Emergency Departments)	Yes	100%	
Prostate Cancer	Yes	**Data not available	
Sentinel Stroke National Audit Programme (SSNAP)	Yes	100%	
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme	Yes	100%	
UK Parkinsons Audit	Yes	100%	
Falls and Fragility Fractures Audit Programme (FFFAP) - Fracture Liaison Service Database	No		Unable to participate due to lack of resources. Seeking to resolve during 2018/19.
Inflammatory Bowel Disease (IBD)	No		Unable to participate due to lack of resources. Seeking to resolve during 2018/19.
National Diabetes Footcare Audit	No		Unable to participate due to lack of resources. Resource now identified allowing participation in 2018/19.
National Ophthalmology Audit	No		Unable to participate due to lack of resources. Seeking to resolve during 2018/19.

There was no data collection from the National Audit teams during 2017/18 for the following audits:

- National Audit of Rheumatoid and Early Inflammatory Arthritis
- National End of Life Care Audit
- National Audit of Seizures and Epilepsies in Children and Young People

* In 2018/19 we aim to increase the number of cases we submit to the BAUS audits identified below, as the cases submitted in 2017/18 have been minimal due to resource limitations:

- BAUS Urology Audits: Cystectomy
- BAUS Urology Audits: Female Stress Urinary Incontinence
- BAUS Urology Audits: Nephrectomy
- BAUS Urology Audits: Percutaneous Nephrolithotomy
- BAUS Urology Audits: Radical Prostatectomy

**Where we are reporting 'data not available' this is because the National Audit lead organisations had not finalised the data before the Quality Accounts were finalised or data collection is still in progress.

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

Ineligible National Audits	Scope	Rationale
Adult Cardiac Surgery	Specialist Audit	Do not provide the service
BAUS Urology Audits: Urethroplasty	Specialist Audit	Do not provide the service
Congenital Heart Disease (CHD)	Specialist Audit	Do not provide the service
Mental Health Clinical Outcome Review Programme	Applies to Mental Health	Do not provide the service
National Audit of Intermediate Care (NAIC)	Specialist Audit	Do not provide the service
National Audit of Psychosis	Applies to Mental Health	Do not provide the service
National Clinical Audit of Specialist Rehabilitation for Patients with Complex Needs following Major Injury (NCASRI)	Specialist Audit	Do not provide the service
Neurosurgical National Audit Programme	Specialist Audit	Do not provide the service
Paediatric Intensive Care (PICANet)	Specialist Audit	Do not provide the service
Prescribing Observatory for Mental Health (POMH-UK)	Applies to Mental Health	Do not provide the service

The table below shows the actions and improvements that have been extracted from the reports published during 2017/18.

A total of 35 National Clinical Audit reports have been published for which the Trust either participated in or was eligible to participate during 2017/18.

National Audit	Date published	Division	Specialty	Actions/Improvements
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	27/06/2017	Speciality Medicine	Cardiology	▶ Change flow of Alex patients, ensuring direct admissions to Cardiology Increase in cath lab capacity - Business case for ground floor Aconbury increase in cath lab capacity ▶ Cardiology consultant appointments – for 7 day ACS working
BAUS Cystectomy Audit	16/04/2017	Surgery	Urology	▶ To continue annual national BAUS audit
BAUS Nephrectomy	16/04/2017	Surgery	Urology	▶ To continue annual national BAUS audit
BAUS Percutaneous Nephrolithotomy	03/05/2017	Surgery	Urology	▶ To continue annual national BAUS audit
Bowel Cancer (NBOCAP)	14/12/2017	SCSD	Bowel Screening	▶ Outlier on stoma closure – recognised and being corrected
COPD Pulmonary Rehab	19/10/2017	Speciality Medicine	Respiratory	▶ The data collected by the team is now being captured on a new and more effective database ▶ Update the SOP to ensure it covers all necessary aspects of our programme, all venues and reflects the changes made in order to improve access and reduce referral to treatment times
Coronary Angioplasty, National Audit of Percutaneous Coronary Interventions (PCI)	14/09/2017	Speciality Medicine	Cardiology	▶ Business case for ground floor Aconbury increase in cath lab capacity ▶ Cardiology consultant appointments – for 7 day ACS working ▶ Continue to work with the Paramedic crews to increase knowledge of ECG interpretation

National Audit	Date published	Division	Specialty	Actions/Improvements
Falls and Fragility Fractures Audit Programme (FFFAP) - National audit of Inpatient Falls	22/11/2017	Speciality Medicine	Geriatric Medicine	▶ In February 2017 Worcestershire Acute Hospitals NHS Trust appointed a Safer Care Practitioner to lead the falls work stream which reports to the Safer Care Group and Quality Improvement Board. A scoping exercise of the falls work stream was carried out at the beginning of the financial year. Since then a number of measures have been completed or are in progress
Falls and Fragility Fractures Audit Programme (FFFAP) - NHFD	14/09/2017	Surgery	Trauma & Orthopaedics	▶ Weekly Harm meetings at both ALX and WRH. 36 hour breaches, Datix's and mortalities discussed. Multidisciplinary involvement ▶ Golden Patient Initiative. First patient for theatre assessed overnight by anaesthetics to ensure early start and improved theatre utilization ▶ Weekly / 2-weekly progress meetings including management to track action plans (not just NOF but NOF a major focus ▶ Consultant / Senior daily ward rounds of all patients. ▶ WRH site has no elective and theatre 3 AM is now trauma. Since Dec 2016 as part of 'winter pressures'
Falls and Fragility Fractures Audit Programme (FFFAP) - FLSD	08/12/2017	Surgery	Trauma & Orthopaedics	▶ Executive Summary Report outstanding

National Audit	Date published	Division	Specialty	Actions/Improvements
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE)	22/06/2017	Women & Children	Obstetrics	▶ Include CDOP summary in perinatal mortality morbidity meetings. Terms of reference and nominated lead update ▶ Shared themes and learning from perinatal deaths must be shared in a timely manner ▶ Relaunch of Saving Babies Lives and development of ongoing action plan to deliver the 4 elements of the care bundle ▶ Ensure updated guidelines on Antenatal monitoring and Pre-eclampsia / treatment pathways / management plans are shared with primary care ▶ Raise awareness of Perinatal Institute GROW and GAP training programmes ▶ Ensure all post-mortem results are linked to DatixWeb include follow up appointment dates ▶ Use audit tool on GROW programme to identify themes and gaps in practice
National Audit of Breast Cancer in Older Patients (NABCOP)	18/07/2017	Surgery	Breast Surgery	▶ Review published data in more detail ▶ Local guidelines to be developed ▶ Discuss Charlson and Edmonton scoring ▶ Adapt MDT proforma
National Audit of Dementia	13/07/2017	Speciality Medicine	Geriatric Medicine	▶ Monthly submission of dementia and delirium assessments for patients aged 75 and over to unify2 ▶ Commence quarterly audits to include use of the "About Me" booklet
National Cardiac Arrest Audit (NCAA)	01/07/2017	SCSD	Resuscitation	▶ This audit has a data gathering objective only therefore no actions required

National Audit	Date published	Division	Specialty	Actions/Improvements
National Diabetes Footcare Audit	12/10/2017	Speciality Medicine	Endocrinology	▶ Improve participation in NDFA * Improve rates of foot assessment on admission to hospital * Improve access to MDFT * Improve outcomes for patients * Funds from NHS England have been sourced that will enable participation in this audit for 18-19
National Diabetes Footcare Audit	14/03/2018	Speciality Medicine	Endocrinology	▶ Executive Summary not yet due
National Diabetes Inpatient Audit	14/03/2018	Speciality Medicine	Endocrinology	▶ Executive Summary not yet due
National Diabetes Transition Audit	23/06/2017	Women & Children	Paediatrics	▶ To have clear transition pathways designed to make the process user-friendly for patients but focussed on sustaining stable HbA1c and minimising DKA ▶ To ensure transition occurs between the ages of 16-19 yrs ▶ Focus on sustaining HbA1c and minimising DKA

National Audit	Date published	Division	Specialty	Actions/Improvements
National Emergency Laparotomy Audit (NELA)	13/10/2017	SCSD	Anaesthetics	5th largest centre for emergency laparotomy nationally. Above the national average in 7 out of 10 parameters for Year 4, Quarter 4 Areas of excellent performance and better than the national average: ▶ Case ascertainment ▶ CT scan performed and reported ▶ Risk of death documented before surgery ▶ Consultant surgeon present in theatre when the risk of death >5% ▶ Consultant anaesthetist present in theatre when the risk of death >5% ▶ Admitted to critical care following surgery when the risk of death >5% ▶ Admitted to critical care following surgery when the risk of death >10% ▶ Establishment of a streamlined EPOCH pathway to reduce time from presentation to theatre ▶ Establish elderly care input for surgical patients – this will be part of a best practice tariff in 2019 ▶ Report results to board – briefing paper in process ▶ Formalise regular NELA working group meetings and joint MDT audit meetings

National Audit	Date published	Division	Specialty	Actions/Improvements
National Heart Failure Audit	10/08/2017	Speciality Medicine	Cardiology	▶ WAHT needs to develop pathways so that all patients admitted with heart failure are seen by Heart Failure Specialists (both nurses and doctors) during the admission, so that they have optimum access to appropriate diagnostic tests, receive the correct disease modifying treatments during the admission and have robust specialist follow up in place at discharge ▶ The Trust has appointed 2 new consultants charged with leading and developing the heart failure service
National Joint Registry	19/09/2017	Surgery	Trauma & Orthopaedics	The NJR Quality Data Provider 2016/17 certificate was issued to all three hospital sites. To achieve the award, hospitals were required to meet a series of six ambitious targets and in doing so demonstrated the high standards being met towards ensuring compliance with the NJR The achievement of the award demonstrates the continued engagement of the Trust with the NJR's data completeness programme. ▶ Data quality and capture:- Ensure the Trust is compliant with submission of data ▶ There will be data on PROMS, consultant and Trust level activity which should be presented 6 monthly to Trust audit and governance meetings ▶ Get it right project endorsed by BOA and RCS to be incorporated ▶ Use of best performing implants which are cost effective to improve savings for the Trust
National Joint Registry - Data Quality Report ALX	07/03/2018	Surgery	Trauma & Orthopaedics	▶ Executive Summary not yet due
National Joint Registry - Data Quality Report KTC	07/03/2018	Surgery	Trauma & Orthopaedics	▶ Executive Summary not yet due

National Audit	Date published	Division	Specialty	Actions/Improvements
National Lung Cancer Audit	21/11/2017	Speciality Medicine	Respiratory	▶ Appointment of clinical data lead for lung cancer for WAHT still outstanding ▶ Low rate of LCNS support – respiratory medicine to review caseload and requirement for further LCNS post ▶ Pathology confirmation and NSCLC NOS – need detailed case note review ▶ Anti-Cancer Treatment – need case note review of good PS patients not receiving anti-cancer treatment
National Lung Cancer Audit	24/01/2018	Speciality Medicine	Respiratory	▶ Actions from previous report remain in progress ▶ Appointment of clinical data lead for lung cancer for WAHT still outstanding ▶ Low rate of LCNS support – respiratory medicine to review caseload and requirement for further LCNS posts ▶ Pathology confirmation and NSCLC NOS – need detailed case note review ▶ Anti-Cancer Treatment – need case note review of good PS patients not receiving anti-cancer treatment
National Maternity and Perinatal Audit	10/08/2017	Women & Children	Obstetrics	▶ Repeat NMPA audit

National Audit	Date published	Division	Specialty	Actions/Improvements
National Maternity and Perinatal Audit Clinical Report	09/11/2017	Women & Children	Obstetrics	▶ Distribute NMPA clinical report 2017 with maternity and neonatal staff. ▶ Audit of elective deliveries prior to 39 weeks without recorded clinical indication ▶ Action plan to address findings of audit ▶ Set up working party to review IOLs ▶ Review IOL guideline ▶ Audit unexpected term admissions to NNU and babies requiring therapeutic hypothermia / cases of HIE ▶ Review evidence for KPI from Guardian intrapartum electronic maternity system
National Maternity and Perinatal Audit Clinical Report	16/02/2018	Women & Children	Obstetrics	Induction of labour working party - Sub group implemented: ▶ IOL women accommodated on ANW ▶ Review of syntocinon utilisation ▶ IOL guideline updated with audits of compliance ▶ Daily review of IOL by Cons on call * Centralisation of inpatient maternity care onto WRH site * Engagement on Saving Babies Lives National Programme - Lead identified for 4 Saving Babies Lives elements
National Oesophago Gastric Cancer Annual Report 2017 (NAOGC)	14/12/2017	Surgery	Upper GI	▶ Increase discussion of HGD cases at MDT ▶ Monitor use of definitive chemo radiotherapy and palliative treatments

National Audit	Date published	Division	Specialty	Actions/Improvements
National Paediatric Diabetes Audit (NPDA)	13/07/2017	Women & Children	Paediatrics	▶ Improve the percentage of children and young people completing all seven key care processes ▶ To improve patients' HbA1c's and reduce the median HbA1c ▶ Implement 24 hour clinical cover for access to advice for health professionals
National Pregnancy in Diabetes Audit	12/10/2017	Women & Children	Obstetrics	▶ Improving preparation for pregnancy - Reiterate importance of pre-pregnancy counselling regularly in child bearing age group ▶ Early contact with specialist support - Referral guidelines need to be drawn up. Need for regular meetings with Primary Care to reiterate importance of early referral ▶ Achievement of safe glucose level in pregnancy ▶ Specialist diabetes services in place
National Prostate Cancer Audit	21/11/2017	Surgery	Urology	▶ To establish robotic surgery in WAHT ▶ More resource to be identified to improve data completeness and quality
National Vascular Registry	22/11/2017	Surgery	Vascular	▶ Ensure that all cases are inputted to National Vascular Registry ▶ To discuss risk adjusted in hospital mortality with the Inter-radiologists and Vascular Surgical teams
UK Parkinson's Audit - Elderly Care and Neurology	27/03/2018	Speciality Medicine	Neurology	▶ Executive Summary not yet due
UK Parkinson's Audit - Physiotherapy	27/03/2018	Speciality Medicine	Neurology	▶ Executive Summary not yet due

Local Clinical Audits

During 2017/18 Worcestershire Acute Hospitals NHS Trust undertook 276 local clinical audits.

The table below shows the actions from Local Clinical Audits that Worcestershire Acute Hospitals NHS Trust has taken to improve the quality of healthcare provided for the 145 audits that were completed during 2017/18. 'Completed' is defined as audit completed and action plan in progress, overdue or completed.

ID No	Audit Title	Division	Specialty	Actions/Improvements	Status of Action Plan
876	ID 876 Trustwide Consent Audit	Corporate	Corporate	▶ Consent Identify to divisions the responsible Consultant using hand-written consent forms for Laparoscopic Cholecystectomy ▶ Consent Identify to Surgical divisions areas in the Trust where the healthcare professional is not completing the confirmation of consent	Action plan in progress at year end
1527	ID 1527 Documentation Audit 2017	Corporate	Corporate	▶ Changes to Health Records Policy ▶ Revised audit process	Action plan in progress at year end
122	ID 122 Audit of pharmacist impact on preventing admission and expediting discharges within the ED	SCSD	Pharmacy	▶ Review Pharmacist job plan within ED to reflect audit results	Action plan in progress at year end
551	ID 551 Bowel Cancer Screening Programme Quarterly Key Performance Indicator Reporting	SCSD	Endoscopy	▶ No action required	No action plan required
666	ID 666 Malnutrition Screening Tool in Outpatient Oncology Services: A pilot	SCSD	Haematology	▶ Screening tool implementation not feasible at this time. No further action to be taken	Action plan completed

ID No	Audit Title	Division	Specialty	Actions/Improvements	Status of Action Plan
693	ID 693 Audit Report on Intravenous Antibiotic Treatment of Suspected Neutropenic Sepsis	SCSD	Oncology	▶ Door to needle time adherence ▶ Revise documentation for Just in Case Pack and rename to Emergency Sepsis Antibiotic Prescription ▶ Dates set for MAU WRH. Await response form A&E Alex/WRH ▶ Meet with A&E and MAU Clinical Leads and agree pathway for improvement ▶ Collection of data on why patients missed the 1 hour target time. Weekly review with A&E	Action plan in progress at year end
1139	ID 1139 An audit of compliance with the BCSH guideline on the management of tumour lysis syndrome (TLS) in adults with haematological malignancies	SCSD	Haematology	▶ To develop local Trust guideline for Prophylaxis and Management of Tumour Lysis Syndrome in adult patients with haematological malignancies ▶ Present at journal club meeting	Action plan in progress at year end
1180	ID 1180 Assessing the technical quality of the Hysterosalpin-gography service. Re-audit	SCSD	Radiology	▶ Ensure practitioners remain conscious of screening times ▶ Ensure practitioners remain conscious of dose ▶ Re-audit	Action plan in progress at year end

ID No	Audit Title	Division	Specialty	Actions/Improvements	Status of Action Plan
1217	ID 1217 The use of Intravitreal Dexamethasone implants in the treatment of Diabetic Macular Oedema.	SCSD	Ophthalmology	▶ Visual acuities should be recorded in LogMAR format as standard for all medical retina clinics and for all injection patient's ▶ Locums to be made aware of NICE guidelines and local protocols at induction ▶ Re-audit with higher numbers and longer term follow	Action plan in progress at year end
1279	ID 1279 Audit of Delays to Theatre for Fractured Neck of Femur Patients	SCSD	Anaesthetics	▶ Reduce delays during the Trauma list at WRH - Staggered lunch for theatre staff same Anaesthetist all day ▶ New #NOF pathway documentation - Documentation now in use	Action plan completed
1285	ID 1285 Prescription of Rate Control Medication and Heart Rate Control in Patient Undergoing CTCA	SCSD	Radiology	▶ Increase the awareness of doctors about importance of starting/increasing the dose of rate control medication if clinic HR >65/min - This has been done in a presentation to consultant cardiologists ▶ Consider modifying the request form on request on ICE to remind requesters to start rate control if HR is more than 65 bpm ▶ Decide dose of rate control medication depending on heart rate	Action plan in progress at year end
1325	ID 1325 Initial 20 weeks of dedicated keratoconus clinic	SCSD	Ophthalmology	▶ Keratoconus Virtual clinic ▶ Cross linking service	Action plan in progress at year end

ID No	Audit Title	Division	Specialty	Actions/Improvements	Status of Action Plan
1339	ID 1339 Perioperative Pain Management in Paediatric Dental extractions	SCSD	Anaesthetics	▶ No action required	No action plan required
1344	ID 1344 Radiographer CT Head Reporting Accuracy	SCSD	Radiology	▶ Re audit in 12 months	Action plan in progress at year end
1348	ID 1348 Adherence to Microbial Keratitis Guidelines (WAHT-OPH -007)	SCSD	Ophthalmology	▶ Improved adherence to the Joint Ophthalmology and Microbiology Microbial Keratitis Guidelines (WAHT-OPH-007) ▶ Improved auditable standards of patient care ▶ Improved documentation	Action plan completed
1368	ID 1368 BSCI Coronary CTCA Dose Review	SCSD	Radiology	▶ No action required	No action plan required
1369	ID 1369 - CTCA doses to Assess Local Practice - Re-Audit	SCSD	Radiology	▶ Send presentation to relevant managers in department for cardiac imaging to be given a priority for reducing dose as most patients being scanned are low to moderate risk for coronary artery disease ▶ New scanner required but this is already on a replacement programme and due in the next 12-18 months	Action plan completed

ID No	Audit Title	Division	Specialty	Actions/Improvements	Status of Action Plan
1385	ID 1385 Audit of Fibromyalgia Self-Management Programme Self Reported Outcomes	SCSD	Rheumatology	▶ Improve data recording of total number of patients invited to and completing programme: Separate database of patients has been created - Accurate data of the patients attending the course is now being collected * Switching focus from 'absolute change' to 'clinically important change' in FIQR score – Agreed by MDT at meeting dated 05/07/2017 * Recommend the Fibromyalgia Service to be commissioned beyond the block contract, in order to ensure that the service is appropriately resourced – including clinical psychology input * Data recording has improved. Separate database now held. Re-audit with new data planned for 2018	Action plan completed

ID No	Audit Title	Division	Specialty	Actions/Improvements	Status of Action Plan
1391	ID 1391 Audit to assess compliance with the standard that 100% of Time Critical Medicines are administered within 30 minutes of the prescribed time, following different methods of training and communication	SCSD	Pharmacy	▶ Increase nurse awareness and ability to identify and prioritise TCMs ▶ Review the Trust Medicines Policy, MedPolSOP 20 (Standard Operating Procedure (SOP) for Adult Ward Medicines Administration excluding injectables) and Trust Injectable Medicines Policy to include the need to prioritise TCMs, provide a procedure for managing a drug administration round with associated competency assurance to ensure timely administration of TCMs ▶ A strategy for the communication of the policy, practice and procedure, training and competency involved in addressing the assurance of timely administration of TCMs should be agreed by the Medicines Optimisation Expert Forum	Action plan in progress at year end
1394	ID 1394 Electronic Anaesthetic Chart Availability Audit - Re-Audit	SCSD	Anaesthetics	▶ High percentage of Obstetric Anaesthetic charts not being scanned - Audit has showed big improvement in number of anaesthetic charts scanned onto EZNotes and easily available. Should improve patient safety by allowing anaesthetists to access old records	Action plan in progress at year end

ID No	Audit Title	Division	Specialty	Actions/Improvements	Status of Action Plan
1401	ID 1401 Duration of fasting for fluids pre-operatively in patients undergoing elective surgery	SCSD	Anaesthetics	▶ Formulate sheet to facilitate discussing order of list at WHO team brief and identify patients able to drink fluids during the morning - Completed and in use in Theatres at ALX ▶ Change patient admission letters to actively encourage drinking on morning of surgery	Action plan in progress at year end
1411	ID 1411 Diagnostic Yield of Prostate Biopsies and PI RADS scoring of MRI Prostates	SCSD	Radiology	▶ Ensure all technically adequate multiparametric MRI scans of the prostate include a PI-RADS score - Improved scoring of abnormality. This enables assessment against guidelines and published literature ▶ All prostate MRI reporting radiologists must have attended a PI-RADS v2 reporting course and regular updates - Most of the radiologists reporting prostate MRI have already attended training courses	Action plan completed
1420	ID 1420 Re-audit of Retrievable IVC Filters	SCSD	Radiology	▶ Proforma for removal of IVC filters to be designed and entered either into CRIS as an electronic request or paper. Should prompt the documentation of indication and removal instructions ▶ Re-audit of previous audit on retrieval of IVC filters	Action plan in progress at year end
1429	ID 1429 Compliance with NICE guidance on DVT	SCSD	Radiology	▶ Consider a re-audit in 12 months time with a larger sample	Action plan in progress at year end

ID No	Audit Title	Division	Specialty	Actions/Improvements	Status of Action Plan
1434	ID 1434 Audit of Integrated Care after Death Pathway for Adults WR4888	SCSD	Palliative Care	▶ Review WR4888 with interested parties/ staff users and make amendments accordingly to document - Document reviewed and ratified ▶ Offer further training, reflection on use of Care pathway to Porters as part of training initiative in conjunction with mortuary manager, Infection protection team, and porter's managers - Ongoing training for users ▶ Continue to raise awareness of bleep holder responsibilities through Palliative & EOLC folder in electronic Bleep holders folder ▶ Feedback report to senior nurses to decide when WRH rollout is to start	Action plan in progress at year end

ID No	Audit Title	Division	Specialty	Actions/Improvements	Status of Action Plan
1435	ID 1435 To ascertain the % of Optimising care as life ends WR 4668 documents used to focus and optimise care for adults as life ends	SCSD	Palliative Care	▶ Consultation and feedback around use of WR4668 as ease of use, time to complete, value as prompt to focus care. Includes this audit ▶ Revision of document WR 4668, Optimising care as life ends for adults and draft of individualised care plan ▶ Consultation on draft with staff ▶ Revised individualised care after death documentation published * Education and training pre-launch to all staff engaged with ward based end of life care and completion of new documents	Action plan in progress at year end
1438	ID 1438 Audit of Handover of Care to Recovery Staff - Re-Audit	SCSD	Anaesthetics	▶ Discuss with IT tickbox to confirm handover taken place in recovery on Bluespier - audit has shown much improved handover with checklist, including important medical and allergy details. Next step to ensure checklist used every time	Action plan completed
1440	ID 1440 Nerve stimulators for neuromuscular blockade - Re-Audit	SCSD	Anaesthetics	▶ No action required	No action plan required
1453	ID 1453 Beriplex audit	SCSD	Haematology	▶ To administer Beriplex within short time - Reduction in thrombotic complications	Action plan completed

ID No	Audit Title	Division	Specialty	Actions/Improvements	Status of Action Plan
1476	ID 1476 Re-Audit of time to trauma CT from ED	SCSD	Radiology	The radiologists have been informed not to wait for creatinine if the patient has a severe traumatic injury - This has been achieved and was a reminder in both the audits done where a patient was identified as waiting for a creatinine result prior to the study* Out of hours reporters (Medica) will prioritise the trauma report - This has already been done with two meetings in the summer to discuss* Document on CRIS or radiology report as to cause for delays in scanning - This has been delivered in education to both radiographers and radiologists.* The primary survey document should encourage this to be used - As above, this will be continued with reminders given to the reporting radiologists in house and radiographers to mention on the report or on the CRIS record if there are any delays in imaging patients either due to delays in ED or in radiology for audit purposes* A primary survey report to be issued by the duty radiologist - This has been mentioned and re-iterated during the consultant meeting. This document will continue to be used currently unless there is another system introduced for this purpose in the future - to encourage early reporting of any major significant findings that should be communicated to the referrer prior to the detailed imaging report	Action plan completed

ID No	Audit Title	Division	Specialty	Actions/Improvements	Status of Action Plan
1480	ID 1480 Platelet use audit - Re-Audit	SCSD	Haematology	▶ No action required	No action plan required
1481	ID 1481 Audit on the Cross-county Auto-Reporting Policy	SCSD	Radiology	▶ No action required	No action plan required
1488	ID 1488 Audit of NICE NG45 pre-op testing compliance	SCSD	Anaesthetics	▶ No action required	No action plan required
1489	ID 1489 Audit of Emergency Theatre Clinical Outcomes	SCSD	Anaesthetics	▶ Improve risk scoring and documentation of emergency patients pre-operatively by encouraging use of NELA, SORT and NSQIP apps/websites - Audit publicised and all consultants/trainees encouraged to use risk scoring tools and discussion at QIM and via email ▶ Discuss with Bluespier to make recording of ASA and Urgency of case mandatory fields	Action plan completed

ID No	Audit Title	Division	Specialty	Actions/Improvements	Status of Action Plan
1490	ID 1490 Audit of rheumatology out-patient service: utilisation of text messaging reminder service and clinic slot utilisation following late cancellation	SCSD	Rheumatology	▶ Presentation of audit findings to department, booking staff and line manager ▶ Poster advertising text messaging reminder service to be placed in rheumatology out-patient reception ▶ Reception staff reminded to ensure patient mobile phone numbers are entered in OASIS ▶ Patient appointment letter to be revised emphasising need for cancellation with >48hrs notice and stating lost income ▶ To establish if text reminder message can be altered and to ensure two reminders are sent for nurse and consultant appointments	Action plan completed

ID No	Audit Title	Division	Specialty	Actions/Improvements	Status of Action Plan
1496	ID 1496 Compliance with Transfusion guidelines on the Electronic Discharge summary	SCSD	Haematology	▶ Improve education and training when completing Bluespier - Inclusion of the requirements of discharging clinicians when completing Bluespier to be added to Blood Transfusion newsletter for Mandatory training ▶ Re-visit Bluespier free text box with IT - It is possible to ignore the Bluespier text box when completing the discharge summary - Re-visit Bluespier free text box with IT ▶ Investigate Athena discharge information - Athena discharge summary in midwifery does not include all of the standard questions - Athena discharge summary in midwifery does not include all of the standard questions, Explore the possibility that the same questions need to be implemented on Athena	Action plan in progress at year end
1497	ID 1497 Central Line Documentation	SCSD	Anaesthetics	▶ Increase usage of LOCSSIP - Further increasing LOCSSIP use with further stock in suitable locations as a reminder	Action plan completed

ID No	Audit Title	Division	Specialty	Actions/Improvements	Status of Action Plan
1510	ID 1510 Bone scans in routine breast cancer staging, do they still have a role	SCSD	Radiology	▶ Ceasing requesting bone scans will result in cost savings (approx. £18,000 per annum), reduction in unnecessary hospital visits , radiological procedures and exposure to ionising radiation in approx. 100 patients per year. Will free up valuable gamma camera time in nuclear medicine and will allow more studies to be performed with in the Trust rather than outsourced to City Hospital	Action plan completed
1516	ID 1516 Audit of Stop Before You Block process	SCSD	Anaesthetics	▶ Email anaesthetic department making all aware of recent wrong sided block and reminding of mandatory SBYB moment before nerve block administered - re-audit after email has shown some improvement in anaesthetic marking but overall still 10-15% non-compliance	Action plan completed
1521	ID 1521 Neck/ thyroid Fine Needle Aspiration : Adequacy of samples	SCSD	Radiology	▶ Check histology results of all FNA samples ▶ Continuous monitoring of results after every 25 patients ▶ Re-audit in 12 months	Action plan in progress at year end
1524	ID 1524 Stop Before You Block - A Re-audit	SCSD	Anaesthetics	▶ Update the clinical guidelines ▶ Continue to use SBYB stickers ▶ During the next re-audit, to provide individual anaesthetists with confidential feedback regarding their compliance ▶ Re-audit in 6 months time	Action plan in progress at year end

ID No	Audit Title	Division	Specialty	Actions/Improvements	Status of Action Plan
1525	ID 1525 Re-audit of CT-KUB	SCSD	Radiology	▶ Presentation of the findings in the departmental meeting	Action plan in progress at year end
1528	ID 1528 Adherence to Procedure 1 and Procedure 2(as a practitioner) of the ionising Radiation(Medical Exposure) Regulations 2000	SCSD	Radiology	▶ Review of random selection of request cards for reporting to cover different referral areas ▶ Remind/educate all staff of the areas we need to be populating in the post processing part of cri ▶ Remind staff there are 3 fields to populate ▶ Re-audit	Action plan in progress at year end
1531	ID 1531 Radiological investigation of Thyroid nodules at first presentation - Re-Audit	SCSD	Radiology	▶ Contact all radiologists directly, who failed to reach the target of 100% reporting for thyroid lesions as per BTA guidance. They will be asked whether they wish to continue to perform thyroid USS, and reminded of the guidance document	Action plan completed
1532	ID 1532 Do we follow NICE Guidelines in imaging of thoracic and lumbosacral spine injury	SCSD	Radiology	▶ Email local centres to see what protocol is used at their centres for further imaging of spinal fractures and use of CT and MRI	Action plan completed

ID No	Audit Title	Division	Specialty	Actions/Improvements	Status of Action Plan
1564	ID 1564 An audit of compliance with the BCSH Guidelines for the Management of Diffuse Large B-cell Lymphoma (DLBCL)	SCSD	Haematology	▶ Add boxes of Prognostic score and EOT PET to be filled on MDT sheet ▶ To circulate email to consultants ▶ EOT PET to be done as routine practice, if clinically relevant ▶ Re audit in a year's time after implementation of above measures	Action plan in progress at year end
1569	ID 1569 Are DNACPR forms filled in correctly	SCSD	Resuscitation	▶ To disseminate the data found among consultants, particularly in medicine where significant numbers of families were not being told regarding DNAR changes	Action plan completed
1572	ID 1572 An audit to assess the compliance of Radiographers with regards to the patient identification SOP	SCSD	Radiology	▶ Highlight to department managers ▶ Wards matrons and sisters informed about lack of compliance with porter slips ▶ Porters and X-ray staff made aware of problems and need for improvement ▶ Irmer ID refresher for radiographers ▶ Re-audit	Action plan in progress at year end
1626	ID 1626 Trust 2222 audit	SCSD	Resuscitation	▶ To encourage team leader reporting from 2222 calls to improve data capture	Action plan in progress at year end
1628	ID 1628 Emergency Equipment Audit (Resuscitation trolleys)	SCSD	Resuscitation	▶ Re-audit	Action plan in progress at year end
667	ID 667 Inpatient EEGs reporting pathway	Specialty Medicine	Neurophysiology	▶ No actions needed	No action plan required

ID No	Audit Title	Division	Specialty	Actions/Improvements	Status of Action Plan
711	ID 711 Sedation Audit Re-audit	Specialty Medicine	Geriatric Medicine	▶ Teaching for all medical staff at Grand Round ▶ Provide information for Junior doctors via email and teaching session ▶ Teaching for nursing staff about close monitoring of patients. ▶ Explore the options for creating a proforma for sedation ▶ Re-audit in 12 months' time	Action plan in progress at year end

ID No	Audit Title	Division	Specialty	Actions/Improvements	Status of Action Plan
1229	ID 1229 Management of Acute Kidney Injury	Specialty Medicine	Renal	▶ Abstract was successfully accepted as a poster by SAMBirmingham and was exhibited 11-12 September 2017. Comments from SAMBirmingham *"This is a very useful audit that demonstrates the importance of appropriate recognition and management of AKI. This audit has shown a clear improvement following the implementation of an AKI checklist"* ▶ The introduction of an AKI checklist led to an improvement in the care of community acquired AKI. The checklist has been rolled out through medical wards in Worcestershire Royal Hospital to audit care of hospital acquired AKI. ▶ Start roll out of AKI checklist Trust-wide ▶ 1229 Adaptation of AKI checklist format to enhance optimal recording	Action plan in progress at year end
1243	ID 1243 Radiation Exposure Re - Audit	Specialty Medicine	Cardiology	▶ Continued awareness of radiation dosage during coronary angiography ▶ Continued education on radiation doses during coronary angiography ▶ For junior medical staff to be aware of optimal radiation exposure during coronary angiography	Action plan completed

ID No	Audit Title	Division	Specialty	Actions/Improvements	Status of Action Plan
1244	ID 1244 Contrast Volume During Coronary Angiography	Specialty Medicine	Cardiology	▶ Awareness of contrast volume during coronary angiography ▶ Continued education regarding contrast volume usage during coronary angiography ▶ Education of junior medical staff regarding contrast volumes during coronary angiography	Action plan completed
1364	ID 1364 An Audit of Treatment Outcomes in a Cohort of HIV Patients Co-Infected with Chronic Hepatitis C in the Semi-Rural Community of Worcestershire	Specialty Medicine	Infectious Diseases	▶ To continue an audit on treatment outcomes in a cohort of HIV co-infected patients with chronic hepatitis	Action plan in progress at year end
1381	ID 1381 Patient Personal and Medical Identification	Specialty Medicine	Geriatric Medicine	▶ Ward stamp ▶ Editing whilst completing Silver Pro-forma ▶ On patient transfer nurses should document at top of history sheet page the Consultant to Consultant and ward to ward transfer information ▶ Re-audit on a larger scale	Action plan in progress at year end
1387	ID 1387 Flexible Bronchoscopy Audit	Specialty Medicine	Respiratory Medicine	▶ Implement WHO safety checklist ▶ Friends and family survey ▶ Bronchoscopist to consider publishing Bronchoscopy performance/ outcomes ▶ Collection of patient feedback on bronchoscopy	Action plan in progress at year end

ID No	Audit Title	Division	Specialty	Actions/Improvements	Status of Action Plan
1389	ID 1389 Ambulatory EEG recordings	Specialty Medicine	Neurophysiology	▶ Discuss in team meeting	Action plan completed
1457	ID 1457 Audit of Inpatient Echocardiogram Referrals	Specialty Medicine	Cardiology	▶ Continue with SpR/ Cons authorisation for Echocardiograms ▶ Publicise Echocardiogram guidelines ▶ Electronic method of tracking Echocardiogram requests needed ▶ Reduce inpatient Echocardiogram demands	Action plan in progress at year end
1459	ID 1459 DNACPR documentation	Specialty Medicine	Geriatric Medicine	▶ Raise awareness of audit findings by presenting in the Countywide Geriatric Medicine teaching session ▶ MCA/ BID to be filed at the front of the notes attached with the DNACPR form ▶ Re-audit January 18	Action plan completed
1549	ID 1549 Carpal tunnel and nerve condition study review	Specialty Medicine	Neurophysiology	▶ Teaching session for GP's ▶ Checklist	Action plan in progress at year end
1561	ID 1561 Countywide Cardiac rehab audit	Specialty Medicine	Cardiology	▶ Patient Satisfaction re-audit ▶ Oasis Data Review ▶ NACR Data Review ▶ Yearly presentation of CR team activity	Action plan in progress at year end
1563	ID 1563 Retrospective audit of the number of non stroke patients admitted to the acute stroke unit	Specialty Medicine	Stroke	▶ Re-audit ▶ Protected HASU beds ▶ Education	Action plan in progress at year end
646	ID 646 Quality of service evaluation in Oral and Maxillofacial Surgery	Surgery	Oral & Max Fax	▶ Re-evaluate quality of service evaluation in Oral and Maxillofacial Surgery	Action Plan in progress at year end

ID No	Audit Title	Division	Specialty	Actions/Improvements	Status of Action Plan
754	ID 754 A retrospective audit to review local follow up rates for Head and Neck Cancer patients and 4-year survival against National Standards	Surgery	Oral & Max Fax	▶ Adjust and re-evaluate follow ups template for the review of patients ▶ Review thyroid function test for patients who have undergone surgery or radiotherapy to the neck ▶ Consider the impact and cost for a vaccination programme for HPV for both males and females	Action Plan in progress at year end
852	ID 852 Mandibular Fractures in WRH 2014-16	Surgery	Oral & Max Fax	▶ No action plan required	No action plan required
1002	ID 1002 Rejected Referrals	Surgery	Oral & Max Fax	▶ Audit impact that new Oral Surgery referral form has had on the appropriate of referrals	Action Plan in progress at year end
1017	ID 1017 Audit of adherence to NICE Guidelines (2000) for third molar extraction	Surgery	Oral & Max Fax	▶ Ensure all staff are aware of guidelines ▶ Education of writing formal diagnosis in clinical notes ▶ Education to improve documentation on consent form	Action Plan in progress at year end
1165	ID 1165 Appropriateness of 2 Week Wait Head and Neck Referrals	Surgery	Oral & Max Fax	▶ Create new form, nationally agreed to reflect new guidelines and to help guide 2WW office ▶ Appropriate referral - educate regarding 2 WW	Action Plan in progress at year end

ID No	Audit Title	Division	Specialty	Actions/Improvements	Status of Action Plan
1172	ID 1172 Compliance with NHSBSP QA Guidelines For Clinical Nurse Specialists Communicating Benign Biopsy Results By Telephone	Surgery	Breast	▶ To reiterate the NHSBSP QA policy to all of the breast care nurses ▶ To have a contact number on the patient letter to enable future questions after the telephone call ▶ To adjust the letter sent out to the patients ▶ To present at directorate audit meeting	Action Plan in progress at year end
1185	ID 1185 Chronic Plaque Psoriasis - Secukinumab (TA 350)	Surgery	Dermatology	▶ Monitoring and ensuring appropriate 12 week monitoring/ follow-up appointments for patients commenced upon Secukinumab	Action Plan in progress at year end
1269	ID 1269 Quality of Vascular Department Ward Rounds	Surgery	Vascular	▶ Vascular ward round has greater quality as measured by comparable parameters with the addition of a ward round checklist	Action plan completed
1323	ID 1323 An Audit into the number of Consultant reviews of patients under the care of the Urology department	Surgery	Urology	▶ Document the grade of registrar leading the ward round. This has been re-audited	Action plan completed
1324	ID 1324 Re-audit into the number of Consultant reviews of patients under the care of the Urology department	Surgery	Urology	▶ Re-audit in 3 years	Action Plan in progress at year end
1358	ID 1358 Senior Review of Trauma & Orthopaedic Patients	Surgery	Trauma & Orthopaedics	▶ Daily Senior Review - Completed - Daily consultant ward round timetable in place ▶ Clear management plan in place for complex patients	Action plan completed

ID No	Audit Title	Division	Specialty	Actions/Improvements	Status of Action Plan
1377	ID 1377 Consent in Urology - Re-Audit	Surgery	Urology	▶ Development of e-consent for common urology	Action Plan in progress at year end
1378	ID 1378 Health Records in Urology - Re-Audit	Surgery	Urology	▶ Highlight the importance of using personal stamps at induction	Action plan completed
1379	ID 1379 Thromboprophylaxis / VTE in Urology - Re-Audit	Surgery	Urology	▶ To increase awareness of the 24hr and 1 week ▶ To continue 6-monthly audit cycle	Action Plan in progress at year end
1399	ID 1399 Urology Patient with Post-op Hospital Stay >30days	Surgery	Urology	▶ No action plan required	No action plan required
1400	ID 1400 Appropriate Management of Post-op Patients with Dual Anticoagulation	Surgery	Urology	▶ No action plan required	No action plan required
1408	ID 1408 Audit of compliance with NICE VTE risk assessment guidelines	Surgery	Trauma & Orthopaedics	▶ The results of the audit has been circulated via email to consultants, middle grades as well as SHOs/ Foundation doctors on Trauma and Orthopaedics. Also the importance of completing and documenting risk assessment on patients on admission and 24 hours post admission	Action plan completed
1409	ID 1409 Audit of use of antibiotics in trauma surgery and compliance with department protocol.	Surgery	Trauma & Orthopaedics	▶ To raise awareness among surgeons and junior doctors on the ward on the importance of adhering to the microbiology guidelines	Action plan completed
1443	ID 1443 Radiation Safety Compliance: An Audit of Thyroid Shield Usage in Urology	Surgery	Urology	▶ To educate theatre users about the use of thyroid shields ▶ Thyroid shields have been re ordered and arrived in Theatres 27/10/2017 ▶ Re-audit in 6 months	Action plan completed

ID No	Audit Title	Division	Specialty	Actions/Improvements	Status of Action Plan
1454	ID 1454 Use of Antibiotics and Implant loss rate at WAHT	Surgery	Breast	▶ Re-audit on use of antibiotics and implant loss	Action Plan in progress at year end
1455	ID 1455 Prescription of Intravenous Fluids in Adult Patients - Re-Audit	Surgery	Trauma & Orthopaedics	▶ Posters put on wards reminding doctors of NICE fluid guidelines - Doctors will now be reminded of NICE guidelines on fluid prescribing through posters	Action plan completed
1456	ID 1456 The impact of loss of paediatric services on suspected testicular torsion outcomes – a reaudit	Surgery	Urology	▶ No action plan required	No action plan required
1463	ID 1463 Application of the WHO Surgical Safety Checklist For Dermatology Surgical Lists	Surgery	Dermatology	▶ To have a team meeting to present the audit and encourage 100% participation in filling the WHO checklist going forward ▶ To email all Dermatology staff (including those who cannot attend the meeting) to fill the WHO checklist prospectively ▶ To re-audit within 2 months	Action Plan in progress at year end
1486	ID 1486 Radiation Safety Compliance: An audit of thyroid shield usage in Urology	Surgery	Urology	▶ No action plan required	No action plan required

ID No	Audit Title	Division	Specialty	Actions/Improvements	Status of Action Plan
1493	ID 1493 An audit into analgesia administered to fractured NOF patients in ED	Surgery	Trauma & Orthopaedics	▶ A training session on how to perform FIB was given to most of our junior doctors in T&O by Mr Knox (Consultant T&O) ▶ Junior doctors were encouraged and taught on how to fill the FIB proforma ▶ Reasons for not considering the FIB should be stated clearly in the notes ▶ Avoidance of administration of NSAID's ▶ 71% of our NOF patients had initial pain assessment on arrival ▶ 93% of our patients had routine pain assessment as part of their regular observations ▶ We had 8 patients who had FIB (previous audit only 1/67)	Action Plan in progress at year end
1533	ID 1533 Flexible uretero-renoscopic treatment of staghorns stones	Surgery	Urology	▶ No action plan required	No action plan required
1556	ID 1556 BAUS Ureteroscopic stone surgery Audit - Re-Audit	Surgery	Urology	▶ No action plan required	No action plan required
1566	ID 1566 Waiting times for patients in ED waiting to be seen by ENT (after referral made)	Surgery	ENT	▶ On call SHO to escalate problem to senior 30 minutes after referral if unable to see patient ▶ Proforma vs handover sheet box ▶ Re-audit for February 2018	Action Plan in progress at year end

ID No	Audit Title	Division	Specialty	Actions/Improvements	Status of Action Plan
1579	ID 1579 Reaudit of Application of the WHO Surgical Safety Checklist For Dermatology Surgical Lists	Surgery	Dermatology	▶ Re audit within 3 years to check standards are being maintained	Action Plan in progress at year end
1593	ID 1593 Establishment of an acute biliary pathway: a re-audit	Surgery	General Surgery	▶ No action plan required	No action plan required
1611	ID 1611 Fascia Iliacia Block at the Alexandra Hospital	Surgery	Trauma & Orthopaedics	▶ Teaching of theory and practice of fascia iliac block, then reaudit the rate of the block done after the teaching (plan to match the number of patients before the teaching)	Action plan completed
1612	ID 1611 Fascia Iliacia Block at the Alexandra Hospital Re-audit	Surgery	Trauma & Orthopaedics	▶ Regular teaching for junior doctor at the beginning of each rotation, and making it a departmental mandatory requirement	Action Plan in progress at year end
1232	ID 1232 Door to ECG time for chest pain in ED	Urgent Care	Emergency Department	▶ Improve door to ECG times	Action plan completed
1303	ID 1303 MAU Clinic Returns	Urgent Care	Acute Medicine	▶ Development of a robust pathway ▶ * Reduction of readmissions within 6 weeks	Action plan in progress at year end
1357	ID 1357 DKA Management Protocol Compliance in A&E	Urgent Care	Emergency Department	▶ DKA audit	Action plan completed
1383	ID 1383 Completion of the Emergency Department Mental Health Matrix	Urgent Care	Emergency Department	▶ Mental health matrix completion	Action plan completed
1393	ID 1393 Handover in the Emergency Department at ALX	Urgent Care	Emergency Department	▶ Handover audit	Action plan completed
1425	ID 1425 Procedural Sedation in the Emergency Department re-audit	Urgent Care	Emergency Department	▶ Teaching ▶ Coding of sedation to be highlighted in Induction and teaching sessions	Action plan completed

ID No	Audit Title	Division	Specialty	Actions/Improvements	Status of Action Plan
1427	ID 1427 Management of Primary Pneumothorax in the Emergency Department	Urgent Care	Emergency Department	▶ Invasive procedures checklist	Action plan completed
1431	ID 1431 Childhood Asthma Audit	Urgent Care	Emergency Department	▶ New ED discharge leaflet and management aide memoire	Action plan in progress at year end
1449	ID 1449 Vital Signs in Children in WRH ED	Urgent Care	Emergency Department	▶ Education of SHOs ▶ Education of nurses	Action plan completed
1451	ID 1451 Paediatric Pain Management in ED Department WRH	Urgent Care	Emergency Department	▶ Continued education during doctor's induction ▶ Continue the auditing cycle in 2018 ▶ Introduction of hourly checklist	Action plan completed
1482	ID 1482 CDU admission proforma documentation	Urgent Care	Emergency Department	▶ No action - CDU now closed	No action plan required
1485	ID 1485 CDU admission performa documentation - Re-Audit	Urgent Care	Emergency Department	▶ CDU audit	Action plan completed
1495	ID 1495 Management of anaphylaxis in ED at WRH	Urgent Care	Emergency Department	▶ Teaching ▶ ED team to consider moving discharge advise to relevant extra document	Action plan in progress at year end
1503	ID 1503 Safeguarding documentation	Urgent Care	Emergency Department	▶ Paeds safeguarding documentation	Action plan completed
1504	ID 1504 Foot and Ankle X-rays	Urgent Care	Emergency Department	▶ Posters in triage	Action plan completed
1507	ID 1507 CT scanning in Head Injury	Urgent Care	Emergency Department	▶ To lease with radiology to discuss result and actions ▶ Department Teaching	Action plan completed
1512	ID 1512 Investigating Transient Loss of Consciousness in ED	Urgent Care	Emergency Department	▶ Education of Juniors	Action plan completed
1518	ID 1518 Use of Abdominal X-Rays in the Emergency Department	Urgent Care	Emergency Department	▶ Abdominal XR WRH	Action plan completed

ID No	Audit Title	Division	Specialty	Actions/Improvements	Status of Action Plan
1519	ID 1519 COPD management in the ED department at WRH	Urgent Care	Emergency Department	▶ Junior education	Action plan completed
1520	ID 1520 Paracetamol Overdose	Urgent Care	Emergency Department	▶ Paracetamol overdose	Action plan completed
1536	ID 1536 The management of patients following blunt trauma to the neck	Urgent Care	Emergency Department	▶ Teaching ▶ Weekly message ▶ Board round	Action plan completed
1537	ID 1537 Management of adult head injury in emergency department	Urgent Care	Emergency Department	▶ Increase awareness ▶ Teaching session	Action plan completed
1538	ID 1538 Acute Ambulatory Care, Outcomes and Safety. Re-audit	Urgent Care	Acute Medicine	▶ Improve documentation of date and time patient seen both first time ▶ Improve percentage patients seen for first time within 15 minutes from arrival ▶ Improve percentage patients seen by consultant within 4 hours from arrival ▶ Reduce readmission for causes similar to be seen in AEC	Action plan in progress at year end
1540	ID 1540 Sepsis and meningitis in children	Urgent Care	Emergency Department	▶ Improving management	Action plan completed
1573	ID 1573 Audit on Antibiotic Prescription Trends After Period of Increased Incidence of C.Diff	Urgent Care	Acute Medicine	▶ Re-audit in 3 months	Action plan in progress at year end

ID No	Audit Title	Division	Specialty	Actions/Improvements	Status of Action Plan
832	ID 832 Colposcopy Audit	Women & Children	Gynaecology	▶ Colposcopists meeting NHSCSP target for New Abnormal Cytology Referrals ▶ Waiting times all referrals to be met ▶ DNA targets to be met Countywide ▶ Biopsy results should be communicated to patients as per national standards ▶ All colposcopists to meet national standards regarding depth/number of pieces of loop excisions ▶ Standard for LA loops to be met ▶ Women to be treated within 28 days of HG disease being found on biopsy ▶ Standard of LG referrals being treated at first visit to be monitored and validated	Action plan completed
838	ID 838 Paediatric Asthma Audit	Women & Children	Paediatrics	▶ Design sticker prototype ▶ Audit of discharge planning and follow up	Action plan completed
843	ID 843 Coeliac disease (CG86)	Women & Children	Paediatrics	▶ To develop a letter to GP regarding investigating first degree relatives	Action plan completed
1101	ID 1101 Management of Postcoital bleeding in Colposcopy	Women & Children	Gynaecology	▶ Circulate to Colposcopy staff	Action plan in progress at year end

ID No	Audit Title	Division	Specialty	Actions/Improvements	Status of Action Plan
1152	ID 1152 Safeguarding Documentation Audit	Women & Children	Paediatrics	▶ Staff to ensure that all safeguarding criteria is completed ▶ Discuss in ward meeting – to be scheduled to take place in February 17 ▶ Reminder to be added to handover sheet and effective handover folder	Action plan completed
1173	ID 1173 Audit Of Investigations performed during child protection medicals at Worcestershire Royal Hospital	Women & Children	Paediatrics	▶ Changes in clinical practise to comply with guidelines ▶ Change extended clotting panel under 'Unexplained bruising/ NAI' on ICE ▶ Reaudit	Action plan in progress at year end
1194	ID 1194 WMPDN Regional DKA Audit	Women & Children	Paediatrics	▶ DKA investigation panel on ICE request ▶ Ensure medical team document fluid calculation in notes	Action plan completed
1274	ID 1274 Decreased Fetal Movements	Women & Children	Obstetrics	▶ Re audit	Action plan completed
1334	ID 1334 Audit of Trial of Instrumental deliveries in 2nd stage of labour	Women & Children	Obstetrics	▶ No further actions required	No action plan required
1370	ID 1370 Type 2 Endometrial Cancer Management	Women & Children	Gynaecology	▶ Re-audit	Action plan in progress at year end
1375	ID 1375 Use of 'Fresh eyes' CTG Review in the Intrapartum Period	Women & Children	Obstetrics	▶ Initiate Fresh Eyes hot week ▶ Include Fresh Eyes on K2 MMT update ▶ Reaudit in 12 months (October 2018)	Action plan completed

ID No	Audit Title	Division	Specialty	Actions/Improvements	Status of Action Plan
1380	ID 1380 Audit of Current Practices to Identify Ways of Providing Best Practice to Improve KPI ST2	Women & Children	Obstetrics	Improve timeliness of initial booking appointment * Discontinued use of fax machines Trust-wide and introduction of generic email addresses for all community teams * To present and discuss findings at Trust board level as well as regional screening board	Action plan completed
1413	ID 1413 Compliance with NICE Aspirin Guidelines	Women & Children	Obstetrics	▶ No further actions required	No action plan required
1421	ID 1421 Management of Neonatal Jaundice	Women & Children	Neonatal	▶ Discuss the local bilirubin threshold charts in paediatric registrar induction ▶ Paediatric registrar to supervise SHOs to ensure bilirubin charts used correctly ▶ All old SBR charts need to be destroyed from Riverbank ward ▶ SBR charts to be included in neonatal pathway on our intranet	Action plan in progress at year end
1447	ID 1447 Biopsy at First Visit for Low Grade Referrals	Women & Children	Gynaecology	▶ Distribute to colposcopists	Action plan completed
1517	ID 1517 RCPCH guideline about managing admitted children - Re-Audit	Women & Children	Paediatrics	▶ Re-audit	Action plan in progress at year end
1547	ID 1547 DKA Audit	Women & Children	Paediatrics	▶ Improve documentation of regular reviews	Action plan in progress at year end
1554	ID 1554 Re Audit of 3rd & 4th Degree Tears	Women & Children	Obstetrics	▶ Re-audit 2018/19 ▶ Review increasing rate of 4th degree tears	Action plan completed

ID No	Audit Title	Division	Specialty	Actions/Improvements	Status of Action Plan
1555	ID 1555 SBAR Handover - Audit of documentation	Women & Children	Obstetrics	▶ Communications to all staff re the importance of documentation of SBAR handover ▶ Re-audit in 12 months	Action plan completed
1326	ID 1326 An audit looking at AMT in acute medical patients	Urgent Care	Acute Medicine	▶ Education of junior doctors at induction ▶ Remind doctors AMT should be done during clerking and AMT should be validated	Action plan in progress at year end
1551	ID 1551 Are clinical observations being performed prior to discharge on children from PAU?	Women & Children	Paediatrics	▶ Presentation of findings at local audit meeting ▶ Dissemination of recommendations via departmental email, notices and posters ▶ To discuss PAU Discharge teaching at departmental teaching sessions	Action plan in progress at year end
1575	ID 1575 Newborn pre-discharge pulse-oximetry screening audit	Women & Children	Neonatal	▶ Present data at audit meeting in order to highlight awareness ▶ Visible poster of pulse oximetry flow diagram placed on the postnatal ward, delivery suite	Action plan in progress at year end
1594	ID 1594 Mitomycin C after TURBT Re audit	Surgery	Urology	▶ No further actions required	No action plan required

Appendix 2: Detailed ratings for Worcestershire Acute Hospital NHS Trust

Overview of Ratings

Date of Inspection Visit: 22-25 November 2016, 7-8 December 2016 and 15 December 2016

Date of publication: 20 June 2017

Our ratings for Worcestershire Acute Hospitals NHS Trust

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

Ratings for Worcestershire Royal Hospital

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

Ratings for Alexandra Hospital

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

Ratings for Kidderminster Hospital and Treatment Centre

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and Emergency Services	Requires improvement	Inadequate	Good	Good	Inadequate	Inadequate
Medical Care	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Surgery	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Maternity and Gynaecology	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Services for children and young people	Requires improvement	Requires improvement	Good	Good	Inadequate	Requires improvement
Outpatients and diagnostic imaging	Inadequate	N/A	Good	Inadequate	Inadequate	Inadequate
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Inadequate	Inadequate

Date of Inspection Visit: 1-3 November 2017 and 8-9 November 2017

Date of publication: 17 January 2018

Inspection covered Urgent Care and Medical Care (including older people's care)

Ratings for the whole Trust

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

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

Ratings for acute services/acute trust

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

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

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

Worcestershire Health Overview and Scrutiny Committee (HOSC)

The Committee welcomes receipt of the draft Quality Account and through the routine work of HOSC, and the activities of individual Members, we hope that the scrutiny process continues to add value to the development of healthcare across all health economy partners in Worcestershire. From regular meetings with you, the Committee recognises the Trust's commitment to continuous improvement and looks forward to further engagement with you in the coming year.

NHS South Worcestershire CCG, NHS Wyre Forest CCG and NHS Redditch & Bromsgrove CCG

The response detailed below represents a collective review from the three Clinical Commissioning Groups (CCGs) in Worcestershire (NHS South Worcestershire CCG, NHS Wyre Forest CCG and NHS Redditch & Bromsgrove CCG). All three CCGs welcome the opportunity to provide comments on the Quality Account prepared by Worcestershire Acute Hospitals NHS Trust (WAHT) for 2017/18.

The Trust's Quality Account is a clearly written document which is easy to read and identifies how the Trust performed against the agreed quality priorities set for 2017/18. The report is open, honest and transparent acknowledging that there are areas where quality requirements have not been fully attained as quickly as had been intended. It is evident however from the narrative within the report that the Trust is working to address these issues and most notably has strengthened its corporate governance functions across the Trust to ensure ward to Board reporting.

Progress has nevertheless in some areas been noticeably slow for example within urgent care and patient flow which is reflected throughout the Quality Account. It should also be noted that this represents the second year where similar quality requirements have not been attained which is both disappointing and concerning to the CCGs.

The CCGs also acknowledge the content provided within the report on staff wellbeing and in particular the staff survey results. The CCGs found the staff survey results to be disappointing but recognise these views were obtained prior to implementation of the 4ward project around delivering sustainable culture change across the Trust. It is hoped that the positive work being undertaken by the Trust this year will improve the staff survey results for 2018/19.

Whilst it is recognised that a number of areas fell short of fully achieving the quality priorities for 2017/18 the Trust did demonstrate noteworthy improvements, in some areas, for which it is to be congratulated. Of note are the improved responses to complaints and serious incident investigations. Also

the progression made in relation to the management of sepsis within the Emergency Department and in ensuring improved learning occurs from mortality reviews across the Trust. The CCGs were also pleased to see the continued positive uptake of influenza vaccinations amongst staff and acknowledge the significant efforts that went into this year's campaign.

Despite the positive work undertaken above, performance across a number of specialties including urgent care, stroke and cancer remain unacceptable. Therefore the CCGs still have significant concerns in relation to the performance and sustainability of some services, workforce (capacity/capability) and of patient flow through the Trust. The quality implications of this ongoing poor performance cannot be underestimated and the CCGs expect the Trust to address these as part of its quality improvement programme during 2018/19.

Commissioners support and welcome the specific priorities identified for 2018/19 to improve on patient safety, patient experience and clinical effectiveness. All are appropriate areas to target for continued improvement and build on the achievements in 2017/18. The CCGs are particularly pleased to see that 'Medicines Management', 'Seven Day Service' Pressure Ulcers' and 'Falls Reduction' have been prioritised for improvement this year.

Given the limited progress seen against the targets set in 2017/18 the Trust is also advised to consider how they intend to ensure the targets for 2018/19 are fully achieved. The CCGs believe that Trusts new Quality Improvement Strategy and plan may assist with this. It is worth noting that the Strategy was developed in conjunction with staff and has clear, measurable objectives and targets. Therefore this should be instrumental in guiding the Trust along its quality improvement journey over the next three years.

The CCGs recognise the frank and honest appraisal made by the Chief Executive Officer (CEO) within the Quality Account. This is particularly in relation to the fact that WAHT are in the midst of their improvement journey and that a significant amount of work is still to be done. The CCGs also concur that whilst there is reason to be optimistic about making the prerequisite changes that this is not guaranteed and will require a clear sense of purpose and determination as well as time and resource to achieve.

Overall Commissioners are happy to accept this Quality Account as an accurate and fair reflection of the Trusts quality profile. The CCGs will continue to work collaboratively with the Trust monitoring quality improvements on a monthly basis, through the Clinical Quality Review Meetings. The CCGs will also continue to undertake Quality Assurance visits to enable the Trust to showcase improvements and identify areas on which to focus improvements and embed learning Trust wide.

Healthwatch Worcestershire

Healthwatch Worcestershire (HWW) has a statutory role as the champion for those who use publicly funded health and care services in the county. Healthwatch Worcestershire welcomes the opportunity to comment on the Worcestershire Acute Hospitals NHS Trust Quality Account (QA) for 2017/18. Healthwatch Worcestershire's principal concern is that patients who live or work in Worcestershire receive safe and quality services from the Trust.

We have used national Healthwatch England guidance to form the response below to the draft Quality Account 2017-2018 for the Worcestershire Acute Hospitals NHS Trust.

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

During 2017/2018 HWW published its Report 'Care in the Corridor' at Worcestershire Royal Hospital. The Report set out 38 recommendations to improve patient experience, including patient privacy, in the Emergency Department (ED) based on surveys of 119 patients and our own observations. We therefore welcome the acknowledgement of the challenges experienced by the Trust's ED and inclusion of the indicator under Priority 2 of Quality Indicator 3 in the QA to improve the Trust's performance for 'patients privacy being maintained when being examined in emergency department' to the national average.

We particularly welcome the measures set out under 'Priority 3 – Care that is a positive experience for our patients and their carers.' The four Quality Indicators identified broadly reflect patients experience as reported to Healthwatch Worcestershire both formally and anecdotally.

We also welcome the commitment made to shared decision making under Quality Indicator 3: Clinical standards for seven-day hospital services.

2. Are there any important issues missed?

Feedback from patients to HWW during the financial year included patient concerns about delays to receiving treatment following referral and cancellation of planned treatment. Healthwatch Worcestershire would welcome the inclusion in the QA of information about the Trusts performance against national 'Referral To Treatment' targets and against nationals standards for cancer waiting times.

We note that the Care Quality Commission (CQC) published a further Inspection Report of the Trust on 6 June 2018. Whilst that publication date was outside of the reporting period of the 2017/18 QA we are aware that the inspection took place between January and March 2018 and therefore believe it would be remiss not to comment on the CQC's most recent assessment of the Trust.

Although the CQC continued to rate the Trust as 'Inadequate' overall and the ratings for effective and responsive services remained the same we welcome the CQC's assessment that the leadership of services at the Trust has improved and the examples of outstanding practice that were found. However, the CQC found numerous areas for improvement which

are identified as either 'Must Do' or 'Should Do' actions.

The QA describes how actions from previous CQC Reports have been reflected in its Quality Improvement Plans. The Trust will want to demonstrate its plans to reflect any further actions identified by the CQC which are not already included in its quality framework and that, where applicable, existing actions are updated to ensure that the issues identified in the CQC report/s are addressed.

We also note that some of the performance indicators for 2018/2019 appear less challenging than in the previous QA. For example, in relation to hospital acquired pressure ulcers (PU):

- The published target for Grade 3 PUs in 2017/18 was "Zero Grade 3 and 4 PUs by March 2018" whilst the target for 2018/2019 is "We will reduce the number of avoidable hospital acquired pressure ulcers from our baseline position of: Grade 2; from 84 to <80 (10% reduction); Grade 3 and deep and ungradable; from our baseline position of 17 to <15 (12%); Grade 4; baseline position 0, we will maintain this performance".

And similarly, in relation to the indicator for fractured Neck of Femur (NoF):

- "All patients with a NoF that are fit for surgery will have an operation within 36 hours by August 2017." In the 2018/19 account the target is set at: "We will evidence an improvement in our time to theatre for patients with a fractured neck of femur improving from a baseline position of 85% of patients going to theatre within 36 hours for 5 out of 12 months to 85% for 8 out of 12 months."

We expect the Trust to provide further explanation to the public about why targets have been revised downwards for the 2018/2019 financial year.

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

The covering report to the QA states that: "2017/18 quality account has been subject to review by the Quality Governance Committee, an editorial panel of patient public forum members, Chief Nurse and NHSI Improvement Director."

Section 5 of the QA "How we chose our quality priorities for 2018/2019 states:

"During January 2018, we revisited the quality priorities set for 2017/18 in partnership with our staff and patients as we recognise and believe that in order for us to provide the highest possible standards we need to understand what is important to patients, their carers and our staff.

Towards the latter part of 2017/18, we have been working alongside patients, their carers, the community and our staff WAHT and from that have developed a Quality Improvement Strategy 2018-2021. We held events on each hospital site inviting patients, visitors and staff to tell us what was important to them and how they would define quality." The QA includes some quotes from these events in the Report. We welcome this initiative.

We note however that the Trust's Quality Dashboard identifies that response rates to the Friends and Family Test have declined over time and are below the national average.

The Trust, along with other local health providers, have committed to a co-

production approach with patients, their carers and the public to service planning and development. We look forward to working with the Trust to explore Outpatients arrangements in 2018/2019, and to seeing the co-production approach further embedded in the work of the Trust.

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

Healthwatch Worcestershire understands the challenges in clearly presenting the Quality Account for patients and the public given the content required by NHS England. None the less the draft Quality Account at times uses language which may be difficult for patients and the public.

Healthwatch Worcestershire would suggest that the Trust could highlight achievements against 2017/2018 Quality Indicators by using a "Traffic Light" approach and shading the lines in the table's green/amber/red according to performance.

Healthwatch Worcestershire suggest that the Trust should produce a summary of the Quality Account in an accessible format specifically for patients and the public, and use this as an opportunity to update patients and the public about how it plans to meet the "Must Do" and "Should Do" actions identified in the CQC Report published on June 2018 that are not already covered in the QA.

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

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

Scope and subject matter

The indicators for the year ended 31 March 2018 subject to the limited assurance engagement consist of the following indicators:

- percentage of patients risk-assessed for venous thromboembolism (VTE); and
- rate of clostridium difficile infections.

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

Respective responsibilities of the directors and Practitioner

The directors are required under the Health Act 2009 to prepare a Quality Account for each financial year.

The Department of Health and NHS Improvement has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the Regulations).

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

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

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

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

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

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

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

- Board minutes for the period 1 April 2017 to 28 June 2018;
- papers relating to quality reported to the Board over the period 1 April 2017 to 28 June 2018;
- feedback from each of NHS South Worcestershire CCG, NHS Wyre Forest CCG and NHS Redditch & Bromsgrove CCG dated 12 June 2018;
- feedback from Healthwatch Worcestershire dated 14 June 018;
- feedback from the Health Overview and Scrutiny Committee dated 13 June 2018;
- the Trust's complaints report published under regulation 18 of the Local Authority, Social Services and National Health Service Complaints (England) Regulations 2009, dated 21 June 2018;
- the national patient survey dated February 2017;
- the national staff survey dated 06 March 2018;
- the Head of Internal Audit's annual opinion over the Trust's control environment dated 24 May 2018;
- the annual governance statement dated 24 May 2018; and
- the Care Quality Commission's inspection reports dated 17 January 2018 and 05 June 2018.

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

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

This report, including the conclusion, has been prepared solely for the Board of Directors of Worcestershire Acute Hospitals NHS Trust. We permit the disclosure of this report to enable the Board of Directors to demonstrate that they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permissible by law, we

do not accept or assume responsibility to anyone other than the Board of Directors as a body and Worcestershire Acute Hospitals NHS Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

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

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

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

Limitations

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

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

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

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

Our audit work on the financial statements of Worcestershire Acute Hospitals NHS Trust is carried out in accordance with our statutory obligations and is subject to separate terms and conditions. This engagement will not be treated as having any effect on our separate duties and responsibilities as Worcestershire Acute Hospitals NHS Trust's external auditors. Our audit reports on the financial statements are made solely to Worcestershire Acute Hospitals NHS Trust's directors, as a body, in accordance with the Local Audit and Accountability Act 2014. Our audit work is undertaken so that we might state to Worcestershire Acute Hospitals NHS

Trust's directors those matters we are required to state to them in an auditor's report and for no other purpose. Our audits of Worcestershire Acute Hospitals NHS Trust's financial statements are not planned or conducted to address or reflect matters in which anyone other than such directors as a body may be interested for such purpose. In these circumstances, to the fullest extent permitted by law, we do not accept or assume any responsibility to anyone other than Worcestershire Acute Hospitals NHS Trust and Worcestershire Acute Hospitals NHS Trust's directors as a body, for our audit work, for our audit reports, or for the opinions we have formed in respect of those audits.

Basis for qualified conclusion

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

- Accuracy and Validity: in our testing we identified six records recorded as 'unknown' which had a completed VTE form in the patient record and two records recorded as 'VTE assessed' which had either a completed VTE form more than 24 hours after the time of admission or no VTE form in the patient record; and
- Completeness: in our testing we identified three records recorded as 'not VTE assessed' which had a duplicate record in the population recorded as 'VTE assessed'.

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 2018:

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

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28 June 2018

Appendix 4 - Mortality Data

Hospital mortality rates – or death rates as they are known commonly – can sometimes be presented in rather an alarmist way by the media. The resulting coverage often seems to forget that despite all the new technology and medical breakthroughs of recent years, people do die in hospital every day.

Most of the time, these deaths are unavoidable – the consequences of major trauma such as road traffic accidents, as well as other serious conditions like heart attacks. Some people die because their illness is incurable; yet others have just come to the end of their natural life and the most important thing is that they have a dignified and respectful death, ideally at home surrounded by their loved ones.

Why do hospitals measure mortality rates?

Not only do they help us better understand the risks of hospital treatments for individual patients, changes in patterns over time can pinpoint where improvements may need to be made. They can also help those people wishing to make a choice about the hospital where they may want to have their treatment.

When it comes to measuring mortality rates, there are three main statistics used:

Crude mortality rate

(produced by the Trust)

What are crude mortality rates?

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

What it tells you is how a hospital or Trust's mortality rate changes over time.

Hospital standardised mortality ratio

(published nationally by Dr Foster Intelligence).

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

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

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

The HSMR scoring system works by taking a hospital's crude mortality rate and adjusting it for a variety of factors

– population size, age profile, level of poverty, range of treatments and operations provided, etc. The idea is that by taking these factors in to account for each hospital, it is possible to calculate two scores – the mortality rate that would be expected for any given hospital and its actual observed rate. It is the difference between these two rates that is important when it comes to HSMR.

Nationally the expected HSMR score for such hospitals is set as being 100. This figure does not represent deaths or percentages – it is a baseline number that statisticians use against which to compare observed performances.

Through the combination of the complexity of the data being measured, along with natural random variation that occurs, HSMR scores, are never absolute figures. Indeed the experts behind the HSMR system suggest that any individual score could vary by as much as +/- 7%. So statically speaking, a NHS trust with a HMSR score of 94 could well have an identical performance to one with a score of 106 and vice versa.

Scores well above 100 suggest that there may be a need to investigate whether or not there is an underlying clinical problem that needs to be addressed. This does not mean that people can or should assume that a real problem exists at all. It could just be that the data on which the calculation was based wasn't as accurate as it should have been. But there again, it could point to a specific clinical issue that needs attention.

Until investigated thoroughly, it is often impossible for anyone to tell what the true reason is behind a lower or higher than expected HSMR score.

Summary Hospital-level Mortality Indicator

(published nationally by the Health and Social Care Information Centre (HSCIC).

The Summary Hospital-level Mortality Indicator (SHMI) is a score that reports on mortality rates at trust-level across the NHS in England, using a standard and transparent methodology. It is produced and published quarterly as an official statistic by the Health and Social Care Information Centre (HSCIC).

Following the recommendations from the national review of the Hospital Standardised Mortality Ratio (HSMR), the Department of Health commissioned the HSCIC to produce and publish SHMI. As part of the review, the Department of Health also commissioned independent statistical modelling work, which was carried out by the School of Health and Related Research (ScHARR) at the University of Sheffield.

The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. In essence, therefore, SHMI is trying to do the same things as HSMR – it's just that different variable factors are taken in to account in calculating the scores. The principle one of these is that SHMI includes deaths following a patient's discharge (within 30 days).

Glossary

A

AEC – Ambulatory Emergency Care

AKI – Acute Kidney Injury

ALX – Alexandra Hospital

AMT – Abbreviated Mental Test score

ANW – Antenatal Ward

ASA – The American Society of Anesthesiologists (ASA) Physical Status Classification System is often used by UK anaesthetists to establish a person's functional capacity. ASA grades are a simple scale describing a person's fitness to be given an anaesthetic for a procedure.

B

BAUS – British Association of Urological Surgeons

Bluespier – Theatre management software

BTA – British Thyroid Association

C

CDOP – Child Death Overview Panel

CDU – Clinical Decisions Unit

CMP – Case Mix Programme

COPD – Chronic Obstructive Pulmonary Disease

CR – Cardiac Rehabilitation

CRIS – Clinical Record Interactive Search

CRM – Cardiac Rhythm Management

CT scan – A computerised tomography (CT) scan uses X-rays and a computer to create detailed images of the inside of the body.

CTCA – Computerised Tomography Coronary Angiography uses computed tomography (CT) scanning to take pictures or images (angiograms) of the coronary arteries of the beating heart.

CTG – Cardiotocography (CTG) is a technical means of recording the fetal heartbeat and the uterine contractions during pregnancy.

CT-KUB – CT of the kidneys, ureters and bladder for the investigation of acute renal colic

CQC – Care Quality Commission

D

DATIX – Trust web-based patient safety application for monitoring patient safety incidents

DKA – Diabetic ketoacidosis is a dangerous complication faced by people with diabetes which happens when the body starts running out of insulin.

DLBCL – Diffuse Large B-cell Lymphoma

DNA – Did Not Attend

DNAR – Do not attempt resuscitation

DNACPR – Do not attempt cardio-pulmonary resuscitation

DVT – Deep Vein Thrombosis

DQSG – Data Quality Steering Group

E

ECG – An electrocardiogram (ECG) is a simple test that can be used to check your heart's rhythm and electrical activity.

ED – Emergency Department

EEG – An electroencephalogram (EEG) is a recording of brain activity.

EOLC – End of life care

EOT-PET – End of treatment positron emission tomography scan. PET scans are used to produce detailed 3-dimensional images of the inside of the body.

eZnotes – the Trust's Clinical Portal and Case Note Viewer.

F

FFFAP – Falls and Fragility Fracture Audit Programme

FIB – Fascia iliaca block is a local anesthetic nerve block, a type of local anesthesia, used for the hip and thigh.

FIQR – Revised Fibromyalgia Impact Questionnaire

FNA – fine needle aspiration

G

GAP – Growth Assessment Protocol

GI – Gastrointestinal

GP – General Practitioner

GROW – Gestation Related Optimal Weight software

H

HANA – Head and Neck Cancer Audit

HASU – Hyper-acute stroke unit

HG disease – Hyperemesis gravidarum (HG) is a pregnancy complication that is characterized by severe nausea,vomiting, weight loss, and possibly dehydration

HGD – High grade dysplasia refers to precancerous changes in the cells of the oesophagus

HIV – human immunodeficiency virus

HR – heart rate

I

IBD – Inflammatory Bowel Disease

ICE – Computer software system that allows users to request pathology tests for patients and view results either by location or by patient

IOL – Induction of Labour

ISO – International Standards Organisation

IT – Information Technology

IVC filters – Inferior vena cava (IVC) filters are placed in patients who have a history of or are at risk of developing blood clots in the legs.

J

JAG – Joint Advisory Group

K

K2 – Trust Maternity Information System

KPI – Key Performance Indicator

KTC – Kidderminster Hospital and Treatment Centre

L

LA loops - Local Anaesthetic loops

LCNS – Lung cancer nurse specialist

LeDeR – Learning Disabilities Mortality Review (LeDeR) Programme aims to make improvements to the lives of people with learning disabilities

LG referral

LOCSSIP – Local Safety Standards for Invasive Procedures

LogMAR – A LogMAR chart comprises rows of letters and is used by ophthalmologists, optometrists and vision scientists to estimate visual acuity. Visual acuity is scored with reference to the Logarithm of the Minimum Angle of Resolution.

M

MAU – Medical Assessment Unit

MBRRACE – Mothers and Babies: Reducing Risk through Audit and Confidential Enquiries is the UK collaboration investigating maternal deaths and severe morbidity, stillbirths, infant deaths and morbidity.

MDT – Multi-disciplinary Team

MINAP – Myocardial Ischaemia National Audit Project

MMT – Maternity Mandatory Training

MRI scan – Magnetic resonance imaging (MRI) is a type of scan that uses strong magnetic fields and radio waves to produce detailed images of the inside of the body.

N

NABCOP – National Audit of Breast Cancer in Older Patients

NAOGC – National Oesophago-Gastric Cancer Audit

NaDia – National Diabetes Audit

NAI – Non-accidental injury

NAIC – National Audit of Intermediate Care

NBOCAP – National Bowel Cancer Audit Programme

NBSR – National Bariatric Surgery Register

NCAA – National Cardiac Arrest Audit

NCEPOD – National Confidential Enquiry into patient Outcome and Death

NDFA – National Diabetes Footcare Audit

NELA – National Emergency Laparotomy Audit

NEWS – National Early Warning Score determines the degree of illness of a patient using six physiological findings and one observation.

NHSBSP QA – NHS Breast Screening Programme Quality Assurance

NHSCSP – NHS Cervical Screening Programme

NICE – National Institute for Health and Care Excellence

NJR – National Joint Registry

NLCA – National Lung Cancer Audit

NAMP - National Maternity and Perinatal Audit

NNAP – National Neonatal Audit Programme

NNU – Neo-natal Unit

NOF – Neck of Femur

NPDA – National Paediatric Diabetes Audit

NSAID – Non-steroidal anti-inflammatory drugs

NSCLC NOS – non-small-cell lung cancer not otherwise specified

NSQIP – National Surgical Quality Improvement Program

O

OASIS – Software system used to record patient activity, such as outpatient attendance, waiting list entries, planned admissions and emergency admissions

Outlier – outside of the national average

P

PAU – Paediatric Assessment Unit

PCI – Percutaneous Coronary Intervention

PEWS – Paediatric Early Warning Score

PICANET – Paediatric Intensive Care Audit Network

PI-RADS – Prostate Imaging Reporting and Data System

PROMS – Patient Reported Outcome Measures

POMH-UK – Prescribing Observatory for Mental Health

R

RCPCH – Royal College of Paediatrics and Child Health

S

SAM – Society of Acute Medicine

SBR – If a doctor thinks a baby may have jaundice they may do a blood test (serum bilirubin or SBR). This is to check for levels of bilirubin in the blood.

SBAR – Situation-Background-Assessment-Recommendation tool.

SBYB – Stop Before You Block

SCSD – Specialised Clinical Services Division

SHO – Senior House Officer

SHOT – Serious Hazards of Transfusion

SOP – Standard Operating Procedure

SORT – Surgical Outcome Risk Tool

SpR/CONS – specialist registrar / consultant

SQUID – Safety and Quality Information Dashboard

SSNAP – Sentinel Stroke National Audit Programme

T

TACO – Transfusion associated circulatory overload

TCM – Time critical medicine

TLG – Trust Leadership Group

TLS – Tumour Lysis Syndrome

TURBT – Transurethral Resection of Bladder Tumour

U

USS – Ultrasound Scan

V

VTE – Venous Thromboembolism (blood clot)

W

2WW – Two-week wait

WAHT – Worcestershire Acute Hospitals NHS Trust

WHO – World Health Organisation

WOW – Worcestershire Obstetric Warning

WRH – Worcestershire Royal Hospital

X

XR – X-ray

Y

YTD – Year to date

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