NHS
Worcestershire
Acute Hospitals
NHS Trust

Quality Account
2019/20

Putting Patients First

Acknowledgements and feedback

Acknowledgements

Worcestershire Acute Hospitals NHS Trust wishes to thank its entire staff and the contributors to this Quality Account.

Feedback

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

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Welcome and Introduction to this Quality Account

Welcome to Worcestershire Acute Hospitals NHS Trust Quality Account for 2019/20. Every year all NHS hospitals in England must write an account for the public about the quality of their services. This is called a Quality Account. It is our pleasure to showcase the work undertaken during the year to continuously improve the quality of our services based on national policy drivers, patient, staff and stakeholder feedback. We are proud to be able to share with you the fantastic work that our staff, patients and carers have undertaken together throughout 2019/20.

The purpose of Quality Accounts is to enable:

- Patients and their carers to make better informed choices
- Boards of providers to focus on quality improvement
- The public to hold providers to account for the quality of NHS Healthcare services they provide.

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

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

This account informs you how well we did against the quality priorities and goals we set ourselves for 2019/20 (last year). It sets out the priorities we have agreed for 2020/21 (this year), and how we plan to achieve them. It also contains an overview of our quality performance based on mandated and locally chosen indicators.

This document is divided into three sections

Part One:
Provides an overview of Worcestershire Acute Hospitals NHS Trust and shares with you a celebration of our successes over 2019/20. We also include a statement from our Chief Executive, Matthew Hopkins. The section concludes with a patient's story of their personal reflections of the care received from our Trust.

Part Two:
Outlines the progress we have made during 2019/20 in relation to the quality priorities we set in our last Quality Account. We also share the priorities we have set for the coming year (2020/21) that have been agreed with our patients, carers, staff and stakeholders. This section then goes on to share our performance against a number of mandatory performance indicators identified by NHS Improvement.

Part Three:
In this section we report on key national indicators from the Single Oversight Framework (SOF) and will also share performance in relation to other indicators monitored by the Board and not already reported in Parts 2 or 3 of the Quality Account.

In this section we will share with you the comments we have received in relation to the Quality Account from our Commissioners, Healthwatch and our external auditors. This section also contains a glossary of terms used within the document.

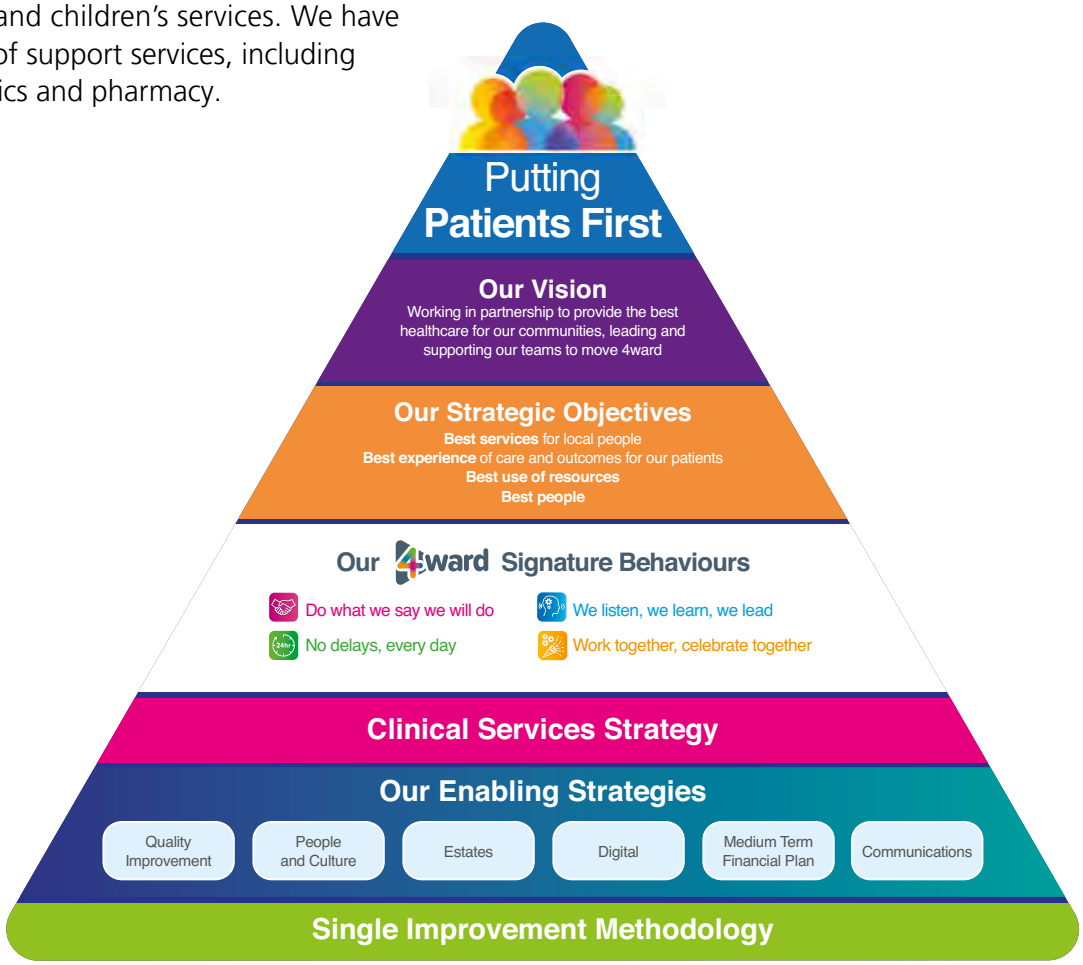
1.1
Worcestershire Acute Hospitals Trust at a Glance

Who we are and what we do…

We serve a population of almost 580,000 this figure is expected to rise by 2021 to 594,000. We know we have an increase in children and young people and older 70 plus age groups.

We provide a broad range of acute services including general surgery, general medicine, acute care, cancer care, intensive care and women and children's services. We have a range of support services, including diagnostics and pharmacy.

We operate services from the Alexandra General Hospital, Redditch; Kidderminster Hospital and Treatment Centre, Kidderminster; Worcestershire Royal Hospital, Worcester; The Princess of Wales Community Hospital, Bromsgrove; Evesham Community Hospital, Evesham, and Malvern Community Hospital, Malvern.



We are investing in our patients, their carers and the community through our Clinical Services Strategy

What our patients and carers say…

"Amazing care in a very difficult time, staff could not have done more to help to look after me and my babies!"

"I had excellent care as usual your services are second to none."

"Very friendly and helpful nothing is too much trouble. Makes you feel well cared for."

"I can't fault anyone who handled my care from the ambulance staff through nursing to the doctor who handled my care."

"Staff were friendly caring and so supportive of the fact my dad had Dementia … Everyone was so professional and you felt you were in good hands."

"Midwives and staff here are so professional, very kind. The room is nice and equipped."

What our staff say…

- We have over 5500 staff
- Over 400 staff who have signed up a 4ward cultural change agenda.

"I love my job and feel that I make a difference in the organisation."

"I feel very privileged to be working within the environment I do."

"We have excellent staff who really care about our patients and colleagues."

"I work with a great team who are always very supportive to me to complete my job on a daily basis."

We are investing in our staff through our delivery of our People and Culture Strategy (2018-21)

Our volunteers say they volunteer with us because…

Our volunteers say they want…

We are investing in our volunteers through our Volunteering strategy (2020 -2023)

Our Values and behaviours

4Ward sits at the heart of our #PuttingPatientsFirst strategy and is the 'how' to how we will deliver both our strategic objectives and our vision. For staff across the organisation, 4ward is how we will deliver the best possible care and best services for our patients and that we are always putting them first in everything that we do.

4ward is a long-term, far-reaching initiative which aims to help colleagues across our Trust work more effectively together in a spirit of mutual support and respect as we tackle the challenges we face and make the most of the opportunities that the future will bring.

Our focus going 4ward is twofold. We want to transform our culture whilst at the same time improving our performance across the whole of Trust, particularly around our wide-ranging quality improvement programme, improving the flow for patients, our preparations for winter and our efforts to achieve financial stability.

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

The behaviours are:

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

1.2
Welcome from our Chief Executive and Chairman

Matthew Hopkins
Chief Executive

Sir David Nicholson
Chairman

Our vision is to ensure that we work in partnership to provide the best healthcare for our communities, and lead and support our teams in moving 4ward.

Never has this been as pertinent than through the unprecedented challenge that the Covid-19 pandemic has presented us with. The collective team effort from our Trust staff, our partners across the health and care system, the voluntary sector, and our wider communities to fulfil our purpose to Put Patients First has been unparalleled.

We are confident that the progress made as an organisation over the past 12 months has, in some part, helped to ensure our hospitals were as equipped and are as ready as they could be to cope with the additional pressures that coronavirus continues to bring.

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

Of particular note is the progress we have made to reduce medicine incidents causing harm, reduce the number of falls resulting in serious harm and, following a sustained focus on Infection Prevention and Control, increase hand hygiene compliance. Results from our Friends and Family Test also show that more than 95% of inpatients and maternity patients would recommend our hospitals.

A number of these successes and achievements were recognised in our CQC report published in September. Most notably, our overall rating was lifted from 'Inadequate' to 'Requires Improvement,' and not forgetting the fantastic achievement at Kidderminster with a 'Good' overall rating.

Areas for continued focus in the months ahead to ensure we provide care that is safe, clinically effective and provides a positive experience for our patients and their carers includes improving sepsis screening, and reducing the number of hospital acquired infections - as well, of course, as continuing our improvement journey in the areas where we have seen progress.

We also have several new areas of focus for the 12 months ahead, including nutrition and hydration, improving outcomes for our dementia patients and reducing hospital acquired functional decline – a key part of our emergency care improvement plan known as HomeFirst Worcestershire.

Of course alongside these, as we emerge from the immediate challenges of Covid-19, the Trust, and the NHS as a whole, will also be focussing efforts on the restoration and recovery phases of the post Pandemic era, with an aim to sustain the improvements and innovations that we have seen during this time.

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

Matthew Hopkins
Chief Executive

David Nicholson
Chairman

A YEAR IN NUMBERS
2019/2020

97,066
Walk-in patients (A&E)

54, 845
Patients arriving by ambulance

158,589
Inpatients

623,538
Outpatients

5,137
Births

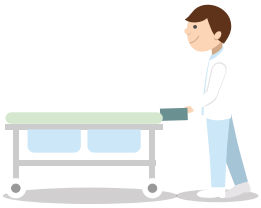
4,109
Emergency Operations

23,620
Elective Operations

2,063
Trauma Operations

6.4 days
Average length of stay

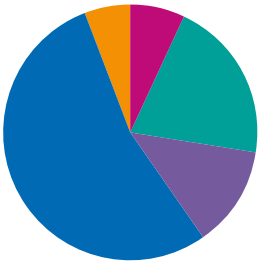
893,100
Number of meals served



1,448,060
Number of sheets laundered

£49.8m
Value of prescriptions issued

Diagnostics



- MRI scans - **20,084**
- Non-obstetric ultrasound scans - **65,463**
- CT scans - **53,549**
- Plain film X-Rays - **216,486**
- Endoscopies - **30,891**

Staff

Total Staff
5,566

Nurses
1,594

Doctors and Consultants
653

Allied Health Professionals
356

Midwives and Midwifery Support Workers
252

Other Support Staff*
2,711

Volunteers
423

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

1.3 A Patient's Story

We are privileged to be able to share with you the story of John, who has been a patient at our Trust since January 2017. John's story stands as an exemplar Putting Patients First and for our 4ward Signature Behaviours programme. John's story is an opportunity to recognise and celebrate innovation, highlighting a caring service and responsive approach that is directly benefiting patients and triangulates with our Quality Improvement Plan – to ensure that services are safe, effective, caring, responsive, and well-led and a positive experience for patients, carers and their families.

John has been undergoing regular treatment at Kidderminster Hospital with occasional consultations at the Worcestershire Royal Hospital Ophthalmology department. John has previous experiences of treatment at a different Trust and shared that at Worcestershire Acute Hospitals NHS Trust we have "broken through a layer of bureaucracy". John has shared that his experience of care, defined as "nurse led", means that a procedure which previously would have taken up to 2 hours, now takes 35 minutes, with greater person-centred care in terms of personal attitude and comfort.

We first had the pleasure of meeting John at our 2018 annual Quality Account consultations; he shared his story and we invited him to attend the Trust Board to personally share his story and experiences at our Trust. We start each of our Board meetings with a patient or carer's story. John then became an active member of our Patient and Public Forum and a Trustee of Sight Concern. John sits on the Trust Specialised Clinical Services Division Governance Committee as a Patient Representative and is focusing in 2020 on supporting wider volunteering initiatives to support the patient experience.

Here is John's story in his own words.

John's Story

I was first diagnosed in 2012 with wet form macular degeneration in my left eye, followed by my right eye in the summer of 2015. A couple of months later I experienced a sub macular haemorrhage.

The impact of sight loss has had a serious consequence on the quality of life of both myself and my family, which has placed a disproportionate reliance on those closest to me. I have been frustrated in the past, wanting to share "the good and the bad" and support learning. I've joined groups such as Sight Concern and the Macular Society which has gone some way to supporting this.

My wife and I moved to the area in January 2017, to be nearer to our family as my sight was deteriorating. My experiences at Worcestershire Acute Hospitals made a fundamental difference to my experience. My previous experiences were with consultants who did care; however the procedures were carried out by different locum doctors offering no continuity. I was left in pain after the procedures and prescribed eye drops for pain management. At Kidderminster Hospital nurses offered to hold my hand and offered reassuring continuity, really taking the time to treat me as an individual. My experience at every visit feels supportive and I have not needed to use eye drops after my visits. This courteous, personal, person-centred approach makes a significant and fundamental difference for a procedure that is unpleasant and uncomfortable. My experience for regular appointments and treatment is dignified, empathic and respectful.

My life has changed and I am working in many new ways. This all kicked off because I needed a sense of having a role to play. My life had changed completely and I needed an interest and I needed a way to contribute. I am now also working with the hospital that treats me to find out how I can support others and I would like to share that you don't have to be part of the medical profession to improve the patient experience. I am sitting on committees and groups with interested, enthusiastic people who are listening and keen to collaborate – watch this space!

PART 2: Our commitment to quality

In part two of our Quality Account we outline our planned quality improvement priorities for 2020/21 and provide a series of statements of assurance from the Board on mandated items, as outlined in the 'Detailed requirements for quality reports 2019/20' (https://improvement.nhs.uk).

In this section we will also review the progress we have made in relation to the quality priorities we set ourselves in the 2018/19 Quality Account.

We aim to continually provide compassionate, high-quality patient care and support for carers through fostering a culture in which care and treatment is safe and of a high-quality consistently tailored to each person's needs and guarantees their dignity and respect. We strive to achieve this through providing health services that always exhibit three key components of patient safety, clinical effectiveness and patient and carer experience. All three are achieved through our staff having the ability to exhibit a caring culture and professional commitment with strong leadership.

2.1 Registration with the CQC

Care Quality Commission

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.

The Trust received an unannounced inspection in May and June 2019. CQC published the findings from this Inspection in September 2019 which demonstrated an improvement in the overall quality rating, and the Trust is now rated as "Requires Improvement".

Overall, the Trust continues to be rated positively "Good" in the "Caring" domain, and "Requires Improvement" in the "Well-Led" domain. The ratings for "Safe" and "Responsive" improved to "Requires Improvement", and the rating for "Effective" improved to "Good".

The inspection report published in September 2019 identified and rated the following as outstanding:

Diagnostic Imaging at the Alexandra General Hospital "Outstanding" for the "Caring" domain.

Our Children's and Young Peoples service had improvements in safe, effective and well-led and as a result are now rated as:

"Good" in every domain: Safe, Effective, Caring, Responsive and Well-led.

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

- Medicines' Management
- Infection Prevention and Control
- Incident Reporting
- Sharing learning across the Trust
- Divisional and Local Leadership
- Engagement in the Trust's improvement journey
- Complaints Management
- Compassionate and caring staff

In December 2019, The Urgent and Emergency Core Services at Worcestershire Royal Hospital and the Alexandra General Hospital were inspected as part of an unannounced focused Inspection. The CQC published their report in February 2020 which identified that further improvements were required to ensure timely ambulance handovers, patient assessment and speciality review. Although no safety concerns were raised during the on-site inspections, Urgent & Emergency Core service ratings were downgraded from "Requires Improvement" to "Inadequate" for "Safe", "Responsive" and "Well-Led", and the Trust was issued with a Section 31 Conditions Notice for both sites. The overall Trust ratings received in the September 2019 Inspection Report remain unchanged.

As well as a summary of findings, which included areas of outstanding and improved practice, the September 2019 and February 2020 inspection reports outlined a list of regulated activity actions the CQC require the Trust to focus on. These are referred to as Must and Should Dos. Must Dos are issues on which the Trust must take action to bring services into line with regulatory requirements. Should Dos are issues on which the Trust should take action, either to comply with minor breaches that did not justify regulatory action, to avoid breaching a legal requirement in future, or to improve services.

To ensure detailed focus on the Must and Should Dos, the Trust devised a tool in 2018 - 'Regulatory Activity Improvement Tool' (RAIT) - and process that would allow for local monitoring of progress made in support of improvements. RAIT allowed the core services to understand where they were required to focus and facilitate the collation of assurance and evidence. The process allowed for detailed testing of the evidence by the Executive Team, at monthly meetings. During the monthly meetings, the Divisional Management Team and supporting Governance teams demonstrate their current ratings and progress and live link to evidence collated to support assurance.

2.2
Our Approach to Quality Improvement and Quality Governance

Quality Improvement

Our Executive lead for quality improvement is the Chief Nursing Officer. In 2018, following a number of consultation events with patients, carers and staff, we launched our three-year Quality Improvement (QI) strategy (2018-21). Quality Improvement is about making health care safe, effective, timely, patient-centred, efficient and equitable. As a Trust we:

- Continually strive to improve and learn.
- Collect a wide range of information to enable us to continuously assess the quality and safety of our services.

A QI approach helps to develop a culture of openness to change through the involvement of staff, patients and carers to achieve systematic sustainable change.

Our QI approach is based on the principle of our staff continuously trying to improve how they work and the quality of care and outcomes for our patients. This requires an approach based on iterative change, continuous testing and measurement, and the empowerment of frontline teams to identify, implement and lead their identified improvements. Throughout 2019/20 we have built on our 2018/19 plans with the implementation of a ward to board approach of reporting on progress and outcomes on our divisional quality improvement plans with ownership with each clinical team.

We encourage an approach whereby service user involvement is considered central to our work, and over time, co-production of service developments and improvement with service users will become a cultural norm. We fully appreciate that developing the culture of continuous QI will take time, effort and persistence. To support the development of a culture of continuous QI we are investing in the QI capability of our staff and volunteers. As a result of this and during 2019/20:

- 7% of staff completed QI training.
- Developed and rolled out in-house Bronze level "introduction to QI" training and in-house Silver level "QI in practice" training; to 441 staff.
- STP Gold level "QSIR practitioner" training; 2 clinical members of staff have completed the QSIR training during 19/20 and 12 are currently part way through the course programme.
- ACT Academy QSIR College "Faculty Associate training"; 3 completed the training and are now delivering QSIR training for the STP

Each clinical division within the organisation produces a Quality Improvement Plan (QIP) annually and the delivery of these is overseen by the Clinical Governance Group (CGG). The QIPs support the delivery against our quality priorities which will be further developed during 2020/21 (Year 3 of our Quality Improvement Strategy).

Engagement in QI has been positive from staff at all levels of the organisation, resulting in 63 improvement initiatives being registered so far with the QI team as part of our "Path to Platinum" accreditation programme; and this number is continuing to grow. A few examples of ongoing QI initiatives are: "Stay in the Bay" initiatives to reduce number of patients experiencing a fall; improvements for insulin management, hand hygiene practices, nutrition and hydration, care in reducing pressure ulcers, sepsis screening, and venous thromboembolism (VTE) assessments.

Quality Governance

The Board ensures robust quality governance through the Quality Governance Committee (QGC); a subcommittee of the Board. The Quality Committee, which is chaired by a Non-Executive Director, meets 11 times per year, and its purpose is:

- To approve the Quality Improvement Strategy (QIS) and receive monthly updates through the report from the Clinical Governance Group.
- To approve the three Plans supporting the QIS.
- To oversee the CQC 'must' and 'should' dos.
- To approve the Trust's annual quality account before submission to the Board.
- To monitor and review the Trust Quality Performance Dashboard.
- To review the Trust's performance against the annual CQUINs.
- To consider matters referred to the Committee by the Trust Board, other Committees or other sources.
- To have oversight of the Infection Prevention and Control Plan and receive regular updates on the action plan.
- To receive the Annual Report for Infection Control prior to it being presented to the Trust Board.
- To monitor the Trust's compliance with the national standards of quality and safety of the Care Quality Commission, and NHS Improvement's licence conditions that are relevant to the Quality Governance Committee's area of responsibility, in order to provide relevant assurance to the Board so that the Board may approve the Trust's annual declaration of compliance and corporate governance statement.

Each clinical division has in place quality governance arrangements to address the key elements of quality and safety. They report directly to the Trustwide Clinical Governance Group (CGG) which in turn reports to the QGC. Each clinical division is required to provide assurance to the QGC against its QIPs.

The Trust has embedded a range of approaches to support effective quality governance and improvement. These are as follows:

- Path to Platinum Programme – ward and clinical division accreditation programme.
- Quality Improvement audits – the audit tool that clinicians use to audit their practice and care environment has become electronic enabling result to be viewed and actioned in real time ensuring any improvements required can be taken immediately.
- Staff Training and Development opportunities supported by our Quality Improvement hub.
- Leadership and organisational development programme.
- A range of approaches to gather patient, service user and carer real-time feedback and engagement.

Patient Safety

We have pledged to prioritise the improvements in the culture of patient safety through our quality improvement strategy, minimise patient safety incidents and drive improvements going forward.

We have focused on reviewing our serious incident process for the investigation of patient reported harms to ensure we are identifying the learning for improvements and where excellent practice has been given. This work has led to re-structuring of our data capture system to increase the capacity for greater quality analysis. We have improved our monitoring of the Serious Incident (SI) process, leading to a continued improvement in meeting the 60 day deadline; overall reduction in SIs (19%).

Being open and honest with patients and their families, when something goes wrong and appears to have caused or could lead to harm in the future through clear lines of explanation and offering an apology for what has happened is vital for our patients in supporting them to find their ways of coping. Building the culture of being open and implementing our duty of candour in practice is a key priority for us. We have conducted a review of our compliance with Duty of Candour (informing of the fact that any person who has used our service and experienced harm by the provision of that service and is offered an appropriate remedy) which has identified gaps in the process for when incidents no longer meet the criteria, and has strengthened our processes.

We have carried out a review of risk registers, which has led to a re-design of the way data is captured, enabling easier reporting and oversight for divisions.

Throughout 2019/20 the Trust has continued to embed the implementation of safety huddles across all ward areas. A safety huddle is a short multidisciplinary briefing, held at a predictable time and place focused on the patients most at risk and the staffing and environmental challenges being faced at the time.

Homefirst Worcestershire Programme

Striving for the best possible patient experience and to achieve our Organisational priority to ensure to improve the safety, efficiency and performance of the Urgent and Emergency Care pathways at the Trust, we recognised we needed to improve the safety and experiences of patients through the Urgent Care pathway and to do so The Home First Worcestershire (HFW) Programme was rolled out throughout 2019. The programme is led by Our Chief Executive, Matthew Hopkins.

The programme measures a number of metrics, but key for our patients are:

1. How quickly we are able to accept patients from the ambulance and in so doing ensure their care is provided in a timely way.

2. Ensure timely safe discharge and ensure, in doing so, that patients are not readmitted within 30 days.

3. Ensure the time patients spend in the emergency department is effectively managed and they are provided with a bed on a ward as their condition requires.

We held a System Accelerated Event in November 2019 and we have progressed with System Improvement (that is, working with Community and Social Care Organisations). The outcomes of this event have ensured that we put in the right processes to ensure patients receive the right care if needed in their own homes and prevent unnecessary admission to our Hospitals, receive care that is on the same day or ensure that their discharge is not delayed. We are progressing these changes over the coming months and will look forward to collating the benefits of such changes.

Launch of Our Digital Strategy

Central to the innovations in patient safety, over the last 12 months has seen the Trust embrace the power of technology to change how we deliver services , empower front line clinical teams, patients and citizens.

The Trust Board approved a Digital Strategy in June 2019, which articulates the ambitions of the Trust to harness the power of IT, whilst recognising the Trust starting position.

Recent advancements have seen the adoption of video consultations changing the way we deliver our services, remote monitoring to enable patients to remain safe in their homes without having to come to hospital. We are working hard to bring the digital infrastructure up to date to enable us to start to deploy a Digital Care Record in the next 12 months which will link to advances taking place at a regional level to link up patient information.

We will develop the digital skills of our clinical workforce through the appointments of a Chief Digital Nurse Officer and Chief Clinical Digital Officer who will spearhead transformational clinical practices and harness the power of information and data, we will also explore how we can create space for a digital campus that will include an innovation spaces and model ward and clinic environments.

Ward Accreditation – Path to Platinum

PATH TO PLATINUM
ACCREDITATION PROGRAMME

YEAR 1

In April 2019 we launched our Trust-wide programme of accreditation. We know this as our Path to Platinum (P2P). We believe that excellence is the sum of many complex parts on our hospital wards and in departments.

Our P2P was implemented to recognise individual teams that distinguish themselves by improving every element of patient care activity. As teams strive for improvement, they can progress through four levels of accreditation – Bronze, Silver, Gold and Platinum – in recognition of significant milestones along their journey to excellence.

For our patients, their families and their carers, the P2P signifies the journey to exceptional care through improved outcomes and greater overall experience and satisfaction.

For our clinical staff, the P2P offers a positive and supportive work environment with greater collaboration between colleagues and leaders leading to higher morale and a lower turnover of staff. The programme provides a road map and tools to assist wards and departments on their journey to providing excellent care.

Our staff have embraced Phase 1 of P2P on 38 of our inpatient wards. It was with great regret, we paused the accreditation process in March 2020 due to the need to support our staff to focus on requirement of care with the outbreak of COVID-19. However, we continued with the principles of the programme and will

be embracing accreditation in September 2020. We will also be starting phase 2 of P2P with our Emergency departments, neonatal and children's wards and theatres.

Freedom to Speak Up Guardian

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

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

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

2.3 Looking back: Review of the Quality Priorities for 2019-20

Priority 1 – Safe Care

Quality Indicator 2019/20	Target 2019/20	Evaluation 2019/20	Trajectory 2020/21
Quality Indicator 1 We will reduce the percentage of medicine incidents causing harm across the Trust.	Our Target for 2019/20 was a reduction to 11.71%.	12.18% of all medicine incidents in the Trust were recorded as causing harm (213 of 1,749). The target was not met but was a reduction from 2018/19.	Our target for 2020/21 is <11.71%.
Quality Indicator 2 We will reduce the number of patients who have a fall with harm whilst under our care.	Our Target for 2019/20 was no more than 12.	There were 9 falls with serious harm in 19/20. The target was met.	Our target for 2020/21 is <6.
Quality Indicator 3 We will continue to improve on progress achieved in reducing the number of all pressure ulcers (PU).	Our Target for 2019/20 was a reduction of 5%.	There were a total of 305 pressure ulcers recorded in 2019/20; a 6.64% increase. Serious Incident PU as we have demonstrated 45.5% reduction over 2019/20 and 64.7% reduction over the last 2 year period. Whilst this target was not met. The major impact on our Quality Improvement for 2019/20 were the reporting changes due to NHSi framework from April 2019. As an organisation we will be reporting ALL Pressure Ulcers (PU). Therefore the direct comparison re data from 2018/19 would not be true representation.	Our Target for 2020/21 is no more than 274; this is reduction of 10% on all PU. No more than 5 Serious Incident Pressure Ulcers this is a 10% reduction from last year.

Quality Indicator 2019/20	Target 2019/20	Evaluation 2019/20	Trajectory 2020/21
Quality Indicator 4 We will achieve excellent infection prevention practices, and our rates of infection will improve in order to improve the safety and experience of our patients.	The specific areas we will focus upon are:		Targets not yet issued or agreed for this year at the time of publication.
	Clostridioides difficile Our Target for 2019/20 was no more than 53.	There were 61 confirmed cases in 2019/20. The target was not met.	Our Target for 2020/21 is no more than 53* (TBC).
	E coli Bacteraemia Our target for 2019/20 was no more than 59 cases.	There were 55 confirmed cases in 2019/20. The target was met.	Our target for 2020/21 is no more than 50 (TBC).
	MSSA Bacteraemia Our target for 2019/20 was no more than 10 cases.	There were 18 confirmed cases in 2019/20. The target was not met.	Our target for 2020/21 is no more than 10 cases (TBC).
	MRSA Bacteraemia Our target for 2019/20 was 0 cases	There were 3 confirmed cases in 2019/20. The target was not met.	Our target for 2020/21 will remain at 0 cases (TBC).
	Hand Hygiene Compliance to Practice Our target for 2019/20 was above 97%.	In 98.23% of all hand hygiene audits completed, there was sufficient evidence of compliance to practice. The target was met.	Our target for 2020/21 is 98% and above (TBC).

Quality Indicator 2019/20	Target 2019/20	Evaluation 2019/20	Trajectory 2020/21
Quality Indicator 5 We will further improve the identification and treatment of sepsis.	Baseline position for screening in the emergency department - Target for 2019/20 was >90%.	The sepsis screening was completed in 95.51% of cases audited. The target was met.	Our target for 2020/21 is >95%.
	Baseline position for sepsis screening inpatients wards Target for 2019/20 was >85%	The sepsis screening was completed in 86.61% of cases audited. The target was met.	Our target for 2020/21 is >95%.
	Baseline position for implementing the sepsis six bundle. **Emergency Department Target** for 2019/20 was >70%	The sepsis screening bundle was completed within one hour in 62.04% of cases audited. The target was not met.	Our target for 2020/21 is >80%.
	Baseline position for implementing the sepsis six bundle. **Inpatients wards** Target for 2019/20 was >90%.	The sepsis screening bundle was completed within one hour in 48.16% of cases audited. The target was not met.	Our target for 2020/21 is >95%.
Quality Indicator 6 We will improve further our compliance with screening for venous thromboembolism (VTE).	Our target for 2019/20 for an initial assessment for inpatients of patients >16 years old was 95%.	96.56% of patients were VTE risk-assessed on admission to hospital. The target was met.	Our target for 2020/21 is >95%.
Quality Indicator 7 We will improve permanent staffing levels.	Our Target position for 2019/20 was Nursing and Midwifery: 9.43%; Doctors 10%.	**Registered Nursing and Midwifery** 11.12% of posts remained vacant. The target was not met. **Medical and Dental** 7.93% of posts remained vacant. The target was met.	*This will continue to be monitored through Workforce metrics, but will not be a Quality Indicator for 2020/21.*

Priority 2 – Care that is Clinically Effective

Quality Indicator 2019/20	Target 2019/20	Evaluation 2019/20	Trajectory 2020/21
Quality Indicator 1 We will monitor and seek to reduce mortality rates for patients whilst under our care.	Target position for 2019/20 was 105.0	Our latest HSMR (for the period Jan-19 to Dec-19) is 102.47 and is 'as expected'. The target was met.	Our target for 2020/21 is a reduction of HSMR to 100.
Quality Indicator 2 We will implement clinical standards for seven-day hospital services.	Baseline position for 2019/20 was: ▶ All patients being reviewed within 14 hours of coming into our care ▶ All our patients have improved access to diagnostics ▶ All our patients have access to a consultant for direct interventions ▶ All our patients have ongoing consultant review.	▶ 63% patients being reviewed with 14 hours of coming into our care ▶ 100% of patients have improved access to diagnostics ▶ 100% of patients who have access to a consultant for direct interventions ▶ 88% of patients have ongoing consultant reviews. 2/4 targets were met.	Our target for 2020/21 is to ensure that: ▶ All patients being reviewed with 14 hours of coming into our care ▶ All our patients have improved access to diagnostics ▶ All our patients have access to a consultant for direct interventions ▶ All our patients have ongoing consultant reviews.
Quality Indicator 3 We will complete an annual programme of local clinical audits.	Our target position for 2019/20 was 80%.	Overall, 58% of the Better Outcomes for Patients Programme of audits were completed. The target was not met.	Our Target for 2020/21 is to complete at least 80% of the local audit plan, as outlined in year 3 of the Clinical Effectiveness Plan.

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

Quality Indicator	Target 2019/20	Evaluation 2019/20	Outcome 2020/21
Quality Indicator 1 We will respond to complaints within 25 working days of receipt and ensure we create learning from the themes from complaints.	Our target position for 2019/20 was >80%.	80.4% of complaints were responded to within 25 working days. The target was met.	Our target position for 2020/21 is >80%.
Quality Indicator 2 We will maintain the percentage of inpatients that would recommend our Trust to friends and family to 94% or above and will achieve recommended national response rates for emergency departments, inpatients, outpatient and maternity services.	Target for 2019/20 was 95%.	The percentage of people who have recommended our hospitals to friends and family: **Accident & Emergency** 82.29% The target was not met. **Inpatient / Day Case wards** 95.35% The target was met. **Maternity Services** 98.15% The target was met. **Outpatients** 92.92% The target was not met. *There will be a national change in process from April 2020, with a focus on recommended rates only.*	Our target for 2020/21 is that >95% of patients across all areas would recommend our Trust to friends and family.

2.4
Our three Quality Priorities and Key indicators for 2020/21

As part of our 2019/20 Quality Account, following consultation with our stakeholders, the Board of Directors agreed three quality priorities to be addressed via the Quality Account during 2020/21. These are shown below.

In this section we outline the progress that we have made during 2019/20 in delivering the priorities. Our Key quality indicators for 2020/21 have been chosen in relation to ***'what is important next year is to ensure we strive for excellence building further the improvement achieved ensuring we are consistently putting patients first and in so doing improve their experiences of the quality of care and treatments they receive?'.***

PRIORITY 1:
Care that is Safe

We will reduce avoidable harm to patients through five key quality indicators which will support the required improvements as outlined in the Quality Improvement Strategy.

Key quality indicators are:

1. Medicines incidents causing harm
2. Infection Prevention & Control
3. Sepsis
4. Nutrition and hydration
5. Hospital acquired functional decline (HAFD).

PRIORITY 2:
Care that is Clinically Effective

We will ensure our care is based upon sound evidence which is made up of three indicators.

Key quality indicators are:

1. Learning from deaths – we will reduce mortality rates
2. Further build on improvements of Clinical Standards of care for patients through implementation of Seven-Day Hospital Services
3. Build the annual programme of local clinical audits and improve clinical effectiveness of our services.

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

We will build on our person and family-centred approach by ensuring that we develop and promote a culture that supports continuous quality improvement along with delivering services that are responsive to the needs of our patients, carers and their families. We will assess in "real-time" our patients' and their carers' experiences of care and how effective they see this to be.

We will do this through four key quality indicators.

Key quality indicators are:

1. Improve and consistently maintain our recommended rates for care from patients and their carers within our Friends and Family Test by:

    a. Improve and consistently maintain patients' experience of their privacy and dignity while receiving care with us
    b. Patients will report that they consistently feel they are listened to with clear lines of communication with staff on treatment and condition
    c. Engage and understand the needs of patients who are receiving care at the end of their lives and ensure they are involved in, have control over decisions about their care

2. Embedding the Dementia bundle to all adult ward areas and consistently improve the outcomes of care for our patients with Dementia and their carers.

PRIORITY 1:
Care that is Safe

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

- Our position for 2019/20 was 12.18%
- Our Target for 2020/21 less than 11.71%

In 2019/20 we:

Achieved our target through implementing a number important mechanisms and practices:

- The Dashboard for the Medicines Safety Key Standards went live on WREN in September and has been proactively reviewed at the Medicines Safety Committee (MSC).
- There was active engagement of the medical and nursing staff within clinical divisions in the development of a medicine dashboard which enabled them to identify actions required to reduce patient harm and visualised reporting of outcomes in the medicines assurance reports for MSC.
- Focused on retraining of staff on the grading of medicine incidents correctly to support correct reporting of all incidents including near misses. This supported clarity in identifying themes and trends, and consequently share learning.

In 2020/21 we will:

- Continue to monitor the themes and trends of reported incidents causing harm to build further our learning and actions required to further improve.
- Monitor progress of clinical divisional action plans for medicines assurance reports via MSC and share good practice across the Trust.
- Create a healthy dialogue through the monthly review of the Medicines Safety Key Standards dashboard at the Medicines Safety Committee.
- Prioritise actions for high risk medicines which can cause harm e.g. insulin.
- Use quality improvement methodology to identify and implement risk mitigation strategies to reduce harm led by the newly established Safe Medicines Practice Group.

This indicator remains a key priority for 2020/21.

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

- Our position for 2019/20 was 9 falls with serious harm
- Our Target for 2020/21 is <6

In 2019/20 we:

Achieved our target through:

- Embedding and sustaining the campaign of 'Stay in the Bay' Trust wide, with staff being constantly present in the area of the ward where a patient has been assessed as having a risk of falls. Wards with a higher prevalence/ risk of falls also sustained 'find your feet' and 'kit where you sit'.
- Participating in the Falls Commissioning for Quality and Innovation (CQUIN); achieved compliance with the three high impact actions to prevent hospital falls and raised awareness of the actions identified as requiring improvement through senior nursing/AHP meetings.
- Participating in the first phase of the new continuous National Audit of Inpatient Falls (NAIF) with positive results published relating to the care and management of patients who sustain a hip fracture as a result of a fall in our hospitals.
- Developing a Falls Newsletter for staff and re-established the Falls Steering Group membership and terms of reference to include senior divisional representation to share updates and information relating to the falls work stream including achievements and lessons learnt.

In 2020/21 we will:

- Complete an audit of 'stay in the bay' initiative and create an action plan for further work required to provide assurance that they are embedded consistently into practice Trust wide.
- Ensure that actions required following completion of the Falls CQUIN are implemented and monitored to provide assurance that improvements are being made.
- Continue to participate in the second phase of the continuous National Audit of Inpatient Falls (NAIF) that now includes questions relating to falls prevention and action the areas of non-compliance to further improve the care and management of patients who sustain a hip fracture as result of a fall in our hospitals.
- Establish a governance process for all falls with harm to improve efficiency and effectiveness of the investigation and ensure learning is shared and actions are implemented.
- Continue with quarterly Falls Newsletters for staff and re-energise the Falls Steering Group to mandate divisional representation whether this is through a senior or falls champion
- Integrate Path to Platinum into the governance process to provide assurance that wards with a high prevalence/increase of falls are actively striving towards improvement but to also celebrate and share good practice where wards have a low prevalence/decrease in falls.
- Include falls e-learning within 'Essential to Role' training to increase Trust compliance and provide assurance that all registered healthcare professionals have a basic understanding of falls prevention in hospital.

We will continue to focus and build on the improvements achieved on this indicator through our QIP year 3.

QUALITY INDICATOR 3:

We will continue to improve on progress achieved in reducing the number of pressure ulcers (PU).

- Our position for 2019/20 was 305 pressure ulcers; a 6.64% increase
- Our Target for 2020/21 is no more than 274; a reduction of 10% on all PU

In 2019/20:

Whilst we did not achieve our target we set, this was due to a need as of April 2019 for the Trust to be compliant with the new NHSI Pressure ulcers: revised definition and measurement framework. This meant that all PU above a category 2 would be subject to an investigation to understand causative and contributory factors affecting why this incident had occurred. We were then able to identify what changes need to occur in order to prevent further incidents in the future and this will be shared/disseminated with the whole MDT via the Tissue Viability newsletter.

The change in reporting Trajectory target for 2019/20 based on NHSi framework that all PU to be reported has reflected in the increase of PU above a category 2.

However, the significant improvement and reduction in Serious Incidents relating moderate/severe harm caused by HAPU end of year is 6, showing a reduction/improvement of **45.45%**.

In 2020/21 we will:

- Every 4 months recognise and reward those inpatient areas who have achieved zero PU.
- Safer Care Accountability and Improvement Forum Launch to contribute to patient safety by receiving assurance of effective investigative process, the identification of themes/trends, lessons to be learnt and evidence of good practice. Outcomes will be reflected within the Path to Platinum Accreditation Programme.
- TV Team will build on the established Tissue Viability Education Programme in Pressure Ulcer Prevention and Management, Wound Management and Vac Competency available to all Allied Health professionals.
- Continue to champion and support the TV Champion programme across clinical areas, and provide Tissue Viability champions events and updates.
- Continue to provide every 4 months the Tissue Viability Newsletter for staff.
- We will continue to focus and build on the improvements achieved on this indicator through our QIP year 3.

QUALITY INDICATOR 4:

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

The specific areas we will focus upon are:

Clostridioides difficile Infection (CDI)

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

- Our position for 2019/20 was 61 cases.
- Our Target for 2020/21 is no more than 53*

**There were revised national definitions of Trust-attributable cases from April 2019, which now includes patient developing infection within 28-days of discharge from our hospitals including those readmitted with Clostridioides difficile within that time period.*

The estimated impact on us was an additional 9-12 cases per annum. Our 2019-20 national target was set at 53 cases to take account of this change (an increase from the target in 2018-19).

When patients with hospital-onset CDI are compared, the Trust achieved an improvement of 4.65% from the previous year. However, with the revised definitions in use we did not achieve our target.

In 2020/21 we will:

A range of actions have been implemented over the course of 2019/20 including work to improve the cleanliness of our wards and departments, and to ensure we use antibiotics in line with best practice. In 20/21 we will continue this work, building on the general increased awareness of good infection prevention practices achieved as a result of the COVID-19 pandemic

Focus on improving antimicrobial stewardship, ensuring prescribing and review of antibiotics in line with national guidance, further review of cleaning frequencies. Continued programme of cleanliness scrutiny meetings, maintaining hand hygiene training and audit programme.

E coli Bacteraemia

- Our position for 2019/20 was 55 cases
- Our target for 2020/21 is no more than 50

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

We are delighted to have achieved the reduction in E coli bacteraemia. We have actively participated in health economy work on the care of urinary catheters, and prevention of urinary tract infection as these are known risk factors for E coli bacteraemia.

In 2020/21 we will:

Explore other opportunities to target risk factors by continuing our work with partner organisations to identify causes of these infections.

MSSA Bacteraemia

- Our position for 2019/20 was 18 cases
- Our target for 2020/21 is no more than 10 cases

We achieved a 25% reduction in MSSA bacteraemia in 2019/20 compared to the previous year, though did not meet our target of 10 cases. We have focused work on improving the care of medical devices such as intravenous drips in order to reduce these infections. We have adopted the Aseptic Non-Touch Technique (ANTT) training programme to help us do this, as well as regular monitoring to ensure care is achieving best practice standards.

In 2020/21 we will:

Continue this focus, extending our ANTT programme to all groups of staff.

MRSA Bacteraemia

- Our position for 2019/20 was 3 cases
- Our target for 2020/21 will remain at 0 cases

We have seen MRSA bacteraemia in 2019/20 as a result of contamination of blood cultures when the blood samples have been taken.

In 2020/21 we will:

Focus part of our ANTT programme on staff who take blood culture samples, to ensure they do not accidentally contaminate them.

Hand Hygiene

- Our position for 2019/20 was 98.23%
- Our target for 2020/21 is above 97%

Hand hygiene is the most important action to prevent cross-infection. We are delighted that we have achieved high levels of hand hygiene throughout 2019/20.

In 2020/21 we will:

Continued hand hygiene training and awareness campaigns. This will build on the very high profile of hand hygiene which has developed as a result of the COVID-19 pandemic during the latter months of 2019/20.

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

This indicator remains a key priority for 2020/21.

QUALITY INDICATOR 5:

We will further improve the identification and treatment of sepsis.

Our position for 2019/20:	Our Target for 2012/21 is:
Baseline position for screening in the emergency department 2019/20: >90%	Target for 2020/21is >95%
Baseline position for sepsis Screening Inpatients wards 2019/20: >85%	Target for 2020/21is >95%
Baseline position for implementing the sepsis six bundle - Emergency department 2019/20: >70%	Target for 2020/21is >80%
Baseline position for implementing the sepsis six bundle - Inpatients wards 2019/20: >90%	Target for 2020/21is >95%

In 2019/20:

The provision of care for individuals who have flagged as potentially suffering from Sepsis has been key and critical. Delivery has previously focused on ensuring baseline screening has been undertaken with success.

In 2020/21 we will:

The next step is to ensure the actions in response to the screen are accurately recorded and follow national guidance. The addition of a QRS code to the Sepsis 6 form will allow easy identification of the relevant cases for review and audit.

Focus on recording the actions in response to the trigger of the Sepsis 6 warning. The ability to identify the forms in the EZNotes portfolio will allow greater scrutiny and there will be plan to provide monthly feedback to services with an action plan when targets are not achieved.

This indicator remains a key priority for 2020/21.

QUALITY INDICATOR 6:

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

- Our position for 2019/20 was 96.56%
- Our Target for 2020/21 is >95%

The baseline assessment for those admitted was met. In 2019/20 we provided a focus for staff through divisional Quality Improvement Plans (QIPs).

In 2020/21 we will:

Focus on the 24 hour review as part of the digital transformation. In addition with the re-establishment of the Trust Thrombosis Committee, there will be a focus on Hospital Acquired Thrombosis (HAT) which will be reported every month to complete the range of metrics which monitor this aspect of care.

We will continue to focus and build on the improvements achieved on this indicator through our QIP year 3.

New indicators for 2020-21

QUALITY INDICATOR 7:

We will ensure that the nutrition and hydration needs of patients in hospital are met.

Our position for 2019/20:	Our Target for 2012/21 is:
N/A (not included as new quality objective)	100% of patients will have an assessment and documentation of their nutritional and hydration needs >90% of patients, who in their care plans are identified as requiring this to meet their needs will have a fluid balance chart and food diary

We believe strongly in the importance of patients eating and drinking well whilst in hospital. Both eating and drinking are imperative in enhancing a person's health and wellbeing, and help to prevent further illness. Dehydration can have a long term impact on a person's recovery from illness and treatments – in turn, a balanced diet provides patients in hospital with the nutrients and energy to function effectively and can have a long term impact on their recovery from illness and treatments.

In 2020/21 we will:

- Through the established three times a week patient audits on the implementation and documentation of the Malnutrition Universal Screening Tool (MUST) we will identify in real time approaches required to meet patients' needs and strive for excellence in their care each and every time, and identify those patients who through early warning interventions require additional approaches in their care.
- 'MUST' is a five-step screening tool to identify adults who are malnourished, at risk of malnutrition (undernutrition), or obese. It also includes management guidelines which can be used to develop a care plan.
- Further enhance the knowledge and skills of staff in caring for patients' nutrition and hydration needs through completion of E – learning resource is rolled out for 90% nursing and health care professionals.
- Complete a 6 monthly audit of fluid balance charts and food diaries. This will provide the evidence on monitoring and assurance levels of care in practice.
- Complete the annual Patient Led Assessment of Clinical Environment (PLACE) we will ensure clinical environments are conducive for patients to take their meals
- Continue to gain feedback from patients/ service users about their experience of food and drink.

QUALITY INDICATOR 8:

We will develop a process of recognition of patients who have a prolonged length of stay which could result in the experience Hospital Acquired Functional decline (HAFD) and raise the awareness among staff.

Our position for 2019/20:	Our Target for 2012/21 is:
2019/2020 – N/A (not included as new quality objective)	Measured through a subset of indicators from the Home First Frailty/ HAFD Dashboard which will be: ▶ % Emergency admissions 75+ ▶ % of patients 75+ discharged with Length of Stay (LOS) 0 days ▶ % of patients 75+ discharged with LOS 1 - 2 day ▶ % of patients 75+ discharged with LOS 3+ days

Our position for 2019/20:	Our Target for 2012/21 is:
2019/2020 – N/A (not included as new quality objective)	▶ Number of patients 75+ with LLOS + 7+ days ▶ Number of patients 75+ with LLOS 21+ day ▶ Total time in A&E 95th percentile Trust daily

We know that keeping patients in a hospital bed when they don't need to be in one can actually slow down their recovery, especially for older or frail patients – this is known as Hospital-acquired Functional Decline (HAFD).

In 2020/21 we will:

As part of our HomeFirst Worcestershire programme we will develop a way of recognising HAFD as quickly as possible to prevent harm to our older patients .

- We will further educate our clinical staff on the best-practice for managing frail patients and the signs to look out for to help spot Hospital-acquired Functional Decline.
- Record through our incident management system patients who exceed the clinically expected length of stay and have potentially experienced HAFD to be able to determine if any harm has been caused and the treatment level that is needed.
- Establish Trust wide education in frailty management (frailty sensitive approach) and awareness of HAFD.
- Communicate HAFD widely to contribute to a social movement of awareness and prevention.

PRIORITY 2:
Care that is Clinically Effective

QUALITY INDICATOR 1:
We will monitor and seek to reduce mortality rates for patients whilst under our care.

- Our position for 2019/20 is 102.47 and is "as expected"
- Our target for 2020/21 is a reduction of HSMR to 100.

In 2019/20 we:

The Trust has made substantial improvements in respect of its mortality metrics throughout 2019/20. Our HSMR, having previously peaked at 113.2 is currently 100.32 (Mar-19 to Feb-20). This is a marked shift from being an outlier to close to the 'ideal' HSMR of 100.

Underlying these improvements are a reduction in crude mortality rate to 2.69% (was 3.06%); Increased number of patients treated; Reduction in the difference between the difference between the deaths 'expected' by the HSMR and those recorded by the Trust to single digits (5, down from 180 in March 2019).

Through cultural engagement we have understood the problem and identify areas for improvement; Benefits from system-wide programmes such as ReSPECT; Smarter, more completely coded episodes; Better clinical care resulting in fewer in-hospital deaths.

In 2020/21 we will:

- Mitigate any impact that Covid-19 has had/is yet to have on our mortality measures.
- Maintain focus on mortality trends and identifying areas for improved patient care.
- Maintain earlier good performance re: clinical coding.

- Aim for HSMR and SHMI to be comfortably within 'expected' levels across both main sites.
- Continue to complete mortality reviews in a timely way, clear backlog an use learning to improve care.
- Further develop the Medical Examiner roles to support MCCD, and the bereavement process and families.

This indicator remains a key priority for 2020/21.

QUALITY INDICATOR 2:

We will implement clinical standards for seven day Hospital services.

Our baseline position for 2019/20:	Our Target for 2012/21 is to ensure that:
▶ 63% patients being reviewed with 14 hours of coming into our care	▶ All patients being reviewed with 14 hours of coming into our care
▶ 100% of patients have improved access to diagnostics	▶ All our patients have improved access to diagnostics
▶ 100% of patients who have access to a consultant for direct interventions	▶ All our patients have access to a consultant for direct interventions
▶ 88% of patients have ongoing consultant reviews	▶ All our patients have ongoing consultant reviews

We have met 2 / 4 Standards.

In 2019/20:

Due to the COVID-19 incident response it was decided to pause the audit data collection of clinical standards 2 and 8, although, it will be possible to retrospectively review performance in early 2020/21. During the COVID -19 response actions the acute medicine consultants where scheduled to work 12 hours per day which is expected to have improved performance against clinical standard 2. This will be retrospectively reviewed in 2020/21. Despite the COVID-19 response, the trust improved the pre COVID-19 performance against the standard of patients being reviewed within 14 hours of admission from 51% in October 2019 to 67% in January 2020.

In 2020/21 we will:

We will review the developed set of Internal Professional Standards for non-elective attendances and admissions. These went live in February 2020, and develop a new non-elective vision at the Alexandra Hospital site, which will be replicated at the Worcestershire Royal Hospital site and will remove the need for Emergency Departments to refer to specialities for assessment/ opinion. This model will ensure all medical patients have a senior review within 14 hours of admission.

We will build on the developed set of Internal Professional Standards for inpatients.

Daily consultant reviews throughout inpatient admission will be addressed through the 2020/21 consultant job plan reviews which will ensure daily board rounds are embedded into all inpatient ward areas. This will be monitored through the Red2green workstream of the HomeFirst Worcestershire Programme, reporting back to the CEO via HomeFirst Worcestershire Board.

This indicator remains a key priority for 2020/21.

QUALITY INDICATOR 3:
We will complete an annual programme of local clinical audits.

- Our position for 2019/20 was 74%
- Our target position for 2020/21 is 80%

In 2019-20 we will:

Overall 16% fewer Better Outcomes for Patients Programme (BOPP) audits have been completed at the end of Quarter 4 2019/20 compared to Quarter 4 in 2018/19, with all clinical divisions completing a lower percentage of their BOPP than at the close of 2018/19. We know from previous years that many audit projects are planned to complete during March, and that was the case in March 2019, with 24% of the plan being completed during the last month of the year. The COVID-19 pandemic and the enormous pressure this has put clinicians under has had an impact in the ability to complete clinical audit projects. It has been crucial that clinical audit has not impacted on clinician's ability to provide critical care for our patients. However, it is notable that despite the impact of the pandemic, 18% of the audit plan was taken to completion during March 2020, which is an achievement.

It is important to note that while 31st March 2019 denotes the year-end, clinical audits that are in progress will continue to progress. Consequently while 58% of the BOPP has been completed to 31st March 2020, as the 'in progress' audit projects complete, the percentage of 2019/20 BOPP audits actually completed will change. For example, while the year-end reported figure for 2018/19 was 74% for BOPP completion, throughout 2019/20 as more audits completed, we can now report that 81% of the 2018/19 BOPP were actually completed.

In 2020/21 we will:

- Ensure that the clinical audit plan of work is continuous, rather than the historic annual start/stop process. This is important as we adopt QI methodology, as improvement cycles may take some time.
- Review our training packages fully to ensure they align with quality improvement methodology.
- Support Clinical Audit Leads to adopt QI methodology when carrying out local clinical audit and when responding to national clinical audit reports.
- Update the Clinical Audit Policy and developing a new Support for Junior Doctors in QI/Clinical Audit' Policy, together with a supporting QI/Clinical Audit Handbook, to ensure that the Trust moves forward with using QI methodology to ensure clinical audit drives improvement.
- Seek to finalise phase 1 of the Clinical Audit Tracking System, with the support of IT, and develop the National Audit module as phase 2.

This indicator remains a key priority for 2020/21.

PRIORITY 3:
Care that is a Positive Experience for Patients and their Carers

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

- Our Baseline Position for 2019/20 was 80.4%
- Our target position for 2020/21 is 80%

We have sustained for two consecutive years, an improved complaint performance on previous years. The focus will be to maintain performance consistently throughout the year. This will be supported by an increased focus on the quality of responses and a reduction in the number of complaints returned from those who are not

satisfied with the responses. Our clinical divisions have focused on improving their quality and timely response in written responses alongside the early, active engagement with complainants, continuing with the successful close working of the Patient Services team to support early resolution where appropriate. From listening and learning from our patients and carers on their issues and complaints we know we must improve their experiences of our abilities to communicate effectively with them on the care and treatments.

We will reduce the number of complaints returned from those who are not satisfied with the response.

- Our Baseline Position for 2019/20 was 13.25%
- Our target position for 2020/21 is 10%

We have sustained year on year improvement for all cases received and reopened. This has decreased from 16.4% in 2018/19 to 13.25% 2019/20. The rate of reopening has remained steady throughout the year.

In 2020/21 we will:

- Work together with our volunteers and staff focus groups, quality reviews, complaints, processes and responses. The outcomes will directly inform a staff training programme and actions throughout the year.
- Develop new mechanisms to regularly review response drafts in detail to provide scrutiny and to improve quality and content.
- Support Divisional teams to make early telephone contact to complainants to pursue informal resolution of complaints and devise mechanisms to assist with the resolution of difficult cases and provide feedback on performance.
- Review all closed cases and ensuring detailed completion of the "Lessons Learnt" Training will be provided for any incomplete entries alongside regular supportive discussions and specific target setting; mentoring, coaching and training will be implemented with good practice sharing.
- Survey our complainants to ask them how they felt about the process and capture improvements and recommendations. Responses will form targeted training and action plans.
- Provide monthly reports with specific issues experienced, lessons learned and actions taken to be shared Trust wide.
- Actively network with local trusts as well as regionally and nationally to share good practice.

We will continue to focus and build on improvements achieved for this indicator through our QIP Year 3.

QUALITY INDICATOR 2:

We will maintain the percentage of inpatients and all visitors to our hospitals who would recommend our Trust to friends and family to 94% and we will maintain baseline response rates for emergency departments, inpatients, outpatients, paediatrics and maternity services. We will specifically focus on ensuring that the public is encouraged and aware of how they can feedback to us and we will demonstrate that we are listening and sharing what we are being told.

- Baseline position for "recommended rates" **95.35% for Inpatients**
- Target for 2020/21 is 95%

In April 2019, national reporting for Friends and Family Tests changed, with a focus purely on recommended rates.

We are pleased that from the results of the Picker inpatient adult survey (2019) it shows a substantial improvement in patients reporting that they are being asked to give views on the

quality of their care. This rose from **11%** in 2018 to **18%**, which is above the national average of **14%**. However we know we can do better as **62%** of patients within the A&E department were given the right amount of information about their treatment or condition compared to **69%** in 2018 (the national average rate **75%**).

In 2019/20:

We did this by:
Ensure we maximize and maintain privacy and dignity throughout a patient's time with us.

We are pleased that the results of the Picker surveys for inpatients and maternity show that:

- 97% of adult patient in hospital patients reported they were treated with respect
- 94% of patients who attended our Emergency department reported they were treated with respect and dignity
- 93% parents reported their child in our children's wards reported their child had privacy when they received their care and treatments
- 98% of Women in our maternity study felt they had been treated with respect

We have achieved this through:

- Continually raising awareness amongst staff of the importance of privacy and dignity for all our patients. Our induction programme for staff when they join the Trust provides an expectation of the standards expected from them.
- Sharing the positive feedback of our Friends and Family test with staff as well as areas of real time.

We will continue to strive for each and every contact counting in meeting this important element of care for patients therefore we will:

In 2020-21:

- Create a new online educational tool to support the staff induction and ongoing learning to raise awareness amongst staff and volunteers on the importance of privacy and dignity for all our patients. This work will be monitored and supported through the ward accreditation Path to Platinum Programme.
- Ensuring that we continue to learn from Voices bereavement questionnaires and feedback and monitor associated improvements.
- Through our education and learning approaches we will ensure staff will always ask who the patient or service user would like their information to be shared with
- Always involve patients and service users in the care planning process
- Where a patient or service user relies on someone to support them with their daily activities, staff will always identify and involve them in the care planning, upon consent
- Implement an electronic Friends and Family app, known as "I want Good Care", that provides real time feedback and reports for staff.
- Improve the access for our patients with disabilities from implementation of electronic app known as "accessible".
- Implement our Volunteering Strategy that will provide support for patients on wards.

This indicator remains a key priority for 2020/21.

Positive Feedback we have received during 2019/20:

Excellent ★★★★★

Posted 06/12/2019

Went into Kidderminster Hospital for day surgery and then stayed overnight. Every single person I had contact with, from the receptionists, nurses, doctors, surgeons, phlebotomists, etc. were incredibly friendly, helpful and caring. The care was astounding. The facilities were clean and everywhere well-equipped. Could not ask for a better experience. Thank you so much to everyone who made such a potentially horrid experience so much easier.

Excellent Care from the Cardiac Catheter Suite Team

Posted 13/06/2019

I went in for Angioplasty on 12 June 2019. The experience from start to finish was excellent. Very clear medical briefings from the Consultants and Nurses. The Consultant explained what he had found and was able to do by way of unblocking an artery while in the theatre. The technical equipment seemed state of the art. The recovery process was very efficiently handled. All the staff were friendly and caring. There was a strong sense of them working as a team. I don't think that their performance could be improved. Well done and thank you to the NHS!

Cardiology /Laurel ward one

Posted 22/05/2019

Arrived at Worcester Hospital with chest pains on 10/5/19 and quickly became very poorly, the speed, calmness and professionalism of the staff was outstanding and no doubt saved my life. When I came to in ICU the staff were milling around talking to me and my partner making sure we were both OK, this is probably the norm to them but to us it was amazing and comforting. After I was moved to Laurel Ward 1 where the care and comfort I received was so nice, always making sure I was OK and tracking down some reading material for me to relieve the boredom. The food was top notch and always served with a smile, plus tea and coffee served regularly. ALL staff deserve much credit, never rushing off after their shift has finished, finding time for much appreciated small talk. Can't speak highly enough of them, I don't ever want to be in that position again with my illness but I would feel at ease knowing how good and caring they are. Thank you all.

Members of the colorectal nursing team who were chosen as national finalists in the Nursing Times Awards.

Developments and highlights from 2019/20

Cardiac Physiologist, Amanda Hayden

Consultant Radiologist, Dr Ashim Lahiri

April 2019

- **Cardiac Physiologist, Amanda Hayden receives international recognition** after being asked to present about a life-saving heart case performed in Worcester, at the World Cardiology Conference in America.

- **Consultant Radiologist, Dr Ashim Lahiri receives 'Frank Farr Award'** by the regional West Midlands Association of Radiologists, in recognition of his 'exemplary commitment and contribution to training Radiologists in the West Midlands'.

June 2019

- **The catering team at the Alexandra Hospital receive a national prize for the quality and sustainability of food they produce**. The Soil Association's 'Food For Life Served Here' award is a widely respected acknowledgement of raising standards for food quality and sustainability in both public and private sector catering.

- **A 'Cake and Shake' scheme is put in place on Ward 12 at the Alexandra Hospital**. The daily slice of cake and a milkshake helps frail and elderly patients recover more quickly.

- **Maternity Bereavement team become national finalists in the NHS Parliamentary Awards.**

Members of the catering team at the Alexandra Hospital.

July 2019

- **The colorectal nursing team are chosen as national finalists in the cancer nursing category in the Nursing Times Awards**. The team were selected for the improvements they have made following the successful pilot of a new telephone triage system which has helped reduce waiting times for patients with suspected bowel cancer.

- **Julia Rhodes (pictured left) received the prestigious Society of Radiographers' Silver Medal award** after nominations from across the region.

Staff on Ward 12 at the Alexandra Hospital delivering their 'Cake and Shake' round.

August 2019

- **The national Infection Prevention Society (IPS) Awards chooses Sue Arthur among the finalists in the link practitioner of the year category**. Sue had recently received an internal award recognising her efforts and leadership to achieve high standards of infection prevention, improving patient safety and providing the best care for patients.

Lead Radiographer, Julia Rhodes

Ward Housekeeper, Sue Arthur.

September 2019

- **The team running the Bowel cancer screening programme in Herefordshire and Worcestershire celebrates 10 years of helping to detect cancer earlier.** The programme has proved to be a resounding success screening over 402,000 patients since its launch.

- **Bereavement support midwife Ashlea Gormley is nominated for Midwife of the Year in the annual Butterfly Awards**, which celebrates the survivors and champions of baby loss.

- **The Trust's overall rating is lifted from 'Inadequate' to 'Requires Improvement' in a CQC report.** The report showed improved ratings in 41 out of 79 categories rated, including double rating uplifts in 9 areas.

October 2019

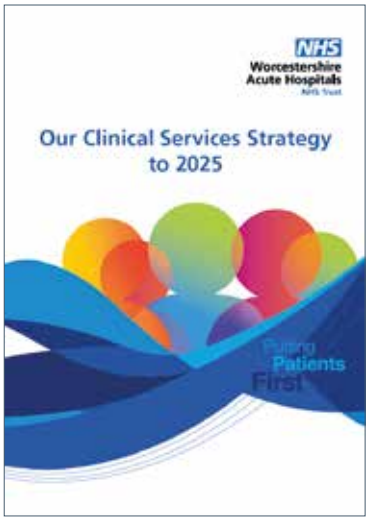
- **The Trust holds its first 'pyramid week'** - a chance to collectively remind colleagues of our purpose, vision and strategic objectives and celebrate how we are working towards delivery of these through our improvement plans, supporting strategies and 4ward behaviours to ensure we are always Putting Patients First.

- **A new process to support people to get the care they would want in a medical emergency is introduced across healthcare settings in Worcestershire.** The Recommended Summary Plan for Emergency Care and Treatment, or ReSPECT, creates personalised recommendations for a person's clinical care in a future emergency in which they are unable to make or express choices.

- **Endoscopy services awarded national accreditation** by the Joint Advisory Group (JAG) of the Royal College of Physicians and British Society of Gastroenterology after a rigorous assessment process.

November 2019

- **The Trust's Clinical Services Strategy is signed off.** The strategy determines how and where our services will be delivered over the next five years.



- **A £4.2million investment in endoscopy** means that patients having endoscopy procedures for gastrointestinal, respiratory or urology-related conditions will receive more advanced investigations, including high-definition cameras and top-of-the-range optical technology – all of which allow for clearer examination of patients.

December 2019

- **A new surgical assessment pathway is launched at Worcester.** The aim of the new dedicated assessment areas in the Surgical Clinical Decision Unit (SCDU), is to help our number one priority of improving patient flow by enabling patients to be assessed by a surgical registrar, with a view to referring them to one of our daily clinics for continued investigation and advice if they do not need admission to a bed.

- **Team Ruby and Team Sapphire – Continuity of Carer midwives from Worcestershire Acute Hospitals NHS Trust – are nominated for Team of the Year in the RCM Awards 2020**. The roll out of the continuity of carer model – which aims to ensure that more mums-to-be see their named midwife, or a midwife from a small team, right through their pregnancy journey including birth – aim to ensure most pregnant women receive their care this way by 2021.

January 2020

- Patients, families and carers affected by cancer benefit from a new monthly programme of health and wellbeing events across Worcestershire aimed at encouraging a positive approach to moving forward after diagnosis. The events offer a 'one stop shop', providing advice and information across a range of topics.

- New mums who are separated from their babies immediately after birth are given iPads to help them bond with their child via a live video link. Babies that suffer complications or premature babies are often sent straight to a neonatal unit so they can receive specialist care, meaning that new mums can often spends hours, without being able to hold or bond with their new-born baby.

- Consultant Anaesthetist, Dr Satinder Dalay was awarded the highest honour by the Association of Anaesthetists at their 2020 meeting.

- Procurement Team (pictured left) receive national accreditation by Department of Health and Social Care.

February 2020

- Nurses and social care staff start working together to help ensure that hospital patients who are fit to go home, get there in a safe and timely way. The Onward Care Team (pictured above) ensure discharge from hospital is timely and effective, in turn reducing delays for people accessing urgent or emergency care.

- Two new, additional wards open at Worcestershire Royal Hospital, providing an extra 33 beds.

March 2020

- Kelly Bill, a Clinical Scientist from Worcestershire Royal Hospital, is shortlisted for the national Healthcare Scientist of the Year award. She was nominated by her colleagues after introducing a ground-breaking new way of assessing patients in the Neurophysiology department in Worcester.

New indicators for 2020-21

QUALITY INDICATOR 3:

We will ensure patients with Dementia and their carers feel that have received care that positively improves their outcomes as reported within the national dementia audit through implementing consistently the dementia bundle with every patient admitted under our care.

- 2019/2020 – N/A (not included as new quality objective)
- Our Target for 2020/21 is 80%

We believe if we can get the standards of care right for our patients with Dementia and their carers, then the fundamental standards of care for all patients can be achieved. It is reported that people with dementia in acute hospitals experience poorer outcomes for all types of admission, stay longer in hospital, and are more likely to be discharged to a care home rather than to their own home, as highlighted in Alzheimer's Society (2009) Counting the cost: Caring for people with dementia on hospital wards. London: Alzheimer's Society and Suarez P, Farrington-Douglas J. (2010) Awareness: improving hospital care for people with dementia. London: eNHS Confederation.

Implementation of a small set of evidence-based practices and interventions can have a positive impact on the quality of care and safety for patients with dementia. Therefore, we will embed the use of the Dementia/Delirium Care Bundle to provide a consistent and reliable culture of care in which patients' needs are met as part of routine practice.

In 2020/21 we will do this by:

- Empowering ward teams to deliver person-centred, evidence-based care as described in the Dementia/Delirium Care Bundle and auditing its use.
- Providing a gateway for specialist advice from Dementia Clinical Nurse Specialists.
- Ensuring that training compliance is improved by including the Health Education England Dementia Training Standards Framework E-Learning in Essential to Role training monitored on ESR.

QUALITY INDICATOR 4:

Ensuring patients and their carers feel listened to and have clear lines of communication with staff about their condition, treatment and care.

Having meaningful conversations are fundamental to the delivery of excellence in health care. Unless we listen and engage, we cannot be certain that we are meeting the needs of the patient we serve. A genuine culture of involvement will enable the Trust to learn and grow in line with our values. In order to be meaningful, engagement needs to be genuine, not tokenistic, and needs to ensure that all members of the community have an equal opportunity to be heard.

We will do this by:

- We will create a front of house PALS service to increase our ability to be an accessible and responsive Trust.
- We will devise ways to clearly share with the public how we are listening "You Said We Did" and we will underpin initiatives with our ward accreditation Path to Platinum programme.
- We will implement training programmes on customer care and communication which will be designed following feedback through patient services and FFT.
- We will continue to deliver and develop our #togtherwearepatientexperience campaign, supporting Patient Experience Champions across our hospitals.

- We will devise new ways to share our compliments within and outside the Trust.
- We will make it easier to share feedback "every day and any day" at our Trust by increasing the visibility of the different ways that the public can feed back on their experience using a variety of media and methods.
- We will develop our commitment to equality and diversity by appointing a lead and improving accessibility across our services.

At the beginning of March 2020 through our experiences during the COVID-19 pandemic we had to take the difficult decision to restrict relatives and friends visiting patients while in hospital. Recognising the impact this had for them at such emotionally difficult time, we implemented a number of initiatives aimed to support family keeping connected. These being:

- Introduction of iPads on wards to enable virtual visiting via a digital app.
- Letters from home
- Hearts in Hands

We have learnt, and are still learning, so much from the experiences of caring for patients during the unprecedented demands of COVID-19. The importance of providing care that is a positive experience for all patients and their carers for those with and following a diagnosis of Coronavirus and those with non-Covid diagnoses has profiled the importance of two new indicators for 2020/21.

QUALITY INDICATOR 5:

We will engage with and understand the needs of patients who are receiving care at the end of their lives and will offer services to meet their physical, psychological, social and spiritual needs and will ensure they are involved in, have control over decisions about their care.

Quality Indicator 5	
2019/2020 – N/A (not included as new quality objective)	Our targets for 2020/21 are: Indicators of success ▶ Increase in engagement in advanced care planning including the uptake of ReSPECT and AMBER Care Bundle for those with uncertain recovery; ▶ Compliance with the use of the Individualised Last Days of Life for Adults Care plan for those identified as being in the last days of life; ▶ Constructive participation in local and national end of life audits; ▶ Positive feedback from patients and those important to them; ▶ Reduction in end of life care related complaints; ▶ Engagement and increased uptake of end of life education and training amongst health care professionals.

In 2020/21 we will do this by:

Individualised Patient Care

- We will continue to promote the delivery of individualised end of life care; engaging patients in discussions and plans for their care, in keeping with national recommendations, trust strategy and policy (including the use of ReSPECT & AMBER Care Bundle).
- We will continue to provide seven day a week face to face specialist palliative care service for hospital inpatients.
- We will promote the sensitive exploration of physical, psychological, spiritual, cultural and social needs of dying patients and offer appropriate support with these needs.

Supporting families and carers

- We will promote the support to those people important to the patient during the last days of life of the patient.
- We will promote the use of available technology to aid communication with staff, patients and those important to them when face-to-face visiting not possible.
- We will identify ways of improving the support to those important to the patients including: developing carers' rooms and carers' comfort packs.
- We will ensure bereavement needs are considered and make arrangements for appropriate support to be offered.

Supporting and empowering staff

- We will ensure leadership for End of Life Care within the Trust is coordinated by an End of Life Steering Group.
- We will ensure all staff are offered high quality palliative and end life care education and development opportunities, including utilising approaches such as mandatory training and 'SAGE & THYME' communication courses.

Communication and information

- We will work collaboratively with community palliative care services to ensure continuity of palliative care on change of care location.
- We will provide patients and those important to them written information regarding end of life care and advanced care planning in an accessible form.
- We will continue to use of Countywide shared palliative electronic record to promote seamless transitions of care between palliative care services.

2.5
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 the 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 3
Trust Board's Quality Dashboard

NHS Outcomes Framework Core Quality Account Indicators

Domain	Indicator	Current Performance	National average value	Where applicable		Trust statement	Previous values (where data available)		
				Best NHS performer	Worst NHS performer				
Preventing people from dying prematurely	SHMI value and banding Published: 11th June 2020	1.0590 Banding 2 – 'as expected' *(Feb-19 to Jan-20)*	—	0.6752	1.2002	*Worcestershire Acute Hospitals NHS Trust considers that this data is as described for the following reasons:* An improvement in timely care for patients whose condition deteriorates is demonstrated by a reducing SHMI. *Worcestershire Acute Hospitals NHS Trust intends to take the following actions to improve this number and so the quality of its services, by:* See quality account priorities.	1.1440 Banding 1 – 'higher than expected' (Apr-18 – Mar-19)	1.0584 Banding 2 – 'as expected' (Apr-17 – Mar-18)	1.0667 Banding 2 – 'as expected' (Apr-16 – Mar-17)
	% of deaths with either palliative care specialty or diagnosis coding Published: 11th June 2020	34.54% *(Feb-19 to Jan-20)*	36.64%	59.12%	9.22%	*Worcestershire Acute Hospitals NHS Trust considers that this data is as described for the following reasons:* Data quality is good but there is room for improvement. *Worcestershire Acute Hospitals NHS Trust intends to take the following actions to improve this number and so the quality of its services, by:* The Trust will continue to improve this performance during 2020/21.	33.63% (Apr-18 – Mar-19)	28.50% (Apr-17 – Mar-18)	28.47% (Apr-16 – Mar-17

Domain	Indicator	Current Performance	National average value	Where applicable		Trust statement	Previous values (where data available)		
				Best NHS performer	Worst NHS performer				
Preventing people from dying prematurely	Patient-reported outcome score for hip replacement surgery – adjusted average health gain (Oxford Hip Score)	22.532 Not an outlier (18/19)	22.258 (18/19)	25.377 (18/19)	18.649 (18/19)	*Worcestershire Acute Hospitals NHS Trust considers that this data is as described for the following reasons:* Outcomes are slowly improving and are above the national average. *Worcestershire Acute Hospitals NHS Trust intends to take the following actions to improve this number and so the quality of its services, by:* See Quality Account priorities – plans to improve access to theatre aim to create further improvement.	22.965 Not an outlier (17/18)	21.508 Not an outlier (16/17)	20.754 Not an outlier (15/16)
	Patient-reported outcome score for knee replacement surgery – adjusted average health gain (Oxford Knee Score)	18.049 Not an outlier (18/19)	17.197 (18/19)	19.979 (18/19)	13.546 (18/19)	*Worcestershire Acute Hospitals NHS Trust considers that this data is as described for the following reasons:* Planned knee surgery has improved as patient flow to the theatre has been addressed. *Worcestershire Acute Hospitals NHS Trust intends to take the following actions to improve this number and so the quality of its services, by:* Improving flow so improving the timeliness of treatment and avoiding pain or deterioration for waiting patients.	17.022 Not an outlier (17/18)	16.413 Not an outlier (16/17)	16.087 Not an outlier (15/16)

Domain	Indicator	Current Performance	National average value	Where applicable		Trust statement	Previous values (where data available)		
				Best NHS performer	Worst NHS performer				
Preventing people from dying prematurely	28-day readmission rate for patients aged 0 -15	Nationally now reporting "Emergency readmissions within 30 days of discharge from hospital" – however only published as part of Outcomes framework so is at CCG or LA level not Trust.	National publications of this data were suspended in 2013			*Worcestershire Acute Hospitals NHS Trust considers that this data is as described for the following reasons:* Children's services in all specialties strive to ensure readmissions are avoided to avoid disruption to children and families. *Worcestershire Acute Hospitals NHS Trust intends to take the following actions to improve this number and so the quality of its services, by:* Ensuring this performance is maintained.	0.02% (18/19)	0.02% (17/18)	0.00% (16/17)
	28-day readmission rate for patients aged over 15 years		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.	10.80% (18/19)	9.62% (17/18)	9.53% (16/17)

Domain	Indicator	Current Performance	National average value	Where applicable		Trust statement	Previous values (where data available)		
				Best NHS performer	Worst NHS performer				
Ensuring that people have a positive experience of care	Responsiveness to inpatients' personal needs – CQC national inpatient survey score Hospital stay: 01/07/2018 to 31/07/2018; Survey collected 01/08/2018 to 31/01/2019 Published May 2020	64.2	67.2	58.9	85.0	*Worcestershire Acute Hospitals NHS Trust considers that this data is as described for the following reasons:* The Trust strives to maintain all elements of patient experience, despite acute bed pressures. *Worcestershire Acute Hospitals NHS Trust intends to take the following actions to improve this number and so the quality of its services, by:* Improvements to the patient flow described in Quality Account priorities.	66.2 (17/18)	65.2 (16/17)	66.5 (15/16)
	The percentage of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends.	66.3%	70.5%	87.4%	39.7%	*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.	58.1% (2018)	56.8% (2017)	55.9% (2016)

Domain	Indicator		Current Performance	National average value	Where applicable		Trust statement	Previous values (where data available)		
					Best NHS performer	Worst NHS performer				
Ensuring that people have a positive experience of care	Inpatient Friends & Family test	% Recom-mend	95%	96%	100.00%	73%	*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.	94.09% (Mar 19)	93.58% (Mar 18)	95.05% (Mar 17)
		Response Rate	34.5%	23.7%	100%	1.1%		18.63% (Mar 19)	11.25% (Mar 18)	11.25% (Mar 17)
	A&E Friends and Family test	% Recom-mend	85%	85%	99%	40%	*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.	82.0% (Mar 19)	73.75% (Mar 18)	97.59% (Mar 17)
		Response Rate	18.8%	12.1%	44.4%	0.00%	*Worcestershire Acute Hospitals NHS Trust considers that this data is as described for the following reasons:* Action to improve patient flow – see Quality Account – will improve patient experience in ED and encourage staff to support work to improve response rates.	5.87% (Mar 19)	3.59% (Mar 18)	4.15% (Mar 17)

Domain	Indicator	Current Performance	National average value	Where applicable		Trust statement	Previous values (where data available)		
				Best NHS performer	Worst NHS performer				
Treating and caring for people in a safe environment and protecting them from harm	% of patients risk-assessed for venous thromboembolism Q4 not published yet – NB no date given as VTE collection was ceased in March due to COVID-19)	96.39% (Q3 19/20)	95.33% (Q3 19/20)	100.00% (Q3 19/20)	71.59% (Q3 19/20)	*Worcestershire Acute Hospitals NHS Trust considers that this data is as described for the following reasons:* VTE assessment rates remain below the national average. *Worcestershire Acute Hospitals NHS Trust intends to take the following actions to improve this number and so the quality of its services, by:* See Quality Account priorities.	94.45% (Q4 18/19)	92.26% (Q4 17/18)	93.75% (Q4 16/17)
	Rate of C.difficile per 100,000 bed days	49.4 (Apr-18 to Mar-19)	22.1	0.0	168.0	*Worcestershire Acute Hospitals NHS Trust considers that this data is as described for the following reasons:* The Trust has re-emphasised simple control of infection measures, particularly at times of extreme bed pressures. *Worcestershire Acute Hospitals NHS Trust intends to take the following actions to improve this number and so the quality of its services, by:* See Quality Account priorities.	36.8 (Apr 17 to Mar 18)	41.0 (Apr 16 to Mar 17)	37.9 (Apr 15 to Mar 16)

Domain	Indicator	Current Performance	National average value	Where applicable		Trust statement	Previous values (where data available)		
				Best NHS performer	Worst NHS performer				
Treating and caring for people in a safe environment and protecting them from harm	Rate of patient safety incidents per 1,000 bed days	52.90 'No evidence for potential under-reporting' (Apr-19 to Sep-19)		26.3	103.8	*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.	43.77 'No evidence for potential under-reporting' (Apr-18 to Sep-18)	37.45 'No evidence for potential under-reporting' (Apr-17 to Sep-17)	39.10 'No evidence for potential under-reporting' (Apr-16 to Sep-16)
	Rate of patient safety incidents that resulted in severe harm or death	0.32% (Apr-19 to Sep-19)	0.31%	0.00%	1.60%	*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.	0.29% (Apr-18 to Sep-18)	0.69% (Apr-17 to Sep-17)	0.12% (Apr-16 to Sep-16)

Clinical Audit 2019/20

During 2019/20 56 national clinical audits and 4 national confidential enquiries covered relevant health services that Worcestershire Acute Hospitals NHS Trust provides. We also undertook 291 registered local clinical audits during 2019/20.

During this period Worcestershire Acute Hospitals NHS Trust participated in 96% of the national clinical audits and 100% of the national confidential enquiries that it was eligible to participate in.

Appendix 1 contains a list of national audits, national confidential enquiries and local audits that Worcestershire Acute Hospitals NHS Trust participated in during 2019/20. Appendix 1 also describes the actions we have taken or are planning to take to improve our services in response to insights from these audits.

Participation in Clinical Research

Clinical research is a driver of quality and effectiveness across the Trust. We prioritise the delivery of national high-quality studies adopted by the National Institute for Health Research (NIHR), which benefit patients and the NHS.

During 2019/20, 1292 patients, carers and staff were recruited into studies, a 14% increase from 2018/19. 710 participants were enrolled into interventional studies, the rest were observational.

We recruited into 58 studies across 15 different clinical specialties, the recruitment for which is shown below. 3 of these studies were commercial. 17 new studies were opened during 2019/20.

Participation in Clinical Research	
Anaesthesia & Perioperative Medicine	129
Cancer	134
Cardiology	133
Dementia and neurodegeneration	12
Diabetes	33
Haematology	148
Infection	75
Mental Health	124
Musculoskeletal disorders	68
Neurology	6
Ophthalmology	10
Renal Disorders	12
Reproductive Health and Midwifery	72
Respiratory	69
Surgery	267

The priority for 2020/21 is to recruit into urgent public health studies that will help us to understand, diagnose, treat and prevent COVID-19.

2019/20 CQUIN Programme

Commissioning for Quality and Innovation (CQUIN)

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

During 2019/20 there were a number of national CQUIN schemes, one locally agreed CQUIN and Specialised CQUIN scheme: the content of the local scheme was agreed between the Trust and the Clinical Commissioning Groups (CCGs) prior to the start of the financial year. However, there have been revised arrangements for NHS contracting and payment during the COVID-19 pandemic the implications for contracting between commissioners and NHS Trusts are to:

1. Provide certainty for all organisations providing NHS-funded services under the NHS Standard Contract that they will continue to be paid for the period April to July 2020.

2. Minimise the burden of formal contract documentation and contract management processes, so that staff can focus fully on the COVID-19 response.

Therefore, as these proposals include block payments CQUINs are included: the operation of CQUINs (both CCG and Specialised) has been suspended for the period from April to July 2020. Thereby, we have not been required to take action to implement CQUIN requirements, nor carry out CQUIN audits or submit CQUIN performance data. Commissioners and Trusts have been advised by NHSIE to take a pragmatic approach to agreement of the final payment amounts for the 2019/20 CQUIN scheme, based on all currently available data and contracting have agreed with CCG a Q3 end attainment. NHSIE are not seeking the submission of 2019/20 quarter 4 data from providers via the national CQUIN data collection.

In 2019/20 the Trust's CQUIN commitments were as follows:

CQUIN Type	CQUIN	Aim	Year End Performance: as determined at the end of Q3
National	**CCG 1a Lower UTI in Older people**	Achieving 90% of antibiotic prescriptions for lower UTI in older people meeting NICE guidance for lower UTI and PHE Diagnosis of UTI guidance in terms of diagnosis and treatment.	**Partial**
	CCG 1b Acute who perform elective colorectal surgery	Achieving 90% of antibiotic surgical prophylaxis prescriptions for elective colorectal surgery being a single dose and prescribed in accordance to local antibiotic guidelines.	**Partial**
	CCG2 Staff Flu Vaccination	Achieving an 80% uptake of flu vaccinations by frontline clinical staff.	**Full**
	CCG3a,b &c Alcohol and Tobacco- Screening and Brief advice	Outlines the need for the NHS to take action to address risky behaviours, with a focus on alcohol and Tobacco consumption. Equip staff to conduct alcohol screening and deliver brief advice and/ or referral through updated processes. Increase the number of people receiving interventions appropriate to their risk category. 3a Achieving 40 - 80% of inpatients admitted to an inpatient ward for at least one night who are asked about their smoking and alcohol use.	**Full**
		3b Achieving 50-90% of identified smokers given brief advice, as outlined in the Alcohol and Tobacco Brief Interventions E-learning programme.	**Full**
		3c Achieving 50-90% of patients identified as drinking above low risk levels, given brief advice or offered a specialist referral.	**Partial**
	CCG7 Three High Impact Actions to Prevent Hospital falls	Achieving 80% of inpatients receiving key falls prevention actions.	**Full**
	CCG 11a SDEC -Pulmonary Embolus	Achieving 75% of patients with confirmed pulmonary embolus being managed in a same day setting where clinically appropriate against clinically appropriate criteria.	**Full**

CQUIN Type	CQUIN	Aim	Year End Performance: as determined at the end of Q3
National	**CCG 11b SDEC -Tachycardia with AF**	Achieving 75% of patients with confirmed atrial fibrillation being managed in a same day setting where clinically appropriate against clinically appropriate criteria.	**Full**
	CCG 11c Community Acquired Pneumonia	Achieving 75% of patients with confirmed community acquired Pneumonia being managed in a same day setting where clinically appropriate against clinically appropriate criteria.	**Full**
Local Area Team	**Oral Surgery (PREMs and PROMs)**	The development and collection of PROMs and PREMs data within the Oral Surgery specialty in order to measure patient satisfaction assess the quality of the service and evaluate areas for improvement of the service.	**Full**
Specialised Commissioning Team	**PSS1 Medicines Optimisation**	This CQUIN aims to support the procedural and cultural changes required fully to optimise use of medicines commissioned by specialised services, ensuring that hospital plans reflect NHS England priorities to improve value from medicines and reduce unwarranted variation.	**Full**

Following the 2019/20 new concept approach to the National CQUINs: focusing on data collection and clinical audit rather than 'action setting' NHSE/I have again focused on the implementation of existing national guidelines, recommendations and interventions which form part of the wider national delivery goals. Guidance (post Covid) has yet to be provided as to whether the same follows for the 2020/21 CQUINS and what achievement will be based on (following suspension) after July 2020.

2020/21 CQUIN Programme:

Acute Providers Indicators:

Prevention of ill health:

- Appropriate antibiotic prescribing for UTI in adults aged 16+
- Cirrhosis and fibrosis tests for alcohol dependent patients
- Staff flu vaccinations

Patient Safety:

- Recording of NEWS2 score, escalation time and response time for unplanned critical care admissions.
- Screening and Treatment of iron deficiency anaemia inpatients listed for major elective blood loss surgery.

Best Practice pathways:

- Treatment of community acquired pneumonia (CAP) in line with BTS care Bundle
- Rapid rule out protocol for ED patients with suspected acute myocardial infarction (excluding STEMI).
- Adherence to evidence based interventions clinical criteria.

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 Worcestershire Acute Hospitals NHS Trust participated in, and for which data collection was completed during 2019/20, 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
Out of Hospital Cardiac Arrest	71%
Dysphagia in People with Parkinson's Disease	43%
Acute Bowel Obstruction	100%
Long Term Ventilation	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
BAUS - Cystectomy	Yes	**Data not available	Unable to obtain case numbers – online system has changed so not able to see number of cases submitted.
BAUS - Nephrectomy	Yes	**Data not available	Unable to obtain case numbers – online system has changed so not able to see number of cases submitted.
BAUS - Percutaneous Nephrolithotomy	Yes	**Data not available	Unable to obtain case numbers – online system has changed so not able to see number of cases submitted.
BAUS - Radical Prostatectomy	Yes	**Data not available	Unable to obtain case numbers – online system has changed so not able to see number of cases submitted.
EPILEPSY 12 - National Audit of Seizures and Epilepsies in Children and Young People	Yes	100%	
FFFAP - National Hip Fracture Database (NHFD)	Yes	n86	
ICNARC - Case Mix Programme	Yes	100%	
Mandatory Surveillance of Bloodstream Infections and Clostridium Difficile Infection	Yes	100%	
MBRRACE - Maternal, Newborn and Infant Clinical Outcome Review Programme	Yes	100%	
NABCOP - National Audit of Breast Cancer in Older People	Yes	100%	
NACAP - Pulmonary rehabilitation	Yes	100%	
NACAP - Secondary Care - Adult Asthma	Yes	** Data not available	Data collection open until 8th May 2020
NACAP - Secondary Care - COPD	Yes	100%	
NACEL - National Audit of Care at the End of Life	Yes	100%	

Eligible National Audits	Participation	% or No's cases submitted	Comments
NACR - National Audit of Cardiac Rehabilitation	Yes	100%	
NOGCA - National Oesophago-gastric Cancer Audit	Yes	100%	
NBOCA - National Bowel Cancer Audit	Yes	100%	
NBSR - National Bariatric Surgery Registry	Yes	n105	
NCAA - National Cardiac Arrest Audit	Yes	100%	
NCAP - Cardiac Rhythm Management (CRM)	Yes	100%	
NCAP - Myocardial Ischaemia National Audit Project (MINAP)	Yes	100%	
NCAP - National Audit of Percutaneous Coronary Interventions (PCI)	Yes	100%	
NCAP - National Heart Failure Audit	Yes	100%	
NEIAA - National Early Inflammatory Arthritis Audit	Yes	100%	
NDA - Adults - National Diabetes Foot Care Audit	Yes	100%	
NDA - Adults - National Pregnancy in Diabetes Audit	Yes	100%	
NDA - Adults - National Core Diabetes Audit	Yes	** Data not available	Data collecting until 31st March 2020. Submission deadline 22md May 2020.
NELA - National Emergency Laparotomy Audit	Yes		205 (Jan 19 – Sept 19) Oct-Dec figures not yet released.
NJR - National Joint Registry	Yes	96% consent rate	
NLCA - National Lung Cancer Audit	Yes	100%	
NMPA - National Maternity and Perinatal Audit	Yes	100%	
NNAP - National Neonatal Audit Programme	Yes	100%	
NPCA - National Prostate Cancer Audit	Yes	100%	
NPDA - National Paediatric Diabetes Audit	Yes	** Data not available	Data collecting until 29th May 2020.

Eligible National Audits	Participation	% or No's cases submitted	Comments
NVR - National Vascular Registry	Yes	100%	
PROMS - Elective Surgery	Yes	n1100 - ALX	Unable to obtain WRH figures due to pre-op closed for COVID-19.
Reducing the Impact of Serious Infections (Antimicrobial Resistance and Sepsis) - Antibiotic Consumption	Yes	** Data not available	Unable to obtain figures.
Reducing the Impact of Serious Infections (Antimicrobial Resistance and Sepsis) - Antimicrobial Stewardship	Yes	** Data not available	Unable to obtain figures.
SHOT - Serious Hazards of Transfusion: UK National Haemovigilance	Yes	100%	
SSNAP - Sentinel Stroke National Audit Programme	Yes	100%	
SSISS - Surgical Site Infection Surveillance Service	Yes	** Data not available	Unable to obtain figures.
TARN - Major Trauma Audit	Yes	100%	
NDA - National Diabetes Inpatient Audit NaDIA	Yes	100%	
Endocrine and Thyroid National Audit	Yes	100%	
FFFAP - (NAIF) National Audit of Inpatient Falls	Yes	100%	
UK Parkinson's Audit	Yes	100%	
Society for Acute Medicine's Benchmarking Audit (SAMBA)	Yes	100%	
NDA - National Diabetes Harm Review NaDIA	Yes	100%	
NASH 3 - National Audit of Seizure Management in Hospitals	Yes	100%	
CEM - Assessing Cognitive Impairment in Older People - Care in ED	Yes	100%	
CEM - Care of Children in the ED	Yes	100%	
CEM - Mental Health - Care in the ED	Yes	100%	
NACAP - Paediatric Asthma	Yes	100%	N65 cases submitted.
Perioperative Quality Improvement Programme (PQIP)	Yes	**Data not available	Participation started late 2019/20.

Eligible National Audits	Participation	% or No's cases submitted	Comments
IBD - Inflammatory Bowel Disease Programme/ IBD Registry	No	N/A	Unable to participate due to lack of resources. Progress has been made during 2019/20 and the in-house built IBD database in testing phase due to complete summer 2020/21. Further recruitment of CNS will need to take place before data can be submitted in the audit.
National Ophthalmology Audit	No	N/A	No participation in 2019/20. Open Eyes was installed late 2019/20 and participation is expected to take place from August 2020.

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

Ineligible National Audits	Scope
Mental Health - Care in Emergency Departments	Audit applies to Mental Health
Mental Health Care Pathway - CYP Urgent & Emergency Mental Health Care and Intensive Community Support	Audit applies to Mental Health
Mental Health Clinical Outcome Review Programme	Audit applies to Mental Health
National Audit of Intermediate Care	Specialist Audit
National Audit of Pulmonary Hypertension (COPD)	Specialist Audit
National Audit of Anxiety and Depression	Audit applies to Mental Health
National Clinical Audit of Psychosis	Specialist Audit
Neurosurgical National Audit Programme	Specialist Audit
Paediatric Intensive Care (PICANet)	Specialist Audit
Prescribing Observatory for Mental Health (POMH-UK)	Audit applies to Mental Health
UK Cystic Fibrosis Registry	Specialist Audit
BAUS - Female Stress Urinary Incontinence	Service no longer undertaken in the Trust - national notice of halt on the use of surgical mesh for SUI surgery as of 10/07/18.
NAD - National Audit of Dementia - Spotlight audit on e-Prescribing	Trust does not provide this service
BTS - Smoking Cessation	Trust does not provide this service
FFFAP - Fracture Liaison Service Database (FLSD) SCSD/ Rheumatology - Prof. Rai	Trust does not provide this service. It has been de-commissioned as of 31/08/19.

A total of 58 National Clinical Audit reports have been published in 2019/20 for national audits that the Trust either participated in or was eligible to participate in. These reports were reviewed in 2019/20 and the table below presents a selection of actions Worcestershire Acute Hospitals NHS Trust intends to take to improve the quality of healthcare provided.

National Audit	Date Report Published	Specialty	Actions/Improvements
NPDA - National Paediatric Diabetes Audit Annual 17/18 Report	09/05/2019	Paediatrics	▶ Twinkle.NET diabetes database to be purchased and implemented to allow healthcare checks and HbA1c's to be monitored more easily and for areas of improvement to be identified on a continuous basis. Clinic proformas will also be introduced to ensure necessary health care checks are completed. ▶ To implement Freestyle Libre pathway from April 2019. ▶ To provide a countywide clinical psychology service. ▶ To request random urine samples to test for microalbuminuria and then early morning urine samples for high random results. ▶ To discuss ways of tracking retinopathy screening with the DESP.
NDA - National Diabetes Inpatient Audit - Hospital Characteristics Report	09/05/2019	Endocrinology	▶ Review the need for 7 day provision of DSN service – Reviewed but no funding available to implement service. ▶ Continuation of MDFT provision after NHSE project completes. Work with the CCG and HACT. Funding guaranteed until March 2020. ▶ Discuss provision of supplementary clinical services with service providers, such as dietitians for inpatient and outpatients and psychological services.

National Audit	Date Report Published	Specialty	Actions/Improvements
NABCOP - National Audit of Breast Cancer in Older Patients 2019 Annual Report	09/05/2019	Breast Surgery	▶ Review completeness of pathology data capture and reporting. ▶ Change initial assessment form to include Frailty Assessment. ▶ Audit use of pre-op optimisation and same day cancellation rate. ▶ Audit patterns of surgery, WLE vs mastectomy ; chemo; by age grouping < or > 75.
National Lung Cancer Audit Annual Report	09/05/2019	Oncology	▶ Identify suitable person for clinical data lead for the lung cancer team. ▶ Respiratory medicine to review caseload and requirement for further LCNS posts. ▶ Case note reviews of relevant cases - Pathology confirmation and NSCLC NOS – need detailed case note review. ▶ Case note reviews of relevant cases - Anti-Cancer Treatment – need case note review of good PS patients not receiving anti-cancer treatment.

National Audit	Date Report Published	Specialty	Actions/Improvements
ICNARC - Case Mix Programme 2018-19 Q4	19/06/2019	Critical Care	▶ Rapid access to ward beds for patients fit for step down from critical care within the target 8 hours to meet best practise standards. See risk register. ▶ Data completeness less than 100% and data processing outside 3 week target despite increased clerk time and medical input therefore will seek automated system for data collection and submission to allow audit time for analysis and creation of improvement plans. ▶ Data accuracy and coding are becoming increasingly challenging with the current pattern of admissions (particularly at WRH). Whilst action plan 2 is awaited will seek to change access to critical care notes and ITU charts to allow better ICNARC data entry from the first 24hrs of a patients stay to ensure correct SMR calculation. This will be supported by seeking ATR for clerical staff to ensure a full complement across county. ▶ Continuous review of other quality markers including discharges out of hours (22:00 till 07:00), early readmission rates, death with predicted mortality of <20%, delayed admission to intensive care(>4hrs) will be fed back to the Critical Care Multidisciplinary Forum and if elevated or abnormal will have appropriate action plan generated and passed on to this audit plan. Forum meetings are monthly and are more responsive to rapid change. ▶ Change of practice re transfers from the Alexandra to Worcester to ensure documentation of specialty treatment as a reason to avoid an increase in errors in non-clinical transfer rates.

National Audit	Date Report Published	Specialty	Actions/Improvements
CEM Feverish Children ALX	22/07/2019	A&E	▶ Triage training to improve and early identification of sick child. ▶ Any child with abnormal observation/ high fever in triage should be escalated to NIC / senior doctor on floor also documented in notes. ▶ Doctors teaching regarding early senior review of sick child by consultant/ ST4 or above.
CEM - Vital Signs in Adults WRH	22/07/2019	A&E	▶ Improve patient flow to ensure timely handovers from WMAS crews. This action is a continuous and therefor marked as a completed action. ▶ Audit of SQUID data to ensure escalation and frequency of observations is in line with trust policy (which is different to RCEM recommendations). ▶ Implementation of E-Obs within the ED.
NPDA Spotlight Audit – The Workforce in Paediatric Diabetes Units 2017/18	12/09/2019	Paediatrics	▶ To determine the proportion of BPT income being used to support clinical services for our children and young people with diabetes. If this is less than 100% then it will be discussed with senior management as per the National recommendation. ▶ The introduction of a young adult diabetes clinic. ▶ To appoint an additional PDSN to support the WRH team who are working above capacity.

National Audit	Date Report Published	Specialty	Actions/Improvements
NEIAA National Early Inflammatory Arthritis Audit 1st Annual Report	10/10/2019	Rheumatology	▶ Establish additional EIA capacity. ▶ Expand EIA service to other sites to promote cross-county working. ▶ Restore workforce with replacement of locum consultant. ▶ Expand workforce including multidisciplinary team to meet local demand. ▶ Ensure commissioners signed up to Best Practice Tariff.
National Pregnancy in Diabetes Audit Report 2018	10/10/2019	Obstetrics	▶ Reinforce pre-pregnancy counselling in diabetic patients of child bearing age to 100%. ▶ Ensure all diabetic ladies use Folic acid until at least 12 weeks of gestation. ▶ Ensure baseline HbA1c to be <48 at conception in all patients.
MBRRACE-UK Perinatal Mortality Surveillance Report 2019	10/10/2019	Obstetrics	▶ Continue to review the PMRT finding to establish any themes and quality improvements. ▶ Continue to implement recommendations from Savings Babies Lives Care Bundle version 2 and GAP care pathway phases 1 and 2. ▶ Review current job plans / roles to ensure adequate time and allied support available for implementation.

National Audit	Date Report Published	Specialty	Actions/Improvements
MBRRACE - Saving Lives, Improving Mothers Care	13/12/2019	Obstetrics	▶ Ensure robust referral pathway is in place for women with pre-existing cardiac conditions (maternal medicine pathway) including pre-pregnancy advice and advice from geneticists - this will be provided by the maternal medicine network once this is established (likely in place by the end of 2020). ▶ Teaching session to juniors on CV disease presenting in pregnancy – to be added to list of topics to be taught to juniors. ▶ Cascade the recommendations to oncology team and primary care to improve the care of women with malignancy. ▶ Cascade recommendations to cardiology team. ▶ Cascade recommendation to ED team for FAST scanning of women of reproductive age who present with collapse. ▶ Update local guideline WAHT-TP-094 Management of Significant Hypertension & Pre-eclampsia in Pregnancy.

National Audit	Date Report Published	Specialty	Actions/Improvements
NVR - National Vascular Registry Annual Report 2019	13/12/2019	Vascular	▶ To investigate and support Interventional Radiology developing daycase lower-limb angioplasty/stenting capacity at the WRH (hub) site, plus investigation/development of low-risk daycase angioplasty options at appropriate 'spoke' hospitals. ▶ To support Interventional Radiology in recruitment/retention of Consultants, IR Nurses and IR Radiographers such that a 24/7 IR service may be implemented. ▶ Re-Audit of major lower limb amputations (compliance to QIF metrics) and implementation of findings. ▶ Recruitment of 2 WTE Consultant Colleagues and 2 WTE ANPs to reflect high-volume workload in vascular emergencies and all key vascular surgical procedures with current minimum workforce requirements and deliver full hub/spoke coverage to further improve NVR metrics. ▶ Urgent engagement with divisional colleagues in SCSD to facilitate expedited diagnostic cross-sectional imaging (urgent outpatient) which currently compromises the delivery of 56-day RTT for NAAASP patients and address the deterioration in RTT NVR metric.

National Audit	Date Report Published	Specialty	Actions/Improvements
NACAP - Secondary Care - Adult Asthma	31/12/2019	Respiratory	▶ Meet with A+E team to discuss barriers to PEF measurement within 1 hour of arrival at hospital. Review A+E triage and asthma paperwork used within the A+E department. ▶ Seek approval for business case for development of asthma specialist nurse team. Business case currently under review. ▶ Review asthma acute pathway/paperwork used within A+E and within acute medicine to ensure that it is aligned with the national QI priority that 95% patients with acute asthma receive systemic steroids within 1 hour of arrival at hospital ▶ Gain approval for local asthma discharge bundle paperwork via respiratory directorate meeting.

Local Clinical Audits

The reports of 291 local clinical audits were reviewed by Worcestershire Acute Hospitals NHS Trust in 2019/20 and the table below provides a selection of actions the provider intends to take, or has taken to improve the quality of healthcare provided.

Audit Title	Specialty	Actions/Improvements
10268 Hypoglycaemia management compliance	Endocrinology	▶ Standardised documentation in hypoglycaemia. ▶ Hypoglycaemia symptoms documentation. ▶ Stickers inserted in notes to make the day team aware of a nocturnal hypoglycaemia; or recurrent hypoglycaemia (>1 hypoglycaemic event during admission); for review of insulin.
10323 Bronchiolitis in Worcestershire Royal's Emergency Department	A&E	▶ Educate emergency department staff in effective handover during bronch. ▶ Education for Dr and Nurses to document name of person attending with child.
10382 ED management of adult asthma	A&E	▶ Encourage doctors to complete asthma Proforma correctly. ▶ Always prescribe oxygen at least for moderate, severe and life threatening asthma. ▶ Inform nurse to repeat obs within 60mins after the first obs. ▶ Give out asthma leaflet.
10202 VTE Risk in Lower Limb Immobilisation	A&E	▶ Written advice should be given to all patients receiving thromboprophylaxis.
10446 Lumber Puncture in Ambulatory Emergency Care	Acute Medicine	▶ A Lumber Puncture Proforma was designed, device and rolled out. ▶ Roll out and education of proforma.

Audit Title	Specialty	Actions/Improvements
1638 Antenatal Combined and Quad testing- Increased chance results- actions and outcomes.	Obstetric	▶ Effective counselling is being offered to women at their booking so that an appropriate screening decision can be made. ▶ Investigate offering private NIPT at WRH.
10487 Appropriate use of telemetry re-audit	Cardiology	▶ The team has agreed to use the request forms and stickers trust wide and upload on the intranet to be more accessible.
10178 Improving Heart Failure Discharge Summaries	Cardiology	▶ Education targeted at doctors working in cardiology ▶ Meeting with Heart Failure Specialist Nurses ▶ Created and displayed a poster to help guide the juniors writing discharge letters on cardiology as to what to include on the ideal heart failure discharge summary.
10407 8B Frailty prevalence audit	Geriatric Medicine	▶ Introduction of the WHAT Clinical Frailty Screening Tool to Divisions/Specialities as per the Clinical Strategy. ▶ Development of a frailty checklist for Clinical Teams to initiate management plan and signposting. ▶ Development of a frailty provision at WRH. ▶ Development of a frailty education as per the frailty A Framework of Care Capabilities NHS Skills for Health. ▶ Development of the MDT workforce for responsive care that includes admissions prevention/timely discharge to reduce the risk of harm from HAFD.

Audit Title	Specialty	Actions/Improvements
10447 Lumbar puncture in Ambulatory Emergency Care	Acute Medicine	▶ A Proforma was designed, devised and to be rolled out. ▶ Present results at clinical governance meeting or grand round meeting. ▶ Centralisation of the lumbar puncture proforma. ▶ Education and inclusion of the proforma in the junior doctors induction pack.
10394 An audit of vaginoscopic approach to outpatient hysteroscopy (OPH) and patient satisfaction	Gynaecology	▶ Standardise our documentation where possible (including GA discussion). ▶ Create an E-Consent for Out Patient Hysteroscopy. ▶ Annual BSGE audit of pain scores during OPH.
10317 41A Epidural waiting times	Obstetrics	▶ Modification to obstetric anaesthetic chart to include time contacted & time anaesthetist in attendance.
10479 42C Prescription in admitted children	Paediatrics	▶ Education of new trainees to familiarise with drug cards to ensure adequate prescriptions. ▶ Stamps with name and GMC. ▶ Regular review of drug charts/re-audits to ensure improvements are being made and no drug errors made. ▶ Use stickers with DOB for drug charts.
10405 Is the smoking status of parents of children admitted with respiratory illnesses established and appropriate advice and support given?	Paediatrics	▶ Presentation of audit at departmental meeting. ▶ Discussion regarding proposed change to PAU clerking sheet. ▶ Posters for parents and staff. ▶ Leaflets available on ward for parents. ▶ Promote E-learning module for staff.

Audit Title	Specialty	Actions/Improvements
10563 Actual oxygen prescription and management compared to Trust Policy	Respiratory Medicine	▶ Register oxygen administration as a risk on the Trust's Risk Management system. ▶ Ensure that the senior management team are aware that there is a lack of understanding among clinicians regarding administration of oxygen. ▶ Design education plan regarding oxygen prescription and administration. ▶ Agree delivery of oxygen education program. ▶ Deliver training program.
10497 Audit of chronic heart failure diagnosis in a non-acute setting within Worcestershire	Cardiology	▶ Implement a Rapid Access Heart Failure Clinic.
10449 An Audit of REACT	A&E	▶ Training to REACT team for robust consistent assessments. ▶ Review KPIs and audit criteria**.**
10203 7D Elective paracentesis in medical day case unit	Gastroenterology	▶ Use Poster to Guide Procedure. ▶ Teach junior Doctors how to perform Paracentesis in Accordance with the Accepted local Standards. ▶ Consider introduction of a procedure proforma if documentation of the procedure remains inadequate.
10514 40A Prevention of term infants (ATAIN) re-audit	Neonatal	▶ Identify the modes of delivery for each unexpected term admission and feedback data at the next audit meeting. ▶ Highlight the importance of maintaining a suitable room temperature for new born babies in theatre.

Audit Title	Specialty	Actions/Improvements
10311 Improving In-patient EEG referrals from acute medical specialities, WRH for epileptogenic seizures	Neurophysiology	▶ Presentation of results to individual Specialities. ▶ The pilot of modified forms and referral criteria. ▶ Amendment to be made to WAHT - NEU-012-V1.1 ▶ Teaching to FY1 FY2 and Associate clinical Practitioners.
10312 Implementation and compliance to the sepsis screening tool/guideline; the 'sepsis six' bundle	Stroke	▶ Education on Sepsis Six bundle. ▶ Availability of ABG Machines. ▶ Doctors should be encouraged by ward nurses to sign the audit stickers.
10260 Audit of Tidal Volumes in Invasively Ventilated Critical Care Patients	Critical Care/ ITU	▶ Ensure tidal volume charts are available at every bed space in ICU.
10061 18B Therapeutic OGD Audit as per BSG Quality and Safety Indicators 2016	Endoscopy	▶ Raise awareness of audit results to all nursing and medical teams. ▶ 2 stage consent process to be followed by all Endoscopists. CD to share with medical teams. ▶ The correct consent form to be utilised. CD to share with medical teams.
10277 Gastroprotection with PPI and anticoagulation	Vascular	▶ Consultants to consider PPI coverage for all vascular patients and document reasons for not prescribing. ▶ Default PPI to be lansoprazole. ▶ Phase out use of enteric coated aspirin. ▶ Request pharmacy provide lansoprazole as ward TTO.

Audit Title	Specialty	Actions/Improvements
10389 Stop before you block - re-audit	Anaesthetics	▶ Arrange for SBYB stickers to be stuck to individual nerve block needle packets as a reminder to anaesthetists to use them. ▶ Recommendation from QI meeting that SBYB stickers filled in by assistant as check performed, immediately prior to needle placement.
10444 Unplanned day case surgery admissions	Anaesthetics	▶ Identify high risk patients for post-operative urinary retention and ask theatres/surgeons to schedule early on list. ▶ Recommend an oral/IV fluid strategy to minimise POUR and PONV.
10520 Re-audit of Adherence to WHO Safety Standards for Local Anaesthetic Procedures	Oral & Maxillo-facial, Orthodontics and Orthognathic	▶ Discuss findings of Cycle 2 at the next departmental audit meeting. ▶ Laminate current SSC and place them in all surgeries. ▶ Re-audit in 6 months.
10561 Negative appendectomy audit	General Surgery	▶ Implementation of AAS / AIRS scoring in all patients suspected of A/c appendicitis.
10534 24A Hereford and Worcester Breast Screening Vacuum Assisted Biopsy (VAB) service review 2019	Radiology	▶ Continue with current practice ensuring compliance with NHS BSP guidelines. ▶ Develop VAB service on a second Trust site in order to improve patient pathway and increase capacity. ▶ Train additional practitioners in view of VAB service expansion. ▶ Participate in national research trials.
10492 17C Discharge Summary Content and Completion Rates	Critical Care/ ITU	▶ Modify Bluespier document/implement new discharge document if EPR realised - remove set text re: suitability for return to ICU.

Audit Title	Specialty	Actions/Improvements
10436 Surgical consent in trauma patients	Trauma & Orthopaedics	▶ Agree as a department to avoid use of abbreviations. ▶ Agree as a department to provide copies of consent to patients. ▶ Suggest Referring to Orthoconsent guideline before obtaining consent. ▶ Re-audit.
10265 Assessing the technical quality of the Hysterosalpingography service Re-audit	Radiology	▶ Continue good practice with regard to cervical cannulation. Work with Gynae team in difficult cases. ▶ Ensure operators are aware of screening times. ▶ Advise good collimation particularly in larger ladies. ▶ Re-audit above criteria in 12 months to ensure improvement in screening times and doses.
10169 Are patients with CLL being tested for TP53 deletion before treatment	Haematology	▶ Treatment protocols for CLL will specifically state requirement to check TP53 status prior to commencement of treatment. ▶ Treatment protocols will recommend specific supportive medications for all regimens which will include requirement for PCP prophylaxis if appropriate.
10421 26B Re-audit of rheumatology out-patient service: utilisation of text messaging reminder service and clinic slot utilisation following late cancellation	Rheumatology	▶ Presentation of audit findings to department. ▶ Poster promoting early cancellation of clinic appointments to be created and placed in rheumatology. ▶ Patient appointment letter to be revised again emphasising need for cancellation with >48hrs notice.

Audit Title	Specialty	Actions/Improvements
10467 Blood cultures contamination rates	Pathology	▶ Feedback to the Microbiology Quality Committee and A&E. ▶ Focus blood cultures collection training to the areas with over 3% contamination rate.
10417 16C Knowledge of major incident policy	Anaesthetics	▶ Take important parts of MIP for anaesthetic / ICU team and have laminated copy available on department walls. ▶ Ask college tutors to add reference to major incident plan to trainee and consultant induction packages.
10119 VTE risk assessment & prophylaxis in elective surgical patients with obesity	Anaesthetics	▶ Feedback results of audit to surgical specialties to highlight missing 24 hour assessments and inaccurate identification of risk factors. ▶ Encourage use of WHO time out VTE question to prompt discussion and action plan regarding dose and timing of clexane.
10402 Pre-operative antiseptic skin preparation before major joint surgery	Trauma & Orthopaedics	▶ All surgeons to use Chlorperp instead of Hydrex for major joint replacement to be compliant with 2019 NICE guidance. ▶ Surgeons to avoid mixing of agents or use intraoperative antiseptics routinely - NICE advised against doing this as there is no evidence, actions can be contradictory and for fear of microbial drug resistance.
10281 32C ENT speciality review of A&E patients: completed loop	Ear, Nose and Throat	▶ Communication to be made to A&E regarding inaccurate timings - ENT SHO's now clocking times directly with A&E admin clerks.

Examples of how Clinical Audit has been used to Drive Improvement

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

The performance of lumbar puncture on patients taking clopidogrel in the acute medicine department.

The audit has contributed to improve safety for patients when having a lumbar puncture LP done and they take clopidogrel.

Re-audit – Group & Save for T&O Surgery

This re-audit demonstrated that substantial savings have been realised by rationalising the G&S samples taken for elective primary joint arthroplasties, and there were no additional problems with any delays for patients requiring blood products.

During the 6 week re-audit £2804 was saved with potential to save >£20,000 per year.

Appropriate use of telemetry – cardiology

Inappropriate use of telemetry has been significantly reduced by two-thirds and improved daily reviews by 20%. This, subsequently, reduced the total duration of unnecessary monitoring by 96 days without needing to invest huge amount of funding while ensuring to maintain patients' safety and adhering to standards.

Outcome of C. difficile in patients with home IV antibiotics

Worcestershire Home IV service demonstrated an excellent negative CDI rate in those discharged from hospital and known to infectious diseases.

Standardised practice for the treatment of all patients with eye problems by Emergency Nurse Practitioners at Kidderminster Treatment Centre Minor Injuries Unit

The audit demonstrated that 100% of Emergency Nurse Practitioners comply with Worcestershire Acute Hospitals NHS Trust local guidance of standardised practice for the treatment, diagnosis and discharge of all patients who present with a variation of eye conditions.

This audit identified a significant positive impact in the turnround time of a CSF Xanthochromia request from the Acute Medical Units across the Trust since introducing the automated Uvikon XS method for CSF Xanthochromia.

An audit to assess the turnround time for CSF Xanthochromia across Worcestershire Acute Hospitals NHS Trust, comparing turnround times between the old service and the new automated 24/7 service.

External Recognition for Clinical Audit Activity

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

Cardiac Rehabilitation
The Cardiac Rehabilitation team from the Alexandra Hospital were awarded the British Association for Cardiovascular Prevention and Rehabilitation (BACPR)'s Green Award.

The team demonstrated that they meet all seven national quality standards set out by the BACPR to support patients with cardiac problems throughout the four phases of recover, which were audited in the National Audit of Cardiac Rehabilitation.

Cancer
An audit assessing adherence to NICE guidance for urgent suspected cancer referrals following implementation of a new two week wait MDT (OMFS/Dermatology) clinic was presented to the Annual Scientific Meeting 2019 in Birmingham by Bethan Edwards and won the Clinical Poster Prize.

Appendix 2: Care Quality Commission (CQC) Inspections and Ratings 2019

Care Quality Commission (CQC) Inspections and Ratings 2019

Services Inspected:

Date	Services Inspected	Report Published
14th – 29th May 2019	Urgent and Emergency Care; Medical Care (including Older Peoples' Care); Surgery; Children & Young People; Outpatients and Diagnostics	20th September 2019
19th – 21st June 2019	Well-Led Inspection	
16th December 2019	Urgent and Emergency Care – Focused Inspection Emergency Departments at Worcestershire Royal Hospital and the Alexandra General Hospital	4th February 2020 Note: Updated Ratings Grid not provided by CQC

CQC Inspection Report published 20 September 2019:

Ratings for the whole Trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement ↑ Sept 2019	**Good** ↑ Sept 2019	**Good** ↔ Sept 2019	**Requires improvement** ↑ Sept 2019	**Requires improvement** ↔ Sept 2019	**Requires improvement** ↑ Sept 2019

Ratings for the acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Worcestershire Royal Hospital	Requires improvement ↑ Sept 2019	Good → ← Sept 2019	Good → ← Sept 2019	Requires improvement ↑ Sept 2019	Requires improvement ↑ Sept 2019	Requires improvement ↑ Sept 2019
Alexandra Hospital	Requires improvement ↑ Sept 2019	Requires improvement ↑ Sept 2019	Good → ← Sept 2019	Requires improvement ↑ Sept 2019	Good ↑↑ Sept 2019	Requires improvement ↑ Sept 2019
Kidderminster Hospital and Treatment Centre	Good ↑↑ Sept 2019	Good ↑ Sept 2019	Good → ← Sept 2019	Requires improvement ↑ Sept 2019	Good ↑↑ Sept 2019	Good ↑↑ Sept 2019
Evesham Community Hospital	Requires improvement ↓ Sept 2019	Good → ← Sept 2019	Good → ← Sept 2019	Requires improvement ↓ Sept 2019	Requires improvement ↓ Sept 2019	Requires improvement ↓ Sept 2019
Overall trust	Requires improvement ↑ Sept 2019	Good ↑ Sept 2019	Good → ← Sept 2019	Requires improvement ↑ Sept 2019	Requires improvement → ← Sept 2019	Requires improvement ↑ Sept 2019

Ratings for Worcestershire Royal Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement  Sept 2019	Good  Sept 2019	Good  Sept 2019	Inadequate  Sept 2019	Requires improvement  Sept 2019	Requires improvement  Sept 2019
Medical care (including older people's care)	Requires improvement  Sept 2019	Requires improvement  Sept 2019	Good  Sept 2019	Requires improvement  Sept 2019	Good  Sept 2019	Requires improvement  Sept 2019
Surgery	Requires improvement  Sept 2019	Good  Sept 2019	Good  Sept 2019	Requires improvement  Sept 2019	Good  Sept 2019	Requires improvement  Sept 2019
Critical Care	Requires improvement June 2017	Good June 2017	Good June 2017	Requires improvement June 2017	Requires improvement June 2017	Requires improvement June 2017
Maternity	Requires improvement June 2018	Good June 2018	Good June 2018	Good June 2018	Good June 2018	Good June 2018
Services for children and young people	Good  Sept 2019	Good  Sept 2019	Good  Sept 2019	Good  Sept 2019	Good  Sept 2019	Good  Sept 2019
End of life care	Good June 2017	Good June 2017	Good June 2017	Good June 2017	Good June 2017	Good June 2017

	Safe	Effective	Caring	Responsive	Well-led	Overall
Outpatients	Requires improvement  Sept 2019	N/A	Good  Sept 2019	Requires improvement  Sept 2019	Good  Sept 2019	Requires improvement  Sept 2019
Diagnostic imaging	Requires improvement  Sept 2019	N/A	Good  Sept 2019	Good  Sept 2019	Requires improvement  Sept 2019	Requires improvement  Sept 2019
Overall*	Requires improvement  Sept 2019	Good  Sept 2019	Good  Sept 2019	Requires improvement  Sept 2019	Requires improvement  Sept 2019	Requires improvement  Sept 2019

Ratings for Alexandra Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement  Sept 2019	Requires improvement  Sept 2019	Good  Sept 2019	Requires improvement  Sept 2019	Requires improvement  Sept 2019	Requires improvement  Sept 2019
Medical care (including older people's care)	Requires improvement  Sept 2019	Requires improvement  Sept 2019	Good  Sept 2019	Good  Sept 2019	Good  Sept 2019	Requires improvement  Sept 2019

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	**Requires improvement**  Sept 2019	**Good**  Sept 2019	**Good**  Sept 2019	**Requires improvement**  Sept 2019	**Good**  Sept 2019	**Requires improvement**  Sept 2019
Critical Care	**Good** June 2017	**Good** June 2017	**Good** June 2017	**Good** June 2017	**Good** June 2017	**Good** June 2017
End of life care	**Good** June 2017	**Good** June 2017	**Good** June 2017	**Good** June 2017	**Good** June 2017	**Good** June 2017
Outpatients	**Good**  Sept 2019	N/A	**Good**  Sept 2019	**Requires improvement**  Sept 2019	**Good**  Sept 2019	**Good**  Sept 2019
Diagnostic imaging	**Requires improvement**  Sept 2019	N/A	**Outstanding**  Sept 2019	**Good**  Sept 2019	**Requires improvement**  Sept 2019	**Requires improvement**  Sept 2019
Overall*	**Requires improvement**  Sept 2019	**Requires improvement**  Sept 2019	**Good**  Sept 2019	**Requires improvement**  Sept 2019	**Good**  Sept 2019	**Requires improvement**  Sept 2019

Ratings for Kidderminster Hospital and Treatment Centre

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement Sept 2019	Requires improvement Sept 2019	Good Sept 2019	Good Sept 2019	Requires improvement Sept 2019	Requires improvement Sept 2019
Medical care (including older people's care)	Good Sept 2019	Good Sept 2019	Good Sept 2019	Good Sept 2019	Good Sept 2019	Good Sept 2019
Surgery	Good Sept 2019	Good Sept 2019	Good Sept 2019	Requires improvement Sept 2019	Good Sept 2019	Good Sept 2019
End of life care	Good June 2017	Good June 2017	Good June 2017	Good June 2017	Good June 2017	Good June 2017
Outpatients	Good Sept 2019	N/A	Good Sept 2019	Requires improvement Sept 2019	Good Sept 2019	Good Sept 2019
Diagnostic imaging	Good Sept 2019	N/A	Good Sept 2019	Good Sept 2019	Good Sept 2019	Good Sept 2019
Overall*	Good Sept 2019	Good Sept 2019	Good Sept 2019	Requires improvement Sept 2019	Good Sept 2019	Good Sept 2019

Ratings for Evesham Community Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	**Requires improvement**  Sept 2019	**Good**  Sept 2019	**Good**  Sept 2019	**Requires improvement**  Sept 2019	**Requires improvement**  Sept 2019	**Requires improvement**  Sept 2019
Overall*	**Requires improvement**  Sept 2019	**Good**  Sept 2019	**Good**  Sept 2019	**Requires improvement**  Sept 2019	**Requires improvement**  Sept 2019	**Requires improvement**  Sept 2019

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

Clinical Commissioning Groups

NHS Herefordshire & Worcestershire Clinical Commissioning Group (CCG) welcome the opportunity to comment on Worcestershire Acute Hospitals NHS Trust's (WAHT) Quality Account. The CCG recognises the Trusts achievements during 2019/20 considering the exceptional challenges they faced as a result of the COVID 19 pandemic.

During these unprecedented times the Quality Account provides a valuable opportunity to look back on the past year, reflect upon the successes and progress made by WAHT and make a candid assessment of the focus needed by both the Trust and collectively across the healthcare system to address the significant challenges we continue to face. It also provides an opportunity for the Trust and other partners to ensure we focus our efforts collectively during 2020/21 towards post pandemic restoration and recovery as well as build on some of the lessons learnt to improve the care and treatment provided to patients across Worcestershire.

From the draft provided, the CCG believe that the Quality Account for 2019/20 contains an accurate reflection of the quality of services provided by the Trust, and whilst not all the data fields were complete in the draft, the CCG has reviewed the information presented against data sources available and to the best of our knowledge believe it is factually accurate.

The CCG recognises the positive progress made against some of last year's quality priorities such as achieving a HSMR within the expected range for the Trust, reducing medicines incidents causing harm and a reduction in patient falls resulting in harm. The CCG also acknowledges the improvements made through a sustained focus on improving Infection Prevention and Control practices across the organisation. It is noted however that there are several areas where the quality requirements were not fully attained during 2019/20. It is acknowledged that the achievement of some of these will have been impacted by the outbreak of the COVID 19 pandemic however this is not applicable to all. In light of this the Trust is advised to consider carefully how they intend to set and monitor measurable outcomes for 2020/21 to ensure they can be fully achieved.

The accumulative impact of the quality improvement work undertaken across the organisation during 2019/20 resulted in the Trusts overall rating against the CQC requirements being lifted from inadequate to requires improvement. This CCG acknowledges this represents a significant step forward and looks forward to working with the Trust to ensure these improvements are sustained and that further improvements can continue to be made.

Despite the positive work identified above the CCG would like to highlight the need for continued and renewed focus on ongoing quality improvements. This is particularly in relation to the restoration of services which were impacted because of COVID and the need for ongoing progress regarding waiting times for access to urgent care. Recent improvements across the system in relation to access to urgent care have significantly improved performance and the CCG will continue to work with the Trust and other partners to ensure these improvements can be sustained. In addition, the CCG will work in conjunction with the Trust to ensure potential

patient safety and patient experience issues as a result of delayed treatment resulting from the COVID 19 pandemic are monitored and addressed.

Commissioners support and welcome the specific quality priorities identified for 2020/21. All are appropriate areas to target for continued improvement and build upon the achievements of 2019/20. The CCG is particularly pleased to see the addition of standards relating to improving nutrition and hydration, dementia care, continued development of the frailty pathway and initiatives relating to the reduction of patient length of stay in hospital. The CCG would however have liked to see more of an emphasis on antimicrobial stewardship within the 2020/21 Quality Account. The CCG is aware this is a key quality improvement initiative for the Trust and would suggest therefore that the commitment to this is made more explicit within the final document.

The Trust has worked in the spirit of openness, candour, and transparency with the CCG over the last year to develop and strengthen relationships. Examples of this include the Trust invitations for the CCG participation in a range of quality and patient safety reviews, quality and safety learning forums and Trust Quality Committee's to promote transparency and an internal culture accepting of challenge. The CCG agrees with the Trust that a vital component to sustain and improve quality during 2020/21 and beyond is the continued implementation of the Home First Worcestershire programme. The CCG looks forward to working with WAHT and other partners across the system to deliver these quality improvements.

Overall Commissioners are happy to accept this Quality Account as an accurate and fair reflection of the Trusts quality profile. The CCG will continue to work collaboratively with the Trust monitoring quality improvements and ensuring learning occurs across the Trust and wider Integrated Care System.

Worcestershire Health overview and Scrutiny Committee (HOSC)

The Worcestershire Health Overview and Scrutiny Committee (HOSC) welcomes receipt of the draft 2019-20 Quality Account for Worcestershire Acute Hospitals NHS Trust. This year's Account provides an extensive overview of the year's work, and is a very fair and reasonable document. If a similar format is taken for subsequent Accounts, please include a summary at the start.

The Committee is supportive of the Trust's targets for improvement, although it is questionable whether some targets (such as reducing the death rate and reducing pressure sores) may be ambitious with the additional challenges in responding to COVID-19.

The HOSC recognises that the challenges presented by COVID-19 are immense, in particular restoring services with capacity for people's physical and mental health which has not been addressed during isolation. The Committee is very keen to look at learning and new ways of working from COVID-19 in its future monitoring of the Trust.

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.

Healthwatch Worcestershire

Healthwatch Worcestershire has a statutory role as the champion for those who use publicly funded health and care services in the county and therefore we welcome the opportunity to comment on the Worcestershire Acute Hospitals NHS Trust Quality Account for 2019/20.

As is our normal practice we have used Healthwatch England guidance to form our response as follows:

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

Healthwatch Worcestershire believes that the overriding priority of patients, their carers and the public regarding Worcestershire Acute Hospitals Trust is that the Trust should provide safe, quality, and accessible services at its hospital sites across Worcestershire. Therefore, the findings of the Care Quality Commission's unannounced inspections in May and June of 2019, which saw the overall rating of the Trust improve from 'Inadequate' to 'Requires Improvement' are to be broadly welcomed. However, it is of concern that urgent & emergency services continue to be assessed as 'Inadequate', particularly given in the public eye it is probably the service which defines the Trust.

We are pleased to see that the Trust has continued with the implementation of the Quality Improvement Strategy and its 3 Priorities that were co-produced with stakeholders including patients and the public in 2018. We welcome the continuation of the Quality Indicators from 2018/19 and the inclusion of new Quality Indicators which reflect some of the areas of improvement identified in the Care Quality Commission's Inspection Report, the delivery of which will improve the safety of services for patients.

We have noted that in 2018/19 improving the management of the Trust's complaints system was a Quality Indicator within Priority 3 of the Quality Improvement Strategy with a target of responding to 80% of complaints within 25 working days of receipt. We are aware that the management of complaints is a focus for patients and influences perception of the Trust. Given the Quality Indicator was achieved in 2018/19 we would therefore have expected the Trust to set itself a stretch target for improvement beyond a target it has achieved.

Healthwatch Worcestershire appreciate the commitment and efforts of all those at the Trust who have been involved in responding to Covid-19 and understand that the response has disrupted much of the work to improve quality.

However, as a priority going forward, we believe that the Trust needs to explain to the local population when and how services for patients which were delayed by Covid-19 such as some cancer treatments and elective surgery will be restored.

2. **Are there any important issues missed?**

We have welcomed the Trust's open and transparent approach to engaging with Healthwatch Worcestershire in its drive to improve quality. Whilst the strategy and activity to deliver it over the past year is documented in the Quality Account it is our view that the Account falls short in reflecting the evident commitment of the Trust's Executive Team and the Trust's clinical and non-clinical staff at all levels to make the improvements that are expected by patients and the public.

Without wishing to detract from the effort referred to above we believe it would have enhanced the Quality Account from a patient and public perspective if the key actions in the Trust's strategy and associated plans to improve urgent and emergency care were clearly incorporated as Quality Indicators.

The Quality Account emphasises that values and behaviours are the foundation of quality improvement at the Trust. In the context of national promotion by NHS England of the importance of the Duty of Candour in influencing individuals' values and behaviour we have noted and welcome the reference in the Quality Account to the role of the Trust's 'Freedom to Speak Up Guardian'. We believe the Quality Account would be enhanced if data was provided to evidence the effectiveness of the role and from which patient and the public could take assurance.

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

In the Trust's 2018/19 Quality Account we welcomed the Trusts commitment to the continuation of the patient and public consultation around 'What does Quality mean to you?' and the involvement of the Patient Experience Committee in the discussions around the Quality Priorities for 2019/20. Whilst we acknowledge the express commitment in the Quality Account to working with patients to improve the quality of services and learning from their experiences it is not clear to us that patients and public have been specifically engaged in developing the Quality Indicators for 2020/21 that are set out in the Quality Account.

Healthwatch Worcestershire encourages the Trust to increase and report upon its engagement with patients, their carers and the public and from minority groups such as those with a learning disability, autism, who live with health inequalities, are members of Black, Asian and Ethnic Minority communities or the LGBT+ community. Evidence of outcomes from patient engagement should also be included, for example the Action Plans that were produced in response to HWW's work on patients experience of the Trust's Fracture Clinics.

We have noted that each of the Trust's clinical Divisions is required to produce a Quality Improvement Plan annually to support the delivery of the Trusts quality priorities. We believe that where appropriate the preparation of these plans provides an opportunity for the Trust to engage with patients and the public to co-produce them.

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

Healthwatch Worcestershire acknowledges the challenge in producing a Quality Account with the detailed information required by NHS England which is also clearly presented and meaningful for patients and the public. In previous comments on the Trust's Quality Accounts we have made suggestions around the presentation of information and we welcome the graphical representation of demand on the Trust during 2019/20 at page 10 of the Quality Account. This year Healthwatch Worcestershire suggests that the Trust publishes a summary of the Priorities, Quality Indicators and results in accessible formats for the information of the public, and includes a glossary of terms and acronyms in the Quality Account.

Worcestershire Acute Hospitals NHS Trust's Patient and Public Forum

This report is very well presented. The introduction sets out very clearly the aims of the report making it easy to follow.

The highlights, from the patient and public perspective, were the improved ratings from CQC, the introduction of HomeFirst, very commendable reduction in mortality with HMSR being in "as expected" range [this was our main concern last year], continued improved response to complaints and the patient story. The latter was written by a member of our group and demonstrates how well staff and patients can work together to improve services when there is an open and transparent environment.

We were disappointed with the CQC downgrading the rating of our emergency services following their unannounced visit last December, as our regular audits on "care in the corridor" in our A&Es had shown gradual improvement.

We had noted on our quality review visits to the wards the good effect of the quality improvement strategy. The clinical teams were keen to demonstrate to us their quality improvement plans and how that was driving up their results.

For next year, we would like particular emphasis on improving the sepsis six bundle and are very supportive of the quality improvement targets

for next year. Hydration and Nutrition have long been priorities for us. Not mentioned, but perhaps implicit in the drive for Equality and Diversity, is caring for the particular needs of those with learning difficulties.

We congratulate the Trust for producing an excellent, transparent account in a very difficult year due to Covid 19.

Rosemary Smart [on behalf of the Patient and Public Forum].

Appendix 4: Mortality Data

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 which have enabled lives to be prolonged, people do die in hospital every day.

Some people die because their illness has reached a point where it is no longer treatable; some die as a result of acute events such as, a heart attack, a stroke or major trauma, such as a road traffic accident; 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. The majority of deaths are unavoidable but a small number follow treatment in hospital which is hoping to improve their life.

Why do hospitals measure mortality rates?

Mortality rates may be a reflection of specific treatment pathways or a whole organisation. 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 have or can be made.

They can also help those people wishing to make a choice about the hospital where they may want to have their treatment. When it comes to measuring mortality rates, there are three main statistics used:

Crude mortality rate (produced by the Trust)

A hospital's crude mortality rate looks at the number of deaths that occur in a hospital in any given year in relation to the number 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.

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. There have been a number of ways developed by statisticians to allow comparisons between different hospitals. These have evolved over the years and seek to make allowance for these differences.

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

One of the more commonly used methods is called the hospital standardised mortality ratio – or HSMR for short – the outcome of 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 recognised risk 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. Though the figures are released by Dr Foster, the methodology is not available for scrutiny.

Nationally the expected HSMR score for an ideal hospital 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 and variation in the way the information is recorded, along with natural random variation that occur, 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%. As a result the figures are always given with a confidence interval or limit which identifies this potential for error. So statistically 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 which fall outside these confidence limits 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. However, it does mean that the hospital needs to review things as it could point to a specific clinical issue that needs attention. Until investigated thoroughly, it is often impossible for anyone to tell what the true reason is behind a lower or higher than expected HSMR score.

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

Another commonly used method is the Summary Hospital-level Mortality Indicator (SHMI) which reports on mortality at trust level across the NHS in England using a standard and transparent methodology. It is produced and published monthly as a National Statistic by NHS Digital. The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. While SHMI is trying to allow comparison between mortality rates between hospitals utilising a similar approach to HSMR there are some differences. The methods uses some different variables which are taken in to account in calculating the scores. The principle difference among these is that SHMI includes deaths following a patient's discharge (within 30 days) which is thought to reflect better on the outcome of an episode of care. In the same way as HSMR, the SHMI is reported as a baseline figure for the average hospital and there will be confidence intervals applied to look to see if hospitals results are within a safe range. Again, any units which are outside these limits would need to establish whether there care issues which require further investigation.

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