Putting Patients First

4ward

NHS

Worcestershire Acute Hospitals

NHS Trust

QUALITY ACCOUNT 2020/21

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 this report and make suggestions for the content of future reports to the Communications Department:

Communications Department
Worcestershire Acute Hospitals NHS Trust
3 Kings Court
Charles Hastings Way
Worcester
WR5 1DD

Telephone: 01905 760453
Email: wah-tr.Communications@nhs.net

Contents

PART 1

Welcome and Introduction to this Quality Account

1.1 Worcestershire Acute Hospitals NHS Trust at a glance 5
1.2 Welcome from our Chair and Chief Executive 11
1.3 A year in Numbers 13
1.4 A Patient's Story 15
1.5 Staff Story 17

PART 2

Our Commitment to Quality

2.1 Registration with the Care Quality Commission (CQC) 20
2.2 Our Approach to Quality Improvement and Quality Governance 22
2.3 Looking Back – Review of Quality Priorities for 2020/21 38
2.4 Quality Priorities and Key Indicators for 2021/22 44
2.5 Statement of Directors' Responsibilities 62

PART 3

Trust Board's Quality Dashboard

NHS Outcomes Framework Core Quality Account Indicators 64
Clinical Audit 2020/21 70
Participation in Clinical Research 70
Commissioning for Quality and Innovation – 2020/21 CQUIN Programme 70

APPENDICES

Appendix 1: Clinical Audit Participation Details 75
Appendix 2: Care Quality Commission (CQC) Inspections and Ratings 95
Appendix 3: External Opinions – What others say about this Quality Account 100
Appendix 4: Mortality Data 104
Glossary 106

Part 1:
Welcome and Introduction to this Quality Account

Every year, all NHS hospitals in England must write an account for the public about the quality of their services. This is called a Quality Account.

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

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

It is our pleasure to showcase the work undertaken during the year to continuously improve the quality of the services we provide.

Quality in our healthcare is made up of three key dimensions:

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

This Quality Account informs you of how well we did against the quality priorities and goals we set ourselves last year in our 2019/20 Quality Account. It sets out the priorities that we have agreed for 2021/22 (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 year's Quality Account is divided into three sections:

PART ONE
An overview of Worcestershire Acute Hospitals NHS Trust, and shares a celebration of our successes in 2020/21, reflecting on the impact and significance of our response to the COVID-19 pandemic. We also include a statement from our Chief Executive, Matthew Hopkins, and Chair, Sir David Nicholson, a Staff Story, and conclude the section with a patient's story of their personal reflections of the care they received within our Trust.

PART TWO
Outlines the progress we have made during 2020/21 in relation to the quality priorities we set ourselves in our 2019/20 Quality Account. We also share the priorities we have set for the coming year (2021/22), 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
We report on key national indicators from the Single Oversight Framework (SOF), and also share performance in relation to other indicators monitored by the Board, not already reported in Parts Two or Three of the Quality Account.

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

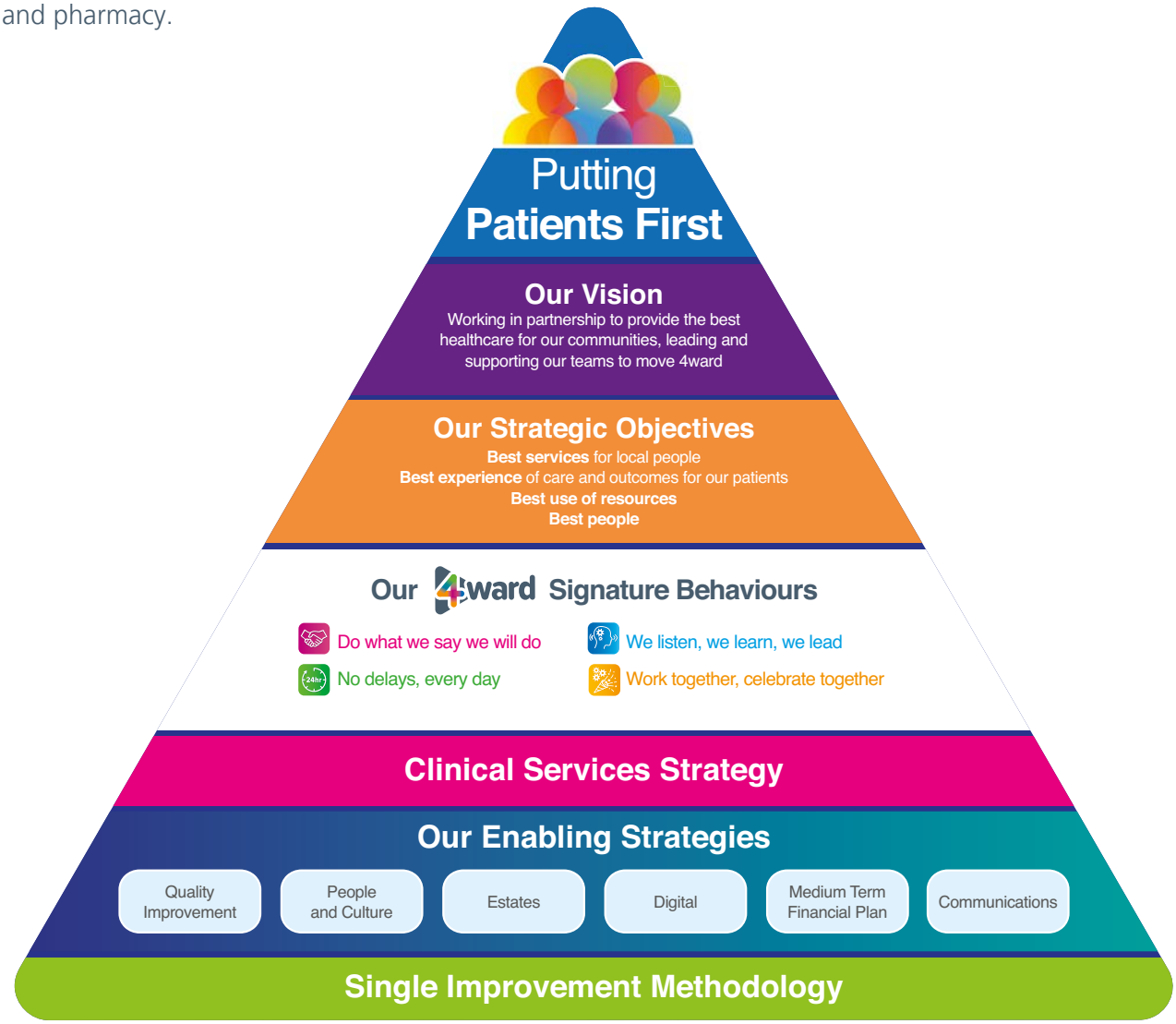
1.1 Worcestershire Acute Hospitals NHS Trust at a glance

Who we are and what we do

We serve a population of almost 596,000. This figure is projected to rise to 610,000 by 2022. The age groups with highest forecasted population growth are those 75 years and older, 60-64 year olds and 15-19 year olds.

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.



Our Strategic Pyramid

What our patients and carers say

"Nurses treated me with respect and showed empathy towards me, very professional and informative. Could not have asked for better treatment and put me at ease."

"Throughout our time we have been supported and looked after by all staff we have met along the way. Everyone has been informative, caring and understanding. We can't fault the care our baby and ourselves have received."

"Everyone made a very worrying time less stressful and put me at ease. The surroundings were colourful and calming with Smooth radio playing which was just right. From the initial consultation through to the final discussion I felt comfortable and treated with dignity and respect. A great team."

"The grace, compassion and bravery you have shown is something I will never forget."

"Excellent care; felt reassured and well informed."

"Each member of staff from security to the receptionist to the nurses were amazing. So kind, caring and helpful in what must be an extremely difficult time. Feel so thankful to them all and so lucky to have a service like this available. Can't say thank you enough."

"Friendly and welcoming atmosphere."

"I was very impressed with the attention and kindness I received. I am very grateful. Many thanks to you all and I will never forget your kindness."

"The staff were brilliant, treated with respect and empathy, made to feel at ease and told exactly what was being done and going to be done throughout my stay, give good advice before being discharged, Brilliant service, well done all."

"Without exception, the care, love and support I received by everyone was outstanding. It was the best experience I have had in any (including private care) hospital and the nursing team all worked so well together."

What our Staff say - Reflections of the COVID-19 pandemic response

"Work/life balance especially with children can be really tough at the best of times and I really have felt supported and I believe that having a bit more flexibility makes work life a lot easier."

"When everyone contributes and works together our job is done more efficiently, more effectively and more easily (sharing the work load)."

"Excellent team work."

"The cross working at operational level worked extremely well. Senior staff were engaged across all specialties which was really helpful. The responsiveness of the senior executive team with regards to the need for laboratory reagents and equipment was excellent … Decisions were made swiftly and easy access to senior decision makers was crucial to this. The sense of all staff in the Trust being part of the same team with a common shared goal."

"Team commitment to patient care and to each other."

"The logistics of moving equipment was amazing the preparation of the ITU bedspaces."

"There was a strong culture of clinical Teams working collaboratively and together across divisions and directorates, with flexibility to take initiative and focus on clinical care."

"The staff morale within the Trust seemed to me to raise enormously, the sense of being involved in something so catastrophic worldwide and having a part in making it more bearable for those that had the virus and those families who were not able to be with loved ones was humble and filled me full of pride - I want to harness that and keep it going even after the pandemic."

"Good team work, good support to redeployed staff, great MDT working and the best patient care."

"We've seen the importance of team work."

"We were given clear advice and we knew what was expected of us at all times."

What our Volunteers say

"One of my favourite parts of being a Patient Property Delivery Service volunteer is being a part of helping brighten the day of both staff and patients by delivering care packages and home comforts whilst visitor restrictions are still in place."

Biomedical BSc Student

"I have thoroughly enjoyed working as a volunteer so far and I have found it very rewarding helping families with loved ones in hospital. Everyone is really friendly and helpful and I feel privileged to be considered as part of the WAHT family."

Pandemic Response Volunteer

"Throughout the pandemic I have really enjoyed the "Keeping In Touch" emails and volunteer updates being shared by the Trust. I have thoroughly enjoyed the new addition of the Quarterly Volunteer Newsletter and it makes me feel a part of the community even though I am not currently volunteering."

Wayfinder

"I love volunteering at Worcestershire Acute Hospitals Trust as no two shifts are the same and I am constantly learning how the hospital works which I hope will help with my future career. My favourite shift was when I had the opportunity to volunteer with Robin Walker and show him the ropes. I was very grateful to be able to represent the volunteers."

Sixth form student and budding doctor

"During my time volunteering at WAHT I have always found joy and satisfaction when busy clinical staff take the time out to engage with me and thank me for my work as a ward volunteer. One doctor personally thanked me and made feel valued and a part of his team."

Retired Ward Volunteer

"I would like to say a big thank you to the Trust for the updates and information you have provided volunteers with this year. It has been amazing from having very little contact, if any in previous years, to lots of lovely, informative updates. I am sure I am not speaking just for myself when I say, that as a volunteer it has really made me feel included, very valued and recognised. I have to say that I found the attached newsletter quite emotional and absolutely brilliant as people are so kind with their offers of help and giving of their time in this crazy place we all find ourselves in."

A&E Volunteer

"I really love the work that I do, providing emotional and spiritual support to patients and staff which may simply be a listening ear for staff and patients who want to talk, be that about the colour of the leaves in the car park or painting a beautiful verbal picture of their grandchildren. As many people are not able to see loved ones this role is seen by many as invaluable and gives them an opportunity to have a conversation."

Chaplaincy Volunteer

"When I first came back to volunteer after a 6 month break due to the COVID pandemic, I shed a tear of joy after a little boy ran and thanked me after I helped him earlier that morning. There is nothing more rewarding than being a Wayfinder."

Retired Chemist

Our Values and behaviours

Putting Patients First

4ward

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, ensuring 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 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 behaviours. Our aim is to encourage all of our staff to positively demonstrate these behaviours and work 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

Building on from the foundations of our cultural improvement journey, which we began in 2017 at Worcestershire Acute Hospitals NHS Trust with our 4ward programme, we have seen the benefits of our 4ward culture in terms of our response to wave one and wave two of the coronavirus pandemic.

During this period, displaying our 4ward behaviours has continued to be a priority for us as an organisation, with a focus around team working, being accountable and innovative and completing work with no delays.

We saw this through our "no delays" response to the COVID-19 pandemic, our deployment of colleagues across the organisation and cross-team working, as well as the re-start and re-set of the NHS post-first wave of the pandemic. This response has supported us in continuing to put patients first and provide the best possible patient care.

Our growing team of 4ward advocates (culture change agents) came together with renewed focus on supporting colleagues' wellbeing, introducing WAHT's Wellbeing Academy – a virtual wellbeing space from colleagues for colleagues, which provided opportunities for holistic wellbeing; for example, advocates led exercise classes, mindfulness sessions, cookalongs, and live content around nutrition, hydration and sleep. The Wellbeing Academy utilised the skills that, as healthcare workers, they already had.

The 4ward advocate team also supported high levels of staff engagement by providing a two-way dialogue from ward to board with regards to morale, showcasing of achievements and also feedback relating to any concerns or issues that were being raised during the new way of working that the pandemic created.

Some of our 4ward advocates undertook Mental Health First Aid training, others helped with wellbeing groups and others supported care packages for clinical teams, whilst other advocates worked on increasing our digital capacity, suggesting ideas for memorials and worked on our single improvement methodology.

4ward advocates also understood that, in order to further progress our cultural improvement work, further engagement was required around our equality and diversity agenda. Therefore, advocates supported colleagues within our BAME, LGBTQ, Faith and Disability Networks and, in partnership, created the first ever WAHT Culture Month in October 2020, which celebrated 3 years of 4ward and also showcased the various elements and successes of our cultural improvement journey.

4ward advocates held sessions with Board members throughout the pandemic, ensuring that the key messages from all colleagues at all levels were being heard, in line with our 'listen, learn, lead' behaviour.

Finally, our 4ward advocates supported the National Staff Survey, walking all departments to ensure colleagues understood what the survey was and why it was important to complete. This year, the Trust achieved its highest participation rate in recent years, and the results indicated another year of improvement in both staff experience and engagement.

1.2 Welcome from our Chair and Chief Executive

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 as through the unprecedented challenge that the COVID-19 pandemic has continued to present us with over the last 12 months. 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 of Putting Patients First has been unparalleled.

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, in spite of the pandemic, to continue to reduce medicine incidents causing harm, reduce the number of pressure ulcers and continue to increase hand hygiene compliance. It is pleasing that the Trust is no longer an outlier in terms of mortality rates. Results from our Friends and Family Test also show that more than 96% of inpatients and maternity patients would recommend our hospitals.

Our successes and achievements were recognised in September 2020, when we were lifted out of Quality Special Measures by NHS England and NHS Improvement after five years, with recognition of excellent progress and hard work, particularly in improving our Urgent and Emergency Care performance.

Sir David Nicholson

Chair

Matthew Hopkins

Chief Executive

However, following an unannounced CQC inspection of the Maternity Core Service at Worcestershire Royal Hospital in December 2020, the Maternity service's overall rating reduced from Good to Requires Improvement (retaining its Good status for being effective and caring). However, we believe that the actions already taken, and the plans we have in place for the immediate future, will help us to further improve the quality and safety of the care we provide to our women and babies.

Areas for continued focus in the months ahead to ensure we provide care that is safe, clinically effective and provides a positive experience for our patients and their carers include increasing the number of thrombosis assessments carried out after 24 hours. While the number of hospital acquired C-Difficile and E-Coli infections reduced, we will continue our focus on meeting our standards for reducing MSSA infections and eliminating MRSA infections - as well, of course, as continuing our improvement journey in the areas where we have seen progress.

Following the launch of the national Patient Safety Strategy in 2019, implementation of key elements will be taken forward in this coming year, for example, co-design of the Patient Safety Partners, Lead Investigator and Medical Examiner roles.

We will focus not only on when things go wrong, but when things go right, ensuring we learn from best practice. Additional quality and safety improvement priorities, such as the Maternity and Neonatal improvement plan, antimicrobial stewardship, the Accelerated Leadership Programme and training and awareness of Learning Disability and Autism, will be areas of focus.

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

Sir David Nicholson
Chair

Matthew Hopkins
Chief Executive

A YEAR IN NUMBERS 20/21

2,723
COVID INPATIENTS

11.2
DAYS IN HOSPITAL
(FOR COVID PATIENTS)

1,996
PATIENTS
DISCHARGED

287,961
OUTPATIENTS
(FACE TO FACE)

170,264
OUTPATIENTS
(VIRTUAL AND TELEPHONE)

74,134
WALK-IN PATIENTS (A&E)

53,608
PATIENTS ARRIVING
BY AMBULANCE

118,114
INPATIENTS

4,950
BIRTHS

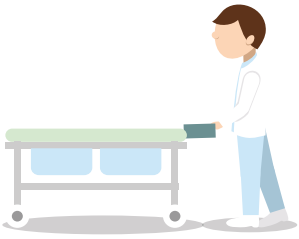
3,612
EMERGENCY
OPERATIONS

8,744
ELECTIVE
OPERATIONS

1,265
TRAUMA
OPERATIONS

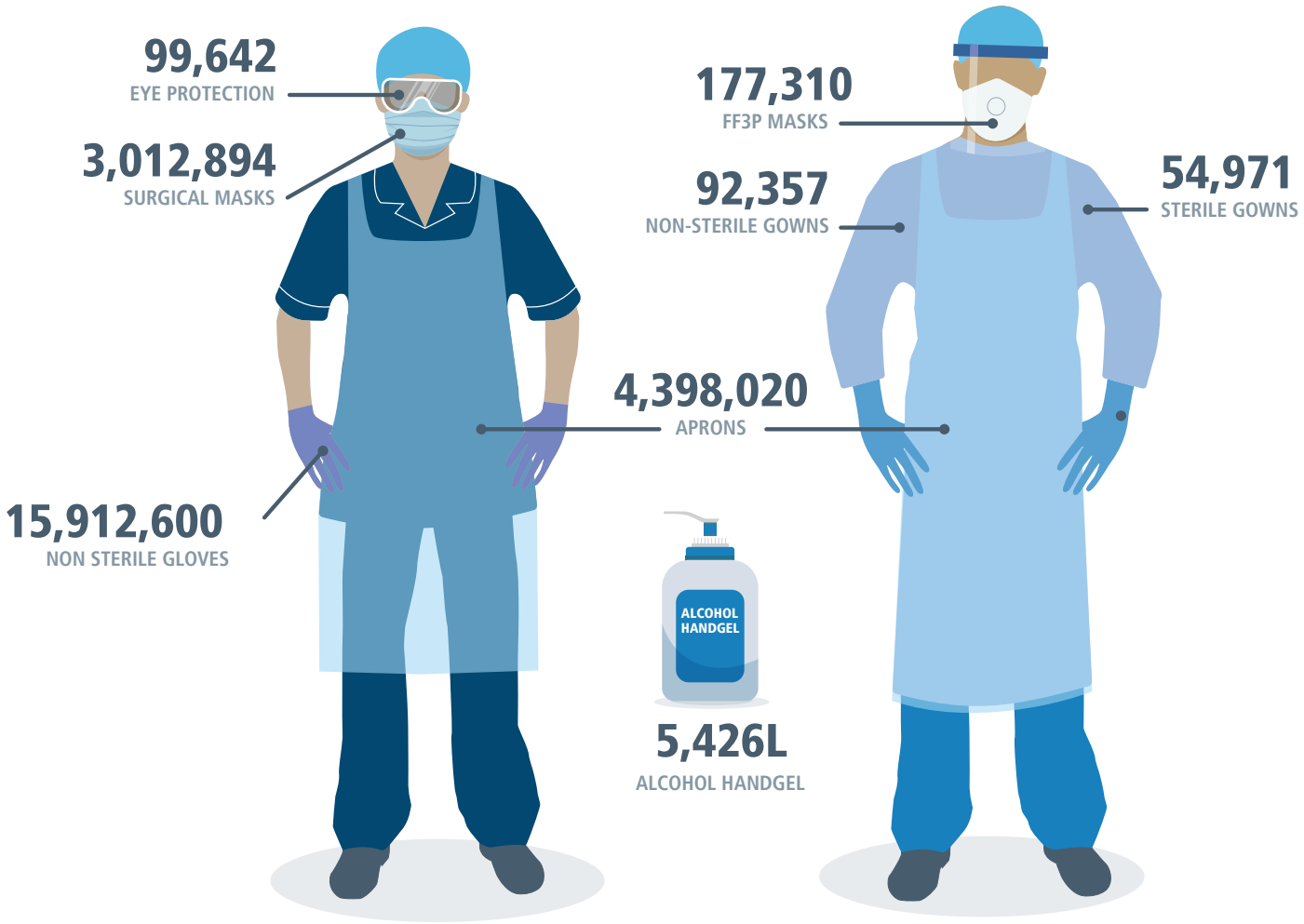
5.6 days
AVERAGE LENGTH
OF STAY

535,177
NUMBER OF MEALS
SERVED

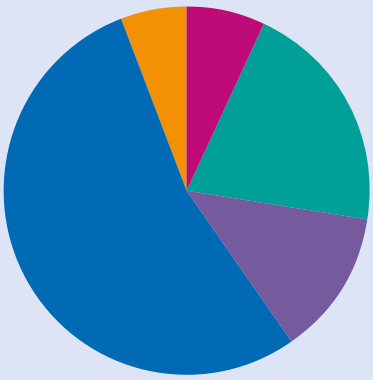


913,798
NUMBER OF SHEETS
LAUNDERED

£48.3M
VALUE OF PRESCRIPTIONS
ISSUED



Diagnostics



- MRI scans - **15,955**
- Non-obstetric ultrasound scans - **48,089**
- CT scans - **50,511**
- Plain film X-Rays - **277,165**
- Endoscopies - **11,420**

Staff

Registered Nurses and Midwives
2,149

Total Staff
6,748

Doctors and Consultants
713

HCAs, Helpers and Assistants
1,304

OTHER CLINICAL STAFF AND ALLIED HEALTH PROFESSIONALS
854

OTHER NON-CLINICAL SUPPORT STAFF
1,728

VOLUNTEERS
423

1.4 A Patient's Story

The world has experienced a year like no other and to mark the year in which we provided care against the backdrop of the COVID-19 global pandemic, we would like to share Phil's Story. Phil's story is about quality of care and stands as an example of how, by listening and responding to feedback and the experiences of our patients and carers, we can ensure we are Putting Patients First by working together to continue to make improvements in the quality of care we provide.

In March 2020, the fastest repurposing of NHS services, staffing and capacity in NHS history was initiated to support effective and timely care for coronavirus patients.

Phil Dolby is a 45-year-old, working as a Chief Superintendent running a department with the West Midlands Police. Phil lives with his wife and their three teenage children. He enjoys cycling, cinema and photography, as well as walks with his wife and their Labrador dog.

Phil's experience of COVID-19 and receiving care at Worcestershire Acute Hospitals NHS Trust has been shared on Twitter and across local & national media and his "phenomenal experience" led him to name a police dog after our Trust – "PD Royal".

Phil was invited to our July 2020 Trust Board meeting, to share his story and to explore how teamwork, the human touch and Putting Patients First saved his life, as well as providing opportunity to explore how we could learn from Phil's experience to facilitate support for families of loved ones at incredibly distressing and challenging times. Phil's story is in his own words.

I spent a month at Worcestershire Royal Hospital at the end of March into April 2020.

My wife, an ex-nurse had called 111 and I was taken by ambulance to Worcestershire Royal Hospital Accident and Emergency department. It was my daughter's 15th birthday.

I spent nearly two days in resuscitation and in Intensive Care I was placed in an induced coma for 13 days; my family were told to prepare for the worst. It was only after the next 21 days of delirium that I became aware of the care and concern showed to me by all staff – from a nurse going to get him an ice cream to help my throat which was on fire, to helping arrange a visit from my wife and children during visiting restrictions, by talking through the window in my downstairs room – a family who hardly recognised the incredibly ill, frail, thin and bearded me; a reunion which went viral on Twitter.

I lost two stone in the four weeks I spent in hospital, gained an infection from the cannula in my arm and I developed deep vein thrombosis with a blood clot; but I survived.

I have connected with the many staff I met during my treatment and recovery in hospital; all these people are putting you first. Many of the staff young and old were choosing to stay away from home, in a hotel room somewhere, many away from their young children – to help me and others.

When I was asked to share my story at the Trust Board, I was asked about quality improvement and learning from my experience. I couldn't fault the care and my treatment but I was aware how important it is that correct information is shared with families at a time when they are desperate for any scrap of news. Because of my experience and the experiences of others I was able to talk about how families can be included at this time and feel confident that their loved one is receiving the very best care.

The Trust set up a Family Liaison Service to ensure that family members are kept updated and to release pressure on nursing teams, to give loved ones a number to call and to provide a service that can provide a proactive approach with messaging. I was invited back to the Trust Board meeting in March 2021 so I could hear first-hand about how the service had been set up.

I was really pleased to see how the Trust had progressed this and was moved to hear first-hand from the staff deployed in to this service about the incredible feedback they had received. They really are making an unbelievable difference – well done to all involved.

1.5 Staff Story

Jackie Edwards

Deputy Chief Nursing Officer, Quality

Over the past year, our patients and staff have been through an extraordinary period of challenge and change. We have had to learn to adapt at pace while ensuring and striving for continuous improvement in the delivery of compassionate approaches of care, both for our patients and for one another.

As we enter the second year of the COVID-19 pandemic, it has been vital for us to reflect on our experiences of providing care during a pandemic. This opportunity to share the Staff Story of the past year for this Quality Account is a privilege – however, I have to stress, one that, in writing, has evoked strong emotions in reflecting upon memories of patients, staff's stories, insights and memories of the environmental challenges and changes we have taken, and the amazing achievements in striving for patients' experiences to be the best they can be. Our staff across all of our hospitals have done and continue to do a magnificent job in working to always put patients first, whatever the challenge and requirement.

Last year we began implementing a quality programme like none other I have experienced in my 33 years of nursing. We were required to pause many of the tried and tested quality improvement and patient experience measures, in order to meet and focus on the infection prevention and control measures required in keeping our patients and staff safe during a pandemic. We were also required to release staff from their usual roles to focus on caring for patients and consider mechanisms to keep patients connected with their loved ones.

These actions were imperative but also, on reflection, we went into unmarked territory.

The amazing commitment by staff in meeting the challenges has been humbling. We deployed staff from their base areas of work to many priority areas in order to effectively manage patients with COVID-19. To name but a few, and by no means more important than others, we saw Ophthalmology nurses, who usually care for patients in clinic areas, move into Critical Care areas, where they may not have worked for a long time; Dietitians into healthcare roles on wards to support bathing and feeding of patients; Deputy Finance Team into "buddy" roles, supporting those staff who were redeployed; Chaplain's Team supporting the wellbeing of staff, patients and families; Quality Hub Team manning support helplines to connect relatives with patients.

Our students - Nurses, Children's Nurses, Midwives, Doctors, Allied Health Professionals, etc. - stepped away from their training into roles providing care and comfort to patients in our hospitals. Their commitment to the NHS and all it stands for is fantastic, and they should feel very proud. The flexibility and bravery shown by our students in supporting in whatever way they could has made me proud to be a member of the NHS.

We were also grateful to the Army who stepped in for a 13-week period to support non-clinical care by providing portering duties in our Accident and Emergency Departments and wards, as well as providing support within the Mortuary Departments.

During the pandemic response, the Trust launched our Staff Wellbeing Academy, with a focus on holistic wellbeing, where staff were further supported by an amazing initiative known as "Project Wingman" – a charity founded in direct response to the pandemic, where airline crew offered their time, knowledge and skills to provide wellbeing and mental health support to our staff.

The support from the public and local businesses has provided a much-needed morale boost for our staff when at work or when travelling to or from our hospitals as they face the challenges that the COVID-19 outbreak has brought. The generous help, support and kindness from our local community has been both uplifting and greatly appreciated.

The learning from our experiences throughout the pandemic has been significant. Our Research Team have prioritised COVID-19 research during the pandemic, which has been imperative to

improving our knowledge of COVID-19. Our teams have worked innovatively to ensure that we are able to continue to provide crucial treatment to our patients safely, and maintain the delivery of high quality care, in spite of the challenges we have faced.

A few examples of innovations include:

- Hearts in Hands ensured both patient and loved one had a knitted heart that gave them something to hold during separation.
- Letters from home saw the Trust encourage family members to write to their loved ones while visiting was restricted.
- Virtual visiting opportunities, such as FaceTime, Zoom and MS Teams, connected patients, staff and families, to support visiting and clinical updates.
- Volunteers at entrances to deliver personal items from family direct to patient.
- Virtual clinics providing clinicians and patients with a secure virtual platform to conduct appointments.
- Remote working opportunities for staff to support social distancing and shielding requirements.

As a Trust, we managed our response to the pandemic through our Command and Control style structure, sharing information locally, regionally and nationally, to ensure clear communication and prioritisation, for the best possible outcomes for our patients.

The COVID-19 response has provided a unique opportunity to evaluate safety through learning. In addition, we have accelerated improvements in many areas, and there will be a number of things that I know as an organisation we will want to continue, to ensure safe and effective care that is

Pictured: One of our volunteers who worked with us during the pandemic.

a positive experience for our patients, their carers and our staff.

As a nurse, experiencing work and life throughout a pandemic has provided me with many humbling moments, which I reflected upon during International Nurses' Day on 12th May 2020. I have had the opportunity to work as part of the team providing the COVID-19 vaccinations to staff throughout Worcestershire. I feel incredibly privileged and proud to have worked with such incredible staff and to have played a part in supporting our strategic objective of Putting Patients First.

I would like to close my story by remembering the patients and staff who have sadly lost their lives during this time. Our thoughts will always remain with their families, friends and colleagues.

J L Edwards.

Jackie Edwards
Deputy Chief Nursing Officer, Quality

Part 2: Our Commitment to Quality

In part two of this Quality Account, we review the progress we have made in relation to the quality priorities we set ourselves in the 2019/20 Quality Account, and we will outline our planned quality improvement priorities for 2021/22. We will also provide a series of statements of assurance from the Board on mandated items.

At Worcestershire Acute Hospitals NHS Trust, we strive to achieve compassionate, safe and high quality care by ensuring that our health services consistently exhibit three key components of patient safety, clinical effectiveness and patient and carer experience. We aim to continue to achieve these key components by fostering a culture across all of our services which ensures that care is tailored to each person's needs, and guarantees their dignity and respect, by exhibiting a professional commitment to ensuring a caring culture.

2.1 Registration with the Care Quality Commission (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, ambulance services, care homes and services in people's own homes and elsewhere meets government standards of quality and safety.

Since July 2015 there have been nine announced inspections undertaken by the Care Quality Commission (CQC), a number of unannounced Core Service inspections, three focused inspections of our Urgent Care Services, and a focused inspection of our Maternity Services.

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

In partnership with NHS Improvement & England (NHSI/E), the Herefordshire & Worcestershire Clinical Commissioning Group (CCG) and West Midlands Ambulance Service (WMAS), safety, quality, risk assessment and assurance tools and processes have been implemented and embedded across the service. Oversight of the continuous improvement has been monitored via the Trust's internal governance structure and the Homefirst Worcestershire Board.

The Trust has continued to satisfy the conditions, submitting fortnightly reporting to the CQC. In February 2021, the Trust applied for the Section 31 Conditions to be removed from the Emergency Departments and, at the time of writing this report, the Trust was awaiting an outcome decision.

On 24th September 2020, the NHS National Director of Improvement confirmed that the Trust has been lifted out of quality special measures after almost five years. They also congratulated the Trust on our excellent progress and hard work, particularly in improving our Urgent and Emergency Care performance.

Throughout 2020, and as part of the COVID-19 response, CQC implemented a Transitional Monitoring Approach. Under this model, the

Trust has completed self-assessments in the following areas:

- Trust-wide focused infection control Board Assurance Framework.
- System-wide responses for the Provider Collaboration Reviews, focused on Urgent Care across Herefordshire and Worcestershire.
- Project Reset in Emergency Medicine, Patient FIRST.

During 2020/21, the CQC conducted one unannounced inspection at Worcestershire Acute Hospitals NHS Trust. On 9th December 2020, the CQC conducted an on-site focused inspection of the Maternity Core Service at Worcestershire Royal Hospital.

Following the inspection, the Maternity service's overall rating reduced from Good to Requires Improvement. The service was rated as Good for being effective and Requires Improvement for being safe and well-led. The service's previous ratings for caring and responsive remained as Good.

The inspection report, published in on 19th February 2021, positively identified that:

- Staff understood how to protect women from abuse and the service worked well with other agencies to do so. Most staff had training on how to recognise and report abuse and they knew how to apply it.
- The service controlled infection risk well. Staff used equipment and control measures to protect women, themselves and others from infection. They kept equipment and the premises visibly clean.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.
- The service had enough medical staff with the right qualifications, skills and experience to keep women and babies safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.
- Staff kept detailed records of women's care and treatment. Records were clear, stored securely and easily available to all staff providing care. However, not all records were up-to-date.
- The service used systems and processes to safely prescribe, administer, record and store medicines.
- The service provided care and treatment based on national guidance and evidence-based practice.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit women and babies. They supported each other to provide good care.
- The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy.

The CQC identified that further improvements were required within Maternity to ensure:

- Effective monitoring and oversight of staffing.
- Monitoring risks, issues and patient outcomes.
- Incident reporting and sharing learning.
- Engaging with staff to make improvements in a timely way.

- Training compliance post COVID-19 pandemic response.
- Governance processes – staff roles, accessible information.

The Trust has maintained its overall quality rating of "Requires Improvement".

Overall, the Trust continues to be rated positively "Good" in the "Effective" and "Caring" domains, and "Requires Improvement" in the "Safe", "Responsive" and "Well-Led" domains.

2.2 Our Approach to Quality Improvement and Quality Governance

Quality Improvement

Our Executive lead for quality improvement is the Chief Nursing Officer. The Trust is in its final year of the existing Quality Improvement (QI) strategy (2018 – 2021). Over the next year, we will engage with patients and patient representatives, volunteers, public and staff to produce our Quality and Safety Strategy 2022 – 2025.

Quality Improvement is about making healthcare safe, effective, timely, patient-centred, efficient and equitable. As a Trust we continue to see improvement as everybody's responsibility and encourages all staff to engage in undertaking improvement work as part of their job.

To support the Trust to embed a culture of Continuous Improvement, the Trust has a dedicated improvement team leading the Improvement Faculty, providing improvement training, facilitation, advice, coaching, expertise, leadership and project management to support the organisation's transformation agenda.

The transformation agenda this year has focused on the system wide "Home First Worcestershire" programme of work alongside the post COVID Restoration and Rehabilitation programme and the National Getting It Right First Time (GIRFT) Programme.

During this unprecedented period for the organisation, the Improvement Team have supported leads throughout the organisation to use recognised Improvement methodology, improvement tools and improvement project governance. Together, this has increased the likelihood of sustained change within the transformational programmes of work and onwards into 2021/22.

Due to the pandemic, the majority of Improvement training for 2020/21 was paused. During this time, the Improvement Team revised and updated their existing training material to be suitable for the virtual learning environment. Virtual learning will become a key element of the Improvement training offer for 2021/22 and beyond. The following improvement training was completed during 2020/21:

- 35 colleagues completed virtual QI awareness training.
- 36 medical colleagues completed the joint Improvement / Clinical Audit training session.
- 23 colleagues completed the national QI e-learning programme.
- One colleague has completed the Quality, Service Improvement and Redesign (QSIR) Practitioner training.

7% of staff have completed some form of QI training to date.

The Improvement Faculty continues to grow and develop. Each Division has identified a lead to undertake the Improvement Faculty Development Programme to become the first cohort of "Divisional Improvement Advisors". During 2021/22, nominated individuals will undertake

QSIR training to a Practitioner levels and later in the year complete the assessment to become a QSIR Faculty Associate. Divisional Improvement Advisors will become part of the wider internal Improvement Faculty, coaching and educating colleagues and therefore helping the organisation to embed a culture of Continuous Improvement.

Our approach to embedding continuous improvement is based on the principle that our staff and patients know what is needed to improve the quality of the healthcare provided to patients. Staff and patients are therefore routinely engaged in improvement work. They are involved in prioritising improvement areas, identifying improvement aims, diagnosing root causes, agreeing how to measure improvement, generating ideas for change and undertaking tests of change. This has been particularly evident in the stakeholder engagement approach undertaken to develop the 10 High Impact Changes as part of the Trustwide Restoration and Rehabilitation programme. Colleagues were invited to participate using a range of engagement channels. This included virtual engagement sessions, surveys, social media and adding feedback to graffiti boards displayed in clinical and non-clinical areas. As a result, the 10 High Impact changes are owned by everyone in the organisation.

Throughout 2020/21 the Trust continued to promote the importance of each nursing and midwifery team developing Improvement capability as a way of ensuring sustained improvement in every element of care activity. Through the Path to Platinum Accreditation programme, ward managers have a roadmap of the standards required to deliver outstanding "platinum" care for our patients. Oversight of these standards has been achieved through a safety and quality information dashboard, and, in addition, there is oversight of the Improvement "approach" that each lead uses to achieve these improvements. In conjunction with an Improvement team coach, nursing teams must provide evidence that they used recognised improvement tools and techniques, therefore consolidating the learning from the classroom and leading to increased likelihood of sustained improvements.

Establishing oversight of improvements in all areas, not just the wards, was a key objective for the Improvement Team during 2020/21. In collaboration with the Digital Team and key stakeholders, the Improvement Team developed a Trustwide Improvement Tracker application. A soft launch of the Improvement Tracker took place during the pandemic. The tracker ensures robust governance of Improvement work and guides improvement leads through the Trust's improvement framework. This application was also designed as an organisation learning tool and will be fully implemented from April 2021 onwards.

The Improvement Tracker was developed using an Agile Project Management approach. Members of the QI team completed a professional qualification in Agile Project Management during 2020 in recognition of the importance of early benefits realisation. The team are finding opportunities to model this new way of delivering change and when their own learning is consolidated they will add Agile Project Management to the suite of internal virtual training courses.

During the majority of the pandemic time period, the Improvement Team supported the Trust COVID response, for example, by:

- Setting up and running the COVID Incident Room.
- Setting up and running the triple offer Wellbeing support for redeployed ITU colleagues.
- Leading improvements in COVID discharge processes.

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 12 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.
- Approve the three Plans supporting the QIS; Patient Safety Plan, Clinical Effectiveness Plan, Patient, Carer and Community Engagement Plan
- Oversee the CQC 'must' and 'should' dos.
- Approve the Trust's annual quality account before submission to the Board.
- Monitor and review the Trust Quality Performance Dashboard.
- Review the Trust's performance against the annual CQUINs.
- Consider matters referred to the Committee by the Trust Board, other Committees or other sources.
- Have oversight of the Infection Prevention and Control Plan and receive regular updates on the action plan.
- Receive the Annual Report for Infection Control prior to it being presented to the Trust Board.
- 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 Quality Improvement Plans (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 training team.
- 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, to minimise patient safety incidents and drive improvements going forward.

We have continued our focus on reviewing our incident reporting processes to ensure we are identifying the learning for improvements and sharing where excellent practice has been carried out. Following the re-structuring of our data capture system to increase the capacity for greater quality analysis, we are now able to extract information that, when analysed, creates a more holistic picture of where changes may be needed for improvement. It is now possible to explore particular themes to generate valuable discussions, both within the Trust and with our external partners, to review processes and initiate actions for improvement. We have developed a user guide for staff on our re-structured electronic incident reporting system; a readily accessible educational reference for processing incident forms. We have also implemented daily summary notification for specific Trust teams, who now receive a single summary of all incidents reported the previous day, enhancing their ability to have oversight of incidents related to their area of work.

Our monitoring of the Serious Incident (SI) process has been maintained during this time, with continued high achievement of the standards for meeting the 60 working day deadline, despite an increase in SIs directly attributable to the pandemic (56% of total).

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 how we record 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 apology) and revised the layout of information to facilitate greater accuracy in the monitoring of incidents meeting the Duty of Candour threshold for all possible steps in the process and this has enhanced the reporting capability on compliance.

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. A dedicated process was introduced to manage risks specifically related to the pandemic, which enabled quick oversight of risks and led to speedy interventions being implemented to reduce the potential impact or likelihood of risks.

Additionally, we introduced risk leads to support local risk management processes, providing dedicated training and opportunities for central and peer support. This has enabled a better co-ordination for establishing the standard for the process, as well as providing clarity on the specifics of recording risks and mitigation with increasing accuracy. We also developed a tool to assess the quality of information for individual risks, which will enable both identification of areas of strength or weakness in the process, but also identify areas for targeted education for staff.

Following the launch of the National Patient Safety Strategy in July 2019, the Trust has evaluated its processes against the principles outlined, with consideration given to the impact on current ways of working. Many of the elements of the strategy are already in place, with progress being made. Due to COVID-19, the strategy was paused temporarily along with a number of national consultations, following which a number of supporting elements were launched, including the Patient Safety Specialist role, National Standards for Patient Safety Investigation, the National Patient Safety Syllabus and the draft framework for involving patients in patient safety.

As a result, the Trust has re-structured its corporate patient safety team to align it to the new ways of working, with revised job descriptions and roles, introduced an improvement role within the patient safety team and identified Patient Safety Specialists have been identified for the Trust. For 2021/22, the Trust has outlined its priorities for continued implementation of the strategy, which includes incorporating the national patient safety syllabus into the Trust's Academy programme, co-designing the Patient Safety Partners' roles in preparation for training and implementation, and establishing the configuration of lead investigator roles to support the National Standards for Patient Safety Investigation.

The key work programmes are intended to increase the profile of patient safety and improvement across the Trust, while upskilling the workforce in the basic and advanced principles of patient safety.

Home First Worcestershire Programme

The main aim of Home First Worcestershire (HFW) to ensure that our patients receive the best healthcare and outcomes, by ensuring:

- Our clinical teams have optimal time and resources to provide great care.
- No-one is admitted to our hospitals unnecessarily.
- If a patient needs a stay in hospital, they are admitted quickly to the right bed to meet their clinical needs.
- If the admission is for planned care, the patient has their procedure at the agreed time and in a location with the right support services.
- All patients are cared for in an appropriate and safe environment, with processes in place to minimise the risk of infection or other avoidable complications.
- When they are ready, the patient is discharged home without delay.

This is our clinical vision for flow.

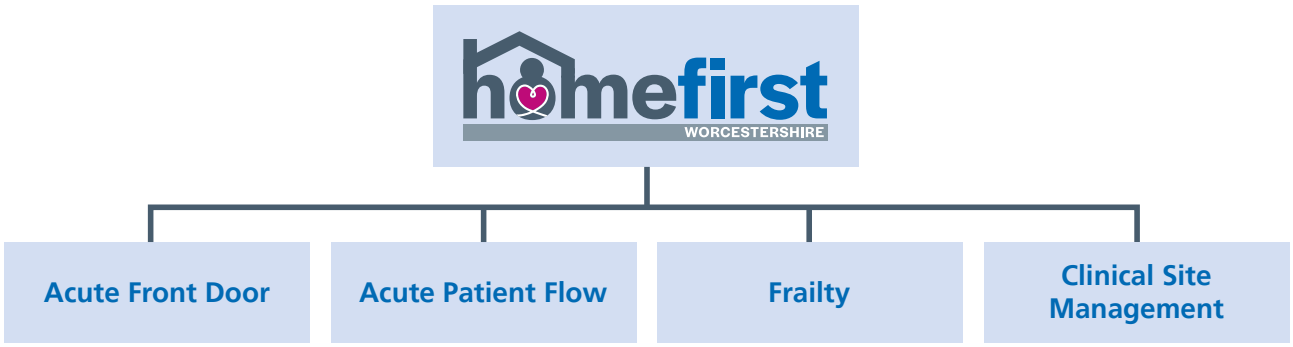
Delivering this will improve quality, safety, timeliness and performance across non-elective care and maintain good levels once improvements have been made.

KEY PRINCIPLES:
HFW uses 3 key principles to drive improvement and transformation in operational and strategic delivery and performance:

1. An acute hospital is the **best** place for someone needing acute care, but **not the best place** when they do not.
2. The Emergency Department (ED) is the **best** place for people believing they have an emergency, but **not the best** place for someone when we know that they no longer need the clinical care that our ED provides.
3. There is only one of every person and we need to do the best that we can do *collaboratively* as a health and social care system to ensure that that person receives the best possible care.

HFW drives delivery of non-elective improvement and transformation via 4 Executive-led work streams:

- Acute Front Door
- Acute Patient



- Frailty
- Flow Clinical Site Management

Throughout 2020/21, the Programme has refreshed its governance structure, the establishment of executive lead work streams and the key priorities contained within those work streams.

The priorities have all progressed and, in the main, been delivered as a result of the team-working approach, our key principles, the Executive oversight and the diligence of our staff.

We also had key quality priorities we wanted to improve upon:

- An increase in the proportion of patients seen by primary care colleagues on the acute site.
- An increase in the 4-hour performance achieved by primary care colleagues on site.
- An increase in the proportion of patients pushed to an Assessment Unit or Same Day Emergency Care (SDEC) space from ED within 4 hours.
- An improvement in ambulance handover times.
- A reduction in the number of patients receiving care in the ED/Resus corridor and number hours spent on those corridors by patients.
- An improvement of 4-hour performance.
- A reduction in average Length of Stay and Length of Stay >21 days, >14 days and >7 days.
- A reduction in the number of Medically Fit for Discharge (MFFD) patients.
- A near elimination in 12-hour breaches.

Publicly available data evidences that the Trust is now in the top 20% of Trusts for General and Acute bed occupancy performance, "total time in A&E" performance and A&E "left without being seen" performance. Delayed Transfers of Care (DTOCs) are in the top third in the country too. The public data also highlights that, between March 2020 and February 2021, the Trust was the 2nd most improved Trust in the country.

During 2021/22, we aim to continue with the delivery of our Home First Worcestershire actions, with a renewed focus in any areas where the pace was slowed down, in particular due to the response to Wave 2 of the COVID pandemic.

Data Quality

The Trust remains committed to the importance and value of quality data and strives to ensure all data is accurate, valid, reliable, timely, relevant and complete. Where risks to data quality are identified, the relevant mitigation measures are

included in the Trust's risk register. To provide assurance of our data quality, we have outlined some of our measures in place below which highlight how we work to ensure the accuracy of our patient records.

The clinical lead for data quality continues to ensure that the clinical 'voice' is heard in respect of data quality issues. A strategy to ensure the complete, accurate and timely recording of all patient information is in progress. The Trust submitted the following number of records during 2020/21 (Apr-Feb) to the Secondary Uses Service (SUS) for inclusion in England's Hospital Episode Statistics:

- A&E records – 141,386
- Inpatient records – 131,885
- Outpatients records – 523,080

The COVID-19 pandemic response impacted our ability to progress many 'business as usual' tasks while resource was re-focused to ensure the accuracy of critical data sent to external agencies in support of the management of the pandemic at both national and regional levels. However, the accuracy and completeness of submitted data for the Trust on the Data Quality Maturity Index (DQMI) for January 2021 was 91.3% (compared to a national average of 82.6% for the same period).

The Trust remains challenged due to supporting many clinical systems that may not all communicate with each other, however, we proactively interrogate data to identify and resolve issues. In 2020/21 several thousand records were improved through a combination of record cleansing, training and process change through data quality input.

Digital Update

The Data Quality Team proactively seek early engagement in the implementation of any new system(s) to ensure data integrity such as the development of the Digital Care Record and OASIS re-implementation. Early engagement in this project has helped us understand differences between key systems that hold the same demographic details, namely NHS number, date of birth and ethnicity. In addition to these, date of death will be included in the next phase, alongside a comparison of any national codes and how these map across our internal systems.

Safety Alerts

A lack of governance for safety alerts recorded on our clinical systems was identified as a contributory factor for several patient safety incidents. The clinical lead has responded by overseeing a programme of work that will cleanse and rationalise safety alerts lists across all clinical systems. A robust governance process has been implemented for the creation, review and removal of alerts on patient records. The improvements have been shared with staff as well as signposting to the new governance policy. All new revisions to alerts will now be reviewed via the Health Records Group and a 'live register' of alerts will be held by the Health Records Manager to prevent any further duplication.

Mandatory training is in place to educate employees of the importance of data quality and data security of patients records regardless of whether they have access to patient data or systems.

In September 2020, the Trust submitted the Data Security and Protection Toolkit with a rating of "Standards Not Fully Met (plan Agreed)" for 2020/2021 applied. The Trust submitted a baseline position in February 2021 for 2021/2022 with 104 out of 110 mandatory evidence items submitted, with a plan in place for full submission in June 2021, CW Audit are currently performing an Internal Audit on the toolkit in preparation for the final submission. As normal processes return following the COVID-19 response, a renewed focus on monitoring compliance against the toolkit will take place in addition to identifying

innovative and creative ways to communicate the learning.

Data quality reports are used to highlight any errors within a patient's notes, such as; missing or invalid information or an inactive GP practice. Correction is performed by the data quality team who will access the national SPINE for the most up to date demographic detail. An example of how errors are flagged and corrected is highlighted below:

Clinical coding team have a suite of data quality reports that flag potential errors. These reports share previous medical history and highlight if chronic conditions have been coded previously, alongside checking for any user type errors that would show an incorrect primary diagnosis against the length of stay for the patient. Any cases are checked by the audit team, one of whom is an accredited auditor. Individual audits are also undertaken randomly to check the overall standard of the coding with a 'pass mark' set at 90% for both primary and secondary diagnosis and procedures. Supportive measures such as additional training and mentoring are in place should they be required.

Embedding best Practice

A task and finish group is in place to ensure lessons are learned and shared from any incidents arising from inappropriately actioned changes. A new governance process has been produced to address the correct process when searching for a patient in the first instance. This mandates that searches begin on static demographic detail, NHS Number or Date of Birth – if an NHS Number is not available then the search should begin with the patient's date of birth as this detail will never change.

A report has been devised to allow the Data Quality Team to investigate changes and check legitimacy. This report provides a view of any changes over the most recent three days and allows the team to contact the user to discuss the changes made. Where an error is highlighted the user will be issued with the governance process and receive refresher training. The Chief Executive's Brief outlined the changes and new governance process for all staff on the 13th November 2020 to demonstrate focus and commitment to data quality at the board level.

Digital Strategy

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

The Digital Strategy, approved in June 2019, has been operationalised over the last 12 months, many aspects of it having been accelerated to support the Trust's response to the COVID pandemic.

The adoption of video consultations supported the continuation of outpatient services. This change is now embedded and signals a digital first approach across our outpatient services. We have introduced remote monitoring for patients with Chronic Obstructive Pulmonary Disease (COPD), and this has helped keep patients safe in their own homes and connected to their clinical team. We have worked with our partners in the Worcestershire healthcare system and have supported the pilot of remote monitoring in care homes.

The introduction of a radiology home reporting solution alongside the adoption of Microsoft Teams for both corporate and clinical services is changing the way that the Trust staff carry out tasks and engage with each other, which demonstrates the blended way in which we now work.

We are working hard to bring the digital infrastructure up to date and have commenced

on an ambitious capital programme, which will see the replacement of critical digital infrastructure. This will bring the Trust up to date and will enable the deployment of a new patient administration system and the Sunrise Digital Care Record.

The Trust has recently been awarded seed funding under the digital aspirant programme to develop a business case to accelerate the adoption of digital. The work to link the Trust and other system partners together continues with the integrated care record programme which will support clinicians through the provision of timely comprehensive patient information to support the delivery of care.

We have recruited a Lead Digital Nurse Officer and Lead Clinical Digital Officer and have an established group of clinical digital champions, who work in a multi-disciplinary team approach with IT professionals and transformational change leads to ensure the benefits of digital are harnessed. The annual plan priority to create a digital innovation hub for the county has taken strides forward and is now in the detailed planning stage and includes an innovation space and model ward and clinic environments.

In addition, we have undertaken work to modernise our IT support services, and the launch of the Next Generation Service Desk (NGSD) and TechBar aims to transform the way all staff access technical support, advice and guidance.

Path to Platinum Accreditation Programme – Ward Accreditation

PATH TO PLATINUM
ACCREDITATION PROGRAMME

YEAR 2

In April 2019 we launched our Trust-wide programme of accreditation. We know this as our Path to Platinum (P2P). P2P was implemented to recognise individual teams that distinguish themselves by improving every element of patient care activity. As teams strive for excellence, they can progress through four levels of accreditation – **Bronze, Silver, Gold and Platinum** – in recognition of significant milestones along their journey to excellence.

Our ward teams had embraced Phase 1 of P2P on 38 of our inpatient wards. We paused the accreditation process in March 2020 and again in January 2021 due to the need to support our staff to focus on the requirement of care with the outbreak of COVID-19.

However, since the programme's initial launch, much work has been done in providing a clearer pathway for accreditation following feedback from our ward teams.

Prior to the first pause in March 2020, the wards taking part in the P2P Programme had been using the revised tools which provided a clearer understanding of how the different levels of accreditation were achieved.

Wards had been identified as potentially being at the stage where they would have achieved Silver status on the P2P dashboard, with remaining requirements still required for full accreditation.

A high percentage of wards would have been at Bronze level on the dashboard and were working towards meeting the remaining requirements. Prior to the pandemic we had seen some sustained performances and improvements in quality metrics.

Quality Improvement Training, delivered by the Improvement team, has been revised for participants undertaking accreditation, with the focus being very much on areas specific to their department and this has encouraged close working with the individual teams. Bronze and Silver training are offered, as well as QSIR practitioner training. The Improvement Tracker will be available for all wards to utilise in support of their accreditation.

Fundamentals of Care Programme

The Fundamentals of Care programme evolved following a review of patient care commissioned by the Chief Nursing Officer at the end of 2019, 'back to the Floor Fridays' and from discussions with our Ward Managers, around how we could continue to be assured that our patients fundamental care needs are being met.

Year 3 of our Quality Improvement Strategy identified key priorities as:

- Nutrition and Hydration
- Hospital Acquired Functional Decline (HAFD)
- Dementia
- End of Life Care

These elements of care have formed focused workstreams, which are led by Matron and Ward Manager representatives, and the programme leads provide support to help inform and deliver improvements and changes in practice.

Workstreams include:

- Standardising Safety Huddles
- Embedding Dementia and Delirium Care Bundle
- Revision of Quality Audits
- Embedding Rockwood Clinical Frailty Score
- Revision of Nursing documentation including care and comfort

Other works streams which have been progressed through Fundamentals of Care include revision of Senior Nurse Quality Checks to ensure these are aligned to the Fundamentals of Care standards.

The Path to Platinum Ward Accreditation Programme, along with revised Quality Audits, will support and monitor the progress of the Fundamentals of Care Programme.

Quality through COVID

Family Liaison Service

Having learnt from patient and family feedback during the first wave of COVID, and in response to the increased demands on clinical staff during the second wave of the COVID pandemic, a Family Liaison Service was set up.

Family Liaison Hub

A blended approach using the skills of clinical and non-clinical staff re-deployed from various substantive roles across the Trust was used to operationalise a service which provided wellbeing updates to love ones of those patients who were unable to make contact themselves, while visiting restrictions were enforced. More than 1,200 connections between patients and their families were made by telephone and digital platforms to enable daily catch-ups, facilitate birthday celebrations and even connect with families and friends abroad.

The merits of the service were evidenced by the overwhelmingly positive response to the

hundreds of connections made between patients and their loved ones. We learned that the power of communication not only supports wellbeing but speeds recovery and we strive to embed this in our everyday practice.

Family and Carer Engagement Service (FACES)

The FACES team was implemented to provide a temporary redirect telephone service, managing external patient enquiry phone calls, in order to release valuable clinical time to ward staff. The service supported Medical and Surgical inpatient wards at both Worcestershire Royal Hospital and the Alexandra General Hospital, and Family and Carers were encouraged to use the service to make a patient wellbeing enquiry. The team was made up of a number of colleagues from a range of roles across the Trust, who had been redeployed or worked to free up capacity within their existing workload.

The FACES team ensured that all calls were recorded, monitored and actioned, working closely with the Family Liaison Hub, by sharing relevant information to make sure that families and carers receive an update in a timely manner.

The aims of the service were to:

- Reduce pressure on clinical staff to ensure their time is spent on clinical care and treatment by reducing the need to answer incoming telephone calls to inpatient ward areas.
- Provide a single recorded and monitored central service for incoming calls from family members and carers to support family and carers so that they were provided with a timely response to their enquiries.
- Provide a timely referral to the Family Liaison Hub (FLH) service, to enable the FLH team to visit the ward to obtain an update and ensure that timely, accurate and relevant information is provided to families and carer.
- Ensure Patient Advice and Liaison Service calls are redirected to the PALS team.

The FACES team supported approximately 240 families in getting information about their loved ones at speed, and the majority of calls were responded to on the same day.

The service provided a positive experience for colleagues from different areas of the Trust to come together and support each other as well as supporting our patients, families and carers.

Patient Safety and Risk Management

Given the operational impact of responding to COVID-19, quality systems and clinical oversight was managed at local/divisional level to ensure an increased level of responsiveness. While a number of the normal committees and work streams have been on hold, a number of innovations have developed to provide improved governance over how we work, while ultimately improving the overall quality and safety of care for patients, with a focus on learning.

These include:

- To ensure the Trust had a responsive approach to clinical risks as they emerged during the COVID pandemic, the Command & Control COVID governance structures received the most up to date information regards patient and staff level risks. An additional process was developed and introduced where each of the command structures at Gold, Silver & Bronze developed dedicated risk registers, focusing on tactical, strategic or operational element of risk.
  - The escalation for COVID risks was managed by the command & control

structures and supported prompt actions to new and emerging clinical risks at operational level.

- During the pandemic, we have continued to hold the Serious Incident & Learning Group weekly with shorter time frames. The group has ensured that the themes from COVID-related Serious Incidents (SIs) are responded to in real time and agreed a process for managing groups of SIs related to outbreaks particularly, to ensure the learning and actions from incidents are responded to quickly.
- A new Bereavement app has been created so all death-related processes are "under one roof" and this went live on 1st December 2020. This ensures all the lessons learnt from families' experiences and the mortality review process, drives real change and improvement.
- The Clinical Effectiveness Team have been working with IT to develop a new and no-cost document publication system, that brings benefits to how we manage our key documents. This involves;
  - A much improved search function
  - The ability to download an app that clinicians can use on their phone for easier and quicker access to documents
  - Automatic archive system (in addition to the one currently managed by the team).
  - The system and app are nearing the test phase.

Safeguarding

Maintaining quality of care:

- Utilisation of strong partnership links within safeguarding to ensure the safeguarding adult, children & young people and PREVENT agenda met – through use of IT, telephone, flexibility in working to ensure timeframes /deadlines were met /urgent priorities attended to.
- Cohesive approach by all team members to deliver the safeguarding agenda during a global pandemic.

Learning:

- The 'safeguarding system' is reliant upon all of its component parts to work effectively.
- Information sharing is key – value of alerts system /integrated approach / how systems can support safeguarding e.g. WREN reports.

Innovations:

Joined up approach with partners to ensure high risk activity continued given the challenges as a result of sickness /shielding etc. e.g. Multi Agency Risk Assessment Conference work.

Examples of Divisional Working

Surgery Division

The work that we have done with the **independent sector** (IS) has been a great example of team working between NHS and private sector hospitals. As at March 2021, we had treated over 3,700 patients across the 3 sites; approximately half of those patients would have been on a cancer pathway. These patients would not and could not have been treated on the Trust site over the last 12 months due to the restrictions regarding elective operating. This has stood us in good stead for the coming period ahead, where we will continue to work with our IS colleagues to provide additional capacity and ensure patients that have waited sometimes up to 22 months for their surgery are treated.

Our Trustwide work on **Harm Reviews** has provided a great platform for us to review the

progress we have made. There is evidence of established and ongoing maturity in the harm review process within the Divisions and, as a result, the methodology has been revised in reflection of the learning from harm reviews undertaken. The focus will now be on harm related to clinical delays and not harm related to time on a waiting list. The Harm Review Panel believes that the revised methodology will provide improved value of clinical and administrative time whilst also ensuring that clinically time is focused to ensure the process results in enlightenment as opposed to a burden that has limited results.

We have been able to see our patients **remotely**, and we expect to build on this further with the implementation of the "Attend Anywhere" system.

Specialised Clinical Services Division

In addition to what is available through the Wellbeing Academy, the Wellbeing "Buddy" role was introduced to support our deployed colleagues during the Pandemic. Clear, defined guidance was provided to the 'buddy' to support in addressing any concerns or queries, and a support system was put in place to support the 'buddy' too.

During the Pandemic the Division held daily meetings, providing an opportunity for the Divisional Management Team to relay key messages and statistics to the Directorates and for the Directorate Management teams to be able to communicate any information to the Divisional Management Team.

All meetings were minuted and circulated daily to the Directorate Operational Team(s) for information and wider cascading.

As the pressures eased, the daily meetings moved to three times a week and continued as a "drop in" session, one day a week.

Black, Asian and Minority Ethnic (BAME) Network

The role of the Black, Asian, minority ethnic (BAME) staff network is simple:

We want to create a culture where all staff & patients regardless of their race or ethnicity feel supported, cared for and are treated with dignity, kindness and respect.

If we can get it right for our BAME colleagues, then we can get it right for all staff & patient groups.

The formation of the Network was largely driven by the disproportionate impact of COVID-19 on members of our Trust workforce from BAME communities, and against the background of recent Back Lives Matter events.

Our Trust's BAME Network was established to ensure our organisation is a fairer and more inclusive place to work. Our Trust Board have championed the implementation of the BAME network to ensure we address any inequalities.

Our aim is to create a culture where all staff and patients feel supported, regardless of their race or ethnicity, and where everyone is treated with dignity, kindness and respect.

The BAME Network was set-up to align to the Trust's 4ward behaviour of *"listen, learn and lead"* in June 2020 under the stewardship of the Director of People & Culture. A group of BAME colleagues and allies were encouraged to meet each week to talk about any issues or concerns in a safe, confidential place. The group is supported by the Trust's Human Resources and Communications Teams.

Following the appointment of an elected Chair to the network in September 2020, members were elected into the posts below by October 2020:

- Vice Chairs
- Secretary
- Communications Lead
- Education and Training Lead
- Support and Advocacy Lead
- Recruitment and Retention Lead

As we embark on a new year, it's important for us to reflect on what the BAME Staff Network has achieved, such as;

- The Network has grown to a membership of nearly 100 individuals, and is an inclusive group. The Network continues to meet virtually via MS Teams each fortnight, sharing issues, experiences and ideas in a safe confidential space.

- There is representation from our Trust at the Herefordshire & Worcestershire STP BAME Group which allows networking with partnering organisations such as; Primary Care, Wye Valley and Health & Care Trust.

- An intranet page and Twitter account were set up to network, raise awareness and share relevant information. In addition, our hospital libraries have created a BAME specific literature section.

- Members of the Network attend the regional BAME and CNO meetings.

- Three task and finish groups have been set up to focus on improving:

  - Recruitment.
  - Education and training and providing.
  - Support and advocacy for BAME staff.

- **In October 2020**, the Trust Board invited the Chair of the Trust's BAME Network to present and showcase the BAME Network Group achievements. As a result, the Board supported the recommendation that all interview panels for roles at Band 8A level and above must consist of a BAME staff member. This has since been implemented by HR with a recommended framework in place to support recruiting managers.

- **In November 2020:** The Lead of the BAME Network Education Task & Finish Group provided the Trust Board with Equality and Diversity training, with a focus on self-understanding and unconscious bias.

- **In December 2020:** The Reciprocal Mentoring Programme was launched which consists of 11 BAME mentors. The aim of this programme is that:

  - **The mentor**, who is a BAME staff member, shares their experiences of what it is like to not only work in our Trust, but to further share their experience of other organisation or what it is like to live in their community; experiences shared could be positive or negative experiences.

  - **The mentee**, who are members of the Trust Board and Divisional Management Teams, will learn from the experiences shared and ensure that when developing and shaping the strategy and culture of the organisation, they are both mindful and experienced enough to ensure that our organisation strives for inclusivity for our staff, patients and visitors.

- In response to a patient complaint, the Chief Nursing Officer worked with the BAME network and our Private Funded Initiative (PFI) Partners; Engie, ISS and Siemens, to develop a statement of intent that sets out how we align our culture and way of working with respect to the Equality & Diversity agenda. This piece of focused work led to members of our PFI partners becoming active members of our BAME network.

- In support of the COVID-19 pandemic response, the Network further:

- Supported the production and implementation of the COVID risk assessment form.
- Facilitated two COVID support sessions for staff.
- Provided BAME specific information in support of the COVID vaccine to alleviate any concerns that BAME staff were experiencing.

- **In January 2021**, the Trust welcomed the appointment of two new BAME Non-Executive Directors to the Trust Board further strengthening the Trust Board's commitment to the Equality and Diversity agenda.

Learning Disabilities

Learning Disability Learning from Deaths Review (LeDeR)

The Learning Disabilities Health Liaison Team (LDHLT) are responsible for monitoring that patients with a diagnosed Learning Disability (LD) are appropriately flagged by staff on the patient administration system. Where a patient with an LD dies in the Emergency Department, hospital or community, the LDHLT registers the deaths with the Learning Disabilities Mortality Review Programme (LeDeR). Reviews are conducted using the LeDeR template and the findings reported in a quarterly board report. The LDHLT is responsible for reviewing deaths in other organisations and supporting the review of deaths in this Trust.

An internal review took place following a letter from NHS England to all Trusts on 3rd April 2020, instructing that decisions on treatments for people with learning disability and or autism should be made on an individual basis. The review of 12 deaths of patients with a learning disability between March and July 2020 was undertaken. The report acknowledged that discussions regarding future health wishes are best achieved before someone becomes acutely unwell and is admitted to hospital, and that acute teams were challenged with treating and supporting the rights and wishes of individuals whose wishes are largely unknown to them. The review concluded that, there was evidence that decisions for treatments and resuscitation made in hospital were based on clinical status and physiological reserve; and that there was no evidence that decisions were made purely on the basis of the presence of a learning disability.

A second review took place of 12 patients with learning disability, admitted to hospital as an emergency and discharged home during the same period, to understand the extent of the problem and identify areas for improvement. The review found that patients with learning disability and chronic conditions did not have ReSPECT forms with them when attending the acute hospital. While there are were systems in Worcestershire to support people with learning disability; there was a lack of evidence that there is an existing robust system for future planning or ReSPECT discussions prior to hospital admission.

NHSE/I LD Improvement Standards Data Collection

Every year as a Trust we complete the Learning Disability Improvement Standards survey which benchmarks our performance against improvement standards.

We take part in this work as part of our commitment to the *national learning disability improvement standards for NHS Trusts*, which was launched in 2018 by NHS Improvement. These standards were designed with people with a learning disability, carers, family members and healthcare professions to drive rapid improvement of patient experience and equity of care. There are four standards; the first three of these apply to all NHS Trusts and cover, respecting and protecting rights, inclusion and

engagement, workforce and specialist learning disabilities services. As outlined in the most recent report available (2019), "A Trust's compliance with these standards demonstrates it has the right structures, processes, workforce and skills to deliver the outcomes that people with learning disabilities, autism or both, their families and carers expect and deserve, as well as commitment to sustainable quality improvement in the services and pathways for this group".

The results are not shared as Trust specific data but gives a general indication. Completion of the data informs our work focus. Our learning in 2021/22 is to ensure that we re-establish a specific Learning Disability Steering group which will be co-ordinated by the Trust and will invite members from both inside and across the community to engage in the process; we will also explore new ways to engage with patients who have a disability in the benchmarking survey, due to low numbers engaging – we have previously sent out a questionnaire to patients but we will in 2021/22 explore face to face engagement and to embed this as part of our annual engagement work plan.

Of all Trusts engaging in the benchmarking, Worcestershire Acute Hospitals NHS Trust had the highest number of staff engaging with the process, as recorded in the report. This represents sustained improvement with staff actively participating in sharing their feedback at all levels of service delivery and improvement.

Freedom to Speak Up Guardian

Our vision is that every member of staff will have the courage to speak up if they have concerns about safety, quality and issues that may jeopardise patient or staff safety. We also want colleagues to address any form of unacceptable behaviour and for our managers to deal with such issues promptly and with compassion and care.

We believe that if our colleagues witness or are 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 the care we provide 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 colleagues in creating 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 45 Freedom to Speak Up Champions who all have substantive roles spread across all of our three main sites and different staff groups.

Over the last 12 months (April 2020 – March 2021), there have been 63 Freedom to Speak Up cases opened. This is an average of 5 cases per month.

We launched a Freedom to Speak Up Portal in October 2020 that provides colleagues with an additional mechanism to raise their concerns in a confidential platform.

Melanie Hurdman is the Trust's Freedom to Speak Up Guardian

2.3 Looking Back – Review of Quality Priorities for 2020/21

Care that is Safe			
Quality Indicator	**Target for 2020/21**	**Evaluation**	**Outcome or Trajectory**
1. We will reduce the percentage of medicine incidents causing harm across the Trust	Less than 11.71%	We achieved our target.	3.21%
2. We will reduce the number of patients who have a fall with harm whilst under our care	<6	We did not achieve our target; however, we have remained below the National benchmark.	8
3. We will continue to improve on progress in reducing the number of pressure ulcers	No more than 274; a reduction of 10% on all PU	We achieved our target.	213
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	**Clostridioides Difficile Infection** No more than 53	We did not achieve our target.	59 cases
	E coli Bacteraemia No more than 50	We achieved our target.	34 cases
	MSSA Bacteraemia No more than 10	We reduced the monthly number of cases occurring by December 2020; however, we did not achieve our target.	25 cases
	MRSA Bacteraemia 0 cases	We did not achieve our target.	2 cases
	Hand Hygiene Above 97%	We achieved our target.	99.51%

Care that is Safe			
Quality Indicator	**Target for 2020/21**	**Evaluation**	**Outcome or Trajectory**
5. We will further improve the identification and treatment of sepsis	Baseline position for screening in the emergency department: >95%	We achieved our target.	97.13%
	Baseline position for screening in inpatient wards: >95%	We did not achieve our target.	76.53%
	Baseline position for implementing the sepsis six bundle in the emergency department: >80%	We did not achieve our target.	75.19%
	Baseline position for implementing the sepsis six bundle in inpatient wards: >95%	We did not achieve our target.	32.17%
6. We will further improve our compliance with screening for venous thromboembolism (VTE)	>95%	We achieved our target.	96.71%
7. We will ensure that the nutrition and hydration needs of patients in hospital are met	100% of patients will have an assessment and documentation of their nutritional and hydration needs	We recognise that this is an area for further focus over the next year.	Quality audits were temporarily suspended during the pandemic therefore data is not available against this metric.
	>90% of patients, who in their care plans are identified as requiring this to meet their care needs, will have a fluid balance chart and food diary	We recognise that this is an area for further focus over the next year.	Quality audits were temporarily suspended during the pandemic therefore data is not available against this metric.

Care that is Safe			
Quality Indicator	**Target for 2020/21**	**Evaluation**	**Outcome or Trajectory**
8. We will develop a process of recognition of patients who have a prolonged length of stay which could result in the experience of Hospital Acquired Functional Decline (HAFD), and raise the awareness amongst staff	Measured through a subset of indicators from the Homefirst Frailty / HAFD Dashboard, which will be:	We continued to monitor the indicators via the Home First Worcestershire Board.	
	% Emergency admissions 75+		35.13%
	% of patients 75+ discharged with Length of Stay (LOS) 0 days		17.47%
	% of patients 75+ discharged with LOS 1 – 2 days		25.9%
	% of patients 75+ discharged with LOS 3+ days		56.56%
	Number of patients 75+ with LLOS 7+ days		1,149
	Number of patients 75+ with LLOS 21+ days		203
	Total time in A&E 95th percentile Trust daily		9.1

Care that is Clinically Effective			
Quality Indicator	**Target for 2020/21**	**Evaluation**	**Outcome or Trajectory**
1. We will monitor and seek to reduce mortality rates for patients whilst under our care	HSMR of 100	We achieved our target.	98.04
2. We will implement clinical standards for Seven Day Hospital Services	All patients are reviewed within 14 hours of coming into our care	*The audit was suspended during 2020/21.* Auditing has now recommenced, and the analysis of data will enable a more comprehensive update on progress.	At November 2020, 56% of patients had been reviewed within 14 hours of coming into our care. The audit was suspended during 2020/21, and has now recommenced.
	All patients have improved access to diagnostics		
	All patients have access to a consultant for direct interventions		
	All patients have ongoing consultant reviews		
3. We will complete an annual programme of local clinical audits	80%	We did not achieve our target.	45%

Care that is a Positive Experience for Patients and their Carers			
Quality Indicator	**Target for 2020/21**	**Evaluation**	**Outcome or Trajectory**
1. We will respond to complaints within 25 working days of receipt and ensure we create learning from the themes from complaints	80%	We did not achieve our target.	69.14%
2. We will reduce the number of complaints returned from those who are not satisfied with the response	10%	We did not achieve our target.	14.8%

Care that is a Positive Experience for Patients and their Carers			
Quality Indicator	**Target for 2020/21**	**Evaluation**	**Outcome or Trajectory**
3. 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 our baseline response rates for emergency departments, inpatients, outpatients, paediatrics and maternity services. We will specifically focus on ensuring that the public is encouraged and aware of how they can feedback to us and we will demonstrate that we are listening and sharing what we are being told	95%	We achieved our target.	96.29%
4. We will ensure patients with Dementia and their carers feel they have received care that positively improves their outcomes, as reported within the national dementia audit, through implementing consistently the Dementia bundle with every patient admitted under our care	80%	We were just below our target.	79.86%
5. Ensuring patients and their carers feel listened to and have clear lines of communication with staff about their condition, treatment and care		A number of initiatives were developed to support patients and their loved ones.	We will focus on increasing accessibility and responsivity. *Please refer to our Quality Priorities within the Quality Account for actions we will take.*

Care that is a Positive Experience for Patients and their Carers			
Quality Indicator	**Target for 2020/21**	**Evaluation**	**Outcome or Trajectory**
6. We will engage with and understand the needs of patients who are receiving care at the end of their lives, and will offer services to meet their physical, psychological, social and spiritual needs and will ensure that they are involved in and have control over decisions about their care.	Increase in engagement in advanced care planning including the update of ReSPECT and AMBER Care Bundle for those with uncertain recovery	We have continued to make improvements in engaging and understanding the needs of patients who are receiving care at the end of their life.	Authorship 84.43% & Awareness 75.16% at March 2021
	Compliance with the use of the Individualised Last Days of Life (LDoL) for Adults care plan, for those identified as being in the last days of life		LDoL Care Plan audit - 95% patients recognised to be in the last days of life having a care plan completed.
	Constructive participation in local and national End of Life audits		Last participated in National Audit for Care at the End of Life (NACEL) in 2019/20
	Positive feedback from patients and those important to them		Planned to repeat patient/carer feedback survey in 2020, but this was postponed by the pandemic. The NACEL audit also gathers feedback from bereaved family members on EOLC. The VOICES survey is not currently being given out due to changes in bereavement service as a result of COVID. The questionnaire is currently under review & plans for an online version in place.

Care that is a Positive Experience for Patients and their Carers			
Quality Indicator	**Target for 2020/21**	**Evaluation**	**Outcome or Trajectory**
continued... 6. We will engage with and understand the needs of patients who are receiving care at the end of their lives, and will offer services to meet their physical, psychological, social and spiritual needs and will ensure that they are involved in and have control over decisions about their care.	Reduction in End of Life Care related complaints	We have continued to make improvements in engaging and understanding the needs of patients who are receiving care at the end of their life.	Number of complaints which include EOLC: **WRH:** **2018/19:** 2.2% (n = 7) **2019/20:** 1.4% (n = 5) **2020/21:** 1.4% (n = 4) **AGH:** **2018/19:** 1.16% (n = 2) **2019/20:** 2% (n = 3) **2020/21:** 3.8% (n = 4)
	Engagement and increased uptake in End of Life education and training amongst healthcare professionals		End of Life Care team have continued to deliver teaching to relevant staff groups. E-learning modules have been identified.

2.4 Quality Priorities and Key Indicators for 2021/22

During 2020/21, The Trust has been required to ensure a clinical focus on the reactive response to the COVID-19 pandemic. Following consultation with our stakeholders, the Board of Directors agreed that the Trust will continue with a renewed focus on those Quality Priorities agreed for Year 3 (2020/21) throughout 2021/22, as our "Year 3 +1 Priorities", to ensure that we continue to strive for high quality patient care.

These key quality priorities are:

- **Priority 1** – Care that is **Safe**
- **Priority 2** – Care that is **Clinically Effective**
- **Priority 3** – Care that is a **Positive Experience** for Patients and their Carers

To better understand what is important to our patients, to understand how our patients feel about the quality of the services we provide, and to ensure that our future quality and safety priorities align to patient needs, we have engaged with the following stakeholders:

- Healthwatch
- Patient and Public Forum
- Youth Forum
- Students

In addition to the above, and in support of the Trust's Big Quality Conversation, we have conducted an online survey, which asks our patients to provide feedback on the quality and safety of services they have received while in our care during 2020/21.

In terms of **Safety**, the survey findings tell us that 70.5% of 227 people who answered the survey question reported feeling "Extremely Safe" or "Very Safe" during their time at one of our

hospitals. Patients told us that the following areas are important to them:

- Infection Prevention and Control (cleanliness, PPE and social distancing)
- Staffing (staffing levels and skilled staff)
- Security

In terms of **Effectiveness**, the survey findings tell us that 70% of 225 people who answered the survey question reported that staff worked together "Extremely Well" or "Very Well" to deliver care and to put patients first. Patients told us that the following areas are important to them:

- Staffing (competent and skilled staff)
- Delays (no long waits, appointments on time and no delays)
- Communication (good and clear communication)

In terms of **Positive Experience**, patients told us that the following areas are important to them:

- Communication (feeling listened to, clear instructions and effective communication)
- Car parking
- Staffing (friendly, caring staff, and positive staff attitude)

The Trust continues to explore the data and will ensure that the findings are reviewed to inform the Quality and Safety Strategy 2022 – 2025 priorities.

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 2020/21 was 3.21%	Our target for 2021/22 is a reduction to less than 11.71%

In 2020/21:
We achieved our target and we have seen a significant reduction in reported medicines incidents causing harm.

We achieved this by:

- Regular review of divisional action plans developed to meet Key Standards for Medicines Safety.
- Pharmacists professionally screening medicines charts when the pharmacy was open.

In 2021/22:
We will achieve our target improvement by:

- Developing actions to meet Key Standards for Medicines Safety.
- Re-establishing Safe Medicines Practice Group to focus on reducing harm associated with insulin using quality improvement methodology.
- Sharing and learning lessons from serious incidents and other incidents including near misses.
- Promoting antimicrobial stewardship and implementation of Start Smart Then Focus principles.

QUALITY INDICATOR 2:

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

Our position for 2020/21 was 8 serious incident falls	Our target for 2021/22 is a reduction to 6 serious incident falls.

In 2020/21:

There have been 8 serious incident falls against a trajectory of 6. We were over trajectory by 2 serious incidents. Despite seeing fewer bed days, the Trust have remained below the national benchmark of 0.19 serious incident falls per 1000 bed days, at an average of 0.04.

In 2021/22:

- Ensure all policies are up to date and circulated Trustwide.
- Once national e-learning tool is back up and running, aim for 80% compliance Trustwide.
- Re-establish 'stay in the bay' post COVID.
- Review and update falls assessments Trustwide through the Fundamentals of Care workstream.
- Re-establish the Falls Steering Group with Divisional representation.
- Develop a data process to capture real time themes and trends from falls and SI falls.
- Develop a governance process to include specialist oversight of all falls with harm being investigated to review, challenge and scrutinise.

QUALITY INDICATOR 3:

We will continue to improve on progress in reducing the number of pressure ulcers.

Our position for 2020/21 was 213 pressure ulcers	Our target for 2021/22 is a reduction of 10% on all HAPU. No more than a total of 247 HAPU.

In 2020/21:

We are pleased to confirm that all trajectories set in reducing Hospital Acquired Pressure Ulcers (HAPUs) by 10 % have been achieved in 2020/21.

Against a trajectory of 274, the Trust reported 213 hospital acquired pressure ulcers 61 below trajectory).

The percentage of patients who sustained a HAPU is 0.45% (this is based on the number of emergency admissions during the year).

In 2021/22:

Our target is a further reduction in all HAPUs by 10% of the 2020/21 achievement of 274 HAPU.

2021/22 Trajectory = Total 247 HAPU
Total 4 Serious Incidents

This will be sustained with continued support to all staff, managers and Matrons through planned teaching curriculum, Intranet resources & Tissue Viability team visibility. Reporting will continue as per NHSE/I Guidance.

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.

Clostridioides Difficile Infection

Our position for 2020/21 was 59 cases.	Our target for 2021/22 a reduction to 53 cases. *This will be revised when the national infection reduction targets are released in quarter 2.*

In 2020/21:
We have improved in 2020/21, with a slight reduction in the number of cases to 59 compared to 61 the previous year.

We did this by improving our cleaning standards, maintaining high standards of hand hygiene, and reviewing each patient who developed infection to see what we could learn.

In 2021/22:
We will be:

- Focusing work on antimicrobial stewardship to improve our prescribing of antibiotics in line with national 'Start Smart Then Focus' principles.
- Reviewing our cleaning arrangements to ensure we maintain the high standards we have achieved in 2020/21.
- Using learning arising from our reviews of patients with this infection, to improve the care we give to patients who develop diarrhoea.

E coli Bacteraemia

Our position for 2020/21 was 34 cases.	Our target for 2021/22 is a reduction to 30 cases. This is a 10% reduction on the 2020/21 outturn. *This will be revised when the national infection reduction targets are released in quarter 2.*

In 2020/21:
We have improved and fully met our improvement target in 2020/21, with 34 cases reported in 2020/21.

We have done this by concentrating on the care of urinary catheters, to ensure this is in line with high impact interventions. We also continue to participate in the health-economy gram-negative infection group.

In 2021/22:
We will be performing a detailed review of all E coli bacteraemia that have occurred over the past year, to identify additional learning that we can implement to reduce these infections further.

We will also continue our work on urinary catheters, and to work with the health-economy.

MSSA Bacteraemia

Our position for 2020/21 was 25 cases.	Our target for 2021/22 is a reduction to no more than 10 cases. *This will be revised when the national infection reduction targets are released in quarter 2.*

In 2020/21:
Despite reducing the monthly number occurring by December 2020, we reported 25 cases by

year-end. We therefore did not meet the target we set this year, with a sharp increase in the number of cases in quarter 2.

In response to the rise in cases we took focused action to improve the care of patients with peripheral cannulae, and commenced a quality improvement project to identify and take forwards other actions to stop the increase in cases.

In 2021/22:
We will continue with our quality improvement project work on Staphylococcus aureus bacteraemia to address the issues being identified. This will include re-launch of the Aseptic Non-Touch Technique (ANTT) programme, and full implementation of procedure packs, as well as frequent monitoring that we are delivering care in line with the national high impact interventions for invasive devices.

We will also continue to review each case of MSSA bacteraemia to identify other learning that we can put into practice.

MRSA Bacteraemia

Our position for 2020/21 was 2 cases.	Our target for 2021/22 will remain at 0 cases.

In 2020/21:
We reported 2 cases of MRSA bacteraemia in 2020/21, breaching the zero target we set.

Both cases have been reviewed, and local action has been taken by the areas involved to ensure this does not happen again.

The actions being taken to address the rise in MSSA bacteraemia cases will also help to prevent further cases of MRSA Trustwide.

In 2021/22:
We will continue with our quality improvement project work on Staphylococcus aureus bacteraemia to address the issues being identified via the project. For MRSA, this will include focus on blood culture technique to avoid contaminated blood cultures.

We are also reviewing our MRSA policy to ensure it remains in line with the evidence-base for practice.

Hand Hygiene

Our position for 2020/21 was 99.51%.	Our target for 2021/22 is to continue maintaining hand hygiene at 98% or above.

In 2020/21:
Our hand hygiene compliance was over 99% in 2020/21, meeting our target.

Hand hygiene has been a major focus for safe practice in 2020/21. As part of measures to protect staff and patients from COVID, we have regularly reminded staff about the importance of hand hygiene, and have increased the availability of alcohol hand gel.

In 2021/22:
We will continue with hand hygiene as a core part of our 'Key Standards to Prevent Infection', with monthly audit in all areas, and regular reminders and awareness raising.

We will also review our monitoring programme for hand hygiene to ensure it is as robust as possible.

Antimicrobial Stewardship

During the past year we have focused on how we use antibiotics (antimicrobial stewardship), aiming to ensure we prescribe and use antibiotics in line with national guidance. All of our Divisions have focused plans to help reduce the overall use of antibiotics, and to ensure all prescriptions for antibiotics are reviewed regularly and stopped as soon as it is safe to do so. We have put in place a monthly audit check to monitor our progress.

This was interrupted by the second wave of the pandemic and we are now re-focusing on this throughout 2021.

The Antimicrobial Stewardship Steering Group, which is set up to provide oversight and input into the development, implementation and on-going review of the antimicrobial stewardship programmes, has reconvened after being paused during the second wave. All Divisions have identified Clinical Leads for antimicrobial stewardship to help drive improvement and optimisation of antimicrobials.

QUALITY INDICATOR 5:

We will further improve the identification and treatment of sepsis.

Baseline position for screening in the emergency department: 97.13%	Our target for 2021/22 is >95%
Baseline position for screening in inpatient wards: 76.53%	Our target for 2021/22 is >95%
Baseline position for implementing the sepsis six bundle in the emergency department: 75.19%	Our target for 2021/22 is >80%
Baseline position for implementing the sepsis six bundle in inpatient wards: 32.17%	Our target for 2021/22 is >95%

In 2020/21:

After months of improvement, Sepsis compliance deteriorated; partly due to changes in the audit process and secondary to increased COVID-related activity. However, the Sepsis Leads have implemented new training and are developing actions with each Division to improve compliance.

In 2021/22:

The Sepsis Clinical Leads are working to improve compliance and it is hoped to improve with the implementation of the new training, a new audit process and recruitment of Physicians Associates to the Sepsis workstream.

QUALITY INDICATOR 6:

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

Our position for 2020/21 was 96.71%	Our target for 2021/22 is >95%

In 2020/21:

We have achieved the initial VTE assessment on admission target every month since April 2019, including throughout the Pandemic.

The same level of performance has not been mirrored for compliance with 24 hour VTE re-assessment. Although the trend is generally upward, the performance is still below the target.

In addition, a robust process for monitoring of Hospital Acquired Thrombosis (HAT) is in place with monitoring of admission data, imaging data and feedback from the coroner on any deaths related to pulmonary embolism which are cross checked with hospital data.

In 2021/22:

We will:

- Continuously monitor VTE compliance with a focus on improving 24-hour review.
- Review of all cases of HAT is undertaken to ensure any process issues with prevention are identified and interventions put in place to improve outcomes.

QUALITY INDICATOR 7:

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

100% of patients will have an assessment and documentation of their nutritional and hydration needs. *Quality audits were temporarily suspended during the pandemic therefore data is not available against this metric.*	Our target for 2021/22 is 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 care needs, will have a fluid balance chart and food diary. *Quality audits were temporarily suspended during the pandemic therefore data is not available against this metric.*	Our target for 2021/22 is >90% of patients, who in their care plans are identified as requiring this to meet their care needs, will have a fluid balance chart and food diary.

New fluid balance charts and food diaries were launched Trustwide in February 2021. The fluid balance charts have been revised following incidents and learning outcomes, and the new documentation describes the escalation required to professionals if concerns are identified.

An audit programme will be implemented every six months to monitor compliance with the new documentation. The first audit has been scheduled to take place in May 2021.

The Senior Nursing Quality Checks, completed by Matrons, have been revised and updated to reflect the changes in documentation, and all audits will be monitored through the Hydration and Nutrition steering group.

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 of Hospital Acquired Functional Decline (HAFD), and raise the awareness amongst staff.

Hospital Acquired Functional Decline (HAFD) has continued to be measured through a subset of indicators from the Homefirst Frailty / HAFD Dashboard.

Indicators
% Emergency admissions 75+
% of patients 75+ discharged with Length of Stay (LOS) 0 days
% of patients 75+ discharged with LOS 1 – 2 days
% of patients 75+ discharged with LOS 3+ days
Number of patients 75+ with LLOS 7+ days
Number of patients 75+ with LLOS 21+ days
Total time in A&E 95th percentile Trust daily

Baseline position for 2020/21:

Home First Worcestershire Frailty/HAFD SPC charts report the metrics that influence Hospital Acquired Functional Decline (HAFD). The metric that best evidences improvement in HAFD (from a subset of the HFW Frailty/HAFD metrics) is **72 hours and above LOS.**

A target/trajectory was not possible as the profile for patients during the Winter months 2020 was unknown due to potential influence of the COVID pandemic. To date there is not enough information to evidence how much COVID has suppressed people's normal access to health activities i.e. have people been waiting longer to seek health services support and therefore have been deconditioning at home. This makes

it difficult to benchmark against previous years as the health profile may have been be much more acute in 2020. We have therefore looked at maintaining within the upper and lower control limit for LOS from 2019 to ensure that this was not widening showing a lack of process governance.

Our Target for 2021/22 is to:

Demonstrate the impact of the Geriatric Emergency Medicine Service (GEMS) team on the Home First KPIs that are a national benchmark for the care of this patient group. The Digital Division – Information Team have created a separate GEMS/Frailty Dashboard using Avon 4 will act as the control group to benchmark GEMS intervention for patients requiring admission to focus on:

- Any difference in LOS and readmission for patients seen by the team compared to those who are not; this will include SDEC
- Identify what % of patients the team are seeing as a proportion of the potential number who would warrant the additional frailty inputs.
- Profile measures such as the Clinical Frailty Score (CFS) to potentially identify consistencies and inconsistencies

In 2020/21:

- Frailty e-learning live as essential training from December 2020; 71.81% of eligible clinical staff have completed at end March 2021.
- Hospital Acquired Functional Decline (HAFD) Matron/Ward Manager Quality Audit questions have been finalised for digital upload to GAP/WREN.
- HAFD and ReSPECT Datix reporting now live; reports to Homefirst Worcestershire Frailty/HAFD/ReSPECT Workstream and Worcestershire ReSPECT Steering Group.
- ReSPECT essential training Awareness and Authorship have met 75% target at end January 2021.

In 2021/22:

- Attendance at Clinical Reference Group to progress the addition of the CFS to existing medical/nursing assessment documents, plus transfer to the WAHT Digital Record and ICS Integrated Health and Wellbeing Record.
- Clinical Frailty Screening using Rockwood at triage and population on the Patient First System.
- Clinical Frailty Score & ReSPECT to be added to Electronic Discharge Summary.

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 2020 is 98.04 (rolling 12 months to December 2020)

Hospital Standardised Mortality Rate (HSMR) relies on a second cut of SUS and this tends to lead to some volatility in the measure. As our HSMR is as much reliant on the coding and submission of SUS by other Trusts as it is our own, this means that we should be mindful of the accuracy of the latest HSMR on HED.

More pertinent to where we are now is the incompleteness of HSMR in general. Ordinarily this measure captures about 85% of all inpatient deaths (and no deaths after discharge). As the coding used for COVID patients ***is not included by the HSMR methodology*** this now means that we are looking at a % of that 85%. Furthermore, we are going to live with this for at least another 12 months (HSMR is based on a rolling 12 months of data).

Our target for 2021/22 is a reduction of HSMR to below 100.

In 2020/21:
The Trust position reflects favourably and we are not seeing a negative effect on reported mortality or quality of coding; the Trust is no longer an outlier in respect of HSMR.

In 2021/22:
We will:

- Develop a Trust Strategy for Learning from Deaths to continually improve the Trust's HSMR.
- Fully implement the Bereavement App to ensure full data collection.

QUALITY INDICATOR 2:
We will implement clinical standards for Seven Day Hospital Services.

All patients are reviewed within 14 hours of coming into our care At November 2020, 56% of patients had been reviewed within 14 hours of coming into our care. However, auditing was suspended during 2020/21.	Our target for 2021/22 is 100%
All patients have improved access to diagnostics	Our target for 2021/22 is 100%
All patients have access to a consultant for direct interventions	Our target for 2021/22 is 100%
All patients have ongoing consultant reviews	Our target for 2021/22 is 100%

Auditing for clinical standards for Seven Day Hospital Services was suspended during 2020/21, to ensure that our teams could be redeployed to support COVID clinical services as part of the Trust's response to wave 1 and wave 2.

Data collection for this audit resumed in March 2021, and the analysis of this data will enable a more comprehensive understanding of progress.

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

Our position for 2020/21 was 45%	Our target for 2021/22 is to complete 80% of the annual programme of clinical audits. (BOPP – Better Outcomes for Patients Programme).

In 2020/21:
At 31st March 2021 45% of the 2020/21 Better Outcomes for Patients Programme (BOPP), which is the Trust's annual clinical audit programme, was completed, with a further 17% of BOPP audits being in progress, which will complete during 2021/22.

It is also important to note that throughout 2020/21 a number of audits that were in progress from the 2019/20 BOPP completed. 2019/20 closed with 58% of the BOPP completed, and this rose to 67% by 31st March 2021.

The clinicians' priority has necessarily been supporting the Trust's response to COVID-19. This has meant a reduction in time available to complete planned clinical audit, with clinicians' dedicated clinical audit time having to be converted to clinical time. In addition, some of the planned audits related to activity that has ceased due to COVID-19, or that has reduced to such an extent as to make the sample sizes too small for meaningful audit.

The BOPP was developed prior to the COVID-19 pandemic. COVID-19 has changed the priorities for clinical audit. Consequently, while 45% of the BOPP had been completed to 31st March 2021, a significant amount of ad hoc audits had been completed. Ad hoc audits are able to respond to issues that emerge throughout the year.

At 31st March 2021, 140 ad hoc audits had been completed. 37 of these were specifically related to COVID-19, with 18 being nationally driven and 19 being locally developed.

At 31st March 2021, a further 109 ad hoc audits were in progress, and will be completed during 2021/22.

It is pleasing to report that, while COVID-19 has impacted on the delivery of the BOPP audit, the Trust participated in 100% of national audits that it was eligible to participate in.

In 2021/22:
We anticipate that post-COVID, and once clinical activity has returned to its pre-COVID levels, the delivery of clinical audit will be back on track.

2018/19 was the last year not impacted by COVID-19, when 74% of the BOPP was delivered, and we will aim to extend delivery to at least 80% in 2021/22.

We are committed to improving the quality of the local clinical audit that is completed, and will continue to support Specialty Clinical Audit Leads to adopt quality improvement methodology, so that they are able to support others to do the same.

We will continue to make clinical audit training available, together with drop-in sessions, 1:1 support and templates, tools and other resources for those carrying out clinical audit. We will continue to work closely with the Quality Improvement Team ensuring that our approaches are consistent.

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 position for 2020/21 was 69.14%	Our target for 2021/22 is an increase to 80%

In 2020/21:

The effect of the coronavirus pandemic on the workload of staff investigating complaints and a national pause of the complaints process, determined that the target improvement position has not been achieved, compared to the previous two financial years. However, taking this into account, the Trust has finished the financial year without a backlog and is on track to meet the target in 2021/22.

Our target had been achieved and sustained for two years consecutively. We were in a good position to continue to maintain this performance; however, in response to the Coronavirus pandemic, NHS England/NHS Improvement advised a nationwide pause of the Complaints Process for Q1 2020/21; this, coupled with an increased clinical workload for our Divisions, specifically for Operational Managers and for those investigating complaints, determined that the Trust's caseload and performance has been inconsistent throughout the year. Improvement was seen in Q3 with performance stabilising in Q4.

Although continuous improvement within the Complaints Process has been ongoing, a number of improvement projects that were proposed for 2020/21 were put on hold due to the need to focus on delivering the core service; these will be included in the work plan for 2021/22.

In 2021/22:

- Bi-monthly focused Divisional meetings.
- Quality Improvement ThinkTanks to share good practice and to use improve methodology and practical tools to support improvement projects and solutions focused approaches.
- An increased focus on Learning from Complaints.
- Development of a Divisional training programme to build on awareness gained in the pilot project with the Patient Representatives; focusing on the quality of responses and "No delays every day".
- Measures will support the Trust in preparation for a national Complaints Standards Framework.

QUALITY INDICATOR 2:
We will reduce the number of complaints returned from those who are not satisfied with the response.

Our position for 2020/21 was 14.8%	Our target for 2021/22 is 10%

In 2020/21:

- We demonstrated improvement on previous years and maintained a similar position to 2019/20 at 14.8% in 2020/21.
- To ensure patient, carer and public satisfaction we worked with Divisional Teams to process and respond to feedback, our complaints and Patient Advice and Liaison Service (PALS) concerns as quickly as possible and within their target time.
- To understand how effective our quality improvement measures have been and to continue to reduce the number of reopened complaints, we engaged with the Patient

and Public Forum to quality review a sample of complaint responses and provide their analysis and feedback. This review confirmed that our actions taken had led to quality improvements with how we respond to our formal complaints and has led to clear actions which will be delivered in 2021/22 to further improve public satisfaction with the complaints process.

In 2021/22, we will:

- Continue the quality review focus with our Patient Representatives to analyse responses to complaints, identify good practice and areas for improvement, in order to reduce the rate of reopened cases. The outcome of this work has directly informed an action plain including a staff training programme to be implemented through the year.
- Continue to corporately regularly review response drafts to provide scrutiny and to continue to improve quality and content.
- Continue progress made in the last quarter of 2020/21 by supporting Divisional Teams to make early telephone contact to complainants to pursue informal resolution of complaints.
- Devise mechanisms to assist with the resolution of complex cases and provide regular feedback on performance.
- Continue to review all closed cases and ensure detailed completion of "Lessons Learnt"; focus groups and training will be delivered, alongside regular supportive discussions and specific target setting.
- Survey our complainants to ask them how they felt about the process and capture improvements and recommendations. Responses will form a training programme and action plans.
- Provide quarterly reports with specific issues experienced, lessons learned and actions taken to be shared Trustwide.
- Actively network with Trusts regionally and nationally to share good practice.

QUALITY INDICATOR 3:

We will maintain the percentage of inpatients and all visitors to our hospitals who would recommend our Trust to friends and family to 95% and we will maintain our baseline response rates for emergency departments, inpatients, outpatients, paediatrics and maternity services. We will specifically focus on ensuring that the public is encouraged and aware of how they can feedback to us and we will demonstrate that we are listening, acting on and sharing what we are being told.

Our position for 2020/21 was 96.29%	Our target for 2021/22 is 95% across all areas

In 2020/21:

- During a challenging and unprecedented year, we refocused our priorities, ensuring that feedback was visible to the public coming into our hospital, specifically displaying "You said, We Listened" posters.
- We improved access for our patients with disabilities by working with AccessAble to create a new tool for all patients accessing our hospitals.
- We recruited a new Patient Experience team to support all of our wards to capture feedback and develop quality improvement projects as a result of feedback, as well as share the many compliments that are received at our Trust every day.
- We softly launched our Volunteering Strategy to ensure we are prepared for when our Volunteers return to support us with how we collect feedback and demonstrate we are listening.

- We met in monthly Patient Experience and Engagement steering groups with staff and the public using online platforms to share feedback and our learning – and to celebrate our compliments.

In 2021/22:

- We will implement training programmes on customer care and communication, which will be designed following feedback through patient services and Friends and Family Test (FFT). We will gain increased understanding of free text feedback to influence this shared by patients, their carers, friends and family.

- We will ensure visibility for the public and awareness that we are a listening Trust, by ensuring the new "We Welcome Feedback" posters are visible for all patients and that our staff are supported to share feedback on these posters. Learning and projects in response to this feedback will be supported.

- We will explore new ways to ensure that FFT is accessible to all of our patients, their carers, friends and family.

- We will ensure that regular meetings with staff and the public take place to ensure that feedback is discussed with patient representatives through regular dialogue.

Our Patient Experience team will ensure that staff are empowered to actively seek out feedback and drive quality improvements in response to feedback.

QUALITY INDICATOR 4:

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

Our position for 2020/21: 79.86% training completion *Quality audits were temporarily suspended during the pandemic therefore data is not available against this metric.*	Our target for 2021/22 is 80%.

In 2020/21:

During the pandemic, around 4,000 people with a known diagnosis of dementia were admitted to the acute hospital as an emergency. On a background of the COVID-19 pandemic, we took part in the RCP National Audit of Dementia survey which reviewed how the pandemic had affected inpatient care for people with dementia.

Alongside other acute hospitals we rapidly responded to the increased demand on our hospitals and our specialist staffs were redeployed to utilise their specialist skills and experience in our temporary Family Liaison service. While data submission, audits and quality improvement programmes were temporarily suspended, progress continued with focus on our priority to improve the care and experience of people dementia via our Fundamentals of Care Programme.

Questions to flag vulnerable patients with dementia on our wards were agreed and embedded in the new standardised ward safety huddles. Ward Manager Quality Audit questions were revised to include questions which identify patients with dementia/delirium.

Focused questions based on the evidence based Dementia/Delirium Care Bundle for were developed for Matrons Quality Audits.

A "What Matters to Me" one-page important information sheet was introduced to allow important information to be gathered quickly to support individualised, person-centred care.

We were shortlisted for the Nursing Times Award in the Care of Older People category for our work

in developing our services for the patients with frailty and dementia. Our Dementia Specialist Team model has been revised following feedback and learning from experiences during the pandemic and now follows a model based on our Family Liaison service.

In 2021/22:

- Continued focus on embedding the evidenced-based practices described in the Dementia/Delirium Care Bundle in all inpatient areas.
- Launch new Ward Managers and Matrons Quality Audits to monitor compliance with evidence-based practices.
- Continued focus on education:
  - Add Delirium Awareness E-Learning to essential to role matrix for eligible staff.
  - Develop and implement a structured face-to-face teaching programme mapped to Health Education England, Dementia Training Standards Framework Tier 2 in addition to existing E-learning modules.

QUALITY INDICATOR 5:

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

In 2020/21:

During COVID, a number of initiatives were developed which included feedback posters, iPads for staff to collect Friends and Family Test (FFT) and telephone helplines to support patients and their loved ones. Developing from this, we will focus on increasing accessibility and responsivity.

In 2021/22:

- 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 Path to Platinum accreditation 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 #togetherwearepatientexperience 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 communication methods.
- We will develop our commitment to equality and diversity by appointing a lead, and improving accessibility across our services.

QUALITY INDICATOR 6:

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

We set out six key indicators for success in relation to understanding the needs of patients who are receiving care at the end of their life.

Indicators for Success in 2020/21	Evaluation 2020/21	Trajectory 2021/22
1. Increase in engagement in advanced care planning including the uptake of ReSPECT and AMBER Care Bundle for those with uncertain recovery;	▶ Increase in the use of the AMBER Care Bundle at WRH between March and December 2020 demonstrated. AMBER Care Bundle document currently under review to emphasise 'Recovery uncertain', in the hope that its use will continue to increase for relevant patients. ▶ ReSPECT essential training, Trustwide results at March 2021: ▶ Authorship 84.43% ▶ Awareness 75.16%	▶ Ongoing training & support for all relevant staff groups in the use of the AMBER Care Bundle to maintain increased usage. ▶ ReSPECT project currently sits within the Home First/ HAFD committee ▶ Discussion re governance of the ReSPECT, consideration being given to the EOLC Steering Group reporting to CGG
2. Compliance with the use of the Individualised Last Days of Life (LDoL) for Adults Care plan for those identified as being in the last days of life;	▶ Use of LDoL Care plan has been audited – results are encouraging with 95% patients recognised to be in the last days of life having a care plan completed. Care plan is currently being reviewed/ updated following actions resulting from the audit.	▶ Revised Last days of Life Care Plan due for introduction in August 2021, with amendments based on audit findings & new prescribing recommendations in line with regional guideline changes. ▶ Repeat audit planned for January – March 2022

Indicators for Success in 2020/21	Evaluation 2020/21	Trajectory 2021/22
3. Constructive participation in local and national end of life audits;	▶ We participated in NACEL (National Audit for Care at the End of Life) in 2019/20. ▶ Data collection planned for summer 2020 was cancelled due to the pandemic; however we are registered to participate in the 2021 data collection.	▶ The Trust is registered to participate in the 2021 NACEL, which will include casenote review, quality survey from bereaved relatives, organisation audit & staff survey. This will run from June – October 2021.
4. Positive feedback from patients and those important to them;	▶ The Hospital Palliative Care Team last undertook a patient/carer feedback survey in May 2019, and received very positive results. ▶ The team had planned to repeat this in 2020, but this was postponed by the pandemic. We intend to repeat in 2021. ▶ The NACEL audit also gathers feedback from bereaved family members on EOLC. ▶ The VOICES survey (Trust bereavement survey) is not currently being given out due to changes in bereavement service as a result of COVID. The questionnaire is currently under review & plans for an online version in place.	▶ HPCT to undertake patient/carer feedback survey by end of 2021/22. ▶ NACEL 2021 will include feedback survey from bereaved family members. Results should be available by end of 2021/22. ▶ Revised online VOICES questionnaire to be introduced in September 2021.

<table>
<tr><th>Indicators for Success in 2020/21</th><th>Evaluation 2020/21</th><th>Trajectory 2021/22</th></tr>
<tr>
<td>5. Reduction in end of life care related complaints;</td>
<td>The table below shows the number of complaints which include EOLC:
<table>
<tr><th></th><th>Total complaints</th><th>From complaints with EoLC component</th><th>% complaints with an EoLC component</th></tr>
<tr><td>WRH</td><td></td><td></td><td></td></tr>
<tr><td>2011-2012</td><td>364</td><td>7</td><td>1.9%</td></tr>
<tr><td>2012-2013</td><td>407</td><td>11</td><td>2.7%</td></tr>
<tr><td>2013-2014</td><td>330</td><td>12</td><td>3.6%</td></tr>
<tr><td>2014-2015</td><td>325</td><td>9</td><td>2.8%</td></tr>
<tr><td>2015-2016</td><td>397</td><td>16</td><td>4%</td></tr>
<tr><td>2016-2017</td><td>479</td><td>11</td><td>2.3%</td></tr>
<tr><td>2017-2018</td><td>354</td><td>7</td><td>2%</td></tr>
<tr><td>2018-2019</td><td>314</td><td>7</td><td>2.2%</td></tr>
<tr><td>2019-2020</td><td>345</td><td>5</td><td>1.4%</td></tr>
<tr><td>2020-2021</td><td>276</td><td>4</td><td>1.4%</td></tr>
<tr><td>Alex</td><td></td><td></td><td></td></tr>
<tr><td>2011-2012</td><td>272</td><td>8</td><td>2.9%</td></tr>
<tr><td>2012-2013</td><td>244</td><td>9</td><td>3.7%</td></tr>
<tr><td>2013-2014</td><td>204</td><td>5</td><td>2.5%</td></tr>
<tr><td>2014-2015</td><td>144</td><td>1</td><td>0.7%</td></tr>
<tr><td>2015-2016</td><td>171</td><td>6</td><td>3.5%</td></tr>
<tr><td>2016-2017</td><td>176</td><td>4</td><td>2.3%</td></tr>
<tr><td>2017-2018</td><td>151</td><td>2</td><td>1.32%</td></tr>
<tr><td>2018-2019</td><td>171</td><td>2</td><td>1.16%</td></tr>
<tr><td>2019-2020</td><td>146</td><td>3</td><td>2%</td></tr>
<tr><td>2020-2021</td><td>104</td><td>4</td><td>3.8%</td></tr>
</table>
</td>
<td>▶ The EOLC Steering group reviews the EOLC Datix dashboard to provide governance in this area.</td>
</tr>
</table>

Indicators for Success in 2020/21	Evaluation 2020/21	Trajectory 2021/22
6. Engagement and increased uptake of end of life education and training amongst healthcare professionals.	▶ EOLC was previously included in Trust Mandatory training. This has now been discontinued. EOLC will now be incorporated into the 'Fundamentals of Care' programme – e-learning modules identified (e-ELCA). ▶ The EOLC team have continued to deliver training in the form of workshops/tutorials/informal ward-based teaching available to all relevant staff groups.	▶ eELCA modules to be included in Trust Mandatory training from 2021 ▶ Tier 1 Go live date 19th April 2021. ▶ To be followed in 2023 by Tier 2 ongoing EOLC training programme for all relevant staff groups ▶ During COVID pandemic EOLC team have continued to offer bespoke training on the wards, eg, Care after death and T34 CSCI training.

Positive feedback we have received during 2020/21

Posted on 12/05/2020

I visited as an outpatient. First to imaging & then to urology. My treatment was first class. Everyone I met was professional, kind, caring & highly efficient. At no point did I feel confused or anxious. All of my questions were answered calmly & clearly, explaining next steps. All of this at a time when the NHS are under extreme pressure with COVID-19. Thank you so much, so lucky to have this facility local to me.

Posted on 19/01/2021

My recent visit to the Breast Unit at Worcestershire Royal was extremely well organised and very reassuring. The process in place means that at an anxious time, I was never left waiting but just passed through the necessary scans with results provided straightaway, no need to come back in two weeks etc. but leaving the same day knowing there were no concerns. I was assigned a nurse practitioner who looked after me throughout and all staff I met were friendly, caring, calm and professional. This would be achievement enough, but during COVID times, the additional measures taken made me feel reassured and comfortable. This is an impressive and really excellent service, very well done both to the staff providing the front line service, and those who have devised this efficient, patient centred, reassuring diagnostic process.

Posted on 11/01/2021

I attended A&E following a fall at home. From the friendly receptionist, nurses, doctors and radiographer I was treated with dignity and kindness. An excellent service. I also received fantastic treatment from fracture clinic the next day. Due to my injury I was admitted onto Ward a few days later for surgery. Nothing was too much trouble for the nurses and student nurses- kind, caring and a credit the NHS. I am now recovering at home. The surgeon and anaesthetic team were again fantastic; I could not fault anything or anyone. The food too was lovely. What would we do without you all?

Posted on 23/12/2020

Just wanted to Thank the staff in women's health. It was extremely difficult today but the nursing staff and doctors were excellent. Kind considerate and very caring. Lovely team can't thank them all enough!

Posted on 21/02/2021

I stayed in the maternity unit for one week and had a C section. The trainee midwives, midwives and doctors were fantastic and professional, I received a very high standard of care in what are difficult times. I was also blown away by the team work in theatre, also how quickly they turn round patients (we heard another baby being born while I was still in recovery). I am extremely grateful to all the staff involved in looking after me. This was a large number of midwives, doctors and theatre staff who all impressed with their kindness and professionalism. It is extremely scary having a baby for the first time especially during COVID times, the midwives did a fantastic job of reassuring me and keeping me informed of my choices and what was happening at every stage. Very very grateful for all the help and high quality of care I received.

2.5 – Statement of Directors' Responsibilities

Company Secretary

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	1.0285 Banding 2 – 'as expected' (Dec-19 to Nov-20)		0.6951	1.1869	*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	1.0428 Banding 2 – 'as expected' (Apr-19 – Mar-20)	1.1440 Banding 1 – 'higher than expected' (Apr-18 – Mar-19)	1.0584 Banding 2 – 'as expected' (Apr-17 – Mar-18)
	% of deaths with either palliative care specialty or diagnosis coding	33.90% (Dec-19 to Nov-20)	36.32%	59.19%	8.14%	*Worcestershire Acute Hospitals NHS Trust considers that this data is as described for the following reasons:* Data quality is good but there is room for improvement *Worcestershire Acute Hospitals NHS Trust intends to take the following actions to improve this number and so the quality of its services, by:* The Trust will continue to improve this performance during 2020/21	34.75% (Apr-19 – Mar-20)	33.63% (Apr-18 – Mar-19)	28.50% (Apr-17 – Mar-18)

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)	22.754 Not an outlier (19/20)	22.315	25.395	18.904	*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:* Plans to improve access to theatre aim to create further improvement	22.532 Not an outlier (18/19)	22.965 Not an outlier (17/18)	21.508 Not an outlier (16/17)
	Patient-reported outcome score for knee replacement surgery – adjusted average health gain (Oxford Knee Score)	17.342 Not an outlier (19/20)	17.356	20.732	12.876	*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	18.049 Not an outlier (18/19)	17.022 Not an outlier (17/18)	16.413 Not an outlier (16/17)

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	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% (16.170

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: 01/07/2019 to 31/07/2019; Survey collected 01/08/2019 to 31/01/2020 Published Feb 2021		66.3 (19/20)	67.1	59.5	84.2	*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	64.3 (18/19)	66.2 (17/18)	65.2 (16/17)
	The percentage of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends. *NHS Staff Survey 2020*		68.46% (2020)	73.86 %	92.00%	49.96 %	*Worcestershire Acute Hospitals NHS Trust considers that this data is as described for the following reasons:* Staff engagement has improved this year but remains in the lowest quartile for Acute Trusts *Worcestershire Acute Hospitals NHS Trust intends to take the following actions to improve this number and so the quality of its services, by:* See Quality Account	66.3% (2019)	58.1% (2018)	56.8% (2017)
	Inpatients Friends and Family test	% recommend	95% (Feb-20)	96%	100%	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% (Feb-20)	23.7%	100%	1.1%		18.63% (Mar-19)	5.65% (Mar-18)	11.25% (Mar-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	A&E Friends and Family test Published Feb -20	% Recommend	85% (Feb-20)	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-19)
		Response Rate	18.8 (Feb-20)	12.1	44.4	0.0%		5.87% (Mar-19)	3.59% (Mar-18)	4.15% (Mar-17)
Treating and caring for people in a safe environment and protecting them from harm	% of patients risk-assessed for venous thromboembolism Q4 not published – NB no date given as VTE collection was ceased in March due to COVID-19		96.39% (Q3 19/20)	95.33%	100%	71.59%	*Worcestershire Acute Hospitals NHS Trust considers that this data is as described for the following reasons:* VTE assessment rates are now above the national average *Worcestershire Acute Hospitals NHS Trust intends to take the following actions to improve this number and so the quality of its services, by:* See Quality Account priorities	94.45% (Q4 18/19)	92.26% (Q4 17/18)	93.75% (Q4 16/17)
	Rate of C.difficile per 100,000 bed days		33 (Apr-19 to Mar-20)	32.22	0	145.0	*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	49.4 (Apr-18 to Mar-19)	36.8 (Apr-17 to Mar-18)	41.0 (Apr-16 to 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	Rate of patient safety incidents per 1,000 bed days	53.1 'No evidence for potential under-reporting' (Oct-19 to March-20)		15.7	110.2	*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	52.90 'No evidence for potential under-reporting' (Apr-19 to Sep-19)	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)
	Percentage of patient safety incidents that resulted in severe harm or death	0.14% ()ct-19 to March-20)	0.31%	0.00%	1.95%	*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	0.32% (Apr-19 to Sep-19)	0.29% (Apr-18 to Sep-18)	0.69% (Apr-17 to Sep-17)

Clinical Audit 2020/21

During 2020/21, 52 national clinical audits and 4 national confidential enquiries covered relevant health services that Worcestershire Acute Hospitals NHS Trust provides. We also undertook 181 registered local clinical audits during 2020/21.

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

Appendix 1 contains a list of national audits, national confidential enquiries and local audits that Worcestershire Acute Hospitals NHS Trust participated in during 2020/21. 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, as well as how we have used clinical audit to drive improvements in the quality of care we provide.

Participation in Clinical Research

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

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

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

Despite these challenges, recruitment of patients, carers and staff into studies was increased to 1469. This included 465 patients who were recruited into interventional studies, of which 374 were in REMAP CAP and RECOVERY, the two interventional COVID-19 studies.

We recruited into 24 studies across 10 different clinical specialties, the recruitment for which is shown below. 3 of these studies were commercial. 11 new studies were opened during 2020-2021.

Participation in Clinical Research	
Cancer and haematology	26
Cardiology	92
Critical Care	160
Health Services Research	2
Infection	1042
Mental Health	33
Musculoskeletal disorders	10
Renal Disorders	6
Reproductive Health and Midwifery	85
Surgery	13

Commissioning for Quality and Innovation – 2020/21 CQUIN Programme

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 throughout the COVID-19 pandemic response 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. 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 NHSI/E 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. NHSI/E are not seeking the submission of 2019/20 quarter 4 data from providers via the national CQUIN data collection.

CQUINs were paused at a National Level end of Q3 2019/20 and contracting is yet to be agreed for 2021/22.

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

CQUIN Type	CQUIN	Aim	Year End Performance: as determined at the end of Q3
National	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

CQUIN Type	CQUIN	Aim	Year End Performance: as determined at the end of Q3
National	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
	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 2019/2020 new concept approach to the National CQUINs: focusing on data collection and clinical audit rather than 'action setting' NHSI/E 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 2020/21, 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
EPILEPSY 12 - National Audit of Seizures and Epilepsies in Children and Young People	Yes	100%	
FFFAP - National Hip Fracture Database (NHFD)	Yes	100% n119	
IBD - Inflammatory Bowel Disease Programme/IBD Registry	Yes	100%	
ICNARC - Case Mix Programme	Yes	100%	
LeDeR - Learning Disability Mortality Review Programme	Yes	100% n17	
Mandatory Surveillance of HCAI	Yes	100%	
MBRRACE - Maternal, Newborn and Infant Clinical Outcome Review Programme	Yes	100%	

Eligible National Audits	Participation	% or No's cases submitted	Comments
NABCOP - National Audit of Breast Cancer in Older People	Yes	100%	
NACAP - Pulmonary rehabilitation Organisational and Clinical audit	Yes	100%	Trust participated in the audit until the service was put on hold during 2020 due to COVID-19. Therefore the 100% is accurate for what we uploaded before being put on hold.
NACAP - Secondary Care - Adult Asthma	Yes	100%	
NACAP - Secondary Care - COPD	Yes	100%	
NACR - National Audit of Cardiac Rehabilitation	Yes	100%	
NOGCA - National Oesophago-gastric Cancer Audit	Yes	** Data not available	Data submission deadline 30/04/21. The Trust is on track to upload 100% of cases
National Ophthalmology Database Audit	Yes	** Data not available	The Trust commenced participation in this audit mid-year and is aiming for 100% data submission by data collection deadline of 14/05/21
NBOCA - National Bowel Cancer Audit	Yes	100%	
NBSR - National Bariatric Surgery Registry	Yes	** Data not available	
NCAA - National Cardiac Arrest Audit	Yes	Q1-Q3 ALX: 18/22 WRH: 48/75	Q4 data not available until approximately June 2021.
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	n5	Recruitment became non-mandatory on 28/03/20. Since then 5 patients have been recruited. Further recruitment has not been possible due to workload and lack of audit administrative support.
NDA - Adults - National Diabetes Foot Care Audit	Yes	100%	

Eligible National Audits	Participation	% or No's cases submitted	Comments
NDA - Adults - National Pregnancy in Diabetes Audit	Yes	100%	
NDA - Adults - National Core Diabetes Audit	Yes	** Data not available	Data collection submission deadline 28/05/2021.
NELA - National Emergency Laparotomy Audit	Yes	Q1 n21 Q2 n50 Q3 n28	Q4 data available 21/06/2021.
NJR - National Joint Registry	Yes	100%	
NLCA - National Lung Cancer Audit	Yes	100%	
NMPA - National Maternity and Perinatal Audit	Yes	100%	
NNAP - National Neonatal Audit Programme	Yes	100%	
NPCA - National Prostate Cancer Audit	Yes	100%	
NPDA - National Paediatric Diabetes Audit	Yes	** Data not available	Data submission deadline 31/05/2021.
NVR - National Vascular Registry	Yes	100%	
PROMS - Elective Surgery	Yes	100%	
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	
TARN - Major Trauma Audit	Yes	N147	
Endocrine and Thyroid National Audit	Yes	** Data not available	A decline in activity and resource due to COVID has meant that while the Trust remains enrolled in the audit, upload of data has been postponed.
FFFAP - (NAIF) National Audit of Inpatient Falls	Yes	100%	
CEM - Fractured Neck of Femur	Yes	** Data not available	Data entry deadline April 2021 so case information not available at time of reporting..
CEM - Pain in Children	Yes	** Data not available	Data entry deadline 03/10/2021.
Society for Acute Medicine's Benchmarking Audit (SAMBA)	Yes	100%	
NDA - National Diabetes Harm Review NaDIA	Yes	100%	

Eligible National Audits	Participation	% or No's cases submitted	Comments
NACAP - Paediatric Asthma	Yes	** Data not available	Data submission deadline 14/05/2021.
Perioperative Quality Improvement Programme (PQIP)	Yes	** Data not available	Data collection until 31/03/2021 so case information not available at time of reporting.
UK Renal Registry National Acute Kidney Injury Programme	Yes	100%	
BAUS Cytoreductive Radical Nephrectomy Audit	Yes	** Data not available	Data collection until 01/04/2021 so case information not available at time of reporting.
BAUS Bladder Outflow Obstruction Snapshot Audit (BOO)	Yes	100% n15	
BAUS Renal Colic Audit	Yes	100% n7	
CEM - Infection Control	Yes	** Data not available	Data collection until April 2021 so case information not available at time of reporting.
Antenatal and Newborn National Audit Protocol 2019 to 2022	Yes	100%	

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

Ineligible National Audits	Scope
Mental Health Clinical Outcome Review Programme	Audit applies to Mental Health
National Audit of Pulmonary Hypertension (COPD)	Specialist Audit
National 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.
FFFAP - Fracture Liaison Service Database (FLSD) SCSD/ Rheumatology - Prof. Rai	The Trust does not provide this service. It has been de-commissioned as of 31/08/19
Cleft Registry and Audit Network (CRANE)	Specialist audit
National Congenital Heart Disease (CHD) - NCAP	Specialist audit
British Spine Registry (BSR)	Specialist audit
Out-of-Hospital Cardiac Arrest Outcomes (OHCAO) Registry	Applies to primary care and ambulance Trusts
National Adult Cardiac Surgery Audit - NCAP	Specialist audit
National Audit of Dementia (NAD) - Spotlight audit in Memory services	Community based audit

Worcestershire Acute Hospitals NHS Trust was eligible to participate in the following national audits; however, data collection was not taking place nationally during 2020/21;

- NDA - National Diabetes Transition Audit
- NHS Provider interventions with suspected/ confirmed carbapenemase producing Gram negative colonisations/ infections
- NACEL - National Audit of Care at the End of Life
- National Audit of Dementia (NAD) - Care in General Hospitals
- NDA - National Diabetes Inpatient Audit NaDIA

A total of 43 National Clinical Audit reports have been published in 2020/21 for national audits that the Trust either participated in or was eligible to participate in. These reports were reviewed in 2020/21 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
Pulmonary rehabilitation clinical audit 2019	09/07/2020	Respiratory	▶ Set-up virtual PR (VPR) and start offering classes ▶ Monitor waiting list and update patients waiting for face-to-face rehabilitation in line with government guidelines ▶ Review patient pathway to ensure patients can access PR in a timely manner and unnecessary steps are removed. Consider the timing of the class an impact for transport patients ▶ Audit wait times for VPR and face-to-face PR every three months (01/07-30/09) ▶ Continue to make bids, where resources are available, for further staffing to run additional PR programmes aiming to increase the number of rolling programmes available across the county and offer satellite programmes to match referral geographical demand. ▶ Audit ISWT for face –to-face group sessions to ensure all patients receive a practice walk ▶ Audit VPR use of activity measure sit to stand as an outcome of exercise capacity after 4 months (approx. 40 patients) ▶ Peer review of assessment to ensure standardised use of ISWT at all venues (Time scale will change due to government guidelines) ▶ Audit completion rates for VPR ▶ Review reasons for drop out ▶ Audit completion rates for standard PR ▶ Review reasons for drop out and access the impact of 'prehab' sessions
NACEL - National Audit of Care at the End of Life Annual Report 2020	09/07/2020	Palliative Care	▶ Improve on the provision of facilities for families & carers of dying patients ▶ We will do this by creating a carers room at Worcestershire Royal Hospital, introducing a SUPPORT programme and purchasing fully reclining carers chairs

National Audit	Date Report Published	Specialty	Actions/Improvements
LeDeR Annual Report 2019	16/07/2020	Corporate	▶ Available funding used by CCGs to support appointment of local LeDeR reviewers. Local reviews now more timely and take into account local issues. ▶ Monitoring in place through the Worcestershire LeDeR steering group ▶ Key work streams for community care ▶ Work continues to ensure information sharing occurs e.g. registration and reasonable adjustments are kept up to date through annual health checks ▶ Guidance drawn up and issued within Acute Trust. Audit of ReSPECT forms will include reference to LD issues. Bereavement staff will not accept Learning Disability in any section of part 1 of the MCCD supported by Medical Examiners. ▶ Recruitment to ME posts continues in order to provide a presence in each bereavement office each weekday.
NMPA - Maternity Care for Women with Multiple Births and their Babies	13/08/2020	Maternity	▶ Introduction of BadgerNet ▶ Chorionicity to be documented on dating scan and to be rechecked when first seen in the twin clinic by Consultant ▶ Mode of delivery to be discussed in twin ANC and documented in the maternity notes ▶ Badgernet to remove risk of ID errors in twins
Epilepsy 12 – Combined Organisational and Clinical Audit. Round 3 cohort 1 2018/19	10/09/2020	Paediatrics	▶ Appoint a Consultant Paediatrician with appropriate expertise to support current team ▶ To collate numbers of local patients, devices used and explore this possibility with Tertiary Epilepsy Service ▶ Co-locate professional with mental health competencies within epilepsy clinic. Develop business case for Psychology hours to support children with epilepsy ▶ Establish Teenager's Epilepsy clinics within the paediatric service tailored to specific needs of this age group

National Audit	Date Report Published	Specialty	Actions/Improvements
NACAP – Children and young People Asthma Secondary Care Audit	03/11/2020	Paediatrics	▶ We have created an Asthma Discharge Checklist sticker that is attached to our Personalised Asthma Action Plans on the ward. This prompts the ward to staff to ensure they have checked inhaler technique, and address any patient or parental smoking. ▶ We will be highlighting with both Emergency Department and Paediatric Ward staff about the importance of early administration of steroids in asthma admissions. This will include a poster on ward and in ED.
NNAP 2020 Annual report based on 2019 Data	12/11/2020	Neonatal	▶ LMS Obstetric Lead Consultant to undertake proposing strategies for midwives and obstetric staff to improve antenatal steroid and magnesium administration to eligible mothers at WRH. ▶ Neonatal Ward Manager to identify nursing leads to review the BAPM QI toolkit for thermoregulation and implement strategies to improve thermal care in babies born less than 32 weeks at WRH. This will be reviewed in the monthly neonatal development meeting. ▶ Badger data quality checks being done by ward administrator ▶ To reconsider how the 2-year follow up developmental checks are taking place and if involvement by community paediatrics in holding formal 2-year development clinics is a viable option ▶ Use of less invasive surfactant administration and other respiratory initiatives within a 'respiratory bundle'. A QI project based around this will be led by the NNAP project group and reviewed within the neonatal development meeting. ▶ Lead for the infant feeding team to review the BAPM infant feeding toolkit and implement strategies to improve the number of babies receiving mothers milk during their stay on the neonatal unit and at discharge.

National Audit	Date Report Published	Specialty	Actions/Improvements
National Diabetes Inpatient Audit 2019 report	12/11/2020	Speciality Medicine	▶ To arrange regular diabetes knowledge update for hospital staff involved in looking after diabetic patients. It can be in the form of study days and will need staff to be released form their ward duties. ▶ To liaise with catering manager about improving choice of meals and the timing they are served for diabetic patients ▶ To prepare business cases for additional consultants and DSNs to improve staffing level
National Diabetes Inpatient Audit – Harms 2019 report	12/11/20	Speciality Medicine	▶ Reduce the incidents of new foot ulcers arising during an admission. Use the CPR checklist (Check, Protect, Refer) developed by podiatrists. Use this on admission and throughout stay
SSNAP Quarterly results July - September 2020	04/12/2020	Stroke	▶ Develop a 24/7 CNS model, which should contribute to overall improvement in this area. ▶ Introduce a dedicated consultant of the week to assess all triaged Stroke patients in a timely manner
NACAP - Secondary Care - Adult Asthma Clinical Audit 2019/20	14/01/2021	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.

National Audit	Date Report Published	Specialty	Actions/Improvements
National Early Inflammatory Arthritis Audit – Second Annual Report	14/01/2021	Rheumatology	▶ Provision of admin support to allow meaningful patient recruitment and data entry ▶ Ensure that emergency access (within 24 hours) to advice is available for people with EIA ▶ Ensure rapid but safe initiation of DMARDs

Local Clinical Audits

The reports of 181 local clinical audits were reviewed by Worcestershire Acute Hospitals NHS Trust in 2020/21 and the table below provides a selection of actions the provider intends to take, or has taken to improve the quality of healthcare provided.

Audit Title	Specialty	Actions/Improvements
ID 10899 Impact of Lipid Passport on management of hyperlipidaemia in ACS	Cardiology	▶ ACS check list on admission. ▶ Retrieval of blood investigations preformed in other Trusts. ▶ Involvement of GPs/CCU/cardiac rehabilitation nursing staff. ▶ Fasting lipid profile/LDL. ▶ EDS? Follow up 3months with Lipid profile/statins.
ID 10871 Management of hypoglycemia in hospital	Endocrinology	▶ Printing a new hypo box content list for all wards with all recommended contents included. ▶ Designing a daily check sheet for nurses. ▶ Making sure all Hypo boxes include a laminated copy of hypoglycaemia management algorithm.
ID 10689 42B Saving Babies Lives vs.2 Element 2: Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction	Obstetrics	▶ Remind CMW team CO monitoring should be performed at booking for ALL patients regardless of smoking status. ▶ Create formal risk assessment for PET proforma as part of handheld notes to be completed at booking. ▶ Remind CMW teams of local guidance re. SFH measurements. ▶ Clarify whether serial SFH measurement is still required for patients undergoing serial USS. ▶ Review of 1 case where birth weight <10th centile not identified as SGA antenatally.

Audit Title	Specialty	Actions/Improvements
ID 10813 From School Vision Screening to Hospital Discharge: An Audit of School Vision Screening Outcomes	Ophthalmology	▶ To create a leaflet or information graphic to accompany the initial 'fail letter' that is sent out to parents. ▶ To work with community optometrists to collect data regarding those referred to community and then get referred to the acute service.
ID 10865 CTPA justification based on Chest X-ray results	Radiology	▶ Present findings at Grand Rounds, Surgical rounds, departmental meetings for all clinical groups. ▶ Design a poster reminder summarising the steps in diagnosis PE and good practice in requesting.
ID 10825 Audit of Triage services - Use of BSOTS	Obstetrics	▶ Re-launch of BSOTS with training support. ▶ Regular meetings with core triage team to discuss issues/ concerns.
ID 10757 22A Audit of Individualised last days of life care plan	Palliative Care	▶ Trust induction to include use of document WR5313 and highlight areas poorly completed. ▶ Include documentation on RGN and HCA workshops/HCA Cert/ Preceptorship/ward based sessions. ▶ Consider simplifying format – for discussion at EOLC planning meeting ▶ Walk the wards to remove old versions and update staff on current version/advise to order.
ID 10919 Fresh Eyes	Obstetrics	▶ Policy Change to reflect SBL V2 Hourly Fresh Eyes. ▶ Appointment of a specialist midwife to oversee fetal monitoring with LMNS input.
ID 10889 To review the compliance of intravenous (IV) Fluid Prescription in The Acute Medicine Division at Worcestershire Royal Hospital in accordance to the NICE Standards.	Acute Medicine	▶ Implementing new fluid balance charts. ▶ Informal group education sessions on the wards regarding importance of accurate fluid balance charts and need to weigh patients. ▶ Disseminate findings at teaching sessions to educate importance of comprehensive assessment and need to review patients' bloods. ▶ Make discussions about fluid balance charts a routine part of board and ward rounds.

Audit Title	Specialty	Actions/Improvements
ID 10771 Starvation times in Trauma patients	Anaesthetics	▶ Fasting specialist interest group. ▶ Update Trust guidelines. ▶ Education programme. ▶ Urgent surgery pathway – prompt via Bluespier. ▶ Inform wards list order after team briefing – "drink until times" E.g. if need morning imaging then can have a light breakfast at 0600 ▶ Examine pre-operative fasting in elective patients.
ID 10471 Safeguarding in children under 2yrs of age presenting to ED	Paediatrics	▶ Improve history taking – details of mechanism of jury and consider in light of development; check for Alerts and look at Safeguarding folder in Ez notes (for clinical purpose) Be extra careful with vulnerable groups. All less than 2 year olds must be discussed with Consultant. ▶ Beware clavicle and humeral (especially <18month old) injuries can be due to NAI. ▶ Next audit review cases in detail if above fractures mentioned and if spiral or metaphyseal (these may be acceptable in upper limb but need to ensure not lower limb). ▶ Alert system between ED and Radiology – All < 2 yo fractures to be sent to ED email alert system. The ED consultant will review the report and notes. Radiology must send an Alert email for any suggestion of NAI. ▶ Share audit with SHOs and ENPs (the most important staff to educate) – awareness training – detail history of mechanism , does it match injury, delays inappropriate, who is with child, who brings child, type of fracture – alarm bells in history and site of fracture alarm bells. Ensure the actions are presented at respective Departmental Clinical Governance meeting.

Audit Title	Specialty	Actions/Improvements
ID 10928 Snap Shot Audit of carbapenem prescribing	Pharmacy	▶ Introduce signposting to organ-specific prescribing guidance for severe infection from sepsis section within MicroGuide. ▶ Disseminate audit findings to clinical governance leads. ▶ Haematology and oncology wards to start Trustwide AMS audit. ▶ Consider implementation of targeted audit of prescriptions for neutropenic sepsis with audit criteria including whether patient meets definition of neutropenic sepsis as per local Trust protocol WAHT-HAE-003* Review antibiotic regimen for Trust Neutropenic Sepsis Guideline.
ID 10691 42D Saving Babies Lives vs.2 Element 4: Effective fetal monitoring in labour	Obstetrics	▶ Regular reminders of Training reminders on effective handover. ▶ Targeted reminders ongoing with training requirements and compliance. ▶ Add compliance to annual PDR and essential to role on ESR. ▶ Appoint a fetal wellbeing midwife to target CTG compliance, meeting and monitor training in conjunction with the LMS to meet the SBL V2 recommendations.
ID 10847 Knowledge, attitude and practice (KAP) survey on usage and toxicity of Local anaesthetic agents amongst health care professionals in Obstetrics and Gynaecology	Gynaecology	▶ Enrolment in accredited knowledge based learning module on safe administration of LA. ▶ Laminated safety information cards should be made available in all clinical areas where LA procedures are undertaken. ▶ IntraLipid Solution to be made available at KTC and WRH and needs to be made available at other sites - LBW/GAU.
ID 10812 Cause of 30-days mortality in Fracture neck femur patients at Alexandra Hospital	Trauma & Orthopaedics	▶ Further audit to review NOF 30 Day Mortality at AGH. ▶ Teaching for Juniors doctors at Induction regarding main causes of death and prevention measures. ▶ Educate Junior doctors on correct MCCD documentation. ▶ Urgent swab page added to NOF pathway documentation that is currently being used in ED. ▶ Re-audit following implementation of these changes in practice.
ID 10827 Fluid Balance Audit	Corporate	▶ Implement redesigned fluid balance chart, re-audit three months after implementation to assess compliance.

Audit Title	Specialty	Actions/Improvements
ID 10639 2C Toxbase Compliance with Performa in Overdose Patients	A&E	▶ Triage nurse or doctor to print Toxbase and O.D proforma to be part of primary ED documents. Senior doctor on the floor to make sure that treating doctor is compliant with it. ▶ To introduce to all new coming staff in the ED department (Nurses, Paramedics, Doctors) to print, fill the proforma in accordance with the guidelines. It has been incorporated in induction meetings of new staff. This is the responsibility of person arranging induction meetings. ▶ Snap fortnightly re-audit to check compliance.
ID 10321 21A Audit of compliance to UK national diabetic retinopathy referral guidelines	Ophthalmology	▶ To set up virtual diabetic retinopathy clinics using OPTOS Camera and OCT scanning.
ID 10550 16A Audit of anaesthetic equipment training	Anaesthetics	▶ Staff to complete self-certification questionnaire detailing if competent or needing training. ▶ Departmental record of above competency records. ▶ Nominated Consultant lead for training. ▶ Creation of online equipment manual library. ▶ Creation of training videos for key complex equipment. ▶ Expand to include ITU equipment.
ID 10481 Polypharmacy and anticholinergic burden in frailty	Pharmacy	▶ Re-audit in 2020 a larger patient sample and from 2019/20 and review whether there are changes in reduction in polypharmacy, and anticholinergic burden. ▶ Present the results of the audit to the countywide geriatric team to enable shared learning from the results. ▶ Audit the conversion to admission rates following assessment of a patient by the pharmacist frailty practitioners, following the completion of a CGA and the reasons for admission.

Audit Title	Specialty	Actions/Improvements
ID 10666 Reaudit: Improving inpatient EEG referrals for epileptogenic seizures from Acute Medicine specialities	Neurophysiology	▶ Distribute new EEG referral form. ▶ Referral criteria available online. ▶ Implement yearly teaching session in junior doctor's schedule. ▶ Devise/research CPD module for interested healthcare professionals.
ID 10662 An audit into the documented assessment of seizures in Worcestershire Royal Hospital Emergency Department	A&E	▶ Education of healthcare professionals to increase awareness of NICE guidance. Present audit findings to Emergency Department colleagues. ▶ Create a proforma for use in the emergency department to aid history taking for patients presenting with seizures.
ID 10636 Audit of chronic heart failure diagnosis in a non-acute setting within Worcestershire (Re-Audit)	Cardiology	▶ Continue the Rapid Access Heart Failure Clinic. Re-audit once clinic is running smoothly and once restrictions linked to the coronavirus pandemic have been lifted* Increase education to GPs about this pathway. ▶ Ensure adequate capacity in secondary care to accommodate up to 75-100 patients per month (86 patients with and NT-proBNP level between 400 and 2000ng/l and 31 patients with an NT-proBNP level greater than 2000ng/l) * Update the clinical advice in ICE below the displayed NT-proBNP result* Create a notification, within ICE, that asks GPs to clarify whether heart failure is suspected before an NT-proBNP is requested.
ID 10372 Are patients with suspected heart failure diagnosed and followed up in a timely manner in accordance with national guidelines?	Cardiology	▶ Implement a Rapid Access Heart Failure Clinic Coordinate with CCGs, GPs, outpatient clinic, echocardiography, specialist nurses and secretarial staff.
ID 10673 Appropriate Use Of Telemetry (Re-Audit, 3rd Cycle)	Cardiology	▶ Telemetry Request Forms, Reminder Stickers, Refresher presentation/Meeting.

Audit Title	Specialty	Actions/Improvements
ID 10734 Audit of coagulation profile requirements for patients undergoing US guided superficial lymph nodal/lesion core biopsies	Radiology	▶ Update referring clinicians and the interventional radiology team regarding current consensus guidelines by summarizing the SIR 2019 paper into a succinct document, which will be emailed/ shared online. ▶ Departmental teaching presentation during county wide Radiologists meeting. ▶ Vetting and protocolling of these procedures by the IR team. ▶ Re-audit to establish whether this improved adherence to recommendations while managing these patients.
ID 10674 22C Turnaround time of Intra-operative PTH requests	Pathology	▶ Formalisation of process with the ENT surgeons. ▶ SOP for PTH to include ioPTH as a section.
ID 10485 Are our individual critical care staff members prepared for flu season at WRH	Critical Care / ITU	▶ Fit testing to be provided to all staff. ▶ Production and dissemination of a mask fit testing policy meeting NHSE/I guidelines. This must clearly describe lines of accountability for staff protection against infectious diseases.
ID 10649 An audit to assess compliance with the standard that 100% patients who have a Comprehensive Geriatric Assessments (CGA) have an accurate and complete medication history	Pharmacy	▶ Standard operating procedure and training programme for medication history taking for healthcare professionals assessing patients in FAU (included in induction training for all medical and nursing staff). ▶ Production of a Trust guideline for non-pharmacy staff documenting an accurate medication history that is accessible to all relevant healthcare professionals. ▶ Production of a medication reconciliation tool for use in FA. ▶ Results disseminated to present findings to healthcare professionals.

Audit Title	Specialty	Actions/Improvements
ID 10738 Appropriateness of information in doppler lower limb requests for DVT	Radiology	▶ The results of the audit will be fed back to the CCG leads during the upcoming meeting, which aim to standardise DVT pathway across the county. ▶ Primary care clinicians will be encouraged to adhere to the NICE guidance and efforts will be made to change the referral template on ICE which will prevent unnecessary Doppler requests. ▶ Point of care D-dimer results will be accepted but clinicians will be encouraged to perform the quantitative/age adjusted tests as suggested on recent NICE guidance. ▶ Due to recent stoppage of DVT led clinics at WRH, a re-audit will be performed reflecting changes in practise and to assess referral criteria from primary care physicians.
ID 10725 22B Integrated Care after death Pathway for Adults Trustwide audit	Palliative Care	▶ Disseminate audit findings to, Ward mangers, Matrons, Bereavement office managers, mortuary manager, Porters managers, and Infection prevention team. ▶ Liaise with Trust infection control and prevention team about validity and use of Notification of risk forms. ▶ Discuss with porters and their managers about compliance with completion of their section, is update and/or further training required? ▶ Review of the existing version by all interested parties to update, simplify information gathered and improve for users. ▶ Refresh and update the Integrated care after death pathway ▶ Review altered version at senior nurse meetings, link-worker meetings and present at Governance.

Audit Title	Specialty	Actions/Improvements
ID 10533 42A Management of Febrile neutropenia in children admitted to Riverbank ward	Paediatrics	▶ Education for medical staff: Other potential areas of infection including the mouth (need to check for herpes/thrush/mucositis). Also need to check LP and bone marrow sites. ▶ Training to medical staff to review CVL site when patient's with suspected febrile neutropenia present to hospital. ▶ More nurses to go on cannulation course.
ID 10658 Palliative Care EDS QIP	Palliative Care	▶ Presentation of audit findings to Hospital Palliative Care Team. ▶ Establishing the minimum amount of data required for this group of patients and the community teams caring for them. In doing so feedback from primary care around the most pertinent information will be actively sought. ▶ Following action 2, explore the development of an additional palliative care discharge letter designed for patients being discharged from the Hospital Palliative Care Team. ▶ Audit findings and outcomes from the action points above should be incorporated into the established palliative care teaching programme provided for junior doctors working within the Trust to improve the quality of EDS for patients with palliative care needs. ▶ Following the actions above the audit should be repeated and the amendments regarding data collection should be incorporated.
ID 10769 Assessing delay to surgery in shoulder and elbow trauma	Trauma & Orthopaedics	▶ Awareness and unified thought process among all Consultants, Registrars and SHOs to treat these injuries as soon as possible. ▶ Implementation of a fast-track referral system to upper limb surgeons. ▶ Specialised and dedicated upper limb trauma list. ▶ Set a protocol comparable to hip fractures for upper limb trauma.
ID 10733 Cross Sectional audit of glaucoma severity in patients who have breached their scheduled glaucoma clinic appointment in a large DGH	Ophthalmology	▶ To create a data capture clinic pathway for all glaucoma patients in Worcestershire and re-audit in 12 months.

Audit Title	Specialty	Actions/Improvements
ID 10495 Pre-operative checklist Audit	Theatres	▶ Redesign of Checklist. ▶ SOP for completion .
ID 10710 Trauma >65 Chest Injury Audit	A&E	▶ Education for ED medical staff – SHO teaching, Middle grade teaching and effective handover. ▶ Re-launch Elderly falls proforma with prompts to check for injuries and update trauma proforma for primary and secondary survey examination findings.
ID 10782 Is Magseed localisation for impalpable breast lesions as effective as wire localisation	Breast	▶ Submit Magseed results to Novel therapeutics committee. ▶ Submit business case and SOP for Magseed localisation of impalpable breast lesions to the Women's and Children's management board for approval.
ID 10858 3A VTE assessment of Lower Limb Fractures Requiring Immobilisation	A&E	▶ VTE proforma for lower limb fractures need to be introduced during induction training for all Doctors including ENP. ▶ Consider designing a Lower Limb Injury clerking sheet (similar to head injury proforma) which can also automatically print out VTE proforma for immobilization to help prompt HCPs to complete. ▶ Consider to have it as a reminder to be included during handovers. Brochures/Posters can be designed to help educate patients whilst in the waiting room or in the plaster rooms.
ID 10855 (AMS) Antibiotic Stewardship in Acute Medicine	Acute Medicine	▶ Awareness training for prescribers in Acute Medicine. ▶ Presentation of audit to Trust infection control and prevention committee to stimulate Trustwide audit/change.

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.

Re-audit of coagulation profile requirements for patients undergoing US guided superficial lymph nodal/lesion core biopsies

Introduction of centralised IR vetting in our hospital has significantly improved compliance with guidelines, which has resulted in improved logistics and reduced pre procedure blood-work. This audit cycle has improved our understanding of the specifics relating to pre procedure clotting profile assessment for low bleed risk procedures. As a result of this audit cycle, requests for patients undergoing low bleed risk core biopsy procedures will be vetted by the IR team, triaged to rule out patients on anticoagulants/patients with liver disease and have an appointment for the procedure booked in without getting routine clotting profile assessments done. In case they have liver disease or take anticoagulants, they will need clotting profile assessments and should be within recommended ranges to safely perform the procedure.

Appropriateness of information in doppler lower limb requests for DVT

This audit informed the development of a DVT referral template to improve consistency in referrals. Emphasis on appropriate use of WELLS score and D-dimer results will be requested from primary care physicians to avoid unnecessary referrals. All results will be fed back to referring primary care clinician.

Quality improvement project on safe and effective oxygen therapy in Avon 2

Significant increase in the knowledge of safe and effective oxygen therapy among medical and nursing staff in Avon 2. Significant increase in compliance with the target oxygen saturation range prescription on drug charts of the patients in Avon 2.

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

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

National Hip Fracture Database

In 2020 the Trust was highlighted as having one of the lowest mortality rates across the nation. This has been achieved through the collective efforts of everyone involved in every aspect of each person's journey, from admission to discharge. In addition to centralising the treatment of the majority of hip fractures to the Alexandra Hospital, easing pressure on the Worcester site, the team worked with system partners in Worcestershire to create a dedicated hip fracture rehabilitation area within the community hospitals, aimed at improving outcomes for patients.

Comparison of post TRUS sepsis rates between sites

Overall TRUS sepsis rate has remained within National figures. 100% compliant with BAUS data. To perform another similar audit in end 2021.

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

CQC Inspection Report published 19th February 2021:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Maternity	Requires improvement Feb 2021	Good Feb 2021	Good Sept 2019	Good Sept 2019	Requires improvement Feb 2021	Requires improvement Feb 2021

Ratings for the whole Trust

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

Ratings for the acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Worcestershire Royal Hospital	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement	Requires Improvement
Alexandra Hospital	Requires Improvement	Requires Improvement	Good	Requires Improvement	Good	Requires Improvement
Kidderminster Hospital and Treatment Centre	Good	Good	Good	Requires Improvement	Good	Good
Evesham Community Hospital	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement	Requires Improvement
Overall Trust	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement	Requires Improvement

Worcestershire Royal Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and Emergency Services	Inadequate Feb 2020	Good Sept 2019	Requires improvement Sept 2019	Inadequate Feb 2020	Inadequate Feb 2020	Inadequate Feb 2020
Medical care (Including older people's care)	Requires improvement Sept 2019	Requires improvement Sept 2019	Good Sept 2019	Requires improvement Sept 2019	Good Sept 2019	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 Feb 2021	Good Feb 2021	Good June 2018	Good June 2018	Requires improvement Feb 2021	Requires improvement Feb 2021
Services for Children & Young People	Good Sept 2019	Good Sept 2019	Good Sept 2019	Good Sept 2019	Good Sept 2019	Good Sept 2019
End Of Life	Good June 2017	Good June 2017	Good June 2017	Good June 2017	Good June 2017	Good June 2017
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 Feb 2021	Good Sept 2021	Good Sept 2019	Requires improvement Feb 2020	Requires improvement Feb 2021	Requires improvement Feb 2021

Alexandra General Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and Emergency Services	Inadequate Feb 2020	Requires improvement Sept 2019	Good Sept 2019	Inadequate Feb 2020	Inadequate Feb 2020	Inadequate Feb 2020
Medical care (Including older people's care)	Requires improvement Sept 2019	Requires improvement Sept 2019	Good Sept 2019	Good Sept 2019	Good Sept 2019	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	Good June 2017	Good June 2017	Good June 2017	Good June 2017	Good June 2017	Good June 2017
End of Life	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 Feb 2020	Requires improvement Sept 2019	Good Sept 2019	Requires improvement Feb 2020	Requires improvement Feb 2020	Requires improvement Feb 2020

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	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

Evesham Community Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and Emergency Services	Requires improvement Sept 2019	Good 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	Good Sept 2019	Good Sept 2019	Requires improvement Sept 2019	Requires improvement Sept 2019	Requires improvement Sept 2019

Note: the provision of Surgical Services ceased at the Evesham Site. Medical Care services are carried out by WAHT at the Evesham site, and have not yet been inspected.

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

NHS Herefordshire & Worcestershire Clinical Commissioning Group (HWCCG)

NHS Herefordshire & Worcestershire Clinical Commissioning Group (HWCCG) welcome the opportunity to comment on Worcestershire Acute Hospitals NHS Trust (WAHT) Quality Account. The CCG recognises the Trusts achievements during 2020/21 considering the exceptional challenges 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 maintain quality as we focus our efforts collectively during 2021/22 towards post pandemic reset, restoration, and recovery. It also offers opportunities to build upon some of the joint working and lessons learnt across our system during the pandemic in our journey towards becoming an Integrated Care System by April 2022.

We are pleased to see the Quality Account begins with patient stories. These reflections and details of patients journey through the Trust give an excellent insight into the services offered by the Trust, the impact on patient outcomes and the great work the Trust is doing to support patient safety. Of particular note the CCG acknowledges the tremendous work undertaken by the family liaison service which was set up during the first wave of COVID and increased its capacity during second wave to keep patient and their loved ones connected.

It has been a challenging year for all of the NHS and WAHT are to be congratulated on the achievements made during 2020/21 despite these challenges. The CCG recognises the positive progress made against some of last year's quality priorities such as the reduction in pressure ulcers and medicines incidents causing harm. Also, the strong commitment within this year's Account to the Home First Worcestershire Programme. The CCG also acknowledges that during 2020/21 for the first time in several years the Trust is no longer registering as an outlier for Mortality which is a significant achievement.

It is noted however that there are several priorities where the quality requirements were not fully attained during 2020/21. It is acknowledged that the achievement of some of these will have been impacted by 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 2021/22 to ensure they can be fully achieved. This is particularly applicable to VTE management and antimicrobial stewardship which have seen limited improvement over a number of years.

The CCG acknowledges the positive work identified above; however, they would also like to highlight the need for continued and renewed focus on ongoing quality improvements. This is particularly in relation to the reset, restoration and recovery of services which have been 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 caused as a result of delayed treatment resulting from the COVID 19 pandemic are monitored and addressed.

HWCCG are satisfied with the quality account for 2020/2021 in that the Trust provides a clear and accurate statement which is a representative and balanced perspective of the quality of healthcare provided by WAHT. Commissioners also support and welcome the specific quality priorities identified for 2021/22. All are appropriate areas to target for continued improvement and build upon the achievements of 2020/21.

The CCG looks forward to working with WAHT and other partners across the system to deliver these quality improvements and to ensure lessons are learnt across the Trust and wider Integrated Care System.

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 2020/21.

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. We welcome the Boards continued oversight and focus on Accident and Emergency service to ensure continuous improvement now the Care Quality Commission has lifted the Trust out of Special Measures.

We appreciate it has been an unusual year with the COVID-19 pandemic causing significant disruption to services. We appreciate the commitment and efforts of all those at the Trust who have been involved in responding to Covid-19 which has understandably disrupted much of the work to improve on the quality priorities identified in the Trust's last Quality Account. We therefore welcome the Trust's continued commitment to the three quality priorities identified for last year and compliment the Trust on identifying measurable outcomes for these priorities.

However, we are concerned about the backlog of patients waiting for treatment. We believe 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?

Healthwatch Worcestershire are not aware of 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. After our comments last year we are pleased to note that the strategy and activity to deliver quality improvements over the past year is documented in the Quality Account and reflects 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.

Following our comment about the Duty of Candour in our response to last year's Quality Account we welcome the inclusion of information in this year's Quality account about the Duty in influencing individuals' values and behaviour.

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

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 were specifically engaged in developing the Quality Indicators for 2020/21 that are carried forward in this Quality Account.

Healthwatch Worcestershire encourages the Trust to increase and report upon its engagement with patients, their carers and the public who live with health inequalities, are members of Ethnic Minority communities, the LGBT+ community and live with disabilities.

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. Given those restrictions the introduction does clearly set out the purpose and structure of the QA and the infographics pages are an easily accessible picture of the work of the hospital. We welcome that the Trust has acted on our suggestion last year and included a comprehensive glossary of terms.

We strongly recommend that the Trust should produce a summary of the Quality Account in an accessible format selecting important information for the public, complemented by an "easy read" version. These should also be produced in languages spoken by minority ethnic communities in Worcestershire.

Worcestershire Acute Hospitals NHS Trust's Patient and Public Forum

In the opinion of the Patient and Public Forum, the most impressive parts of this document are the reports of how the Trust has supported staff and patients through the pandemic. The Trust has shown both empathy and flexibility in adapting to this difficult situation. For staff, the development of wellbeing support and care packages and, for patients, the setting up of the patient liaison service and FACES are the highlights.

Introduction of the BAME network and further development of the Freedom to Speak Up group are also to be celebrated.

It is good to have a staff story as well as a patient story.

The Trust is to be congratulated on being the second most improved Trust in the country.

It is good to see the emphasis on improving our data and digital services but worrying that some clinical systems do not talk to each other.

There were positives in our targets for last year, particularly reduction in medicine incidents and number of pressure ulcers.

In our report last year, we said we hoped to see an improvement in sepsis which sadly has not happened.

For next year, the Patient and Public Forum hope to see an improvement in sepsis, our clinical systems communicating with one another and improved learning from complaints and deaths.

Worcestershire Health Overview and Scrutiny Committee (HOSC)

Worcestershire HOSC were unable to provide commentary for the 2020/21 Quality Account.

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

One of the more commonly used methods is the hospital standardised mortality ratio (HSMR) – the outcome of which is published nationally. 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.

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, an 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. 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 focus on learning from deaths as it could point to a specific clinical issue that needs improvement.

Summary Hospital-level Mortality Indicator

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 method uses some 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. SHMI is reported as a baseline figure for the average hospital with confidence intervals applied to monitor results and ensure they are within a safe range. Where a Trust is outside of these limits an investigation into the reasons for this needs to occur, and appropriate action sought.

Glossary

Word	Definition
4ward	The Trust's culture change programme, launched in 2018.
A&E	Accident & Emergency.
Acute Front Door	One of the workstreams within our Homefirst Worcestershire programme, which focuses on urgent medical treatment, for example, our A&E Departments, Acute Medical Units, Same Day Emergency Care and patients arriving by Ambulance.
Acute Patient Flow	One of the workstreams within our Homefirst Worcestershire programme, which focuses on making sure that, if a patient needs acute treatment, they are cared for in a safe environment that is appropriate to their clinical needs. This also includes planning for a patient's discharge from the hospital.
AMBER Care Bundle	This simple clinical tool is designed to be used with patients in the last year of life who are admitted to hospital with an acute deterioration in their clinical condition that renders their immediate recovery uncertain but who are not thought to be irreversibly dying.
Antimicrobial Stewardship	An approach to promote and make sure we prescribe antimicrobials (for example, antibiotics) following evidence based prescribing, to preserve their effectiveness in the future.
Aseptic Non-touch technique (ANTT)	A technique used during clinical procedures to identify and prevent microbial contamination of aseptic parts and sites by ensuring that they are not touched either directly or indirectly.
BadgerNet	An IT system used in Maternity Services.
BAME	Black, Asian & Minority Ethnic.
BAPM	British Association of Perinatal Medicine.
BAUS	British Association of Urological Surgeons.
Bluespier	This application is used by Acute Trust personnel who need to create or view any patient letters or documents, schedule theatre sessions, record a patient's journey through theatre, view full details of all patient activity in theatre & other areas, prepare Electronic Discharge Summaries, record maternity or other specialty /department specific assessments.
BOPP	Better Outcome for Patients Programme.
BSOTS	Birmingham Symptom Specific Obstetric Triage System.
CAP	Community Acquired Pneumonia.
CCG	Clinical Commissioning Groups, responsible for purchasing Health and Social care form NHS Trusts.
C-Difficile	Clostridium difficile, also known as C. difficile or C. diff, is bacteria that can infect the bowel and cause diarrhoea.
CFS	Clinical Frailty Scale.
Chorionicity	The number of placentae of a pregnancy.

Word	Definition
Clinically Effective	Clinical Effectiveness is an umbrella term describing a range of activities that support clinicians and healthcare professionals to examine and improve the quality of care. This focuses on making sure our patients have the best outcomes.
Commissioners	See CCG.
COPD	Chronic Obstructive Pulmonary Disease.
COVID-19	COVID-19 is an illness caused by a virus called coronavirus.
CQC	The Care Quality Commission 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, ambulance services, care homes and services in people's own homes and elsewhere meets government standards of quality and safety.
CQUIN	Commissioning for Quality and Innovation - A payment framework that allows commissioners to agree payments based on agreed quality improvement and innovation work.
DATIX	The Trusts web-based patient safety application for monitoring patient safety incidents.
DMARDs	Disease-modifying anti-rheumatic drugs.
DSNs	Diabetes Specialist Nurses.
DTOC	Delayed Transfers of Care.
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 apology.
DVT	Deep Vein Thrombosis (a blood clot).
Dysphagia	Medical term for swallowing difficulties.
E-Coli	A Bacteria that normally lives in the intestines. Some types of E. Coli can cause an infection.
ED	Emergency Department.
eELCA	e-learning programme for "End of Life Care for all".
EOLC	End of Life Care.
Ez Notes	The Trust's Clinical Portal and Case Note Viewer.
FACES	Family and Carer Engagement Service.
FAU	Frailty Assessment Unit.
FFT	Friends and Family Test (feedback), launched in 2013 to help providers and commissioners understand if patients are happy with the service provided. Patients can provide feedback quickly and anonymously.
First Wave	The first 'Spike' in the number of Coronavirus cases; this wave commenced 23rd March 2020.
FLH	Family Liaison Hub.

Word	Definition
GAP	The Trust's Generic Audit Portal.
GEMS	Geriatric Emergency Medicine Service.
GIRFT	Getting It Right First Time - a national programme designed to improve medical care in the NHS, by reducing unwanted variations.
HAFD	Hospital Acquired Functional Decline. This is where keeping a patient in a hospital bed when they don't need to be in one can slow down their recovery.
HAPU	Hospital Acquired Pressure Ulcers.
HAT	Hospital Acquired Thrombosis.
Healthwatch	Provides an independent voice for people who use publicly funded health and social care services.
HFW	HomeFirst Worcestershire – our Trustwide programme focused on making sure we help our patients get back home quickly.
HOSC	Worcestershire Health Overview and Scrutiny Committee - responsible for scrutinising services relating to local NHS bodies and health services.
HSMR	Hospital Standardised Mortality Ratio. An overall quality indicator that compares a hospital mortality rate with the average national experience, accounting for the types of patients cared for.
ITU	Intensive Therapy Unit.
KPI	Key Performance Indicator.
LDoL	Last Days of Life.
LGBTQ	Lesbian, Gay, Bisexual and Trans (LGBT+) network.
LOS	Length of stay - the duration of one episode in hospital.
MDT	Multidisciplinary Team.
MFFD	Medically Fit for Discharge - this is when a patient no longer needs to be cared for in an acute hospital bed.
MRSA	Methicillin-Resistant Staphylococcus Aureus is a type of bacteria that is resistant to several widely used antibiotics. This means infections with MRSA can be harder to treat than other bacterial infections. You might have heard it called a "superbug".
MSSA	Meticillin-sensitive Staphylococcus aureus are germs that many people may carry on their skin and in their nose without causing an infection or harm.
Must Do's	An action that the Trust is required to take, as outlined by the CQC following an inspection to ensure it is compliant with regulatory requirements.
NACEL	National Audit for Care at the End of Life.
NCEPOD	National Confidential Enquiry into Patient Outcome and Death.
NGSD	Next Generation Service Desk - The Trust's modernised IT Support service.
NHS	National Health Service.

Word	Definition
NHSE/I	National Health Service England & Improvement.
NICE	National Institute for Health and Care Excellence.
NNAP	National Neonatal Audit Programme.
Oxford Hip Score	A short tool specifically designed and developed to assess function and pain with patients undergoing hip replacement surgery.
Oxford Knee Score	A tool specifically designed and developed to assess function and pain after total knee replacement surgery.
P2P	Path to Platinum - The Trust's accreditation programme.
Palliative Care	Palliative Care is the active, holistic care of patients with advanced, progressive illness. Management of symptoms, the provision of psychological, social and spiritual support, delivered in an individualised approach is paramount.
PALS	Patient Advice and Liaison Service.
PDR	Personal Development Review.
PHE	Public Health England.
Positive Experience	By Positive Experience we mean making sure that our patients and their families/carers and out staff have a good experience when accessing the healthcare we provide.
PPF	Patient and Public Forum.
PREVENT	A training programme as part of the Governments counter-terrorism strategy.
PU	Pressure Ulcers.
Putting Patients First	The Trust's Purpose.
QGC	Quality Governance Committee.
QI	Quality Improvement.
QIP	Quality Improvement Plan.
QIS	Quality Improvement Strategy.
QSIR	Quality, Service Improvement and Redesign.
Quality Account	A Quality Account is a report about the quality of services offered by an NHS healthcare provider.
RCP	Royal Collage of Psychiatrists.
ReSPECT	Recommended Summary Plan for Emergency Care and Treatment. This process allows people to record their wishes about how they would like to be treated in a future emergency in which they do not have capacity to make or communicate their choice.
Resus	Resuscitation.
Safe	By Safe we mean avoiding any unintended or unexpected harm to people we provide healthcare to.

Word	Definition
SDEC	Same Day Emergency Care.
Second Wave	The second 'Spike' in the number of Coronavirus cases; this wave commenced 23rd September 2020.
Seed Funding	Initial funding.
SHMI	Summary Hospital-level Mortality Indicator. The national way of measuring mortality. Includes deaths related to all admitted patients that occur in all settings - including those in hospitals and those that occur up to 30 days after discharge.
Should Do's	An action that the Trust should take, as outlined by the CQC following an inspection to make an improvement.
SI	Serious Incident - events in healthcare where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant that they warrant additional resources to mount a comprehensive response.
SOF	NHS Single Oversight Framework outlines the approach NHSE/I will take to oversee organisational performance and identify where commissioners and providers may need support.
SOP	Standard Operating Procedure.
Start Smart Then Focus	A tool kit used for Antimicrobial Stewardship.
STP	Sustainability and Transformation Partnership - a collaborative partnership between all local health and care organisations across Herefordshire and Worcestershire supported by voluntary sector and Healthwatch representation.
SUS	Secondary Uses Service - repository for healthcare data in England which enables a range of reporting and analyses to support the NHS in the delivery of healthcare services.
TRUS	Transrectal Ultrasound.
UTI	Urinary Tract Infection.
VTE	Venous Thromboembolism (blood clot).
WAHT	Worcestershire Acute Hospitals NHS Trust.
WMAS	West Midlands Ambulance Service.
WREN	Worcestershire Reporting Network. The Trust's informatics data reporting network.

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