Worcestershire Acute Hospitals NHS Trust

Quality Account 2021/22

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Welcome and Introduction

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 a Quality Account is to enable:

- Patients and their families and carers to make better informed choices about their healthcare providers
- Boards of providers to focus on improving quality
- 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 over the last 12 months 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 provides information about how well we did against the quality priorities we set ourselves last year in our 2020/21 Quality Account. It sets out our priorities for 2022/23 (this year), which we have agreed with our patients, carers, staff and stakeholders, and outlines how we plan to achieve those targets. It also contains an overview of our quality performance, based on locally chosen indicators, and a report of the key national indicators from the NHS Outcomes Framework.

We will also share with you the comments we have received in relation to the Quality Account from our Commissioners, Healthwatch, Worcestershire Health Overview and Scrutiny Committee, and our Patient and Public Forum.

About Worcestershire Acute Hospitals NHS Trust

We serve a population of more than 592,000. This figure is projected to rise by 4.5% over the next 10 years. The age groups with the highest forecasted population growth are amongst our very elderly population. Worcestershire experienced slightly fewer COVID-19 deaths versus the national average per 100,000 populations.

We operate services from:

- Alexandra Hospital, Redditch
- Kidderminster Hospital and Treatment Centre, Kidderminster
- Worcestershire Royal Hospital, Worcester
- Princess of Wales Community Hospital, Bromsgrove
- Evesham Community Hospital, Evesham
- Malvern Community Hospital, Malvern

We provide a broad range of acute services:

- General surgery
- General medicine
- Acute care
- Cancer care
- Intensive care
- Women's and Children's services

We have a range of support services, including diagnostics and pharmacy.

Our Strategic Pyramid

Putting Patients First

Better never stops, and our vision, as set out in our strategic pyramid, 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.*

Our purpose and vision shape our objectives:

- **Best Services for Local People**: We will develop and design our services with patients, for patients. We will work actively with our partners to build the best sustainable services, which enable people in the communities we care for to enjoy the highest standards of health and wellbeing.
- **Best experience of care and best outcomes for our patients**: We will ensure that the care our patients receive is safe, clinically excellent, compassionate and an exemplar of positive patient experience. We will drive the transformation and continuous improvement of our care systems and processes through clinically-led innovation and best use of technology.
- **Best use of resources**: We will ensure that services – now and in the future – meet the highest possible standards within available resources for the benefit of our patients and the wider health and care system.
- **Best people**: We will invest in our people to ensure that we recruit, retain and develop the right staff with the right skills who care about, and take pride in, putting patients first.

These objectives are underpinned by our 4ward behaviours which we will all strive to model as positively as we can, as often as we can:

- Do What We Say We Will Do
- Listen, Learn, Lead
- No Delays, Every Day
- Work Together, Celebrate Together

Improvement & Innovation
4ward Improvement System

Key to making all of this happen, and making sure that our teams are empowered and equipped with the skills, tools, techniques and mind-set to drive continuous improvement in every part of our Trust, is our single improvement methodology – the 4ward Improvement System.

Initially working with our chosen partner, the Virginia Mason Institute, but with an increasing focus on building our own capacity and capability, our 4ward Improvement System will give us:

- A shared method for identifying and seizing every opportunity to improve the quality and safety of care we provide.
- A common language to describe those improvements.
- Robust ways of measuring the improvements we have made and the benefits that have delivered in terms of patient experience and outcomes; staff morale; efficiency and waste reduction; organisational reputation and our contribution to leading improvement not just in our Trust but across our local health and care system.
- Hope for a better future and a clear road map to help us move 4ward to that better future together.

A Welcome from our Chief Executive and Chair

At Worcestershire Acute Hospitals NHS Trust, we are committed to providing compassionate, safe and high quality care by ensuring that our services consistently exhibit the three key components of quality – patient safety, clinical effectiveness and patient and carer experience.

We aim to continue to achieve these by fostering a culture across all services that fulfils our purpose of putting patients first - ensuring patient-centred care that is tailored to each person's needs and guarantees their dignity and respect, and by empowering our staff to make improvements in their own areas.

In 2021/22, in spite of the continuing challenges that the Covid-19 pandemic has continued to present us with, a collective team effort from our Trust staff, our partners across the health and care system, the voluntary sector, and our wider communities has meant we can celebrate successes in a number of areas.

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

Of particular note is the progress we have made to meet our targets in continuing to reduce medicine incidents causing harm, reduce falls with harm, reduce the number of pressure ulcers and continue to increase hand hygiene compliance. Results from our Friends and Family Test also show that more than 96% of inpatients would recommend our hospitals.

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 a reduction in prescribing of antibiotics, and a focus on reducing the number of C-Difficile, E-Coli and MSSA infections. We are pleased that our target to eliminate MRSA infections in 2021/22 was met.

We are also making good progress on the continued implementation of the actions in our Maternity Improvement Plan which sets out how we will continue to work on national and local improvement plans to continually improve the service we offer to women and families in Worcestershire. The development of our Quality Strategy 2022-2025 – in partnership with our

patients, stakeholders, and partners - will bring together the requirements of local and national strategies, with a refreshed commitment to quality and patient safety.

Of course, alongside these, and, as we continue to emerge from the challenges of the pandemic the Trust, and the NHS as a whole, is also continuing to focus efforts on the recovery of services.

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 21/22

2,033
COVID INPATIENTS

9.47
DAYS IN HOSPITAL (FOR COVID PATIENTS)

1,741
PATIENTS DISCHARGED (COVID)

361,681
OUTPATIENTS (FACE TO FACE)

140,904
OUTPATIENTS (VIRTUAL AND TELEPHONE)

113,266
WALK-IN PATIENTS (A&E)

53,638
PATIENTS ARRIVING BY AMBULANCE

151,357
INPATIENTS

5,010
BIRTHS

4,267
EMERGENCY OPERATIONS

18,093
ELECTIVE OPERATIONS

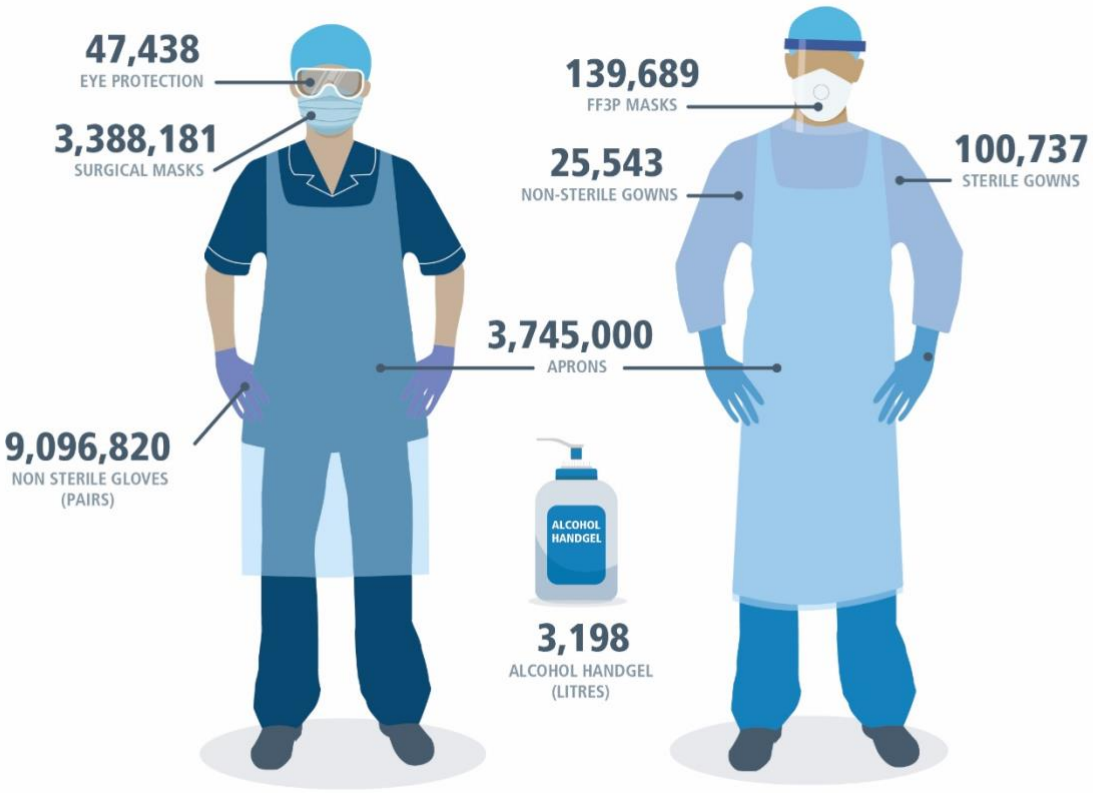
2,169
TRAUMA OPERATIONS

5.8
AVERAGE LENGTH OF STAY

770,285
NUMBER OF MEALS SERVED

878,149
NUMBER OF SHEETS LAUNDERED

£53.2m
VALUE OF PRESCRIPTIONS ISSUED



Diagnostics

- MRI scans - **18,704**
- Non-obstetric ultrasound scans - **65,547**
- CT scans - **63,745**
- Plain film X-Rays - **181,472**
- Endoscopies - **18,347**

Staff

Registered Nurses and Midwives
2,241

Total Staff
6,806

Doctors and Consultants
728

HCAs, Helpers and Assistants
1,291

OTHER CLINICAL STAFF AND ALLIED HEALTH PROFESSIONALS
859

OTHER NON-CLINICAL SUPPORT STAFF
1,687

VOLUNTEERS
80

Our Commitment to Quality

In this section of this Quality Account, we review the progress we have made against the priorities we set ourselves in the 2021/22 Quality Account, and we will outline our quality improvement priorities for the next 12 months (2022/23). In addition, we will provide a statement from the Board on mandated items.

At Worcestershire Acute Hospitals NHS Trust, we are committed to providing compassionate, safe and high quality care by ensuring that our services consistently exhibit the three key components of quality – patient safety, clinical effectiveness and patient and carer experience. We aim to continue to achieve these components by fostering a culture across all services that ensures patient-centred care that is tailored to each person's needs and guarantees their dignity and respect, and by empowering our staff to make improvements in their own areas.

Registration with the Care Quality Commission (CQC)

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

Safety, quality, risk assessments and assurance tools and processes have been implemented and embedded across the service, in partnership with NHSI/E, CCG and WMAS, and oversight of the continuous improvement has been monitored via the Trust's internal governance structure and the Home first Worcestershire Board.

The Trust continued to satisfy the conditions, submitting fortnightly reports to the CQC. The Trust submitted applications for the Section 31 Conditions to be removed from the Emergency Departments in February 2021, and in April 2021, the CQC formally confirmed that all conditions had been removed from both Emergency Departments.

Throughout 2021/22, in response to the COVID-19 requirements, CQC have focused their formal inspection activity on areas of high risk, and implemented a Transitional Monitoring Approach to ensure continued engagement, oversight and assurance.

During 2021/22, the Trust has remained proactively engaged with the CQC, and facilitated a number of monitoring calls such as:

- Transitional Monitoring Approach – Well-led
- Transitional Monitoring Approach – Critical Care

In May 2021, the CQC announced '*A new strategy for the changing world of health and social care - Our Strategy from 2021'*. In support of the new ways of CQC working alongside the

Trust, a 2-day (onsite & remote) engagement event took place in November 2021, which included:

- Opening session with the Executive Team.
- CQC meeting with the clinical teams in areas such as the Emergency Departments, Critical Care, Maternity and Outpatients at both Worcestershire Royal and the Alexandra Hospitals
  - Virtual engagement sessions with Respiratory Teams, Ward 1 (KTC), Radiology, End of Life Care, Clinical Research, Outpatients, International Nurses, Roster Team, #CallMe, Freedom to Speak Up.
- Open staff engagement sessions.

A further one day (on-site) engagement event was held in February 2022 at Worcestershire Royal Hospital which included visits to:

- Emergency Department and tour of new Urgent Care Village construction site.
- Surgical Same Day Emergency Care (SDEC) Unit
- Critical Care
- Maternity
- Speciality Medicine - Avon 4 ward

Informal feedback from the CQC following both engagement sessions was positive, with many examples of high quality patient care and good leadership. The CQC expressed their gratitude for the welcome they received, the openness and honesty of the colleagues they spoke to and shared their profound admiration for everything that our staff had achieved and are achieving.

It is important to note that CQC are still developing the framework for inspection under their new strategy.

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

Ratings for the Whole Trust at 2019						
	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 at 2019						
	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

Data Quality

We support a culture of valuing high quality data and strive to ensure all data is accurate, valid, reliable, timely, relevant and complete. Identified risks and relevant mitigation measures are included in the risk register.

We have taken the Covid 19 incident period as an opportunity to progress the development of a holistic Patient Tracking List (PTL), which we have been striving towards for some time. The principle being that any patient awaiting any treatment in the Trust will be visible in one PTL, which will enable different views depending on your interest. Existing logic has been reviewed, which has enabled understanding of how issues are generated and the data warehouse tables have been rewritten.

We are making more transparent the system constraints and user errors that create issues, so that these can be considered as part of the OASIS re-implementation and the new Digital Care Record; and can be incorporated into the RTT training plan. This is a very complex undertaking, but we are on track to have the holistic PTL in place for the start of the next financial year.

In response to the management of the Covid 19 incident which commenced in March 2020, much of resource available for data quality management was re-focused to manage Covid related data and more recently the restoration of services.

To ensure the accuracy of critical data sent to external agencies for management of the pandemic at national and regional level the Data Quality team became responsible for reporting deaths to the COVID 19 Patient Notification System (CPNS), management of the central government Shielded patient database for the Trust and contributed towards the delivery of daily reporting through the incident control governance process.

As part of the Digital Division the Data Quality team are requesting involvement in the implementation of all new systems; and are expecting to contribute significantly to the development of the Digital Care Record and the re-implementation of our patient administration system – OASIS. In preparation for the re-implementation the Data Quality Team and the Business Intelligence section within Information are working together on Data Integrity project. A portal is under construction to help identify areas of concern and will allow investigation and transparency ready for the DCR project. The portal is looking at the integrity between the same information being held on all the systems that Demographic data is entered, alongside the completeness of what data is being collected. The project has begun to look at differences between OASIS (Source), Bluespier and ICE concentrating on NHS Number, Date of Birth and Ethnicity, with Death Date collection being the next phase, whilst comparing against National Codes and how these are mapped to our internal systems.

The Trust submitted the following number of records during 2021/22 to the Secondary Uses Service (SUS) for inclusion in England's Hospital Episode Statistics:

- **A&E Records**: 205,737
- **Inpatient Records**: 140,121
  - Elective 84,079 (DC – 78,253 | Ordinary EL 5,826)
  - Non-EL 56,042
- **Outpatient Records:** 502,589

Review of Quality Priorities for 2021/22

Care that is Safe				
Quality Indicator	**Target for 2021/22**	**Outcome**		**Evaluation**
1. We will reduce the percentage of medicine incidents causing harm across the Trust	Less than 11.71%	2.92% a further reduction from 2021 figures at 3.21%		We met our target
2. We will reduce the number of patients who have a fall with harm whilst under our care	<6	5		We met our target
3. We will continue to improve on progress in reducing the number of pressure ulcers	No more than 247; a reduction of 10% on all pressure ulcers (Total 4 Serious Incident pressure ulcers)	220 total pressure ulcers 1 Serious Incident pressure ulcer		We met our target
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.				
• Clostridium difficile Infection	No more than 61	90		We did not achieve our target
• E coli Bacteraemia	No more than 30 (Local target) *(National target of 128)*	36 achieved the national target <128		We met our target
• MSSA Bacteraemia	No more than 10 *(No national target provided)*	23		We did not achieve our target
• MRSA Bacteraemia	0 cases	0		We met our target
• Hand Hygiene	98% and above	Compliance: 99.68%	Participation: 93.49%	We met our target .
5. We will further improve the identification and treatment of sepsis	Baseline position for screening in the emergency department: >95%	98.79% (Apr-21 to Feb-22)		We met our target
	Baseline position for screening in inpatient wards: >95%	81.46% (Apr-21 to Feb-22)		We did not achieve our target
	Baseline position for implementing the sepsis six bundle in the emergency department: >80%	74.69% (Apr-21 to Feb-22)		We did not achieve our target
	Baseline position for implementing the sepsis	54.19% (Apr-21 to Feb-22)		We did not achieve our target

	six bundle in inpatient wards: >95%		
6. We will further improve our compliance with screening for venous thromboembolism (VTE)	>95%	96.34%	We met our target
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	**Adult** **97.36% had an** • Has the MUST action plan been completed correctly? • If the score is less than 2, has appropriate action been taken? 97.51% • If the score is 2 or higher, has the patient been referred to dietetics? 86.91% • Has the care and comfort round documentation been completed? 99.07% **Day case** • Has the correct section on the MUST action plan been completed correctly? 99.35% • If the score is less than 2, has appropriate action been taken? 99.28% • If the score is 2 or higher, has the patient been referred to dietetics? 0% (based on 1 patient)	We did not achieve our target
	>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	**Adult** • If on A Fluid Balance Chart, are the totals correctly calculated and recorded within the last 12/24 hours? 94.39% • If patient is on a Fluid Balance Chart, is the positive/negative daily fluid balance recorded? 94.51% **Day case** • If appropriate, has a fluid balance chart been commenced? 100%	We met our target
8. ESR Frailty Essential Training for Clinical Staff (incorporates HAFD) % eligible trained	Measured through a subset of indicators from the Homefirst Frailty / HAFD Dashboard:		
	New priority for second half of Year 3+1, 2021/22		
	Corporate	100%	
	Digital	87.07%	
	SCSD	87.76%	
	Specialty Medicine	83.85%	
	Surgery	79.19%	
	Urgent Care	59.42%	
	Women and Children's	59.42%	
	Trust wide total	83.66%	

	Home First Frailty Dashboard - Total time in A&E 95th percentile Trust daily	WRH (19.7)	Alex (10.2)	Trust wide (15.3)	
	% Emergency admissions 75+	WRH (27.2%)	Alex (42.5%)	Trust wide (31.8%)	
	% of patients 75+ discharged with Length of Stay (LOS) 0 days	WRH (18.8%)	Alex (25.3%)	Trust wide (21.8%)	
	% of patients 75+ discharged with LOS 1 – 2 days	WRH (19.6%)	Alex (26.9%)	Trust wide (23.1%)	
	% of patients 75+ discharged with LOS 3+ days	WRH (61.6%)	Alex (47.7%)	Trust wide (55%)	
	Number of patients 75+ with LLOS 7+ days	WRH (78)	Alex (51)	Trust wide (129)	

Care that is Clinically Effective			
Quality Indicator	**Target for 2021/22**	**Outcome**	**Evaluation**
1. We will monitor and seek to reduce mortality rates for patients whilst under our care	HSMR of below 100	Rolling 12 months to Jan 22 | 102.72 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 the latest HSMR on HED should be taken with caution.	This remains well within expected range and is below the combined Midlands trusts value (105.41)
2. We will implement clinical standards for Seven Day Hospital Services	All patients are reviewed within 14 hours of coming into our care	• The clinical audit programme for regular monitoring of performance against 7DS clinical standards 2 & 8 is now in place supported by clinical divisions and the Clinical Effectiveness team. • Performance against clinical standard 2 has increased, by 22% since October 2021, to 74% in November '21 being reviewed by a consultant within 14 hours of admission to hospital. • Weekday performance improved from 45% in October '21 to 64% in November '21 • Weekend performance improved from 59% in October '21 to 87% in November '21 • 7-day consultant cover now in place in Acute Medicine. • 7-day consultant cover now in place on approx. 60% of inpatient medical wards, and 6-day cover on all other wards • Documentation improvements on both sites, and increased recruitment to acute medicine consultant posts.	We met this standard. 7 day services ceased March 2022

3. We will complete an annual programme of local clinical audits	80%	At 31st March 2022 24% of the 2021/22 annual programme of clinical audits was complete, with a further 20% in progress. Due to the rolling nature of clinical audit projects, which extend across years, we monitor progress on a rolling 2-year basis, which gives a clearer indication of audits completed. In addition to annual programme audits 118 ad-hoc (non-programme) clinical audits had been completed at 31st March 2022.	We did not meet our target

Care that is a Positive Experience for Patients and their Carers			
Quality Indicator	**Target for 2021/22**	**Outcome**	**Evaluation**
1. We will respond to complaints within 25 working days of receipt and ensure we create learning from the themes from complaints	80%	80.62% of complaints were responded to within 25 working days	We met our target
2. We will reduce the number of complaints returned from those who are not satisfied with the response	10%	16.6% of complaints received in year and closed have been reopened at the time of writing.	We did not meet our target
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 and	95%	Inpatients Recommend – 96.09% Outpatients Recommend – 92.61% ED Recommend – 76.58% Maternity Recommend – 93.08%	We met the target for inpatients, however, we did not meet our target for Outpatients, ED and Maternity

sharing what we are being told			
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% training completion	• 10 of 12 actions from RCP National Audit of Dementia Recommendations completed (2 outstanding actions to be completed via Trust annual account report). • Dementia & Delirium Assessment performance dashboard available via WREN. • Dementia Awareness e-learning live as essential training from October 2020, 89.9% eligible staff have completed at end March 2022 (standard is 90%). • Agreed questions for dementia care included in safety huddles. • Quality Audit questions revised and finalised to include 2 questions related to dementia/delirium identification and action for patients aged 65+. • Deep dive questions based on dementia/delirium care bundle agreed for digital upload to GAP/WREN (currently on hold). • Condensed "What Matters to Me" document (based on "About Me" document to aid person-centred care during COVID visiting restrictions.	We met our target
5. Ensuring patients and their carers feel listened to and have clear lines of communication with staff about their condition, treatment and care	Creation of a Front of House PALS service	The number of people contacting the PALS service has risen sharply throughout the year to previously unseen levels which have been sustained and continued to rise. Measures have been introduced in response to this, to support efficiency within the PALS team. It has not been possible to move to a front of house service with the sustained high level of telephone calls and increased emails.	Expected to be met in 2022
	Ease of sharing feedback and increasing visibility	There has been progress with the Trust's "Commitment to Carers which has resulted in an integrated approach and partnership with Worcestershire Association of Carers. Underpinning this is the Trust's active engagement in the Carer's Partnership Network. Initiatives this year include: ➢ Joint delivery of a social media campaign for Carer's Right's day ➢ Development of a series of measures to gain Carer feedback to assess how Carers are listened to and included in information about care	Good practice examples and integrated approaches Expected to be met in 2022

		➢ Inclusion of specific Carer questions in the Big Quality Conversation 2021-22 ➢ Integrated communication approaches including engagement with the Trust's Poet in Residence to acknowledge Carers "After Care/r" We created a variety of ways for the public to share feedback about services and experiences through The Big Quality Conversation – through QR code posters and a survey available in different languages across our hospitals, to a social media campaign, videos and face to face conversations. Engagement with stakeholders in the local D/deaf community supported a mini tender carousel competition to award a contract for Sign language at the Trust – we engaged with the community to design an approach for 2022-23 which will include a focus on feedback and quality improvement. The local D/deaf community engaged with 'The Big Quality Conversation' to share their experiences of care, creating a British sign language (BSL) video and interpreted café session to support active engagement. We increased our networking throughout the year across the Integrated Care Services locally to amplify our messaging and strengthen our partnerships and approaches. We have extended the opportunity to meet and work with us in a variety of ways to local organisations including Healthwatch to continue conversations of joint interest and provide a variety of ways to "feed-back. We met with patients directly where services affected them, during our face to face pre-engagement consultation on a cancer service based at Kidderminster Treatment Centre. We invited our volunteers to feed back to us after each volunteering session, so that we could understand what is working well and where we can improve. Feedback was overwhelmingly positive and ensured that we continued to deliver responsive and positive experiences for our local community.	
	"You Said We are Listening" – underpin initiatives with Path to Platinum	How divisions are "listening" to and acting on patient feedback has been reported into and discussed at bi-monthly-quarterly Patient, Carer and Public Engagement steering group meetings which include Patient Representatives, The Worcestershire Association of Carers and Healthwatch. Examples of how we have listened include: • The approach taken to engage with D/deaf patients and engage a contractor	We met our target

		that meets need (responding directly to feedback/concerns/complaints from members of the D/deaf community) • The Garden Suite pre-consultation in response to public concerns and feedback (This was an informal consultation, and engagement approach (informal conversations based on survey questions) with patients to understand experiences of using the temporarily relocated suite. • Ongoing Patient and Public Forum quality projects • #CallMe was launched in Patient Experience Week: #ExpoOfCare in June 2021 and won the British Medical Journal Award for Digital Innovation Team of the Year award – created in response to feedback the initiative supports every patient to be called by their preferred name New volunteer roles developed to support patient experience include Discharge/Pharmacy roles, new Wayfinder roles at both hospitals, Patient Parcel small gift delivery service and Patient Experience roles in the Emergency Department.	
	Appoint a Lead for Equality and Diversity and improve accessibility across our services	Through human resource department lead for Equality and Diversity we have: • We launched Accessible Guides through a partnership with “AccessAble”. Stakeholders have been involved throughout the process to ensure that the Guides created are as accessible as possible. ➢ Patient Stories have been shared in a variety of ways at the Trust Board monthly meetings to support across the equality, accessibility and inclusion agenda ➢ We asked specific questions in The Big Quality Conversation to help us to understand and monitor equality, diversity and equal opportunity monitoring – to inform us about how we can continue to diversify how we engage and continue to improve accessibility to our approaches and services. ➢ We have invited patients, carers and Patient Representatives to committees and meetings to have conversations about how we can continue to develop and improve accessibility and co-produce solutions together, this includes working together at The Patient, Carer and Public Engagement Committee, Clinical Governance Group and Quality Governance Committee. We have explored new ways of doing this which	

		includes commissioning a poem "Made of Stories" which was read at the Dementia Steering group, working with local students and school children to bring art and creativity into a clinical environment and working with volunteers who are registered blind.	
	Devise new ways to share compliments within and outside our trust	Compliments are reported into and discussed at the bi-monthly-quarterly Patient, Carer and Public Engagement steering group. Reports are shared with the Patient and Public Forum and Clinical Governance Group. Next steps include with support of the digital infrastructure to input compliments for both divisional and trust wide real-time views.	Expected to be met in 2022
	Implement training Programmes on customer care designed through feedback from patient services and FFT	As we continue to explore our patient feedback, we will explore how training opportunities can be introduced to support improvement and share best practice.	Expected to be met in 2022
	Continue to develop our #TogetherWeArePatientExperience campaign supporting Patient Experience Champions	Our teams have been supported to ensure that patient experience is a focus through a variety of other measures which include *#CallMe* and associated training, regular divisional reporting and ongoing Ward Accreditation	We met our target
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	1050 patients were supported with the AMBER Care Bundle in 2021/22 (718 at WRH & 332 at ALX), compared with 634 in 2020/21 (326 at WRH & 308 at ALX). This demonstrates a significant increase in usage at WRH. ReSPECT training: Awareness – 89% Authorship – 76%	We met our target
	Compliance with the use of the Individualised Last Days of Life for Adults care plan, for those identified as being in the last days of life	Last audited in March 2020 – results: 95% compliance (95% of expected deaths had a LDOL care plan in place). Previous audit result was 90% compliance, therefore an improvement Re-audit planned for Summer 2022.	We met our target
	Constructive participation in local and national End of Life audits	Participation in National Audit for Care at the End of Life (NACEL) – final results of round 3 awaited. Registered to take part in round 4 during summer 2022. Local audit programme in place as part of BOPP	We met our target

<table>
<tr><td></td><td>Positive feedback from patients and those important to them</td><td>VOICES bereavement survey currently under review. Aiming to relaunch in Spring/Summer 2022.

NACEL Round 3 also included feedback from bereaved relatives – final results awaited</td><td>We met our target</td></tr>
<tr><td></td><td>Reduction in End of Life Care related complaints</td><td>In 2020/21 percentage of total complaints with EOLC component = 2.1%
In 2021/22 percentage of total complaints with EOLC component = 1.8%
Demonstrating slight improvement as a whole trust, despite a slight increase in number of EOLC complaints at WRH.

<table>
<tr><th></th><th>Total</th><th>Formal 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>2021-2022</td><td>341</td><td>6</td><td>1.8%</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>
<tr><td>2021-2022</td><td>151</td><td>3</td><td>2%</td></tr>
</table>
</td><td>We met our target</td></tr>
<tr><td></td><td>Engagement and increased uptake in End of Life education and training amongst healthcare professionals</td><td>The below is the total percentage of staff who have undertaken the EOLC e-learning since it was introduced in Spring 2021.

A wide range of palliative & EOL Care education is delivered throughout the year.</td><td>We met our target</td></tr>
</table>

		<table><tr><th>Division</th><th>Eligible Headcount</th><th>No. of Staff Completed as at 31/03/22</th><th>% of Staff Completed as at 31/03/22</th></tr><tr><td>365 Corporate</td><td>102</td><td>67</td><td>65.69%</td></tr><tr><td>365 Specialised Clinical Services Division</td><td>1248</td><td>1118</td><td>89.58%</td></tr><tr><td>365 Specialty Medicine</td><td>958</td><td>843</td><td>88.00%</td></tr><tr><td>365 Surgery</td><td>700</td><td>596</td><td>85.14%</td></tr><tr><td>365 Urgent Care</td><td>495</td><td>406</td><td>82.02%</td></tr><tr><td>365 Women & Children</td><td>130</td><td>91</td><td>70.00%</td></tr><tr><td>Grand Total</td><td>3633</td><td>3121</td><td>85.91%</td></tr></table>	

Our Quality Priorities and Key Indicators for 2022/23

During 2021/22, the Trust has been required to continue its clinical focus on the COVID-19 pandemic response, and focusing on how we can restore our services.

Over the last 12 months, we have consulted with our stakeholders, partners and patients to construct our Quality Strategy 2022 – 2025, which will bring together the requirements of local and national strategies, with a refreshed commitment to quality and patient safety.

For Year 1 of our strategy – 2022/23 – our priorities have been formulated through ongoing engagement throughout 2020/21 and 2021/22, and action focused refinement with:

- Staff, including Divisional Directors, via Quality Strategy socialising sessions
- Patients, via the Big Quality Conversation, compliments, complaints, Friends and Family feedback
- System Partners, through engagement with the annual accounting process and monthly quality forums:
    - Herefordshire and Worcestershire Clinical Commissioning Group
    - Worcestershire Health Overview and Scrutiny Committee
    - Healthwatch Worcestershire
    - Integrated Care System
- Patient and Public Forum, Volunteers, Youth Forum through assurance processes/reviews and engagement via forums
- Students via engagement sessions.

We conducted our second Big Quality Conversation online survey, and asked patients, carers and the public to provide feedback on the quality and safety of services they have experienced during 2021/22.

The survey was viewed over 2152 times, with over 585 either full (345) or partial (240) responses representing a 23% increase on 2021 figures. Of those completing the survey:

- 30.64% (110) Male respondents
- 63.79% (229) Female respondents
- Of 352 responses, 311 are recorded as White: English/Welsh/British

% of responses and associated clinical areas:

- Worcestershire Royal Hospital: 81.45%
- Alexandra Hospital: 23.64%
- Kidderminster Hospital and Treatment Centre: 14.73%
- Evesham Community Hospital (Burlingham Endoscopy ward only): 2.36%

Our quality statements are laid out under the three dimensions of quality, with priority areas under each quality statement.

- Care that is **Safe**
- Care that is **Clinically Effective**
- Care that is a **Positive Experience** for Patients and their Carers

Respondents to the survey told us that the following areas are important to them and are addressed throughout this quality account:

- **Infection Prevention and Control:**
  - Personnel Protective equipment (PPE)
  - Cleanliness
  - Social Distancing
- **Communication:**
  - British Sign Language
  - Interpreters
  - Clear Communication
  - Being Kept Informed
  - Keeping in touch with family
- **Staffing:**
  - Competent staff
  - Visibility of Staff
  - Enough Staff
  - Staff Attitudes
  - Caring Staff
- **Responsive:**
  - Waiting times
  - Quick Treatment
  - Regular Monitoring
- **Effective:**
  - High Standard of Care
  - Quick Treatment

Care that is Safe: **These year's survey findings tell us that 70.49% of 454 responses reported feeling "extremely safe or very safe" and 19.82% reported feeling "somewhat safe". This shows an increase in response and satisfaction rate from 227 (2021) responses to 454 (2022) responses, with an overall satisfaction increase of 0.45%.**

Quality Statements:

- Our patients will continue to receive the highest levels of Infection Prevention and Control (IPC) excellence, reducing the risk of nosocomial (healthcare acquired) infections in hospital
- Our patients will be represented in our governance processes, in particular by ensuring Patient Safety Partners are involved in the implementation of the National Patient Safety Strategy
- Our patients' nutrition and hydration needs will be met during their time in our hospitals
- Our patients will experience safe and timely discharges from hospital and transfers between services
- Our patients will continue to receive timely identification and treatment of sepsis
- Digital Care Record

Care that is Clinically Effective: **These year's survey findings tell us that 70.55% of 420 responses reported that staff worked together "Extremely well or very well" and 19.29% felt that staff worked together "Somewhat well". This shows an increase in response and satisfaction rate from 225 (2021) responses to 420 (2022) responses, with an overall increase of 0.55%.**

Quality Statements:

- We will commit to continuous learning from deaths and monitor and seek to reduce mortality rates for patients whilst under our care
- Our patients will experience better health outcomes due to a regular programme of clinical audit and subsequent quality improvement projects
- Our patients will receive timely treatment and care through improved waiting times, seven day services and a focus on reducing backlog
- Develop new Research and Development Strategy
- Work with educational partners to improve the training for our staff

Care that is a Positive Experience for Patients and their Carers: **These year's survey findings tell us that 75.06% of 421 respondents felt that the quality of care that they had received was "Outstanding or good" and 19% felt that it "requires improvement".**

Quality Statements:

- Our patients will experience better access to our services, particularly for our patients and their carers who live with health inequalities This includes members of Ethnic Minority communities, the LGBT+ community and people who live with disabilities or vulnerabilities.
- Our patients and their carers will be provided with a variety of methods for providing feedback on their experiences of our services, to ensure learning and improvements can be prioritised.

Priorities for 2022/23

Care that is Safe

Our patients will continue to receive the highest levels of Infection Prevention and Control (IPC) excellence, reducing the risk of nosocomial (healthcare acquired) infections in hospital

Reducing Clostridium difficile	**Our target for 2022/23 is: 61**
We will do this by: • Achieving the standards set out in the 2022-23 *Key Standards to Prevent Infection* • Participating in regional Clostridium difficile collaborative • Divisions will focus on improving detection and management of patients with diarrhoea, based on learning from cases in 2021-22. Fewer cases will have these issues detected as an "amber" lapse in care. • Recognising patients with previous Clostridium Difficile Infection on admission, so that prescribing can take account of previous infection and reduce the risk of recurrence. • Ensuring a proactive programme of deep cleaning beds and trollies will be established on both sites. • Ensuring a programme of deep cleaning Emergency Departments and admission areas. • Meeting the national standards in all areas for cleanliness minimum standard: nursing and estates as well as cleaning services.	

Antimicrobial stewardship	**Our targets for 2022/23 are:** 1. Achieve a cumulative reduction of 4.5% for prescribing of antibiotics in "Watch" and "Reserve" groups compared to 2018 baseline. 2. Commissioning for Quality and Innovation (CQUIN) target: Achieving 60% of all antibiotic prescriptions for UTI in patients aged 16+ years that meet NICE guidance for diagnosis and treatment.
We will do this by: • Target 1 will be achieved by – undertaking and completing review of treatment guidelines for antimicrobial prescribing taking into account the following; national treatment guidance (i.e. National institute for Care and Excellence (NICE) guidelines), local resistance patterns, rationalising empirical guidance for broad spectrum antibiotics (i.e. co-amoxiclav) and monitoring compliance to prescribing guidelines via quarterly point prevalence surveys reported via Antimicrobial Stewardship steering Group (ASG). • Target 2 will be achieved by – establishing an Multi-Disciplinary team task and finish group to monitor and action CQUIN progress, updating local antimicrobial treatment guidelines for the diagnosis and treatment of Urinary Tract Infections producing education and training materials and delivering ad-hoc education and training sessions with feedback and progress updates for directorates.	

Our patients will be represented in our governance processes, in particular by ensuring Patient Safety Partners are involved in the implementation of the National Patient Safety Strategy

Transition to the Patient Safety Incident Response Framework	**Our target for 2022/23 is to fully implement and transition to the new Patient Safety Incident Response Framework (PSIRF)**
We will do this by: We will review changes to the PSIRF following feedback from the early adopter sites. This program is scheduled to be incrementally delivered as and when National documentation has been approved. We will start to roll out the PSIRF throughout 2022 and will review bi-annually to ensure progress against national targets.	

Improvement of the quality of investigation reports, including implementation of the new Patient Safety Investigation standards	**Our target for 2022/23 is 35% of all patient safety investigations will be conducted according to the new investigation standards**
We will do this by: We will transition to the new PSIRF during 2022 and will be implementing the new investigation standards. The aim in the first year will be to demonstrate that 35% of all patient safety investigations are conducted utilizing the new investigation approach. This percentage will be increased yearly.	

Our patients' nutrition and hydration needs will be met during their time in our hospitals

Nutrition and hydration assessments	**Our target for 2022/23 is 100%**
We will do this by: • Assessing and evaluating all our patients as clinically appropriate • Monitoring compliance against these standards through senior nurse audits, with an improvement approach to support areas of non-achievement • Ongoing training available to support staff in evidence based completion of assessments	

Food diaries and fluid balance charts	**Our target for 2022/23 is 100%**
We will do this by: • All patients that require a fluid balance chart will have one, and the documentation will be up to date, contemporaneous and used to support clinical decision making • Monitoring compliance against these standards through senior nurse audits, with an improvement approach to support areas of non-achievement • Ongoing training available to support staff in evidence based completion of assessments	

Our patients will experience safe and timely discharges from hospital and transfers between services

Rollout of Discharge Production Boards (DPBs) on all inpatient ward areas	**Our target for 2022/23 is >95%**
We will do this by: • Ward to Board roll out of the DPB model • Monitoring of key discharge metrics to demonstrate improvement	

Our patients will continue to receive timely identification and treatment of sepsis

Baseline position for screening in the emergency department	**Our target for 2022/23 is >95%**
We will do this by: • Continuous monitoring of use of the Sepsis Six bundle within our Emergency Departments through governance processes and audit. • Implementation of the Digital Care Record.	

Baseline position for screening in inpatient wards	**Our target for 2022/23 is >95%**
We will do this by: • Continuous monitoring of use of the Sepsis Six bundle within our Emergency Departments through governance processes and audit. • Implementation of the Digital Care Record.	

Baseline position for implementing the sepsis six bundle in the emergency department	**Our target for 2022/23 is >85%**
We will do this by: • Trust Sepsis Lead to work with Divisions to increase the use of the sepsis six bundle. • Implementation of the Digital Care Record.	

Baseline position for implementing the sepsis six bundle in inpatient wards	**Our target for 2022/23 is >85%**
We will do this by: • Trust Sepsis Lead to work with Divisions to increase the use of the sepsis six bundle. • Implementation of the Digital Care Record.	

Digital Care Record

The Digital Care Record (DCR) is a high-tech electronic patient record system which will modernize and improve the way we deliver patient care across the Trust.

Introducing a DCR system will mean that all patient information will be available electronically, on screen, at any hospital location at any time. It will transform the way we admit, treat and discharge our patients. It will improve referral management, reducing the number of cancellations and rescheduled appointments. It is the first step to allow us ultimately to share patient records with other appropriate NHS organisations.

Phase 1 documentation roll-out

We will do this by:

- "Phase 1" is scheduled to go live at the end of 2022, and will contain the most common Medical and Nursing documents used for recording care or assessing risk for adults receiving care in an inpatient setting, for example:

- Adult Acute Medical Admission Document
- Adult Acute Medical Daily Review Document
- Surgical Admission Assessment
- Adult Surgical Daily Review Document
- Comorbidities
- Biographical Details
- Inpatient Risk Assessment for VTE
- Nursing Admission
- Assessment of Nursing Care Needs
- Patient Property - Disclaimer Form
- Dementia Assessment Tool
- Falls Prevention Assessment and Intervention
- Falls Risk Assessment Care Plan Inpatient
- Bedrails Assessment and Implementation Plan
- Mobility Assessment
- Adult MUST Assessment Action Plan
- Pressure Ulcer Prevention Care Plan
- Water low Chart
- Oral Care Assessment and Recording Tool
- Alcohol Consumption and Smoking Screening Tool
- Patient Admission Assessment for Risk of Infection
- Stool Charts
- Wound assessment
- Urinary Catheter
- Oral Care Assessment and Recording Tool
- Alcohol Consumption and Smoking Screening Tool
- PVD Form
- Intentional Care and Comfort Record
- New2 Observation and Pain Management Chart
- Glasgow Observation Chart
- Sepsis Screening Tool
- Fluid Balance Sheets
- Discharge Checklist
- Rockwood Assessment

Care that is Clinically Effective

We will commit to continuous learning from deaths and monitor and seek to reduce mortality rates for patients whilst under our care

Relatives contacted by medical examiner team and invited to raise concerns	**Our target for 2022/23 is 90%**
We will do this by: • Recruitment to Medical Examiner and Medical Examiner Officer posts. • Setting up systems to ensure all deaths are reviewed and family discussions occurring before MCCD's (Medical certificate for cause of death) are forwarded to the registrar. • All concerns logged and issues passed on through appropriate escalation pathways.	

Outcomes of mortality reviews will be reported and improvement actions developed	**Our target for 2022/23 is 90%**
We will do this by: • Ensuring standard templates to report output from clinical team mortality meetings and divisional governance meetings with the focus primarily on quality improvement activity arising as a result of mortality reviews. • Reporting overseen at Learning from deaths group where sharing of learning and improvement initiatives occurs. • Presenting a quarterly learning from deaths report to Quality Governance Committee.	

Reducing SHMI to remain within the "as expected" range
We will do this by: • Monitoring for and review of any high relative risk of death diagnostic groups to ensure best practice in clinical care and coding are provided.

Our patients will experience better health outcomes due to a regular programme of clinical audit and subsequent quality improvement projects

Participating in a programme of national audits for which we are eligible	**Our target for 2022/23 is >95% of national audits for which we are eligible**
We will do this by: • Continuing to participate in all national audits that we are eligible to participate in. • Ensuring that baseline assessments are carried out for all new national audits, seeking to overcome any obstacles to participation where necessary.	

Outcomes of national audits will be reported and improvement actions will be generated and monitored	**Our target for 2022/23 is 90% of relevant* national audits will have a baseline audit/ progress update, with actions generated and monitored, via the National Clinical Audit Module.** **relevant – excludes some national audits that are registries*
We will do this by: • Launching the National Clinical Audit Module on Clinical Audit Tool (CATs) (estimated June 2022), to facilitate reporting of national audits, recording of actions and monitoring, with regular reports being provided to Divisions and Clinical Governance Group by the Clinical Audit Team.	

Our patients will receive timely treatment and care through improved waiting times, seven day services and a focus on reducing backlog

Eliminating 104 week waits for elective treatment in 2022/23	**Our target for 2022/23 is 0 104 week waits**
We will do this by: • Increasing throughput at Kidderminster Hospital and Treatment Centre. • Implementing new theatre capacity at the Alexandra Hospital.	

Restoring diagnostic and treatment activity to pre-covid levels	**Our target for 2022/23 is 104%**
We will do this by: • Increasing throughput at Kidderminster Hospital and Treatment Centre, including development of Community Diagnostic Hub. • Implementing new theatre capacity at the Alexandra Hospital.	

Develop new Research and Development Strategy

Develop new Research and Development Strategy
We will do this by: The new Research and Development Strategy has been approved by the Trust Board in April 2022. We will implement the strategy and report progress to Quality Governance Committee.

Work with educational partners to improve the training for our staff

Work with educational partners to improve the training for our staff during 2022/23,
we will do this by:

Medical staffing:

- Ensuring alignment with Health Education England education contract

Medical Education:

- Adopting Midlands Charter across all aspects of medical education
- Continuing to pursue relationship with Worcester University – Three Counties Medical School; Birmingham University and Warwick University
- Approving new build Simulation Centre

Care that is a Positive Experience for Patients and their Carers

Our patients will experience better access to our services, particularly for our patients and their carers who live with health inequalities. This includes members of Ethnic Minority communities, the LGBT+ community and people who live with disabilities or vulnerabilities.

Implementing a real-time accessibility information service that supports access to our facilities	**Our targets for 2022/23 are:** • Friends and Family Test: Achieve 95% Recommended rate in A and E, Inpatients/Day case, Maternity and Outpatients.

We will do this by:

- We will ensure that patients, carers, family and friends are offered a variety of ways to feedback about services across our hospitals – by providing and making available cards, text message and iPad “every day” and throughout a patients’ journey. We will explore ways to maximise on the visibility and ensure that our patients are aware that we invite them to feedback about the quality of their care.
- Public feedback will be displayed in ward/clinic areas in a standardised and consistent way – clearly demonstrating actions and improvements from comments. ‘You said – we listened’ - ward areas will display positive comments and update their boards monthly.
- Divisions will present action plans at governance meetings in response to Care Quality Commission (CQC) patient Experience surveys and provide headlines and progress at the Patient, Carer and Public Engagement steering group to ensure a standardised approach to action and improvement.
- Carer’s Conversation Cafes in partnership with the Worcestershire Association of Carers will offer an additional mechanism to engage directly with carers and provide opportunity to feedback about experiences. Themes will be presented to the Patient, Carer and Public Engagement Group and reported into Clinical Governance Group.
- Engagement events with the D/deaf community will raise awareness of how the community can feedback about their experiences which will directly inform developments for sign language provision at the Trust. Themes and actions will be

reported into the Patient, Carer and Public Engagement Group and Clinical Governance Group.

- We will develop a Patient Advice and Liaison service (PALS) Front of House Service at Worcestershire Royal Hospital to provide an additional support mechanism for the public to feedback concerns, compliments and issues.
- Wards will consistently offer Learning Disability patients the Easy Read Friends and Family Test which is available within the Learning Disability Resource pack

Strengthening pathways for patients with Learning Disabilities (LD)
We will do this by: • Sharing of key messages, actions, learning, improvements, patient stories and incidents for People with a Learning Disability and autistic people (LeDeR) through the LD Steering Group. • Re-establishing LD Champions, holding training events to share skills, supporting wards with embedding the use of the LD Traffic Light Symbol to highlight there maybe additional needs/reasonable adjustments – monthly audits by LD Team to monitor. • Introduce New National Training Programmes as they become available (Summer 2022) • LD National Survey – Review results and make SMART actions for improvements, working with Divisions to make improvements, monitoring actions through LD Steering Group and reporting to CGG. (To check with Claire this is correct forum) • Resource Packs to be printed and made available for each ward area to support teams with LD appropriate resources. • Quarterly LD Bulletins to be shared with teams – showcasing good practice, patient stories, key messages and news.

Developing diagnostic access with community hubs and implement care in new, purpose built facilities to meet patient needs	**Our target for 2022/23 is to open one Diagnostic Hub**
We will do this by: • Working with partners to develop facilities and pathways	

Our patients and their carers will be provided with a variety of methods for providing feedback on their experiences of our services, to ensure learning and improvements can be prioritised.

Implementing a digital solution that enables patients to provide feedback in real-time	**Our targets for 2022/23 are** • 4star rating from patients and carers. • Friends and Family Test: Achieve 95% Recommended rate in A and E, Inpatients/Day case, Maternity and Outpatients.

We will do this by:

- We will explore a whole-system web based IT solution to capturing and monitoring feedback: this will include further ways for the public to feedback and strengthen our messaging that we are a listening Trust.
- To support this, we will explore creating a greater visibility of the importance of giving feedback in the main entrances of our hospitals.
- We will bring in new ways to understand the patient feedback journey which will provide a new management interface, tableau dashboards and an internal and public launch

Greater engagement with patients and carers through the annual Big Quality Conversation, feeding into yearly priorities	**Our target for 2022/23 is** (increase by 10%)

We will do this by:

- We will deliver targeted engagement with staff, patients, carers and the wider community.
- We will do this through a poster campaign and through local community groups, developing staff webinars, working with our volunteers and engaging with community networks.
- We will engage using a mixed mode approach of face to face conversations and workshops and harnessing digital technology

Increasing Compliments and recommendation rates	**Our target for 2022/23 is increase compliments by 15%**

We will do this by:

- We will update the Datix Reporting system to provide a mechanism for any member of staff to upload and register a compliment at the Trust.
- We will maximise awareness with staff through our internal Communications and we will monitor improvement through the Patient, Carer and Public Engagement steering group.
- We will report on progress with our target into the Clinical Governance Committee

Reducing the number of complaints returned from those who are not satisfied with the response	**Our target for 2022/23 is 15%**

We will do this by:

- Explore the roll out of surveying patients and carers to gain feedback on the quality of the process and identify areas for improvement
- Explore Business Case against benchmarking from other Trusts to expand Complaints Team and service function (if required) to meet National Complaints Standards Framework.
- Produce regular thematic reports on reopened complaints to identify reasons and areas for action/need for additional training.

Statement of Directors' Responsibilities

The Directors are required, under the Health Act 2009, to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of the 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 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

Quality Dashboard – NHS Outcomes Framework

Domain	Indicator	Current Performance	National average value	Where applicable		Trust statement	Previous values (where data available)		
				Best NHS performer	Worst NHS performer				
Preventing people from dying prematurely	SHMI value and banding Published: 12th May 2022	1.0410 Banding 2 'as expected' (Jan-21 – Dec-21)	N/A	0.7127	1.1897	***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**	1.0321 Banding 2 'as expected' (Apr-20 – Mar-21)	1.0428 Banding 2 'as expected' (Apr-19 – Mar-20)	1.1440 Banding 1 'higher than expected' (Apr-18 – Mar-19)
	% of deaths with either palliative care specialty or diagnosis coding Published: 12th May 2022	34% (Jan-21 – Dec-21)	39%	11%	64%	***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**	34.11% (Apr-20 – Mar-21)	34.75% (Apr-19 – Mar-20)	33.63% (Apr-18 – Mar-19)

Domain	Indicator	Current Performance	National average value	Where applicable		Trust statement	Previous values (where data available)		
				Best NHS performer	Worst NHS performer				
	Patient-reported outcome score for hip replacement surgery – adjusted average health gain (Oxford Hip Score)	COVID-19 note In order to respond to the challenges posed by the coronavirus pandemic, NHS hospitals in England were instructed to suspend all non-urgent elective surgery for patients for parts of the 2020/21 reporting period. This has directly impacted upon reported volumes of activity pertaining to Hip & Knee replacements reported in PROMs. In addition it is possible that behaviours around activities relating to the completion, return and processing of pre and post-operative questionnaires may have also been impacted when compared to earlier years data where behaviours and processes related to managing the current pandemic were not in place.				*Worcestershire Acute Hospitals NHS Trust considers that this data is as described for the following reasons:* Outcomes are slowly improving and are above the national average *Worcestershire Acute Hospitals NHS Trust intends to take the following actions to improve this number and so the quality of its services, by:* See Quality Account priorities – plans to improve access to theatre aim to create further improvement	22.754 Not an outlier (19/20 Final)	22.532 Not an outlier (18/19 Final)	22.965 Not an outlier (17/18 Final)
	Patient-reported outcome score for knee replacement surgery – adjusted average health gain (Oxford Knee Score)					*Worcestershire Acute Hospitals NHS Trust considers that this data is as described for the following reasons:* Planned knee surgery has improved as patient flow to the theatre has been addressed *Worcestershire Acute Hospitals NHS Trust intends to take the following actions to improve this number and so the quality of its services, by:* Improving flow so improving the timeliness of treatment and avoiding pain or deterioration for waiting patients	17.342 Not an outlier (19/20 Final)	18.049 Not an outlier (18/19 Final)	17.022 Not an outlier (17/18 Final)

Domain	Indicator	Current Performance	National average value	Where applicable		Trust statement	Previous values (where data available)		
				Best NHS performer	Worst NHS performer				
	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 publication of this data have been suspended			*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 publication of this data have been suspended			*Worcestershire Acute Hospitals NHS Trust considers that this data is as described for the following reasons:* Despite bed pressures, the Trust ensures patients are fit enough to cope at home wherever possible *Worcestershire Acute Hospitals NHS Trust intends to take the following actions to improve this number and so the quality of its services, by:* Maintaining safe discharge practice	10.80% (18/19)	9.62% (17/18)	9.53% (16/17)
Ensuring that people have a positive experience of care	Responsiveness to inpatients' personal needs scored from the National Inpatient Survey Hospital stay: 01/11/2020 to 30/11/2020 Survey collected 01/01/2021 to 31/05/2021	73.4	74.5	85.4	67.3	*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:*	66.3 (19/20)	64.3 (18/19)	66.2 (17/18)

Domain	Indicator		Current Performance	National average value	Where applicable: Best NHS performer	Where applicable: Worst NHS performer	Trust statement	Previous values (where data available)		
	Published: 17th March 2022						Improvements to the patient flow described in Quality Account priorities			
	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 2021*		60.7%	66.9%	89.5%	43.6%	*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	68.6% (2020)	63.3% (2019)	57.9% (2018)
	Inpatient Friends and Family test **Mar-22** **Published: 12th May 2022**	**% Positive**	**97%**	**93%**	**100%**	**66%**	*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*	**96%** **(Mar-21)**	**94%** **(Mar-19)**	**94%** **(Mar-18)**
		Response Rate	**30%**	**18%**	**100%**	**1%**		**33%** **(Mar-21)**	**18%** **(Mar-19)**	**6%** **(Mar-18)**
	A&E Friends and Family test **Mar-22**	**% Positive**	**78%**	**73%**	**100%**	**49%**	*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	**86%** **(Mar-21)**	**82%** **(Mar-19)**	**74%** **(Mar-18)**

Domain	Indicator		Current Performance	National average value	Where applicable		Trust statement	Previous values (where data available)		
					Best NHS performer	Worst NHS performer				
	Published: 12th May 2022	**Response Rate**	**17%**	**10%**	**41%**	**1%**	*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.	**19%** **(Mar-21)**	**6%** **(Mar-19)**	**4%** **(Mar-18)**
Treating and caring for people in a safe environment and protecting them from harm	% of patients risk-assessed for venous thromboembolism		The VTE data collection and publication is still suspended to release capacity in providers and commissioners to manage the COVID-19 pandemic.				*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 Published 15th September 2021		61.7 (Apr-20 to Mar-21)	22.2	0.0	140.5	*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	39.4 (Apr-19 to Mar-20)	50.0 (Apr-18 to Mar-19)	36.8 (Apr-17 to Mar-18)
	Rate of patient safety incidents per 1,000 bed days		52.8 (Apr-20 to Mar-21)	N/A	27.2	118.7	*Worcestershire Acute Hospitals NHS Trust considers that this data is as described for the following reasons:*	53.1 'No evidence for potential	52.90 'No evidence for potential	43.77 'No evidence for potential

Domain	Indicator	Current Performance	National average value	Where applicable		Trust statement	Previous values (where data available)		
				Best NHS performer	Worst NHS performer				
	Published: 29th September 2021 Transition to annual reporting					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	under-reporting' (Oct-19 to Mar-20)	under-reporting' (Apr-19 to Sep-19)	under-reporting' (Apr-18 to Sep-18)
	Percentage of patient safety incidents that resulted in severe harm or death Published: 29th September 2021	0.36%	0.44%	0.03%	2.80%	*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	0.26% (Oct-19 to Mar-20)	0.32% (Apr-19 to Sep-19)	0.29% (Apr-18 to Sep-18)

Clinical Audit 2021/22

During 2021/22 44 national clinical audits and 2 national confidential enquiries covered relevant health services that Worcestershire Acute Hospitals NHS Trust provides. We also undertook 142 registered local clinical audits during 2021/22.

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 2021/22. Appendix 1 also describes the actions we have taken or are planning to take to improve our services in response to insights from these audits.

Participation in Clinical Research

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

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 2020/21.

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

The Clinical Research and Innovation strategy is one of the building blocks of our Trust vision of putting patients first. Being delivered in accordance with our 4ward signature behaviour's will contribute to our strategic objectives of providing the best services for local people, delivered by the best people.

Our research participants will have the best experience of care, and we will ensure that our research team makes the best use of the resources we are provided with from the NIHR, research funders and charitable funding.

This strategy will raise awareness of and engagement with research and innovation at the Board and throughout the Trust and will result in:

- Increased participation in Clinical Research
- Increased income and improved efficiency
- Increased awareness of Clinical Research and Innovation across the Trust
- Enhanced reputation externally
- Successful clinical recruitment too hard to recruit to areas
- Opportunities to create new roles within the Trust's workforce to support delivery of the Clinical Strategy

The strategy was approved by the Trust Board in March 2022 and implementation will be the focus of 2022/23.

Commissioning for Quality and Innovation (CQUIN)

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

During 2021/22, CQUINS were paused at a national level. However, these have been reintroduced for 2022/23. There are 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.

For 2022/23, the Trust's CQUIN commitments have been agreed as follows:

CCG	CQUIN
CCG1	Achieving 90% uptake of flu vaccinations for staff with patient contact.
CCG2	Achieving 60% of all antibiotic prescriptions for UTI in patients aged 16+ years that meet NICE guidance for diagnosis and treatment.
CCG3	Achieving 60% of all unplanned critical care unit admissions from non-critical care wards of patients aged 18+, having a NEWS2 score, time of escalation (T0) and time of clinical response (T1) recorded.
CCG8	Ensuring that 70% of surgical inpatients are supported to drink, eat and mobilise within 24 hours of surgery ending
CCG9	Achieving 35% inpatients (with at least 1-night stay) with a diagnosis of alcohol dependence who have an order or referral for a test to diagnose cirrhosis or advanced liver fibrosis.
Specialised Services	**CQUIN**
PSS1	To reduce the delays in assessment, investigation, and revascularisation in patients with chronic limb threatening ischaemia and in turn reduce length of stay, in-hospital mortality rates, readmissions and amputation rates
PSS2	Achieving high quality shared decision making conversations to support patients to make informed decisions based on available evidence and their personal values and preferences and knowledge of the risks, benefits and consequences of the options available to them with regard to both their clinical condition and the consequences of the current pandemic.
PSS3	Achieving priority categorisation of patients within selected surgery and treatment pathways according to clinical guidelines

Appendix 1: Clinical Audit Participation Details, including examples of how clinical audit has been used to drive improvement

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 2021/22, 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.

NB: both of the below studies are studies that were scheduled to have closed during 2021/22. However, the national deadline has been extended due to the number of cases still outstanding. The figures below are accurate at the time of this report.

National Confidential Enquiry into patient Outcome and Death (NCEPOD)	% of cases returned
Transition from child to adult health services: Clinician questionnaire	50%
Epilepsy: Hospital attendance	17%

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	ALX – n430 WRH – n478	
IBD - Inflammatory Bowel Disease Programme/IBD Registry	Yes	100%	
ICNARC - Case Mix Programme	Yes	100%	

Eligible National Audits	Participation	% or No's cases submitted	Comments
LeDeR -Learning from Lives and Deaths of People with learning disability and autistic people (Previously known as Learning Disability Mortality Review Programme)	Yes	Managed to get a number last year	1/4/21 – 31/3/22
MBRRACE - Maternal, New-born and Infant Clinical Outcome Review Programme	Yes	100%	
NABCOP - National Audit of Breast Cancer in Older People	Yes	100%	
NACAP - Pulmonary rehabilitation Organisational and Clinical audit	Yes	Cohort 1 – 100% Cohort 2 – ** data not available	Cohort 1 – 1 April 2021 to 30 September 2021 Cohort 2 – 1 October 2021 to 28 February 2022 submission deadline 8th July 2022
NACAP - Secondary Care - Adult Asthma	Yes	Cohort 1 – n24 Cohort 2 – ** data not available	Cohort 1 – 1 April to 30 September 2021 Cohort 2 – 1 October 2021 to 31 March 2022 submission deadline 13 May 2022
NACAP - Secondary Care – COPD	Yes	** data not available	Submission deadline 13 May 2022
NACR - National Audit of Cardiac Rehabilitation	Yes	** data not available	Submission deadline 30 June 2022
NOGCA - National Oesophago-gastric Cancer Audit	Yes	100%	
National Audit of Dementia (NAD) - Care in General Hospitals	Yes	N/A	There was no national data collection for hospitals in the 2021/22 financial year
NBOCA - National Bowel Cancer Audit	Yes	** data not available	Submission deadline is by July 2022
NCAA - National Cardiac Arrest Audit	Yes	ALX Q1 – 5 Q2 – 6	Q4 data not available until mid-April 2022

Eligible National Audits	Participation	% or No's cases submitted	Comments
		Q3 – 2 WRH Q1 – 14 Q2 – 13 Q3 – 12	
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	n87	
NDA - Adults - National Diabetes Foot Care Audit	Yes	** Data not available	Submission deadline Friday 17 June 2022
NDA - Adults - National Pregnancy in Diabetes Audit	Yes	100%	
NDA - Adults - National Core Diabetes Audit	Yes	** Data not available	Submission deadline June 2022
NELA - National Emergency Laparotomy Audit	Yes	Q1 n32 Q2 n38	1/12/21 – 30/11/22 1/12/22 – 30/11/23
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%	

Eligible National Audits	Participation	% or No's cases submitted	Comments
NPDA - National Paediatric Diabetes Audit	Yes	** Data not available	Submission deadline 27th May 2022
NVR - National Vascular Registry	Yes	Q1 – n129 Q2 – n138 Q3 – n121	Q4 not available until mid-April 2022
PROMS - Elective Surgery	Yes	100%	
SHOT - Serious Hazards of Transfusion: UK National Haemovigilance	Yes	100%	
SSNAP - Sentinel Stroke National Audit Programme	Yes	100%	
TARN - Major Trauma Audit	Yes	** Data not available	TARN has not processed all recent submissions. Submission deadline 8th July 2022
FFFAP - (NAIF) National Audit of Inpatient Falls	Yes	** Data not available	Deadline of 8th April for checking data entries
CEM - Pain in Children	Yes	** Data not available	Data collection deadline 03/10/22
Society for Acute Medicine's Benchmarking Audit (SAMBA)	Yes	WRH – 100% ALX – 0%	ALX - particularly severe staffing issues around that time
NDA - National Diabetes Harm Review NaDIA	Yes	100%	
NACAP - Paediatric Asthma	Yes	Cohort 1 – 100% Cohort 2 – ** data not available	Cohort 1 – 1st April 2021 to 30th September 2021 Cohort 2 – 1 October 2021 to 31 March 2022 -Submission deadline 13 May 2022
Chronic Kidney Disease Registry	Yes	100%	
National Perinatal Mortality Review Tool	Yes	100%	
National Outpatient Management of Pulmonary Embolism	Yes	WRH n15 ALX n13	
BAUS Management of the Lower Ureter	Yes	n32	

Eligible National Audits	Participation	% or No's cases submitted	Comments
in Nephroureterectomy Audit			
NACEL - National Audit of Care at the End of Life	Yes	Case note review n40 Staff survey n43 Quality survey n23	

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 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
FFFAP - Fracture Liaison Service Database (FLSD) SCSD/ Rheumatology - Professor. Rai	The Trust does not provide this service. It was de-commissioned 31/08/19
Cleft Registry and Audit Network (CRANE)	Specialist audit
National Congenital Heart Disease (CHD) - NCAP	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 Child Mortality Database	Sole providers of data are Child death overview panels (CDOP) Does not apply to the Trust
National Audit of Cardiovascular Disease Prevention	Primary Care
Transurethral Resection and Single Instillation Mitomycin C Evaluation in Bladder Cancer Treatment	Mitomycin C is not given - this is not our standard practice
National Smoking Cessation 2021 Audit	Trust does not provide this service.

Worcestershire Acute Hospitals NHS Trust was eligible to participate in the following national audits, however the below audits were removed from the Quality Account list and did not take place nationally during 2021/22;

- BAUS Cytoreductive Radical Nephrectomy Audit
- CEM - Severe Sepsis and Septic Shock

- National Comparative Audit of Blood Transfusion programme - 2021 Audit of the perioperative management of anaemia in children undergoing elective surgery

A total of 35 National Clinical Audit reports have been published and reviewed in 2021/22 for national audits that the Trust either participated in or was eligible to participate in. These reports were reviewed in 2021/22 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
Mental Health - Care in the ED WRH	15/04/2021	Urgent Care	• An appropriate area of the ED should be available in which patients with mental health problems may be observed. This should be both safe and as calm and quiet as possible – move to new department • An appropriate programme should be in place for to train ED nurses, health care assistants, and doctors in mental health and mental capacity issues. • Promotion of mental health triage documentation in the ED
Mental Health - Care in the ED ALX	15/04/2021	Urgent Care	• Educating on triage
SSNAP Quarterly results Jan - March 2021	02/06/2021	Stroke	• Develop a 24/7 CNS model to contribute to early assessment and subsequent flow of patients that may impact on an improvement in the performance in terms of Thrombectomy. • Medical Workforce Recruitment – Rolled over from Q3 AP • Stroke Scanning Pathway • Stroke Specific Clerking Paperwork • Quarterly meeting with data analyst, data in-putter and lead practitioner for stroke to ascertain areas for improvement and sustaining improvement by early identification of areas not performing well. • Weekly data review meetings to ensure data accuracy. • Daily completion of exception reports to identify any areas where targets are not maintained to identify common themes in order to work towards possible solutions. • Working with the health and care trust daily to coordinate the flow of patients to rehab beds and to the Community Stroke team, further enhanced by weekly in-reach from the community.

National Audit	Date Report Published	Specialty	Actions/Improvements
			• Working with the H&C trust by providing input into the Job description and jointly interviewing for a full time coordinator to work across the stroke pathway to facilitate patient flow.
NACAP - Secondary Care - COPD	10/06/2021	Respiratory	• Implementation of a discharge bundle • Business Case for COPD • Best Practice Tariff submitted to increase COPD team support for discharge bundle implementation. • Current Rask Finish working group has reviewed COPD pathways. • Appropriate oxygen prescription and target saturations • Smokers are identified, offered and prescribed smoking cessation pharmacotherapy • Ensure spirometry results available for all patients admitted • Ensure that all patients requiring NIV on presentation receive it within 120 minutes of arrival. • Ensure that all current smokers are identified, offered, and if they accept, prescribed smoking cessation pharmacotherapy. • Educate on smoking cessation effectiveness from health care professionals. Review prescribing policy with pharmacy. Currently no smoking cessation services available within county • Implementation of a discharge bundle • Access respiratory specialist care within 24hrs • Deep-dive case review of COPD mortality and readmissions
NPDA - National Paediatric Diabetes Audit	10/06/2021	Paediatrics	• The introduction of a young adult diabetes clinic. • Improving the care of patients with a HbA1c between 69 and 80 mmol/mol managed at Kidderminster Hospital and the care of patients with a HbA1c >80 mmol/mol at Worcester Hospital and the Alexandra Hospital. • Children and carers to receive more information on managing illness. • To redesign vacant clinical psychology post to help with recruitment and retainment. • To address clinics being age appropriate with our Trust's youth forum.
NABCOP - National Audit of Breast Cancer in Older Patients	03/08/2021	Breast	• Review completeness of pathology data capture and reporting • Audit patterns of surgery, WLE vs mastectomy; chemo; by age grouping < or > 75

National Audit	Date Report Published	Specialty	Actions/Improvements
2021 Annual Report			

Local Clinical Audits

A total of 146 local clinical audits were reviewed by Worcestershire Acute Hospitals NHS Trust in 2021/22 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 11022 HIV Testing in Tuberculosis	Infectious Diseases	• No actions required - compliance 100%
ID 10949 Postmenopausal pathway audit	Gynaecology	• Implementation of registrar PMB clinic to run alongside consultant hysteroscopy clinic. • Change practice where ET 5-8mm for pipelle biopsy and ET >8mm for hysteroscopy.
ID 10941 VTE prophylaxis prescribing in Trauma and Orthopaedics	T&O	• Presentation and key findings and recommendation circulated to other doctors via email to highlight what can be done to increase standard of care. • Compulsory for all patients to have the VTE prophylaxis form completed and Clexane prescribed correctly based on their weight and renal function. • Ask or estimate patient's weight or weigh patient if able on admission to ensure adequate dose prescribed. • Review patient's renal function on admission and review regularly as their renal function can change throughout inpatient stay and may require lower dose of Clexane or Unfractioned heparin.
ID 10633 Pre-procedure Antibiotic therapy in Urology	Urology	• Improvements in sepsis risk after implementation of new ATB guidelines.
ID 11081 Mental Health Matrix and Overdose Proforma	A&E	• Encourage triage nurses to print overdose proforma and mental health matrix as soon as patients with intentional OD are triaged. • Awareness should be made on the various proformas used in mental health during the orientation program for junior doctors.
ID 10938 AMT recording (Re-audit)	Acute Medicine	• Poster about recording AMT and its importance and stick on MAU doctor's office walls and gallery. • Speak to acute medicine consultants - to remind juniors on post take regarding importance of AMT recording.
ID 10857 Audit of completion of dementia screening tool	Geriatric Medicine	• Redesign screening tool to be more streamlined. • Promulgation of audit results to doctors by presentation at grand round.
ID 10974 Opioid prescribing at the end of life	Palliative Care	• Present audit findings to hospital palliative care team. • Launch of Version 4 of Individualised last days of life care plan and anticipatory medications. • F1 doctor teaching. • 'Essentials in palliative care' ward teaching programme. • Liaison with intensive care consultants. • Present audit findings to pharmacy team. • Junior doctor induction.

ID 11071 25G Re-audit of appropriateness of clinical indications of Brain MRI performed in Worcestershire Acute Hospitals NHS Trust, requested by the Primary care physicians	Radiology	• Presentation in the County Radiologist Meeting. • Audit discussion at the Neurology / CCG meeting.
ID 11086 1B Use of broad spectrum antibiotics in acute medicine at Worcester Royal Hospital.	Acute Medicine	• Inform clinical governance for further advice and input. • Inform antibiotic stewardship for further advice and suggestions. • To develop/review clinical guidelines in the use of this group of antibiotics.
ID 11135 Re-Audit on appropriate Documentations	A&E	• Presentation to be done and emphasis put on need to document date, time and name. Also emphasis on completion on back of PAS card. • Reminder to receptionists to flag receipt of blank documentation for scanning. • Email to be sent out emphasising need to document date, time name and completion on back of PAS card.
ID 11124 Management of Neonatal Jaundice (CG98) Re-Audit	Paediatrics	• Changes to Neonatal bilirubin charts for ease of use. • Education of how to use charts for new SHOs. • Education to nursing and midwifery team via newsletter. • Review of harm moving patient up a chart based on gestation. • Investigate option of adding box on ICE request for SBR that allows date and time of birth to be inputted. Time from birth could be included in SBR reports to produce plotting errors.
ID 11095 27B Re-audit of Giant Cell Arteritis Fast Track Clinic against BSR 2020 Guidelines	Rheumatology	• Present audit findings to Rheumatology department and circulate to Vascular team. • Increase number of weekly clinic slots designated to GCA from 3 to 5. • Circulate reminder to primary care physicians of required GCA blood tests via ‘Member Practice Update’.
ID 11084 AKI management in orthopaedic inpatients re-audit	T&O	• Presentation of re-audit results to local NHS trust T&O/Vascular surgery Clinical Governance Audit Meeting. • Printed AKI checklist on wards. • Junior Doctor education on AKI management at induction.
ID 11073 Audit of EEG performed from time of referral against NICE Guidance	Neurophysiology	• To ensure data is entered and coded correctly on to oasis, ensures all dates and referral sources are accurate. • Rebook and restart of patients into all available EEG appointment slots. • Validation of all referrals to ensure appropriate referrals are on the waiting list – therefore ensuring improvement with NICE compliance. • Scientist staff working in flexible approach to reduce backlog and therefore increase compliance with standard. • Ensure cancelations are filled promptly. • Calling of patients to reduce DNA’s.

ID 10850 2A Handover In Emergency Department Alexandra Hospital - Re Audit	A&E	• Handover should be in writing every day at 08:00,13:00 and 22:00hrs • All handover sheets should be completed and left in handover box in Doctor's Office. • 15 minutes to be allocated to all senior Doctors for handover to take place safely and appropriately in the seminar room. • If senior Doctors coming on shift are late, wait ten minutes and do handover with team – record absence of senior on handover sheet. • 0800hrs – night registrar to handover to morning registrar in seminar room with day SHO present. • 2000hrs registrar leaving at 2300hrs will do handover with night team. • New Doctors to have importance of handover re-iterated in their induction. • All Doctors on shop floor to be present in board round/handover at 1200hrs.

Examples of how Clinical Audit has been used to Drive Improvement

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

- **The use of stent with - versus without string through pandemic: 2 PDSA cycles**

This audit saw the use of QI methodology where the lead undertook 2 PDSA cycles. It highlighted that the Trust is 100% compliant with stent insertion post uteteroscopy and that the Trust has evolved to increase its use to stent-with-string since the pandemic. The Trust also has more nurse led stent-with-string removals following successful training and the new stent techniques reduced the rate of accidental removal, and is now standard practice.

- **Re-Audit to assess the Compliance of Pre-Operative Antibiotic prescribing in Vascular Surgery patients**

This audit was undertaken following a discussion regarding antibiotic stewardship at a clinical governance meeting in 2020. It led to the revision of the Trust guidelines and the vascular induction booklet was updated.

- **Audit of assessment of COVID clinical compliance in patient flow management in the SHO 'hot' clinic**

This audit highlighted that there was no provision for a 'HOT' sheet and that there was no shared drive access which caused limitations. Following the completion of the audit, access to shared drives are now up and running along with the implementation of a 'HOT' sheet which since going live has improved communication between staff.

- **ID 10857 Audit of completion of dementia screening tool**

The lead undertook 2 PDSA cycles, implementing small step changes after the 1st PDSA cycle. It's clear from the findings that the changes that were made following the 1st PDSA cycle, to include education and awareness of the dementia screening tool, were sustainable as the

compliance increased in 5/6 areas that were audited. The Clinical Audit Team put a poster together for dissemination in the speciality as an opportunity for shared learning to demonstrate the positive impact of the audit and the benefits of using QI methodology.

- **10909 Quality improvement project to enhance patients' awareness of their current hospital admission**

Following the 1st PDSA cycle, a checklist was introduced in the patient notes which prompted clinicians to tick the three-point checklist. In case of confused or delirious patients they can give a reason and sign the checklist. Following the analysis of the 2nd PDSA cycle, it is clear that the introduction of this checklist means that patients have more awareness with regards to their hospital admission.

- **11014 Is there a significant difference to prescribed CPAP pressure using the Oxford CPAP algorithm when using AHI vs ODI**

This audit showed good use of QI tools in the use of 2 PDSA cycles. Whilst compliance is good at with an increased standardisation of care, the audit led to create a new Trust policy which is to be put forward for approval.

- **ID 11119 Platelet Usage for Line insertion in Haematology patients**

Since completing this audit, a Vascular Access Steering Group with key stakeholders has been created which will review the booking and timely insertion of lines, and to enable the correct line to be placed in each patient. This audit has provided evidence that an improvement in this service will be extremely beneficial for patients.

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

Worcestershire Royal Hospital

	Safe	Effective	Caring	Responsive	Well-Led
Urgent and Emergency Services	Inadequate Feb 2020	Good Sept 2019	Requires Improvement Sept 2019	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
Surgery	Requires Improvement Sept 2019	Good Sept 2019	Good Sept 2019	Requires Improvement Sept 2019	Good Sept 2019
Critical Care	Requires Improvement Jun 2017	Good Jun 2017	Good Jun 2017	Requires Improvement Jun 2017	Requires Improvement Jun 2017
Maternity	Requires Improvement Feb 2021	Good Feb 2021	Good Jun 2018	Good Jun 2018	Requires Improvement Feb 2021
Services for Children & Young People	Good Sept 2019	Good Sept 2019	Good Sept 2019	Good Sept 2019	Good Sept 2019
End Of Life	Good Jun 2017	Good Jun 2017	Good Jun 2017	Good Jun 2017	Good Jun 2017
Outpatients	Requires Improvement Sept 2019	N/A	Good Sept 2019	Requires Improvement Sept 2019	Good Sept 2019
Diagnostic Imaging	Requires Improvement Sept 2019	N/A	Good Sept 2019	Good Sept 2019	Requires Improvement Sept 2019

Alexandra Hospital

	Safe	Effective	Caring	Responsive	Well-Led
Urgent and Emergency Services	Inadequate Feb 2020	Requires Improvement Sept 2019	Good Sept 2019	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
Surgery	Requires Improvement Sept 2019	Good Sept 2019	Good Sept 2019	Requires Improvement Sept 2019	Good Sept 2019
Critical Care	Good Jun 2017	Good Jun 2017	Good Jun 2017	Good Jun 2017	Good Jun 2017
End Of Life	Good Jun 2017	Good Jun 2017	Good Jun 2017	Good Jun 2017	Good Jun 2017
Outpatients	Good Sept 2019	N/A	Good Sept 2019	Requires Improvement Sept 2019	Good Sept 2019
Diagnostic Imaging	Requires Improvement Sept 2019	N/A	Outstanding Sept 2019	Good Sept 2019	Requires Improvement Sept 2019

Kidderminster Hospital and Treatment Centre

	Safe	Effective	Caring	Responsive	Well-led
Urgent and Emergency Services	Requires Improvement Sept 2019	Requires Improvement Sept 2019	Good Sept 2019	Good 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
Surgery	Good Sept 2019	Good Sept 2019	Good Sept 2019	Requires Improvement Sept 2019	Good Sept 2019
End Of Life	Good Jun 2017	Good Jun 2017	Good Jun 2017	Good Jun 2017	Good Jun 2017
Outpatients	Good Sept 2019	N/A	Good Sept 2019	Requires Improvement Sept 2019	Good Sept 2019
Diagnostic Imaging	Good Sept 2019	N/A	Good Sept 2019	Good Sept 2019	Good Sept 2019

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

➢ NHS Herefordshire and Worcestershire Clinical Commissioning Group

NHS Herefordshire & Worcestershire Clinical Commissioning Group (HWCCG) welcome the opportunity to comment on the Worcestershire Acute Hospitals NHS Trust (WAHT) Quality Account 2021/22. The CCG recognises the Trust's achievements during 2021/22 considering the exceptional challenges faced through the pandemic response and associated operational pressures.

The Quality Account provides an 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.

We understand that specific areas of data collection and publication have been suspended to release capacity in providers and commissioners to manage the pandemic, however we are pleased to see that WAHT is meeting specific targets set for 2021/2022, including:

- Reduction of falls with harm
- Reduction of the number of pressure ulcers
- No cases of MRSA bacteraemia
- Compliance with VTE assessments
- Improved hand hygiene compliance

It is also positive to see that the Trust has also achieved a CQC quality rating of 'Good' in the 'Caring' and 'Effective' domains and maintained 'Requires Improvement' in its overall Trust quality rating. In addition, the Maternity Services continue to make good progress on internal actions and also national recommendations in relation to improving its services via the Maternity Improvement Plan.

The CCG acknowledges the improvement and positive outcomes as above, however, they would also like to reinforce the need for continued and renewed focus on ongoing quality improvement. Specific focus areas to highlight include antimicrobial stewardship, Clostridium difficile infection rates, identification and treatment of sepsis, nutrition and hydration assessments of all inpatients.

The CCG would also like to highlight the need for continued and renewed focus on wider 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. The CCG will continue to work with the Trust and other partners to ensure these areas are prioritised across the system to ensure improvements can be made and sustained.

At the very end of 2021/22 the final Ockenden Report was published, reflecting a further 15 Essential and Immediate Actions for Maternity services, following the review into maternity services delivered by another Trust within the region. Whilst not explicitly reflected within the Quality Account, the Trust has continued to be a vital partner within the Local Maternity and Neonatal System (LMNS) during 2021/22. HWCCG look forward to working closely with the Trust during 2022/23 as they demonstrate their commitment to further improving good quality services for mothers and babies across Worcestershire.

HWCCG are satisfied the Quality Account for 2021/2022 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 2022/23. All are appropriate areas to target for continued improvement and build upon the achievements of 2021/22.

As we move towards becoming Herefordshire and Worcestershire Integrated Care Board (ICB), we look forward to continuing the close working relationship with the Trust and other partners across the system to deliver further quality improvements and collaboration to ensure lessons are shared and learnt across the Trust and wider system.

Simon Trickett
Chief Executive NHS Herefordshire and Worcestershire CCG &
Designate Chief Executive Herefordshire and Worcestershire ICB

➢ Healthwatch Worcestershire

Healthwatch Worcestershire's response to the Quality Account of the Worcestershire Acute Hospitals NHS Trust for the financial year 2021/22 approved at the Public Board Meeting on 26th May 2022.

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 2021/22.

This has been another extraordinary and difficult year for providers of NHS services and Healthwatch Worcestershire appreciates and acknowledges the effort and commitment of the staff at the Trust who have been working hard to do their best for patients under difficult circumstances.

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 in the county.

In April 2021 the CQC formally confirmed that all conditions had been removed from both of the emergency care departments.

We are pleased to see that the Trust has continued with the implementation of the Quality Improvement Strategy and its 3 Priorities that were co-produced with stakeholders including patients and the public in 2018: Care that is safe: Care that is clinically effective, and Care that is a positive experience for Patients and Carers.

We recognise that during 2021/22, the Trust has been required to continue its clinical focus on the COVID-19 pandemic response, and the restoration of services and that this may have impacted on the delivery of some of the improvement priorities identified for 2021/22 However, there has been measurable progress across many of the improvement priorities identified last year and we appreciate the value of carrying forward to 2022/23 those priorities where targets were not met and/or further improvement is likely to continue into 2022/23.

Improvement Priorities 2022/23:
Healthwatch Worcestershire recognises that the identified improvement priorities for 2022/23 are likely to improve patient experience, safety and outcomes. We welcome the inclusion of clear numerical targets for the majority of priorities against which progress can be measured and evaluated. We would make the following comments:

Care that is Safe:
We have welcomed the Trust's transparency in delivering the 'Digital Care Record' project. We are optimistic that its implementation has the potential to both significantly improve patient safety and the quality of care patients experience within the Trust. Its integration with Herefordshire and Worcestershire's shared digital care record will also contribute to improvements in care as patients journey through health and social care services in the county and beyond.

Healthwatch Worcestershire are pleased to note that the target to eliminate MRSA infections in 2021/22 was met and welcome the continued focus on infection protection and control to reduce C. Difficile infections and strengthening antimicrobial stewardship.

We note the implementation of the Patient Safety Incident Response Framework and recognise the importance of including patients in the governance processes.

We note the focus on patients' nutrition and hydration needs and welcome the clearly measurable targets for improvement**.**

Safe and timely discharge from hospital and transfers between services: we are not entirely sure what a Discharge Production Board is or its role in improving patient's experience of the discharge process but we welcome the focus on this as in our survey & Hospital Discharge Report we found that it was an area that patients and carers often found challenging. A more detailed explanation of how the objectives are going to be achieved would have been of benefit in understanding this priority.

Timely identification and Treatment of Sepsis: we are note that this is a priority brought forward from 2021/22 where the targets set were only partially met and welcome its inclusion in the 2022/23 priorities as an important area for patient safety.

Care that is Clinically Effective:
We note the commitment to continuing to learn from deaths and monitor and seek to reduce mortality rates for patients whilst under the care of the Trust. We note that this has been brought forward as a priority from 2021/22 even though the target that was set was met last year. We welcome the continuing focus on learning from deaths.

We recognise that the Trust's involvement in a regular programme of clinical audits and subsequent quality improvement projects is likely to result in better outcomes for patients and welcome the Trust's commitment to this, together with developing a new Research and Development Strategy and a focus on improving staff training.

One of the clear concerns for patients and the public in Worcestershire is the backlog of care and the waiting times for treatment. We welcome the priority around patients receiving timely treatment and care through improved waiting times, seven day services and a focus on reducing backlog: eliminating 104 week waits for elective treatment and restoring diagnostic and treatment activity to pre covid levels and hope that it can be achieved.

Care that is a Positive Experience for Patients and Carers:
We welcome the priority around patients accessing services with a clear focus around health inequalities including accessible information, strengthening the learning disabilities pathway and developing diagnostic capabilities via a community diagnostic hub. We hope that patients and carers have been involved in the planning and development of the Community Diagnostic hub.

We note that patients and their carers will be provided with a variety of methods for providing feedback on their experiences of services, to ensure learning and improvements can be prioritised. We support the continued emphasis on patient feedback as it is of such importance in continuous improvement.

2. Are there any important issues missed?

One of the areas of concern raised with Healthwatch Worcestershire and most frequently reported upon in the local media is the pressure on the Accident and Emergency Department, the waiting times and especially Ambulance Handover Times. Whilst we are aware that this is a whole system issue it might have been useful to address some of these concerns within the Quality Account.

We note that the Trust is making good progress on the continued implementation of the actions in their Maternity Improvement Plan which sets out how the Trust will continue to work on national and local improvement plans to continually improve the service offered to women and families in Worcestershire, whilst this has not been detailed in the 2022/23 improvement priorities.

For some time Healthwatch Worcestershire has been concerned about the quality of stroke service provided by the Trust. We have therefore welcomed the Trust's commitment to improve it, both by its implementation of an innovative workforce plan and its commitment to patient safety as evidenced by its response to Healthwatch Worcestershire's request through the Stroke Programme Board to report on harm reviews for those stroke patients for whom NHSE's targets in relation to effective stroke care are missed.

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

The Trust conducted their second 'Big Quality Conversation' online survey and used the results to help inform their Improvement Priorities for 2021/22. Whilst acknowledging the difficulties of face to face engagement during the last two years we would hope that going forward this will be extended beyond digital engagement to promote inclusivity.

The QA also state that the 2022/23 priorities have been formulated through ongoing engagement and action focussed refinement with staff; patients; family feedback; system partners; patient public forum; youth forum, and students via engagement sessions. Healthwatch Worcestershire recognises that the Trust has increased its engagement with, and the reporting of, 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 by means such as Carers' cafes and engaging with the D/Deaf community.

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

Healthwatch Worcestershire acknowledges that there is a challenge in producing a Quality Account which is clearly presented and meaningful for patients and the public, taking into

account the technical information required by NHS England. 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 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.

Jo Ringshall
Chair – Healthwatch Worcestershire

- **Worcestershire Acute Hospitals NHS Trust's Patient and Public Forum**

Considering the continuing pressures on the Trust from the ongoing pandemic and increasing pressures on patient flow, it is rewarding to see that several targets were met and that innovation continued.

We congratulate the Trust on initiating the "call me" facility which is already having a positive impact for patients as well as the Trust receiving an award for the initiative.

We welcome the development of PALS front of house at Worcester Royal Hospital, the Research and Development Strategy, the roll out of the Digital Care Record and the new Worcester Urgent Care Department later this year.

We also welcome the Trust becoming more inclusive with the development of the LGBT and disability networks.

Increasing methods of obtaining patient feedback and working more closely with Carers' organisations and the deaf community are also welcomed.

It was good to note that volunteers are beginning to come back on site and look forward to this being fully implemented.

Sepsis is still an area the PPF would like to see improving as well as learning from deaths and complaints [our concerns from last year].

We were disappointed to see there were no targets for stroke for next year as we feel this should be a priority.

We would also like to see better liaison between the Trust and primary care to ensure the patient has seamless transition between them.

Rosemary Smart
Chair of Patient and Public Forum

➢ Worcestershire Health Overview and Scrutiny Committee (HOSC)

The Worcestershire Health Overview and Scrutiny Committee (HOSC) welcomes receipt of the 2021-22 Quality Account for Worcestershire Acute Hospitals NHS Trust in its draft format, although it is disappointing that some data and figures are not yet available.

Members of the Committee have appreciated the support the Trust has given to the scrutiny process during the year and the Members look forward to working with the Trust in the future. Through the routine work of HOSC, we hope that the scrutiny process continues to add value to the development of healthcare across all health economy partners in Worcestershire.

Councillor Brandon Clayton
Chairman of Worcestershire Health Overview and Scrutiny Committee

Glossary of Terms:

Word	Definition
4ward	The Trust's culture change programme, launched in 2018.
LDOL	Last days of life care plan
ELOC	End of life care
LGBT	Lesbian, Gay, Bisexual and Transgender
CQUIN	The Commissioning for Quality and Innovation (CQUIN) payment framework
MCCD	Medical certificate for cause of death
LeDeR	Learning disability mortality review
LDALN	Learning disability additional learning needs
VTE	Venous thromboembolism (VTE)
MBRRACE	Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK
PROMS	Patient reported outcome measures
SSNAP	The Sentinel Stroke National Audit Programme (SSNAP)
COPD	Chronic obstructive pulmonary disease (COPD)