Quality Department Annual Report

2014-2015

Together Towards World Class

University Hospitals Coventry and Warwickshire NHS Trust

We CARE We ACHIEVE We INNOVATE

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In May 2014 a number of wards achieved 600 days free of Clostridium difficile. Over the past five years the Trust has cut its infection rates of Clostridium difficile by a third.

SECTION 5 Patient Experience 40

Statement on Quality from Chief Medical Officer and Director of Quality

Welcome to our first integrated Quality Department Annual Report. The Trust's vision is to provide world class, quality healthcare delivered with kindness and compassion to all those who come through its doors. The Quality Department is committed to supporting the Trust in this.

Whilst the last 12 months have remained challenging, with an ever increasing demand on departments and staff, University Hospitals Coventry and Warwickshire NHS Trust, has remained committed to providing services to the highest standard.

The last year has seen notable achievements within the teams which make up the Quality Department. We would particularly like to bring to your attention the following which you can read about in further detail within the body of this report.

- The organisation and attention to detail of the Trust's CQC inspection, which took place in March 2015, saw the Effectiveness & Compliance Team of the Quality Department praised [by the CQC] as being one of the best organised inspections it had encountered to date. The staff of the Quality Department, along with the rest of the Trust, eagerly await the results of the inspection and the opportunity to learn from its findings;

- The last 12 months has seen the enhanced integration of the four functions of the Effectiveness & Compliance Team: clinical audit, compliance, effectiveness and the newly created assurance function. This, along with the physical relocation of this team, in November 2013, to sit alongside the Safety & Risk Team and Patient Experience Team has further facilitated the triangulation of knowledge held by the three Associate Directors of Quality and, therefore, upwards through the Director of Quality and Chief Medical and Quality Officer to the Trust Board;

- We are particularly pleased to inform you that the Safety and Risk Team successfully bid for £245,329 from the NHS Litigation Authority (NHSLA) in relation to the 'Sign Up to Safety' campaign. This is particularly significant as this was only one of 67 successful bids out of 243 bids received by the NHSLA;

- The recently expanded Patient Experience Team worked with the Trust's Nursing Team on a patient information project. This involved informational posters and boards, displaying pertinent information (for patients), being placed outside and inside wards as well as the production and distribution to all wards of 12 core patient information leaflets, the latter being produced by the Health Information Centre;

- We find it reassuring to note that the Clinical Evidence Based Information Service (CEBIS), a Team dedicated to the facilitation of research knowledge at the Trust, launched an online survey in August 2014. The survey has shown that the service is highly valued by staff who rated their experience at 9.5 out of 10.

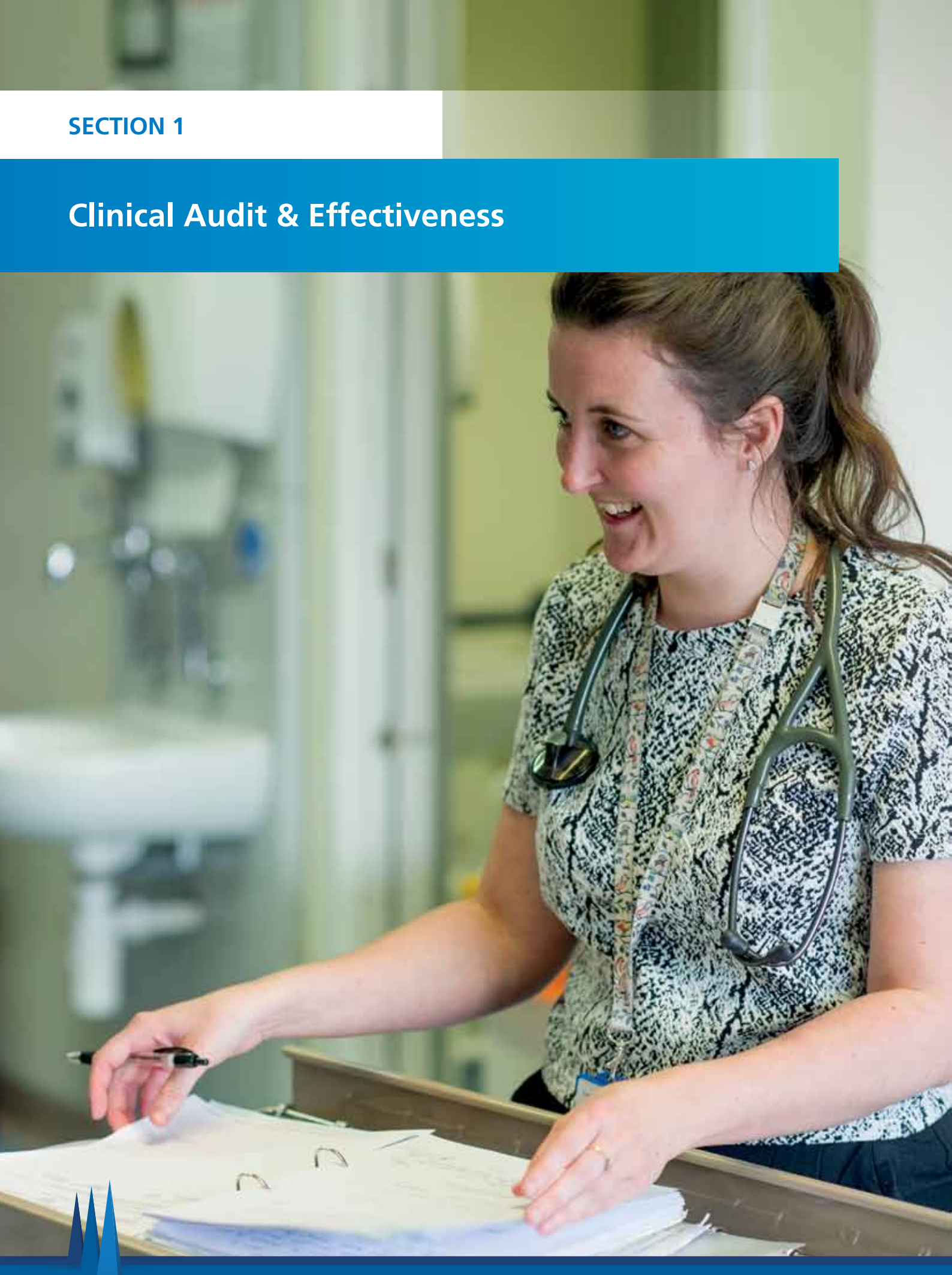
Finally, we would like to take this opportunity in this, our first Quality Department Annual Report, to thank our departmental staff, wider Trust staff, patients, relatives, carers, along with the external organisations who have helped us in our quest for continuous improvement in the quality of services at the Trust. We look forward to working with you again in the coming year.

Professor Meghana Pandit
Chief Medical & Quality Officer

Jenny Gardiner
Director of Quality

SECTION 1

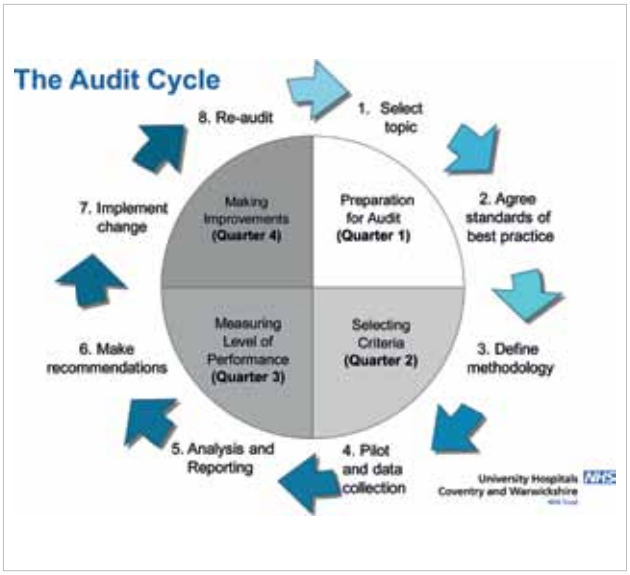
Clinical Audit & Effectiveness



Introduction to Clinical Audit

UHCW NHS Trust is committed to improving services through systematic clinical audit.

"Clinical audit is a quality improvement cycle that involves measurement of the effectiveness of healthcare against agreed and proven standards of high quality, and taking action to bring practice in line with these standards so as to improve the quality of care and health outcomes" (Healthcare Quality Improvement Partnership (HQIP), New Principles of Best Practice in Clinical Audit, 2011).



This clinical audit section of the Quality Department Annual Report has been developed to augment the information provided in the UHCW Quality Account, section 2.4.2. It provides additional detail regarding the benefits gained through participation in both national and local clinical audits and the rationale for non participation in certain national audits. Participation rates for audits that UHCW took part in during 2014-2015 are detailed in the main Quality Account document.

Clinical audit is important because it allows care delivery to be reviewed to ensure that what should be done is being done, and if not it provides a framework to enable improvements to be made. It is the responsibility of all healthcare professionals to critically review their work to ensure care is given according to the best available evidence. Involvement in clinical audit is a means for all healthcare professionals to reflect on their own and their team's practice. Clinical audit should be effectively carried out by all healthcare professionals throughout the organisation in order to improve the quality of care received by patients.

The Clinical Audit function of the Effectiveness & Compliance Team is responsible for facilitating all clinical audit projects, incorporating both national and local priorities, throughout UHCW. The function provides expertise and support to clinical specialties to monitor and improve patient care through:

- Clinical audit training, awareness and support to all healthcare professionals.
- Support and facilitation to healthcare professionals and other relevant staff conducting and/or managing clinical audits.
- A formal review of the Trust-wide Clinical Audit & Effectiveness Programme to ensure that it meets the organisation's aims and objectives as part of the wider quality improvement agenda.

Progress reports on clinical audit activities are presented quarterly to the Patient Safety Committee. The Patient Safety Committee is responsible for receiving and monitoring assurances and these are then reported to the Quality Governance Committee who in turn report to Trust Board. In accordance with the requirements set out in the NHS Audit Committee Handbook, the Clinical Audit function also reports twice a year to provide assurance on clinical audit activity to the Audit Committee.

"Day Surgery ward staff were amazing, kind and caring. Anaesthetist was wonderful – I was terrified but he put me at ease and the surgeon was excited by the work he had done and was proud of the repair. All in all an excellent experience."

Performance reports on clinical audit activity are also produced on a quarterly basis for discussion at Clinical Group Quarterly Performance Reviews.

Clinical specialties also hold monthly Quality Improvement & Patient Safety (QIPS) meetings at which they discuss standing quality agenda items which include clinical findings. Specialty groups also use this time to plan how they will implement the recommendations made as a result of clinical audits.

They also review the Quality & Patient Safety (QPS) dashboard reports for their specialty which include a section detailing progress against the specialty clinical audit programme. The QIPS meetings provide an opportunity for clinical audit to link with other quality improvement activities such as mortality reviews, monitoring of clinical adverse events, complaints, patient involvement and clinical guidelines.

National Audit

National clinical audit is designed to improve patient outcomes across a wide range of medical, surgical and mental health conditions. Its purpose is to engage all healthcare professionals across England and Wales in a systematic evaluation of their clinical practice against standards and to facilitate improvement in the quality of treatment and care. National clinical audits are largely funded by the Department of Health and commissioned by Healthcare Quality Improvement Partnership which manages the National Clinical Audit and Patients Outcome Programme (NCAPOP). Most other national audits are funded from subscriptions paid by NHS provider organisations. Priorities for the NCAPOP are set by the Department of Health with advice from the National Clinical Audit Advisory Group (NCAAG).

National audits meet the following criteria:

- National coverage (achieved or intended).
- The main focus is improving the quality of clinical practice.
- Evaluate practice against clinical criteria/guidelines and/or collects outcome data.
- Apply the complete audit cycle and/or monitor clinical/patient outcome data in an ongoing way as part of a programme of driving change.

Participation in national audits is important because it enables UHCW to demonstrate that it monitors quality in an ongoing, systematic manner to board level. A high level of participation provides a level of assurance that our organisation takes quality seriously and that clinical teams and individual healthcare professionals monitor and improve their practice.

The value of national clinical audits comes not only from our participation but also from our willingness to use the information obtained to take action to make improvements. The Clinical Audit function ensures that the data from national clinical audits and the relevant local and national knowledge gained is used to take action through audit action plans to improve patient care.

The reports of 17 national clinical audits were reviewed by UHCW in 2014-2015 and action plans were developed. The audit action plan is a tool for turning recommendations (made following review of the audit results) into practice, therefore realising benefits for both patients and/or staff.

The following are brief summaries of some of the key actions the Trust has taken to improve the quality of healthcare as a result of the review of national clinical audit reports:

Audit Title	Key Actions
CEM Consultant Sign Off 2012/13	A new casualty card has been introduced which includes a box to show consultant sign-off has occurred. A formalised system for consultant sign-off has been introduced and embedded in the Emergency Department. This is to ensure that all patients who present to the Emergency Department are reviewed by a Consultant prior to discharge or referral.
CEM Severe Sepsis and Septic Shock 2013/14	Introduction of and updates to the Sepsis Six Pathway, sepsis power training, the identification of sepsis champions and a Trust wide sepsis campaign. A3 posters of the new Sepsis Six Pathway have been printed, laminated and put up in all Acute Medicine areas of the hospital. This is to be rolled out further across the Trust with posters to be put in all clinical areas. This will ensure the early identification and treatment of patients with sepsis.
National Audit of Continence	A business case has been put forward to employ a Trust wide Continence Nurse Specialist. This will ensure that all patients receive the appropriate investigations. Portable bladder scanners have been purchased by the Friends of St Cross. This will result in fewer patients receiving unnecessary urinary catheterisations, reduce catheter-associated urinary infections and provide a cost saving for the Trust.
National Audit of Services for People with Multiple Sclerosis 2011	Patients are now able to self refer to Improving Access to Psychological Services (IAPT) for support when living with Multiple Sclerosis and suffering with symptoms such as depression and anxiety.
National Audit of Seizure Management (NASH)	Development and introduction of a first seizure checklist in the Emergency Department. This will ensure that all patients who present to the Emergency Department, having had their first seizure, receive the appropriate checks, investigations and treatment.
National Paediatric Diabetes Audit 2012/13	Virtual clinics have been introduced for paediatric diabetes patients. This will ensure all patients with high HbA1c levels are monitored appropriately and allow for earlier identification of complications and thus earlier action taken.

The following table details the eight audits included in the Quality Account list published by the Department of Health in which UHCW did not participate.

Of these eight audits, UHCW is eligible to participate in one – the National Cardiac Arrest Audit. Of the rest, in three we do not provide the relevant service, in one UHCW does not perform the procedure and the other three are not applicable to Acute Trusts.

UHCW has established a group dedicated to ensuring we both comply with the continuing data collection requirements for the National Cardiac Arrest Audit and for ensuring we address the recommendations of the NCEPOD report Time to Intervene. The Trust is currently in the process of registering to participate in this national audit.

Audit Title	Rationale for Non-participation
National Cardiac Arrest Audit	UHCW is currently in the process of recruiting to a new role which will support the data entry requirements to this national audit. Registration to this ongoing audit will take place during 2015/16.
Chronic Kidney Disease in Primary Care	Not eligible – not applicable to Acute Trusts.
Elective surgery (National PROMs Programme)	Not eligible – service not provided at UHCW.
National Audit of Intermediate Care	Not eligible – service not provided at UHCW.
National Confidential Inquiry into Suicide and Homicide for People with Mental Illness (NCISH)	Not eligible – not applicable to Acute Trusts.
Pulmonary Hypertension Audit	Not eligible – service not provided at UHCW.
Paediatric Intensive Care Audit Network (PICANet)	Not eligible – procedure not performed.
Prescribing Observatory for Mental Health (POMH)	Not eligible – not applicable to Acute Trusts.

The following table outlines participation rates in the National Clinical Audit and Patient Outcomes Programme (NCAPOP) from 2010/11 to present day.

Participation in the National Clinical Audit and Patient Outcomes Programme (NCAPOP)	
2010/11	100%
2011/12	95% (non-participation in 1 audit)
2012/13	98% (non-participation in 1 audit)
2013/14	97% (non-participation in 1 audit)
2014/15	98% (non-participation in 1 audit)
Comments on Performance	Participation in the national cardiac arrest audit is due to commence in 2015/16.

As detailed in the Quality Account, section 5.2, there were eight national clinical audits that had a lower than expected participation rate. UHCW has investigated the reasons why this occurred as described below:

Audit Title	Participation Rate	Rationale for Low Participation Rate
National Clinical Audit of Rheumatoid and Early Inflammatory Arthritis	17%	It is suspected that participation in the audit is low because the Trust does not currently have a dedicated early inflammatory arthritis clinic. In order to improve participation in this audit, discussions will take place with the clinical teams around the implementation of a dedicated early arthritis clinic. The participation rate of 17% is only an estimate and is based upon the clinical teams anticipating they would see approximately 2 patients per week. Unfortunately due to the audit methodology it is difficult to identify the exact number of patients via clinical coding for inclusion in this audit. For the 18 patients submitted at baseline, 14 of those patients also had at least one follow-up form completed, showing a follow-up completion rate of 78%.
Congenital Heart Disease Audit	0%	No procedures carried out, therefore no cases to be submitted.
Head and Neck Cancer (DAHNO)	0%	The national DAHNO database has been decommissioned and it is no longer possible to submit data to this audit. 100% of data for the period April 2014 to March 2015 has been collected locally and is on track to be submitted when the new online tool goes live.
Renal Replacement Therapy (Renal Registry)	0%	The UK Renal Registry has moved to a new server and the start of the collection of 2014 data was delayed. 100% of the data for the period April 2014 to March 2015 has been collected locally and is on track to be submitted when required by the UK Renal Registry.

Audit Title (Continued)	Participation Rate	Rationale for Low Participation Rate
National Lung Cancer Audit (NLCA)	0%	The National Lung Cancer Audit database has been decommissioned; however we are now able to submit data to this audit via the National Cancer Registration Service. 100% of data for the period April 2014 to March 2015 has been collected locally and we are currently preparing the 2014 data for submission prior to the national deadline of 29.05.15.
Inflammatory Bowel Disease inc. Ulcerative Colitis & Crohn's Disease and Paediatric IBD (UK IBD Audit)	2%	Unfortunately UHCW has been unable to submit all cases to this audit due to resource not being available to assist with the data submission requirements. Funding is currently being identified to recruit 1.5 WTE additional Clinical Nurse Specialists who will be able to support this audit. Once these posts have been appointed, participation in this national audit will improve.
National Audit of Pregnancy in Diabetes (NPID)	81%	81% of cases were submitted to this audit by the national deadline of 12.02.15. Unfortunately two possible cases for inclusion in the audit were missed; therefore the opportunity to obtain consent from the patients' to submit their data has now passed. Follow up information is required for a further three patients, once obtained these cases will be submitted to the audit increasing our participation rate up to 93%.
NCEPOD Tracheostomy Care	68%	This study incorporated 5 different elements including questionnaires to be completed based upon Insertion, Critical Care, Ward Care and the Ward. The study also included a case note review. The percentage participation rate reflects our participation in all five elements of the study.

Local Audit

Most clinical audit activity in NHS Trusts will involve individual healthcare professionals evaluating aspects of care that they themselves have selected as being important to them and/or their team; these are classified as local clinical audit. Each specialty has the opportunity to develop a local clinical audit programme which includes the clinical audits they consider to be a local priority. These audits can be identified in a number of ways as follows:

- those audits which were on the clinical audit programme for the previous financial year which had not been started
- potential re-audits
- risk management issues and/or incidents
- service priorities
- local guidelines
- identified deficiencies in care
- topics of clinician interest.

The reports from 88 local clinical audits were reviewed by UHCW in 2014-2015.

The following are brief summaries of some of the key actions the Trust has taken to improve the quality of healthcare as a result of the review of local clinical audit reports:

Audit Title	Key Actions
Audit of Sedation in Paediatrics	The process for paediatric sedation has been changed in order to avoid failed sedation and failed scans which cause unnecessary distress to paediatric patients and their family. An MRI under general anaesthetic service is being explored and is included in the 3 year plan for Women and Childrens Services. This will also contribute to significant cost savings for the Trust.
Review of appropriateness of antimicrobial prescriptions in the Acute Medical Unit and review of adherence to local guidelines	Ongoing education provided to junior doctors on prescribing broad spectrum antibiotics then narrowing according to the focus of infection. Ongoing daily presence of an antimicrobial stewardship team on the Acute Medical Unit (AMU) and daily education of junior doctors on appropriate antibiotic use and prescribing. This ensures that patients receive the appropriate antibiotics to treat the source of infection.
Audit to assess Radiographer's compliance with Patient Group Direction (PGD) for Non ionic Contrast	''Check before you inject' posters have been printed and put in Computed Tomography (CT) scanning rooms at Coventry and Rugby Hospitals. Patient Group Direction workshops up and running for staff in order to continue to raise awareness of the clinical guidelines. This is to ensure practice continues to provide a safe environment for patients at risk of Contrast Induced Nephropathy (CIN).
Re-audit of the use of oxytocin in labour	Introduction of oxytocin stickers in all areas where they may be required, to be used prior to start of Oxytocin; resulting in improved effectiveness of care for patients.
Intra & post operative fluid management documentation Audit	Introduction of a new fluid chart to ensure that patients receive the appropriate hydration during their admission.
Audit of NICE CG 65: Perioperative hypothermia (inadvertent)	The findings of this audit have been shared with clinical staff to raise awareness of, and ensure care is delivered in accordance with the NICE clinical guidelines. To ensure patients are kept comfortably warm and complications are avoided due to inadvertent hypothermia.
Audit of 'Is standard day-case catheter ablation safe and cost-effective'?	The audit has led to an increase in day-case catheter ablations. This is a cost saving to the Trust equating to £250 per patient who would have been staying overnight as opposed to having this procedure performed as a day case.
Audit of Syncope Management	The audit on Transient Loss of Consciousness has led to the implementation of a new arrhythmia nurse-lead Transient Loss of Consciousness clinic.
NICE QS 24 & NICE CG 32 – Audit of Parenteral Nutrition	This audit has led to improved appropriateness of patient care after a review of the parenteral nutrition assessment stickers used for every patient's assessment documentation. Reintroduction by the nutrition team of the CORTRAK method of nasojejunal tube insertion, a procedure that is safer for patients and brings financial savings to the Trust.

Overview of Clinical Audits registered during 2014/15

At any one time, there are numerous clinical audit projects being undertaken within the Trust. There were a total of 274 clinical audit projects registered with the Clinical Audit Department in 2014/15; these are classed as mandatory audits, local audits and clinician ad-hoc audits. This is an increase from 258 registered in 2013-14. Mandatory audits are considered to be a Trust priority (e.g. national audits, audits in response to newly implemented NICE guidance etc) and local audits are identified by clinical specialties according to their own service needs. Clinician Ad Hoc audits are not planned for on the Clinical Audit & Effectiveness Programme but are completed by clinicians on an ad hoc basis throughout the year and are considered for full registration by the Clinical Audit Department upon receipt of a completed report and action plan.

The Clinical Audit Department was notified of a total number of 120 Clinician Ad Hoc audits taking place during 2014/15. Of these, 13 audits have been fully registered as a result of receiving a completed report and action plan; 20 were abandoned/closed and 87 audits are in progress and will be considered for full registration upon receipt of a completed report and action plan.

Figure 1 below demonstrates the breakdown of audits by type registered with the Clinical Audit function between 1st April 2014 and 31st March 2015.

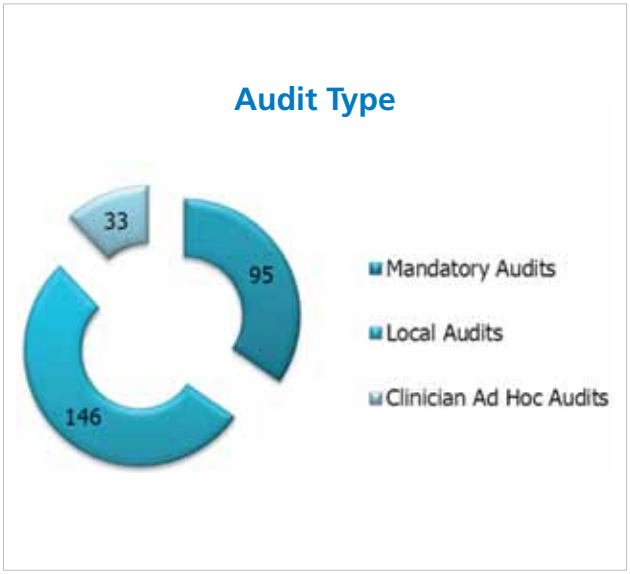
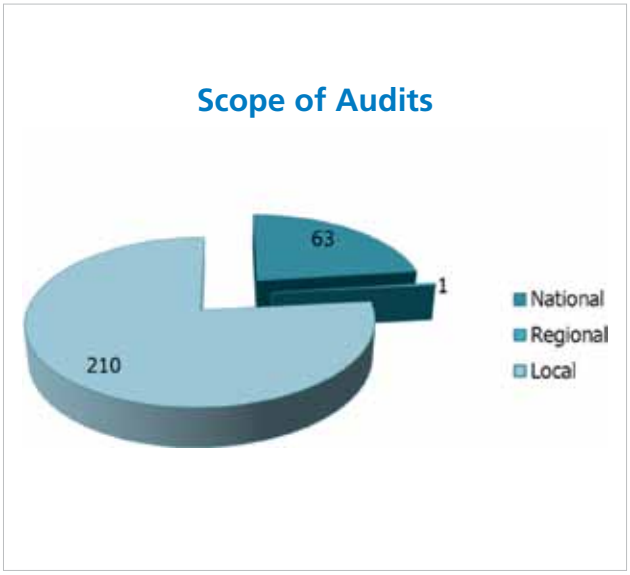


Figure 2 breaks the audits down further and demonstrates whether the audits were facilitated and managed locally in the Trust, nationally or regionally.



Key Achievements 2014/15

PROGRESS AND COMPLETION RATES OF CLINICAL AUDITS

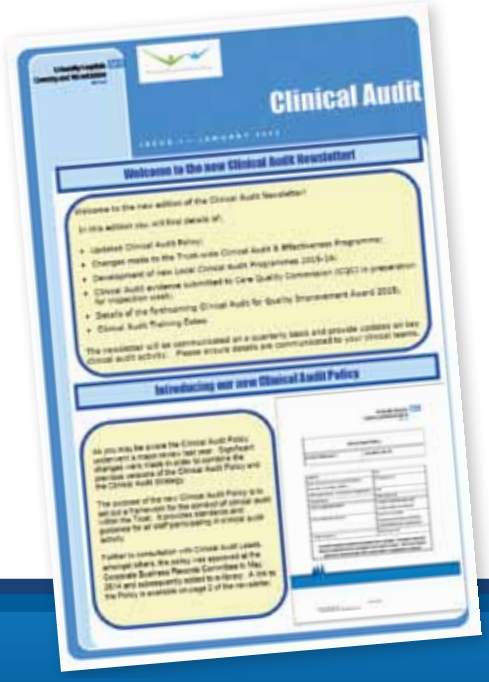
The function has introduced a number of initiatives to improve the completion rate of clinical audits to help further improve performance.

Some examples include incorporating reporting of progress made with completion of audits per specialty and specialty group into the Trust-wide Clinical Audit & Effectiveness Programme. Clinical Audit Facilitators now have monthly meetings with Clinical Audit Leads to discuss progress with audits within each specialty and build on existing working relationships.

Furthermore, reporting of progress made with completion of outstanding action plans via Quarterly Performance Review meetings has improved communication and increased knowledge and understanding of audit amongst specialties. The reporting of information is developing and will be further advanced during 2015/16.

CLINICAL AUDIT NEWSLETTER

Reinvigoration of the Clinical Audit Newsletter during 2014/15 has provided key information and raised awareness amongst clinical leads about any upcoming events and items of importance regarding clinical audit activity. There are plans to develop the newsletter further during 2015/16.


Clinical Audit

Welcome to the new Clinical Audit Newsletter!

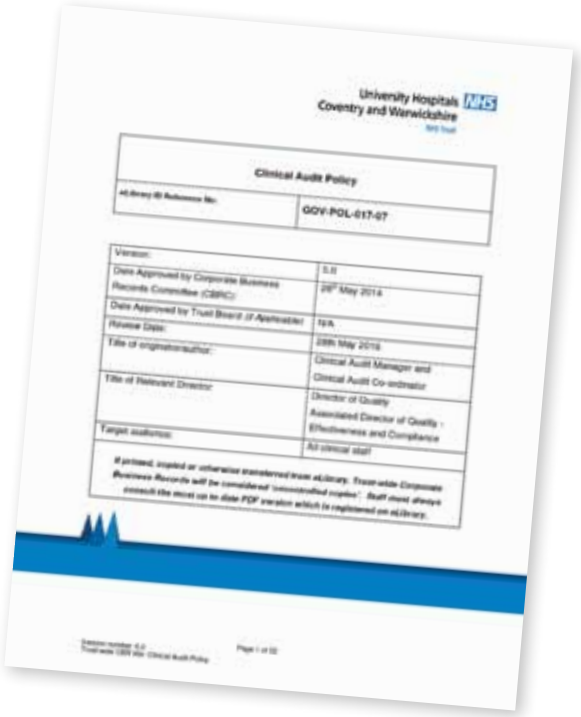
Introducing our new Clinical Audit Policy

SPECIALTY CLINICAL AUDIT PROGRAMMES

To address one of the key challenges of reducing the number of outstanding clinical audits registered in previous financial years, specialties were informed that they could have no more than 12 audits included on their local clinical audit programmes for 2015/2016 and that this should take into account any existing audits outstanding from previous years. This will ensure audit programmes are realistic and achievable by the end of the financial year.

CLINICAL AUDIT POLICY

The UHCW Clinical Audit Policy underwent a major review during 2014/15. Significant changes were made in order to combine the previous versions of the Clinical Audit Policy and Clinical Audit Strategy. The new policy sets out a framework for the conduct of clinical audit within the Trust. It provides standards and guidance for all staff participating in clinical audit activity.


University Hospitals Coventry and Warwickshire NHS

Clinical Audit Policy

GOV-POL-017-07

CLINICAL AUDIT TRAINING

The Clinical Audit function delivers an annual programme of *Introduction to Clinical Audit Training* with sessions held throughout the year, the ethos being to make training more accessible to all healthcare professionals in an open learning environment. To support trainee doctors, both Foundation Years 1 and 2, bespoke training is delivered to meet the requirements of their portfolios and provide the necessary skills, advice and support for good practice when conducting clinical audits.

Some of the benefits of undertaking the training for both patients and staff are as follows:

Patients	Staff
• Improve patient care • Enhance quality of service provider • More satisfied patients	• Helps to demonstrate the benefits of practice to others • More effective use of clinical time • Helps to advance practice • Identify areas for making practice more efficient

During 2014/15 a total of 58 members of staff, including Nurses, Midwives, Consultants and Medical Trainees participated in the training sessions.

Some of the feedback received from participants who attended the training is detailed below:

"I now understand the value of using the tools provided by the Clinical Audit Department"

"I know how to write up the Clinical Audit Report and structure the Action Plan using SMART Principles"

"The data analysis examples provided were really helpful"

"I now understand how to identify standards / guidelines"

UHCW ANNUAL CLINICAL AUDIT FOR QUALITY IMPROVEMENT AWARD 2014

UHCW Healthcare professionals across the Trust were invited to submit their clinical audits for the Quality Improvement Award. The event took place in July at Grand Round which is a forum that provides an opportunity for colleagues to learn, update and connect in a multidisciplinary setting.

A total of 20 qualifying entries were received and five audits were shortlisted. Judges and audience scores resulted in a clear winner of Audit of Sedation for Paediatric MRI by Dr Brian Shields (Paediatric Consultant) and Dr Maurice Collins (CT1). The content and style of the audit was scored highly due to its unique take, on presenting the findings relating to the patients journey and benefits realisation including cost savings. Dr Collins was awarded with a £150 gift voucher to put towards a course or conference.

Dr Collins has confirmed that as a result of the audit the service has improved. Furthermore, a Working Party has been formed to address on-going issues around the service and to look at cost savings.

The £150 gift voucher contributed to entering the audit into a Junior Doctor Audit Competition which ran in conjunction with the Clinical Audit Support Centre (CASC) and HQIP. The entry was successfully shortlisted from a number of entries. The audit was displayed in a Poster presentation which received positive feedback.

A summary of **Audit of Sedation for Paediatric MRI scans at UHCW** is below:

Audit of Sedation for Paediatric MRI scans at UHCW

Dr Maurice Collins, CT1 and Dr Brian Shields, Paediatric Consultant

This project was aimed at assessing effectiveness of awake sedation of children for CT/MRI scans at UHCW. Our trust guidelines are based on recent National Institute for Health and Care Excellence (NICE) guidance that suggests either chloral hydrate or midazolam sedation depending on age and weight.

It was felt amongst the paediatric department that more often than not sedation was inadequate to allow successful scans. Failed scans sometimes lead to children being referred to Birmingham Childrens Hospital (BCH) for scans under general anaesthetic (GA) where there is currently a 3-4 month waiting list. This whole process is distressing both for child and parents and can lead to delays in diagnosis.

The main aims of the audit were:

- To ensure current practice is undertaken in accordance with local guidelines.
- To review practice and make improvements to patient care where required.
- To review outcomes to ensure that they are as expected.

60 scans were reviewed during a 6 month period in 2013; 38 cases of Midazolam sedation and 22 cases of Chloral Hydrate sedation.

Findings

Sedation was undertaken according to UHCW guidelines.

We found that only 18% of children undergoing midazolam sedation (n=38) ended up having a successful scan whereas 90% of children undergoing chloral hydrate sedation (n=22) were successful. 11 children ended up being referred to BCH for scans under general anaesthetic. This represents 1/3 of all of the failed scans. Failed scans combined with referral to BCH cost the Trust approximately £32,000 over a 6 month period.

Standard: Sedation should be effective.
Adherence: 27/60 (45%)

Age (yrs)	Successful Midazolam Sedation	Successful Chloral Sedation
7	0/4 (0%)	1/1 (100%)
6	1/5 (20%)	-
5	0/6 (0%)	-
4	3/7 (42%)	1/1 (100%)
3	3/12 (25%)	5/5 (100%)
2	0/4 (0%)	12/14 (85%)
1	-	-
<1	-	1/1 (100%)
Total	**7/38 (18%)**	**20/22 (90%)**

Costs of failed scans:

Costs over 6 months	
Cost of 20 patients referred to BCH for MRI scans under GA	£17,543
Cost of failed midazolam scans at UHCW (£581 x 31)	£18,011 approx
Total	**£31,537.64 +**

Cost to patients

- Distress caused by attempting procedure with inadequate sedation
- Delayed diagnosis
- Wasted appointments

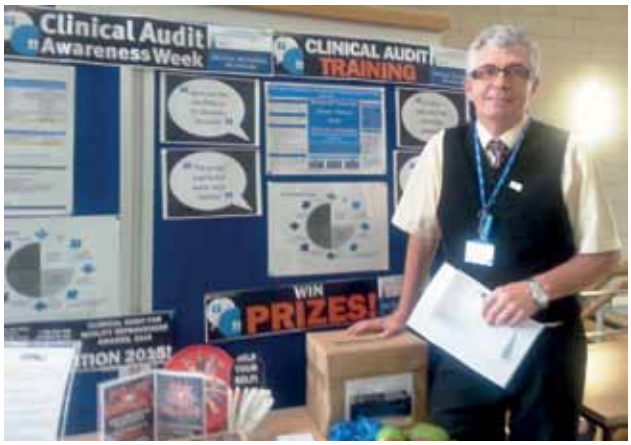
Actions

As a result of this audit the following actions are being undertaken at UHCW NHS Trust:

- UHCW should stop the use of Midazolam for sedation
- The indications for CT/MRI should be reviewed
- A MRI under general anaesthetic service should be developed at UHCW
- A working group should be formed to include radiology, anaesthetics, paediatrics, management, nursing and MRI radiographers.

CLINICAL AUDIT AWARENESS WEEK

In conjunction with HQIP, UHCW organised a Clinical Audit Awareness Week to raise the profile of national and local clinical audit, and promote the benefits of audit to a wider audience. During a week in October three events were held, including one at the Hospital of St Cross, Rugby. The events ran over lunchtime to ensure that they were accessible to all staff.



The event offered the opportunity to meet clinical audit staff to answer queries and provide advice on clinical audits. Also information was provided on audits that are undertaken at the Trust.

A daily quiz and prize draw attracted a considerable amount of interest. Free handy tools for individuals to take away provided guidance for 'Simple steps to a successful Clinical Audit' thus heightening the promotion of and importance of undertaking Clinical Audit in the Trust.

The Clinical Audit Team plans to participate in Clinical Audit Awareness Week in 2015.

TOGETHER TOWARDS WORLD CLASS

The department is actively participating in the Trust's vision to be a national and international leader in healthcare.

Together Towards World Class

Three individuals have successfully undertaken the role of Change Makers within the team. Their role involves promotion of the five workstreams of World Class, Experience, Conversations, Leadership, People and Services.

To date staff have been involved in Listening Events giving an opportunity to represent the department to give feedback. Change Makers were also pivotal in the promotion of the Staff Impressions survey, which included the first Friends and Family Test, by encouraging staff to complete the survey and offer advice and support where necessary.

Change Makers through their daily working life maintain an open working relationship with all staff and offer guidance to individuals as and when required. They have helped with testing the Behavioural Framework, which is a series of simple statements regarding behaviour; furthermore they have helped endorse this amongst colleagues with the Quality Department.

Change Makers continue to promote the Trust Values and Behaviours Framework which consist of

More recently Change Makers have been tasked with engaging staff in conversation and dialogue about being a world class organisation. This will include reminding staff about work that has taken place to date under the Together Towards World Class programme and the five work streams. Members of staff will also be asked for identification of topics which need to be undertaken in the next 12 months to help progress the journey towards World Class.

Further Developments for 2015/16

PROGRESS WITH NATIONAL CARDIAC ARREST AUDIT (NCAA)

Funding has now been secured to help facilitate the data submission requirements in the National Cardiac Arrest Audit (NCAA), one of the audits required for reporting in the Quality Account. A post has been appointed to and it is envisaged that the Trust will be in a position to begin submitting data to this audit early in 2015/16.

AUDIT OF DOCUMENTATION AND CONSENT

Progress has been made further to the completion of the Trust wide Audit of Documentation and Consent. The audit is undertaken within each specialty on an annual basis to ensure documented information relating to the care of patients is completed in accordance with both national and local recommendations. The Trust-wide Documentation & Consent Audit report for 2013/14 incorporates the findings of the audit and also reports on how the Trust is performing overall.

Generally the Trust findings were good; many specialties (19/42) have improved their compliance when compared to the results obtained in 2012/13.

There was improvement in the compliance obtained for 26/55 of the documentation and consent standards and a decrease in compliance for 18/55 standards. For the remaining standards compliance remained the same or a comparison could not be made. Average compliance across all standards was 77%, a decrease from 79% in 2012/13.

During 2015/2016 the outcomes of the Documentation and Consent audits will be reported in the Quarterly Performance Reviews.

IMPLEMENTATION OF THE CLINICAL AUDIT FUNCTION DEVELOPMENT PLAN

The Clinical Audit function has created a comprehensive Development Plan which encompasses the vision for growth and improvement for the future. Although this is in its preliminary stages, significant progress has already been made.

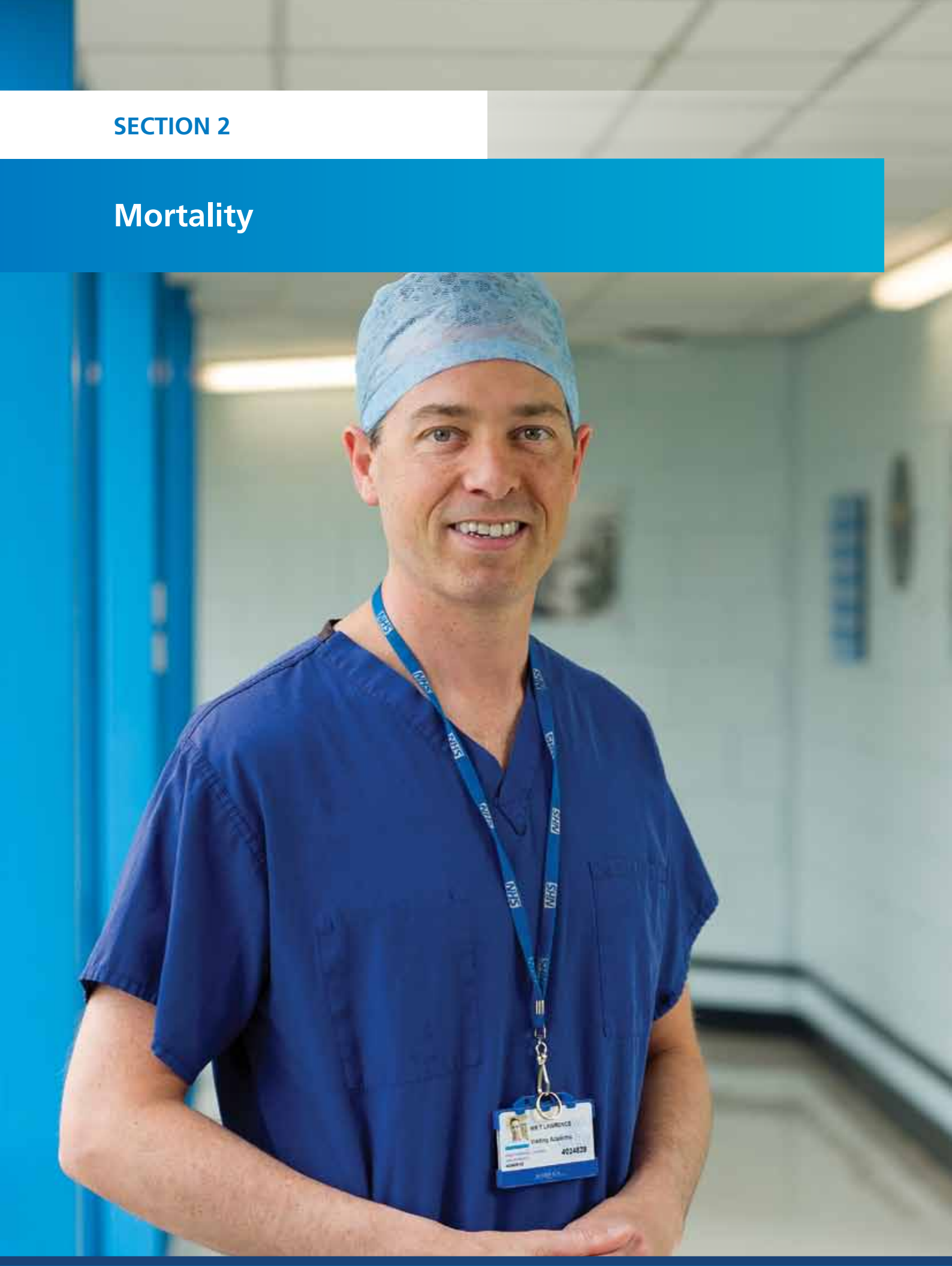
Examples of objectives included are as follows:-

- Undertake a review of all reporting mechanisms alongside reporting requirements in relation to the Quality Account, Trust Board, and reporting in line with NHS Trust Development Authority.
- Develop the audit process to ensure clinical audit action plans are robust and follow SMART principles.
- Research national awards for clinical audit for UHCW to participate in.
- Increase representation on national/regional working groups in relation to clinical audit.
- Develop the roles of Clinical Audit Leads.

The vision for the function is to continue working towards becoming a world class provider, by constantly improving existing systems and processes, and working collaboratively for all involved in clinical audit, within the common aim to improve patient care.

SECTION 2

Mortality



The Pharmacy Department installed the innovative Medi-365 system in the Emergency Department which is a robotic medicine cupboard. This new system has improved the control and management of drugs and medicines.

Introduction to Mortality

Reviewing mortality has become increasingly important for trusts to provide assurance and evidence that patient outcomes are being monitored, and any issues relating to the quality of patient care are being addressed. This forms part of the Outcomes Framework section 1 (preventing patients from dying early) and section 5 (ensuring the safety of patients).

UHCW is committed to accurately monitoring and understanding its mortality outcomes to ensure the highest possible standard of care for all patients. It subscribes to Dr Foster's Quality Investigator (QI) tool and has been monitoring the Hospital Standardised Mortality Ratio (HSMR) for a number of years with clinicians being able to access their own specialty's information. The HSMR is calculated using the number of deaths compared with the number of patients who would be expected to die, taking into account age, complexity of illness, deprivation and gender. The baseline for England is set at 100 and a lower figure indicates fewer patients died than expected.

Dr Foster's Quality Investigator is used to monitor specific diagnosis and procedure groups, as well as specialty mortality through an alert system. The Trust has a robust process for investigating mortality alerts, which involves a clinical and coding review and triangulation of outcomes with those found in the Trust wide mortality review process (see below). Any actions and learning are fed back through the Trust's governance processes.

The Trust has an extensive mortality review system where all inpatient deaths, over the age of 18, are reviewed by the consultant responsible for the patient's care at point of death. This system utilises the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) grading system to classify overall patient care. Any case that does not have a NCEPOD grade A (Good Care) has a more in depth, secondary review that highlights learning and identifies any necessary actions. This learning is disseminated through the Trust's governance processes.

The above is overseen by the Trust Mortality Review Committee (MRC). This is chaired by the Deputy Chief Medical Officer and the membership is comprised of representatives from the CCG, Dr Foster, clinical coding, the Trust Clinical Lead for Mortality, senior clinicians and senior representatives from key specialty areas such as Critical Care, Neurosurgery and Palliative Care. The Committee meets twice each month and has a range of functions. It receives monthly dashboards that monitor the Trust's mortality performance and reports from specific alert investigations are presented to the meeting. Specialties also report their mortality learning and outcomes to this meeting on a quarterly basis. The Committee also discusses and approves any new developments for the mortality processes in the Trust and reports into the Trust's Patient Safety Committee. Furthermore mortality data is reported to the Trust's Quality Governance Committee on a monthly basis and to the Trust Board twice per year.

Trust Mortality Performance for 2014 – 2015

Dr Foster Data

The Hospital Standardised Mortality Ratio (HSMR) is a standardised measure of hospital mortality devised by Professor Sir Brian Jarman of Imperial College London, and is published every year by Dr Foster in the Good Hospital Guide. It is the observed number of in-hospital spells resulting in death divided by an expected figure, for a basket of 56 diagnoses which represent 80% of hospital mortality in England. Day cases are excluded unless the patient died. The expected figure is derived from a logistic regression model which adjusts for case-mix factors. The national benchmark for HSMR is 100 and the data is provided monthly by Dr Foster, but this data is three months in arrears. The HSMR provides indication for areas of investigation and highlights any significant mortality risks. The HSMR is adjusted for palliative care coding to give a more accurate depiction of mortality.

The Trust's current HSMR for March 2014 to February 2015 is 108.99. The most recent HSMR figure (February 2015) is 105.81 – within the 'expected' range.

Dr Foster re-models its data to account for the changing patterns of in-hospital deaths and admissions. As standards in hospitals improve, actual mortality rates will decrease. However Dr Foster keeps the expected value at 100 and mortality ratios are adjusted in relation. From April 2015, Dr Foster has changed the process of data re-modelling from annually to a monthly basis to provide the most accurate and current data.

As stated above the Trust monitors its HSMR on a monthly basis. Figure 1 below shows the HSMR Trend for March 2014 to February 2015.

HSMR TREND: MARCH 2014 – FEBRUARY 2015

As shown in Figure 1, there are three high relative risk outliers for the months June 2014, September 2014 and October 2014. These impact upon the overall HSMR for the year, generating a significantly high mortality risk.

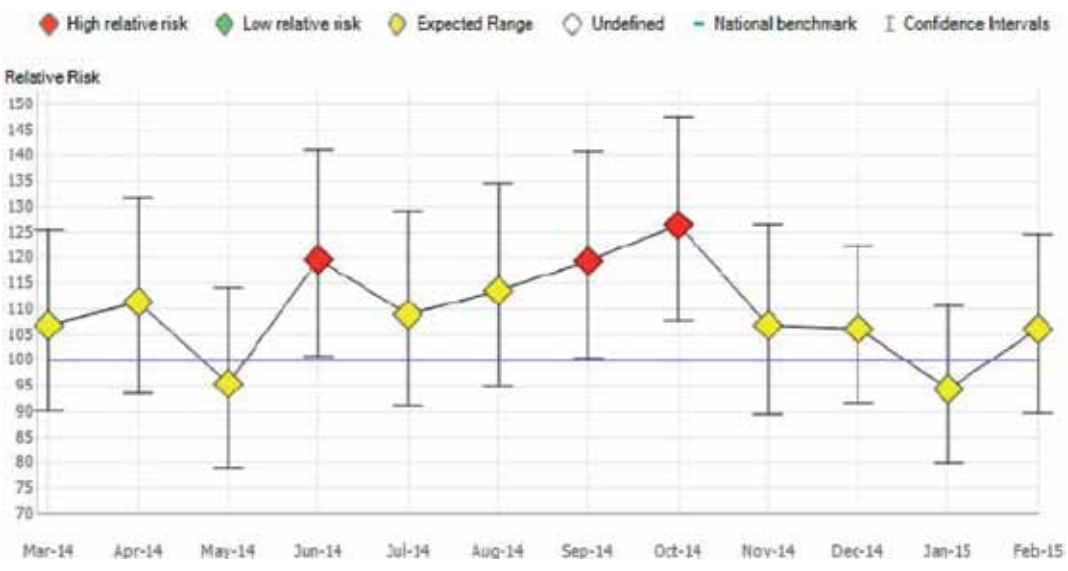


Figure 1: HSMR trends for March 2014 – February 2015. Source: Dr Foster Intelligence

Previously to the re-modelling of data, June 2014, September 2014 or October 2014 were not high relative risks when using the previous yearly benchmark. The HSMR for UHCW for this time period was previously 103.08 – within the expected range.

In comparison to 14 other West Midlands Acute Trust peers, UHCW and 2 other trusts have significantly high HSMR's between March 2014 and February 2015. There is 1 trust which has a significantly low HSMR for the time period. The remaining trusts have a HSMR within the 'expected' range.

Figure 2 highlights that the HSMR crude mortality rate is consistently lower than national crude rates, with the exception of 2 months (September 2014 and October 2014).

Dr Foster Mortality Alerts are generated when there is a significant high or low relative risk for a variable. This includes aspects such as: diagnosis group, specialty, admission type, day of admission/discharge, procedure group, patient locality and many more. UHCW monitors high and low risks through diagnosis/procedure groups and these are reported to the Mortality Review Committee monthly for discussion and investigation. Any associated actions from the investigations are monitored by the Patient Safety Committee.

As shown below in Table 1, the 3 types of alerts are similarly distributed for this financial year.

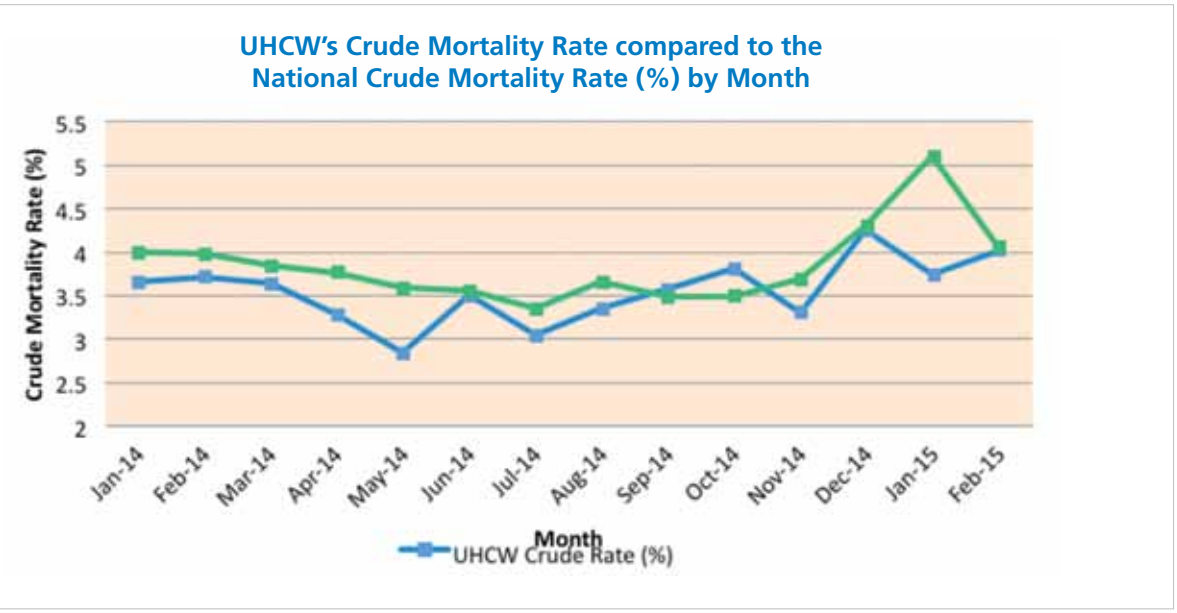


Figure 2: UHCW HSMR Crude Mortality Rate in Comparison to National Crude Rate (%). Source: Dr Foster Intelligence.

	CuSum Alerts	High Relative Risk	Green Alerts
Percentage of Alerts for 14/15	16 (30.8%)	19 (36.5%)	17 (32.7%)

Table 1: Dr Foster Alerts by alert type: 2014-2015

The Trust introduced Apple iPods to record and review patient's observations. The upgrade comes just six years after the original system was introduced to replace the traditional observation charts at the end of patients' beds.

SUMMARY HOSPITAL-LEVEL MORTALITY INDICATOR (SHMI) DATA

The SHMI is a national indicator published by the NHS Health and Social Care Information Centre (HSCIC). The indicator can be used by hospitals to help them better understand trends associated with patient deaths. It explores all inpatient mortality and mortality after 30 days of hospital discharge. The HSCIC release SHMI publications on a quarterly basis and this data is 6 months in arrears. The national benchmark is 1, but is often multiplied by 100 for comparison to the HSMR. Similar to the HSMR, a value below the benchmark indicates fewer deaths than expected, while a value above this highlights more deaths than expected. UHCW reports SHMI data to the Mortality Review Committee on a quarterly basis for review.

Unlike the HSMR, the SHMI value is not affected by the Trust's palliative care coding. The national average for palliative coding is 25.46%, and the range is between 0 – 49.39%. UHCW's palliative coding rate for the most recent SHMI publication (October 2013 – September 2014) is 11.4%. This is low in comparison to other trusts. Figure 3 (below) provides a pictorial chart of UHCW's palliative coding rate in comparison to all non-specialist acute providers in England.

The SHMI value for the most recent publication (October 2013 – September 2014; released April 2015) is 1.0228. This is within the expected range. The HSMR for this time period is 108.73. In comparison to 14 West Midlands Acute Trusts, UHCW has the 8th lowest SHMI value. Figure 4 overleaf shows that there are 5 Trusts which have a high SHMI value (red), indicating there are significantly more deaths than expected, and there is 1 Trust with a low SHMI value (green), demonstrating a significantly low risk for mortality.

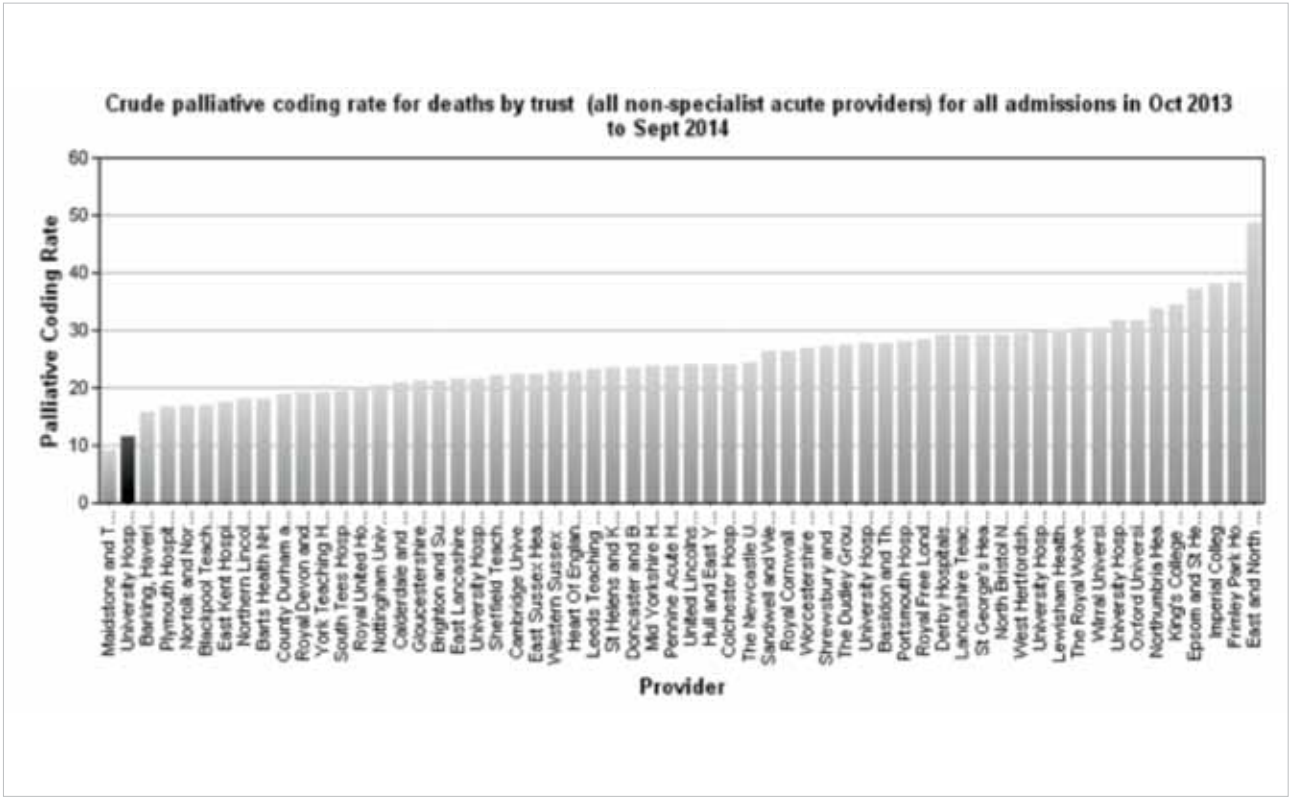
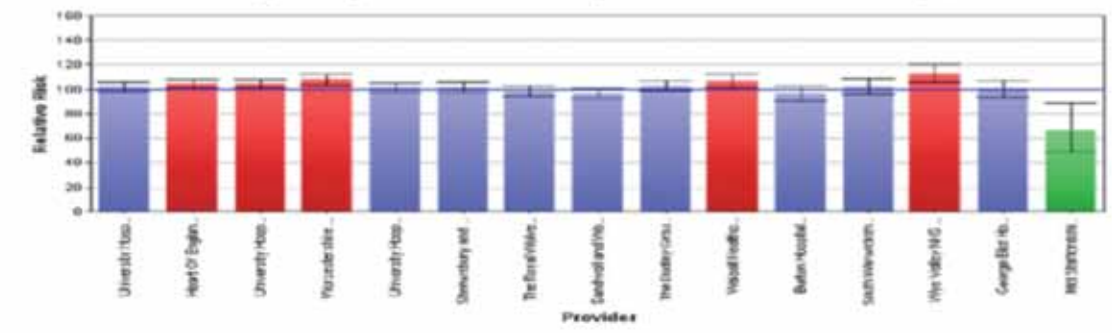


Figure 3: A pictorial representation of UHCW's palliative coding rate compared nationally. There are 4 Trusts with a lower palliative coding rate than UHCW. Source: Dr Foster Intelligence

SHMI by provider (West Midlands Acute Trusts) for all admissions in Oct 2013 to Sept 2014



Provider	SHMI Spells	SHMI
University Hospitals Coventry and Warwickshire NHS Trust	90984	102.28
Heart Of England NHS Foundation Trust	161047	104.73
University Hospital Of North Staffordshire NHS Trust	130111	104.56
Worcestershire Acute Hospitals NHS Trust	73984	108.02
University Hospitals Birmingham NHS Foundation Trust	62074	101.27
Shrewsbury and Telford Hospital NHS Trust	66556	101.53
The Royal Wolverhampton NHS Trust	63928	98.37
Sandwell and West Birmingham Hospitals NHS Trust	71745	96.14
The Dudley Group NHS Foundation Trust	68689	103.07
Walsall Healthcare NHS Trust	42621	106.76
Burton Hospitals NHS Foundation Trust	41928	96.25
South Warwickshire NHS Foundation Trust	32222	102.32
Wye Valley NHS Trust	28417	113.01
George Eliot Hospital NHS Trust	23076	100.30
Mid Staffordshire NHS Foundation Trust	2037	66.61

Figure 4: UHCW Peer Comparison for SHMI October 2013 – September 2014. Source: Dr Foster Intelligence

TRUST WIDE MORTALITY REVIEW

Since the inception of the Trust wide Mortality Review (TWMR) process in July 2011 there has been continual promotion of the importance of reviewing mortality as a central aspect of monitoring patient safety.

The number of completed reviews has increased with each financial year. It should also be noted that the number of reviews to be completed has also increased. This is testament to the support this process receives from specialties and the work conducted by the mortality team in continuing to promote this process and provide support wherever necessary. Of the completed reviews, 90.5% received an NCEPOD grade A – good standard of care. This is higher than previous years (Table 3) indicating an improvement in patient care.

The Trust clinical lead for mortality works with specialties to help improve and standardise mortality processes and improve productivity in regards of timeliness of completion of data. An audit of NCEPOD As is currently underway to assure the NCEPOD grading given is appropriate, with preliminary results indicating this is satisfactory.

Learning from mortality reviews are shared throughout the Trust by a mortality newsletter. This is produced on quarterly basis and contains data analysis, case learning and performance data.

Financial Year	Completed Reviews	Total Deaths	Percentage Completed
2011-2012 (July 2011 – March 2012)	1211	1394	87%
2012-2013	1727	1901	91%
2013-2014	1868	1952	96%
2014-2015	1882	2035	92%

Table 2: Primary Review Completion Rates by Financial Year
N.B. The data for FY 2011/2012 is from July 2011 – March 2012. Data collected 11/5/15

	NCEPOD Grade				
Financial Year	A	B	C	D	E
2011-2012	76.6%	18.0%	3.1%	1.5%	0.8%
2012-2013	83.8%	10.8%	3.5%	1.6%	0.4%
2013-2014	87.9%	7.8%	2.1%	1.5%	0.6%
2014-2015	90.5%	4.2%	2.9%	1.3%	1.1%

Table 3: NCEPOD Grading from Primary Reviews by Financial Year

Learning from Mortality Reviews

Mortality reviews provide an excellent opportunity to retrospectively review cases and learn from them. This allows for actions to be taken to ensure the future care the Trust provides is of a world class standard.

All reviews graded NCEPOD B-E have a further secondary review from a different member of staff to assess the care quality the patient received, identifying learning and actions to improve processes within the Trust.

Mortality Review	Key Actions and Learning
Secondary Review Learning from NCEPOD B-E Deaths	A thematic analysis was conducted for all NCEPOD E deaths for the financial year 14/15 to explore the learning outcomes. There were 4 identified themes: 1. Poor and Unclear Documentation 2. Issues with Handover/Transfer 3. Further Training for Staff 4. Clinical/Nursing Errors Clinical Errors was the most common re-occurring theme; it addresses situations regarding recognition of patients' symptoms and deterioration, and managing them accordingly. It also includes the accuracy of using equipment and interpreting results.

Mortality Review (Continued)	Key Actions and Learning
Secondary Review Learning from NCEPOD B-E Deaths *(Continued)*	Communication between members of staff during patient handovers, episodes of shared care, and ward transfers are also documented as an area for improvement, with a need for a more robust handover system, especially during the night time. Similarly, five cases noted that the documentation of patient notes was inadequate, including consent documentation processes and the accuracy of operation notes. It was noted on these cases that it was more difficult to maintain standards of care when the patient notes are inaccurate or unclear, and filing of all notes need to be consistent. Further training for staff members to educate and increase awareness was an outcome for four cases, including utilising the Amber Care Bundle, and understanding Sepsis criteria. The learning from reviews is shared with staff in a variety of different ways, such as through specialty Quality Improvement and Patient Safety meetings or presentation of Root Cause Analysis outcomes at the Grand Round. This helps enable Trust wide learning.
Dr Foster Alert Investigations	• Vascular Surgery Specialty There was 4 actions from an investigation led by the Vascular Surgery Department including setting up a multi-disciplinary team meeting for mortality and morbidity to discuss cases cross-specialty involving Vascular Surgery, Interventional Radiology, and Anaesthetics. Another action was to create a pathway regarding the management of ischemic leg, so there is a documented process to follow. The other actions were regarding a cross-specialty case review with Critical Care. • Clinical Oncology Specialty There were several actions from this investigation completed by the Clinical Oncology team relating to improving the palliative care coding of patients who are terminally ill. There was another action involving the gastroenterology team to aid in the reviewing of patients who had received endoscopic intervention in the week prior to their death to gain a better understanding. • Grand Round Presentation Investigating alerts can lead to Trust wide learning. To share the information, the Grand Round (weekly event) is useful for reaching a wider audience from many specialties and different areas of clinical practice. This year there was a presentation by the Renal department discussing the alert 'Acute and Unspecified Renal Failure'. They outlined the investigation and methodology, and the actions which have taken place as a result of this alert and a further audit to assess whether the actions are having a positive impact. Areas for improvement in the hospital in relation to the alert were also highlighted, including ensuring more patients are seen in less than 24 hours, and also recognising when patients should be on the End of Life Care Pathway. The implementation of an Acute Kidney Injury (AKI) Care Bundle was discussed and how to use it this is because the majority of patients involved in the alert were outliers on other wards. It was discussed how this system can help provide further information on caring for those with AKI at a Trust wide level. Audit results show that many areas of care for AKI had improved; including the identification of the AKI cause, the measuring of Creatinine, and the referrals for urgent ultrasound.

Table 4: Learning from Mortality Reviews: NCEPOD B-E deaths and Dr Foster Alert Investigations

A state-of-the-art £1.4m robot was launched this year to perform keyhole surgery. The new Da Vinci robot will conduct prostate, kidney, bowel, throat and heart operations with minimal intrusion for patients.

Changes in Practice

During 2014-2015 there have been a number of changes to the mortality review processes at UHCW. There has been a drive to improve the completion rates of both primary and secondary mortality reviews and many departmental processes have been changed to facilitate this. This has led to an increase in the number of completed primary and secondary reviews as highlighted previously in Table 2. The use of Dr Foster aids the Trust by indicating potential areas for improvement by using the alert system so UHCW can fully explore trends and themes within the Trust relating to mortality.

The HSMR is adjusted for variables including palliative care. The adjustments are made to account for confounding variables which could affect the HSMR. The Specialist Palliative Care team and the Trust coding team have been working closer together to increase the palliative care coding to better reflect the Trust case mix and have a more representative HSMR value.

Many specialties have developed a rota system to complete mortality reviews to address issues regarding misallocation of patients to consultants and to be able to objectively review patients to avoid bias when reporting their level of care.

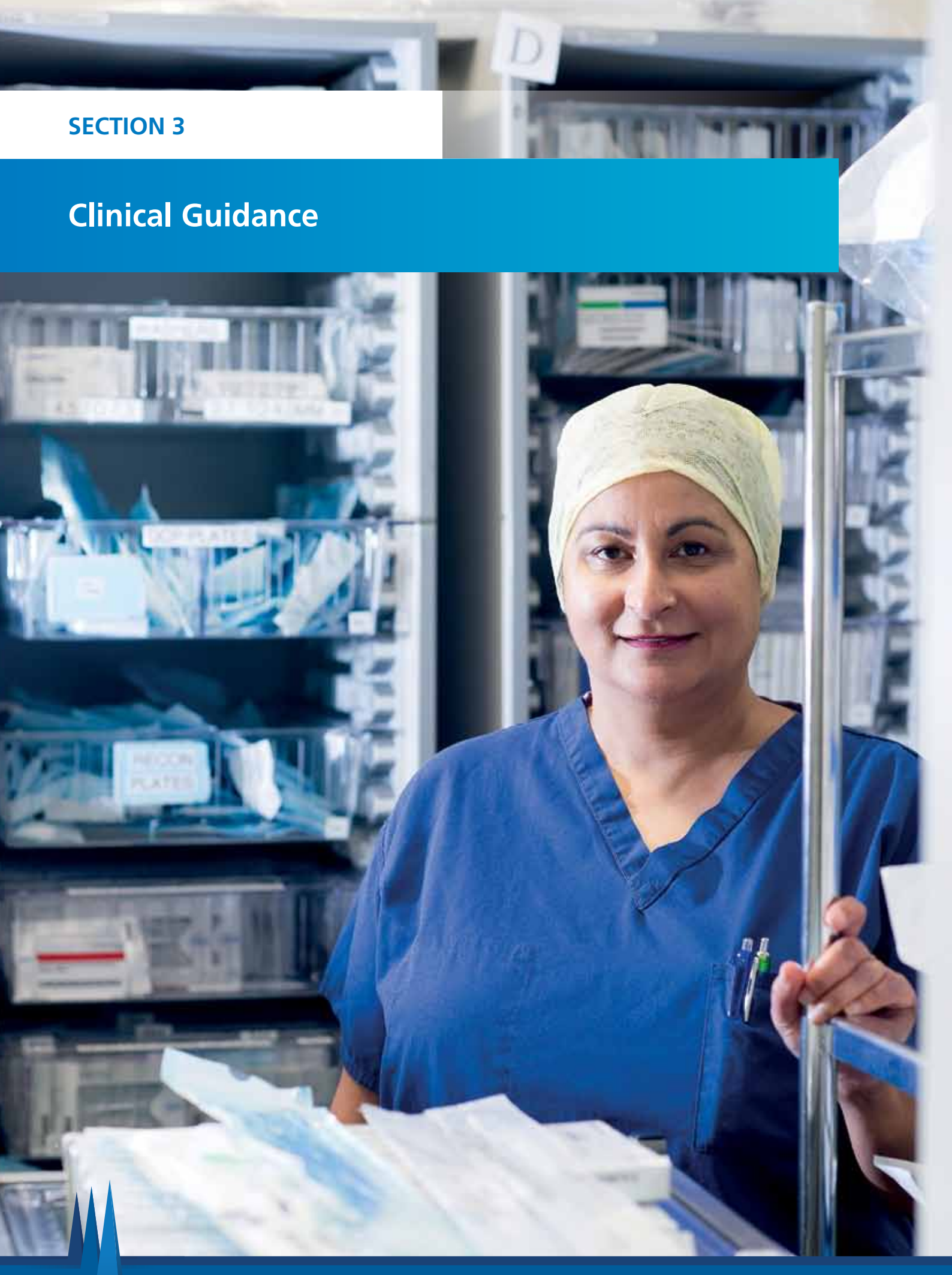
FURTHER DEVELOPMENTS FOR 2015-2016

Despite the number of changes in the past financial year there is always the need to revisit, revitalise and re-launch. Thus in the coming financial year the Trust is aiming to develop these key areas of mortality processes within the Trust:

- Further development of the secondary mortality review process, and generating the secondary review as an e-form on the Clinical Results Reporting System – similar to the primary review form.
- Specialty Mortality reports further being developed and amended to increase improvements within departments and provide relevant and useful information.
- Increase specialty reporting of mortality data to the Mortality Review Committee to provide an overview of specialty specific mortality outcomes and risks.
- Greater use and analysis of mortality data to give an indication of trends and comparison to similar Trusts.
- Closer links with other governance teams in the Trust, such as the Clinical Risk Team. They provide information on Clinical Adverse Events and the grading of harm to a patient, and the outcomes from Root Cause Analyses. These can be cross checked with mortality cases to provide assurances that the actions arising from mortality investigations are being followed-up.
- Contacting other Trusts with a low HSMR to learn and implement best practice.
- The Trust will be participating in the following mortality research: Evaluation of a National Surveillance System for Mortality Alerts in conjunction with Imperial College and Diabetes UK – Diabetes Mortality and Morbidity Project.

SECTION 3

Clinical Guidance



Introduction to Clinical Guidance

Clinical Guidance reduces variations in practice and provides a focus for discussion among health professionals and patients. It enables professionals from different disciplines to come to an agreement about treatment and development of recommendations, against which practice can be measured. Clinical Guidance can help commissioners and purchasers to make informed decisions and provide managers with a useful framework for assessing treatment costs.

Trust Clinical Guidelines

Good clinical guidelines aim to improve the quality of care provided to patients. They can change the process of healthcare and improve patient outcomes.

By using clinical guidelines that are developed using the best available research evidence they can:

- Provide recommendations for the treatment and care of people by health professionals.
- Be used to develop standards to assess the clinical practice of individual health professionals.
- Be used in the education and training of health professionals.
- Help patients to make informed decisions.
- Improve communication between patient and health professional.

The e-Library is the Trust's in-house electronic Records Management System for the management of Trust-wide clinical and non-clinical information which incorporates clinical guidelines. It is available on the intranet to all staff.

The ultimate aim is to ensure the information held within the clinical guidelines directory is effective, up to date and standardised. To ensure this all clinical guidelines must meet specified criteria and are subject to a robust approval process prior to publication on the system.

Table 1 below shows the break down of clinical guidelines by status: the number of current, expired and those guidelines requiring review in April 2015.

There are currently 995 clinical guidelines on the e-Library system, this number includes 885 current, 82 under review and 28 expired guidelines.

The total number of clinical guidelines on e-Library has increased from 929 to 996 during April 2014 – April 2015.

There has been a reduction in the number of expired guidelines on e-Library from 84 (9%) in April 2014 to 28 (3%) in April 2015. This is due to a robust reminder system to obtain updated guidelines and relevant evidence documents being put in place.

Status	Number
Current	885
Expired	28
Under Review	82
Total	995

Table 1: e-Library status as at April 2015

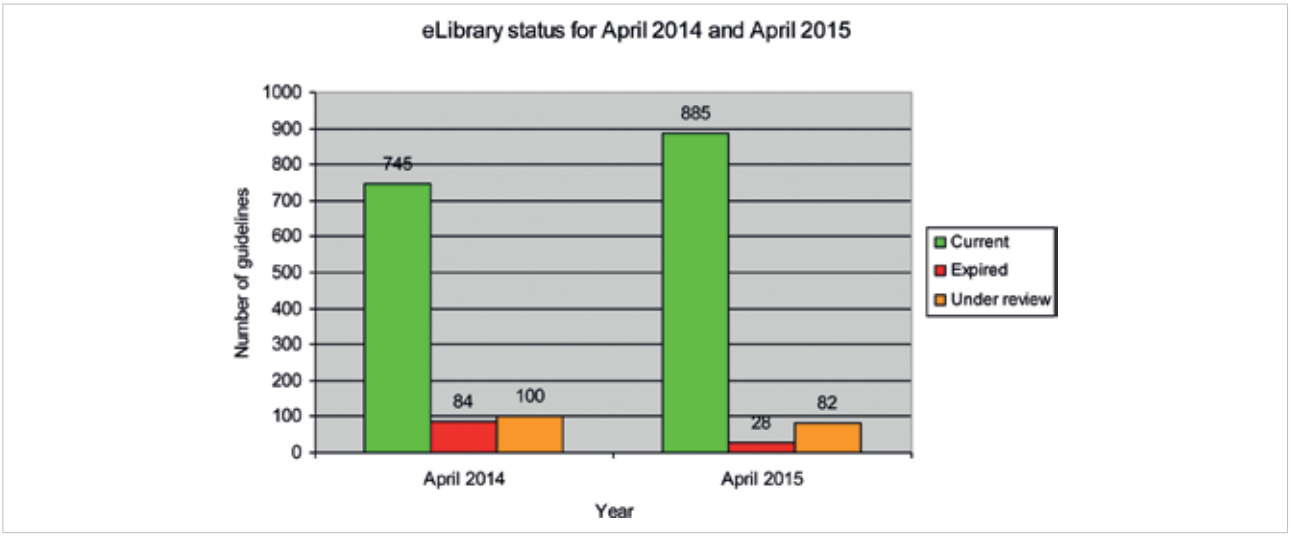


Figure 1: e-Library status for 2014 and 2015

Expired guidelines have been reported in greater detail at the Clinical Guidance Governance Group (CGGG) and followed up by the Chair of this meeting.

Details of expired guidelines and those due to be reviewed are included in the monthly Quality and Patient Safety (QPS) reports. The reports are discussed at specialty Quality Improvement and Patient Safety Meeting (QIPS) meetings.

The Clinical Guidelines Facilitator is working with individual clinicians and attending specialty QIPS meetings to expedite the development and approval of clinical guidelines. All new and revised guidelines are reported at monthly clinical audit facilitator meetings to help inform the local clinical audit forward programme.

In September 2014 the Clinical Guidance Governance Group became responsible for overseeing the monitoring and reporting of local Trust clinical guidelines on e-Library. Dan Strong (Joint Chair of CGGG) has taken an active role in the development of the Trust e-Library system and provides support in following up guidelines that have expired.

There is now a dedicated pharmacist that provides support for reviewing clinical guidelines that contain drug regimes. Where necessary, these are then submitted to the Medicine Management Committee (MMC) for approval.

FURTHER DEVELOPMENTS IN 2015-2016

- Work is ongoing with Information & Communications Technology (ICT) to develop and improve the functionality of the e-Library system. The first of the developments are due to be rolled out in June 2015.
- The aim of these developments is to result in a more user friendly system and improve accessibility for end users. ICT is also developing an e-Library reporting function.

The developments include:

- Primary specialty field allocated to all guidelines.
- Tracking status to identify stage in approval process.
- Direct reporting from e-Library.
- There is a process being developed for literature searches to be provided for all guidelines one month before the review date. The evidence summaries will be disseminated to authors to encourage more timely review and update of guidance. The Clinical Guidelines Facilitator is working with Library and Knowledge Services to provide and disseminate this information.
- The Clinical Guidance Newsletter will be introduced in early 2015-2016. This will comprise information on clinical guidelines such as the e-Library which stores the clinical guidelines, guidelines in development and those which are due to expire. The newsletter will also include details on guidance issued by NICE, highlighting areas where implementation has resulted in service improvements.

NICE Guidance

The National Institute for Health and Care Excellence (NICE) was established as a Special Health Authority in April 1999 to promote clinical excellence and effective use of resources within the NHS. NICE is an independent organisation which provides guidance, sets quality standards and manages a national database to improve people's health and prevent and treat ill health. Its recommendations are based on evidence of both clinical and cost effectiveness.

NICE currently produces eleven types of guidance/standards:

- Clinical guidelines (CG)
- Public health guidelines (PH)
- Safe staffing guidelines (SG)
- Quality standards (QS)
- Technology appraisals (TA)
- Interventional procedures (IPG)
- Medical technologies (MTG)
- Diagnostics (DG)
- Highly specialised technologies (HST)
- Social care guidelines (SCG)
- Medicines practice guidelines (MPG)

NICE is moving to a new way of guideline numbering. This started in January 2015 when NICE introduced National Guidance (NG) which will be used for all guidelines whether they are clinical, public health, social care, safe staffing or medicines practice guidelines.

Putting NICE guidance into practice benefits everyone; people who use health and social services and their carers, the public, NHS organisations, local authorities, health and social care professionals, and policy makers. It can help organisations to meet the legal requirements of the NHS Constitution and Health and Social Care Act (2012). NICE guidance and quality standards can also help UHCW meet regulatory requirements from organisations such as the Care Quality Commission.

Using NICE guidance may also help cut costs, while at the same time maintaining and improving services, by ensuring that the care provided is both clinically and cost effective.

Compliance with NICE Guidance recorded on the NICE Database

There are 453 guidance documents registered on the NICE database. 129 of these have been identified as 'not applicable' when the procedure or service is not provided by UHCW.

Compliance for 2014/15

There were 135 guidance documents issued by NICE in the 2014/15 financial year. 33 of these have been identified as 'not applicable' when the procedure or service is not provided by UHCW.

Figure 1 (overleaf) shows the compliance rates for each type of guidance that has been issued by NICE between April 2014 and March 2015. From the 135 guidance documents issued by NICE during 2014/15 there are 34 (47%) registered as fully compliant and 4 (5%) as partially compliant.

The non compliance of NICE guidance is reported at monthly CGGG meetings. Steve Cooke (Joint Chair of this meeting) is providing support to address non compliance.

Baseline assessments are completed for each piece of NICE guidance. The outstanding recommendations are identified from the completed baseline assessments. The associated action plans from the recommendations are to be followed up by CGGG.

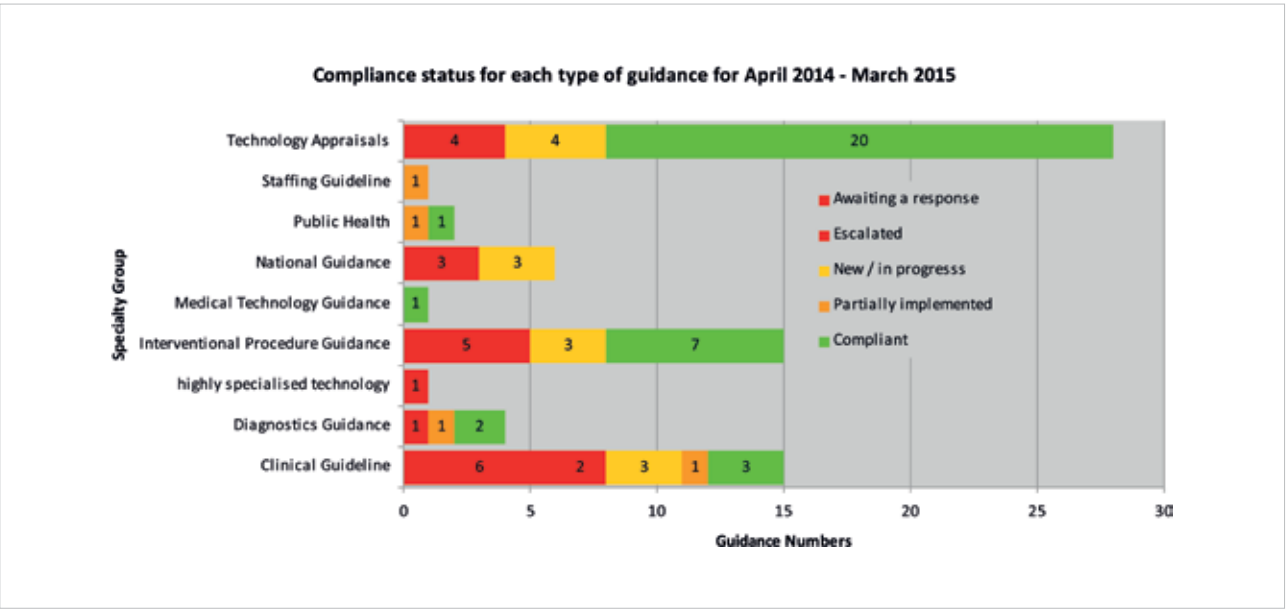


Figure 1: Compliance status 2014/15. Guidance that has been identified as not applicable to UHCW has been removed to calculate compliance rates. Quality Standards are not included in compliance rates.

TECHNOLOGY APPRAISALS (TAS)

The Department of Health select the technologies for appraisal by NICE. The technologies chosen will have a significant impact on patient health, health inequalities, government policy or NHS resources. The process involves manufacturers, patient groups and professional organisations. It is a statutory duty for all Trusts to implement the recommendations made within technology appraisals within 90 days of issue.

The new process for responding to a NICE Technology Appraisals (TAs) has now been implemented and as a result has improved the timescales of implementation. For the majority of TAs, the drugs recommended are added to the Trust drug formulary and therefore available for patients with the 90 day target.

QUALITY STANDARDS (QS)

There have been 29 new Quality Standards issued between April 14 and March 2015. The overall total of Quality Standards now registered on the database is 86.

Further Developments for 2015-2016

- The Clinical Effectiveness Team is working on a new process to identify NICE Clinical Guidelines reported as fully implemented and associated Quality Standards. These will be added to the clinical audit programme. A clinical audit will be undertaken against the recommendations made in the NICE guidance.
- From June 2015, any Clinical Guidelines and Quality Standards that are reported as fully implemented at the CGGG will be discussed, and a decision will be made to include them on the clinical audit programme. There are plans to include NICE guidance compliance in QPS reports for discussion at specialty meetings and Quarterly Perfomance Reviews.

SECTION 4

Compliance and Assurance

Compliance

COMPLIANCE AGAINST STANDARDS

The Compliance Function within the Quality Department ensures the Trust is delivering care against internal and externals standards. It cuts across all services within UHCW NHS Trust, to ensure that all current regulations are being met and also the Trust is prepared for future regulation changes and CQC inspections, alerts, policies and procedure updates. The function provides the internal co-ordination and response to these activities that demonstrate whether the Trust is meeting standards, identifies any gaps and supports services to understand and agree the actions required to meet standards. The Compliance Function acts independently and separately from the Quality Department's Assurance Function.

ACHIEVEMENTS IN 2014-2015

The Compliance Function has responded to and delivered a number of key achievements during 2014-2015, namely:

- The Trust has for some time recognised that an independent comprehensive inspection by the Care Quality Commission (CQC) was likely to occur in 2014. In response to this, an independent company was commissioned to support the organisation to deliver a 'mock' CQC inspection. Representatives from UHCW and partner organisations participated in a day long inspection structured around the eight core services reviewed by the CQC. The independent company provided reports against each of the eight core services containing publically available performance data and key lines of enquiry for use by the mock inspectors during their review of the Trust's services. The findings of the inspectors were presented back to members of the Executive Team at the end of the day's inspection. This initiative provided staff at all levels of the organisation with the opportunity to experience what it is like to be inspected by the CQC and additionally, generate action plans in response to the feedback on the quality of care delivered by the Trust. The Compliance Team led the organisation and delivery of this event.
- The Trust was advised formally in December 2014 that a comprehensive inspection by the CQC would take place from 10 March 2015 to 13 March 2015. This then provided the focus of activity for the Compliance Function for the remainder of the financial year. In response to data requests from the CQC, the Compliance Function co-ordinated the collation and submission of over 1000 separate pieces of evidence as part of the pre inspection response. These were submitted in January 2015 to allow the CQC time to review in preparation for the formal inspection. The Compliance Function then worked with representatives from the CQC to ensure that the organisation of the three day inspection went as smoothly as possible. This involved establishing the logistics to support up to 60 CQC time inspectors on the two Trust sites over the three days, responding to data requests during the inspection and any changes of arrangements requested by the inspectors. Post the onsite inspection there were a number of further data requests which were addressed. The full inspection report is still awaiting publication.
- There has also been an ongoing review of actions against a number of action plans related to the Quality Governance Framework and previous inspection reports from the CQC.

FURTHER DEVELOPMENTS FOR 2015-2016

Looking ahead in 2015-2016, the Compliance Function will:

- Provide the co-ordination of any Trust response to the publication of both the draft CQC inspection report (for factual accuracy) and the final public inspection report expected in August 2015.
- Work with the Nursing function to establish an internal approach to self assessment of the Fundamental Standards of Care to identify any gaps in care delivery and responding action plans. This will include assessment against the new regulations, Duty of Candour and display of the CQC ratings.
- Complete a further self assessment against Monitor's Well Led Governance Framework.
- Develop a log of external inspections that take place across the Trust.
- Support the delivery and outcomes of any inspections completed by the West Midlands Quality Review Service.

Assurance

ASSURANCE OF CARE

The Assurance Function within the Quality Department provides the Trust with evidence that it is meeting internal and external standards of care. It acts as the internal 'independent and objective' assessor of the delivery of safe and effective care. In response to the Trust's Quality Strategy, this new service was established in October 2014 and aims to provide an ongoing systematic approach to assessing whether the Trust is meeting, for example, the Fundamental Standards of the Care Quality Commission (CQC). The Assurance Function acts independently and separately to the Quality Department's Compliance Function.

ACHIEVEMENTS IN 2014-2015

Despite being a new service the Assurance Function has already delivered on a number of objectives, namely:

- In response to the findings of the mock CQC inspection held in October 2014, the Getting The Basics Right Programme was developed and delivered to provide trust wide assurance against those aspects of care considered 'quick wins. Multidisciplinary teams, comprising of representation from doctors, nurses, pharmacist, estates and quality, reviewed 70 Trust services against a set of core key lines of enquiry over a period of 5 weeks during January and February 2015. The results were reported separately to the Specialty groups' management teams for action and also aggregated into a trust wide 'heat map' as part of the preparation for the CQC inspection visit in March 2015.
- In response to the CQC inspection in March 2015, a trust wide review of single use IV practice was completed and reported.
- Ongoing review of progress against the recommendations of the national Francis, Berwick and Keogh reports has taken place. The findings provided assurance against practice across the Trust.
- In response to the direction of travel described in the Quality Strategy, administrative support from the Quality team has been withdrawn from the specialty Quality Improvement in Patient Safety (QIPS) meetings. Agenda management has, however, continued to be provided during the transitional phase. Specialty groups have established their own QIPS support in preparation for full withdrawal of Quality Team support by May 2015. The Quality Department will continue to have oversight of the quality of these key meetings, particularly reviewing the issues discussed and the actions taken in response.

FURTHER DEVELOPMENTS FOR 2015-2016

Looking ahead in 2015-2016, the Assurance Function will continue to be developed and strengthened, focusing on the following:

- Building on the learning from Getting The Basics Right, the Trust's Assurance Programme will be developed and implemented. The unannounced inspections of services delivered by Clinical Groups will provide the ongoing independent assurance of care and thus the realisation of key objectives within the Quality Strategy. The programme will ensure that there is a core set of key lines of enquiry that reflect the Fundamental Standards of Care across the Trust alongside Clinical Group specific lines of enquiry that are supported by qualitative and quantitative data driven intelligence.
- The use of data to support the Assurance Programme will be strengthened. Through the creation of the Quality Department's Information Hub, this virtual collation and review of the quality performance data currently available will be used to inform specific and relevant lines of enquiry within Getting The Basics Right.
- Much of the quality data is derived from software systems utilised by members of the Quality Team. The management of these systems will be strengthened during 2015-2016 to further support the Trust's Assurance Programme.

SECTION 5

Patient Experience

Consultants Kieran Jefferson and Donald MacDonald with patient Bruce and his wife Heather at the Da Vinci Robot Launch

Patient & Public Experience & Involvement

INTRODUCTION TO PATIENT EXPERIENCE & INVOLVEMENT

The Clinical Commissioning Group Outcomes Indicator Set 2014-2015, Domain 4 'Ensuring that people have a positive experience of care' explicitly mentions, amongst others, improving people's experience of outpatient care, hospitals' responsiveness to personal needs, A&E services, women's experience of maternity services, end of life care and children and young people's experience of healthcare.

The last 12 months has seen the completion of the roll out of the Friends and Family Test questionnaire to all areas of the Trust including outpatients, daycase, children and young people. In addition, plans are in place to introduce a neonatal survey for parents and relatives to complete. This and the other activities and results outlined below demonstrate the Trust's ongoing commitment to routinely listening to and involving its patients, carers, relatives in designing its services and improving patient experience.

SURVEYS

The Trust's Patient Experience Team oversees the following surveys. In this section a brief overview is given of each along with the results for 2014-2015:

- **Friends and Family Test**
- **National Patient Survey Programme**
- **Impressions**

Impressions

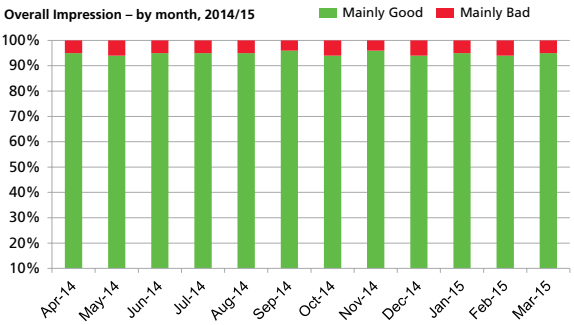
Background: Impressions is the Trust's bespoke patient survey system. It was developed with a company called Lepidus Ltd in 2007 as one of the first real time patient experience feedback systems in the country. The questions are based on the areas covered in the National Patient Survey Programme and over the years has been developed to keep abreast of the national picture. For example, the Friends and Family Test question was added in 2012 and questions regarding staff treating patients with compassion as a result of the Francis Inquiry recommendations in 2013. Impressions allows feedback not only from patients but also relatives, carers and visitors and on any visit type. Impressions allows feedback from respondents in their own words. Known as verbatim comments, these are sent out on a daily basis to relevant members of staff for action when appropriate.

The suite of surveys can be accessed online (from the Trust's website and QR codes advertised on posters and business cards) as well as paper questionnaires to be found throughout wards and departments.

QR Code

Impressions Results for 2014-2015

Amongst the questions, respondents are asked whether they had a mainly good or mainly bad impression of the Trust and its services. The results for this question for 2014-2015 are shown below:



The Trust is pleased to note that scores were consistently in the 90%+ range. Impressions also asks respondents to feedback in their own words about their experiences and suggestions for improvements. As noted above, these comments/suggestions are sent to relevant members of staff on a daily basis and, where possible/appropriate acted upon to develop services in line with what our patients want.

Patients who left feedback indicated the highest and lowest levels of satisfaction with the following areas of service:

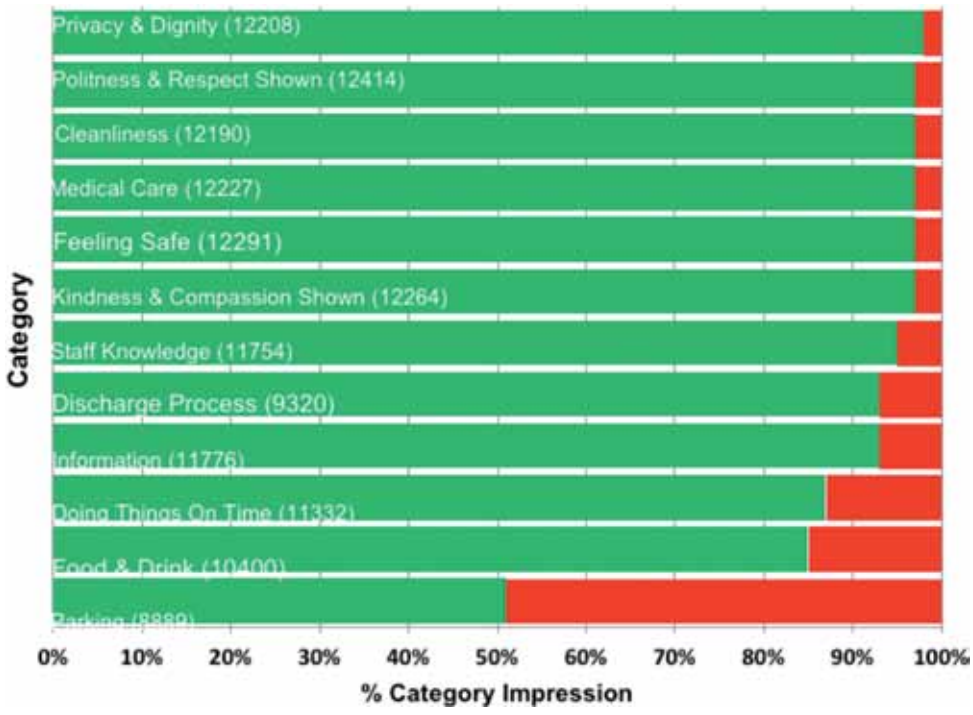
Highest	Lowest
Politeness & Respect Shown	Parking
Feeling Safe	Food & Drink
Privacy & Dignity	Doing things on time

Relatives who left feedback indicated their highest and lowest levels of satisfaction with the following areas of service:

Highest	Lowest
Cleanliness	Parking
Privacy & Dignity	Doing things on time
Kindness & Compassion Shown	Information

Carers who left feedback indicated their highest and lowest levels of satisfaction with the following areas of service:

Highest	Lowest
Food & Drink	Parking
Feeling Safe	Doing things on time
Privacy & Dignity	Staff knowledge



Influencing Factors:

The table on the previous page indicates which areas of service, overall, afforded the highest and lowest levels of satisfaction amongst patients, relatives and carers during 2014-2015.

Actions taken as result of feedback on Impressions are noted in Survey Work – Key Achievements 2014-2015 and Survey Work Further Developments for 2015-2016 below.

Friends and Family Test (FFT)

Background: The Friends and Family Test (FFT) is a national initiative overseen by NHS England. It is an initial single question, which asks patients whether they would recommend the NHS service they have received to friends and family if they need similar care or treatment, plus a supplementary question asking why the patient has responded as they have.

As stated above, the FFT question has been incorporated into the Trust's bespoke patient survey system, Impressions, and has been rolled out across the Trust services to the following timeline.

Inpatients	April 2012
A&E	April 2013
Maternity	October 2013
Outpatients	October 2014
Day Case	October 2014

On its introduction, the FFT was a Net Promoter Score (NPS) question which meant that based on the response category chosen by respondents to the initial FFT question, respondents were classed as promoters, passives or detractors of the service they were feeding back about.

However, patients found this concept confusing and in October 2014, NHS England decided to no longer treat the FFT as an NPS question. From that date, results were to be presented as a percentage of recommenders and non recommenders: patients who respond to the FFT question that they are 'extremely likely' or 'likely' to recommend the service being asked about, are called recommenders. Patients who respond that they are 'neither likely nor unlikely', 'unlikely', 'extremely unlikely' or 'don't know' (if they would recommend the service being asked about), are called non recommenders.

The Trust uses various methods to collect the FFT: paper questionnaires, which are available throughout the wards and departments, text (inpatients, A&E attendees and out-patients which meet the Trust's criteria to receive the FFT text) and online via the Trust's website or QR codes.

FFT Results for 2014-2015

The Trust is pleased to note that during 2014-2015, patients responding to the Friends and Family Test, indicated the highest levels of satisfaction in areas such as staff treating them with kindness and compassion, politeness and respect and the lowest in areas such as parking, doing things on time and food and drink.

National Comparisons for Friends and Family Test

NHS England publishes the results for the FFT for inpatients, A&E and maternity on its website which allows for a national comparision of the data in these areas; the results are also published on NHS Choices. National data isn't available for Outpatients and Day Case also, with regard to Maternity, there is no national data for the response rate for the ante natal and post natal questions (both hospital and community).

How the Trust compares nationally is summarised here. However, further information, including detailed graphs, regarding the national comparison is provided in the Trust's Quality Account, section 3.9.

Inpatients: The Trust is disappointed to note that with the exception of June's response rate, both its response rates and recommender rates fall below the national average.

A&E: The Trust is pleased to note that for 7 months its response rate was higher than the national average and for October virtually the same. However, it is disappointing that with the exception of September, its recommender rate was below.

Maternity: ***Antenatal question:*** the Trust is pleased to note that for 8 months its recommender rate was higher than the national average. ***Birth question:*** the Trust is pleased to note that for 9 months its recommender rate was higher than the national average. However, with the exception of April and October, its response rate was below. ***Postnatal in hospital question:*** the Trust is pleased to note that for 11 months its recommender rate was higher than the national average. ***Postnatal community question:*** the Trust is pleased to note that for 6 months its recommender rate was higher than the national average.

Actions taken as result of feedback on FFT are noted in Survey Work – Key Achievements 2014-2015 and Survey Work Further Developments for 2015-2016 below

National Patient NHS Survey Programme:

Background: The National Patient Survey Programme has been running since 2002 and is a mandatory programme which all Trusts have to take part in. The programme is run by the Picker Institute on behalf of the Care Quality Commission. The surveys overseen by the Trust's Patient Experience Team are shown below. Guidance stipulates that surveys can either be carried out in house or by using one of 5 approved contractors recommended by the CQC.

The Trust commissions Quality Health Ltd to carry out the surveys on its behalf. The methodology for all the surveys is essentially the same with 850 patients being sent a questionnaire by post with reminders being sent out. However, it has been agreed that this sample size will increase for the 2015-2016 inpatient survey.

Quality Health Ltd provides the Trust with its results for each survey via 3 separate reports:

- top line results (containing raw figures for the current and previous year's survey);
- management report (containing full statistical analysis including trends and recommendations);
- comments report (containing all the verbatim comments given by respondents).

The CQC provides the Trust with a benchmark report which compares how the Trust has fared nationally by indicating, for each question, whether the Trust scored 'about the same', 'better' or 'worse' when compared with all other Trusts in the country.

National Survey Results 2014-2015:

During 2014-2015, two national patient surveys were undertaken: the annual Inpatient Survey and the Accident and Emergency Department Survey. Whilst the Trust is pleased to note an improvement in the scores in a large number of the questions asked in the A&E Survey, the results of its Inpatient Survey are mixed.

Surveys overseen by the Patient Experience Team:

Survey Type	Frequency
Inpatients	Annual
Outpatients	Every 2 or 3 years
A&E	Every 2 or 3 years
Maternity Services	Every 2 or 3 years
Paediatrics	Run for the first time in 2015-2016

Also, in 2014-2015, in a departure from drawing up action plans to address the issues highlighted in the surveys, the Patient Experience Team carried out an exercise whereby it examined the results of both surveys and linked them to various improvement initiatives already taking place at the Trust and in particular to its organisational development programme, Together Towards World Class, which was launched in March 2014.

National Comparisons for Surveys Undertaken as Part of NHS Survey Programme:

The CQC benchmark reports for the Inpatient and A&E surveys indicate the following:

Inpatient Survey: the Trust scored worse in 3 questions compared to most other trusts: information giving whilst in A&E, being asked for their views on service, information giving about making a complaint. The Trust scored better in 1 question when compared to most other trusts in 1 question: explanation of risks and benefits of an operation. In all other questions, it scored about the same.

A&E Survey: the Trust scored better in 1 question, relating to information giving in A&E when leaving the department, than other trusts. In all other questions, it scored about the same.

Analysis of **all** the surveys undertaken during 2014-2015 allows the Trust to conclude:

Patient, relative and carer satisfaction levels remain high particularly with staff treating patients with politeness and respecting their privacy and dignity. The Trust is particularly pleased that patients report feeling safe in its care.

There continues to be high levels of dissatisfaction with parking. The Trust also notes a level of dissatisfaction with timeliness and food and drink.

Actions taken as result of feedback from surveys undertaken as part of the NHS Survey Programme are noted in section Survey Work – Key Achievements 2014-2015 and Survey Work Further Developments for 2015-2016 below.

Survey Work- Key Achievements 2014 – 2015

- The Trust achieved the Commissioning for Quality and Innovation (CQUIN) target for the Friends and Family Test; (the CQUIN payment framework enables commissioners to reward excellence, by linking some of the providers' income, to performance against improvement targets).
- The Patient Experience Team worked with the Trust's Organisational Development Team to identify any correlation between good/bad patient and staff experience based on the patient and staff FFT results respectively. Essentially the results were inconclusive due to the low response rates in some of the FFT staff and or/patient FFT results. It was agreed that the two teams should repeat the exercise to try to establish [any correlation] in order that appropriate action can be taken;
- A bespoke paediatric survey was designed for inclusion on the Trust's patient survey system, Impressions. The survey was designed for online completion via the Trust's website and QR code as well as paper questionnaires being available for those who prefer to give their feedback this way. The online and paper questionnaires feature cartoon characters which were designed by Trust staff and selected by paediatric patients [for inclusion in the survey] through a competition which was held in Autumn 2014. The overall questionnaire was designed with the paediatric specialty.

Timmy the Turtle

Sookie the Starfish

Fonzie the Fish

- An online survey centre was designed for the Trust's website which enables quicker access to the suite of Impressions' questionnaires at one click;

- In response to the falling satisfaction levels with food and drink, particularly indicated by results from the FFT and Impressions, ISS (the company who provide catering, portering and cleaning services to the Trust) and the Trust have carried out a review of the patient menus. From this review, actions were taken which include the introduction of greater meal/snack choice at lunch time and the implementation of a seven day menu cycle for lunch time. The new menus went live in April 2015.
- In response to the continuing poor satisfaction levels with parking and access to University Hospital, on site developments (led by the Estates Department) have now begun which have included: the move of the taxi rank from outside the main entrance to the Clinical Sciences Building (CSB) entrance to enable the expansion of a drop off zone, redesign of identified off site pinchpoints including the roundabout at the junction of the Ansty Road/ Hinckley Road/Clifford Bridge Road.

Survey Work – Further Developments for 2015-2016

- The Trust has set internal targets for both the FFT response rate and recommender rate above the national averages noted above. To support this target increase in both recommender and response rates, the following developments are planned:
  - The piloting of reports at both Specialty and Ward level which will include pertinent data from the Quality Department to bring about improvements in patient experience.
  - Joint working with the Nursing and Patient Experience Teams to raise awareness of the new targets for the FFT as well as the reports noted in the bullet above.
  - Launch of paediatric survey on 1st April 2015;
  - The design of a bespoke neonatal survey for inclusion on the Trust's patient survey system, Impressions ready for go live in June 2015. As with all Impressions' surveys access will be online via the Trust's website and QR code and paper questionnaires being made available. The survey was designed with the neonatal specialty.
  - Consideration of development work to make FFT accessible to all patient groups in line with national guidance.

PATIENT ADVISOR TEAM (PAT)

Background: During 2014-2015, the Trust piloted a Patient Advisors' Team made up of the lay, former members of Patients' Council. The latter, having given valuable insight into patient experience since 2002, had become somewhat tired and members felt it was time for a different method of working and, as a consequence, it was agreed to pilot a different method of engagement based on a model used at University Hospital Leicester.

PAT during 2014-2015 and Further Developments in 2015-2016: Overall, this new model, which saw members working at both Specialty and Trust level, was not entirely successful. An evaluation was carried out at the end of the pilot and the decision was taken to halt the monthly meetings but for members to continue to work at Specialty level. In the meantime, the Patient Experience Team are to research a new model for a patients' forum at the Trust. However, this research will begin following the findings of the CQC Inspection as [the results] may have a bearing on any new model.

OTHER ACTIVITIES BY THE PATIENT EXPERIENCE TEAM IN 2014-2015:

In the following section is listed some of the other key activities carried out by the Patient Experience Team during 2014-2015:

We Are Listening Campaign

Background: The We Are Listening Campaign was devised in 2013 as part of the Trust's response to Francis. The Campaign's aim has been twofold: to make our patients, relatives and carers aware of the various mechanisms available to them to feedback on their experiences and to increase the amount of feedback we receive. This is in line with the organisational vision to become a national and international leader in healthcare, and Together towards a World Class Patient Experience.

Achievements in 2014-2015:

- The original poster for this campaign which was placed along the corridors, behind Perspex frames has been updated. The posters still include the same members of staff as before but they have been updated with the new Patient Information logo and new text describing how people can feedback to the Trust.
- Whilst updating the original campaign poster, new posters were also designed which display 'You Said, We Did' initiatives that have been implemented to improve the patient experience at the Trust. These new posters were displayed in preparation for the Trust's recent CQC visit and the Patient Experience Team also recognise that it is important for patients, visitors and carers to know their feedback can make a difference and has a positive impact on the hospital experience. The new design follows a similar format as the original but on the new design the staff members are brought to the forefront of the campaign poster and in the placards they are holding 'You Said, We Did' initiatives are clearly displayed. These campaign posters have been strategically displayed along the corridors and will be updated later in 2015 with more 'You Said, We Did' initiatives from around the Trust.

Further Developments in 2015-2016

Various activities are planned which include the following:

- Production of "I am the Patient Experience" video to highlight the messages of the I am the Patient Experience Initiative (see below for further details);
- Executives to 'man' the listening booth at various locations of the Trust;
- Promotional messages by the Patient Experience Team through Hospital Radio.

Patient Experience Week

The Patient Experience Team organised the Trust's first Patient Experience Week during 9th – 13th February 2015. Various activities were organised which included:

- Launch of 'I am the Patient Experience' Initiative – developed by the Beryl Institute, an American organisation set up initially by Beryl Health in 2006, the initiative reminded staff that whether they are a doctor, nurse, porter, accountant, Chief Executive or secretary, they all contribute to patient experience at the Trust;
- Street Interviews were held in Rugby town centre asking passersby about their experiences at the Trust;
- Healthwatch Coventry and Healthwatch Warwickshire were invited to have stands in the main reception at University Hospital and the Outpatient Department at the Hospital of St Cross and interviewed patients and staff about their experiences;
- Patient Experience Volunteers visited wards and departments to interview patients using the FFT questionnaires;
- Delivering Excellence Workshops, sponsored by NHS Midlands and East, were held for staff which gave an overview of key tools staff can use to improve patient experience.

Patient Experience Week 2015-2016:

The next Patient Experience Week is planned for February 2016.

You Said, We Did in 2014-2015

Background: To demonstrate the Trust is acting on the feedback it receives, the Patient Experience Team has introduced twice yearly monitoring of the actions taken [as a result of feedback] with Wards and Departments. Below is just an example of some of the changes implemented as result of feedback.

Changes as a result of feedback in 2014-2015:

A&E waiting times: Every 30 minutes, the reception team talk to the nurse co-ordinator to understand the position of the department. The waiting time is then updated in accordance with the information received. *Source – FFT*

Refreshments: A vending machine has been installed in the Labour Ward waiting area. *Source – FFT*

Signage: Clearer signage has now been installed for the Ophthalmology Department in Outpatients, to help direct patients who are visually impaired. Source- Patient Advisors Team.

Joint Working between Patient Experience Team & Nursing Team: During 2014 – 2015, the Patient Experience and Nursing Teams joined forces to produce some pertinent patient information. To date, the joint working has involved:

- New posters have been placed outside every ward detailing information about the ward manager, contact details, specialties treated as well as generic information about the Trust.
- Looking After You Boards have been placed on the wards. The Boards contain information about safety, staffing levels as well as information about patient experience;
- Place mats have been introduced on wards, predominantly for use during meal times they include information on ward routines, infection prevention measures, uniforms, protected meal times and how to feedback etc.

Further Developments for 2015 – 2016:

The Patient Experience Team will continue to collect data from all areas of the Trust twice a year (November and May) demonstrating what actions have been taken as result of patient, relative, carer feedback. This exercise, as previously, will inform a revision to the You Said/We Did posters which were put up around the Trust in February 2015.

Patient Story Programme to Trust Board

Background: The Patient Story Programme to Trust Board has been running at the Trust since 2011. This programme is presented at either private or public Trust Board. These stories are presented in a variety of formats including video, in person, 'show and tell' style or written to make them as interactive as possible. The programme gives patients, carers, relatives and staff the opportunity to discuss their hospital experiences be they positive or negative. The Patient Story is a standing agenda item which shows the Trust's commitment in always wanting to learn how the patient experience can be enhanced and improved for our patients.

Patient Story Programme 2014-2015:

The following formed part of the Patient Story Programme during 2014-2015:

- Personal appearance by a relative of a patient
- Personal appearance by a patient with learning disabilities
- Letter about a birth experience in Lucina Birth Unit
- Letter of complaint

Patient Story Programme for 2015-2016:

The Patient Story Programme for 2015/16 has been agreed by the Trust's Chief Medical & Quality Officer, Professor Meghana Pandit, and the Patient Experience and Engagement Committee. The stories and themes which make up the programme for the following year include:

- Healing Arts Update
- Complainant story
- You Said, We Did update
- Equality and Diversity initiative
- Patient Experience video
- Feedback from a patient who has benefited from the Trust's Da Vinci Robot
- Patient Story about their perspective of the Trust's discharge process
- Carers' Pass Pilot
- Feedback from Activity Co-Ordinators

Patient Experience Diaries

Background: The Patient Experience Diary is a simple tool to enable patients, their relatives and carers to keep a 'diary' of any questions and/or reflections they may have about their care and treatment at UHCW. It includes information about the Trust's 'Getting Emergency Care Right' (GECR) campaign and empowers patients to 'check and challenge' their healthcare team.

The diary is currently being piloted on wards 1, 23 and 52 at University Hospital and Cedar Ward at the Hospital of St Cross. The main aim of this diary is to empower patients with the GECR campaign questions so that both they and their relatives can feel more involved in healthcare decisions.

Measures of success for this pilot are:

- Use of and return of the diaries by patients' increases.
- Staff are engaged in the pilot.
- Compliments, feedback and good practice are highlighted on the new Patient Safety and Information boards.

Ward staff on the pilot wards have been briefed about the purpose of this diary; however there has been some resistance to handing them out. Patient Experience Volunteers have been recruited to speak to patients and relatives on the pilot areas to encourage the purpose and use of them. The Patient Experience Team is also working in partnership with the Pharmacy Team who have agreed to trial this diary to test if this feedback tool can be beneficial and help them improve communication with patients' about their medication.

Patient Experience Team – Further General Developments for 2015-2016

During 2015-2016, the Patient Experience Team look forward to continuing with implementing further service improvements as noted above along with the following:

Always Events: developed by the National Quality Forum, an American not for profit organisation which aims to improve quality of health care in the United States, the Trust will implement Always Events. Concentrating on elements of the patient experience that healthcare providers should always get right, Always Events are of paramount importance [to patients, relatives and carers]. This initiative will also complement the Trust's Sign up to Safety campaign; please see page 69 for further details.

Health Information Centre: there is to be a service review which will include amongst others, the introduction of a satellite Health Information Centre, the implementation of information prescriptions and an expansion of the service at the Hospital of St Cross.

It's the Little Things: working with the Trust's Arts Co-ordinator and the Voluntary Services Department, the Patient Experience Team will introduce a series of patient experience improvement services. Amongst others under consideration is the introduction of hair and beauty treatments at the bedside;

Training: – expand the knowledge of ways and means to improve patient experience amongst staff by working with TMI, a management consultancy well known in service- based culture change, and a company the Trust has worked with in 2013 and 2015;

Complaints

INTRODUCTION TO COMPLAINTS

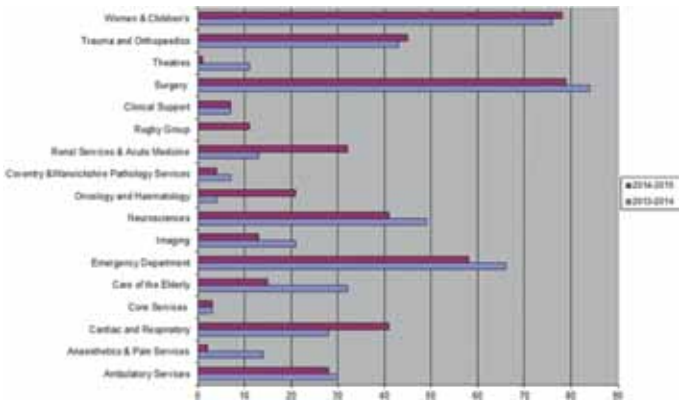
This section provides an overview of patient complaints formally registered by UHCW between April 2014 and March 2015. It includes numbers, our performance in replying and, information on the cases requested by the Parliamentary and Health Service Ombudsman (PHSO) which is the second stage in the NHS Complaints Procedure. UHCW works in accordance with the NHS Complaints Regulations 2009 and operates an established centralised Complaints Service that works within that statutory document and which has been in place since 2003. This ensures a fair and consistent approach to complaints but also, a direct point of contact for the complainants and the local Independent Complaints and Advocacy Services (ICAS). The Complaints Service links in appropriately with PALS, Patient and Public Involvement and Quality and Patient Safety to ensure as a Trust we properly capture patient experience.

TOTAL NUMBER OF COMPLAINTS 2012/13 2013/14 2014/15

This graph compares complaint activity over the past 2 financial years with the blue line showing activity in 2013/2014 and the magenta line showing activity in 2014.2015.

COMPLAINTS BY SPECIALITY 2014 & 2015

The bar chart below describes the complaint activity by Speciality. The top three greatest numbers of complaints received within the Specialties came from Surgery, Women and Children's and the Emergency Department. Within these Specialties there was a reduction in the number of complaints received.



THE RESPONSE RATE PERCENTAGE BY SPECIALTY GROUP AS AT 1ST MAY 2015

The table below demonstrates the performance of the Speciality Groups against the 25 day response rate standard. The percentage achieved is set out in the final column. Within that time frame some responses may not have reached their deadline for response and this figure is shown in brackets. These figures will be updated for the end of Quarter 1.

TRENDS IN COMPLAINTS ACTIVITY

The greatest number of complaints received in the period 2013 – 2015 related to:

- Womens and Children's
- Surgery and
- Emergency Department

The most frequent used descriptors for the nature of the complaint were:

- Diagnosis
- Discharge
- Pain relief
- To Take Outs (TTOs) and Medication
- Post-Operative issues

The least number of complaints were received by

- Theatres.
- Anaesthetics and Pain Service, yet pain relief features as one of the most frequent triggers for a complaint.
- Core Services.

Activity reporting

The month with least complaint activity was June in 2013- 2014 and January in 2014-2015. The month with the greatest activity in 2013- 2014 was March and in 2014 and 2015 was July. Therefore, there does not appear to be a correlation between time of year and the number of complaints received.

Response within 25 Working Days by Specialty Group	Received	% replied to within 25 W/D
Ambulatory Services	28	50% (2 outstanding in time)
Anaesthetics & Pain Services	2	0%
Cardiac & Respiratory	41	41% (1 outstanding in time)
Core Services Division	3	100%
Care of the Elderly	15	62% (1 outstanding in time)
Emergency Department	58	50% (2 outstanding in time)
Imaging	13	85%
Neurosciences	41	61% (2 outstanding in time)
Oncology & Haematology	21	57%
C&W Pathology Services	4	75%
Renal Services & Acute Medicine	32	34% (2 outstanding in time)
Rugby Group	11	55%
Clinical Support	7	71% (1 outstanding in time)
Surgery	79	43% (5 outstanding in time)
Theatres	1	0%
Trauma & Orthopaedics	45	67% (2 outstanding in time)
Women & Children's	78	44% (14 outstanding in time)
Totals:	479	

Examples of Complaints and Actions		
ID	**Main Issue of Complaint**	**Action**
5756	Patient's operation cancelled on the day due to previous procedure overrunning and not enough theatre staff available.	Patient reassured procedures only cancelled as a last resort and management did seek support in additional theatre staff but to no avail. Advised that the Surgery Group are working with the Theatre Group towards Urology having extended operating days which is planned to commence in April 2015, subject to recruitment and staff rotas being changed.
5471	Patient and mother attempted to contact ward on morning of planned surgery as per admission letter, to check bed status but there was no answer, despite trying different extension numbers, so attended the ward as planned.	Group Manager has requested sentence asking patient to call ward at 7.00am to be removed from the admission letter, as the ward staff are most likely unable to confirm whether the procedure will be going ahead due to the continually changing bed status.
5512	Nursing staff had difficulty in obtaining patient's blood pressure so attached blood pressure cuff to calf. Patient developed a blister on the part of the leg where the cuff was attached and other issues to the leg arose from this.	Staff reminded to undertake a risk assessment on all patients who are presenting with existing wounds and are receiving treatment for these. Also reminded to take steps to be more proactive and liaise closely with multi-disciplinary teams.
5289	On discharge patient's TTOs (take home medication) were not ready so was asked to ring the ward the following morning. The next day advised that the doctor had not actually written the prescription and when eventually completed at 4.00pm, there was then a problem with the medication. TTO's eventually ready at 11.30pm the day after patient's discharge.	Ward Manager highlighted problems to Clinical Lead as patients should have a clear discharge pathway. Clinical Lead subsequently confirmed that the Neurosurgery Senior House Officer's (SHO) have been reminded that prescriptions for discharge need to be completed as early as possible, preferably in the morning.

Examples of Informal Contacts	
Concern	**Outcome**
Patient expressed concern regarding his cancelled surgery, expressing his desire that his aim was to achieve an immovable, assured and imminent date for his surgery.	After further liaison with the Group Manager for Surgery, patient was offered a date for 27 February 2015.
Concern regarding early discharge of patient from AMU 1 without informing family members.	It was evident from the investigation staff have a window of opportunity of 4 hours prior to the ambulance collecting the patient from the ward which would have given staff ample opportunity to contact the family. The Ward Manager has apologised and we have detailed specific actions in the letter she intends to disseminate to ward staff to prevent a recurrence in the future.

Examples of Informal Contacts (Continued)	
Concern	**Outcome**
Concerns regarding continuity of care at the respiratory clinic and confusion as to which Consultant the patient was under.	It was apparent this patient had been under a Consultant who had since left the Trust. As a result, she was placed back on the original Consultant's list and an appointment was arranged for her the next week on Monday 30 March at the respiratory clinic.
Whilst visiting a friend on Ward 2, enquirer stayed whilst the patient had a lumbar puncture. However, she felt dizzy whilst in the room and left to sit on a chair by the nursing station, asking if she could have a bowl as she felt sick. A staff member had directed her to the bathroom and did not appear to know where to access a sick bowl. As a result the patient was sick and she stated she was left for several minutes before anyone came to her assistance. Patient is upset that a member of staff failed to show any concern for a visitor who was poorly and did not offer to take her to the bathroom.	Referred concerns directly to the Ward Manager who was aware of this patient's concerns. She advised the patient came out of the room but the member of staff she spoke with was an agency member of staff and was unsure where to access the sick bowl as the ward only had a limited supply on that day. The Ward Manager felt staff did all possible to support this lady and apologies were offered if she felt staff were insensitive towards her.
Concerns regarding partner's stay on Ward 25. It was noted the side room had not been cleaned appropriately for 4 days after patient's C section and this only happened when the concern was raised with the midwife. The patient's daughter was to receive 12 hour IV injections and the mother was asked to remind staff when this was due to take place. Patient's partner also witnessed 2 nurses giving his daughter an injection from the day before because it had not been signed off appropriately. He felt staff left his partner to cope with no offer of assistance. Lastly when his partner was discharged she was given 7 injections to be administered by herself and when checked by the community midwife she only required 4. Overall, he felt the level of care was unacceptable.	We advised the Ward Manager who welcomed this feedback and would discuss all issues with staff concerned. We added she was very disappointed and saddened his family did not have the experience they were expecting and she would value the opportunity to discuss this further. I explained I was happy to provide further contact details for the Ward Manager if they wish to speak with her further regarding this matter.
Concerns regarding the attitude of a member of staff in the Dietetic Department. Patient expressed the wish to raise a formal complaint but when he was asked to put this in writing he declined stating he could not do so because of his disability. It was agreed we would take his concerns over the telephone and we would respond to the patient verbally with the outcome. The patient did mention that he gets very frustrated and this may appear at times as aggressive which he stated was not his intention.	Contacted the Dietetic Manager who advised she was aware of the situation on the day of the appointment as the Dietician had been extremely upset about this patient's behaviour so much so it had been reported as an untoward incident. The Dietetic Manager agreed to contact the patient, and it was apparent the patient's main concern was he wanted to be weighed and this can only be carried out on certain scales due to his use of a wheelchair. She has since made arrangements for the patient to attend the clinic for weight check only and the patient was happy with the outcome.

FURTHER DEVELOPMENTS IN 2015-2016

Complaints Service Moving Forward 2015/16 will demonstrate:

- Increased engagement with internal stakeholders.
- Increased engagement with external stakeholders.
- Greater staff awareness of the role of the Complaints Department by using the Market Place induction event.
- Improved local resolution response rates.
- Decreased requests for further local resolution.
- Improved communication links with the PALS.

Chief Medical and Quality Officer, Meghana Pandit was made a Professor of Practice at the University of Warwick in March 2015. Professor Meghana Pandit, who is also Deputy Chief Executive Officer at the Trust, has taken up a new professorial teaching fellow role at the University of Warwick's Warwick Manufacturing Group (WMG), working in its Institute of Digital Healthcare (IDH).

Patient Advice and Liaison Service (PALS)

INTRODUCTION TO PALS

The PALS is an independent and confidential advice and support service for patients and their relatives/ friends. It offers the opportunity to raise concerns enabling appropriate intervention at an early stage, the contacts received through PALS can assist the Trust in improving patient experience.

Over the past few months there have been significant changes within the PALS which has seen the service now operate with three members of staff. The PALS office is located in the main reception area and provides easy access to patients and visitors and the service supports all areas of the Trust. Data suggests that UHCW received 1790 PALS enquiries for 2014-2015 with the majority contacting the service with enquiries about initial referral and waiting times as well as patients questioning why they have not received routine/review appointments and cancellation of out-patient appointments. PALS also received a number of requests for information covering a wide range of issues from general services available including how to access support and for assistance with aspects of present care. The category of information is in the main a range of low level requests and this includes signposting requests from relatives and carers to respective wards. PALS are continuing to engage with staff at all levels to develop a systematic approach to pass on information to service users in a timely fashion.

FURTHER DEVELOPMENTS IN 2015-2016

The PALS Service Moving Forward 2015/16 will demonstrate:

- Increased engagement with internal stakeholders.
- Increased engagement with external stakeholders.
- Greater staff awareness of the role of the PALS by using the Market Place induction event.
- Improved closure of the enquiry within five working days.
- Improved communication links with the Complaints Department.

Examples of PALS Contacts

Concern	Outcome
Patient's Father advised that his son, who has learning difficulties, was awaiting an MRI scan and had two failed appointments, the first where they chose to leave as there was a 2 hour wait as there was only one scanner available and the second when they arrived late due to heavy traffic.	The matter was referred directly to the x-ray department and a member of the team contacted the patient's son to arrange a further appointment.
Patient was admitted to Ophthalmology Day Unit, however, prior to discharge details regarding the incorrect eye was circled on the discharge letter. Family were aware of the error so no eye drops were administered incorrectly, however, they wished to draw the matter to our attention.	Sister from the Surgical Day Unit contacted patient's son and daughter-in law to apologise for the stress and any potential risk to injury. She advised the family the Trust were taking the matter seriously and the member of staff had been informed to ensure full awareness had been raised. The family were further advised the Unit would look at changing their procedures as a result. Family were happy with the explanation offered and reassured their concerns had been taken seriously.
Daughter contacted feedback to advise that her mother was awaiting a pre-op appointment prior to surgery and despite a number of attempts by the daughter to ascertain a date she had been unsuccessful.	Contacted staff in the pre-op department and an appointment was subsequently arranged. Daughter was happy with the outcome.
Concerns regarding problems with a dislocated finger and lack of continuity between referral to fracture clinic and physiotherapy.	Arranged for the patient to receive a telephone call from the consultant and she was happy with the outcome.

Health Information Centre

INTRODUCTION TO HEALTH INFORMATION CENTRE

Background: UHCW's Health Information Centre (HIC) aims to support the Trust's commitment to the national policies of informed consent, shared decision making and patient choice, as imbedded in the current NHS Constitution (March 2013) and for the requirements of CQC. It also aims to provide quality standards in the timely provision of health information, meeting the needs of all patients, visitors and staff in accordance with the Trust's priority of delivering safe, high quality, evidence based care.

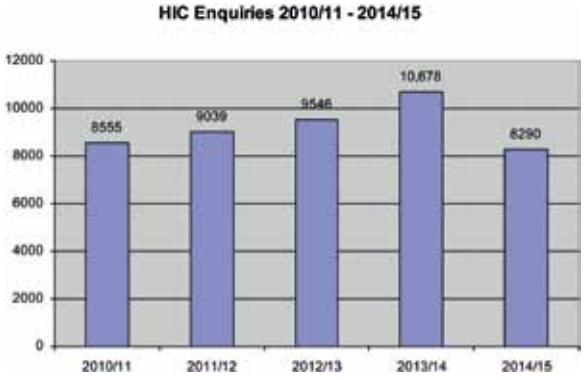
The Health Information Centre services are free and confidential and available to all patients, carers, visitors and staff.

The Centre provides access to a comprehensive range of reliable information on health conditions, treatments and procedures as well as information on all NHS services such as hospital services, GPs and dentists, healthy lifestyles, current health issues, travel insurance, vaccinations, local and national support groups and many other health related issues. The Centre is also a gateway to sources on information on benefits, support, social care, community care, equipment suppliers and other issues that patients and carers may suddenly have to face following a hospital stay or serious diagnosis.

As the Trust is a regional centre for many specialities, including a Regional Trauma Centre, the Health Information Centre is an important resource to meet the needs of patients and relatives/carers who are brought to our hospital from outside the local area. This may include information relating to local accommodation, transport, local services, online access, as well as health related information to their trauma or condition.

The Health Information Centre staff also administer the Trust's written patient information approval process, which ensures that all patient information written by staff on conditions, procedures and services is produced to national standards. Once approved this information is made available.

HEALTH INFORMATION STATISTICS 2014-2015



Displays 2014-2015

Total number of displays in 2014/15 – 39

Displays enable the Health Information Centre to showcase local and national support groups, Trust Specialty services and a wide range of health related topics, as well as promoting the Centre's services.

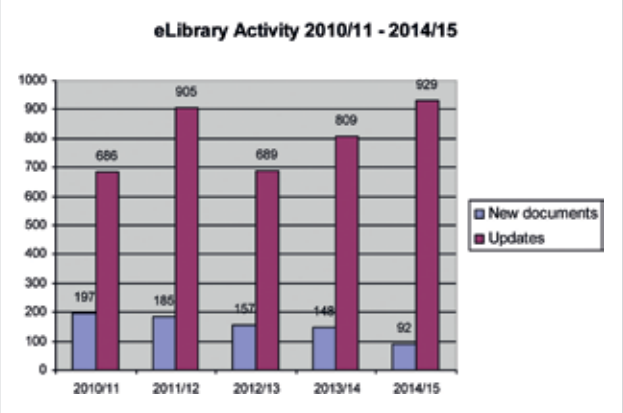
Examples of displays which were well received this year are: Parkinson's, Sun Awareness, Alzheimer's, Epilepsy, Dietitian's Week, Falls Awareness, Smoking Cessation, Lupus, and Alcohol Awareness.

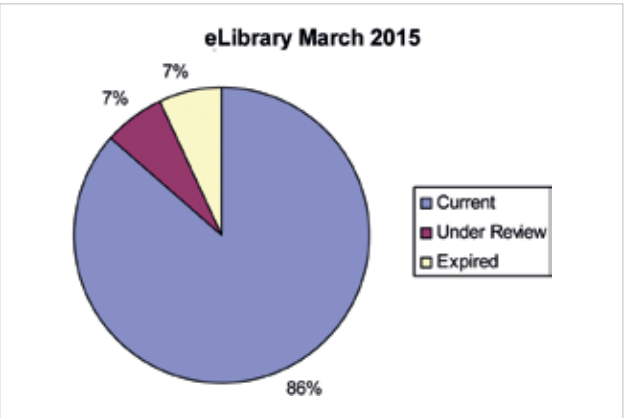
e-Library Statistics 2014-2015

e-Library is the Trust's document management system (DMS) which stores and manages all Trust approved corporate and clinical documents. There are more than 2000 Patient Information documents and web links on e-Library which are available to all staff to access on behalf of their patients. The Health Information Centre staff administers the Trust's patient information approval process and the patient information directory of e-Library and works hard to ensure that documents are approved, reviewed, and updated in a timely way.

During March 2015, an audit of the patient information e-Library indicated 86% were current which is slightly lower than our 90% target: the target was missed due to staffing levels within the Health Information Centre.

e-Library patient information activity April 2014 – March 2015





HEALTH INFORMATION CENTRE ACHIEVEMENTS 2014-2015

The Health Information Service has achieved the following this year:

- Managed the Trust's Health Information.
- Administered the Patient Information Approval Process.
- Contributed and supported preparation for the CQC visit.
- Produced and distributed a set of 12 core patient information leaflets to all areas across the both hospital sites.
- Designed a patient information logo to be used on patient information going forward to demonstrate that whatever media the logo appears on, [it] meets the Trust's standard for patient information.
- Supported a number of departments to enable them to meet their national standards relating to patient information.
- Ensured Trust patient information was maintained to national and local patient information standards.
- Permanent fixture of the Trust's newly implemented Induction 'Market Place.' This has helped promote the service and health information provision to new starters.
- Review of Health Information Centre Service 2014-2015: In October 2014 a review of the Health Information Centre (HIC) was conducted by the newly appointed Patient Experience Manager to ascertain the current level of service being provided to staff and patients with regards to health and patient information.

  105 members of the public (including patients, relatives, carers and community groups) and UHCW NHS Trust staff answered a questionnaire as part of this review. This survey included questions to determine people's awareness of the Health Information Centre, their thoughts of the service they received and how they would like to receive health information and any recommendations they may have to improve the service. 58 patients and 47 members of staff completed the questionnaire about the HIC.

Newly designed patient information logo

Findings from the review survey found that 69% of patients and 43% of staff members who completed the questionnaire did not know about the HIC and the services it provides. However, once the services the HIC provides was explained to the participants of the survey, 95% of staff and 77% of patients said they would definitely use this service.

It should be noted that the majority of staff who took part in the review survey of the HIC and had used its services did praise the centre's team for the standard of information they helped produce for patients. Feedback from members of the public who took part in the survey also supported this opinion and they too praised the team for the professional help that was provided to them.

As evident from findings from the patient and staff survey, promotion and marketing of the HIC needs to be implemented and the Health Information Team recognise this however, the team has maintained the centre and the patient information provision to high standards even whilst carrying a vacancy and sickness within team. The team have also embraced and accommodated the Macmillan Information Service into the centre on a temporary basis.

Changes to the main reception area at University Hospital which has an impact on the centre make it challenging to plan for the future but the team is committed to maintaining patient information standards and achieving the objectives below.

FURTHER DEVELOPMENTS FOR 2015-2016

- Administer the Patient Information Approval Process.
- Hold a Health Information Innovation Workshop with different staff members to agree the Health Information Strategy (this will be aligned to TTWC work streams) for 15/16 onwards.
- Develop and design a pilot to trial a patient information prescription service with a chosen specialty i.e. Cardiology.
- Continue work of core leaflets in ward and clinic areas.
- Deliver e-Library training to Ward Clerks and HCAs.
- Raise profile of the Health Information service and information available on e-Library to staff.
- Increase presence at the Hospital of St Cross.
- Will contribute to an enhanced patient experience and health information.
- Work in partnership with the Pharmacy Team to improve information and communication for patients about their medication.

CLINICAL EVIDENCE BASED INFORMATION SERVICE (CEBIS)

Provided by Library & Knowledge Services, **CEBIS** is a unique value-added service that facilitates the implementation of research knowledge within the Trust.

CEBIS Information Specialists carry out comprehensive searches of multiple international databases, produce evidence summaries and provide access to full text papers upon which Clinicians are able to make evidence based decisions regarding patient care or service development. This is supported by an in-house ICT system which provides seamless, secure access to all documents, discussion forums and papers. Clinicians are also able to make CEBIS referrals directly through individual patient records which demonstrates evidence based practice at the point of care.

CEBIS has maintained interest at a national level with conference presentations to the Chartered Institute of Library & Information Professionals (CILIP) Health Libraries Group, North West Health Librarian Network and the Scottish Health Information Network.

The production of a CEBIS video with patient involvement has been a successful tool for demonstrating the service internally and externally.

This year 540 referrals have been made to CEBIS, 65 of which were via CRRS, our patient management system.

The majority of referrals continue to be complex and in areas where research evidence is poor. Evidence in Practice Groups (EPGs) are now embedded in several Specialties.

The aim of EPGs is to review, discuss and draw conclusions from the evidence located. This can result in a change in practice, confirm best practice, demonstrate the need for a guideline, audit, patient information or research. Several recent referrals have resulted in case report publications and conference paper/poster presentations, ensuring external access to knowledge acquired in the Trust.

In August 2014 CEBIS launched an online survey to capture service outcomes. Staff rated their overall experience of the service as 9.5 out of 10.

For further information, please refer to the Library & Knowledge Services – Annual Report 2014-2015.

Using CEBIS on this occasion:	
Provided new knowledge to me	77%
Provided new knowledge to my Specialty/Department	70%
Resulted in a better informed clinical decision	46%
Resulted in a better informed patient consultation	44%
Resulted in the development/revision of a guideline/pathway	16%
Resulted in the development/revision of a clinical service	9%
Resulted in a research proposal	7%
Resulted in a conference paper/poster submission	11%
Confirmed limited research evidence available in this area	18%
Confirmed current practice is best practice	21%
Saved time	37%
How did CEBIS change patient care as a result of the information given on this occasion?	
Advice given to patient or family	38%
Treatment (medication, therapy or procedure)	46%
Did you handle this situation differently as a result of the information CEBIS gave you?	
Definitely yes	34%
Probably yes	43%
What adverse events did using CEBIS avoid on this occasion?	
Patient misunderstanding of disease or treatment	25%
Additional testing or procedures	7%
Misdiagnosis	5%
Patient morbidity	4%

SECTION 6

Safety and Risk Management

"#NHSSuperSunday Fantastic care from @nhsuhcw team this week for a friend's daughter. Looking after her AND her family really well. Thank you!"

Introduction to Safety and Risk Management

The NHS Outcomes Framework Domain 5 focuses on 'Treating and caring for people in a safe environment and protecting them from avoidable harm'.

Don Berwick's report "*A Promise to Learn, A Commitment to Act*" clearly expects NHS organisations to "*Place the quality of patient care, especially patient safety, above all other aims*".

The activities and results outlined in this section demonstrate how the Safety and Risk Management Team has contributed to the Trust's Quality strategy through its systems and processes for managing incidents, risks, safety alerts, corporate business records and medical revalidation.

The Safety and Risk Management Team provides expertise and support to our clinical specialties to facilitate the monitoring and improvement of safety for all users of UHCW, including our patients, visitors and staff.

This is accomplished through a range of approaches:

- Incident management training, awareness and support to all staff.
- Support and facilitation to staff conducting incident investigations.
- Risk assessment and risk management training, awareness and support to all relevant staff.
- Support and facilitation to staff who are required to produce corporate business documents such as strategies, policies and procedures.
- Facilitation of the Corporate Business Records Committee.
- Facilitation of medical appraisal and revalidation.
- Facilitation of gap analyses of patient safety alerts.

Patient safety summary reports are provided to the Patient Safety Committee, the Risk Committee and the Quality Governance Committee monthly and Health & Safety reports are provided to the Health & Safety Committee quarterly. Medical revalidation reports are provided to the Trust Board quarterly.

Specialty level reports are also provided to the specialties for discussion at their monthly Quality Improvement & Patient Safety (QIPS) meetings, alongside other Quality data and information, enabling the Quality Department and the individual specialties to triangulate data to generate learning and to indicate any areas requiring attention.

Patient Safety – Sign up to Safety

The Trust joined the "**Sign up to Safety**" campaign which was launched in June 2014 by the Secretary of State for Health "*to make the NHS the safest healthcare system in the world, building on the recommendations of the Berwick Advisory Group.*"

The national campaign sets out a 3-year shared objective to save 6,000 lives and halve avoidable harm to patients.

The campaign is focused around developing a safety improvement plan in the following 5 key areas:

- Put safety first
- Continually learn
- Honesty
- Collaborate
- Support

The Trust has submitted its pledges to the national campaign (details of these are in appendix 1). The Safety and Risk Management Team will monitor the Trust's progress with the campaign, specifically focusing on five key themes that the Trust's Chief Officers selected:

1. Clinical handover
2. Sepsis/deteriorating patient
3. Getting Emergency Care right
4. Right staff, right place
5. Learning/Feedback/Always events

Successful bid to the NHS Litigation Authority

We were also delighted to hear that UHCW was successful in its bid for funding of £245,329 from the NHS Litigation Authority (NHSLA) in relation to the "Sign up to Safety" campaign. The Trust was one of only 67 successful bids out of 243 bids received by the NHSLA.

Our bid is related to Human Factors education (particularly relating to never events). Human factors (HF) can be defined as those factors that can influence people and their behaviour; such as environmental, organisational and job factors, and individual characteristics which influence behaviour at work (Implementing Human Factors in Health care (NPSA)). Through root cause analysis of incidents the Trust identified Human Factors as contributory factors common to our never events as well as to the three highest volume/high value medico-legal claims specialities (Trauma & Orthopaedics, Emergency Department & Theatres).

Background

More than 75% of patient safety failures involve 'human factors', something much wider than simple human error. Unfortunately, even highly skilled, knowledgeable and hard working health care workers deliver variable performance as a consequence of simply being human. In aviation, acknowledging, accepting and then seeking to manage this human vulnerability led to a field of expertise known as Crew Resource Management (CRM). In healthcare this is referred to as Team Resource Management (TRM). Currently the Trust procures Human Factors (HF) training from an external company on an ad-hoc basis, usually relating to serious incidents where we believe this specialist input would benefit the staff involved.

The introduction of 'risk facilitators' to the three specialities and audio surgical safety checklists in theatres will enable the Trust to implement a systematic programme of Human Factors training and awareness, leading to a cohort of HF experts and trainers in the three selected specialties.

The facilitators themselves will undergo TRM training via an accredited training scheme which will enable them to train other staff in their specialties on a rolling basis so that ultimately all staff will have received HF training.

In addition, the facilitators will use their skills to provide incident feedback and learning outcomes to staff and patients. They will also listen to patient feedback and respond accordingly, which will support the introduction of "always events" into wards and departments.

At present, the WHO Surgical Safety Checklist used throughout the NHS when patients undergo surgical procedures, is a generic checklist, and does not require that any speciality and procedure-specific checks are completed. Current compliance is excellent but has not prevented 'Never Events'.

In light of the Trust's Never Events, innovation workshops were held to identify creative ideas that might have a positive impact on the safety in our Theatres. One of these ideas was to trial an audio checklist to minimise the potential for surgical errors thus preventing "Never Events" and improving patient safety in operating theatres. The audio checklist is a simple innovative concept that has not been tested elsewhere and could be a valuable HF tool used in Theatre settings to enhance staff awareness of the safety checks that they are undertaking.

Anticipated Outcomes

The NHS Litigation Authority (NHSLA) is supporting its member organisations to reduce harm and thereby reduce claims through this one-off discretionary payment in 2015. There will be additional financial benefit to the Trust if we are able to reduce the cost of claims over time, as this will be reflected in our contributions to the Clinical Negligence Scheme for Trusts (CNST). We see this as an opportunity to invest in Human Factors training which is a key local and national priority for healthcare.

Nationally, the Clinical Human Factors Group (CHFG) is a broad coalition of healthcare professionals, managers and users of services who have partnered with experts in human factors from healthcare and other high-risk industries to campaign for change in the NHS. Acting as an *"independent campaign group (registered as a charitable trust) their aim is to stimulate dialogue and demonstrate through concrete action how a better understanding of the role of human factors can have a significant impact on safety, quality and productivity in healthcare"*. (http://chfg.org/about).

The impact of human factors adoption in healthcare has been identified as a key requirement to coordinating training and education on safety issues. In addition there are proven benefits to having dedicated specialists within specialty teams (as demonstrated in other industries, such as aviation).

We believe that having dedicated facilitators in Theatres providing hands-on training and advice, combined with the audio safety checklist will result in a reduction in the likelihood of Theatre "never events".

Patient Safety Incidents

In 2012 the key functions and expertise for patient safety developed by the National Patient Safety Agency (NPSA) transferred to the NHS Commissioning Board Special Health Authority (the Board Authority). This was to ensure that patient safety is at the heart of the NHS and builds on the learning and expertise developed by the NPSA, driving patient safety improvement.

The Board Authority will harness the power of the National Reporting and Learning System (NRLS), the world's most comprehensive database of patient safety information, to identify and tackle important patient safety issues at their root cause.

"*Healthcare organisations should continue to report patient safety incidents to the NRLS. Working across sectors the NHS Commissioning Board Authority will utilise patient safety incident data to analyse risk, drive learning and improve patient safety.*" (NPSA/NRLS website)

Patient safety incidents are defined as "*any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS care.*" (NPSA/NRLS website)

The NRLS is an NHS agency which "*receives confidential reports of patient safety incidents from healthcare staff across England and Wales.*"

This information is used to enable "*Clinicians and safety experts*" at the NRLS to "*analyse these reports to identify common risks to patients and opportunities to improve patient safety.*"

Additionally the NRLS "*works with organisations providing NHS care, colleges and professional groups to set priorities and develop and disseminate actionable learning.*" (NRLS website). Resources include:

- Patient safety alerts.
- Seven Steps series of patient safety guides.
- Regular feedback on the data we collect.
- Safety information on specific topics, such as safety of medicines.

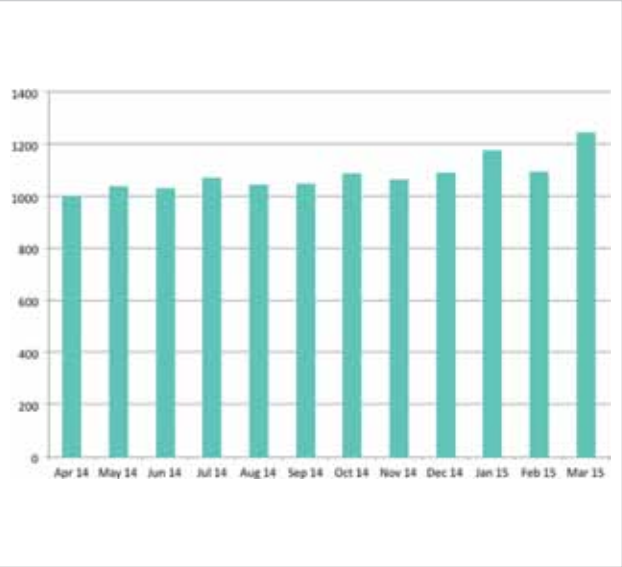
The Trust encourages staff to report all incidents, however minor through our online incident reporting system (Datix), which is monitored and managed by the central Safety Team. Overall incident reporting continued to show an upward trend in 2014/15, the majority of incidents being of minor or no harm to patients, which is an indication of an open, learning culture. The Safety and Risk Management team shares the learning and improvements across the organisation as well as with our commissioners, other local providers and with NHS England via NRLS.

The Safety and Risk Management team uploads PSI data via Datix to the NRLS daily, (50-60 incidents each day) to ensure that any serious incidents or national trends can be quickly detected by the NRLS team.

This report provides an overview of PSIs reported by UHCW between April 2014 and March 2015.

Patient Safety Incidents reported by month

Each reported incident is graded and investigated by the clinical specialities or departments within the Trust. The level of investigation is dependent on the grading of the incident and is laid down in the Trust's incident management policy.



Graph: Number of PSIs reported by month

"Thank you to all the staff on intensive care at @nhsuhcw for doing everything they possibly can. My family and I appreciate it."

There are four levels of grading (green, amber, blue and red), calculated by multiplying the consequence and likelihood of the incident, each requiring a commensurate level of investigation (see table below).

Green-graded incidents should not require further investigation or action but it may be appropriate to conduct an aggregated investigation when a large number of green-graded incidents of a particular type have been reported. The Safety and Risk Management Team support this process, providing expertise in root cause analysis (RCA) and investigation report writing.

Amber-graded incidents may require further local investigation and again the Safety and Risk Management team support this.

Blue-graded incidents require an investigation/RCA according to the nature of the incident, in particular the level of harm to a patient.

All red-graded incidents or incidents causing major harm or death are escalated to the appropriate Chief Officer, Clinical Director and the Safety and Risk Management Team.

Score	1	2	3	4	5
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost Certain**
Time Framed	Not expected to occur for years	Expected to occur at least annually	Expected to occur at least monthly	Expected to occur at least weekly	Expected to occur at least daily

	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients (physical/ psychological harm)	Minimal injury requiring no/ minimal intervention or treatment.	Minor injury or illness, requiring minor intervention Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Increase in length of hospital stay by 4-15 days An event which impacts on a small number of patients	Major injury leading to long-term incapacity/ disability Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients

Consequences	Likelihood				
	Rare (1)	**Unlikely (2)**	**Possible (3)**	**Likely (4)**	**Almost certain (5)**
Negligible (1)	1	2	3	4	5
Minor (2)	2	4	6	8	10
Moderate (3)	3	6	9	12	15
Major (4)	4	8	12	16	20
Catastrophic (5)	5	10	15	20	25

Year on Year comparison

As a Trust we aim to increase the reporting of PSIs year on year. This is an established methodology used across the NHS, based on the understanding that *"an increase in incident reporting should not be taken as an indication of worsening patient safety, but rather as an increasing level of awareness of safety issues amongst healthcare professionals and a more open and transparent culture across the organisation."* (NRLS Website)

The table below shows a steady increase in reporting and also the percentage of increase as compared to the previous year.

If rates are perceived to fall in individual departments or specialities then the Safety and Risk Management team will review this with the speciality or department lead, both at the QIPS meetings and separately on the ward using a spot check tool that we have devised to survey wards and departments on their knowledge and experience of incident reporting.

Financial Year (FY)	Total Number of Incidents	Increase in Reporting Figures on Last FY	
		By Number	By Percentage
2012/13	11881	-	-
2013/14	12312	431	3.6%
2014/15	12991	679	5.5%

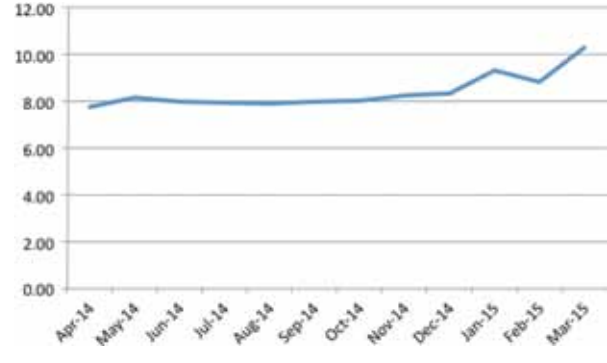
Rate of PSIs 2014-2015

The table shows the increase in reporting rate over the year.

The Trust aims to meet or exceed a reporting rate of 10% in all specialties. (Proportion of inpatient episodes leading to harmful events is around 10% (and around half are preventable) – DH (2000). *An Organisation with a memory: Report of an expert group on learning from adverse events in the NHS*).

Most Frequently reported PSIs:

The PSIs that are reported most frequently are patient falls and pressure ulcers. For all pressure ulcers that are hospital- acquired and all patient falls that result in a serious injury a root cause analysis (RCA) investigation is held.



Graph: Rate of incident reports per 100 admissions:

The outcomes of these investigations are fed back into practice and monitored at a corporate level through the Patient Safety Committee and at a regional level at the Coventry and Warwickshire Learning Forum hosted by the Commissioning Support Unit for the Clinical Commissioning Group. The Safety and Risk Management Team provides data to the relevant Trust committees and groups that monitor and review specific incidents, e.g. the Falls Forum, the Tissue Viability Team.

Learning from PSIs

The aim of incident reporting is to learn from them and implement actions that reduce the likelihood of them occurring again. There are many examples of learning from incident reporting in 21014/15, some of which are highlighted below.

Rate of PSIs 2014-2015
The position of some of the toilet tissue dispensers was found to cause patients to have to reach too far and over-balance from the toilet. Collaborative work has been done by the Trust and the dispenser manufacturer to reduce this risk.
An investigation highlighted a problem with how x-rays are prioritised when requested as urgent. This led to an action for the Radiology Department to review and clarify the time-line for urgent and routine requests as a way of reducing error and improving the patient's experience.
In response to an incident where poor record keeping was found, the Maternity Department launched a self audit campaign which gets the staff to audit their own records against best practice standards.
Incidents relating to patients' *Do Not Attempt Cardio-Pulmonary Resuscitation* (DNACPR) orders led to several actions: • Amendment of the Trust's Resuscitation Policy • An updated patient information leaflet. • Large communication notices were displayed in every ward (and where appropriate for board rounds and doctors' offices) at both hospital sites; small DNACPR notices were placed by computers and work stations • Resuscitation Committee delivered a presentation at the Grand Round to highlight key issues to staff
Incident reports identified that patients were having plaster changes and adjustments in the Plaster Room but the event was not being recorded or documented. Actions taken: • Development of documentation that provides a full record of patient care • Plaster request forms were developed • Worked with clinical coding so that all episodes of care are now correctly coded. This now means that these patients also generate the appropriate income to the Trust for treatment received. • Clinical guideline/process change
Incidents were raised due to the breakdown of process when taking blood from patients in the outpatient Phlebotomy department. A number of posters have been placed in each Phlebotomy cubicle to resolve some of these issues
Incidents highlighted issues relating to inpatients waiting for imaging who were unsupervised. This highlighted the need for regular formal checks to be performed. As a result there is now a person in post to carry out regular (15 minute) monitoring with the introduction of a checklist.

Serious Incidents Requiring Investigation (SIRI):

At UHCW these investigations are conducted under the direction of our weekly Significant Incident Group (SIG), which is chaired by the Director of Quality and has membership which includes the Chief Nursing Officer and Chief Medical Officer. SIG appoints an investigation lead with appropriate seniority and expertise in root cause analysis (RCA). The outcome of the investigation is written into a formal report with an action plan that is presented to SIG by the investigator. SIG approves the report and actions and these are then shared with the relevant teams, with our commissioners and with the patient/s involved in the incident. In this way we share and implement any learning or safety measures to try to reduce the likelihood of the same incident occurring again.

Any case that meets the criteria laid down in the national Serious Incident Framework as published by NHS England is reported to the CCG and is then classified as a Serious Incident Requiring Investigation (SIRI). Examples of SIRIs are:

- Avoidable or unexplained death.
- Health Care Associated Infection outbreaks.
- Grade 3 and 4 pressure ulcers.
- Data loss & information security.
- Maternal deaths.
- Child protection incidents.
- Never events.
- Abuse (proven or suspected).

The progress of all SIs and SIRIs is monitored by the Safety and Risk Management team and is reported to SIG on a weekly basis by the Patient Safety Manager. Once complete the final RCA report is approved by the group and any resulting actions are assigned and monitored via Datix.

SI actions are also reported at a corporate level to Patient Safety Committee by the Patient Safety Manager.

During 2014/15 the Safety and Risk Management team managed 206 SIRIs and a further 47 non-SIRI cases went through SIG.

To meet the requirements of the national SIRI Framework we are required to complete investigations and provide a comprehensive report for each case within a set time frame, generally within 45 working days with some exceptions when an investigation involves other agencies.

We achieved closure within timescale in 172 (85%) of cases. The reason for investigations taking longer to complete is usually due to SIG requiring additional information or scrutiny, which results in a more thorough investigation.

As a result of the SIs and SIRIs investigated in 2014/15 we have implemented 423 individual actions from 96 action plans, which the team has monitored for completion or escalated when overdue.

"From the moment I arrived at the Hospital of St Cross I was treated very well, from the consultants, the staff on ward and staff in theatre. Thanks to everyone for making my stay pleasant and comfortable."

Never Events

"Never events" are a sub-set of Serious Incidents and are defined as *'serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers'*. (Department of Health Never Events List 2013/14)

Some types of incidents hold high potential for significant harm, and are designated never events regardless of the actual degree of harm that has occurred. Some types of incidents are designated never events only if death or severe harm results.

For 2014/15 the full list of NEs is as follows (the list has undergone significant changes for 2015/16):

Surgical:
- Wrong Site Surgery
- Wrong Implant/prosthesis
- Retained foreign object post-operation

Medical Events:
- Wrongly prepared high-risk injectable medication
- Maladministration of potassium-containing solutions
- Wrong route administration of chemotherapy
- Wrong route administration of oral/enteral treatment
- Intravenous administration of epidural medication
- Maladministration of Insulin
- Overdose of midazolam during conscious sedation
- Opioid overdose of an opioid-naïve patient
- Inappropriate administration of daily oral methotrexate

Mental Health (Mental Health premises only):
- Suicide using non-collapsible rails
- Escape of a transferred prisoner

General Healthcare:
- Falls from unrestricted windows
- Entrapment in bedrails
- Transfusion of ABO-incompatible blood components
- Transplantation of ABO incompatible organs as a result of error
- Misplaced naso- or oro-gastric tubes
- Wrong gas administered
- Failure to monitor and respond to oxygen saturation
- Air embolism
- Misidentification of patients
- Severe scalding of patients

Maternity:
- Maternal death due to post partum haemorrhage after elective caesarean section

During 2014-2015 we reported three "never events":

- 1 x Misplaced naso-gastric (NG) tube
- 2 x Retained foreign body post-procedure

Each case was investigated in accordance with the national *Framework for Reporting and Learning from Serious Incidents Requiring Investigation (NPSA 2010)*.

What else have we done to reduce the likelihood of a never event?

The Safety and Risk Management (SRM) Team ensures that all serious incidents are logged on a central web-based software system called "Datix". The "actions" module facilitates management of all actions, providing a status report for the Patient Safety Committee.
The owners of the actions provide updates directly onto the system until completion; the SRM team can then monitor each resulting action plan via Datix and escalate outstanding actions as appropriate.

The Trust has undertaken a number of measures to address the risks identified. Examples are:

- Communicated the Trust Clinical Operating Procedure for Theatre Counting and Managing a Count Discrepancy to reinforce its use.
- Improved the list-planning process to ensure effective and responsive scheduling of elective surgical activity in the Obstetric Theatres.
- Changes made to the rostering of scrub personnel to consider the complexity and number of planned procedures.
- Obstetric Theatres is now transferring its management to come under General Theatres.
- The assessment and confirmation of instrument integrity is now practiced in all theatre counts.
- 'Power Training' sessions have been taking place across the wards to ensure all relevant nursing staff are updated regarding safe nasogastric tube management.
- Staff are not allowed to utilise NG tubes for feeding or medications unless they have the approved competences.
- Introduced 'Cue Cards' for nursing staff as a prompt when placing NG tubes and delivering feeding.
- Updated NG feed prescription paperwork to incorporate safety framework for confirming NG tube position prior to connection of feed.
- Updated the medical staff regarding consideration of dislodged NG tube or aspiration if new respiratory symptoms arise in a patient with an NG in-situ.
- Introduced the concept of "Always Events".

Always Events

Always events are defined as *'Those aspects of the patient and family experience that should **always** occur when patients interact with UHCW healthcare professionals and the delivery system.'* (Institute for Health Care Improvement).

Whilst never events are tragic incidents that should never occur, the Institute for Health Care Improvement's *Always Events framework* (2014) provides us with a framework for clarifying what should happen for every person, every time they encounter the health care system. Based on decades of research by The Picker Institute on the patient and family experience, an Always Event is a practice or set of behaviours that, when implemented reliably, will ensure an optimal patient and family experience and improved outcomes. The goal of the process is an "Always Experience"; the Always Event is a tool for achieving this goal.

The stages for implementation of Always Events are described in the diagram right.

From patient to process

1. Understand patient experience "What matters to me"	2. Develop Always Event(s)	3. Integrate Always Event(s) into Work Process(es)
Impressions FFT Patient Surveys	Team Discussions Prioritise Agree One or Two	Trial Audit Business as Usual

At a Grand Round in November 2014 the Safety and Risk Management Team introduced Always Events to the staff in attendance, having already piloted schemes in Radiology and Phlebotomy.

The stages to implementation from patient to process, which these two departments piloted, are:

1. Understand form patients and service users what matters to them. Departments can do this by utilising their feedback from the Impressions system, Friends & Family Test results and other patient surveys.
2. Use the feedback to determine what Always Events may be relevant to the department; prioritise one or two to try out.
3. Integrate those Always Events into everyday practice.
4. Once these become "business as usual" audit them for compliance.

This is to be developed further as part of the Trust's Together Towards World Class strategy (World Class Experience) and is a workstream within the Trust's Sign up to Safety Campaign.

In addition, the Trust's clinicians were keen to develop clinical Always Events, based on those aspects of clinical care that should always occur. Already, we have seen some examples of this that specialties want to introduce.

This is therefore a work in progress that we aim to progress further in 2015/16.

Duty of Candour

Following the Francis Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry and a series of other reviews, the duty of candour became part of a regulatory registration package which was implemented in October 2014.

Clinicians have an ethical duty of candour to inform patients about mistakes that cause serious harm to their patients.

The General Medical Council states in the Good Medical Practice Guide: *'If a patient, service user their parents and carers under your care has suffered serious harm or moderate harm, through misadventure, or for any other reason, you should act immediately to put things right, if that is possible. You should explain fully to the patient or service user what has happened and the likely long and short-term effects. When appropriate, you should offer an apology. If the patient or service user is under sixteen and lacks the maturity to consent to treatment, you should explain the situation honestly to those with parental responsibility for the child'.*

The Nursing and Midwifery Council (NMC) Code (2015) outlines the responsibilities of all nurses and midwives in relation to public and patient safety. UK nurses and midwives must be open and candid with all service users about all aspects of care and treatment, including when any mistakes or harm have taken place.

The Care Quality Commission's (CQC) Regulation 20 is to ensure that providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in general in relation to care and treatment. It sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.

In response to the Duty of Candour the Safety and Risk Management Team has led on the production of a new Trust policy (Duty of Candour (Being Open) Policy), which is based on national and international evidence, a local audit of UHCW incidents of moderate harm and above and constructed in consultation with our clinical staff.

The policy includes clear information for staff on what they should do when they are involved in a serious incident and the support available to them to deal with the consequences of what happened and how to communicate with the patients or service users, their families and carers.

Following an incident that falls within the duty of candour the patient will receive an apology and an information leaflet with details of what will happen next and a contact name and number will be provided. Following the investigation they will receive a further letter and they will be given an opportunity to discuss the findings with a member of the clinical team.

The policy will be monitored through the Trust's Significant Incident Group and Patient Safety Committee, with regular auditing and reporting to our commissioners.

Patient Safety Alerts

In January 2014 the NHS England Patient Safety Domain launched the National Patient Safety Alerting System (NPSAS), an improved three-level system for highlighting patient safety risks in NHS organisations, and implementing action to reduce risk.

The re-launch of a patient safety alert system was part of the government's response to the Francis report.

The new NPSAS is a three-stage system, based on that used in other high risk industries such as aviation. The system is used to disseminate patient safety information at different stages of development to NHS organisations. It differs from the previous NPSA system by allowing more rapid dissemination of urgent information via the Central Alerting System (CAS), as well as encouraging information sharing between organisations and providing useful education and implementation resources to support providers in reducing risks to patients. It should therefore provide patients and their carers with greater confidence that the NHS is able to react quickly and rapidly to risks that are identified.

The three stages of patient safety alerts

- **Stage One Alert: Warning**
  This stage will 'warn' organisations of emerging risk. It can be issued very quickly once a new risk has been identified to allow rapid dissemination of information. In the interests of timeliness, extensive consultation at this stage is not envisaged.

- **Stage Two Alert: Resource**
  This may be issued some weeks or months after the stage one alert. It may consist of:
  - Sharing of relevant local information identified by providers from a stage one alert;
  - Sharing of examples of local good practice that mitigates the risk identified in the stage one alert;
  - Access to tools/resources that will help providers implement solutions to the stage one alert;
  - Access to learning resources.

- **Stage Three Alert: Directive**
  At this stage organisations will be required to confirm we have implemented specific solutions or actions to mitigate the risk. For those organisations that have already demonstrated good practice and locally developed appropriate risk mitigating strategies at stages one or two, sign-off should be a formality.

When alerts are received by the Trust they are disseminated via the Safety and Risk Management Team to the appropriate lead for the alert. The lead will review the alert and complete a gap-analysis against the actions listed within it.

"Had six operations surrounding brain tumour removal. The urgency was explained thoroughly and I trusted the surgeon implicitly. The four months I stayed for, I was surrounded by the most caring and capable people I have ever had the privilege to know."

The Patient Safety Manager will support the lead to assign any actions to relevant staff and ensure that all actions have been completed to the national deadline. The Patient Safety Manager reports the status of the PSAs to the Patient Safety Committee. Any overdue alerts are considered for inclusion on the corporate risk register.

The table below lists the Patient Safety Alerts which have been issued by NHS England in the 2014/15 financial year.

Of the 16 alerts received in 2014/15 only one has not be completed on time. This is the stage three alert "Standardising the early identification of Acute Kidney Injury". The alert calls for an algorithm to be integrated into the Laboratory Information Management System (LIMS). This is dependent on conclusion of other projects within the Trust. In the meantime a work around has been implemented by ICT and the risk is logged on the Trust risk register.

Alert Stage	Title of Patient Safety Alert	Issue Date
1	Managing risks during the transition period to new ISO connectors for medical devices	27.03.15
1	Risk of severe harm and death from unintentional interruption of non-invasive ventilation	13.02.15
1	Risk of death from asphyxiation by accidental ingestion of fluid/food thickening powder	05.02.15
1	Harm from using Low Molecular Weight Heparins when contraindicated	19.01.15
1	Risk of death or serious harm from accidental ingestion of potassium permanganate preparations	22.12.14
1	Risk of death and serious harm from delays in recognising and treating ingestion of button batteries	19.12.14
1	Risk of Distress and death from inappropriate doses of naloxone in patients on long-term opioid/opiate treatment	21.11.14
2	Resources to support the prompt recognition of sepsis and the rapid initiation of treatment	02.09.14
1	Risks arising from breakdown and failure to act on communication during handover at the time of discharge from secondary care.	29.09.14
1	Risk of inadvertently cutting in-line (or closed) suction catheters	17.07.14
1	Risk of harm relating to interpretation and action on PCR results in pregnant women	23.06.14
3	Legionella and heated birthing pools filled in advance of labour in home settings	17.06.14
3	Standardising the early identification of Acute Kidney Injury	09.06.14
1	Risk of using vacuum and suction drains when not clinically indicated	06.06.14
1	Warning Residual anaesthetic drugs in cannulae and intravenous lines	14.04.14
1	Minimising risks of omitted and delayed medicines for patients receiving homecare services	10.04.14

Learning

There has been a consistent approach to learning from PSIs, SIs and alerts throughout the Trust. The Safety and Risk Management Team produces and contributes to the following reports for regular distribution:

- Quality dashboards are produced quarterly for all specialties, with qualitative & quantitative data relating to their incident, complaints, claims & clinical audit & effectiveness. They also include narrative about Trust wide safety issues. These reports are discussed at the specialties' multi-disciplinary Quality Improvement & Patient Safety (QIPS) meetings.
- Monthly feedback to QIPS leads which also identifies themes and trends.
- Email feedback via Datix to individual reporters once incidents are closed.
- High level reporting to corporate committees.
- Specialties produce their own safety newsletters for staff and the Trust has a corporate safety newsletter which includes themes and lessons from incidents, complaints and claims, as well as national updates.
- Lessons learned from RCAs are regularly shared with staff at the weekly Grand Round. We have also presented "never events" to Grand Round and introduced the concept of "always events" and "human factors".
- The Trust has an internal patient safety alert system, whereby we disseminate safety messages quickly via the Communications department to the relevant staff.
- We share lessons learned at the monthly Clinical Quality Review Group meeting with our commissioners.
- We share lessons learned with local providers at the quarterly Coventry & Warks Learning Forum, hosted by Coventry & Rugby CCG.
- Patient safety alerts (PSAs) are fed into the clinical audit programme where appropriate.
- PSA updates are provided to the specialty QIPS meetings and lessons learned are shared with the relevant staff.

Training

Throughout the year the team has reviewed some of its training and information sharing methods. This had led to the re-introduction of formal face to face RCA training. This course has been well received and more sessions are planned for 2015/16.

Following the success of this training the team plan to introduce a formalised programme of training to include the various aspects that are managed by the Safety and Risk Management team.

The Patient Safety Manager has been involved in the Trust wide induction review programme and plans to include a face to face session and a "market place" information stand in the new Trust induction programme.

The team has created opportunities to provide "on the job" training in risk management by getting out onto wards and departments. This has taken the form of spot checks by the Safety and Risk Management Team, making contact with various staff groups, e.g. Nurses, Doctors, Allied Health Care Professionals and Health Care Support Workers to gain their opinions on the reporting system and, where required to train those members of staff in their local workplace.

Where the team identifies any staff groups or specialties that require specific input we have provided specific support and training, either directly or by procurement of external training. Examples are:

- Presentations at Junior Doctors education sessions.
- Presentations at Specialty QIPS meetings.
- Risk management training for the senior Operations Team.
- Risk management for senior managers (external company-led sessions).
- Presentations and risk management information for Trust groups and committees, e.g. Hospital at Night Committee, Infection Prevention & Control Committee, End of Life Care Committee, Falls Steering Group.

Further Developments for 2015-2016

- Lead the Sign up to Safety campaign, monitoring improvements and reporting these to Patient Safety Committee.
- Aim to increase UHCW patient safety incident reporting by a further 5%.
- Review Safety and Risk Management training.
- Conduct a gap-analysis against the 2015/16 list of never events.
- Initiate a Human factors Strategy for the Trust.
- Develop clinical always events with the clinical specialties.

Health & Safety

Health and Safety Law places duties upon both employers and employees to provide a safe and healthy working environment. To this end the Trust must ensure it has compliance with the regulatory framework in order to meet its requirements. The Trust reviewed its Health and Safety and Latex Allergy Management Policies during the year.

Key Points:

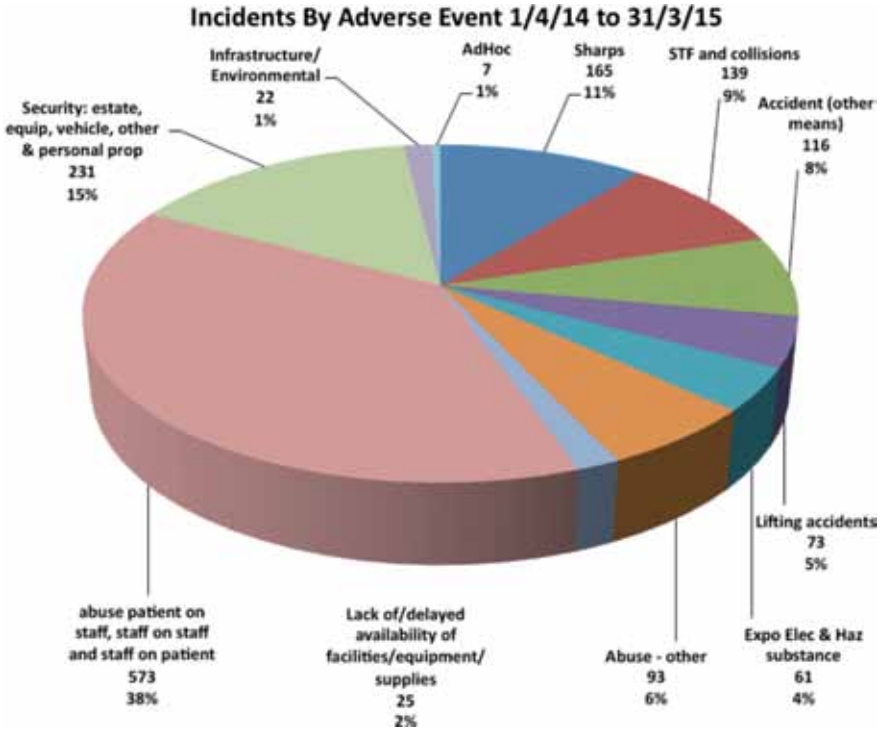
Some of the key issues addressed are:

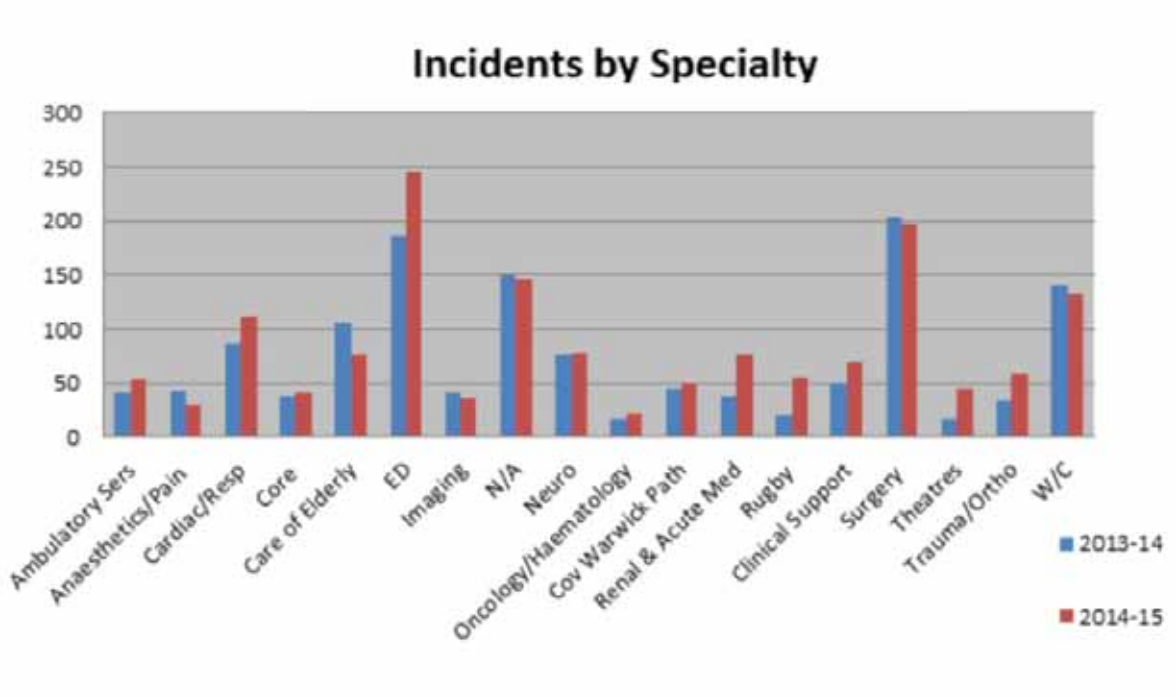
- Mandatory training 3 yearly update is showing an upward trend in compliance.
- The Awaken Display Screen Equipment training and self assessment package launched.
- Storage and use of liquid nitrogen reviewed.

Incident Reporting:

Incident figures for the financial year 1/4/14 – 31/3/15 are detailed in the table below and shown as a comparison with the previous year.

2013/14		2014/15		Trend
Abuse-Staff by patients	372	Abuse-Staff by patients	544	↑
Sharps	165	Sharps	165	↔
Slips, Trips and Falls	139	Slips, Trips and Falls	139	↔
Accident caused by some other means	167	Accident caused by some other means	116	↓
Security – personal property	80	Security – personal property	107	↑


Incidents By Adverse Event 1/4/14 to 31/3/15
Infrastructure/ Environmental 22 1%
AdHoc 7 1%
Sharps 165 11%
STF and collisions 139 9%
Accident (other means) 116 8%
Security: estate, equip, vehicle, other & personal prop 231 15%
Lifting accidents 73 5%
abuse patient on staff, staff on staff and staff on patient 573 38%
Lack of/delayed availability of facilities/equipment/ supplies 25 2%
Abuse - other 93 6%
Expo Elec & Haz substance 61 4%


Incidents by Specialty
300
250
200
150
100
50
0
Ambulatory Sers
Anaesthetics/Pain
Cardiac/Resp
Core
Care of Elderly
ED
Imaging
N/A
Neuro
Oncology/Haematology
Cov Warwick Path
Renal & Acute Med
Rugby
Clinical Support
Surgery
Theatres
Trauma/Ortho
W/C
2013-14
2014-15

"Dr Roger Townsend spoke with respect and compassion. He went the extra mile in terms of care and explanation. He has a great personality and duty of care. He is passionate about his work and an excellent practitioner."

Learning

Injuries from Slips, Trips and Falls (STF) accounted for 36% (13) of reports made to the Health and Safety Executive under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR), usually due to a Specified Injury. Ten of the STF victims sustained a fracture.

Following the introduction of safer Sharps devices there has been a significant fall in the number of RIDDOR reportable sharps injuries from 9 in 2013/14 to just 2 in 2014/15.

Steps have been taken to prevent recurrence of these incidents. For example:

- There will be trials of new insulin pen safety devices.
- A more slip resistant vinyl has replaced the flooring outside Histology which historically has had a high incidence of slips.
- ISS reviewed the procedure and alternative routes for moving roll cages of stock at peak visitor times, to avoid any further collisions with visitors on the main corridor.

Information and Training

The induction training programme is managed via the Learning and Development team and this has meant that face to face delivery for health and safety risk management is no longer required.

The eLearning programme generally appears to be running well with the compliance numbers increasing month on month for the 3 yearly update, see figure 1. This training is wholly managed and coordinated by Learning and Development Team.

The Awaken eLearning system for Display Screen Equipment (DSE) training and risk assessment was launched in August 2014.

The package affords greater flexibility to enable a number of other statutory training packages to be introduced in the Trust. Some of these packages will be assessed with the vendor over the coming year for roll out across the Trust.

Figure 1: Health & Safety 3-yearly training compliance

Further Developments for 2015-2016

- Further development of the Awaken DSE training package is envisaged for 2015-2016, increasing the number of self assessments undertaken.
- Inspection of Trust satellite sites and auditing of Trust departments will be undertaken during the financial year.
- Facilitate career progression for staff expressing an interest in Health and Safety via work experience.

Risk Management

The Trust's Risk Committee supports the Quality Governance Committee in assuring that the Trust delivers high quality, safe services to patients. It oversees and monitors the corporate risk register and ensures that the Trust has the appropriate strategies, processes, systems, policies, and procedures in place to manage risk.

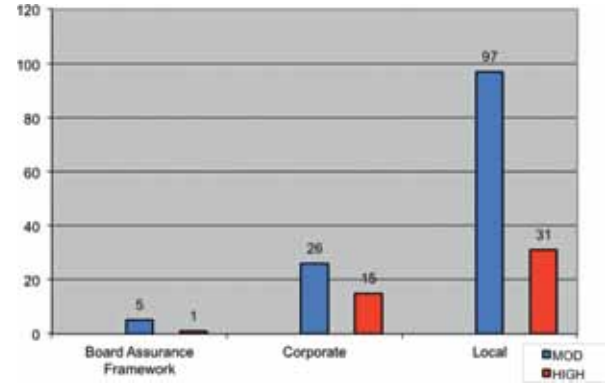
The Trust's Risk Management Strategy and Policy are made available to all staff via our e-Library, which is accessible on the Intranet site.

Managers are responsible for ensuring that risks are identified and managed in accordance with Trust policy.

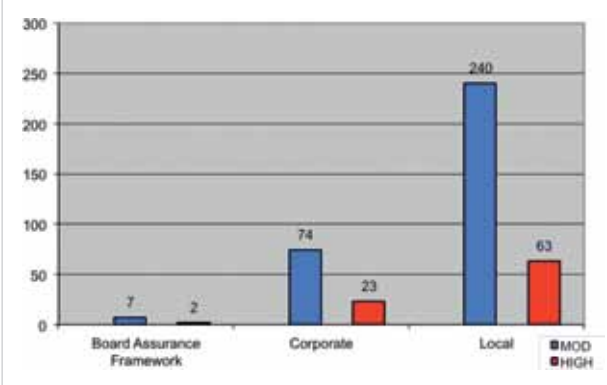
The Risk Manager monitors the risk register and provides monthly reports to the Risk Committee. The various risk "sub-types" are reviewed at the relevant corporate committees; for example patient safety risks are reviewed at the Patient Safety Committee.

All specialties have their own risk registers, which are logged centrally on the Trust's web-based risk managements system, Datix, which is managed by the system manager who is a member of the Safety and Risk Management team.

Reports are prepared for corporate and specialty committees using data from the Datix system.



Number of Risks Logged During the Financial Year



Current Open Risk Gradings at 31st March 2015

Training

Courses were held during the year for risk assessor and risk management training aiming to improve the quality and process of risk assessments and managing risks identified.

Further training was provided by external companies regarding Root Cause Analysis, enabling staff to identify contributory factors regarding incidents and implementing appropriate controls.

Further Developments in 2015/16

- Review the Trust's Risk Management Policy
- Improving the quality of the risk register by engaging staff, monitoring risks and challenging risk owners about their controls and actions.
- Improving the Risk module that is held within Datix to optimise its use and make it more user-friendly for all staff;
- Working with risk owners to ensure that the risk register accurately reflects the assurance framework;
- Overseeing the process of developing and refreshing the risk register based on:
- Risks identified from within the organisation, including a programme of further training for all staff and the Trust Board;
- Risks that arise from local partners in the NHS and Social services organisations;
- Risk identified from national policy and guidance issues.

Medical Revalidation

Background

Medical revalidation was confirmed as a statutory requirement, by the Secretary of State for Health, on the 3rd December 2012; and was introduced nationwide from April 2013. It is the process by which all doctors need to satisfy the General Medical Council (GMC) that they are up-to-date and fit to practise. Its purpose is to demonstrate that licensed doctors are up-to-date and provide greater assurance to patients, the public, employers and other healthcare professionals. Licensed doctors have to revalidate once in every five year revalidation cycle.

The national schedule will ensure GMC have revalidated the majority of licensed doctors by the end of March 2016 and all licensed doctors by March 2018 – the end of the first cycle.

Revalidation is based primarily on the outcome of annual appraisal through a doctor's formal link (prescribed connection) with an organisation, known as a designated body. Each designated body has a Responsible Officer (RO) who is responsible for ensuring processes are in place to support medical appraisal and revalidation along with submitting recommendations to the General Medical Council (GMC). The RO for UHCW is Professor Meghana Pandit, Chief Medical & Quality Officer.

There are three types of recommendation an RO can make:

a) Positive recommendation – confirms that a licence to practise should be continued.
b) Request for deferral – made where there are no unaddressed concerns about an individual's fitness to practise, but there is insufficient evidence to support a recommendation or where there are concerns being investigated.
c) Notification of non-engagement – the medical practitioner has failed to engage in local processes to support revalidation. The GMC will investigate such instances through a formal process, which can result in the withdrawal of a doctor's license to practice.

To date, positive recommendations have been made for 323 of the Trust's 542 prescribed connections. Overall 38 requests for deferral have been made, of which 3 are still awaiting a positive recommendation. The Trust has had no confirmed cases of non-engagement and seeks to capture those deemed as failing to comply before it becomes necessary for such a recommendation to be submitted.

2014-2015

In April 2014 NHS England (NHSE) introduced the Framework for Quality Assurance (FQA) to provide guidance with regards to quality assessing the revalidation and appraisal process. With this the Trust is obligated to provide Quarterly Appraisal Reports (QAR) to NHSE. The figures reported for the appraisal year 1st April 2014-31st March 2015 are as follows:

Q1 – 49% compliant
Q2 – 87% compliant
Q3 – 65% compliant

Figures for the last quarter (1st January – 31st March 2015) are currently being ratified and are reportable to NHSE by 29th May 2015.

The FQA also requires the Trust to take part in an Annual Organisational Audit (AOA). In order to address points highlighted by the 2014 AOA the Revalidation Team developed an action plan. With this in place, several changes to strengthen and standardise the revalidation and appraisal process have already been made including:

- The delivery of an in-house appraiser training programme to ensure a continued supply of quality trained medical appraisers.
- The establishment of an Appraiser Support Group to provide guidance to appraisers in their role, as well as the opportunity to share elements of good practice.
- The development of a calibrated checklist to enable the qualitative assessment of appraisals, along with an agreement by the Revalidation Team that 10% of appraisals completed in each quarter will be reviewed against this and the findings shared with the relevant stakeholders.
- An updated Medical Appraisal Policy in line with NHSE's policy and the incorporation of a process to request postponement of appraisal. The latter will ensure the RO has a record of valid reasons for appraisals not taking place in order to convey accurate figures in QAR.
- Providing doctors with an online appraisal system, Equiniti 360 Clinical's Revalidation Management System (RMS), in order to support them through the revalidation process. The system follows an appraisal process aligned to the GMC's principles of Good Medical Practice. It also allows for efficient tracking of where doctors are in the appraisal and revalidation process, in addition to providing reporting functions which are aligned to criteria specified in the QAR and AOA.

In order to assure the Trust Board that progress on the action plan is being made and requirements are being met, biannual updates are presented and are accessible on the Trust's intranet site.

Further Developments for 2015/2016

- Deliver in-house refresher training to appraisers who first completed a course in 2012, ensuring the consistent quality of appraisers.
- Work with HR to ensure the accurate and timely capture and dissemination of information relevant to doctors starting employment at the Trust. Particularly in relation to the implementation of the Medical Practice Information Transfer from, to meet requirement 1.1.5 of the Core Standards laid out in the FQA.
- Ensure recommendations from a recent internal audit of the medical appraisal and revalidation processes are fed back to appropriate stakeholders to improve the quality of data available and help develop a more robust system.

It can be seen that UHCW is continuing to work to embed revalidation across the Trust to ensure it is viewed as a tool by which doctors can reflect on and develop their practice, and thus deliver a higher quality of care to patients. Going forward, we will continue to assess ourselves against the FQA in order to strengthen processes further.

Corporate Business Records

All NHS records are public records under the terms of the Public Records Act 1952. The secretary of State for Health and all NHS organisations have a duty under the Public Records Act, to make arrangements for the safe keeping and eventual disposal of all types of records and all individuals who work in an NHS organisation are responsible for any records they create or use in the performance of their duties.

The Records Management: NHS Code of Practice, published in 2009, by the Department of Health is a guide to the required standards of best practice in the management of all NHS records/information (clinical and non-clinical). The Code is for those who work within, or under contract to NHS organisations in England and is based on current legal requirements and professional best practice.

The IG Toolkit is an online system which allows NHS organisations and partners to assess themselves against Department of Health Information Governance policies and standards on an annual basis. The Toolkit is the key tool for assessing the Trust's records management programme and is used by the Care Quality Commission – Essential Standards of Quality Outcome 21 : Records, to ensure practices and standards are in place for the secure and confidential management of the Trust's records.

Business Records Management at UHCW NHS Trust

In compliance with national legislation and guidance, UHCW recognises records management as a corporate responsibility for providing health, care and advisory services to NHS patients and/or service users.

The Trust's business records form its corporate memory, providing evidence of actions and decisions and representing a vital asset to support daily functions and operations. Business records protect the interest of the Trust and the rights of patients, staff and members of the public. They also support consistency, continuity, efficiency and help deliver services in consistent and equitable ways.

The Trust has a robust process in place to ensure all clinical and non-clinical Trust-wide Corporate Business Records, (strategies, policies and procedures), are created, developed, approved, implemented, disseminated and archived to comply with national legislation and national standards, and to support the delivery of high quality evidence-based health care.

The Trust has an in-house electronic records management system for the storage and management of Trust-wide Corporate Business Records (Trust-wide CBRs). The system is accessed through the Trust's intranet site and has a two level access system which allocates 'read only' permission to users and 'write' access permission to system administrators. It is accessible to all staff 24/7 and has a tutorial facility on how to use the system.

Management of Trust-wide Corporate Business Records – 2014-2015

The Trust's Corporate Business Records Manager, manages the approval process for all Trust-wide CBRs which are consulted on at relative operational level committees, quality checked by the Quality Department, prior to being Trust approved by Corporate Business Records Committee (the Trust's approving body). All Trust approved CBRs are registered on e-Library within five working days of approval and a unique e-Library reference is applied to all approved Trust-wide CBRs.

Version 12 (2015) of the annual Information Governance Toolkit which consisted of 45 requirements, was assessed on the basis of level 0 to level 3, with 3 being the highest, was submitted by the Trust to the Department of Health on 31st March 2015. The Trust scored level 2 (satisfactory) for all requirements including 400, 601 and 603 (records management) and evidence was audited and made available to support the submission.

The Trust's Records Management Strategy and Trust's Business Records were reviewed and approved by CBRC in January 2015.

Corporate Business Records Committee Terms of Reference were reviewed and approved in April 2015.

A review of the e-Library activity was undertaken in January and February 2015, prior to CQC visit. e-Library was used by the CQC inspectors to peruse the strategies, policies and procedures during their visit in March 2015.

Currently there are 179 Trust-wide CBRs registered on e-Library.

Further Developments for 2015/2016

- Comply with legal legislation and national requirements such as the annual IG Toolkit submission (requirements 400, 601 and 603), and CQC – Essential Standards of Quality Outcome 21: Records.
- To progress with technological developments to e-Library records management system are supported to ensure records remain accessible and usable throughout their life cycle.
- Business records management to be incorporated within the IG training portfolio.
- Trust-wide review of operational business records to be undertaken.

Appendix

"The new Children's Emergency Department is brilliant for kids & stressed out parents! The whole team from reception, triage to the doctor were all fantastic."

The five Sign up to safety pledges

UHCW SIGN UP TO SAFETY CAMPAIGN

Over the next 3 years we will...

1. PUT SAFETY FIRST

Commit to reduce avoidable harm in the NHS by half and make public our goals and plans developed locally. **We will...**

- Work to achieve our vision of delivering world class levels of patient safety.
- Accomplish the patient safety priorities set out publically in our Quality Account 2013-2014 and in our Quality Strategy, namely:

  Achieve consistency and accurate conveyance of knowledge and information between all multidisciplinary team members by the utilisation of our electronic handover tool which is available to all staff.

  The aim of clinical handover is to achieve efficient transfer of high quality, comprehensive information when patient responsibility changes. Inadequate handover of clinical information carries significant risk for patients, clinicians and the organisation as a whole. Current handover practices in the Trust vary in format and process. Our aim is to develop a robust handover policy, communicate and roll out training and then measure and improve compliance with the electronic handover tool.

- Relaunch the Sepsis 6 campaign which was designed to improve the reliability of sepsis care for patients. Our aim is to raise awareness of this common, but often unrecognised condition and thereby reduce the mortality rate of those affected. We will provide training for not only healthcare professionals but also the wider public and patients in the recognition and immediate actions to take if they suspect sepsis.
- Continue to implement our Getting Emergency Care Right campaign to ensure patients get the right care at the right time in the right location.
- Ensure safe staffing – a critical component to safety is the greater focus on the right staff in the right place to ensure that high standards of care are delivered. UHCW has had a long history of using the Safer Nursing Care Tool (SNCT) and workforce planning to support strategic and operational staffing to meet patient demand. This program will be developed and enhanced including greater transparency within and outside the organisation to ensure safer staffing.
- Continue to implement programmes to reduce harm – the Patient Safety Thermometer (PST) has been embedded at UHCW and is a key tool in understanding patient harms and improvement areas. A steady rise in PST scores from low 90's to consistently above 95% harm free care has occurred. Our ambition to further refine safety programs in harms to reduce them in all areas to 98% harm free care, so our patients and community have a clear view of our ambition to improve safety.
- Develop and enhance further technological solutions for patient safety. We will upgrade the VitalPac monitoring system for patient observations and introduce more bedside solutions and alerts to help staff monitoring and identifying patient risk. This will feed performance datasets to continue to drive up safety standards.

2. CONTINUALLY LEARN

Make our organisation more resilient to risks, by acting on the feedback from patients and by constantly measuring and monitoring how safe our services are. **We will...**

- Strengthen our current learning processes by:
  - Expanding and advertising our Clinical Evidence-Based Information Service (CEBIS) to improve evidenced based clinical decision-making.
  - Utilising CEBIS to identify national and international safety excellence and develop local initiatives that build on that learning.
  - Building upon the success to date of our primary and secondary mortality review system.
  - Fully utilising the modules and enhancements to our risk management system to ensure incidents, complaints and claims are efficiently reviewed and acted upon and staff receive timely feedback. We aim specifically to improve the reporting uptake and direct feedback for our doctors in training so that we maximise the learning opportunity available through this group of staff.

- Continue to learn from our hospital-acquired pressure ulcers and falls incidents to minimise the risk to our patients and work collaboratively with our health partners to share our initiatives.
- Learn from our patient feedback system, "Impressions" and the Friends & Family Test (FFT), what it is that our patients and their families expect of us and work with them to improve those services.
- Publish information relating to patient feedback and complaints.
- Introduce the concept of "**always events**" to the organisation, i.e. we pledge to always…. We plan to start with a Theatre Always Events list which will become a poster on display in all of our theatres to remind staff of their pledge. We aim then to roll this out to other departments, both clinical and non-clinical so that staff can pledge their own **always events**.

3. HONESTY

Be transparent with people about our progress to tackle patient safety issues and support staff to be candid with patients and their families if something goes wrong. **We will...**

- Communicate fully with patients and families when things go wrong and develop our existing processes to fully implement the new "Duty of Candour", monitoring those processes to ensure openness and transparency are the norm.
- Provide training for staff to equip them to be able to manage difficult conversations with patients and families when adverse incidents occur.
- Further promote our *Putting Patients First* leaflets to encourage our patients and families to speak up with their questions and concerns so that they are fully involved with their care – no decision about me without me.
- Publish our quality and safety outcomes to patients and the public.
- Continue to ask our patients via our feedback system Impressions whether they felt safe in our care.

4. COLLABORATE

Take a leading role in supporting local collaborative learning, so that improvements are made across all of the local services that patients use. **We will...**

- Share our experience of Human Factors training and initiatives to support the national Clinical Human Factors Group in establishing a resource centre and knowledge network for human factors thinking to improve patient safety.
- Engage with our local commissioners and other health providers by attending the quarterly Learning Forum, taking the lead in areas such as root cause analysis tools and templates, falls prevention and pressure ulcer prevention.
- Continue to support the National Institute of Health Research Collaborations for Leadership in Applied Health Research and Care West Midlands (NIHR CLAHRC WM), whose aim is to conduct imaginative, high-quality health service evaluations to improve patient care. This is a collaboration of patients and the public, service personnel and applied health researchers.
- Work with our international and national partners on the Dr Foster Global Comparators programme to continually improve quality and safety. Current collaborations include sharing our work on reducing mortality related sepsis.

5. SUPPORT

Help people understand why things go wrong and how to put them right. Give staff the time and support to improve and celebrate the progress. **We will...**

- Establish an online staff "library" of key learning from serious incident investigations
- Nominate and train quality/safety champions in all departments and specialties.
- Celebrate the success of our staff by encouraging nominations in various categories and recognising and rewarding them at our annual Outstanding Service and Care Award (OSCA's) ceremony.
- Conduct regular Executive Quality Walkrounds, enabling staff and patients to discuss safety concerns directly with our Board members.
- Introduce a system of awards for quality, which celebrates (through systematic monitoring and inspection) world class safe quality care, excellent quality governance and world class patient experience.

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