QUALITY DEPARTMENT ANNUAL REPORT

2015-2016

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RISK MANAGEMENT

Statement on Quality from the Chief Medical Officer and Director of Quality

Welcome to the second 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 (UHCW) 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.

• After receiving the Trust's Care Quality Commission (CQC) inspection report in August 2015 an action plan was developed. The Quality Department adopted a focussed approach for supporting the delivery of all the 'must do' actions and the Trust has made significant progress in the delivery of the 'should do' recommendations arising from the report. Addressing the CQC recommendations has led to learning and development across the Trust. In particular the Trust Risk Committee is now re-established and monitors corporate risks across the organisation led by the Chief Executive Officer

• The integration of the four functions of the Effectiveness and Compliance Team in the previous year alongside the Safety and Risk Team and Patient Experience Team has further facilitated the triangulation of knowledge across the teams with a notable increase in shared projects, team working and learning, particularly in relation to patient experience and the Duty of Candour. This has been facilitated and supported 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 were particularly pleased to hear of our successful bid by the Patient Safety and Risk Team for funding from the NHS Litigation Authority (NHS LA) in relation to the 'Sign Up to Safety' campaign. Key staff have now been appointed and training put in place to create a team of cascade trainers. The project will focus on the Emergency Department, Trauma and Orthopaedics, and Theatres.

• It is very reassuring to report that the recently expanded Patient Experience Team has significantly improved its performance against the 25 working day response target by achieving 85% compliance. Another well received initiative led by the Patient Experience Team has been the "Hello my name is" project, the first Always Event for the Trust.

Finally, we would like to take this opportunity in this 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.

Prof. Meghana Pandit (Chief Medical and Quality Officer) Jenny Gardiner (Director of Quality)

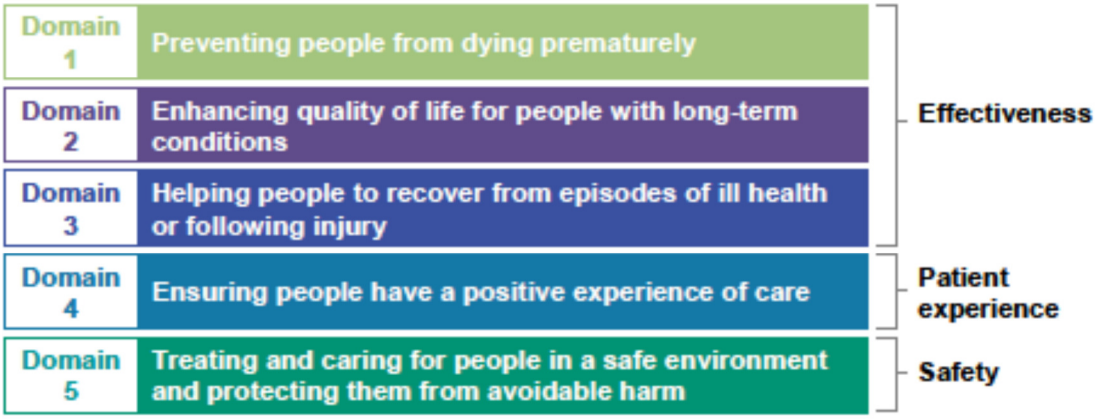
CLINICAL AUDIT, EFFECTIVENESS AND COMPLIANCE

CLINICAL AUDIT, EFFECTIVENESS AND COMPLIANCE

Introduction

A single definition of quality was first set out in *High Quality Care for All* (Department of Health 2008). The definition set out three dimensions: clinical effectiveness, patient experience and safety. All three must be present in order to provide a high quality service.

The Clinical Effectiveness dimension is described as quality care which is delivered according to the best evidence as to what is clinically effective in improving an individual's health outcomes.



The Trust wants to provide effective evidence based care across all services which will rank it as world class in the delivery of healthcare thus achieving the best outcomes for patients. The care that the Trust provides reflects clinically effective practice that complies with regulatory and statutory frameworks. The Effectiveness and Compliance Function of the Quality Department has been created to focus on the delivery of the three domains of this dimension.

The Effectiveness and Compliance function comprises of:

- Clinical Audit
- Clinical Effectiveness – Mortality, Clinical Guidelines and NICE guidance
- Compliance
- Assurance

CLINICAL AUDIT AND 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).

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. 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 Team is responsible for facilitating all clinical audit projects, incorporating both national and local priorities, throughout UHCW. The team provides expertise and support to all clinical Specialties to monitor and improve patient care.

Overview of Clinical Audit during 2015-16

Clinical Audits Newly Registered During 2015-16

At any one time, there are numerous clinical audit projects being undertaken within the Trust. There were a total of 244 clinical audit projects registered with the Clinical Audit Team in 2015-16; these are classed as mandatory audits, local audits and clinician ad-hoc audits. This is a decrease from 274 registered in 2014-15.
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.

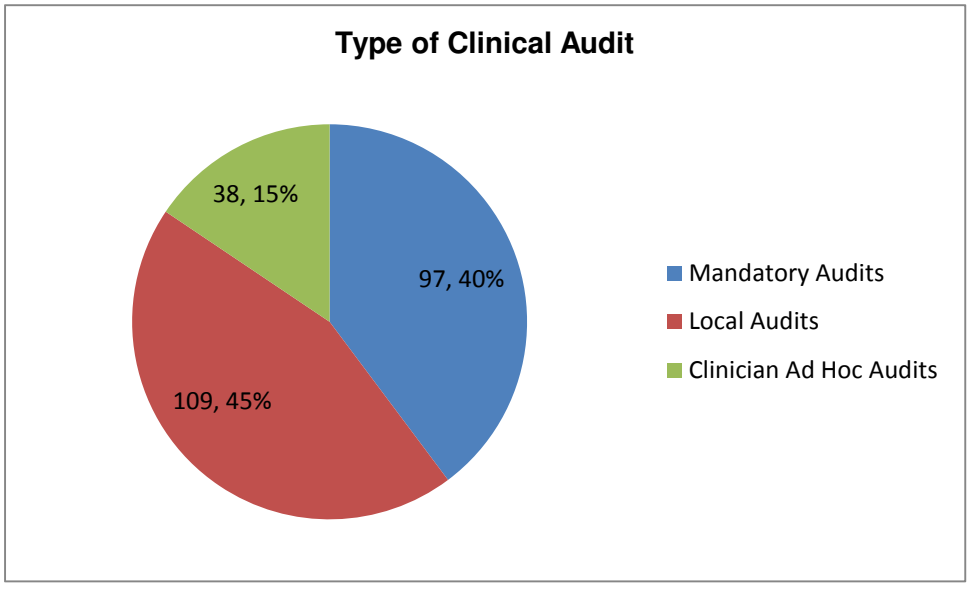


Figure 1: demonstrates the breakdown of audits by type registered with the Clinical Audit Team between 1 April 2015 and 31 March 2016.

Clinician ad-hoc audits are not planned for within the Clinical Audit Programme but are completed by clinicians on an ad-hoc basis throughout the year and are considered for full registration by the Clinical Audit Team upon receipt of a completed report and action plan.

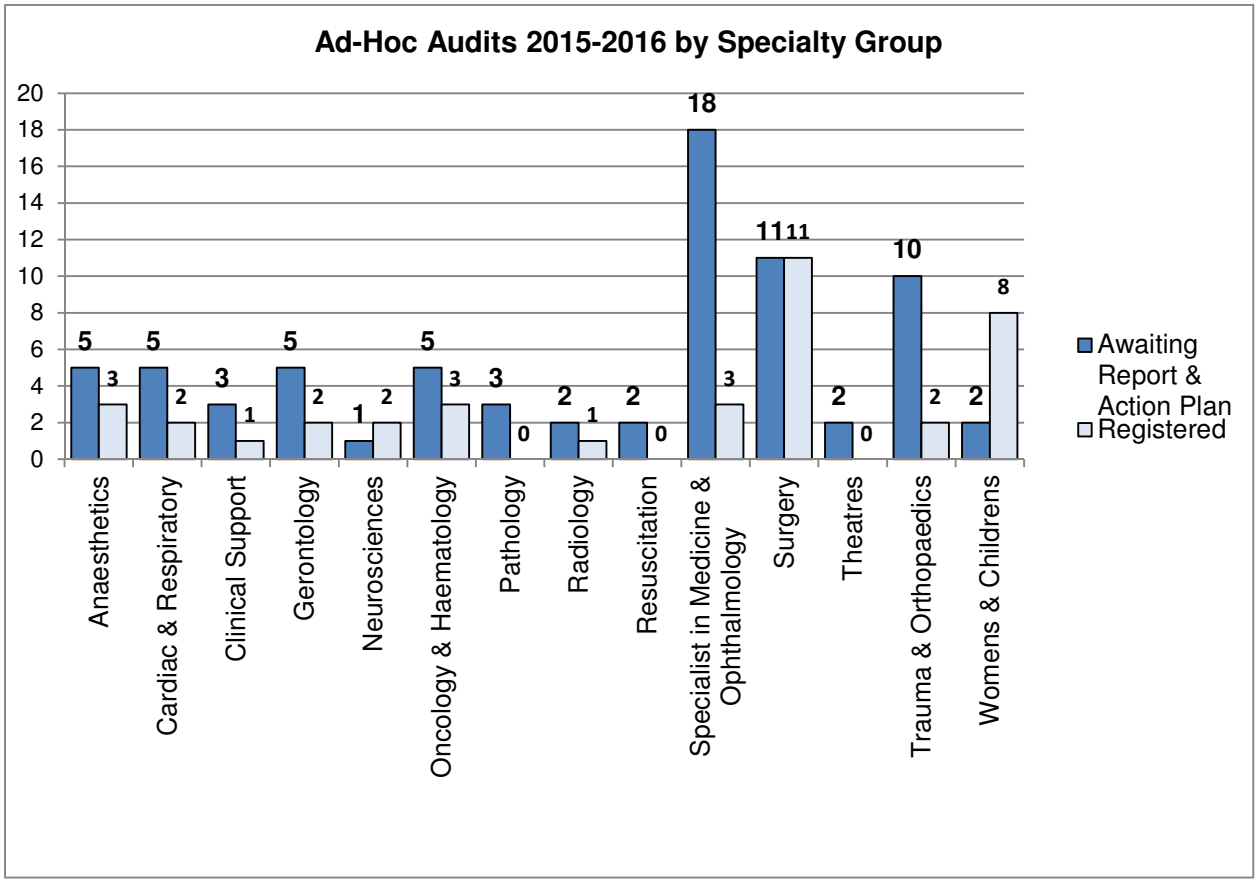


Figure 2: demonstrates the breakdown of clinician ad-hoc audits received per Specialty Group within the Trust between 1 April 2015 and 31 March 2016. It details those which have been fully registered and those where the Clinical Audit Team is awaiting a copy of the report and action plan.

The Clinical Audit Team was notified of a total number of 138 clinician ad-hoc audits taking place during 2015-16. Of these, 38 audits have been fully registered as a result of receiving a completed report and action plan; 26 were abandoned / closed and 74 audits are in progress and will be considered for full registration upon receipt of a completed report and action plan.

Trust-wide Clinical Audit Programme 2015-16

For 2015-16 the Clinical Audit Team continued with an initiative, introduced in September 2014, to include all active mandatory and local clinical audits on the Trust-wide Clinical Audit Programme, regardless of the financial year the audits took place. The purpose of this being to provide an accurate and transparent illustration of all new and existing clinical audit activity Trust-wide. A total number of 456 clinical audits were included on the programme from 1 April 2015; this comprised of 206 audits newly registered for 2015-16 and 250 audits still active from previous years.

The Clinical Audit Team introduced another initiative to restrict clinical Specialties to including a maximum number of twelve audits on their local clinical audit programme for 2015-16 and that this figure would take into consideration any existing audit activity. By restricting the number of audits a Specialty could have, it was hoped this would lead to an overall reduction in the number of clinical audits still active from previous years (250 in total). This initiative proved to be very successful and led to the closure of 126 audits during the course of 2015-16. This reduced the overall number

of clinical audits included on the Trust-wide Clinical Audit Programme from 456 to 330 as reported to the Patient Safety Committee in March 2016. See charts overleaf.

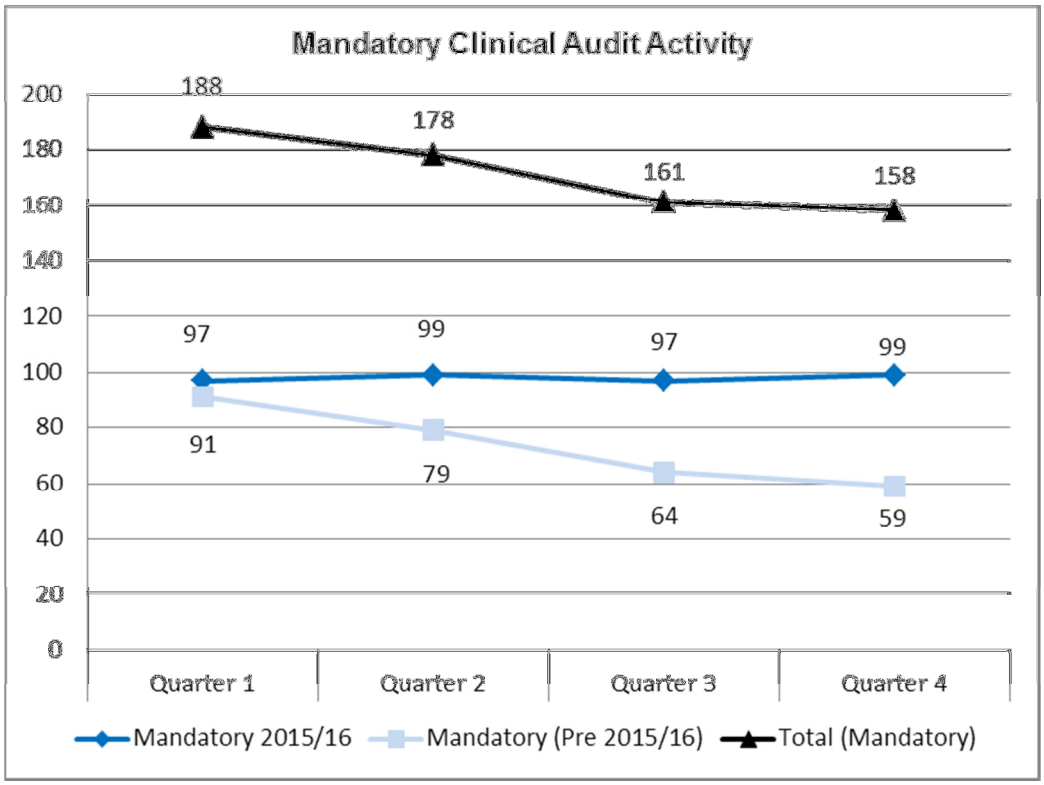


Figure 3: demonstrates the reduction in the overall number of active mandatory clinical audits between 1 April 2015 and 31 March 2016, broken down by those registered in 2015-16 and those active from previous financial years. It shows that the reduction relates to those mandatory audits registered prior to 2015-16. (Figures are demonstrated per quarter of the 2015-16 financial year)

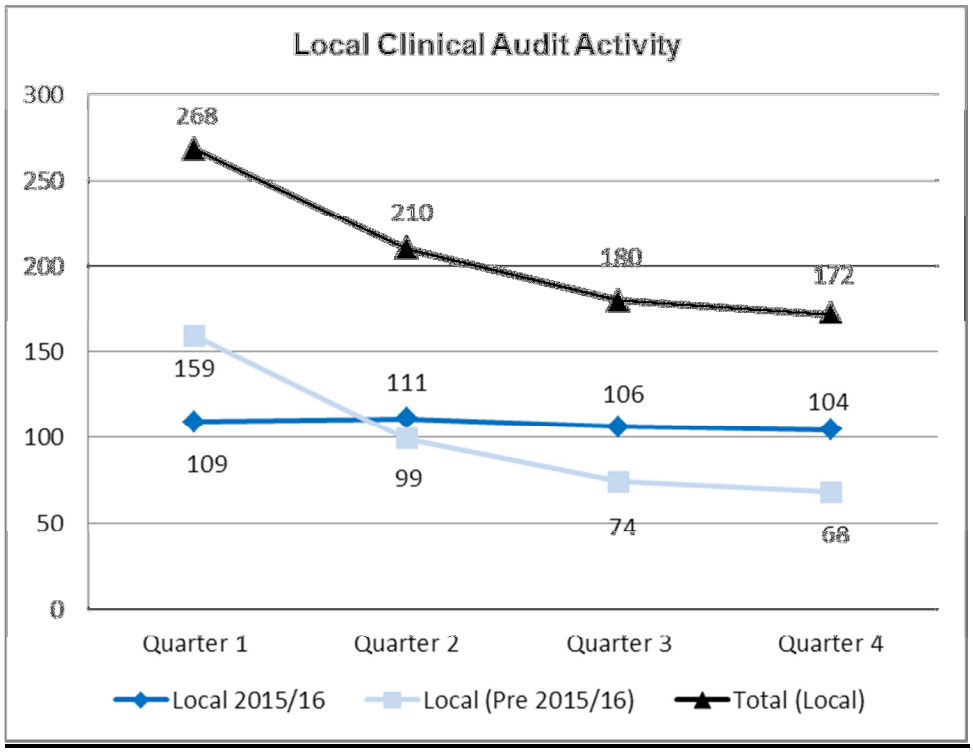


Figure 4: demonstrates the reduction in the overall number of active local clinical audits between 1 April 2015 and 31 March 2016, broken down by those registered in 2015-16 and those active from previous financial years. It shows a significant reduction in those local audits registered prior to 2015-16. (Figures are demonstrated per quarter of the 2015-16 financial year)

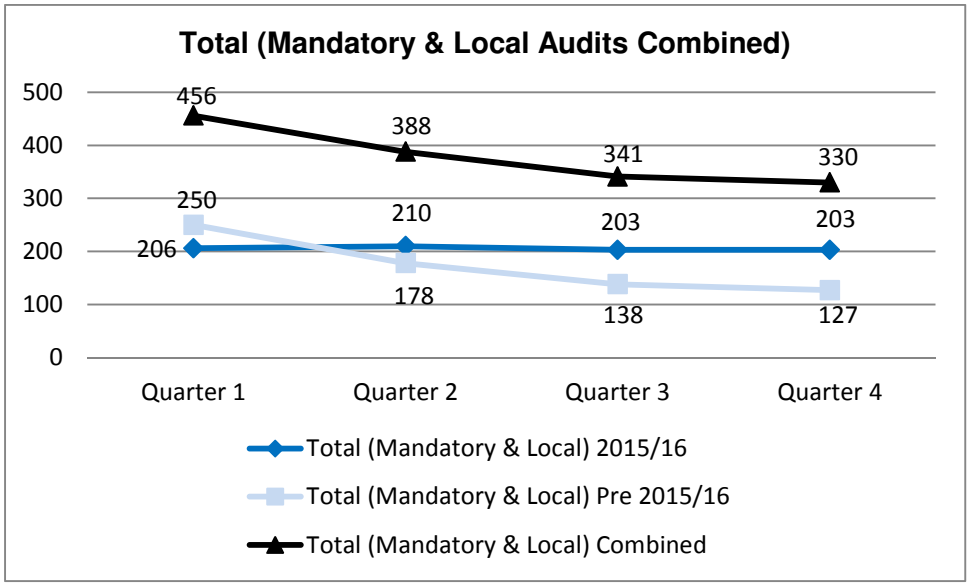
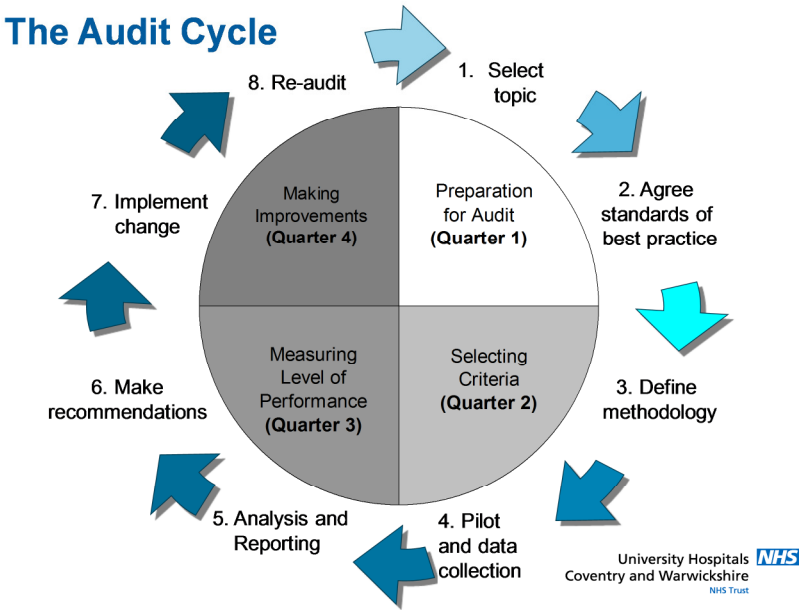


Figure 5: demonstrates the reduction in the overall number of active mandatory and local audits, as a combined total, between 1 April 2015 and 31 March 2016, then broken down by those registered in 2015-16 and those active from previous financial years. It shows that a significant reduction in the number of audits registered prior to 2015-16, occurred during quarter 1 and 2 (1st Apr - 30th Sept 2015). (Figures are demonstrated per quarter of the financial 2015-16 year)

Clinical Audit Trajectory – How We Monitor Performance

The Clinical Audit Team monitors the progression of all clinical audit activity in line with the Clinical Audit Trajectory, with the exception of national audits (where timescales are dictated) and audits which collect data on a continuous basis. The trajectory has been designed to coincide with the stages of the clinical audit cycle (demonstrated below) and the desired progress is aligned to each quarter of the financial year. The purpose of the trajectory is to ensure all Specialties are on track to complete audits on their individual audit programmes by the end of the financial year and avoid a backlog of audits encroaching on the following year's audit programme.



Performance against the Clinical Audit Trajectory is reported at Specialty level and Specialty Group level within the Trust-wide Clinical Audit Programme.

Clinical audit performance at Trust-wide level is reported on a quarterly basis to the Patient Safety Committee and twice per year at the Audit Committee. The overall end of year completion rate for the 2015-16 clinical audit programme was reported to be 56% which exceeded the target completion rate of 50% at the end of quarter 4. The target of 50% has not been achieved since 2012/13 when the end of year completion rate was reported to be 51%.

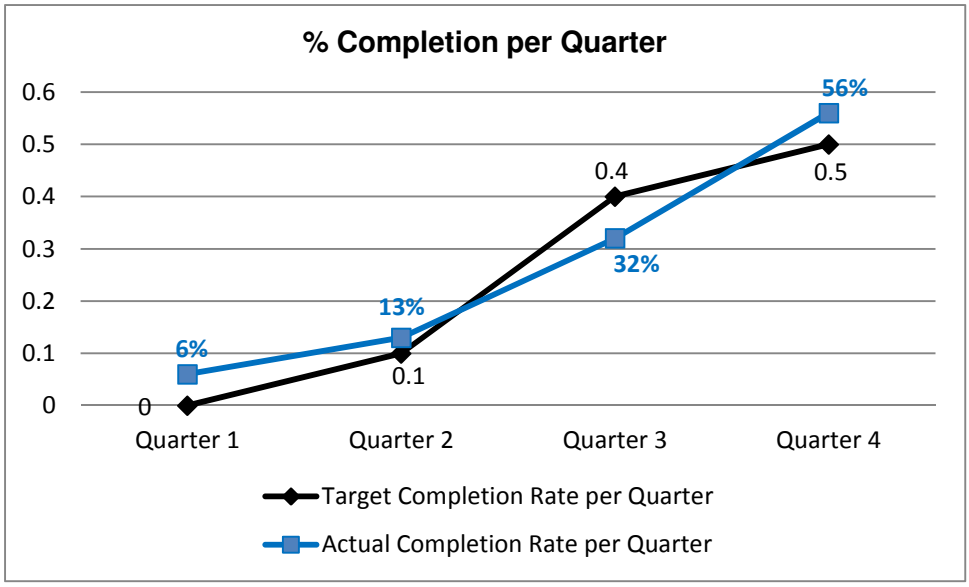


Figure 6: demonstrates the percentage completion rate for the Trust-wide Clinical Audit Programme 2015-16, broken down per quarter of the financial year. It highlights how the percentage completion rate achieved compares with the target completion rate per quarter. The results indicate that the target completion rate was met (and exceeded), each quarter with the exception of quarter 3.

The trajectory was first introduced in 2012-13 with the caveat that the end of year target completion rate of 50% would be increased over the coming years as and when the process became established. An objective has been included within the revised Quality Strategy (yet to be approved) to achieve 90% completion of the annual Clinical Audit Programme by 2019. With this in mind, the Clinical Audit Team have plans to increase the % target completion rate over the coming financial years with the end of year target for 2016-17 being 65%.

Clinical Audit Database – How the Clinical Audit Team Monitors Progress with Audits

All fully registered clinical audit activity within the Trust is recorded on the Clinical Audit Database which is updated and owned by the Clinical Audit Team. The database contains key information pertaining to individual audits and also records progress made in line with the stages of the clinical audit cycle. The team of Clinical Audit Facilitators are the main administrators of the database and rely on Specialties to keep them updated on progress made with clinical audit projects. This is vital so that the information held in the database is an accurate representation of the Specialties' performance. The information recorded (extract below) is used to compile reports at Trust level on clinical audit activity.

Clinical Audit Performance at Specialty Group Level

Clinical audit performance at Specialty Group level is provided within Table 2. The definition of the terms used as performance measures in Table 2 are outlined below in Table 1:

Definitions for Performance Measures used in Table 2	
Total number of projects	This denotes the total number of clinical audit projects registered on the Clinical Audit Database and included on the Trust's Clinical Audit Programme regardless of the financial year the projects were registered in.
Audits registered in 2015-16	The total number of new clinical audit projects registered during 2015-16 and included in the Trust's Clinical Audit Programme.
Audits registered prior to 2015-16	The total number of clinical audit projects registered prior to 2015-16 and thus outstanding from previous financial years.
Mandatory audits	Clinical audits considered a priority for the Trust e.g. National audits (see definition below), those required for external compliance and assurance such as those related to a Commissioning for Quality & Innovation (CQUIN) and those required for internal compliance and assurance such as audits required to demonstrate compliance against NICE recommendations and Quality Standards or as a result of a local risk management or complaint issue.
Local audits	Clinical audits identified by clinical Specialties in response to service priorities, local guidelines, topics of clinician interest.
National audits	Defined as those included on the National Clinical Audit & Patient Outcomes Programme (NCAPOP), required for reporting in the annual Trust's Quality Account, included in the Consultant Outcomes Publication Programme or other national audits lead by Royal Colleges / other professional bodies.
Clinician ad-hoc audits proposed	The total number of clinician ad-hoc audits proposed by clinicians on an ad-hoc basis during 2015-16 regardless of whether or not they have been registered on the Clinical Audit Database.
Clinician ad-hoc audits registered	Defined as the total number of clinician ad-hoc audits which have been fully registered on the Clinical Audit Database upon receipt of a completed report and action plan.
Continuous data collection	Defined as those audits which collect data on a continuous basis.
Re-audits	Re-audits are defined as those undertaken of the same topic audited previously to ensure practice has improved in line with the recommendations made in the initial audit.
Abandoned	The total number of clinical audits registered in 2015-16 and abandoned by clinical Specialties or by the Clinical Audit Team. There can be many justified reasons for abandoning a clinical audit including lack of resource within the Specialty to undertake the audit, the audit no longer considered to be a priority, lack of clinical engagement or for example a national audit not going ahead as originally planned.
Action plans to be finalised	Defined as those audits which are at the stage of finalising the audit report and action plan.
Action plans in progress	The total number of clinical audits for which the Clinical Audit Team are in receipt of an action plan and actions are in progress and being monitored through to implementation.
Completed projects (Stage 1, 2 or 3)	Completed projects are grouped into three different stages:

	- Stage one completion is defined as those audits where findings have been shared with the clinical teams and audit reports and action plans are being finalised - Stage two completion is defined as those audits which have action plans in progress (as described above) - Stage three completion is defined as those audits where all actions have been fully implemented and the audit has been closed The % completion is worked out based upon only those clinical audits registered during 2015-16 and included on the Clinical Audit Programme. Please note audits which collect data on a continuous basis and national audits (where timescales are dictated) are excluded from the completion rate.
Projects to be carried over to 2016-17	Denotes the total number of clinical audits carried over into the next financial year either because data collection is continuous or audits have not been fully completed during 2015-16.

Table 1: Definitions for performance measures used within Table 2

Clinical audit performance at Specialty Group level – data reported as at 14 April 2016.															
Target completion rate at end of each qtr (%)	**Total number of projects***	**Audits registered in 2015-16**	**Audits registered prior to 2015-16**	**Mandatory audits**	**Local audits**	**National audits**	**Clinician ad-hoc audits proposed**	**Clinician ad-hoc audits registered**	**Continuous data collection**	**Re-audits**	**Abandoned**	**Action plans to be finalised**	**Action plans in progress**	**Completed projects (Stage 1, 2 or 3)**	**Projects to be carried over to 2016-17**
Group 1 - Cardiac & Respiratory	30	22	8	19	11	16	7	2	12	13	0	9	1	57%	29
Group 2 - Renal & Acute Medicine	10	7	3	6	4	3	0	0	5	5	0	0	3	0%	10
Group 4 - Emergency Medicine	13	7	6	11	2	10	0	0	1	2	0	6	1	100 %	11
Group 5 - Neurosciences	14	8	6	5	9	5	3	2	3	8	0	3	3	50%	12
Group 6 - Oncology & Haematology	13	12	1	2	11	1	8	3	3	3	0	4	1	56%	13
Group 7 - Surgery	45	32	13	21	24	16	22	11	16	21	5	10	5	50%	44
Group 8 - Trauma and Orthopaedics	6	3	3	3	3	2	12	2	3	3	0	2	1	N/A	6
Group 9 - Women and Children's	33	16	17	25	8	14	10	8	7	11	4	5	14	60%	33
Group 10 – Specialist in Medicine & Ophthalmology	26	16	10	12	14	7	21	3	5	8	2	8	2	67%	23
Group 11 - Anaesthetics	14	4	10	9	5	7	8	3	4	7	2	1	5	N/A	14

Group 12 - Theatres (UH & Rugby St Cross)	13	10	3	6	7	4	2	0	0	2	0	3	1	14%	13
Group 13 - Gerontology	11	3	8	9	2	5	7	2	0	0	0	3	2	0%	11
Group 14 - Radiology	7	1	6	1	6	1	3	1	1	4	0	1	2	N/A	7
Group 15 - Rugby St Cross Hospital	2	2	0	0	2	0	0	0	0	1	0	0	2	100 %	2
Group 16 - Clinical Support	25	22	3	7	18	1	4	1	0	1	2	7	4	73%	19
Group 17 - Pathology	8	7	1	0	8	0	3	0	0	0	1	3	1	71%	6
Trust-wide Audits	11	6	5	11	0	3	0	0	1	2	0	0	2	0%	11
Infection Prevention & Control	8	3	5	2	6	0	0	0	2	6	0	0	0	0%	8
Nursing	0	0	0	0	0	0	0	0	0	0	0	0	0	N/A	0
Palliative Care	3	1	2	2	1	3	0	0	0	3	0	1	1	N/A	3
Resuscitation	5	3	2	2	3	2	2	0	1	4	0	2	0	100 %	4
TOTALS (2015-16)	185			92	93	60	74	38	64	82	16	34	11	56%	167
TOTALS (Pre 2015-16)	109			58	51	38				1		34	39	N/A	109

Table 2: Clinical audit performance at Specialty Group level – data reported as at 14 April 2016.

**Please note total number of projects is reported as at 14 April 2016 and will therefore be less than the number of audits the Specialty started out with at the beginning of the financial year.*

Key Achievements of 2015-16

Clinical Audit Newsletter

The Clinical Audit Newsletter has developed further in 2015-16 and is widely distributed across the Trust. This has proved to be an effective communication tool to keep all staff informed of developments and progress with clinical audit activity.

By issuing the Clinical Audit Newsletter at regular intervals this helps maintain open communication with all staff increasing awareness and providing an understanding of clinical audit progress, demonstrating the expertise that is offered to help with conducting clinical audits in line with the Trust process.

It also promotes important events held during the year keeping staff abreast of any clinical audit developments, training and general news.

National Audit Participation

For 2015-16, the Trust has participated in 100% of national clinical audits. The importance of participation in national clinical audits is that it enables UHCW to demonstrate that it monitors quality in an ongoing, systematic manner. A high level of participation provides a level of assurance that UHCW takes quality seriously.

Clinical Audit Awareness Week

The Clinical Audit Awareness Week ran from 19 to 23 October 2015, it was the third annual event hosted by the Clinical Audit Team. In order to maximise the opportunity for staff to be able to access information available, three lunchtime sessions were held across the two sites offering the opportunity for multi-disciplinary staff to come along and meet the Clinical Audit Team and find out more about clinical audit in general.

On offer was a prize draw, a competition, free fruit and handy tools to take away. The event also celebrated the winners of the UHCW Clinical Audit for Quality Improvement Awards 2015, Audit to Improve Paediatric Prescribing (Local), and the National Paediatric Diabetes Audit (National), alongside promotion of the National Cardiac Arrest Audit and local Clinical Audit Training.

The Clinical Audit Team was able to raise awareness of clinical audit and offer support to a number of healthcare professionals.
Other non-clinical staff were also made aware of the Clinical Audit Function, what clinical audit is and what the team at UHCW offer.

National Cardiac Arrest Audit (NCAA) 2015-16

The Trust is now participating in NCAA. This is a mandatory and national audit of in-hospital cardiac arrests within acute hospitals in the UK and Ireland. The joint initiative between the Resuscitation Council (UK) and ICNARC (Intensive Care National Audit & Research Centre) aims to identify and facilitate necessary improvements in the prevention, care delivery and outcomes from cardiac arrest. It further aims to decrease incidence of avoidable cardiac arrests, incidence of inappropriate resuscitation and promote adoption and compliance with evidence-based practice. Data collection began in October 2015.

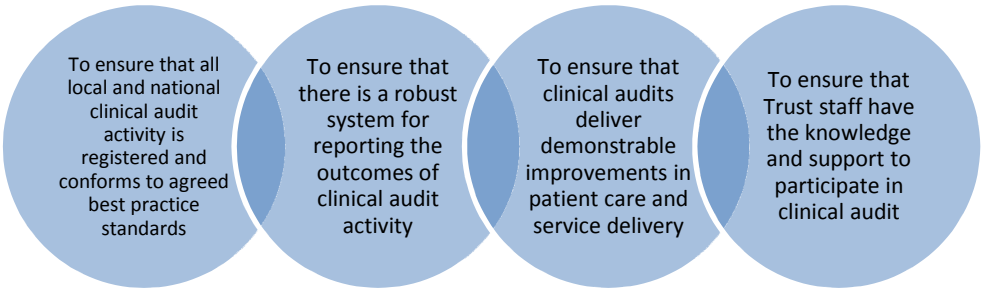
Audit of Documentation and Consent

The Audit of Documentation and Consent is to ensure documented information relating to the care of the patient is completed in accordance with both national and local recommendations. The following changes were introduced for 2015-16:

- A new standard to support the 'Getting Emergency Care Right' initiative. The audit will determine compliance against documented evidence of the patient having a daily senior review by a decision maker at ST6/7 or Consultant level which includes whether medication has been reviewed and if actions and management plans for the day have been recorded
- Stroke Services have participated in the documentation audit for the first time
- Reports to Quarterly Performance Review Meetings now include Documentation and Consent. Variance in compliance is shown per round of the audit as well as end of year performance

Clinical Audit Development Plan

Over the last twelve months work has been undertaken to further develop the Clinical Audit Development Plan 2016/18 which has now been approved by the Patient Safety Committee.
The overarching statement for the plan is to 'Improve patient care through a continuous programme of clinical audit and compliance with national and local frameworks', which gives a firm direction and focus for work to be undertaken over the next two years to enable this objective to be met.
Incorporated into the Clinical Audit Development Plan are four key objectives which are as follows:-



Formal Self Assessments: In order to ensure that all local and national clinical audit activity is registered and conforms to agreed best practice standards during 2015-16 work has been carried out to undertake a formal self-

assessment against the national Clinical Audit Assurance framework to identify actions to further develop existing clinical audit processes.

Benefits Realisation: In order to ensure that clinical audits deliver demonstrable improvements in patient care and service delivery, a pilot project has been introduced to explore the feasibility of capturing benefits realised from clinical audit activity, including inpatient experience and cost improvement.

Recognition of Staff

In response to 'Breaking Free - A Bigger Buzz', a competition was held to 'Name the Bee'. Jessica Hammond, Clinical Audit Facilitator with her entry of Bertie was chosen as one of the winners of the competition.

Michelle Hodgetts, Clinical Audit Manager, was nominated as a World Class Colleague for compassion in the World Class Colleagues recognition scheme where staff can nominate a UHCW individual or team for demonstrating behaviour in line with the Trust's six values.

Clinical Audit Training

Introduction to Clinical Audit Training 2016

The Introduction to Clinical Audit Training, aligned to the Trust process continues to provide an opportunity for multi-disciplinary staff involved in clinical audit to develop their knowledge and skills in this area. The structured training ensures that delegates receive an overview of how to conduct a clinical audit with supporting information to help them achieve a clinical audit that is of a high standard. This helps support the delivery of good quality clinical audits with robust actions and provides assurance at Trust level.

"The group exercises were very helpful"

"This will be extremely helpful to me in the future"

During 2015-16, considerable positive feedback was received

"A very informative training session"

"The training gave me the confidence to complete a clinical audit"

Provision of External Clinical Audit Training

The Clinical Audit Team was selected and invited to provide external clinical audit training at Warwick Medical School. The team was asked to provide workshops to support medical students at the beginning of their third year MB ChB course, in the Student Selected Component (SSC), which is an integral part of UK undergraduate curricula.

The workshops were delivered to different final year medical students over a series of three days. The format was interactive and encouraged group discussion and joint working, as the various stages of the clinical audit cycle were explained.

The delivery of training also allowed the Clinical Audit Team to develop a collaborative working relationship with Warwick Medical School. The feedback received was very positive and the overall experience helped build good relationships with the medical students, some of whom began placements at UHCW soon after the training.

UHCW Annual Clinical Audit for Quality Improvement Award 2015

The Clinical Audit for Quality Improvement Award 2015 was held at Grand Round and attracted entries from UHCW clinical staff of all disciplines, who had conducted clinical audits demonstrating effective application of the recognised clinical audit cycle in accordance with UHCW policy and had contributed the most to clinical quality improvement.

The main aim of the event was to showcase the dedication and hard work of individuals committed to improving patient care. Twenty entries were received from multi-disciplinary staff across a number of Specialties which were reduced to a long-list of ten by the Clinical Audit Team. These were then further shortlisted by the panel of judges. The four shortlisted candidates were invited to present their clinical audits at Grand Round on Friday 17th July.

To showcase the top ten shortlisted entries, an Executive Summary for each audit was displayed on Competition Day for staff to read. Copies were also available for staff to take away.

Over 100 multi-disciplinary staff attended the event and they were invited to participate in final judging via key pad votes which were provided to determine the overall winner. The Gold Award of Excellence was awarded to Dr A Ntovolou, ST1 for the Audit to Improve Paediatric Prescribing (Project No. 2210).

The aim of the audit was to address all the common prescribing errors/omissions identified during the first cycles of the audit and maintain the improvement whilst trainees rotated from other posts.

The Chairman, Mr Andy Meehan, presented Dr Ntovolou with £150 towards a course/conference or book tokens.

For 2015, the Clinical Audit for Quality Improvement Awards introduced a new category which was an award nominated by the Clinical Audit Team, for the best National Clinical Audit.

This was to recognise the importance of participation in national clinical audits as it enables UHCW to demonstrate that it monitors quality in an ongoing, systematic manner. It also acknowledges that a high level of participation provides a level of assurance that the Trust takes quality seriously.

The Clinical Audit Team awarded the prize for Best National Clinical Audit Award 2015 to National Paediatric Diabetes Audit (Project No. 1857) Dr Karthikeyan, Consultant Paediatrician and her team. The audit aims to address a series of questions relating to paediatric diabetes care.

The audit is undertaken to allow benchmarking between Trusts to ensure young patients with diabetes are receiving the high standards of care recommended by the National Institute for Health and Care Excellence (NICE). Each year recommendations are made which aim to not only improve the quality of care and outcomes for children, but also to reduce the inequalities in care highlighted by the audit.

The Clinical Audit Team awarded the prize in light of the success of the audit to date and its sustainability.

- ✓ The National Paediatric Diabetes Audit is a longstanding national audit (running for the past 10 years)

- ✓ The Project Team is committed to making changes and improving patient care with a significant improvement being made within the last eighteen months

- ✓ The Project Team is made up of multidisciplinary staff, therefore a wide range of clinical knowledge and expertise contributes to this audit and any resultant actions; resulting in a greater impact on the quality of care provided

- ✓ Evidence of significant improvements to practice, demonstrated by the national audit results, resulting in the Trust compliance being better than the national average but more importantly recognising that improvements are still required

The Chairman, Mr Andy Meehan presented the award to Rebecca Van Ristell, Paediatric Diabetes Specialist Nurse, on behalf of Dr Karthikeyan and the team.

The Clinical Audit for Quality Improvement Award demonstrates the Trust's commitment to supporting those who undertake clinical audits, assisting them in developing their auditing skills throughout the process, and raising deeper awareness of the important contribution that clinical audit makes to the wider quality agenda.

Further Developments for 2016-17

Clinical Audit Policy

To ensure that all local and national clinical audit activity is registered and conforms to agreed best practice, work has commenced on reviewing the Clinical Audit Policy. Areas and topics have been identified for inclusion as a result of the self-assessment against the Clinical Audit Assurance Framework.

Web-Based Clinical Audit Database

To improve reporting mechanisms the Clinical Audit Team will progress the development of a Web-Based Clinical Audit database. One of the main aims is for healthcare professionals to have access to the database which will enable them to view and update progress against their own clinical audit activity.

Increase the Profile of National Clinical Audit results and Associated Learning within the Trust

The depth of knowledge and learning from national clinical audits is key as it enables UHCW to demonstrate that it monitors quality in an ongoing, systematic manner. To improve this the team will start to introduce individual Executive Summaries for each national audit that UHCW participates in. By promoting national audits and associated learning it is hoped that higher levels of participation will be achieved which in turn could result in an increase of the levels of assurance provided to the Trust.

Evaluation of Clinical Audit Activity within the Trust

The Clinical Audit Team will develop an evaluation process which will allow healthcare professionals involved in clinical audit activity to provide valuable feedback on the support they received from the team during completion of their audit/s. By gaining views and opinions from all staff involved in clinical audit, it is anticipated this will help support staff with their clinical audit activity.

MORTALITY

Introduction to Mortality

UHCW is committed to accurately monitoring and understanding its mortality outcomes. Reviewing patient outcomes such as mortality is important to the Trust as it helps provide assurance and evidence that the quality of care is of a high standard and identify any issues to be addressed to improve patient care. Reviewing mortality helps fulfil two of the five domains set in the NHS Outcomes Framework:

- Preventing people from dying prematurely
- Treating and caring for people in a safe environment and protecting them from avoidable harm

The Trust uses mortality indicators such as the Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital Level Mortality Index (SHMI) to compare mortality data nationally. This helps to identify areas for improvement. Although these indicators are not a measure of poor care in hospitals, it does provide a 'warning' of potential problems and helps identify areas for investigation.

In addition to this, the Trust has an in-depth mortality review process where each death of an inpatient aged 18 and above is subjected to an initial review of their care and graded according to the standard of care they received. Further reviews are conducted by an appropriate Consultant or team if problems in care are identified. This is to encourage learning from patient outcomes.

All mortality processes are overseen by the Trust's Mortality Review Committee, chaired by a Deputy Chief Medical Officer. The Mortality Review Committee reports into the Trust's Patient Safety Committee each month. Furthermore mortality data is reported to the Trust's Quality Governance Committee on a monthly basis and to the Trust Board twice yearly.

Trust Mortality Performance for 2015-16

Mortality Indicators

Mortality indicators act like a smoke alarm and can provide warning where there may be potential problems. If there have been more deaths than expected, it does not mean however that these deaths were avoidable, or that there has been poor care.

Hospital Standardised Mortality Ratio (HSMR) (provided by Dr Foster Intelligence)

The HSMR is a mortality indicator (provided monthly) which looks at inpatient deaths in comparison to 'expected' deaths. Expected deaths are calculated by assigning each patient a mortality risk by accounting for factors such as age, co-morbidities, diagnosis group, gender, palliative coding, and many more. The HSMR is comprised of 56 diagnosis groups which contribute to 80% of inpatient hospital mortality (nationally). The HSMR is calculated using the calculation below:

$$\frac{Actual\ deaths}{Expected\ deaths} x100$$

The national benchmark for mortality performance is 100. If the HSMR value is above 100 it indicates that there have been more deaths than expected. If the HSMR value is below 100 it indicates that there have been fewer deaths than expected. If there is a statistically significant difference between the actual number of deaths and expected number of

deaths, a positive 'alert' or a negative HSMR 'alert' will occur. Negative alerts highlight areas for investigation to identify improvements in care. Positive alerts indicate areas where performance has been better than expected. HSMR data is received by the Trust three months in arrears. The most recent release of data includes mortality for all deaths prior to and including December 2015. The HSMR for the most recent 12 months of data (January 2015 – December 2015) is 103.26. This is within the 'expected' range for mortality (there is no significant difference between observed and expected deaths). The HSMR value for December 2015 is 79.95 which is significantly low (significantly fewer deaths than expected; positive alert).

HSMR Trend: January 2015 – December 2015

The chart below shows the HSMR trend for UHCW for each month between January 2015 and December 2015. It highlights that UHCW had significantly more deaths than expected during August 2015 (shown in red below). Despite this, UHCW's HSMR has been below 100 since September 2015, indicating fewer deaths than expected and became significantly low in December 2015.

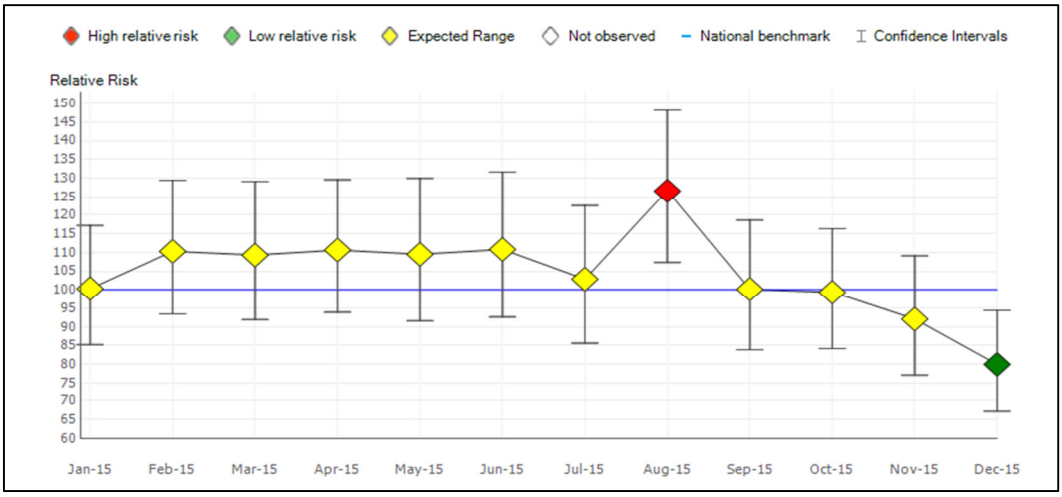


Figure 7: HSMR trends for January 2015 – December 2015. Source: Dr Foster Intelligence

Changes in Practice

Types of Mortality Alerts

Using Dr Foster, the company which provides the Trust with the HSMR, the Trust can also monitor whether the number of deaths has deviated from the 'expected number' of deaths at a variety of levels including: diagnosis group, procedure group, and Specialty level. There are 3 types of mortality alerts which are received through Dr Foster:

1. High Relative Risk Alerts – negative alerts where there are significantly more deaths than expected

2. Cumulative Sum Alerts (CuSum alerts) – negative alerts which signal that a pattern of activity has gone beyond the 'expected' threshold. CuSum charts plot patient outcomes against their mortality risk

3. Positive Alerts – these can either be low relative risk alerts, or positive CuSum alerts. They both measure whether there have been significantly fewer deaths than expected

Diagnosis Group and Procedure Group Alerts

Each month, diagnosis and procedure groups which have generated negative alerts (significantly more deaths than expected) are discussed at the Mortality Review Committee, which agrees appropriate action to address the alerts. In addition to this, in June 2015 the Mortality Review Committee launched multiple investigations into diagnosis groups which had the largest difference in observed and expected deaths. These alerts had in-depth case note reviews, coding reviews and procedure reviews to help identify areas for improvement. Several key areas for improvement were noted and the following actions are underway:

- Evidence based care bundles are being created by Specialties for diagnosis groups with a large mortality rate. A care bundle is a set of interventions that, when used together, significantly improve patient outcomes. They aim to reliably deliver the best possible care for patients and have been proven to improve patient outcomes

- Work is ongoing with the Coventry and Rugby Clinical Commissioning Group to promote adequate community care to reduce avoidable hospital admissions

- Development of local guidelines for diagnosis and management of specific diagnosis groups such as Heart failure

Specialty Mortality Reports

Further to monitoring diagnosis and procedure alerts, each Specialty within the Trust also receives a Specialty Mortality Profile report twice a year to provide an update on their mortality performance. These are discussed initially at their Specialty meetings, and then the outcomes of these discussions are reported to the Mortality Review Committee by the Specialty's Mortality Lead or Clinical Director.

Palliative Care Coding

Palliative care is also important within the Trust as it focuses on providing patients with relief from the symptoms, pain, physical and mental stress of a serious illness. UHCW has been one of the lowest Trusts for recording palliative care for several years. Work has been ongoing in the Trust during the year to increase the number of patients receiving palliative care by our Specialist Palliative Care Team including twice daily ward visits to provide additional support to patients and nurses. Due to this, the recording of palliative care has increased. Between January 2014 and December 2014, the palliative care rate for deceased patients at UHCW was 8.78%. However, following changes within the Specialist Palliative Care Team this year, the palliative coding rate of deceased patients has increased to 23.81% (January 2015 - December 2015). The national average for palliative coding during this time was 24.77% indicating that UHCW is now reporting similarly to other Trusts.

Summary Hospital-level Mortality Indicator (SHMI) (Provided by the Health and Social Care Information Centre; HSCIC)

The SHMI is a national indicator published by the HSCIC quarterly and is 6 months in arrears. It differs from the HSMR in several ways:

- 'Expected' deaths are calculated using different variables – for example, mortality risk is not adjusted for patients receiving palliative care
- Includes all diagnosis groups instead of the 56 used in the HSMR
- Includes all inpatient deaths and those who die within 30 days of hospital discharge

The national benchmark for the SHMI is 1. 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.

The most recent publication for the SHMI is for July 2014 – June 2015 (published by the HSCIC in January 2016). The majority of Acute Trusts in this publication were within the 'expected' mortality range (80.15%; 109 Trusts). UHCW is also within the expected range, as the value is 1.054. During this time period there were 2935 deaths recorded compared to 2783.937 'expected' deaths.

Trust-wide Mortality Review – An Overview

Each inpatient aged 18 or above is subjected to a primary mortality review by the Specialty involved in their care at the time of their death. This helps to provide assurance that the quality of care was of a high standard and helps to identify areas for improvement when possible. All patients subjected to a review have their care graded by a Consultant, using the National Confidential Enquiry into Patient Outcomes and Death (NCEPOD) Classification of Care (Table 4 below):

NCEPOD Classification of Care		
A	Good Practice	A standard that you would accept for yourself, your trainees and your institution
B	Room for Improvement	Aspects of clinical care that could have been better
C	Room for Improvement	Aspects of organisational care that could have been better
D	Room for Improvement	Aspects of both clinical and organisational care that could have been better
E	Less than Satisfactory	Several aspects of clinical and/or organisational care that were well below satisfactory

Table 3: NCEPOD Classification of Care

All patients who are graded NCEPOD B-D have a secondary review form completed as the grade highlights that there were aspects of care which could have been improved. The purpose of the secondary review is not to attribute blame to teams, but to identify areas for learning and actions to help improve patient care and avoid similar problems occurring. This is a multi-disciplinary approach and is discussed in Specialty meetings to ensure that learning is shared. Theme analyses are conducted from secondary reviews and shared throughout the Trust to promote improvements in patient care.

Deaths which are graded NCEPOD E have an investigation reviewing all aspects of care. This is completed by the Clinical Director or Mortality Lead for the Specialty involved and reported to the Mortality Review Committee. The committee then discusses the case and agrees appropriate action. Trend analyses for NCEPOD E deaths are also conducted in the Trust to enable identification for improvement areas and to disseminate learning.

Specialties with a small number of deaths discuss every death during their Quality Improvement and Patient Safety meetings or Mortality and Morbidity meetings to collectively share views regarding quality of care provided. In larger Specialties, this is not always possible so they focus on discussing all mortality reviews which are graded B-E in their meetings to ensure that important messages are shared amongst the team.

Trust-wide Mortality Review – Completion Rates

The completion rate of primary mortality reviews has been increasing since the implementation of the process in 2011 despite there being more deaths each year. This is as a result of the support this process receives from Specialties and the work conducted by the Clinical Effectiveness Team in continuing to promote this process and provide support where necessary. Of the 1992 adult inpatient deaths between April 2015 and March 2016, the majority of these have

had a primary mortality review completed (83.78%) and more are being completed daily. Figure 8 below highlights that 91% of patients reviewed received an NCEPOD grade A – good standard of care. This is higher than previous years indicating an improvement in patient care. All patients who appear in a mortality alert received through Dr Foster are reviewed to ensure that a primary mortality review was completed and followed up if still outstanding.

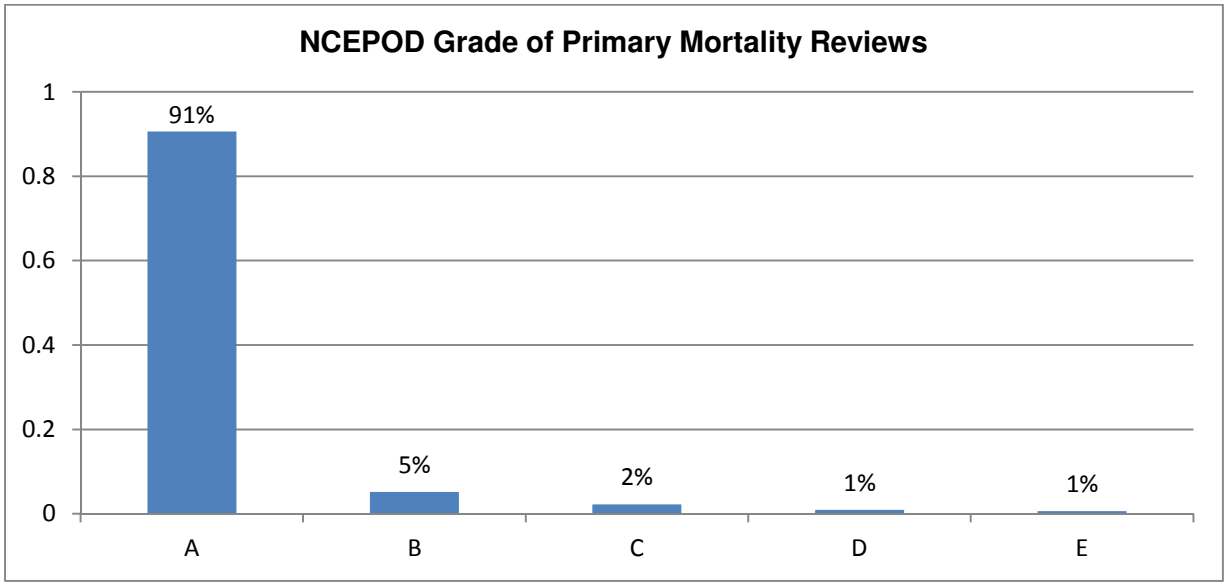


Figure 8: NCEPOD Grades of completed primary reviews. April 2015 – March 2016. Data collected 30/03/2016

The Trust's Clinical Lead for Mortality conducts an annual quality assessment of primary mortality reviews which have been graded NCEPOD A for 'good care'. This is to provide assurance that the grading of care is appropriate and accurate. The most recent report was presented to the Mortality Review Committee in December 2015. The findings of this were that there was difficulty measuring the appropriateness of the grading due to a lack of recorded information on the primary mortality review. However, upon further investigation into patient records, the care was of a high standard and therefore should remain as "A" graded cases. These results were published in the mortality newsletter placing emphasis on timely and appropriate recording of information.

Secondary Mortality Reviews

For all deaths in 2015-16 which have had a completed primary mortality review, there were 140 requested secondary reviews (cases graded NCEPOD B-E), suggesting 140 opportunities for learning. This figure is likely to increase as more primary mortality reviews are completed. Of the completed secondary reviews, 16.5% of these have been re-graded to NCEPOD A (good care) following discussions with their Specialties' team members. The Trust is proactive regarding utilising opportunities to identify areas for improvement and challenging each other's views which is highlighted by the number of cases re-graded.

NCEPOD E Deaths

The Trust had a corporate objective for 2015-16 to reduce the number of NCEPOD E deaths to fewer than 15 due to 27 NCEPOD E cases received in the previous financial year. A review of NCEPOD E deaths was conducted and as a result, extensive work has been undertaken regarding education of escalation of patient observations. There have been 6 NCEPOD E deaths during this financial year – a reduction of over 75%.

Key Achievements of 2015-16

The Trust has been working to improve the mortality review process for Consultants to continually improve completion rates and to identify learning and appropriate actions efficiently. During the financial year 2015-16 UHCW has been streamlining the mortality review process. The following changes have taken place, or are in the process of being completed:

- Revised the primary mortality review form for deaths which occur under the Emergency Department – movement to a database reporting system and revised questions for relevance

- Moved UHCW's paper secondary mortality review form to the Clinical Reporting Results System (CRRS) to enable ease of completion and recording of themes on a centralised system

- The process for NCEPOD E graded deaths has been formalised to ensure an appropriate pathway for these cases to optimise learning

- Improved Consultant input into the mortality newsletter – each Specialty is requested to detail a case they have encountered during the year which has beneficial learning for the Trust

- Regular feedback mechanisms such as online surveys have been implemented to improve communication between the Clinical Effectiveness Team and clinicians in order to streamline the processes

- Closer working with the Bereavement Team to ensure patient documents are reviewed by the appropriate Consultant in a timely manner

- Discussions with other Trusts regarding their mortality processes to share ideas and promote improvement locally and nationally

Further Developments for 2016-17

The Clinical Effectiveness Team will progress the following in 2016-17:

- Improve the use of mortality data to give indications of trends and areas for improvement
- Increase the accuracy of reporting on the Patient Administration System and in hospital records
- Improve engagement from clinicians regarding the mortality review process and investigation process
- Establish mortality training for clinicians to help them understand the processes and how to respond appropriately to problems arising from mortality reviews or from the mortality data received by Dr Foster
- Improve the identification of 'avoidable' deaths from mortality reviews
- Proactively monitor diagnosis groups which are close to becoming mortality alerts
- Revise methodology for investigating mortality alerts to ensure the investigations are comprehensive and improvements are easily identifiable
- Develop more care bundles for diagnosis groups with a large mortality rate and establish a group chaired by a Deputy Chief Medical Officer to monitor effective implementation and audit use of the care bundles.

CLINICAL GUIDANCE

Introduction to Clinical Guidance

Clinical Guidelines are designed to support the decision-making processes in patient care. The content of a guideline is based on a systematic review of clinical evidence which is the main source for evidence-based care.
The reasons the NHS use clinical guidelines are:

- To describe appropriate care based on the best available scientific evidence and broad consensus
- To reduce inappropriate variation in practice
- To provide a more rational basis for referral
- To provide a focus for continuing education
- To promote efficient use of resources
- To act as a focus for quality control, including clinical audit
- To highlight shortcomings of existing literature and suggest appropriate future research

Trust Clinical Guidelines

The Trust has a dedicated resource that seeks to ensure all clinical guidelines are relevant and up to date. 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. All approved guidelines meeting the Trust's standards are held on e-Library. e-Library is available on the intranet to all staff.
All clinical guidelines must meet specified criteria and are subject to a robust approval process prior to publication on the system.
In 2015-16 approximately 380 guidance documents were reviewed and updated. Approximately 100 new guidance documents were developed and approved for inclusion on e-Library.
At any one time there are a number of guidance documents on e-Library that require review by the original author. This may be because they are approaching their expiry date or because new national guidance has been issued that impacts on the local guidance.
e-Library clinical guidance activity for period April 2015 – March 2016 shows on average 9 new guidelines and 34 reviewed guidelines have been updated on e-Library each month. On average 15 guidelines expired each month for this period.
Monthly status of clinical guidance on e-Library is recorded to monitor the number of expired guidelines ensuring the 5% target is not breached. Figure 9 shows the number of guidelines at each status per month.

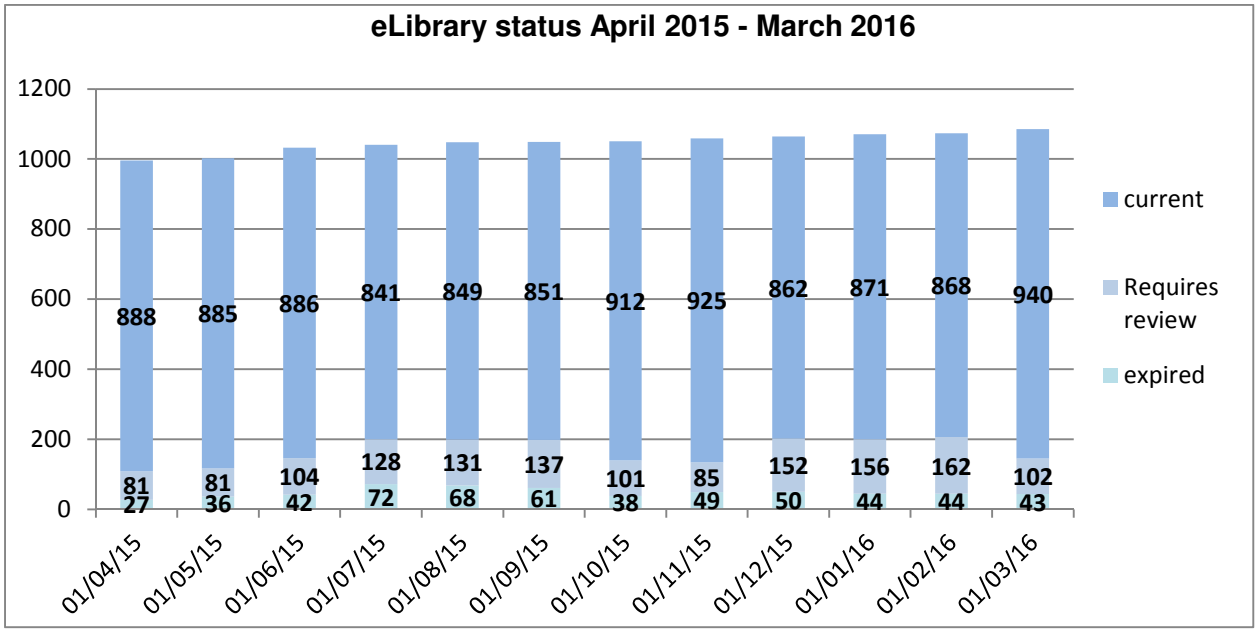


Figure 9: e-Library status from April 2015 to February 2016

Data from the beginning and end of 2015-16 has been recorded. The total number of clinical guidelines on e-Library has increased from 996 to 1085 in this time period.

The graphs show the e-Library status at April 2015 and March 2016.

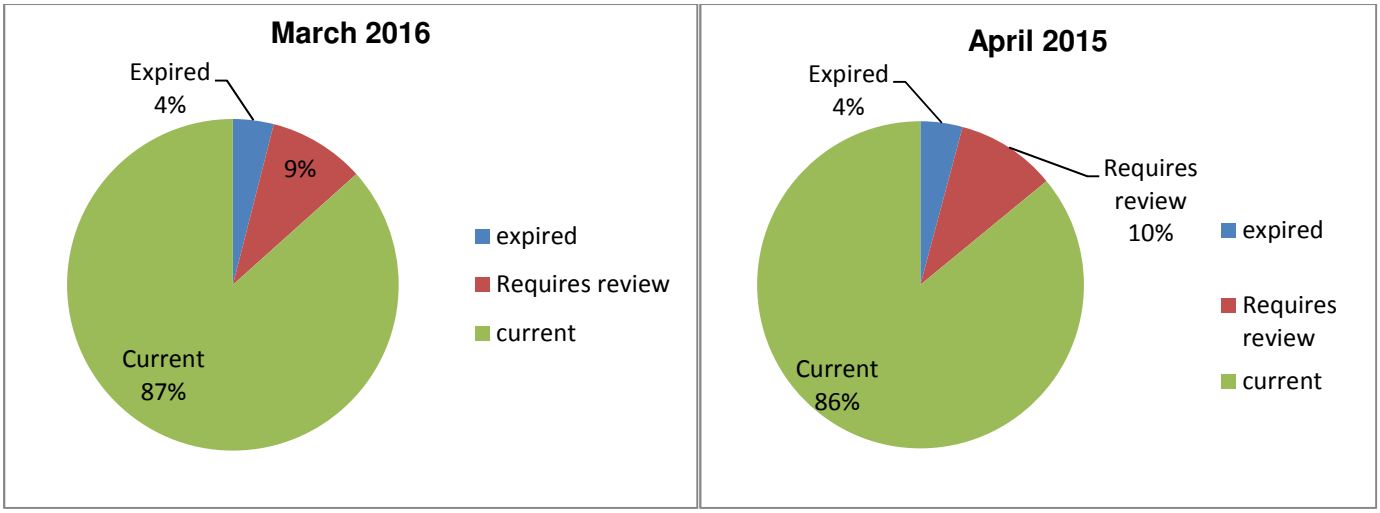


Figure 10: shows the e-Library status at the start end of 2015-16

The target for the number of expired guidance on e-Library is set at no more than 5%. This has been met consistently in 2015-16.

Key Achievements in 2015-16

UHCW Policy for the Development and Management of Local Clinical Guidelines and Clinical Operating Procedures

The procedure for the Development and Management of Local Clinical Guidelines and Clinical Operating Procedures has been revised and amendments made following a wide consultation exercise. The procedure was reviewed further

in light of the consultation feedback. The revised version has now been approved by Corporate Business Record Committee.

Changes in the process that have been developed over the last year include:

- Gap analysis undertaken to ensure that all guidelines reference each other so that contradictions do not occur
- Fast track approval of guidelines that do not require change
- Escalation of expired guidelines
- Introduction of Specialty clinical guideline leads, to co-ordinate guideline development, dissemination and implementation.
- Simplified clinical guideline template
- Introduction of a guide to writing clinical guidelines

Horizon scanning

The Trust ensures that national guidance including National Institute for Health and Care Excellence guidance is available to Specialties. This ensures that local guidelines are continually reviewed, updated and implemented in line with the latest national guidance.

In 2015-16 a new horizon scanning process was developed which is designed to improve the support clinicians receive for development of their Specialty clinical guidelines. Horizon scanning undertaken by Clinical Evidence Based Information System (CEBIS) specialists provides a consistent approach across all Specialties in identifying relevant new national guidance. This information along with relevant NICE guidance and existing local guidelines is disseminated to Specialty guideline leads.

e-Library Working Group

Early in 2016 the e-Library working group was re-established. The actions being progressed are to review the e-Library Operational Policy and develop a business continuity plan for e-Library. The e-Library administrators are exploring ICT development requirements for 2016-17.

Reporting

Reporting of status of local clinical guidance on e-Library has improved. Quality and Patient Safety (QPS) reports now include details of new local guidance that have been added to e-Library and also the percentage of expired guidelines for each Specialty. The reports also provide details of NICE guidance relevant to the Specialty and the status of implementation.

Quarterly Performance Review data has been updated to include the performance against the previous quarter for local guidelines and implementation of NICE guidance.

New and revised clinical guidelines that are added to the e-Library system are promoted using the weekly Trust communication.

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 introduced National Guidance (NG) in 2015 which replaced clinical guidelines, public health guidance, social care guidelines, safe staffing guidelines and 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 2012 and Health and Social Care Act 2008.

NICE guidance and quality standards can also help UHCW meet regulatory requirements from organisations such as the Care Quality Commission (CQC).

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.

NICE Guidance Compliance

In total there are 603 guidance documents registered on the UHCW bespoke NICE database since it was first developed four years ago. 171 of these have been identified as 'not applicable' where the procedure or service is not provided by UHCW.

There were 163 guidance documents issued by NICE in the 2015-16 financial year, 39 of these have been identified as 'not applicable' when the procedure or service is not provided by UHCW. Figure 11 shows the compliance rates for each type of guidance that has been issued by NICE between April 2015 and March 2016.

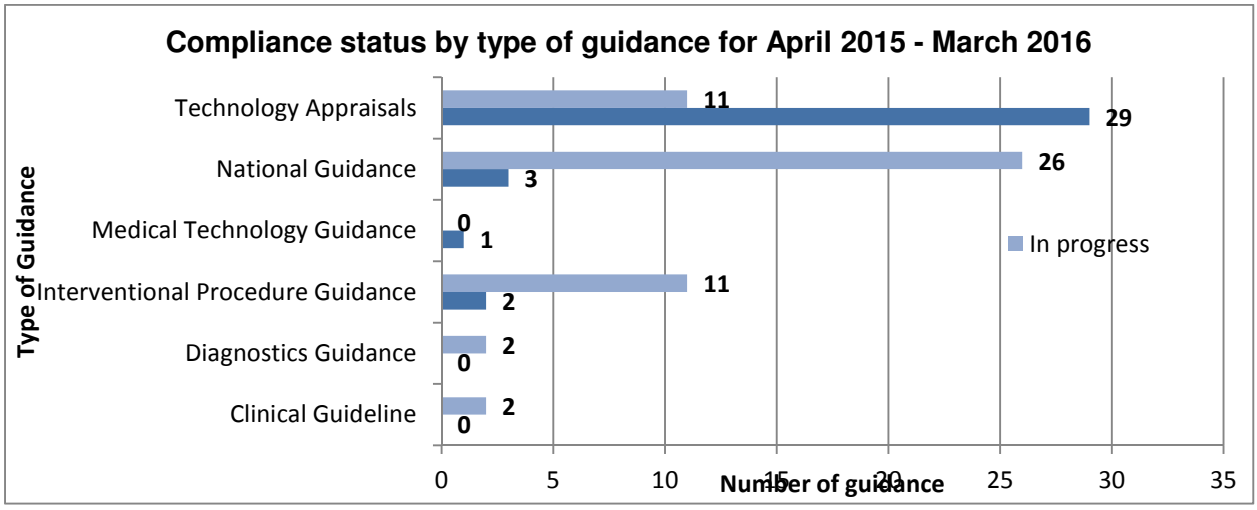


Figure 11: Compliance status 2015-16. Guidance that has been identified as not applicable to UHCW has been removed to calculate compliance rates. Quality Standards are not included in compliance rates.

Work is continuing to improve reporting status of NICE guidance.

Technology Appraisals (TAs)

The Department of Health select the technologies for appraisal by NICE. The technologies chosen have a significant impact on patient health, health inequalities, government policy or NHS resources. It is a statutory duty for all Trusts to implement the recommendations made within TAs within 90 days of issue.

The process for responding to a NICE TA was implemented in 2015 and as a result has improved the timescales of implementation. The majority of drugs recommended in published TAs are added to the Trust's Drug Formulary and are available for patients within the 90 day target.

Quality Standards (QS)

The overall total of Quality Standards now registered on the database is 111. There have been 22 new Quality Standards issued between April 2015 and March 2016, with 10 reported as fully implemented, 17 partially implemented and 9 not applicable to the Trust.

Clinical Audit

NICE clinical guidelines, national guidelines and quality standards that are reported as compliant by the Specialty are put forward to be included on the Trust Clinical Audit Programme. When a clinical audit project is completed it provides assurance that the recommendations made by NICE have been implemented. The Clinical Audit Team will also highlight non-compliant recommendations, which can then be addressed to improve patient care.

Newsletter

The first clinical guidance newsletter was issued in January 2016 which was designed to provide key information and raised awareness of the UHCW procedure for developing clinical guidance.

Further Developments for 2016-17

- Reduce the number of expired guidelines to 4%
- Develop the clinical guideline and NICE database for reporting, managing and monitoring clinical guidance
- Develop an electronic form to be used by clinicians for submission of new and revised guidelines that require inclusion on e-Library
- Launch the revised policy for clinical guidelines alongside the mobile application
- Identify 'Top 20' diagnosis and procedures to ensure relevant guidance is available for Specialties
- Establish a process to identify priority areas for undertaking clinical audit against NICE guidance

COMPLIANCE AND ASSURANCE

Introduction to Compliance and Assurance

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 Care Quality Commission (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.

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.

Compliance

Key Achievements of 2015-16

UHCW is governed by a regulatory framework that requires healthcare providers to be registered with the CQC and therefore licensed to provide healthcare services. The Trust's current registration status is 'registered with no conditions' and the CQC has not taken enforcement action against UHCW during 2015-16.

UHCW underwent two inspections by the CQC during 2015-16. The first was a Care Quality Commission (CQC) comprehensive inspection which took place in the Trust from 10 to 13 March 2015. The Compliance Team supported the development of, a high level "must do" and "should do" action plans focused on addressing the specific areas of improvement identified in the CQC report that was published in August 2015. All action plans have been updated, discussed and reported to the Chief Inspectors of Hospital Programme Board. The Must Do action plan was fully completed in March 2016.

The outcome rating of the overall review resulted as follows:

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

Individual site ratings of each area resulted as follows:

University Hospital

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

On review, the CQC deemed Outpatients and Diagnostic Imaging 'inadequate' for the Safe Domain. This was specifically in relation to services provided by the diagnostic imaging services. In response the Diagnostic Imaging department developed a specific action plan to address the issues highlighted by the inspection process.

Hospital of St Cross, Rugby

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good	Good	Good	Requires improvement	Requires improvement	Requires improvement
Medical care	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Surgery	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	Not rated	Good	Good	Requires improvement	Good

The second CQC review was a multi-agency inspection of the Coventry health economy on 11 May 2015, as part of a national review of health services for children looked after and safeguarding. The Trust received the report with no rating in December 2015 and a joint action plan, led by the Coventry and Rugby Clinical Commissioning Group was submitted to the CQC in response to the recommendations made.

In addition, a pilot Urgent and Emergency Thematic Review took place at the Hospital of St Cross in the Rugby Urgent Care Centre on 23 February 2016. This review covered the geographical area of the South Warwickshire System Resilience Group and a report will be issued in due course but with no rating.

Preparation for a review was under taken by West Midlands Quality Review in December 2015, to assess effective discharges within the Trust. Data sets were prepared to compare the smooth transition of discharges from an acute setting into a community setting however, the review did not take place.

The Compliance Team has continued to strengthen its systems and processes that support compliance activities across the Trust through the following:

- Appointment of a Compliance Officer
- Creation of the Compliance Development Plan

- Introduction of a joint newsletter with the Assurance Function to raise awareness of the requirements of regulatory activities and inspection outcomes

Further developments for 2016-17

In 2016-17 the Compliance Team will:

- Continue to assist in the completion of future Inspection related action plans
- Prepare the Trust for future CQC inspections
- Work with teams across the Trust to prepare for future CQC inspections
- Develop a log of external inspections that take place across the Trust
- Introduce a notifications process to ensure standardisation of approach to activities that are reported externally to the Trust, particularly to the CQC
- Support the delivery and outcomes of any inspections completed by the West Midlands Quality Review Service

Assurance

The Assurance Function aims to provide an ongoing objective approach to assess whether the Trust is meeting the fundamental standards of care and provide support for service improvements. The main assessment used by the team is called “Getting The Basics Right” (GTBR). This enables the Trust to ensure that these reviewed standards are being met.

Key Achievements of 2015-16

The inaugural Getting The Basics Right (GTBR) programme was implemented during January and February 2015 followed by Getting The Basics Right 2 Programme (GTBR2) which commenced on 28 September 2015 and ran for 6 weeks and concluded in early November 2015. The aim of the GTBR Programme is 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 review Trust services against a set of core key lines of enquiry. GTBR composed of 25 key lines of enquiry utilised with 68 service areas and GTBR2 increased the key lines of enquiry to 78 for outpatients, 94 for wards and 103 for theatres. The results from both programmes were analysed and reported to the Chief Inspector of Hospitals Programme Board, separately to the Specialty Groups’ management teams for action and also aggregated into a Trust-wide ‘heat map’.

For GTBR2 additional area specific key lines of enquiry were developed to be used in Radiology Services on the University Hospital site. These were developed to assess progress and improvement of specific findings in the Trust’s CQC Comprehensive Inspection report and were completed at the same time as the full radiology review.

Reviewers who took part in GTBR2 were asked to complete a short questionnaire. The subsequent feedback facilitated learning to further adapt and strengthen the Programme.

An information resource was developed for reviewers. This benefits both the Trust and the reviewers: the aim being to reduce inconsistencies in reporting.

An Assurance Trust-wide newsletter has been published. The newsletter aims to increase awareness of the GTBR assurance programme and to encourage staff to learn from the reviews and to facilitate sharing and learning from good practices.

GTBR2 increased the number lines of enquiry from those used in the initial programme to improve relevance and monitoring of standards.

Figure 12 demonstrates the progress made between comparable key lines of enquiry for the service areas reviewed in the two programmes.

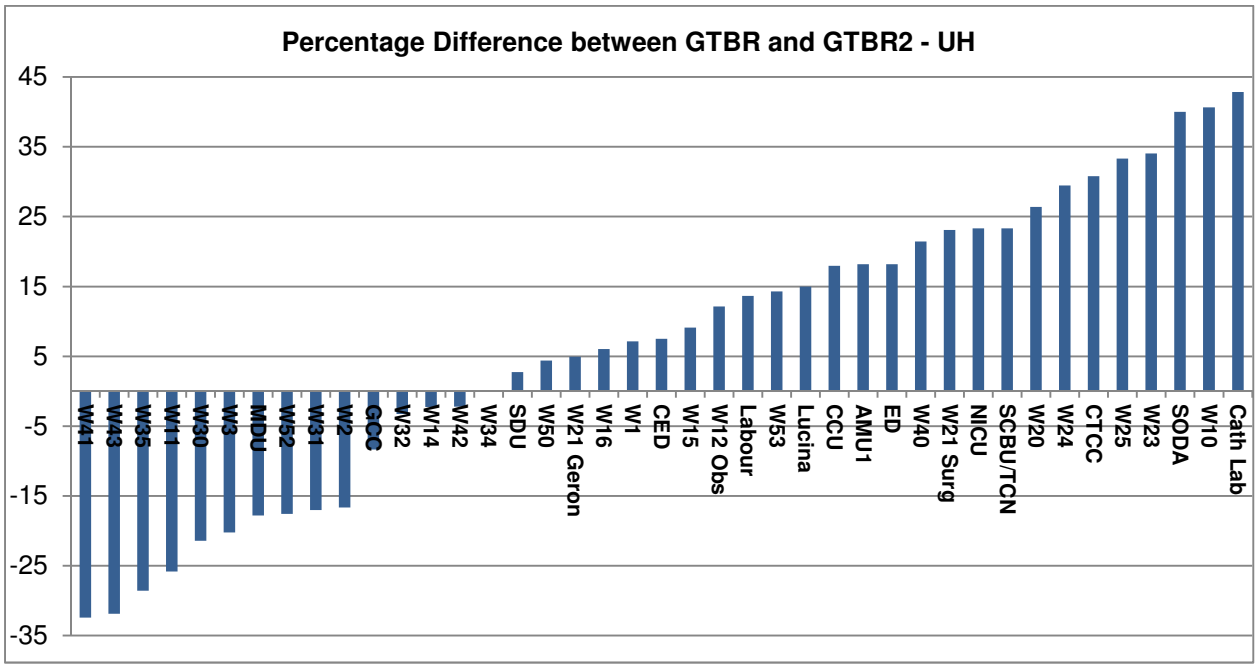


Figure 12: Details percentage comparison between UH wards reviewed in both GTBR and GTBR2, using comparable questions.

Figure 13 below, highlights the changes in levels of assurance for areas at the Hospital of St Cross, Rugby, for comparable questions applied in GTBR and GTBR2. Results improved for all areas except one indicating assurance that fundamentals of care are becoming embedded in every day practice.

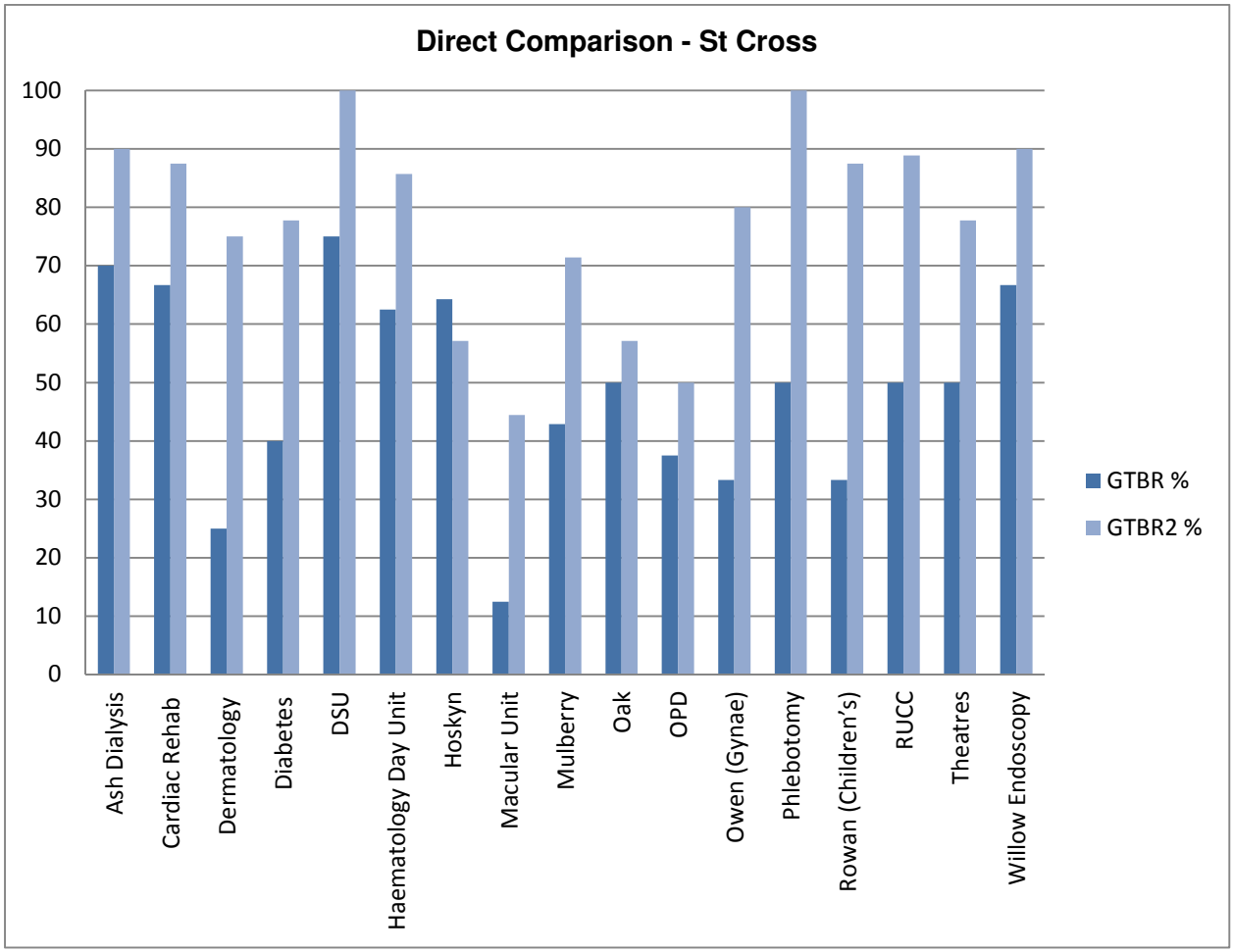


Figure 13: Comparison all areas reviewed at St Cross in both GTBR and GTBR2.

Figure 14 below portrays the range of compliance the wards achieved at both University Hospital and the Hospital of St Cross for GTBR and GTBR2.

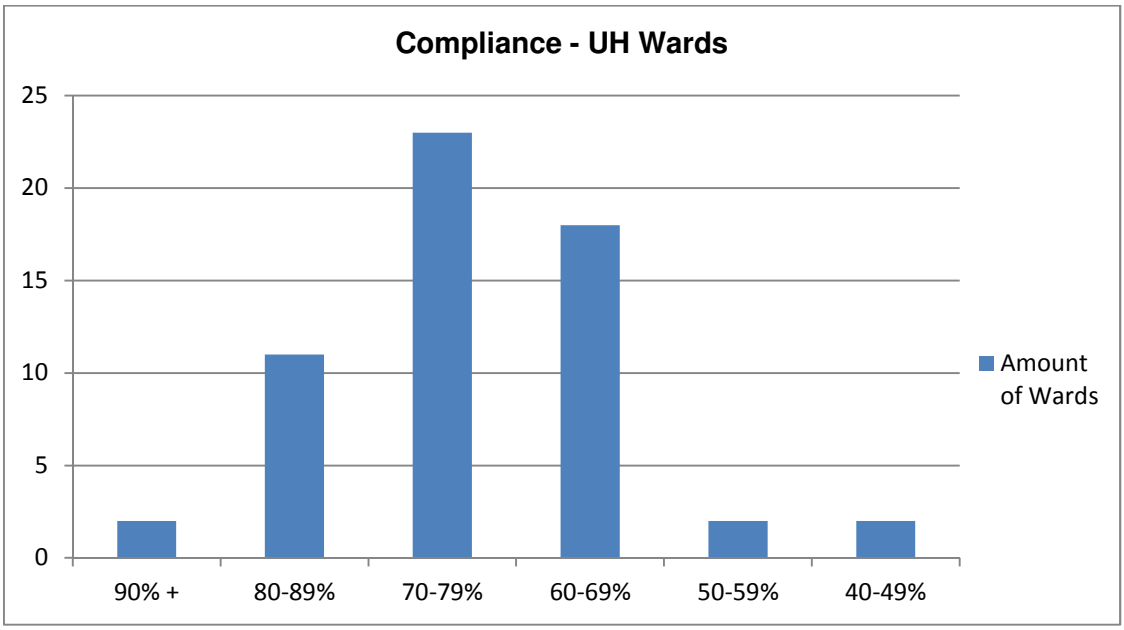


Figure 14: Details percentage comparison between UH wards reviewed in both GTBR and GTBR2, using comparable questions

The majority of ward areas gained assurance for between 70-79% of the questions asked. Figure 15 shows the range of compliance the outpatient services achieved at both University Hospital and the Hospital of St Cross.

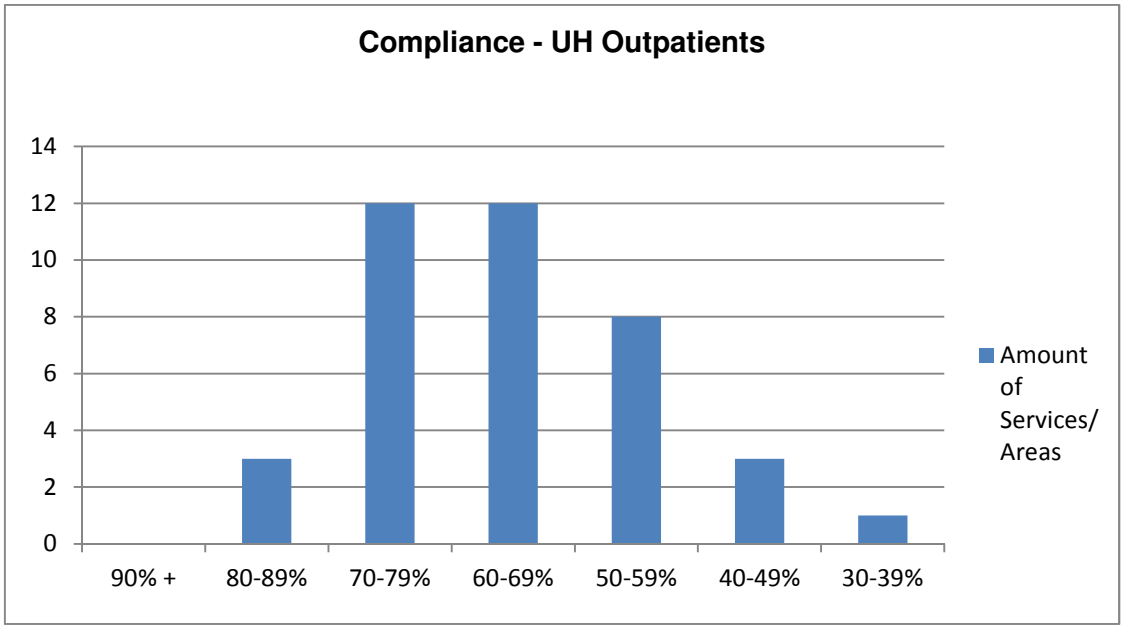


Figure 15: Showing the range of results for outpatient/ service areas over UH and St Cross sites.

The majority of outpatient areas provided assurance for 60-79% of questions used.

It has been recognised that GTBR is a valuable means of gathering assurance of the Trust's fundamental standards of care so it will be repeated twice year. It is anticipated that GTBR3 and GTBR4 will continue to show significant improvement of outputs.

During completion of the first two GTBR programmes, it was recognised that staff from UHCW work on behalf of the Trust at several other sites across the county and beyond into Worcestershire. A feasibility study was undertaken, in January 2016, to explore whether the methodology utilised for GTBR could be used to gain assurance for the Trust at such sites. The study has been completed and the results published.

Further Developments for 2016-17

In 2016-2017, the Assurance Function will continue to be developed and strengthened, focusing on the following:

- Building on the learning from GTBR2, the Trust's Assurance Programme will be developed and implemented for GTBR3 and GTBR4 which are planned to occur during 2016-17. The programme will continue to 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

- It is planned that triangulation of data from other assurance programmes within the Trust e.g. QUESTT (a nursing performance tool) will be applied to formulate key lines of enquiry for future Getting The Basics Right programmes

- Introduce approaches to reduce the paper burden of Getting The Basics Right

PATIENT EXPERIENCE

PATIENT EXPERIENCE AND INVOLVEMENT

Introduction to Patient Experience and Involvement

The NHS Outcomes Indicator set 2015-16, Domain 4: 'Ensuring that people have a positive experience of care' explicitly mentions improving peoples' experience of outpatient care, hospitals' responsiveness to personal needs, improving people's experience of accident and emergency 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 embedding of the Friends and Family Test (FFT) across the Trust and the introduction of bespoke surveys for neonatal services, critical care and cardiothoracic critical care. This and the other activities and results below demonstrate the Trust's ongoing commitment to routinely listening to and involving its patients, carers and relatives in designing service 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 survey along with the results for 2015-16.

Activity from surveys overseen by the Patient Experience Team:

Surveys overseen by Patient Experience Team	Responses 2015-16	Responses 2014-15
Family and Friends Test and Impressions	48,577	34,356
Inpatient (IP) Survey	528	354
Maternity Survey	187	NA
Children & Young People's Survey	154	NA
A&E Survey		282
Total number of people feeding back	**49,446**	**34,992**

Table 1: Surveys overseen by the Patient Experience Team

Impressions

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 and any pertinent, emerging themes in patient experience that the Trust may want further feedback about.

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 where appropriate.

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

Impressions Results for 2015-16

Amongst the questions asked on Impressions, 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 2015-16 are shown below.

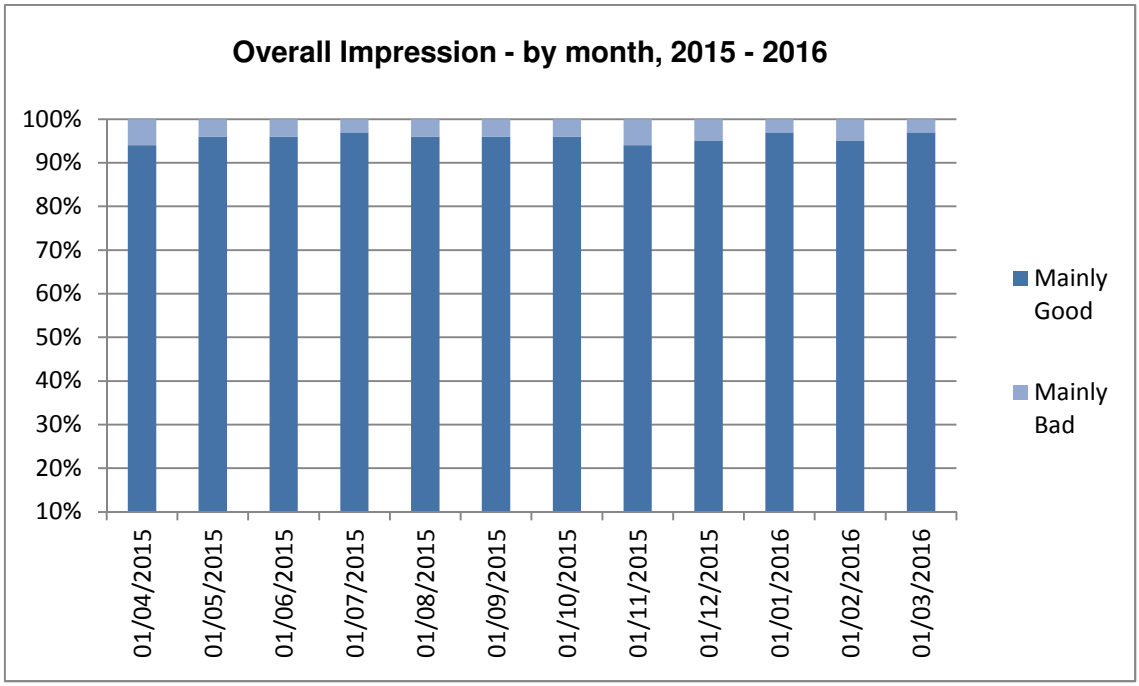


Figure 1: Overall Impressions results by month 2015-16

As with the previous year, scores were consistently in the 90% + range. Patients who left feedback indicated the highest and lowest levels of satisfaction with the following areas of service:

Highest	***Lowest***
Privacy and Dignity	Parking
Kindness and Compassion	Food and Drink
Politeness and Respect	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 and Dignity	Doing things on time
Politeness and Respect	Information

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

Highest	***Lowest***
Cleanliness	Parking
Food and Drink	Discharge Process
Staff Knowledge	Doing things on time

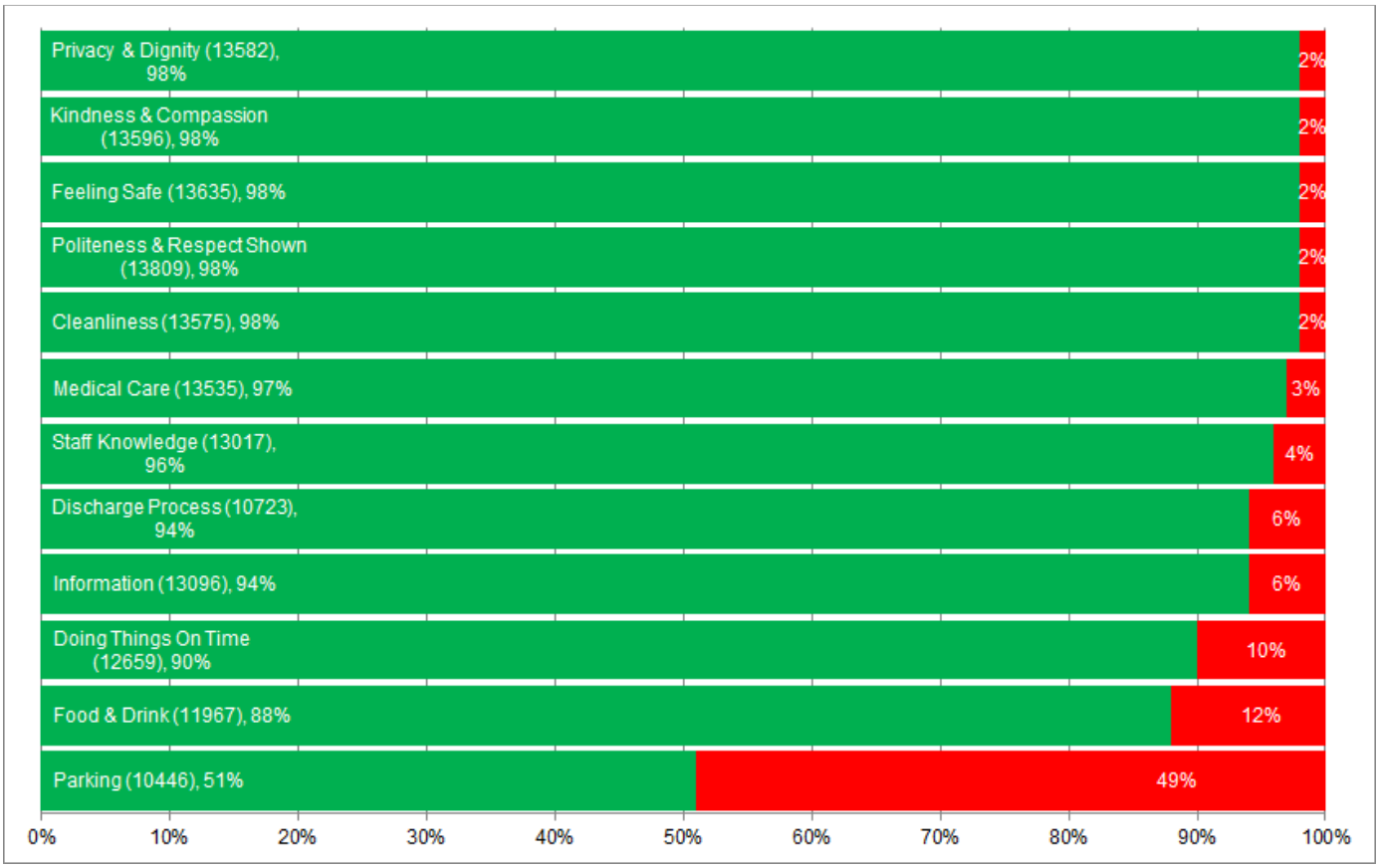


Figure 2: Influencing Factors

The graph above indicates which areas of service, overall, afforded the highest and lowest levels of satisfaction amongst patients, relatives and carers during 2015-16. There has been a little change from last year with privacy and dignity affording the highest satisfaction score and the lowest scoring areas remaining the same: car parking, food and drink and doing things on time.

Friends and Family Test (FFT)

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. The question has been incorporated into the Trust's bespoke patient survey system, Impressions, and has been rolled out across all Trust services in line with national guidance. Results are 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.

Average FFT Recommender Rate 2015-16

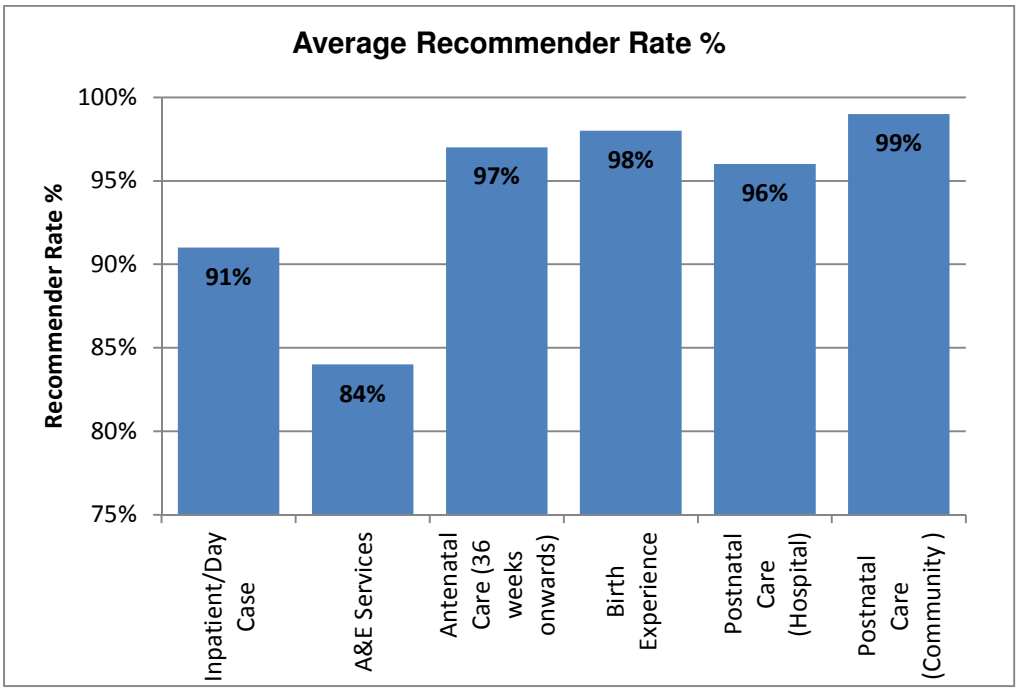


Figure 3: average FFT recommender rate 2015-16

Average FFT Response Rate 2015-16

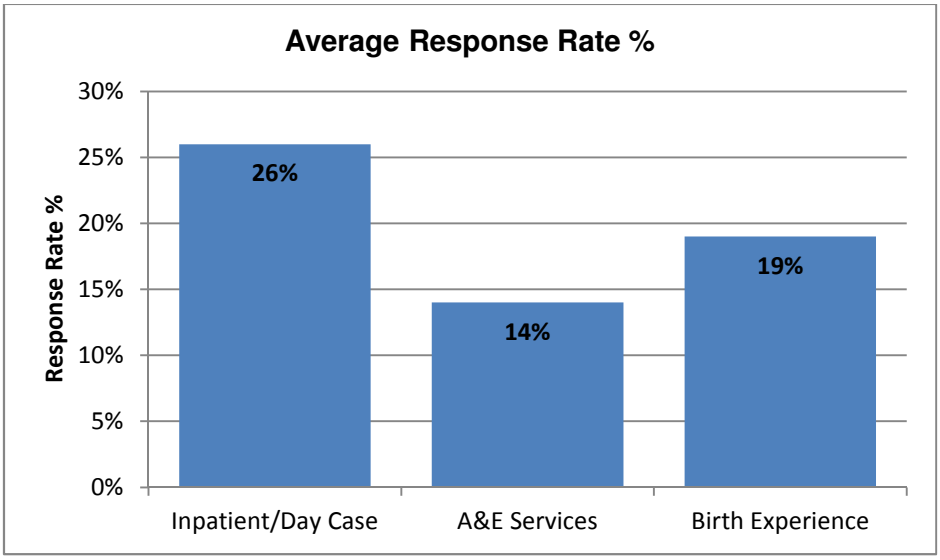


Figure 4: average FFT response rate 2015-16

The tables above show the Trust's average recommender and response rates for 2015-16. Whilst the Trust continues to strive to improve its response rates, it can be noted that the average recommender rates, with the exception of A&E, were 91% or above for the whole year. Additionally, respondents to the FFT indicated high levels of satisfaction in areas such as staff respecting their privacy and dignity and treating them with kindness and compassion.

National Comparison of Friends and Family Test

NHS England publishes the results for the FFT on its website which allows for a national comparison of the data; the results are also published on NHS Choices.

How the Trust compares nationally is summarised below.

Inpatients: The Trust notes that in 7 out of 12 months the response rate is higher than the national average with the recommender rate being lower (than the national average) for the whole year.

A&E: The Trust notes that in 7 out of 12 months the response rate is higher than the national average with the recommender rate being lower (than the national average) for the whole year.

Maternity Friends and Family Test

- **Antenatal question:** For 10 months the recommender rate was higher than the national average
- **Birth question:** For 11 months the recommender rate was higher than the national average. However, with the exception of June, July and August, its response rate was below the average
- **Postnatal in hospital question:** For 11 months the recommender rate was higher than the national average
- **Postnatal in community question:** For 10 months the recommender rate was higher than the national average

National Patient NHS Survey Programme

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.

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
Children & Young People's	Run for the first time in 2015-16

Table 2: National Patient NHS Surveys

Guidance stipulates that surveys can either be carried out in house or by using one of five approved contractors recommended by the CQC. The Trust commissions Quality Health Ltd. to carry out surveys on its behalf. Quality Health Ltd. provides the Trust with its results for each survey via four separate reports:

- Top line results (containing raw figures for the current and previous years' survey)
- High level recommendations report (containing Quality Health Ltd.'s initial recommendations)
- Management report (containing full statistical analysis including trends and recommendations)
- Comments report (containing all 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 2015-16

During 2015-16, the results of three national patient surveys were received: the annual Inpatient Survey, Maternity Services Survey and the first Children and Young People's Survey.

Inpatient Survey: The response rate was 44%. Many scores for the Accident and Emergency service have remained static. However, the percentage of patients saying they received enough information about their condition and treatment is up from 66% to 76% along with an increase of 36% to 44% of patients saying they had a choice of hospitals. Scores about the admission process are mixed with some regarding length of time on the waiting list prior to admission deteriorating significantly. This is counterbalanced by a significant increase in patients saying they didn't have to wait long to get to a bed on a ward, 70% compared to 59% last year. Cleanliness scores have improved and food scores have remained static. Overall, both doctor and nurse scores have declined slightly along with the scores on the explanations and information given before and after operations.

Maternity Services Survey: The response rate was 42%. In general, scores have significantly improved in many areas since the survey conducted in 2013-14. This is particularly true regarding a vast improvement in the scores in women saying they were given a choice of where to have their baby, continuity of care, and women saying they have seen the same midwife throughout their pregnancy and a choice of baby feeding. Scores have also improved with regard to being treated with respect and dignity, confidence in both hospital and community based staff, cleanliness and being treated with kindness and understanding.

Children & Young People's Survey: The response rate was 26%. This was the first national Children and Young People's Survey. In line with the national picture, the response rate for the Trust was low with 154 questionnaires returned from a sample size of 597. Areas where the Trust scored above the mean average of the 40 Trusts who also commissioned Quality Health Ltd. (representing 1,941 respondents) was the clarity of explanations about how operations or procedures had gone. Issues where the Trust scored 5% or more below the mean are pain control, organised play and activities (age appropriate) on the wards, being told what would happen on discharge and advice on how to look after themselves post discharge. Parent and carer findings were similar to those indicated by the respondents.

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

The CQC benchmark reports for the Inpatient, Maternity Services and Children and Young People's Surveys indicate the following:

- **Inpatient Survey:** Of the 11 sections, the Trust scored approximately the same as all other trusts with the exception of three sections where a lower score was achieved. Of the 63 questions, the Trust scored approximately the same as all other trusts with the exception of 7 questions, which included being asked views on quality of service and information giving on how to complain.

- **Maternity Services Survey:** In all questions with the exception of one, the Trust approximately the same as all trusts.

- **Children & Young People's Survey:** the Trust scored about the same as all other trusts to all the questions.

<u>Survey Work – Key Achievements of 2015-16</u>

Actions taken in response to survey feedback in 2015-16 include:

- In response to the continuing poor satisfaction levels with parking and access to University Hospital, on site developments (led by the Estates Department) have continued with the completion of the redesign of the off-site pinch points including the roundabout at the junction at the Ansty Road/Hinckley Road/Clifford Bridge Road and the redesign of onsite roads along with the re-routing of traffic.

- Bespoke surveys for Neonatal Services, Critical Care Unit and Cardiothoracic Critical Care were designed and added to the Impressions suite of questionnaires.

- In response to low satisfaction levels with food and drink, the Trust has worked with its catering provider to improve the menu and the way in which food ordering is carried out at the Trust.

- March 2016 saw the Insight Team at NHS England hold the first national FFT Awards. The Trust submitted two entries both of which were shortlisted – the Patient Experience Team under the FFT Champions Award and Maternity Services under the Best FFT Initiative in Other NHS-funded Services. Maternity Services were runners up in their category.

You Said, We Did

To demonstrate that 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. Ward areas have the opportunity to provide update on the feedback they have acted upon on the 'Looking After You' Boards which are situated inside all ward areas. Below are some examples of the changes implemented as result of feedback.

You Said: "Patients wanted to know who's who and what the uniforms are."
We Did: Placemats have been provided for each patient bedside table. The placemats include information about the ward routine as well as having a pictorial uniform guide.

You Said: "There is no Wi-Fi to be able to connect to the internet at the Hospital of St Cross."
We Did: Free Wi-Fi has now been introduced at the Hospital of St Cross; there is also a free connection at University Hospital too.

You Said: "Staff don't hear you when you knock on the door to be let onto the ward."
We Did: A doorbell located outside the wards was trialled in three areas earlier this year. This pilot proved successful and has been rolled out across the hospital. Doorbells have now been fitted outside every ward.

Key Achievements of 2015-16

Always Events

In conjunction with the Nursing Team and Workforce, the Patient Experience Team took the decision to implement the national and international campaign, 'Hello My Name Is', at the Trust as the first in a series of Always Events.
To this end a small working group was set up to oversee the successful launch of the campaign during Patient Experience Week (see below). A short video, which includes key information about the campaign and featuring Trust

staff has been produced for airing at various Trust events, and was shown at Grand Round at the beginning of the Launch.

https://www.youtube.com/watch?v=f3auPpAM0Gc

In addition to the video, Patient Experience Week also saw members of the working group visiting all areas of the Trust talking to staff about the campaign, asking them to sign up to its principle of always introducing themselves to patients and, for those willing, to have their photographs taken holding their pledge sheets with their name hand written on it. It is intended to use these photographs to build a virtual wall of staff who have signed up. The coming year will see the working group embarking on a series of activities to embed the principles of 'Hello My Name Is' across the Trust.

Staff participating in the launch of the 'Hello My Name Is' campaign

Patient Experience Week

This Patient Experience Week this year was held from 25 February 2016 to 2 March 2016. In order not to detract from the impact of the 'Hello My Name Is' Campaign, it was decided to limit the activities during the week to the launch of the campaign and the provision of Towards Service Excellence Workshops run by TMI Ltd, a management company well known in service-based culture change, and a company the Trust has worked with in 2013 and 2015. Workshops aimed at providing staff with the knowledge and skills to improve patient experience were held across three days with a total of nearly 400 staff attending. Feedback from attendees was overwhelmingly positive with staff contacting the Patient Experience Team to express interest in taking forward some of the ideas put forward.

Patient Story Programme to Trust Board

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 meetings. These stories are delivered in a variety of formats including video, in person, 'show and tell' style or written to make them interactive. The programme gives patients, carers, relatives and staff the opportunity to discuss their hospital experiences with Board members, whether positive or negative. The Patient Story is a standing agenda item that demonstrates the Trust's commitment to learn how the patient experience can be enhanced and improved for patients in line with its aspiration of becoming world class.

Examples in the Patient Story Programme during 2015-16, included feedback on both positive and negative experiences, for example:

- Complainant story was delivered by the individual
- A Volunteer's Tale was told in person to the Board
- Positive written account (from a parent's point of view) of the Neonatal care their son received
- Healing Arts Update presented by the Arts Co-ordinator with a demonstration of the Arts Cart 'Artie'

- Feedback from a patient who has benefited from the Trust's Da Vinci Robot was presented by the two lead Consultants of this technology

The Patient Story Programme for 2016-17 has been agreed by the Trust's Chief Medical Officer and Deputy Chief Executive Officer, Professor Meghana Pandit and the Patient Experience and Engagement Committee.

Staff Recognition

The Patient Experience Team were shortlisted for NHS England's Friends and Family Test Champions of the Year along with Maternity Services who were shortlisted in the best Family and Friends Test initiative in any other NHS funded service.

Improving the Patient Experience for Blind/Visually Impaired and Deaf/Hearing Impaired Patients

It was recognised that the hospital experience for patients who are blind/visually impaired and deaf /hearing impaired needed to be improved. This could only be achieved if staff were equipped with the knowledge and understanding of this group of patients' needs, and this led to the development of an awareness raising video.

The video illustrates the correct and incorrect ways of communicating with and caring for these patients. It provides staff with invaluable bite-sized pieces of information which will help them feel more confident when caring for a blind/visually and deaf/hearing impaired patient.

This video is part of a training package developed by the Equality and Diversity Team, Patient Experience Manager and the Head of Voluntary Services. To complement this video a communications box has been funded by the Volunteers Service. This box contains key equipment to help and support staff with the additional needs of these patients which will ensure the quality of their hospital stay is improved. This training was offered and delivered to all wards, across the two hospital sites this year.

Further Developments for 2016-17

During 2016-17, the Patient Experience Team looks forward to continuing to implement further service improvements including:

- Training for staff on the reporting system of the Trust's bespoke patient feedback system, Impressions
- Awareness raising for staff on the patient involvement toolkit
- World Class Cafes to be held to facilitate learning about aspects of patient experience
- The design of a bespoke customer care course for staff
- Provision of more Towards Service Excellence Workshops run by TMI in the autumn

HEALTH INFORMATION

Introduction to the Health Information Centre (HIC)

UHCW's HIC 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 of 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 illness.

The HIC 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 in line with NHS England's Information Standard. Meeting national standards ensures that the information produced is clear, accurate, balanced, evidence-based and up-to-date. Once approved this information is made available to all staff via the Trust's in-house patient information database, e-Library.

Health Information Enquiries

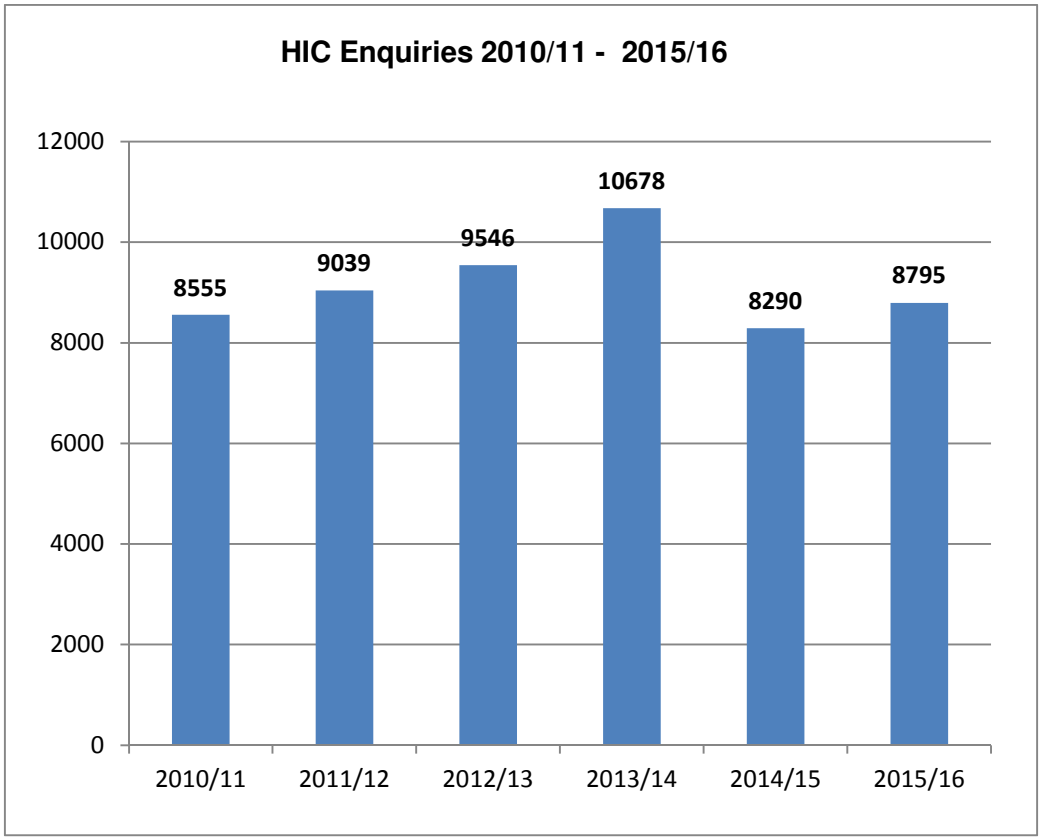


Figure 5: HIC enquiries from 2010-11 to 2015-16

Displays 2015-16

A total number of 33 displays were produced in 2015-16.
Displays enable the HIC 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. The displays are placed either in the HIC itself or in an area just outside the HIC within the main reception.
Examples of displays which were well received this year are: Eye Health, Pressure Ulcers, Parkinson's Disease, Sun Awareness, Alzheimer's Disease, Epilepsy, Smoking cessation, Lupus, Nurse Recruitment, Organ Donation, and Alcohol Awareness.

e-Library Patient Information Activity 2015-16

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.

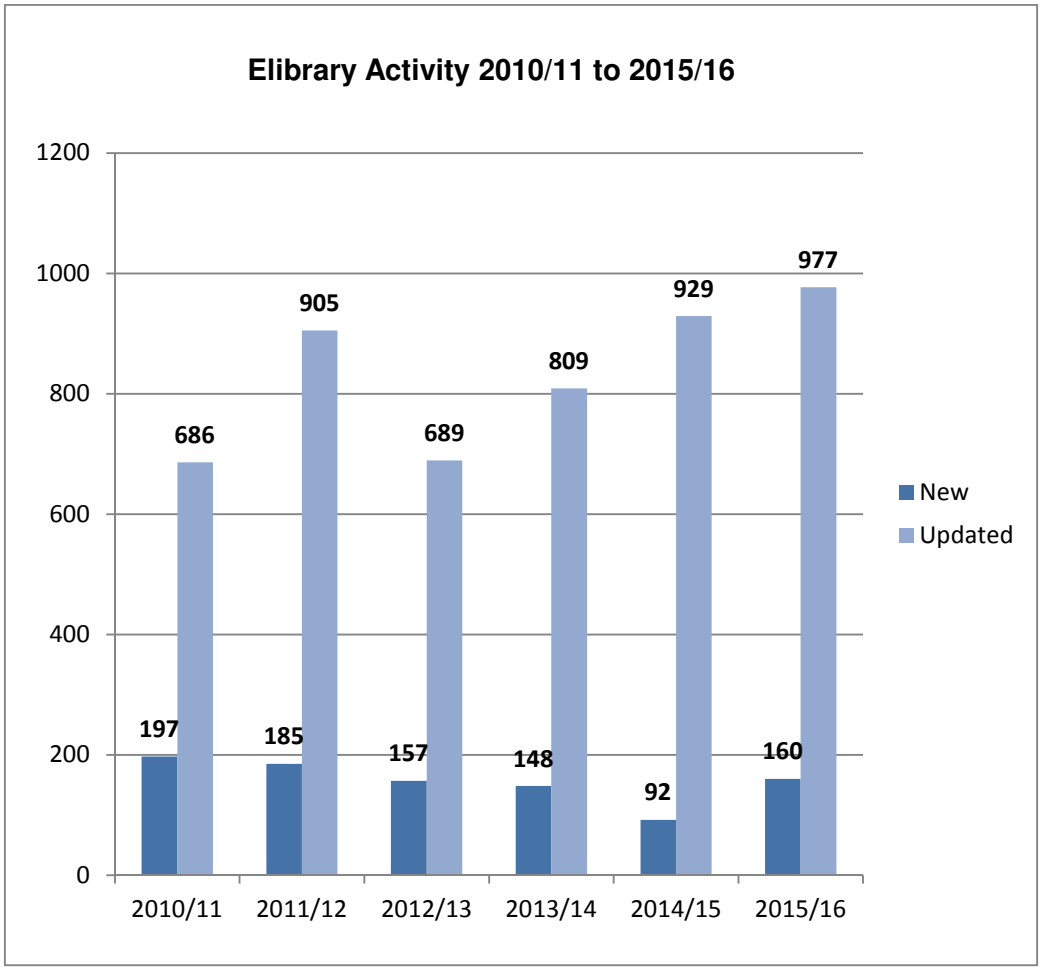


Figure 6: e-Library activity from 2010-11 to 2015-16

Key Achievements of 2015-16

The Health Information Team has achieved the following this year:

- Managed the Trust's Health Information

- Administered the Patient Information Approval Process

- Managed and maintained the distribution of the Trust's 12 core patient information leaflets to all areas across the both hospital sites. All core leaflets are available in written and audio format, in both English and Polish and available online: www.uhcw.nhs.uk/for-patients-and-visitors/help-and-support

- The Trust has signed up to the British Sign Language (BSL) Charter which has been drafted by the British Deaf Association (BDA). The Trust has committed to two pledges on the Charter which are to ensure access for Deaf people to information and services, and to consult with the local Deaf community on a regular basis. The Health Information Team is committed to making information more accessible and the following patient information is available in easy read format:
    - Welcome to Our Hospital - University Hospital
    - Welcome to Our Hospital - Hospital of St Cross
    - Tell us what you think (PALS and Complaints information)
    - How to stop the spread of germs and infections

- Planning for when you leave hospital (discharge information)

The Team worked in partnership with Grapevine Coventry, Coventry and Warwickshire Partnership Trust and the Trust's Independent Advisory Group to produce these guides for University Hospital and the Hospital of St Cross. These are available in hard copy and online: www.uhcw.nhs.uk/for-patients-and-visitors/help-and-support

- All information carousels across both hospital sites now have a sign advertising that written patient information is available in other languages and other formats. This message is also translated into Polish, Punjabi and Romanian which are the top three languages for UHCW

- Following feedback from the recent CQC visit waiting time posters in Outpatient areas have now been translated and are displayed conveying the message in English, Polish, Punjabi and Romanian

- The Health Information team are working with the Outpatients Manager to signpost staff and patients to the Information stands and the Health Information Centre as well as e-Library resources (for staff) on behalf of their patients

- The Team has supported and worked in partnership with the Macmillan Information service

- Supported a number of departments to enable them to meet their national standards relating to patient information and trained staff in the use of e-Library

- Ensured Trust patient information was maintained to national and local patient information standards

- Become a contributor to the Trust's Induction 'Market Place' which has helped promote the service and health information provision to new starters

- Implemented the Patient Information Prescription Pilot

Further Developments for 2016-17

- Continuation of the Patient Information Prescription Service
- Improve patient information in all ward and clinic areas
- Raise the profile of the HIC and information available on e-Library to staff
- Increase presence at the Hospital of St Cross, Rugby
- Continue to convert the Trust's twelve core leaflets into easy read format
- Awareness raising sessions on specific clinical topics will be developed whereby members of the public will be invited to attend
- Website content will be reviewed

PATIENT RELATIONS

Introduction to Patient Relations

In the vast majority of cases patients, relatives and carers are satisfied with the care, treatment and service they receive. On the occasions where a patient, relative or carer is dissatisfied, it is important that they feel comfortable in raising their concerns so that the Trust can resolve any misunderstandings or, if failings have occurred, ensure that learning and improvements take place.

The Trust is committed to resolving any concerns at the earliest opportunity and this is often achieved through the patient, relative or carer discussing their concerns directly with the service. The Patient Advice and Liaison Service (PALS) is available to provide confidential advice and support to any patient, relative or carer who may not feel comfortable raising their concern with the service directly, or where they have done so but their concern remains unresolved. The PALS aim to resolve any concerns that are raised with them quickly and informally.

Should the patient or carer feel that their concern should be formally investigated they are able to make a formal complaint. The Trust operates a centralised complaints service, which ensures that a patient centred approach is taken to the management of complaints and that all complaints received are thoroughly investigated and responded to within a timely manner, usually within 25 working days of receipt.

In addition to the valuable learning and improvements that result from individual concerns or complaints, complaints and PALS data is analysed to identify any themes and the intelligence generated is shared across the organisation so that the necessary improvements can be made. Additional mechanisms to share intelligence include regular reporting to the Patient Engagement and Experience Committee and monthly reports to Chief Officers, such as the Chief Nursing Officer. The Chairman of the Trust Board reviews the Trust's handling of feedback and complaints on a monthly basis.

Complaints

Introduction to Complaints

In 2015-16 the Complaints Service received 574 complaints, which is an increase of 95 complaints from 2014-15. The service continues to improve its timeliness of response, going from 52% of complaints responded to within 25 working days in 2014-15 to 83% in 2015-16.

Complaints Activity

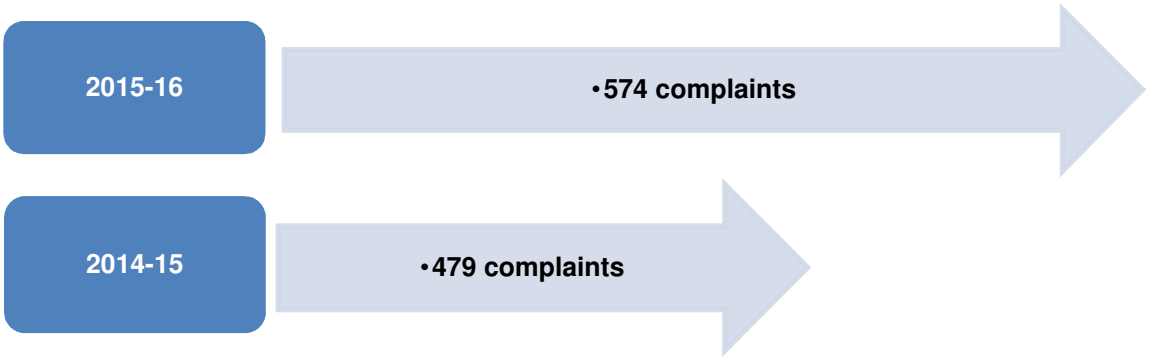


Figure 7: the number of complaints received in 2014-15 and 2015-16

An increase in the number of complaints could suggest that more patients are dissatisfied with the care, treatment or service they have received. However, other factors may influence the number of complaints received, such as patients and carers being more comfortable in making a complaint, the accessibility of the Complaints Service and the availability and level of support provided in raising a complaint. The reasoning behind an increase in complaints is therefore difficult to establish.

The graph below compares the number of complaints received by month for the 2015-16 and 2014-15 financial years. In 2015-16 the greatest numbers of complaints were received in October, whereas in 2014-15 the greatest numbers of complaints were received in July. However, in both years the fewest complaints were received in the months of December, January and February. It is however important to note that complaints are not always made in the same month that the issue of concern occurred, with some complaints being raised many months later.

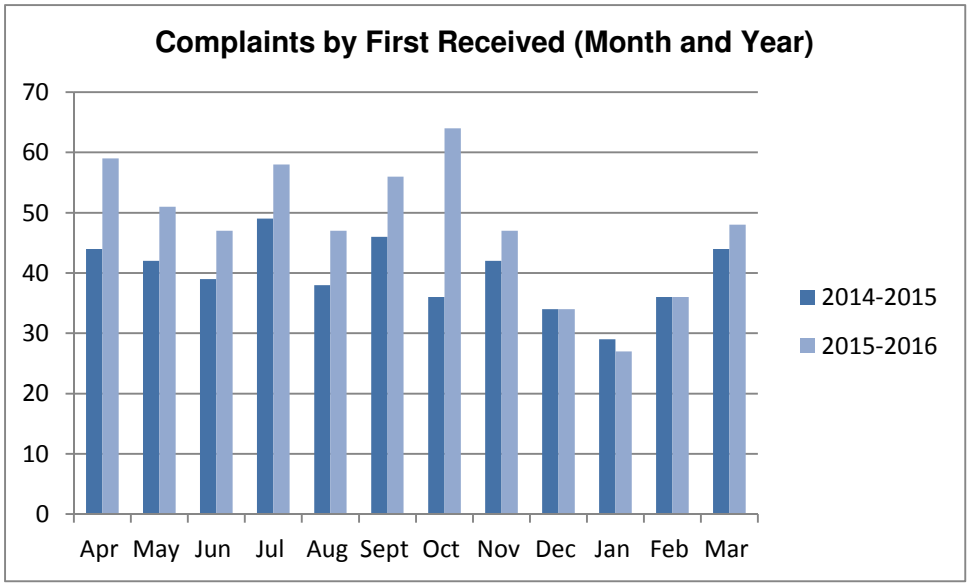


Figure 8: comparison of the number of complaints receiver per month in 2014-15 and 2015-16

Of the complaints received in 2015-16, 40% were upheld, 33% partially upheld and 27% not upheld. Partially upheld means that the complaint investigation identified failings, but the primary complaint was not upheld. This shows that in 2015-16, failings were identified in 73% of the complaints received.

Complaint Activity by Specialty Group 2015-16

The chart below shows complaint activity by Specialty Group in 2015-16 and 2014-15. In 2015-16, the greatest numbers of complaints were about Surgery, followed by Women and Children's, which was followed by Trauma and Orthopaedics. Surgery and Women and Children's also had the greatest number of complaints in 2014-15.

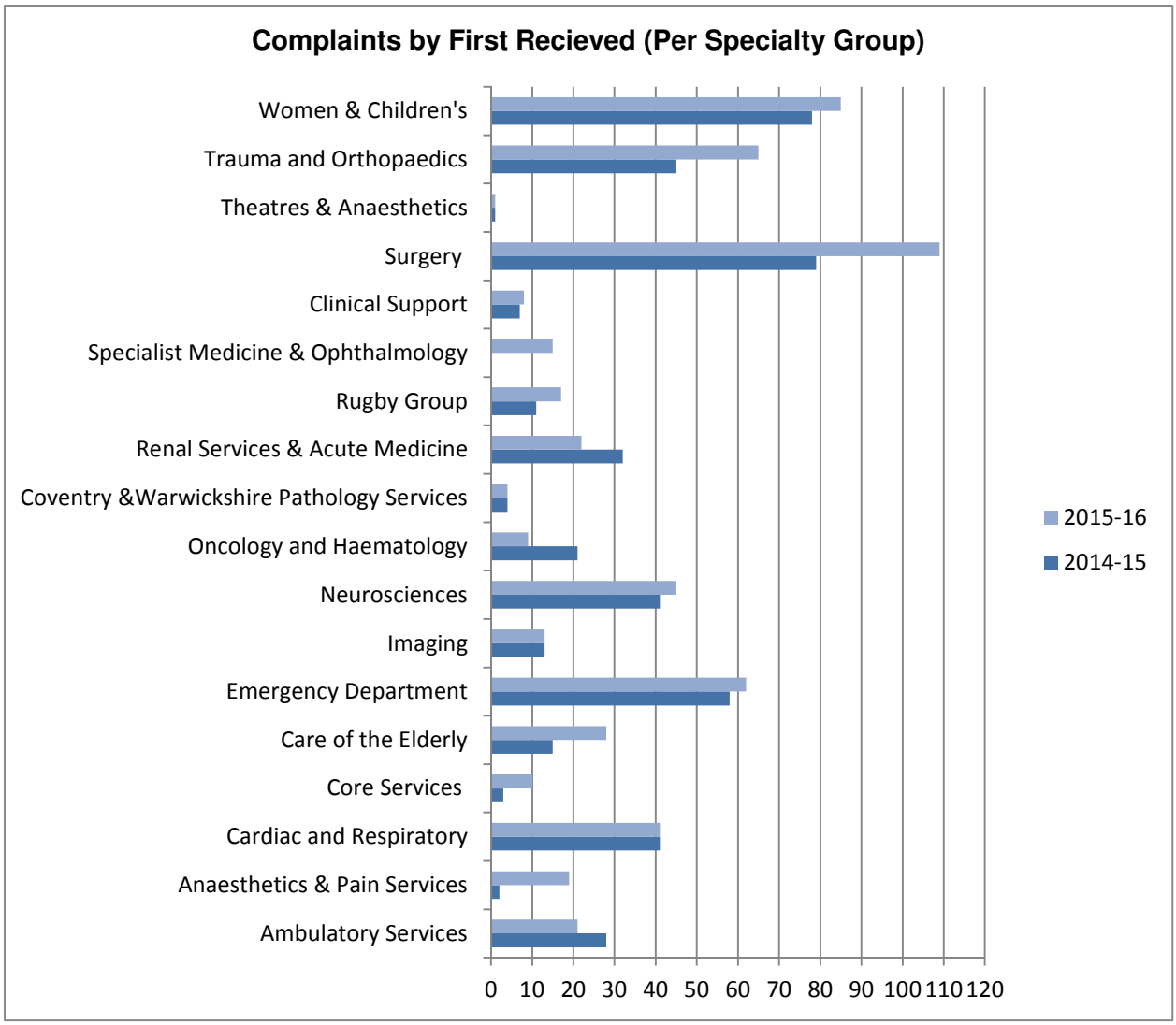


Figure 9: comparison of complaint activity per Specialty Group in 2014-15 and 2015-16

Trauma and Orthopaedics did not see a significant increase in any one area, with slight increases being seen across a range of subjects.

Trend Analysis

In both 2014-15 and 2015-16 the following subjects featured in the top 5 complaints received:

Subjects	2014-15	2015-16
All aspects of clinical treatment	242	313
Communication / information given to patients	75	79
Attitude of staff	46	36
Admissions, discharge and transfer arrangements	33	33
Failed to follow agreed procedure	36	5
Appointments, delay / cancellation (outpatient)	17	40
Appointments, delay / cancellation (inpatient)	23	33

Table 3: comparison of the most common subjects per complaints received in 2014-15 and 2015-16

Featured in the top 5 subject areas complained about in both 2014-15 and 2015-16

Featured in the top 5 subject areas complaint about in 2014-15 but not in 2015-16

Featured in the 2015-16 top 5 subject areas but not in 2014-15

The above shows that there has been a significant reduction in complaints received about failure to follow agreed procedure but that there has been a significant increase in complaints about the delays and cancellations for both outpatient and inpatient appointments.

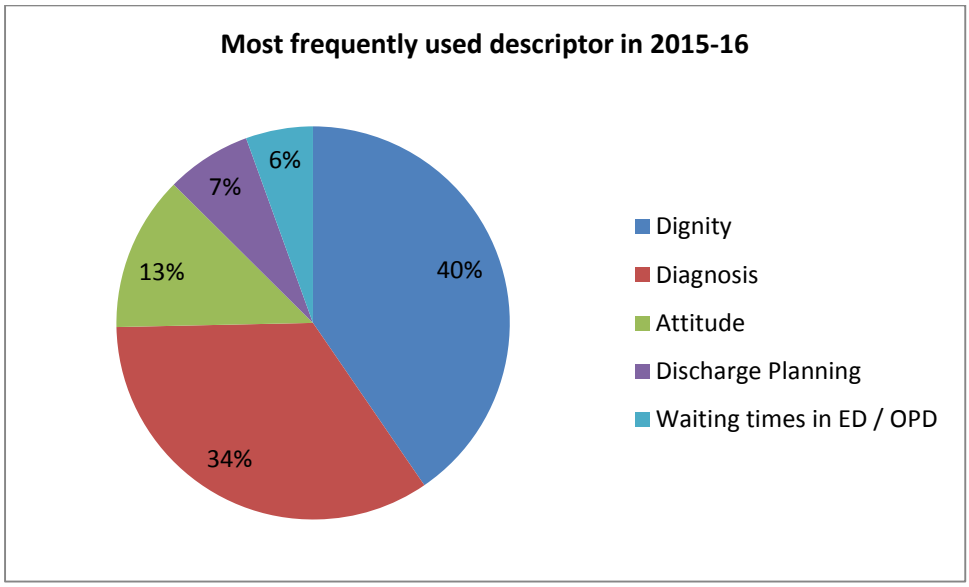


Figure 10: most frequently used descriptors 2015-16

In addition to the specific subject of the complaint, reported on above, the Trust also records the area the complaint would fall into, known as descriptors. As can be seen from the chart above, there are two main areas that complaints fall within, dignity and diagnosis.

Parliamentary Health Service Ombudsman (PHSO)

The Trust recognises the value of having an independent body that patients, relatives and carers can refer their complaint to should the Trust not be able to resolve their concern to their satisfaction. In such instances and in accordance with the regulatory requirements, the Trust advises patients, relatives and carers of their option to refer their complaint to the PHSO should the Trust be unable to resolve the complaint to their satisfaction. The Trust embraces the PHSO's scrutiny of its Complaint Handling and uses the PHSO's findings as an opportunity to learn and improve. In addition to the PHSO's case work, the Trust review and seek to learn from the reports that the PHSO produce throughout the year.

In 2015-16, a total of 25 complaints were referred to the PHSO. 11 different Specialties featured in the complaints referred.

The below table shows a summary of the primary subject matter of those complaints that were referred to the PHSO

Primary Subject Matter	Number of times featured in a referral
Clinical Judgement Query	1
Nursing Care	1
Consent to Treatment	1
Communication	5
Poor Medical Care	9
Clinical Judgement Query	5
All Aspects of Clinical Treatment	4

Table 4: primary subject matter of the complaints referred to the PHSO 2015-16

The above table shows that the majority of cases referred to the PHSO primarily concern clinical care and treatment or communication.

The PHSO considered and made judgement on fifteen complaints in 2015-16. None of the complaints considered were fully upheld, seven were partially upheld and eight were not upheld. In each case partially upheld the PHSO recommended an apology be given for the failings identified and recommended the creation of an action plan to reduce the likelihood of the same failings reoccurring. In three of these cases the PHSO also recommended that the Trust compensated the patient, relative or carer for the impact the failings had had on them.
The table below provides details of the seven cases that were partially upheld along with a summary of the decision of the PHSO and the actions taken to learn and improve from the failings identified.

Complaint	Decision	Recommendation	Actions
Complainant raised grievances relating to communication, the use of safeguarding barriers and delays in organisation and care	The PHSO were satisfied that the safeguarding order was used accurately, and records did not evidence that the patient was regularly repositioned	The Trust was advised to produce a letter of apology and an action plan to reduce the likelihood of the failings reoccurring	Several actions were implemented, including: • review of intentional documentation rounding procedures and work with the Tissue Viability Team at a Link Worker Study Day • continued education and teaching on pressure ulcer prevention (Trustwide) • sharing and learning promoted among ward staff • discussion of this case presented at Trust's Annual Record Keeping Training Day
Complainant raised grievances relating to misdiagnosis of a stroke, failure to monitor the patient and communication	The PHSO found no failings in initial assessment but expect stroke to be identified sooner. The neurological examination was inadequate and the apology for communication failings was found to be insufficient. The PHSO could not confirm that the failures contributed to the patient's death.	The Trust was advised to apologise, produce an action plan and provide £500 in compensation	Several actions were implemented, including: • discussion and feedback on this case provided to the Cardiology team at the Quality Improvement and Patient Safety (QIPS) meeting • review of nursing handover procedures including provision of information to the family/NOK • feedback to Junior Doctors regarding the importance of documentation • introduction of a complaints management plan to improve the timeliness of responses
Complainant raised grievances relating to withheld controlled medication, and poor communication	The PHSO found that medication was terminated without a conscious decision to do so. Trust communication should have been better. The Trust did acknowledge the failures in their response to the	The Trust was advised to produce an apology and an action plan to reduce the likelihood of failings reoccurring	Several actions were implemented, including: • a review of the ED business case to support NICE guidelines, and the Medicine Reconciliation Policy • reviews of patient medication to take place within Pharmacy, an e-handover for the Pharmacy team, Doctors training programme to include on-call Pharmacy services, and Pharmacy investment to

Complaint	Decision	Recommendation	Actions
	complaint but did not recognise the significance of the failures		comply with 24 hr NICE guidelines • Core Competency Training for Summary Care Records • Senior Clinical Review of medication charts and a named clinician for each outlier
Complainant raised grievances relating to continuity of care, poor communication, and lack of accurate drug documentation	The PHSO identified failures in consistency of care, but found no evidence of delayed treatment or diagnosis. The Trust was found to have caused additional distress to the family by failing to acknowledge the issues with discharge	An apology was given to the family for the distress caused, and the Trust was advised to produce an action plan and provide £250 in compensation	Several actions were implemented, including: • re-drafting of the Transfer Policy to include risk assessment and guidance on the appropriateness, frequency and monitoring of moves • review of and provision of discharge training continued but to include development for Discharge Link Nurses in all wards and departments • all complaints to be triaged by the Complaints Coordinator to assess and identify the relevant issues, and use of the Complaints Management Plan and a QA Tool to ensure the highest quality standards
Complainant raised grievances relating to drug mismanagement and poor communication	The PHSO found that the Trust identified their failings and managed appropriately via internal mitigation to prevent a repeat of the event. The Trust was found to have communicated appropriately and shared this event with the wider NHS to promote learning with regard to the event.	The Trust was advised to produce an apology for the impact of the failings and provide £800 in compensation	Several actions were implemented, including: • discussion with the Junior Doctor to involved to reflect and learn from the incident • additional education on prescribing for children included in doctor induction in addition to paediatric dispensing training • reminder given to doctors regarding prescribing rules and emphasis on reference to the BNF and triple checking o calculated medications
Complainant raised grievances relating to the clinician's attitude during consultations, lack of information regarding diagnosis and poor communication	The PHSO found that there had been failings in communication relating to the patient's diagnosis	The staff involved made an apology to the complainant. An action plan was produced and the acknowledged failings were identified	Several actions were implemented, including: • introduction of notices throughout clinics advising patients that they can acquire a copy of their consultation letters • Junior Doctors are advised to question previous decisions, especially prior to surgery; the Junior Doctors are also encouraged to discuss significant departures from previous decisions with a senior clinician before performing the procedure • the department will emphasise the importance of clear communication and accurate note-keeping
Complainant raised grievances relating to the premature discharge of her son, and poor and inappropriate treatment when leaving the site which it is believed contributed to the patient's death	The PHSO found that the patient's condition was not suitably assessed and that he should not have been discharged. They also found that the Trust was unreasonable in its decision to forcefully remove the patient. There was insufficient evidence to confirm that this treatment contributed to the patient's death	The Trust was advised to produce a letter of apology, an action plan to reduce the likelihood of a repeat of the failings	Several actions were implemented, including: • a gap analysis of the NICE/Clinical Guidelines, discussion of the case at a QIPS meeting and presentation of the case anonymously at the Trust's Annual Record Keeping Training Day • inclusion of Alcohol Liaison Service induction training for ED Junior Doctors, training for Clinical Site Managers and Security Officers in the use of the Criminal Justice and Immigration Act 2018, and Registrar and Consultant Alcohol Liaison refresher training • discussion and sharing of the case at the Observation Ward's monthly meeting

Table 5: recommendations and actions taken as a result of 3 complaints partially upheld by the PHSO

Performance Measures

The complaints service received 271 complaints by letter, 303 by email and none by telephone in 2015-16. In the interests of ensuring accessibility, the Complaints Service will be exploring the reasoning behind this in 2016-17. To further increase the accessibility of the Complaints Service, Easy Read leaflets have been produced in conjunction with a local learning and development charity. These leaflets are available across the organisation on the wards and the PALS provide these to patients, relatives and carers when appropriate.

Overall Performance against the 25 Day Response Rate Standard

The Trust is committed to providing timely responses to any complaints received and the complaint management plan is designed to ensure complaints are responded to within 25 working days of receipt. The graph below shows the Trust's performance against the 25 working day response rate over the last three financial years.

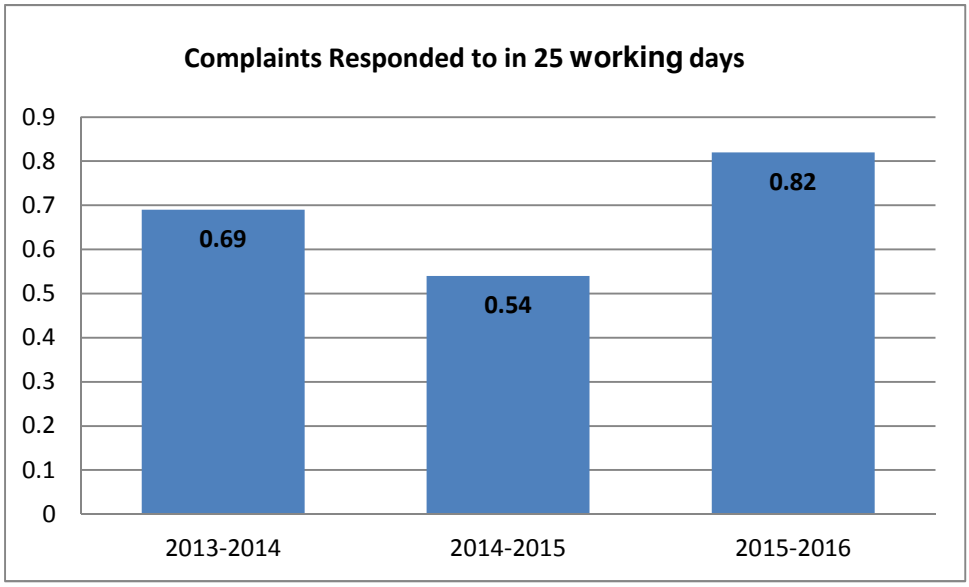


Figure 11: comparison of the Trust's performance against the 25 working day response standard from 2013-14 to 2015-16

As can be seen from the above chart, the Trust responded to over 80% of complaints received within 2015-16 within 25 working days, which is a marked improvement on previous years. The improvement results from the implementation of a clear complaint management plan that ensures complaints are quickly actioned and progressed, with clear escalation points so that management support is provided as and when necessary. In addition, complaint response rates are now reviewed at Specialty Monthly Performance Reviews. Effective monitoring of performance against the 25 working day timeframe helps ensure that any operational issues impacting on the effective handling of complaints are identified and resolved.

Performance against the 25 working day response standard by Specialty Group for 2015-16

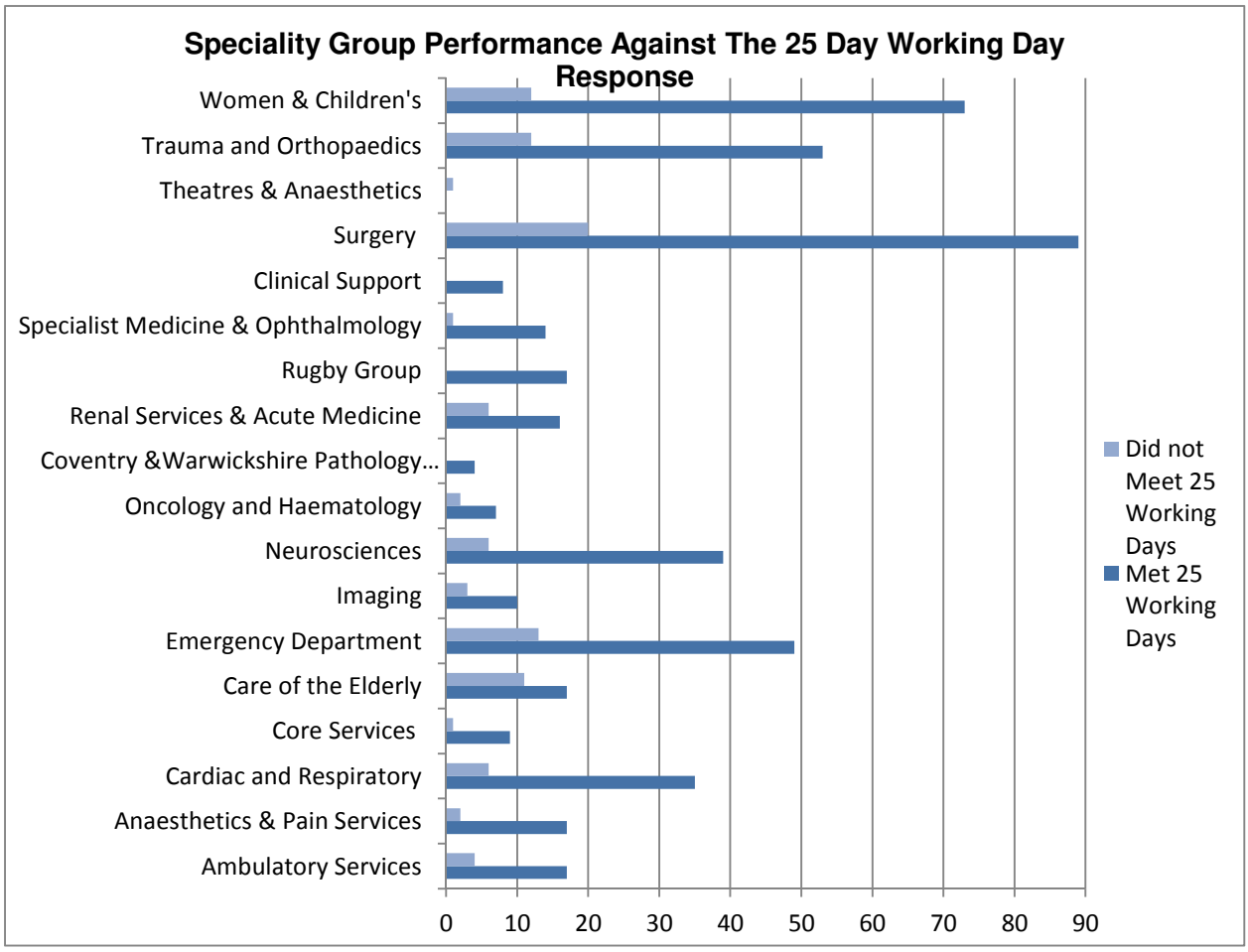


Figure 12: comparison of Specialty Group performance against the 25 day working day response standard

The graph shows that the Specialty of Surgery has more complaints responded to outside of the 25 day response standard than any other Specialty. However, in terms of percentage of complaints responded to within the 25 working day response standard, at 27% Care of the Elderly have the lowest percentage response rate.

Complaints returned for further local resolution

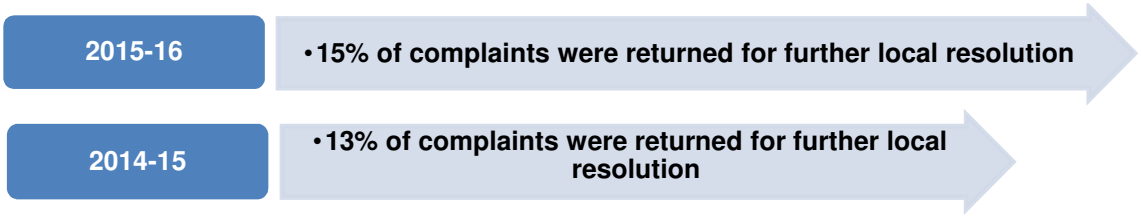


Figure 13: comparison of complaints returned for further local resolution in 2014-15 and 2015-16

In 2015-16, 15% of complaints were referred back for further local resolution. The six months of data collected in 2014-15, if applied as an average across the year, would have produced a further local resolution rate of 25%. The number of complaints referred for further local resolution was therefore achieved in 2015-16. Further reducing the number of complaints referred for further local resolution will continue to be a priority in 2016-17. The chart below shows the number of complaints referred for further local resolution by Specialty.

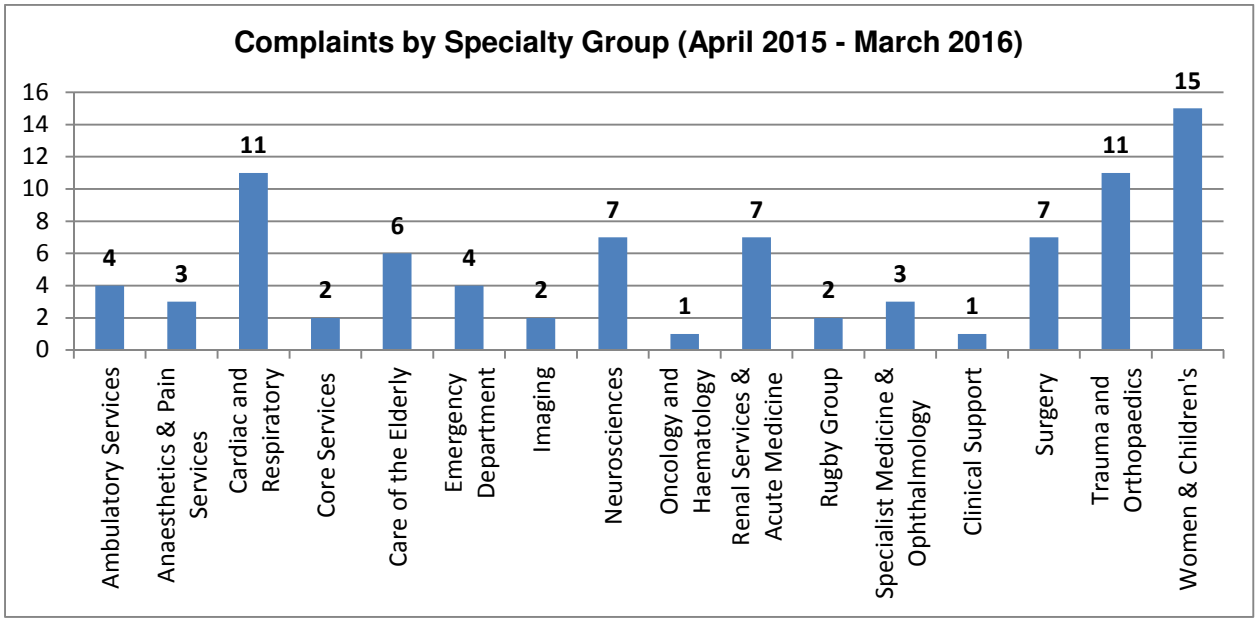


Figure 14: number of complaints returned by Speciality Group 2015-16

Member of Parliament (MP) Enquiries

In November 2015, the Complaints Service took over responsibility for managing concerns or enquiries raised by MPs on behalf of their constituents. The Complaints Service co-ordinates the investigation and response to MP enquiries, ensuring that they are fully investigated and a comprehensive and timely response is provided. Within the 5 months to the end of the financial year, the Complaints Service managed 36 enquiries. These enquiries are not reported in the complaint data unless they are registered as formal complaints, which in the vast majority of cases is not appropriate.

Examples of Complaints and Actions

Member of Parliament (MP) – Car parking An MP contacted us on behalf of their constituent who was unhappy with the lack of car parking spaces at University Hospital Coventry. They explained that they recently attended the hospital for an outpatient appointment and that they had encountered significant traffic congestion. They said that they had no option but to get out of the car and walk and they were concerned about the anxiety this situation causes patients and their carers.	The Trust responded to the MP apologising for the inconvenience caused. Assurance was given that the Trust was aware of the congestion issues at University Hospital, Coventry and the problems this causes for patients, staff and the operational effectiveness of the Hospital. The Trust explained to the MP the steps that University Hospital Coventry was taking to resolve this issue, which includes working with Coventry City Council and specialist designers to review the parking situation and traffic flows; obtaining planning permission for a further 250 car parking spaces and reassessing the viability of a Park and Ride Service.
Patient fall Mr H's family complained that when Mr H was transferred to the Hospital of St Cross, Rugby, he was not properly cared for allowing him to suffer a fall. They also complained that Mr H had to wait in the ambulance for a long period when being transferred from University Hospital Coventry to the Hospital of St Cross Rugby and they were unhappy with the level of communication the family received.	Mr H's fall was reported as a Clinical Adverse Event the same day as the fall. Mr H's family was informed that Mr H had fallen the same day and the incident was reviewed by the Serious Incident Group. This resulted in a full Root Cause Analysis investigation being undertaken. The family was invited to share the findings of the investigation and the resulting actions. The investigation found that the ward handover was inadequate which meant that the receiving ward did not properly understand Mr H's needs. A full review of the handover process was carried out as well as the assessments that are carried out when a patient is first received onto a ward.
Staff attitude Mr B complained about the manner of the Consultant that had reviewed him at an outpatient appointment. He complained that the Consultant had made no effort to welcome him or put him at ease, that they failed to explain the purpose of the appointment or explain any of the tests they were performing and that they abruptly ended the appointment without explaining what will happen next or giving him an opportunity to ask questions.	The Consultant concerned provided Mr B with all of the information he felt was not provided at the appointment. The Consultant explained that the clinic was not running to schedule on the day of Mr B's appointment and that they were also on call to provide emergency advice, which had meant they were bleeped during the appointment. However, this information was given as an explanation as to why they may not have conducted the appointment in the most appropriate manner rather than an as excuse. The Consultant apologised for Mr B's experience and assured him that they had reflected on this and that they would factor this learning into future practice.

Key Achievements of 2015-16

- The Complaints Service worked with the Patient Safety Team with the implementation of the Duty of Candour process to ensure that this, combined with the Complaints Handling Process, remains patient centred. The Service works closely with the Lead Nurse for Patient Experience and Professional Standards to ensure learning is appropriately disseminated and a joined up and patient centred approach is taken when managing complex complaints. The Complaints Service also delivered training on complaint handling and associated issues across the Trust on events such as the Bi-annual Nursing Summit

- Healthwatch Coventry were invited to present at the monthly Complaints Service meeting, where they explained their role in more detail

- The Complaints Service also took over responsibility to responding to complaints or concerns received from Members of Parliament on behalf of their constituents, ensuring that timely and through responses are provided

- To help raise awareness of the complaints process across the Trust the Complaints Service has attended the Market Place Induction Event with the aim of making any staff joining the Trust aware of the Complaints Service and the Complaints process

- Responding to complaints within the 25 day response rate standard was a key objective for the Complaints Service in 2015-16. An ambitious target of 90% of complaints responded to within 25 working days was set. A Complaints Management Plan was implemented with clear timeframes and escalation points which positively impacted response rates. In 2014-15 the Trust responded to 54% of complaints within 25 working days. In 2015-16 this increased to 82%. Improving response rates will continue to be a key objective in 2016-17

- In 2014-15 13% of complaints were returned for further local resolution and this increased to 15% in 2015-16. In January 2016, the Complaints Service implemented an audit tool to help understand the reasons why people had returned their complaint for further local resolution. The findings of this audit were shared with the Patient Experience and Engagement Committee and it will help inform the work being undertaken to increase satisfaction with the Complaint Handling Process and the initial response

- The PALS has appointed a substantive PALS Co-ordinator and a Head of Patient Relations has been appointed to oversee both the PALS and Complaints Service. These key appointments have improved communication between the services and helped ensure the services work collaboratively to improve the patient experience

Further Developments for 2016-17

- The Complaints Service will continue its work on meeting the 25 working day response rate. This will involve further improving compliance with the Complaint Management Plan, delivering organisational wide training in areas such as statement writing

- Through fully utilising the functions of the case management system, Datix, the Complaints Service will be able to better manage and report on workflow. The service will continue to review what information is captured on Datix and how this information is captured to maximise its ability to produce and disseminate intelligence Trust-wide

- Working with the Lead Nurse for Patient Experience and Professional Standards, the Complaints Service will develop a training plan with the objective of improving the organisation's ability to resolve dissatisfaction at an early stage and to conduct timely and effective investigations

- The Complaints Service will work with Specialties to ensure that clear actions result from complaints where failings are identified. The service will develop processes to monitor the completion of those actions through to completion

- In the interests of openness and transparency, the Complaints Service will review its communications strategy. The strategy will review how complaints data, performance data and intelligence is shared to maximise the value of complaints and to allow for increased scrutiny

- The Complaints Service will continue its work to analyse the results of the audit that has been put in place to capture the reasons for complaints being returned for further local resolution. The service will then explore ways in which the complaints processes can better suit the needs of the complainant and improve their satisfaction with the Trust's handing and response to their complaint

Patient Advice and Liaison Service (PALS)

Introduction to PALS

The PALS is an independent and confidential advice and support service, helping resolve patients, relatives or carers concerns with the treatment, care or service being provided. The PALS liaise with the service to help resolve concerns quickly and informally to the satisfaction of the enquirer. Where necessary, the PALS will help patients, relatives or carers raise a complaint and provide the necessary support through that process.
In addition to the individual learning and improvements that result from individual enquiries, the PALS analyse enquiries data to identify and share learning opportunities across the organisation.
The PALS is appropriately located in the main foyer area, making it easily accessible to patients, relatives and carers.
The enquiries the PALS received in 2015-16 range from questions about waiting times, appointments and cancellations and lost property through to supporting patients and families through a Root Cause Analysis Investigation. The 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. This also includes signposting requests from relatives and carers to respective wards.
The PALS is continuing to engage with staff at all levels to ensure that learning and improvements take place to improve the service for future patients.

PALS Activity

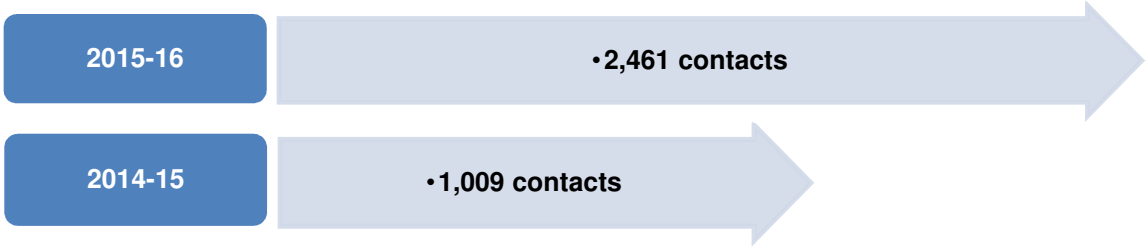


Figure 15: comparison of PALS contacts 2014-15 and 2015-16

Improvements to processes in 2015-16 have allowed enquiries to be more accurately categorised, recorded and reported. This data shows the number of enquiries received in 2015-16 compared to 2014-15, rather than the number of contacts made to PALS in these periods, which was the method of reporting in the 2014-15 report.

Enquiry Activity by Specialty Group

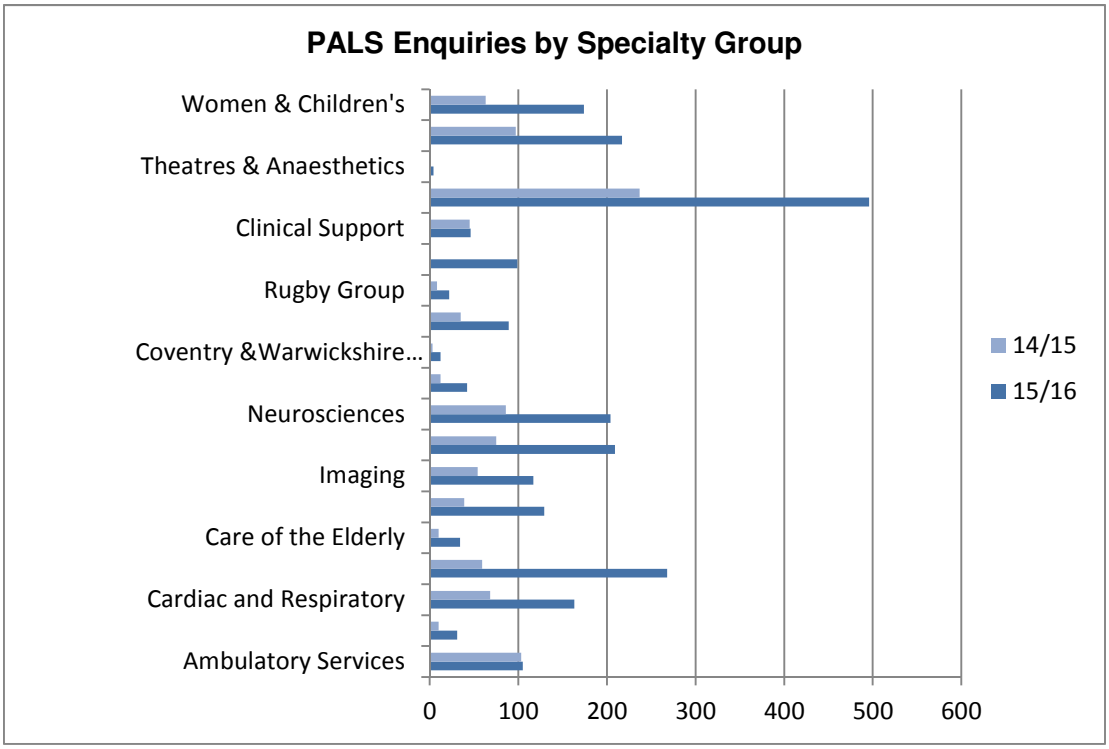


Figure 16: comparison PALS contacts by Specialty Group in 2014-15 and 2015-16

The above chart shows that Surgery received the most enquiries in 2015-16, which is consistent with 2014-15. Analysis of the enquiries received during 2015-16 concerning Surgery show that 49% relate to delay and cancellations for inpatients and outpatients appointments. Enquiries relating to car parking, how to access to health records and information on the complaints process has contributed to the increase of enquiries under Core Services.

Trend Analysis

PALS Enquiry by Subject

Subjects	2015-16
Communication / information given to patients	267
Attitude of staff	81
Admissions, discharge and transfer arrangements	88
Appointments, delay / cancellation (outpatient)	499
Appointments, delay / cancellation (inpatient)	294

Table 5: most common subjects per PALS contacts in 2015-16

The largest number of concerns received in 2015-16 related to the outpatient appointment process. The level and quality of information provided to patients is also a common cause of enquiries. The number of enquiries concerning the attitude of staff has increased in 2015-16 and the PALS report that these enquiries usually arise from dissatisfaction with the way staff or the Trust handle their enquiry or concern.

Method of Contact

Method	2015-16
Email	624
Letter	62
In person	449
Telephone	1320
Executive Office	6
Totals	2461

Table 6: comparison of method of contact in 2015-16.

To ensure that the PALS is accessible to all, they are contactable by a range of means. The above table shows that the majority of patients, relatives and carers contact the PALS by telephone. This is in line with the PALS objective of resolving enquiries with minimum formality and the PALS are able to resolve some enquiries in a single telephone conversation. The increase of in person contacts suggests that the repositioning of the PALS Office to the main entrance is of benefit and allowing more people to access the service in person.

Examples of PALS Enquiries and Actions

Equality and Diversity – Translation Services Mrs H contacted the PALS and stated that her mother has been in hospital undergoing several tests for Dementia. The patient speaks only Punjabi and has had the use of translation services during her appointment. The relative alleges the translators have told her mother she is undergoing 'mad tests' or that 'she is mental' which she feels is a confusing and upsetting translation to the patient and would like this raised as a concern.	PALS liaised with Translation Services who investigated and raised awareness of the care with the translation services.
Signposting – Mental Health Services Mrs S contacted the PALS unhappy that she now longer has access to a mental health nurse. She explained she was feeling increasingly "depressed" and "some days felt suicidal"	The PALS contacted the PALS team responsible for the Mental Health Services (Under the Coventry and Warwickshire Partnership NHS Trust) and asked that they contact this lady. The following day the PALS spoke with Mrs S to ensure someone had contacted her. She advised she now had an appointment to meet with her new mental health nurse.
Reassurance – Clinical Processes Patient has been admitted twice to UHCW and on both occasions has contracted Norovirus, enquirer would like to know Trust's policy for dealing with this and how it protects is patients.	The PALS liaised with the Infection, Prevention and Control team asking them to contact this lady directly and talk through the process of events once Norovirus is confirmed within UHCW

Key Achievements of 2015-16

- Through their casework, the PALS have focussed on strengthening their relationships with PALS departments in other Trusts, identifying key points of contact and sharing learning in respect of the services offered and processes. In addition, the PALS have met with Healthwatch Coventry and discussed the performance of the PALS and their role within the complaints process

- Ensuring all staff across the organisation are aware of the PALS and how to support any patient that is dissatisfied with the treatment, care or service they have received is crucial to delivering an accessible service. To help raise awareness of the PALS process and their availability, PALS staff have attended the Market Place Induction Event with the aim of making any staff joining the Trust aware of the service

- The PALS have undertaken a review of their processes and operational approach to ensure that complaints are handled in the most effective manner. It was identified that improved use of the case management system, Datix, will allow for better performance management and significant work has been undertaken to improve the quality of the data captured and live reporting has been introduced to allow this data to be effectively analysed and reported on

Further Developments for 2016-17

- The PALS will design and introduce a service user survey, to better understand and learn from the service user experience. To meet the needs and expectations of service users will be able to complete this survey electronically, by post and in person. This feedback will be used to ensure that PALS continues to provide a patient-centred service

- The PALS will review their opening hours with a view to extending them to better meet the needs and expectations of service users. A business case will be prepared to assess the viability of the PALS delivering a seven day service to service users. This will be a significant step for the PALS ensuring that the organisation offers a truly patient-centred service that is available at the time that they need it

- The PALS will continue its focus on developing key stakeholder relationships. Internally, the PALS will focus on increasing the awareness and understanding of the PALS amongst key staff groups to ensure that the enquiries processes is clearly understood and adhered to. The PALS will also use their skills and experience to help develop the ability of Trust staff to resolve dissatisfaction at the earliest possible stage

- Externally the PALS will continue to work collaboratively with other PALS Officers, but also it will seek to liaise more closely with other relevant services to ensure that they are aware of the support the PALS can provide so that they can signpost patients, relatives or carers accordingly

- PALS will build upon the work undertaken in 2015-16 to complete the process improvement work, performance management and stakeholder engagement to improve and monitor the working day response rate. The PALS will complete the implementation of the necessary performance monitoring tools required to regularly report on its performance against this response rate

- The improved use of Datix, combined with quality insurance processes, will allow the PALS to perform greater data analysis. This will enable the PALS to produce and disseminate valuable intelligence across the organisation, helping the organisation identify opportunities to improve the patient treatment, care and experience.

PATIENT SAFETY AND RISK MANAGEMENT

PATIENT SAFETY

Introduction to Patient Safety

The NHS Outcomes Framework 2015-16 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 actions and accomplishments demonstrate how the Patient Safety and Risk 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 Patient Safety Team provide expertise and support to the Trust to facilitate the monitoring and improvement of safety for all users of UHCW, including patients, visitors and staff.

This is realised through a range of approaches:

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

Risk and Patient Safety summary reports are provided to the Quality Governance Committee, Patient Safety Committee, Risk Committee, Safeguarding Vulnerable Adults and Childrens Committee, End of Life Care Committee, Hospital at Night Committee and Infection Prevention & Control Committee. Medical revalidation reports are provided to the Trust Board. Reports are also provided to the clinical Specialties for discussion at their monthly QIPS meetings, alongside other quality data and information, enabling the Quality Department and the individual Specialties to triangulate data to generate learning and to signal any areas requiring attention.

Patient Safety

Sign Up To Safety

The Trust joined the 'Sign up to Safety' (SutS) 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 taking shape at UHCW with the formation of a SutS Programme Board which is chaired by the Chief Medical & Quality Officer. The Board receives updates from the leads of the various work streams and monitors progress with the implementation of Human Factors training and education.
The Associate Director of Quality (Safety & Risk) presented the Trust's progress report to a conference in Liverpool hosted by the NHS Litigation Authority in March 2016.

Patient Safety Incidents

On 1 April 2016 the statutory patient safety functions previously delivered by NHS England transferred with the national Patient Safety Team to NHS Improvement

These statutory functions are the responsibility for:

- Operating the National Reporting and Learning System (NRLS); and using information from the NRLS, and elsewhere, to develop advice and guidance for the NHS on reducing risks to patients
- From the perspective of providers of NHS-funded care, existing processes and policies for incident reporting and receiving and acting on national patient safety alerts has not changed
- The NRLS '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. Resources include:

- Patient safety alerts, including Rapid Response Reports
- Regular feedback on the data collected
- Safety information on specific topics, such as safety of medicines.

The Trust encourages staff to report all incidents, however minor through its online incident reporting system (Datix), which is monitored and managed by the Patient Safety Team. Overall incident reporting continued to show an upward trend in 2015-16, the majority of incidents being of minor or no harm to patients, which is an indication of an open and learning culture. The Patient Safety Team shares the learning and improvements across the organisation as well as with commissioners, other local providers and with NHS Improvement via NRLS.

The Patient Safety Team uploads Patient Safety Incident (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 Patient Safety Incidents (PSIs) reported by UHCW between April 2015 and March 2016.

Patient Safety Incidents Reported by month

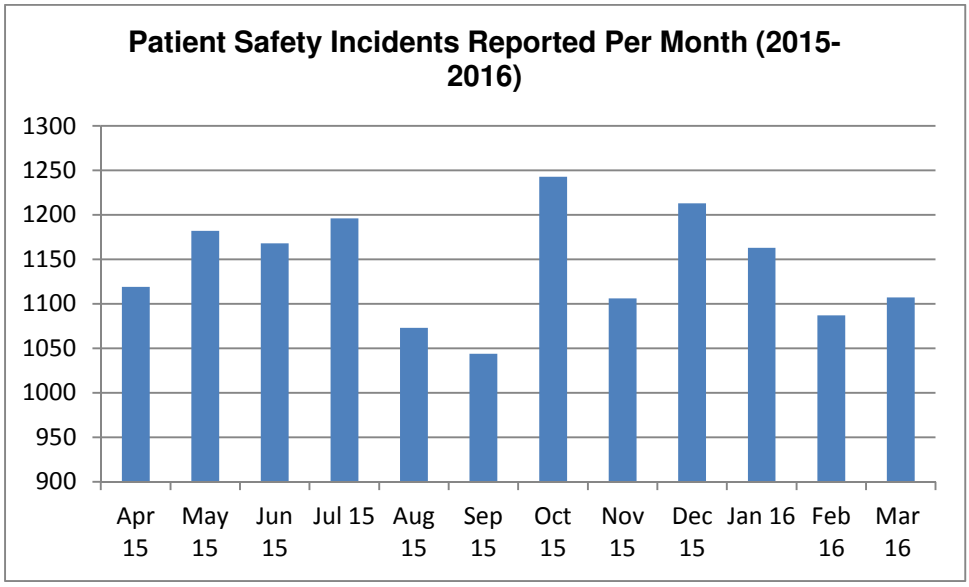


Figure 1: patient safety incidents reported per month 2015-16

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.

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).

Incident Risk Grading Matrix

Consequence

Score	1	2	3	4	5
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Time Frame	**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**

Table 1: Consequence grading for patient safety incidents

Likelihood

	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	Major injury leading to long-term incapacity/disability Increase in length of hospital stay by >15 days Mismanagement of	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large

	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
			impacts on a small number of patients	patient care with long-term effects	number of patients

Table 2: likelihood grading for patient safety incidents

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

Table 3: patient safety incident risk grading matrix

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 Patient Safety 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 Patient Safety 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 Patient Safety Team.

Year on Year Comparison

The Trust aims 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 increase compared to the previous year.

Financial Year (FY)	Total number of incidents reported	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%
2015-16	13733	742	4.4%

Table 4: patient safety incidents report and increase in reporting from 2012-13 to 2015-16

If rates are perceived to fall in individual departments or specialities then the Patient Safety Team review this with the speciality or department lead, both at the QIPS meetings and separately on the ward using a spot check tool devised to survey wards and departments' knowledge and experience of incident reporting.

Rate of Patient Safety Incidents 2015-16

At the end of the 2014-15 financial year the NRLS amended their benchmarking criteria. Prior to 01/04/2015 a cohort of 29 acute teaching Trusts were benchmarked by comparing the number of incidents per 100 Finished Consultant episode, admission and appointments to calculate a rate of incident reporting. With Trusts aiming to meet or exceed a reporting rate of 10% in all Specialties, the proportion of inpatient episodes leading to harmful events is around 10%. The Trust had a rate of 10.32 % as at 31 March 2015.

From 1 April 2015 until 1 September 2015 a cohort of 136 acute non-specialist Trusts were benchmarked by comparing the number of incident reported per 1000 bed days. The rate had a variance from 31.65 at the lowest to 61.32 at the highest. UHCW had a rate of 38.25.

The Trust monitors this rate internally. Below is a graph which shows the rate per 1000 bed days for the 2015-16 financial year.

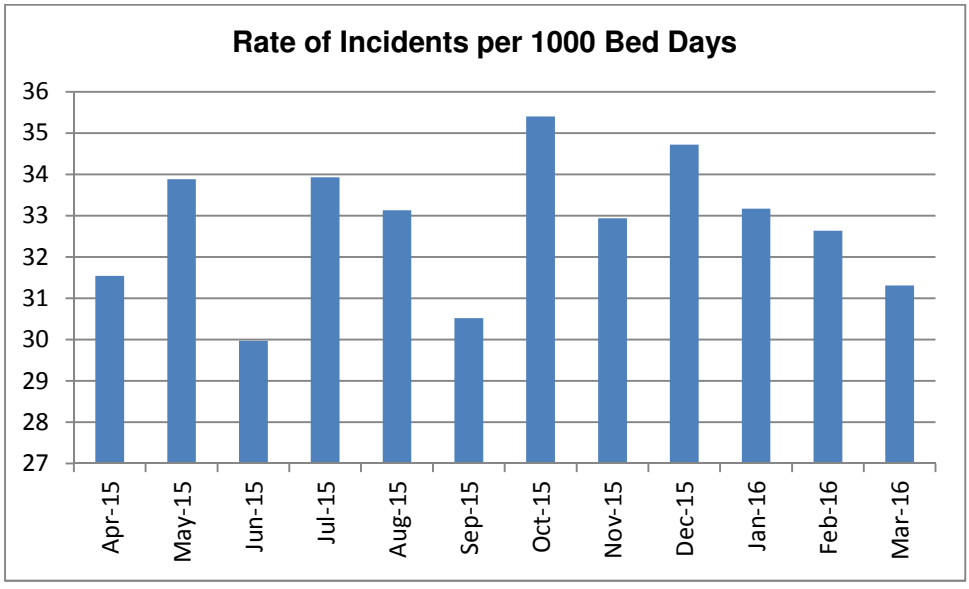


Figure 2: rate of incident reports per 1000 Bed days

Most frequently reported Patient Safety Incidents

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 undertaken. 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 supporting Coventry & Rugby Clinical Commissioning Group (CCG).

The Patient Safety 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.

Serious Incidents Requiring Investigation (SIRI)

At UHCW these investigations are conducted under the direction of the 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 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 commissioners and with the patient/s involved in the incident. In this way any learning or safety measures are shared and implemented 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 Patient Safety 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 the Patient Safety Committee by the Patient Safety Manager.
During 2015-16 the Patient Safety Team managed 182 SIRIs and a further 33 non-SIRI cases went through SIG.
To meet the requirements of the national SIRI Framework the Trust is required to complete investigations and provide a comprehensive report for each case within a set time frame, generally within 60 working days with some exceptions when an investigation involves other agencies.

Closure was achieved within timescale in 178 (97.8%) 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 2015-16 629 individual actions from 104 action plans, have been initiated which the team has monitored for completion or escalated when overdue.

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 incident 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.
The list of Never Events published by NHS England underwent significant changes in the 2015-16 financial year. The number of never events listed was reduced from 25 in 2014-15 to thirteen in 2015-16.
During 2015-16 the Trust reported three wrong-site surgery 'never events'.
Each case was investigated in accordance with the national Framework for Reporting and Learning from Serious Incidents Requiring Investigation (NPSA 2010).

What else has been done to reduce the likelihood of a never event?
The Patient Safety Team ensures that all serious incidents are logged on 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 Patient Safety Team 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 include:

- Clinical Guideline developed to include recommendations to ensure provision of the best possible quality image intensifier images intra-operatively to enable identification of correct spinal level
- Ensure better documentation with regards to clinical management plans, communication, and handovers within and between medical teams are in place
- Clearer communication within the wider clinical professional teams (medical and nursing)
- Consent procedure and documentation review and implementation of new policy
- A guideline for spinal surgery agreed and published on e-Library, suggesting the use of clips attached to ligament prior to image intensifier x-rays to identify the correct level
- Explore process for transfer or sharing of clinical information when patients are seen at other Trusts by UHCW clinical staff to ensure it is reliable and robust

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 statutory requirements in regulations 9-20 of the Health & Social Care Act 2008 (Regulated Activities) 2014 Regulations which was implemented in November 2014.
The General Medical Council states in the Good Medical Practice Guide:

"The Care Quality Commission's (CQC) Regulation 20 ensures 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 Duty of Candour the Patient Safety Team is leading on the production of a new Trust policy (Duty of Candour (Being Open) Policy), which is based on national guidance and feedback on a local audit of UHCW incidents of moderate harm and above in consultation with our clinical staff.

Following an incident that falls within the Duty of Candour requirements 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 an investigation of an incident they will receive a further letter and they will be given an opportunity to discuss the findings with a member of the clinical team.

Once approved the policy will be monitored through the Trust's Significant Incident Group and Patient Safety Committee, with regular audit and reporting to 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 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.

When alerts are received by the Trust they are disseminated via the Patient Safety Team to the appropriate lead for the alert. The lead reviews the alert and completes a gap analysis against the actions listed within it. The Patient Safety Manager supports the lead to assign any actions to relevant staff and ensures that all actions have been completed to the national deadline. The Patient Safety Manager reports the status of the Patient Safety Alerts (PSA) 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 2015-16 financial year.

Alert Stage	Title of Patient Safety Alert	Date received
1	Risk of death or severe harm due to inadvertent injection of skin preparation solution	26/05/2015
1	Harm from delayed updates to ambulance dispatch and satellite navigation systems.	09/07/2015
2	Addressing antimicrobial resistance through implementation of an antimicrobial stewardship programme	18/08/2015
2	Supporting the introduction of the National Safety Standards for Invasive Procedures	14/09/2015
2	Support to minimise the risk of distress and death from inappropriate doses of naloxone	26/10/2015
1	Risk of death and serious harm by falling from hoists	28/10/2015
1	The importance of vital signs during and after restrictive interventions/manual restraint	03/12/2015
1	Risk of using different airway humidification devices simultaneously	15/12/2015
1	Risk of severe harm or death when desmopressin is omitted or delayed in patients with cranial diabetes insipidus	08/02/2016

Table 5: patient safety alerts issued by NHS England during 2015-16

All of the alerts received in 2015-16 were completed within the timescale set.

Learning

There has been a consistent approach to learning from PSIs, SIs and Alerts throughout the Trust. The Patient Safety 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 and clinical audit and effectiveness. They also include narrative about Trust-wide safety issues. These reports are discussed at the Specialties' multi-disciplinary QIPS meetings
- Monthly feedback to QIPS leads which also identifies themes and trends
- Email feedback via Datix to individual reporters once incidents are closed
- 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
- The Trust has an internal patient safety alert system, whereby safety messages are disseminated quickly to the relevant staff
- Lessons learned at the monthly Clinical Quality Review Group meeting with our commissioners
- Lessons learned with local providers at the quarterly Coventry & Warwickshire Learning Forum, hosted by Coventry & Rugby CCG are shared

- 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 2016-17.

Following the Trust-wide induction review in 2014-15, the Patient Safety Manager now delivers a face to face presentation at Trust Induction about the Trust's approach to incident reporting.

The team has created opportunities to provide 'on the job' training in risk management by visiting wards and departments. This has taken the form of spot checks by the Patient Safety Team, making contact with various staff groups, e.g. Nurses, Doctors Allied Healthcare 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 support and training has been provided, either directly or by procurement of external training. Examples are:

- Presentations at Junior Doctors' education sessions
- Presentations at Specialty QIPS meetings
- 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

Key Achievements of 2015-16

- Training presentations have been delivered at Trust Induction, Junior Doctor's rotation
- Incident reporting awareness spot checks have been undertaken across the Trust
- An increase in reporting of 4.4% has been achieved
- RCA and Datix training continues to evaluate well and a rolling programme is in place

Further Developments for 2016-17

- Increase UHCW patient safety incident reporting by a further 5%
- Conduct a gap analysis against the 2015-16 list of never events
- Develop a Human Factors Strategy for the Trust
- Develop clinical Always Events with the clinical Specialties.

RISK MANAGEMENT

Introduction to Risk Management

Risk at UHCW is defined as the chance that something will happen leading to a negative impact on the achievement of one or more of the Trust's aims and objectives. It is measured in terms of likelihood (frequency and possibility) of the risk occurring and the severity/consequence (impact or magnitude of the effect of the risk).
The healthcare environment is highly complex and has inherent risks. The Trust acknowledges that things can, and do go wrong and is committed to the proactive management of risk as an integral component of the overall framework of governance and internal control.
Given the complexity of the organisation, there can be several consequences arising out of any risk that materialises and therefore an integrated approach to risk management is taken, which incorporates all types of risk, including (but not restricted to) strategic, clinical, quality, financial, health and safety, operational, external compliance, human resources and risks to the Trust's reputation.
UHCW is committed to ensuring that the management of risk underpins all strategies, processes and activities that lead to the achievement of the aims and objectives of the Trust.
The key aims are to safeguard against the following risks which could affect the delivery of the Trust's objectives:

- To deliver Excellent Patient Care and Experience
- To deliver Value for Money
- To be an Employer of Choice
- To be a Research Based Healthcare Organisation
- To be a Leading Training and Education Centre

Strengthening Risk Management

Following the CQC Comprehensive Inspection in 2015, a number of recommendations were made relating to risk management. In response, actions were identified to address the risk management issues raised. All actions from the inspection have been implemented in order to strengthen the risk management principles and processes throughout the Trust.

The Risk Committee terms of reference were reviewed and the committee was re-established in February 2016. The group now meet monthly and the meeting is chaired by the Chief Executive Officer. The committee reviews the corporate risk register monthly in conjunction with individual speciality local risk registers, bi annually, as per the rolling work plan schedule.

A Trust Risk Manager was appointed in March 2016; to further support the risk management structure across the Trust and line manage both the Systems Manager for Datix and the Support Officer.

The risk register has been regularly monitored and provides monthly reports provided to the Risk Committee for the corporate risk register. The various 'Sub Types' are reviewed at the relevant corporate committees for example 'Safety Clinical' risks are all reviewed at the Patient Safety Committee.

Figure 3 details the number and ratings of corporate risks over the 12 month period.

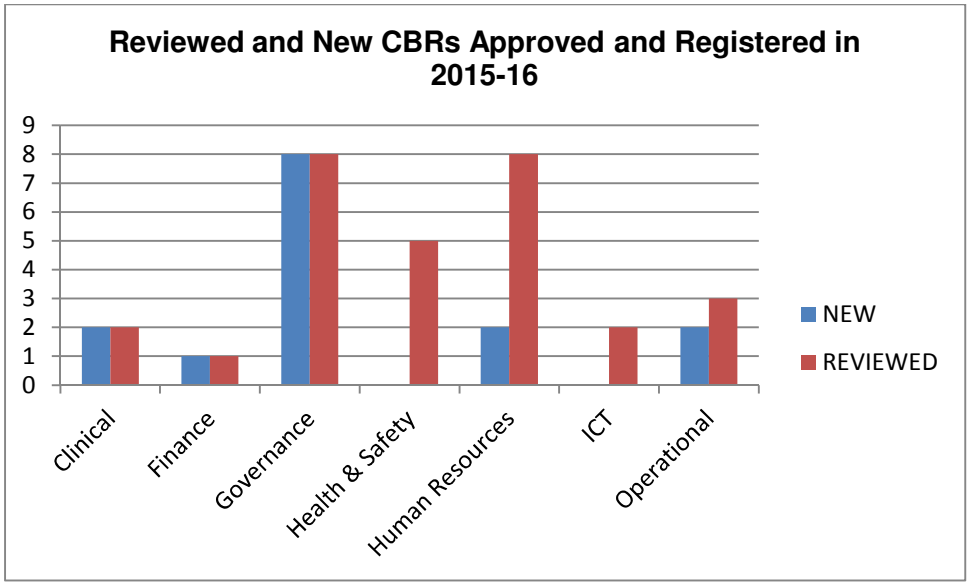


Figure 3: number of corporate risks by Current risk level for April 2015-March 2016

Datix

The Trust utilises Datix throughout the Quality Department and wider organisation to record and manage any risks that are identified via a web-based incident reporting and risk management software system for health and social care organisations.

The team has maintained strong working relationships with Datix and their software support team and continue to seek their advice and technical support.

The team successfully further developed the system early in 2016 to include the Complaints module to support the KO41 Regulations from the Health and Social Care Information Centre, and allow the Complaints and PALS team to have 'Dashboard' overview of their portfolios; this has been well evaluated by the team and nationally UHCW has been one of the first and few Trusts to have achieved this.

Key Achievements of 2015-16

- **Risk Committee**: following a review of the Risk management pathway throughout the Trust the Executive team have supported a re-structure of the Risk Committee. This has been pivotal for the direction of a positive Risk Management culture throughout the Trust

- **Risk Manager Post:** the Trust successfully recruited to the post of a Trust Risk Manager to supplement the existing team and support the corporate risk process via the Risk Committee

- **Virginia Mason Work Stream:** the Patient Safety and Risk Team have been selected as a key area to benefit from the Virginia Mason; the key lines of improvement will facilitate streamlining of the current processes in place for the use of Datix in particular for the recording of patient safety incidents. This is critical for the Datix team to shape a platform of changes and developments to the Datix system

Further Developments for 2016-17

Datix Developments

Delivery Group: the multi-professional forum and will be revised to improve and monitor the setup of Datix its functions, user interface and future developments. The group's terms of reference will be reviewed to include an approval process for developments to the system to enhance quality control.

Risk/Datix Newsletter: a monthly Risk/Datix newsletter will be introduced to act a platform of communication from the Risk/Datix Team across the Trust.

Dashboards: portfolio of 'Dashboards' on Datix will be developed to allow users to directly access pertinent key performance data and to further streamline the resource required from the Risk team to extract data from Datix. The 'Dashboards' will be designed to allow direct access to current data on Datix that is specifically related to each Specialty area, this process is currently extracted manually each month by the Team and constitutes a significant amount of administration time.

Training

In conjunction with the Health and Safety Team and the agreed Training Needs Analysis for 2016-17, 'Introduction to Risk Management for Managers' 4.5 hour classroom based session is planned to roll out in autumn 2016 for all senior and departmental managers.

An in house Datix training programme will be delivered to support users with direct training on the purpose of the system, its functions and core user standards to ensure the system is being utilised to its maximum potential. This is in addition to providing open sessions for staff to 'Drop in' and receive on the spot guidance and advice with the Datix system.

Standard Operating Procedures (SOPs)

A number of standard operating procedures will be developed to support the function of Datix to optimise its use for users, as well as SOPs to support the technical administration requirements. Furthermore the team are committed to devising a Risk Management SOP to strengthen the culture for Risk Management, support education of the principles of risk management and standardise the methodology across the Trust.

MEDICAL REVALIDATION

Introduction to Medical Revalidation

Medical revalidation has been a statutory requirement since December 2012; and was introduced in the UHCW from April 2013. Its purpose is to demonstrate that licensed doctors are up-to-date and fit to practise.

The Trust is regarded as a Designated Body (DB), and all DBs have a statutory duty to support their Responsible Officers (RO) in discharging their duties under the RO Regulations.[1] It is expected that Trust Boards and Executive Management Teams will oversee compliance by:

- monitoring the frequency and quality of medical appraisals in their organisations
- checking there are effective systems in place for monitoring the conduct and performance of their doctors
- confirming that feedback from patients is sought periodically so that their views can inform the appraisal and revalidation process for their doctors and
- ensuring that appropriate pre-employment checks (including pre-engagement for Locums doctors) are carried out to ensure that medical practitioners have the qualifications and experience appropriate to their work
-

The national schedule will ensure the General Medical Council (GMC) has 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.
The RO for UHCW is Professor Meghana Pandit, Deputy Chief Executive Officer & Chief Medical Officer.

There are three types of recommendation an RO can make:

1. Recommendation to revalidate - confirms that a license to practise should be continued

2. 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

3. 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 464 recommendations to revalidate have been made for the Trust's 589 prescribed connections. Overall 56 requests for deferral have been made, of which 5 are still awaiting a 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.

Key Achievements of 2015-16

As part of NHS England's Framework for Quality Assurance (FQA) the Trust must provide NHS England (NHSE) with assurance of its appraisal rates on a quarterly basis. Data reported in the table opposite for the appraisal year 1 April

[1] The Medical Profession (Responsible Officers) Regulations, 2010 as amended in 2013' and 'The General Medical Council (Licence to Practise and Revalidation) Regulations Order of Council 2012'

2015 - 31 March 2016 reflects those who have successfully completed an appraisal and where the RO accepts that postponement was reasonable.

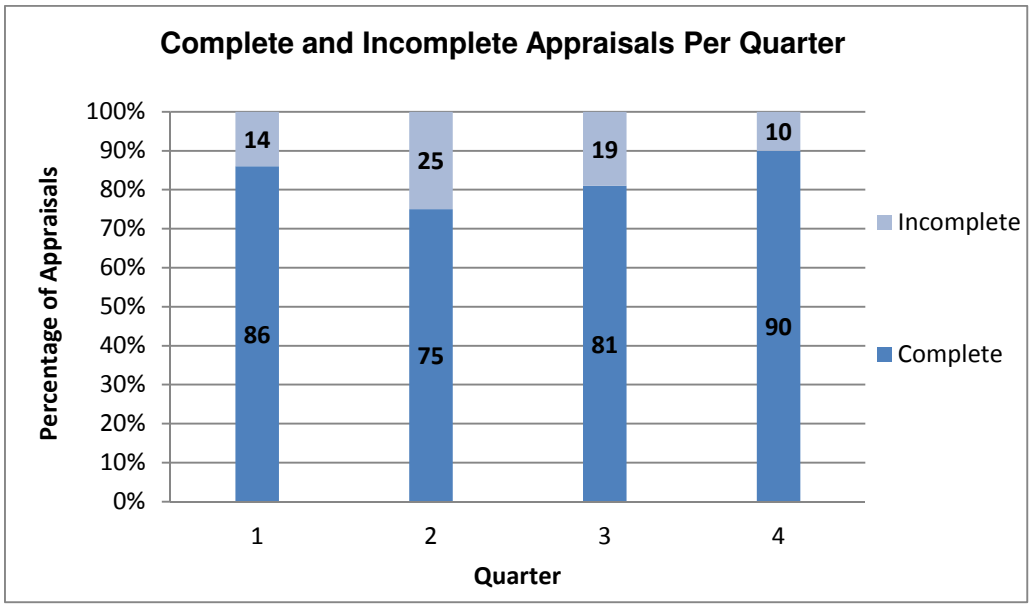


Figure 4: complete and incomplete appraisals during each quarter of 2015-16

For the last quarter (1 January 2016 – 31 March 2016) of the 217 appraisals due, 119 appraisals in this period were not completed. Fourteen have a valid reason for postponement (e.g. sick leave, maternity leave) 53 were still within the fifteen month window and eight have since left the Trust. Overall 423 appraisals were completed this year meaning compliance was at 83%.

In order to assure the Trust Board that progress is being made and requirements are being met biannual updates are presented with the inclusion of quarterly figures. In addition board reports also outline progress made to date on an agreed action plan. Reports are accessible on the Trust's internet site.

The following actions to strengthen the revalidation and appraisal process were taken during the year:

- The use of a Medical Practice Information Transfer (MPIT) form went live in Workforce in August 2015 to meet requirement 1.1.5 of the Core Standards laid out in the FQA. This ensures the RO is provided with any relevant information about a new starter's previous practice in a timely manner

- Delivery of five in-house appraiser top-up training sessions to 44 appraisers who first completed a course in 2012 since there is a need for training to be updated on a 3 yearly basis. The Medical Revalidation Appraiser training programme also continues to run to ensure the appraiser to appraisee ratio is maintained. There are currently 96 trained appraisers in the Trust

- NHSE Independent Verification Visit – Representatives from NHSE Regional Medical Directorate (Midlands & East) visited the Trust on March 2016 to undertake independent verification of the processes that support Medical Revalidation. The visit aimed to scrutinise matters including policies and process, compliance, governance and quality assurance. Initial feedback from the visit was positive with minor changes to policy required. The Trust is still awaiting formal feedback in the form of a report

- In April 2015 CW Audit found the transfer from paper appraisals to the Revalidation Management System (RMS) had resulted in the loss of reportable dates to allow the flagging up of overdue appraisals. Since then all paper appraisals stored in paper format have been scanned so that data can be accessed quicker and stored more securely

Further Developments for 2016-17

The Trust will continue 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, the Trust will continue to assess itself against the FQA in order to strengthen processes further.

- Educational appraisals - By the end of July 2016 the Trust needs to ensure all named Educational and Clinical Supervisors are formally approved with the GMC. Part of this approval depends on an adequate educational appraisal as part of the appraisal process. Along with Medical Education and RMS providers Equiniti 360 Clinical, a process for confirming this requirement has been met will be put in place

- Increase appraisal rates - better utilisation of RMS report functions and sharing of information with Groups to ensure timely capture of breached appraisals. Appropriate chasing of overdue appraisals within

- Strengthening of process and working relationships with HR– especially in relation to the sharing of information to ensure accurate and timely dissemination of information to doctors (i.e. in relation to perceived non-engagement, sick leave, maternity leave, retirement and conduct and capability)

- Implementation of any actions highlighted from the NHSE Verification Visit

CORPORATE BUSINESS RECORDS

Introduction to Corporate Business Records (CBRs)

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 used for assessing the Trust's records management programme and ensures that 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 healthcare 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 interests 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 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 healthcare.

All Trust-wide CBRs processed for approval are assessed to ensure they contain no discriminatory practices (or the potential for discrimination) on the grounds of age, sex, race, disability, sexual orientation, religion and belief or gender.

The Trust has an in-house electronic records management system for the storage and management of Trust-wide Corporate Business Records (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 2015-16

The Trust's Corporate Business Records Manager, manages the approval process for all Trust-wide CBRs which are consulted on at operational level committees, quality checked by the Quality Department, prior to being Trust approved by Corporate Business Records Committee (CBRC, 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. Currently there are 182 Trust-wide CBRs registered on the system.

Version 13 (2016) of the annual Information Governance Toolkit which consists 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 31 March 2016. The Trust scored level 2 (satisfactory) or above 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 Policy were reviewed and approved by CBRC in January 2015 and will be further reviewed in 2018.

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

Key Achievements of 2015-16

44 Trust-wide CBRs were Trust approved and registered on e-Library for all staff to utilise between April 2015 and March 2016.

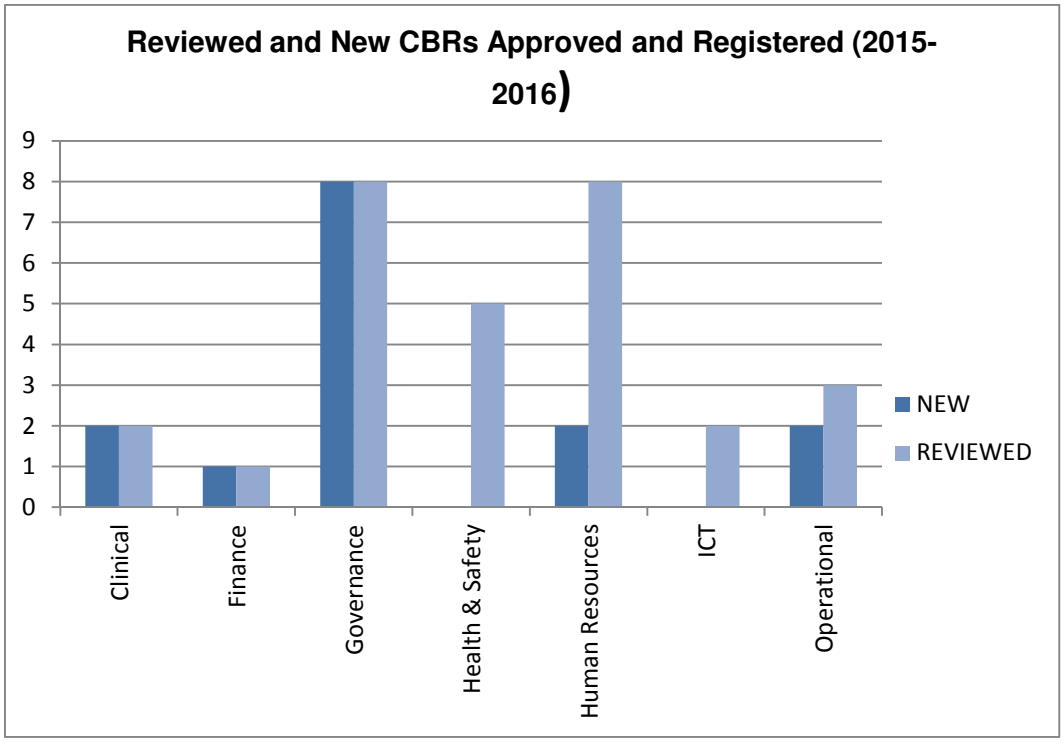


Figure 5: reviewed and new CBRs approved and registered in 2015-16

A review of corporate information (non-clinical) was undertaken in four departments within the Trust to enable managers to identify: the location of records; any information security concerns; create an information asset register;

protect the legal rights of the organisation, its employees, its patient and third parties and to provide authentication so that actions may confidently be taken on reliable information. This review is the first stage of the implementation of a five year plan to be developed across the Trust.

Further Developments for 2016-17

- Comply with legal legislation and national requirements such as the annual IG Toolkit submission (requirements 400, 601 and 603), and CQC – Regulation 17 – Good Governance

- To progress with technological developments to e-Library records management system, to ensure records remain accessible and usable throughout their life cycle

- The first stage of a five year plan is currently in operation to ensure a robust process is in place for the management of underpinning operational procedures to support the implementation of Trust-wide CBRs

APPENDIX

The 5 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*

- Re-launch the *Sepsis Six* 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 90s 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 clinical **'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 '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 (OSCAs) ceremony
- Conduct regular Executive Quality Walk rounds, 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.