Worcestershire Acute Hospitals NHS Trust

Evidence appendix

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This evidence appendix provides the supporting evidence that enabled us to come to our judgements of the quality of service provided by this trust. It is based on a combination of information provided to us by the trust, nationally available data, what we found when we inspected, and information given to us from patients, the public and other organisations. For a summary of our inspection findings, see the inspection report for this trust.

Facts and data about this trust

Details of sites and locations registered with CQC

- Worcestershire Royal Hospital
- Alexandra Hospital
- Kidderminster Hospital and Treatment Centre.
- Evesham Community Hospital
- Malvern Community Hospital

Specialist services provided at the trust

The standard specialties at the trust include general medicine, oncology, surgery, maternity, trauma and paediatrics.

Background to the trust

Worcestershire Acute Hospitals NHS Trust was established in April 2000 and provides a service across five sites: Worcestershire Royal Hospital; Alexandra Hospital; Kidderminster Hospital and Treatment Centre; Evesham Hospital; and Malvern Community Hospital. The trust provides a range of elective, non-elective, surgical, medical, women's, children's, diagnostic and therapeutic services, rehabilitation services, including stroke services and cardiac stenting.

The trust has been inspected by the Care Quality Commission (CQC) regularly since March 2015. Please see the table below for a summary of the CQC inspections at Worcestershire Acute Hospitals NHS Trust:

Date	Area	Site
March 2015	Emergency departments	Worcestershire Royal and Alexandra Hospital
July 2015	Full comprehensive across all core services	Trust-wide
July 2016	Radiology - Unannounced specialist inspection	Worcestershire Royal Hospital
November 2016	Full comprehensive across all core services	Trust-wide (with the exception of Evesham Community Hospital and Malvern Community Hospital)
April 2017	Unannounced focussed inspection based on Section 29a Warning Notice issued January 2017	Trust-wide (with the exception of Evesham Community Hospital and Malvern Community Hospital)

The trust has received two Section 29A Warning Notices, one in January 2017 following the November 2016 inspection; and one in July 2017 following the April 2017 inspection. This Notice included detail about how the trust had failed to comply with the requirements and therefore, needed to make significant improvements in the healthcare provided. As a result, the trust remains in special measures. Trusts are placed in special measures when there are concerns about the quality of care they provide.

Facts and data about the trust

Worcestershire Acute Hospitals NHS Trust provides acute healthcare services to a population of around 580,000 in Worcestershire and the surrounding counties. There are approximately 734 inpatient and day case beds, of which 73 are maternity and 32 are critical care.

In late October 2015, the obstetric and neonatal services were deemed no longer sustainable at Alexandra Hospital and in November 2015 these services were centralised at Worcestershire Royal Hospital. In September 2016, the paediatric inpatient service was centralised on the Worcestershire Royal Hospital site.

The trust is structured under seven divisions:

- Asset management and information technology
- Corporate services
- Clinical support
- Medicine
- Surgery
- Women and children
- Urgent care

The trust employs 5,036 staff as of August 2017, including 583 doctors, 1,384 nursing staff and 3,069 other staff. All staff turnover peaked at 13.0% in November 2016. Both medical and nursing vacancies remain a high risk for the trust with some 513.4 WTE reported in November 2017 (8% vacancy rate), the trust target was 7 %. (*Source:* November 2017 board report).

The health of people in Worcestershire is varied compared to the England average. Deprivation is lower than average and about 15% (14,500) children live in poverty. Life expectancy for both men and women is similar to the England average.

Information from the last Census in 2011, found that ethnic minorities are relatively small in Worcestershire; with just over 92% of people living in the county classed as White British compared to almost 80% in the whole of England. However, statistics show that Black and Minority Ethnic groups in Worcestershire have risen from 24,700 (4.6%) in 2001 to around 43,000 (7.6%) in 2011, with the vast majority residing in the district of Redditch (12.6%).

Patient numbers

Trust activity for August 2016 to July 2017:

- 187,598 A&E attendances (-1% change compared to the same time 2015/16)
- 134,003 inpatient admissions (+3% compared to the same time 2015/16)
- 846,688 outpatient appointments (+3% compared to the same time2015/16)
- 1,902 deaths (0% compared to the same time 2015/16)
- 5,192 births (-5% compared to the same time 2015/16)
- 33,906 surgical bed days (+4% compared to the same time 2015/16)
- 1,769 critical care discharges (-4% compared to the same time 2015/16)

Financial position

Whilst the trust did achieve its financial control target in 2016/17 of a £34.6m deficit, including delivery of 91% of its £28 million cost improvement target. This leaves the trust with a significant financial deficit for the future years.

The trust submitted a financial plan for 2017/18 to NHSI which delivers a £42.7 million deficit after delivery of a £20.9 million savings programme. The plan recognises that the trust has insufficient cash resources and includes a requirement for £31.3 million of cash support from the Department of Health to maintain the trust's cash flow in 2017/18.

The trust has underperformed both financially and operationally which has resulted in the trust missing key operational performance targets, subsequently the trust is £1.5m adrift of the pre plan as at month four 2017/18. Prime drivers of the deficit include premium costs for agency and locum staff due to significant medical and nursing vacancies and non-attainment of additional revenue due to poor performance against key performance indicators. (*Source:* May 2017 Way Forward Report).

(*Source:* Finance & Performance Committee Report to Trust Board – Month 4 *2017).*

What people who use the trust's services say

In the CQC Inpatient Survey 2016 (published May 2017) the trust performed about the same as other trusts for nine of the 11 questions. Responses were received from 531 patients at Worcestershire Acute Hospitals NHS Trust. Two questions were worse than other trusts:

- For being given enough privacy when being examined or treated in the emergency department.
- Waiting to get a bed on a ward.

The trust's overall score in the Friends and Family Test for the percentage of patients who would recommend the trust was about the same as the England average between August 2015 and August 2016. However, the response rate was less than the national average at 16.4% compared to an England average of 24.7%.

The National Cancer Patient Experience Survey 2016 showed that 88% of cancer patients rated their care at Worcestershire Acute Hospitals NHS Trust as very good. The trust scored better than the national average in a number of areas, including:

- Patients were told they could bring a family member or friend when told they had cancer. 81% compared to 76% national average.

- Hospital staff told patients they could get free prescriptions. 87% compared to 80% national average.
- Doctors had the right notes and other documentation with them. 98% compared to 80%.
- Patients were definitely given enough support from health or social services during treatment. 61% compared to 53%.
- Practice staff definitely did everything they could to support patients. 67% compared to 62%.
- The trust showed progress in discussing taking part in cancer research with patients, scored 31% in 2016 in comparison to 24% in 2015.

Is this organisation well-led?

Leadership

As this was a focused inspection to follow up on the leadership and governance issues relevant to the Section 29A Warning Notice served in July 2017, only evidence relevant to these headings is included in this evidence appendix.

To write the well-led report, and rate the organisation, we interviewed the members of the board and a range of senior staff across the trust. This included clinical and non-clinical service and specialty directors. We met and talked with a range of staff to ask their views on the leadership and governance of the trust. We looked at a range of performance and quality reports, audits and action plans; board meeting minutes and papers to the board, investigations, and feedback from patients, local people and stakeholders.

There was increasing stability in the executive team with two changes since our previous inspections. Staff spoke positively about this stability and the focus on achieving and sustaining good patient care.

A number of executives had taken up post since March 2017, the chief executive and chief nursing officer commenced in March 2017, with the chief medical officer starting in May 2017. There continued to be instability in the chief operating officer post, the deputy chief operating officer was now in this position on an interim basis. The director of human resources post was vacant at the time of the inspection but this post had been appointed to with a director of people and culture due to commence in early 2018. Two other director posts had been recruited to a director of performance and an interim director of governance, these were non-voting posts. Two new non-executive directors started in January 2017 and one started in August 2017. Staff welcomed having people in substantive roles, for example one person said “now we have a bit of hope”.

The leaders understood the challenges to quality and sustainability. They were able to identify the actions needed to address them and recognised the significant volume of work required to improve the quality of care at the trust and ensure it was sustained. As a trust in special measures they were getting support from a number of external agencies in order to achieve this. The challenge was to continue to address the issues at an appropriate pace. The trust had developed a quality improvement plan which was reviewed both internally and externally through monthly oversight meetings with key stakeholders. This identified the actions required to address the areas for improvement.

Not all divisional leads had the necessary experience, knowledge, capacity or capability to lead effectively. Shortly before our inspection there had been a reconfiguration of the clinical divisions which included a separate acute/urgent care and specialised services division. During our inspection we found a risk of instability across the management divisions with some posts being filled by interim staff or acting up posts. However, staff believed the new reconfiguration would lead to better support for their teams and stronger clinical leadership.

The need to develop leaders had been identified by senior management and actions were being implemented to manage this.

Leaders were becoming more visible and approachable. Prior to the current executive team there had been frequent changes in the executive post holders including the chief executive. Staff felt this had been difficult to keep up with. However, the new team were described as more visible staff found the stability encouraging.

The executive team were very aware of the staff culture and the impact of the many changes as demonstrated in the annual staff survey results in which the trust had seen deterioration. The 2016 results indicated only 48% of staff considered the trust a good place to work against the average of all acute trusts of 62%. These were worse than the 2015 results. Furthermore, only 56% of staff would be happy with the standard of care should a friend or relative require treatment, this was against the average of all trusts of 70%. Anxiety, stress and depression were the prime reasons for staff sickness.

The executive team saw the culture and behaviours of staff as key to the success of improving patient care. They were introducing a programme called '4ward' this aimed to transform the culture and improve performance. Four signature behaviours had been developed to support this, they were:

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

This was a long term programme that will take three years to embed.

The board spoke of how they needed to set the example in their behaviours, they needed to be open with the community and seek feedback and engage with staff on their responsibilities including holding people to account.

Trusts are required to meet the Fit and Proper Persons Requirement (Regulation 19 of the Health and Social Care Act) Regulations 2014. This regulation ensures directors of NHS organisations are fit and proper to carry out this important role.

At the inspection in November 2016, we found that there were omissions in the personal files of the executive team. When we returned on the unannounced inspection in December 2016, we reviewed these files again and found them to be in order and meeting the requirements of the regulation. However, on reviewing the files of the three executive directors and two non-executive directors at the April 2017 inspection we found two files were satisfactory, three files did not contain the required disclosure and barring checks and one had a significant number of other check missing.

At this inspection we found the trust had developed a fit and proper persons test checklist which covered the requirements of the regulation, including a disclosure and barring check, financial checks and references. This was situated at the front of each file to demonstrate the information required was present. We looked at seven staff files of the executive directors, including three non-executive directors. These demonstrated that the fit and proper persons test was part of the recruitment process and involved a combination of self-declaration and checks.

Vision and strategy

The trust had a vision for what it wanted to achieve and objectives to support this in the short term however, a longer term robust strategy had not yet been developed.

There was no clear strategy in place, however, the 'Way Forward' plan was endorsed by the board in June 2017. The plan recognises the challenges the trust faces across service provision, performance against key performance indicators, financial sustainability and culture. To address

this, the plan focused on: investing in staff, delivering better performance and flow; improving safety, stabilising finances, corporate governance and strategic planning. A three year plan was due to replace this initial way forward process.

There were four strategic objectives in place:

- Deliver safe, high quality compassionate patient care
- Design healthcare around the needs of our patients, with our partners
- Invest and realise the full potential of our staff to provide compassionate and personalised care
- Ensure the trust is financially viable and makes the best use of resources for our patients

The trust's current values were based on the acronym PRIDE:

- Patients at the centre
- Respect for everyone
- Improve and innovate
- Dependable
- Empower

Staff were aware of the trust values and could describe and direct us to posters on display across the trust; however these were not embedded into practice.

Culture

Most staff said they felt respected, supported and valued. Staff said the new executive team had made a difference to the trust.

The trust had appointed a new director of people and culture who was due to commence their post in the new year.

The trust had introduced a comprehensive cultural change programme called '4ward' which was delivered by the PULSE UK organisation and involved every staff member. The methodology follows a systems engineered, psychological approach and has been successfully implemented inside national and international organisations. The process aligns all staff to the collective achievement of shared goals through determining the vision, priorities and signature behaviours for the organisation. The majority of the board and divisional leadership teams had attended the initial workshop with positive feedback in terms of the program's staff engagement and improvement potential.

The trust had a people and culture strategy 2017 to 2020. Their vision was for their colleagues to feel empowered to improve performance through collective achievement, be accountable for their actions and transform care at every opportunity. The trust launched the 4ward project in October 2017. This is a long term initiative which aims to help colleagues across the trust to work more effectively together.

The 4ward project had four signature behaviours which we saw displayed across the trust namely:

Core Competence	Signature behaviour
Improving performance	No delay, every day
Leading collective achievement	Work together, celebrate together
Accountability	Do what we say we will do
Transforming care	We listen, we learn, we lead

We met with different groups of staff including consultants, nurses, mental-health leaders and clinical and directorate leads. We also held drop-in groups that all staff could attend. Most said the trust was supportive to them.

Staff spoken with said they felt positive and proud about working for the trust and their team.

The trust had endorsed and rolled out internal professional standards, adopted with permission from another NHS trust. The trust had promoted these in the emergency department staff spoke of feeling empowered by having these as it gave then a framework on which to challenge colleague's behaviours if they were not in line with these standards. However, we also heard from staff that they felt that there was poor management of consultant behaviours across the trust. This was fed back to the trust and their action for improvement included:

- For this topic to be addressed through the 4ward cultural change programme. 4ward is a "long term initiative which aims to help colleagues across the trust work more effectively together in a spirit of mutual support and respect."
- The introduction of the National Clinical Assessment Service Behavioural Impact agreement which looks at the handling of concerns about a practitioner's behaviour and conduct.

The trust had an appointed freedom to speak up guardian and provided them with sufficient resources and support to help staff to raise concerns. The freedom to speak up guardian was allocated three days a week for the role and had visited wards and departments to promote the role and seek feedback from staff. Staff knew how to use the whistle-blowing process and about the role of the freedom to speak up guardian.

The trust recognised staff success through staff awards and feedback. For example, we saw the Worcestershire Way newsletter which outlined an award given to a staff member who provided "outstanding care" to patients with bowel cancer.

To promote the opportunities for career progression the trust was developing an education academy to support career pathways in medicine, nursing and midwifery, which was due to be in place March 2018. To strengthen the opportunities for internal progression the trust had introduced procedures and guidance for different "levels" of recruitment, for example; internal to a department, internal to the trust and open recruitment which encouraged staff to seek progression/ development/experience within the trust rather than moving to another employer. Senior staff spoken with during our inspection confirmed they were promoting and encouraging staff to develop. Staff confirmed they had received a good take up and which was encouraging in promoting and recruiting new staff.

Governance

A governance framework was in place but this was not yet embedded or mature enough to be fully effective in identifying and mitigating risks or in providing assurance that actions were resulting in improvements to the safety and quality of patient care.

The new trust executive team had recognised that the structure within the hospital required improvement to provide good governance. There had been a restructuring of the divisions and a revision of the governance structure. The trust also appointed a director of governance in September 2017.

The board supported in its governance role by a number of sub board committees specifically the by quality governance committee and the audit and assurance committee. The trust had a clear framework which set out the structure of ward, team, division and senior trust meetings. Managers used meetings to share essential information, such as learning from incidents and complaints and to take action as needed.

The divisions presented to the quality governance committee. During our inspection we observed a quality governance committee meeting. During this meeting the clinicians that were reporting gave their assessments but there was limited challenge between the clinicians or reflection and analysis. However, the chief nursing officer did challenge the clinicians to reflect on their level of assurance.

The trust were aware that some of their systems and reporting lacked robustness, for example, there were trust-wide issues with mandatory training data collection that had been occurring since we inspected in November 2016. To mitigate this each ward and department kept spreadsheets of staff compliance with training, however compliance with some training was very low.

Concerns were raised during the April 2017 unannounced inspection regarding the management of mortality and morbidity.

The learning from deaths report of October 2017 demonstrated an improvement in the Hospital Standardised Mortality Ratio (HSMR) (102 for August 2016 to July 2017, against a benchmark of 100, this meant that the trust was performing worse than the standard). The HSMR is an indicator of healthcare quality that measures whether the mortality rate at a hospital is higher or lower than would be expected. The Summary Hospital-level Mortality Indicator (SHMI) is a hospital-level indicator which reports mortality at trust level across the NHS in England using standard and transparent methodology. The data as of October 2017 was at 1.06 against a standard of 1.00, this meant that the trust was performing slightly worse than the standard. Divisional reporting of improvement plans to address gaps in care identified through the process was still limited. This meant that the trust could only provide limited assurance that learning and improvement from the mortality review process was occurring.

There was a transition plan in place to move from the current process to one compliant with the standards set out by in the national learning from deaths report. A template for capturing outcome of directorate mortality review meetings was being trialled during October 2017.

On reviewing the divisional governance meetings for the women's and children's division for August and September 2017, it was noted in the minutes for August that 'CQC had identified perinatal mortality and morbidity meetings as an area requiring improvement'. It stated that a draft agenda template and terms of reference had been circulated for comment; staff were requested to discuss at their respective directorate meetings and provide feedback at the next divisional governance meeting. On reviewing the minutes for September 2017 there was no update of this action. However, the divisional lead for women's and children's services described how monthly perinatal morbidity and mortality meetings had taken place since September 2017. There was now a standard agenda in place, any deaths or stillbirths were reviewed as well as any babies who were transferred out of the unit.

Across the emergency departments there was mixed findings in relation to mortality and morbidity meetings. Monthly mortality and morbidity meetings took place at the Worcestershire Royal Hospital which were well attended by medical and nursing staff. Primary reviews of all deaths in the ED had taken place and secondary reviews were carried out when appropriate. The meetings were well structured and all relevant facts regarding mortality and morbidity were discussed. However at the Alexandra Hospital attendance at the meetings was poor, with only two staff members recorded as attending the meeting minutes we reviewed. The minutes provided lacked detail and there was little evidence of actions or learning as a result. We were told emails were disseminated to staff with details of learning; however, staff we spoke with were unable to recall any recent learning from deaths.

At the September 2017 governance meeting for the women's and children's division there was a record that the women's and children's services report for MBRRACE UK (Mothers and Babies:

Reducing Risk through Audits and Confidential Enquiries) 2015 births had been reviewed and an action plan was being developed.

Management of risk, issues and performance

During the April 2017 inspection we found that, not all incidents that were required to be reported externally as “serious” were correctly classified and externally reported.

We looked at three serious incidents and found that there were clear systems in place to review and manage serious incidents which included a precise action plan and root cause analysis report. We also looked at five incidents and found however that there was not a robust system of review and management of these. For example, two of the incidents did not identify who was conducting the investigation and another which involved verbal abuse towards a member of staff did not identify any support or action to ensure the safety of staff.

There were arrangements for identifying, recording and managing risks, issues and actions. Further work was being undertaken to support directorates with risk management training and risk registers.

We asked the trust for a copy of their current risk register and board assurance framework. The corporate risk register summary that was initially provided included a description of the risk, the effect and the impact but no actions or controls. In response to us querying this, the trust provided a further document which contained more detail. This document was titled “Corporate Risk Report” not corporate risk register.

The corporate risk register should be used by the trust board directors to aid their decision making, priorities and assurances against its strategic intent. For the purpose of this inspection we have reviewed the document entitled corporate risk report as the corporate risk register. This was a very detailed document that was not always fully populated. It lacked conciseness, assurances on the correct actions to mitigate risks and was cumbersome to use due to the over detailed information on progress, which did not clearly offer assurances to directors. The document was not dated so it was not possible to tell when it or the individual risks were last reviewed, which was key to understanding current risks and gaps in controls. There was a current risk score but no indication of when “current” was. There was no reference to how this document connected to the board assurance framework.

The document was 55 pages long and described 25 risks. Many risks were duplicated, for example, five separate risks described the same or very similar staffing risks and three separate risks describe the same or very similar equipment and capital risks. All risks were within their review date.

The date the risk was identified for each of the 25 risks was as follows:

2011: 1 risk	2012: 1 risk	2014: 4 risks	2015: 4 risks	2016: 3 risks	2017: 12 risks

Therefore, 10 risks had been on the register for over two years. However, we noted that the risks did reflect the ongoing challenges facing the trust and their presence on the register ensured they received review.

Of those 10 risks, three had a reduced risk rating, two remained the same and five increased. The trusts assessment of how the risks had been mitigated, controlled or reduced from the initial rating which originates from the dates in the table above to the “current” undated rating, was as follows:

Risk rating.	..reduced	..unchanged	..increased
Current number of risks	8	11	6

This, together with the actions described would indicate that the controls, actions and mitigations were not being effective in the majority of cases and required further review. Having six risks that had increased their rating indicates the risks were not under control. There was a target rating for all the risks. There were some anomalies, for example, one risk “CR unit failure” had a lower initial score that its target score; and there were a number of fields left blank, including one with no director lead (divisional staffing shortages) and a number with no identified gaps in controls or assurances (nursing vacancies and lack of investment in plant/machinery).

The trust had recognised that both its corporate risk register and board assurance framework required review and this work was in progress at the time of the inspection.

As a result of a Section 29a Warning Notice issued in January 2017 the trust implemented a quality improvement programme (QIP) which was discussed monthly at the quality improvement review group. The QIP was made up of six work-streams which included:

- Improving patient outcomes
- Operational Improvement
- Governance
- Patient, carer and public engagement
- Safe care
- Culture and workforce

To support the required improvement, the trust has implemented a focussed audit process that had matrons auditing records on each ward with specific areas reviewed, such as venous thromboembolism (blood clots) assessments, National Early Warning Scores and patient weight. This process was augmented by executive auditing and fed into a new quality dashboard known as the safety and quality information dashboard.

This was used to drive improvement and had improved staff’s understanding of safety and quality in the service which was confirmed with staff spoken with.

The trust had identified and was acting on a number of significant concerns for example, a significant number of mixed correspondences, some of which should have been sent to GP practices (21,271) were found on the trust’s document management system. Some of these items had been in the system up to five years. The review was made up of three cohorts and there were 370 letters awaiting review and action. A harm review had identified only one patient requiring further investigation. A total of 1,537 items relating to deceased patients was under negotiation with the Clinical Commissioning Group. To ensure learning from this incident the trust had updated their operating procedure and ensured that all clinicians and support staff using the document management system attended a training programme. Senior staff confirmed they had notified clinicians that all correspondence held on the management system should be cleared within 12 weeks. This was being monitored and fed back to the divisional leads. Data provided by the trust showed that as of the middle of November 2017 there were over 2,000 correspondences over 12 weeks on their system. The aim was that all correspondence would be cleared within 12 weeks of the relevant patient contact and a flagging system would highlight those exceeding this.

Concerns had been identified in February 2017 and reported by the elective care intensive support team that a number of patients on pathways that were viewed as non- referral to the treatment (RTT) were in fact recognised as active RTT pathways. This meant some patients had been waiting over 18 weeks from RTT. This was due to poor RTT data quality for patients identified as non-RTT not being visible on the patient tracking list. Some of these patients were showing on the patient administration system as non-RTT resulting in some patients breaching 52 weeks. A programme of work had been established to ensure that the trust records were accurate, and patients were managed appropriately. The trust had sought external support and guidance from the NHSI Intensive Support Team around methodology, cohorting, the project plan and current reporting. The 357,000 open records had been grouped into 20 cohorts with similar

characteristics. The outcome of the sample validation should identify the work streams required to resolve the issues. Of the 75,553 records, 33,000 related to deceased patients and 42,553 were duplicate records. The remaining 281,477 records had been grouped into the 20 cohorts. This meant 29,720 records needed to be validated in the initial phase. For the elective planned list every record would require individual validation.