Trust Board Responses to Questions from the Public

December 2024

Worcestershire Acute Hospitals NHS Trust

No.	Question:	Governor/ Member of Public/ Patient Forum	Response:
2	To what extent is the Trust (WAHT) currently operating a Complaints System which 1) Currently provides responses to complainants which are flexible, prompt and effective	Julie Harris – Member of Public	As a Trust, we see complaints as an opportunity for us to reflect and learn. Where possible, we strive to resolve concerns informally, either through the PALS service or through discussions with complainants. We have a Complaints Policy and process which outlines how to address complaints, and we make use of the PHSO "Good Complaint Handling Guides". We aim to respond to formal complaints within 25 working days, or 40 working days for those more complex. We recognise that each complaint is individual and therefore, the process does require flexibility, and it may be necessary and reasonable to adapt timescales and our approach depending on the specifics of a case. In such cases, this will be discussed with the Complaints Team, including Head of Complaints, Divisional Management Teams and Executives. We recognise that it may not always be possible to meet the response times; however, we will keep complainants informed if there is going to be a delay in responding to their concerns. Our complaints investigations are carried out by appropriate colleagues across the organisation, including operational, nursing and clinical staff alongside their usual management and clinical duties. These duties can often require quick action to ensure patient safety and are continuity, which can at times impact our response times. Our processes for writing complaint response letters are currently under review to ensure all concerns raised are addressed and to maximise reflection and learning. We believe that these changes will further support us in providing robust and effective responses to all complaints.
	2) Complies with the TRUST Complaints Policy		The Trust's Complaints Policy was last reviewed and approved by the Chief Nursing Officer in December 2023. All clinical Divisions are aware of, and comply to, the current Complaints policy, with allowances for exceptional circumstances as agreed to by either the Head of Patient Safey & Complaints or the Executive Board. Compliance with responding to complaints is discussed and monitored through Trust ward to Board governance processes.

			Elements of the Complaints Policy are currently under review by the Team Leader for PALS & Complaints, Head of Patient Safety & Complaints and Associate Director for Clinical Governance & Risk to better align the policy with the principles of the Patient Safety Incident Response Framework (PSIRF). Legal requirements around data protection and safeguarding must take precedence over the complaints policy and procedure.
	3) To what extent do you consider that the above statement is being compromised by the Trust when complainants have virtually no opportunity to discuss the content of their complaint with the allocated investigator until AFTER it has been investigated or discuss further important information, almost all communication with the Trust about the complaint has to be via email, even if the complaint is complex/serious?		As a Trust we encourage complaint investigators to engage with complainants early in the process, to ensure a clear understanding of concerns and the outcome sought. We recognise that it can be challenging for staff to have productive conversations regarding concerns without any knowledge of the circumstances, and therefore it is not unusual for an initial investigation to be undertaken before a truly constructive conversation can take place in relation to the care episode/s. We acknowledge that this may result in complainants feeling that they were not given an opportunity to further discuss concerns. We will share this with our Complaints team to include in their ongoing piece of work around setting clear terms of reference for complaints. In some cases, where there are a number of concerns or the complaint covers a longer period of time, it can be beneficial to have the details of the complaint in writing, to ensure this can be referred back to and reduce misunderstandings or any elements being missed. It is also important to understand that those undertaking a complaint investigation – operational, nursing and clinical staff – do so alongside their usual management and clinical duties. Unfortunately, this means that they may be unable to take a phone call. As such, email correspondence is often necessary, to enable investigating officers to focus attention both on clinical duties and the complaint investigation. Our Complaints Policy supports the use of communication agreements. There may at times be instances where the level of contact requested by a complainant may have a negative impact on staff and services. At times, there may be agreement with senior management and the Executive team to agree methods of communication. We recognise that this can be frustrating for complainants and may add to the distress or concern during a difficult time. We will share this with our Complaints Team to reflect on when considering how our complaints processes can adapt in the future.

	4) Given that the number of complaints submitted to the Trust in recent times is significant, to what extent do you think the quality of service to complainants has been compromised?		The Trust, and the NHS, have seen a significant increase in numbers of complaints received in the years following the global pandemic. It is unfortunate that this increase in numbers has likely compromised our complaints process to some extent. At a time where waiting lists continue to be impacted, our patient numbers grow and illnesses associated with longer life expectancy place greater demands on NHS services, it has been necessary to focus our resource on clinical care, facilities and support services. As such, it has not been possible to increase specific resource for complaints handling. We would like to offer assurance that our Executive Board are aware of this pressure, and, in response, there are a number of workstreams ongoing to make our complaints process more effective, improve the standard of responses and provide greater centralised oversight. The Executive Team have supported provision of additional resource into the Divisional Teams where challenges have been identified, and this is ongoing. As a Trust, we see complaints as an opportunity for us to reflect and learn. As such, we are actively pursuing changes that will allow a proportionate response to concerns, ensuring appropriate resources are available for complaints about serious and complex concerns.
	5) Does the Trust comply with NHS COMPLAINT STANDARDS - SUMMARY OF EXPECTATIONS (2022)?		As an NHS organisation, there are a number of requirements that we must comply with. Our Complaints Policy and procedure meet the legal requirements of the NHS Complaints Regulations, Duty of Candour and the NHS Constitution. PHSO produced the NHS Complaints Standards as a guide to effective complaints handling. These include welcoming complaints in a positive way, being thorough and fair, promoting a learning culture and giving fair and accountable responses. As a Trust we strive to meet these expectations, and there are a number of workstreams ongoing with a focus to further align us with the PHSO guidelines. This includes: ➢ Looking at how we triage and acknowledge complaints ➢ Quality assurance processes ➢ Aligning our learning and actions with the existing structure for patient safety incidents.

			However, some of these can take time and significant resource to implement in such a large acute Trust. We acknowledge that there are improvements to be made to the current process, and in line with a positive learning culture, we continue to listen to feedback and strive to continuously improve. We hope that this has answered your queries regarding the Worcestershire Acute Hospitals NHS Trust and the complaints process. Complaints handling can be a very nuanced field, and it isn't always the case that a single process can be applied to all. However, we are satisfied that the Trust engage with the complaints process in line with the current policy, and that there is a proportionate and proactive approach to addressing the areas where improvement needs have been identified.

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3	The Trust Learning from Deaths Policy states the following: In summary the Trust (WAHT) is required to report on a quarterly basis via a Board meeting held in public the following data: • Total number of patient deaths (including those occurring in the ED) • The number of deaths subject to case record review and the number of these patients with a learning disability • An estimate of the number of deaths judged more likely than not to have been due to problems with care. • A summary of the learning and improvements resulting from the mortality review process. I cannot find any trace of these specific numbers having been published. If they have been published, can you please indicate where they are to be found; if they have not been published, can you please indicate why not.	Katheen Houghton – Member of the Public	The Trust Board receives a Learning from Deaths report every quarter, prepared by the Learning from Deaths Lead, and Mortality Indices continue to be monitored through our Deteriorating Patient, Resuscitation, End of Life and Mortality Studies (DREAMS) group on a monthly basis. This report includes information around number of patient deaths, case record reviews, deaths reviewed as not to have been due to issues with care and a summary of learning and improvements. The Trust's mortality data is published quarterly via the publication of a joint performance report to the Foundation Group Four Boards meeting, held quarterly in public, which allows learning to be shared between the four Trusts. This report includes the following: • Summary Hospital level Mortality Indicator (SHMI) • Numbers of deaths • Numbers of deaths compared to number of expected deaths • Commentary on learning/thematic reviews including action plans
	(2) In previous Board meetings the Trust has given one aggregate Mortality rate encompassing both the Alexandra Hospital and the Worcester Royal Hospital; can a separate rate be given for each site as one aggregate rate is misleading given that the Alexandra Hospital monthly number of actual deaths appears to be month on month between		Summary Hospital level Mortality Indicator (SHMI) is an NHS metric that reports mortality at Trust level in England using a standard methodology. The Trust SHMI value has been 'as expected' for 57 consecutive months. • SHMI data comes from the office of national statistics, it is published and freely available on the NHS England website (including breakdown by site). https://digital.nhs.uk/data-and-information/publications/statistical/shmi

	10% and 12% above the expected number; using an aggregate does not show the true picture.		• SHMI is essentially the ratio of deaths of people who have died either in hospital or within 30 days of discharge, compared to the 'national average'. As such, SHMI is a statistical construct. SHMI cannot consider fully local populations, different service models, availability of community services and so on, which may contribute to local differences. • NHS England are clear that 'Where a Trust has an 'as expected' SHMI, it is inappropriate to conclude that their SHMI is lower or higher than the national baseline, even if the number of observed deaths is smaller or larger than the number of expected deaths. This is because the variation from the number of expected deaths is not statistically significant'. • NHS England recommends reporting SHMI by Trust, rather than by site for multi-site Trusts. The SHMI value for our Trust, and both of our acute hospitals, is 'as expected'. It is true that the SHMI is higher at the Alexandra Hospital (ALX) than at Worcestershire Royal Hospital (WRH) (whilst remaining in the 'as expected' range), however NHS England outline: "**The difference between the number of observed deaths and the number of expected deaths cannot be interpreted as the number of avoidable deaths for the trust**. The SHMI is not a direct measure of quality of care. The expected number of deaths for each trust is not an actual count of patients, but is a statistical construct which estimates the number of deaths that may be expected at the trust on the basis of average England figures and the characteristics of the patients treated there." In the 'interpretation guidance for Trusts' statement provided by NHS England: "The range of SHMI values is considerably greater at site level than at trust level. There are several factors which contribute to this. These include some sites having different specialisms and service models (for example, dialysis, maternity, and paediatrics) and also some inconsistencies in how trusts have defined their 'sites'." It recommends SHMI publication by Trust rather than by site, although where sites differ, it also recommends that Trusts explore the reasons for this. The Trust has undertaken a review of the difference in SHMI values between ALX and WRH. The Learning from Deaths Lead does not accept that there is a 'significantly [in the statistical sense of the word] higher mortality rate [in the sense of SHMI] at the Alex compared to the Worcester site'. There are differences between the two sites in terms of patient populations, and access to services (both in hospital and in the community).

			Trust absolute mortality (numbers of patients who die) exhibits marked seasonality, which might be expected, but is often forgotten. We have more deaths in Winter than Summer. Our internal reporting shows what is 'normal for us over the past five years', to give context rather than be absolutely focussed on one particular number and comparing it to the previous month. February always has a lower mortality number as there are only 28 days in it. Absolute mortality will generally increase over time as the population ages, we admit more patients, take more ambulances etc.
	(3) In previous Board meetings it has been stated that the Trust is investigating why the mortality rate at the Alexandra Hospital is significantly higher than at Worcester Royal Hospital; are there any indicators yet as a result of this investigation as to why this is the case?		In April 2024 SHMI methodology was changed. This change in methodology exaggerated a long-standing difference in SHMI between the two acute hospitals (ALX and WRH) within the Trust. Although the NHS is clear that only Trust level SHMI should be used and reported on, this difference has been explored more fully to understand the differences in patient flow, treatment and outcomes from a mortality point of view. The deep dive analysis into the site differences and out-of-hospital deaths revealed no obvious causes of clinical concern but rather reflected differing services, demography, and limitations of the SHMI model when comparing sites with different specialties and service provision (e.g., hot vs. cold sites).

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1	Please can the following questions be submitted to the Trust Board at the next Trust Board meeting on 10 December 2024? - Darlington nurses are currently taking legal action against their Trust for failing to provide them with single sex changing rooms. Wes Streeting met with the nurses and is horrified that they have had to resort to legal action. Are female staff working for Worcestershire Acute Hospitals NHS Trust provided with single sex changing rooms and toilets? Are trans-identifying male staff prohibited from using the women's changing rooms and toilets? To be clear, I mean single biological sex, not single legal sex.	Karen Joyce – Member of Public	All clinical Divisions and Estates have confirmed that all toilets are single sex. Changing room availability varies within our clinical Divisions, as outlined below: ➢ Medicine Division do not have changing rooms, with the exception of a changing room at the Alexandra Hospital (ALX) Emergency Department. Most staff will come to work in uniform due to a lack of changing facilities. ➢ Surgery Division have single sex changing facilities – these are located on the Worcestershire Royal Hospital (WRH) site for the Beech wards. ➢ Maternity have single sex changing facilities. ➢ Specialised Clinical Services Division (SCSD) have changing facilities available for Theatre staff. These are: ○ WRH Main theatres – single sex male and female changing rooms. ○ WRH Maternity theatres – single sex male and female changing rooms. ○ ALX Theatres 1 – 7 – single sex male and female changing rooms and a separate male consultant changing room. ○ West Theatres 8 and 9 – single sex male and female changing rooms and a gender-neutral changing room. ○ Kidderminster Treatment Centre (KTC) – single sex male and female changing rooms. In addition, there are rooms which could be used to change individually and could be utilised as gender-neutral spaces if required (1 in the wellbeing space and 1 in the Band 6 office area).