Worcestershire NHS
Acute Hospitals NHS Trust

Worcestershire Acute Hospitals NHS Trust

Quality Account 2011/12

Patients | Respect | Involvement | Delivery | Efficiency

Taking pride in our healthcare services

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Glossary

Statement from the Chief Executive

During 2011/12, we continued to focus on improving quality and safety in all that we do across the Trust and our Quality Account for 2011/12 aims to share that with you to show where we have made progress and where we still have work to do.

We have seen a year of changes across the organisation with new Directors in post and more robust plans for the future of the organisation. I joined the Trust in January 2012 and I am committed to continuing and developing further our key priorities.

Our vision remains "to be the safest, most patient centred and efficient Trust" although we are clear that this ambition now stretches wider than the West Midlands.

In order to deliver this vision, we have agreed a number of strategic priorities.

We are clear that these priorities need to be translated into meaningful and continuous improvements for the patients that we treat and there is clear commitment at Board level to make sure this happens.

Our Quality Account reflects how we are going to do this and also illustrates the progress we are making in some of the key areas identified.

During 2011/12 we have seen a number of successes including our commitment to introduce the FASTHUG and FIDDLE mnemonics to identify and check some of the key aspects of the general care of all our critically ill patients. We also treated unprecedented numbers of patients across our three hospital sites and met the majority of our operational targets.

While we have not yet quite managed to hit the national stroke target, we have seen significant progress during the course of the year and this is a key area going forward into 2012/13 where we will focus on improving the care for this group of patients.

However, we do know that there are areas that we have to work still harder to improve the experience of our patients. Our performance in relation to the Emergency Access target in A&E was disappointing all year and this is a key priority of the Board moving forward to ensure that we ensure that 95% of the patients who attend our A&E department are seen, treated and admitted (if required) within the four hour period.

We were disappointed with the outcome of the dignity and nutrition inspection by the Care Quality Commission in March 2011. However an enormous amount of work has been done since then to take on board the lessons learnt and improve the quality of our services. All of our wards now have quality dashboards which enable us to see how they are performing against some of the key quality standards which are so important to us and for rapid action to be taken if we perceive problems are starting to arise.

During the course of the year, we have sought external and independent assurance on a number of key quality issues and have brought in external experts to help advise us and work with us to improve quality in a number of areas. This continues going into next year with some of our key priorities around the elimination of pressure ulcers and falls.

I would like to take this opportunity to thank all colleagues who have helped undertake this work in the last year and also to thank all of our staff for their contribution in delivering patient care across the Trust. We will be ensuring we work closely with our staff, patients and the public going forward to deliver the objectives in this Quality Account, to ensure we are an organisation that continually assesses our performance and strives to improve the experience of our patients.

I am pleased therefore to present our Quality Account for 2011/12 to you which I believe to be a fair and accurate report of our quality and standards of care across the Trust.

Penny Venables
Chief Executive

Part 2

Looking Forwards:
Priorities for improvement -2012/13

Looking forwards:
Priorities for improvement - 2012/13

2.1 Background

We are developing a five year strategy as part of our business plan and to achieve Foundation Trust status. The first step has been to create an annual plan for 2012/13 based on a review of our services, the care we provide, the views of our stakeholders and our ambitions for the future. This work has involved significant engagement with internal and external stakeholders such as NHS Worcestershire, LINks, and Clinical Commissioning Groups with a programme of events to engage the public in the service review.

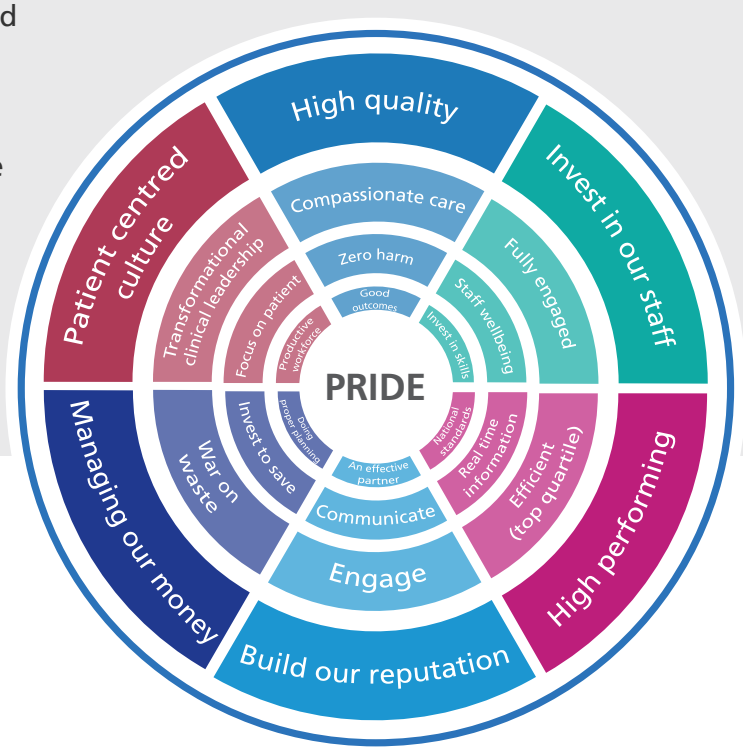
The Annual Plan sets out six strategic priorities and 18 annual objectives for 2012/13 to improve quality and safety.

Our six Strategic Priorities

1. Deliver **safe, effective, innovative** and **compassionate patient care**
2. Achieve **strong operational performance** compliant with all national requirements
3. Ensure the Trust is **financially viable** and gets the maximum value from the resources at its disposal
4. Build a **positive reputation** through enhanced engagement with patients, the public, staff, GPs, Partners and wider communities that we serve
5. Develop a **culture that is recognised as patient centred**, driven by inspiring and accountable leaders
6. Invest and **realise the full potential of our staff**, becoming the preferred employer of choice

18 Annual Objectives

1. Address unwarranted clinical variation
2. Improve patient reported experience of care
3. Implement innovative service developments
4. Deliver service transformation which achieves upper quartile productivity
5. Achieve all key national targets / standards
6. Achieve comprehensive real time information
7. Improve the Trusts Liquidity rating to 3
8. Deliver a year-end surplus
9. Produce a robust long term financial model (LTFM) underpinning the integrated business plan (IBP) meeting Monitor requirements
10. Design and deliver effective external communications
11. Be an engaging and effective local partner within the local health economy (LHE)
12. Support the social and economic development of Worcestershire
13. Develop and implement a framework for transformational clinical leadership
14. Develop and implement a programme for patient-centred cultural integration
15. Deliver workforce efficiencies
16. Develop / maintain a fully engaged workforce
17. Design and deliver a strategy for 'healthy and productive' workforce
18. Develop an 'excellence in innovation' strategy



2.2 Quality Improvement Priorities 2012/13

We have set out four priorities for Quality Improvement in 2012/13 based on a review of our services, quality outcomes, consultation and changing national and local context.

Improvement Priority 1: Patient Safety

Address unwarranted clinical variation	
Why is this a priority?	Reducing variation in the way care is delivered is a key factor in making it more reliable and therefore safer.
Measures:	• Reduction of avoidable pressure ulcers • Reduction of harm from patient falls in hospital - incident reporting system • Increased use of Patient at Risk Score (PARS) and escalation • Summary Hospital level Mortality Indicator (SHMI)
Targets:	Elimination of avoidable pressure sores • 35% reduction in significant harm as result of falls • 45% of patients aged 75+ have an Abbreviated Mental Test (AMT) assessment completed, 75% of those with a score <7 receive a care plan • 95% use of PARs / escalation • 95% patients Venous-thromboembolism (VTE) assessment • 50% reduction in incidence of medication errors • SHMI below 100 • WHO Checklist 100%
Reporting route:	Reports received by the Patient Safety Committee and through the organisation's governance structures to the Board.
Responsible Officer:	Chief Nursing Officer Chief Medical Officer

Improvement Priority 2: Clinical Effectiveness

We will provide appropriate treatment and care at the right time for patients who have had a stroke.	
Why is this a priority?	Evidence shows that best practice is for patients to be immediately admitted to an acute stroke unit, where staff have the skills and expertise to manage stroke patients. The Trust is using the Royal College of Physicians SINAP audit tool and the NHS Improvement Accelerating Stroke Improvement (ASI) programme to improve its services and to drive standard setting and improvements to the patients experiences.
Measures:	• Assess all patients for suitability for thrombolysis • Thrombolyse patients within 45 minutes of arrival at hospital • Perform CT scan for 50% suspected stroke patients within one hour and all patients within 24 hours • Admit at least 80% stroke patients directly to a stroke ward from the emergency department • At least 90% stroke patients to spend 90% of their time in a specialist stroke ward • All patents to have a swallowing assessment within 4 hours of admission • Patients leaving hospital to be supported by the Early Supported Discharge Team • Patients to be assessed and treated in a timely manner by speech and language therapy, physiotherapy and occupational therapy. • Patients with a suspected TIA (Transient Ischemic Attack) are seen the same or next day by a stroke specialist and investigated in a one stop clinic
Targets:	The Trust currently benchmarks its services with other providers nationally using the Royal College of Physicians SINAP audit tool and the NHS Improvement Accelerating Stroke Improvement (ASI) programme indicators below. **Direct admission to a stroke unit** - 90% of patients with a confirmed stroke will be admitted to a stroke unit within four hours of arrival at hospital. **Acute stroke care** Proportion of patients spending 90% of their time on an acute stroke unit - whilst this is no longer a DH vital sign, we will maintain an internal operational standards of **80%** *of patients spending 90% of their time in stroke ward* **Management of high risk TIA** The ASI and CQUIN targets are **60%**.*(Proportion of high risk TIA patients investigated and treated within 24 hours of first contact with a health professional.)*
Reporting route:	The service is currently managed on both sites by the General Managers for Medicine. The Directorates are managed by the Hospital Directors. Performance against national standards is reported to Trust Board on a monthly basis. Performance and progress of the action plan is monitored through the Stroke Task Force and monthly progress reports are widely circulated internally and externally to stakeholders.
Responsible Officer:	Chief Operating Officer / Hospital Directors

Improvement Priority 3: Meet the Emergency Access Target

We will provide appropriate treatment and care to recognised national reporting standards for patients presenting to our hospitals as emergencies.	
Why is this a priority?	Acute Trusts are required to receive, assess, admit, discharge or transfer 95% of patients attending Emergency Departments within four hours. Due to the challenges in achieving this quality standard we have made this a priority for the coming year as we recognise this directly affect patients.
Measures:	• Actual number of patients being seen, admitted, discharged or transferred within four hours of presentation at either of our emergency departments • Less than 5% of all patients leaving the emergency department without being seen by a healthcare professional • Less than 5% of all patients having cause to re-attend the emergency department with a complaint they have previously attended with within a seven day timeframe • All ambulance borne patients receiving an initial healthcare professional assessment within 15 minutes of arrival at one of our emergency departments • Less than 1% of patients having a treatment plan that lasts over six hours within one of our emergency departments • Less than 0.5% of patients having a treatment plan that lasts over 12 hours from arrival within one of our emergency departments • 95% of all patients referred to a speciality team to be seen by that team within 60 minutes of referral • No patient to be nursed in a non-cubicle area for any time period greater than 30 minutes of their total emergency department attendance
Targets:	The Trust currently performance monitors a number of the above listed criterion, and is assessed by its Commissioners. Additional monitoring systems will be introduced to corroborate performance in support of :- • Less than 1% of patients having a treatment plan that lasts over six hours within one of our emergency departments • Less than 0.5% of patients having a treatment plan that lasts over 12 hours from arrival within one of our emergency departments 95% of all patients referred to a speciality team to be seen by that team within 60 minutes of referral • No patient to be nursed in a non-cubicle area for any time period greater than 30 minutes of their total emergency department attendance
Reporting route:	The service is currently managed on both sites by the General Managers for Medicine. The Directorates are managed by the Hospital Directors. Performance against national standards is reported to Trust Board on a monthly basis. Performance and progress of the action plan is monitored through the Emergency Services Improvement Group and monthly progress reports are widely circulated internally and externally to stakeholders.
Responsible Officer:	Chief Operating Officer / Hospital Directors

Improvement Priority 4: Patient Experience

To improve patient/carer reported experience of care	
Why is this a priority?	Patients are at the centre of all we do. We want to receive their feedback on their experience of our services so that we can make improvements that matter to patients.
Measures:	National and local surveys measures: • Net promoter score (would you recommend this hospital to your family and friends?) • Patients reporting that they were treated with respect and dignity • The number of written formal complaints
Targets:	• Net promoter score improved by ten points • National inpatient survey results improvement • 10% increase (or achievement of 95%) in positive responses to 'no decision about me without me' • 95% patients surveyed treated with respect and dignity • 10% reduction in rate of written formal complaints on inpatient care
Reporting route:	Reports to the Patient Experience Committee and through the organisation's governance structures to the Board
Responsible Officer:	Chief Nursing Officer

2.3 Commissioning for Quality and Innovation (CQUIN) payment framework

The CQUIN framework is about improving the quality of healthcare. Our commissioners are allowed to reward excellence by linking a proportion of our income to the achievement of locally set improvement goals agreed annually. These are embedded within our contract and are important for implementing NICE Quality Standards, for improving patient experience and for driving improvement against outcomes.

"A proportion of Worcestershire Acute Hospital NHS Trust's income in **2011/12** (1.5%, £3.9m) was conditional on achieving quality improvement and innovation goals agreed between Worcestershire Acute Hospitals NHS Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation (CQUIN) payment framework."

Achievement of the 2011/12 CQUINs is reported in part three.

For 2012/13 the CQUIN monies available has increased to 2.5% of the contract value, in monetary value £6.5m and will be secured if the necessary improvements are made in a further ten areas of patient care.

The CQUINs agreed with our main commissioner, NHS Worcestershire, for 2012/13 are listed below:

	Goal name:	Description:
1	Venous-thromboembolism prevention (VTE)	Reduce avoidable death, disability and chronic ill-health from Venous-thromboembolism (VTE)
2	Patient Experience	Improve responsiveness to personal needs of patients and realtime feedback
3	Dementia	Improve awareness and diagnosis of dementia, using risk assessment, in an acute hospital setting
4	NHS Safety Thermometer	Improve collection of data in relation to pressure ulcers, falls, urinary tract infection in those with a catheter, and VTE
5	Making Every Contact Count	Making every patient contact count through systematic healthy lifestyle advice delivered through front line staff
6	Safe Care	Reduction in harm to patients as part of the Safe Care programme
7	Stroke care	Swallow assessments
8	Safe discharge	Improving communication between secondary and primary care at time of discharge
9	Medicines Management	Antimicrobial stewardship
10	Palliative care	Improved support for palliative care patients at the end of life

Our specialist Commissioners have agreed a further three CQUINs.

	Goal name:	Description:
1	Implementation of clinical dash-boards for specialised services	Ensuring that providers implement and routinely use the required clinical dashboards for specialised services
2	(Neonatal) Increase effectiveness of hypothermia treatment	Increase effectiveness of hypothermia treatment
3	(Neonatal) Discharge planning/ family experience and confidence	Improvement in timely discharge pathway

The Trust acknowledges the importance of the CQUIN goals and is committed to achieving the necessary improvements to patient care. These goals are built into our Trust quality improvement plan 2012/13.

Further details of the agreed goals for 2012/13 are available on request from the Director of Nursing & Midwifery or electronically at:
http://www.institute.nhs.uk/world_class_commissioning/pct_portal/cquin.html

Part 3

Looking Back:
Review of Quality Performance 2011/12

Part 3

Looking Back:
Review of Quality Performance - 2011/12

This section sets out the Trust's performance in 2011/12 under the three domains of quality:

- Patient Safety
- Clinical Effectiveness
- Patient Experience.

We report on our progress in achieving the quality improvement priorities set in the 2011/12 Quality Account and use national targets and other key indicators to describe our quality performance during the year.

During 2011/12, the Trust treated unprecedented numbers of patients in its hospitals, performed well in delivering against its strategic objectives and consistently met the majority of its key operational targets.

For 2011/12, the Trust set itself explicit goals of ensuring good standards of care and of transforming the outcomes and experience of care for all our patients. We experienced periods of high emergency demand, particularly over the winter months, when there was also a significant number of wards closed due to the norovirus infection. The resultant pressure on staff and beds required substantial clinical and management effort, alongside effective joint working with the Trust's partners in community, Primary Care and Social Care services. Despite the scale of the challenges, the Trust maintained a constant focus on safety and patient experience.

In the late stages of 2010/11 the organisation was deeply disappointed when the CQC identified shortcomings in the quality of aspects of our care on two wards at the Alexandra Hospital, Redditch. The Trust took immediate action and this included commissioning an independent review of our work on dignity and nutrition and ward sister leadership. Examples of key improvements include:

- Protected mealtimes have become the norm, with non essential activity ceasing until after mealtimes.
- Visiting times were extended, although families are now welcome to visit at anytime, particularly if they wish to participate in the care of their relative.
- A quality dashboard for all wards is in place which enables nursing care to be monitored month on month.
- To support challenged wards, a Nursing Intensive Support Team can be mobilised to support the ward team regain a hold on their standards of care.
- A development programme for the senior ward sisters was introduced, which included a focus on their responsibility and accountability for nursing standards.
- Nursing audits were streamlined to make them more meaningful and release nursing time.

The Trust made significant improvements over the past 12 months, and has fully taken on board the lessons learnt from the CQC inspection in the latter part of 2010/11 and the Trust is registered with the CQC without conditions.

Commissioning for Quality and Innovation (CQUIN) payment framework – 2011/12

We had ten CQUIN targets agreed with our commissioners and three with our specialist commissioners in 2011/12. They covered one or more of the domains of safety as shown in this table. This is how we did.

			Quality Domain		
Goal Name	**Description of Goal**	**Achieved**	**Safety**	**Effectiveness**	**Patient Experience**
VTE prevention	Reduce avoidable death, disability and chronic ill-health from Venous-thromboembolism (VTE)	Yes	Yes		
Patient Experience - personal needs	Improve responsiveness to personal needs of patients	Partially			Yes
Stroke	Enhance quality of services for patients with stroke and TIA	Yes		Yes	Yes
Dementia	Improve access to support for patients with a confirmed or suspected diagnosis of dementia who are being treated within the acute sector	Partially		Yes	Yes
Safe care	Reduction in harm to patients as part of the Safe Care programme	Yes	Yes		
End of Life	Improvements in the experience of patients and their families at the end of life	Yes			Yes
Medicines management	Improving patient safety through application of good medicines management processes	Yes	Yes	Yes	
Brief Intervention	Delivery of health promotion interventions for people at risk	Partially		Yes	

We also achieved the three Specialist Commissioner CQUINs

			Quality Domain		
Goal Name	**Description of Goal**	**Achieved**	**Safety**	**Effectiveness**	**Patient Experience**
Access to Organs for Transplant	Improving access to Organs for Transplant	Yes		Yes	
Avoiding preventable blindness in neonates	Screening for Retinopathy of Prematurity (ROP)	Yes		Yes	
Improving neonatal care pathways	Auditing Neonatal Pathways	Yes		Yes	

For the three CQUINs partially achieved, a summary of performance and the actions being taken in 2012/13 are provided below:

Patient Experience Improve responsiveness to personal needs of patients	A selection of questions from the national inpatient survey is used to measure Trust's performance in meeting personal needs. Our performance improved from 65.8 to 66 against a CQUIN target of 67. By comparison with other Trusts using Picker, the Trust achieved equivalent scores in 74% of areas and significantly better scores in 4.5% of areas. Our improvement priority to improve patient/carer reported experience of care will continue the work to improve this: • A plan to promote 'no decision about me without me' will be developed, with the aspiration that 95% of patients will provide a positive response when surveyed. • A ten point increase will be achieved in responses to the net promoter question. • Additional plans will focus on those areas where patients were most dissatisfied. The results will be seen in the 2012/13 national inpatient survey.
Dementia Improve access to support for patients with a confirmed or suspected diagnosis of dementia who are being treated within the acute sector	Baselines were established in Q2 for the proportion of patients over 75 years receiving an assessment (7.4%) and a subsequent care plan, where required (46.3%). In Q3, performance had risen significantly to 20% (on target) and 77% (end of year target 75%), respectively. The target for staff completing specific dementia training (81) was significantly exceeded (133). Key actions being taken in 2012/13 are: • Identification and assessment of patients with dementia, including implementation of the dementia care pathway. • Extend training of staff.
Brief Intervention Delivery of health promotion interventions for people at risk	The Trust has improved on all Q1 baselines for assessing patients' smoking and alcohol intake status, and for delivering brief interventions in response. All alcohol targets have been exceeded. The targets for recording smoking status (92/94%) were very narrowly missed in Q2 and 3(91.7/93.8%). The targets for undertaking a subsequent brief intervention with smokers were achieved in Q2 (80% against 55%) but were missed in Q3 (50% against 65%). Key actions being taken in 2012/13 are: • Identify from the people who attend pre-operative assessment clinics, those whose health is at risk through smoking and alcohol and provide a brief intervention.

3.1 Patient Safety

"**Patient safety.** The first dimension of quality must be that we do no harm to patients."

"**Keep patients as safe as possible**. The NHS must strive to be the safest health system, keeping patients in environments that are clean, and reducing avoidable harm."

(High Quality Care for All: Professor the Lord Darzi 2008)

2011/12 Quality Improvement Priorities

We set two quality improvement priorities for patient safety during 2011/12. This is how we did:

Patient Safety – Improvement Priorities 2011/12	
1. Reduce the harm caused by the application or omission of medications	Partially achieved
The Trust has had no incidents leading to serious harm or death during 2011/12 (compared with 2 the previous year). Minor harm events have not reduced in number but, due to a rise in near miss reporting, this is now a lower proportion of events reported. The overall level of incident reporting is rising, particularly at WRH. Incident reports are reviewed at Directorate and Trust levels to ensure that policies and procedures are effective and to address individual performance issues. This work will be carried forward into 2012/13 and come under the work required to reduce the variability of care, one of our improvement priorities. The implementation of electronic prescribing is planned for 12/13 to effect further improvement.	
2. Ensure that effective handover occurs within all teams, which includes not only handover of patient care but transfer of information relating to best practice.	Achieved
The Situation, Background, Assessment, Recommendation (SBAR) communication tool is being rolled out across the Trust for completion by the end of March 2012. A pre-implementation audit indicated that 48% of nurses had not received any communication skills training and that 96% were unaware of SBAR. A subsequent post- implementation audit revealed a 32% increase in communication skills training (80%) and an 88% increase in staff knowledge of SBAR (84%), 84% of staff reported using SBAR. This work will be carried forward into 2012/13 and come under the work required to reduce the variability of care, one of our improvement priorities.	

Patient Safety Incidents

The safety of our patients is our top priority. Our aim is 'no avoidable harm'. We strive to learn from patient safety incidents, and the near miss 'nearly' incidents to understand what causes them and to take action to avoid reoccurrence.

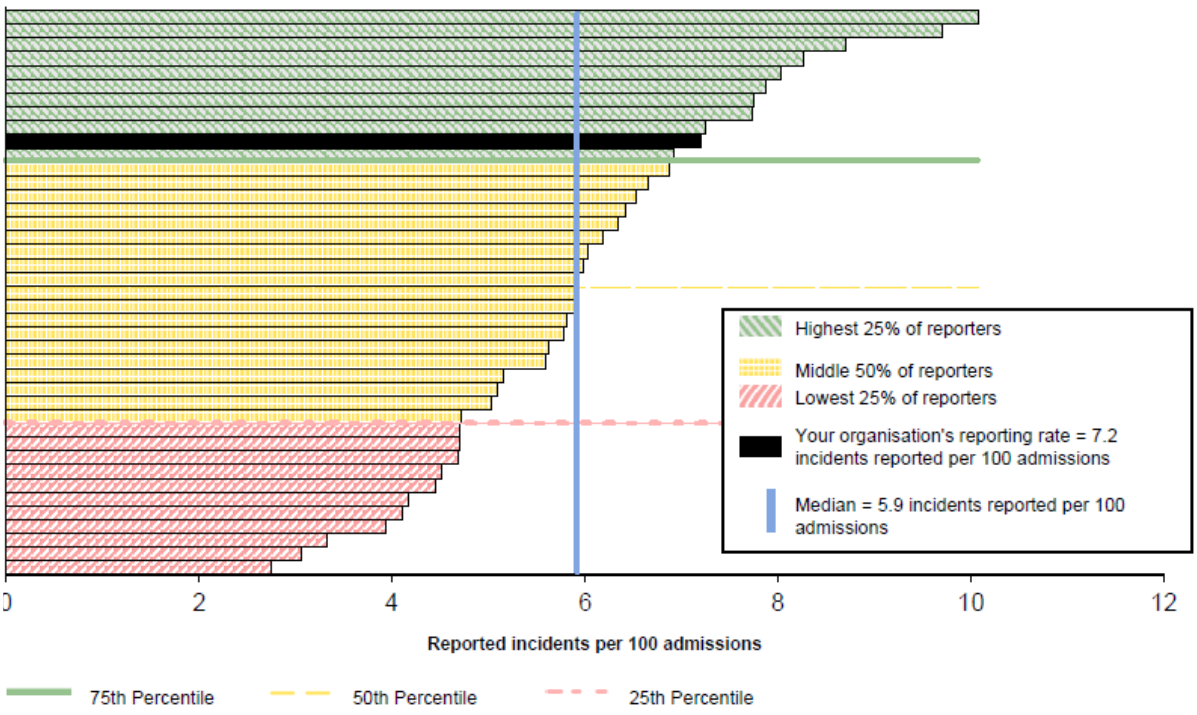
The first step in doing has been to foster a culture of incident reporting so that we know when things go wrong. Reporting incidents is encouraged and a high reporting rate is an indicator of a good safety culture. All our incident data is submitted to the National Reporting and Learning System (NRLS).

We receive feedback reports that allow us to compare our reporting culture and the incidents reported with 41 similar acute Trusts.

Our reporting culture is good. The latest NRLS report covering the period from April to September 2011 shows that we remain in the top 25% highest reporters with a reporting rate of 7.2 incidents per 100 admissions.

This and previous reports can be found at this link:
http://www.nrls.npsa.nhs.uk/patient-safety-data/organisation-patient-safety-incident-reports/directory/?entryid33=26007&p=4&char=W

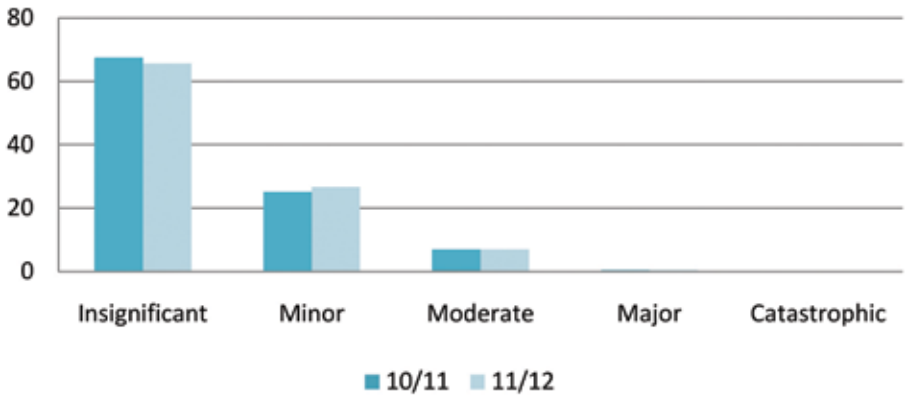
Comparative reporting rate, per 100 admissions, for 41 large acute organisations



Harm from incidents

92.4% of our reported incidents and near miss events result in no or minor harm. The rates of harm reported are similar to other Trusts as the NRLS report demonstrates. All serious near misses are investigated as Serious Incidents. The graph below reflects an overall increase in reports received from 2011/12.

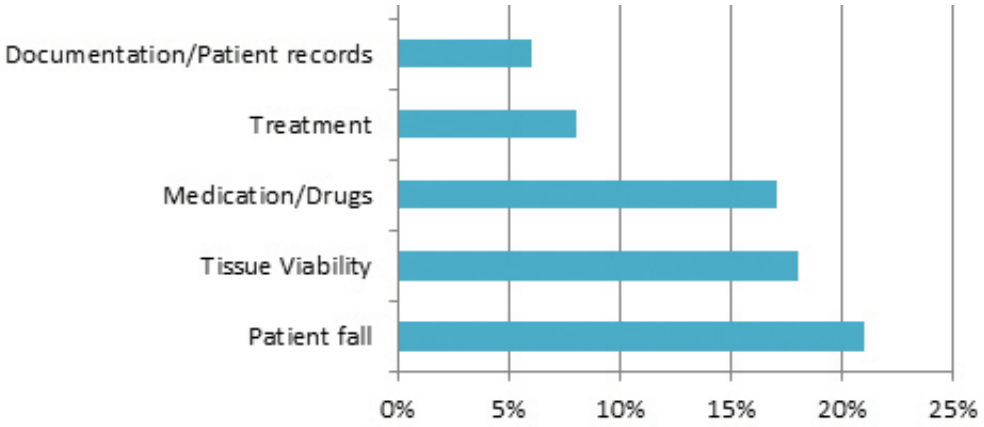
Incident and Near Miss report - Harm by %



What type of incidents occur?

The top six patient safety incidents reported in 2010/11 are provided below. The NRLS report shows that our profile is similar to other Trusts

Top six Patient Safety Incidents by %



Patient falls in hospital

The number of patient falls reported has remained relatively static over the past four years whilst the number of reported incidents, accidents and near misses overall has risen. The High Impact Action Group has led the work to reduce falls and the seriousness of injuries sustained by determining the causes of falls and the resulting harm and developing interventions. One such intervention is the introduction of 'STEDY' frames on each ward to assist patients at risk of falling to mobilise safely. We have continued to assess patients on admission for their risk of falling, using the 'leaf' system to easily identify patients at high risk and planning their care to avoid falls. One of our targets for 2012/13 is the reduction of falls causing serious harm by 35.

Tissue viability (pressure ulcers)

During 2011/12 we embarked on a quality initiative to **eliminate** avoidable **hospital acquired pressure ulcers**. This is an intensive programme aimed at embedding care processes within all aspects of nursing care within the Trust which will prevent the development of pressure ulcers.

Pressure Ulcer Prevention (PUP)

The national programme designed to eliminate pressure ulcers being acquired in hospital and the work to raise awareness and address these has resulted in greatly increased reporting. As a result of a focus on the importance of reporting, the number of pressure ulcers and other tissue damage injuries have become one of our top three reported incidents in 2011/12.

Of the 1693 tissue viability incidents reported in 2011/12,

- 295 (23%) were recorded as 'pressure ulcer developed as an inpatient' (both avoidable and un-avoidable).
- 963 (77%) were reported as patients having pressure ulcers prior to admission to hospital.

We are working on various projects including access to equipment to relieve pressure, enhancing nursing skills and implementing a new SSKIN bundle in order to ensure that the process is fully understood and sustainable now and in the future. Any difficulties which would hinder the successful roll out are being tackled in readiness for the go live date on the 14 May 2012.

The initiative is important not only to our patients but links into our **six strategic priorities** for 2012/13.

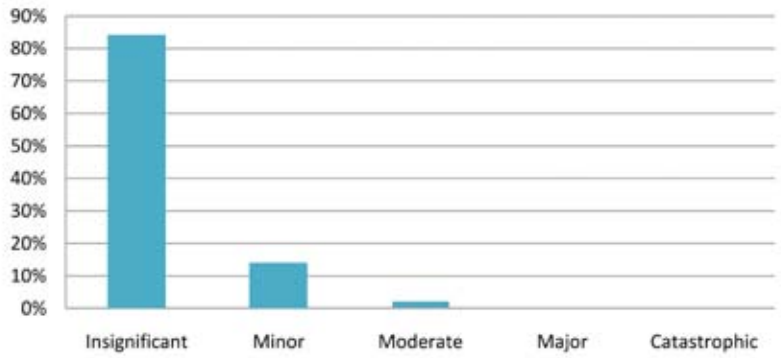
Medication errors

The actions taken in 2011/12 to address harm from medication errors are described earlier in this section.

97.8% of reported medication incidents and near misses resulted in no, or minor, harm in 2011/12. The high reporting has helped us to understand what can go wrong in the prescribing and administration of medicines and is helping us to design out potential errors.

The proportion of **harm events** for 2011/12 is much the same as the previous year at 18 per month. There were six major harm but no catastrophic events.

Harm from medication incidents - 2011/12



Documentation

Documentation related incidents have reduced from previous years. This coincides with the outsourcing of our patient records management service and an improvement in the provision of patient records at the time they are required.

Progress in the Management of Serious Incidents (SI)

We had 145 SIs in 2011/12 and all were reported to the Strategic Health Authority (SHA). The Trust has experienced an increase in reported SIs during the year. This is a reflection of an increasing intolerance of harm within the organisation, as well as changes in reporting requirements to the SHA:

- The internal serious incident process, which goes beyond the requirements of the SHA SI reporting policy, identifies reported incidents where serious harm/death might have been a consequence of the incident or if it was a near-miss linked to a 'Never Event', as defined by the National Patient Safety Agency (NPSA).
- The SHA reporting policy for 2011/12 required the Trust to escalate, for example, serious pressure damage and all significant harms resulting from a fall on hospital premises, which had not been included in the 2010/11 external reporting requirements.
- 15 (75%) of the infection control SIs in 2011/12 were related to diarrhoea and vomiting outbreaks and three were MRSA blood stream infections as reported in the infection control section later in this report.
- Seven SIs were due to non-clinical events.

	SHA SI		Internal SI	
	number	% of total	number	% of total
10/11	86	1.05	60	0.73
11/12	145	1.56	86	0.92

Top five serious incident categories 2011/12	Total
Tissue Viability (inc. pressure ulcers)	46
Patient fall	34
Infection control	20
Obstetric speciality specific	13
Treatment	13

Each of the Serious Incidents is subjected to an investigation process that looks not only at the incident in isolation, but also the surrounding human factors. A thorough root cause analysis is undertaken and a robust action plan to prevent recurrence is devised. These plans undergo executive level scrutiny before sign off, and progress in completing the actions is reviewed to ensure actions are completed and are effective.

Every six months trends and common themes are reviewed. Identification of these themes is crucial in ensuring that the Patient Safety element of the overall Quality Improvement strategy has a focus on issues relevant to the patients under our care.

Never Events

Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers.

Regrettably we have had three never events in 2011/12, two of which resulted in no harm to the patient and the other minor harm.

- A wrong site surgical event.
- A retained foreign object event.
- An incorrect prescription and supply of daily oral methotrexate

Each event was investigated as a Serious Incident. Robust action to prevent reoccurrence has been taken in each case.

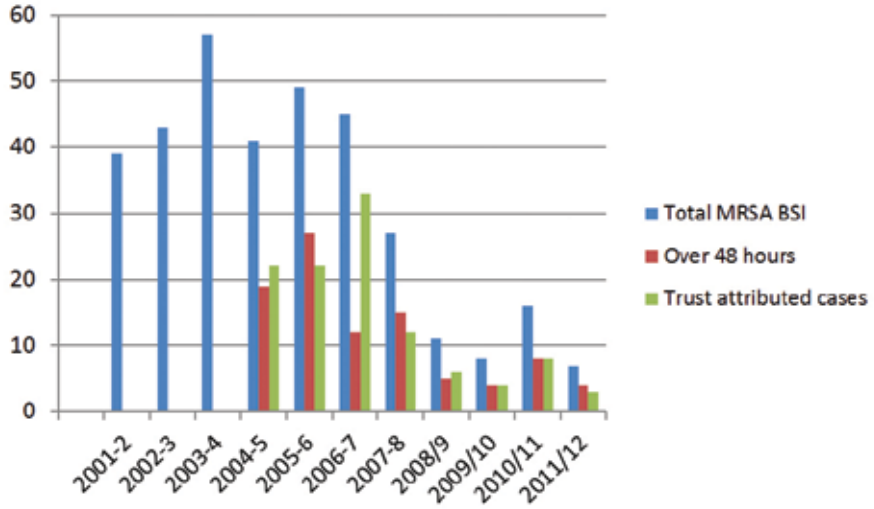
Safety Alerts

The NHS uses information from incidents to generate patient safety alerts. Three Patient Safety Alerts were issued in 2011/12 through the NHS Central Alerting System. Six safety alerts had a completion date during 2011/12. We acted on all the recommendations made contained within these alerts and had none open beyond the target date at the year end. We missed the deadline for two alerts previously issued, both of which were closed by the year end.

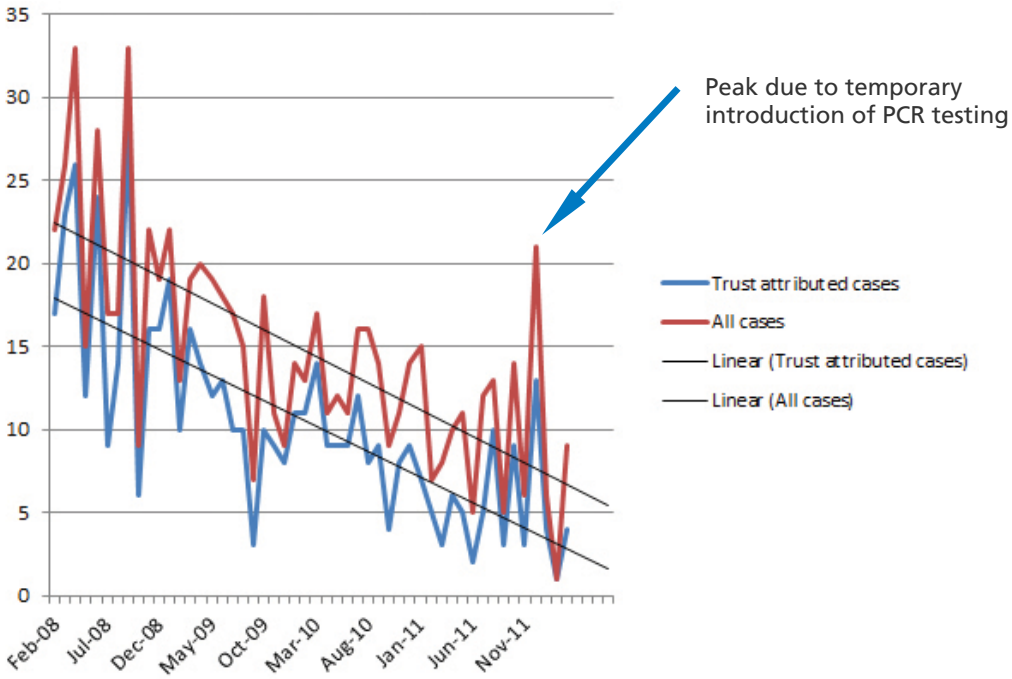
Infection Control

The Trust has continued to show falls in both C *difficile* infection (CDI) and MRSA bloodstream infections (BSIs), and this was better than the target set for both (65 compared with a trajectory of 81 for Trust attributable cases of CDI, three compared with a trajectory of 5 for MRSA BSIs). This is in spite of introducing a new testing methodology for CDI, with a different sensitivity, which could lead to a potential increase in the number of detected cases. This is in the national context of continuing declines in both infections. We attribute the good results to continued emphasis on infection reduction, hygiene, cleaning, antibiotic stewardship and training.

MRSA Blood Stream infections (BSIs) 2001 -2012



C difficile infection (CDI) trend February 2008 - March 2012



Patient Environment Action Team (PEAT)

PEAT is an annual assessment of inpatient healthcare sites in England with more than ten beds. PEAT is self assessed and inspects standards across a range of services including food, cleanliness, infection control and patient environment (including bathroom areas, décor, lighting, floors and patient areas). The scores are awarded in a range of five categories from 'unacceptable' to 'excellent'.

The PEAT inspections were conducted in February and March 2012 and involved members of the Patient and Public Forum.

PEAT Assessment 2012			
Site Name	Environment Score	Food Score	Privacy and Dignity Score
The Alexandra Hospital	4 Good	5 Excellent	5 Excellent
Kidderminster Hospital	5 Excellent	5 Excellent	5 Excellent
Worcestershire Royal Hospital	4 Good	5 Excellent	5 Excellent

The results are available on the NHS Information Centre website:
http://www.ic.nhs.uk/statistics-and-data-collections/facilities/patient-environment-action-team-peat

Patient Safety Walkrounds

Patient safety walkrounds are a way of ensuring that Board members are informed first hand, about the safety concerns of frontline staff.

Helen Blanchard, Chief Nursing Officer and Dr Charles Ashton, Medical Director with staff in A&E at WRH

Dr Steve Graystone, Director of Patient Safety and Lynne Todd, Non-Executive Director visit maternity

The aims of walkrounds are to:

- demonstrate top level commitment to patient safety.
- establish lines of communication about patient safety among employees, executives, and managers
- provide opportunities for senior executives to learn about patient safety
- identify opportunities for improving safety
- encourage reporting of issues, errors and near misses
- promote a culture for change pertaining to patient safety
- establish local solutions to minimise risk

18 walkrounds were scheduled during the year.

- At the Alexandra Hospital the areas visited included medical wards as well as pathology and maternity services.
- At Worcestershire Royal Hospital visits were undertaken in Critical Care, endoscopy and the cardiac catheter laboratory as well as medical and surgical wards.
- At Kidderminster the Minor Injuries Unit and the outpatient and endoscopy services were visited.

Some visits had to be postponed due to infection control issues but have been rescheduled.

Action plans followed each visit and have led to improvements such as:

- Improved weekend occupational therapy input to shorten length of stay of patients undergoing joint replacements.
- Improved utilisation of endoscopy lists and better management of equipment.
- Enhanced consultant input into inpatient ante-natal and post natal care.
- Significant progress in moving to a paper free pathology requesting and reporting system.
- Improved security for staff working in the MIU at Kidderminster.

3.2 Clinical Effectiveness

Effectiveness of care. This means understanding success rates from different treatments for different conditions.

Provide the most effective treatments. Patients need improved access to the treatments they need supported by improved diagnostics to detect disease earlier.

(High Quality Care for All: Professor the Lord Darzi 2008)

2011/12 Quality Improvement Priorities

We set three quality improvement priorities for clinical effectiveness during 2011/12. This is how we did:

Clinical Effectiveness – Improvement Priorities 2011/12	
3. To introduce the FASTHUG & FIDDLE mnemonics as a means of identifying and checking some of the key aspects in the general care of all critically ill patients.	Achieved
• All foundation year one doctors have been educated in effective patient review using the FASTHUG & FIDDLE assessment tool. • Audit of use of the tool has been included in consultants' job planning objectives for 2011/12. There has been a staged roll-out in ITU/CCU with 100% compliance being achieved Trustwide from February 2012. • An adapted version has also been introduced to ward areas. • This work will be carried forward into 2012/13 and come under the work required to reduce the variability of care, one of our improvement priorities.	
4. Facilitate the establishment of meaningful mortality and morbidity reviews within each directorate.	Achieved
• Directorates now undertake reviews (based on a standard template) and measure their impact (reviews completed, effect on coding, opportunities for improvement identified). • A system is now in place to ensure all directorates are provided with Dr Foster data and then review it. • The GTT (Global Trigger Tool) has now been incorporated into the mortality review template which is used for review of every patient death. • Directorate performance, as evidenced by SHMI and HSMR indicators, is kept under review by the Medical Director of Patient Safety. • The Trust's position regarding SHMI/HSMR has improved over the year, and many directorates have improving relative risk. • This work will be continued into 2012/13 and come under the work required to reduce the variability of care, one of our improvement priorities.	

5. To investigate, treat and provide specialist stroke care for patients with suspected stroke or TIA to the standards outlined by current NICE guidelines and the Accelerating Stroke Improvement standards.	Partially achieved

A Stroke Task Force has been established and has advanced:

- county-wide urgent TIA clinics;
- ring-fencing beds within the Acute Stroke Unit.
- An increase in stroke co-ordinator time on one site ensured that 84% of patients with suspected stroke are admitted to a Stroke Unit within 4 hours of arrival in hospital (national average, 58%). A second site is now implementing the same increase (baseline 19%).

This priority will be carried forward to 2012/13 in its entirety.

Plans for improvement include:

- Development of psychological support services, the stroke services redesign, joint discharge plans with the community and development of early supported discharge team in partnership with the PCT.

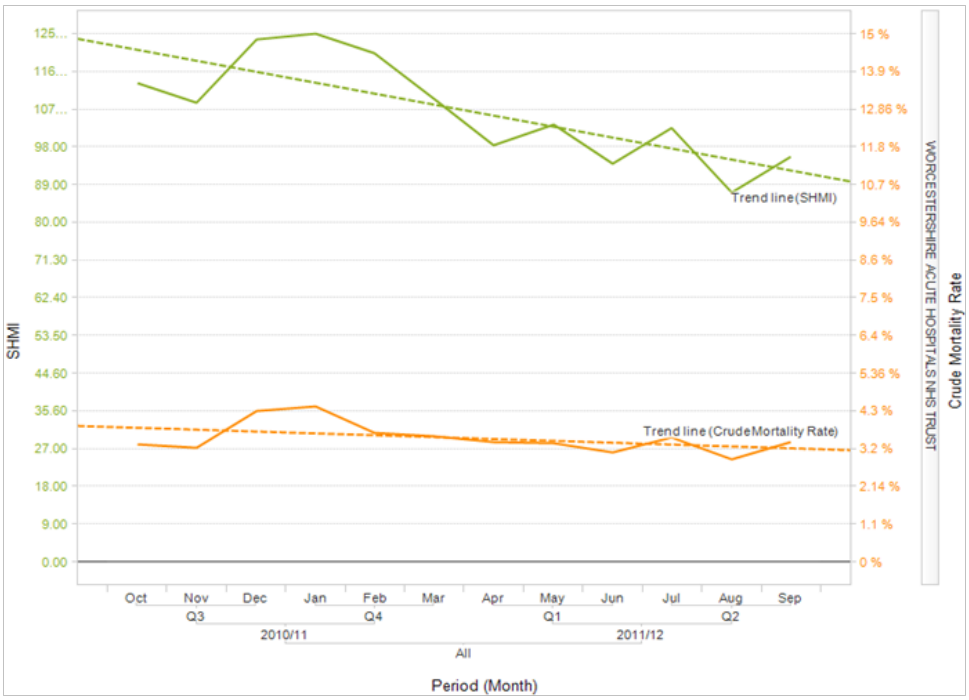
Mortality Relative risk

We use a number of indicators to understand the outcomes of patients treated by the Trust. The **Summary Hospital Mortality Indicator** (SHMI) calculates the relative risk of death of all patients managed by the trust including the period up to 30 after discharge whilst the **Hospital Standardised Mortality Ration** (HSMR) calculates the relative risk of death occurring whilst in a hospital setting.

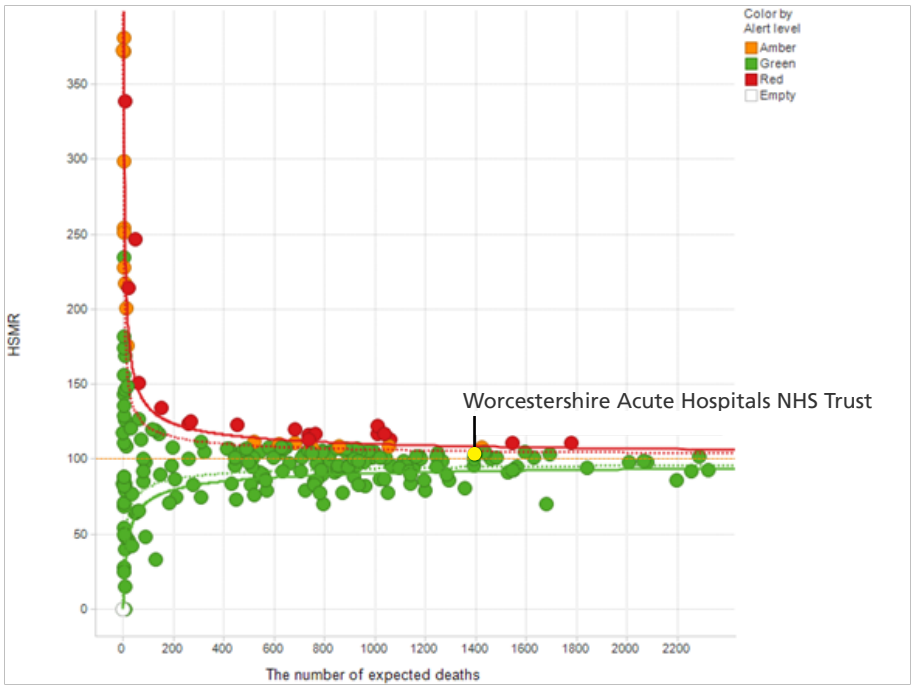
The calculations are based on a number of factors such as the patients' age, the illness they were admitted with and any other medical conditions they also had. The risk for any group of patients is calculated by dividing the number of patients not surviving by the number of patients not expected to survive. A number under 100 indicates more survivors than expected. The crude mortality rate demonstrates the percentage of patients admitted to the hospital who do not survive. This measure doesn't take into account any factors that may make the risk of surviving less likely so is only of limited value in understanding if there is a problem.

At the time of publishing the most recent data provided with regards the SHMI covers the period up to September 2011.

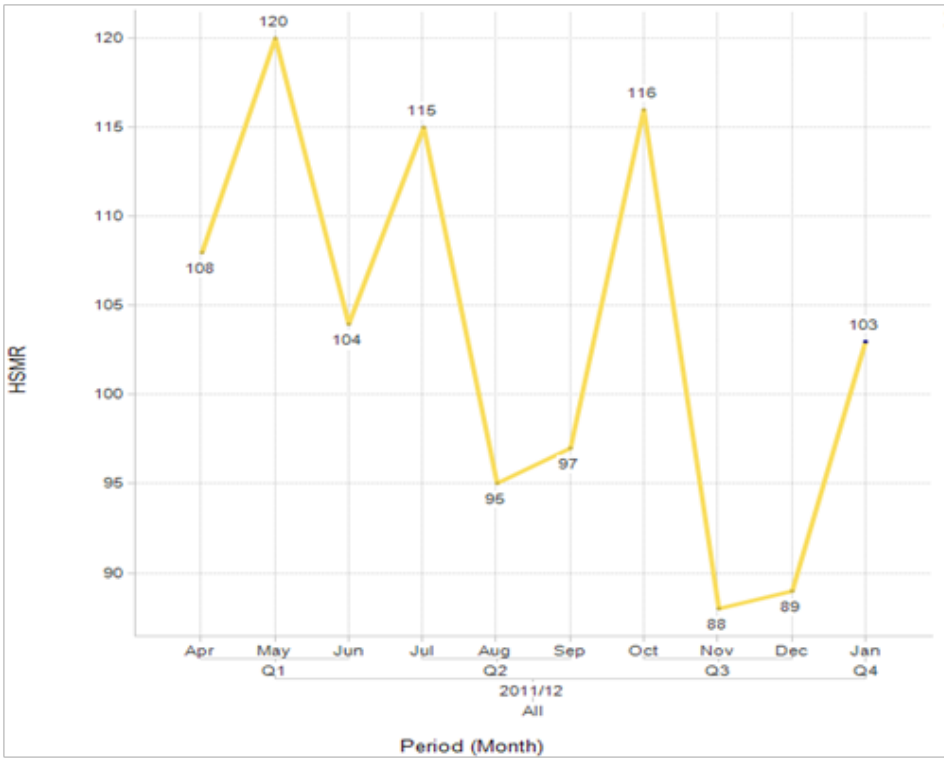
The **SHMI** for the Trust together with the crude mortality over the last 12 months is displayed in the diagram overleaf. There is a slight reduction in crude mortality but a significant reduction in the relative risk using the SHMI calculation. The relative risk for the first half of 2011/12 is 97 compared with 110 for 2010/11 which is within the expected range.



The **HSMR** has the advantage of being updated monthly. The graph below shows our HSMR performance with respect to other NHS organisations up to January 2012. It shows that the relative risk for patients managed by the Trust is within the expected range and no different to the majority of other organisations.



This HSMR graph shows the month on month relative risk from April 2011 to January 2012.



The graph above shows an improving trend. At publication the full year position shows an outcome of 103.

A further factor to be considered is the rate of improvement of the rest of England. This process is known as 'rebasing'. The figures in the diagram above show the rebased position and thus the move from 110 (in 2010/11) to 103 between years indicates an improvement of seven points ahead of the rest of England.

The significant change from 2009/10 to 2010/11 was of concern and during 2011/12 a number of initiatives, based on further analysis of the data and learning from other 'high performing' organisations were launched with the full support of the Trust Board including establishment of routine reviews of the care record, by a consultant, of all patients who die in our care.

The public Trust Board has a standing agenda item for review of the relative risk of death and actions being undertaken to reduce the risk for patients cared for by the Trust. A small number of diagnostic groupings have been highlighted where the relative risk is higher than expected.

Specific reviews of these patient groups have been undertaken and issues identified have been addressed. The main finding was related to the way medical staff recorded clinical information. A set of actions have been undertaken to ensure that the primary condition being treated is clearly identified, as well as other medical conditions the patient may have, so that none of the patient's care needs are lost during the handover of care between teams.

Patient Reported Outcome Measures (PROMS)

Trusts are required to report on PROMs which are used to collect information for elective NHS patients undergoing hip or knee replacements, groin hernia surgery or varicose vein procedures.

PROMS are short, self-completed questionnaires. They measure the patient's health gain as reported by the patient using pre and post operative questionnaires. These questionnaires can be completed by a patient or individual about themselves, or by others on their behalf.

The first questionnaire is given during the patient's preoperative assessment or on the day of admission. A second questionnaire is sent six months from date of surgery. For varicose vein and groin hernia procedures, the survey is sent out three months following surgery.

Key Results
Our participation rates in the quarter ending December 2011 were:

- Groin Hernia 37%
- Hip replacement 48%
- Knee replacement 59%
- Varicose Veins 24%

Our patients reported positive health gains for all these procedures and our results fall within the average and we are not an outlier for any of the four procedures.

Emergency readmissions within 28 days of discharge from hospital

Emergency readmissions for both elective and non elective patients remain within national norms.

- Emergency readmission (28 days) = 4.3% (4.5% in 2010/11)

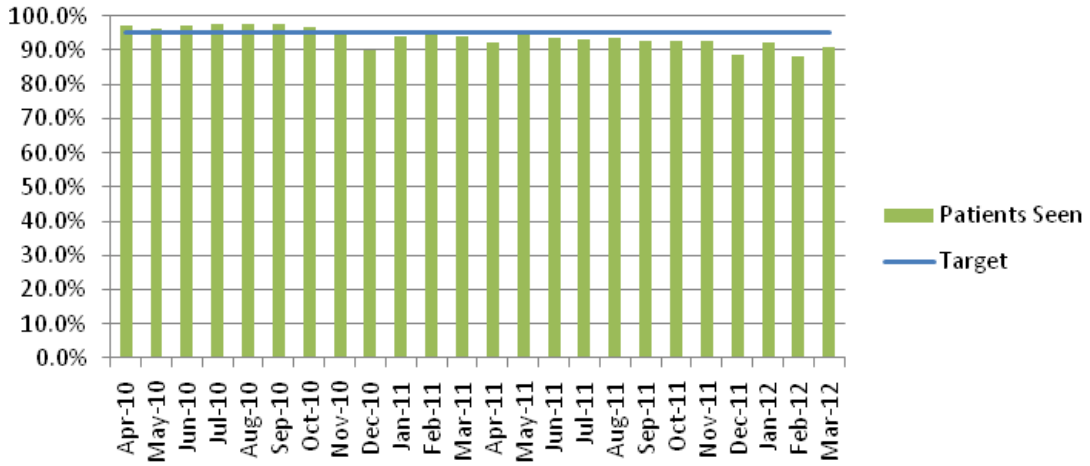
[The readmissions calculation is our local calculation and will differ from that reported by Dr Foster (which includes readmissions to other Trusts)]

The Medical Directors for Worcestershire Acute Hospitals NHS Trust (WAHT) and NHS Worcestershire audited 50 sets of records for patients that had been readmitted within 28 days and found that only one patient admission could have potentially have been avoided.

Emergency Access

During 2011/12 acute Trusts were required to extend the measures used to assess quality within emergency departments. Historically, Worcestershire Acute Hospitals NHS Trust had reflected the quality of its emergency service by use of the four hour Emergency Access Standard. This standard measures the time spent by patients within the emergency department from arrival to discharge, admission or transfer. The national standard is that 95% of patients should be treated within four hours. This standard is measured at an organisational level and made up of individual site performance within both the Alexandra and Worcestershire Royal Hospital sites and also by patients receiving treatment at the Kidderminster Minor Injuries Unit.

Percentage of A&E patients treated within four hour target



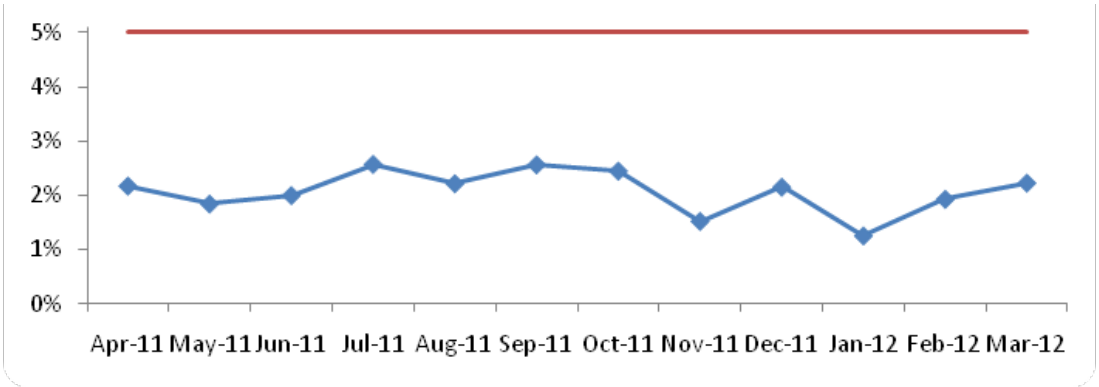
Despite a range of improvement schemes centred upon enhancing the patient's journey throughout the emergency pathway, the Trust fell short of meeting national targets, with 90.02% of patients being treated within four hours. We are disappointed with our performance and are taking every step necessary to improve our future performance to meet the national standards.

A range of factors influenced this year's performance both directly and across the local health economy. Towards the end of the year local partners came together to review the overall quality of care being provided to patients within our emergency departments. Despite the waiting time performance, the review group were impressed with the overall care administered, with all patients assessed receiving high quality clinical interventions.

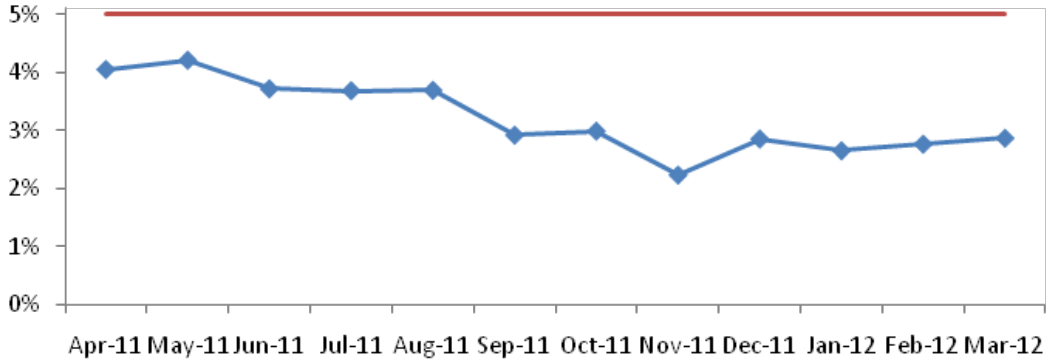
In relation to the extended range of quality indications introduced during 2011/12 the Trust sustained commendable performance. These indicators cover a range of issues including the percentage of patients returning to the emergency department within seven days of discharge, the number of patients attending an emergency department but

taking self-discharge prior to being seen by a doctor, together with average waiting times for clinical assessment following ambulance conveyance and overall average waiting times to see an emergency department doctor. Against these very meaningful indicators the Trust maintained a high performance.

Patients leaving emergency department without being seen



Trust A&E re-attendance within seven days



Such performance indicates that a number of issues that present themselves within the emergency department, such as underachievement of the four hour Emergency Access Standard are impacted upon by issues both within the wider Trust and across the Health Economy. During 2012/13 intensive work will continue to improve the four hour journey standard as we recognise this is a cause of frustration to many of our patients.

Cancer Waiting Times Targets

We use the Somerset Cancer Register (SCR) to measure cancer waiting time. This encompasses the National Minimum Dataset and includes the Cancer Waiting Times dataset and Cancer Registry dataset. The system also includes the Royal College Datasets. Trust staff use SCR to collect clinical cancer data for each cancer site along the patient pathway. Cancer waiting times are monitored monthly and reported to the Trust Board.

Multi disciplinary team (MDT) Co-ordinators and Clinicians use the system to support the National Clinical Audit Support Programme (NCASP) datasets and data is collected, entered and uploaded for national cancer audits (see part four for details of the audits).

An audit undertaken in 2011 provided significant assurances that

- Cancer waiting times data reported to the Trust Board is accurate and supported by source documentation;
- Systems are in place to ensure that cancer waiting times data collection processes are streamlined to facilitate timely reporting of data.

All the targets were met with the exception of the 62 day wait for first treatment.

Description	Target	Performance April 2011 to March 2012*	Result
2 week wait Suspected Cancers (All)	93%	96.50	Achieved
2 week wait for Symptomatic Breast Patients	93%	95.60	Achieved
31 day wait for first treatments	96%	98.64	Achieved
31 day wait for second or subsequent treatments: surgery	94%	98.49	Achieved
31 day wait for second or subsequent treatments: anti cancer drug treatments	98%	99.25	Achieved
62 day wait for first treatments	85%	83.14	Under achieved
62 day wait for first treatments from a screening programme	90%	93.57	Achieved

*March 2012 figures will not be final and uploaded until 10 May 2012

We have taken a range of measures to eliminate delays across the patient pathway and achieve the 62 cancer wait target. These include

- the cancer team working proactively with clinical directorates to prevent all avoidable breaches
- a new investment into equipment and training to improve cancer multi-disciplinary team meetings
- increase capacity in response to the increased demand resulting from a range of cancer awareness campaigns

This puts the Trust in a much stronger position to achieve the cancer targets in 2012/13.

Maternity Services

Maternity services in Worcestershire continue to see a small but steady increase in the number of babies born. A total of 6228 babies were born in the County in 2011/12 an increase of 42 births on the previous year. The number of women giving birth across the county in 2011/12 was 6076 an increase of 25 deliveries on the previous year.

Births and Deliveries broken down by site

Site	Babies born 2011/12	Women delivered 2011/12	Babies born 2010/11	Women delivered 2010/11
WRH	4100	3981	4091	3995
Alex	2128	2095	2095	2056
Home	104 planned 29 unplanned (BBA)		103 planned	
Total	6228	6076	6186	6051

104 babies were planned births at home; this represents 1.7% of our total numbers.

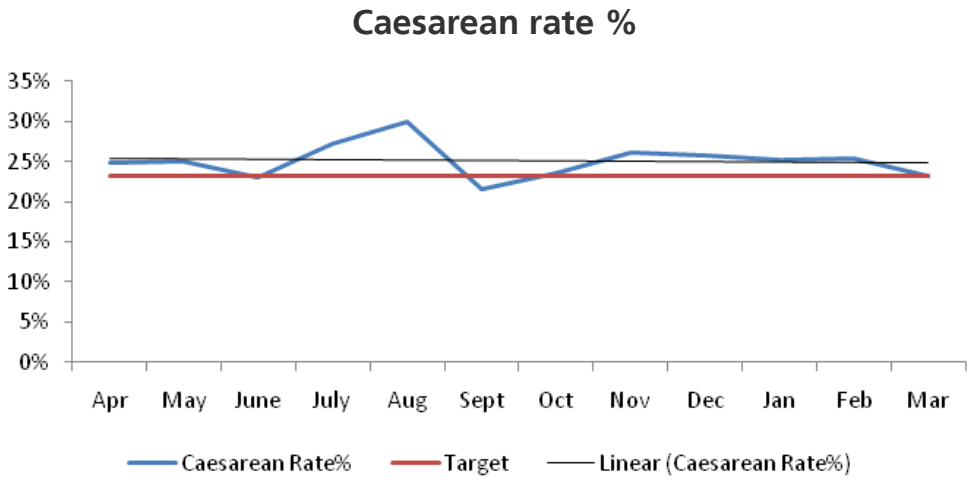
Unicef Baby Friendly Initiative Stage 3

WAHT Maternity services were assessed countywide against Unicef's BFI standards on infant feeding, with particular support for breast feeding and were successful in being fully accredited by them at Stage 3.

This is a well deserved achievement for our maternity services and is a reflection of our commitment to supporting breast feeding women and their babies.

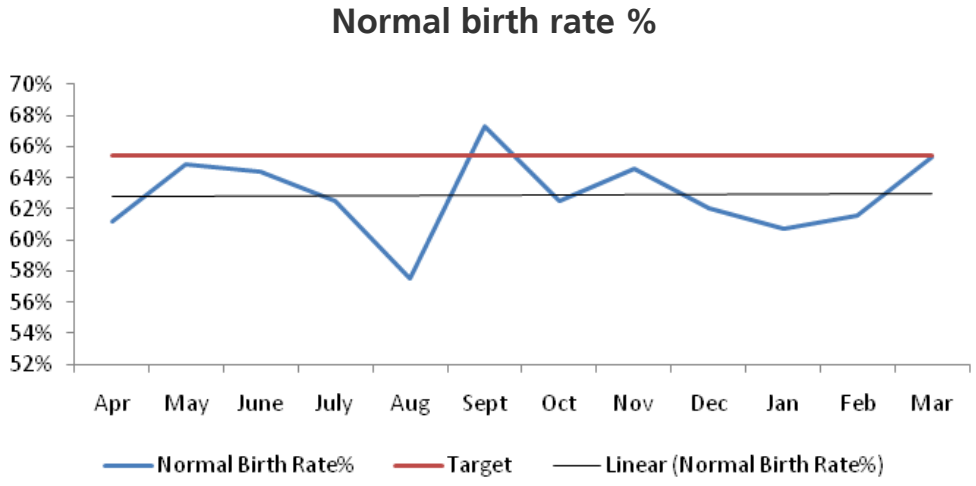
Caesarean section rates

Caesarean section rates for the county for 2011/12 was 25.0% a small reduction of 0.3% on the previous year. Work continues to reduce the caesarean section rate further. All women who have a caesarean section are seen by a consultant post delivery and discussion about the expected mode of delivery for the next pregnancy is discussed with them. We have locality based midwife led 'vaginal birth after caesarean section' clinics where women can spend time discussing their labour and delivery when they have had previous caesarean sections. These clinics are to support women to give birth vaginally and women are referred to these clinics by the consultant obstetrician.



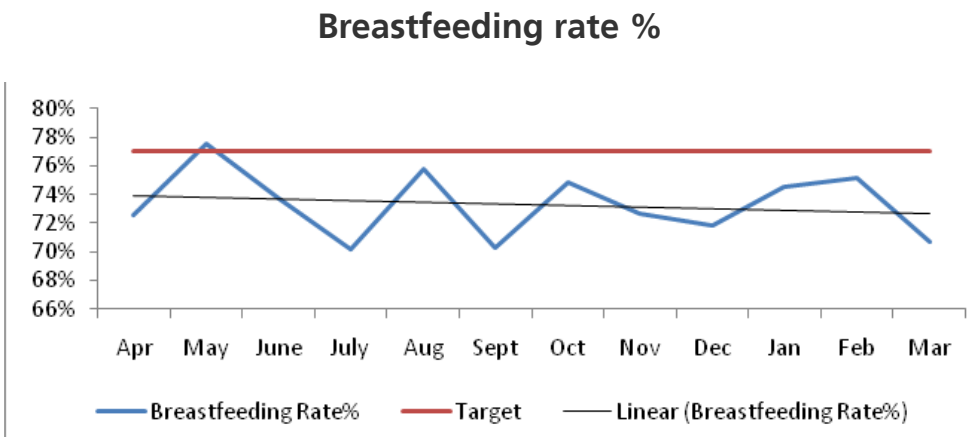
Promoting Normal Birth

The vaginal birth rate for WAHT in 2011/12 was 62.9%. The senior midwifery team have facilitated increased training for midwifery staff on the use of water for pain relief and for birth on both delivery suites, with an increase in the number of inflatable pools available for women to use. The use of birthing pools for labour and delivery has increased in 2011/12 with 399 women using water for pain relief during labour (compared to 238 women the previous year) and 166 babies born in water (compared to 56 the previous year).



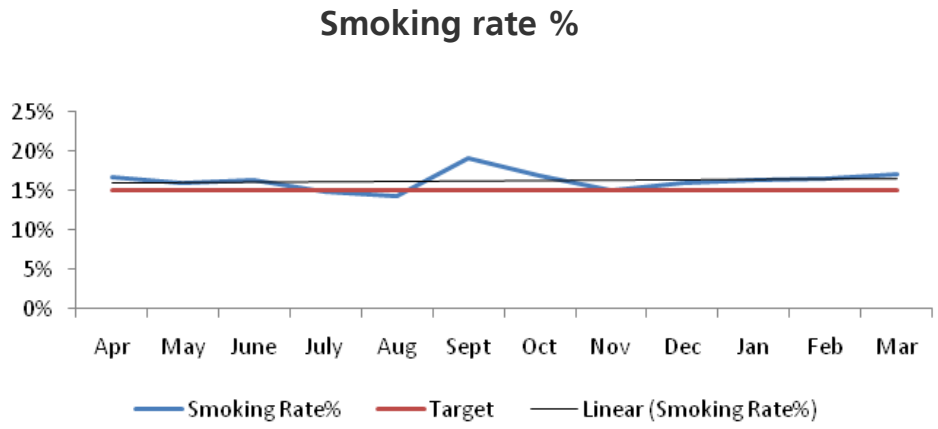
Breastfeeding rates

Breastfeeding rates for WAHT are 73.3% in 2011/12. This is a similar rate to the previous year. A joint action plan is in place with NHS Worcestershire to promote breastfeeding rates including mapping to show where breastfeeding support services need to be targeted.



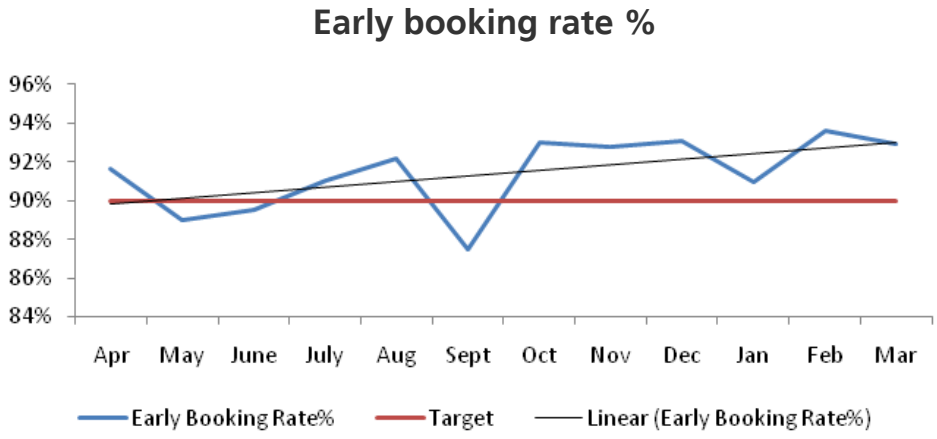
Number of women smoking at delivery

The number of women smoking at delivery has remained fairly constant at 16.3 % in 2011/12. Numerous providers of smoking cessation services are available for women to access across the County. WAHT maternity services have become a smoking cessation provider also in 2012 with a new post holder in the Kidderminster community midwifery team working alongside community midwives and women who smoke to support them to quit during their pregnancy. In addition, the Trust has commenced carbon monoxide testing for all pregnant women at booking in 2012; this is not just for women who smoke but for all pregnant women. Testing for carbon monoxide in the mothers home where they are non smokers allows the community midwife to give advice and information to women on the dangers of passive smoke and encourage other smokers in the householders to quit smoking also.



Early Booking

The number of women booked by maternity services before 13 completed weeks of pregnancy was 91.4% in 2011/12 an increase from 88% on the previous year. This high early booking figure allows women to access antenatal screening services at an early gestation providing them with increased choices around screening for Downs Syndrome.



Antenatal Screening for Downs Syndrome

WAHT Maternity Services have fully implemented the National Screening Committee's guideline, endorsed by NICE for first trimester combined Downs Screening in 2011/12. All women who are booked early can be offered first trimester combined Downs Screening.

Mid Trimester Anomaly Scanning

All pregnant women are offered a detailed anomaly scan between 18-21 weeks of pregnancy. New guidance from the National Screening Committee endorsed by NICE recommends that additional scanning time of ten minutes should be added to this anomaly scan to measure cardiac outflow tracts on the baby and to scan in detail facial bones to detect cleft palate and other facial abnormalities. The Trust has implemented this change from January 2012 and now all pregnant women are offered a 30 minute detailed anomaly scan between 18-21 weeks of pregnancy incorporating these changes.

CQC Visit to Maternity Services March 2012

The CQC made an unannounced visit to the Trust to assess the Trusts' maternity and gynaecology services on how we manage terminations of pregnancy within the Trust. The two assessors viewed patient records from October 2011 and discussed with staff our processes and documentation surrounding offering women terminations of pregnancy. The CQC assessors were assured that the correct documentation was in use and that our systems and processes gave no cause for concern and were happy with what they found.

What's new for 2012 /13

- Work is expected to commence in May 2012 for a new six bedded transitional care unit which will replace our current small five bedded facility on the Worcestershire Royal site.
- A second theatre is to be commissioned with maternity services at Worcestershire Royal Hospital this will bring the total number of dedicated obstetric theatres to two.

Acute Stroke Services

Stroke services for Worcestershire were reviewed in June 2011. The conclusion reached at that time was that centralising acute stroke services at Worcestershire Royal Hospital had the potential to give the highest quality of acute stroke care for Worcestershire. Making this change was considered to be very difficult to achieve and may require identifying another service which could move off the Worcestershire Royal Hospital site. Actively working to improve services at both Worcestershire Royal Hospital and the Alexandra Hospital was therefore recommended.

Since June 2011 improvements to stroke care for Worcestershire residents have been achieved.

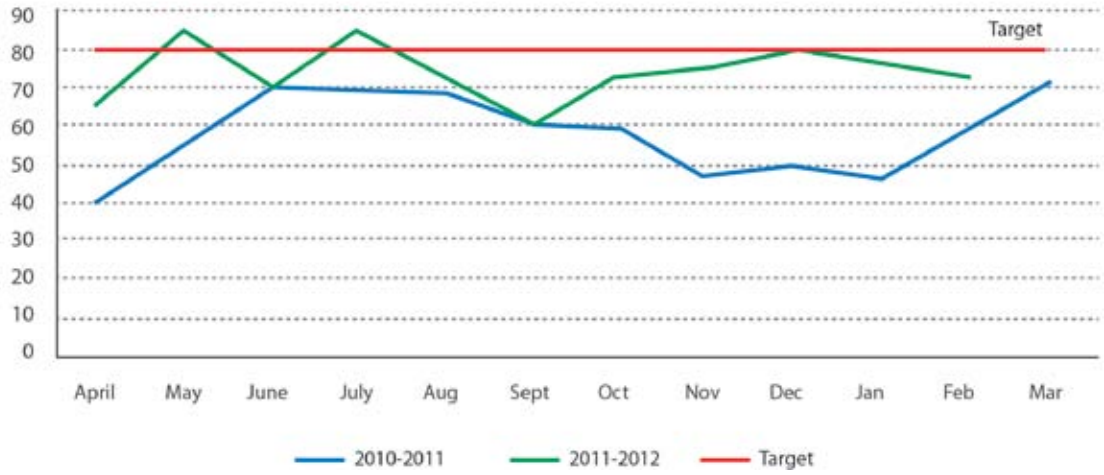
- The proportion of eligible patients receiving thrombolysis within 60 minutes of arrival has increased from 50% (Q12) to 67% (Q3)
- The proportion of patients admitted directly to a stroke unit has increased from 50% (2010/11 Q4) to 70% (2011/12 Q3).

Despite these improvements, Worcestershire is still not achieving key performance standards for the quality of care of people with stroke.

A follow-up appraisal of stroke services was in progress as the time this report was being published and due for reporting in May 2012. It is anticipated that the report will recommend changes required to achieve the standards required by the National Stroke Strategy and NICE guidance.

Percentage of patients admitted directly to an Acute Stroke Unit

Percentage of patients spending 90% of their time on an Acute Stroke Unit



Peer Reviews and external visits

Peer Review programmes, whether part of a national, regional or local process, are an important part of quality assurance processes in which colleagues from other Trusts examine the services we provide against an agreed set of standards. Formal reports are provided and action plans developed where required. The following section provides details of these and their findings.

Cancer Peer Review

The National Cancer Peer Review programme is an integral part of the trust internal governance system and supports quality assurance of cancer services which enables continuous quality improvements. Our cancer services team established the Cancer Peer Review Programme across the Trust from 2009 and has developed and progressed over the previous twelve months. The programme now involves self-assessments by cancer multidisciplinary teams (MDTs) and services, and external or internal reviews against nationally agreed quality measures. This has been recognised by the National Peer Review Team as exemplary practice.

The following cancer teams and services completed a self-assessment against the quality standards contained within the Manual of Cancer Services during 2011 and were then subject to a Trust internal validation by a Trust approved panel including patients and commissioners.

Internal Validation

MDT / service	Site / countywide
Breast	Worcestershire Royal Hospital
Breast MDT	Alexandra Hospital
Gynae MDT	Worcestershire Royal Hospital
Gynae MDT	Alexandra Hospital
Urology MDT	Countywide
Acute oncology services	Countywide
Clinical chemotherapy services	Countywide
Intrathecal services	Countywide
Oncology pharmacy services	Countywide
Brain and CNS locality	Countywide
Teenagers and young adults services	Countywide
Sarcoma locality	Countywide

The internal validation sessions took place over a three month period from September 2011 to December 2011. If there are any immediate risks or serious concerns highlighted the Chief Executive is informed on the day of the review and all relevant general managers and MDT leads are required to provide a response to these concerns within a specified time.

During both external Peer Review and the Trust internal validation process, significant evidence of good practice was seen. All teams and services demonstrated excellent engagement in the peer review process and were able to produce the documentary evidence required to a high standard.

The key worker role for cancer patients is now well established in the Trust and the commitment shown by clinical nurse specialists is clearly evident. All cancer MDTs were able to demonstrate involvement in both local and national patient satisfaction surveys with outcomes processed through the teams' operational meetings and general work programmes. Access to the Macmillan Cancer Information and Support centres across the Trust has been of great value to patients and ensures the availability of specific high quality tailor made information.

There were no immediate risks identified during 2011 and concerns raised have been addressed through the relevant departments and teams who monitor and review regularly for improvement.

The areas recommended for improvement, and the actions we have taken in response, are given below:

Areas highlighted for improvement by cancer peer review	How we have responded
Complex and fragmented pathways for oncology provision in the Trust	A single non-surgical oncology provider has been established and the transition of services will improve consistency of patient pathways
Difficulties for MDTs working within multiple cancer networks with different sets of guidelines and protocols	A countywide MDT approach is being developed to improve consistent care across the Trust and encourage teams to standardise clinical protocols and guidelines
Access to high level psychological support for cancer patients and supervision for staff delivering psychological support in the Trust	Cancer services in collaboration with NHS Worcestershire are working towards solutions for the improvement in provision of psychology services
The chemotherapy and acute oncology services across the Trust are complex. Issues around capacity, environment and staffing have been identified	Developments are in progress to address the issues identified within the chemotherapy and acute oncology services and the Trust welcomes an external visit in May 2012 to assist in measuring this progress

External Visits

During May 2011 the Trust received an external visit from the central zone peer review team to assess the following teams

MDT /Service	Site / countywide
Colorectal MDT	Worcestershire Royal Hospital
Colorectal MDT	Alexandra Hospital
Head and neck service	Countywide
Cancer paediatric services	Countywide

The outcomes from the external visit were very positive and the external peer review team congratulated the head and neck and paediatric teams in particular for the quality of service provided and the patient user links they have developed. Within the Trust the enhanced recovery service was highlighted as good practice for colorectal patients and new nurse led services acknowledged.

Enhanced Recovery after major bowel surgery was introduced at Worcestershire Royal Hospital more than a year ago. This novel programme, which aims to improve the overall care and experience of patients undergoing bowel surgery, starts early in the patient journey at the time of their diagnosis and continues even after their discharge from hospital.

The careful planning and implementation of this programme involved the collaborative efforts of a multidisciplinary team of specialist surgeons, anaesthetists, specialist nurses, theatre and nursing teams, physiotherapists, pharmacists, dieticians, pain team and senior management. A dedicated Enhanced Recovery Nurse was appointed to facilitate this change and her role has been crucial to the success of this programme.

Nearly 250 patients have now undergone major bowel surgery within this programme since its implementation in February 2011. More than half underwent laparoscopic (key-hole) bowel surgery which has the established advantages of reduced post-operative pain, quicker recovery and shorter hospital stays. The interventions of this programme have been successful in reducing the average length of stay in hospital dramatically by up to five days; most patients are now discharged home within five days of their operation. The post-discharge support provided by this programme continues to monitor patients at home and resultantly readmission rates have been kept low and in line with national standards.

The programme is rigorously evaluated. Patient feedback through routinely collected evaluation forms/surveys, individual letters of appreciation and a patient focus group have been extremely positive and encouraging.

Cancer Peer Review Programme for 2012/2013

The number of MDTs and cancer services for review has increased since the peer review programme was revised in 2011 and requires internal validation of key documents to be performed every other year (with self-assessment required annually).

The chemotherapy and acute oncology services will be subject to an external visit in May 2012 with upper gastrointestinal, colorectal, skin and teenager and young adult's services to undergo an internal validation in September 2012

The Trust process of internal validation has been regarded as a very robust and transparent system by the national team and the work of the cancer services has been highlighted in the Cancer Peer Review report 2010- 2011

"The Trust has had a new Cancer Team in place since May 2009 which has significantly raised the profile and performance of cancer services."

The Trust peer review programme has achieved positive and significant improvements for our patients along their care pathways. The involvement of patients and commissioners of care on our internal validation panel was also seen as good practice. The public report can be found at www.cquins.nhs.uk

Cancer awareness and early diagnosis is high on the health agenda and the Trust has been involved in planning a series of cancer awareness campaigns during 2011 /2012. Research has also shown that awareness of potential cancer symptoms in the general public is very poor. The British way is often "let's wait and see – maybe it will go away".

The cancer awareness campaigns were aimed at increasing the levels of awareness and understanding to encourage behaviour change in terms of increased earlier presentations to GPs, This inevitably resulted in an increased number of referrals to secondary care cancer services. Cancer services prepared an action plan to ensure all services across the trust were aware and prepared for the campaigns impact

We took part in the following campaigns

- National bowel cancer awareness campaign
- Regional (East plus West Midlands) lung cancer awareness campaign
- Network-wide (four West Midlands Cancer Networks) local cancer awareness month. This campaign focused on urology, upper GI, head and neck, breast and gynaecology cancers

Acute oncology service

All patients receiving anticancer treatment are given contact details for a 24 hour, 7 day per week telephone helpline that is staffed by appropriately trained and experienced oncology/haematology nurses. The UKONS oncology/haematology 24 hour triage tool is used to identify patients requiring admission but also those patients that can be managed safely on an out-patient basis or in collaboration with colleagues in primary care.

We have developed a model for an acute oncology service that is currently being implemented. A key aim of this service is to ensure appropriate management of acute oncology patients on their care pathway. Two Macmillan funded Acute Oncology Nurse Practitioners are already in post and they have identified cases where the model has avoided the unnecessary emergency admission of patients.

Paediatric services

The Paediatric Oncology Shared Care Unit (POSCU) Level one Peer Review visit was held in May 2011. The reviewers considered the POSCU multidisciplinary team (MDT) to be a strong service that clearly has the support of local families. The close working relationship with Orchard Community Children's Nursing and Palliative Care Team was highly commended.

It was highlighted that in practice the children and young people's lead cancer nurse undertakes many of the deputy lead clinician duties alongside her duties as lead nurse for the service; including providing cover in the absence of the lead clinician.

Previous comments regarding chemotherapy training documentation/frequency of updates and development of a formal administration register have all have been

addressed. The children and young people's lead cancer nurse has implemented local training until the required numbers of nurses have completed the network approved foundation level (oncology) training at BCH. Two places per year are currently funded by the Trust.

The POSCU patient experience survey shows a high level of satisfaction with the service from families. A local family support group has been developed by the children and young people's cancer nurse working with the CLIC Sargent social worker (from Birmingham Children's Hospital) and Worcestershire Acorns Children's Hospice. The Peer Review Team recognised the regular use of informal patient feedback to develop the POSCU service.

West Midlands Quality Review Service (WMQRS); vulnerable adults in acute service

The national definition of a vulnerable adult is being reviewed but in essence it means a person who is at risk of harm, abuse or exploitation through mental or physical illness or age. We have a duty of care to protect vulnerable people while they are under the care of one or more of our services.

We participated in the WMQRS peer review programme covering standards of care for vulnerable adults in September 2011. The Quality Standards used in the review are based on national guidance of best practice in terms of service structure and processes.

The formal feedback following the visit was extremely positive with no immediate risks or concerns identified by the specialists on the peer review and latterly we were invited to present our best practice at a learning event.

The WMQRS team combined the overall findings into a final report for the whole of the West Midlands which is available at this link: http://www.wmqi.westmidlands.nhs.uk/wmqrs/publications/for-review-programme/124

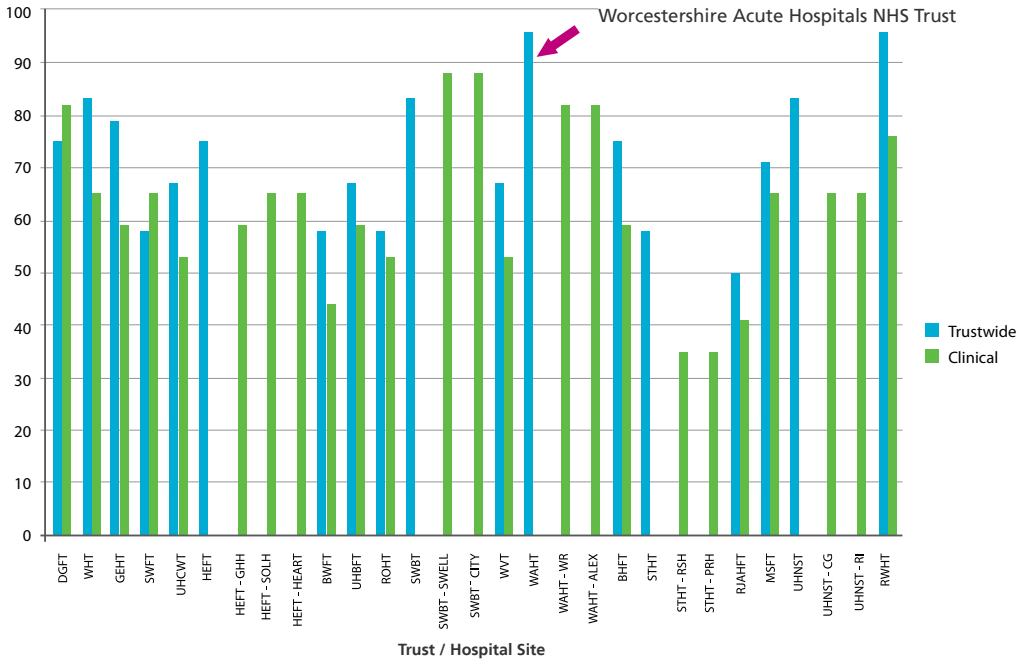
Worcestershire Acute Hospitals NHS Trust were recognised as being the highest performing Trust in meeting all of the applicable standards for vulnerable adults. This can be seen in the graph opposite:

In particular the report stated:

"Particularly good support for people with learning disabilities and people with dementia was identified at… Worcestershire Acute Hospitals NHS Trust."

We continue our work to further enhance our standards in caring for vulnerable adults.

Vulnerable Adults - Trustwide and Clinical
Percentage of applicable standards met
(Max. total applicable QSs: Trustwide = 24 Clinical Areas = 17)



Vascular Surgery

The first Vascular Society public report on outcomes for elective Abdominal Aortic Aneurysm (AAA) surgery in the United Kingdom has been published this year by the Vascular Society. The report covers the period between October 2008 and September 2010 and compares surgical units. Cases included are those discharged from hospital or who died after AAA repair between these two dates. Data on outcomes is derived from surgeon collected data held on the Vascular Society's National Vascular Database (NVD). The report reports raw data, unadjusted for case-mix.

Our vascular team perform the highest volume of AAA repairs in the West Midlands and we perform well with good data completeness and a mortality rate of 3.1%.

Worcestershire Acute Hospitals NHS Trust:
Elective Abdominal Aortic Aneurysm 1/10/2008 to 30/09/2010

Hospitals: Worcestershire Royal Hospital, Alexandra Hospital, Kidderminster Hospital
Region: West Midlands

NVD - elective mortality									Data contribution to National Audit is 98.9% of HES data. Standard: good
Open			EVAR			Overall			
No	*Died*	*Mortality*	*No*	*Died*	*Mortality*	*No*	*Died*	*Mortality*	
121	5	4.1	38	0	0	159	5	3.1	

Service Developments in 2012/13

We are planning a range of service developments designed to improve access to services and outcomes for Worcestershire patients. The developments are listed below. The Trust's Annual plan for 2012/13 contains details of these.

Service Development	Description
Improve outcomes for cardiac patients through Emergency Primary Percutaneous Coronary Intervention (PPCI) 24/7 (a surgical procedure used for the treatment of Myocardial Infarction/heart attack)	Second Cardiac Catheter lab in place operating 24/7 PPCI access.
Improve breast cancer outcomes through breast screening digitalisation and extension to age range	Age range extension programme delivered (awaiting PCT approval).
Improve access to radiotherapy for residents of Worcestershire: construction phase	Capital development plan 12/13 completed. Enabling car park works in Q1 2012-13. Construction to commence Q2 2012-13.
Introduce bariatric surgery	Minimum 35 patients per year repatriated from other Trusts.
Extend endoscopy services	Reduce patient waiting time and waiting list initiatives . Growth in activity – bowel cancer screening programme.
Introduce endobronchial ultrasound service (EBUS) to image the chest	Minimum 40 procedures per year repatriated from other Trusts
Implement seven day radiology service	Implementation on one site. Evaluation against agreed criteria linked to improved processes of care and specifically at weekend. Compliance with European Working Time Directive.
Improve outcomes for non-elective surgical patients (ALX) through the introduction of a surgical assessment unit (SAU)	Consultant-led assessment provided regularly throughout the day linked to same-day imaging and diagnostics. Nurse-led early discharge is facilitated. Improved patient reported experience.

3.3 Patient Experience

Patient experience. Quality of care includes quality of caring. This means how personal care is – the compassion, dignity and respect with which patients are treated.

(High Quality Care for All: Professor the Lord Darzi 2008)

2011/12 Quality Improvement Priorities

We set one quality improvement priority for patient experience during 2011/12. This is how we did:

Patient Experience – Improvement Priority 2011/12	
6. By improving the patient discharge process we will reduce the number of patients that have a delayed discharge, improve the quality of discharge documentation and improve the experience of patients and their families.	Achieved
There have been significant improvements in the number of delayed discharges and in length of stay. There was a 0.3 day reduction in LOS for emergency medicine in line with target set The percentage of delayed discharges has been under the 3% target level throughout the year. A wide range of actions for the Trust and the wider health economy have been identified for 2011-13, and these are being implemented successfully.	

Delivering Same-Sex Accommodation (DSSA)

The NHS has set out its commitment to privacy and dignity in a number of critical policy initiatives. These include the NHS Constitution which states clearly that all patients should feel that their privacy and dignity are respected while they are in hospital. High Quality Care for All (2008), Lord Darzi's review of the NHS, talks of the need to organise care around the individual, *'not just clinically but in terms of dignity and respect'*. The Chief Nursing Officer's report on privacy and dignity (2007) identifies same-sex accommodation as a *'visible affirmation'* of the NHS's commitment to privacy and dignity.

Trusts are expected to have a plan, agreed with their commissioners, to ensure men and women do not share bedrooms, bed bays, toilets and washing facilities and that women-only day areas are provided. Any providers failing to meet the obligations in their plan may have funds withheld as a result.

The Trust Board has reaffirmed a declaration of its commitment to the provision of same sex accommodation. This can be found at www.worcsacute.nhs.uk

Significant investment has ensured that all our facilities meet the DSSA requirements. However, in 2011/12 we had a total of 37 instances where the delivery of same sex accommodation was breached. 19 of these occurred in January 2012 when the Trust was experiencing extreme pressure from emergency patient admissions:

In response to these breaches we have created an escalation process to alert senior staff at a much earlier stage where there is a potential for a same-sex accommodation breach so that action can be taken to prevent them. The executive team also review the circumstances around each breach.

Inpatient Survey 2011

The findings from the 2011 inpatient survey for Worcester Acute Hospitals NHS Trust were published by the Care Quality Commission (CQC) on 24th April 2012.

The survey, carried out by Picker on behalf of the Trust, asked the views of adults who had stayed overnight as an inpatient in July 2011. The survey was sent to 850 patients who were admitted to the Trusts services and the response rate was 55%. There were 46% male and 54% female responses and 96% of them were white.

Our inpatients were asked what they thought about different aspects of the care and treatment they received at Worcestershire Acute Hospitals NHS Trust.

The survey highlights a number of findings, with Worcestershire Acute Hospitals achieving **similar average performance** in most categories when compared to other hospitals.

However, compared with other Trusts, lower scores were achieved for
- the explanations given on how to feel after the operation or procedure
- the danger signals to look out for after going home

We have developed robust actions for implementation to improve in these areas.

Picker compared the Trusts performance with the 2010 survey and noted there had been significant improvements in a number of areas; examples include standards of cleanliness and shared sleeping accommodation.

When compared with the Picker survey results from 2010, the Trust:

Improved significantly (better) on 7 questions:
- Information regarding conditional treatment in the accident and emergency department.
- Waiting more than four hours for admission to a bed on a ward.
- Waiting a long time to get a bed on a ward.
- Shared sleeping area with opposite sex.
- Being bothered by sharing a sleeping area with opposite sex
- Sharing shower or bathing facilities with opposite sex.
- Toilets not up to the standard of cleanliness they expected.

Further analysis of the more detailed Picker reports is being undertaken to identify the key messages from the survey. Improvement plans are being developed and will be monitored through the Patient and Carer Experience Committee and the Integrated Governance Committee.

2011 Outpatient Survey

427 patients responded to the 2011 outpatient survey giving a response rate of 50.7% (previous year was 54%, national average 52%). The Picker average is 48% response rate.

Picker conducted the survey on our behalf and we are able to compare our results with other organisations served by them. Changes seen when we compared the historical Picker survey results from 2004 and 2009 we:

We improved significantly (better) on ten questions:
- Appointment started 15 minutes after stated time
- Insufficient time to discuss health and medical problem with doctor
- Doctors not fully explaining reasons for treatment and action
- Doctors not always giving clear answers to questions
- Other staff not listening fully to what patient had to say
- Not having full confidence and trust in other staff
- Not completely discussing worries and fears with other health professionals
- Not involved in decisions regarding care or treatment
- Not discussing their questions regarding care or treatment
- Did not receive copies of all letters between hospital and GP

The CQC compare the outpatient survey results from all Trusts. This comparison shows that we are not better or worse than other Trusts, but about the same. However we are encouraged by the improvements reported for ten questions and that no questions showed a worse response.

National Cancer Patient Survey

This is one of the largest cancer surveys to have been undertaken anywhere in the world; this national survey provides insights into the care experienced by cancer patients across England who were treated as day cases or inpatients during September-November 2011.

The survey is in progress and as of 5 April 2012:

The overall national response rate was:	58%
The response rate for this Trust was:	66%

The Trust level report for the survey will be available in the summer of 2012 and we look forward to receiving the report.

All multi-disciplinary tumour site specific cancer teams (MDTs) will address any specific issues the survey has highlighted and report back via hospital management teams. Improvements are ongoing and will be reviewed by the external and internal National Cancer Peer Review process within the Trust.

The **2010 s**urvey showed that we were one of the middle ranking Trusts nationally, patients rated the Trust in three questions out of 59 in the Top 20% of Trusts as follows:

- Complete explanation regarding tests
- Trust not changing admission dates
- Practice staff support.

The issues identified for improvement included:

- Providing the family with an opportunity to talk to hospital doctors
- Providing information on support groups
- Providing information on financial help
- Providing information on free prescriptions
- Providing the family with all information needed to help provide care at home
- The doctor having the right notes and other documentation with them

Proportion of patients reporting access to a Clinical Nurse Specialist

The survey showed that we were in the middle range for access nationally.
A clinical nurse specialist is in post for all clinical tumour sites.

Actions and progress from the 2010 survey

The 2011 survey will be published later in the year and show what effect the actions have had on patient's views of their care. These actions have been taken in 2011/12:

- We now have access to the RELATE service directly from the Macmillan Pods and satellites across the Trust.
- We now participate in the nation information prescription project to ensure bespoke information is prepared and provided to patients.
- We have provided further information to cancer patients on free prescriptions and displayed posters in prominent areas including pharmacy.
- The implementation of eZ notes will take place in the summer of 2012.

Local Cancer Patient Surveys

A periodic survey of relevant patient groups is carried out to ensure that observations made by patients are considered and acted upon by multi-disciplinary cancer teams. This is a requirement of national quality indicators (National Peer Review measures).

The first local chemotherapy patient experience survey was undertaken in 2011 and provided comprehensive information about the needs and expectations of chemotherapy patients within the Trust. Further improvements have been identified and an action plan for operational leads developed.

During 2011 local patient satisfaction surveys for all the Cancer multi-disciplinary teams were undertaken. Many areas of good practice were identified and useful MDT site specific information was gained for MDTs to assist in their planning for service improvement. Specific clinical audit action plans were also produced for all teams to incorporate into the MDT work programme.

Local patient surveys

The inpatient survey is carried out each month. The questions cover all aspects of the patient journey from arrival and admission, the care and treatment received during their stay, and discharge arrangements.

Areas that have scored positively include:

- Privacy when being examined or treated in the accident and emergency department
- Hand-wash gels available for patients and visitors
- Privacy when discussing condition or treatment
- Patient addressed by preferred name
- Patients being treated with respect and dignity
- Cleanliness of the hospital ward
- Doctors and nurses working well together

The inpatient survey encourages patients to comment on aspects of care that were particularly good or anything that could be improved. The following are examples of the statements were made:

- *I have always chosen this hospital and always will. I always have had good care from doctors and nurses. They are always there for you no matter how big or small. Can't praise enough.*

- *I have had many operations and find the staff to be really friendly and have a good sense of humour. Everything is fully explained and will always answer questions. The wards are clean and tidy.*

- *Nothing is too much trouble for the nurses. They are all very friendly in all wards. When I use the bell the nurses came right away.*

- *From arrival to A&E on Sunday evening to the transfer and days spent in CCU I could not have asked for any better treatment. The whole staff were extremely helpful and professional in carrying out their difficult duties - a team to be proud of.*

- *Very grateful for the care and compassionate behaviour of all staff including medics, porters, cleaners, x-ray etc. I was very apprehensive as this was my first stay in a hospital so am relieved to have been so well looked after. The care, consideration and overall help from all members of the hospital team was unbelievable. Their patient and endurance when dealing with confused and difficult patients was beyond belief. Everyone was cheerful and upbeat which helped enormously.*

- *I was very impressed by the way the nurses looked after patients. Always ready to help patients, nothing was too much trouble. Friendly and very organised.*

We did receive some negative feedback that shows we don't always get it right and we will continue to work hard at customer care and some of our processes. Examples of these include:

- ensuring patients have a good understanding about their condition and treatment
- patient having somewhere they could lock to keep their belongings
- information about medication side effects to watch for when at home
- being asked to give their views on the quality of care.

All wards now have 'welcome to the ward' leaflets and comment cards for patients to comment on the quality of care and experience. Pharmacists work with ward staff to provide information on medications.

Online feedback for experiences of care

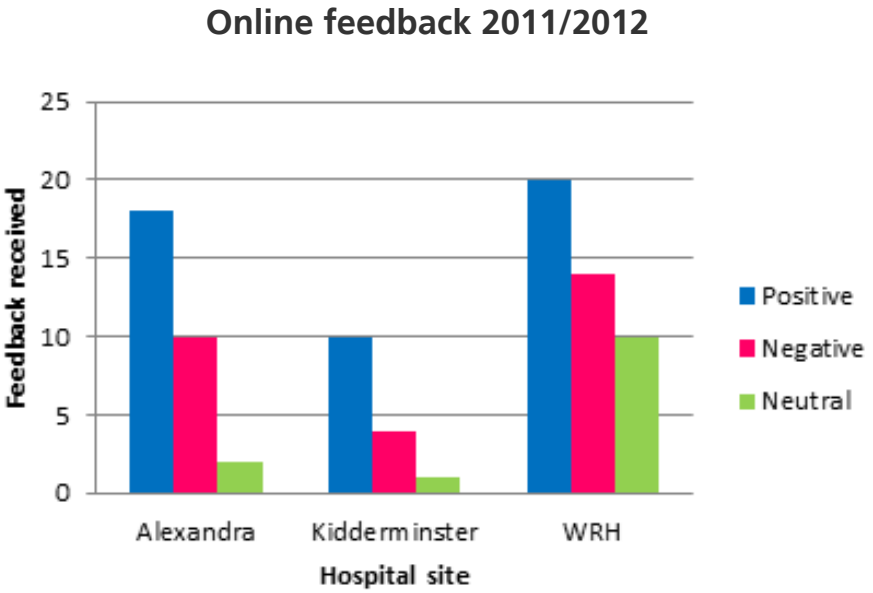
More and more people are now using the internet to record their experiences of care in our hospitals. The NHS Choices (www.nhs.uk) and Patient Opinion (www.patientopinion.org.uk) websites allow patients and visitors the opportunity to comment on our services and in 2011/12, as part of a series of measures to make it easier for people to let us know about their experiences at the earliest opportunity, we also made it easier for them to contact us directly via a feedback form on our own website (www.worcsacute.nhs.uk).

Over the course of the year we received 82 pieces of feedback via these methods.

NHS Choices – 26 comments posted (eight relating to the Alexandra Hospital, seven relating to Kidderminster Hospital and 11 relating to Worcestershire Royal Hospital)

Patient Opinion – (six relating to the Alex, two relating to Kidderminster and 12 relating to Worcester)

WAHT website - 43 comments received (16 relating to the Alex, six relating to Kidderminster and 21 relating to Worcester)



We categorise the feedback as positive, negative or neutral. The following charts show the breakdown of the feedback per site.

The feedback received is very varied, but negative themes included car parking, smokers outside our hospital entrances and poor communication. Positive feedback focussed on friendly, courteous, caring staff.

We aim to respond to all online feedback as quickly as possible and, where contact details have been provided, we also contact the person directly. We take all feedback extremely seriously and the online feedback report is taken to our quarterly Patient and Carers Experience and Engagement Committee quarterly to monitor the responses and ensure, where necessary, lessons are learned.

Compliments

Many patients are very happy with the care they receive and we receive a large number of compliments from them and their families. We have begun to formally capture the compliments received and feed this information back to our staff to reflect the positive impact they have on people's lives. The next Quality Account will report on the types of compliments received.

Complaints

During 2011/12, the Trust received a total of 707 formal complaints, an increase from 635 in 2010/11 and continuing the upwards trend.

Complaints Received	07/08	08/09	09/10	10/11	11/12
Total number of complaints received	421	480	616	635	707
Number responded to within target *	302	346	412	396	527
Percentage *	71%	72%	67%	69%	81%
Number of complaint meetings	49	76	100	100	113
Number of Healthcare Commission/ Ombudsman requests	12	16	11	18	23

We investigate every complaint we receive and aim to provide a response to the complainant within our own timescale of 25 working days from receipt. Where the investigation has identified areas for improvement, we develop an action plan.

During the financial year 2010/2011 we had 20 enquiries from the Ombudsman. The Ombudsman investigated ten of these cases and one was upheld. Nine are still either under investigation or local resolution is continuing.

We have maintained the high number of meetings senior staff have with complainants to better understand the cause of their complaint and respond personally.

The two divisions analyse their complaints every quarter to determine trends, what actions can be taken to address the cause of complaints and the impact of actions already taken. This has been reported to the Quality Assurance and Scrutiny Committee, a sub-committee of the Trust Board.

As with most acute Trusts, most complaints are related to inpatient stays. The table below shows how many complaints were received for inpatients, outpatients and accident and emergency attendances in 2011/12 and the previous four years. It also provides a measure of activity, finished consultant episodes (FCEs) which is used to determine whether the number of complaints has increased or decreased with activity. It shows that as our activity has increased, so have the number of complaints.

Ratio of complaints to activity	07/08	08/09	09/10	10/11	11/12
In patients					
FCEs	101029	105229	107310	111322	113327
Complaints	325	318	424	421	457
Ratio per 100 FCEs	0.32	0.30	0.39	0.38	0.40
Out patients					
Appointments	450796	464613	476597	485039	501458
Complaints	54	105	119	135	150
Rate per 100 appointments	0.01	0.02	0.02	0.03	0.03
A&E					
Attendances	132811	135596	138061	140705	143429
Complaints	42	57	74	80	101
Rate per 100 attendances	0.03	0.04	0.05	0.06	0.07

What do patients complain about?

The top three reasons for complaining are the same as last year:

Reason	No.
All aspects of clinical treatment	375
Attitude of staff	66
Appointments delay/cancellation – outpatient	65

We introduced a local coding system in 2010/11 to break down the national codes into something we could use to better record and understand the reasons why people complain. This analysis shows that the most frequently raised issue in complaints was *"lack of communication"*, followed by *"medical treatment"*, *"attitude of medical staff"*, *"miscommunication"* and *"attitude of nursing staff"*.

ACE programme

Rani Virk, Lead Nurse for Quality and Patient Experience with ACE cards

In response to the increased number of complaints related to the attitude of staff, we introduced the ACE programme. Staff across our three hospitals are taking part in the **'Active Caring for Everyone'** (ACE) programme. This is about improving the day to day interactions they have with patients and their families, and ensuring every moment of contact, no matter how small, impacts on the patient experience in a positive way. So far, senior clinical staff have received training to support their teams in delivering a great patient experience, and our Dignity Champions are being helped to develop their roles further to promote good relationships and interactions with patients in their clinical areas. We are planning on delivering ACE training to 3,000 staff over the next 12 months.

Staff feedback so far has been very positive from both nurses and doctors. They have found it thought provoking and motivating and a reminder that, whatever the pressures, their focus should be on improving the patients' experience.

Most importantly, we are now receiving the feedback from our patients about the care they have received which will help us identify areas for improvement and also share good practice.

Some of the other actions we have taken in response to complaints are provided below:

- A new system has been introduced for extended consultant cover in emergency medicine
- Ward sisters carry out Quality Rounds to ensure patients have access to call bells
- A matron undertook a dependency audit of her wards to ensure there were sufficient nursing staff to ensure patients are not waiting for assistance
- All patients are assessed for their nutritional needs on admission and then reviewed at least weekly: this includes ensuring that food charts are in place for any patients assessed as 'at risk', red tray system is in place for patients requiring assistance, red jugs and beakers are in place and protected mealtimes are adhered to. Meal time co-ordinators now ensure that patients receive, and are encouraged to eat, the most appropriate food
- Countywide review of neurology services
- Introduction of care pathway for patients with dementia; Clinical staff have received dementia awareness training; An alert is entered into the patient administration system to note that a patient has dementia
- Response to a concern about the attitude of nursing staff includes new leadership on the ward, ward sisters attending leadership training programmes, improved links with the clinical facilitators at the University and all staff have individual training plans for the next twelve months. There are regular ward meetings as well as individual appraisals.

Staff pledge to promote dignity in care

Staff across the Trust pledged their support for Dignity Action Day on Wednesday 1 February 2012.

Clinical and non-clinical staff were encouraged to come along to the stand at the hospital on the day and commit to signing a dignity pledge outlining what they would do to promote dignity in care in their role and also to register as a Dignity Champion.

They joined the 230 Dignity Champions across the county's acute hospitals who have already pledged their support for the Dignity in Care Campaign and who want to ensure their patients have a good experience of care as inpatients or during an outpatient visit.

The Dignity in Care Campaign aims to put dignity and respect at the heart of care services and has developed a ten point Dignity Challenge following feedback from people and what they expect from good quality care:

1. Have a zero tolerance of all forms of abuse
2. Support people with the same respect you would want for yourself or a member of your family
3. Treat each person as an individual by offering a personalised service
4. Enable people to maintain the maximum possible level of independence, choice and control
5. Listen and support people to express their needs and wants
6. Respect people's right to privacy
7. Ensure people feel able to complain without fear of retribution
8. Engage with family members and carers as care partners
9. Assist people to maintain confidence and a positive self-esteem
10. Act to alleviate people's loneliness and isolation

Janet Gillard, Senior Healthcare Assistant with Sonya Murray, Lead Nurse for Workforce Transformation / Recruitment and Retention

Our staff pledges – in their own words:

Samantha Pearson, Clerical Assistant on the Renal Unit, Kidderminster Hospital *"Every patient deserves respect. There should be no difference in the care patients receive - whatever their age their dignity should be respected."*

Gareth Marlow, a Junior Charge Nurse at the Alexandra Hospital pledged "To treat people as individuals and in a manner they deserve.'"

Di Frost, Senior Sister, Hazel - "I want our patients to be treated as I would want my family to be cared for."

Lin Hill, Practice Development Nurse - "I am passionate about all aspects of care delivered to all our patients on the ward."

Improving the Experience of Our Cancer Patients

The arrangements for providing cancer care in Worcestershire are complex with four cancer networks covering the county. Worcestershire cancer services relate to all four cancer networks with all relevant clinical and referral protocols being agreed by separate network site-specific groups. However 2011 has seen a major step forward in the implementation of Worcestershire Acute Hospitals NHS Trust (WAHT) and NHS Worcestershire's strategy for cancer, with the appointment of University Hospitals Coventry and Warwickshire NHS Trust as our strategic partner for non-surgical oncology service provision.

This strategic partnership will allow us to take forward the development of cancer services for Worcestershire, including the provision of radiotherapy locally. The Worcestershire Oncology Project Board and all the work streams, are working closely with our service users to ensure that their views, needs and expectations are taken into account in the development of any new service provision. This will lead to long lasting improvements in the quality of cancer services for Worcestershire residents; patient pathways will be improved with the streamlining of services, enabling enhanced communication and overall better care for patients, especially those with complications.

Radiotherapy: Due to historical cancer care arrangements, Worcestershire patients have to travel to Coventry, Cheltenham or Wolverhampton for radiotherapy treatment. By the beginning of 2014, a new state of the art radiotherapy facility will be open on the Worcestershire Royal Hospital site. The new arrangements will enable 90-95 per cent of radiotherapy to be delivered within Worcestershire. This means county patients will have care closer to home, no longer having to travel outside of Worcestershire for treatment. The state of the art radiotherapy facilities will also mean more effective targeting of tumours, less damage to surrounding tissue and less risk of complications.

Acute Oncology: Significant steps have already been taken this year to develop a new acute oncology service to support patients presenting with complications of their disease or treatment and prevent unnecessary admissions.

Initial artist's impression of how the new radiotherapy centre will look

Improving Information and Communication for cancer patients

The Macmillan Cancer Information and Support Services are available to provide cancer information and support to anyone affected by cancer across the Trust.

Funded by the charity Macmillan Cancer Support, the centres provide an open access service for anyone looking for information about cancer, including how to reduce risk of cancer, spotting the symptoms, information for people newly diagnosed with cancer, living with and after cancer and signposting to a wide range of services.

Open from Monday to Friday, the centres on each hospital site provide a calm and welcoming environment where centre users can talk in confidence to specially trained volunteers or Macmillan staff.

A cancer diagnosis can often have a severe financial impact on patients and their families and the Information and Support service has developed close links with the Macmillan/ Citizens Advice Bureau service which offers help on a range of issues including debt, benefits and employment. Patients, their families and carers can be seen at each hospital site.

Another new Macmillan initiative has launched this April which brings together Macmillan with Relate and will ultimately enable us to refer patients for counselling.

The Information and Support Centres have led the way in establishing the Information Prescription service across the Trust and the staff continue to offer support and training to Trust staff as they develop their own methods of using the web based health information service.

All members of cancer MDTs are encouraged and supported to attend Advanced Communication Skills Training. There is evidence that effective communication between patients and clinicians is fundamental to the delivery of high-quality cancer care. Currently 88% of core members of cancer MDTs have undertaken the training. The uptake is monitored through cancer services to ensure participation of all core MDT members.

The Cancer Team have developed a cancer patient information folder to support patients attending Worcestershire Acute Hospitals throughout their cancer journey. This is now implemented and embedded into practice across the Trust. User involvement was pivotal in the development and ongoing review of this patient resource, which has been well accepted and appreciated by patients, families and their carers. Within this folder there is a feedback form to enable continuing involvement of patients, their families and carers in future improvements for this folder and to help us improve our services.

3.4 What our staff say

The 2011 NHS National Staff Survey was undertaken by Quality Health for Worcestershire Acute Hospitals Trust. Questionnaires were sent to a sample of 848 staff and 464 staff responded which is a response rate of 55%. This response rate is in the highest 20% of Acute Trusts and compares to a response rate of 54% in the 2010 staff survey. The overall staff engagement score for the Trust in 2011 is 3.60 out of 5 which is average when compared to other Acute trusts.

Our Top 4 ranked questions – where we scored better than average

- Staff motivation at work is better than average for acute trusts – 3.82 average for acute trusts
- 72% of staff say that hand-washing materials are always available compared to 66% average for acute trusts
- 92% of staff believe the Trust provides equal opportunities for career progression or promotion compared to 90% average for acute trusts
- 84% of staff have been appraised in the last 12 months compared to 81% average for acute trusts

Bottom 4 ranked questions – where we need to improve

- 12% of staff experienced violence from patients, relatives or the public in last 12 months compared to 8% average for acute trusts which is a cause for concern
- Effective team working was 3.60 compared with 3.72 for acute trusts
- 28% of staff have received equality and diversity training in the last 12 months compared to 48% average for acute trusts.
- 32% of staff felt pressure to attend work when feeling unwell in the last 3 months compared to 26% average for acute trusts

The percentage of staff who would recommend the Trust to friends/family needing care

- The staff recommendation of the Trust as place to work or receive treatment score is 3.47 out of 5.0 compared to an average of 3.50 for acute trusts. Staff engagement will be key in achieving all of our Trust objectives but particularly 'Building Our Reputation'. It is important that we recognise that our staff are our ambassadors for patient care.

Our response to the 2011/12 staff survey result is:

- Improve communication between senior managers and staff.
- Ensure all staff feel valued and are recognised for their individual contribution.
- Empower staff to contribute to improvements in their area of work
- Ensure all staff have had the appropriate training for their role in the last 12 months.
- Provide a varied programme of equality & diversity training.
- Promote a positive working environment to reduce stress at work.
- Improve the quality of appraisals and the feedback that staff receive from managers.
- Ensure that there are robust procedures in place for reporting and dealing with bullying/violence and harassment from patients/relatives/public and that staff report all incidents.

Workforce indicators:

- The Cumulative sickness rate for 2011/12 was 3.93%. This is a significant improvement on 2010/11 which was 4.21%.
    - The range of sickness absence rates for Acute Trusts in our SHA is 3.29% to 4.84%. We are 9th out of 18 which is in the middle quartile.
- Cumulative turnover for 2011/12 has increased to 9.30% compared to 8.35 last year. The average cumulative turnover for acute trusts in the SHA according to January Productive Workforce Metrics Dashboard was 10.95%.

3.5 Who has been involved in setting the content of the Quality Account and the priorities for 2011/12

The writing of this Quality Account has drawn upon the significant engagement with internal and external stakeholders such as NHS Worcestershire, Worcestershire LINks, Clinical Commissioning Groups and the public to develop the Annual Plan and as part of the Joint Services Review.

Our staff have been involved through a series of events that have developed and then launched the Trust's strategic priorities and Annual Plan. There has also been a Quality Workshop that demonstrated the commitment of clinicians and managers to quality improvement and started the work to refine our approach to quality and how we achieve it.

We have used our nominated Non-executive Director and patient representative to review our Quality Account and ensure that it is an accurate reflection of the quality of our services.

3.6 Statements

Worcestershire Acute Hospitals NHS Trust has sought and received the following statements from NHS Worcestershire, Worcestershire LINKs and the Worcestershire County Council Health Overview and Scrutiny Committee.

3.6.1 Worcestershire LINks

This has been a difficult year for the Trust but Worcestershire LINk is pleased to see that so much has been achieved. In particular we are delighted with the progress made with the project to provide a local radiotherapy service and look forward to its completion. This will make a huge difference for those with cancer in Worcestershire. Although there was a stroke service review during the year it is likely to be 2012-2013 for the reconfiguration of the service to be achieved. We should like to remind Worcestershire's health economy that this will need to involve other trusts and services in order to provide a good service for those who suffer a stroke.

We are delighted to see that assessments on over 75 year old patients are being done on admission to hospital to check whether they have dementia and so need more specialist care. This is in addition to the other screening done on admission. Please be aware that dementia can strike patients at an earlier age than this and to be aware of this when admitting other patients.

The Trust has made considerable improvements in nursing care since the CQC visit last year. On our visits we have noticed on many wards that food, hydration and privacy and dignity are high on the staff's agenda and that patients have often commented on the high quality of care. The introduction of the ACE programme is having a positive effect on those wards which have received the training, and we look forward to this being rolled out across the Trust.

One of the key complaints that LINk receives is about parking. We note that there are inequalities here between the sites, and costs will vary as some patients will pay on leaving, whilst other pay on arriving. The latter must make judgments about how long they will be at the site, and may need to return to the pay station to purchase additional time if the clinic they are visiting is running late. They cannot buy a further hour or two, and have to pay for a minimum of two hours again, thus paying £6 for four hours, whereas those who park behind a barrier would only pay £4.50 for the same amount of time. This is grossly unfair and we urge the trust to resolve this issue. Similarly, if clinics are running late patients should not be financially penalized.

We are delighted to see the increased rate of patient safety incident reporting. This is important as the learning from such incidents should help staff to give safer care. Similarly the key improvements made with regard to CQUIN payments is good news for the Trust and we are pleased to see that for the three areas partially achieved there are actions for the coming year to ensure improvement.

The outcome of the Joint Service Review is key to the success of Worcestershire's health economy. We remind the Trust that wherever services will be located, patients and their carers will need to find affordable means of travelling, and that this is taken into account in future planning.

We are pleased to see the inclusion of Venous-thromboembolism prevention in the CQUINS for 2012-2013 and hope that the avoidable death rate from the condition will be reduced. Patient falls are still top of the Patient Safety Incidents and we look to see improvement in this area. Similarly with tissue viability, we are very pleased to see the emphasis on improvement in order to reduce the number of hospital acquired pressure ulcers for the coming year. We note the pressure that A&E is under, and suggest that this will only be resolved by further collaborative work with Worcestershire Health and Care Trust and Social Care services.

We receive many comments from patients and their carers about the responses to complaints. We ask the Trust to review the policy for this and to find ways to respond more quickly and in terms that are acceptable to those who have made the complaint. We also suggest that the Trust find ways to reduce the use of locums in order to make reductions in salary payments but also to find doctors who want to be full members of staff.

We wish the Trust success for the coming year.

Response from Worcestershire Acute Hospitals NHS Trust

We would like to thank Worcestershire LINks for providing this commentary and will take the opportunity to respond to some of the points raised:

Complaints – We too were dissatisfied with the time and indeed the way in which we responded to complaints so the process has been changed and we look forward to providing better responses to complainants and reporting an improved position for 2012/13. We have reviewed our policy and have an action plan to introduce the changes required.

Improvement in nursing care – We welcome the encouraging observations of Worcestershire LINk on the improvements in dignity and nutrition aspects of care.

Car Parking: We are attempting to provide additional car parking capacity at all three sites whilst ensuring that funding is not diverted from clinical services.

The building of the Radiotherapy centre at Worcestershire Royal Hospital will provide an additional 180 patient and visitor spaces. The Alexandra Hospital has had 70 new car parking spaces provided and Kidderminster Hospital will gain 65 once the Hulme Street Primary Care building is completed.

The pricing of car parking is under review but we would encourage patients and visitors to take advantage of the park and ride service from Sixways when attending Worcestershire Royal Hospital as this is both cheaper and avoids the potential stress of car parking on site.

3.6.2 Worcestershire Health Overview and Scrutiny Committee

The HOSC considers that the Quality Account provides a fair reflection of the healthcare services provided by Worcestershire NHS Acute Hospital Trust.

worcestershire county council

There is some concern that the use of abbreviations, acronyms and jargon mean that the document is not people friendly. However, the difficulty of producing an easily read document dealing with such technical matters is recognised.

The Objective Setting Process
The challenges of the Trust are not underestimated. The QA refers to the Annual Plan which sets out six strategic priorities and 18 annual objectives (aiming at improvement of quality and safety) for 2012/13. The response of HOSC is to the three improvement priorities detailed in the QA:

1. Address unwanted clinical variation
2. Provide appropriate treatment and care at the right time for patients who have had stroke.
3. Improve patient/carer reported experience of care.

There are links between the objectives of the Hospital Trust, the Health and Care Trust and Ambulance Trust. The authors of the QA pointed out that there is no requirement to cooperate with other trusts when deciding on objectives but the HOSC view is that this could be helpful.

Section 3.5 of the report details who was involved in setting the content of the QA. There is no evidence of public consultation. It is suggested that consulting the public on quality matters will ensure that the process of deciding on objectives is well-grounded.

Priorities for 2012/13

Address unwanted clinical variation
HOSC notes that the aim to reduce the number of falls in hospitals is closely linked to work being carried out by the Ambulance and Health and Care trusts and suggests there may be opportunities for cooperative working.

Provide appropriate treatment and care at the right time for patients who have had stroke
There has been public concern over the last year about the standard of stroke care [Worcester News articles dated 07.03.12 and 09.01.12 refer]. HOSC welcomes the commitment to provide appropriate treatment and care at the right time.

Improve patient/carer reported experience of care
HOSC hopes that the information provided through improved patient/carer reporting can be shared with other trusts and agencies, so that a complete picture can be created.

Accident and Emergency Waiting Times.
HOSC is surprised that this was not a QA quality improvement priority, especially as in the 'Statement from the Chief Executive' it is stated, 'Our performance... in A&E was disappointing all year and this is a key priority this year.'

Trust Profile
Matters relating to structure and finance are being dealt with as part of a Joint Service Review and are not part of HOSC's response to the QA.

In section 3.2, Clinical Effectiveness, it is noted the Trust had received a very favourable assessment following the West Midlands Quality Review Service assessment of vulnerable adults in acute services. However, the HOSC considered that the definition of a vulnerable adult could apply to all patients and the Trust needed to be clearer about safeguarding and there needed to be a clear structure.

Review of Priorities Set for 2011/12

HOSC notes that in respect of patient safety the Trust partially achieved its improvement priority relating to the reduction of harm caused by application or omission of medication.

The Trust is congratulated for achieving its aims in respect of effectively 'handing over' patient care. Objectives relating to the effectiveness of checks on the general care of critically ill patients were also achieved, as was establishing meaningful mortality and morbidity reviews.

The Trust is also congratulated for achieving its patient experience priority, which related to the reduction in the number of occasions a patient's discharge from hospital was delayed.

The priority relating to stroke care was only partially achieved but it is noted that this has been carried forward.

Staff Issues
In discussions with Trust managers about the QA it was found that the Trust Board was disappointed about the number of complaints made about the attitude of staff. This lack of tolerance of poor standards is laudable.

However HOSC notes that there were only 66 complaints resulting from 750,000 patient visits (with an additional number of visitors) in this category. By comparison 12% of staff experienced violence from patients, relatives or the public. HOSC understands the importance of the role of staff in achieving high quality standards. It shares with the Trust concern that the level of unacceptable behaviour of some members of the public is higher than the national average.

Response from Worcestershire Acute Hospitals NHS Trust

We would like to thank Worcestershire health Overview and Scrutiny for providing this commentary and respond to some of the points raised:

Achieving the Emergency Access Standards (A&E waiting times): This is one of the Trust's highest priorities and as such is already included as such in the Trust's Annual Plan for 2012/13. In response to the HOSC commentary we have decided to include the actions we are taking to meet the access target in the Quality Account to make our commitment explicit.

Stroke: Improving stroke care is indeed one of our highest priorities. Since the Quality Account was provided to HOSC for its commentary, it has been agreed to centralise stroke services on one site, Worcestershire Royal Hospital, to secure an improvement in care and performance. The HOSC supported this change at their May meeting and Stroke services will be centralised from November 2012.

Co-operation with other providers: We interact and cooperate with other providers on many levels in the course of delivering health (and social) care in Worcestershire including the necessity for a county-wide effort to achieve the Emergency Access Targets. We do recognise that there are opportunities to engage further for specific issues.

Public involvement and consultation: Our efforts have been focussed on the development of the Trust's Annual Plan, which has involved the public and has significantly influenced this Quality Account, and the Joint Services Review which is under way. As the Trust moves forwards under new leadership, we will consult widely and engage the public in the development of our services and the content of next year's Quality Account from an earlier stage.

3.6.3 NHS Worcestershire

As the lead Commissioner for Worcestershire Acute Hospitals NHS Trust, NHS Worcestershire (NHSW) has taken reasonable steps to ensure the accuracy of data provided in this Quality Account. NHSW believes that the Quality Account provides an accurate reflection of the quality of services provided by the Trust.

NHSW is fully supportive of the Trust's quality improvement priorities that are identified for 2012/13. NHSW is keen to highlight indicators of performance and areas for improvement in 2012/13.

NHS Worcestershire notes indicators of performance, including:

- Reducing the relative risk of patients dying in the first 30 days after discharge from hospital (pages 24 to 26). The Summary Hospital Mortality Indicator (SHMI) of 97 in Summer and Autumn 2011 was an improvement relative to the SHMI of 110 for the same period in 2010.
- Consistently achieving the 18-week referral to treatment waiting-time target.
- Working to reduce the risk of healthcare acquired infection (page 20). At the end of 2011/12, the Trust was 66% ahead of the trajectory for MRSA bloodstream infections and 25% ahead of the Clostridium Difficile infection trajectory.
- Achieving six of the seven national Cancer waiting time targets for all suspected cancers, symptomatic breast patients, first treatments, second or subsequent treatments for surgery and cancer drug treatments and first treatments from a screening programme. The seventh Cancer waiting time target was a maximum of 62 days wait for the first treatment, and this was partly achieved in 2011/12. (page 30).
- Fully achieving 10 of the 13 CQUIN targets listed on pages 12 and 13.
- The contribution from the Trust's staff towards delivering clinical care, participating in audits and external reviews, implementing better standards of care and their commitment to continuous quality improvement.

In addition to the areas commended above, the Trust has underperformed on a number of indicators. NHSW looks to the Trust to provide significantly more confidence that consistent quality is achieved and sustained across all services:

- **Emergency access:** the Trust fell well below meeting the national target of 95% of A&E patients being seen within 4-hours. NHSW notes changes introduced to reduce demand and support the effective discharge of patients. Delivering improved performance in Emergency Access continues to be a high priority for the NHSW so that a minimum of 95% of patients are seen within 4-hours. NHSW notes the new system introduced to extend Consultant cover in Emergency Medicine.

- **Stroke Services:** From an exceptionally low starting point in April 2011, the Trust has quadrupled the assessment and treatment within 24 hours, of people at high risk of stroke and experiencing a transient ischaemic attack (mini-stroke) - however significantly more assurances are still required because the 60% target was only achieved in the final two of the twelve months in 2011/12. Therefore, consistently achieving this 60% target will be closely monitored by NHSW. The Trust did not ensure that 80% of stroke patients spent at least 90% of their in-hospital time on a stroke unit. Therefore, NHSW sees as a high priority, the introduction of a revised stroke pathway, to ensure that much improved stroke services will be available to the people of Worcestershire and beyond.
- **Patient Falls in hospital:** While the High Impact Action Group introduced a number of interventions to reduce patient falls in hospital, NHSW continues to be concerned about the numbers of patient falls resulting in serious harm. NHSW notes the Trust's 2012/13 target to reduce by 35%, the significant harm to patients resulting from falls (page 6).
- **Infection Outbreaks:** There were disruptive Norovirus outbreaks in the Trust which, in February culminated in almost half of the beds at Worcestershire Royal Hospital being unavailable. NHSW continues to see the uninterrupted availability of beds as an essential pre-requisite to providing patients with the care that they require. NHSW is actively performance managing the Trust to minimise and in time, eradicate the impact of Norovirus and other infections on the availability of beds at the Trust's hospital sites.
- **Delivering Same Sex Accommodation:** Despite all of the Trust's facilities meeting the requirements for delivering same sex accommodation, there continued to be breaches in 2011/12 (page 44). NHSW is pleased to note the Trust's revised escalation process and assurances provided that this will negate further breaches in the future.

This Quality Account is the Trust's annual report to the public about the quality of services that are delivered. However, while the document provides lots of helpful information, it is generally presented from the points-of-view of the Trust's internal processes (patient safety, clinical effectiveness, patient experience etc.) rather than from the perspective of patients and the people who finance the services (national insurance contributors).

Therefore, NHSW believes that future Quality Accounts from Worcestershire Acute Hospitals NHS Trust must be much more helpful and indeed relevant to the public and that the various quality indicators are grouped together by service and/or patient pathway. This would help patients to more easily find the information in which they are interested.

NHSW believes the Quality Account 2011/12 is an accurate report of the quality of healthcare services provided. NHSW is satisfied that the Quality Account provides assurance on a range of the services provided by the Trust and that the accuracy of data in the Quality Account is being validated through the external audit process.

Response from Worcestershire Acute Hospitals NHS Trust:

We would like to thank NHS Worcestershire for providing this commentary and respond to some of the points raised.

Emergency access: NHSW are aware of the considerable efforts we are making to achieve this target (set out in improvement priority 3) and the importance we place upon it.

Stroke services: We welcome the recognition of improvements made during the year and the support of NHSW in centralising stroke care onto one site to further improve care and performance.

Infection outbreaks: The Norovirus outbreaks did indeed lead to significant bed and ward closures despite the efforts of our Infection Control Team and clinical staff. Closing wards is an essential step to controlling the spread of Noroviris, as well as placing patients coming in from the community with the infection immediately in side rooms. All outbreaks of infection are reviewed to understand the cause and learn lessons. We are sorry the outbreak caused disruption to patients and their families who were in the hospital or who had their appointments cancelled.

Presentation of information: Feedback on the clarity of the Quality Account is helpful to us as we seek to improve the way in which we communicate real information on the quality of the services we provide to the public. Healthcare is a complex business with many different ways of measuring and describing the quality of services. We have made efforts to write in plain English and present complex information in a way that the public can understand. Professor Lord Darzi defined quality in healthcare in the three 'domains' of safety, effectiveness and experience and we followed DH guidance in presenting the information in this way in the Quality Account over the last three years. We intend to provide a short version of our achievements, performance and priorities for the coming year in addition to the formal Quality Account.

Part 4

Assurance Statements

Assurance Statements

Assurance statements relating to the quality of NHS Services

This section contains the nationally requested mandatory statements of assurance that must be included in the Quality Account to comply with regulations. Some additional local information has been added to explain the statements and where we have taken action to improve.

4.1 Review of Services

During 2010/11 the Worcestershire Acute Hospitals NHS Trust provided and/ or sub-contracted 41 NHS services.

Worcestershire Acute Hospitals NHS Trust has reviewed all the data available to them on the quality of care in 41 of these NHS services. The income generated by the NHS services reviewed in 2010/11 represents 100% per cent of the total income generated from the provision of NHS services by the Worcestershire Acute Hospitals NHS Trust for 2010/11.

4.2 What others say about us

Statements from the CQC

Worcestershire Acute Hospitals NHS Trust is required to register with the Care Quality Commission and its current registration status is 'registered with no conditions'. The Care Quality Commission has not taken enforcement action against Worcestershire Acute Hospitals NHS Trust as of 31st March 2012

Worcestershire Acute Hospitals NHS Trust has participated in one special review or investigation by the Care Quality Commission relating to the following areas during 2011/12.

Termination of pregnancy services

The review was part of a wider investigation by the Care Quality Commission who made unannounced visits to Trusts and Pregnancy Advisory Clinics across the country, following press coverage that had indicated that in some cases, termination requests were filled in inappropriately by clinicians based on the baby's sex.

The report had not been received before the Quality Account was published but a review of documentation held by the Trust has shown that records relating to requests for termination of pregnancies were correctly completed and there were no irregularities or concerns.

NHS Litigation Authority Risk Management Standards

The NHSLA is in effect the NHS insurance scheme. As part of the drive to improve risk management and reduce the number of claims for clinical negligence received by the NHS, the Litigation Authority has two schemes against which member Trusts are assessed. There are three levels to each scheme with Level 3 being the highest. We currently hold

- Risk Management Standards – Level 1
- Clinical Negligence Scheme for Trusts - Maternity standards – Level 2

4.3 Participation in Clinical Audits and Confidential Inquiries

During April 2011 – March 2012, 40 national clinical audits and three national confidential enquiries covered NHS services that Worcestershire Acute Hospitals NHS Trust provides.

During that period Worcestershire Acute Hospitals NHS Trust participated in 90% national clinical audits and three national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Worcestershire Acute Hospitals NHS Trust was eligible to participate in during April 2011 – March 2012 are as follows:

National confidential enquiries

Title	Number of cases identified in the Trust	Number of questionnaires Requested	Number of questionnaires Returned	Report Due Date
Alcohol Related Liver Disease	305	305	Data collection phase	Spring 2013
Cardiac Arrest Procedures	11	11	9	Summer 2012
Bariatric Surgery *(organisational audit)*	n/a	1	1	Autumn 2012

National Clinical Audits

The Department of Health have provided a list of which national clinical audits should be included in Quality Accounts. The audits for which the Trust is eligible to participate are provided below.

The national clinical audits and national confidential enquiries that Worcestershire Acute Hospitals NHS Trust participated in, and for which data collection was completed during 2010/11 are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

National Audit Projects - 2011-12							
Overall Participation: 36/40 (90%)							
No.	Project Title	Eligible	Participated	Sample Requested	Sample Submitted	% **Participation**	COMMENTS
Peri-Neonatal							
1	Perinatal Mortality (MBRRACE-UK)	yes	yes	45	45	**100%**	
2	National Neonatal Audit Programme (NNAP)	yes	yes	787	787	**100%**	
Children							
3	BTS Paediatric pneumonia	yes	yes	68	29	**43%**	
4	BTS paediatric asthma	yes	yes	20	20	**100%**	
5	Pain Management in Children	yes	yes	50	50	**100%**	
6	Childhood Epilepsy (RCPCH National Childhood Epilepsy Audit)	yes	yes	32	3	**9%**	
7	PICANet: Paediatric intensive care	no	no	Do not provide the service.			
8	NICOR Congenital Heart Disease Audit- Paediatric surgery	no	no	Do not provide the service.			
9	National Paediatric Diabetes Audit NPDA(RCPH)	yes	yes	277	277	**100%**	
Acute Care							
10	BTS Emergency Use of Oxygen	yes	yes	166	123	**74%**	
11	BTS Management of Adult Community Acquired Pneumonia	yes	yes				Ongoing
12	BTS NIV-National Non-Invasive Ventilation Audit	yes	yes				Ongoing

13	BTS National Pleural Procedures Audit	yes	yes	19	19	100%	
14	Cardiac Arrest -National Cardiac arrest Audit	yes	no	Trust's own audit provides more data information and it is compared with the national results			
15	CEM Vital signs in majors	yes	yes	50	50	100%	
16	ICNARC-Case Mix Programme	yes	yes	1003	1003	100%	Ongoing
17	Potential donor audit-NHS Blood & Transplant	no	no	Do not provide the service.			
18	National Audit of Seizure Management (NASH)	yes	no	Did not participate			
Long Term Conditions							
19	National adult Diabetes Inpatient Audit-NDA	yes	yes	3245	3245	100%	
20	National Clinical Audit of HMB - Clinical Audit(2nd yr)	yes	yes	480	150	31%	
21	National Pain Database: chronic pain diseases	yes	yes	1	1	100%	
22	Ulcerative colitis & Chron's disease-IBD Clinical Audit- 3rd Round	yes	yes	40	40	100%	
23	National Parkinson's Audit	no	no	Do not provide the service.			
24	BTS Adult asthma	yes	yes	46	17	37%	
25	BTS National Bronchiectasis Audit	yes	yes	11	11	100%	
Elective procedures							
26	NJR: Hip and knee replacements	yes	yes	1129	968	86%	
27	National Elective Surgery PROMs: four operations	yes	yes				
28	Intra-thoracic transplantation (NHSBT)	no	no	Do not provide the service.			
29	Liver Transplantation (NHSBTUK)	no	no	Do not provide the service.			

30	Coronary angioplasty-NICOR Adult Cardiac Interventions Audit	yes	yes	649	649	100%	
31	Peripheral vascular surgery-VSGBI National Vascular Database	yes	yes	166	259	64%	
32	National Carotid Intervension Audit	no	no	Do not provide the service.			
33	CABG and Valvular surgery (Adult cardiac surgery audit)	no	no	Do not provide the service.			
Cardiovascular disease							
34	Acute Myocardial Infarction Audit Programme (MINAP)	yes	yes	263	350	75%	
35	Heart Failure Audit	yes	yes	240	240	100%	
36	SINAP acute stroke-Stroke Improvement National Audit Programme	yes	yes	1087	836	77%	Submitted (836) cases excluding Q1 from the ALEX.
37	Cardiac Rhythm Management Audit	yes	yes	400	400	100%	
Renal disease							
38	Renal Replacement Therapy (Renal Registry)	no	no	Do not provide the service.			
39	Renal Transplantation (NHSBT UK Transplant Registery)	no	no	Do not provide the service.			
Cancer							
40	Lung Cancer (LUCADA)	yes	yes				Ongoing
41	Bowel Cancer (NBOCAP)	yes	yes				Ongoing
42	Head & Neck Cancer (DAHNO)	yes	yes				Ongoing
43	National O-G Cancer Audit	yes	yes				Ongoing
Trauma							
44	National Hip Fracture Database (NHFD)	yes	yes	782	642	84%	
45	TARN: Severe trauma	Yes	no	Participating in TARN from 2012/13			

Psychological Conditions							
46	Prescribing in Mental Health Services (POMH)	no	no	Do not provide the service.			
47	Schizophrenia (National Schizophrenia Audit)	no	no	Do not provide the service.			
Blood Transfusion							
48	Bedside Transfusion(National Comparative Audit of Blood Transfusion)	yes	yes	50	50	**100%**	
49	Medical use of blood(National Comparative Audit of Blood Transfusion)	yes	yes	90	90	**100%**	
Health Promotion							
50	Risk factors (National Health Promotion in Hospitals Audit)	yes	no	Did not participate in			
End of Life							
51	National Care of the Dying-Hospitals-Round 3 (2 sites)	yes	yes	60	60	**100%**	

The reports of 9 out of 51 of all national clinical audits were reviewed by Worcestershire Acute Hospitals in 2011 and Worcestershire Acute Hospitals NHS Trust either has or intends to take the following actions to improve the quality of healthcare provided as described below:

Audit	Actions Taken
ID 385 NJR Hip and knee replacements	Monthly review of all hip and knee replacements to ensure NJR data is being captured in every case. NJR data to be captured by Bluespier Operation note and data entry.
ID729 National Care of the Dying Audit	Share results with the HIA Group for discussion and agreement of actions. Education & Training, review compliance with LCP (care after death goals), improve communication with patient & relatives (Providing leaflet to support significant conversations), Improve GP liaison re diagnosis of dying & death, HSPCT 7/7 working and 3 day MDT review.
ID734 BTS Emergency O2 Audit	Review the provision of training and its availability by developing tailored training sessions and promoting and raising awareness on the use of oxygen by doing a week of oxygen use information, outside the staff cafeteria and utilising messages on the "home screen" on the Trust computers.
ID 737 BTS Audit of Chest Drain Insertion	Better use of procedure room on laurel 2 for pleural procedures and the provision of a storage cupboard for equipment in addition to the Provision of privacy curtains
ID 744 BTS Annual Asthma Audit	In co-operation with the Emergency Department; all patients will have peak flow recorded on admission and receive systemic steroids within one hour of admission. And all patients to have clearly documented follow up by the respiratory nurse.
ID655 National Elective Surgery PROMs: four operations	• Establish a roll out plan with clinical teams. • Review training for all staff working in pre-assessment settings, identify clinical leads for each area • Improvement on the information provided to the staff on PROM's i.e. training video, patient information booklets, PROM's posters, displaying participation rates and monitor closely the participation and refusal rates and communicate monthly the PROM's performance information to all the clinical leads and circulate the PROM's E bulletin. • Contacts with early implementer sites to share their lesson learnt in early roll out of PROM's for all surgical procedures. • Matrons were made responsible for ensuring action plans for any of their areas with a poor participation rate below 80% are implemented and compliance improved.
ID819 Survey of HAI and antibiotic consumption	Review of value for money of mandatory elective admission MRSA screening programme in low risk cases and to consider returning to screening in targeted cases only following consultation with the Trust Board .

Audit	Actions Taken
ID887 College of OT Professional Standards for OT Practice Audit	Ensure any role expansion in a post is reflected within the job description and if required put forward for matching and to expand the departments HITS (Head injury therapy service) to patients attending A&E at the Alex also,to do more goal planning with strokes and to review national guidelines in regard to our service.
ID 898 Renal Colic Audit	To increase emphasis on repeating pain scores and to add reminder of US for >60s to all the staff through internal training.
ID 637-National Neonatal Audit Programme (NNAP)	• Feedback figures to the joint Perinatal meetings each quarter. • To complete the specially adapted area in the neonatal case record and to include this in rapid case note reviews as part of clinical governance meetings. • Improve documentation and completion of 'ad hoc' forms on Badger database. Current figures do not reflect what happens in practice. • Await national guidance on approach to babies discharged before screening due • Continue to promote breast feeding through baby friendly approach and use of TCU and outreach to reunite mothers and babies as soon as possible

The reports of 157 out of 322 of all local clinical audits were reviewed by the provider in 2011 and Worcestershire Acute Hospitals NHS Trust intends to take the following actions to improve the quality of healthcare provided in the selection of audits provided below:

Audit	Specialty	Actions Taken
	Alexandra Hospital	
ID 901 Documentation of Non Obstetric Epidurals and Spinals of Non Obstetric Epidurals and Spinals	Anaesthesia	• Review anaesthetic chart and edit the Anaesthetic chart to allow more space for documentation of epidurals and spinals • Review clinical documentation: If epidural or spinal used as a sole technique motor and sensory block level should be recorded- Asepsis/ Catheter in space/ LORTS or LORTA/ Insertion level/ Infiltration to skin needs to be better documented.
ID 710 Mental Health Assessments	Emergency Medicine	• Improved awareness of matrix forms and assessment: New doctor induction booklet produced • New S136 policy introduced. Training for middle grades at teaching and awareness courses • Establish monthly meetings with psychiatric lead to discuss issues/feedback • Mental Health Assessment Team now assess moderate risk as well as high risk out of hours • Psychiatric Liaison team now available until 9pm weekdays to reduce length of stay in ED for psychiatric patients.

Audit	Specialty	Actions Taken
ID 868 Patients Presenting Abdominal Pain Action Plan	General Surgery	• Review Radiology Requests: Clinicians to look at radiology request for justification • Review current guidelines and the development of appendicitis guidelines • Compare results with the clinical presentation and Compare outcome to other Trusts.
ID 914 "Our NHS" Campaign Inpatient and Relative Survey	Cancer Services	• Route to Success in Acute Hospitals initiative to be launched in April 2012 encompassing the Our NHS Campaign & introducing AMBER as a means of promoting action planning for end of life care & enabling discussion around choices at end of life using the Map of Medicine End of Life Discharge Pathway.
ID 911 Audit of 2 week referrals for suspected Skin Cancer	Dermatology	• To improve 14 day target compliance by suggesting that GPs ask patients whether they are planning to go away or on holiday in the next 2 weeks before making referral and to offer transport to patients who have difficulty travelling • Highlight importance on appointment letter to reduce DNA/cancellation rate. • Suggestions to improve 62 day target compliance to address hospital-wide bed/theatre availability issues.
ID 746 Oral Fluids in Older People: Are we getting it right?	Medicine	• All patients are to be weighed on admission and have fluid balance charts as per guideline. • Daily estimated fluid requirement is to be documented on fluid chart using fluid matrix. • Care and Comfort charts are to have the 'cups' removed. • Patients receiving <70% BFR require closer supervision and a clear documentation in clinical notes as to why their intake is low.
ID 760 Audit of intrapartum and postnatal bladder care	O&G	• Improve documentation of care • Education and increased awareness of PFAT and bladder care • Review bladder care guidelines and re-audit on both sites at same time.
ID 822 WHO Growth Charts	Paediatrics	• Advertise guidance and importance of including growth chart by developing a poster • To use WHO growth charts in all new patients 0-4 yrs: Include WHO chart as part of admission bundle.
ID 775 An audit of completion of assay request forms	Pathology	• Correct completion of amnioglycoside assay request forms and vancomycin assay request forms by presentation of findings and discussion with junior doctors.

Audit	Specialty	Actions Taken
ID811 Occupational Therapy Expected Date of Discharge (EDD) Audit	Therapies	• Review the Trust current use of EDD to aid patient flow and provide goals for support services. • More assistance from those planning patient care to refer to OT when the patient is ready to be seen for functional assessment and with a realistic working time set i.e. the EDD – being an appropriate date after OT referral.
ID 717 Audit of CTPA-percutaneous lung biopsy under CT guidance	Radiology	• To discuss outcome with the team for further evaluation/discussion • Review highlighted discrepancies with relation to the RCR advise and suggest formal local protocol • Review progress following instigation of CTPA protocol to see if raised issues are resolved.
ID 827 Audit of DVT Prophylaxis	T&O	• Ensure patients are provided with leaflet/ information about VTE risk pre-operatively. • Documentation and checking of TED stockings being checked at ward rounds.
ID 1005 Audit of Testicular Cancers and 2 week wait referrals	Urology	• Review the current urgent referral system to determine whether GP's should review their urgent ultrasounds prior to making an urgent urological referral? • Review the setting of the 2 week waiting cancer clinic • Review the current guidelines to determine whether stringent guidelines required regarding ultrasound.
Worcestershire Royal Hospital		
ID 747 Volatile Agent Usage Audit	Anaesthesia	• Put the equivalent of WRH's reminders of what/when to use each volatile on the anaesthetic machines. • Review the availability of Isoflurane and make it available as a default in anaesthetic rooms • Consider the use of circle systems in the anaesthetic rooms where complex cases are regularly performed.
ID 894 Audit of Use of TIMI score calculation in patients with ACS	Cardiology	• Cardiac assessment team will continue to encourage use of TIMI risk score by acute physicians • New ACS protocol to be finalised and advertised: printed posters and protocols to be circulated and displayed In MAU when new Troponin protocol finalised – these should include TIMI

Audit	Specialty	Actions Taken
ID625 Filter changes in CVVHF	Intensive Care	• Possible revision of guidelines: filters can be continued to be used if functioning well, as most filters either fail or are stopped electively within 72 hours • Review renal replacement prescribing sheet: Achieved beyond target with mean APTT ratio within the optimum range; mean APTT at time of failure also within optimum range however - suggestion to revise range on prescribing sheet with a possible amendment to renal replacement prescribing sheet to incorporate a space for documenting reason for using haemasol with the possible amendment to renal replacement prescribing sheet to incorporate a reminder to enforce this section of the guideline in clinical practice.
ID 917 Audit of the ambulatory care pathway for Cellulitis.	Emergency Medicine	• Review with the departmental staff, local prescribing policies, current teaching programme, Trainee handbook and ENP training.
ID 1000 Audit of Management of patients post total Thyroidectomy	General Surgery	• Maintain awareness of protocol by presentation of the audit results, inclusion of protocol in induction pack. • To include hypocalcaemia management post Thyroidectomy in the junior doctors' surgical induction pack and writing a specific protocol. • Clear documentation of any voice changes at follow up and a Post op reminder for inclusion.
ID 820 Blood Glucose Measurements in Acute Medical Admissions	Acute Medicine	• Dissemination of results to the ward staff and present the findings at the medical grand round. • Clarification on the use of BM section in clerking proforma.
ID 609 Audit of One-to-One Care in Established Labour 2011	O&G	• Dissemination of audit data across the wards through handovers and posters • Co-ordinate suturing training to correspond with rotations to delivery suite so that midwives can move easily to obtain their competencies, Suturing workshops added to the mandatory maternity training (monthly) as well as on delivery suite (drop-in sessions)
ID591 Audit of ROP Screening	Ophthalmology	• Results were discussed with local neonatal paediatricians. • Discussion around the implementation of 'must' guidelines.

Audit	Specialty	Actions Taken
ID 779 Audit of Congenital Adrenal Hyperplasia management in children	Paediatrics	• Audit Action plan inserted in front of notes • Guidelines to be put on the intranet • Clarity on the emergency management upon admission • Re-audit to include survey to parents experience.
ID819 Survey of HAI and antibiotic consumption	Pathology	• Review of value for money of mandatory elective admission MRSA screening programme in low risk cases • Discuss screening in targeted cases only.
ID755 Rectal MRI Prior to Total Mesorectal Excision (TME)	Radiology	• MRI workload distribution • Discrepancy notification through error review meetings • MRI scan supervised by reporting Radiologist
ID 835 Are we assessing cognition and analgesic requirements	T&O	• Educate doctors and nursing staff regarding NICE best practice in analgesic • requirements in patients admitted with fracture neck of femur • Modify admission templates to include pain assessment and cognitive function; To include pain assessment section and AMT scoring in clerking proforma .
ID 765 Audit of Therapies Service	Therapies	• Organise a Stakeholder event to further discuss the outcome of the review and opportunities to increase the Therapy hours of service • Presentation and Sharing of results with Therapies staff across all three services.
ID 981 Are all vascular patients on best medical therapy?	Vascular Surgery	• A form to be included as part of the discharge of a peripheral vascular disease patient from the vascular ward, in order to ensure that all elements of best medical therapy have been reviewed. • In the outpatient setting, patients should have their blood pressure checked, their HbA1C should be checked (if diabetic and blood testing is feasible) and their medication should be reviewed to ensure that they are on an aspirin and a statin. All patients who are smokers should also be advised to stop smoking.

Clinical Audit - Presentations and Publications Portfolio 2011/12

These clinical audits were presented or published in 2011/12

Specialty	Project ID -Title	Comments	Presentations / Submissions	Date of presentation
Gynaecology	**ID759 Outcome of Laparoscopic Hysterectomy**	A safe procedure with no complication rate in terms of injuries and blood transfusions. Conversion rate to open was 2%. Our data is comparable to national practice.	A poster presentation in BSG(British endoscopic society)	Sept 2011
Departments of Infectious Diseases1, Respiratory Medicine2 and Microbiology3	**ID785 An audit into cases of tuberculosis in Worcestershire 2006-2011**	This audit is the first step in the development of future local audit standards including the discussion of delays to diagnosis of TB and HIV, discussion of all cases at an MDT and the collection of outcome data.	A poster presentation Federation of Infection Societies Scientific Meeting, Manchester	Nov 2011
Pathology	**ID819 Screening for Methicillin resistant staphylococcus Aureus (Results, Costs and Achievements).**	In conclusion, the introduction of mandatory elective and non-elective screening has done little to improve our ability to detect MRSA carriage, and has brought with it a high associated cost. This has been recently described by other authors (Collins J et al).	A poster presentation Federation of Infection Societies Scientific Meeting, Manchester	Nov 2011
Urology	**ID506-Do the BAUS Guidelines for Laparoscopic Urological Training produce a safe, independent practitioner**	BAUS guidelines for laparoscopic training aid the development of safe, competent laparoscopic practitioners. Our reported data is comparable to National contemporary practice. Our conversion rate does appear high at 7.1% but this may reflect the small number of cases analysed and would be expected to fall with increasing experience. Current BAUS Laparoscopic Urological Training guidelines are producing competent laparoscopic surgeons.	Midlands Urology Annual Regional Meeting, Birmingham British Association of Urological Surgeons Annual Oncology Meeting, London West Midlands Surgical Society Annual Meeting, Worcester	11/10/11 14/11/11 18/11/11

Specialty	Project ID -Title	Comments	Presentations / Submissions	Date of presentation
Urology	**ID689-PCNL Audit**	Our findings are comparable with those of the BAUS national audit for PCNL. This demonstrates that newly appointed urological surgeons can provide a safe and effective PCNL service using the prone oblique approach.	Royal College of Surgeons of Edinburgh-Lister Centenary Meeting	9/2/12
Medicine	ID141-2010-11 Discitis Audit	This small-scale study has sought to identify areas of good practice and deficiencies in our current treatment of patients with discitis and epidural abscess. Recommendations: -Ensure appropriate microbiological investigations performed -Early recognition of sepsis -Reduce Hickman line infection rate	Presentation at the Outpatient Parenteral Antimicrobial Therapy Conference	2-3/3/11

4.4 Research

The number of patients receiving NHS services provided or sub-contracted by Worcestershire Acute Hospitals NHS Trust between April 2011 and March 2012 that were recruited during that period to participate in research approved by a research ethics committee was 828. Continued research success can be seen in areas such as Oncology and Haematology, with growth in some previously inactive specialities such as ENT and dementia.

Worcestershire Acute Hospitals Trust was involved in conducting 145 clinical research studies approved by a research ethics committee in 2011/12. 39 such studies were opened within the reporting period.

Participation in clinical research demonstrates Worcestershire Acute Hospitals NHS Trust's commitment to improving the quality of care we offer and to making our contribution to wider health improvement.

Our engagement with clinical research also demonstrates Worcestershire Acute Hospitals NHS Trust's commitment to testing and offering the latest medical treatments and techniques.

4.5 Data Quality

Information Governance (IG) Toolkit attainment levels

Worcestershire Acute Hospitals NHS Trust Information Governance Assessment Report score overall score for 2011/12 was 73%.

Information Governance is the mechanism by which the Trust measures its IG compliance in relation to the law and central guidance to assess if information is handled correctly and protected from unauthorised access, loss, damage and destruction. Compliance is measured by the mandatory on-line submission of the NHS IG Toolkit. The evidence-based return is made annually at the end of March against 45 standards. An updated version of the IG Toolkit is released every year by the Department of Health.

The Trust increased the toolkit score from 72% to 73%. Under the previous scoring system 70% and over equated to a green status, however in the new scoring system is all 45 standards must achieve a minimum of a level 2 score. As 4 standards are scored below a level 2 the Trust has been rated 'unsatisfactory'

The Trust has reduced the number of level 1's from 5 to 4 and has an action plan in place to increase the 4 remaining level 1's to a level 2 before the 21st March 2013, to achieve a satisfactory status next year.

Coding

Worcestershire Acute Hospitals NHS Trust was subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission and the error rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) were:

- Primary Diagnoses Incorrect [7.5%]
- Secondary Diagnoses Incorrect [5.7%]
- Primary Procedures Incorrect [11.2%]
- Secondary Procedures Incorrect [4.0%]

The performance of the Trust, measured using just the clinical coding HRG error rate, is better than the national average of 9.1 per cent using the 2009/10 full year results. This year the Trust's average HRG error rate is 6.5 per cent.

The results of this year's audit are again above national average and the coding department has worked very hard to attain this result.

The Trust is constantly striving to improve clinical coding. This includes addressing the recommendations from the annual audits along with some other further improvements.

Actions taken to improve clinical coding

1. As well as the external audits the trusts qualified internal auditor carries out clinical and staff audits to ensure the accuracy and standardisation in coding.
2. Four members of the Clinical coding team have passed the Accredited Clinical Coding qualifications and other members of the team are currently studying for the exam.
3. A mortality coding and verification process has been introduced.
4. Improved timeliness of coding completeness to provide the trust with timely coded data to support business processes and planning services for patients.

Data Quality

Good quality information underpins the effective delivery of patient care and is essential if improvements in quality of care are to be made. Improving data quality, which includes the quality of ethnicity and other equality data, will thus improve patient care and improve value for money.

Worcestershire Acute Hospitals NHS Trust will be taking the following actions to maintain and continue to improve data quality in the Trust.

The Trust is committed to pursuing a high standard of accuracy, completeness and timeliness within all aspects of data collection in accordance with NHS Data Standards. The Trust has always put and continues to place high emphasis on recording and using good quality data to support patient care. Data Quality is integrated into the Trusts business processes and there is a structure of reporting throughout the organisation and to the Board. All staff are accountable for recording data accurately and supported by training, guidance and feedback on an adhoc basis and via internal and external audits. Regular monitor of key data is undertaken and issues are addressed promptly. The Trust liaises closely with the PCT on any data quality concerns they may have from their commissioner role or raised by GP's.

Patient's valid NHS number was:

99.6% for admitted patient care;
99.6%for out patient care; and
84.3% for accident and emergency care."

Patient's valid GP was:

100% for admitted patient care;
100% for out patient care; and
100% for accident and emergency care."

Inpatient Ethnic Origin

97% - the same as in 2010/11

Actions taken to improve data quality

1. The Trust has been subject to internal and external data quality audits over the last twelve months and the results have provided high levels of assurance around the quality of our data. Any recommendations from these audits have been actioned.

2. The Data Quality Group meets on a regular basis in order to monitor and implement improvements in data quality. The national data quality dashboards show the Trust is equal to or above national average for almost all data quality measures for inpatients, outpatients and A&E.

3. A concerted effort has been made in order to improve the level of missing NHS numbers for A&E which has resulted in an improvement from 72% to 84%. Work is continuing on improving the levels of NHS numbers within the A&E department. Postcode and GP data is 100% complete.

4. A recent project has been undertaken to address the issue of duplicate registrations and this had subsequently become an integral part of Trust data processes.

5. Access to information by senior staff managing ward areas has become readily available through the development of the ward dashboard, which ensuring they can access figures about their service and feeding back on completeness and accuracy of data.

Glossary

This section provides a definition of the terms and acronyms used in this report.

ACE	'Active Caring for Everyone' programme
CQC	Care Quality Commission
C. Difficile	Clostridium difficile
CDI	Clostridium difficile infection
CQUIN	Commissioning for Quality and Innovation payment framework
DH	Department of Health
DSSA	delivering same sex accommodation
EDD	Expected date of discharge
EDS	Electronic discharge summary
GP	General Practitioner
GTT	Global Trigger Tool - a tool used to identify harm events from a review of patient notes.
HOSC	Health Overview & Scrutiny Committee - Worcestershire County Council
HSMR	The Dr Foster Hospital Standardised Mortality Ratio
INR	International Normalised Ratio - a measure of blood clotting time
IP&C	Infection prevention & control
IUD	Intra uterine death
LINks	Local Involvement Networks
LIPS	Leading Improvements in Patient Safety
LoS	Length of stay
MDT	Multi-disciplinary team
MRSA	meticillin resistant Staphylococcus aureus
MRSA BSI	meticillin resistant Staphylococcus aureus blood stream infections
NHSW	NHS Worcestershire - our primary commissioning PCT
NHSW	National Health Service
NICE	National Institute for Health & Clinical Excellence
NRLS	National Reporting and Learning System
PCT	Primary Care Trust
PEAT	Patient Environment Action Team
PPCI	Worcestershire Primary Percutaneous Coronary Intervention - a treatment used following heart attacks
QIPP	Quality, Improvement, Productivity and Performance
SBAR	Situation, Background, Assessment, Recommendation - a means of reliably passing on information
SHA	Strategic Health Authority
SI	Serious Incidents
SHMI	Standardised Hospital Mortality Indicator – this looks at the relative risk of death of all patients managed by the Trust and includes the period up to 30 after discharge.
TIA	Transient Ischaemic Attack - a 'mini' stroke
VTE	Venous thromboembolism also known deep vein thrombosis or DVT
WMQRS	West Midlands Quality Review Service