Worcestershire NHS
Acute Hospitals NHS Trust

Worcestershire Acute Hospitals NHS Trust

Quality Accounts 2012/13







Patients | **Respect** | **Involvement** | **Delivery** | **Efficiency**

Taking pride in our healthcare services

Section 1

1.1 Statement from the Chief Executive

I am delighted to present to you my second Quality Account for Worcestershire Acute Hospitals NHS Trust, covering 2012/13. The following document aims to share with you what we have done to improve quality and safety over the last 12 months and also what we intend to focus on moving into 2013/14.

When we talk about quality, we mean the safety and experience of all of our patients and their relatives and carers. We also mean the measurement of the effectiveness of our treatments and what we are doing to improve them. I am pleased to report that during 2012/13 we saw a number of improvements across the Trust and achieved many of our national operational targets.

Although we managed to hit the 4 hour A & E access target during the second quarter of this year, the unprecedented levels of demand coupled with the incidence of Norovirus we experienced right across our hospital sites, has meant that we failed to achieve this for quarters 3 and 4. We did meet the 18 week referral to treatment target and only narrowly missed one of the national stroke targets for the year relating to 90% of patients spending 80% of their time on a stroke ward. The Standard is 80% we achieved 79.1%. However we did achieve 9 consecutive months for all standards.

Some of the work that we focused on this year was around the reduction in hospital acquired avoidable pressure ulcers and we are delighted to see the significant improvements over the course of the year, showing we are moving towards this goal. While we have struggled with C. difficile infection, we have seen a reduction in the incidence of this towards the latter part of the year with some of the additional measures we have put in place around the anti-microbial prescribing.

We saw the publication of the Robert Francis Report into the failings at Mid Staffordshire Hospital during the course of the year which the Board has read and accepted the findings from. Patient safety and patient care is at the forefront of all we do and we will work with all our staff going forward to maintain and further develop the culture of openness and transparency embodied in the Robert Francis Report.

We saw a number of our key programmes embedded across the Trust during the year that reflected these values including the Active Caring for Everyone (ACE) project that has seen a further 1,157 staff trained during the year to deliver improved patient experience and communication. We are also reviewing how we deal with complaints and how we listen and respond to those who are unhappy with our services. We will further build on this work in 2013/14. Listening to our patients and their families is extremely important to us and we took part in a trial established by the NHS Midlands and East during the year on the Friends and Family test. Throughout the year we scored in excess of 71 and at year end achieved a ten point increase in satisfaction from our patients with a score of 81.

This account also sets out our priorities for 2013/14 moving forwards.

I would like to take this opportunity to thank all our patients, their carers, staff and stakeholders for helping us formulate our quality improvement programme. I know that we have a workforce that is committed to delivering high quality care to all of our patients and we

will continue to work closely with them and the public going forward to deliver the improvements outlined in this Quality Account.

I am pleased therefore, to present our Quality Account for 2013/14 to you which I believe to be a fair and accurate report of our standards of care across the Trust.

Penny Venables

Chief Executive

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Section 2

The progress the Trust made in achieving its four priorities for improvement during 2012/13 is described in section 3.

2.1 Priorities for improvement for 2013/14

Following analysis of its performance during 2012-13, and particularly in the outcomes areas captured in the new National Quality Dashboard (NQD), the Trust has identified five key improvement priorities where a particular focus is required to drive further improvement in 2013-14. These plans will enable the Trust to close the gap between its own performance in these particular areas with that of the top performing Trusts, learning from the best practice in those Trusts where appropriate.

Patient Safety

Reduce the incidence of C. Difficile and MRSA	
Why is this a priority?	• Analysis from the Trust's performance dashboard and the Midlands and East Quality Observatory Acute Trust Quality Dashboard shows that for C.Difficile the Trust is a significant outlier both locally and nationally. • The Trust's Integrated Governance Committee has had a priority focus on C.Difficile throughout 2012-13 when the Trust also participated in an external Local Health Economy review of C.Difficile.
Measures:	• Number of C. Difficile cases • Number of MRSA blood stream infections
Targets:	• Reduce the incidence of C.Difficile ≤48 • Reduce the incidence of MRSA <1
Reporting route:	• Trust Infection Prevention & Control Committee,
Responsible Officer:	• Chief Nursing Officer

Improve the number of patients waiting less than 4 hours in A&E to more than 95%	
Why is this a priority?	• Despite good performance in the first 4 months of 2012-13, performance was subsequently affected by a 10% increase in emergency admissions, and significant Norovirus outbreaks. • At the end Feb 2013 the National Quality Dashboard showed an alert for the Trust and the Trust is an outlier locally.
Measures:	• % of patients waiting in A&E
Targets:	• Improve the number of patients waiting less than 4 hours in A&E to more than 95%)
Reporting route:	• Chief Operating Officer's Group
Responsible Officer:	• Chief Operating Officer

Clinical Effectiveness

Improve mortality in outlying specialties to the national average	
Why is this a priority?	• The Trust's overall mortality rate is within the expected range and the NQD shows that the Trust's performance is better than expected. • The Trust's long term ambition is to be in the top 25% of its peer group, however, and data shows it to be a significant outlier for coronary heart failure, renal and stroke, contributing to an overall Summary Hospital Mortality Index of 97 in Q2 2012-13. • Whilst performance has improved during 2012--13, the Trust plans to move further towards achieving its ambition by focussing plans for 2013-14 on the outlying specialities.
Measures:	• Summary Hospital Mortality Index (SHMI) • Hospital Standardised Mortality Ratio (HSMR)
Targets:	• Achieve a mortality ratio of 100 or less for each outlying specialty - coronary heart failure, renal and stroke
Reporting route:	• Executive Risk Management Committee
Responsible Officer:	• Chief Medical Officer

Improve outcomes and experience for patients with a fractured neck of femur through implementation of a new pathway	
Why is this a priority?	• Although the mortality rate for fractured neck of femur (hip) is good (SHMI 82 as at Q1 2012-13), the Trust's internal processes have highlighted that performance in line with best practice could be significantly improved.
Measures:	• % of patients taken to theatre following admission within 36hrs
Targets:	• 90% of patients taken to theatre within <36 hours of admission
Reporting route:	• Executive Risk Management Committee
Responsible Officer:	• Chief Operating Officer

Patient Experience

Improve outcomes and experience for patients with Stroke to achieve all stroke targets	
Why is this a priority?	• Performance against key stroke targets has continued to improve. At the end of the year, the direct admission rate to a stroke ward was 76.67% (target 70%). • The percentage of patients spending 90% of their time on a stroke ward had improved from 73.54 to 79.1% (target 80%) • TIA care had improved from 40.29 to 60.15% (target 60%). • In order to continue this improving trend, and in the light of the outlying SHMI for stroke, the Trust now plans the following actions for 2013/14. These have been informed by a local review of stroke services which drew on best practice from around the country.
Measures:	• % of patients directly admitted to stroke unit • % of patients spending 90% of their time on the stroke unit • % patients with TIA investigated & treated within 24hrs of first contact with a health professional
Targets:	• 70% or more of patients directly admitted to the stroke unit • 80% or more of patients spending 90% of their time on the stroke unit • 60% or more of patients with TIA investigated & treated within 24hrs of first contact with a health professional
Reporting route:	• Chief Operating Officer's Group
Responsible Officer:	• Chief Operating Officer

2.2 Goals agreed with commissioners – the CQUIN payment framework

A proportion of Worcestershire Acute Hospitals NHS Trust income in 2012/13 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.

We had 10 CQUIN targets agreed with our main Commissioners, NHS Worcestershire, in 2012/13. They covered one or more of the domains of quality as shown in the table below. Our performance against each Goal is given below:

			Quality Domain			
Goal Name	Goal Description	Achieved	Safety	Effectiveness	Patient Experience	Innovation
Venous-Thromboembolism (VTE) Prevention	To reduce avoidable death, disability and chronic ill-health from Venous-Thromboembolism (VTE).	Fully Achieved	Yes			
Patient Experience	National Inpatient Survey: Improve responsiveness to personal needs of patients and Real-time feedback.	Partially Achieved			Yes	
Dementia	Improve awareness and diagnosis of dementia, using risk assessment, in an acute hospital setting.	Partially Achieved		Yes	Yes	
NHS Safety Thermometer	Improve collection of data in relation to pressure ulcers, falls, urinary tract infection in those with a catheter, and VTE.	Fully Achieved	Yes			
Making Every Contact Count (MECC)	Making every patient contact count through systematic healthy lifestyle advice delivered through front line staff.	Partially Achieved		Yes		Yes
Improving Palliative Care	Improved support for palliative care patients at the end of life.	Fully Achieved		Yes	Yes	Yes
Safe Care	Reduction in harm to patients as part of the Safe Care programme.	Partially Achieved	Yes			
Stroke Care	Increasing the timely assessment of swallowing in Stroke patients.	Partially Achieved				
Safe Discharge	Improving communication between secondary and primary care at time of discharge.	Partially Achieved	Yes	Yes	Yes	
Medicines Management	Improvement in self-assessment audit score for antimicrobials using the University of Hospitals of South Manchester Hospital antimicrobial self assessment tool.	Fully Achieved				

We had 7 CQUIN targets agreed with our Specialised Commissioners in 2012/13. Our performance against each goal is given below:

			Quality Domain			
Goal Name	Goal Description	Achieved	Safety	Effectiveness	Patient Experience	Innovation
Venous-Thromboembolism (VTE) Prevention	To reduce avoidable death, disability and chronic ill-health from Venous-Thromboembolism (VTE).	Fully Achieved	Yes			
Patient Experience	**National Inpatient Survey:** Improve responsiveness to personal needs of patients and Real-time feedback.	Partially Achieved			Yes	
Dementia	Improve awareness and diagnosis of dementia, using risk assessment, in an acute hospital setting.	Partially Achieved	Yes	Yes	Yes	
NHS Safety Thermometer	Improve collection of data in relation to pressure ulcers, falls, urinary tract infection in those with a catheter, and VTE.	Fully Achieved	Yes			
Implementation of Clinical Dashboards for Specialised Services	Ensuring that Providers implement and routinely use the required clinical dashboards for specialised services.	Fully Achieved	Yes	Yes		Yes
(Neonatal) Increase Effectiveness of Hypothermia Treatment	Increase effectiveness of hypothermia treatment.	Fully Achieved	Yes	Yes		
(Neonatal) Discharge Planning/Family Experience and Confidence	Improvement in timely discharge pathway.	Fully Achieved	Yes	Yes		

The following 2013/14 CQUINs have been agreed with our 3 Clinical Commissioning Groups (CCGs), NHS Redditch and Bromsgrove, NHS South Worcestershire and NHS Wyre Forest:

		Quality Domain			
Goal Name	**Goal Description**	**Safety**	**Effectiveness**	**Patient Experience**	**Innovation**
Friends and Family Test	To improve the experience of patients in line with Domain 4 (Ensuring that people have a positive experience of care) of the NHS Outcomes Framework. The Friends and Family Test will provide timely, granular feedback from patients about their experience.			**Yes**	
NHS Safety Thermometer	Improve collection of data in relation to Pressure Ulcers, Falls and Urinary Tract Infection (UTI) in those with a Catheter.	**Yes**		**Yes**	
Dementia	To incentivise the identification of patients with dementia and other causes of cognitive impairment alongside their other medical conditions, to prompt appropriate referral and follow up after they leave hospital and to ensure that hospitals deliver high quality care to people with dementia and support their carers			**Yes**	
Venous-Thromboembolism (VTE) Prevention	To reduce avoidable death, disability and chronic ill health from Venous Thromboembolism (VTE).	**Yes**			
Improving Palliative Care (AMBER: Assessment, **M**anagement, **B**est practice, **E**ngagement of individuals and carers, for people whose **R**ecovery is uncertain.)	Expansion of AMBER bundle: Amber Care Bundle makes it easier for medical and nursing staff to have future planning conversations with patients whose recovery is uncertain thereby enhancing the patient experience and care of patients with palliative care needs. It allows the patient to be involved in decisions about their care and where they want to die.		**Yes**	**Yes**	
Improving Patient Flow	To improve the flow of patients through the health system, improving patient experience and provider performance. Improving patient flow is recognised as critical to increasing patient safety by supporting the patient to receive the right care, in the right place at the right time.		**Yes**	**Yes**	
Management of Long-term Conditions	Improved discharge for COPD (Chronic Obstructive Pulmonary Disease) patients. All patients admitted with a COPD exacerbation should have the COPD care bundle commenced within 24 hours. All patients admitted with a COPD exacerbation should be discharged with a completed COPD care bundle.		**Yes**		
Safe Care	Reducing falls in all adult Inpatient areas including the Accident and Emergency (A&E) Department.	**Yes**		**Yes**	
Improving Health Outcomes for Teenage Mothers and Babies	Improving health outcomes for Teenage Mothers and their babies through a tailor made pilot programme.		**Yes**	**Yes**	**Yes**
Medicines Management	Appropriate antimicrobial stewardship is an important contributor to reducing healthcare-associated infections. Robust systems are required to provide appropriate levels of antimicrobial stewardship.	**Yes**	**Yes**		
Quality	Creating a climate of Quality and Patient Safety through facilitated reflection and understanding on the patient safety culture of the organisation/team or staff group.	**Yes**	**Yes**	**Yes**	

Our Specialist Commissioners, West Midlands Specialised Commissioning Group has agreed the following 6 CQUINS:

		Quality Domain			
Goal Name	**Goal Description**	**Safety**	**Effectiveness**	**Patient Experience**	**Innovation**
Friends and Family Test	To improve the experience of patients in line with Domain 4 (Ensuring that people have a positive experience of care) of the NHS Outcomes Framework. The Friends and Family Test will provide timely, granular feedback from patients about their experience.			**Yes**	
NHS Safety Thermometer	Improve collection of data in relation to Pressure Ulcers, Falls and Urinary Tract Infection (UTI) in those with a Catheter.	**Yes**		**Yes**	
Dementia	To incentivise the identification of patients with dementia and other causes of cognitive impairment alongside their other medical conditions, to prompt appropriate referral and follow up after they leave hospital and to ensure that hospitals deliver high quality care to people with dementia and support their carers			**Yes**	
Venous-Thromboembolism (VTE) Prevention	To reduce avoidable death, disability and chronic ill health from Venous Thromboembolism (VTE).	**Yes**			
Quality Dashboards	Demonstration of the use of dashboards in the monitoring and improvement of quality.	**Yes**	**Yes**		
Neonatal Intensive Care (NIC) Services	Inline with the Prescribed Services Specialised CQUIN Menu.	**Yes**	**Yes**		

Further details of the agreed goals for 2012/13 and for the following 12 month period are available on request from the Director of Finance.

Section 3

3.1 Review of Quality Performance

The Trust's Vision for Quality

The Trust's vision is to provide the highest quality standards and to be recognised as a provider of care which is clinically effective, focused entirely on the needs of patients and carers. We define quality as embracing the following three components:

- **Patient Safety** – there will be no avoidable harm to patients from the healthcare they receive, this means ensuring that the environment is clean and safe at all times and that harmful events are avoided.
- **Effectiveness of Care** – the most appropriate treatments, interventions, support and services will be provided at the right time to those patients who will benefit. Our patients will have healthcare outcomes which achieve those described in the NHS Outcomes Framework and NICE Quality standards.
- **Patient Experience** – patients will experience compassionate care and effective communication. Our staff will work in partnership with patients, relatives and their carers to achieve the best possible health outcomes.

The Trust has well established clinical governance processes to underpin the assurance of quality through the Quality Governance Framework and participation in relevant clinical audits.

Clinical Services Strategy

The Trust's Clinical Services Strategy supports the provision of high quality care across its services and aims to secure optimal levels of efficiency through redesign, better working practices and application of best clinical evidence but also include the reconfiguration of services to ensure clinical sustainability in line with exacting operating standards.

During 2012-13, the Trust conducted an extensive engagement process both with its own clinicians (at specialty level) and with clinical commissioners on preparing an ambitious, coherent and sustainable 5 -year clinical services strategy for 2013 – 2018.
The following key strategic themes emerged from this process:

- The need to ensure all specialties consistently provide services which are high quality, safe & offer outstanding patient experience;
- The need to overcome medical workforce challenges in delivering 24/7 specialist care;
- The need to ensure services have the right capacity to meet future demand;
- The opportunity to grow particular services (in response to increasing demand, by repatriating out of county services and through developing new outreach services);
- The opportunity to develop Centres of Excellence in key specialties;
- The challenge to improve clinical productivity and efficiency;
- The desire to respond to stakeholder and public demands to keep services as locally accessible as possible whilst also ensuring that patients with more complex needs gain access to the right specialist expertise 24/7;
- The need to ensure critical clinical adjacencies are secured, and;
- The need to establish a clinically sustainable configuration of services in a way which supports all the other key strategic themes.

Taking these key themes into account a clinical services strategy and model for reconfiguration has been outlined with local commissioners for acute services on the existing three sites.

This work was submitted to the Worcestershire Clinical Senate in March 2013 and has been endorsed as clinically sustainable prior to an external review by the National Clinical Advisory Team.

At the heart of the model of care are three main service changes as follows:

1. Centralisation of In-Patient Paediatric Services onto the WRH site with local Paediatric Assessment Unit services at both the WRH and Alexandra sites
2. Centralisation of Consultant Obstetric Services onto the WRH with an adjacent midwifery led unit and a standalone midwifery led unit in the Redditch locality
3. A major Emergency Department at the WRH site and a networked Emergency Unit at the Alexandra site.

The strategic service changes proposed will need to go to formal public consultation prior to any final approval. Engagement work has been undertaken during 2012 and will continue in 2013 to help the public understand the case for change and why these changes are appropriate and necessary in meeting that case for change going forward.

Maintaining Quality and Safety

The National Quality Dashboard is now in place and we will regularly monitor this and report the benchmarked information to our Public Trust Board meetings following analysis within internal quality governance processes.

In order to ensure that cost improvement programmes do not adversely impact on the quality of patient care, there is a quality governance framework in place as part of the Trust's QIPP Programme Management Office. For each internal Quality Improvement or Cost Improvement Plan (QIPP/CIP) scheme a Quality Impact Assessment (QIA) is prepared with clinical approval. The Chief Medical Officer, Chief Nursing Officer and Medical Director for Patient Safety undertake a monthly review of Quality impact Assessments (QIAs), and review those schemes previously identified with a level of risk. The Chief Medical Officer / Chief Nursing Officer report will be formally reported to the Board.

Quality Strategy

A Quality Strategy is currently being developed to set out the Trust's approach to delivering continuous quality improvement and our key priorities for the next five years. It builds on the existing processes and developments to date, and considers the further developments needed to drive the improvements, including the supporting structures and reporting mechanisms. This will drive clinical governance processes and align them with the new operational structure.

The Trust's response to the 'Francis Report'.

The 'Francis Report' published in February 2013, has set out wide ranging recommendations for improvement for every part of the NHS System. The report is complex and has 290 recommendations. The Trust is considering the findings and recommendations and how to apply them to our work. We take these very seriously and a comprehensive assessment is being undertaken. An initial evaluation has been completed and some work has been

incorporated into the plan as far as is possible. Further revision of the plan will be agreed at a later stage.

Following the publication of the Francis Inquiry Report, the Trust will continue to talk to staff across the Trust about the NHS Constitution, its principles, core values, rights, responsibilities and pledges. Within this our PRIDE values (Patents; Respect; Involvement; Delivery; Efficiency) will be reviewed with our staff. Our aim is to ensure that the NHS Constitution is central to our work and that our values are co-produced with our staff and lived out every day across the organisation.

The Trust has reviewed its approach to listening to its staff and taken into account the Francis Inquiry recommendations. From 2013/14 we will ensure greater levels of engagement with staff across the organisation. We will hold a wider range of staff engagement sessions and 'team briefs' promoting openness, transparency and candour. We will debate the NHS Constitution and NHS Values through a staff development programme and via recruitment, induction, training and appraisal.

3.1.1 Performance against national targets

The Department of Health require trusts to report a selection of quality indicators in their Quality Accounts. These are provided in section 4.6. A table showing our performance against all national targets is also provided in section 4.6

The Trust Performance Dashboard

In 2012/13 we have developed an improved dashboard that shows our performance against a set of quality, financial, workforce and other indicators which is used across the Trust and reported to every public Board meeting. This allows us to clearly see where we are achieving our objectives and targets and provides an early warning of where we are not, helping us to see where we need to take action. The dashboard has been successfully used to track our progress in achieving our quality improvement priorities for the year. It is continually evolving and being refined to meet our needs.

Ward dashboard

The Nursing quality dashboard enables ward level performance to be reviewed in a number of ways. It provides an early warning of emerging concerns for wards and also allows us to recognise the well performing areas. Any wards that reach a specified number of alerts become an 'alerting ward' which prompts a review of the ward team by the matron. If a ward is an 'alerting ward' twice, the Head of Nursing offers support and advice and should any ward 'alert' three times or greater the Chief Nursing Officer intervenes. This is an opportunity to seek assurance that actions are effective and assistance to unblock challenges are offered.

A Nursing Intensive Support Team (NIST) is instigated to help rescue a falling clinical area when the need arises. This team is comprised of senior nursing staff with additional specialist support.

The impact of the nursing quality dashboard has been this ability to clearly observe ward performance and offer early responsive support and advice. The dashboard has some recognised limitations and the Information Team are assisting with its further development and refinement.

3.1.2 Patient Safety

The Trust had one improvement priority for patient safety during 2012/13 with a supporting set of targets. This is how we did:

Patient Safety	
1. Address unwarranted clinical variation	Partly Met

The Trust achieved the following improvements in 2012/13:

- 90% reduction in hospital acquired pressure ulcers (target 100% reduction in grade 2, 3 & 4)
- Mortality rate reduced: Summary Hospital-level Mortality Indicator (SHMI) of 96.7 (target below 100).
- 70% patients aged 75+ had an Abbreviated Mental Test (AMT) assessment completed, 83% of those with a score <7 receive a care plan (targets 45% & 75% respectively)
- 94% use of Patient at Risk Score (PARS) & appropriate escalation (target 95%)
- 95% patients received Venous-thromboembolism (VTE) assessment (target 95%)
- 100% compliance with the WHO Safer Surgery Checklist
- 20% reduction in falls resulting in serious harm (target 35%)
- There was no significant change in the rate of medication errors and further work is planned during 2013/14

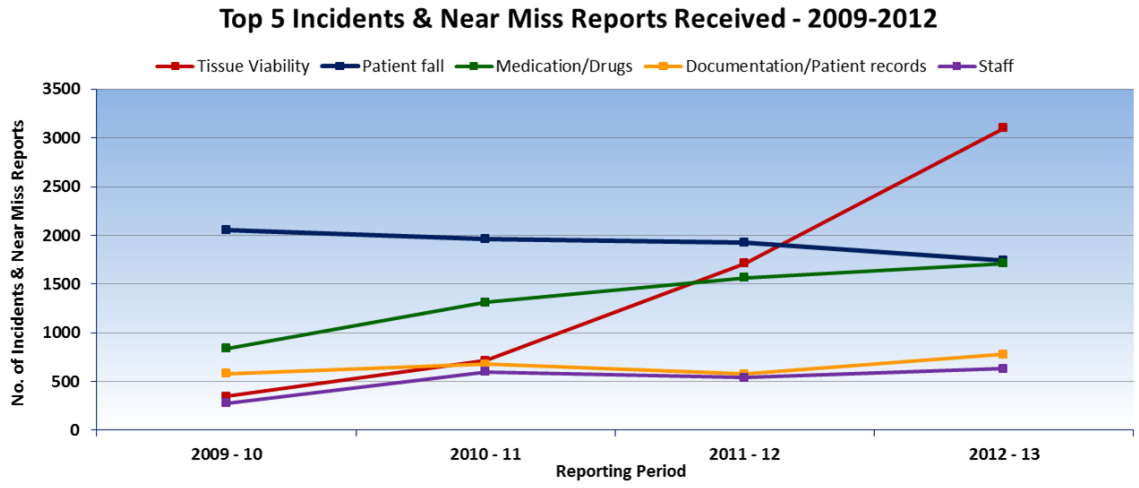
Incidents, serious incidents, never events and lessons learnt:

Incident reporting

The reporting of incidents is an essential ingredient for an open, learning culture that helps us to find out what went wrong during a patient's care and work to prevent it from happening again. Incident reporting is actively encouraged and we have a good reporting culture. When compared to similar trusts we are in the top 25% of reporters.

We have seen year on year increases in the reporting of incidents accidents and near-miss events with 11,277 incidents and near misses reported compared with 9,384 in 2011/12, a 20% increase.

The top 5 categories of patient safety incidents reported remains unchanged when comparing 2012/13 with the previous year although the order in which they appear has slightly changed with pressure ulcers (Tissue Viability) becoming the most reported incident category following the programme to reduce hospital acquired pressure ulcers to zero and increased awareness of the need to report them.

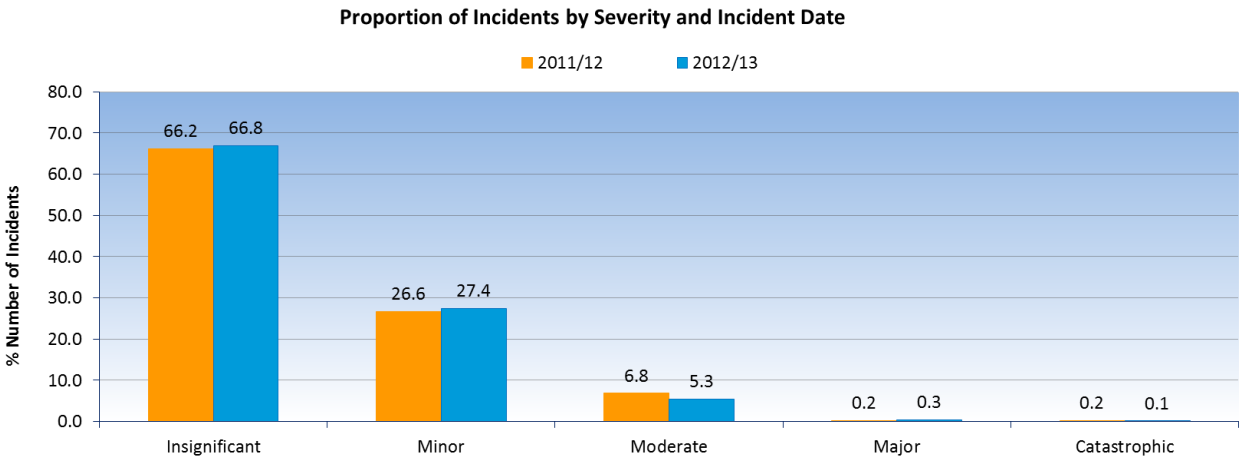


The majority of Tissue Viability incidents are reported within the subcategory of *'admitted with pressure damage'*, i.e. patients admitted from the community with pre-existing pressure ulcers. An increased number (and percentage) of Tissue Viability incidents are moisture lesions as the Tissue Viability Team are more active in reviewing pressure areas and re-categorising such. All grade 3 and 4 pressure ulcers acquired within our care continue to be reported and investigated as serious incidents.

A downwards trend in the total number of patient falls is encouraging. Medication and drug related incidents have increased with 55% being incidents, 45% near misses but with 98.5% of all reports recording insignificant or minor harm.

The overall severity of harm reported has remained similar to 2011/12 with 94% of incidents reported resulting in insignificant or minor harm.

	2011/12		2012/13	
Severity	Number	%	Number	%
Insignificant	6215	66.2	7538	66.8
Minor	2492	26.6	3088	27.4
Moderate	642	6.8	603	5.3
Major	20	0.2	39	0.3
Catastrophic	15	0.2	9	0.1
Totals	9384	100.0	11277	100.0



Serious incidents (SI)

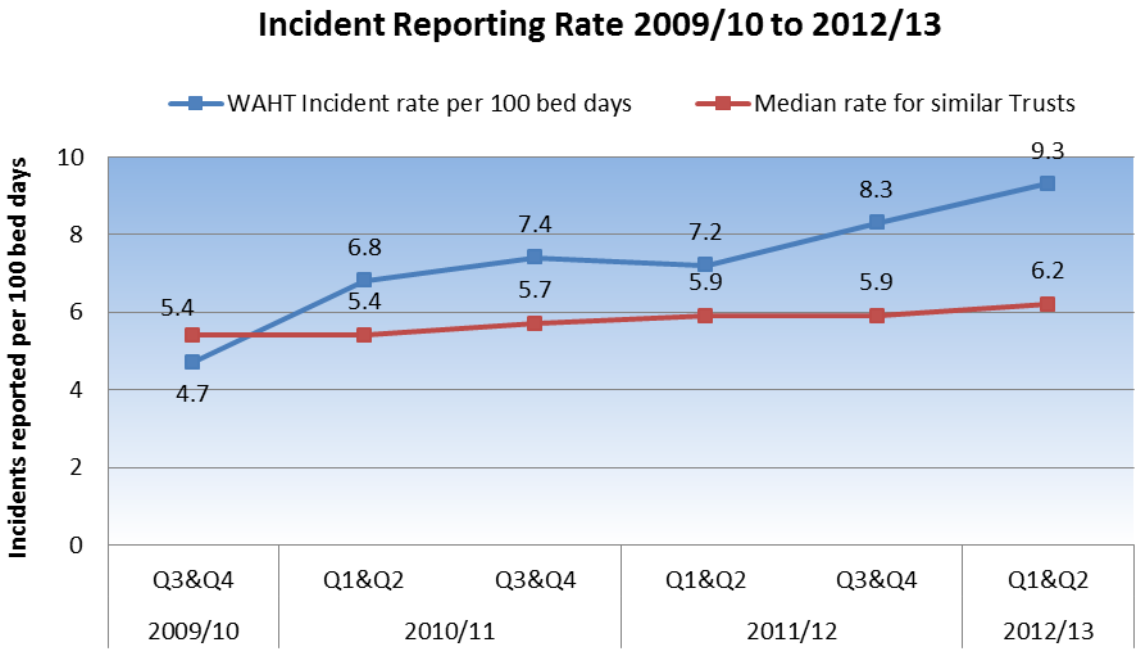
Serious incidents are defined in a policy provided by our former Strategic Health Authority and Commissioners and include some non-clinical incidents and incidents. They are not a direct measure of serious harm or death as a result of incidents. The Health & Social Care Information Centre receives information exported directly from the Trust's incident reporting system to the National Reporting & Learning System (NRLS) which does provide this measure.

- We reported 162 serious incidents (SIs) during 2013/14 compared with 150 during 2011/12.
- The National Reporting & Learning System (NRLS) data for the first six months of the year (the latest available) shows that:
    - 12 incidents resulted in serious harm (10) or death (2), 0.2% of all incidents reported
    - The rate of all incidents reported is 9.3 per 100 bed days

The National Reporting and Learning Service say that *"Organisations that report more incidents usually have a better and more effective safety culture. You can't learn and improve if you don't know what the problems are."*

Our reporting rate has improved from below the mean in 2009/10 to be in the top 25% reporters when compared with similar Trusts:

	2009/10 Q3&Q4	2010/11 Q1&Q2	2010/11 Q3&Q4	2011/12 Q1&Q2	2011/12 Q3&Q4	2012/13 Q1&Q2
Incident rate per 100 Bed Days	4.7	6.8	7.4	7.2	8.3	9.3
Median rate for similar Trusts	5.4	5.4	5.7	5.9	5.9	6.2



The top 5 categories of serious incidents reported were:

Category	11/12	12/13
Tissue Viability	48	57
Patient fall	35	35
Infection Control	20	23
Obstetric speciality specific	13	14
Treatment	13	11

The increase in serious incidents reported within the category of tissue viability coincides with the awareness programme and mandatory reporting of all avoidable grade 3 and 4 pressure ulcers developed while under the care of an Acute Trust.

All serious incidents are investigated by assigned leads and supporting staff. The reports are reviewed at a Trust level committee (The Patient Safety Committee, the Trust Infection Prevention and Control Committee and the Skin Matters Group) to ensure that the

investigation was adequate, root causes and contributory factors have been identified and that the recommendations can be turned into actions to reduce the likelihood of the incident recurring. Learning from specific incidents is applied locally but also shared with areas that undertake similar work so that learning is shared.

Never Events

Never events are defined as serious, largely preventable patient safety incidents that should not occur if the available preventative measures had been implemented. We have reported two never events in 2012/13.

- Wrong implant / prosthesis - Ophthalmology – an incorrect lens was used during cataract surgery.
- Retained foreign object post-operation – an implant was retained during knee ligament repair surgery

Actions taken – each of the incidents required another surgical procedure to correct but resulted in no long term harm to the patients.

Each incident was robustly investigated and the root causes identified. The (World health Authority) WHO safer surgery checklist had been used in each instance.

- Ophthalmology have changed their system for recording and checking which lens is required for the patient and have implemented it across the Trust.
- Reinforce the required practice of locating the missing object before the patient leaves the operating theatre by the use of x-rays if necessary.
- The WHO checklist continues to be reviewed for its effectiveness and this is again an key objective for 2012/13

Near miss never events:

In line with the national framework guidance we will be formalising our existing never event near miss reporting process.

Lessons learnt from incidents

We learn from incidents and near misses in three ways:

- By investigating serious incidents to find the root causes, developing solutions for those causes and then implementing them where the incident occurred and more widely if required. This helps to reduce the likelihood of a similar incident reoccurring. Key messages on preventing recurrence are extracted from the Serious Incident reports and communicated to front line staff in a number of ways such as through medicines safety bulletins.
- By tracking which incidents happen and where. Knowing this helps us to target wards, departments and systems that are generating errors and near misses and understand why they are happening. Ward dashboards record incidents for falls and pressure ulcers and trigger interventions from senior staff.
- By triangulating different information from incidents, complaints, claims, audits and other sources to see if there are any common themes or causes.

Some of the improvements made, in addition to those undertaken for inpatient falls and pressure ulcers, are:

- Changes to the Ophthalmology record keeping processes to ensure that the latest test results are presented to the clinician when a patient attends for treatment
- Changes to prescription charts to ensure that antibiotics are prescribed as the policy dictates

- Including neurological observations in the care of patients with delirium or dementia who have fallen
- A new referral pathway for patients presenting with symptoms of TIA
- Providing links between different IT systems to improve communication of test results to the Emergency Department

Duty of Candour

From 1 April 2013 the new standard NHS contract will require all NHS and non-NHS providers of services to NHS patients to comply with the duty of candour.

If a 'reportable patient safety incident occurs or is suspected to have occurred' all providers must provide to the 'service user and any other relevant person all necessary support and all relevant information in relation to that incident.' As soon as practicable after becoming aware of the incident, or that an incident might have occurred, the provider must conduct an investigation and also notify the 'relevant person'. All this must be done within ten days.

The Trust plans to implement the Duty of Candour by reviewing and amending its current policies for clinical governance, 'Being Open' and complaints to incorporate the duty into practice. Education programmes will be reviewed to reflect the changes develop a culture of openness and transparency.

Monitoring of, and learning from, Serious Incidents and Never Events are made public via Board papers through reports by the Chief Medical Officer and the Integrated Governance Committee.

Safety Thermometer

The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing the prevalence of patient harms and 'harm free' care. The NHS Safety Thermometer provides a quick and simple method for surveying patient harms on one day per month and analysing results so that organisations can measure and monitor local improvement and harm free care over time.

Worcestershire Acute Hospitals NHS Trust has been involved in data collection within all inpatient clinical areas (exclusions apply as per the national guidance) from March 2012 and collected data of the following harms: falls, pressure ulcers, catheter associated urinary tract infections and venous thromboembolisms (VTEs).

The data is submitted monthly to the NHS Information Centre and more information, including the data quality reports, can be accessed on the following website: http://www.ic.nhs.uk/thermometer .

In addition, regional strategic health authorities produce regional reports that are then shared with organisations. However, data comparison should be undertaken with caution due to the differences in service provision and patient profiles at each organisation.

Achievements:

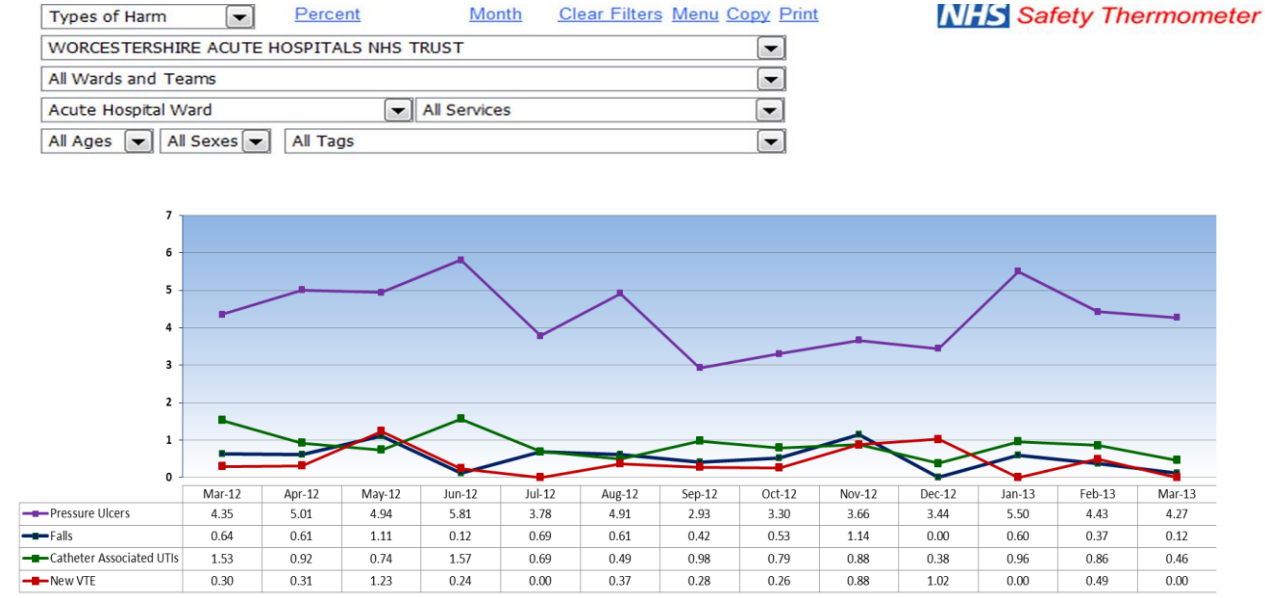
Harm Free Care:
The target for achieving harm free care is 95% each month. The following represents monthly results for the Trust:

	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
Number of Harm Free Event	730	912	749	763	830	766	683	722	741	749	777	763	826
Number of Surveys	782	978	810	826	873	815	716	758	792	786	836	813	867
% Harm Free Care	93.35%	93.25%	92.47%	92.37%	95.07%	93.99%	95.39%	95.25%	93.56%	95.29%	92.94%	93.85%	95.27%
Target	>=95%	>=95%	>=95%	>=95%	>=95%	>=95%	>=95%	>=95%	>=95%	>=95%	>=95%	>=95%	>=95%

In the months marked as red we did not achieve the target of 95% harm free care, but the score is a combination of 4 harms: pressure ulcer, falls, VTEs and catheter associated Urinary Tract Infections (UTIs).

Pressure ulcers were the highest contributing factor, although the majority were patients admitted with existing pressure ulcers or developed it within 72 hours of admission.

Types of Harm:



	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
Pressure Ulcers	4.35	5.01	4.94	5.81	3.78	4.91	2.93	3.30	3.66	3.44	5.50	4.43	4.27
Falls	0.64	0.61	1.11	0.12	0.69	0.61	0.42	0.53	1.14	0.00	0.60	0.37	0.12
Catheter Associated UTIs	1.53	0.92	0.74	1.57	0.69	0.49	0.98	0.79	0.88	0.38	0.96	0.86	0.46
New VTE	0.30	0.31	1.23	0.24	0.00	0.37	0.28	0.26	0.88	1.02	0.00	0.49	0.00

The Safety Thermometer data has provided valuable prevalence data that has been used in conjunction with the incidence data to support the following patient safety and quality improvements initiatives:

- Falls (reported below)
- Pressure Ulcers (reported below)
- Catheter Associated UTIs
- VTEs

Future Plans:
As part of the CQUIN agreed with our commissioners, the Trust will continue to collect data through the Safety Thermometer on the following harms: falls, pressure ulcers and catheter associated UTIs and measure and monitor local improvements and harm free care over time.

Reducing patient falls in hospital

The incidence of patient falls is a key indicator of the quality of nursing care. Worcestershire Acute NHS Trust is committed to reducing and preventing inpatient falls. A CQUIN was in place with a target to reduce the falls that resulted in serious harm by 35% in the financial year.

35 patients suffered serious harm as a result of a fall in hospital in this financial year, a 20% reduction from the 44 serious injuries in 2011/12.

What we have done in 2012/13 to reduce patient falls:

In November 2012 we launched a Falls Prevention and Reduction Initiative to reduce and prevent adult inpatient falls and improve patient care and experience with the ambition of achieving a 15% reduction in adult in-patient falls by January 2014. This initiative builds on existing practice and continues to be embedded across the Trust and we saw a decrease in the total number of falls reported in January and February.

Next steps

The Falls Prevention and Reduction Delivery Team and the Steering group will continue to drive improvements and monitor compliance across the Trust through the actions describe below.

National policy:
The Falls Prevention and Reduction Delivery Team and the Steering group will continue to implement all appropriate “Fallsafe” care bundles across the adult inpatient areas in the Trust.

Performance:
The weekly success measures audits will continue to be undertaken in all adult inpatient areas and the Falls Prevention and Reduction Delivery Team and the Steering group will continue to monitor performance through a CQUIN agreed for 2013/14.

Education:
In addition to the Falls Rapid Spread training and competency assessments of registered nurses and non-registered nursing staff, all registered nurses, operating department practitioners, physiotherapists and occupational therapists are required to complete the Royal College of Physicians Fallsafe e-learning module. A clear plan on how the target of ensuring that 80% of staff completed the Fallsafe e-learning module will be developed. In relation to medical staff, a development of a bespoke e-learning module is currently being considered.

Equipment:
The Falls Prevention and Reduction Delivery Team has scoped whether sufficient supply of Arjo Sara Stedys (walking aids) exists across the Trust and the scoping exercise revealed that 13 additional Stedys are required. In addition, the Delivery Team has also identified TABS® mobility monitors, which consist of bed and chair pads connected to a wireless pager that can notify nurses of the high risk of falls patients who are attempting to mobilise. The product is due to be trialled in three clinical areas in the summer of this financial year. Funding is currently being sought to purchase additional Arjo Sara Stedys and potential funding options are being explored to fund the purchase of TABS mobility monitor packs should the trial be successful.

Pressure Ulcer Prevention (PUP)

Avoidable pressure ulcers are another key indicator of the quality of nursing care. The NHS Midlands and East SHA ambition to achieve Zero avoidable pressure ulcers by December 2012 became the number one priority objective for WAHT for 2012/13.

What we have done in 2012/13 to reduce pressure ulcers

To assist delivery of this ambition a Rapid Spread Action Tool Model was implemented. This successful approach enabled significant reduction in avoidable pressure ulcers (PU) and patient harms. Zero category 3 and 4 pressure ulcers were reported in November and December 2012.

Management approach

The rapid spread action tool model encompasses a process of winning hearts and minds, mobilising staff to a common goal, implementing large scale change and removing barriers to change at a very fast systematic pace.

The full support of Trust and Management boards was key to success. A multidisciplinary "Delivery" Team was developed which utilised the skills and authority of Chief, Deputy and Heads of Nursing, Tissue Viability Team, Matrons, Therapist. Improved reporting was essential and achieved by developing processes within the patient safety team and Informatics dept. The Communications team and a framework for education and training for all staff was integral to success.

Outcomes

The number of avoidable pressure ulcers has significantly reduced and 3 only were reported for Nov and Dec 2012 – zero category 3 and 4's. However 13 were reported between January and March 2013.

The SSKIN bundle (a five step model for pressure ulcer prevention) has been incorporated within the intentional rounding – Care and Comfort rounds, improved user-friendly documentation, patient information, different ways of working, and time frames regarding baseline skin assessment and equipment provision have been enhanced.

A robust process of reporting and monitoring has been developed, any patient that now develops a Category 2,3 or 4 pressure ulcer must have a root cause analysis completed – the ward manager interviewed, by the TV Lead Nurse and either Head of Nursing or Deputy Chief Nurse and action plans developed.

Conclusions

Different ways of working have been embedded across the Trust, the challenge now is sustainability – this process has been enhanced by utilising innovations within the Change Champions programme and Pressure Ulcer Collaborative programme

Weekly Pressure Ulcer Prevention (PUP) sustainability audits take place and areas that don't achieve the standards set, are monitored and action plans put in place.

Next steps - In 2013/14 we will:

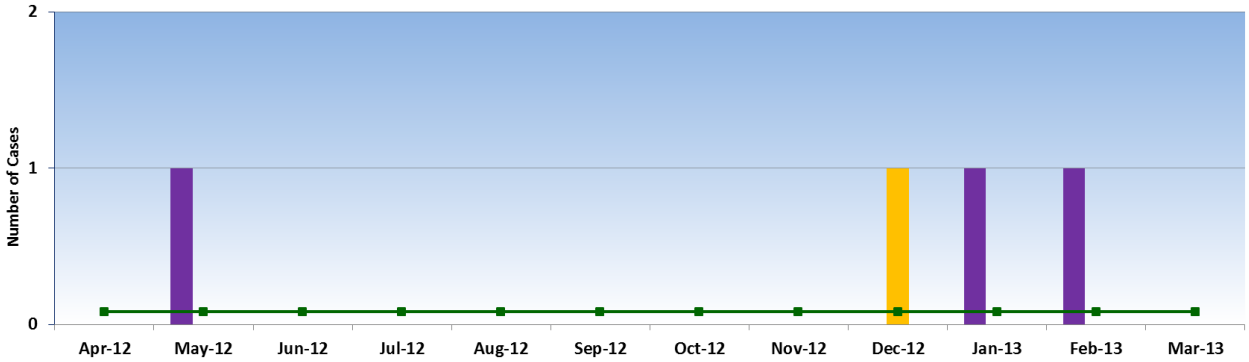
- Re-energise PUP actions
- Focus on preventing heel PUs especially if related to wearing of anti- embolic stockings or hosiery
- Purchase of heel "off-loading" devices
- Trend analysis of origins of PUs - develop action plans to prevent/change practice

- Target further education & training in "hot spot" areas
- Partnership with Worcestershire Health & Care NHS Trust
- Public campaign to raise awareness
- Launch of Transformation projects related to E learning & further mandatory competency training related to prevention of PUs
- Work with Worcestershire Health & Care NHS Trust to achieve CQUIN target

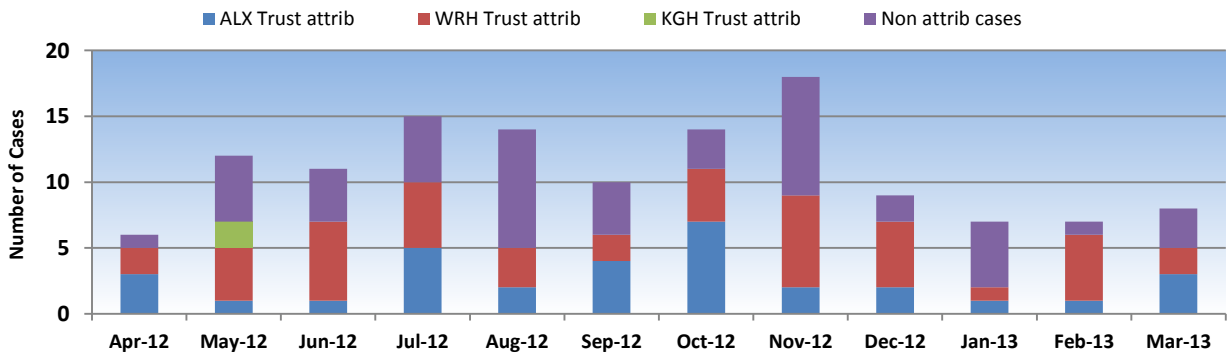
Infection prevention and control

The Trust has continued to work hard to meet nationally set targets for reduction in MRSA bloodstream (BSI) and *C difficile* infections(CDI), however it has not succeeded in remaining within the lower targets which were set for 2012/13 compared with 2011/12. There were 3 Trust-attributable MRSA BSI against a target of 2, and one non-attributed case, and 80 cases of CDI against a target of 52 (see figures below).

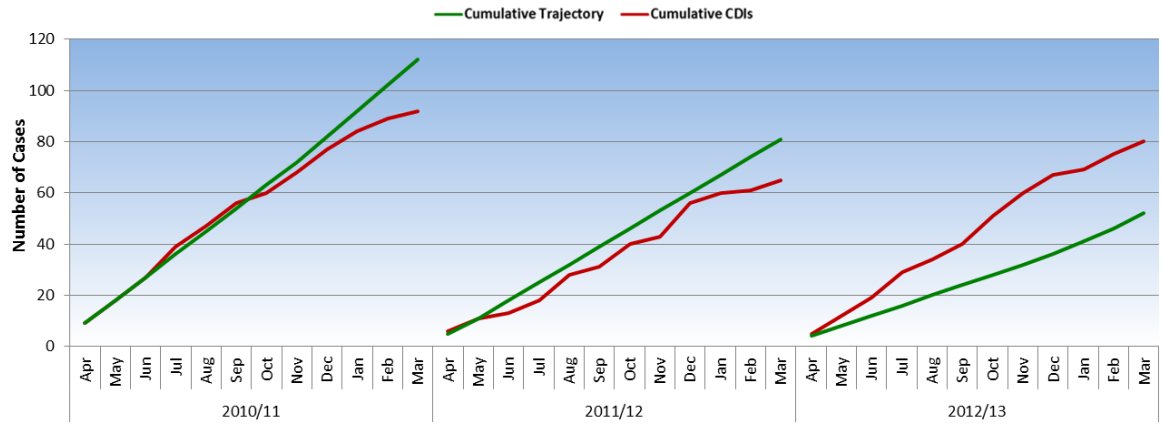
MRSA BSIs April 12 –Mar 13



CDI cases by location and Trust attribution April 12 – Mar 13



Progress against CDI trajectory compared with 2 previous years



However as a result of a number of actions, there was a considerable reduction in the number of cases reported for the 4th quarter of 2012/13 which it is hoped will be sustained into 2013/14 to meet the new target of no more than 48 cases. There are several factors which caused the increase in 2012/13. These include changes to the testing methodology, active case finding of patients with a diarrhoeal illness, and repeat testing on relapse of patients with previous documented infection.

The Trust has worked collaboratively with the local Health Economy to understand the factors contributing to CDI in Worcestershire patients (through detailed investigation of each case), and in partnership has developed and implemented further actions to reduce risk of infection. These include promoting and driving and delivering reductions in antibiotic usage (both in hospital and in the community), enhanced cleaning (including the use of Hydrogen Peroxide Vapour decontamination), provision of educational and other information on CDI for patients and staff, and re-enforcing personal infection prevention and control practice (including hand hygiene) for all staff through training and audit.

An external review of practice across the Worcestershire Health Economy (undertaken in January 2012) has acknowledged this collaborative inter-agency working and has endorsed the measures which have been taken to reduce CDI whilst encouraging further progress to achieve sustainable reductions.

The NHS Litigation Authority (NHS LA) Risk Management Standards

The NHS LA provides a risk pooling scheme for NHS Trusts, essentially and insurance scheme for clinical negligence claims. The scheme set out organisational and clinical standards for general and maternity services in England. Discounts on the contributions to the scheme are possible by attaining three levels of compliance with their Risk Management Standards with 3 being the highest.

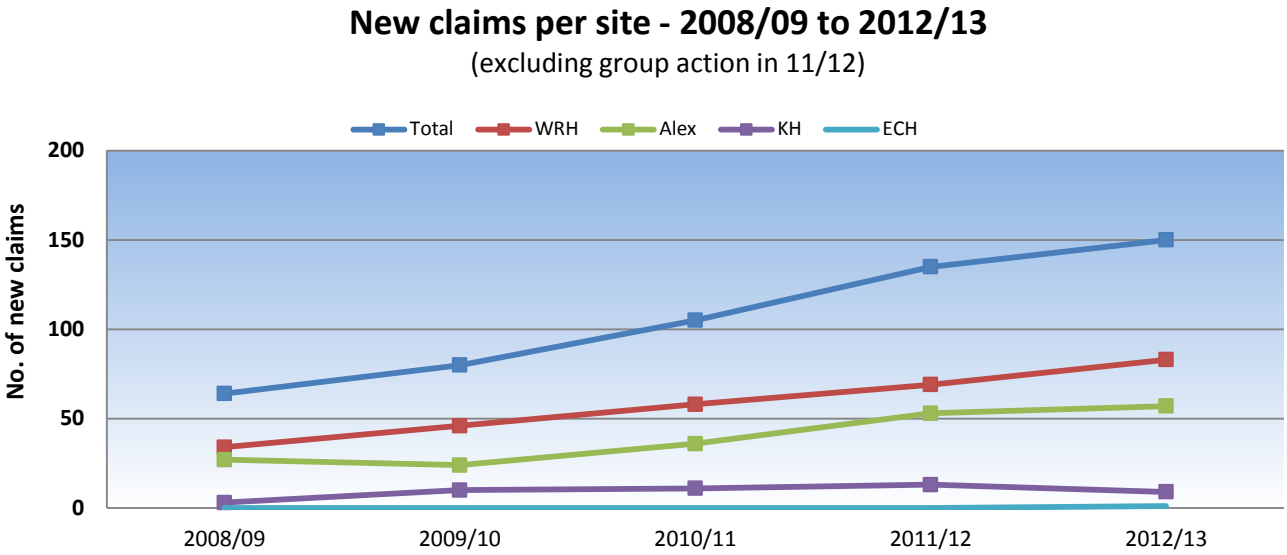
NHSLA – Acute Trust Standards
The Trust maintained Level 1 of the NHS Litigation Authority Risk Management Standards at an assessment in September 2012 with a score of 50 / 50

CNST – Maternity Standards
Maternity Services maintained Level 2 of the Clinical Negligence Scheme for Trusts with a score of 48 / 50. This is a considerable achievement as the risk management standards have revised since the previous assessment and become more difficult to achieve. Particularly pleasing was the feedback that the assessors were very impressed with the quality and depth of preparation for the assessment and the high quality of the documents presented for review it was evident that risk management systems were embedded across the whole of the maternity service.

How the Trust reports the level of claims against it

All clinical negligence claims made against the Trust are managed through the Legal Service Department and in accordance with the NHS LA scheme guidance. Claims are reviewed for themes and impact and are reported through the Trust's clinical governance structure to the Trust Board, with significant claims being taken directly to the Board.

In common with other NHS Trusts, we have seen an increase in the number of claims received. There has been a 10% increase in the last year but since 2008/09 the increase has been 130%.



A firm of solicitors organised a group action against the Trust following a critical CQC report in 2011. 38 claims from this group action were settled in 2012. These claims have not been included in the trend graph above.

The tables below show the details of claims received and settled for the last three years.

New claims by site:

	2010/11	2011/12 (excluding CQC)	2012/13
Alex	36	53	57
KH	11	13	9
WRH	58	69	83
ECH	0	0	1
Total	**105**	**135**	**150**

A significant number of claims are either withdrawn or not pursued by claimants following the disclosure of records. The figures for the last three years are given below and range from 46% to 76% of cases withdrawn.

Closed Claims per Site for the past three years

	2010/11		2011/12		2012/13	
Total	**68**		**96**		**98**	
	Settled	Withdrawn	Settled	Withdrawn	Settled	Withdrawn
	37	**31**	**30**	**66**	**24**	**74**
	54%	46%	31%	69%	24%	76

3.1.3 Clinical Effectiveness

The Trust had two improvement priorities for clinical effectiveness during 2012/13. This is how we did:

Stroke Services

Clinical Effectiveness	
2. We will provide appropriate treatment and care at the right time for patients who have had a stroke	Almost Met

The Trust achieved the following improvements during 2012/13:

- 79.1% of stroke patients spent 90% of their time in stroke ward (target 80%)
- 76% of patients with a confirmed stroke were admitted to a stroke unit within four hours of arrival at hospital (target 70%)
- 61% of high risk TIA patients were investigated and treated within 24 hours of first contact with a health professional (target 60%)

Very good progress has been made towards meeting the performance targets for delivering care to stroke patients this year. We missed achieving our improvement priority by less than 1%. We have been commissioned to deliver a centralised stroke service (with Hyper Acute stroke capacity) on the Worcester site and the improvements have been made in advance of this. The building of the SCDU (Surgical Clinical Decisions Unit) is now underway. This paves the way for the move to a centralized stroke unit at Worcestershire Royal Hospital.

Alongside this work, the pathway for stroke patients is being improved. There has been a strong focus upon timely access to the stroke unit, ensuring that patients moves within the Stroke unit are minimised and they spend 90% of their inpatient stay within the Stroke wards. Another area of focus has been the high risk TIA service. Here patients of a high risk score are seen within 24hours of referral and have a period of assessment to reduce the risk of having a Stroke. All of these areas have significantly improved their performance. Recognising that the next step is centralisation and then meeting the National specification for Stroke there is a realisation that the journey is on-going however the commitment and dedication to deliver the best Stroke care with improved outcomes for the residents of Worcestershire remains the focus of the Trust.

Emergency Access:

Clinical Effectiveness	
3. We will provide appropriate treatment and care to recognised national reporting standards for patients presenting to our hospitals as emergencies	Not met

The Trust achieved the following improvements during 2012/13:

- The Trust improved its performance against the A&E 4 hour access target for the 4 months July to October but was not able to sustain this across the winter months achieving 92.37% overall (target 95%).
- This was against a background of a 10% increase in emergency admissions and an unprecedented level of Norovirus outbreak.

This year has been a challenging one in which to deliver the emergency access standard. The trust delivered improvement of this standard for five consecutive months across all sites, achieving the standard in four months. The challenges have been many this year: poor

weather, snow and floods, reoccurrence of Norovirus and emergency attendances rising significantly resulting in extreme winter pressures have impacted adversely upon our ability to meet the access standard.

The trust has seen a rise in the level of severity of patients conditions (acuity) as well as a rise in the age range of patients, particularly in the over 75's. The whole of the health economy has seen a difficult winter and this has resulted in a lower than expected performance.

As a result of this pressure the local health economy is working together to develop more robust pathways that will deliver seamless care and moving towards a more integrated approach to ensure timely discharge to community beds or intermediate care provision enabling the patient to go home with support.

Whilst the Trust recognises that improvement has to be made in a sustainable way it is recognised that it is a local health economy response that is required hence its commitment to work with partner organisations to ensure that this is successful.

Patient Outcomes:

HMSR / SHMI – Mortality & Morbidity indicators

A process for the review of every avoidable death at Directorate level and includes carers where appropriate, has been established. There is an automatic review of every death in paediatrics, head & neck and obstetrics. In addition, the Medical Director for Patient Safety monitors mortality & morbidity data and initiates Directorate review where issues are identified.

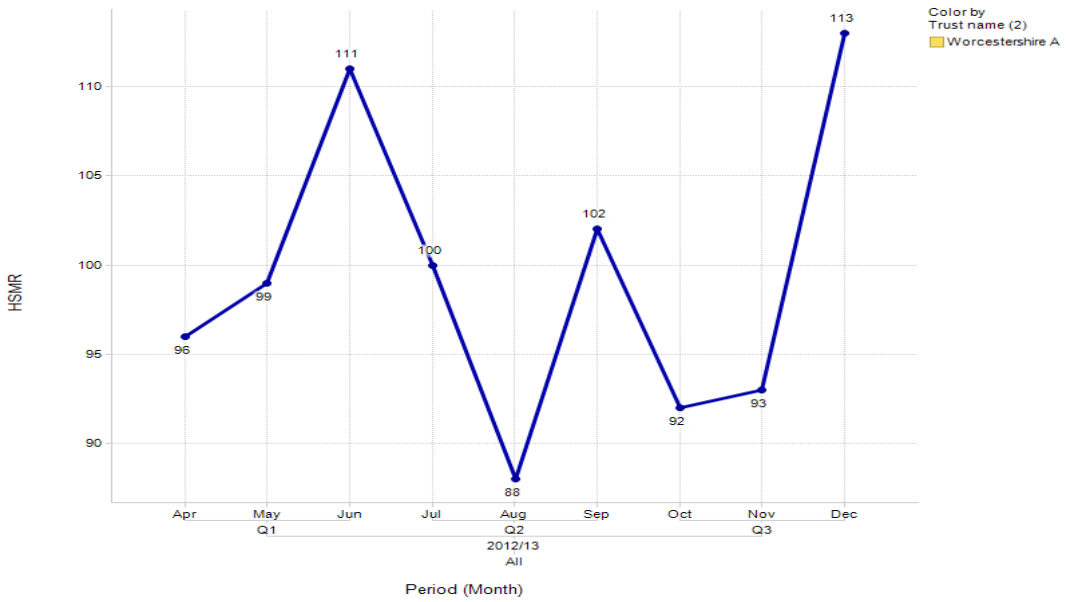
The Board receives mortality data via the Integrated Governance Committee (IGC). Any outlier data is subject to a disease specific audit. This approach has been associated with a progressive reduction in our published mortality data. The review outcomes will continue to be monitored through the Executive Risk management Committee (ERMC) and IGC and included in the IGC report to Trust Board.

Mortality relative risk

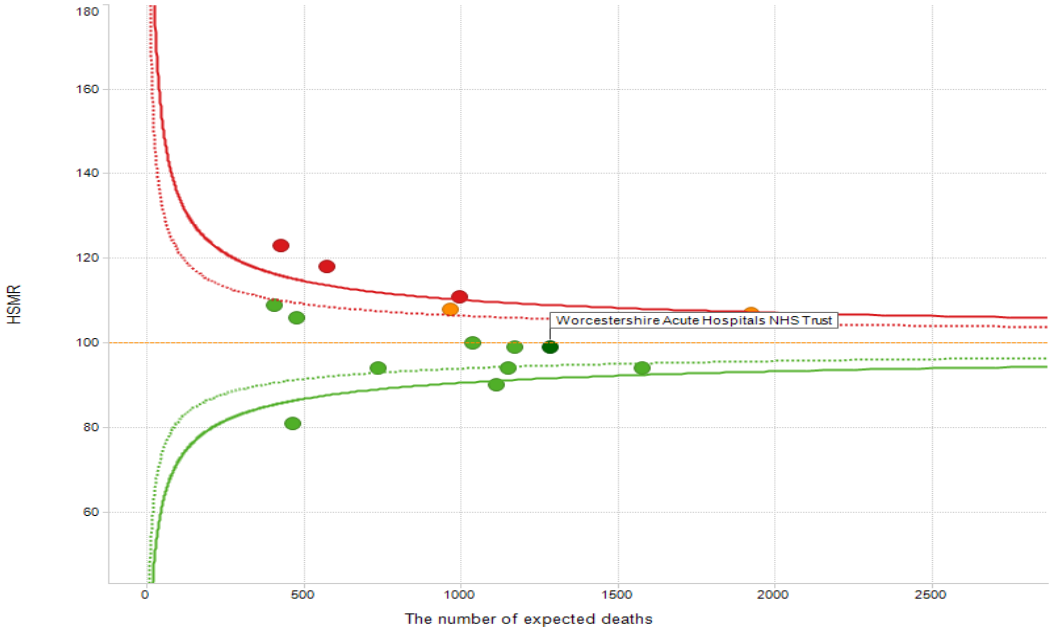
The Hospital Standardised Mortality Ratio (HSMR) gives an indication of the relative risk of death. Any values under 100 indicate a lower risk and over 100 a higher risk than expected.

The HSMR for April - December 2012 (rebased for 2012/13 and the latest available) was **99.0**.

The month on month figures for the financial year to December 2012 are provided in the graph below. The variation seen through the year is expected.



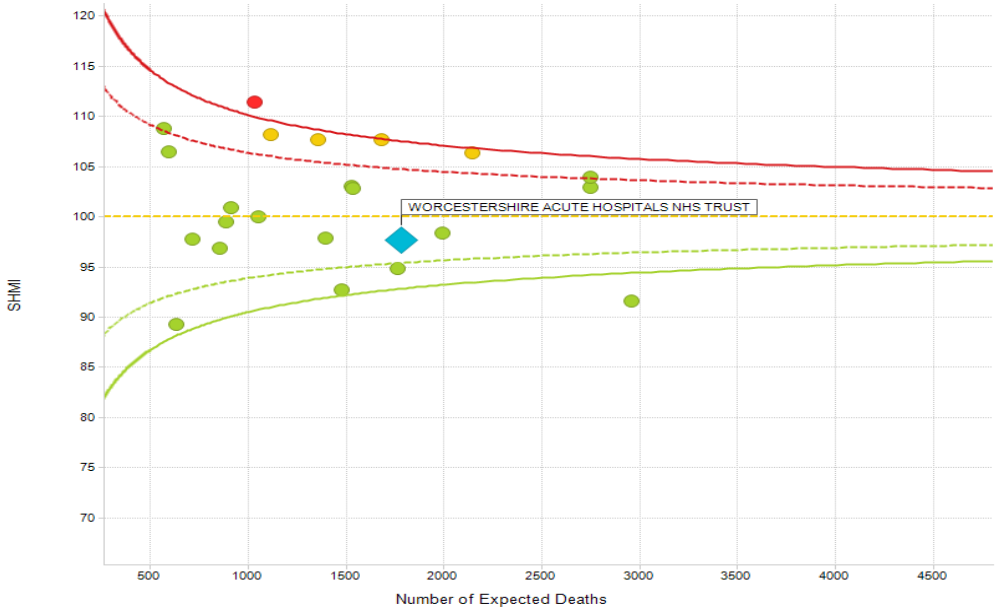
The position of the Trust compared with the rest of the SHA cluster April – December 2012 (rebased) is provided in the funnel chart below which shows that the Trust is just below the 100 line and within the expected range (i.e. within the red and green lines)



Summary Hospital Mortality Index (SHMI)

The department of health have released the Summary Hospital Mortality Index (SHMI) data for the full 2011/12 financial year. **The figure for WAHT is 103.1** which puts the organisation in the 'outcome as expected' category.

The SHMI for 2012 Quarter 1 and 2 (the latest available) shows a value of 97.88.
The position of the Trust compared with other Acute Trusts in the region for the period April to November 2012 is given below. Again, this shows the Trust to be within the expected range.



Patient Recorded Outcome Measures - PROMS

PROMS are a Department of Health (DoH) national initiative, which has been running since April 2009. The aim is to gain patient feedback on the outcome of their operation and the impact on their quality of life and use that as a quality measure.

The Trust's participation rate for PROMs comparing last year's data (Q1-Q4) with January 2012 - December 2012 shows:

- improvement in knee replacement participation rate
- consistent variation in participation rate for Hip Replacement ranging from 60-75%
- significant reduction in the varicose veins participation rate. The reduction in the rate reflects the picture nationally due to the reduced number of varicose vein operations being carried out.

The DH target response rate is 80%, which the Trust has not been able to achieve consistently across all the 4 selected procedures. An action plan had been drawn up, in conjunction with Quality Health, and the Trust's clinical leads which highlighted the areas of practice that needed to be addressed in the Trust in order to improve the response rate

In response to the latest results the clinical teams have key leads responsible for PROMs across the 3 sites that are tasked with improving the patient participation rate of completing the PROMs questionnaires.

Health gains measured through PROMs:

An overview of the results of health gain is provided below and in more detail in section 4.6

Unilateral hip replacements	Declined to below average
Unilateral knee replacements	Data not available
Inguinal Hernias	Declined to below average
Varicose veins	Improved to above average

Cancer Services

2012/13 has seen significant achievements for cancer services in Worcestershire. The achievement of all the required approvals for the radiotherapy centre, as well as securing its funding, and signing the contracts is a massive accomplishment and the cancer services team has been instrumental to this development.

The constitution of the "Worcestershire Cancer Board" is another major attainment in creating the structure that will meet the challenges of the next few years, including the dissolution of cancer networks, and changes to peer review, data collection and commissioning. The overall aim is to ensure that every cancer patient in Worcestershire has access to holistic, timely, state of the art treatment that is quality assured, and delivered locally whenever possible.

Cancer Waiting Times Targets

We use the Somerset Cancer Register (SCR) to measure cancer waiting times. 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.

For financial year ending March 2013, all targets were met.

Description	Target	Performance April 2012 to March 2013	Result
2 week wait Suspected Cancers (All)	93%	95.73	Achieved
2 week wait for Symptomatic Breast Patients	93%	94.93	Achieved
31 day wait for first treatments	96%	97.62	Achieved
31 day wait for second or subsequent treatments: surgery	94%	97.25	Achieved
31 day wait for second or subsequent treatments: anti-cancer drug treatments	98%	100	Achieved
62 day wait for first treatments	85%	88.55	Achieved
62 day wait for first treatments from a screening programme	90%	95.01	Achieved

The strong performance of our organisation in cancer waiting time measures throughout the year has not been easy to achieve, and reflects hard work from everybody in the Trust,

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

- The cancer team working proactively with clinical directorates to prevent all avoidable breaches
- Weekly tracking lists updated and sent to Directorate Managers giving information on patients on 31 day and 62 pathway, including actions required to expedite patient pathways and prevent breaches
- Investment by the Trust in eZnotes hardware to enable effective cancer multi-disciplinary team meetings to continue
- Increased capacity in response to the increased demand resulting from a range of cancer awareness campaigns.
- Weekly attendance at Trust Access meetings to update on cancer targets and discuss any actual or potential breaches

This puts the Trust in a strong position to maintain and improve on cancer targets in 2013/2014.

Cancer Peer Review

During May 2012 the Trust received an external visit from the central zone peer review team to assess the following teams:

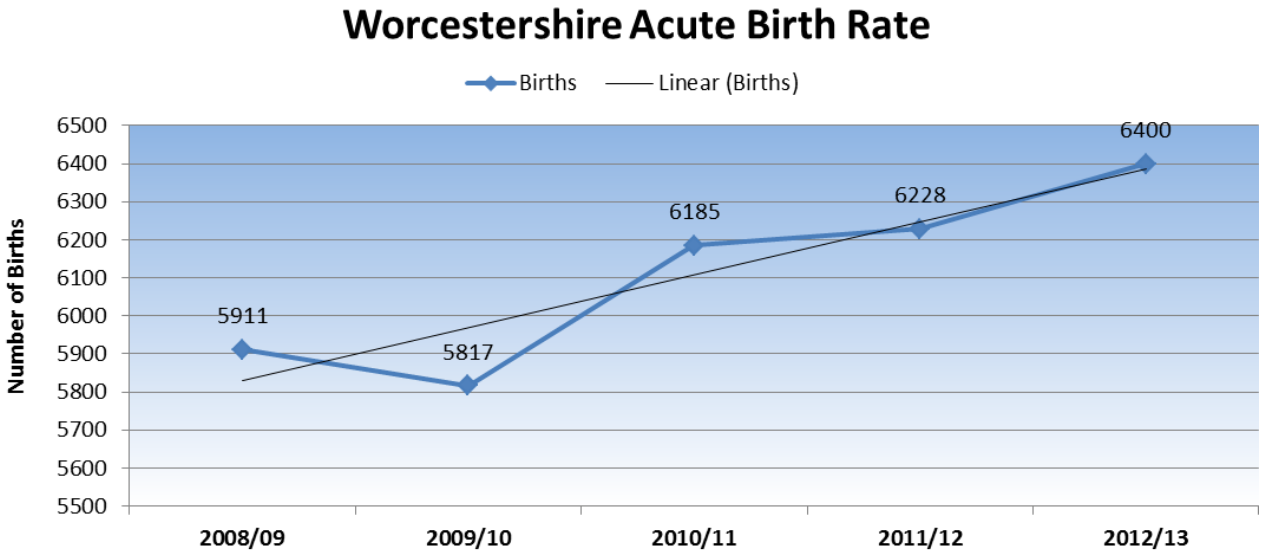
- Chemotherapy Services
- Acute Oncology Services

The outcomes from the external visit were largely positive and the external peer review team congratulated the chemotherapy service for progress made since the previous peer review. The Trust had identified that the facilities on the chemotherapy suite at the Alexandra Hospital were not adequate and were in the process of refurbishment when the review took place. The external team acknowledged this progress but wished to identify a risk regarding the process of chemotherapy delivery to the chemotherapy suite. This risk was addressed immediately and resolved

Acute Oncology Services were commended on a variety of good practices led by an enthusiastic nurse lead, who has driven the service development with excellent engagement with A/E and palliative care services. The service has completed the relevant audits with a database of triage and treatment of acute oncology presentations showing admission prevention and reduction in length of stay. The cancer team completed a very robust and comprehensive internal validation programme in 2012 to review selected cancer teams and services against a series of quality measures. This ensures the Trust regularly reviews and assesses services to direct service improvements and share good practice.

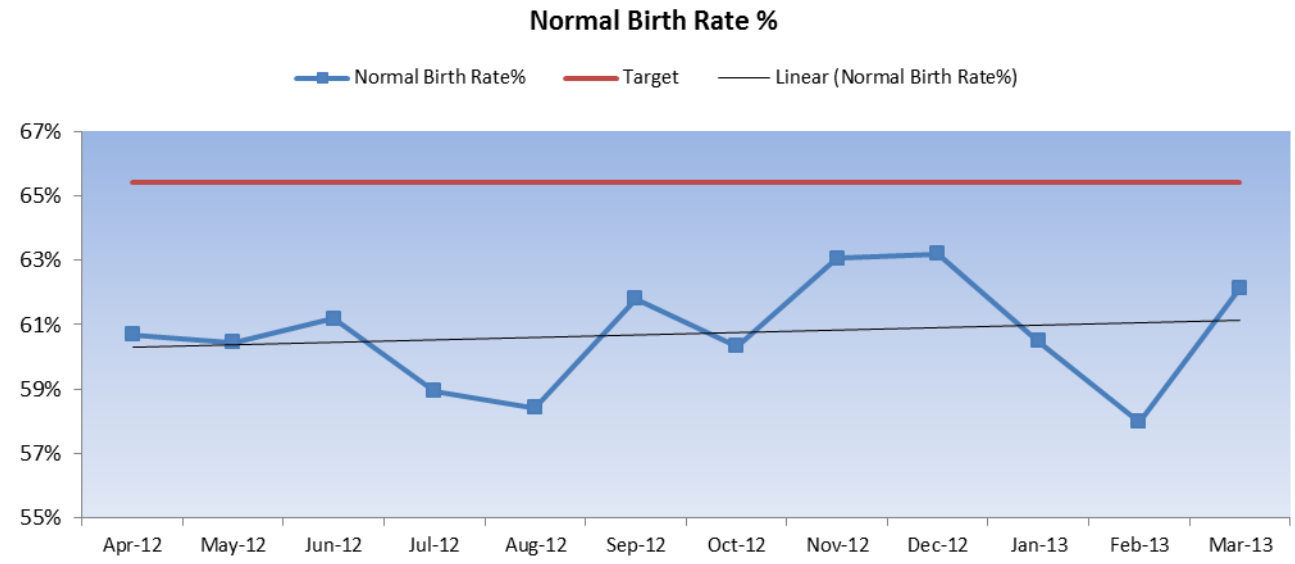
Maternity Services

Maternity services in Worcestershire continue to see a rise in the number of babies born in 2012/13. A total of 6397 babies were born in the county in 2012/13, an increase in 169 on the previous year. This increase is part of an upward trend seen over the last 5 years.



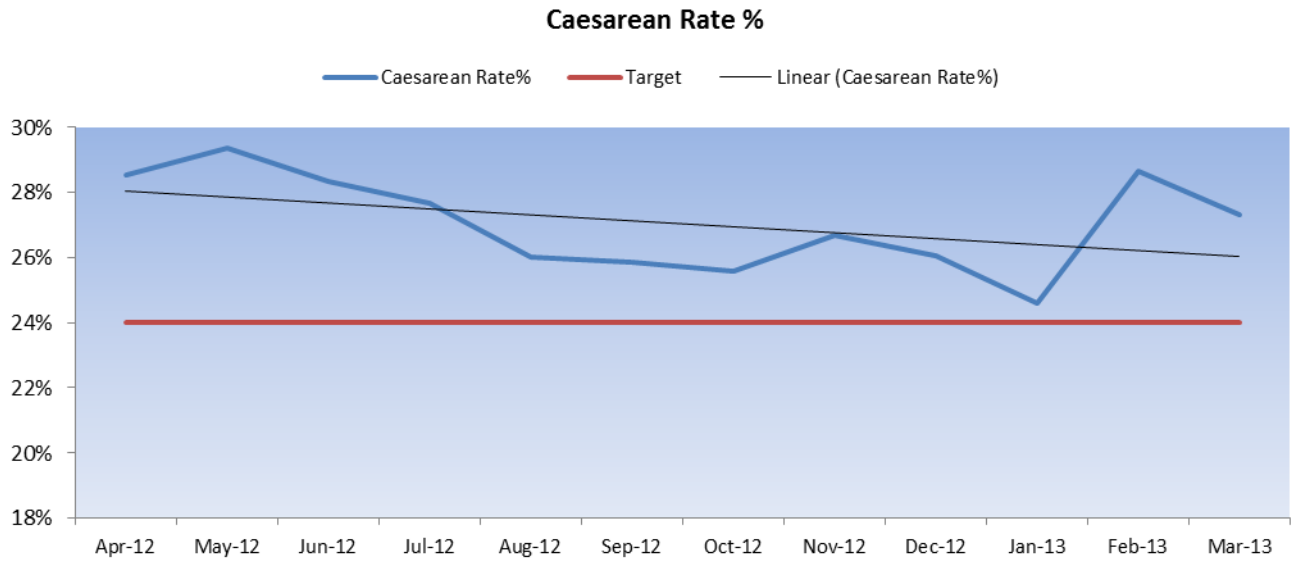
Promoting normal birth

The vaginal birth rate for women delivering in Worcestershire is 60.7% with a target of 65.4%



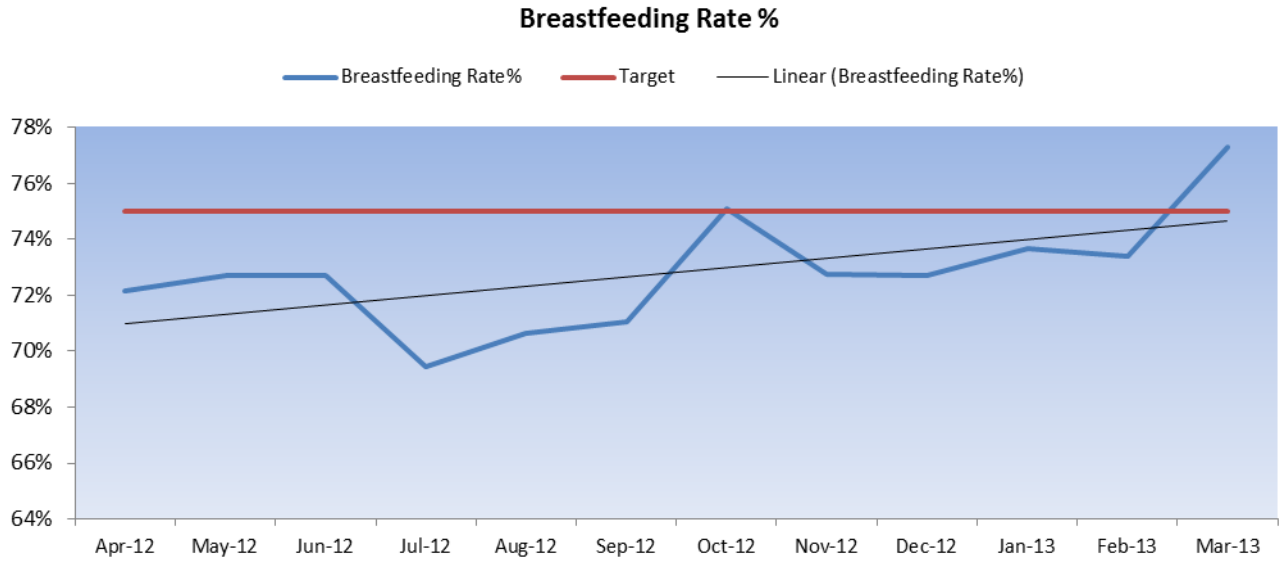
Caesarean Section Rates

Caesarean Section rates have risen in 2012/13. The impact of NICE guidance on caesarean Section, published in Dec 2011, has had the biggest impact on caesarean section rates as clinicians now have to offer women a choice of mode of delivery. The target of less than 24% of births being caesarean section was not met.



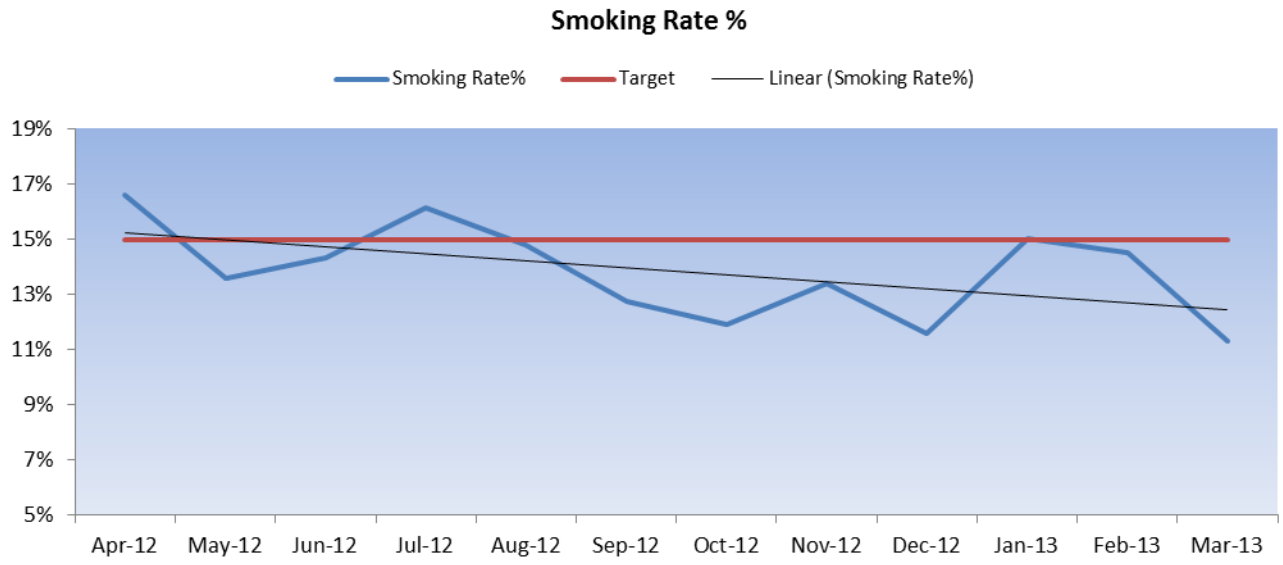
Breastfeeding Rates

The number of babies who were breastfed following delivery in 20912/13 is 72.7% with a target of 75%. The Trust is working in partnership with health visiting colleagues to promote breastfeeding within Worcestershire.



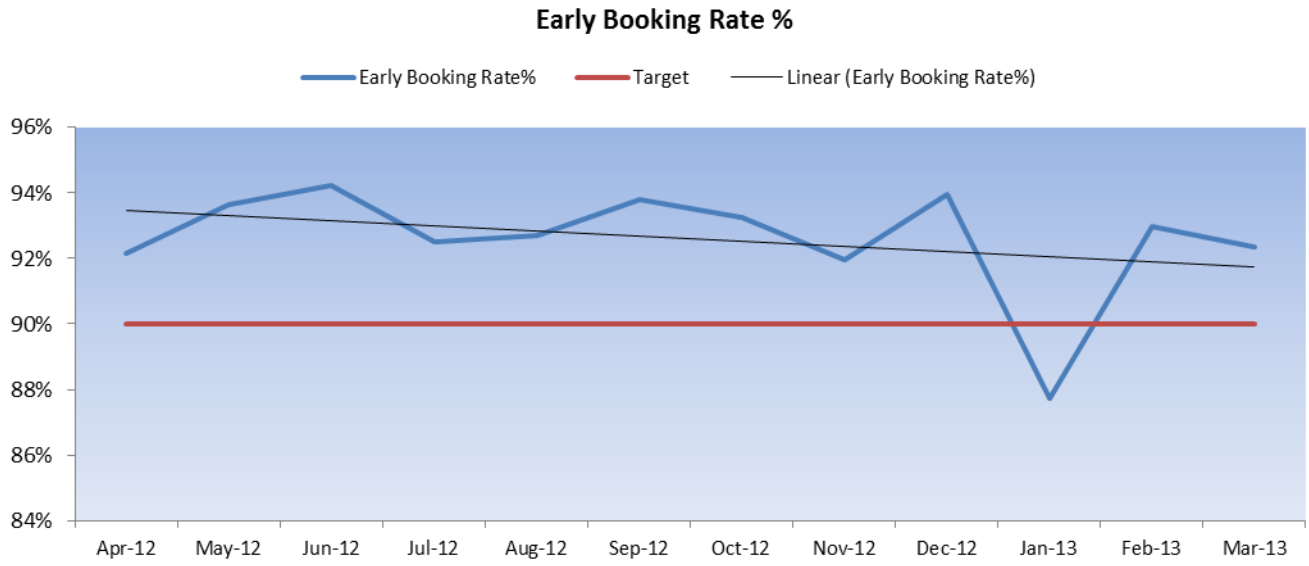
Number of women smoking at delivery

Smoking cessation rates amongst pregnant women are the lowest for many years. Maternity services employed two smoking cessation advisors in 2012 to work in the Kidderminster and Redditch community midwifery teams to support pregnant women quit smoking. The smoking advisors provide advice and support to pregnant women who want to quit smoking by setting quit dates and supporting them through Carbon Monoxide testing, home visits and telephone support. For the first time in some years the percentage of women smoking at delivery has fallen below 16% to 13.8%, the target being 15%.



Early Booking

Maternity services are booking 92.6% of women before 12+6 weeks of pregnancy against the target of 90%. By booking women early they are able to access antenatal screening in the first trimester of pregnancy allowing them increased choice around screening for Downs Syndrome.



New Transitional Care Unit for Mothers and Babies at WRH

Maternity services opened a new transitional care unit (TCU) facility, within the postnatal ward area at WRH in December 2012. The transitional care unit cares for babies who no longer need neonatal intensive care facilities, or for babies who need extra support in the first few days/weeks after being born. The care is carried out to babies alongside their mothers so both mothers and babies are cared for together. This new facility has one bed/cot more than the previous TCU and the design is such that all patients, women and babies can be seen from the central midwifery station.

3.1.4 Patient Experience

The Trust had one improvement priority for patient experience with a number of supporting targets in 2012/13. This is how we did:

Patient Experience	
4. To improve patient/carer reported experience of care	Partially Met

The Trust achieved the following improvements during 2012/13:

- Increased Friends & Family Test score by 10 points
- 96% patients surveyed responded positively about being involved in decisions about their care ('no decision about me without me')
- >99% patients surveyed reported being treated with respect and dignity
- The rate of complaints per 10,000 bed days did not reduce (target 10% reduction).

Listening to patients

The Trust places a high value on listening to and acting on patient feedback in order to drive quality improvements. This has been emphasised by the Francis Report. In 2012-13 it participated in the Regional pilot project for the Friends and Family Test which has since been rolled out nationally. This work is reported to Board each month and forms part of the assurance on the feedback from patients and our response. We are building on this work and in 2013/14 have this as a core element of our annual objectives. In addition, all Trust training programmes will promote the values set out in "Compassion in Practice - care, compassion, competence, communication, courage and commitment", a strategy for nurses and care givers. Information will continue to be presented at the Board meetings and in our Quality Account which sets out an honest assessment of our progress. In 2013-14 a Patient Experience Strategy will include the publication of patient feedback, such as local inpatient surveys, on the Trust website to improve transparency.

The Friends and Family Test

Since April 2012, as part of the regional scheme, patients have been asked whether they would recommend hospital wards to their friends and family if they needed similar care or treatment. This means every patient in these wards and departments will be able to give feedback on the quality of the care they receive.

When patients are discharged, or within the 48 hours that follow, they are asked to answer the following question:

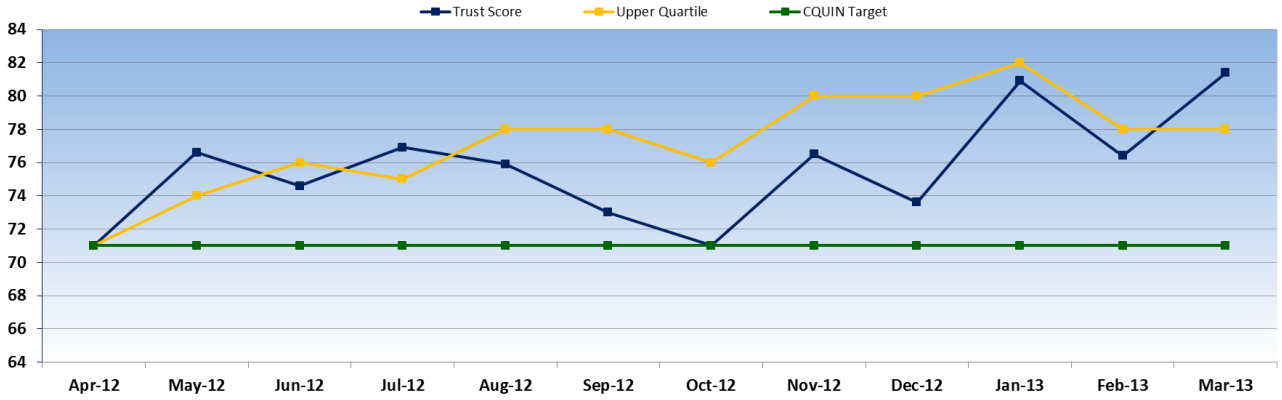
> *'How likely are you to recommend our ward/A&E department to friends and family if they needed similar care or treatment?'*

Patients are invited to respond to the question by choosing one of six options, ranging from 'extremely likely' to 'extremely unlikely'

The Trust's target for the year was to improve by 10 points or remain in the top 25% of highest scoring Trusts (the upper quartile). We achieved the 10 point increase despite a dip in performance in September and October and were close to the moving upper quartile mark. We also achieved the CQUIN associated with this measure and sustained levels well above the regionally set upper quartile mark of 71.

2012/13 Net Promoter Results - Trend with Upper Quartile and CQUIN Target

	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
Trust Score	71.0	76.6	74.6	76.9	75.9	73.0	71.0	76.5	73.6	80.9	76.4	81.4
Upper Quartile	71.0	74.0	76.0	75.0	78.0	78.0	76.0	80.0	80.0	82.0	78.0	78.0
CQUIN Target	71.0	71.0	71.0	71.0	71.0	71.0	71.0	71.0	71.0	71.0	71.0	71.0



Starting in April 2013 we will participate in the national programme which has been extended to the A&E Department. From October 2013, the test will also been available to women who use maternity services, and as soon as possible will be extended further to everyone using NHS services.

The test results will be published on the NHS Choices website from July 2013.

Same Sex Accommodation

The Trust is pleased to confirm that we remain compliant with the requirements around eliminating mixed sex accommodation unless it is in the patient's overall best interest, or reflects the patient's personal choice. We reported zero breaches in 2012/13.

Every patient has the right to receive high quality care that is safe, effective and respects their privacy and dignity. We are committed to caring for patients in same sex accommodation, because it helps to safeguard their privacy and dignity when they are often at their most vulnerable.

Caring for Vulnerable Adults

There has been strengthened multi agency working and regular contributions to the Worcestershire Adult Safeguarding Board and its sub committees over the last twelve months. We have had very positive reviews of our processes to safeguard vulnerable adults generally and those with learning disabilities in particular following inspections by the former Midlands & East Strategic Health Authority, NHS Worcestershire and HealthCheckers as well as the Care Quality Commission.

During the year 2012/13 the Trust has

- increased the number of staff trained in the principles of Safeguarding Adults by 71% (55% of all staff)
- increased the number of staff trained in the principles of Mental Capacity Act by 77% (40% of all clinical staff)

The impact of this increased awareness has been seen in

- an increase in the number of safeguarding alerts raised by staff
- an increase in the number of applications under the Deprivation of Liberties Safeguards from 4 to 22 in the year.

The Mental Capacity Act Deprivation of Liberties Safeguards (DOLS) provide protection for vulnerable people who are accommodated in hospitals or care homes in circumstances that amount to a deprivation of their liberty and who lack the capacity to consent to the care or treatment they need. Those people who need this protection tend to be those with more severe learning disabilities, older people with any of the range of dementias or people with neurological conditions such as brain injuries.

The Law provides that deprivation of liberty:

- should be avoided whenever possible
- should only be authorised in cases where it is in the relevant person's best interests and the only way to keep them safe.

Ward managers and matrons are authorised to undertake the initial application following a prescribed assessment of the situation. This application is then subject to review by Best Interest Assessors from the Social Services Team. The individual patient will have a personal representative appointed who provides independent support, acting only in the best interests of the person involved, rather than in the interests of service providers.

Compliments

Our staff receive many compliments and positive comments through the year. We can't record them all but we capture the written compliments we receive and share them with staff to celebrate and reinforce the excellent and appreciated care that we give. A 'Chaplain's Blog' also records the good news stories from Worcestershire Hospitals.

This year we recorded:

- 290 compliments for Worcestershire Royal Hospital and Kidderminster Hospital during the year.
- 468 compliments for the Alexandra Hospital.

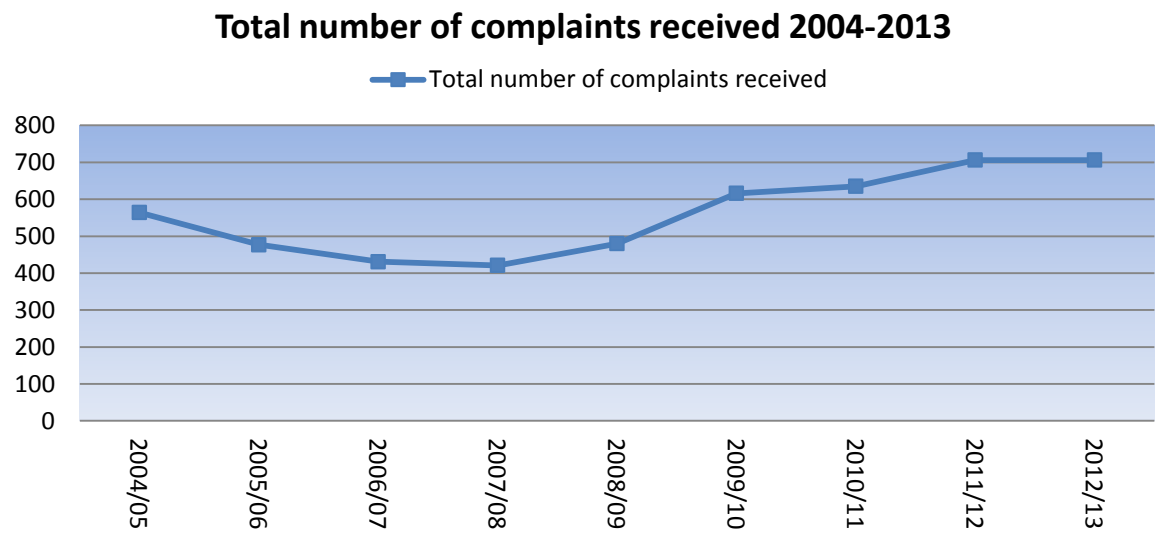
The themes taken from the compliments include:

- Excellent staff
- Professionalism
- Excellent care and attention
- Exceeding expectations

Complaints

Complaints provide a very important opportunity for the Trust and its staff to understand what goes wrong from the patient's perspective and use this to improve all aspects of the services we provide. A full, in depth review of the Trust's approach to responding to complaints commenced in early 2013 and continues as this Quality Account is being written. The aim is to improve the process of receiving and responding to complainants to maximise this learning and provide a better response to our patients and their carers and relatives.

The Trust received 706 complaints in 2012/13, the same number as in 2011/12. The graph below shows the trend in complaints reporting since 2004/05 with a gradual increase since 2007/08.



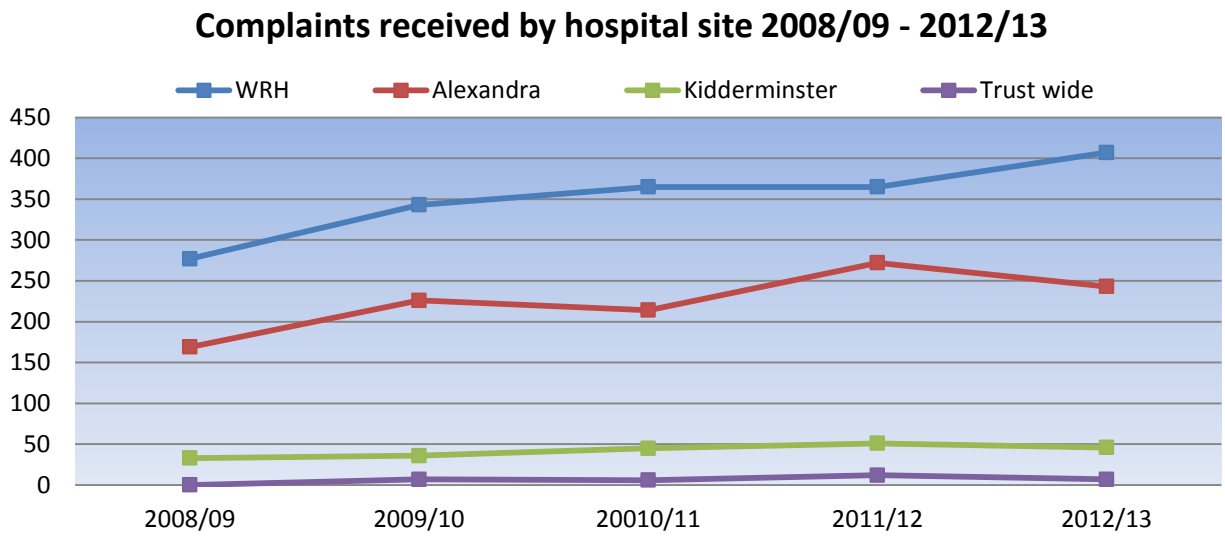
Our target of reducing the number of complaints received by 10% in the year was not met. On reflection, this was not a helpful target and we will in future focus on the helping people to make their concerns known and monitoring the impact of the actions we take to reduce the likelihood of the same things happening again.

All complaints have the primary reason for the complaint recorded using national subject codes called KO41a. For each of the past five years 'All aspects of clinical treatment' has been the top subject of complaints.

The most frequently cited issues in complaints we received in 2012/13 were 'Lack of communication', 'Medical Treatment', 'Delay in receiving treatment', 'Miscommunication' and 'Attitude of nursing staff'

Subject (K041 classification – top 5)	**2008 /09**	**2009 / 10**	**2010 / 11**	**2011 / 12**	**2012/13**
All aspects of clinical treatment	291 (61%)	333 (54%)	363 (57%)	376 (53%)	415 (59%)
Appointments, delay / cancelation (out patients)	44 (9%)	61 (10%)	58 (9%)	64 (9%)	45 (6%)
Communication / information to patients (written and oral)	46 (10%)	52 (8%)	40 (6%)	43 (6%)	30 (4%)
Attitude of staff	48 (11%)	49 (8%)	62 (10%)	69 (9%)	66 (9%)
Admissions, discharge and transfer arrangements	25 (5%)	38 (6%)	37 (6%)	-	45 (6%)
Aids and Appliances, Equipment including Access	-	-	-	35 (5%)	-

The graph below shows the complaints received by trust site for the last five years. More patients are seen at Worcestershire Royal Hospital and it also attracts the most complaints.



We set ourselves an internal standard of responding to 90% of complaints within 25 working days. We didn't achieve this during the year. We did however hold more resolution meetings with complainants and introduced a requirement for managers to contact the complainant by telephone at the earliest opportunity to make early contact, express regret and begin the process of communication and response. We had 16 complaints referred to us for review by the Ombudsman.

	08/09	09/10	10/11	11/12	12/13
Percentage of complaints responded to within target of 25 working days	72%	67%	69%	81%	66%
Number of complaint meetings held (supported by Patient Services)	76	100	100	113	168
Number of Healthcare Commission / CQC / Ombudsman requests	16	11	18	30	16

A range of actions, both local and Trust-wide have been taken in 2012/13, in response to complaints, including the ACE programme described below.

The complaints data is also analysed and the wards receiving the highest number of complaints (taking into account their activity) are reviewed by senior nurses to determine any underlying causes which are then addressed. Complaints are monitored as part of the ward quality dashboard to enable triangulation with other patient experience indicators. The Trust implemented learning from feedback events where patient stories are shared with staff and the opportunity to reflect on what they could do differently next time is enabled.

Active Caring for Everyone - ACE with PACE

ACE (Active Caring for Everyone) training was introduced in 2011 in response to staff attitude appearing regularly as one of the highest causes of complaints. ACE is a training programme developed from patients and staff feedback on what good patient care/experience looks and feels like across the trust. The training is focussed on improving the day to day interactions of all staff with patients and their families, ensuring every point of contact, no matter how small, results in a positive patient experience. The aims include:

- Understand your own role and responsibilities in delivering high levels of customer service.
- Recognise good customer service, and actively seek ways to achieve, and where possible exceed customers' expectations.
- Take personal responsibility to solve problems and handle customers concerns in an honest, timely and constructive manner.
- Adopt a consistent, dependable and proactive approach to customer relationships— demonstrate a passion for excellence.
- Acknowledge service gaps and embrace a culture committed to continuous improvement –both personal and organisational.

We trained a further 1157 staff In 2012/13 and since the programme began in November 2011, 2047 staff have attended the course. 92% of the staff attending the course thought it was excellent or good.

'How it feels to me'

These patient story sessions were introduced in response to formal and informal feedback from patients on their experience of care. We began by looking at the emerging themes and those issues that are consistently in the top categories of the complaints that Worcestershire Acute Hospitals NHS Trust receives. Although in the very early stages we have developed a twelve month programme with a different theme each month.

The sessions are the patient's or carer's own story and are based on a number of different topics such as living with a particular condition such as dementia or a learning disability or they could be related to living with a particular symptom, for example chronic pain or breathlessness. Some of the sessions are based on the personal experiences that people have of Worcestershire Acute Hospitals NHS Trust such as life as a carer or communication within the hospital. We would also like to cover some very sensitive areas such as dying.

The 'How it feels for me' sessions are aimed at all levels staff across the Trust, whether it is a nurse, doctor, manager, porter or housekeeper. The sessions are delivered by the people living with the condition, symptom or who have had that particular experience. The intention is that our staff will not only empathise with the person sharing their experiences or story but to also learn and therefore change their own practice or behaviour. The sessions also provide an opportunity for wider organisational learning such as promotion of the carer charter and policy.

National Inpatient Survey 2012

The Inpatient Survey is part of a series of mandatory annual surveys required by the Care Quality Commission of all acute NHS Trusts to meet their essential standards for quality and safety.

A total of 850 patients, discharged in July 2012 were identified and 840 patients were eligible and sent a questionnaire. Overall, 429 responded, giving a response rate of 55%. This was a higher response rate than national average of 48% and the Trust acknowledges the time and effort taken by patients to contribute to this survey.

Key information about the patients who responded:

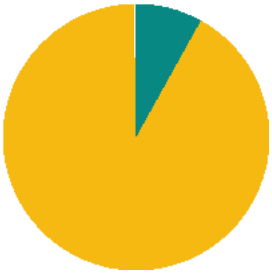
- 32% of patients were on a waiting list/planned in advance
- 62% were admitted as an emergency or urgent case.
- 56% had an operation or procedure during the stay.
- 48% were male; 50% were female and 2% did not reply.
- 9% were aged 16-39; 20% were aged 40-59; 19% were aged 60-69 and 49% were aged 70+; 3% did not reply.

Results

The results published by the CQC show the Trust to be 'about the same' as other Trusts.

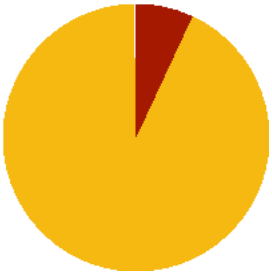
Picker Comparisons

We used the Picker institute to undertake the inpatient survey. A breakdown using the results of Trusts that employed Picker to do the analysis are provided below:



A total of 73 questions were used in both the 2011 and 2012 surveys. Compared to the 2011 survey, our Trust is:

- Significantly BETTER on 6 questions
- Significantly WORSE on 0 questions
- The scores show no significant difference on 67 questions



How do we compare to other trusts?

The survey showed that our Trust is:

- Significantly BETTER than average on 0 questions
- Significantly WORSE than average on 6 questions
- The scores were average on 80 questions

CQC analysis of Worcestershire Inpatient 2012 survey

The CQC confirms statistically significant improvements in the scores for:

- Patients being afforded privacy when discussing their care and treatment
- Patients being asked their views on quality of care.

The CQC also highlighted areas for improvement required from the patient feedback were on:

- Rating for food remained low
- Discharge in relation to staff explaining medication side effects, advice on discharge and patients not receiving copies of letters sent between hospital doctors and their family GP.

The CQC have scored the Trust ‘amber’ which indicates the Trust ‘remains about the same’ as most other Trusts in the survey.

The Trust has commissioned a ‘ready to go’ group to drive improvements in the patient discharge process and communication. Process to monitor monthly feedback from patients and staff on the quality of food are already in place and refinements to the menu are being made continually.

Local inpatient surveys

We also carry out a monthly inpatient survey across the Trust in addition to the yearly national inpatient survey. The questions asked are designed to cover all aspects of the patient journey from admission, the care and treatment received during their stay to discharge arrangements. Used with information from other sources, this helps us to identify

what we are doing right, what we are not doing well enough and respond to it at the local ward level.

Areas that have patients have responded positively to in the survey include:

- The people responding felt they had been treated with respect and dignity that the doctors and nurses worked well together, and they were happy with the care they had received.
- The cleanliness of the hospital room, ward and toilet & bathroom
- Nurses washing their hands between touching patients
- Patients were able to find a member of hospital staff to talk to about any worries or fears
- Staff showed care and compassion while giving care and treatment

Some of the feedback we received shows we don't always get it right and we will continue to work hard at customer care and improving some of our processes. Examples of this include:

- Being involved as much as you wanted to be in decisions about your care and treatment
- experiencing noise at night
- information about the side effects of medication and what to watch for after discharge
- Safe storage of belongings

Our staff have been provided with the findings of the surveys. Actions taken during the year to improve the patient experience include:

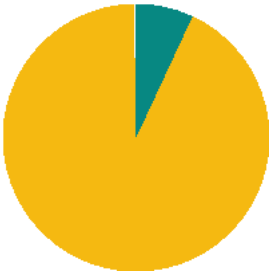
- The introduction of the "Shush" campaign to understand and remove the causes of noise such as the volume of phone and nurse call systems.
- Pharmacists are working with ward staff to provide patients with better information on medications.

Accident & Emergency Department Patient Survey

This patient survey was undertaken in the first three months of 2012. A total of 850 patients from our Trust were sent a questionnaire. 823 patients were eligible for the survey, of which 274 returned a completed questionnaire, giving a response rate of 33%.

How this score compares with other trusts		Based on patients´ responses to the survey, this trust scored
9.2 /10	Click to expand for questions about **Travel by ambulance (answered by those who travelled by ambulance only)**	WORSE / ABOUT THE SAME / BETTER
6.3 /10	Click to expand for questions about **Reception and waiting**	WORSE / ABOUT THE SAME / BETTER
8.1 /10	Click to expand for questions about **Doctors and nurses (answered by all those who saw a doctor or nurse)**	WORSE / ABOUT THE SAME / BETTER
8.2 /10	Click to expand for questions about **Care and treatment**	WORSE / ABOUT THE SAME / BETTER
8.2 /10	Click to expand for questions about **Tests (answered only by those who had tests)**	WORSE / ABOUT THE SAME / BETTER
8.1 /10	Click to expand for questions about **Hospital environment and facilities**	WORSE / ABOUT THE SAME / BETTER
6.1 /10	Click to expand for questions about **Leaving the A&E Department (answered only by those who were not admitted to hospital or to a nursing home)**	WORSE / ABOUT THE SAME / BETTER
7.3 /10	Click to expand for questions about **Overall views on experience**	WORSE / ABOUT THE SAME / BETTER

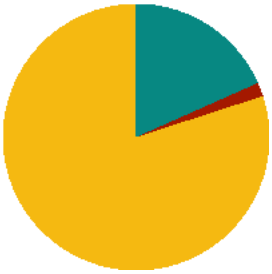
We also used the Picker institute to undertake the inpatient survey. A breakdown using the results of Trusts that employed Picker to do the analysis are provided below:



Have we improved since the 2008 survey?

A total of 42 questions were used in both the 2008 and 2012 surveys. Compared to the 2008 survey, our Trust is:

- Significantly BETTER on 3 questions
- Significantly WORSE on 0 questions
- The scores show no significant difference on 39 questions



How do we compare to other trusts?

The survey showed that our Trust is:

- Significantly BETTER than average on 11 questions
- Significantly WORSE than average on 1 question
- The scores were average on 48 questions

We have taken a range of actions in the following areas to improve patients' experience of the Emergency Department:

- Provide the patient with regular updates on the stage and future stages of their current journey.
- Ensure patients receive appropriate tests in a timely manner.
- Ensure senior nurse or Doctor is available when a patient needs to discuss their care.
- Reduce the delays in providing pain relief.

National Cancer Patient Experience Survey 2012

Patient experience is given a high priority by the Trust. The National Cancer Patient Experience Survey reported in July 2012 was a valuable source of patient feedback and the benchmarking helped to focus the Trust on key areas for improvement. The Trust response rate was 72% (national 68%) which is a very high response rate and highly robust data was obtained from a large sample of 754 patients.

The Trust was found to be one of the middle ranking Trusts on the National Cancer Patient Experience Survey ranking 131 out of 160. The survey reported that the Trust was in the bottom 20% of Trusts as rated by patients on 22 questions out of 64 and in the top 20% of Trusts on 2.

A high level action plan was developed by cancer services following the publication of the 2011/2012 report; this has been monitored through the trust Patient and Carer Experience Committee. Actions taken by the team concentrated on communication, patient involvement in decision making and providing information for patients and family.

- A "Did You Know" Poster was developed detailing how patients can bring a friend to clinic and, to ask for written information about their cancer diagnosis and treatment options. The poster also highlights to patients an awareness of concessionary parking and free prescriptions.
- The cancer services website has been updated and the link promoted across the Trust.
- The profile of the three Macmillan Cancer Information and Support Centres was raised together with access to the Macmillan/Relate counselling service, Macmillan/Citizens Advice Bureau and translation and interpretation assistance.
- An update and re-run of the Worcestershire patient personal folders was completed and promoted across the Trust championed by Clinical Nurse Specialists (CNS's).

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.

Local cancer surveys

A periodic survey of relevant patient groups to ensure observations made by patients are considered and acted upon by multi-disciplinary cancer teams (MDT) and is also a Trust requirement. The Trust local cancer patient satisfaction surveys allow the trust to review the individual tumour site MDT's and focus on hospital site specific service improvements. The 2012 local patient satisfaction survey was completed and areas of good practice were identified and useful MDT site specific information gained for MDT's to assist in their planning for service improvement.

- Verbal and written information is important to patients, their carers and families as evidenced by local Trust surveys. The Clinical Nurse Specialists (CNS) have undertaken Information Prescriptions Training enabling them to provide personalised information for patients. They also work closely with the Macmillan Cancer Information and Support Service to signpost to appropriate services.
- The surveys have also shown the need to provide a permanent record of consultation and many teams have now committed to offering this record together with a copy of the letter sent to the GP, with an outline provided in the Worcestershire Patient Folder

The first local chemotherapy patient experience survey was undertaken by Cancer Services during 2011 and the outcomes provided comprehensive information about the needs and expectations of chemotherapy patients within the Trust. Further improvements have been identified and action plans are being taken forward by operational leads.

Additionally the Cancer team have developed a chemotherapy treatment record to supplement the patient treatment record. This provides more detailed specific chemotherapy information including a record of every treatment cycle given and a side effect diary to facilitate self-management by patients of their symptoms. This has been developed in collaboration with clinical colleagues and user involvement.

Improving information and communication for cancer patients

The Macmillan Cancer Information and Support Service (CISS) is available to provide cancer information and support to anyone affected by cancer .The CISS 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, at CAB offices or in their own homes.

Another new Macmillan initiative was launched in April 2012 bringing together Macmillan with Relate Worcestershire which provides free, confidential counselling for anyone affected by cancer. They offer specialist counselling for individuals, couples, families and young people, including psycho-sexual counselling.

The Macmillan Cancer Information and Support Service, Macmillan/Citizens Advice Bureau and Macmillan/Relate work closely together to identify ways in which they can improve the patient experience.
The Information and Support Centres have led the way in establishing the Information Prescription service across the Trust and their staff continue to offer support and training to Trust staff as they develop their own methods of using the web based health information service.

On 1st June 2012, seven volunteers from the Macmillan Cancer Information and Support Service received the national Deborah Hutton award for their practical support and care

given to people affected by cancer, above and beyond the expectation of their role. The volunteers dedicate their time to volunteering in the Macmillan Cancer Information and Support Centres, offer support to the Centre managers and provide information and signposting to other services for anyone who has been affected by cancer.

Worcestershire Cancer User and Involvement Group
This group is the formation of three previous User Groups and is dedicated to influencing and improving cancer services across Worcestershire.

Unfortunately, funding streams for the group have now ended with the cessation of Cancer Networks but the group continues to meet on a bi-monthly basis with the assistance of local support groups. Membership of the group is made up of patients' carers, together with health and social care professionals.

The Public and Patient Forum

The Public and Patient Forum (PPF) play an important role in evaluating the Trust's performance from the patient's perspective. The PPF carried out 19 clinical visits in 2012 involving observation of practice speaking to ward staff about their practices and patients/ carers about their experiences of privacy and dignity, nutrition and the environment they are being nursed.

The information gained through this work has enabled us to make improvements in care including:

- Nutrition i.e. menu choices, promoting mealtimes guidelines, introduction of hot meals for patients across the 3 hospital sites and patient information.

- Dignity - all wards and departments to: use well-fitting curtains or screens when providing personal care; use of dignity signs and more recently supported the introduction of dignity pegs; to have appropriate patient night wear available; to identify appropriate quiet/private areas to discuss sensitive matters.

Patient Led Assessment of the Care Environment (PLACE)

These new, national assessments replace the PEAT programme and commenced in April 2013 so results are not available for 2012. The Patient Forum members lead the local assessment of the care environment to a nationally set programme. Facilitated by Trust staff, they will undertake independent assessments during unannounced visits to wards.

Cleanliness

The Ward Sisters are accountable for cleanliness standards at ward level; which is monitored through the housekeeping audits. To strengthen accountability for cleanliness at ward level the infection prevention and control team delivered training to ward sisters on how to test and challenge cleanliness before "sign off" of audit results. All cleanliness performance is captured as a pre-rectification score which is always corrected at the time of the audit or immediately afterwards. Cleanliness results are also included on the ward quality dashboard to enable triangulation with other patient safety and experience metrics such as infection rates. Overall cleanliness performance is presented to the Trust Board each month and is reviewed into four distinct categories; Nursing, Estates, Cleaning and overall aggregated scores.

Matrons complete monthly observational audits which include cleanliness of toilets/bathrooms, nursing equipment and are responsible for acting on PEAT review findings (now replaced by PLACE). Cleanliness and environmental monitoring occurs through the monthly Patient Environment Action Groups (PEAG) chaired by the site heads of nursing, who in turn report into the Trust infection prevention and control committee.

We also ask patients what they think of the standards of cleanliness using the Hospedia entertainment system on a weekly basis. In 2012/13 93% of patients answering the questions answered “Clean” or “very clean”. Feedback is shared with housekeeping teams and wards on a weekly basis to recognise high standards and enable speedy review of wards that require this based on patient views.

Performance in cleanliness is reported to the Trust Board each month. The results for 2012/13 show that improvements have been made and the Trust regularly reports high standards of cleanliness

Indicator	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
Cleaning Standards (Overall) - WRH	98.1%	98.9%	98.2%	92.0%	95.0%	96.0%	95.0%	97.0%	97.0%	98.0%	98.0%	97.0%
Cleaning Standards (Nursing) - WRH					90.0%	94.0%	95.0%	97.0%	96.0%	98.0%	98.0%	98.0%
Cleaning Standards (Environmental) - WRH					98.0%	98.0%	96.0%	97.0%	97.0%	99.0%	99.0%	99.0%
Cleaning Standards (Cleanliness) - WRH					95.0%	96.0%	95.0%	96.0%	97.0%	97.0%	97.0%	97.0%
Cleaning Standards (Overall) - ALX	98.0%	96.0%	97.0%	94.0%	95.0%	95.0%	95.0%	95.0%	96.0%	96.0%	96.0%	96.0%
Cleaning Standards (Nursing) - ALX	81.0%	90.0%	84.0%	81.0%	87.0%	84.0%	93.0%	91.0%	95.0%	97.0%	93.0%	94.0%
Cleaning Standards (Environmental) - ALX	99.0%	98.0%	96.0%	94.0%	95.0%	96.0%	97.0%	94.0%	98.0%	97.0%	96.0%	98.0%
Cleaning Standards (Cleanliness) - ALX	98.0%	97.0%	96.0%	94.0%	96.0%	96.0%	96.0%	96.0%	97.0%	97.0%	97.0%	97.0%
Cleaning Standards (Overall) - KGH	98.0%	98.0%	96.0%	95.0%	94.0%	95.0%	94.0%	96.0%	96.0%	96.0%	97.0%	96.0%
Cleaning Standards (Nursing) - KGH	97.0%	93.0%	91.0%	91.0%	88.0%	86.0%	90.0%	94.0%	96.0%	99.0%	100.0%	97.0%
Cleaning Standards (Environmental) - KGH	98.0%	99.0%	97.0%	97.0%	93.0%	94.0%	92.0%	95.0%	96.0%	92.0%	98.0%	99.0%
Cleaning Standards (Cleanliness) - KGH	98.0%	98.0%	96.0%	97.0%	98.0%	97.0%	96.0%	98.0%	98.0%	98.0%	97.0%	98.0%

2012/13 Tolerances		
On Target	Of concern	Action Required
>=95%	90% - 94%	<90%

3.1.5 What our staff thought of our services.

The 2012 NHS National Staff Survey was undertaken by Quality Health for Worcestershire Acute Hospitals NHS Trust. Questionnaires were sent to 850 staff which was the official sample number for the Trust. Of these 850, 372 staff completed the survey making our % response rate 44% compared to last year which was 55% and the national average for acute Trusts this year of 49%.

As the organisation was very keen to engage with as many staff as possible this year and to hear their views, it was decided to undertake an additional full survey of all qualifying staff which equated to 4166 staff. 1778 completed surveys were returned from this additional survey giving a response rate of 43%.

The overall staff engagement score for the Trust in 2012 is 3.64 out of 5 which is slightly lower than average when compared to other Acute Trusts, but is showing an increase from 2011.

Our Top 5 ranked scores – where we scored most favourably with other acute Trusts in England

- Percentage of staff witnessing potentially harmful errors, near misses or incidents in the last month is 28% (34% average for acute Trust's)
- Percentage of staff experiencing physical violence from staff in last 12 months is 2% (3% average for acute Trusts)
- Percentage of staff saying hand washing material are always available is 66% (60% average for acute Trusts)
- Percentage of staff appraised in last 12 months 86% (84% average for acute Trusts)
- Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months 22% (24% average for acute Trusts)

Our Bottom 5 ranked scores – where we scored least favourably with other acute Trusts in England.

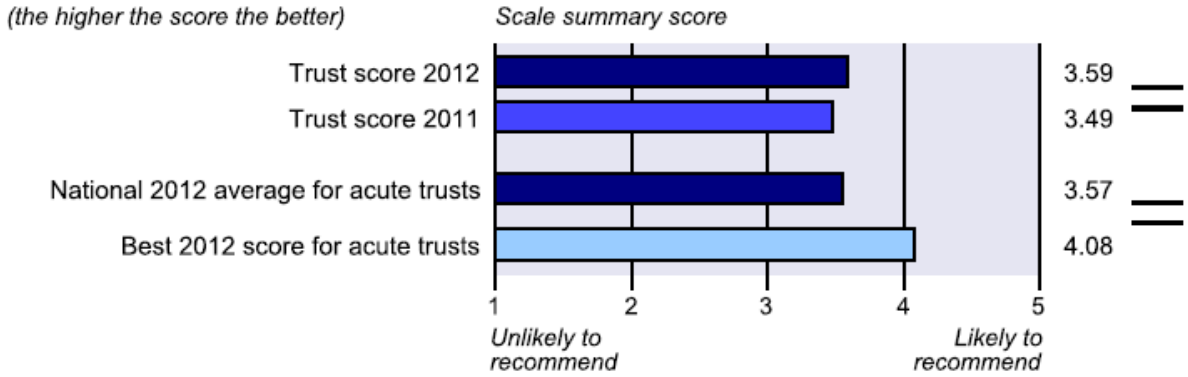
- Effective team working scored 3.51 (3.72 average for acute Trusts)
- Percentage of staff reporting errors, near misses or incidents witnessed in the last month 85% (90 % average for acute Trusts)
- Percentage of staff able to contribute towards improvements at work 61% (68% average for acute Trusts)
- Percentage of staff agreeing that their role makes a difference to patients 87% (89% average for acute Trusts)
- Fairness and effectiveness of incident reporting procedures scored 3.41 (3.50 average for acute Trusts)

Our response to the 2012/13 staff survey result is:

- To improve the effectiveness of team working
- To ensure that there are robust procedures in place for reporting errors, near misses or incidents
- To empower staff to contribute to improvements in their area of work
- To ensure roles are designed effectively and staff feel they can make suggestions to their roles which will make a difference to patients
- To ensure that incident reporting procedures are fair and effective
- To ensure training and development is effective in staff feeling satisfied with the quality of work and patient care they give

- To improve the quality of appraisals and the feedback that staff receive from managers
- To improve the communication between senior managers and staff
- To continue to provide and promote equality and diversity training for staff
- Ensure the organisation has a clear vision and strategy for the future and that staff feel they are part of it.

KEY FINDING 24. Staff recommendation of the trust as a place to work or receive treatment



Workforce indicators:

- The cumulative sickness rate for 2012/13 was 3.92. This figure has remained the same as last year.

The range of sickness absence rates for Acute Trusts in our SHA is between 3.15% and 4.93%. We are joint 4th out of 18 (Based on Jan13 figures reported in Mar 2013 on Productive Workforce Metrics Dashboard).

- Cumulative turnover for 2012/13 based on a rolling 12 month period from March 2012 to end of Feb 2013 is 8.81% which is a decrease on last year's figure of 9.30%.
- Average Cumulative turnover for Acute Trust in the SHA is 9.55%.

The average cumulative turnover for acute trusts in the SHA according to January Productive Workforce Metrics Dashboard was 9.55%. (Based on Jan13 figures reported in Mar 2013 on Productive Workforce Metrics Dashboard).

Listening to Staff

The Trust has reviewed its approach to listening to its staff and taken into account the Francis Inquiry recommendations. From 2013/14 we will ensure greater levels of engagement with staff across the organisation. We will hold a wider range of staff engagement sessions and 'team briefs' promoting openness, transparency and candour. We will debate the NHS Constitution and NHS Values through a staff development programme and via recruitment, induction, training and appraisal.

3.2 Who has been involved in setting the content of the Quality Account and the priorities for 2012/13

The writing of this Quality Account and the setting of priorities for 2013/14 has drawn upon the engagement with internal and external stakeholders through 2012/13 including:

- NHS Worcestershire and Worcestershire's three Clinical Commissioning Groups through regular Quality Review Meetings,
- The Health Overview and Scrutiny Committee through regular correspondence and engagement
- Worcestershire LINks, including having members on our quality and safety committees where review of incidents, complaints, trends and actions taken in response takes place
- The Patient & Public Forum, who have an active role in local inspections
- the public, through the JSR consultation
- The Trust's 'Sounding Board'
- and our staff

The NHS Trust Development Authority (NTDA) instructed aspirant Foundation Trusts to review quality information provided in the National Quality Dashboard (NQD) and use this to help select improvement priorities for 2013/14. This, along with feedback from our stakeholders, informed the choice of improvement priorities for 2013/14 which were selected by the Executive Team and agreed by the Trust Board. The priorities are provided in section 2.1

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.

3.3 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.

3.3.1 Healthwatch

Healthwatch Worcestershire, which came into being on 1 April 2013 welcomes the opportunity to consider the 2012/13 Quality Account that has been prepared by the Worcestershire Acute Hospitals Trust. We have considered the Quality Account in the light of the Department of Health's Guidance and have prepared the following comments:

Do the priorities of the provider reflect the priorities of the local population?

In that the national targets are prescriptive, the priorities of the Trust reflect those areas which are underperforming or not delivering consistent results e.g. infection control, accident and emergency treatment, mortality rates, falls and stroke treatment, and which obviously must continue to be very important to the local population in terms of access and confidence.

The local Clinical Commissioning Groups (previously NHS Worcestershire) have the flexibility to reflect their population's priorities, and those of the Worcestershire Health & Well Being Board, in the Trust's contract and the Commissioning for Quality and Innovation Payment framework (CQUIN).

Are there any important issues missed in the Quality Account?

- It would be useful to see the headline results produced for each of the hospital sites in order to focus where additional effort is most necessary.
- Demonstrating where investigating serious incidents and learning from complaints has led to improved practice.
- Time to respond to complaints.
- Some benchmarking against/good practice learning from other trusts.

Has the provider demonstrated they have involved patients and the public in the production of the Quality Account?

The Trust's Public & Patients' Forum undertakes site visits; Worcestershire LINks (Healthwatch Worcestershire from 1.4.13) was represented on the Trust's Quality & Safety Committee, and Worcestershire Health Overview and Scrutiny Committee receive regular reports, which should all feed into the Trust's planning.

Involvement in clinical audits and research and subsequent learning is welcomed. It is also encouraging that the Trust was a pilot site for the Family & Friends initiative, and that more effort is to be made encouraging staff to participate in surveys and contribute to process and practice improvements, including patient exit questionnaires.

Is the Quality Account clearly presented for patients and the public?

No document of 85 pages could be called user friendly! However, it is extremely comprehensive and informative. Although there is a full glossary, a suggestion would be to spell out first usage followed by the acronym to avoid having to refer frequently to the glossary, and maybe explain the calculation and significance of some of the measures, e.g. Standardised Hospital Mortality Indicator (SHMI)/ Hospital Standardised Mortality Ratio (HSMR).

We look forward to working with the Trust in the preparation of its Quality Account for the coming year, and for which we will be able to comment from a more informed position.

Response from Worcestershire Acute Hospitals NHS Trust

We would like to thank Healthwatch for providing this commentary so soon after coming into existence. We would like to clarify that the Trust's mortality rates are within the expected range and that our efforts to further improve the overall rate are focussed on those specialties that have higher rates. This is described in our third improvement priority for 2013/14.

A common theme from the commentaries received is that, while comprehensive, the subject matter makes a simple explanation difficult. We continually strive to improve the presentation of information and the words we use to explain often complex matters. Acronyms do have their meaning provided in the text but the published version will be checked to ensure that this is completed in every instance. We thank Healthwatch for its useful suggestions and look forward to close working in the future.

3.3.2 Worcestershire Health Overview and Scrutiny Committee (HOSC)

"The Worcestershire Health Overview and Scrutiny Committee (HOSC) does not take the view that its role is to be a 'critical friend'. It aims to be constructive at all times but it reserves the right to make robust objections when appropriate, which it considers will help maintain public confidence in the service under scrutiny.

The HOSC also continues to hold the view (which was recently endorsed in the Robert Francis Report*) that each health provider should make full use of the statutory requirement to publish Quality Accounts to ensure that progress towards high-quality care is led by the Board and that the public is provided with meaningful information on outcomes of care.

It is considered that implicit in the term *meaningful information* is that the Quality Account is available for the public and easily understood.

Due to this year's local elections, the HOSC's consideration of draft Quality Accounts was scheduled earlier than usual. Health service providers kindly provided early drafts of their Quality Accounts to accommodate the HOSC. Councillors are aware that therefore some of the comments made by the HOSC are likely to be addressed in subsequent versions of the Quality Accounts.

In making its response the HOSC considers information made available throughout the year which is supported by the Quality Account. The information received on a regular basis regarding Worcestershire Acute Hospitals NHS Trust (the Trust) includes:

- Regular bulletins through the Trust's public newsletter, 'Roundup' (ceased publication in December 2012);
- Specific presentations in respect of proposals for significant changes;
- Board Meetings, to which Councillor Gerry O'Donnell and Jim Parish, the lead HOSC members for the Acute Hospitals Trust, are invited. Board meetings are open to the public; and
- A HOSC scrutiny review of complaints related to attitude and communications which was recently completed.

Comments

- It is considered that the Quality Account is more accessible than last year's document, which was itself an improvement on the previous year. This progress appears to stem from a commitment to greater openness. Readability of the document would improve further however if jargon and abbreviations were addressed and an easy-read summary was provided;
- It is considered that the priorities for 2013/14 including A&E waiting times, the stroke pathway and occurrences of Clostridium difficile are in keeping with public expectations;
- The measurement of the priority to 'Improve mortality in outlying specialities' against the national average' is queried given the inevitable movement of the 'national average';
- The HOSC welcomes the Trust's plans to introduce the new 'duty of candour' expected in the NHS Constitution;
- The Trust has been asked to quantify the decrease in the number of falls in January and February and whether this was significant (see 3.1.2 Patient Safety);
- It is understood that it is felt necessary to remove the identities of other trusts from the charts showing comparative mortality rates (see 3.1.3 Clinical Effectiveness). This is unfortunate since it gives an easily understood rating which would be of some reassurance to the public;
- It is considered that a key area of complaints to be addressed by the Trust is around communications as this appears to be a problem area;
- It is noted that the number/extent of staff feeling they are able to contribute towards improvements is slightly lower than the national norm. This is in line with the HOSC assessment of the situation. Therefore, the response of the board to empower staff to contribute is welcomed (see 3.1.5 What our staff thought of our services);
- In the early draft version of the Quality Account seen by the HOSC, it is indicated that text will be included about patient and public engagement. It is hoped that this will clearly show where engagement was from and how views were obtained; and
- The HOSC accepts that the priorities and targets set by the Trust are made as a matter of professional judgement but it is reiterated that these would instil even more confidence were they produced as a result of cross-trust collaboration."

**The Mid Staffordshire NHS Foundation Trust Public Inquiry – Chaired by Robert Francis QC*

Response from Worcestershire Acute Hospitals NHS Trust

We would like to thank the Worcestershire Health Overview & Scrutiny Committee for providing this commentary and respond to some of the points made:

- We recognise that the Quality Account contains a lot of technical terms and details, most of which are required by the regulations and guidance that govern its content. We will, however, be providing a short, easy read version that explains the key points.
- The improvement priority to "improve mortality in outlying specialties" is not measured against a "national average" but against the relative risk of death when demographic and other factors are taken into account. The expected rate is expressed as 100. Anything less than 100 is better than expected and the aim for this improvement priority. The Trust's overall mortality ratios are provided in section 3.1.3.

- The decrease in patient falls in hospital in January and February is encouraging. While it may be a result of our efforts to reduce patient falls, we will have a clearer idea as more data is collected through the coming year.
- Reducing falls in hospital continues to be one of our priorities this year.

3.3.3 Clinical Commissioning Groups (CCGs)

"On behalf of NHS South Worcestershire CCG, Redditch & Bromsgrove CCG and Wyre Forest CCG:

A significant component of the work undertaken by the three new Clinical Commissioning Groups for Worcestershire, NHS South Worcestershire CCG, NHS Redditch and Bromsgrove CCG and NHS Wyre Forest CCG includes the quality assurance of health services provided for the population of Worcestershire. This includes steps to assure the public of the data included within this Quality Account.

Suggestions made for the 2011-12 Quality Account regarding the layout of the report, have in part been considered. There are some welcome explanations of significant terms (for example the explanation of Deprivation of Liberty Safeguards) and a useful brief justification for areas selected as priority for improvement in 2013-14. Other significant terms would benefit from an explanation as to their meaning in addition to details of actions that will be taken, for example regarding the implementation of the Duty of Candour. The report would continue to benefit from being presented by service / clinical pathway to enable members of the public to view a range of data together concerning an area of service that is of specific interest to them.

Areas of success such as the new Transitional Care Unit (Maternity) at Worcester Royal Hospital, smoking cessation rates for mothers at the point of delivery and improvements in Cancer services are to be congratulated. Commitment to strengthening staff engagement is welcomed by Commissioners along with plans to roll out 'How it feels to me' sessions to enhance staff members empathy and understanding of the patient experience.

Work to increase equality of access and user experience for vulnerable groups is commendable and considerable improvements have been experienced in the delivery of care for individuals with dementia and learning disability.

The three Worcestershire CCGs recognise the improvement work that has been undertaken to address areas where quality falls below that expected from Commissioners, patients and their carers/ families. The Quality Account contains useful and clear details of further actions that are planned for 2013-14.In 2012-13 Commissioners were required to issue a number of contract queries regarding performance with WAHT. Commissioners would wish to see considerable improvements in these areas (midwife to birth ratio, A+E performance, levels of staff mandatory training and treatment for TIAs). Actions in the following areas of concern are of priority for Worcestershire Commissioners in reducing avoidable harm and enhancing the patient experience:

- **Accident + Emergency**

Improvement is required in the time taken for people to be seen, admitted, discharged or transferred when they present to the Emergency Department (end of year performance for the 95% target for 2012-13 was 91.70%, a further deterioration from the previous year's result of 92.15%, despite an overall reduction in attendance across the year). There is recognition that the health economy needs to work in partnership to ensure that people present to the right place at the right time and that options other than A+E attendance for

those who are not acutely unwell are accessible and the public have confidence in using them.

- **Infection Prevention and Control**

This year the Trust significantly exceeded the number of cases for Clostridium Difficile (C. Diff) and Methicillin-Resistant Staphylococcus Aureus (MRSA) bacterium that were previously agreed between the Trust and Commissioners. Toward the end of the year (January to March) the number of cases of C Diff was more in line with expectation. For this trajectory to continue, the Trust will need to maintain focus on planned actions, including working with partner organisations across the health economy. The challenge of zero tolerance for MRSA acquired within the Trust this year will be significant. Norovirus outbreaks continued to present challenges and the impact on available beds at the Trust has been significant on a number of occasions, at times for significant periods. Assurance regarding the Trusts ability to minimise the spread, and hence the time period that outbreaks result in bed closures, remains a priority for Commissioners.

- **Reducing incidents that result in harm to patients – pressure ulcers and falls resulting in significant injury**

The Trust failed to reach the agreed target of a 35% reduction of falls with harm for 2012-13. A reduction in the number of falls with harm at the start of 2013 were unfortunately not maintained into March, although the overall reduction in events leading to moderate, major or catastrophic harm over the year is noted. Rapid Spread initiatives and other components detailed within the Quality Account need to demonstrate a significant impact. Recognising the improvement work that has commenced and the CQUIN scheme component agreed for the overall rate of falls for 2013-14, consideration of a reduction in incidents resulting in serious harm would be welcomed as an improvement priority.

The majority of information submitted appears to provide an accurate account. The opening statement is slightly misleading in stating that ‘we did manage to meet the national stroke target’ as this was not consistently the case until August 2012. Accurate detail regarding stroke performance is however recorded further into the report in section 3.1.3.

Welcome additions would include, in the spirit of openness and transparency, details of how the Trust plans to comply with the Francis Inquiry recommendation to make the details of upheld complaints available to both Commissioners and the public. Detail of actions taken in response to the themes of complaints for 2012-13 would act as a demonstration of transparency and provide public assurance of lessons learned. Commissioners would also welcome the sharing of complaint information in a timely manner.

Whilst patterns of incident themes appear to have been analysed more detail could be provided to reassure the public that lessons learned have been implemented to avoid or minimise repeat occurrence. This is particularly pertinent for areas of surgery where Never Events (events defined by the Department of Health that should never happen) have occurred.

Overall Worcestershire Clinical Commissioning Groups believe the Quality Account for 2012-2013 to be a reasonably balanced report that reflects most issues regarding the quality of health care services delivered by Worcestershire Acute Hospitals Trust.”

Response from Worcestershire Acute Hospitals NHS Trust

We would like to thank the three Worcestershire Clinical Commissioning Groups for providing their commentary on the Quality Account and respond to some of the points made:

A&E Performance:

We described the challenges in meeting the emergency access target in section 3.1.3. As always Worcestershire Acute Hospitals NHS Trust is committed to working with all of our partners to deliver this standard for our patients and it has been reflected by the Area teams that to deliver a consistent approach to the 4 hour access quality standard it requires a whole system response. The impact on the Trust and its patients is considerable and patient safety remains our primary concern.

We welcome the CCGs recognition of this and look forward to their work in resolving this issue which is being experienced nationally.

Stroke Targets
The draft version of Chief Executive's statement did state that the stroke targets had been met because that was the expectation when it was written. The final figures showed that we missed one target (stroke patients spending 90% or more of their time on a stroke ward) by less than 1%. This has been corrected in the final version.

High Risk Transient Ischaemic Attack (TIA)

Improvement in the management of TIAs was made and maintained during the year. The Trust is now seeing more high risk patients within the standards set and is delighted that the end of year position indicates that the Trust has achieved 61.5% for the whole year against a target of 60%, as the graphic below demonstrates.

The Proportion of High Risk TIA Patients Investigated and Treated Within 24 Hours

	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
% of High Risk TIA Patients Investigated and Treated Within 24 Hours	45.8%	51.6%	42.9%	71.4%	64.3%	60.6%	73.1%	62.1%	61.5%	62.5%	71.4%	63.0%
Target (<=5%)	>=60%	>=60%	>=60%	>=60%	>=60%	>=60%	>=60%	>=60%	>=60%	>=60%	>=60%	>=60%

This position is now more sustainable and centralisation of stroke services will deliver a consistent response for our patients.

Patient Falls
We have described our performance in reducing inpatient falls in section 3.1.2. A reduction was seen during the year and although we didn't achieve the target of reducing falls resulting in serious harm by 35%, these incidents did reduce by 20%. The early signs of this shortfall were seen and acted upon during the year and the 'Fallsafe' prevention and reduction programme was launched. The CCGs are aware that the reduction of falls is an ongoing high priority for the Trust and is monitored at Board level. This is set out in the Trust's Annual Plan.

3.3.4 The Patient and Public Forum

The Trust's own Patient and Public Forum asked us to include a statement in the Quality Account which we are happy to do:

"The Patient Forum congratulates the Trust on all that was achieved during 2012-13. We have noted improvements on wards, and patients tell us that they are more satisfied with the care that they receive. We note the new priorities and CQUINs for 2013-14, and find these appropriate, measurable, and, we believe, achievable.

In recent months senior staff have asked the Patient Forum to carry out visits to talk to patients in specific areas, which we have done. We have a continuing piece of work, requested with regard to emergency care, and A&E. We feel that the contribution we make to the Trust is valued highly, and look forward to more requests from staff during the coming months, to talk to patients and carers to find out what they think.

We wish the Trust well for the year 2013-14."

Response from Worcestershire Acute Hospitals NHS Trust

We are grateful to the Patient & Public Forum for taking the time to prepare this commentary. The Trust is privileged to work with the Forum whose members have actively worked across our hospitals in the interests of patients throughout the year.

Section 4 – Assurance Statements and Data

4.1 Review of Services

During 2012/13 the Worcestershire Acute Hospitals NHS Trust provided and/ or sub-contracted 43 NHS services.

Worcestershire Acute Hospitals NHS Trust has reviewed all the data available to them on the quality of care in 43 of these NHS services. The income generated by the NHS services reviewed in 2012/13 represents 100% per cent of the total income generated from the provision of NHS services by the Worcestershire Acute Hospitals NHS Trust for 2012/13.

4.2 Participation in clinical audits & National Confidential Enquiries

During April 2012 – March 2013, 42 national clinical audits and 4 national confidential enquiries covered NHS services that Worcestershire Acute Hospitals NHS Trust provides.

During that period Worcestershire Acute Hospitals NHS Trust participated in 38 [90%] national clinical audits and 100% 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 2012 – March 2013 are provided in the list 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 2012/13 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 confidential enquiries

Title	Number of cases identified in the Trust	Number of questionnaires Requested	Number of questionnaires Returned	Report Due Date
Subarachnoid Haemorrhage (This study is still open)	42	9	Data collection phase	
Alcohol Related Liver Disease	75	6	3	Spring 2013
Bariatric Surgery (organisational audit)	2			Autumn 2012
Cardiac Arrest Procedures	11	11	9	June 2012

No other confidential enquiries were carried out in 2012/13

National Clinical Audits

National Clinical Audits	Eligible	Participated	% of Participation	Comments
Acute Coronary Syndrome or Acute Myocardial Infarction (NICOR-MINAP)	yes	yes	51%	
Adult Cardiac surgery (NICOR-ACS)	no	no	**Do not provide the service**	
Cardiac Arrest (NCAA-ICNARC)	yes	no	**Local Audit**	
Cardiac Arrhythmia (NICOR-HRM)	yes	yes		Participation rate data to follow
Congenital heart disease (NICOR-Paediatric cardiac surgery)	no	no	**Do not provide the service**	
Coronary Angioplasty (NICOR-CA)	yes	yes	100%	
Heart failure (NICOR_HF)	yes	yes	39%	Data Collecting.
Vascular surgery (VSGBI Vascular Surgery Database)	yes	yes		Participation rate data to follow
Pulmonary hypertension (IC)	No	no	**Do not provide the service**	
Adult Asthma	yes	no	0%	Did not participate in 12/13
Bronchiectasis	yes	yes	100%	
Chronic Obstructive Pulmonary Disease (COPD) (COPD Discharge Audit)	yes	yes	93%	
Diabetes (Paediatric) (RCPCH-NPDA)	yes	yes	100%	
Inflammatory bowel disease (RCP-IBD) 4th Round	yes	yes		Registered and dataset requested. Audit runs to 30/08/13
Pain Database	yes	yes	100%	
Renal Registry (UKRR)	no		**Do not provide the service**	
Asthma Deaths (RCP) NRAD	yes	yes	100%	
National Adult Diabetes Audit-ANDA (NHS IC)	yes	yes		Participation rate data to follow
Adult community acquired pneumonia (BTS)	yes	yes		Data entry still open on the BTS Site until 31/5/13.
Adult Critical Care (ICNARC CMP)	yes	yes	100%	
Emergency use of oxygen (BTS)	yes	yes	100%	
National joint registry (NJR)	yes	yes		This is a continuous audit - Participation rate data to follow
Non-invasive ventilation (BTS)	yes	yes		Data collection completes on 31/05/13
Trauma (TARN)	yes	Yes	36%	We have commenced participation in this audit during 2012/13 Total 61 TARN Cases submitted
Renal colic (CEM) Bowel cancer (NBOCAP)	yes yes	yes yes	81%	Sample size (50 per site)- submitted:Alex: 50 casesWRH: 31 Cases Audit in progress
Lung cancer (LUCADA)	yes	yes		Upload due 30/6/12 for all patients diagnosed 1/1/12 – 31/12/12
Head and neck oncology (IC DAHNO)	yes	yes		Audit in progress
Oesophago-gastric cancer (RCS - NAOGC)	yes	yes		Audit in progress
Cardiothoracic transplant	no		**Do not provide the service**	
Comparative audit of blood transfusion 2012 Audit of blood sampling and labelling/	yes	yes	100%	
Renal transplantation (NHSBT UK Transplant Registry)	no		**Do not provide the service**	
Potential donor	no		**Do not provide the service**	
Carotid interventions (RCP-CIA)	yes	yes	68%	
Fractured neck of femur (CEM)	yes	yes	100%	
Hip fracture database (BOA-NHFD)	yes	yes	93%	
Parkinson's disease (Parkinson's UK)	yes	no	0%	Winter pressures precluded participation
(SSNAP) Stroke National Audit Sentinel and SINAP) Programme (combined Sentinel and SINAP)	yes	yes	100%	**Organisational Audit Report-received Clinical Audit** - 12/12/12 Ongoing to 2013
National Audit of Dementia (CCQI)	yes	yes	**100%**	

Epilepsy 12 (Childhood Epilepsy) (RCPCH)	yes	yes		Audit in progress
Fever in children (CEM)	yes	yes	100%	
Neonatal intensive and special care (RCPCH-NNAP)	yes	yes	100%	
Paediatric asthma (BTS)	yes	yes	100%	
Paediatric Intensive Care (PICA Net)	no		**Do not provide the service**	
Paediatric pneumonia (BTS)	yes	yes	95%	Data entry completed on 05/04/13
Child Health (CHR-UK)	yes	yes	100%	
Maternal infant and Perinatal Mortality	yes	yes		Audit in progress - participation data awaited
Prescribing Observatory for Mental Health (POMH- UK)	no		**Do not provide the service**	
Psychological therapies	no		**Do not provide the service**	
Suicide and homicide in mental health (NCISH)	no		**Do not provide the service**	
Health promotion in hospitals (NHPHA)	yes	no	**Local Audits**	

The reports of 11 national clinical audits were reviewed by Worcestershire Acute Hospitals in 2012 and Worcestershire Acute Hospitals NHS Trust intends to take the actions to improve the quality of healthcare provided as described below.

Actions taken following national clinical audit reports:

Title	Action Points
BAPEN's 1st Nutrition Screening Audit (British Association for Parenteral and Enteral Nutrition)	• Re-Audit MUST tool on the wards to ensure all patients are being screened on admission to hospital • Discussion of different raining approach, possible introduction of e-learning for ward staff to be trained and gain competencies • Change to MUST score on EDS
National Clinical Audit of Heavy Menstrual Bleeding - Clinical Audit (2nd year)	• Discuss the outcome of the first 2 years • Continue with the audit
Childhood Epilepsy (Royal College of Paediatric and Child Health (RCPCH) National Childhood Epilepsy Audit)	• Care Pathway on Intranet – accessible to GP and Hospital Trust Staff. NICE guidelines on Trust Intranet. Email all Consultant Paediatricians and A/E consultants • Adult Neurologists already putting business case together. Audit presented to Trust Audit committee and request noted. • Consultant Job plans to be reviewed (October 2012) we hope to include our sister hospital the Alexandra. • We have networked with a neighbouring hospital who have a good database and have booked a visit 14th Nov. 2012
National Hip Fracture Database (NHFD)	• Monthly review of all hip and knee replacements to ensure NHF data is being captured in every case • Contact IT to review NHFD data capture - Bluespier Operation note and data entry programmed to Capture NHFD data
National Neonatal Audit Programme (NNAP)	• Admit small babies < 29 weeks onto platform with overhead heater • Support earlier discharge using outreach nurses and for selected babies milk fortifier • Maternity database - Await introduction of maternity database

	• Ensure all blood and CSF cultures recorded on badger
Coronary angioplasty- National Institute for Cardiovascular Outcomes Research (NICOR) Adult Cardiac Interventions Audit - PCI	• Improving access for Primary PCI for Worcester and Hereford patients from 9-5 to 24 hours. This requires the provision of our second Cath Lab
National Elective Surgery PROMs: four operations	• Improving existing participation compliance for PROM's for: Hip & Knees, Inguinal hernia's, Varicose veins • Poor communication and ownership of PROM's performance to staff and patients • Potential lack of 'readiness' for the roll out of PROM's questionnaires for all elective surgical procedures in October 2012 than ophthalmology
College of Emergency Medicine (CEM) National Pain Management in Children	• Improved frequency of re-evaluation of pain and at an earlier time - Departmental meeting, nursing staff meeting. Notice in CD cupboard for nursing staff when giving morphine/diamorphine • Faster treatment of severe pain - Departmental meeting, nursing staff meeting • Codeine for moderate pain - Pharmacy contacted to add to stock list
CEM National Severe Sepsis in Septic Shock Management in Adults in A&E	• To continue excellent care - Departmental meeting -results disseminated to nursing staff and doctors • Ensure rotating junior Emergency Department (ED) staff are aware of management of sepsis and practising excellent care - Induction/teaching. Daily board rounds in the ED Timing of blood cultures - Establish electronic blood ordering through PF: IT are setting up an new interface • Blood glucose on all patients - Nursing staff meeting
Percutaneous Nephrolithotomy British Association of Urological Surgeons (BAUS) National Audit	• Our findings were consistent with National Data from BAUS - Continued monitoring of outcomes of PCNL for PHR • Further project to include full data from departmental PCNL surgery - Further audit study including consultant Urologist data
Bedside Transfusion (National Comparative Audit of Blood Transfusion)	• The Hospital Transfusion Team should work with the hospital group responsible for the patient identification policy to ensure that the policy specifically covers blood transfusion • The blood administration policy should state 'no wristband, no transfusion' and it should be the responsibility of the person administering the blood to ensure a wristband is applied if it is found to be missing • Where wristbands are printed from the patient administration system, there should be 24/7 access to this facility for the staff responsible for printing wristbands and a contingency for providing an alternative in the event of a system failure. All staff should be trained in the use of the alternative system • If a form of identification other than a wristband is used it should be able to be physically attached to the patient not to the cot, incubator, bed, chair or other item of equipment that could result in the identification being transposed

	A risk assessed alternative should be in place if the patient either cannot or refuses to wear a wristband. For each individual case there should be a clearly documented rationale why an alternative has been used • Patients should be encouraged, where possible, to take an active role in the bedside check by stating their full name and date of birth, helping to ensure correct identification - Continuing education of trust staff in theory training. Pre op sessions to promote patient awareness. • Blood should not be transfused if any discrepancy is noted by the healthcare practitioner carrying out the bedside check. The discrepancy should be corrected and, if necessary, the blood reissued with repeat blood sampling • All IT systems that are used to support blood transfusion should use the same core set of patient identifiers • Healthcare staff should ensure that post transfusion observations are carried out prior to the discharge of day patients and should provide contact information for the patient to use in the event of them feeling unwell following the transfusion - Post transfusion advisory form to be given to the patient on discharge.
British Thoracic Society (BTS) National Pleural Procedures audit (Chest Drain)	• Better use of procedure room on Laurel 2 for pleural procedures - Storage cupboard for equipment • Provide privacy curtain
Survey of Healthcare Acquired Infections (HAI) and antibiotic consumption.	• Review of value for money of mandatory elective admission MRSA screening programme in low risk cases • Consider returning to screening in targeted cases only - Goes against national guidance so requires sign-off by board

The reports of 7 local clinical audits were reviewed by the provider in 2012/13 *(at the Clinical Audit & Effectiveness Committee – a significantly higher number were reviewed at Directorate level)* and Worcestershire Acute Hospitals NHS Trust intends to take the following actions to improve the quality of healthcare:

Selected actions resulting from local clinical audit in 2012/13

Audit	Specialty	Proposed Actions
'Voices' - end of life care	Nursing	Competencies for End of Life to be developed by the AMBER Champions via 'Quality End of Life Care for All' (QELCA) Programme Education - whole disease pathway approach Involve Hospital Specialist Palliative Care Team & site specific Clinical Nurse Specialists (CNS) Use of Ward Meetings to feedback VOICES comments forward areas consistently highlighted
Amber Care Bundle	Nursing	Increase AMBER Champions Network - Medical/Surgical Champions to be recruited from non-cancer Clinicians
5 day review/stop for antibiotic therapy	Microbiology	Revise drug chart to promote compliance with indication and review documentation
Glaucoma Patient Referrals	Ophthalmology	To introduce a one stop glaucoma clinic for new patients referred with glaucoma in which all required measurements will be completed on first clinic appointment.
Maternal Readmission	Obstetrics	Develop guidelines for the re-admission process to acute hospital for postnatal mothers and babies Review community midwife caseloads Inclusion of HED (Healthcare Evaluation Dataset) / HES (Hospital Episode Statistics) data analysis regarding maternity readmissions in monthly maternity reports
Management of nasogastric Tube	Nursing	Nurses to attempt to obtain aspirate before requesting x-ray
Use of Prothrombin Concentrate Complex (Beriplex)	Haematology	A more detailed local protocol/algorithm to 'standardise' PCC advice and usage within the trust, including post administration monitoring. A 'junior doctor checklist' that can be worked through to ensure appropriate, safe and timely use of PCC within the trust (which could be used for further auditing purposes).

Clinical Audit - Presentations and Publications Portfolio 2011/12

Microbiology

Poster presentations at the national Federation of Infection Societies meeting, held in Liverpool in November 2012.

- Door to needle time audit (page 254 of abstract file)
- Fusobacterium (page 202)

http://www.hisconference.org.uk/documents/FISHIS2012AbstractContents.pdf

Urology

Sepsis rates post biopsy was presented in March by Dr Sonpreet Rai at the Royal College of Surgeons Presidents meeting and won the Lister Legacy Prize for best presentation.

Audit on the use of CT KUB in the Investigation of Suspected Renal Calculi was presented in London by Dr William Fusi-Rubiana

Audit of Assessment of Retention of Urine was presented at the Royal College of Surgeons Presidents meeting on 8th March 2013 by Dr Mel Cheung.

4.3 Participation in clinical research

The number of patients receiving NHS services provided or sub-contracted by Worcestershire Acute Hospitals Trust in the financial year 12/13 that were recruited during that period to participate in research adopted on the NIHR portfolio was 914.

Participation in clinical research demonstrates Worcestershire Acute Hospitals Trust commitment to improving the quality of care we offer and to making our contribution to wider health improvement. Our clinical staff stay abreast of the latest possible treatment possibilities and active participation in research leads to successful patient outcomes.

There were 82 clinical staff leading or actively participating in research approved by a research ethics committee at Worcestershire Acute Hospitals Trust during the financial year 12/13. These staff participated in research covering 16 medical specialties.

2012/13 was also the fourth year of a five year programme from the Department of Health aimed at doubling patient recruitment into clinical trials in every provider organisation in England. Worcestershire Acute Trust has increased recruitment 2.5 times the levels in year one.

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

4.4 What others say about us

Care Quality Commission (CQC)

Worcestershire Acute Hospitals NHS Trust is required to register with the Care Quality Commission (CQC) 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 2013.

Worcestershire Acute Hospitals NHS Trust has participated in no special reviews or investigations by the Care Quality Commission relating during 2012/13.

The CQC has performed planned unannounced inspections at Kidderminster Hospital, the Alexandra Hospital and Worcestershire Royal Hospital during 2012/13. Our compliance with the CQC essential standards of quality & safety at the year-end is as follows for our registered sites:

CQC outcomes	Alexandra Hospital	Kidderminster Hospital	Worcestershire Royal Hospital	Evesham Community Hospital	Tenbury Community Hospital
1	Inspected 25/7/12 - compliant	Inspected 25/7/12 - compliant	Inspected 25/7/12 - compliant	***Not inspected	***Not inspected
2	Inspected 25/7/12 - compliant	***Not inspected	Inspected 25/7/12 - compliant	***Not inspected	***Not inspected
4	Inspected 25/7/12 - compliant	***Not inspected	Inspected 25/7/12 - compliant	***Not inspected	***Not inspected
5	Inspected 25/7/12 - compliant	Inspected 25/7/12 - compliant	Inspected 25/7/12 - compliant	***Not inspected	***Not inspected
6	Inspected 25/7/12 - compliant	***Not inspected	Inspected 25/7/12 - compliant	***Not inspected	***Not inspected
7	Inspected 25/7/12 - compliant	Inspected 25/7/12 - compliant	Inspected 25/7/12 - compliant	***Not inspected	***Not inspected
8	Inspected 25/7/12 - compliant	***Not inspected	Inspected 25/7/12 - compliant	***Not inspected	***Not inspected
9	**Not inspected	***Not inspected	**Not inspected	***Not inspected	***Not inspected
10	**Not inspected	***Not inspected	**Not inspected	***Not inspected	***Not inspected
11	**Not inspected	***Not inspected	**Not inspected	***Not inspected	***Not inspected
12	**Not inspected	***Not inspected	**Not inspected	***Not inspected	***Not inspected
13	Inspected 25/7/12 - compliant	Inspected 25/7/12 - compliant	Inspected 25/7/12 - compliant	***Not inspected	***Not inspected
14	Inspected 25/7/12 - compliant	***Not inspected	Inspected 25/7/12 - compliant	***Not inspected	***Not inspected
16	Inspected 25/7/12 - compliant	***Not inspected	Inspected 25/7/12 - compliant	***Not inspected	***Not inspected
17	**Not inspected	***Not inspected	**Not inspected	***Not inspected	***Not inspected
21	Inspected 24/5/12 - compliant	Non-compliant - Minor impact on patients	Inspected 18/09/12 - compliant	***Not inspected	***Not inspected

Worcestershire Acute Hospitals NHS Trust has made the following progress by 31st March 2013 in taking such action:

Outcome 21 Records – Kidderminster Hospital

The CQC judged that the Trust was not meeting this standard following an inspection in July 2012. It judged this had a minor impact on people using the service and action was needed for this standard.

An action plan was completed and work to make improvements was commenced to address the shortfalls in the compliance. The Trust has evaluated its compliance with Outcome 21 and will be informing the CQC that it believes that it is ready for re-inspection.

4.5 Quality of Data

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 Trust's 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 GPs.

Worcestershire Acute Hospitals NHS Trust submitted records during 2012/13 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data are provided below.

Patient's valid NHS number was:
- 99.7% for admitted patient care;
- 99.8%for out patient care; and
- 97.8% 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 valid Ethnic Origin was:
- 97% for admitted patient care

Actions taken to improve data quality

Information Governance toolkit

The Toolkit score for 2013 will be 76% improving over the last year by 3%. The 4 standards scored at a level 1 now meet the requirements of a level 2 and this means the toolkit will have moved from an unsatisfactory to satisfactory standard. Many of the requirements in the toolkit are data quality and clinical coding standards.

Data Quality Group

The Quality Group meets monthly to ensure year-on-year improvements in the timeliness and quality of the Trusts data. The group receives national guidance, comparative data quality reports, audit reports, and reviews PAS enhancements and operational procedures to ensure data capture is completed in an accurate and timely manner. It also supports the data assurance element of the Information Governance (IG) toolkit.

One of the elements of IG and national standards is completeness of the NHS number. A project has been undertaken and as a result A&E NHS number completion has increased from 70% to 97.5%

A range of audits are carried out by the trusts to provide internal and external assurance regarding the accuracy and timeliness of its data. These include;

- Worcestershire Acute Hospitals NHS Trust was subject to the Payment by Results A&E clinical coding audit during 2012/13 by the Audit Commission and the error rates to be reported in the published audit for that period for investigation and treatment coding have not yet been published. The Trust has already addressed the recommendations highlighted by the auditors at the feedback meeting.

- Worcestershire Acute Hospitals NHS Trust was not subject to the Payment by Results inpatient clinical coding audit during 2012/13 by the Audit Commission.

  In line with toolkit requirement 505, an IG coding audit of 200 sets of notes was recently completed. The percentage of HRG's that would change as a result of the audit was 8.5%. This means the Trust has maintained a Level 2 of the Information Governance Toolkit, Requirement 505.

- A coding internal audit schedule is in place and the coding auditor has conducted several clinical and staff audits.

- The annual data quality audit for 2012/13 (IG toolkit requirement 506) carried out by Internal Audit. This showed a 3% error rate for all areas audited, covering key fields submitted nationally from the inpatients, outpatients and inpatient waiting list data. The Trust has an action plan in place to fully implement the requirements of this standard.

Clinical Coding

The trust worked with an external company to improve the accuracy and timeliness of its coded data. Presentations have been delivered to clinicians and junior doctors by clinical directors and the importance of recording co-morbidities and chronic conditions have been re-iterated. Following the project a process was put in place to ensure regular updates to the Coding website, implement local coding policies in conjunction with clinicians, and provide training and guidance to Coders to ensure consistency in coding conventions.
Recently a Coding Dashboard has been developed to monitor coding by directorate which reports on key coding performance measures. This dashboard is to be promoted to clinical leads.

Systems being implemented that will promote data quality

Promoting use of information to staff at all levels in the organisation results itself in promoting and improving the quality of data. The Trust has recently invested in various systems that increase the use of information.

- Polaris is the Trust's new Performance Navigation tool. It is the Trust's Business Intelligence solution which will provide up-to-date, accurate, high quality information to the people that need it at the time they need it. The Polaris Performance Navigator is at an early stage of development. When fully developed it will be the central point of navigation for all the Trust's information needs, a one stop information shop.

  As part of Polaris two key projects are under way.

  1 - Performance Dashboard - An electronic Performance Dashboard has been developed which bringing together clinical, activity, workforce and financial information. This provides an overview of Trust performance with drill through to lower levels of detail.

  2 - i-Health BI - A data warehouse has been procured called i-Health BI which initially encompasses inpatient, outpatient and A&E data. A full suite of reports will be available by summer 2013.

- Theatre Tracker - A Theatres Tracker has been implemented that includes a wide range of utilisation and data quality reports. Through theatre staff using the dashboard information and querying the results, as well as using the data quality reports, the theatre information should be improved.

- Outpatient Improvement Project – a range of booking efficiency reports are now available to support improved utilisation of clinics and improve data quality of booking information.

During the last twelve months through a series of projects and audits the quality of the trusts data has been scrutinised and areas for improvement identified. Through the implementation of future projects the Board and senior staff will continue to be provided with accurate, timely, relevant and standardised patient information. This is required to support and deliver its core business objectives and to monitor the Trusts activity and performance for internal and external management purposes and improved patient care.

4.6 Mandatory Indicators and National Targets

All trusts are required by the Department of Health to provide a core set of indicators relevant to the services they provide using a standardised statement.

The eight indicators relevant to Worcestershire Acute Hospitals NHS Trust are provided below using information from the Health & Social Care Information Centre and cover the last two reporting periods where the data is available.

Title	Indicator	2011/12	2012/13	National Average	Highest and lowest NHS Trust and Foundation Trust scores for the reporting period
Summary Hospital Mortality Indicator (SHMI)	a) the value and banding of the summary hospital-level mortality indicator ("SHMI") for the trust for the reporting period;	During 2011/12 the Trusts SHMI was 101.99 The Trust was then in in band 2	The SHMI for the first 6 months of 2012/13 was 97.88. The Trust is in Band 3	There is no 'national average'. The expected mortality ratio is 100 This puts the Trust into 50% of Trusts with the lowest relative risk.	For similar Trusts to ours in the first 6 months of 2012/13: Highest: 68.49 Lowest: 121.07
	b) the percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period.	• From April 2011 to March 2012, 25% of deaths had a palliative care code (WRH 27%, AGH 21% KGH 79%)	• From April 2012 – Feb 2013 31% of all deaths had a palliative care code (WRH 26%, AGH 40%, Kidderminster 52%).	N/A	N/A
	The Worcestershire Acute Hospitals NHS Trust considers that this data is as described for the following reasons:		We use the Healthcare Evaluation Dataset (HED) tool for analysis of HES data to provide SHMI and palliative care statistics.		
	The Worcestershire Acute Hospitals NHS Trust has taken the following actions to improve this number, and so the quality of its services, by:		• Reviewing the SHMI and HSMR data on a monthly basis. The data is broken down by diagnostic code and where there appears to be a significant contribution to potentially avoidable mortality casenote reviews are undertaken. • identifying avoidable factors and making changes to improve patient care. The Trust has identified 3 such areas for specific focus during 2013/14 with the aim of improving outcomes for patients presenting with a stroke, congestive cardiac failure or acute renal failure.		

Title	Indicator Casemix adjusted average health gain	2011/12 Health Gain	2012/13 (provisional data – April to December 2012) Health Gain	National Average (provisional data – April to December 2012) Health Gain	Highest and lowest NHS Trust and Foundation Trust scores for the reporting period Health Gain
Patient Recorded Outcome Measures **(PROMS)**	(i) groin hernia surgery	0.869	-1.261	-0.521	Highest = 4.271 Lowest = -5.216
	(ii) varicose vein surgery	19.606	22.328	20.496	Highest = 24.161 Lowest = 16.408
	(iii) hip replacement surgery	14.752	13.056	15.666	Highest = 20.197 Lowest = 16.408
	(iv) knee replacement surgery	-8.236	Not Available	-8.204	Highest = -3.470 Lowest = -12.461
	The Worcestershire Acute Hospitals NHS Trust considers that this data is as described for the following reasons:		• The information has been obtained from the Health & Social Care Information Centre • The indicator used is – casemix adjusted average health gain • The data for 2012/13 is provisional and cover only the first three quarters of the year		
	The Worcestershire Acute Hospitals NHS Trust has taken the following actions to improve this number, and so the quality of its services, by:		• Improving the responses rate for PROMS questionnaires as described in the Quality Account		

Title	Indicator	2011/12	2012/13	National Average	Highest and lowest NHS Trust and Foundation Trust scores for the reporting period
Readmission rates	The percentage of patients aged (i) 0 to 14; and (ii) 15 or over, readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period.	**0 to 14** Data not available Health & Social Care Information Centre for this period. **15 or over** Data not available Health & Social Care Information Centre for this period.	**0 to 14** Data not available Health & Social Care Information Centre for this period. **15 or over** Data not available Health & Social Care Information Centre for this period.	**0 to 14** Data not available Health & Social Care Information Centre for this period. **15 or over** Data not available Health & Social Care Information Centre for this period.	**0 to 14** Data not available Health & Social Care Information Centre for this period. **15 or over** Data not available Health & Social Care Information Centre for this period.
	The Worcestershire Acute Hospitals NHS Trust considers that this data is as described for the following reasons:	The latest data available from the Health & Social Care Information Centre for the national average and highest and lowest scores is for 2010/11. We are unable to provide data for the periods requested.			
	The Worcestershire Acute Hospitals NHS Trust has taken the following actions to improve this number, and so the quality of its services, by:	As above.			

Title	Indicator	2011/12	2012/13	National Average	Highest and lowest NHS Trust and Foundation Trust scores for the reporting period
Patient Survey – Responsiveness to patient's needs	The trust's responsiveness to the personal needs of its patients during the reporting period	66	65.2	68.1	Highest: 84.4 Lowest: 57.4
	The Worcestershire Acute Hospitals NHS Trust considers that this data is as described for the following reasons:		The data is collected by an independent contractor on behalf of the Trust using robust methodology and is used for the associated CQUIN.		
	The Worcestershire Acute Hospitals NHS Trust has taken the following actions to improve this number, and so the quality of its services, by:		• Making it easier for patients to speak to doctors during their stay in hospital • Developing and improving information on the discharge process • Expanding the clinical leadership capacity by creating more time for Ward Sisters to supervise and to be more visible to patients, carers and staff.		

Title	Indicator	2011/12	2012/13	National Average	Highest and lowest NHS Trust and Foundation Trust scores for the reporting period
Staff recommending the trust as a provider of care	The percentage of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends.	2011 = 3.49	2012 = 3.59	National 2012 Average for acute Trusts = 3.57	Highest: 4.08 Lowest: 2.90
	Note: This score is not presented as a percentage by the CQC. We therefore can only monitor our performance on this metric by reviewing the score from the 2013 Staff Opinion Survey which will be available in March 2014.				
	The Worcestershire Acute Hospitals NHS Trust considers that this data is as described for the following reasons:		• the data has been published by the Care Quality Commission based on the data supplied from the independent contractor who administered our 2012 Staff Opinion Survey		
	The Worcestershire Acute Hospitals NHS Trust has taken the following actions to improve this number, and so the quality of its services, by:		• regularly feeding back to staff through daily brief • patient stories, • monitoring the responses from patients, the public and staff on surveys and complaints and compliments		

Title	Indicator	2011/12	2012/13	National Average	Highest and lowest NHS Trust and Foundation Trust scores for the reporting period
Venous thromboembolism Risk assessments	The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period	93.3	95.7%	94.1%	Highest = 100% Lowest = 84.6%
	The Worcestershire Acute Hospitals NHS Trust considers that this data is as described for the following reasons:		The data is reviewed and scrutinised by a range of people on a monthly basis.		
	The Worcestershire Acute Hospitals NHS Trust has taken the following actions to improve this number, and so the quality of its services, by:		The trust is developing an electronic prescribing system with a mandatory requirement to complete the VTE due to be piloted in Autumn 2013 or early 2014.		

Title	Indicator	2011/12	2012/13	National Average	Highest and lowest NHS Trust and Foundation Trust scores for the reporting period
C. difficile infection	The rate per 100,000 bed days of cases of C.difficile infection reported within the trust amongst patients aged 2 or over during the reporting period.	22.80 cases per 100 000 bed days	27.75 cases per 100 000 bed days	N/A	N/A
	The Worcestershire Acute Hospitals NHS Trust considers that this data is as described for the following reasons:		The 2012/13 data is not available from the Health & Social Care Information Centre. We have provided the figure for 2012/13 provided by the Health Protection Agency as we believe this to be accurate and it provides a comparison between this and the last reporting period.		
	The Worcestershire Acute Hospitals NHS Trust has taken the following actions to improve this rate, and so the quality of its services, by:		• Promoting and driving and delivering reductions in antibiotic usage (both in hospital and in the community), • enhanced cleaning (including the use of Hydrogen Peroxide Vapour decontamination), • provision of educational and other information on CDI for patients and staff, and • re-enforcing personal infection prevention and control practice (including hand hygiene) for all staff through training and audit		

Title	Indicator	2011/12	2012/13 (April – September 2012) The latest data available	National Average (April – September 2012) The latest data available	Highest and lowest NHS Trust and Foundation Trust scores for the reporting period
Incidents	The number and, where available, rate of patient safety incidents reported within the trust during the reporting period,	<u>Number of incident reports:</u> April 11 – Sept 11 = 4318 October 11 to March 12 = 4741 <u>Rate of patient safety incidents:</u> April 11 – Sept 11 = 7.2 per 100 admissions October 11 to March 12 = 8.3 per 100 admissions (median 5.9)	Number of incident reports: 5541 Rate of patient safety incidents: • 9.33 per 100 admissions	Number of incident reports: 4060 average Rate of patient safety incidents: • 6.2 per 100 admissions (average)	For similar Trusts – as provided by the NRLS: Highest Number: 6485 Highest rate: 12.6 Lowest number: 859 Lowest rate: 1.99
	the number and percentage of such patient safety incidents that resulted in severe harm or death	April 11 – Sept 11 = Number: ○ 17 severe harm ○ 2 deaths Percentage: ○ 0.4% severe harm ○ 0.0% death October 11 to March 12 = Number: ○ 9 severe harm ○ 11 deaths Percentage: ○ 0.2% severe harm ○ 0.2% death	Number: 12 • 10 severe harm • 2 deaths Percentage: • 0.2% Severe harm • 0.0% deaths	Number (average) • 23.7 severe harm • 5.46 deaths Percentage: • 0.6% severe harm • 0.1% death	This data is not available
	The Worcestershire Acute Hospitals NHS Trust considers that this data is as described for the following reasons:		• The national comparison data is provided by the National Reporting and Learning system using data that we export incident data, which is checked before it is released. • We are compared against a 'cluster' of 39 similar large Acute Trusts so that the comparison is meaningful.		
	The Worcestershire Acute Hospitals NHS Trust has taken the following actions to improve this rate (for incident reporting) and number (of incidents that result in severe harm or death) and so the quality of its services, by		• Continuing to encourage incident reporting (in line with the NHS Outcomes Framework) • Improving the investigation and response to incidents • Making care more reliable by reducing unwarranted variation.		

National Targets:
Worcestershire Acute Hospitals NHS Trust's performance against the NHS national targets is provided below:

Worcestershire NHS
Acute Hospitals NHS Trust

Section 3 - Review of Quality Performance

3.1.1 Delivery of National Targets

Reducing the Incidence of Avoidable Harm

A key part of infection prevention and control is the management of specific infections and their risks.

Cumulative Incidences of Clostridium Difficile (C.diff)

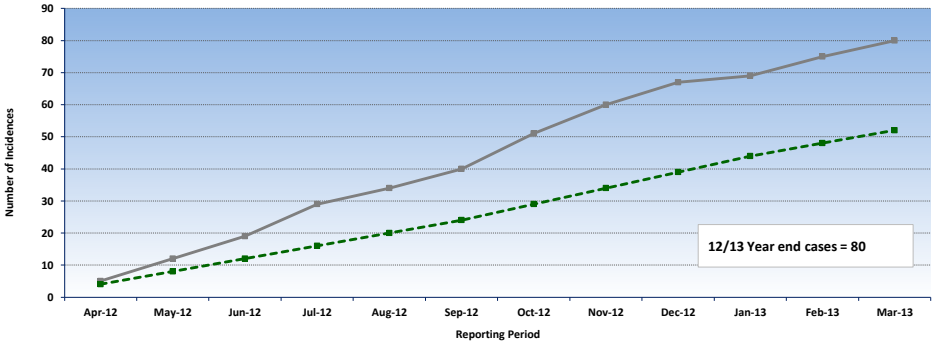
	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
Number of Incidences (Cumulative)	5	12	19	29	34	40	51	60	67	69	75	80
Threshold (Cumulative)	4	8	12	16	20	24	29	34	39	44	48	52

Rationale

Clostridium Difficile (C.diff) is an organism which is found in the intestines of approximately 2% of normal adults.

Results

The numbers of hospital attributable C. Difficile infection has exceeded the cap for 12/13. Actions from an external review of the Trust's (and local Health Economy's) practices and procedures to prevent C. difficile will be implemented into 2013/14.



Clostridium Difficile (C.diff) % Positivity Rate

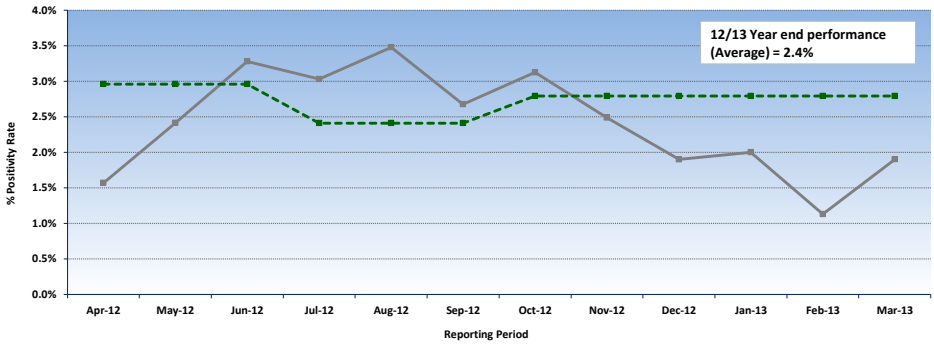
	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
Positivity Rate % (Trust Attributable/Non-Attributable)	1.6%	2.4%	3.3%	3.0%	3.5%	2.7%	3.1%	2.5%	1.9%	2.0%	1.1%	1.9%
Threshold % (National Benchmark - Acute Trusts)	3.0%	3.0%	3.0%	2.4%	2.4%	2.4%	2.8%	2.8%	2.8%	2.8%	2.8%	2.8%

Rationale

Clostridium Difficile (C.diff) is an organism which is found in the intestines of approximately 2% of normal adults.

Results

Positivity rates are dependant upon the number of tests conducted. Worcestershire Acute NHS Hospitals Trust is within the upper quartile of Trusts for the number of tests it conducts, and as the chart shows remains well below the national benchmark since November 2012.



Section 3 - Review of Quality Performance

3.1.1 Delivery of National Targets

Reducing the Incidence of Avoidable Harm

A key part of infection prevention and control is the management of specific infections and their risks.

Cumulative Incidences of Methicillin-Resistant Staphylococcus Aureus (MRSA)

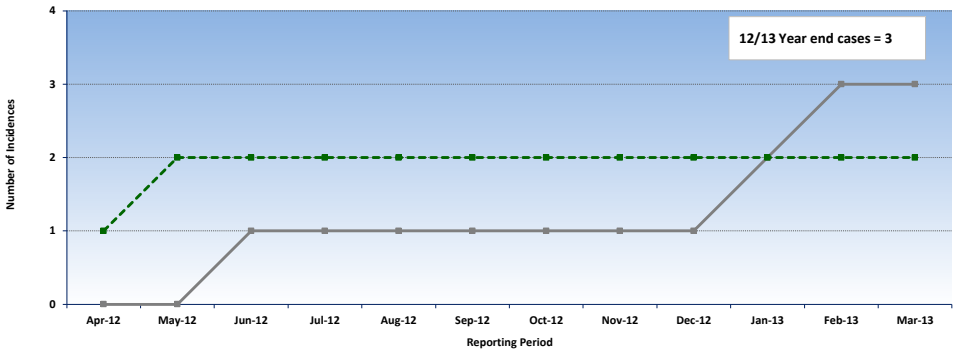
	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
Number of Incidences (Cumulative)	0	0	1	1	1	1	1	1	1	2	3	3
Threshold (Cumulative)	1	2	2	2	2	2	2	2	2	2	2	2

Rationale

MRSA is a bacterium that can cause infections. The Trust screens all elective admissions unless within the exemption categories set out by the Department of Health.

Results

The numbers of trust attributable MRSA bloodstream infections for 2012/13 was 3 cases against a trajectory of 2. Detailed root cause analysis of these cases has been undertaken to take forward learning into 2013/14 to support achievement of the 2013/14 target of zero cases.



Elimination of Avoidable Venous Thrombo-Embolism (VTE)

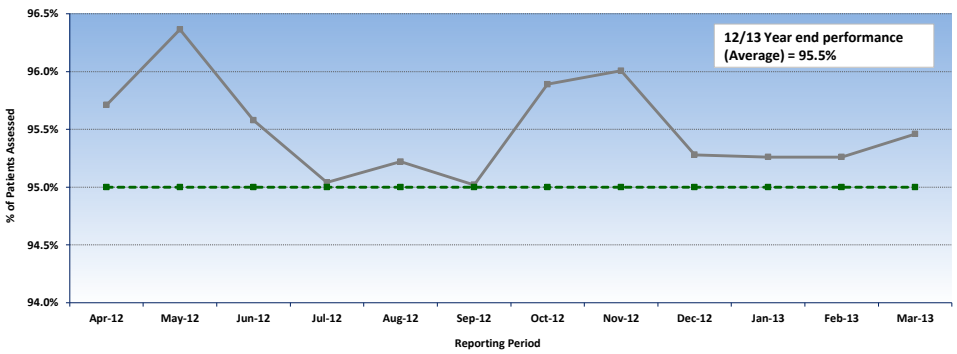
	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
% of Patients Having VTE Risk Assessment	95.7%	96.4%	95.6%	95.0%	95.2%	95.0%	95.9%	96.0%	95.3%	95.3%	95.3%	95.5%
Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%

Rationale

To reduce avoidable death, disability and chronic ill health from Venous Thromboembolism (VTE). 95% Patients will have a risk assessment and appropriate preventative intervention(s).

Results

The Trust remains fully compliant against this indicator.



Section 3 - Review of Quality Performance

3.1.1 Delivery of National Targets

Mortality Relative Risk

We use a number of indicators to understand the outcomes of patients treated by the Trust. The established measurements used across the country are the **Hospital Standardised Mortality Ratio (HSMR)** and **Standardised Hospital Mortality Index (SHMI)**. The calculations for these measures are based on a number of factors such as the patient's age, the illness they were admitted with and any other medical conditions they also had.

Hospital Standardised Mortality Ratio (HSMR)

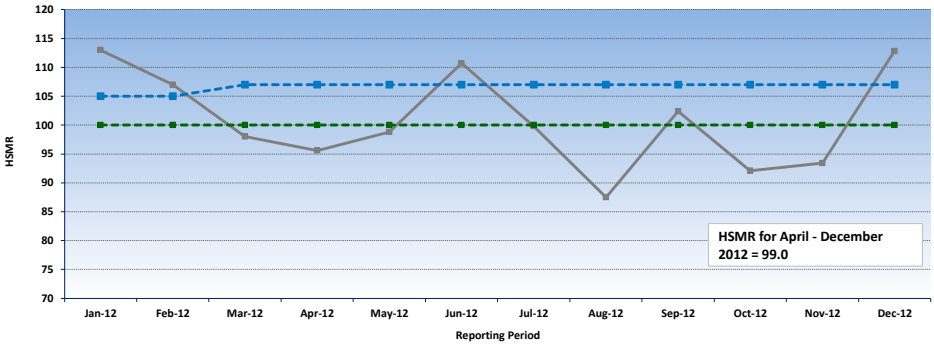
	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12
Hospital Standardised Mortality Ratio (HSMR)	113	107	98	96	99	111	100	88	102	92	93	113
Upper Control Limit (UCL)	105	105	107	107	107	107	107	107	107	107	107	107
Target (Reduced HSMR below 100)	<100	<100	<100	<100	<100	<100	<100	<100	<100	<100	<100	<100

Rationale

The Hospital Standardised Mortality Ratio (HSMR) calculates the relative risk of death occurring whilst in a hospital setting. A number under 100 indicates more survivors than expected.

Results

The HSMR for April - December 2012 (rebased for 2012/13 and the latest available) was 99.0. This shows the Trust to be within the expected range. Variation through the year is expected.



Standardised Hospital Mortality Index (SHMI) *

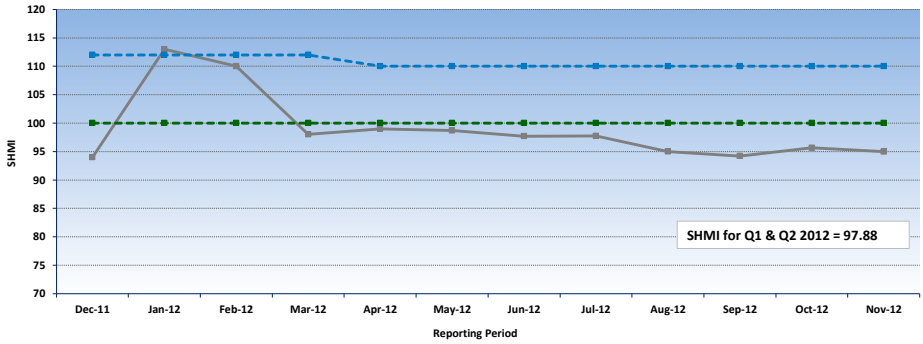
	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12
Standardised Hospital Mortality Index (SHMI)	94	113	110	98	99	99	98	98	95	94	96	95
Upper Control Limit (UCL)	112	112	112	112	110	110	110	110	110	110	110	110
Target (Reduced SHMI below 100)	100	100	100	100	100	100	100	100	100	100	100	100

Rationale

The Standardised Hospital Mortality Index (SHMI) calculates the relative risk of death of all patients managed by the Trust including the period up to 30 days after discharge. A number under 100 indicates more survivors than expected.

Results

The SHMI for 2012 Quarter 1 and 2 (the latest available) shows a value of 97.88. This shows the Trust to be within the expected range.



Section 3 - Review of Quality Performance

3.1.1 Delivery of National Targets

Cancer Waiting Times

The Government's document 'Improving Outcomes: A Strategy for Cancer' confirmed that cancer waiting times remain an important issue for cancer patients and the NHS should continue to ensure that cancer services are delivered to patients in a timely manner.

31 Days: Wait For First Treatment: All Cancers

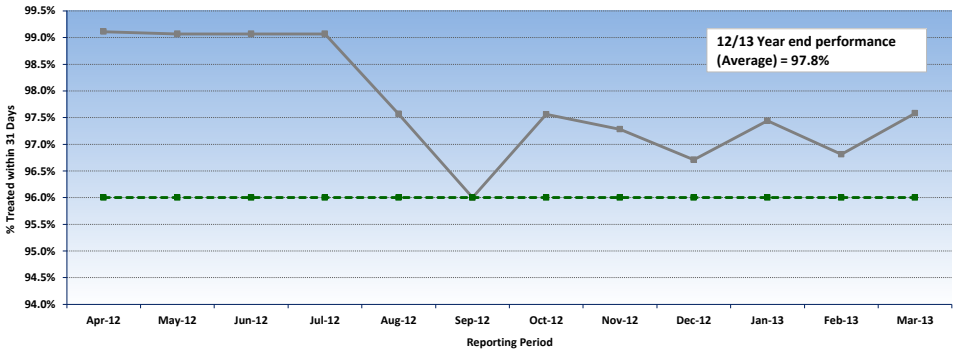
	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
% of Patients having their first treatment within 31 days	99.1%	99.1%	99.1%	99.1%	97.6%	96.0%	97.6%	97.3%	96.7%	97.4%	96.8%	97.6%
Target (>=96%)	>=96%	>=96%	>=96%	>=96%	>=96%	>=96%	>=96%	>=96%	>=96%	>=96%	>=96%	>=96%

Rationale

Cancer patients should wait no more than 31 days from the decision to treat to the start of their first treatment.

Results

Target sustained throughout the year.



31 Days: Wait For Second Or Subsequent Treatment: Surgery

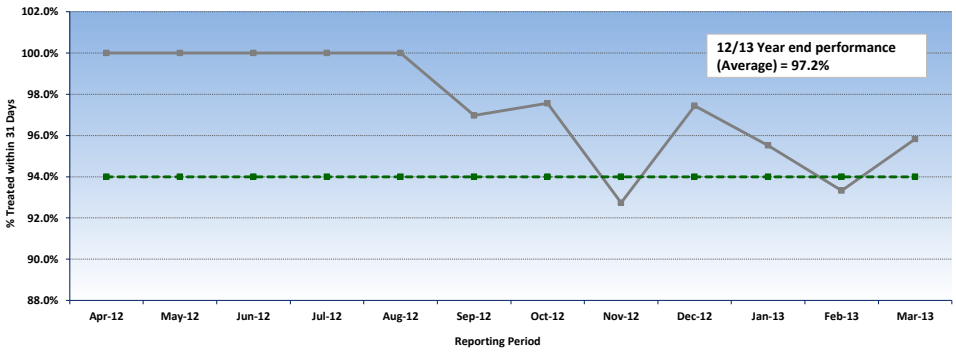
	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
% of Patients having their second or subsequent treatment within 31 day.	100.0%	100.0%	100.0%	100.0%	100.0%	97.0%	97.6%	92.7%	97.4%	95.5%	93.3%	95.8%
Target (>=94%)	>=94%	>=94%	>=94%	>=94%	>=94%	>=94%	>=94%	>=94%	>=94%	>=94%	>=94%	>=94%

Rationale

It is expected that any subsequent surgical, drug or radiotherapy treatments will be delivered within 31 days.

Results

Target achieved in 10 of 12 months of 12/13.There remains an on-going risk of non-achievement in individual months due to the low denominator, whereby just one breach for clinically appropriate reasons can trigger non achievement of the standard. .



Section 3 - Review of Quality Performance

3.1.1 Delivery of National Targets

Cancer Waiting Times

The Government's document 'Improving Outcomes: A Strategy for Cancer' confirmed that cancer waiting times remain an important issue for cancer patients and the NHS should continue to ensure that cancer services are delivered to patients in a timely manner.

31 Days: Wait For Second Or Subsequent Treatment: Anti Cancer Drug Treatments

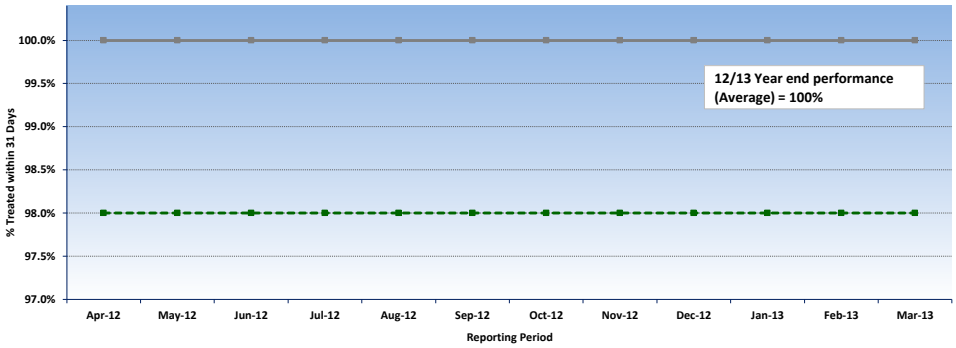
	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
% of Patients having their second or subsequent treatment within 31 day	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Target (>=98%)	>=98%	>=98%	>=98%	>=98%	>=98%	>=98%	>=98%	>=98%	>=98%	>=98%	>=98%	>=98%

Rationale

Cancer patients should wait no more than 31 days from the decision to treat to the start of their first treatment.

Results

Target acheved consistently.



62 Days: Wait For First Treatment From Urgent GP Referral: All Cancers

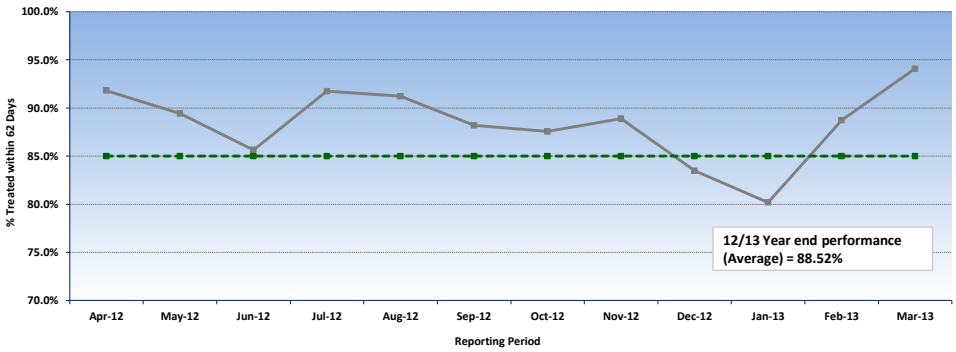
	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
% of Patients having their first treatment within 62 days	91.8%	89.4%	85.7%	91.7%	91.2%	88.2%	87.6%	88.9%	83.5%	80.2%	88.7%	94.1%
Target (>=85%)	>=85%	>=85%	>=85%	>=85%	>=85%	>=85%	>=85%	>=85%	>=85%	>=85%	>=85%	>=85%

Rationale

All patients should wait a maximum of 62 days from their urgent GP referral to the start of their treatment.

Results

Improved performance overall in 12/13, with achievement in 10 months. Extreme emergency bed pressures during winter impacted on performance in December and January.



Section 3 - Review of Quality Performance

3.1.1 Delivery of National Targets

Cancer Waiting Times

The Government's document 'Improving Outcomes: A Strategy for Cancer' confirmed that cancer waiting times remain an important issue for cancer patients and the NHS should continue to ensure that cancer services are delivered to patients in a timely manner.

62 Days: Wait For First Treatment From National Screening Service Referral: All Cancers

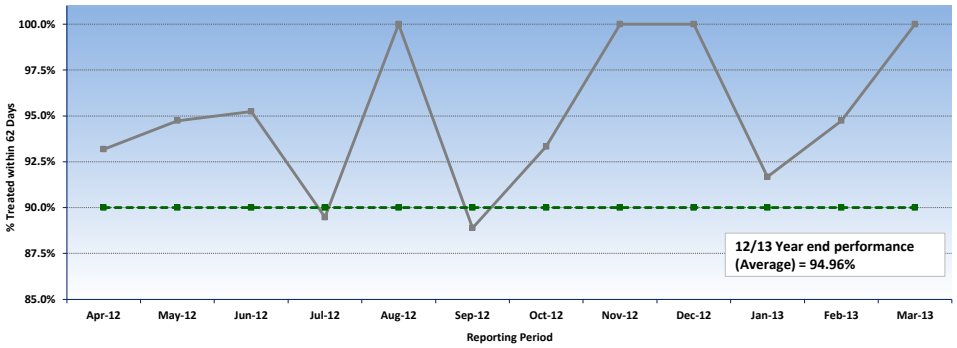
	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
% of Patients having their first treatment within 62 days	93.2%	94.7%	95.2%	89.5%	100.0%	88.9%	93.3%	100.0%	100.0%	91.7%	94.7%	100.0%
Target (>=98%)	>=90%	>=90%	>=90%	>=90%	>=90%	>=90%	>=90%	>=90%	>=90%	>=90%	>=90%	>=90%

Rationale

All patients should wait a maximum of 62 days. This 62-day standard also includes all patients referred from NHS cancer screening programmes (breast, cervical and bowel).

Results

Target achieved in 10 of 12 months of 12/13.There remains an on-going risk of non-achievement in individual months due to the very low denominator, whereby just one breach for clinically appropriate reasons can trigger non achievement of the standard. .



62 Days: Wait For First Treatment From Consultant Upgrades: All Cancers

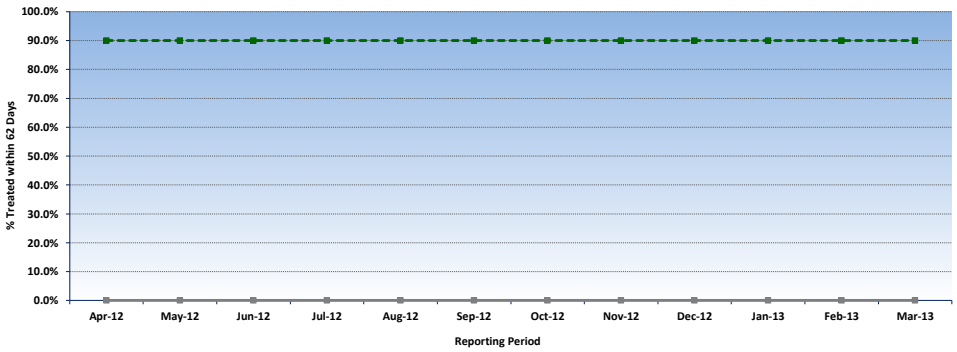
	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
% of Patients having their first treatment within 62 days	Achieved	Achieved	Achieved	Achieved	Achieved	Achieved	Achieved	Achieved	Achieved	Achieved	Achieved	Achieved
Target (>=85%)	>=90%	>=90%	>=90%	>=90%	>=90%	>=90%	>=90%	>=90%	>=90%	>=90%	>=90%	>=90%

Rationale

All patients should wait a maximum of 62 days. This 62-day standard also includes all patients whose consultants suspect they may have cancer.

Results

Target acheved consistently.



Section 3 - Review of Quality Performance

3.1.1 Delivery of National Targets

Cancer Waiting Times

The Government's document 'Improving Outcomes: A Strategy for Cancer' confirmed that cancer waiting times remain an important issue for cancer patients and the NHS should continue to ensure that cancer services are delivered to patients in a timely manner.

2 Week Wait: All Cancer Two Week Wait (Suspected cancer)

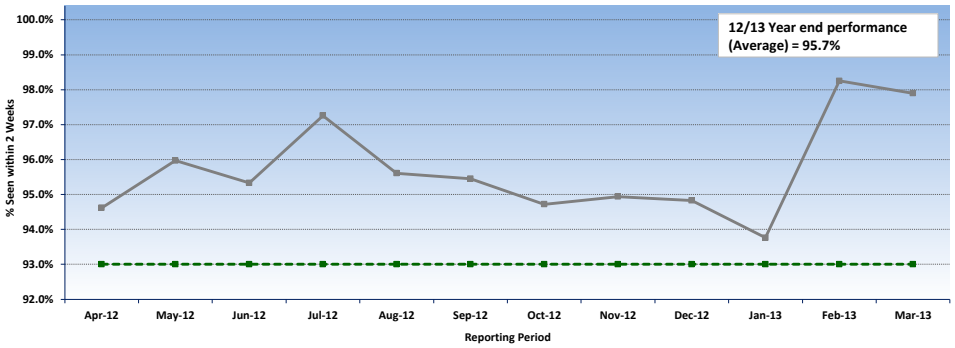
	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
% of Patients seen within 2 weeks	94.6%	96.0%	95.3%	97.3%	95.6%	95.5%	94.7%	94.9%	94.8%	93.8%	98.3%	97.9%
Target (>=93%)	>=93%	>=93%	>=93%	>=93%	>=93%	>=93%	>=93%	>=93%	>=93%	>=93%	>=93%	>=93%

Rationale

All patients referred with suspected cancer by their GP have a maximum wait of two weeks to see a specialist. This also applies to all patients referred for investigation of breast symptoms, even if cancer is not initially suspected.

Results

Target sustained throughout the year.



2 Weeks Wait: Wait for Symptomatic Breast Patients (Cancer Not initially Suspected)

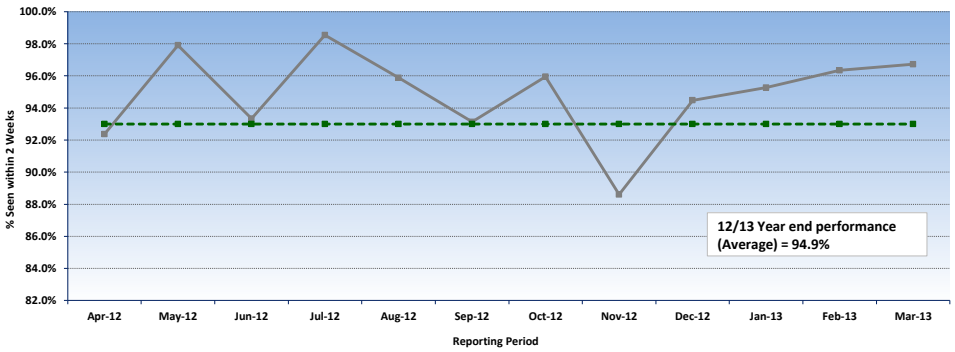
	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
% of Patients seen within 2 weeks	92.4%	97.9%	93.3%	98.5%	95.9%	93.1%	96.0%	88.6%	94.5%	95.3%	96.4%	96.7%
Target (>=93%)	>=93%	>=93%	>=93%	>=93%	>=93%	>=93%	>=93%	>=93%	>=93%	>=93%	>=93%	>=93%

Rationale

All patients referred for investigation of breast symptoms, even if cancer is not initially suspected will have a maximum wait of two weeks to see a specialist.

Results

Target achieved in 10 of 12 months of 12/13. April and November performance impacted by patients' requested delay of their appointments beyond 2 weeks due to Easter and half term holidays.



Section 3 - Review of Quality Performance

3.1.1 Delivery of National Targets

Referral to Treatment Times (RTT)

Reduced waiting times lead to better outcomes for patients. Part of the NHS pledge to put patients at the centre of everything they do involves making sure that you are diagnosed and start treatment as soon as possible, at a time that is convenient for you. The NHS Constitution says you have the right to access certain services commissioned by NHS bodies within maximum waiting times. Achieving the 18 Weeks Standard will help to sustain a better quality of life for patients.

Referral to Treatment (Admitted Pathway)

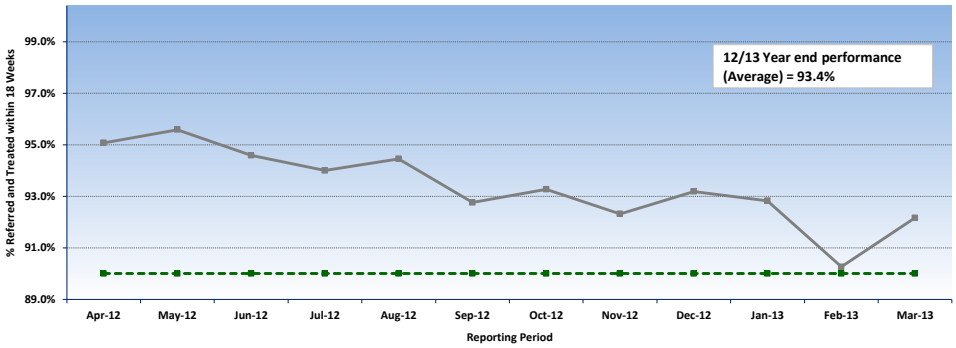
	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
% of Patients Referred and Treated within 18 Weeks	95.1%	95.6%	94.6%	94.0%	94.5%	92.8%	93.3%	92.3%	93.2%	92.8%	90.3%	92.2%
Target (>=90%)	>=90%	>=90%	>=90%	>=90%	>=90%	>=90%	>=90%	>=90%	>=90%	>=90%	>=90%	>=90%

Rationale

Reducing the amount of time patients wait for treatment improves health outcomes and also patient experience. This is a measure of the referral to first treatment time.

Results

Target achieved sustainably throughout 12/13, but strong performance impacted over the winter period by extreme emergency demand.



Referral to Treatment (Non-Admitted Pathway)

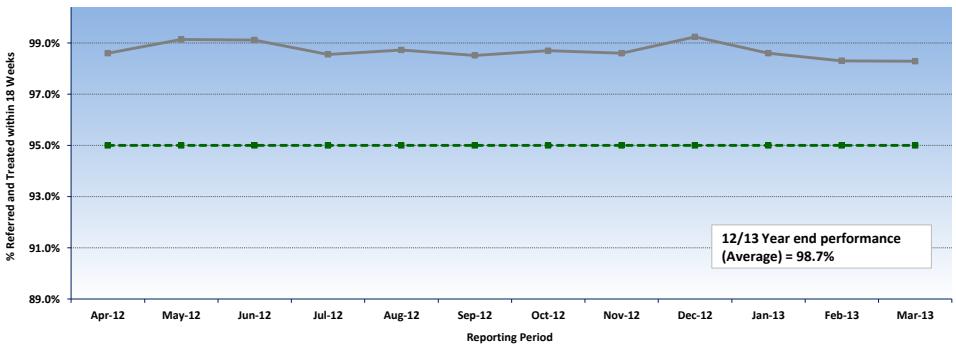
	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
% of Patients Referred and Treated within 18 Weeks	98.6%	99.1%	99.1%	98.6%	98.7%	98.5%	98.7%	98.6%	99.2%	98.6%	98.3%	98.3%
Target (>=95%)	>=95%	>=95%	>=95%	>=95%	>=95%	>=95%	>=95%	>=95%	>=95%	>=95%	>=95%	>=95%

Rationale

Reducing the amount of time patients wait for treatment improves health outcomes and also patient experience. This is a measure of the referral to first treatment time.

Results

Target achieved sustainably throughout 12/13.



Section 3 - Review of Quality Performance

3.1.1 Delivery of National Targets

Referral to Treatment Times (RTT)

Reduced waiting times lead to better outcomes for patients. Part of the NHS pledge to put patients at the centre of everything they do involves making sure that you are diagnosed and start treatment as soon as possible, at a time that is convenient for you. The NHS Constitution says you have the right to access certain services commissioned by NHS bodies within maximum waiting times. Achieving the 18 Weeks Standard will help to sustain a better quality of life for patients.

Referral to Treatment (Incomplete Pathway)

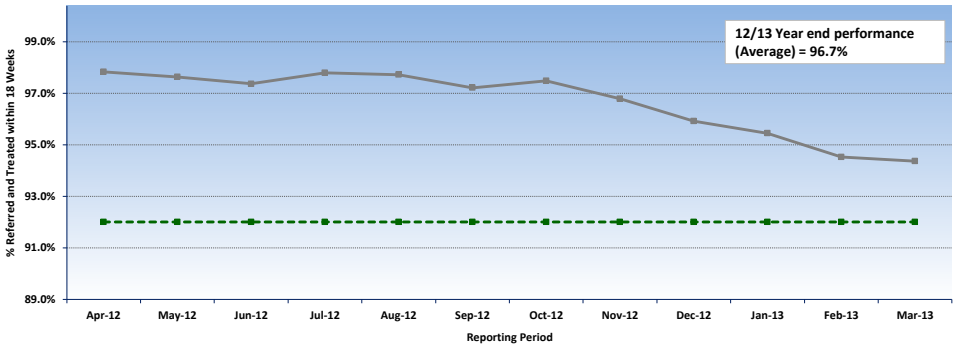
	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
% of Patients Referred and Treated within 18 Weeks	97.8%	97.6%	97.4%	97.8%	97.7%	97.2%	97.5%	96.8%	95.9%	95.5%	94.5%	94.4%
Target (>=92%)	>=92%	>=92%	>=92%	>=92%	>=92%	>=92%	>=92%	>=92%	>=92%	>=92%	>=92%	>=92%

Rationale

Reducing the amount of time patients wait for treatment improves health outcomes and also patient experience. This is a measure of the referral to first treatment time.

Results

Target achieved sustainably throughout 12/13, but strong performance impacted over the winter period by extreme emergency demand.



Section 3 - Review of Quality Performance

3.1.1 Delivery of National Targets

Accident & Emergency (ED) Clinical Quality Indicators

The A&E clinical quality indicators were introduced to:
1) Create a more balanced view of performance that measures patient safety and clinical effectiveness as well as time measures
2) Encourage a spirit of continuous improvement with better information leading to better clinical outcomes and patient experience
3) Provide information that is easier to understand for patients

The Proportion of Patients Being Seen, Admitted, Discharged or Transferred Within 4 Hours of Presentation to ED

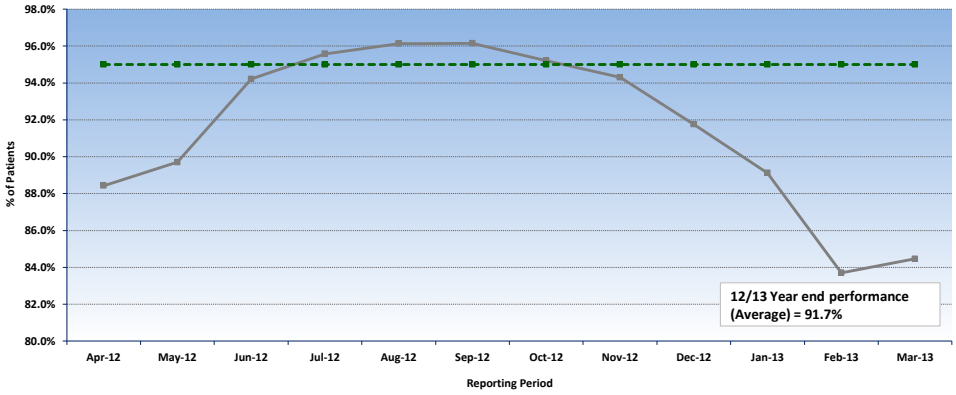
	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
% of Patients Seen, Admitted, Discharged or Transferred within 4 Hou	88.4%	89.7%	94.2%	95.6%	96.1%	96.2%	95.2%	94.3%	91.8%	89.1%	83.7%	84.5%
Target (>=95%)	>=95%	>=95%	>=95%	>=95%	>=95%	>=95%	>=95%	>=95%	>=95%	>=95%	>=95%	>=95%

Rationale

This is measured from the time of arrival and registration on the hospital information system to the time that the patient leaves the department to return home or to be admitted to the ward bed (including the A&E department observation beds).

Results

Following interventions made through the Emergency Access Standard Board there followed a significant improvement for 4 months. A Norovirus outbreak was declared in November reducing capacity and the Trust was compromised with 'Winter' with high admission of frail elderly, trauma through the poor weather and the lack of throughput to community beds.



All Ambulance Borne Patients Receiving and Initial Assessment Within 15 Minutes of Arrival to the ED

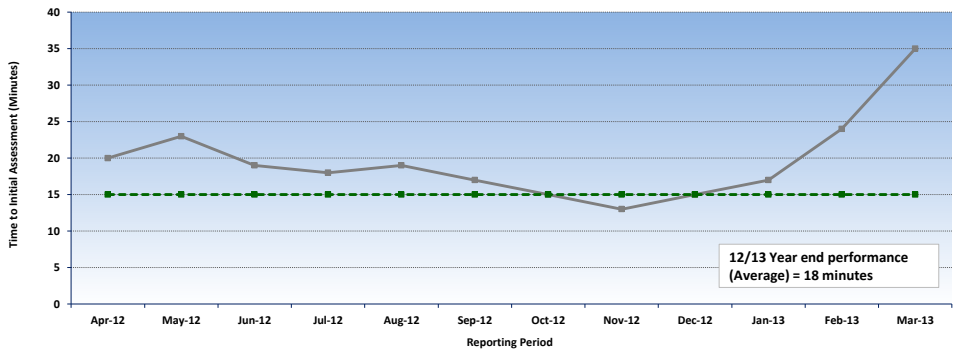
	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
Time to Initial Assessment (95th Percentile)	20	23	19	18	19	17	15	13	15	17	24	35
Target (<= 15 Minutes)	<=15 Mins	<=15 Mins	<=15 Mins	<=15 Mins	<=15 Mins	<=15 Mins	<=15 Mins	<=15 Mins	<=15 Mins	<=15 Mins	<=15 Mins	<=15 Mins

Rationale

This applies only to patients who are brought in by ambulance and is measured from the time of arrival in the department to the time the ambulance crew hand the clinical care of the patient to the nursing staff.

Results

There have been a number of issues with the turnaround time and during the winter period capacity issues raised more constraints within the system . Norovirus, frail elderly patients and lack of throughput constrained the ability to take in a timely way at the ED.



Section 3 - Review of Quality Performance

3.1.1 Delivery of National Targets

Accident & Emergency Clinical Quality Indicators

The A&E clinical quality indicators were introduced to:
1) Create a more balanced view of performance that measures patient safety and clinical effectiveness as well as time measures
2) Encourage a spirit of continuous improvement with better information leading to better clinical outcomes and patient experience
3) Provide information that is easier to understand for patients

Time from Arrival to Treatment in Minutes (Median)

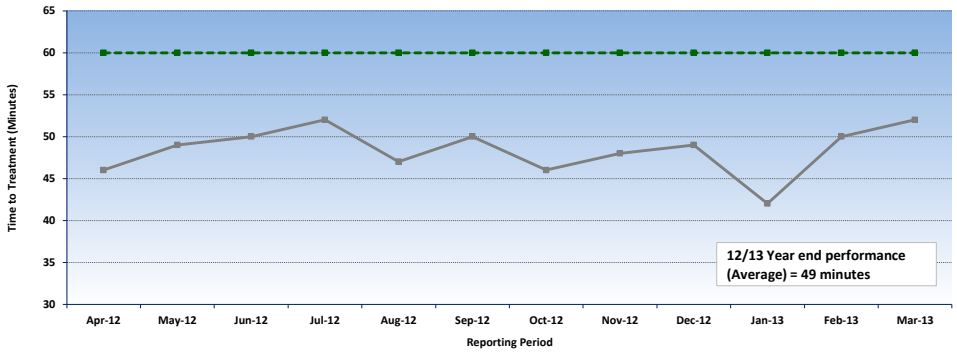
	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
Time to Treatment (Median for all Patients)	46	49	50	52	47	50	46	48	49	42	50	52
Target (<= 60 Minutes)	<=60 Mins	<=60 Mins	<=60 Mins	<=60 Mins	<=60 Mins	<=60 Mins	<=60 Mins	<=60 Mins	<=60 Mins	<=60 Mins	<=60 Mins	<=60 Mins

Rationale

Measured for all patients, this is the time from arrival to seeing a doctor or nurse practitioner who will start the treatment for the patient's condition.

Results

All patients are reviewed at triage and treatment commenced as soon as possible whether by practitioner or Doctor to ensure patient receive the most appropraite treatment in a timely way.



The Proportion of all Patients Having to Re-attend the ED Within a 7 Day Timeframe

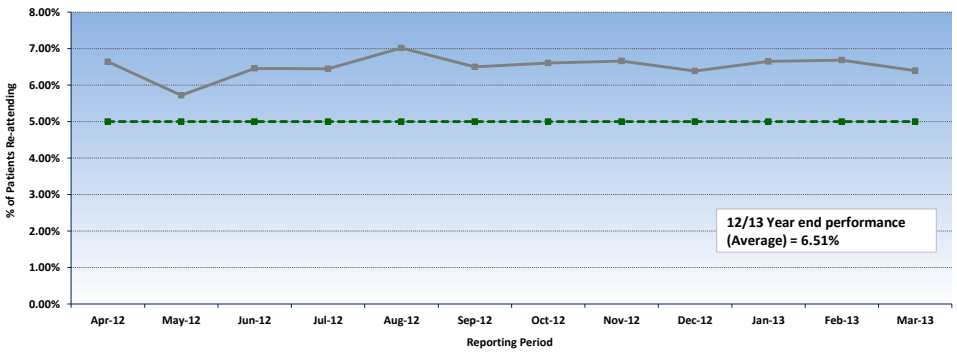
	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
% of Patients Re-attending within 7 Days	6.64%	5.72%	6.46%	6.45%	7.02%	6.50%	6.61%	6.66%	6.39%	6.65%	6.69%	6.40%
Target (<=5%)	<=5%	<=5%	<=5%	<=5%	<=5%	<=5%	<=5%	<=5%	<=5%	<=5%	<=5%	<=5%

Rationale

Patients who return to the same A&E within seven days of the original attendance are known as an 'unplanned reattender'. Patients are encouraged to return if their condition gets worse, particularly in younger patients, and this figure also depends on the provision of primary or urgent care in the community.

Results

The re-attender is multifactoral however the Trust is investigating the issues surrounding re-attenders to ensure that this situation improves.



Section 3 - Review of Quality Performance

3.1.1 Delivery of National Targets

Accident & Emergency Clinical Quality Indicators

The A&E clinical quality indicators were introduced to:
1) Create a more balanced view of performance that measures patient safety and clinical effectiveness as well as time measures
2) Encourage a spirit of continuous improvement with better information leading to better clinical outcomes and patient experience
3) Provide information that is easier to understand for patients

The Proportion of all Patients Leaving the ED Without Being Seen by a Healthcare Professional

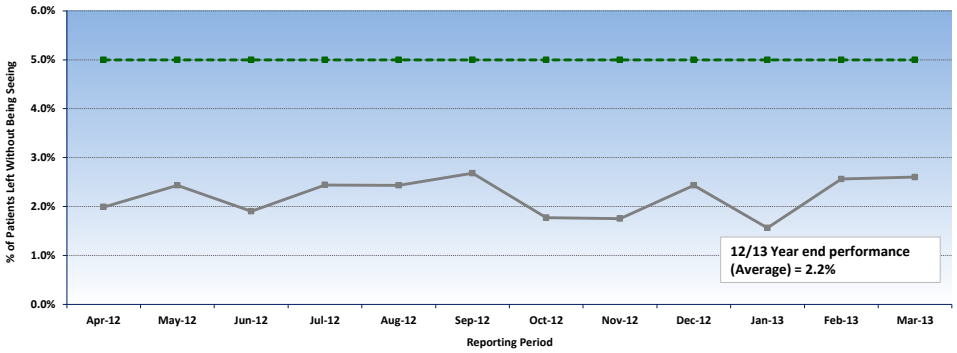
	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
% of patients who left the department without being seen	2.0%	2.4%	1.9%	2.4%	2.4%	2.7%	1.8%	1.8%	2.4%	1.6%	2.6%	2.6%
Target (<=5%)	<=5%	<=5%	<=5%	<=5%	<=5%	<=5%	<=5%	<=5%	<=5%	<=5%	<=5%	<=5%

Rationale

Patients may sometimes leave the department without waiting to be seen – particularly if there is a long wait for a doctor or if the patient has been advised on alternative sources of care.

Results

The trust endeavours to ensure that all patients are seen however there are patients who decide to leave and the reasons are numerous. The trust tries to ensure depending upon presenting complaint that should the patients leave without informing the department that they are contacted to ensure their safety.



Section 3 - Review of Quality Performance

3.1.1 Delivery of National Targets

Acute Stroke Care

Effective treatment of stroke can prevent long-term disability and save lives. Stroke experts have set out standards which define good stroke care to include immediate access to a high quality stroke unit and assessment from a multi-disciplinary clinical team for the majority of the patients stay in hospital.

The Proportion of Patients Spending at Least 90% of their Total Stay in Hospital in a Specialist Stroke Unit

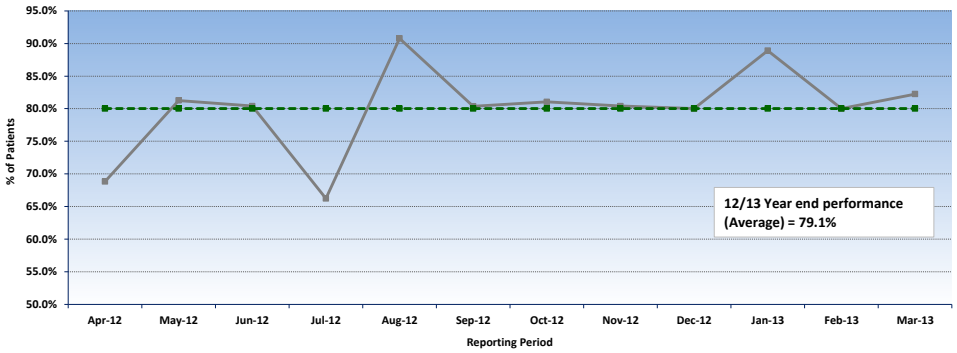
	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
% of Patients Spending 90% of their stay on the Stroke Unit	68.8%	81.3%	80.4%	66.2%	90.8%	80.4%	81.0%	80.4%	80.0%	88.9%	80.0%	82.2%
Target (>= 80%)	>=80%	>=80%	>=80%	>=80%	>=80%	>=80%	>=80%	>=80%	>=80%	>=80%	>=80%	>=80%

Rationale

All stroke patients spend the majority of their time at hospital in a stroke unit with high-quality stroke specialist care.

Results

The Trust has consistently delivered on the Standard and recognises that the next step is towards centralisation to deliver a more sustained approach.



The Proportion of Patients with a Confirmed Stroke will be Admitted to a Stroke Unit Within Four Hours of Arrival at Hospital

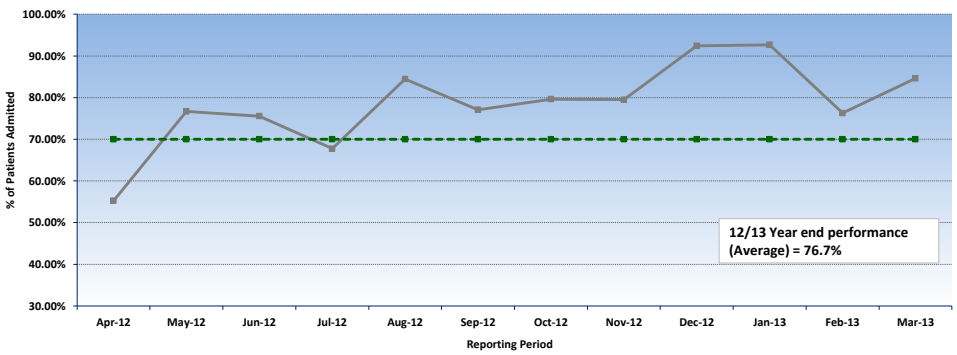
	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
% of Patients Admitted to a Stroke Unit Within 4 Hours	55.29%	76.67%	75.56%	67.74%	84.44%	77.08%	79.63%	79.49%	92.45%	92.68%	76.27%	84.62%
Target (>=70%)	>=70%	>=70%	>=70%	>=70%	>=70%	>=70%	>=70%	>=70%	>=70%	>=70%	>=70%	>=70%

Rationale

Patients presenting with symptoms of stroke need to be assessed rapidly and treated in an acute stroke unit by a multi-disciplinary clinical team which will assess, manage and respond to their complex care needs, and maximise their potential for recovery.

Results

The Trust has consistently achieved this standard since Aug. 12 and has continued to maintain this standard.



Section 3 - Review of Quality Performance

3.1.1 Delivery of National Targets

Acute Stroke Care

Effective treatment of stroke can prevent long-term disability and save lives. Stroke experts have set out standards which define good stroke care to include immediate access to a high quality stroke unit and assessment from a multi-disciplinary clinical team for the majority of the patients stay in hospital.

The Proportion of High Risk TIA Patients Investigated and Treated Within 24 Hours

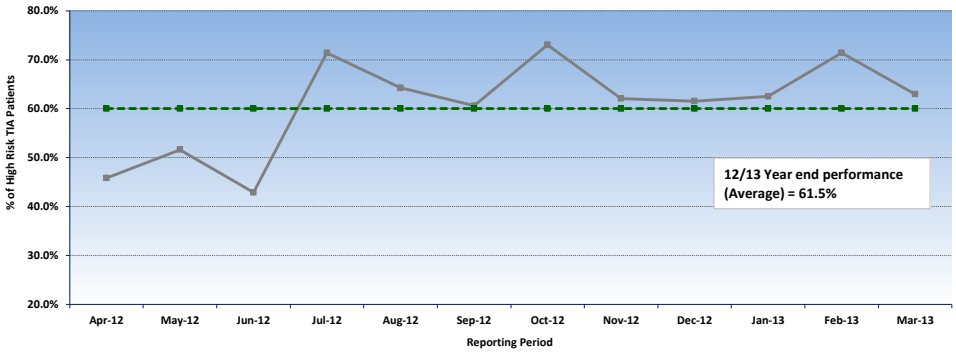
	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
% of High Risk TIA Patients Investigated and Treated Within 24 Hou	45.8%	51.6%	42.9%	71.4%	64.3%	60.6%	73.1%	62.1%	61.5%	62.5%	71.4%	63.0%
Target (<=5%)	>=60%	>=60%	>=60%	>=60%	>=60%	>=60%	>=60%	>=60%	>=60%	>=60%	>=60%	>=60%

Rationale

% of High Risk TIA patients investigated and treated within 24 hours of first contact with a health professional. Patients with a suspected TIA are seen the same/next day by a Stroke specialist and investigated in a one stop clinic.

Results

The Trust is now seeing more high risk patients within the Standard and delighted that the end of year position indicates that the Trust has achieved 61.5% for the year. This position is now more sustainable and moving forward to centralisation will deliver a more consistent response to our patients.



Appendix 1 - Statement of Director's responsibilities in respect of the Quality Account

The directors are required under the Health Act 2009, National Health Service (Quality Accounts) Regulations 2010 and National Health Service (Quality Account) Amendment Regulation 2011 to prepare Quality Accounts for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporate the above legal requirements).

In preparing the Quality Account, directors are required to take steps to satisfy themselves that:

- the Quality Accounts presents a balanced picture of the Trust's performance over the period covered;
- the performance information reported in the Quality Account is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Account has been prepared in accordance with Department of Health guidance.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Account.

By order of the Board

Harry Turner
Chairman
..... Date 26-6-13

Penny Venables
Chief Executive
..... Date 26-6-13

Chris Tidman
Director of Resources
& Deputy Chief Executive
..... Date 26-6-13

Stewart Messer
Chief Operating Officer
..... Date 26-6-13

Mr Mark Wake
Chief Medical Officer
..... Date 26-6-13

Helen Blanchard
Chief Nursing Officer
..... Date 26-6-13

Appendix 2 – Independent Assurance Report

INDEPENDENT AUDITORS' LIMITED ASSURANCE REPORT TO THE DIRECTORS OF WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST ON THE ANNUAL QUALITY ACCOUNT

We are required by the Audit Commission to perform an independent limited assurance engagement in respect of Worcestershire Acute Hospitals NHS Trust's Quality Account for the year ended 31 March 2013 ("the Quality Account") and certain performance indicators contained therein as part of our work under section 5(1)(e) of the Audit Commission Act 1998 (the Act). NHS trusts are required by section 8 of the Health Act 2009 to publish a Quality Account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010, the National Health Service (Quality Account) Amendment Regulations 2011 and the National Health Service (Quality Account) Amendment Regulations 2012 ("the Regulations").

Scope and subject matter

The indicators for the year ended 31 March 2013 subject to limited assurance consist of the following indicators:

- Percentage of patient safety incidents that resulted in severe harm or death reported on page 72 of the Quality Account; and
- Percentage of patients risk-assessed for venous thromboembolism (VTE) on page 71 of the Quality Account.

We refer to these two indicators collectively as "the indicators".

Respective responsibilities of Directors and auditors

The Directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the Regulations).

In preparing the Quality Account, the Directors are required to take steps to satisfy themselves that:

- the Quality Account presents a balanced picture of the trust's performance over the period covered;
- the performance information reported in the Quality Account is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and
- the Quality Account has been prepared in accordance with Department of Health guidance.

The Directors are required to confirm compliance with these requirements in a statement of directors' responsibilities within the Quality Account.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;

- the Quality Account is not consistent in all material respects with the sources specified in the NHS Quality Accounts Auditor Guidance 2012/13 issued by the Audit Commission on 25 March 2013 ("the Guidance"); and
- the indicators in the Quality Account identified as having been the subject of limited assurance in the Quality Account are not reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

We read the Quality Account and conclude whether it is consistent with the requirements of the Regulations and to consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Account and consider whether it is materially inconsistent with:

- Board minutes for the period April 2012 to June 2013;
- papers relating to the Quality Account reported to the Board over the period April 2012 to June 2013;
- feedback from the Commissioners dated 31/05/2013;
- feedback from Local Healthwatch dated May 2013;
- the Trust's complaints report published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009, dated 12/06/2012;
- feedback from other named stakeholder(s) involved in the sign off of the Quality Account;
- the latest national patient survey dated 2012;
- the latest national staff survey dated 2012;
- the Head of Internal Audit's annual opinion over the trust's control environment dated 19/04/2013;
- the annual governance statement dated 05/06/2013;
- Care Quality Commission quality and risk profiles dated April 2012 to March 2013;
- the results of the Payment by Results coding review dated 05/2012

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with these documents (collectively "the documents"). Our responsibilities do not extend to any other information.

This report, including the conclusion, is made solely to the Board of Directors of Worcestershire Acute Hospitals NHS Trust in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 45 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 2010. We permit the disclosure of this report to enable the Board of Directors to demonstrate that they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permissible by law, we do not accept or assume responsibility to anyone other than the Board of Directors as a body and Worcestershire Acute Hospitals NHS Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement under the terms of the Audit Commission Act 1998 and in accordance with the Guidance. Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- testing key management controls;
- analytical procedures;
- limited testing, on a selective basis, of the data used to calculate the indicators back to supporting documentation;
- comparing the content of the Quality Account to the requirements of the Regulations; and
- reading the documents.

A limited assurance engagement is narrower in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore. The nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Account in the context of the criteria set out in the Regulations.

The nature, form and content required of Quality Accounts are determined by the Department of Health. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS organisations.

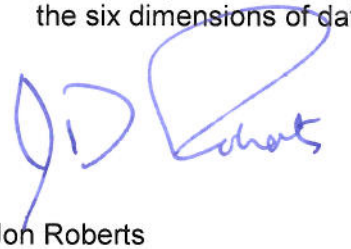
In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by Worcestershire Acute Hospitals NHS Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2013:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the Guidance; and

- the indicators in the Quality Account subject to limited assurance have not been reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.



Jon Roberts
Senior Statutory Auditor
for and on behalf of Grant Thornton UK LLP

Colmore Plaza
20 Colmore Circus
Birmingham
B4 6AT

27 June 2013

Glossary

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

ACE	'Active Caring for Everyone' programme
Acuity	The level of severity of a patient's illness
Alex	Alexandra Hospital
C. Difficile	Clostridium difficile
CAB	Citizens Advice Bureau
CCG	Care Commissioning Group
CDI	Clostridium difficile infection
CIP	Cost Improvement Programme
CISS	Macmillan Cancer and Information Support Service
CMO	Chief Medical Officer
CNO	Chief Nursing Officer
CNS	Clinical Nurse Specialist
CQC	Care Quality Commission
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
ERMC	Executive Risk Management Committee
GP	General Practitioner
HED	Healthcare Evaluation Dataset – a software programme that analyses the HES data to make sense of statistics and allow a relative risk to be placed on healthcare outcomes
HES	Hospital Episode Statistics
HOSC	Health Overview & Scrutiny Committee - Worcestershire County Council
HRG	Health Resource Group - a grouping consisting of patient events that have been judged to consume a similar level of resource.
HSMR	The Dr Foster Hospital Standardised Mortality Ratio
IG	Information Governance
IGC	Integrated Governance Committee
INR	International Normalised Ratio - a measure of blood clotting time
IP&C	Infection prevention & control
IUD	Intra uterine death
KGH	Kidderminster Hospital
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
NQD	NHS National Quality Dashboard
NRLS	National Reporting and Learning System
NTDA	NHS Trust Development Authority
PCT	Primary Care Trust
PAS	Patient Administration System
PEAT	Patient Environment Action Team
PLACE	Patient-Led Assessments of the Care Environment
PPCI	Worcestershire Primary Percutaneous Coronary Intervention - a treatment used following heart attacks
PRIDE	The Trust's values - Patents; Respect; Involvement; Delivery; Efficiency
QIA	Quality Impact Assessment
QIPP	Quality, Improvement, Productivity and Performance
SBAR	Situation, Background, Assessment, Recommendation - a means of reliably passing on information
SHA	Strategic Health Authority
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.
SI	Serious Incidents
SSKIN	A five step model for pressure ulcer prevention
TIA	Transient Ischaemic Attack - a 'mini' stroke
VTE	Venous thromboembolism also known as deep vein thrombosis or DVT
WMQRS	West Midlands Quality Review Service
WRH	Worcestershire Royal Hospital