Worcestershire Acute Hospitals NHS Trust

# Quality Account

## 2013/14

Patients | Respect | Improve and innovate | Dependable | Empower

Taking **PRIDE** in our healthcare services

**Part 1**

## 1.1 Statement from the Chief Executive

I am delighted to present my third Quality Account for Worcestershire Acute Hospitals NHS Trust which aims to share the progress we have made on improving quality and safety across our three hospitals over the last year, as well as highlighting where we still have work to do, and what our priorities are moving into 2014/15.

The safety and experience of all our patients, their relatives and carers, and the effectiveness of our treatments remain central to what we all do at the Trust and this account hopefully illustrates the progress we have made so far in our journey to improve services as well as outlining the further priorities we want to address.

Our commitment to safety and quality is highlighted in the CQC's Intelligent Monitoring Report, which has placed the Trust in band six – the grouping for hospitals that pose the lowest risk to patients – in two consecutive reports in 2013/14.

One of our proudest achievements in 2013/14 is successfully meeting all the national standards for stroke care and in so doing, improving the outcomes and experience for this important group of patients. This is primarily down to the opening of a centralised stroke unit at Worcestershire Royal Hospital which offers specialised assessment and diagnosis to patients presenting with stroke symptoms. The service will continue to be developed in 2014/15 with, amongst other things, the development of an in-house speech and language therapy service.

One of the major outcomes of this work is a significant improvement in stroke mortality across the county where previously we had identified this as an outlying specialty.

After some difficulties with C. difficile infection in 2012/13, we achieved our target to reduce cases in 2013/14 with 40 cases against a target of 48. However, we failed to meet our zero target for MRSA blood stream infections, with three cases. This improvement priority will now be carried forward and there continues in place an active screening programme to detect and eradicate MRSA. The Infection Prevention & Control Team is also working hard to continually review infection prevention practice to minimise the risk from MRSA and other Healthcare Associated Infections.

The four hour A&E access target has remained a challenge, with an increase in emergency admissions and patients with more complex and acute conditions affecting performance since November 2013. Achieving the 95% standard remains a key priority and work is continuing across the county's health and social care economy to improve the situation.

Improving the outcomes and experience for patients with fractured neck of femur also remains a focus for us, and our aim is for patients to be operated on within 36 hours of admission. This improvement priority will roll over into 2014/15, with improvement plans in place which include ring fencing beds in some areas, and undertaking these procedures seven days a week.

In order to support our strategic development, annual planning, governance and delivery of performance and financial targets, we have put in place a new organisational structure from November 2013, with five new divisions led by a senior clinician, nurse and manager.

We aim to put these divisions in the 'driving' seat and in time this will result in greater autonomy, responsibility and accountability. In addition it will facilitate the Divisions ability to for transform services to deliver high quality patient care across the organisation.

We are already seeing the benefits of the new structure, with many service developments coming to fruition, and many more in development.

Other highlights include

- The establishment of a five-day a week ambulatory emergency care unit operated by GPs at the Worcestershire Royal Hospital sites, giving patients same day emergency care. Benefits include fewer admissions, shorter length of stay, fewer patients waiting in A&E and greater patient satisfaction.
- A new six-bedded Transitional Care Unit is providing support and treatment to new mums and their babies who no longer need full neonatal care;
- Pharmacy services have been extended to seven days a week in our Emergency Departments and Acute Medical Units.

Access to the sight saving treatment Lucentis has also been much improved, with our ophthalmic nurses now trained to administer this injection – the first centre to do this in the West Midlands.

We also remain in the top 25 per cent of acute trusts for our Family and Friends Test results. Preparations are underway to roll the questionnaire out to our staff in 2014/15.

Over the next 12 months, we will learn the results of a commissioner-led public consultation about the future configuration of emergency care and women's and children's services in Worcestershire. We are also preparing for the opening of our long-awaited £22m Radiotherapy Centre, and a midwife-led birth centre. All of these offer exciting opportunities to sustain safe services and further improve the quality of care for our patients into the future.

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 committed workforce dedicated to delivering high quality care to 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.

*Signature*

**Penny Venables**

**Chief Executive**

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# Section 2 – Review of Quality Performance

## 2.1 Introduction

The Trust's Annual Plan for 2013/14 set out how we would deliver further improvements in the quality of care provided to our patients and how our services would be developed. This year has also seen some significant challenges to the Trust and changes in the way we manage ourselves. These arrangements, challenges and our quality performance for the past year are described below.

### 2.1.1 Quality Governance Structure

The Quality Governance Committee is a sub-committee of the Trust Board. It is chaired by an Associate Non-executive Director with Executive and Non-executive membership. It receives reports covering all of the domains of quality. The primary committees reporting to it are:

- The Safe Patient Group: chaired by the Chief Medical Officer
- The Clinical Effectiveness Committee: chaired by the Associate Medical Director for Leadership, Revalidation & Audit
- The Patient Experience Committee: chaired by the Chief Nursing Officer
- The Trust Infection, Prevention, Protection & Control Committee: Chaired by the Chief Nursing Officer
- The Cancer Board: Chaired by the Chief Executive

The clinical Divisions report to the Safe Patient Group, Clinical Effectiveness Committee and Patient Experience Committee.

### 2.1.2 Acute Hospital Services Review

The recently completed Independent Clinical Review on the future of acute hospitals in Worcestershire concluded that a modified proposal should be put to public consultation. Acute Trust services would be reconfigured in the following ways:

- Establishing a new Paediatric Assessment Unit at the Alexandra Hospital.
- Moving inpatient services for sick children to Worcestershire Royal Hospital.
- Moving consultant led maternity services to Worcestershire Royal Hospital.
- A Commissioner priority to enhance local access and birthing choice including consideration of a Midwifery Led Unit for North Worcestershire and extending local maternity assessment services.
- Hospital based emergency services across Worcestershire will be networked and led by consultants with an Emergency Centre at the Alexandra Hospital, co-located with an integrated Urgent Care Centre and a Major Emergency Centre at the Worcestershire Royal Hospital.

The aim is to provide the highest possible quality of evidence based care. The challenge for the Trust is to maintain and indeed improve the quality of care up to, during and after the reconfiguration takes place.

Some services have already been reconfigured, for example, interventional cardiology (heart catheterisation), stroke services and some acute surgery has been centralised at Worcestershire Royal Hospital. Other services including paediatrics, obstetrics and emergency care are closely monitored so that we can act to maintain quality and safety in advance of wider reconfiguration.

Emergency pressures

The high level of patients admitted as emergencies has had a significant impact on our services and our ability to meet the waiting time targets such as the 18 week referral to treatment target and seeing 95% of patients within 4 hours of attending

Accident and Emergency. Our management of infection control has helped to limit the closure of beds due to Norovirus

Clinical and Management Restructure
Our clinical and management teams were reconfigured in November 2013 to form five new clinical Divisions and provide a structure for greater autonomy, responsibility and accountability for transformation, service development and delivery of high quality patient care across the organisation.

Governance Committees:
Our committee structure was revised to provide a better focus on quality management with the Quality Governance Committee overseeing the work of committees covering patient safety, clinical effectiveness, patient experience and infection control.

### 2.1.3 Our response to the Francis Report

It is now over a year since Robert Francis QC published his final report of the public inquiry into Mid Staffordshire NHS Foundation Trust. Our response to the report is set out below as immediate actions, further actions and key themes to address:

Immediate actions:
Following a high level assessment led by the executive team, the immediate actions for the Trust were set out against the relevant report recommendations.

As far as was possible at the time of publication actions were incorporated into the Annual Plan 2013/14 and strengthened the Trust's approach to embedding the NHS Constitution and Core NHS Values, Duty of Candour, Listening to Staff, Listening to Patients.

Further actions:
An executive workshop was held in April 2013 to commence a more detailed evaluation of the Francis Report, specifically to ensure full alignment with the new management structures, leadership portfolios, delivery plans, performance monitoring and management, clinical governance, and information and safety intelligence.

An additional nursing "task and finish" group was also established to take forward some of the key areas around nursing highlighted in the report.

The executive workshop identified key themes and actions for the Trust to focus on and deliver in 2013/14;

**Putting patients first**

- Review of the Trust values to align these more closely with the NHS constitution
- Delivery of leadership programme for Ward Sisters
- Introduction of values based recruitment so that the right staff are selected - not just for the right skills but also for the right values and behaviours that support effective team working and the delivery of excellent patient care and experience.
- Assessment centre recruitment process in place for healthcare assistants and newly qualified nurses

**Listening to patients**

- Patient and Carer Experience Strategy developed and implementation plan in place
- External review of complaints processes undertaken
- Customer Care training delivered to frontline staff

**Openness, transparency and candour**

- Whistleblowing and 'being open' policies updated to encourage openness, transparency and raising of concerns
- Employment contracts were changed to reflect Trust values and the requirements of 'being open'.

**Standards**

- Publicly available Board papers and performance quality dashboards
- Increase in nurse staffing levels
- Introduction of e-rostering with better management of nursing rotas
- Reduced use of agency nurses
- Competency based training for healthcare assistants
- Six monthly review of nurse staffing levels
- Introduction of ward quality dashboards, reported to the Board
- A range of peer review visits to review quality of services both internal and external involving patients, commissioners, non-executive directors and staff

**Leadership and accountability**

- Review of contracts to include reference, as necessary, to the NHS Constitution and Values, Managers Code of Conduct and Duty of Candour

**Information and performance**

- Introduction of business intelligence system
- Benchmarking undertaken against a range of quality indicators
- Additional scrutiny of a range of outcomes data resulting in changes to service delivery e.g. stroke pathway
- Expansion of 'real time' information systems, for example, Accident and Emergency

**Nursing and medical practice**

- Evidence of action where there are concerns about quality
- Evidence of clinical staff raising concerns about quality and these being acted upon
- Introduction of supernumerary Ward Sisters in some ward areas
- Establishment of county wide nursing senate with University of Worcester
- Joint working with university on 6Cs programme (Care, Compassion, Competence, Communication, Courage, Commitment
- Increased opportunities for students and newly qualified nurses and doctors to meet with Chief Medical Officer (CMO) and Chief Nursing Officer (CNO)

### 2.1.4 Inspections and peer reviews during 2013/14

There are many different organisations that have a remit to inspect or accredit elements of the services NHS Trusts deliver, the aim being to improve the quality of healthcare and the environment it is provided in. In this year we had over 40 individual accreditation visits, peer reviews and inspections during the year from a wide range of organisations including: The Care Quality Commission (CQC), the Trust Development Authority (TDA), Worcestershire Clinical Commissioning Groups (CCG), Clinical Pathology Accreditation, National Cancer Peer Review, the Patient and Public Forum and organisations responsible for the training and education of doctors and nurses. We also invited the Royal College of Surgeons and the Royal College of Paediatrics and Child Health to review our services.

The results of many of these inspections and reviews are provided in this Quality Account. Recommendations for improvement are almost always made but, with some exceptions, the overall results provide assurance that the services we provide safe and effective.

### 2.1.5 Quality Strategy

Our mission is to provide our patients with safe, effective and personalised care delivered consistently across all sites by skilled and compassionate staff. The Trust's Quality Strategy was approved in March 2014 to set out our objectives for quality improvement over the next two years and describe how we will further develop our ability to continually improve safety, effectiveness and the experience of care for our patients. This is part of our response to the Francis Report. It will be further revised as the new Divisions develop and set their quality ambitions and the Quality Governance Committee will monitor the implementation of the Quality Strategy.

**2.1.6 Continuing work:**
Some actions will take longer than a year to implement. Planning for the next 5 years, including the development of the 2014/15 annual plan with the newly created Divisional structure, is nearing completion. Delivering a high quality service was the key focus of this planning process and as such the next steps for delivery of the recommendations of the Francis Report are an integral part.

Alongside our response to the Francis Report, these plans have considered other national reviews e.g., Keogh (Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report 2013), Berwick (A promise to learn – a commitment to act, 2013) and Cavendish (An Independent Review into Healthcare Assistants and Support Workers in the NHS and social care settings).

The Board are committed to move towards a more outcome focussed and ambitious approach to quality and away from a more traditional approach of action plans and tick boxes.

The aim is to identify key ambitions that will drive the organisation that are well understood and owned by all stakeholders. Underneath these will be a key set of measurable and timely objectives to be delivered each year, identified by staff at the frontline.

Examples of those already under development for 2014/15 include:

- Delivery of leadership programme for new Divisional management teams
- Delivery of a new and improved patient feedback service
- Delivery of first year of patient and public engagement strategy
- Introduction of performance management reviews for each Division

**2.1.7 Contract Queries**

During 2013/14 Commissioners issued a small number of Contract Query Notices, a contract management mechanism by which either party to the contract can raise concerns about adherence to it. These tend to relate to either quality or performance issues. At the end of 2013/14 there remained 4 open Contract Query Notices. This included one for the 18 weeks RTT target and one for midwife to birth ratios which although improving had not quite met best practice standards (although they do meet regionally agreed standards) by the end of 2013/14. The other two related to:

- **Clinical Review of Diagnostic Results**
    - An audit identified that a small but nonetheless important proportion of diagnostic results were potentially not being clinically reviewed. This prompted a task and finish group including commissioner clinical representation to review the audit evidence and develop an action plan to mitigate any identified risks. Significant progress has been made to date in delivering the action plan and the work stream remains on-going to reduce the proportion of results which are not reviewed to best practice levels.

- **Mandatory Training**

- There are a number of areas of mandatory staff training for which the Trust is monitored through the contract. For example, information governance, document handling and medicines management training. Despite significant effort within the Trust the uptake rates were below the target level at the end of 2013/14. The Trust publicises all mandatory training requirements through a variety of communication routes and pay progression is linked to completion of mandatory training. An action plan is being developed for 2014/15 by the Director of HR, Divisional management teams and the training department to improve uptake.

## 2.2 Priorities for improvement for 2013/14 – achievement and progress

We identified five improvement priorities where a particular focus was required to drive further improvement in 2013/14. Details of our achievements are provided below:.

### Patient Safety

**1. Reduce the incidence of *Clostridium Difficile* (CDI) and Meticillin-resistant *Staphylococcus aureus* bloodstream infections (MRSA BSI)** — Partially Met

**Overview of achievement:**

- We **achieved** the target to reduce cases of *Clostridium Difficile* (CDI) with 37 (month 11) against a target of 48. The details of which are provided in the Infection Control section.
- We **did not achieve** the MRSA blood stream infections as we had 3 cases against a target of zero

**Taking it forward:**

This improvement priority is carried over into 2014/15

**2. Improve the number of patients waiting less than 4 hours in A&E to more than 95%** — Not met

**Overview of achievement:**

The year-end performance was 93.59%. We achieved the 95% standard in 5 months between May and October 2013 but an increase in A&E attendances and admissions and delays in discharging patients has affected performance since November.

There has been an 8.8% increase seen in the number of A&E attendances since December 2013 coinciding with the re-introduction of the NHS 111 triage service in the last week of November.

The Trust has experienced a 5.3% increase in emergency admissions. This unplanned increased has left the Trust in a position where it has had to cancel elective work in order to prioritise patient safety.

Unlike many of its peers, the Trust does not manage all of the Minor Injury Units (MIUs) within the county. If the MIU performance is included, then at a health economy level the 95% standard has been achieved.

**Taking it forward:**

This improvement priority is carried over into 2014/15

The CCGs and the Trust have commissioned the Emergency Care Intensive Support Team to review and improve the winter schemes.

### Clinical Effectiveness

**3. Improve mortality in outlying specialities to the national average** — Partly met

**Overview of achievement:**

The three outlying specialities identified were acute cerebrovascular events, acute renal failure and congestive cardiac failure.

Review of the acute cerebrovascular (stroke) pathway, backed by review of patient care episodes, led to a centralisation of care onto a single site. The Hospital Standardised Mortality Ratio (HSMR – a measure of expected deaths for the population) for this group has improved from 125.47 in 2011/12 to 99.7 in 2013/14

A review of patient's records with acute renal failure demonstrated some minor issues with access to specialist renal services but this appeared to have little impact on overall outcome. Greater focus on this group of patients has reduced the HSMR from 124 in 2011/12 to 106 in 2013/14

Review of patients with congestive cardiac failure demonstrated some issues with the rigor of diagnosis with reliance on clinical opinion rather than objective evaluation of cardiac function. The diagnostic and management pathway was reviewed and improved by Cardiology team. However this has not resulted in an improvement with relative risk remaining at 125

**Taking it forward:**

Renal services continue to be a focus for improvement and the appointment of a renal physician is planned. The commissioning of renal services for Worcestershire continues to be challenged with the CCGs.

The care of patients presenting with congestive cardiac failure will remain a focus for improvement with a further audit of patient records being undertaken to identify care issues that require improvement.

| **4. Improve outcomes and experience for patients with a fractured neck of femur through implementation of a new pathway** | Not met |
|---|---|

**Overview of achievement:**

WAHT have performed well with regards to operation within 48 hours but have failed to perform well with regards to operations within 36 hours as reported in National Hip Fracture Database (NHFD).

A revised structure and a programme of work have resulted in improvements towards the end of the year. Live performance data is being used for performance reviews; the escalation policy to access additional theatre capacity at short notice has been reviewed; extended theatre work into the weekend is being trialled; 'ring fencing' two beds for patients is also being trialled; a new Trust-wide leadership structure has been in place since December 2013 allowing for better development of services across all our site.

Further detail is provided in the Surgical Division review in section 2.3.1

**Taking it forward:**

This improvement priority is carried over into 2014/15

## Patient Experience

| **5. Improve outcomes and experience for patients with Stroke to achieve all stroke targets** | Met |
|---|---|

**Overview of achievement:**

The Trust has met all the targets and standard in every month with the exception of December 2013 when we did not achieve "80% or more of patients spending 90% of their time on the stroke unit". This was due to the shortage of stroke beds in the community hospitals.

To help us achieve this target, we have centralised the stroke services to the Worcestershire Royal Hospital site and successfully recruited additional specialist and support staff. In addition, our plan for an in-house speech and language therapy service (an important part of a comprehensive stroke service) has been approved.

**Taking it forward:**

- To get Hyper-Acute Stroke Unit beds (HASU) fully operational on the Stroke Unit
- To have ambulatory clinic for patients with Transient Ischaemic Attack "up and running"
- To provide 7-day services

## 2.3 Reports from our Clinical Divisions

The five new Clinical Divisions were formed in November 2013. Each of the new Divisional Management Teams has provided a short summary of the services they provide, an overview of their quality performance in 2013/14 and their own improvement aims for 2014/15. Cancer services cut across many other services and an overview of its performance is given here too.

### 2.3.1 Surgical Division

**Services provided:**

The Division of Surgery brings together the surgical services that are currently provided on different hospital sites within the Trust. This has helped us to develop single surgical teams working across all these sites.

The division manages the following services:

- Trauma and orthopaedics (services which help with problems in bones and muscles)
- Hand services (services which help with problems in the bones and muscles in the hand)
- Vascular services, for example, treatment of varicose veins or other blood vessel problems
- Upper gastro-intestinal tract (services which help with problems in the upper part of the gut, for example: oesophagus, stomach)
- Lower gastro-intestinal tract (services which help with problems in the lower part of the gut, for example, small and large bowels)
- Services which help with problems in the breast
- Urology (service which helps with problems in the parts of the body that produce and carry urine)
- Services which helps with problems in the ear, nose and throat
- Maxillofacial surgery and orthodontics (service which helps with in the face, jaws or teeth)
- Dermatology (service which helps with disorders in the skin)

**Quality performance in 2013/14:**

The division has implemented a new “Emergency Surgery Pathway” since February 2014. This “pathway” facilitates the transfer of the most acutely ill emergency patients from the Alexandra Hospital to Worcestershire Royal Hospital.

One of the improvement priorities for 2013/14 was to improve the outcomes and experience for patients with a fractured neck of femur through the implementation of a new pathway. We aim to take patients to the operating theatre within 36 hours of admission. This has been challenging, mainly due to the availability of beds and operating theatres. The division is implementing a number of methods to improve performance in this area. These methods include ring fencing beds in some areas and undertaking these procedures 7 days a week.

We have demonstrated a much improved performance in infection control and prevention during the year with a reduction in hospital acquired infections within the division. Surgical site surveillance of patients undergoing orthopaedic operations has shown that the orthopaedic service has a significantly low rate of post-operative infections when benchmarked with other acute trusts.

There have been challenges regarding the national 18 week treatment target, which measures the waiting time from referral to receiving hospital treatment. The pressures on all in-patient beds have affected our ability to achieve this target. A plan is in place to improve this during next year.

Our three counties upper gastro-intestinal cancer team has been nominated for a national award from the British Medical Journal (Cancer Care Team shortlist 2014) for treatment of early oesophageal of cancer. Robin Walker MP took the time to meet staff and patients at Worcestershire Royal Hospital on 21 March to find out about their experiences and about the success of the shortlisted team. The cancer team covers Worcestershire, Gloucestershire and Herefordshire. Surgery is carried out at Gloucestershire Royal Hospital, and all other care takes place at a patient's local hospital. Worcestershire hospitals also offer regular patient support group meetings.

Consultant surgeon Martin Wadley said:

*"The treatment for oesophageal cancer is safer and more effective than ever, but the survival rates aren't changing. The problem is that the symptoms are not well known and many people are diagnosed too late. Working with my colleagues in Gloucestershire and Herefordshire, we're treating more people earlier. Early stage cancer can be treated without major surgery, and with excellent results."*

**Improvement aims for 2014/15**

| Improvement priority | Why is it a priority? | Target(s) | How will we measure it? |
|---|---|---|---|
| 18 weeks referral to treatment waiting time target | Swift treatment of patients | 90% | Performance Reports on patient waiting time from referral |
| Improve outcomes and experience for patients with a fractured neck of femur through implementation of a new pathway | Timely treatment improves outcome and provides a better standard of care for patients | 90% within 36 hours of admission to hospital | Performance Reports |
| Cancer performance – 31 and 62 day targets | Swift treatment leads to better outcomes | Adherence to 31/62 day targets | Performance Reports |

### 2.3.2 Medical Division

**Services Provided**

The Medical Division comprises of four Directorates:

- Emergency Medicine
- Specialty Medicine 1
- Specialty Medicine 2
- Haematology, oncology and palliative Care

**Quality performance in 2013/14:**

The division centralised the care of stroke patients at the Worcestershire Royal Hospital site this year. This was to help ensure that patients who have suffered a stroke are cared for by experienced, specialist staff and that all patients receive a rehabilitation programme designed to their needs. As well as improving the quality of care, we have met all the NHS standards and performance measures for stroke care since this service has been centralised.

*"Centralising stroke services in this way has been trialled nationally and it is proven to save more lives. I'm pleased to say that this move has been a success for our patients. This is all part of a bigger journey to make a modern stroke centre in Worcester."*
**Jane Schofield, Deputy Chief Operating Officer**

The "Ambulatory Emergency Care" Unit (designed to treat GP referrals and avoid unnecessary hospital admissions) has been established within the Emergency

Departments. This has helped to reduce the demands on Accident and Emergency and enabled patients to be seen more swiftly and promptly by a Medical Consultant ensuring the necessary care and treatment is commenced in a timely manner.

The recruitment and retention of Medical staff remains a challenge within the Division. A sustainable workforce plan is being developed to ensure that adequate and appropriate medical staff are employed thus reducing reliance on locum cover and improving quality, this is also the same with nursing teams and as a division we are looking at how we can ensure we look at maintaining the good levels of increased nursing ratios that we have across our medical wards

The division is committed to expanding its services locally to improve access for the county below are just 3 examples of how the division is working to provide services locally and improve patient experience

- The cardiology team have since August 2013 , started implanting complex devices at Worcester Royal Hospital so that our patients no longer require to travel outside the County for the original implant and follow up visits. This has improved convenience for our patients and a reduced inpatient waiting times.

- Our infectious diseases team have also implemented one stop shops for the management of liver disease through using fibre optic techniques to manage this chronic disease locally and thus preventing patients having to travel to Birmingham.

- Development of a pleural effusion service that looks at reducing un-necessary hospital admissions through direct access to this clinic by GPs

**Improvement aims for 2014/15**

| Improvement priority | Why is it a priority? | Target(s) | How will we measure it? |
|---|---|---|---|
| Development of permanent second cardiac catheter laboratory. | To provide a resilient Primary Percutaneous Coronary Intervention (PPCI) service | Opening of second catheter laboratory. | Greater access to Cardiac services in the county through both the emergency and elective services |
| Service redesign of AMU | Redesign of AMU to include frailty unit to support the reduction of the length of stay and improved patient experience in supporting frail elderly to be returned home within 72 hours. | Staffing and opening of 3 dedicated areas with a specific functions in improving the emergency patient pathway | Improve EAS performance<br><br>Reduction in patient complaints through an Improved patient experience for patients requiring emergency assessment<br><br>Improved staff experience |
| Appointment of Renal Consultant at Alexandra Hospital | Appointment of renal consultant at the Alexandra Hospital to ensure patients receive timely and appropriate care as required by a renal consultant. | Renal consultant in post | Improved mortality data for renal disease at The Alexandra |

### 2.3.3 Women and Children Division

**Services provided:**

The Women and Children Division was formed to bring together all services for women and children across the county.

Our Maternity Service provides care for pregnancy, birth and postnatal care in hospital, women's homes and community venues. We have two Consultant led delivery suites, one at Worcestershire Royal and one at Alexandra Hospital sites. We provide a full range of children's care throughout the county, including a neonatal unit for sick and premature babies on the Worcester and Redditch sites. We offer gynaecology services across the county with surgical operations taking place in Kidderminster, Worcester, Redditch and Evesham.

**Quality performance in 20013/14:**

***Maternity***

This year 5,807 mothers gave birth to 5,964 babies which is slight decrease from 2012/13 when 6220 women gave birth in the Trust. We are measured on the following "Key Performance Indicators" (KPI) which aims to measure the quality of care we provide from Maternity services.

| Key Performance Indicator | Results in 2012/13 | 2013/14 target | 2013/14 results | Comments |
|---|---|---|---|---|
| Women booked for antenatal care before 12 weeks and 6 days of pregnancy | 92.6% | 90% | 89.9 | Women should contact Maternity Services as soon as they are aware of their pregnancy to ensure appropriate advice of care options as soon as possible |
| Normal Vaginal Birth rate | 60% | 63% | 63.2% | This is an important measure as it indicates appropriate use of interventions. We are within national rates |
| Caesarean section rate | 26.9% | 27% | 26.3% | This is an important measure as it indicates appropriate use of interventions. We are within national rates |
| Breast feeding initiation rate | 72.7% | 70% | 73.4% | It is important to encourage mothers to breast fed as it provides the best nourishment for new born infants and is also beneficial to the mother |
| Smoking at delivery | 14.4% | 13.5% | 14.4% | Mothers should be encouraged to stop smoking during pregnancy to reduce the risks to their unborn baby and the impact on her own health |
| Percentage of women receiving Midwife Led Care | 32% | 35% | 29.6% | We aim to increase the percentage of women receiving Midwife Led Care to improve normal birth rates |

We have opened an Intervention Room, in addition to the existing obstetric theatre, on the Worcester Royal Hospital Delivery Suite. This is to ensure women who require urgent operative interventions have increased access to emergency theatre space if a complication arises.

This year has seen the appointment of a Bereavement Support Midwife to help and support families when a baby dies at or around the time of birth. The midwife will support families whilst in hospital and when they return home at this time of great sadness.

We now offer partners the opportunity to stay overnight on the postnatal ward with their partner and new-born baby.

"The opening of the Transitional Care Unit is an exciting development for the Trust. We hope these improvements will allow us to provide a more open, caring environment for those mums and babies who may need a little bit of extra support."
**Patti Paine, Divisional Director of Nursing and Midwifery**

***Gynaecology***

During the year it has been a challenge to meet the national target of 18 weeks, measuring the waiting time from referral to receiving hospital treatment. The pressures on all in-patient beds, through increased number of medical patients admitted as emergencies, have affected our ability to achieve this target. We ended the year achieving 84% of women having their operations within 18 weeks of referral from their GPs, against a national target of 90%

***Neonatology***

We have a local Neonatal Intensive Care Unit which cares for sick and premature new born babies. There are eighteen cots on the Worcester Royal Hospital site, and an 8-cot Special Care Baby Unit at the Alexandra Hospital. We have had a total of 976 admissions this year in 2013-14 (582 to the neonatal units, 204 to Transitional Care and 190 to the Post natal wards)

We have opened a new 6 bedded "Transitional Care Unit" which added an additional bed for mothers and babies to remain together whilst receiving care. This means that babies who require additional support and treatments, not full neonatal care, can be cared for in this area. Mothers have welcomed the opportunity to stay in hospital with their babies and participate in their care. The Neonatal Outreach service enables early discharge for preterm babies who may still require additional support at home.

***Paediatrics***

We have achieved the national recommendations for Diabetes Care in Children as stipulated nationally with Diabetes Best Practice. These recommendations aim to provide better care and additional support to children and families, improving the long term health outcomes for children with diabetes.

We have had 7,239 child admissions to the paediatric in-patient wards during 2013/14 We offer a limited service to support care at home for sick children in conjunction with Worcestershire Health and Care Trust.

**Improvement aims for 2014/15**

| Improvement priority | Why is it a priority? | Target(s) |
|---|---|---|
| Increase both parent and patient feedback within Paediatric services | To understand what both parents and children feel about their experience whilst receiving care | To receive feedback from 20% of paediatric admissions. This will be from a combination of children, young adults and parents |
| Introduction of Midwifery Led Unit at Worcester Royal Hospital | To be able to offer a full range of choices for place of birth to women choosing to give birth in Worcester | 10% of all births in Worcester taking place within the Midwifery Led Unit in its first year of opening |
| Improving our compliance with the 18 week 'referral to treatment' target for Gynaecological procedures | To improve women's experience of gynaecological care by achieving waiting time targets | Achieve 90% of operative procedures within 18 weeks from referral |

### 2.3.4 Clinical Support Division

**Services provided:**

The Clinical Support Division provides pathology, pharmacy, and radiology services, not only for the Acute Trust - but also the community hospitals and GP practices across Worcestershire.

**Quality performance in 2013/14:**

- To ensure the pathology laboratories provide a safe and high quality service to defined standards, we take part in the Clinical Pathology Accreditation (CPA) scheme. In 2013/14, several of the laboratories were inspected by representatives of the CPA scheme as part of their regular inspection programme. We learnt from the findings and addressed areas requiring improvements. Subsequently, all laboratories, including microbiology, histopathology and biochemistry and haematology, have been granted on-going full accreditation status.
- Pharmacy services supporting the Emergency Department and Acute Medical Unit are now available seven days a week; this is a significant improvement from a weekday service at the Acute Medical Unit previously. This has helped to prevent unnecessary admissions. This scheme has attracted interest from the Department of Health Strategy Group and information regarding the scheme has appeared in the Health Service Journal[1].
- To further improve access to the pharmacy service to the wards, we have extended the opening hours and provided additional cover at short notice, for example, when additional beds are open.

*"The A&E Pharmacy team's focus will be to ensure that the right medicine is available at the right time for attending patients. They will also assist in the identification of medication issues and problems to improve both quality and safety. Worcestershire patients want to be involved and informed about the medicines they take and not to have to wait for supplies on discharge. This pharmacy initiative will benefit patients attending A&E who do not need to be admitted, as well as patients who are."*
**Rachael Montgomery, Chief Pharmacist (Clinical services)**

- In the radiology department the waiting times and the reporting turnaround times are better than average when comparing with other trusts. For example, our average CT report turnaround time is 1.3 days, compared to a national average of 2.56 days. Our average MRI report turnaround time is 2.44 days - compared to a national average of 4.97 days.
- There has been a delay in extending the Medicines Management Services (MMS) to the Alexandra Hospital. The MMS involves checking all medicines brought into hospital by patients to ensure that they are still suitable for use. This service is now expected to commence in early autumn 2014 and it will improve access to medicines for inpatients and for discharges at the Alexandra Hospital.
- The introduction of the Safemeds system (a computerised system to improve prescribing for patients) has been delayed. This is because the system links to the new Electronic Discharge System, which is currently being developed and tested for implementation.
- The increasing demand for radiological investigations particularly in MRI, CT and ultrasound, has resulted in the six week target from referral to appointment not being met for a few patients (less than 10) this year.

**Improvement aims for 2014/15**

[1] HSJ Local, 17th September 2013, http://www.hsj.co.uk/hsj-local/acute-trusts/worcestershire-acute-hospitals-nhs-trust/pharmacists-drafted-in-to-help-ae-staff/5063138.article?blocktitle=Worcestershire-Acute-Hospitals-NHS-Trust&contentID=5320

| Improvement priority | Why is it a priority? | Target(s) | How will we measure it? |
|---|---|---|---|
| Deliver ward-based Medicines Management Services (MMS) at Alexandra Hospital | Equity of care, reduce medication risk and make better use of medicines resource. | MMS in place at Alexandra Hospital by 31/3/15 | Key performance indicators for wards that implement MMS |
| Roll out Safemeds system | Safemeds is a key tool for reducing risks associated with prescribing and medicines administration, leading to improvements in medicines management for patients | Safemeds in place by 31/3/15 | Monitored as part of a research project |
| Develop appropriate 7-day services tailored to the needs of the speciality | Targeted MMS services to reduce medicines risk and improve patient flow | 31/3/15 | Key performance indicators will be developed, relevant to the outcomes of the service development. |
| Bring the Pathology Directorate up to the ISO 17025 standards of competence for the testing and calibration of laboratories (replaces CPA accreditation). | It will soon be a requirement that all laboratories are assessed against these standards, failure to meet these standards may result in closure of the laboratory. | Become compliant with ISO 17025 laboratory standards by 2015. | Successful assessment of the laboratories by the relevant external bodies against ISO 17025. |
| Ensure all plain films are reported in a timely way | To ensure any pathology is identified as soon as possible. | 100% plain films reported ideally within 1 week | Using data from Radiology Information System (RIS) |
| Increase MRI, CT and ultrasound capacity | To ensure inpatients receive early investigation within waiting time standards to support effective management of a patient's treatment and discharge | Inpatients have relevant scan within 48 hours of request | Using data from RIS |

### 2.3.5 Theatres, Ambulatory Care, Critical Care and Outpatients Division (TACO)

**Services Provided**

The TACO Division encompasses a diverse range of clinical services - from routine Outpatient and Ambulatory activity to some of the most complex patients on our premises in Critical Care. The key aim of our Division is to facilitate equitable countywide safe patient care, delivered by a united, skilled and appreciated workforce. A significant component of the Division's work relates to provision of appropriate resources – theatre and outpatient clinic capacity, access to critical care and diagnostic endoscopy- to support patient care delivery undertaken by other Divisions. The Division also includes Ophthalmology, Rheumatology and Pain clinical specialties.

**Quality performance in 2013/14:**
TACO is a new Division and brings together a number of services that previously have been aligned to different directorates and therefore lacks some of the continuity of the other Divisions. Nevertheless there have been a number of significant quality performance developments during 2013/14:

- In Ophthalmology the ophthalmic nurse practitioners have successfully completed surgical training of intravitreal injection of Lucentis and have started to provide the first Nurse led Lucentis injection service in the West Midlands, offering significantly improved access to this sight saving treatment for our patients.

- The Division has implemented Trust-wide leadership for anaesthetics and critical care
- Following a ”never event” in theatres (more details on p.25), we have revised the management structure and used human factors training to redesign and build more reliable processes and develop a new approach to using the World Health Organisation (WHO) safer surgery checklist.

**Improvement Aims for 2014/15**

We are committed to delivering the right care to the right person at the right time with a committed and appropriate workforce. Our intention is to continue to develop and embed county wide services and to ensure adequate clinical support and provision of standardised pathways and equipment. The main improvement strategies for 2014/15 are:

| Improvement priority | Why is it a priority? | Target(s) | How will we measure it? |
|---|---|---|---|
| Work in partnership with colleagues in primary care towards an integrated rheumatology service | Integrated care across primary and secondary care so that care is delivered to the right patient in the right place at the right time. | To develop a jointly agreed referral pathway<br>To develop an education and support programme for partners in primary care | Referral pathway in place and functional<br>Education and support programme in place and accessible for primary care |
| Redesign an equitable and standardised pre-operative assessment service | Introduce standardised process for patient assessment across the Trust | To be developed | TBC |
| Improve efficiency in Theatres and Outpatients through robust scheduling processes and standardised operating procedures | To ensure efficient , safe and cost effective utilisation of resources | Establish a baseline of unutilised sessions and then determine a target.<br>Introduce prospective scheduling processes | Reduction in the number of unused theatre sessions |
| Provide a streamlined, accessible countywide endoscopy service and enhance the county Bowel Scope screening programme | Equity in patient experience and access to this service by improving access and capacity at the WRH site<br>Standardisation of service across the Trust<br>Create dedicated inpatient lists to improve patient flow | Align endoscopy capacity with the local population’s demand for the service<br>Create dedicated inpatient lists to improve patient flow | Pathway implemented on all sites<br><br>Increased throughput in endoscopy<br><br>Dedicated inpatient lists in place |
| Create a theatre admissions area on the WRH site | To enhance privacy and dignity, to improve patient experience and ensure a timely access to theatre. | To open a dedicated admissions area | Admissions area open and functional |

### 2.3.5 Cancer Services

Cancer care for Worcestershire patients is set to be transformed in 2015 with the opening of the Worcestershire Oncology Centre. The centre at Worcestershire Royal Hospital will provide state of the art radiotherapy services to county patients. This will reduce travel time for patients and their families who currently have to travel out of the county and will mean more local accessible cancer services.

**Services**

The hospital has a Cancer Services Team working closely with colleagues throughout the Trust to provide patient-centred care. The work of the Cancer Services Team is monitored by the Cancer Board, who monitors all the Trust's work on cancer and reports its findings to the Trust Board.

***Radiotherapy Centre:***

*"Patients told us that the centre should be homely, comfortable, personal and friendly, with a feeling of relaxation and warmth. They wanted a light airy environment and contact with the outside environment, especially nature views, to help their wellbeing. These opinions have strongly influenced the design."*

**Anne Sullivan, Cancer Services Manager and Macmillan Lead Cancer Nurse**

**Quality Performance in 2013/14**

In 2013/14, we have made the following key achievements:

- Excellent progress on the new radiotherapy centre which is now structurally complete and is on track to open as planned in January 2015. The centre will potentially make the Trust one of the country's top cancer care providers. We are in the process of building a work force of cancer specialists, including four consultants, clinical physics staff, radiotherapy staff, nursing and administration staff. Many of these posts have successfully been recruited to.
- Developed and implemented an action plan to improve our outcomes from the National Cancer Patient Experience Survey, resulting in the hospital becoming the sixth most improved hospital in England. The Trust was in the top 20% of all trusts on 6 items including "staff controlled pain" and patients receiving "understandable answers to important questions all/most of the time from their Clinical Nurse Specialist". Cancer Services developed a bespoke patient information tool which is now recommended as good practice on the National Survey Website.
- The Trust's Cancer Peer Review programme involving patient representatives has achieved positive and significant improvements for our patients along their care pathways. For example, we have introduced the "key worker" role as central to the patient's care and improving patient access to services across the Trust.

  The National Cancer Team have recognised the Trust Cancer Services Team's Peer Review process, which involves evaluation of cancer multidisciplinary teams against National Quality Standards as exemplar for good practice and recommends the model to other trusts.
- Raised the profile of the Macmillan Cancer Information and Support Centres, resulting in a significant increase in referrals of patients. Between January and December 2013, the services showed a 9.7% growth with a total of 5429 interventions. The Trust Macmillan Cancer Information and Support Centres partnership with the Citizens Advice Bureau and RELATE service model has been so successful it has since been adopted in other parts of the County.

**Improvement Aims for 2014/15**

| Improvement priority | Why is it a priority? | Target(s) | How will we measure it? |
|---|---|---|---|
| Provision of radiotherapy closer to home. | Improving patient access to local cancer treatment. | Jan 2015 | Monitor progress and risks through the Worcestershire Oncology Project. |
| Monitoring patient access to timely diagnosis and treatment. | To support the operational services of the hospital to care for patients with cancer. | On-going.<br><br>Measured monthly. | Performance against cancer waiting times targets. |
| Monitor quality of cancer patient care and experience. | The hospital should provide comprehensive, state of the art treatment that is quality assured and delivered locally whenever possible. | August 2014 - National Patient Experience Survey outcomes report.<br><br>31 July 2014 - National Cancer Peer Review programme. | National Patient Experience Survey outcomes and the National Cancer Peer Review programme. |

## Cancer Waiting Times Targets

We met all the cancer waiting time targets, apart from 62 day cancer wait (1st referral to treatment). The graphs showing performance during the year are provided in Section 4, National Targets.

## 2.4 Goals agreed with commissioners – the CQUIN payment framework

A proportion of Worcestershire Acute Hospitals NHS Trust income in 2013/14 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 11 CQUIN targets agreed with our main Commissioners, NHS Worcestershire, in 2013/14. 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** |
| **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. | **Achieved** | | | **Yes** | |
| **NHS Safety Thermometer** | Improve collection of data in relation to Pressure Ulcers, Falls and Urinary Tract Infection (UTI) in those with a Catheter. | **Achieved** | **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 | **Partially Achieved** | | | **Yes** | |
| **Venous-Thromboembolism (VTE) Prevention** | To reduce avoidable death, disability and chronic ill health from Venous Thromboembolism (VTE). | **Partially Achieved** | **Yes** | | | |
| **Improving Palliative Care (AMBER: A**ssessment, **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. | **Achieved** | | **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. | **Achieved** | | **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. | **Achieved** | | **Yes** | | |
| **Safe Care** | Reducing falls in all adult Inpatient areas including the Accident and Emergency (A&E) Department. | **Not Achieved** | **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. | **Achieved** | | **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. | **Achieved** | **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. | **Achieved** | **Yes** | **Yes** | **Yes** | |

Further details of the agreed goals for 2013/14 and for the following 12 month period are available on request from The Director of Resources.

**CQUIN – Specialist Commissioners**

Our Specialist Commissioners, Prescribed Services agreed the following 6 CQUINS:

| | | | Quality Domain | | | |
|---|---|---|---|---|---|---|
| **Goal Name** | **Goal Description** | **Achieved** | **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. | **Achieved** | | | **Yes** | |
| **NHS Safety Thermometer** | Improve collection of data in relation to Pressure Ulcers, Falls and Urinary Tract Infection (UTI) in those with a Catheter. | **Achieved** | **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 | **Partially Achieved** | | | **Yes** | |
| **Venous-Thromboembolism (VTE) Prevention** | To reduce avoidable death, disability and chronic ill health from Venous Thromboembolism (VTE). | **Partially Achieved** | **Yes** | | | |
| **Quality Dashboards** | Demonstration of the use of dashboards in the monitoring and improvement of quality. | **Achieved** | **Yes** | **Yes** | | |
| **Neonatal Intensive Care (NIC) Services** | Inline with the Prescribed Services Specialised CQUIN Menu. | **Achieved** | **Yes** | **Yes** | | |

## 2.5 Patient Safety

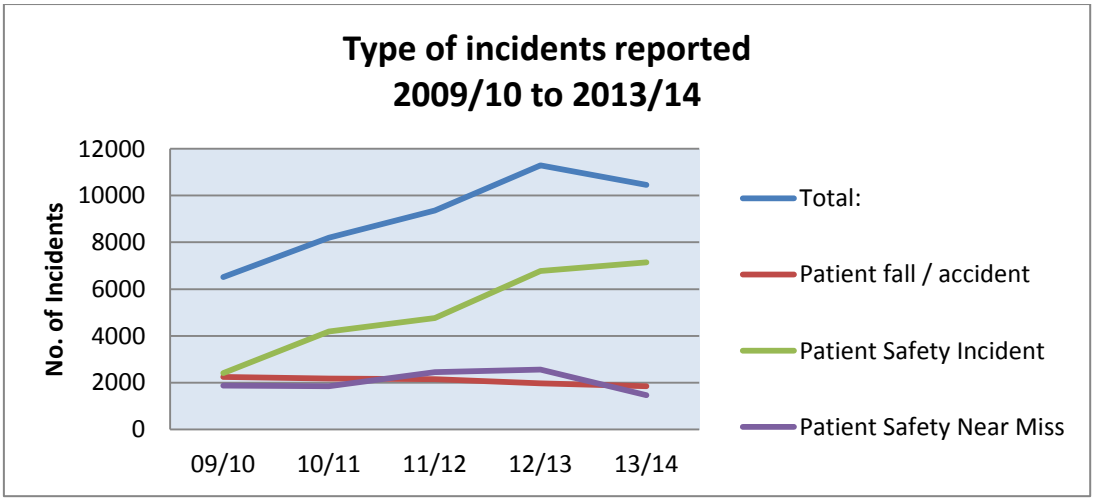
The restructuring of the Trust's quality committees enhanced the role of the existing safety committee to form in February 2014 a new Safe Patient Group under the chairmanship of the Chief Medical Officer. This Group oversees all the elements of patient safety in prevention, monitoring, investigating and taking action following incidents. This committee reports to a sub-committee of the Board, the Quality Governance Committee.

### 2.5.1 Patient Safety Incidents

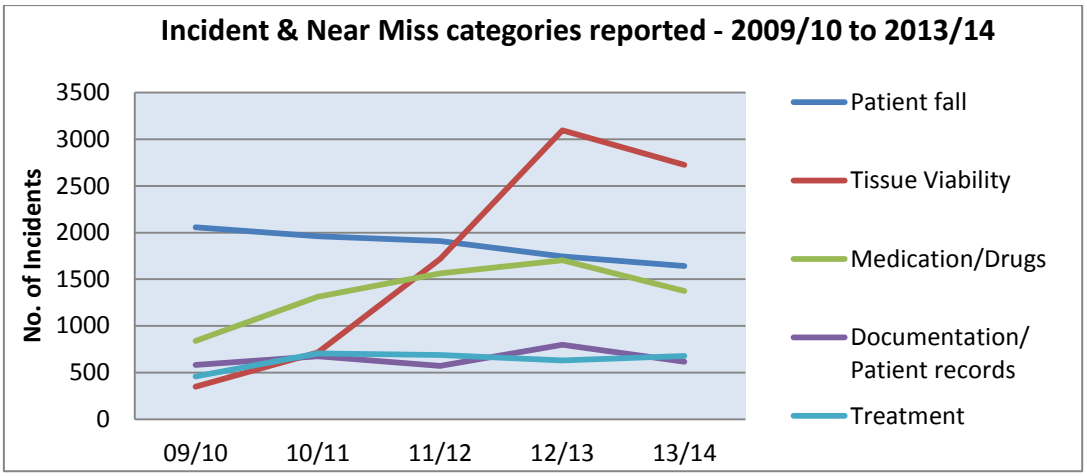
Having a healthy incident reporting culture is important to gather information about errors, harm and near misses to allow us to improve safety. A high reporting rate is encouraged by the NHS Outcomes Framework and we are consistently in the top 25% of high reporters when compared with similar Trusts. This is an indication that our staff feel able to report incidents and near miss events although we know that many incidents still go unreported. The important thing is to work to prevent incidents occurring by using the information on causes and contributory factors locally and in wider improvement programmes in areas such as falls, pressure ulcers and infection control.

A total of 10,470 incident and near miss events were reported during 2013/14, a reduction from 11,291 the previous year and the first decrease in reporting rates since incident reporting commenced. This is mainly due to a reduction in the number of 'insignificant' incident reports received (see the section covering severity), patient falls and tissue viability incidents reported. This is potentially because of our work to reduce in-patient falls and pressure ulcers but other factors such as pressure of work impacting on the reporting of 'insignificant' harm or near miss events could be present.

| | 09/10 | 10/11 | 11/12 | 12/13 | 13/14 |
|---|---|---|---|---|---|
| **Patient fall / accident** | 2245 | 2169 | 2146 | 1964 | 1845 |
| **Patient Safety Incident** | 2406 | 4188 | 4761 | 6773 | 7129 |
| **Patient Safety Near Miss** | 1866 | 1847 | 2452 | 2554 | 1496 |
| **Total:** | **6517** | **8204** | **9359** | **11291** | **10470** |



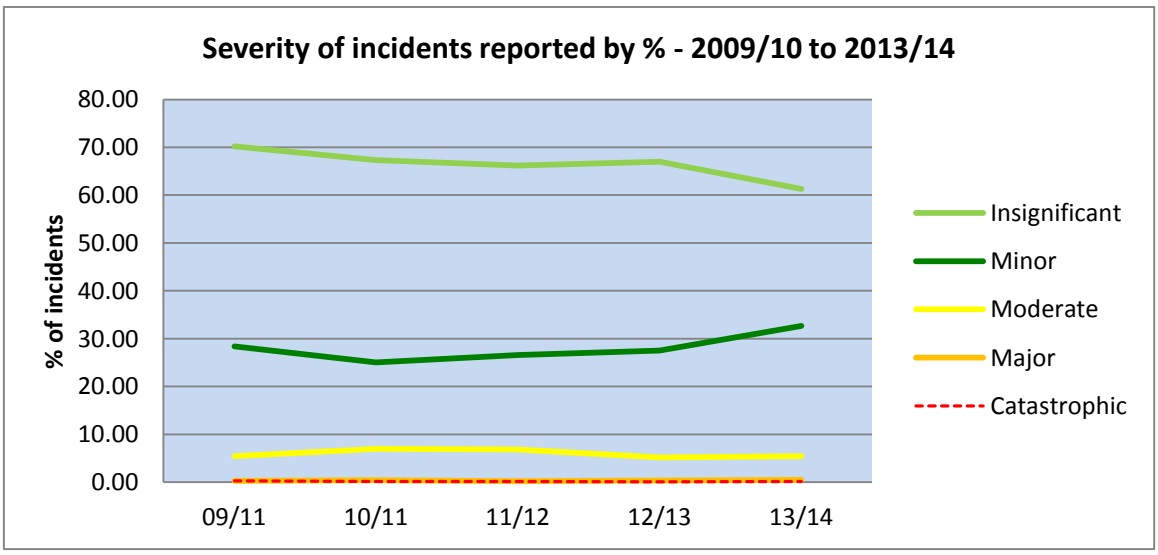

**Incident Categories**
The top 5 reported categories of incidents are reported in the graph below.
'Staffing' was previously the fifth most reported category in 2012/13 but has fallen to the seventh. Bed management was the seventh, but is now the sixth highest reported category.




**Severity**

- More than 93% of incidents reported continue to result in insignificant or minor harm. The table below shows the incidents by severity for the past 5 years.
- 1184 fewer 'insignificant' reports were received but an increase in incidents classed as causing 'major' harm were reported. A review showed that this is primarily due to the high number of incidents within A&E, graded as major, reported when operating beyond capacity but not related to specific harm.
- The number of 'catastrophic' incidents reported increased to 14 this year but remains within the range seen since 2009/10.
- A reduction in the number and proportion of incidents rated as 'insignificant' is the biggest contributor to the reduction in reports received and is primarily a result of ward based Pharmacists recording in-process errors on another audit system.

| | 09/10 | 10/11 | 11/12 | 12/13 | 13/14 |
|---|---|---|---|---|---|
| **Insignificant** | 4575 | 5528 | 6197 | 7563 | 6419 |
| **Minor** | 1554 | 2057 | 2490 | 3103 | 3418 |
| **Moderate** | 354 | 574 | 637 | 578 | 569 |
| **Major** | 17 | 34 | 20 | 38 | 52 |
| **Catastrophic** | 17 | 11 | 15 | 9 | 14 |
| **Totals:** | 6517 | 8204 | 9359 | 11291 | 10472 |



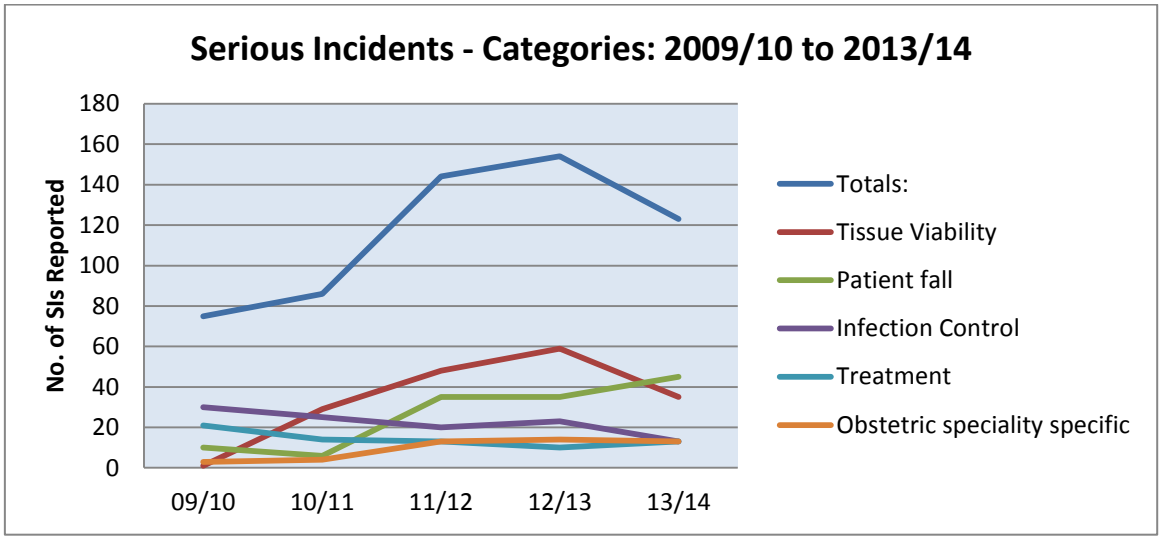

**Serious Incidents**

Serious incidents requiring investigation (SIs) are defined by NHS England and our commissioners. They include avoidable or unexpected death, serious harm events, Never Events and other circumstances that prevent an organisation from delivering healthcare services.

We had 127 SIs reported in 2013/14, a reduction from 154 during 2012/13.
This is partly due to a reduction in SIs related to tissue viability and infection control, demonstrating the impact of the measures reported in this Quality Account to reduce both.
SIs related to patient falls in hospital increased to 45 from 35 the previous year.

| Category | 13/14 |
|---|---|
| **Patient fall** | 45 |
| **Tissue Viability** | 37 |
| **Obstetric speciality specific** | 14 |
| **Infection Control** | 13 |
| **Treatment** | 13 |
| **Neonatal specialty specific** | 2 |
| **Medication/Drugs** | 2 |
| **Diagnosis** | 1 |
| **Totals:** | 127 |

The graph below shows the trends over the past 5 years for the reporting of the top five serious incidents categories (which account for 90% of all SIs reported by our Trust)




Serious incidents are reviewed and investigations closed by the Serious Incident Group. Actions and learning from serious incident reviews includes:

- Identification of delays in decision making around DNACPR (Do Not Attempt Cardio Pulmonary Resuscitation) has resulted in the Trust, in collaboration with the wider health economy, developing an e-learning training package aimed at improving decision making around this area of care. This will form part of the mandatory training for senior staff.
- The importance of giving parents advice while still in patient on measures to prevent cot death i.e. no co sleeping / bed sharing especially when unusually tired or having taken sedative drugs. This advice should be given at an early stage so it can be practiced by mothers while in the hospital and not just at discharge.

- Patient's with dementia / delirium to have appropriate care pathway completed and updated throughout admission. Multiple ward transfers should be avoided as should transfers during the night.
- Use of high visibility bays for patients at risk of falls / escalation for additional staff to increase supervision.
- Improvement to screening for orthostatic hypotension.
- The value of monthly obstetric skill drills for the multidisciplinary team on delivery suite.

**Never Events**

**Never events** are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

We had two never events in 2013/14, one in each of the following categories:

- Wrong implant/prosthesis – Ophthalmology: an incorrect lens was inserted but replaced in the same operating session
- Wrong gas administered - Medical ward: air was administered to a patient instead of oxygen

Each incident was investigated and changes in practice and the working environment made to prevent reoccurrence of similar incidents.

Wrong implant/prosthesis

- Non-compliance with the WHO surgical safety checklist was identified. This has led to a change in the method of identifying correct implant required and the purchase of a large screen for use in theatre.
- A temporary reduction in the number of cases per list was implemented.

Wrong gas administered

- Bed space safety checks have been implemented.
- Review of the use of piped air in ward areas and the storage of air flow meters.
- Education regarding oxygen policy.

**Categories of incidents**

**Tissue Viability**

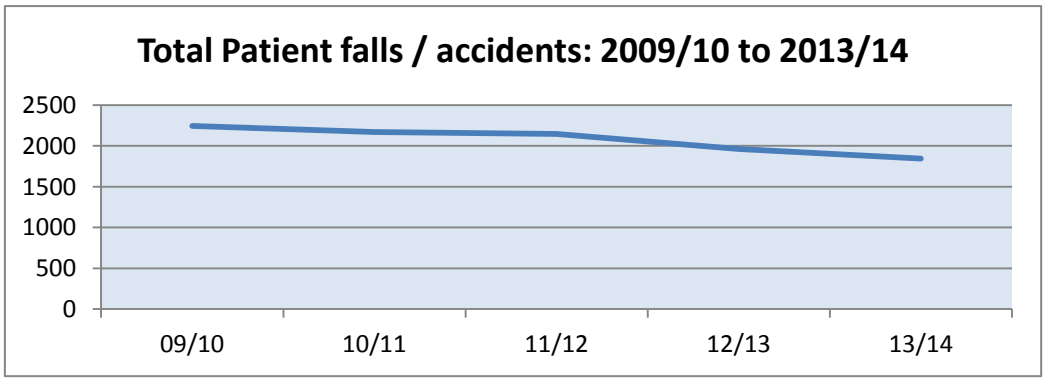
Tissue viability remains the highest category for all patient safety incidents reported. This includes pressure damage (ulcers) and moisture lesions which account for 84% of all incidents within this category.

- 60% of the incidents reported are for patients 'admitted with pressure damage', which are often discovered in the A&E and Acute Medical Units as patients are admitted.
- We monitor the development of new or deterioration of existing pressure damage during a patients stay and any serious damage (grade 3 and 4) are reported and investigated as Serious Incidents.
- There were 37 serious incidents related to pressure damage in 2013/14 compared with 59 in 2012/13.

Further details on the work to prevent pressure ulcers is provided later in this section.

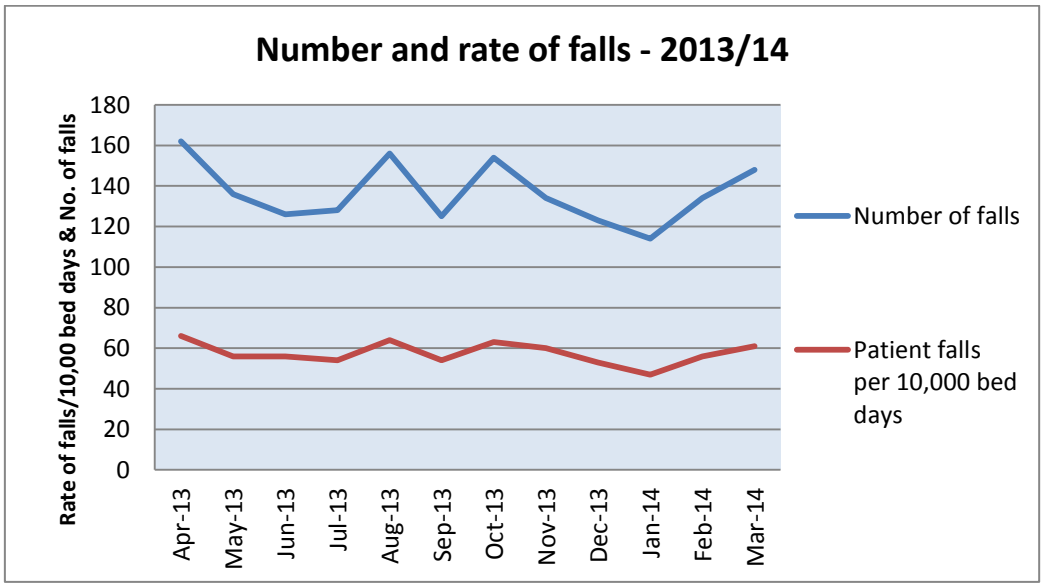
**Patient Falls in Hospital**

The number of patient falls Trust wide is relatively unchanged over the past year but a small fall in incidents reported each year continues with 103 fewer falls reported in 2013/14 than the previous year.




Falls resulting in serious harm are reported and investigated as serious incidents. 45 patients fell and suffered serious harm in 2013/14, an increase from 35 in 2012/13 and 44 in 2011/12.

We also measure the falls against the Trust's activity – the number of falls per 10,000 bed days. A CQUIN set a reduction target of 55.56 patient falls per 10,000 bed days. We achieved a rate of 57.




We have attempted benchmarking patient falls with similar Trusts but this is early work. Information from the National Reporting and Learning System (NRLS) shows that the mean rate of falls reported for Acute Trusts is 54 per 10000 bed days. However, there is some uncertainty as to the reliability of this comparison due to differences in patient population, reporting and classification of falls.

The number of inpatient falls is an important indicator of quality of nursing care in the hospital. The Trust agreed with the Commissioner to achieve a 5% reduction of inpatient falls in the first 6 months of 2013/14 and to maintain this reduction for the remaining part of the year.

To reduce the number of inpatient falls, the Trust has a Falls Prevention and Reduction Steering Group. They analysed the falls that had occurred and identified the actions required for improvement. For example:

- 63% of the staff, including the staff who work in wards with higher number of falls, have undergone training in falls prevention

- We have audited the common environments in which falls occur, for example, toilets and bathroom.
- We have improved our risk assessments and care plans in relation to patient falls.
- We have introduced a “checklist” to help staff reviewing the patient’s medications after a fall.

We will continue to reduce inpatient falls by:

- Ensuring all relevant staff have completed training in falls prevention
- Early identification of those patient at high risk of falls
- Implementation of falls reduction strategies within clinical areas

**Pressure Ulcers**

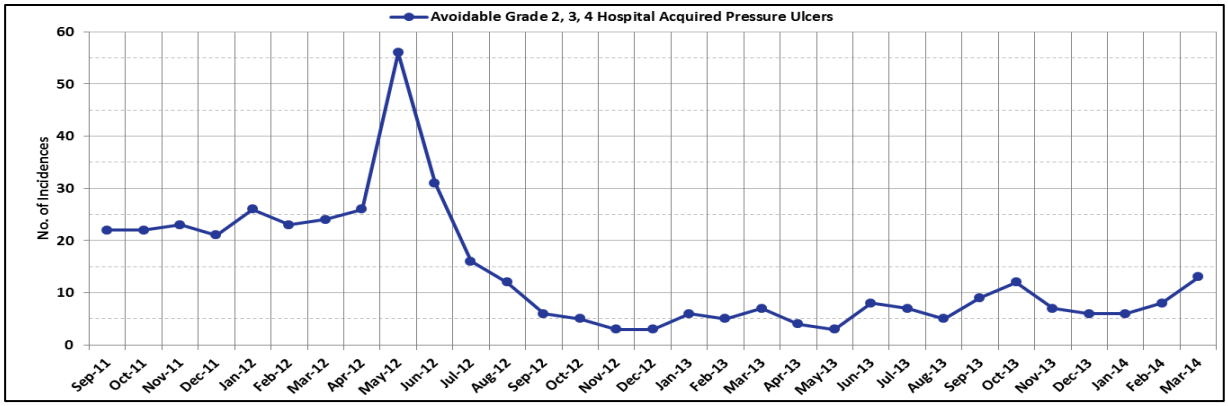
Pressure ulcers are injuries caused when an area of skin is placed under pressure, leading to breaking down of the skin and the underlying tissue. There are 4 grades of pressure ulcers, depending on their severity. Grade 1 is the lowest (patches of discoloured skin) and grade 4 the highest (open wounds that expose the underlying bone or muscle).

It is not always possible to prevent pressure ulcers in particularly vulnerable people. However some pressure ulcers are avoidable if the appropriate prevention and treatment measure are given. In the NHS, the prevention of avoidable pressure ulcer is seen as a key indicator of quality of nursing care.

Since 2012, the Trust has been implementing a number of measures to reduce the occurrence of pressure ulcers. Below are some of these measures:

- We have implemented a “care bundle” with a collection of five interventions that are aim to manage pressure ulcers
- We undertake an in depth investigations on all cases of grades 2, 3 and 4 pressure ulcers and learn from the mistakes made
- We conduct monthly audits on pressure ulcer prevention. When wards do not achieve the standards set, they are monitored and action plans are put in place.
- We have improved our staff education by targeting "hot spot" areas.
- We adopt the use of effective appliances and equipment, for example, the Trust have purchase “off-loading” devices to help to relieve pressure on patient’s heels

The graph below show the number of avoidable pressure ulcers per month since September 2011.

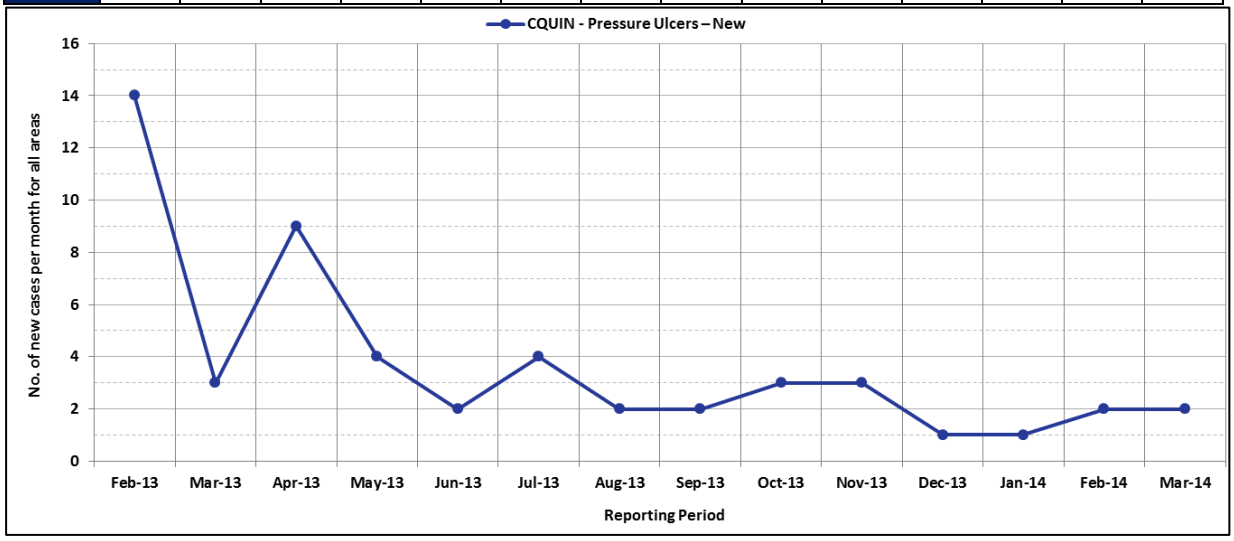



The peak in May 2012 was relating to an improvement programme within the Trust, resulting in an exceptionally high level of reporting in that month. The subsequent reduction in the number of pressure ulcers is due to the measures described above becoming embedded in the clinical areas.

**CQUIN Target on Pressure Ulcers**

The CQUIN target requires a reduction in the number of patients developing hospital acquired pressure ulcers and then being able to sustain this reduction. The ultimate aim is to eliminate all avoidable pressure ulcers. We have successfully met this target month on month for the year 2013/14.

| | Feb-13 | Mar-13 | Apr-13 | May-13 | Jun-13 | Jul-13 | Aug-13 | Sep-13 | Oct-13 | Nov-13 | Dec-13 | Jan-14 | Feb-14 | Mar-14 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| All New PU | 14 | 3 | 9 | 4 | 2 | 4 | 2 | 2 | 3 | 3 | 1 | 1 | 2 | 2 |
| Patients | 813 | 895 | 849 | 792 | 813 | 801 | 801 | 780 | 784 | 766 | 791 | 883 | 801 | 831 |




**Medication incidents**

97% of the medication incidents and near misses reported result in insignificant or minor harm. There has been a reduction in the number of medication incidents reported this year, primarily due to a decrease in the number of 'insignificant' events reported. Ward Pharmacists report many errors in prescriptions that they find during their checking process as incidents. A new method of recording and auditing this information was introduced this year and has contributed to the reduction in medication incidents reported. During the year we had two incidents resulting in major harm and one catastrophic harm (which do not appear on the graph below due to their low numbers).

- Anaphylactic shock resulting in admission to ITU.
- Interaction between two prescribed medications
- Wrong gas administered (a never event)

**Infection Control**

The Trust has continued to work hard to meet nationally set targets for reduction in *Clostridium difficile* infections (CDI) and methicillin-resistant *Staphylococcus aureus* bloodstream infection (MRSA BSI).

<u>CDI</u>

The Trust has achieved the target set for 2013/14 as there were 40 cases of CDI against a target of 48.

This achievement is due chiefly to our effort in working with our staff and patients, as well as with our partners in the community and neighbouring trusts. We have succeeded in reducing the use of specific antibiotics (for example Co-amoxiclav) and providing education to patients and staff. We have improved environmental hygiene by investing in

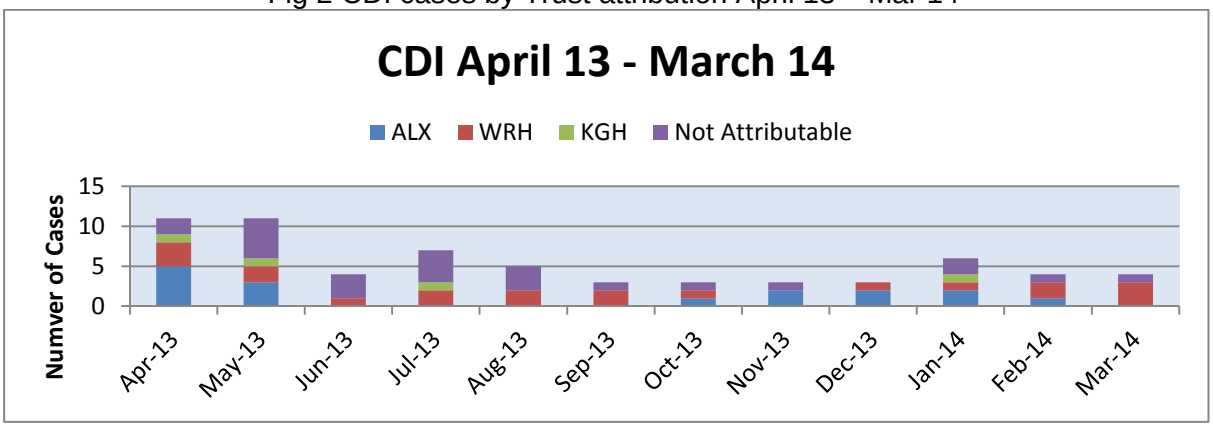
*"As well as putting new measures in place this year to limit the spread of infection where possible, we are reminding people early on what they can do to help and hope that they take the key messages on board through our Pull Together to Prevent Infection campaign."*
**Heather Gentry, lead infection prevention and control nurse**

equipment to clean patient rooms and wards with hydrogen peroxide vapour.

In addition, we conduct an investigation on each of the infection cases to ensure that we learnt lessons where appropriate.

Cross infection of patients in hospital is extremely rare with only one possible instance identified by typing the strains during the year.

Fig 2 CDI cases by Trust attribution April 13 – Mar 14




MRSA

There were 3 (against a target of 0) MRSA blood stream infections that were attributable to the Trust. We conduct an in depth review on all cases of MRSA BSI to ensure that we learn lessons from these incidents.

**Safety Thermometer**

The "Safety Thermometer" is a survey tool, developed by the NHS, to provide a "temperature check" on the proportion of patients that are free from harm at a point in time. The tool measures four types of harm:

- Bed sores (also known as pressure ulcers)
- Falls
- Urine infection in patients with a catheter
- Blood clots in a vein (also known as venous thromboembolism)

Our ward staff collect data on the four types of harm on a monthly basis and this data is sent to the NHS Information Centre. More information, including the data quality reports, can be accessed on the following website: http://www.ic.nhs.uk/thermometer.

In 2013/14, we agreed with our Commissioner to use the "safety thermometer" to monitor improvement in our hospitals. The target for achieving harm free care is 95% each month. The following represents monthly results for the Trust:

| Month | Apr-13 | May-13 | June-13 | July-13 | Aug-13 | Sep-13 | Oct-13 | Nov-13 | Dec-13 | Jan-14 | Feb-14 | Mar-14 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Number of patients surveyed | 856 | 792 | 813 | 801 | 801 | 780 | 784 | 766 | 791 | 883 | 801 | 831 |
| Number of patients "harm free" | 799 | 738 | 775 | 751 | 760 | 743 | 741 | 716 | 746 | 843 | 758 | 791 |
| % of patients "harm free" | 93.34% | 93.18% | 95.33% | 93.76% | 94.88% | 95.26% | 94.52 % | 93.47% | 94.31% | 95.47% | 94.63% | 95.19% |

## 2.5.2 Claims made against the Trust

All clinical negligence claims made against the Trust are managed through the Legal Service Department and in accordance with the NHS Litigation Authority 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%.

**New Claims by Site**

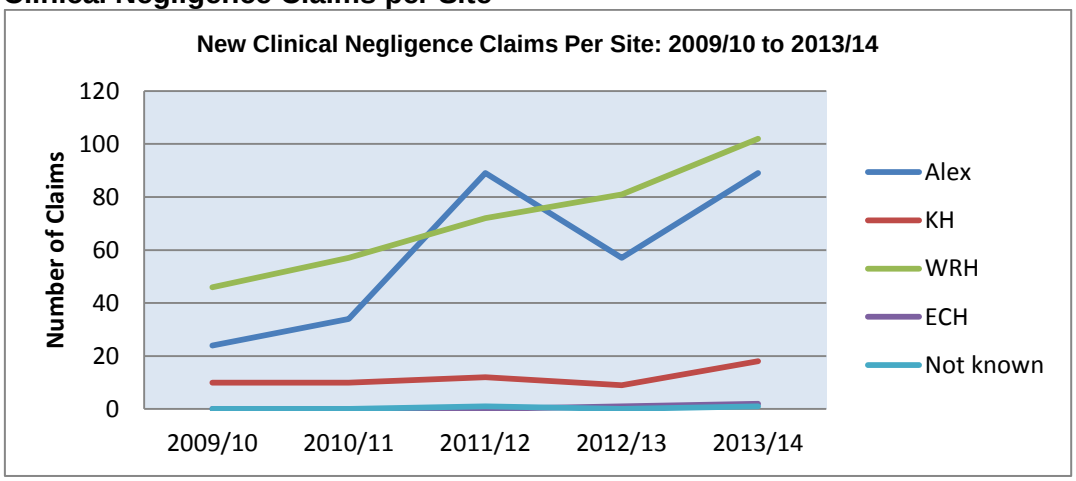
231 new claims were received between 1 April 2013 and 31 March 2014.
This is an increase on previous years however it also includes 30 claims that were notified as a second group of cases following the CQC report in 2011 and 17 cases relate to the colorectal surgeon under review.
The higher number of cases received in 2011/12 included 39 cases relating to the first group of cases following the CQC report.

**Number of new claims per site**

| | 2009/10 | 2010/11 | 2011/12 | 2012/13 | 2013/14 | Total |
|---|---|---|---|---|---|---|
| **Alex** | 24 | 34 | 89 | 57 | 97 | **293** |
| **KH** | 10 | 10 | 12 | 9 | 20 | **59** |
| **WRH** | 46 | 57 | 72 | 81 | 111 | **358** |
| **ECH** | 0 | 0 | 0 | 1 | 2 | **3** |
| *Not known* | 0 | 0 | 1 | 0 | 1 | **2** |
| **Total** | **80** | **101** | **174*** | **148** | **231**** | **715** |

* This includes a group legal action, consisting of 39 claims
**This includes two group legal actions: one consisting of 30 claims and another 17 claims

**New Clinical Negligence Claims per Site**



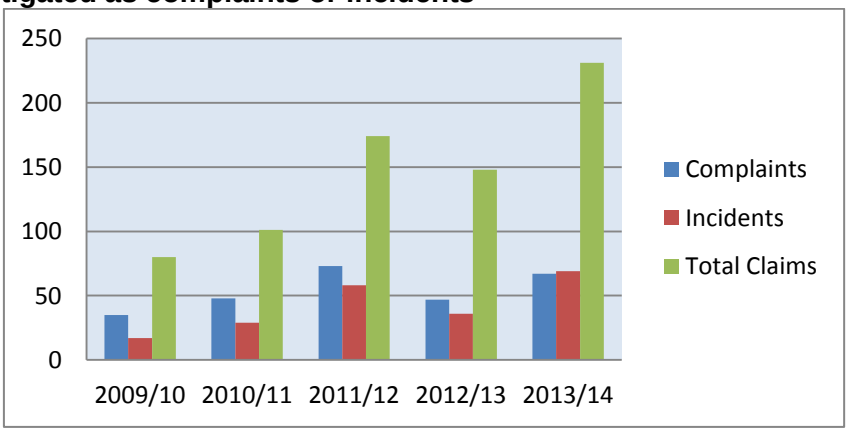

**Incidents or Complaints before a Claim**

Prior to notification of the claims 67 (29%) received in 2013/14 had been investigated as a complaint, which is a small reduction on previous years, and 69 (30%) had been investigated as an incident, which is a slight increase. However this indicates that the Trust has investigated less than a third of claims prior to them being received which can impact on the timeliness of any subsequent investigation including tracing staff that have since left.

**Number of claims per year investigated as a complaint or incident**

| | Complaints | Incidents | Total Number of Claims Received |
|---|---|---|---|
| **2009/10** | 35 (44%) | 17 (21%) | 80 |
| **2010/11** | 48 (48%) | 29 (29%) | 101 |
| **2011/12** | 73 (42%) | 58 (33%) | 174 |
| **2012/13** | 47 (32%) | 36 (24%) | 148 |
| **2013/14** | 67 (29%) | 69 (30%) | 231 |

**Claims investigated as complaints or incidents**




**Categories of Claims**

At the time of notification of a claim very little information may be provided by the claimants' solicitors therefore it can be difficult to categorise the nature of the potential claim. Categorisation may be subject to change during the lifetime the lifetime of the claim as the investigation progresses and expert evidence is obtained. Also some claims may relate to more than one category.

The NHS Litigation Authority lists a number of categories for allocating the type of incident to which a claim can relate to.

| Top 10 categories per year | 2009/ 2010 | 2010/ 2011 | 2011/ 2012 | 2012/ 2013 | 2013/ 2014 |
|---|---|---|---|---|---|
| Failure to diagnose/delay in diagnosis | 45 | 46 | 66 | 73 | 73 |
| Failure/delay treatment | 18 | 19 | 30 | 38 | 56 |
| Inadequate nursing care | 1 | 3 | 44 | 7 | 29 |
| Intraoperative problems | 7 | 15 | 16 | 13 | 15 |
| Lack of assistance/care | 0 | 0 | 35 | 5 | 20 |
| Inappropriate treatment | 4 | 5 | 14 | 7 | 10 |
| Failure to recognise complication of treatment | 2 | 4 | 10 | 7 | 0 |
| Failure to warn (informed consent) | 3 | 2 | 0 | 2 | 7 |
| Failure to make timely response to abnormal fetal heart rate | 0 | 0 | 4 | 5 | 5 |
| Failure to perform tests | 1 | 3 | 5 | 3 | 1 |

**Closed Claims**

There were 144 claims closed between 1 April 2013 and 31 March 2014.

- 43 (30%) claims were settled and 101 (70%) were withdrawn or the files closed following review where there had been no activity for more than 12 months.
- The cost of damages of the claims that were settled was £1,876,269.
- The date of the incident of the settled claims ranged was between December 2000 and March 2012 with the claims being notified between May 2008 and August 2013.
- 6 of the settled claims had initially been investigated as an incident; 9 had been investigated as a complaint and 7 had been investigated as both an incident and a complaint.
- A significant number of claims are either withdrawn or not pursued by claimants following the disclosure of records. The figures for the last five years are given below and range from 46% to 74% of cases withdrawn.

### 2.5.3 Safeguarding patients

**Safeguarding Adults at Risk**

There has been strengthened multi agency working. Trust staff have continued to make regular contributions to the Worcestershire Adult Safeguarding Board and its sub committees. We have had positive reviews of our processes to safeguard adults at risk following inspections by the CCGs and the Care Quality Commission and this has supported the findings of the internal quality inspections.

During the year 2013/14 the Trust has

- increased the number of staff trained in the principles of Safeguarding Adults to 73%
- increased the number of staff trained in the principles of Mental Capacity Act to 53% of all clinical staff
- the content of the training in relation to the Mental Capacity Act has been changed to help staff to embed theory into practice.

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 that have been supported.

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.

**Safeguarding Children**
Children & Young People (defined as those who have not yet reached their 18th birthday) access services from many areas within the Trust, the highest contact areas being Paediatrics, Maternity and Emergency Departments. It is staff within these areas that are often responsible for raising issues relating to the welfare and / or child protection concerns of the children that they have contact with.

The Trust has statutory responsibilities (Children Act 1989 & 2004) to safeguard and promote the welfare of children. These responsibilities are monitored by the Care Quality Commission, outcome 7 and Worcestershire Safeguarding Children Board, via Section 11 Audit.

**During the year 2013/14 the Trust has**

- Continued to strengthen multiagency working
- Attended Worcestershire Safeguarding Children Board meetings and its subgroups
- Made changes to practice following learning from multi agency case reviews
- Initiated a Trust Children's Board, with a safeguarding children sub group, to roll out and monitor the safeguarding children agenda on a trust wide basis.

**Identified issues that are being addressed during 2013/14**

- The Section 11 self-assessment audit identified that in areas of The Trust where there is regular contact with children and young people compliance was good. However, for other clinical areas where children access services for example outpatient clinics, theatres, Ear Nose and Throat and Orthopaedics, the compliance level rated as – Requires Attention. This was also the rating level for contracted services within The Trust.

The Trust will resubmit a second Section 11 audit to Worcestershire Safeguarding Children Board in December 2014 to give a clearer indication of the issues surrounding contracted services within the Trust, and also to update on progress made with achieving compliance in the identified clinical areas.

- The low uptake of safeguarding children training – 43% of staff trained at Level 1, or above, giving a shortfall of 57% compliance.

An action plan is underway to ensure that staffs complete this mandatory training. Action taken to date include

- classroom taught sessions for staff who prefer not to use on line training modules
- Trust wide awareness raising of the need for staff to complete training
- production of a training report, highlighting areas of non-compliance with training at both divisional level and individual staff level for managers.

The training uptake figures are being monitored on a monthly basis.

## 2.6 Clinical Effectiveness

We established a new Clinical Effectiveness Committee in November 2013 under the chairmanship of a new Associate Medical Director for Revalidation, Leadership & Clinical Audit. This brings together the different elements of clinical effectiveness into one forum to enable better coordination, direction and cooperation with the new clinical Divisions. This committee also reports to a sub-committee of the Board, the Quality Governance Committee.

### 2.6.1 Consultant level indicators

The first set of consultant level indicators were published by NHS England in 2013 and covered 10 clinical specialties, all of them surgical except interventional cardiology, 8 of which are provided by this Trust. Further indicators will be developed over time. None of these indicators show any areas of concern for our clinicians at this time.

We will be using consultant level indicators as part of our quality improvement processes at the individual consultant level as well as providing assurance for ourselves and our stakeholders on outcomes of these procedures.

### 2.6.2 Medical Revalidation / HED tool

Revalidation is the process by which licensed doctors are required to demonstrate on a regular basis that they are up to date and fit to practise. Revalidation aims to give extra confidence to patients that their doctor is being regularly checked by their employer and the GMC. The cornerstone of revalidation is annual medical appraisal. On the basis of medical appraisal output and other information available to the Responsible Officer (RO) from local clinical governance systems the RO makes recommendations to the GMC and GMC will consider the RO's recommendations and decide whether to renew the doctor's licence to practice. Revalidation started on 3 December 2012 and is well underway. Doctors will be normally revalidated every five years from now on.

Between 1 April 2013 and 29 April 2014, a total of 78 doctors have been recommended by the RO and revalidated by the GMC. There were 14 deferrals (to a future date) by the RO in view of insufficient evidence for a positive recommendation at this point.

Over the last year we have made several changes to facilitate and strengthen the revalidation system and standardize appraisal process, appointed Associate Medical Director for Revalidation, arranged training sessions for appraisers and appraisees and registering all consultants, SAS doctors on the Equiniti Revalidation Management System (ERMS) for appraisals. To ensure that all medical appraisals are of excellent quality and meet the standards Appraiser forums have been established and a new quality assurance tool for medical appraisals is currently being developed. Our revalidation team has also reviewed the newly developed HED (Healthcare Evaluation Data) tool on consultant revalidation which benchmarks individual performance against others within the organisation and nationally. Validity of the information in HED consultant revalidation module is currently addressed at regional and national level to ascertain if this can reliably inform the revalidation process.

### 2.6.3 Mortality overview

Mortality rates are measured and published in two ways, each of which uses routinely gathered data to give a ratio between the actual number of patients who die in hospital and the calculated number based on average numbers in England (the Hospital Standardised Mortality Ratio or "HSMR") and also within 30 days of being discharged (the Summary Hospital-level Mortality Indicator or "SHMI").

The Trust uses a recognised tool[2] to review the relative risk of mortality for our services and compare this with other Trusts to see where there may be issues that require further investigation.

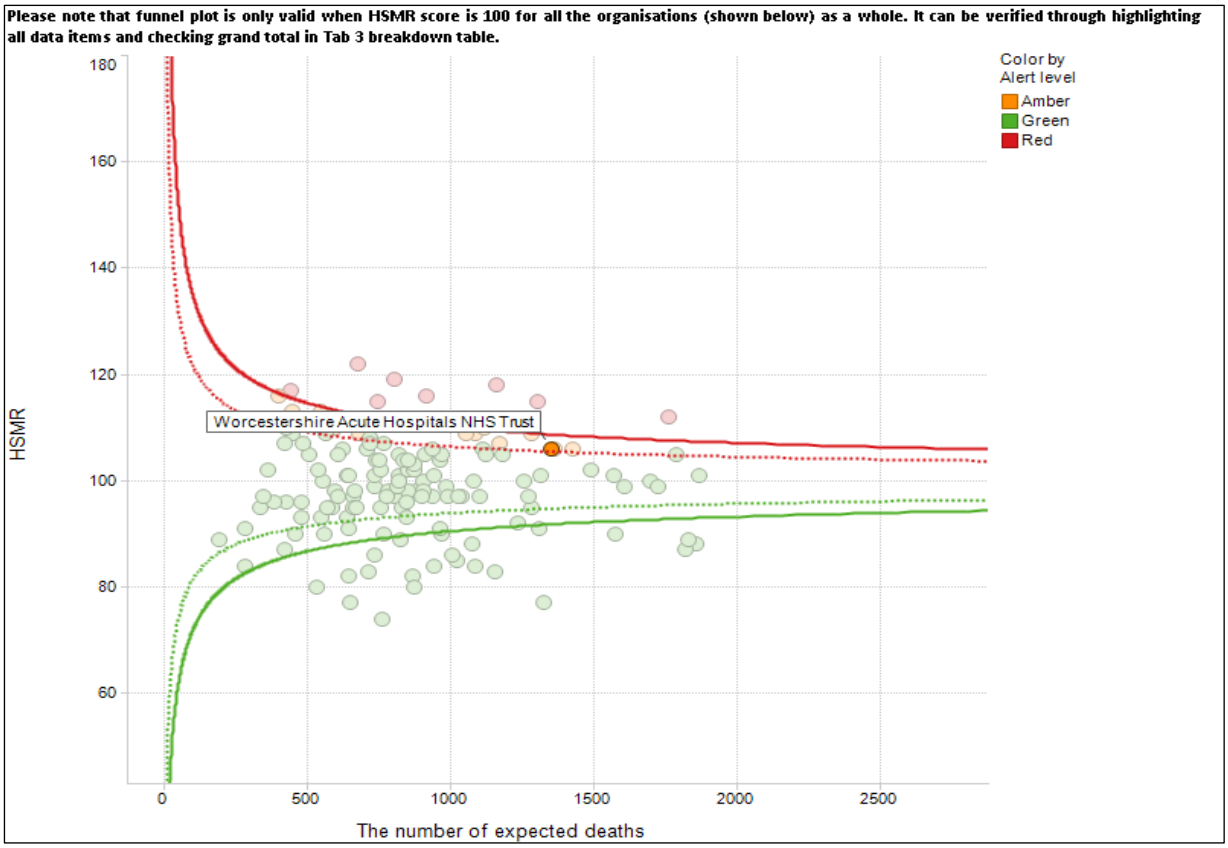
The expected rate is 100 so if a Trust has an HSMR or SHMI of greater than 100, then there are more deaths than expected and if below 100, fewer deaths. Some variability either side of 100 is expected by chance and the 'confidence' in the accuracy of these figures is shown in the graphs provided below.

The accuracy of the data of diagnoses and outcomes is very important and reviews of patient records where higher than expected mortality is observed, often reveal inaccuracies in coding. The HSMR is often quoted as being a 'smoke signal' and unexpected mortality rates need to be investigated to determine whether there is a real problem with the quality of care provided or the recording of diagnoses and outcomes is a cause.

The Quality Governance Committee reviews this information on behalf of the Board and actively seeks assurance on the quality and safety of care provided as a factor in the HSMR. The follow-up reviews requested by the committee have revealed coding issues as the primary reason for a higher than expected HSMR.

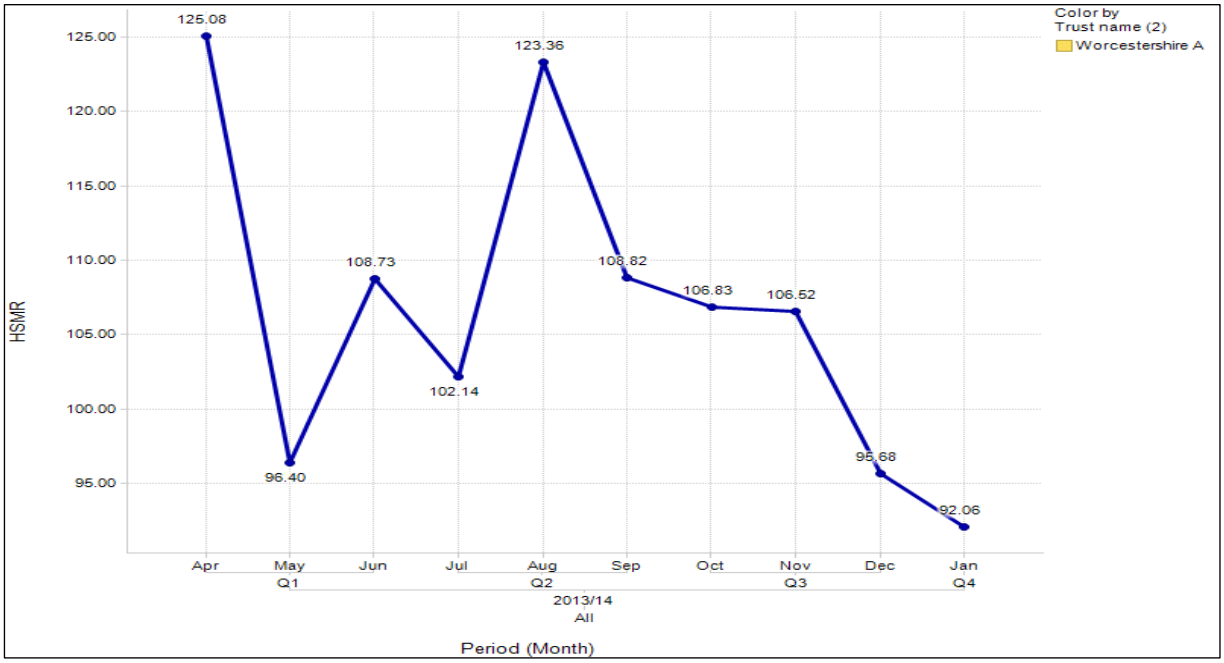
## HSMR April 2013 – January 2014 = 106.13

At the time of completion of this account only data for the period April 2013 – January 2014 was available. **The value for this period is 106.00.** The funnel plot (graph below) shows the Trust's position compared with other acute Trusts in England. This is statistically greater than would be expected by chance.




[2] Healthcare Evaluation Dataset (HED) tool we use to measure morality, it uses the same data as the Dr Foster tool.

However, the overall trend shows a reduction in relative risk since a peak in August 2013, with the last 2 months values below 100.




We undertake a more detailed analysis of the diagnostic groups contributing to HSMR on a monthly basis. If a particular diagnostic group shows a higher than expected value, a detailed review of the patient records is undertaken to establish if there is a real cause for concern and if so what action needs to be taken.

Following this process reviews of the records of patients in the following diagnostic groups have been commissioned:

| Diagnostic group | HSMR | Current position – March 2014 |
|---|---|---|
| Pneumonia | 110 | Commenced |
| Sepsis | 133 | Commenced |
| Bronchitis | 136 | Commenced |
| Biliary tract disease | 141 | Commenced |
| Other' Gastrointestinal Disorders | 156 | Completed –No issues identified with respect to quality of care provided. |
| Leukaemias | 183 | Commenced – preliminary findings indicate a recording/coding problem as no patient appeared to have been treated for leukaemia |
| Cardiac arrest | 127 | Commenced – preliminary findings indicate most patients arrived in cardiac arrest but died following a short period of return of spontaneous circulation. |
| Skin and Subcutaneous Tissue Infections | 137 | Commenced |
| Acute and Chronic Renal Failure | 107 | Commenced |
| Cardiac Dysrhythmias | 130 | Commenced |

Clinical experts are required to complete their review within 8 weeks and provide a report to the Safe Patient Group chaired by the Chief Medical Officer.

**Mortality risk for patients admitted with surgical diagnoses at Alexandra Hospital**

During 2013 we became aware of a higher HSMR for a group of 'acute abdomen' emergency surgical conditions at the Alexandra Hospital than at Worcestershire Royal Hospital. Both figures were within statistically acceptable limits of variation but, in view of the concerns that had been raised, a review of deaths occurring during that time was undertaken by the AMD (Associate Medical Director) for Patient Safety.

In addition in October 2013 the Trust asked the Royal College of Surgeons (RCS) to undertake a review of surgical services with a focus on Colorectal, Upper GI and Breast Surgery services at the Alexandra Hospital. The Trust also advised key stakeholders of these concerns and how they were being addressed.

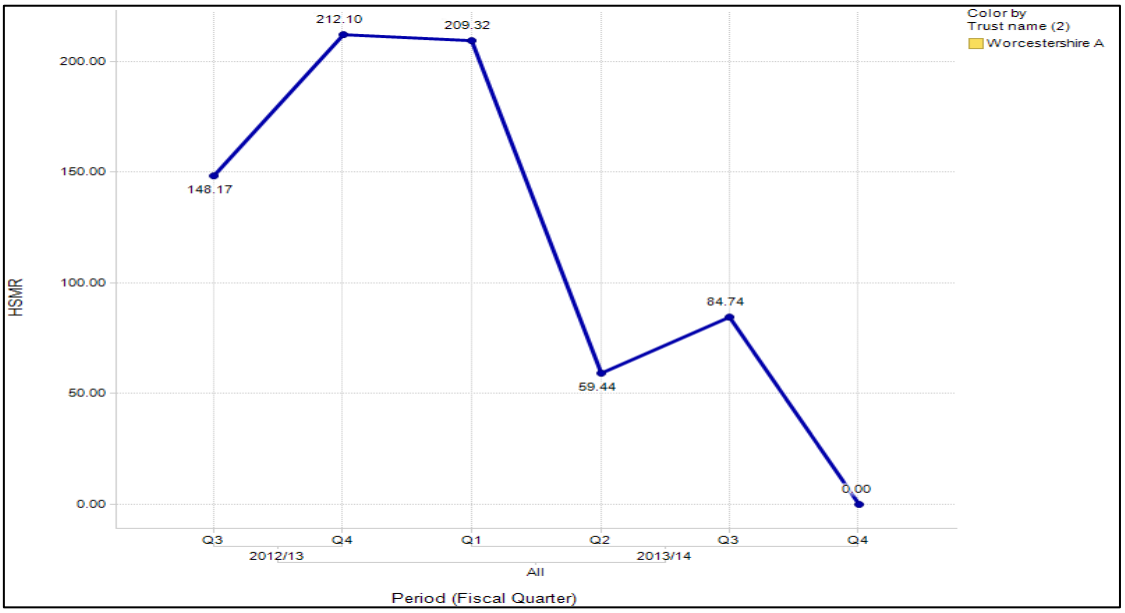
The Chief Medical Officer and the Divisional Director of Surgery met with senior surgical colleagues across the Trust to understand the risks and how to reduce them.

The Chief Medical Officer and the Chief Operating Officer formed a Task and Finish Group for Emergency Surgery to oversee the management of this important matter and to ensure patient safety was maintained, risk evaluations undertaken and that timely and effective decision-making was in place. The Task and Finish Group met on a fortnightly basis and developed and managed a detailed action plan to reduce the risks.

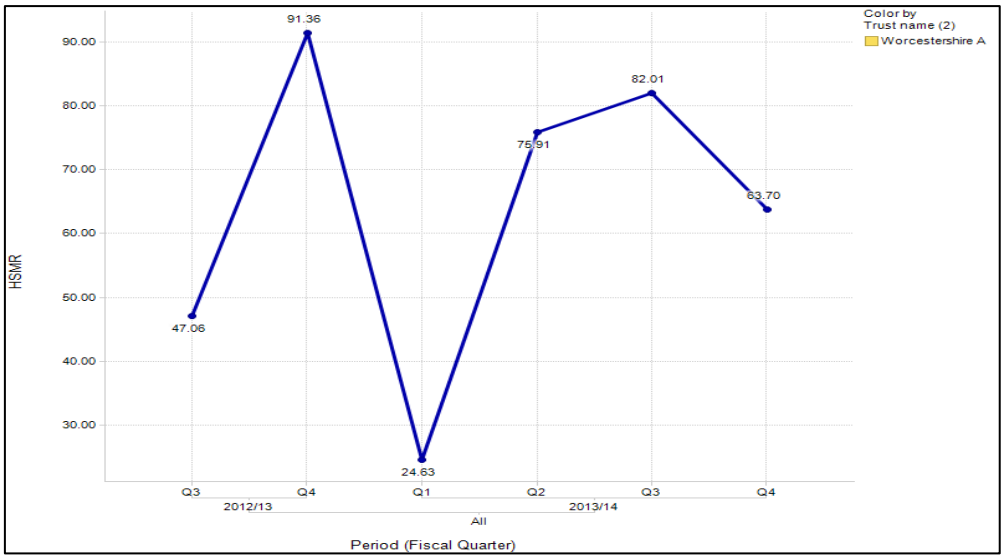
Following advice from clinical colleagues, a change to the existing Emergency Surgery pathway from 3rd February 2014 meant that the most acute patients (Acute Abdomen and/or Perforated Viscus) have been transferred from the Alexandra Hospital to Worcestershire Royal Hospital. On average 2-3 patients per week have been transferred.

The Task and Finish Group continues to meet and review the outcome data for patients as well as ensuring that all the measures in the action plan are being delivered.

The trend line (below) shows that for patients admitted to the Alexandra Hospital with diagnoses of abdominal pain, cancer of the colon, cancer of the rectum, intestinal obstruction or peritonitis cared for by general or colorectal surgical teams the HSMR is improving.




The trend line for WRH indicates no change with values consistently below 100 giving some confidence that the changes are not adversely impacting on care delivered at this site.




As additional assurance the clinical records of all patients dying at Worcestershire Royal Hospital since October 2013 who fall into this diagnostic grouping have been reviewed by the AMD for Patient Safety. No deaths have occurred following transfer of patients from the Alexandra Hospital to WRH. No issues with the quality of care provided were identified.

**A review of weekend mortality relative risk**

Following publication of data by Dr Foster indicating that for the NHS as a whole there was a higher risk of death for patients admitted at weekends we reviewed and compared our mortality ratios for weekday and weekend patient admissions between April 2012 and November 2013.

We determined that:

- The overall HSMR between April 2012 and November 2013 is higher than expected at 105.2 with no difference between hospital sites
- The trend for 2013/14 is improving
- The relative risk for all **weekday** admissions although higher than the average of 100 is within expected normal limits. There is no site difference and no significant difference between elective and emergency admissions.
- The relative risk for **weekend** admissions is higher than expected between April 2012 and November 2013 but is not significant and there is no difference between hospital sites. However the trend is one of improvement and for 2013/14 the value is within expected normal limits.
- The HSMR for emergency admissions at weekends has been higher than expected but is improving such that for 2013/14 the relative risk lies well within expected normal limits

The improving trend is encouraging however we continue to focus on ensuring that patients admitted as emergencies at weekends have the same level of care as that which is provided during the week.

**SHMI April – November 2013 = 99.46**

This indicator follows the HSMR closely for WAHT. The value tends to be lower than the HSMR figure. This gives the Trust some confidence that the Trust is not discharging patients into the community in a manner that increases their risk of death.

## 2.6.4 Clinical Audit

Clinical audit is a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria or standards and improvement action being taken where required. We have programmes for clinical audit both within specialties and across the Trust based on NICE guidance, standards, risks and local priorities. Our participation in national and local clinical audits is provided in detail in section 4. An example of a national clinical audit that shows improvement in a service is provided below.

**National Audit of Paediatric Diabetes Services**
The published audit results that relate to 2010-11 and 2011-12, show that the paediatric diabetes service is improving, with the help of additional staff that have been employed, and that families think that they are being well supported. We have summarised the following highlights:

- There has been improvement in the 'care processes' (for example, an annual blood pressure measurement) across the three sites (Alexandra Hospital, Kidderminster Hospital and Worcestershire Royal Hospital) of the Trust. We performed 'considerably better than average' in the financial year 2011-2012.
- However, there had been a deterioration of our performance on controlling of blood sugar in 2011-2012, with all three sites achieving worse 'control' of the patients' diabetes than average for the UK. (Since then additional staff were employed at the beginning of the financial year 2012-2013; and there has been a dramatic improvement in the results).
- Our admission rate with severe hypoglycaemia (low blood sugar crises) was and still is lower than average. This may be due to our active policy of making local teenagers aware of the effects of alcohol upon their diabetes.
- In addition to the above, we were described as 'one of the best district general hospitals' by the organisers of the national research project on structured education for young people with diabetes.

### 2.6.5 Research and Development Services

*"Research is a core part of the NHS. Research enables the NHS to improve the current and future health of the people it services."* — NHS Constitution (2009)

Doing research into health and the delivery of healthcare services is vitally important to the NHS because the outcomes can be used to influence the quality of services delivered to patients. This means that patients are able to gain access to the best available treatments and services, which have been rigorously tested, as well as innovative and leading edge treatments that can significantly improve health outcomes

The hospital has a Research and Development (R&D) Department with the following responsibilities:

- to promote and encourage research activities within the hospital
- to ensure research governance[3] is maintained to a high level in all research projects in the Trust.
- along with the R&D Committee, to ensure the safety of all patients participating in research and ensure the reputation of the hospital with regard to research are protected at all times
- to support researchers to become involved in and recruit to the National Institute for Health Research Clinical Research Network (NIHR CRN)NIHR portfolio studies[4].

[3] Research Governance refers to a range of principles and standards aim to ensure research is of high quality, safe and ethical.
[4] The National Institute for Health Research Clinical Research Network (NIHR CRN) Portfolio consists of high-quality clinical research studies that are eligible for support from the NIHR Clinical Research Network in England. The key

Additionally, the hospital has a Service Level Agreement for a Research Management and Governance service. This service has been provided by West Midlands (South) Comprehensive Local Research Network (WM(S) CLRN) since 2008/2009 and the Agreement is reviewed annually and renewed as appropriate. The Department has worked extremely closely with colleagues in WM(S) CLRN to ensure that new national initiatives have been introduced efficiently without compromising our commitment to maintaining high governance standards.

**Quality performance in 20013/14:**

Each year the Trust agrees a target to increase recruitment into NIHR portfolio studies with West Midlands (South) Comprehensive Local Research Network. For the past few years the hospital has been unable to meet this target, however in 2012/13 this target was surpassed with 1056 participants recruited versus a target of 1013. This is the first year since 2009/10 in which this target has been met.

For 2013/14 the recruitment target was agreed at 1025, representing a 5% increase on last year's target. To date 1009 participants have been recruited across 47 portfolio studies. Therefore at the current recruitment rate the hospital should make target.

**Improvement aims for 2014/15**

| Improvement priority | Why is it a priority? | Target(s) | How will we measure it? |
|---|---|---|---|
| A key priority for Department of Health, Trusts and Research Networks is to engage with the Life Sciences Industry | Department of Health priority | An increase in commercial studies compared to last year | Number of patients recruited into commercial studies and number of commercial studies open |
| Maintain recruitment into National Institute for Health Research (NIHR) portfolio studies during a year of transition when there will be a national restructure within the Research Networks. | It is imperative that recruitment rates continue to follow targets to secure the position of the hospital during Research Network Transition | Recruitment target set at 1025 patients, the same as for 2013/14 | Number of patients recruited into portfolio studies |
| Work more collaboratively with Higher Education Institutes and other NHS organisations, to improve the hospital ability to lead and initiate research and innovation, as well as being an active member of West Midlands Academic Health Science Network (WMAHSN) | It is essential that the hospital engage in transition processes, including working together with other NHS organisations to support new hosting arrangements. It is vital for the future success of the organisation that the hospital makes every effort to maintain a stable and secure research workforce. | Collaborative working and involvement with HEI's and West Midlands Academic Health Science Network | Number of collaborative projects and involvement with the WMAHSN |

objective of the NIHR is to improve the quality, relevance, and focus of research in the NHS and social care by distributing funds in a transparent way after open competition and peer review.

## 2.7 Patient Experience

Our patient experience feedback programme and complaints are monitored through the Patient Experience Committee. This committee meets bi-monthly and has an annual work programme reviewing all areas of patient feedback (including equality and diversity issues) and monitoring improvements in the quality of care, engagement and experience for patients and carers. The Committee reports to the Quality Governance Committee.

In line with the ambitions for the NHS set out by NHS England in 'Everyone Counts: Planning Patients 2014/14 to 2018/19 we aim to make sure that public, patient and carer voices are at the centre of our healthcare services from planning to delivery.

In 2013-14, we published our "Patient and Carer Experience Strategy". The Strategy's key objective is for patient and carers to have a positive experience of care by listening to them and acting on their feedback. We collect information on the patients and carers' feedback from local and national inpatient surveys and we publish this information on the Trust's website.

This section provides information on complaints, patient feedback on our services and provides information on a few key elements of our patient experience programme.

### 2.7.1 Complaints

This year we engaged an external reviewer to examine our whole complaints process and make recommendations for improvement. We are now working to meet these recommendations to ensure that we respond better to individual complaints, and in a more timely manner, and also use the valuable opportunity to learn and improve that each complaint provides to improve the services we provide. This work will continue through 2014/15.

**Complaints received**

The number of formal complaints has reduced to 599 and is lower than 2012/13, when there were 707 formal complaints for the financial year. This has been a result of actions the Trust has taken to encourage more local responsiveness to resolving concerns, and to the "Active caring for everyone" (ACE) with Pace programme.

There are three categories of complaints, in order to ensure a proportionate response. Category 1 complaints are those that can be resolved quickly, and we aim to respond within five working days. Category 2 complaints are the vast majority of complaints and we aim to reply within 25 working days. Category 3 complaints are matters more serious and may involve a serious incident investigation: response time is negotiated with the complainant.

| Categories of complaints received in 2013/14 | Total |
|---|---|
| Category 1 | 10 |
| Category 2 | 578 |
| Category 3 | 11 |
| Totals: | 599 |

We monitor complaints by themes, and also by locally agreed subject coding which is used to identify the subject matter. The table below shows the top 5 themes codes (KO41a) for complaints:

| Top 5 Complaint Themes in 2013/14 | Total |
|---|---|
| All aspects of clinical treatment | 374 |
| Attitude of staff | 53 |
| Appointments, delay/cancellation (out-patient) | 47 |
| Appointments, delay/cancellation (in-patient) | 30 |
| Admissions, discharge and transfer arrangements | 27 |

| Top 5 sub-subjects matter of complaints in 2013/14 | Total |
|---|---|
| **Lack of communication** | 164 |
| **Medical treatment** | 139 |
| **Patient comfort** | 117 |
| **Attitude of medical staff** | 99 |
| **Delay in receiving treatment** | 93 |

The table below show the number of complaints received in each of the hospital sites:

**Complaints received by Trust site in 2013/14**

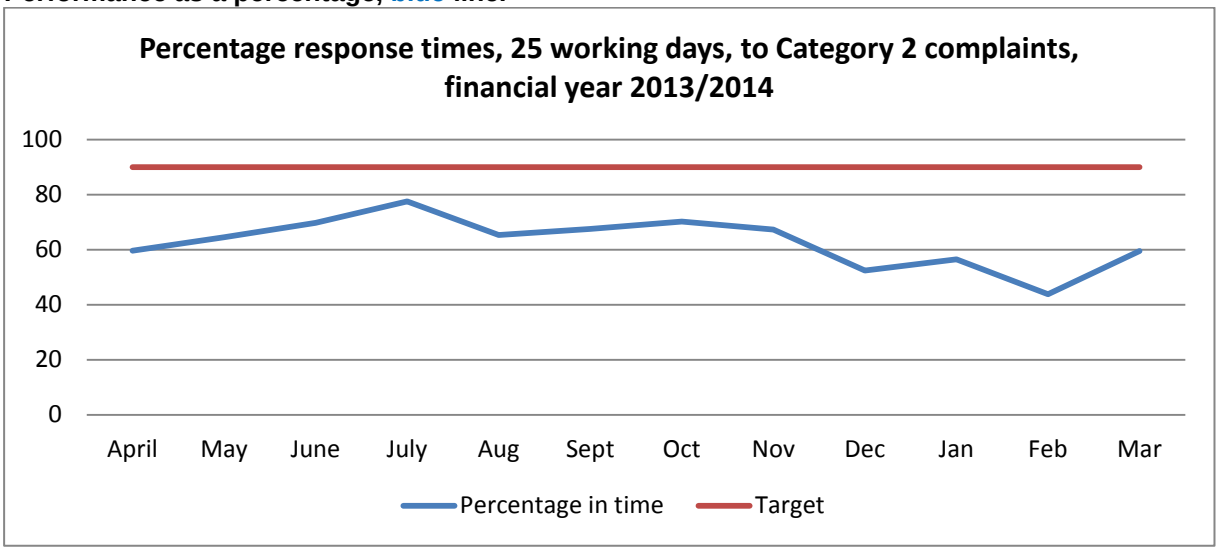
| | Apr 13 | May 13 | Jun 13 | Jul 13 | Aug 13 | Sep 13 | Oct 13 | Nov 13 | Dec 13 | Jan 14 | Feb 14 | Mar 14 | Tot |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| TW | 0 | 0 | 0 | 1 | 0 | 1 | 3 | 0 | 0 | 0 | 1 | 1 | 7 |
| WRH | 32 | 41 | 27 | 30 | 28 | 20 | 28 | 29 | 23 | 26 | 29 | 18 | 331 |
| ALEX | 19 | 13 | 13 | 18 | 19 | 17 | 19 | 20 | 16 | 16 | 16 | 18 | 204 |
| KGH | 6 | 8 | 4 | 1 | 1 | 3 | 0 | 8 | 5 | 5 | 4 | 3 | 48 |
| Oth | 0 | 0 | 0 | 1 | 2 | 0 | 1 | 3 | 2 | 0 | 0 | 0 | 9 |
| Tot | 57 | 62 | 44 | 51 | 50 | 41 | 51 | 60 | 46 | 47 | 50 | 40 | 599 |

(TW= Trust wide, Oth= Other, e.g. Evesham Community Hospital)

**Response times**

We have not met our own target to respond to category 2 complaints within 25 days. The restructure that created the five new clinical Divisions in November may have had a negative impact on response times. Most of the delays have been due to a delay in the investigation.

**Response within 25 working days (whole Trust). Target 90% - red line.**
**Performance as a percentage, blue line.**




We monitor the complaints received, the categories and the areas that they relate to. Complaints related to wards are also monitored. When patterns and trends are detected, the Divisional management teams are expected to undertake an in-depth review and to address any underlying causes.

Training in complaints handling and prevention is taking place including how to investigate and how to prevent complaints. The training also explores how we respond to complaints and to understand of the complainants' point of view.

Divisions are provided with regular reports on their performance, and delayed responses are escalated to Divisional Directors.

**Learning from complaints**
One of the most important aspects of monitoring complaints is to ensure that the Trust learns from complaints received and takes action to ensure that the situation that led to the complaint is not repeated. Work will take place in the coming year to improve action planning and sharing learning.

Examples of learning that took place in the last year are:

- Ensuring that all staff caring for patients have received training in recognising the deteriorating patient, and use of the Amber Care Bundle
- An out patient clinic was reviewed to ensure it was more streamlined and efficient
- Work is on-going to improve the situation when patients in the Emergency Department are waiting for pain relief
- Ward staff have been reminded about the correct procedure for storing patients' valuables
- Planning for theatre maintenance will be done sooner to ensure that surgeons can schedule their patients' operations appropriately
- Additional training has been provided to booking staff to ensure that there are alerts for when patients have repeatedly had outpatient appointments cancelled.
- A new, overnight home care service has been set up to provide a carer, paid for by social care, to settle patients back into their own home so they do not have to stay overnight.
- The Division is looking at how women are made aware, in advance, that student midwives may be present in clinic.
- Staff have been made aware of the correct information to provide regarding concessionary car parking.
- A system has been introduced to identify the patient's main carer so that that they can receive more detailed information by telephone.
- Wards have been reorganised, and there are now daily consultant ward rounds with increased opportunities for relatives to speak to consultants.
- The admission documentation has been revised so that the section on contacting patients' relatives is clearer.
- There are now strict criteria in place regards moving people between wards which will ensure optimal care and safety.
- Ward to look at a protocol for ensuring that the correct sick note is given.
- Pre-assessment clinic provides leaflets which advise on some procedures. There is an ongoing project to increase the number of leaflets which will be available.
- Doctors have been advised that they can request reports if they cannot find them in the patient's notes.
- The directorate is looking to provide additional doctor cover out of hours to ensure people get prompt treatment. Junior doctor complement has been increased in time for winter and these appointments will be made permanent in the next 6-9 months.
- Management of biliary drains education for staff
- Customer care course for member of staff who spoke inappropriately.
- Radiology department will email all abnormal results to the haematology department, or requesting consultant.
- Senior consultant will update juniors at weekly update about being alert for cerebral haemorrhage.

**Parliamentary and Health Services Ombudsman**
In the last financial year there were the following communications with the Parliamentary and Health Service Ombudsman.

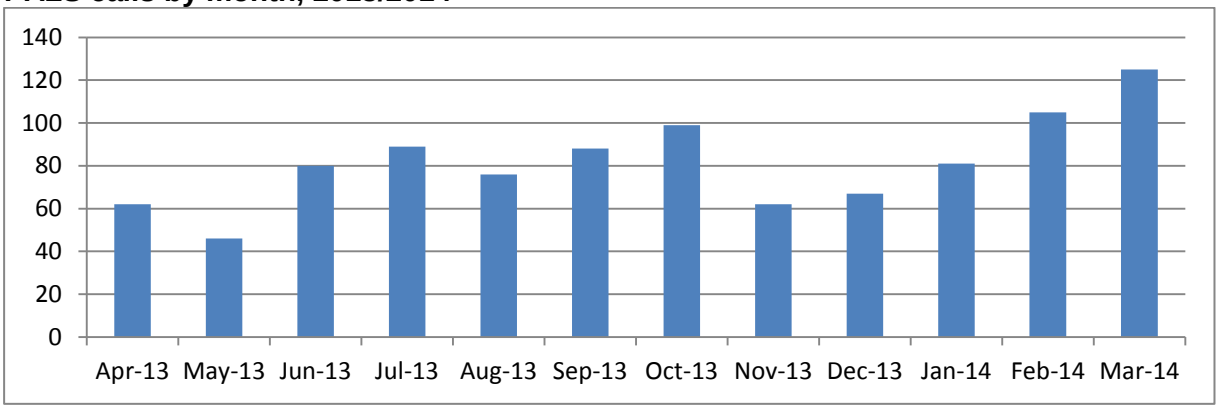
The Ombudsman will ask the Trust for information about a case, and based on that information will decide whether or not to proceed to investigation.

| Date of request | Proceeded to investigation? | Upheld? |
|---|---|---|
| 2 April 2013 | No | N/A |
| 8 April 2013 | Yes | No |
| 16 April 2013 | No | N/A |
| 30 April 2013 | Yes | Partially |
| 20 May 2013 | No | N/A |
| 5 November 2013 | Yes | Yes |
| 20 December 2013 | Yes | In progress |
| 29 January 2014 | Yes | In progress |
| 31 March 2014 | Yes | In progress |

### 2.7.2 Patient Advice and Liaison (PALS)

A new PALS officer was appointed in February 2014. This has meant more PALS call have been recorded, and more importantly, more have been followed up and closed to the satisfaction of the caller.

**PALS calls by month, 2013/2014**




| Top 5 subject matter of PALS call in 2013/14 | Total |
|---|---|
| **PALS providing information or sign posting** | 261 |
| **Medical treatment** | 111 |
| **Lack of communication** | 76 |
| **Delay in receiving treatment** | 61 |
| **Delay in outpatient appointment** | 44 |

### 2.7.3 The Friends and Family Test

The Friends and Family Test (FF&T) is a simple way for patients to provide feedback on the care and treatment they receive to improve services.

Since April 2012, we have been asking our patients whether they would recommend hospital wards to their friends and family if they needed similar care or treatment. This means that every patient in these wards and departments have been able to give feedback on the quality of the care they receive.

We triangulate the Friends and Family test results with other information such as complaints, staffing levels and other indicators to understand what may have led to low scores on individual wards and then take action to address these causes.

When patients are discharged, or within the 48 hours that follow, we ask them 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?'***

The patients will respond to the question by choosing one of six options, ranging from 'extremely likely' to 'extremely unlikely'.

The scores are calculated as follows:

| | | |
|---|---|---|
| **Proportion of respondents who would be extremely likely to recommend (response category: "extremely likely")** | ***(minus)*** | **Proportion of respondents who would not be extremely likely to recommend (response categories: "neither likely nor unlikely", "unlikely" & "extremely unlikely"** |

This gives a score of between -100 and +100.
(*Please note that the Friends and Family Test score is a numerical score and not a percentage*)

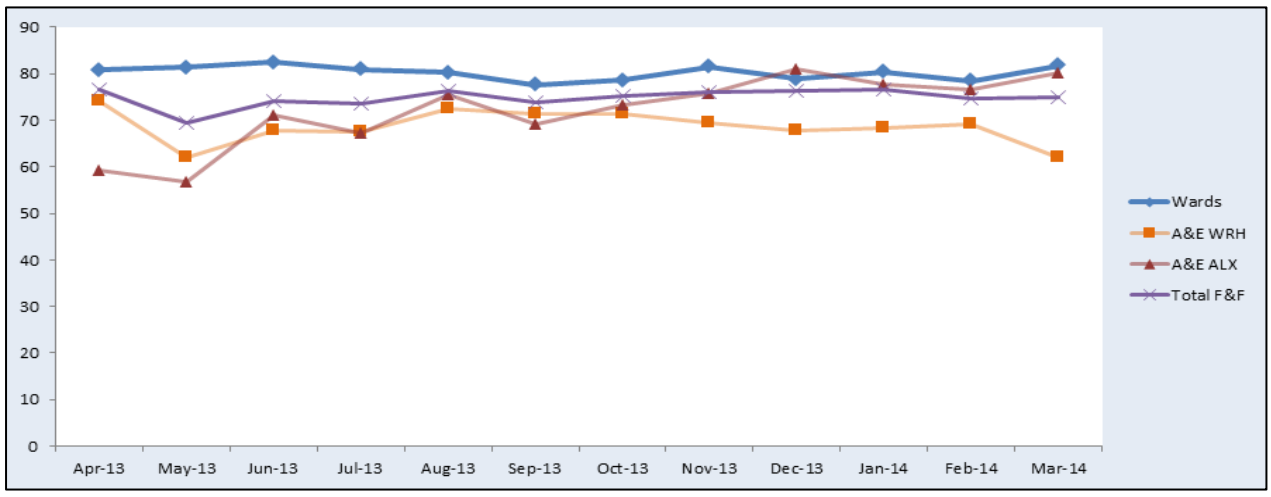
It is important to highlight that the "likely" responses are not mentioned in the calculation. However they form part of the total and the numbers of "likely" responses are therefore highly influential on the final score.

More information on the NHS Friends and Family Test can be found at: *http://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2013/07/Publication-Guidance.pdf*

The table below shows the "Friends and Family Test" score for all our wards, Accident & Emergency Department at Worcester Royal Hospital and Accident & Emergency Department at Alexandra Hospital. This is based on the total responses (2013/14) 22626 responses.

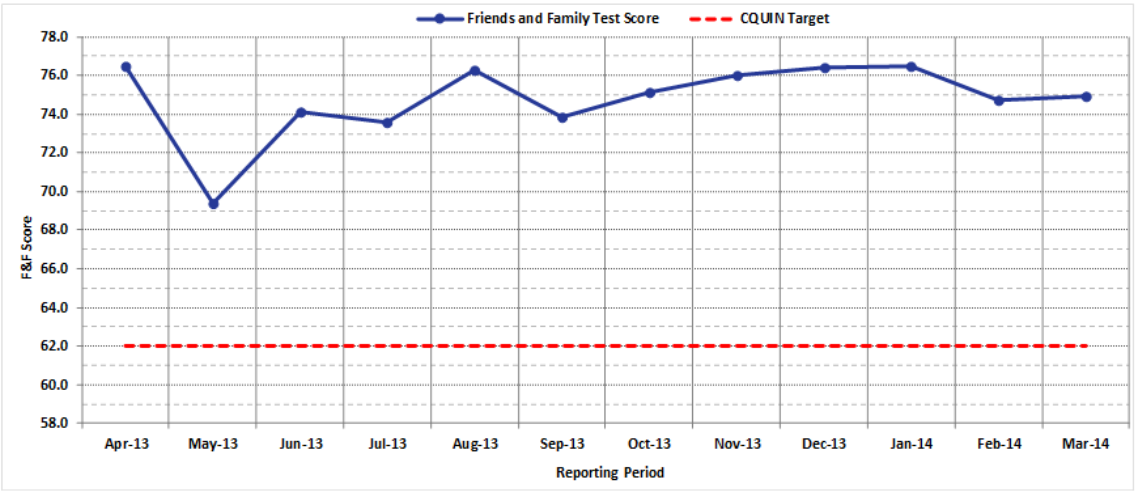
The Trust's target for the year was to remain in the top 25% of Trusts, which we achieved.

| | Apr-13 | May-13 | Jun-13 | Jul-13 | Aug-13 | Sep-13 | Oct-13 | Nov-13 | Dec-13 | Jan-14 | Feb-14 | Mar-14 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Wards** | 80.7 | 81.3 | 82.4 | 80.9 | 80.2 | 77.6 | 78.5 | 81.5 | 78.9 | 80.4 | 78.4 | 81.7 |
| **A&E WRH** | 74.1 | 61.9 | 67.8 | 67.5 | 72.4 | 71.4 | 71.5 | 69.3 | 67.8 | 68.4 | 69.1 | 62.1 |
| **A&E ALX** | 59.1 | 56.8 | 71.1 | 67.1 | 75.4 | 69.2 | 73.4 | 75.7 | 80.9 | 77.6 | 76.7 | 80.1 |
| **Total F&F** | 76.5 | 69.4 | 74.1 | 73.6 | 76.3 | 73.9 | 75.1 | 76.0 | 76.4 | 76.5 | 74.7 | 74.9 |



The table below show the Trust's net promoter score against the CQUIN target

| | Apr-13 | May-13 | Jun-13 | Jul-13 | Aug-13 | Sep-13 | Oct-13 | Nov-13 | Dec-13 | Jan-14 | Feb-14 | Mar-14 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Trust Score | 76.5 | 69.4 | 74.1 | 73.6 | 76.3 | 73.9 | 75.1 | 76.0 | 76.4 | 76.5 | 74.7 | 74.9 |
| CQUIN Target | 62 | 62 | 62 | 62 | 62 | 62 | 62 | 62 | 62 | 62 | 62 | 62 |




Since 1st October 2013, the Friends and Family Test has been extended to Maternity Services.

Our women will be surveyed at three times during their pregnancy with a response rate of 15% expected to be achieved:

- When they are 36 weeks pregnant
- Birth and care on the postnatal ward
- 10 days after birth

### 2.7.4 Same Sex Accommodation

The Trust is pleased to confirm that we remain compliant with the requirements regarding eliminating mixed sex accommodation unless it is in the patient's overall best interest, or reflects the patient's personal choice. We have had no breaches in this requirement in 2013/14.

### 2.7.5 National Inpatient Survey

**Actions taken following the 2012 National Inpatient Survey**

The findings from the 2012 inpatient survey for the Trust were published by the Care Quality Commission (CQC). The survey, carried out by Picker on behalf of the Trust, asked the views of adults who had stayed overnight as an inpatient in July 2012. The survey was sent to 850 patients who were admitted to the Trusts' services and the response rate was 55%; Picker average response was 48%, so the Trust had a better response.

The inpatients were asked what they thought about different aspects of the care and treatment they received on all sites within the Trust. The survey highlighted a number of findings, with Worcester Acute Hospitals NHS Trust achieving mostly average performance in comparison with other hospitals on all of the categories looked at by the survey. However, compared with other Trusts surveyed by Picker, lower scores were achieved for the explanations given on whom to contact if they are worried on discharge, copies of GP

letters, food and opportunity to talk to a doctor. The Trust has improved overall from 2011 statistically on six questions.

A high level action plan was put in place based on these findings:

**Healthy food on menu and food ratings** – this work was led by the patient environment operational group. Encouraging results are being seen from visits undertaken internally and externally and current surveys' undertaken with Hospedia and the FF&T.

**Not enough opportunity to talk to a doctor and involving patient in decision making** – this work was led by the Medical Director. Patient outcomes have been reviewed in terms of safety, effectiveness and experience with three committees overseeing these quality domains and reporting to the Integrated Governance Committee. This includes: monitoring mortality rates (more details on p. 34, under the section on "mortality overview"); learning from patient satisfaction surveys, reviewing complaints and incidents trends reviewed by Divisions / Directorates and the committees (more details on p.41, under the section on "complaints").

**Not informed who to contact if worried on discharge; no copies of GP letters** – this work has commenced by reviewing organisational policy, processes and structure for discharge; including the development of robust patient discharge advice and GP copy letters.

## Care Quality Commission (CQC) – Survey of adult inpatients 2013

The CQC conducted an adult inpatients survey took place between September 2013 and January 2014. A summary of the patients' responses compared to previous year's feedback is provided below.

**Questions the patients responded we continue to do well in are:**

| Questions | 2012 | 2013 |
|---|---|---|
| Were you given enough privacy when being examined or treated in the A&E Department? | 8.6 | 8.7 |
| Did you ever share a sleeping area with patients of the opposite sex? | 9.3 | 9.4 |
| Were you ever bothered by noise at night from hospital staff? | 7.8 | 8.1 |
| In your opinion, how clean was the hospital room or ward that you were in? | 8.8 | 9.0 |
| How would you rate the hospital food? | 5.2 | 5.7 |
| Were you offered a choice of food? | 8.5 | 8.7 |
| When you had important questions to ask a nurse, did you get answers that you could understand? | 8.2 | 8.4 |
| Did you have confidence and trust in the nurses treating you? | 8.5 | 8.8 |
| In your opinion, were there enough nurses on duty to care for you in hospital? | 7.3 | 7.6 |
| Did a member of staff say one thing and another say something different? | 8.1 | 8.4 |
| Were you involved as much as you wanted to be in decisions about your care and treatment? | 7.0 | 7.3 |
| How much information about your condition or treatment was given to you? | 8.2 | 7.6 |
| Did you find someone on the hospital staff to talk to about your worries and fears? | 5.5 | 6.3 |
| Do you feel you got enough emotional support from hospital staff during your stay? | 7.1 | 7.3 |
| After you used the call button, how long did it usually take before you got help? | 6.0 | 6.2 |
| Did a member of staff answer your questions about the operation or procedure? | 8.8 | 9.0 |
| Were you told how you could expect to feel after you had the operation or procedure? | 6.9 | 7.2 |
| Did the anaesthetist or another member of staff explain how he or she would put you to sleep or control your pain? | 9.0 | 9.2 |

| Questions | 2012 | 2013 |
|---|---|---|
| Afterwards, did a member of staff explain how the operation or procedure had gone? | 7.6 | 8.1 |
| Were you given enough notice about when you were going to be discharged? | 6.9 | 7.2 |
| Discharge delayed due to wait for medicines/to see doctor/for ambulance. | 5.9 | 6.2 |
| Did the doctors or nurses give your family or someone close to you all the information they needed to care for you? | 5.7 | 6.2 |
| Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital? | 7.3 | 7.5 |
| Did hospital staff discuss with you whether additional equipment or adaptations were needed in your home? | 7.9 | 8.7 |
| Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital? | 8.5 | 8.8 |
| Overall, did you feel you were treated with respect and dignity while you were in the hospital? | 8.7 | 9.0 |
| Overall hospital experience | 7.8 | 8.1 |

**Areas where the patients scored lower are as follows:**

| Questions | 2012 | 2013 |
|---|---|---|
| How do you feel about the length of time you were on the waiting list? | 8.6 | 7.9 |
| From the time you arrived at the hospital, did you feel that you had to wait a long time to get to a bed on a ward? | 7.3 | 7.1 |
| Did you ever use the same bathroom or shower area as patients of the opposite sex? | 8.9 | 8.4 |
| Did you get enough help from staff to eat your meals? | 7.8 | 7.3 |
| Did you have confidence and trust in the doctors treating you? | 8.9 | 8.7 |
| Did a member of staff explain the purpose of the medicines you were to take at home in a way you could understand? | 8.5 | 8.3 |
| Were you told how to take your medication in a way you could understand? | 8.4 | 8.2 |
| Did a member of staff tell you about any danger signals you should watch for after you went home? | 5.0 | 4.8 |

We had scored similarly to last year's scores on the majority of the patients responses. An action plan is being compiled with the Picker inpatient survey results and the CQC trust wide.

### 2.7.6 Hospedia Survey

Hospedia is the bedside entertainment system that is available in ward areas across the Redditch and the Worcester sites (with the exception of Aconbury wards) and is used to capture near real time patient feedback. We use this to respond to negative feedback quickly and the information gathered is also used to triangulate with the Friends & Family test responses for both positive and negative experiences.

**The positive feedback from Hospedia has been:**

- Patients had been treated with compassion, kindness and respect.
- They were able to speak to someone about their anxieties and fears.
- Patients were assisted with their meals.

The Patient Experience website was developed to signpost patients and carers on where and how they can provide feedback on their experience during their journey in hospital. This form of feedback is increasing in popularity among all patients and carers. Further development on the use of social media is being promoted.

### 2.7.7 "How it feels for me"

Since 2012, we have been holding "how it feels for me" sessions where a patient or carer stands up and talks about their experience in our hospitals. The sessions provide a unique insight into patient experience and the staff can learn from their experiences. We have covered patient experiences such as:

- Learning Disability
- Pain
- Breathlessness
- Dementia
- End of life

> *"The learning disability champion is an important role in supporting the Trust to effectively meet the needs of this vulnerable patient group.*
> **Kay Dalloway, acute liaison nurse for learning disabilities**

We have also used patient stories in these areas for learning, presenting them to the Trust Board meetings and other committees as well as using them to develop and improve pathways of care within:

- Sepsis
- End of life care
- Tissue viability

### 2.7.8 Patient Opinion

More and more people are now using the internet to record their experiences of care in our hospitals. The NHS Choices (www.nhs.uk) and Patient Opinion (www.patientopinion.org.uk) websites allow patients and visitors the opportunity to comment on our services and are the sources of the majority of our online feedback.

Over the course of the year we received 316 pieces of feedback via these methods.

111 patients posted comments on NHS Choices
60 patients posted comments on Patient Opinion
144 from the Trust's online feedback form (this was taken offline in November 2013, with visitors directed to NHS Choices and Patient Opinion)
1 email to the communications email address

Of these comments, 183 were classed as positive, 121 were classed as negative and 12 were neutral.

Worcestershire Royal Hospital received the most comments -180 – with 86 for the Alexandra Hospital and 50 for Kidderminster Hospital and Treatment Centre.

All comments are passed to the manager of the area mentioned, and a response is formulated and posted back on to the websites. Where there are clear concerns about care, the comments are also passed to the Patient Services Team for follow up action where required.

We are also starting to see an increasing number of patients using Twitter and Facebook to give us feedback on services. In 2013/14 patients commented on various difference services, including A&E services, maternity and surgery. As with other online comments, all feedback is passed directly to the manager concerned. Concerns are taken offline and followed up as required.

All feedback is reported to and monitored by the Patient and Carer Experience Committee.

### 2.7.9 Learning Disabilities

Improving the care provided to people with learning disabilities is part of our Quality Agenda. Currently we have two Learning Disability Nurses that work within the Acute Trust to ensure that the recommendations made by Death by Difference (Mencap 2007) and the report on Winterbourne View are implemented and monitored. The care needs of people with learning disabilities are incorporated into both the Safeguarding and Privacy and Dignity agendas.

**Standards, Policy and Procedures for People with a Learning Disability**
The Learning Disability Policy addresses those important issues for people with a learning disability such as equality of access, easy read information, 'best interest' decisions as well as the role of the Community Learning Disability Teams. In 2014 / 2015 the Trust will be implementing a self-assessment framework that looks at hospital stay.

**Access to Care and Services for People with a Learning Disability**
The alert system on our patient administration system automatically alerts the Learning Disability Nurses when a person known to have learning disabilities is admitted to the Acute Trust. Care pathways have been developed for both unplanned and scheduled admissions. A referral to the Learning Disability Nurses ensures that such issues as Do Not Activate Resuscitation, Mental Capacity Assessments, Carer needs and use of 'My Hospital Book' or the A&E 'My Hospital Book' are reviewed and addressed.

**Staff Training and Development in Learning Disabilities**
The Learning Disability Nurses have ensured that the education of staff has been incorporated into a number of the Acute Trusts existing training programmes as well as delivering training within wards and clinical departments. The number of staff receiving learning disability training has increased year on year.

**Evaluating and Monitoring Care**
There is an Acute Trust Learning Disabilities Steering Group which develops and evaluates actions that have been identified through audits, patient feedback, internal / external reviews and reports. We invited Health Checkers to undertake a follow up visit to A&E to ensure that the suggested improvements had been implemented. This identified a need to make further improvements to signage across all the Acute Trust sites. In addition to this Health Checkers have agreed to undertake further reviews of clinical areas in response to patient feedback to ensure the Acute Trust addresses the needs of those people with a learning disability and their carers.

**Learning Disability Patients' Feedback**
A questionnaire is posted to all people with a learning disability who have received care and treatment within the Acute Trust. People can also provide feedback via the Hospedia system. All feedback is reported into the Patient and Carer Experience Committee .The feedback has identified other areas that require further development. These include improving communication in relation to treatment, providing additional support when required for procedures and further development in easy read patient information. Response to this feedback is being taken forward as part of the staff training, patient stories and a review of current patient information leaflets.

### 2.7.10 Privacy and Dignity

The Trust has a Privacy and Dignity working group which includes membership of nurses, housekeeping, volunteers managers, patients and public forum members, matrons and specialist nurses. We have had announced and unannounced visits from the CQC, CCGs and the Patient & Public Forum this year which did not reveal any major issues with privacy and dignity and we have used this feedback and information to revise our policy and make changes to further improve privacy and dignity for patients in our care.

**Dignity Champions**
A "dignity champion" is a member of health or social care staff, who volunteer to help ensure that patients are treated with dignity and respect; a basic human right. We work closely with the Royal Voluntary Service and Age Concern to recruit volunteers for wards and departments across the Trust.

We currently have 262 dignity champions registered onto the Department of Health database – Dignity in Care website. There is an active campaign to get more staff registered.

The Dignity and Nutrition Link nurse study days are now delivered on a quarterly basis which includes patient experiences received from variety of patient groups including:

- Deaf Direct
- Sight concern
- Carers stories
- Patient stories
- Learning Disabilities
- End of Life feedback
- Dementia care
- Nutrition and hydration updates and training

We have a Privacy and Dignity policy and Mealtimes guidelines. These have been revised and compliance with them monitored through monthly quality reviews.

### 2.7.11 End of Life Care

The Trust has a Specialist Palliative Care and End of Life Team. Over the last two years, we have increased our investments into end of life care. As a result, we have been able to dramatically influence the care and communication for patients with a life-threatening illness and for those at end of life, and their families.

The "AMBER care bundle" is a collection of up to five interventions to manage the care of hospital patients who are facing uncertain recovery and who are at risk of dying in the next one to two months. It was developed at Guy's and St Thomas' Hospital NHS Foundation Trust and further information on this approach of care can be found on http://www.ambercarebundle.org/forprofessionals/for-professionals.aspx

To help us implement the care bundle, we run a staff education programme in collaboration with a local hospice and have "champions" on all wards.

We conduct a quarterly audit on the use of the AMBER care bundle. The results to date (over 500 patients) have shown that the use of the care bundle has contributed to:

- Patients felt they were being treated with dignity and respect,
- Greater clarity around patient preferences and plans about how these can be met,
- Improved decision making by the patients
- Lower emergency admission rates

There are benefits for the staff too, as the audit results show improved communication between different teams and increased nurses' confidence about when to approach medical colleagues to discuss treatment plans.

The Specialist Palliative Care Team have also recently commenced a seven-day working service across the Trust. This should further improve our care. Work is now also underway to provide a replacement for the "Liverpool Care Pathway" (that is being withdrawn nationally on 15th July 2014), that includes clear guidelines and principles for the care of the dying patient. This will also include a 'carers' diary' to help aid communication between families and ward teams.

### 2.7.12 Improving Nutrition and hydration experiences

In 2013/14, we have made the following changes based on what our patients tell us:

- Culturally sensitive meals and adapted cutlery made available
- Finger menu's introduced for patients with dementia.
- Availability of hot food in evening across the 3 sites following patient feedback.
- Review of bread suppliers following feedback from patients
- Improved taste, choice and palatability the puree diets.
- Improved quality of supplement drinks has resulted in more choice and availability of favours for patients.
- The dieticians and catering staff reviewed the men's from the patient feedback received. Patients feedback positively following the introduction of the fruit pots were at the Alexandra site.

### 2.7.13 Patient and Public forum

We work closely with the Trust's Patient & Public Forum (PPF), members of which sit on several of our committees including the Trust Board and carry out review visits across the Trust. The PPF informally use the NHS Institute for Innovation and Improvement's "15 steps challenge" methods during their inspections and clinical visits which are very candid and open. *(ref: http://www.institute.nhs.uk/productives/15stepschallenge/15stepschallenge.html)*

The PPF's description of their role and work during the year is provided below:

> *"The Patient and Public Forum carried out 36 clinical visits in 2013 across our three hospital sites. These visits involved observation of practice, speaking to ward staff about their practices and patients/carers about their experiences of privacy and dignity, nutrition and the environment in which they are being nursed.*
>
> *The information gained through this work has enabled us to make improvements in care. We have, for example:*
>
> - *Improved our menu choices, promoted mealtimes guidelines, introduced hot meals for patients across the three hospital sites*
> - *introduced dignity curtains in all wards and departments and Dignity Patient Experience Groups*
> - *made appropriate patient night wear available*
> - *ensured equipment and ward environments are clean and fit for purpose for patients*
> - *reviewed ways to communicate and identify appropriate quiet/private areas to discuss sensitive matters*
>
> ***Patient Forum***
>
> *The Patient Forum of the Acute Trust consists of volunteers with a particular interest in acute services. We work in small groups, and make visits to wards and clinics.*
>
> *When the Forum visit wards, we sit quietly and observe what is happening to patients. We take time to talk to patients and carers about how the patient is being looked after, including such things as drinks within reach of patients where appropriate, call bells within reach, and how long it takes for a call bell to be answered and the request acted upon. We often observe meal times, and check the quality of food, whether patients receive their choice, and how much is eaten. We observe patients who need help with eating their food, and how the staff interact with the patient being helped to eat.*

*We check for cleanliness, check the bathrooms, toilets, and any other facilities. We check that the patient's bed space is clean. We note the electronic white board that lists patients and look to see that it is up-to-date.*

*On all of our visits we also talk with staff, nursing, cleaning and catering staff, as they can explain anything that we notice, add further information about how the ward is functioning, and whether there is anything else that it would be helpful to add to our report which we write after the visit, and this is sent to the Chief Nursing Officer and the Chair of the Board.*

*We also check notice boards, making sure that these are not overcrowded, and that the information is relevant and up-to-date. Sometimes there are noticeboards in corridors and we check those too.*

*We also look at the public toilets to be found off corridors, and make sure that these are clean and fit for purpose.*

*Following our report, the ward or clinic visited writes an Action Plan to show how they will address any issues that were found. This is really helpful, as we can then check how our recommendations have been addressed on subsequent visits to the ward or clinic. Most of our recommendations are carried out and it is particularly pleasing when we find that we have helped a ward or department to achieve an improvement they have wanted for some time.*

*During this year we made visits on all three hospital sites. We went to both A&E departments to see how they managed such large volumes of patients coming in. We also visited Minor Injuries Unit at Kidderminster, especially in relation to the use of NHS 111 by patients and how NHS 111 responds. We have noticed how well trained the Health Care Assistants are, and hope that the Trust continues to give these members of staff such supportive training.*

*The Forum is usually welcome wherever we go; if there is an infectious outbreak on a ward or in a hospital we stay away. In the main our visits are unannounced, so what we see is how it is. This is very useful as it gives us a view of that day, the experience for patients, and how the staff are responding to pressures.*

*As well as making visits to wards and clinics we have been invited to sit on committees to represent patients' views. Committees where we have a voice include, for example, privacy and dignity, food and hydration, end of life and patients' safety, patients' experiences. We also take part in Patient Led Assessment of the Care Environment (PLACE) inspections as lay assessors. We advise about the wording and presentation of questionnaires. We have attended some nursing staff training, which has really helped us to appreciate the complexity of nurses roles. We look forward to these opportunities for training continuing for us. One of our members sits on the Trust's Board as patient representative.*

*We take this opportunity to thank all the staff for their welcoming attitude and cooperation during our visits."*

### 2.7.14 Spiritual and Pastoral Care

The Spiritual and Pastoral Care Team includes 3 Chaplains and a team of clergy and lay volunteers across all three Trust sites. The team has undergone some staff changes this year and this has enabled us to provide more face-to-face time with the patients.

**"Chaplain's Blog" and Social Media**
This "Chaplain's Blog" (which is found at www.revdavidsouthall.com) was initiated by Rev. Dr. David Southall and launched in March 2013. The Blog has provided a forum to promote the good news stories of patients throughout the Trust and has gained 220,000 views. A survey suggests that it has had significant impact on staff morale and community confidence in our Trust. It culminated with David being awarded the Chairman's Special Award at the Staff Annual Achievement Awards.

There has been considerable interest from the local media, including regular appearances on BBC Radio Hereford and Worcester, and articles in local newspapers including a regular Chaplain's Blog column in *the Worcester News*. The Chaplaincy also regularly 'Tweet'

**Multi-faith Provision**
The provision of multi-faith services for patients continues to grow. We have a resource list of multi-faith practitioners who freely give of their time to meet the spiritual needs of patients within a number of faith communities. This year, Iman Ahmed regularly leads Friday Prayers for Muslim staff and patients at Worcestershire Royal Hospital. We have a new Roman Catholic Chaplain, Father Paul Johnson and we have an expanding team of Roman Catholic Volunteers.

**Future Developments**
During the next year the Spiritual and Pastoral Care Team will:

- Develop a "Mindfulness" provision for staff and patients to aid emotional resilience
- Work on improving Bereavement Care within the Trust with colleagues to enhance the service given to those who have lost a loved one in Hospital.
- Continue to develop the use of social media to enhance patient's spiritual care within the Trust and NHS.

## 2.8 What our staff thought of our services

### 2.8.1 Staff Survey

The 2013 NHS National Staff Survey was undertaken by Quality Health for the Trust. Questionnaires were sent to 850 staff which was the official sample number for the Trust. Of these 850, 345 staff completed the survey making our response rate at 42%. This compared to last year which was 44% and the national average for acute trusts this year of 48%.We are working with staff side to encourage a greater response rate, tied in with the Staff Friends and Families test which is about to be launched.

We included some additional questions to the 2013 national survey. These questions were about patient experience, long shifts, the Trust's visions and values, as well as a set of local questions around how the Trust manage incidents and complaints and how we continually improve the service. We are currently analysing these responses with a view to agreeing any necessary actions.

**Our Top 5 ranked scores (where we scored most favourably with other acute trusts):**

| Questions | Trust's score | National average |
|---|---|---|
| Hand washing materials are always available | **70%** | 60% |
| Staff experiencing harassment, bullying or abuse from other staff | **21%** | 24% |
| Staff reporting errors, near misses or incidents witnessed in the last month (the higher the score the better)[5] | **93%** | 90% |
| Staff experiencing physical violence from staff | **2%** | 3% |
| Staff experiencing physical violence from patients, relatives or the public in the last 12 months | 12% | 15% |

**Our Bottom 5 ranked scores – where we scored least favourably with other Acute Trusts surveyed by Quality Health)**

| Questions | Trust's score | National average |
|---|---|---|
| Effective team working (based on a scale of 1 – 5 where 5 is the best) | **3.56** | 3.74 |
| Staff feeling pressure in last 3 months to attend work when feeling unwell | **35%** | 28% |
| Staff witnessing potentially harmful errors, near misses or incidents in last month[6] | **38%** | 33% |
| Staff having equality and diversity training in last 12 months | **45%** | 60% |
| Work pressure felt by staff (on a scale of 1 – 5 where 5 is worst) | **3.17** | 3.06 |

**Our 5 most improved responses from last year are:**

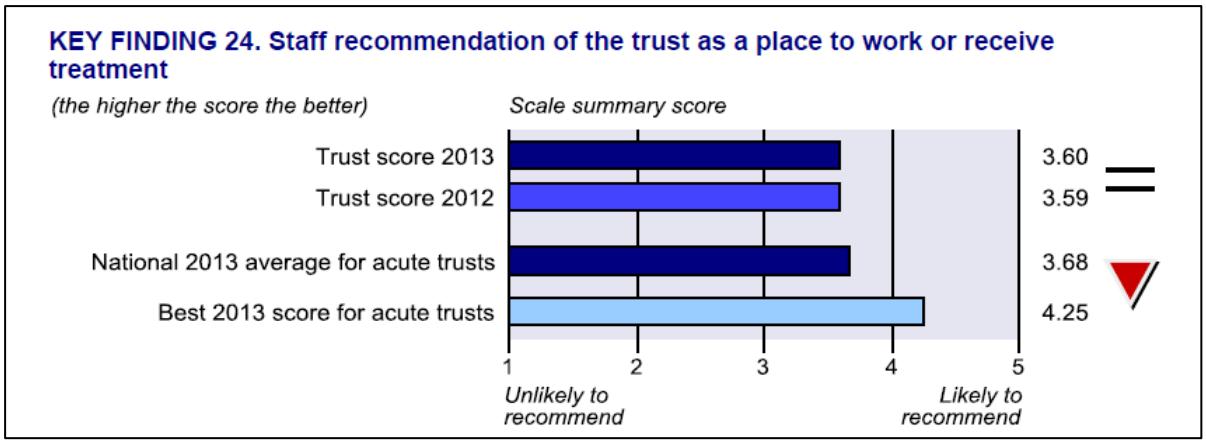
| Questions | Trust's 2012 score | Trusts 2013 score | % Improvement |
|---|---|---|---|
| Agreed that they would recommend their organisation as a place to work | **52%** | 59% | ↑7% |
| Agreed that immediate manager will help with difficult tasks | **62%** | 68% | ↑6% |
| Staff often / always enthusiastic about their job | **68%** | 74% | ↑6% |
| Staff often / always feel that time passes quickly when they are working | **75%** | 81% | ↑6% |
| Agreed that patient / service user care is the organisation's top priority | 60% | 66% | ↑6% |

**The 5 areas that have declined the most from last year are:**

| Questions | Trust's 2012 score | Trust's 2013 score | % Improvement |
|---|---|---|---|
| In the last month witnessed no errors or near misses that could have potentially hurt patients | **70%** | 66% | ↓4% |
| In the last three months had not felt pressure from colleagues to attend work when they had not felt well enough to perform their duties | **73%** | 70% | ↓3% |
| Staff saying that in an average week they have not worked additional UNPAID hours over and above the hours for which they are contracted | **40%** | 37% | ↓3% |
| In the last three months had not put themselves under pressure to attend work when they had not felt well enough to perform their duties | **8%** | 5% | ↓3% |
| Agreed that staff are informed about errors, near misses and incidents that happen in the organisation | 36% | 34% | ↓2% |

**"Friends and Family Test" for staff**

For the questions that asked staff if they would recommend the Trust as a place to work or to receive treatment, both of these showed small improvement compared to our 2012 results as shown in the chart below, although it is slightly below the national average:




**Staff Engagement**

There is a section in the survey concerning staff engagement. This is made up of three areas:

- staff ability to contribute towards improvements at work
- staff recommendation of the Trust as a place to work or receive treatment:
- staff motivation at work

The overall staff engagement score for the Trust in 2013 is 3.69 on a scale of 1 to 5 (where 1 is the minimum score and 5 the maximum score). This is an improvement from the 2012 staff survey results, but is lower than the average when compared to other acute hospitals.

The responses relating to staff engagement all show an improvement compared to the 2012 staff survey results. When compared to other acute trusts administered by Quality Health 4 out of 9 questions showed a worse result.

**Progress from the 2012/13 staff survey**

Compared with the 2012 staff survey, this year's survey results show one statistically significant change. It relates to the percentage of staff witnessing potentially harmful errors, near misses or incidents in last month. This year's score is 38%, increasing from 28% last year, which indicates a deterioration.

Following the 2012/13 staff survey, the Trust introduced four staff pledges:

- **Staff Pledge 1: To provide all staff with clear roles, responsibilities and rewarding jobs.**

  There has been deterioration when looking at the percentage of staff saying they have had to work extra hours, but a positive improvement for staff agreeing their role makes a difference to patients, work pressures felt by staff and effective team working.

- **Staff Pledge 2: To provide all staff with personal development, access to appropriate education and training for their jobs, and line management support to enable them to fulfil their potential.**

  The percentage of staff who have received appraisal in the last 12 months has deteriorated compared to 2012, but the percentage of staff reporting having a well-structured appraisal has increased as well as the support from immediate managers.

- **Staff Pledge 3: To provide support and opportunities for staff to maintain their health, well-being and safety.**

  This includes the key finding about staff witnessing potentially harmful errors, near misses or incidents in the last 12 months which shows a significant deterioration. The percentage of staff feeling pressure to attend work when feeling unwell has increased as

well as the percentage of staff experiencing physical violence from patients, and feeling the incident reporting procedure being fair and effective is worse.

The percentage of staff receiving health and safety training in last 12 months has improved as well as the percentage of staff saying hand washing materials are always available.

- **Staff Pledge 4: To engage staff in decisions that affect them, the services they provide and empower them to put forward ways to deliver better and safer services.**

  The percentage of staff reporting good communication between senior management and staff has improved, together with the percentage of staff feeling able to contribute towards improvements at work.

**Our response to the 2013/14 staff survey result is to work on 4 key themes for improvement as part of an action plan.**

- To improve staff satisfaction and to encourage staff engagement by, for example: understanding why some staff would not recommend the organisation as a place to work and to take action accordingly
- To improve leadership by implementing a new management structure and introducing a leadership programme
- To provide equality and diversity training across the Trust
- To improve patient safety and staff safety arrangements, for example, to encourage staff to report patient safety incidents and health and safety concerns

### 2.8.2 Workforce Indicators

As of 31st March 2014 our workforce indicators showed the following position:

- 74% of our staff (not including medical staff) had had an appraisal
- 57% of junior and middle grade medical staff had had an appraisal
- 62% of Consultants had had an appraisal
- 66% of our staff had completed their Fire Safety training
- 86% of staff had completed their Information Governance Training
- 78% had completed Hand Hygiene training
- 67% had completed their infection control training
- 57% had completed their manual handling update training
- 75% had completed resuscitation update training

- The rolling sickness rate for 2013/14 was 3.87% as at 31st March 2014.
- The range of sickness absence rates for Acute Trusts puts us between 3.24% and 4.50%. We were 4th out of 17 (based on November 2013 figures)
- Turnover for 2013/14 based on a rolling 12 month period was 9.85% which is an increase on last year's figure of 9.19% but is still within average range

**Sickness rate for past 3 years**

| Worcestershire Acute Trust Cumulative 12 month Sickness Rate | |
|---|---|
| | **Cumulative % rate** |
| **2013/14** | 3.87% |
| **2012/13** | 3.88% |
| **1011/12** | 3.92% |

| **Productive Workforce Metrics Dashboard – (**Nov 13 are the latest figures available) | | |
|---|---|---|
| **Cumulative 12 month sickness rate** | **Worcestershire Acute** | **Acute Trusts Benchmark** |
| | Cumulative % rate | Cumulative % rate |
| **December 2012 to November 2013** | 3.81% | 4.05% |
| **December 2011 to November 2012** | 3.95% | 4.24% |
| **December 2010 to November 2011** | 4.16% | 4.16% |

| **Worcestershire Acute Trust Turnover Rate ( rolling 12 months) -** Please note that different parameters are used from those used on the Productive Workforce Metrics | |
|---|---|
| | **Cumulative % rate** |
| **2013/14** | 9.85% |
| **2012/13** | 9.19% |
| **2011/12** | 9.30% |

| **Productive Workforce Metrics Dashboard –** (Nov 13 are the latest figures available) | | | | |
|---|---|---|---|---|
| **Cumulative Turnover Rate (Rolling 12 months)** | **Worcestershire Acute** | **Worcestershire Acute** | **Acute Trusts Benchmark** | **Acute Trusts Benchmark** |
| | **Cumulative % rate (all staff)** | **Cumulative % rate (excluding Med & Dental)** | **Cumulative % rate (all staff)** | **Cumulative % rate (excl Med & Dental)** |
| **December 2012 to November 2013** | 14.07% | 8.21% | 11.60% | 7.01% |
| **December 2011 to November 2012** | 14.76% | 8.72% | 13.87% | 9.28% |
| **December 2010 to November 2011** | 14.57% | 9.16% | 14.38% | 9.23% |

### 2.8.3 Engagement with Staff

We know from academic research that there is a strong correlation between the extent to which staff feel engaged and mortality rates so the people working for the Trust are critical to delivering the highest quality care. Engaging with staff to understand what works well and what concerns they have helps to seize opportunities to share good practice and deal with any issues that threaten safety, effectiveness or the patient and staff experience.

A number of new staff engagement initiatives have been put in place in 2013/14 to build on this. These include:

- 8x8s – this is a monthly informal meeting for eight middle and senior managers to meet with the Chief Executive and discuss items of importance
- "How Was It For You" – these are sessions for staff who have been a patient or carer to tell us their own experiences
- monthly "Big Thank You" events to formally recognise the work of teams within the Trust
- Annual staff achievement and long service awards.

These initiatives will be further developed in 2014/15. In addition, there will be monthly surgeries and lunches, run by the Trust's Chairman, for staff to raise any issues or concerns.

### 2.8.4 Staff Recruitment

The Trust continues to actively recruit to frontline clinical posts. There has been a steady increase in the number of qualified and unqualified staff employed by the Trust due to increased investment to ensure that staffing levels are adequate. Turnover for both staff groups is consistently around 10%.

The Trust continues to recruit most nursing graduates from University of Worcester with over 90% of graduates in Adult and Children's nursing taking up posts with us. Challenges remain in some areas in the recruitment of experienced medical/emergency nurses and theatre staff particularly at the Alexandra Hospital. A number of targeted recruitment actions have been taking place such as the use of our partners at HCL Workforce Solutions, local advertising and a review of the recruitment and interview processes/skills in these areas.

Recruitment based on values has been formally implemented for Band 5 nursing posts and healthcare support worker posts. This will be extended to all nursing posts by March 31st 2015.

### 2.8.5 Pre and Post Registration Education

The Trust has close links with the University of Worcester for both pre and post Registration Education in nursing and midwifery. The Trust employs over 90% of newly qualified registrants on graduation.

Health Education West Midlands commissions pre-registration nursing and midwifery education on behalf of the Trust from the University. We provide clinical placements in our hospitals for student nurses and midwives so that they can gain practical experience during their training. This accounts for half of the training programmes. The University of Worcester has been voted by students in the National Student Survey as the University of choice for pre-registration nursing and midwifery programmes.

The University also now provides pre-registration physiotherapy and occupational therapy training. Several Trust staff contribute to pre-registration training and some hold honorary lecturer posts.

We also have a large portfolio of continuing professional developments with the University for nurses, midwives and Allied Health Professionals. These include a senior leadership programme, physicians associate programme and practice development project on the wards.

### 2.8.6. Health Care Support Workers (HCSW)

The Cavendish report published in the summer focussed on the role of the unqualified workforce. The Trust has reviewed its Essential Skills Programme and associated competencies for HCSWs in the light of the report. This programme is mandatory for all new support workers. A scoping exercise is being undertaken to identify the continuing clinical development needs of the unqualified workforce supporting nursing and a report and recommendations will be available by May 31st 2014.

## Section 3 – Priorities for improvement

### 3.1 Priorities for improvement 2014/2015

This year, we have identified seven Quality Improvement Priorities that cover the three dimensions of quality and will be delivered over the next two years. These were developed with the input from the organisations described in 3.3 and 1, 2 and 3 are carried forward from 2012/13. The priorities are summarised below and national targets marked*:

| Quality Priorities 2014/14 | Quality Dimensions | | | Additional CQC Quality domains | |
|---|---|---|---|---|---|
| | Safe | Effective | Caring | Responsive | Well-Led |
| 1. Reduce the incidence of *Clostridium difficile* and MRSA* | ✓ | ✓ | | | |
| 2. Increase the numbers of patients waiting <4hours in A&E* | ✓ | ✓ | | ✓ | ✓ |
| 3. Improve the outcomes and experience for patients with fractured neck of femur | ✓ | ✓ | ✓ | | |
| 4. Reduce avoidable deaths by improving Mortality Surveillance | ✓ | ✓ | | | |
| 5. Reducing harm from medicines incidents* | ✓ | ✓ | | | |
| 6. Reducing variation in mortality between week days and weekend working | ✓ | ✓ | | | ✓ |
| 7. To provide services that meets the needs of children, young people and adults with mental health needs | ✓ | ✓ | ✓ | ✓ | |

**Further details are provided below:**

| 1. Reduce the incidence of *Clostridium difficile* and MRSA | |
|---|---|
| **Why is this a priority?** | • To ensure we continue to build on the progress made during 2013/14 to reduce harm caused by HCAIs |
| **How we will deliver the improvement?** | • Good antimicrobial stewardship<br>• HPV decontamination programme<br>• Improve MRSA screening rates<br>• Ensure timely removal of devices<br>• Improve attendance at IP&C training events<br>• Whole health economy approach<br>• Delivery of HCAI CQUIN. |
| **Measures:** | • MRSA screening rates<br>• CQUIN milestones<br>• *Clostridium difficile* and MRSA rates |
| **Targets:** | • Achieve annual targets for reduction in *Clostridium difficile* and MRSA |
| **Reporting route:** | • Divisional Quality Committees<br>• Trust Infection, Prevention and Protection Committee<br>• Quality Governance Committee |
| **Responsible Officer:** | • Chief Nursing Officer |

| 2. Improve the number of patients waiting less than 4 hours in A&E to >95% | |
|---|---|
| **Why is this a priority?** | • To ensure we minimise delays for patients attending the A&E dept.<br>• Inconsistent delivery of this indicator during 13/14 |
| **How we will deliver the improvement?** | • Delivery of the countywide Urgent Care Strategy<br>• To deliver the internal transformation programme for urgent care<br>• Improve access to sub-acute beds<br>• Reconfigure Medical Admission Units |
| **Measures:** | • Availability of sub-acute beds<br>• Delayed transfers of care |
| **Targets:** | • >95% of patients wait < 4 hours in A&E |
| **Reporting route:** | • EAST<br>• Trust Management Committee<br>• Quality Governance Committee |
| **Responsible Officer:** | • Chief Operating Officer |

| 3. Improve outcomes and experience for patients with fractured neck of femur | |
|---|---|
| **Why is this a priority?** | • Inconsistent delivery of this indicator during 13/14 |
| **How we will deliver the improvement?** | • Reconfiguration of theatre lists to improve timely access<br>• Delivery of urgent care strategy<br>• Improve utilisation of T&O lists<br>• Improve access to orthogeriatrics and rehabilitation |
| **Measures:** | • Improved utilisation<br>• Improved access to theatre session |
| **Targets:** | • >90% to theatre in <36 hours |
| **Reporting route:** | • Quality Governance Committee |
| **Responsible Officer:** | • Chief Operating Officer/Chief Medical Officer |

| 4. Reduce avoidable deaths by improving Mortality Surveillance (with focus on acute surgery, acute medicine and renal medicine) | |
|---|---|
| **Why is this a priority?** | • The Trust acknowledges the need to have in place a more robust system to identify any areas of excess mortality and take action to reduce avoidable deaths |
| **How we will deliver the improvement?** | • Directorates and Divisions will hold effective Mortality and Morbidity (M&M) Meetings and act upon the findings, reporting the outcomes to the Safe Patient Group<br>• Widen the usage of the Health Evaluation Data (HED) tool to enable more detailed analysis at a Speciality level or Site of Hospital Standardised Mortality Ratio (HSMR) Summary Hospital Mortality Index (SHMI) within all Divisions<br>• Triangulation of quality indicators to identify factors that lead to harm<br>• Re-introduce the usage of the global trigger tool (GTT) to identify harm<br>• Undertake targeted case note reviews<br>• Introduce systematic death certification reviews |
| **Measures:** | • Divisional M&M Reporting<br>• Number of applicable Directorates using the HED tool<br>• Divisional HSMR and SHMI Reporting |
| **Targets:** | • Achieve a mortality ratio of 100 or less for each diagnostic group |
| **Reporting route:** | • Divisional Quality Committees<br>• Safe Patient Group |
| **Responsible Officer:** | • Chief Medical Officer |

| 5. Reducing harm from medicines incidents | |
|---|---|
| **Why is this a priority?** | • The Trust aspires to deliver harm free care and is committed to improving the system and processes for identification, monitoring and reduction of medication errors<br>• Figures from the Midlands and East Quality Observatory show a reported error rate of 11.9 per 1000 bed days within the Trust. This is likely to be just the 'tip of the Iceberg' with academic studies indicating that only 1 in 10 - 20 medicines related errors are ever reported, that 5% of all errors result in avoidable harm and that these harm events add between 2 – 10 days to a patient's length of stay. Medication errors can be fatal and the Trust has experience of care episodes where medication errors have contributed to patient harm and death. |
| **How we will deliver the improvement?** | • Implementation of an Electronic Prescribing System across the Trust, to reduce user error, aid medicines management and generate reports<br>• As part of the Electronic Prescribing System, implementing a patient discharge module that will produce electronic TTOs, to reduce the risk of error between primary and secondary care<br>• Targeting practices and processes to ensure our Medical Workforce are supported in the correct usage of Medicines<br>• Target higher risk medications such as anticoagulation and insulin |
| **Measures:** | • A reduction in harm associated with medicines<br>• Divisional Reporting |
| **Targets:** | • Implementation of Electronic Prescribing:<br>  ○ Inpatient Areas - by 06/14<br>  ○ Specialities - by 11/14<br>  ○ Outpatients Areas - by 01/15<br>• Increase compliance with policies (e.g. antibiotics) and formulary at the point of prescribing<br>• Reduce adverse drug events |
| **Reporting route:** | • Divisional Quality Committees<br>• Safe Patient Group<br>• Medicines Safety Committee<br>• QGC |
| **Responsible Officer:** | • Chief Medical Officer |

| 6. Reducing variation in mortality between week days and weekend working | |
|---|---|
| **Why is this a priority?** | • In line with the publication of the Francis Report, Keogh's 10 Clinical Standards and other patient safety focused publications, all Trusts need to work towards providing safe and effective care 7 days a week<br>• The Trust needs to maintain the trend of improvement for relative risk for weekend admissions as commenced in late 2013/14, when the value moved to within expected normal limits |
| **How we will deliver the improvement?** | • Changes to job plans in partnership with Consultants and HR, to enable routine weekend working including Consultant Ward Rounds<br>• Delivery of 6 day working within Elective Services<br>• Maintaining universal 7 day provision of acute hospital services<br>• Increase in Diagnostic Services coverage<br>• Investment in development of roles such as Physician's Assistant and Advanced Nurse Practitioners.<br>• Re-introduce Hospital at Night.<br>• Regularly review and compare weekend mortality rates with weekdays |
| **Measures:** | • Hospital Standardised Mortality Ratio (HSMR)<br>• Summary Hospital Mortality Indicator (SHMI) |
| **Targets:** | • Undertake staffing changes in Acute Surgery in 14/15<br>• Undertake staffing gap analysis and recruitment in Acute Medicine in 14/15<br>• Introduce weekend working into all new posts in 14/15 |

| | |
|---|---|
| | • Undertake staffing changes in Acute Medicine in 15/16 |
| **Reporting route:** | • Safe Patient Group |
| **Responsible Officer:** | • Chief Medical Officer |

| **7. To work with Partners to ensure services are commissioned to meet the needs of children, young people and adults with mental health needs** | |
|---|---|
| **Why is this a priority?** | • Changes to the provision of mental health services during 13/14 have resulted in a reduction in the quality of services provided to patients with mental health needs, resulting in inappropriate admissions to our acute hospitals |
| **How we will deliver the improvement?** | • County wide strategy for the delivery of mental health care to patients in the acute setting<br>• Service Level Agreement in place with Worcestershire Health & Care Trust identifying levels of support provided by the mental health teams<br>• Confirmation from CCGs on the commissioning of mental health services |
| **Measures:** | • Delayed transfers of care statistics<br>• % patients with mental health needs presenting to A & E assessed prior to admission |
| **Targets:** | • 95% of medically fit patients with mental health needs will be transferred to an appropriate environment within 24 hours of the decision that they are fit for discharge from an acute bed<br>• 95% of patients with mental health needs presenting in A&E will not be admitted to an acute bed unless they require acute hospital care |
| **Reporting route:** | • Quality Governance Committee |
| **Responsible Officer:** | • Chief Nursing Officer |

## 3.2 CQUINS agreed for 2014/15

The following 2014/15 CQUINs have been agreed with our 3 Clinical Commissioning Group's (CCG's), 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 | To reduce the amount of harm the patients experience through reduction in the prevalence of 'new' Pressure Ulcers. | 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 | |
| Reduction of surgical site infection for patients undergoing surgery | To reduce the incident rate of surgical site infection for Caesarian Sections (emergency and planned) and other surgical procedures which show an increased incidence rate of SSI. They can contribute to extended length of stay and increased morbidity and mortality as well as increased prescribing costs in primary care. | Yes | | Yes | |
| Hydration and Fluid Management | Promotion of hydration and fluid management in all in-patient settings through implementation and embedding of a hydration bundle. A number of reports have identified dehydration in patients as a contributory factor to sustaining injury from falls, developing pressure ulcers or increasing the risk of developing infection or deep vein thrombosis (Royal College of Nursing and National Patient Safety Agency 2007). This is evidenced particularly in the care of older people, as a continued failure in patient care (Health Service Ombudsman 2011) | Yes | | Yes | |
| Safe Care | Reducing falls in all adult Inpatient areas including the Accident and Emergency (A&E) Department. | 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 | |

## Specialist Commissioners CQUINS

Our specialist Commissioners, Prescribed Services, have agreed the following 5 CQUINS:

| | | Quality Domain | | | |
|---|---|---|---|---|---|
| Goal Name | Goal Description | Safety | Effectiveness | Patient Experience | Innovation |
| Retinopathy of Prematurity | Retinopathy of prematurity is one of the few causes of childhood visual disability which is largely preventable. Many extremely preterm babies will develop some degree of ROP although in the majority of babies this does not progress beyond mild disease which resolves spontaneously without treatment. A small proportion develop potentially sever ROP which can be detected through retinal screening. If untreated severe disease can result in serious vision impairment and consequently all babies at risk of sight-threatening ROP should be screened (RCPCH 2008). | | Yes | Yes | |
| Breast milk in preterm infants | There is evidence to show that maternal breast milk has particular advantages for preterm infants. It is associated with reduced incidence of necrotizing enterocolitis and infection which significantly contribute to preterm morbidity and mortality as well as increased hospitalization. It is also important for maternal bonding in a particularly vulnerable patient group. | | Yes | Yes | |
| Parenteral Nutrition | During early postnatal life, the nutritional needs of preterm infants is usually met through parenteral nutrition. This indicator aims to improve the proportion of preterm babies who start TPN by day 2 of life. It excludes babies | | Yes | Yes | |

| | | | | | |
|---|---|---|---|---|---|
| | who undergo surgery on day 1 or 2 of life. | | | | |
| **NHS Safety Thermometer** | The same as the CQUIN agreed with our CCG Commissioners | **Yes** | | **Yes** | |
| **Dementia and delirium care (FAIR)** | The same as the CQUIN agreed with our CCG Commissioners | | | **Yes** | |

## 3.3 Who has been involved in setting the content of the Quality Account and the priorities for 2013/14

The writing of this Quality Account and the setting of priorities for 2014/15 has drawn upon engagement with the Trust's internal and external stakeholders through 2013/14 including:

- Worcestershire's three Clinical Commissioning Groups through regular Quality Review Meetings,
- The Health Overview and Scrutiny Committee through regular correspondence and engagement
- Healthwatch
- The Patient & Public Forum, who have an active role in local inspections
- The public, through the Acute Services Review consultation
- The Trust's 'Sounding Board'
- Our staff

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.

In addition to this we asked our key external stakeholders what they would expect to see in this Quality Account. Our key stakeholders include:

- Healthwatch
- Worcestershire Health Overview and Scrutiny Committee
- Clinical Commissioning Groups

The key points from their suggestions are as follows:

- To reflect on the areas that the Trust has done well and identify improvements required
- To include the Trust's priorities for improvements in 2014/15
- To improve the style of the presentation so that the public can understand the contents
- To highlight in the Quality Accounts where the Trust has identify areas for improvements from the results of the Family and Family test and findings from complaints
- To indicate how the Trust have involved the service users and staff and to consider engaging them creatively, over and above the established method
- To have effective handovers over weekends and bank holidays, in particular for high risk patients
- To improve the interface between hospital and adults social care so as to avoid unnecessary delays when patients are discharged
- To report on indicators for quality, for example, infection prevention and control, learning from serious incidents, mandatory training

## Section 4 – Assurance Statements

### 4.1 Review of Services

During 2013/14 the Worcestershire Acute Hospitals NHS Trust provided and/ or subcontracted 44 NHS services.

Worcestershire Acute Hospitals NHS Trust has reviewed all the data available to them on the quality of care in 44 of these NHS services.

The income generated by the NHS services reviewed in 2013/14 represents 100% per cent of the total income generated from the provision of NHS services by the Worcestershire Acute Hospitals NHS Trust for 2013/14.

### 4.2 Participation in Clinical Audits and National Confidential Enquiries

During 2013/14, 44 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 33 out of 34 [97%] of 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 2013/14 are provided in the list below:

The national clinical audits that Worcestershire Acute Hospitals NHS Trust participated in, and for which data collection was completed during 2013/14 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.

**National confidential enquiries**

| Title | Number of cases identified in the Trust | Number of questionnaires Requested | Number of questionnaires Returned | Report Due Date |
|---|---|---|---|---|
| **Subarachnoid Haemorrhage** | 42 | 9 | 4 | November 2013 |
| **Alcohol Related Liver Disease** | 75 | 6 | 3 | June 2013 |
| **Lower Limb Amputation** (This study is still open) | 7 | | Data collection phase | Autumn 2014 |
| **Tracheostomy Care** | 10 | 10 | 10 | 2014 |

No other confidential enquiries were carried out in 2013/14

## National Clinical Audits

| National Clinical Audits (Hyperlinked) | Eligible | Participated | % of Participation | Comments on Progress |
|---|---|---|---|---|
| Acute Coronary Syndrome or Acute Myocardial Infarction (NICOR-MINAP) | yes | yes | 100% | |
| 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 | 100% | |
| 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 | 56% | Lack of resources within the department has resulted in not enough patients being seen. Business cases for 2 new heart failure nurses being developed. |
| Pulmonary hypertension (IC) | No | No | **Do not provide the service** | |
| Chronic Obstructive Pulmonary Disease (COPD)<br><br>(COPD Discharge Audit) | yes | yes | **N/A** | Audit period to be from January 2014 onwards. Therefore no data available for 2013-14 Quality accounts. |
| Diabetes (Paediatric) (RCPCH-PNDA) | yes | yes | N/A | 125 cases submitted, participation rate cannot be calculated due to the paediatric diabetes denominators unknown. |
| Inflammatory bowel disease (RCP-IBD) 4th Round | yes | yes | N/A | Data entry closed Jan 2014, therefore will not be included in 2013-14 quality accounts. |
| Renal Registry (UKRR) | no | no | **Do not provide the service** | |
| National Adult Diabetes Audit-ANDA (NHS IC) | yes | yes | N/A | Audit to commence 20th September |
| Adult Critical Care (ICNARC CMP) | yes | yes | 100% | |
| Emergency Laparotomy | yes | yes | N/A | New audit for 2014 therefore will not be included in 2013-14 Quality Accounts |
| Emergency use of oxygen (BTS) | yes | yes | | Report will be included in Quality Accounts. |
| National joint registry (NJR) | yes | yes | 100% | On-going on both sites. |
| Trauma (TARN) | yes | yes | 100% | On-going on both sites. |
| Paracetamol Overdose (CEM) | yes | yes | N/A | Sample size (50 per site).<br>Data collection finished jan 14 therefore not included in 2013-14 Quality Accounts |

| | | | | |
|---|---|---|---|---|
| Bowel cancer (NBOCAP) | yes | yes | 134.8% | Report will be included in Quality Accounts. |
| Lung cancer (LUCADA) | yes | yes | 148% | Report will be included in Quality Accounts. |
| Head and neck oncology (IC DAHNO) | yes | yes | >80% | Plans to look at Action plan in May 14. |
| Oesophago-gastric cancer (RCS -NAOGC) | yes | yes | >80% | Data Collection:<br>The Third Annual Report will include data on patients diagnosed between 1 April 2011 and 1 April 2013. The data submission deadline for this report will be Tuesday 1 October 2013. The publication date for the Third Annual Report will be May 2014 |
| Comparative audit of blood transfusion - Multi audit programme | yes | yes | 100% | |
| (SSNAP) Stroke National Audit Sentinel and SINAP) Programme (combined Sentinel and SINAP) | yes | yes | | Data only submitted in January 2014 therefore will not be included in 2013/14 Quality Accounts |
| National Audit of Seizure Management (NASH) | Yes | yes | 100% | The trust has appointed another Neurologist so from Feb 2014 there is an official first fit clinic which would aim to comply with NICE guidelines seeing the patients quickly not the 3-4 months as previously occurred. I do not think that the NASH 2 was a driver for this. There were no unexpected findings from the NASH project. |
| Severe Sepsis & Septic Shock (CEM) | yes | yes | 100% | Sample = 50 per site. |
| Epilepsy 12 (Childhood Epilepsy) (RCPCH) | yes | yes | 100% | Very small numbers submitted to the national audit. |
| Moderate or severe asthma in children (care provided in emergency departments) | yes | yes | N/A | The data collection period has been delayed. Data collection will now start on Monday 16th September and close on 31st January 2014 |
| Neonatal intensive and special care (NNAP) | yes | yes | 100% | The Trust was acknowledged as outstanding for NNAP and received an certificate of recognition |
| Paediatric asthma (BTS) | yes | yes | N/A | Data entry still open on the BTS Site until 31/01/14 |
| Paediatric Intensive Care (PICA Net) | no | no | **Do not provide this service** | |
| Prostate cancer | TBC | TBC | N/A | Started data collection in Dec 2013 |
| Rheumatoid and early inflammatory arthritis | TBC | TBC | N/A | Started data collection Jan 14 |
| Child Health (CHR-UK) | yes | yes | 100% | |
| Maternal infant and Perinatal Mortality | yes | yes | | Ann Tonks (Regional Project Manager) : Electronic notifications only for any deaths from 1st July 2012. Units can produce their own figures from the new system. |
| Prescribing Observatory for Mental Health (POMH- UK) | no | no | **Do not provide this service** | |
| National Audit of Schizophrenia | no | no | **Do not provide this service** | |

| | | | | |
|---|---|---|---|---|
| National confidential enquiry into patient outcome and death (NCEPOD) | yes | yes | 100% | |
| Suicide and homicide in mental health (NCISH) | no | no | **Do not provide this service** | |
| Elective surgery (National PROMs Programme) (IC) | yes | yes | | PROM'S Questionnaires for 4 procedures are submitted quarterly. Participation numbers are monitored by the Trust committees. |
| Falls and Fragility Fractures Audit Programme (FFFAP) | Yes | | | On-going data collection for the database. |
| National Vascular Registry* | Yes | Yes | 100% | New registry launched Dec 2013 |
| Mental health clinical outcome review programme: National Confidential Inquiry into Suicide and Homicide for people with Mental Illness (NCISH) | No | No | **Do not provide this service** | |

The reports of 6 national clinical audits were reviewed by the provider in 2013/14 and Worcestershire Acute Hospitals NHS Trust intends to take the following actions to improve the quality of healthcare provided:

**Actions taken following national clinical audit reports:**

| Title | Action Points |
|---|---|
| **Trust wide Re-audit of the Blood Transfusion Care Pathway** | • Presentation of the results to Trust Transfusion Committee/Presentation of audit to the link nurse day<br>• Improvement on documentation in the care pathways and consider mechanisms that would achieve this i.e. further learning/workshops<br>• Review audit tool to better reflect practice<br>  ○ Audit standards need to more accurately represented on the audit tool<br>• Education of users at induction / mandatory training and link nurse training |
| **Childhood Epilepsy 12 (RCPCH National Childhood Epilepsy Audit)** | • 95% compliance with the national guideline requirements. |
| **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<br>• 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<br>• Blood glucose on all patients - Nursing staff meeting |
| **Cardiac Arrythmia** | • 12/01/2014 Sent report to Dr Foster awaiting update<br>• The network population is older than average so there is an 18% greater need for pacemakers and 17% greater for iCDS than the national average.<br>• Implant rates for all device classes are seriously below the national average. The situation is particularly drastic for PM which fell sharply from an already low level. the rate is now only half the national target and is far from the national average. This would suggest the need for a local pacing |

| | |
|---|---|
| | review.<br>• The ICD implant rate rose but the overall rate is below the national average for CRT. A substantial rise in 2010 has been followed by a small fall in 2011, so that the rate is also below the national average. |
| **National Neonatal intensive and special care Audit Programme (NNAP)** | • WRH received a letter of commendation for completeness of data collection. The problem is to do with recording when babies have their eyes checked for ROP because of prematurity. Many babies are discharged from the Alex SCBU before their first screen is due, and until recently there was no easy way of retrospectively adding data. This has now been rectified, and we have a data clerk supervising completeness of data we submit for NNAP. |
| **National Paediatric Diabetes Audit NPDA(RCPH)** | • Dr Scanlon stated that the paediatric service is improving, with the help of additional staff that have been employed and the families think that they are being well supported. |
| **BTS Pneumonia for paediatrics** | • To use Amoxicillin as drug of choice for community acquired pneumonia.<br>• Only the complicated pneumonia needs to be followed up in clinic<br>• Children with O2 saturation less than 92% needs admission to hospital<br>• Blood culture is not an integral investigation in community acquired pneumonia. |

The reports of 45 local clinical audits were reviewed by the provider in 2013/14 and Worcestershire Acute Hospitals NHS Trust intends to take the following actions to improve the quality of healthcare provided:

Corporate audits such as record keeping, consent presented at the relevant corporate groups. Due to a substantial change to the structure of the Trust we are reviewing our processes within the Clinical Audit department for 2014-15. We have plans for a robust process to monitor the position of the audits throughout the year and ensure outcomes are achieved. We are also converting to an online clinical audit management system to encourage staff to register their clinical audits and update their action plans.

| Project Title | Directorate | Aims | Outcomes |
|---|---|---|---|
| **Re-audit of the Management of loco-regional breast cancer recurrences** | General Surgery | 1) To see if we are meeting national guidance of <31/7 between diagnosis of local recurrence and first treatment<br>2) If patients are getting staging investigations in the 2 week wait period.<br>3) To see if, by staging these patients, we are delaying their treatment and, if so, does staging alter management? | The 1st audit cycle was carried out in 2011 and it clearly showed that the Trust was not achieving the standards required for investigations or treatment in appropriate time<br><br>Hospital protocol: (CT scan & NM bone scan) ≤ 2 weeks of diagnosis = 2011 57% 2013 100%<br>Cancer Reform Strategy (DoH):<br>31 day standard from diagnosis/decision to first treatment to cover all cancer treatments. =2011 75% 2013 100%<br><br>CG80 NICE Guidelines state that all patients with breast cancer should get multi-disciplinary team (MDT) care = 100% 2011/2013 |

| | | | |
|---|---|---|---|
| | | | The 2013 results were a result of the following actions implemented.<br><br>Book CT scan and NM bone scan at time of seeing patient in clinic/receiving biopsy results.<br><br>By making sure their scans are prompt, this will speed up decisions made for Mx. If for surgery, book surgery date at time of diagnosis but can always be changed. |
| **Sepsis Six: Improving Management Re-audit** | Medicine | ➢ Initial audit and then a re-audit after a set of interventions.<br><br>➢ Aiming to identify the current management of sepsis in newly admitted patients in AMU. Then introduce a set of inventions and carry out a re-audit to identify any change/improvement in management of septic patients. | The audit consisted of looking at all new admissions over a one week period who met the criteria for sepsis in AMU. The criteria evaluated was<br><br>Time to first administration of oxygen, intravenous fluids and antibiotics.<br><br>Taking of blood cultures, other relevant bloods tests (including lactate) and urine output monitoring.<br><br>The data was collected for 12 days, and then interventions were introduced in the next 14 days such as:<br>• Teaching session for nurses working in AMU<br>• Producing a poster and displaying on AMU<br>• Easy follow guidelines were produced for sepsis<br>• Sepsis pathway emailed to all clerking doctors.<br><br>A total of 32 patients (19 Males, 13 Females) were identified in the pre-intervention group. 22 of these patients met the criteria for severe sepsis. Only 15 out of 32 (47%) had their lactate measured. 10 out of 22 (45%) received fluids within an hour. 12 out of 22 (55%) had their blood culture sample taken after administration of antibiotics and only 12 out of 22 (55%) had antibiotics administrated within an hour of medical assessment<br><br>Post-intervention the results however improved dramatically. A total of 30 patients were identified in the post-intervention group (12 Males, 18 Females). Antibiotics administration within an hour went up by 22%.. Lactate was performed in 26/30 (87%) patients presenting with sepsis compared to 47% in the pre-intervention group. Similarly, |

| | | | |
|---|---|---|---|
| | | | identification of severe sepsis, and administration of intravenous fluids also showed improvement ultimately improving patient care.<br><br>Further actions have also been completed ready for the next sepsis six audit which will be completed in 2015. They are as follows:-<br>Continuous teaching sessions for AMU nursing staff.<br>Sepsis guidelines available on intranet<br>A4 sized sepsis pathway guidelines to put in severely septic patients' files to make everyone aware<br>Sepsis six box |
| **Deep Vein Thrombosis (DVT) Audit** | Medicine | • Re- audit into the assessment and management of patients presenting with DVT symptoms<br>• To identify where improvements are required in the assessment and referral pathways e.g use of DVT nurse referral/admission.<br>• To assess whether we are using the wells score, performing D-dimers appropriately and referring to DVT nurse/USS<br>• Impact will be on current practice through better use of DVT pathway and educate current/future clinical staff. | • The audit was completed at WRH in 2011and data was collected using patient first reporting system (scanned CAS card and notes/referral forms). The initial findings were that A&E staff were not complying with the recommended guidance. As a result of the audit the junior handbook was updated with new criteria and new proformas for nurses to complete. The findings for the re-audit and the previous audit are as follows:-<br>• Standard 1 – Wells score performed (standard achieved) 2011 51% 2014 93%<br>• Standard 2 – D-dimer performed appropriately if Wells < 2, 2011 71% 2014 91.8% (standard achieved).<br>• Standard 3 – Enoxaparin given (standard 90% not achieved) 2011 77% 2014 85% improvement since previous audit<br>• Standard 4 & 5 patients referred for investigation (standard 90% not achieved). 2011 70% 2014 88% improvement since previous audit |

**Clinical Audit Publications in 2013/14**

- Audit of patient's inability to lift the water jugs as a contributor to dehydration Phillipa Johnstone, FY1 Surgery
- Presented at National Foundation Doctors Presentation day in January and has been accepted for Joint NACT UK UKFPO Foundation Programme Sharing Event being held on 11 June 2014 at the Holiday Inn, Regent's Park, London

## 4.3 Research and Development

The number of patients receiving NHS services provided or sub-contracted by Worcestershire Acute Hospitals NHS Trust in the 2013/14 that were recruited during that period to participate in research adopted on the NIHR portfolio was 1009.

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

There were 87 clinical staff leading or actively participating in research approved by a research ethics committee at Worcestershire Acute Hospitals NHS Trust during the financial year 2013/14. These staff participated in research covering 17 medical specialties.

2013/14 was the final 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 more than 2.5 times the levels in year one.

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

## 4.4 Registration with the 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 2014.

Worcestershire Acute Hospitals NHS Trust has participated in one special review but no investigations by the Care Quality Commission relating during 2013/14. The special review covered the Mental Health Act Section 120 and was carried out in September 2013 across the whole of Worcestershire

The CQC has performed planned unannounced inspections covering infection control at the Alexandra Hospital and Worcestershire Royal Hospital during 2013/14 and we were found to be compliant with regulations.

We are compliant with all the CQC essential standards of quality & safety at year-end.

The CQC's Intelligent Monitoring Report has placed the Trust in band six – the grouping for hospitals that pose the lowest risk to patients – in two consecutive reports in 2013/14.

## 4.5 Quality of Data

**Data Quality**

All NHS organisations have a responsibility to ensure their data is accurate and compliant with legal and regulatory frameworks. High quality data means better patient care and patient safety. Both clinical and non-clinical staff rely on the availability of accurate information in order to be able to provide timely and effective decisions. If data is not correct and up to date there could be consequences for the safety of our patients.

Worcestershire Acute Hospitals NHS Trust recognises the importance of high quality data and is committed to pursuing the highest standards of accuracy, completeness, and timeliness of data in order to support patient care.

**Actions taken to improve data quality**

Information Governance Toolkit attainment levels

The Toolkit score for 2014 will be maintained at 76% and all of the 45 standards will achieve a minimum of a level 2. This will result in a 'Satisfactory' status for the Trust which is a requirement for an application for foundation trust status and provides assurance to patients and stakeholders that the Trust places a high priority on handling their information in a secure and confidential manner.

Due to previous positive results the Trust was not subject to a Coding Payment by Results audit for 2013/ 14. However an audit was carried out in line with the Toolkit standard 505 and this was undertaken by the Trust coding auditor and an external coding auditor. The auditors examined 200 episodes and there were improvements in all areas with the exception primary diagnosis. However this was a minor error in using the 4$^{th}$ digit of the code or incorrect sequencing and HRG changes reduced by 50% from last year.

The audit result shows that, out of 200 episodes of stay, 121 of these 200 were found to be totally correct. This is a small improvement from 109 last year. More details on the results of from this audit is as follows

| Area of audit | 2013/14 result | 2012/13 result |
|---|---|---|
| Primary diagnosis (main condition for the patient on admission to hospital) | 88.5% of these shows the main part of the code was correct. | 91.5% of these shows the main part of the code was correct. |
| Secondary diagnosis | 94.3% correct | 90% correct |
| Primary Procedure (first operation code) | 93.6% correct | 85% correct |
| Secondary Procedure (any other operations or procedures carried out during the patients stay in hospital | 90.6% correct | 87.8% correct |
| HRG changes (changes in the financial groupings used for costing) | 4.5% | 8.5% |

The coding auditor has completed six clinical audits and the lessons learned have been shared between clinicians. The reports have been fed through the Trust committees to ensure the Trust Board are aware of good practice and improvements required to continually improve the quality of coded data.

**Current systems and processes in place for monitoring and improving Data Quality.**

In order to maintain compliance with legal and regulatory requirements, the Trust routinely monitors the quality of its data. Monitoring reports and audits have been used to improve processes, training documentation and use of computer systems.

An overview of the processes currently in place to help highlight, improve, and mitigate data quality issues are detailed below:

**Data Quality Policy**

The Trust is currently in the process of reviewing its current Data Quality policy which will be made available to staff via the intranet/leaflet. The policy includes the Trust governance framework arrangements for data quality. It also includes guidance around the importance of recording key data items in an accurate and timely manner. The responsibility to record Trust data accurately is included in all staff contracts and job descriptions.

**Data Quality Group**

The Data Quality Group administers the Data Quality policy and reports to the Information Governance Committee. The group meets on a monthly basis and covers the following regular agenda items:

1) NHS Numbers.
2) Secondary Users Submissions (SUS) data quality dashboards.
3) Data Quality Team updates.
4) Information Governance Toolkit.
5) Information Standards Notices (ISN's).
6) Commissioner data quality queries.

A comprehensive suite of reports are regularly sent out to the relevant staff for action.

**Data Quality Team**

The Trust has a dedicated data quality team of staff who are responsible for dealing with errors and omissions in the data. Where individuals are found to be making regular errors or there is a particular type of error occurring regularly, these are fed back to the relevant staff.

**Clinical Coding Team**

The Trust has a high level Clinical Coding policy which is in line with national requirements. The policy is supported by detailed procedures which provide clinical and clerical staff with guidance on the recording of source documentation to support clinical coding process. The policy promotes the case note as the most detailed source of documentation available in conjunction with access to the Trusts electronic clinical systems. The Clinical Coding manager promotes the clinical coding policy internally and is part of a regional network for coding.

In order for the Trust to have timely information to support the Trust business it is essential for the majority of admissions to be coded within 4/5 working days of the end of the month. The Trust is currently operating at 97% coded within 5 days against a target of 95%.

In line with national requirements all of the clinical coding staff complete a National Clinical Coding Standards Course followed by a refresher training courses every 3 years, along with specialty workshops to maintain a high standard in their clinical coding expertise. Five members of the team have passed their Accredited Clinical Coding qualifications and further members of the team are currently studying for the exam.

As part of the Trust's wider re-structuring plan, a 'Head of Coding' role has been introduced in to the Clinical Coding team structure which will be an outward facing role focussing on

working more closely with the new Divisional teams to identify specific areas for improvement, provide training and promote the importance of accurate data recording.

**Clinical Informatics/Information Team**

The Clinical Informatics team work to ensure all reasonable endeavours are undertaken to ensure data is accessible and up to date. This includes the development and maintenance of processes for collecting and validating data. In-house systems and processes are developed and maintained to ensure the completeness/integrity of data within the current and evolving requirements of the Trust.

The Information Team have developed a comprehensive suite of data quality reports which are regularly sent to the relevant staff for action. Any areas of concern are addressed at the Data Quality Group meetings.

**Audits carried out by Clinical Coding Department**

The internal Clinical Coding audits this year include 'Coding from the Electronic Discharge Summary (EDS) against coding in the Community with the case notes'. The purpose of the audit was to highlight the difference in income between coding from the EDS against the case notes. The results of the audit showed that on 28 patients 12 had HRG changes gaining the Trust £26,963. The conclusion of the audit was that Clinical Coding should be resourced to fund a Clinical Coder visiting Community sites 4 days each month.

The Trust completed a Clinical Coding IG Audit in November 2013; this was carried out by our qualified auditor and a qualified auditor from the Dudley group of Hospitals. An internal audit was also carried out to qualify the cost to the Trust of coding patients who had been transferred to the community from the Electronic Discharge summary.

A new Clinical Coding department structure will enable further internal audits to be carried out in 2014/15.

**Audits carried out by Internal Audit Department**

The Internal Audit department were commissioned to carry out an audit on Data Quality (Coding) in 2013/14. A draft report has been written, however the final report with any recommendations is pending.

**Future plans for improving Data Quality**

The Trust is formulating a Data Quality Strategy in accordance with the Trust's overall Quality Strategy that describes how the trust will structure itself and the improvement processes it will use to achieve its data quality improvement objectives.

The Data Quality Strategy will encompass but is not limited to the following areas:

**Data Quality Steering Group**

A proposal is currently being worked on which will outline the framework for a new Data Quality Steering Group. The main objective of this group is to 'operationalise' data quality so that errors are fixed at source.

This group will further expand on the work being done by the current Data Quality Group by proactively looking forward to issues that may arise, but to also review/implement the recommendations coming out of:

1) The Francis Report.
2) NHS England (National Quality Board).
3) National Audit Office.

An education and training programme aimed at front-line staff is also being considered which aims to raise the awareness of the clinical, operational, and financial impact of poor data quality on the service.

**Use of Business Intelligence (BI)**

The high level aim of the Trust's Business Intelligence project is to convert the significant amount of data available across the Trust into meaningful information to support decision making. Therefore the improvement of data quality is imperative to the success of this project. BI is an enabler to the improvement of data quality. The following main aspects will be covered by the project:

1. Review/Update of existing Business Rules: Reviewing the business rules which are applied throughout our reporting is an integral phase of the project, and will ensure our reporting reflects the on-going operational changes the organisation is facing.
2. Data Availability: Making the data more accessible and useful facilitates ownership of the data, thus helping to drive improvements in the timeliness and quality of the source data.
3. Automation of data capture/reporting to reduce any margins for error.

**Data Assurance Kite Mark**

Due to resource constraints, the Trust is only able to provide assurance around 'high profile' key performance indicators such as Mortality, Cancer, A&E, RTT etc.

The Business Intelligence Project will automate some of the work associated with providing assurance. With that in mind, the Trust is currently looking into the feasibility of development 'Data Quality Assurance Kite Mark's' which assess the data quality against 6 key areas for each of its Key Performance Indicators (KPI's). The areas will cover:

1. Accuracy
2. Validity
3. Reliability
4. Timeliness
5. Relevance
6. Completeness

The primary aim is to provide a quick 'at a glance' visual indication that the information presented is accurate so that informed decisions can be taken.

**Service Evaluation of Clinical Coding Practices:**

The Trust will be (needs date) participating in a national project in evaluating hospitals' coding practices. This is led by a research team from Leicester University. The research will seek to understand the factors that influence coding practices in hospitals, and to share this understanding in order to support good practices and identify opportunities for improvement. As it is a national study, the researchers will compare coding practices in hospitals so as to provide fresh insights into why variability arises, and to suggest how the quality of hospital data might be improved. This involves an evaluation of the Trust's coding practices.

## 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 | 2012/13 | 2013/14 (Latest data available on HSCIC includes first 2 quarters of 13/14. Monthly breakdown not available. Oct 2012 – Sep 2013) | 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 2012/13 the Trusts SHMI was<br><br>102.7<br><br>The Trust was then in Band 2 (indicates that the trust's mortality rate is 'as expected') | The SHMI for Oct 2012 – Sep 2013 was<br><br>105.5<br><br>The Trust is in Band 2 (indicates that the trust's mortality rate is 'as expected') | In Oct-2012 to Sep-2013:<br>• 8 trusts had a 'higher than expected' SHMI value (Band 1)<br>• 17 trusts had a 'lower than expected' SHMI value (Band 3)<br>• 116 trusts had an 'as expected' SHMI value (Band 2) | For Oct 2012 – Sep 2013:<br><br>Highest: 118.6<br><br>Lowest: 63.0 |
| | b) the percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period. | From Apr 2012 – Mar 2013, 15.1% of deaths were reported with palliative care coding at either diagnosis or specialty level | From Oct 2012 – Sep 2013 15.5% of deaths were reported with palliative care coding at either diagnosis or specialty level | From Oct 2012 – Sep 2013:<br><br>Average of 20.9% of deaths were reported with palliative care coding at either diagnosis or specialty level, nationally. | For Oct 2012 – Sep 2013:<br><br>Highest: 44.9%<br><br>Lowest: 0% |
| | **The Worcestershire Acute Hospitals NHS Trust considers that this data is as described for the following reasons:** | | a) The Summary Hospital-level Mortality Indicator (SHMI) reports on mortality at trust level across the NHS in England. Data as published on HSCIC.<br>b) Percentage of deaths reported in the SHMI where the patient received palliative care. Data as published on HSCIC. | | |
| | **The Worcestershire Acute Hospitals NHS Trust has taken the following actions to improve this number, and so the quality of its services, by:** | | This is detailed in section 2.6.3 and includes:<br>Monitoring of HSMR and SHMI with reviews of outlying diagnostic groups and requested reviews (such as weekends) to determine the reasons. Improvements in coding. | | |

| Title | Indicator<br><br>PROMs casemix-adjusted scores | 2012/13<br><br>Adjusted average health gain | 2013/14<br>(provisional data – Apr 2013 – Dec 2013)<br><br>Adjusted average health gain | National Average<br>(provisional data – Apr 2013 – Dec 2013)<br><br>Adjusted average health gain | Upper and Lower 95% control limit for the Trust<br>(provisional data – Apr 2013 – Dec 2013)<br>Health Gain |
|---|---|---|---|---|---|
| **Patient Recorded Outcome Measures**<br><br>**(PROMS)** | (i) groin hernia surgery | 0.099<br>Not an outlier on the EQ-5D Index measure | 0.066<br>Not an outlier on the EQ-5D Index measure | 0.086 | UCL (95%) = 0.114<br>LCL (95%) = 0.057 |
| | (ii) varicose vein surgery | Too few modelled records to calculate adjusted health gain | Too few modelled records to calculate adjusted health gain | 0.101 | N/A |
| | (iii) hip replacement surgery | 0.444<br>Not an outlier on the EQ-5D Index measure | 0.442<br>Not an outlier on the EQ-5D Index measure | 0.439 | UCL (95%) = 0.485<br>LCL (95%) = 0.392 |
| | (iv) knee replacement surgery | 0.301<br>Not an outlier on the EQ-5D Index measure | 0.321<br>Not an outlier on the EQ-5D Index measure | 0.330 | UCL (95%) = 0.380<br>LCL (95%) = 0.281 |
| | **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<br>• The indicator used is EQ‑5D™ Index – captures in a single value a range of generic health issues in a broad but clearly-defined way.<br>• The data for 2013/14 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:** | | • The new clinical divisions are taking the lead for improving their response rates. Clinical leads are being identified to lead in PROM's and be responsible for disseminating the results and displaying them in clinic areas for patients.<br>• Clinical areas will be promoting PROM's by having posters displayed. | | |

| Title | Indicator | 2012/13 | 2013/14 | National Average | Highest and lowest NHS Trust and Foundation Trust scores for the reporting period |
|---|---|---|---|---|---|
| **Readmission rates** | The percentage of patients aged<br>(i) 0 to 14; and<br>(ii) 15 or over,<br><br>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**<br>Data not available Health & Social Care Information Centre for this period.<br><br>**15 or over**<br>Data not available Health & Social Care Information Centre for this period. | **0 to 14**<br>Data not available Health & Social Care Information Centre for this period.<br><br>**15 or over**<br>Data not available Health & Social Care Information Centre for this period. | **0 to 14**<br>Data not available Health & Social Care Information Centre for this period.<br><br>**15 or over**<br>Data not available Health & Social Care Information Centre for this period. | **0 to 14**<br>Data not available Health & Social Care Information Centre for this period.<br><br>**15 or over**<br>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 | 2012/13 | 2013/14 | 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 | 65.2 | Not available | Not available | Not available |
| | **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<br>• Improving patient information<br>• 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 | 2012/13 | 2013/14 | 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. | 2012 = 64.05%<br><br>Placed in the 3rd Quartile<br><br>Trusts in 4th Quartile are the top performers. | 2013 = 61.52%<br><br>Placed in the 2nd Quartile<br><br>Trusts in 4th Quartile are the top performers. | Average score for 1st quartile: 52.057<br><br>Average score for 2nd quartile: 62.017<br><br>Average score for 3rd quartile: 70.569<br><br>Average score for 4th quartile: 83.781 | Highest: 93.92%<br><br>Lowest: 39.57% |
| | **The Worcestershire Acute Hospitals NHS Trust considers that this data is as described for the following reasons:** | | % to strongly agree / agree with the Q12d. 'If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation'<br>Data published on NHS Staff Survey website. | | |
| | **The Worcestershire Acute Hospitals NHS Trust has taken the following actions to improve this number, and so the quality of its services, by:** | | • new staff engagement initiatives have been put in place in 2013/14 – see section 2.8.3 | | |

| Title | Indicator | 2012/13 | 2013/14 | England 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 | Qtr 1: 95.9%<br>Qtr 2: 95.1%<br>Qtr 3: 95.7%<br>Qtr 4: 95.3% | Qtr 1: 95.76%<br>Qtr 2: 94.53%<br>Qtr 3: 95.09%<br>Qtr 4: not available | Qtr 1: 95.48%<br>Qtr 2: 95.84%<br>Qtr 3: 95.79%<br>Qtr 4: not available | Qtr 1: H = 100% L = 78.78%<br>Qtr 2: H = 100% L= 81.70%<br>Qtr 3: H = 100% L = 74.09%<br>Qtr 4: not available |
| | **The Worcestershire Acute Hospitals NHS Trust considers that this data is as described for the following reasons:** | | The DoH data collection asks for three items of information:<br>1. Number of adults admitted as inpatients in the month who have been risk assessed for VTE on admission to hospital using the criteria in the National VTE Risk Assessment Tool<br>2. Total number of adult inpatients admitted in the month<br>3. Calculated from (1) and (2), the percentage of adult hospital admissions, admitted within the month assessed for risk of VTE on admission | | |
| | **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 continues to develop an electronic prescribing system with a mandatory requirement to complete the VTE due to be piloted in 2014. | | |

| Title | Indicator | 2012/13 | 2013/14 | 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. | 28.90 cases per 100,000 bed days | 14.0 cases per 100,000 bed days. (trust's own figures) | N/A | N/A |
| | **The Worcestershire Acute Hospitals NHS Trust considers that this data is as described for the following reasons:** | | The 2013/14 data is not available on HPA's website, link provided by the Health & Social Care Information Centre. | | |
| | **The Worcestershire Acute Hospitals NHS Trust has taken the following actions to improve this rate, and so the quality of its services, by:** | | | | |

| Title | Indicator | 2012/13 | 2013/14 (Apr – Sep 2013) The latest data available | National Average (April – Sep 2013) 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><br><br>April 12 – Sept 12 = 5541<br>October 12 to March 13 = 5687<br><u>Rate of patient safety incidents:</u><br>April 12 – Sept 12 = 9.3 per 100 admissions<br>October 12 to March 13 = 9.6 per 100 admissions | Number of incident reports: 5276<br><br><u>Rate of patient safety incidents:</u><br>• 8.26 per 100 admissions | Number of incident reports: 4399 average<br><br>Rate of patient safety incidents:<br>• 7.0 per 100 admissions (average) | For similar Trusts – as provided by the NRLS:<br><br>Highest Number: 7835<br>Highest rate: 12.7<br><br>Lowest number: 1761<br>Lowest rate:3.0 |
| | the number and percentage of such patient safety incidents that resulted in severe harm or death | April 12 – Sept 13 =<br>Number: 12<br>o 10 severe harm<br>o 2 deaths<br>Percentage:<br>o 0.2% severe harm<br>o 0.0% death<br>October 12 to March 13 =<br>Number:<br>o 10 severe harm<br>o 6 deaths<br>Percentage:<br>o 0.2% severe harm<br>o 0.1% death | Number: 22<br>• 16 severe harm<br>• 6 deaths<br><br>Percentage:<br>• 0.3% Severe harm<br>• 0.1% deaths | Number (average)<br>• 22.8 severe harm<br>• 4.9 deaths<br><br>Percentage:<br>• 0.5% severe harm<br>• 0.1% death | Number<br>Highest: 81 severe harm<br>Lowest: 1 severe harm<br><br>Highest: 15 deaths<br>Lowest: 0 deaths<br><br>Percentage:<br>Highest: 2.6% severe harm<br>Lowest: 0% severe harm<br><br>Highest: 0.3% deaths<br>Lowest: 0% deaths |
| | **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.<br>• 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)<br>• Improving the investigation and response to incidents using Human Factors methodology and sharing learning of causes and solutions.<br>• Triangulating between incidents and other information to improve understanding of causative and contributory factors in avoidable harm | | |

## National Targets

### Cumulative Incidences of Clostridium Difficile (C.diff)

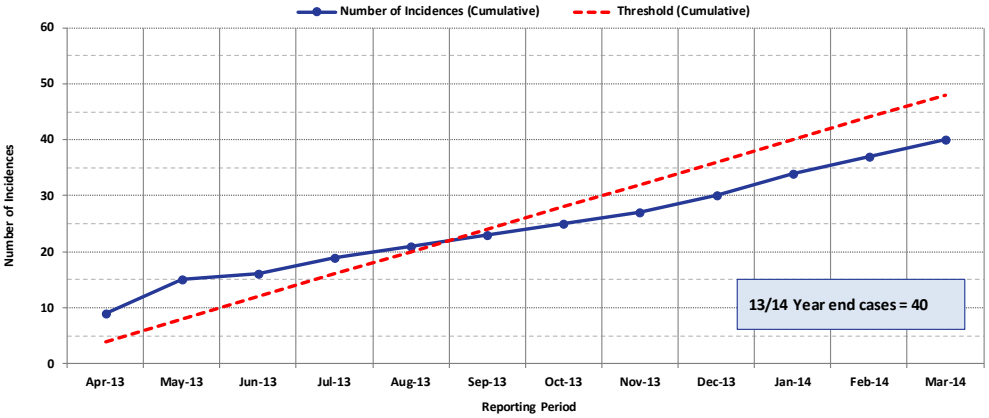
| | Apr-13 | May-13 | Jun-13 | Jul-13 | Aug-13 | Sep-13 | Oct-13 | Nov-13 | Dec-13 | Jan-14 | Feb-14 | Mar-14 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Number of Incidences (Cumulative) | 9 | 15 | 16 | 19 | 21 | 23 | 25 | 27 | 30 | 34 | 37 | 40 |
| Threshold (Cumulative) | 4 | 8 | 12 | 16 | 20 | 24 | 28 | 32 | 36 | 40 | 44 | 48 |

**Rationale**

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

**Results**

The Trust has achieved the target set for 2013/14 as there were 40 cases of CDI against a target of 48. This achievement is due chiefly to our effort in working with our staff and patients, as well as with our partners in the community and neighbouring trusts.



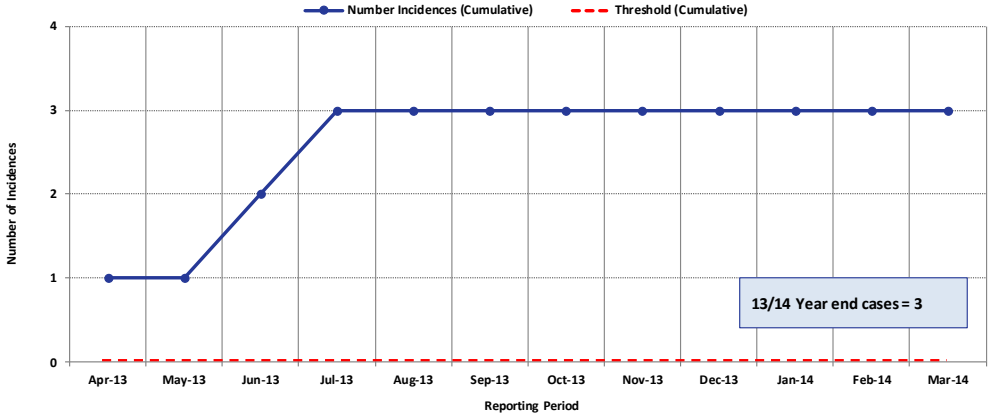

### Cumulative Incidences of Methicillin-Resistant Staphylococcus Aureus (MRSA)

| | Apr-13 | May-13 | Jun-13 | Jul-13 | Aug-13 | Sep-13 | Oct-13 | Nov-13 | Dec-13 | Jan-14 | Feb-14 | Mar-14 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Number of Incidences (Cumulative) | 1 | 1 | 2 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 |
| Threshold (Cumulative) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

**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**



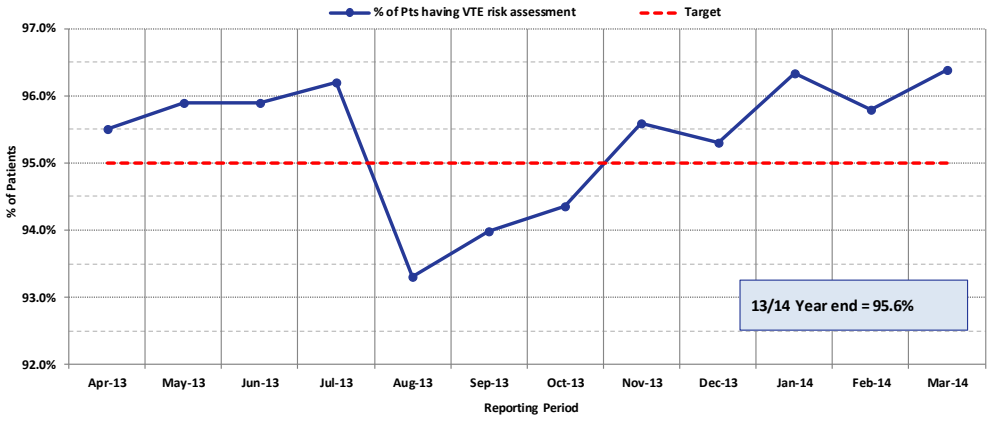
## Elimination of Avoidable Venous Thrombo-Embolism (VTE)

| | Apr-13 | May-13 | Jun-13 | Jul-13 | Aug-13 | Sep-13 | Oct-13 | Nov-13 | Dec-13 | Jan-14 | Feb-14 | Mar-14 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| % of Patients Having VTE Risk Assessment | 95.5% | 95.9% | 95.9% | 96.2% | 93.3% | 94.0% | 94.4% | 95.6% | 95.3% | 96.3% | 95.8% | 96.4% |
| Target (>= 95%) | 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**



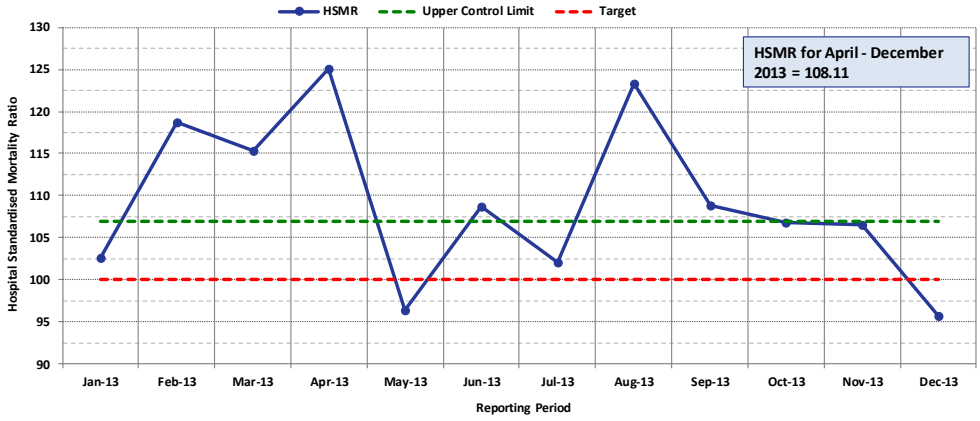

## Hospital Standardised Mortality Ratio (HSMR)

| | Jan-13 | Feb-13 | Mar-13 | Apr-13 | May-13 | Jun-13 | Jul-13 | Aug-13 | Sep-13 | Oct-13 | Nov-13 | Dec-13 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Hospital Standardised Mortality Ratio (HSMR) | 103 | 119 | 115 | 125 | 96 | 109 | 102 | 123 | 109 | 107 | 107 | 96 |
| Upper Control Limit (UCL) | 107 | 107 | 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**



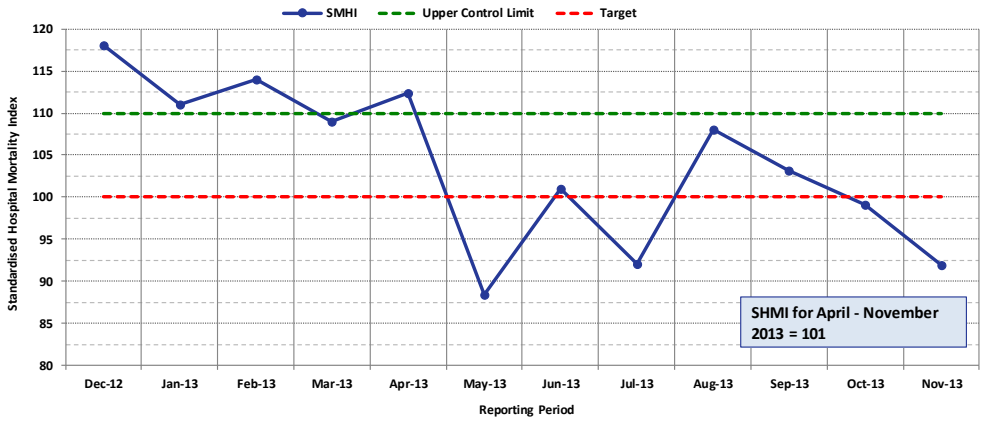
## Standardised Hospital Mortality Index (SHMI) *

| | Dec-12 | Jan-13 | Feb-13 | Mar-13 | Apr-13 | May-13 | Jun-13 | Jul-13 | Aug-13 | Sep-13 | Oct-13 | Nov-13 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Standardised Hospital Mortality Index (SHMI) | 118 | 111 | 114 | 109 | 112 | 88 | 101 | 92 | 108 | 103 | 99 | 92 |
| Upper Control Limit (UCL) | 110 | 110 | 110 | 110 | 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**




## 31 Days: Wait For First Treatment: All Cancers

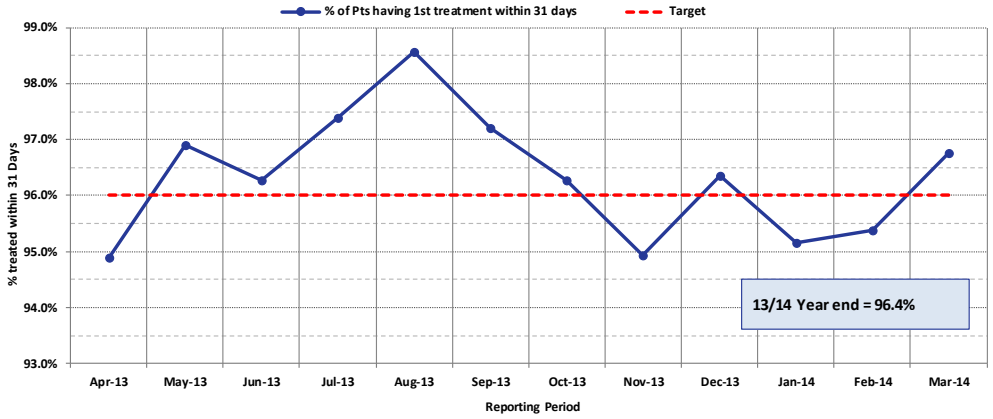
| | Apr-13 | May-13 | Jun-13 | Jul-13 | Aug-13 | Sep-13 | Oct-13 | Nov-13 | Dec-13 | Jan-14 | Feb-14 | Mar-14 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| % of Patients having their first treatment within 31 days | 94.9% | 96.9% | 96.3% | 97.4% | 98.6% | 97.2% | 96.3% | 94.9% | 96.4% | 95.2% | 95.4% | 96.8% |
| 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**

The Trust achieved overall however there were some patients who exceeded this standard due to patient choice and demand depending upon speciality.



## 31 Days: Wait For Second Or Subsequent Treatment: Surgery

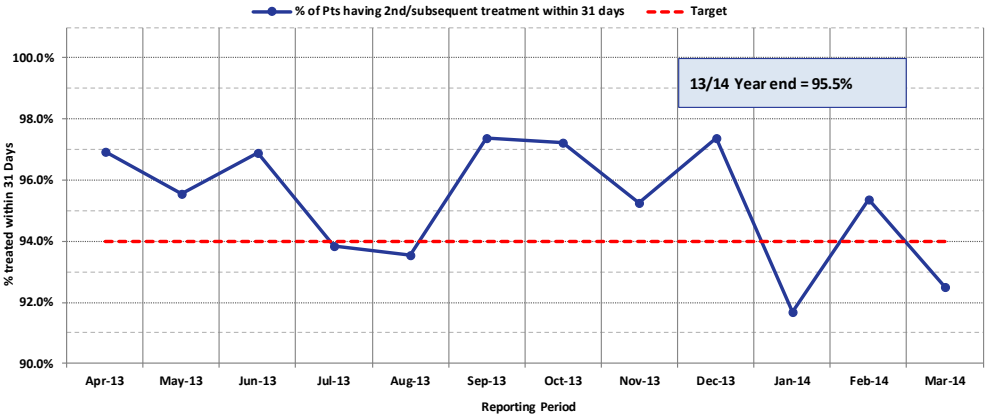
| | Apr-13 | May-13 | Jun-13 | Jul-13 | Aug-13 | Sep-13 | Oct-13 | Nov-13 | Dec-13 | Jan-14 | Feb-14 | Mar-14 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| % of Patients having their second or subsequent treatment within 31 days | 96.9% | 95.6% | 96.9% | 93.9% | 93.6% | 97.4% | 97.2% | 95.2% | 97.4% | 91.7% | 95.4% | 92.5% |
| 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**

Overall the Trust achieved however for those patients who did not meet this standard, this was due to reasons such as choice , complexity and demand upon certain specialities.




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

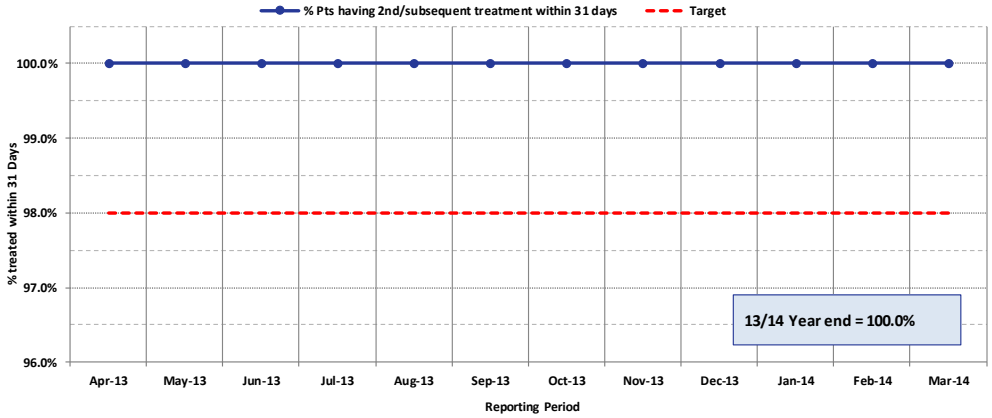
| | Apr-13 | May-13 | Jun-13 | Jul-13 | Aug-13 | Sep-13 | Oct-13 | Nov-13 | Dec-13 | Jan-14 | Feb-14 | Mar-14 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| % of Patients having their second or subsequent treatment within 31 days | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 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 achieved consistently.



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

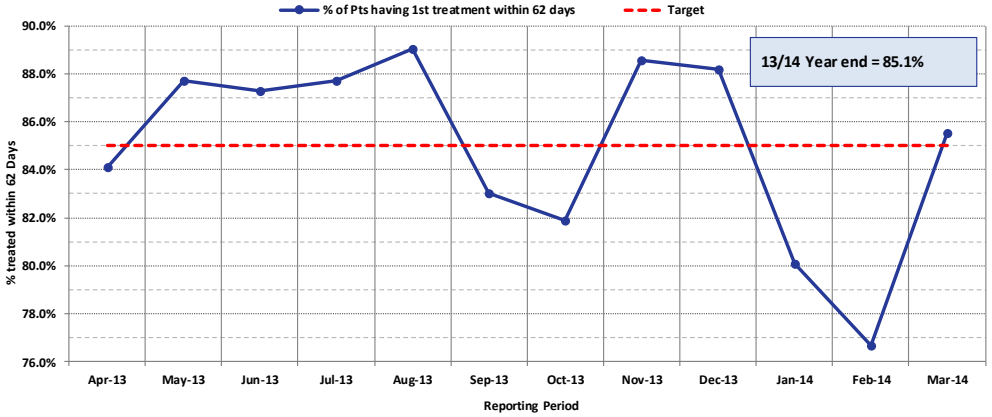
| | Apr-13 | May-13 | Jun-13 | Jul-13 | Aug-13 | Sep-13 | Oct-13 | Nov-13 | Dec-13 | Jan-14 | Feb-14 | Mar-14 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| % of Patients having their first treatment within 62 days | 84.1% | 87.7% | 87.3% | 87.7% | 89.0% | 83.0% | 81.9% | 88.6% | 88.2% | 80.1% | 76.7% | 85.6% |
| 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**

Overall the Trust achieved however for those patients who did not meet this standard, this was due to reasons such as choice , complexity and demand upon certain specialities.




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

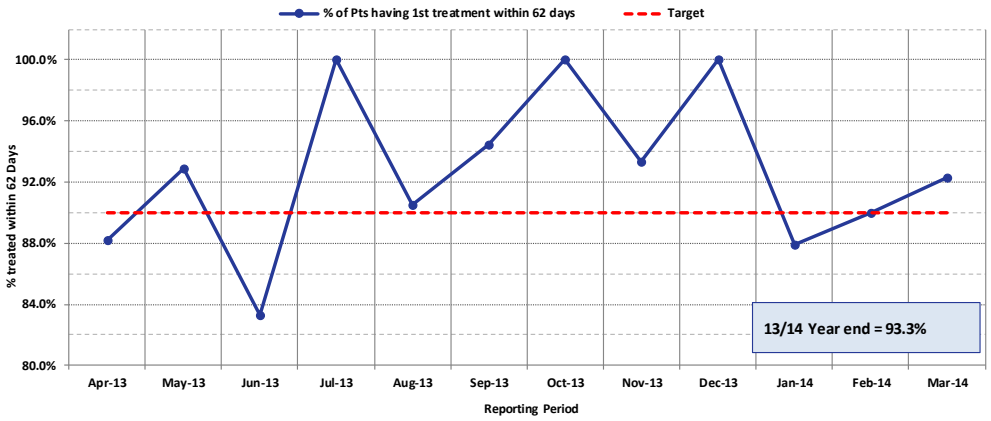
| | Apr-13 | May-13 | Jun-13 | Jul-13 | Aug-13 | Sep-13 | Oct-13 | Nov-13 | Dec-13 | Jan-14 | Feb-14 | Mar-14 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| % of Patients having their first treatment within 62 days | 88.2% | 92.9% | 83.3% | 100.0% | 90.5% | 94.4% | 100.0% | 93.3% | 100.0% | 87.9% | 90.0% | 92.3% |
| 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**

Overall the Trust achieved however for those patients who did not meet this standard, this was due to reasons such as choice , complexity and demand upon certain specialities.



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

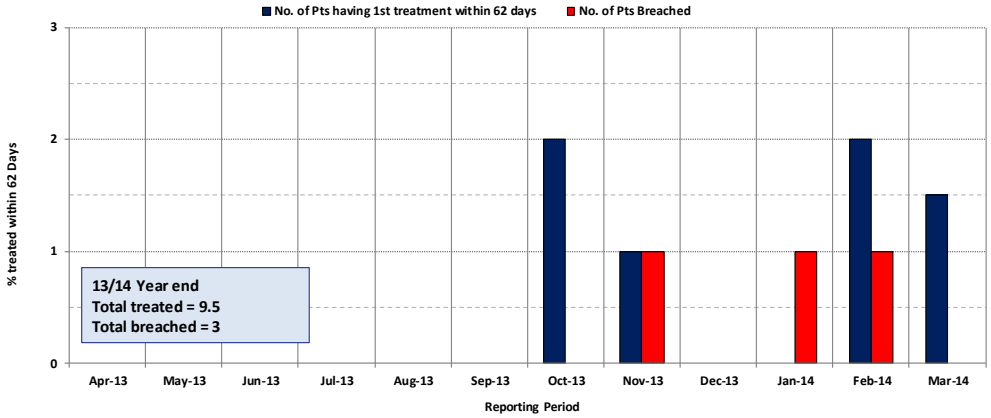
| | Apr-13 | May-13 | Jun-13 | Jul-13 | Aug-13 | Sep-13 | Oct-13 | Nov-13 | Dec-13 | Jan-14 | Feb-14 | Mar-14 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Number of Patients having their first treatment within 62 days | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 1 | 0 | 0 | 2 | 1.5 |
| Number of Patients breached | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 1 | 1 | 0 |

**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**

This needs to be seen in the context of numbers which is approximately 4 patients




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

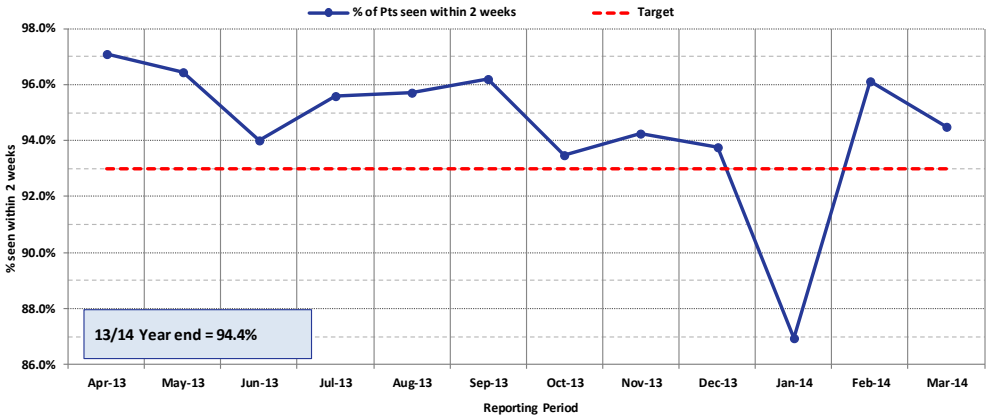
| | Apr-13 | May-13 | Jun-13 | Jul-13 | Aug-13 | Sep-13 | Oct-13 | Nov-13 | Dec-13 | Jan-14 | Feb-14 | Mar-14 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| % of Patients seen within 2 weeks | 97.1% | 96.5% | 94.0% | 95.6% | 95.7% | 96.2% | 93.5% | 94.3% | 93.8% | 87.0% | 96.1% | 94.5% |
| 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**

Overall the Trust achieved this standard however post Christmas holidays there was a decline in performance. This is multifactorial partly due to patient choice partly due to the Bank Holiday.



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

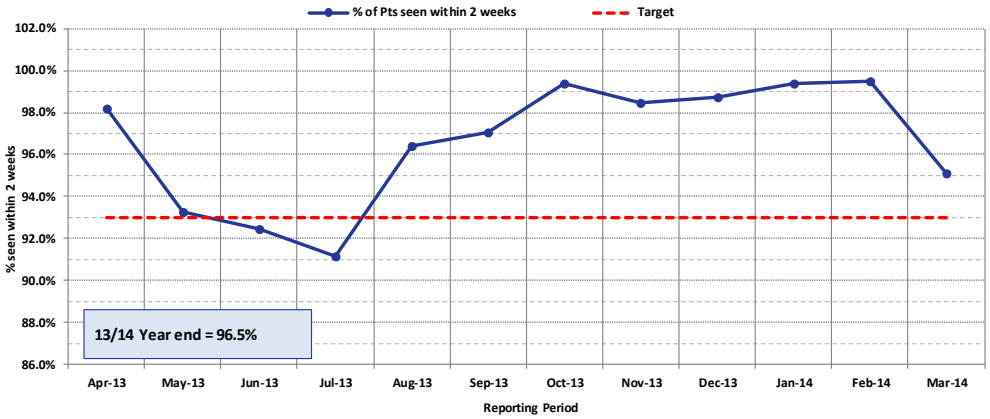
| | Apr-13 | May-13 | Jun-13 | Jul-13 | Aug-13 | Sep-13 | Oct-13 | Nov-13 | Dec-13 | Jan-14 | Feb-14 | Mar-14 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| % of Patients seen within 2 weeks | 98.2% | 93.3% | 92.4% | 91.2% | 96.4% | 97.1% | 99.4% | 98.5% | 98.7% | 99.4% | 99.5% | 95.1% |
| 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**

The Trust achieved overall however June and July posed a challenge




## Referral to Treatment (Admitted Pathway)

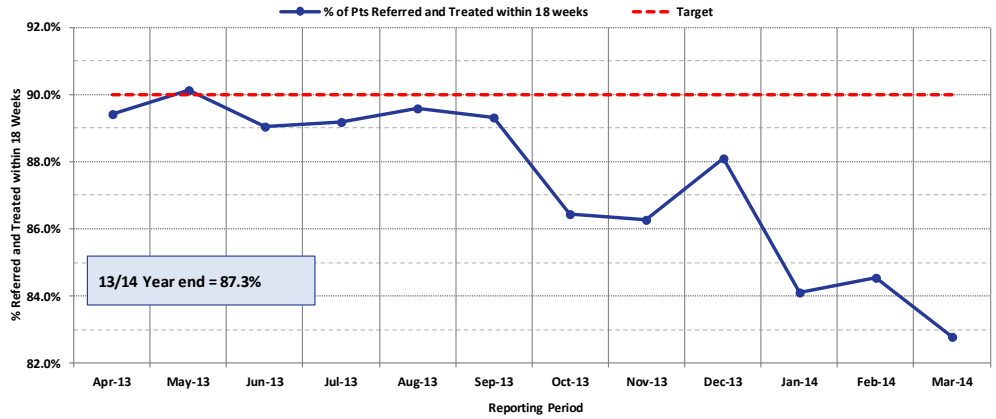
| | Apr-13 | May-13 | Jun-13 | Jul-13 | Aug-13 | Sep-13 | Oct-13 | Nov-13 | Dec-13 | Jan-14 | Feb-14 | Mar-14 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| % of Patients Referred and Treated within 18 Weeks | 89.4% | 90.1% | 89.0% | 89.2% | 89.6% | 89.3% | 86.5% | 86.3% | 88.1% | 84.1% | 84.6% | 82.8% |
| 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**

The current position regarding our admitted waits has not improved due to the 4.5% increase in referrals. The Trust remains constrained by the unprecedented high level of emergency activity impacting upon performance. Other factors are Norovirus, NHS111 ,Delays in transfer of care (5.0%) .



## Referral to Treatment (Non-Admitted Pathway)

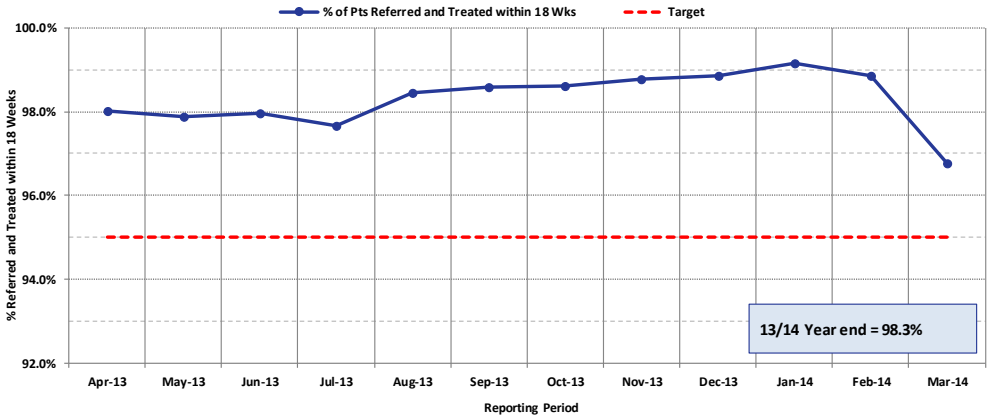
| | Apr-13 | May-13 | Jun-13 | Jul-13 | Aug-13 | Sep-13 | Oct-13 | Nov-13 | Dec-13 | Jan-14 | Feb-14 | Mar-14 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| % of Patients Referred and Treated within 18 Weeks | 98.0% | 97.9% | 98.0% | 97.7% | 98.5% | 98.6% | 98.6% | 98.8% | 98.9% | 99.1% | 98.8% | 96.8% |
| 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**

The Trust achieved overall




## Referral to Treatment (Incomplete Pathway)

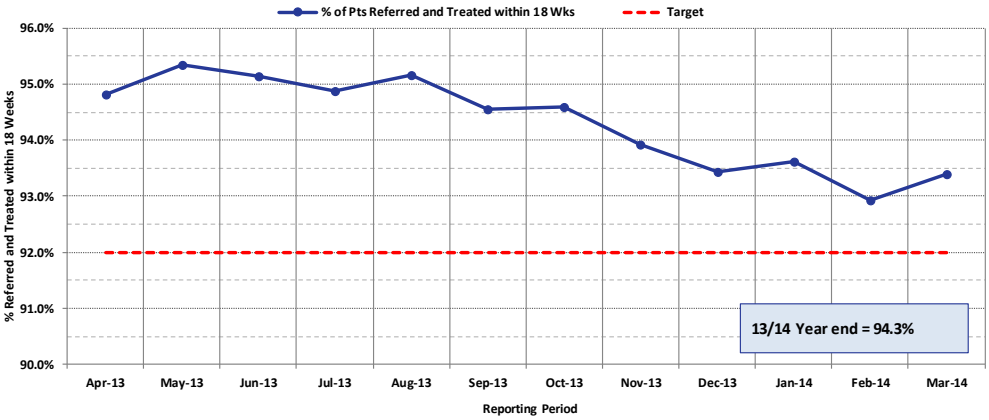
| | Apr-13 | May-13 | Jun-13 | Jul-13 | Aug-13 | Sep-13 | Oct-13 | Nov-13 | Dec-13 | Jan-14 | Feb-14 | Mar-14 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| % of Patients Referred and Treated within 18 Weeks | 94.8% | 95.3% | 95.1% | 94.9% | 95.2% | 94.6% | 94.6% | 93.9% | 93.4% | 93.6% | 92.9% | 93.4% |
| 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 13/14, but strong performance impacted over the winter period by extreme emergency demand.



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

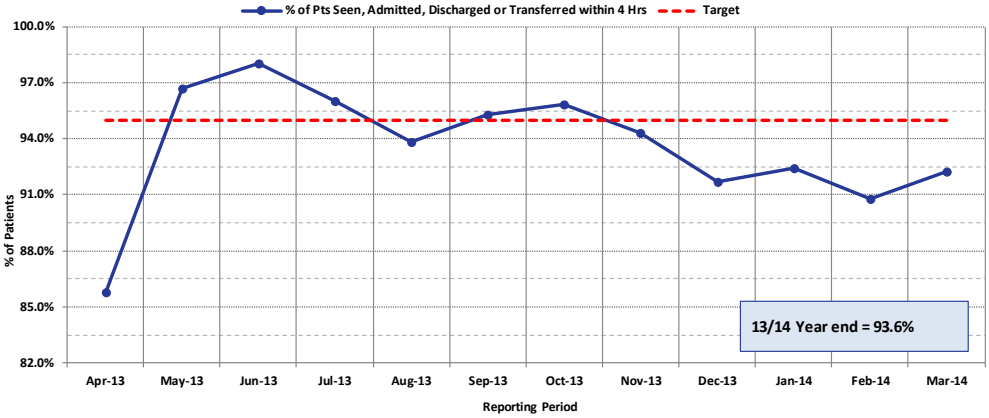
| | Apr-13 | May-13 | Jun-13 | Jul-13 | Aug-13 | Sep-13 | Oct-13 | Nov-13 | Dec-13 | Jan-14 | Feb-14 | Mar-14 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| % of Patients Seen, Admitted, Discharged or Transferred within 4 Hours | 85.8% | 96.7% | 98.0% | 96.0% | 93.8% | 95.3% | 95.8% | 94.3% | 91.7% | 92.4% | 90.8% | 92.3% |
| 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**

The Trust remains constrained by the unprecedented high level of emergency activity impacting upon performance. Other factors are Norovirus, NHS111 ,Delays in transfer of care (5.0%) . High levels of Ambulance activity presenting in surges, particularly in the evenings, leaving the departments at their maximum capacity.




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

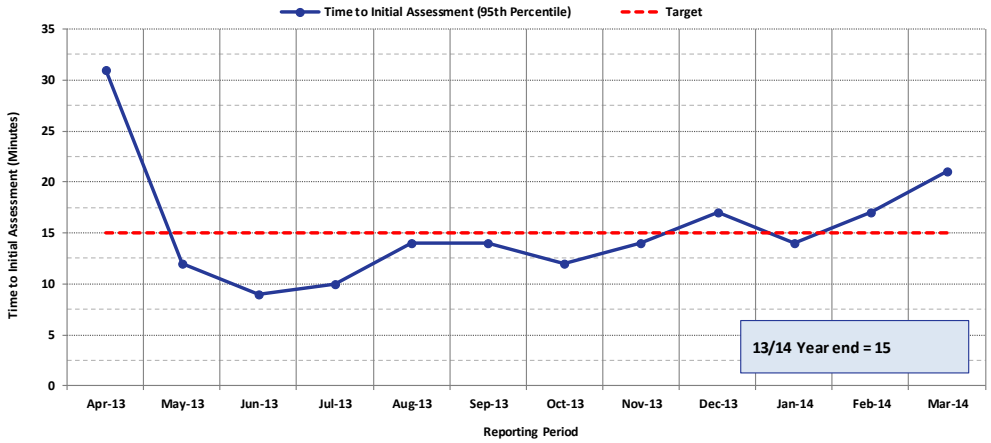
| | Apr-13 | May-13 | Jun-13 | Jul-13 | Aug-13 | Sep-13 | Oct-13 | Nov-13 | Dec-13 | Jan-14 | Feb-14 | Mar-14 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Time to Initial Assessment (95th Percentile) | 31 | 12 | 9 | 10 | 14 | 14 | 12 | 14 | 17 | 14 | 17 | 21 |
| Target (<= 15 Minutes) | <=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**

The Trust remains constrained by the unprecedented high level of emergency activity impacting upon performance. Other factors are Norovirus, NHS111 ,Delays in transfer of care (5.0%) . High levels of Ambulance activity presenting in surges, particularly in the evenings, leaving the departments at their maximum capacity.



## Time from Arrival to Treatment in Minutes (Median)

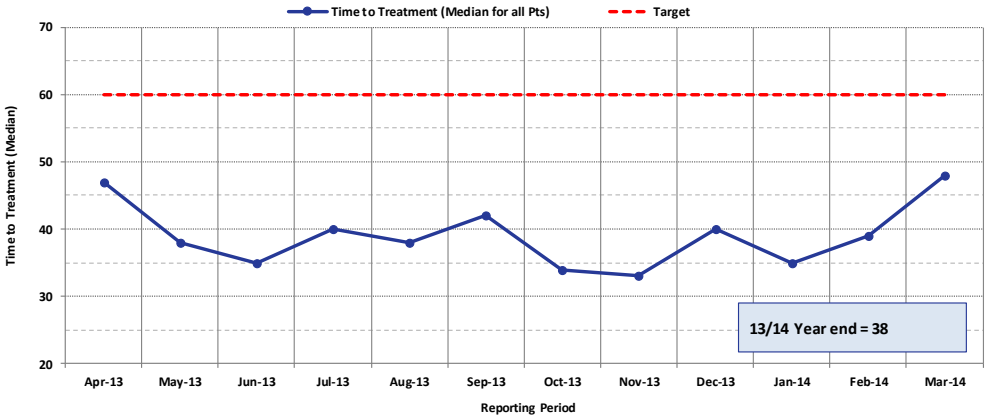
| | Apr-13 | May-13 | Jun-13 | Jul-13 | Aug-13 | Sep-13 | Oct-13 | Nov-13 | Dec-13 | Jan-14 | Feb-14 | Mar-14 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Time to Treatment (Median for all Patients) | 47 | 38 | 35 | 40 | 38 | 42 | 34 | 33 | 40 | 35 | 39 | 48 |
| Target (<= 60 Minutes) | <=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 appropriate treatment in a timely way.




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

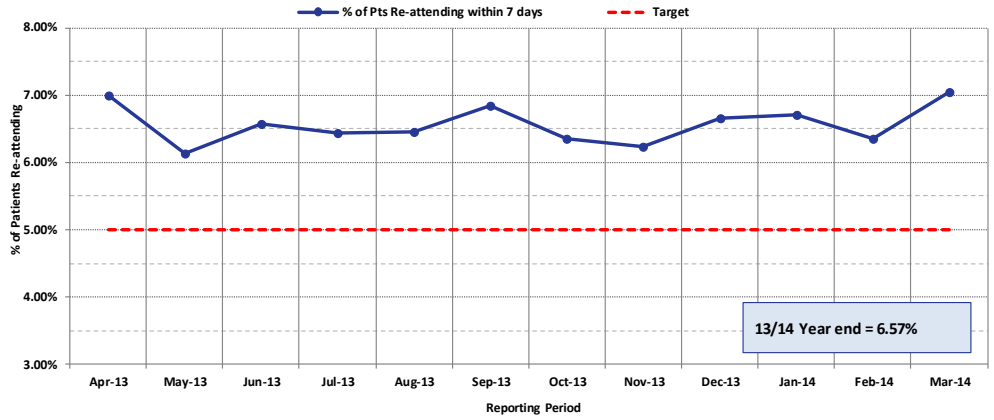
| | Apr-13 | May-13 | Jun-13 | Jul-13 | Aug-13 | Sep-13 | Oct-13 | Nov-13 | Dec-13 | Jan-14 | Feb-14 | Mar-14 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| % of Patients Re-attending within 7 Days | 7.00% | 6.14% | 6.57% | 6.43% | 6.45% | 6.85% | 6.36% | 6.23% | 6.66% | 6.70% | 6.35% | 7.05% |
| 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'.

**Results**

The Trust consistently recieves between 6-7% of re-attends 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.



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

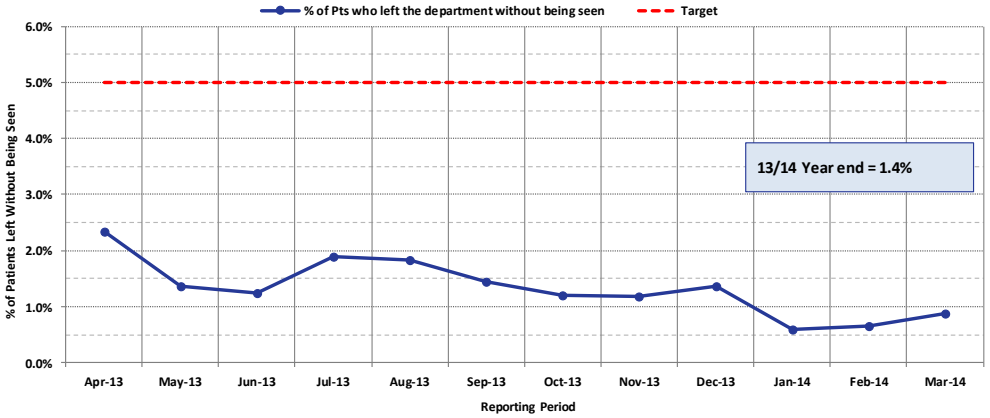
| | Apr-13 | May-13 | Jun-13 | Jul-13 | Aug-13 | Sep-13 | Oct-13 | Nov-13 | Dec-13 | Jan-14 | Feb-14 | Mar-14 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| % of patients who left the department without being seen | 2.3% | 1.4% | 1.3% | 1.9% | 1.8% | 1.5% | 1.2% | 1.2% | 1.4% | 0.6% | 0.7% | 0.9% |
| 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.




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

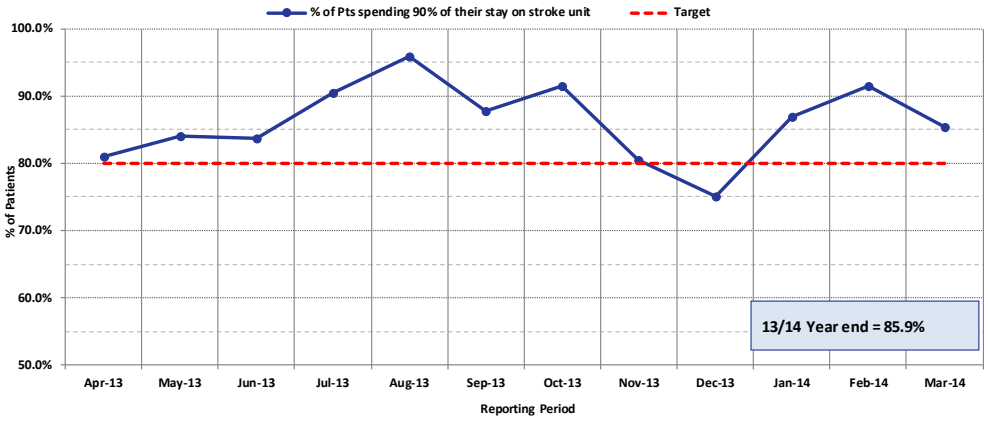
| | Apr-13 | May-13 | Jun-13 | Jul-13 | Aug-13 | Sep-13 | Oct-13 | Nov-13 | Dec-13 | Jan-14 | Feb-14 | Mar-14 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| % of Patients Spending 90% of their stay on the Stroke Unit | 81.0% | 84.0% | 83.6% | 90.4% | 95.9% | 87.7% | 91.5% | 80.4% | 75.0% | 86.9% | 91.4% | 85.4% |
| 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 achieved overall regarding length of stay however in December 2013 there was a shortage of downstream capacity with the community and to enable the admissions of acute stroke patients who were awaiting rehab had to be stepped down into a sub acute ward.



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

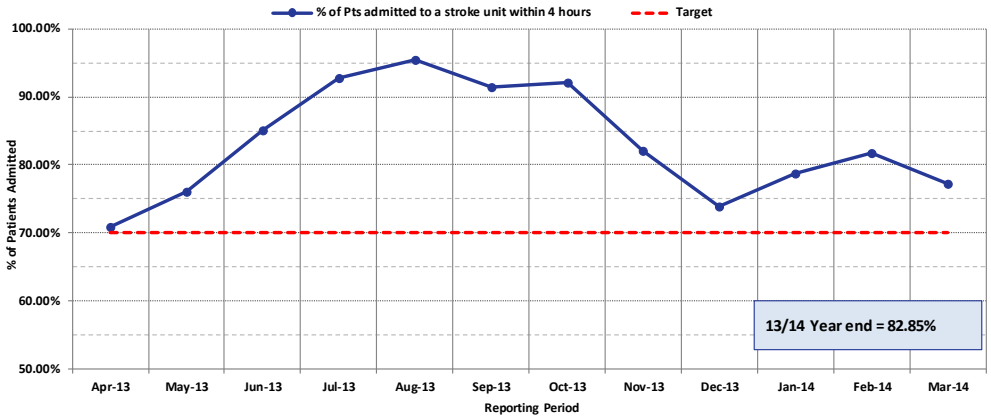
| | Apr-13 | May-13 | Jun-13 | Jul-13 | Aug-13 | Sep-13 | Oct-13 | Nov-13 | Dec-13 | Jan-14 | Feb-14 | Mar-14 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| % of Patients Admitted to a Stroke Unit Within 4 Hours | 70.83% | 76.09% | 85.11% | 92.68% | 95.35% | 91.49% | 92.11% | 82.05% | 73.91% | 78.72% | 81.82% | 77.27% |
| 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.




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

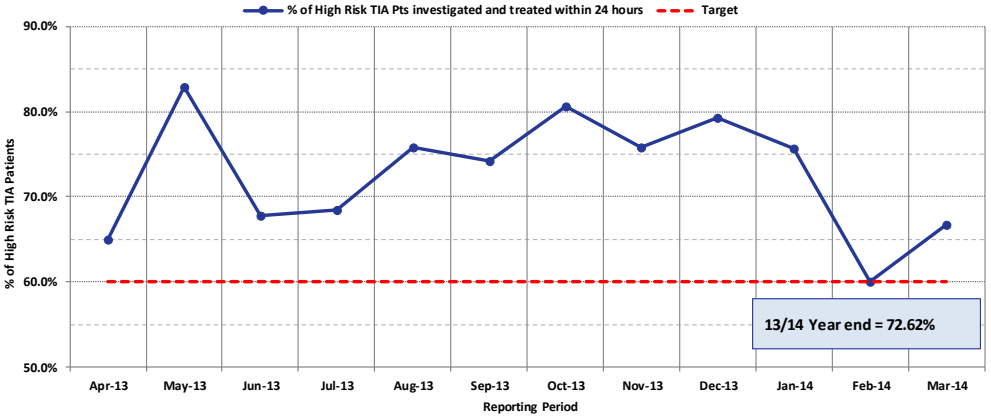
| | Apr-13 | May-13 | Jun-13 | Jul-13 | Aug-13 | Sep-13 | Oct-13 | Nov-13 | Dec-13 | Jan-14 | Feb-14 | Mar-14 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| % of High Risk TIA Patients Investigated and Treated Within 24 Hours | 65.0% | 82.9% | 67.7% | 68.4% | 75.9% | 74.2% | 80.7% | 75.8% | 79.3% | 75.7% | 60.0% | 66.7% |
| Target (>=60%) | >=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 has achieved overall



# Appendix 1 – Statements

### Worcestershire Health Overview and Scrutiny Committee (HOSC) Comments

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' Trust (the Trust) includes regular bulletins, specific presentations about proposals for significant changes, and board meetings, which HOSC's two lead members attend.

Overall Comments

1. The report, although long, is clear in its language and presentation, which makes it accessible to the reader. The new format of structuring the report around divisions makes it much easier to follow.
2. The report does an effective job of presenting questions and providing answers to those questions.
3. HOSC members would welcome some analysis of performance by hospital site.

Review of Quality Performance

1. The HOSC is pleased with progress around stroke services, which has been achieved through centralisation of services.
2. The HOSC is pleased with progress achieved with end of life care, as there have been some concerns raised around communication and handover, which we understand continue to be addressed by the Trust. To provide reassurance it remains important to communicate to the public the message that hospital is not always the most appropriate place to be for end of life care.

Priorities for Improvements 2014-15

1. Whilst endorsing the priorities listed in the report, HOSC members have concerns about patient flow, which will be looked at by completion of a desktop study of statistical data on the work of the hospital hub which manages the availability of hospital beds through monitoring the flow of patients in and out hospital.
2. The report should include further commentary about A&E performance, to reflect public concerns over activity and waiting times. HOSC has looked at on-going work by the Trust and other partners to reduce the pressures on A&E, and it remains important to reassure the public that this is improving.
3. Regarding patient discharge, HOSC members stress the importance of discharging patients at appropriate times during the day, and are pleased to hear about the Trust's new project 'Home for lunch'.
4. The report should explain the fact that several priorities have been carried forward from the previous year, such as pressure ulcers.
5. HOSC members would like the report to include further commentary on plans for birthing care.
6. The public has been concerned about a blanket approach to restricting visitors during outbreaks of norovirus, and understand that a more focused approach is planned for 2014/15.

Patient Experience

1. HOSC is interested in how the Friends and Family Test and the Trust's own patient experience feedback programme will evolve. HOSC is keen that patient feedback forums are representative of the local population and HOSC would give more weight to this type of patient feedback, compared to the patient stories selected for the Trust's Board meetings.

Board Meetings

1. The Board is encouraged to hold its meetings in an environment which compliments public engagement

## Our Commissioners - Worcestershire CCGs

**The response of NHS Redditch and Bromsgrove Clinical Commissioning Group (CCG), NHS Wyre Forest CCG and NHS South Worcestershire CCG to Worcestershire Acute Hospitals Trust Quality Account 2013/14.**

A significant component of the work undertaken by NHS Redditch and Bromsgrove CCG, NHS Wyre Forest CCG and NHS South Worcestershire CCG includes the quality assurance of NHS funded services provided for the population of Worcestershire. This includes steps to assure the public of the content of this Quality Account.

Suggestions made for previous Quality Accounts regarding the layout of the report, have in part been considered. There are many welcome explanations of significant terms and extended use of plain English in the body of the report. 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. This has in part been commenced with the introduction of Division specific improvement areas and may be developed further for the Quality Account of 2014/15.

Actions taken by the Trust in response to the Francis report (Inquiry into the failings of Mid Staffordshire Hospital) recommendations are welcomed in view of the transparency and open culture that the report hoped to create. The Clinical Commissioning Groups (CCGs) would like to continue to work in partnership with the Trust where there is early indication of an area where quality or patient safety falls below that expected. A number of Quality Assurance visits have been undertaken by Worcestershire CCGs, providing opportunity for positive levels of assurance for areas of concern raised. Plans to align CCG quality assurance visits with the Trusts processes for quality and compliance monitoring will provide opportunity for Quality and Patient Safety leads across both organisations to work closer together for the benefit of patients.

Areas of success highlighted within the Quality Account including the development of a Quality Strategy, reduction in the number of Clostridium difficile cases, work to limit the impact of Norovirus outbreaks and levels of reported pressure ulcers acquired within hospital are to be congratulated. Commitment to the restructuring and strengthening of governance and leadership is welcomed alongside a focus on improving processes by which concerns / complaints are resolved, managed and where necessary investigated. This has undoubtedly contributed toward the profile of the Trust, using the Care Quality Commission's Hospital Intelligent Monitoring banding, remaining at the lowest level of risk, band 6.

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 detail of actions that have been taken in response to a number of areas of identified concern and this level of transparency is what the public of Worcestershire deserve.

In areas where funding was conditional to the achievement of quality improvements (CQUINs) success has been seen, particularly in areas relating to the careful use of antibiotics to reduce the risk of Clostridium difficile (antimicrobial stewardship) and the care of people whose recovery from ill health was uncertain.

In 2013-14 Commissioners were required to issue a number of Contract Query Notices regarding issues of quality and performance with WAHT. Commissioners welcome improvements made in some areas (midwife to birth ratio) but continue to wish to see considerable improvements in areas where Contract Query Notices have been in place for some time (levels of staff mandatory training, the reviewing of diagnostic results). Actions in the following areas of concern are of priority for Worcestershire Commissioners in reducing avoidable harm and enhancing the patient experience:

- **Staff completion of mandatory training**
- **The timely review of requested diagnostics**

- **The recognition of impaired cognition (including dementia) for vulnerable patients and its contribution to patient safety incidents**
- **Reducing incidents that result in harm to patients, particularly falls resulting in significant injury**
- **Implementing timely learning following serious incidents by ensuring that investigations are undertaken promptly**

The Trust again failed to reach the agreed target reduction for falls for 2013-14. 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 repeat CQUIN scheme agreed for 2014-15, consideration of a reduction in falls resulting in serious harm would be welcomed as an improvement priority.

A number of additions would be welcomed. Detail of the actions being taken by the Trust to improve the retention of staff, enhance team effectiveness and strengthen engagement with its workforce would go some way to allaying concerns surrounding the potential impact of the Acute Services Review mentioned early in the Quality Account.

Whilst Commissioners agree with specific improvement aims and most priorities for improvement identified (for example a focus on improving waiting times for treatment in the Emergency Department to below 4 hours for at least 95% of patients), it is felt that reducing harm from all incidents, including falls resulting in serious harm, with the target of a reduction in the severity of harm experienced across all incidents, would be a more appropriate improvement priority than focusing specifically on one area of incident (medicines) that resulted in the lowest frequency of serious incident category reported. Commissioners welcome the level of detail provided regarding surgery mortality concerns at the Alexandra Hospital, including the requested review by the Royal College of Surgeons. Whilst the 'Quality Performance in 2013/14' for Cancer Services details welcomed improvements planned for 2014/15 there is minimal recognition of the impact of delayed cancer waits in 2013/14.

Overall Worcestershire Clinical Commissioning Groups believe the Quality Account for 2013-2014 to be a report that reflects most issues regarding the quality of health care services delivered by Worcestershire Acute Hospitals Trust.

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## Healthwatch

1. <u>Do the priorities of the provider reflect the priorities of the local population?</u>
   - The local Clinical Commissioning Groups (CCGs) have the flexibility to reflect their population's priorities and those of Worcestershire's Health and Well Being Board in the Trust's contract, and particularly the Commissioning for Quality and Innovation Payment framework (CQUIN) for 2014/15. The inclusion of improving participation in, and learning from, the Family & Friends Test; greater identification of dementia and cognitive impairment patients; and improving Patient Flow; reflect issues raised with Healthwatch during 2013/14. However, late night discharge has also been reported and should be avoided.
   - The inclusion of the national targets, to reduce infection (Priority 1), increase the number of patients waiting less than 4 hours in A&E (Priority 2) and providing services which meet the needs of children, young people and adults with mental health needs (Priority 7) are welcomed, as these safety concerns have also been raised during 2013/14.
   - The continuing developments in response to the Francis, Keogh, Berwick and Cavendish reviews, more timely response to and learning from complaints, and the greater involvement of patients and carers, particularly in the development of new radiology and maternity services, should help create public confidence in the range, safe delivery and consistency of quality healthcare provided by the Trust.

2. Are there any important issues missed in the Quality Account?

- The priorities for 2013/14 - achievement and progress - could identify which of these were national targets.
- It is helpful to set out the 2014/15 improvement aims for the 5 new Clinical Divisions, but we would encourage all the Divisions to seek regular patient/public feedback and compare against, and learn from, local/national benchmarking.
- In order to demonstrate the Board's intention to maximise Patient Safety and feedback, perhaps a chart could be included to show the reporting structure of the Patient Safety Group, Divisional Quality Committees, Patient & Carer Experience Committee, Patient & Public Forum, Quality Governance Committee etc., their membership and interaction.
- It may be timely to add a paragraph on the Acute Services Review, Integrated Care and Well Connected work which, once progressed, may have a beneficial effect on concerning rates of staff pressure, sickness levels, turnover, training and survey response figures.

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

- The involvement of patient groups/feedback to the Quality Governance Committee of the Board is unclear and could be better defined to demonstrate proactive effectiveness.
- With the reorganisation of the Clinical Divisions, the involvement of patients in the progress of their 2014/15 priorities and future developments is encouraged.
- Staff should also be encouraged to participate in surveys and contribute to service improvements.

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

- The document has a good introductory statement from the Chief Executive and is, in the main, understandable and informative.
- Although a glossary will be included, it would be helpful if abbreviations could be spelled out on their first use with the abbreviation in brackets for ease of use e.g. see section Medical Division, Improvement aims for 2014/15.
- The length of the document has increased to over 70 pages, which may discourage readership and involvement.
- It is unfortunate that the content is prescribed by the Department as the main areas of concern for the public could be in a much shorter publication with the details given in the Annual Report, rather than the Trust having to produce two extensive documents.

## Appendix 2 - 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. 28 May 2014

Penny Venables
Chief Executive ..... Date. 28 May 2014

Bev Edgar
Director of HR and OD ..... Date. 28 May 2014

Chris Fearns
Director of Strategic Development ..... Date. 28 May 2014

Stewart Messer
Chief Operating Officer ..... Date. 28 May 2014

Chris Tidman
Director of Resources
& Deputy Chief Executive ..... Date. 28 May 2014

Mr Mark Wake
Chief Medical Officer
..... Date. 28 May 2014

Lindsey Webb
Chief Nursing Officer
..... Date...2 June 2014

Prof. Julian Bion
Chair of the Quality
Governance Committee
..... Date. 28 May 2014

John Burbeck
Non-Executive Director /
Vice Chair
..... Date. 28 May 2014

Stephen Howarth
Non-Executive Director
..... Date. 28 May 2014

Bryan McGinity
Non-Executive Director
..... Date. 28 May 2014

Andrew Sleigh
Non-Executive Director
..... Date. 28 May 2014

Lynne Todd
Non-Executive Director
..... Date. 28 May 2014

## Appendix 3

## External Auditor's 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 2014 ("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 2014 subject to limited assurance consist of the following indicators:

- rate of clostridium difficile infections; and
- percentage of patients risk-assessed for venous thromboembolism (VTE).

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 2013/14 issued by the Audit Commission on 17 February 2014 ("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 2013 to June 2014;

- papers relating to the Quality Account reported to the Board over the period April 2013 to June 2014;

- feedback from the Commissioners dated 02/05/2014;

- feedback from Local Healthwatch dated 02/05/2014;

- feedback from other named stakeholder(s) involved in the sign off of the Quality Account;

- the latest national patient survey dated 16/04/2013;

- the latest national staff survey dated 25/02/2014;

- the Head of Internal Audit's annual opinion over the Trust's control environment dated 23/04/2014;

- the annual governance statement dated 03/06/2014;

- Care Quality Commission quality and risk profiles dated 01/04/2013 to 31/03/2014; and

- Care Quality Commission Intelligent Monitoring Reports dated 24/10/2013 and 13/03/2014.

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 44 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 2014. 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

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.

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- 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 2014:

- 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.

Grant Thornton UK LLP

Grant Thornton UK LLP

Colmore Plaza
20 Colmore Circus
Birmingham
B4 6AT

27 June 2014

## Glossary of Terms

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

| | |
|---|---|
| A&E | Accident and Emergency |
| ACE | 'Active Caring for Everyone' programme |
| Alex | Alexandra Hospital |
| AMD | Associate Medical Director |
| AMU | Acute medical unit |
| C. Difficile | Clostridium difficile |
| CCG | Care Commissioning Group |
| CDI | Clostridium difficile infection |
| CPA | Clinical Pathology Accreditation |
| CQC | Care Quality Commission |
| CQUIN | Commissioning for Quality and Innovation payment framework |
| CT | Computerised tomography scanning |
| ECH | Evesham Community Hospital |
| FF&T | Friends and Family Text |
| GP | General Practitioner |
| HASU | Hyper-Acute Stroke Unit beds |
| HCSW | Health Care Support Workers |
| HED | Healthcare Evaluation Dataset – a software programme that analyses the Hospital Episode Statistics data to make sense of statistics and allow a relative risk to be placed on healthcare outcomes |
| 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 |
| i.e. | that is |
| IP&C | Infection prevention & control |
| ISO | International Organisation for Standardisation |
| KGH | Kidderminster Hospital |
| MMS | Medicines Management Services |
| MRI | Magnetic resonance imagining |
| MRSA | Meticillin resistant Staphylococcus aureus |
| MRSA BSI | Meticillin resistant Staphylococcus aureus blood stream infections |
| NIHR | National Institute for Health Research |
| NRLS | National Reporting and Learning System |
| NTDA | NHS Trust Development Authority |
| PPCI | Worcestershire Primary Percutaneous Coronary Intervention - a treatment used following heart attacks |
| PPF | Patient & Public Forum (PPF), |
| Outlying speciality | This refers to a speciality requiring development and improvement so that it will care to the standard expected. |
| R&D | Research and development |

| | |
|---|---|
| RCS | Royal College of Surgeons |
| RIS | Radiology Information System |
| 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 |
| TACO | Theatres, Ambulatory Care and Outpatients Division |
| TDA | Trust Development Authority |
| TIA | Transient Ischaemic Attack - a 'mini' stroke |
| WHO | World Health Organisation |
| WMAHSN | West Midlands Academic Health Science Network |
| WRH | Worcestershire Royal Hospital |