Worcestershire Acute Hospitals NHS Trust

Quality Account

2014/15

Patients | Respect | Improve and innovate | Dependable | Empower

Taking **PRIDE** in our healthcare services

Section 1

1.1 Statement from the Chief Executive

I am delighted to present my fourth 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 2015/16.

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.

2014/15 has been a successful year on many fronts. We've seen a significant reduction in the number of patient falls across our three hospitals, we've achieved our C. difficile target and, although we did not meet the zero target for MRSA blood stream infections, we further reduced our number of cases to just one.

Despite an increase in the number of cancer referrals coming into the Trust, we met the majority of our cancer waiting time targets, narrowly missing the symptomatic breast 2 week wait, and the 62-day wait. A comprehensive action plan is in place to tackle these and ensure we get back on track.

The four hour A&E access target has remained a challenge. Although emergency admissions have reduced, A&E attendances and conveyances to A&E by ambulance have both increased. The complexity and frailty of patients we are treating is also much higher than it has ever been. This is also leading to longer hospital stays, which has had an adverse effect on our 18 week referral to treatment target.

The Trust received an unannounced, but not unexpected visit, from the Care Quality Commission to its two emergency departments in March. The CQC identified a number of areas which needed improving. At the time of writing this Quality Account, the Trust had actioned most of them and identified plans to ensure all the CQC's recommendations are carried out. Full details of the enforcement action taken, and the actions taken by the Trust are available in Section 2.3.5

We continue to work with our partners across the health and social care economy on a number of initiatives to help improve patient flow through our hospitals and, moving into 2015/16 there will be further actions that will be taken. This includes the opening of a mobile theatre on our Alexandra Hospital site in the spring, and the opening of a GP-led Urgent Care Centre at Worcestershire Royal Hospital in the summer.

Highlights of the past 12 months have undoubtedly been the long-awaited opening of our £25 million Worcestershire Oncology Centre, and the completion of our Meadow Birth Centre - both offering brand new services to county patients. There will be a chance to celebrate these significant achievements in April when we will welcome HRH The Princess Royal who is visiting both services.

I am also delighted that a number of our staff and services have been shortlisted for or won national awards. We have received recognition for excellence in ophthalmology, procurement, HR, anaesthetics and our chaplaincy services. Our own awards ceremony in

September – which formed part of a wider Staff Appreciation Week – also recognised 17 members of staff and teams for their outstanding achievements.

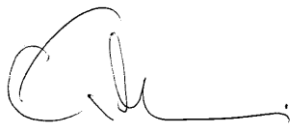
The next 12 months will see the opening of Worcestershire's dedicated breast care unit, marking the culmination of many years of fundraising from dedicated supporters. The unit will also contain a Haven centre which will enable people with breast cancer to benefit from free one-to-one emotional support and complementary therapies to help relieve the side-effects of treatment.

A whole host of plans are also in place to improve efficiency and patient experience across the Trust, including making improvements to our pre-operative assessment service, developing a theatre admissions unit at Worcestershire Royal and expanding our pharmacy service.

Following the General Election in May we are also expecting to receive the West Midlands Clinical Senate's report of the clinical model put forward by the Future of Acute Hospital Services in Worcestershire programme board, and we are looking forward to having an agreed clinical model which can be taken forward.

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 2014/15 to you which I believe to be a fair and accurate report of our standards of care across the Trust.



Chris Tidman
Acting Chief Executive

(PP: Penny Venables, Chief Executive

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WAHT is committed to continuous improvement of data quality. The Trust supports a culture of valuing high quality data and strives to ensure all data is accurate, valid, reliable, timely, relevant and complete. This data quality agenda presents an on-going challenge from ward to Board. Identified risks and relevant mitigation measures are included in the WAHT risk register. This report is the most complete and accurate position available. Work continues to ensure the completeness and validity of data entry, analysis and reporting.

Section 2 – Priorities for improvement 2015/16 & Statements of Assurance from the Board

The Trust's Annual Plan for 2014/15 set out how we would deliver further improvements in the quality of care provided to our patients and how our services would be developed over two years. 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 Priorities for improvement for 2014/15 & 2015/16 – progress

We identified seven improvement priorities where a particular focus was required to drive further improvement over a two-year period to 2015/16. Our progress with these in their first year and amendments made are described below:

1. Reduce the incidence of *Clostridium Difficile* (CDI) and Meticillin-resistant *Staphylococcus aureus* bloodstream infections (MRSA BSI)	Partially Met
Overview of achievement: • *C.difficile* trajectory achieved for 2014-15 Target of zero trust attributable MRSA bacteraemia not met with one case reported in March 2015	
Taking it forward: This improvement priority continues into 2015/16 under the **Sign up to Safety** priority and the following actions will be taken to maintain improved performance and promote zero tolerance: ***Clostridium difficile*:** A more challenging trajectory of no more than 33 hospital attributable cases is set by NHS England for 2015-16. The Trust will endeavour to achieve this with measures including: • Further antimicrobial stewardship • A sustained programme of hydrogen peroxide environmental decontamination both in response to cases and as part of routine environmental cleaning • Timely review of individual cases to ascertain new lessons to be learned • Health economy review of both hospital attributable and community *Clostridium difficile* cases to ascertain further lessons to be implemented **MRSA:** • Continued universal screening for emergency and elective admissions • Improved reporting of MRSA screening to select for high risk locations and procedures to ensure a focus in these areas	

2. Improve the number of patients waiting less than 4 hours in A&E to >95%	Not Met
Overview of achievement: • For the whole of 2014/15, the Trust achieved 90.22% of patients waiting less than 4 hours in A&E	
Taking it forward: This improvement priority continues into 2015/16. To maintain safety and improve patient experience it has been agreed that we will take a number of immediate and radical short term measures to minimise risk and extend this activity to include other clinical standards underpinning the Emergency Access Target.	

3. Improve mortality in outlying specialities to the national average	Partly Met
Overview of achievement: • A trust wide method to review each patient death in hospital has been introduced and is maturing • Directorates are holding mortality and morbidity review meetings and are continuing to develop • 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 is yet to be implemented	
Taking it forward: This improvement priority will be carried forward into 2015/16	

4. Improve outcomes and experience for patients with fractured neck of femur (hip)	Partly Met
Overview of achievement: • 80% of patients are now operated on within 36hrs of admission compared with the target of 90%. This is a considerable improvement from the range of 40-60% prior to the improvement programme. • A visible and encouraging improvement has been seen in timeliness of surgery along with a change in culture and attitudes developed through a multi-disciplinary approach and cross-site monthly meetings using teleconferencing.	
Taking it forward: This improvement priority will be carried forward into 2015/16	

5. Reducing harm from medicines incidents	Partly Met
Overview of achievement: • The e-prescribing project has been delayed due to supplier issues with roll-out. • The Trust has invested in medicines safety by appointing a Medicines Safety Officer and additional support to improve the reporting and learning from medicines incidents. • The Trust Medicines Safety Committee (MSC) receives quarterly Medicines Risk reports from all Divisions, summarising medicines incidents, actions and learning at Divisional level. MSC meets monthly and reviews all medicines related serious incidents to identify and share Trust-wide actions and learning. • In addition to the publication of Medicines Safety Bulletin on the Trust's Daily Brief, a Medicines Management Link Nurse scheme has been set up so that learning can be shared as soon as possible throughout the nursing workforce. • The Medicines Safety Committee has ensured that 100% of all F1 doctors working in the Trust have completed a core number of e-learning modules, concentrating on the prescribing of identified high risk medicines. • Medicines Management training has been reviewed across most staff groups to identify key priorities and ensure consistency between staff groups undertaking the same medicines-related tasks, and to ensure this training is recognised and documented.	
Taking it forward: 2015/16 • This improvement priority will be carried forward into 2015/16	

6. Reducing variation in mortality between week days and weekend working	Partly Met
Overview of achievement: • HSMR - The value for weekend emergency admissions is 104.8 for the Trust (AGH 110.1 =WRH 102.1) and for weekday emergency admissions 108.2 for the Trust (AGH 105.4 WRH 108.7). • SHMI - The SHMI value for the first quarter of 2014/15 (the latest information available) is 103.4 which lies within expected variation.	
Taking it forward: This improvement priority will be carried forward into 2015/16.	

7. To work with Partners to ensure services are commissioned to meet the needs of children, young people and adults with mental health needs	Removed
Overview of achievement: • The Trust continues to work with other partners to improve services in this area and is pleased to see an increasing focus on the need for improvement in this area.	
Taking it forward: This remains an important ambition in support of which the Trust will continue to work proactively with commissioners and other partners. • County wide strategy for the delivery of mental health care to patients in the acute setting • Service Level Agreement in place with Worcestershire Health & Care Trust identifying levels of support provided by the mental health teams • Confirmation from CCGs on the commissioning of mental health services	

2.2 Priorities for improvement 2015/2016

Our Quality Improvement Priorities were identified in 2014/15 and designed to be delivered over a two year period. These were developed with the input from the organisations described in 3.3 and 1, 2 and 3 were carried forward from 2012/13.

The priorities have been reviewed at year-end and revised to focus improvement activity for 2015/16. The changes are described below:

Quality Priorities 2015/16	Quality Dimensions			Additional CQC Quality domains	
	Safe	Effective	Caring	Responsive	Well-Led
1. Restore operational performance with a specific focus on Emergency Departments	✓			✓	
2. Sign Up to Safety Campaign	✓				✓
3. Improve outcomes and experience for patients with a fractured hip	✓	✓	✓		
4. Improve Mortality Surveillance	✓				✓
5. Reducing variation in mortality between week days and weekend working	✓	✓			
6. Reducing harm from medicines incidents	✓				✓

1. Restore operational performance with a specific focus on Emergency Departments	
CQC Domain: Safe, responsive	
Why this is a priority	Capacity constraints and compromised triage and assessment processes in the Worcestershire Royal Hospital Emergency Department leading to action by the Regulator (CQC) at the end of 2014/15
How we will deliver the improvement	Delivery of internal action plan to address the issues leading to the CQC concerns and conditions
Measures:	Compliance with the standard of triaging patients within 15 minutes Emergency Access Standard – 95% of patients seen within 4 hours Patient outcomes
Targets:	Emergency Access Standard and associated clinical standards
Reporting route:	Urgent Care Operational Team / Trust Management Committee Trust Board
Responsible Officer:	**Chief Operating Officer**

2. Sign Up to Safety Campaign	
CQC Domain: Safe, well – led	
Why this is a priority	The Secretary of State for Health set out the ambition of halving avoidable harm in the NHS over the next three years, and saving 6,000 lives; delivered through the Sign up to Safety Campaign
How we will deliver the improvement	• The Trust has developed a set of goals to support each of the five Sign up To Safety Campaign pledges over the next three years. • These will be turned into a safety improvement plan
Measures:	Number of harm events Staff attending appropriate training
Targets:	Reduce by half the number of harm events reported whilst remaining, overall, high reporting organisation

Reporting route:	Safe Patient Group Quality Governance Committee
Responsible Officer:	**Chief Medical Officer**

3. Improve outcomes and experience for patients admitted with a fractured hip	
CQC Domain: Safe, effective, caring	
Why this is a priority	To ensure we continue to build on the progress made during 2014/15 on this important indicator of quality of care
How we will deliver the improvement	Reconfiguration of theatre lists to improve timely access Delivery of urgent care strategy Improve utilisation of Trauma & Orthopaedic lists Improve access to orthogeriatrics and rehabilitation
Measures:	Improved utilisation Improved access to theatre session
Targets:	More than 90% of patients arrive in theatre within 36 hours of admission
Reporting route:	Quality Governance Committee
Responsible Officer:	**Chief Operating Officer/Chief Medical Officer**

4. Improve Mortality Surveillance	
CQC Domain: Safe, well-led	
Why this is a priority	The Trust acknowledges the need to make further progress to have in place a robust system of mortality surveillance.
How we will deliver the improvement	Following re-launch in March 2015, 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 Widen the usage of the Health Evaluation Data (HED) tool to enable more detailed analysis of mortality at a speciality level or hospital level within all Divisions Triangulation of quality indicators to identify factors that lead to harm Undertake targeted case note reviews Introduce systematic death certification reviews
Measures:	Divisional Mortality & Morbidity reporting Number of applicable Directorates using the HED tool Divisional level HSMR and SHMI Reporting
Targets:	Achieve a mortality ratio within the expected range for all diagnostic groups
Reporting route:	Divisional Quality Committees Safe Patient Group
Responsible Officer:	**Chief Medical Officer**

5. Reducing variation in mortality between week days and weekend working	
CQC Domain: Safe, effective	
Why this is 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 to maintain the trend of improvement for relative mortality risk for weekend admissions
How we will deliver the improvement	Review job plans in partnership with Consultants and HR, to enable routine weekend working including Consultant ward rounds Medical workforce plan to provide 7 day working Investment in development of roles such as Physician's Associate and Associate Nurse Practitioners. Re-introduce 'Hospital at Night'. Increase in diagnostic services
Measures:	Regularly review and compare weekend mortality rates with weekdays Hospital Standardised Mortality Ratio (HSMR) Summary Hospital Mortality Indicator (SHMI)
Targets:	First draft of Medical Workforce Plan in April 2015 Rolling job plan reviews at Divisional level
Reporting route:	Safe Patient Group
Responsible Officer:	**Chief Medical Officer/Chief Operating Officer**

6. Reducing harm from medicines incidents	
CQC Domain: Safe, well-led	
Why this is 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
How we will deliver the improvement	The implementation of an electronic prescribing system across the Trust, to reduce user error, aid medicines management and generate reports As part of the electronic prescribing system, introduce a patient discharge module that will produce electronic 'To Take Out' drugs (TTOs), to reduce the risk of error between primary and secondary care Developing a Medicines Optimisation Strategy to ensure our medical workforce are supported in the correct usage of medicines and have reliably safe practices and processes Target higher risk medications such as anticoagulation and insulin Introducing direct pharmacy support to the Emergency Departments Ward based medicines management supported throughout the Trust
Measures:	Harm associated with medicines Divisional reporting of harm / incidents
Targets:	Implementation of electronic prescribing Increase compliance with policies (e.g. antibiotics) and drug formulary Reduce adverse drug events / incidents
Reporting route:	Divisional Quality Committees Medicines Safety Committee, Safe Patient Group Quality Governance Committee
Responsible Officer:	**Chief Medical Officer**

2.3 Assurance Statements

2.3.1 Review of Services

During 2014/15 the Worcestershire Acute Hospitals NHS Trust provided and/ or subcontracted 45 NHS services.

Worcestershire Acute Hospitals NHS Trust has reviewed all the data available to them on the quality of care in 45 of these NHS services.

The income generated by the NHS services reviewed in 2014/15 represents 100% per cent of the total income generated from the provision of NHS services by the Worcestershire Acute Hospitals NHS Trust for 2014/15.

2.3.2 Participation in Clinical Audits and National Confidential Enquiries

During 2014/15, 45 national clinical audits and 4 national confidential enquiries covered relevant NHS services that Worcestershire Acute Hospitals NHS Trust provides.

During that period Worcestershire Acute Hospitals NHS Trust participated in 75% 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 NHS Trust was eligible to participate in during 2014/15 are as follows (see Table 1 & 2 below).

The national clinical audits and national confidential enquiries that Worcestershire Acute Hospitals NHS Trust participated in and for which data collection was completed during 2014/15, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry

National confidential enquiries

- NCEPOD (National Confidential Enquiry into Patient Outcome and Death)
- MBRRACE-UK (mothers and Babies: Reducing risk through audits and confidential enquiries across the UK)

	Worcestershire Acute NHS Trust Participation	Percentage of required number of cases submitted
NCEPOD		
• Gastrointestinal Haemorrhage	Yes	88%
• Sepsis	Yes	100%
• Lower Limb Amputation	Yes	88%
• Tracheostomy care	Yes	100%
MBBRACE	Yes	100%

No other confidential enquiries were carried out in 2014/15

National Clinical Audits

Name of National Audit	Trust Participation	Comments
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	✓	100% Action plan being monitored
Adult Community Acquired Pneumonia	✓	On-going

Name of National Audit	Trust Participation	Comments
British Society for Clinical Neurophysiology (BSCN) and Association of Neurophysiological Scientists (ANS) Standards for Ulnar Neuropathy at Elbow (UNE) testing	✓	100% Fully Compliant with the standards
Bowel cancer (NBOCAP)	✓	95% Action plan being monitored
Cardiac Rhythm Management (CRM)	✓	100% Action plan being monitored
Case Mix Programme (CMP)	✓	100% Compliant with the standards
Chronic Kidney Disease in primary care	✓	Only done in Primary Care
Congenital Heart Disease (Paediatric cardiac surgery) (CHD)	N/A	Do not provide this service
Coronary Angioplasty/National Audit of PCI	✓	100%
Diabetes (Adult)	N/A	Did not run this year
Diabetes (Paediatric) (NPDA)	N/A	The directorate is waiting until 2015 for national peer review allowing time for full implementation of action plan and embedding good practice so progress can be assessed in more meaningful manner.
Elective surgery (National PROMs Programme)	✓	Further information in section 3.5
Epilepsy 12 audit (Childhood Epilepsy)	✓	100% Actions being monitored
Falls and Fragility Fractures Audit Programme (FFFAP)	✓	96.9%
Fitting child (care in emergency departments)	✓	100% Alexandra 100% WRH
Head and neck oncology (DAHNO)	✓	91%
Inflammatory Bowel Disease (IBD) programme	✓	100%
Lung cancer (NLCA)	✓	100%
Major Trauma: The Trauma Audit & Research Network (TARN)	✓	37%
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)	✓	Further information in table below
Medical and Surgical Clinical Outcome Review Programme, National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	✓	Further information in table below
Mental health (care in emergency departments)	✓	100% Alexandra 100% WRH
National Adult Cardiac Surgery Audit	N/A	Do not provide this service
National Audit of Dementia	N/A	Nationally not started
National Audit of Intermediate Care	N/A	Do not provide this service
National Cardiac Arrest Audit (NCAA)	✓	51 cases started submitting data June 2014
National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme	✓	100%
National Comparative Audit of Blood Transfusion programme	✓	100%
National Confidential Inquiry into Suicide and Homicide for people with Mental Illness (NCISH)	N/A	Do not provide this service
National Emergency Laparotomy Audit (NELA)	✓	85%

Name of National Audit	Trust Participation	Comments
National Heart Failure Audit	✓	56%
National Joint Registry (NJR)	✓	104%
National Prostate Cancer Audit	✓	70% (Network figures)
National Vascular Registry	✓	100%
Neonatal Intensive and Special Care (NNAP)	✓	100%
Non-Invasive Ventilation - adults	✓	Nationally didn't take place
Oesophago-gastric cancer (NAOGC)	✓	>80%
Older people (care in emergency departments)	✓	100% ALX 0% WRH (not taking part)
Paediatric Intensive Care Audit Network (PICANet)	N/A	Do not provide this service
Pleural Procedure	✓	100%
Prescribing Observatory for Mental Health (POMH)	N/A	Do not provide this service
Renal replacement therapy (Renal Registry)	N/A	Do not provide this service
Pulmonary Hypertension (Pulmonary Hypertension Audit)	N/A	Do not provide this service
Rheumatoid and Early Inflammatory Arthritis	✓	100%
Sentinel Stroke National Audit Programme (SSNAP)	✓	70-80%

The reports of 13 national clinical audits were reviewed by the provider in 2014/15 and Worcestershire Acute NHS Trust intends to take the following actions to improve the quality of healthcare provided.

Action plans received for the following national audits

Audit Title	Response
Bowel cancer (NBOCAP)	The trust was an outlier in the outcomes for retained stoma rate of 72% compared to 51% nationally. The data reported is retrospective from April 2011 – March 2012. In 2013 the fusion of the two colorectal MDT's occurred and therefore the Surgeons are confident by using the information from an in-house Enhanced recovery database, that the Trust can provide assurance that there is a less than 50% stoma retention rate for this subset of Trust patients
Falls and Fragility Fractures Audit Programme (FFFAP)	WAHT compliance rates in meeting the standards set by British Orthopaedic Association, British Geriatric Society and BPT set by DH for Hip fracture care has improved in meeting most of the standards over the last 4 years. Surgery within 36 hours has shown steady improvement but remained below the national average. Provision of weekend operating lists and ring fencing of bed for hip fracture patients has helped and this is likely to result in sustained improvement. There have not been major structural changes so far. The improvement reflects leadership, change in culture and improved staff engagement. Regular Multidisciplinary countywide meeting video-linked with all sites including medical, nursing staff and managers is an important step towards consistency high quality care. Pathways have been developed and implemented. A new

Audit Title	Response
	Trauma Nurse Practitioner appointed. The Hip fracture group led by clinical director for trauma and orthopaedic are committed to improving standards of care.
British Society for Clinical Neurophysiology (BSCN) and Association of Neurophysiological Scientists (ANS) Standards for Ulnar Neuropathy at Elbow (UNE) testing	The National audit results provide assurance that Worcestershire Acute NHS Trust is fully compliant with the national guidance for Ulnar Neuropathy at Elbow Testing.
Epilepsy 12	The results showed that Worcestershire Acute NHS Trust was compliant in all 12 performance indicators for Epilepsy in children.
National Chronic Obstructive Pulmonary Disease (COPD) Audit programme	As a result of the results for the Secondary Care work stream of COPD the Trust is part of the selected few that have been approached to take part in a national initiative to implement COPD care bundles.
SSNAP Sentinel Stroke National Audit programme	The results have helped focus the stroke team and as a result there is a monthly stroke specialty meeting to discuss domains where actions are needed to make improvements and share new ideas and put into practice. There is investment in a new stroke management system that will alleviate pressures and ensure timely data entry for each stroke patient.
NELA (National Emergency Laparotomy Audit)	The National audit shows nationally that there is an issue managing emergency laparotomy patients. In our Trust a pathway is being developed and put in place between Anaesthetists and Surgeons to ensure appropriate management of emergency laparotomy patients.
NNAP	The Trust neonatal unit has been identified for good performance where all babies had temperature records and all were within one hour of admission. Only half of the national neonatal unit took the temperature of all their babies on time and recorded it.

Local Clinical Audits:

The reports of 117 local clinical audits were reviewed by the provider in 2014/15 and Worcestershire Acute Hospitals NHS Trust intends to take the following actions to improve the quality of healthcare provided:

The Clinical Audit Forward Plan is now an established part of the clinical audit process and it has helped the Trust over the last year provide focus around the priority areas of care. It is regular monitored via the Divisions and the Clinical Effectiveness Committee. It has enabled us to assurance to our regulators the Commissioners that we are continuously improving the quality of care provided to our patients.

To ensure that lessons learnt from the outcome of clinical audits are shared across the divisions.

Examples of clinical audits that have shown improvement in patient care are provided below.

Audit Title	Outcome	Improvement
Sepsis – Improving Management Dr Sumitra Kafle (FY1)/ Dr Mirella Ling (Consultant)	Antibiotics administration within an hour has risen. Lactate was performed in (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.	The Sepsis six care bundle will be developed into new clinical guidelines A reaudit will be undertaken in April 2015.

Audit Title	Outcome	Improvement
NICE guidelines CG108 Chronic Heart Failure in Cardiology Dr Ismail Badran (FY1)/ Dr Dzifa W Abban (Consultant)	The audit has revealed that many patients referred for open-access echo as "query heart failure with raised BNP" actually have undiagnosed AF.	A referral protocol has been put in place between GP and WAHT
Reversal of Warfarin for Patients Undergoing Neck Of Femur (NOF) Surgery Re-Audit Dr Arul Ramasamy (STR)/ Dr Chris Hill (ST5)/ Dr Peter Grice (FY1)/ Dr Karan Mangat (ST7)/ Dr Oliver Shastri (FY1)	Re-audit demonstrates that there is generally good compliance with Trust Guidelines and NICE guidelines on reversal of Warfarin for patients undergoing NOF fracture surgery • Only 1 patient potentially did not receive Vit K which could have delayed surgery • No patients had surgery delayed due to high INR	To re-iterate trust guidelines during departmental induction to ensure that new junior doctors working in Trauma & Orthopaedics are aware of the importance of Warfarin reversal for patients with a fractured hip
Audit of post-operative analgesia administration in patients with fractured neck of femur: with dementia Dr Stephanie Shayler (Career Grade) Dr Nicola Heron (Consultant)	The results show excellent adherence to the recommendations by NICE and WAHT that all patients admitted to acute settings due to a fractured neck of femur should undergo assessment of their mental state. They also demonstrated that such patients were prescribed paracetamol regularly (unless contraindicated) and most received a form of opioid in the 3 day post-operative period for analgesia. However, there was a marked discrepancy found in the medication received by patients with dementia compared to those without.	Use of an appropriate pain assessment tool for patients with dementia to ensure pain is recognised and recorded appropriately (ie, Abbey Pain Score) Consider prescription of paracetamol by alternative routes in all patients who have experienced a fractured neck of femur (ie, oral and intravenous) Consider the use of analgesia prescribed on a regular basis and incorporate the use of transdermal opioid patches such as Buprenorphine.
Identification and process for referral of urgent radiological findings to 2 week wait office (Adherence to NPSA standards) Dr Peter Holland (Consultant) Julian Freshwater (PACS Support Officer)	To demonstrate that the processes put in place by radiology across the Trust complied with NPSA guidance 16, and that they are robust.	The standard of 100% was achieved. The results reassure us that there is no risk to patient safety with regard to a failure to act on radiological imaging reports, and that the current process for referral to the 2 Week Wait office is robust. The evidence that referrers and referral sources have received and responded to an emailed report, and that all non-response is followed up by the Communicator team, provides the required 'safety net' to meet NPSA guidelines.

There is a new structured national audit process currently being developed within Worcestershire Acute NHS Trust to enable accurate and timely reporting on national clinical audits.

A new clinical audit management system will be available in summer 2015 this will enable clinicians and other clinical staff to manage their own clinical audit activity and provide real time monitoring reports and dashboards for the Divisions. It will provide assurance that the Trust has robust processes and procedures for following up the actions arising from clinical audits.

Clinical Audit Publications in 2014/15

Surgery:

How accurately does CRP predict anastomotic leak after laparoscopic colorectal surgery?
Published by: Dr P Waterland, Dr J Ng, Dr V. Decaro, Dr K Goonetilleke, Mrs D Nicol, Mr S Pandey in colorectal journal

An audit of enhanced recovery analgesia guidelines in colorectal patients.
Published by: Dr V.Decaro, Dr J.Marriott, Mrs D.Nicol, Dr L.Bone,
Presented in at the Euroanaesthesia 2015 Congress in Berlin.

Using Clinical Audit to Improve Sepsis Rates Post TRUS Biopsy
Published by: Dr N Gill, Mr V Koo, Dr A Dyas, Dr P Holland
Abstract in BAUS annual meeeting June 2014

TownHall PSA testing
Published By: Mr P,H. Rajjayabun
Presented at Royal College Surgeons (Edinburgh) Audit day March 2015.

Pinnaplasty outcomes and complications
Published by: Mr S Mitchell, Mr Hollis
Presented at Midlands institute of otology meeting 16 Jan 2015.

Women & Childrens:

Antenatal Management of Women over the Age of 40 years
Published by: R, Imtiaz, R.Salt
Presented at RCOG national conference in Manchester in Nov 27th and 28th 2014.

Clinical Support:

Documentation of Conclusions and TNM Assessment on Initial Staging CTs
Published by: S.Ali, U,Udeshi
European Society of Radiology in Vienna and UK

TACO:

A safer epidural service: an audit of compliance with standard monitoring of patients with epidurals for labour
Presented at GAT Annual Scientific Meeting 11-13th June 2014 – won prize for best oral presentation
Beard L, Stacey K, Millett S, Marriott J

2.3.3 Participation in Research

The number of patients receiving NHS services provided or sub-contracted by Worcestershire Acute Hospitals NHS Trust in 2014/15 that were recruited during that period to participate in research approved by a research ethics committee was 999.

This increasing level of 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.

There were 93 clinical staff leading or actively participating in research approved by a research ethics committee at Worcestershire Acute Hospitals NHS Trust during the financial year 2014/15. These staff participated in research covering 18 medical specialties.

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

2.3.4 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 7 CQUIN targets agreed with our main Commissioners, NHS Worcestershire, in 2014/15. They covered one or more of the domains of quality as shown in the table below. Our performance against each goal is given below: See **Appendix 1**

Further details of the agreed goals for 2014/15 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 5 CQUINS also provided in **Appendix 1**:

2.3.5 Registration with the Care Quality Commission (CQC)

Worcestershire Acute Hospitals NHS Trust is required to register with the Care Quality Commission (CQC) and its current registration status is registered with conditions.
Worcestershire Acute Hospitals NHS Trust has the following conditions on registration:

- Usual conditions: the regulated activates that WAHT has registered for may only be undertaken on our registered premises.
- Section 31 of the Health & Social Care Act: (See table below)

The CQC has taken enforcement action against Worcestershire Acute Hospitals NHS Trust during 2014/15.

- See the table below

Worcestershire Acute Hospitals NHS Trust participated in special reviews or investigations by the CQC during the reporting period (see table below).
Worcestershire Acute Hospitals NHS Trust intends to take the following actions to address the points made in the CQC's assessment.
Worcestershire Acute Hospitals NHS Trust has made the following progress by 31st March 2015 in taking such action (see table below).

Date	Inspection body	Type of inspection	Outcome	Actions taken
24/3/2015	CQC	Unannounced inspection of Emergency Departments	Section 31 condition - ensure every patient attending the emergency department at WRH has an initial assessment within 15 minutes of arriving at the hospital	1. Increased the number of assessment cubicles in the Emergency Department from 18 to 30 2. Reengineered patient flows enabling direct referral by GPs with specialist assessment units for appropriate patients. 3. Increased triage capacity

			Warning Notice – Regulation 15 – unsafe or unsuitable premises Warning notice – Regulation 16 – unsafe equipment Warning Notice – Regulation 22 – sufficient numbers of suitably qualified, experienced persons employed	to enable rapid assessment during periods of heavy demand. Regular scheduled review of any patient waiting in the department. Enhanced management of staffing numbers in Emergency Care through both prospective and retrospective review, 4. Introduction of the Emergency Department Assistant role to support clinical teams 5. Development of escalation policies to ensure effective management of patient flow during periods of peak demand. 6. Additional checks and audits of patient care are in place Weekly & monthly reports are made to the CQC on progress.

2.3.6 Quality of Data

Data Quality

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

The Trust is committed to pursuing a high standard of accuracy, completeness and timeliness within all aspects of data collection in accordance with NHS Data Standards.

The Trust has always put and continues to place high emphasis on recording and using good quality data to support patient care. Data Quality is integrated into the Trust's business processes and there is a structure of reporting throughout the organisation and to the Board. All staff are accountable for recording data accurately and supported by training, guidance and feedback on an ad-hoc basis and via internal and external audits. Regular monitor of key data is undertaken and issues are addressed promptly. The Trust liaises closely with the Clinical Commissioning Groups (CCGs) on any data quality concerns they may have from their commissioner role or raised by General Practioners (GPs).

Worcestershire Acute Hospitals NHS Trust submitted the following number of records during 2014/15 to Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published date:

- A&E records 136349
- Inpatient records 151221
- Outpatients 589491

The percentage of records in the published data are below.

Patient's valid NHS number was:
99.6% for admitted patient care;
99.7%for outpatient care; and
97.8% for accident and emergency care."

Patient's valid GP was:
100% for admitted patient care;
100% for outpatient care; and
100% for accident and emergency care."

Inpatient valid Ethnic Origin was:
96.9% for admitted patient care

Information Governance Toolkit Attainment

The Toolkit score for 2014 increased from 76% to 78% and has remained as an overall satisfactory level, with all of the standards achieving a minimum of a level 2. The overall score is likely to increase for the final submission at the end of March 2015 as the Trust has sufficient evidence in place to move from three standards from a 2 to a level 3. A recent external audit of the Toolkit standards covered secondary use assurance and corporate assurance and also included the three standards moving to a level 3. There are some recommendations from the audit which the Information Governance team intend to implement them before the end of March.

Worcestershire Acute Hospitals NHS Trust has taken the following actions to maintain and improve data quality in the Trust.

Data Steering Quality Group

During 2014/15, the Data Quality Steering Group has been reviewed in line with the Data Quality Policy. An Executive Lead is being appointed and there will be senior level division representation on the Group. The group will receive national guidance, comparative data quality reports, audit reports, and reviews Patient Administration System (PAS) enhancements and operational procedures to ensure data capture is completed in an accurate and timely manner. t will also support the data assurance element of the Information Governance (IG) toolkit.

NHS Number

One of the elements of IG and national standards is completeness of the NHS number. Our NHS number compliance averages 99%.

Board assurance around data quality is received through the Audit and Assurance Committee. Papers giving an overview of monitoring and improvement of data quality were presented in May 2014 and February 2015. The latter also covered recommendations for moving the data quality agenda forward in 2015/16.

A range of audits has been carried out by external auditors on behalf of the Trust to provide internal and external assurance regarding the accuracy and timeliness of its data. These include;

- Continuous audit cycle - In order to meet the requirements of the IG toolkit 506 standard, an auditor was employed by the Trust to conduct a continuous process of auditing case notes against the Trusts PAS. This process is documented in the Data Quality Policy and reports are included as a standing agenda item for the Information Governance meeting. The findings will be reported back to the Divisions as part of the IG reporting system due to be implemented in April.
- Clinical Coding / IG audit - In order to meet the IG Toolkit 505 requirements; an audit of 200 case notes was conducted in January 2015.
- Internal coding audits - A coding internal audit schedule is in place and the coding auditor has conducted several clinical and staff audits.

Clinical Coding Error Rate

In line with the requirements of the IG toolkit standard 505, a coding audit which included auditing 200 sets of case notes, was undertaken by an external coding auditor and the Trusts qualified coding auditor.

The table below shows the overall percentage of correct coding.

Primary diagnosis	90.2%
Secondary diagnosis	88.2 %
Primary procedure	81.3%
Secondary procedure	94.4%

The overall conclusion was ‘The Clinical Coding is of a generally high standard, but it was recognised that a reduction in the percentage for primary procedures needs to be addressed.’ 50% of the case notes audited were medicine, therefore by the nature of the specialty there are less procedures included in the audit which has increased the overall percentage of errors and omissions. Additionally the trust selected April 2014 data and the latest version of OPCS4.7 had just been introduced which did not provide sufficient time for the staff to be fully trained in its use. To address these issues a further batch of 100 sets of notes are to be audited and results recorded as an addendum to the report.

2.4 NHS Outcomes Framework Mandatory Indicators

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. They are set out under the NHS Outcomes Framework domains.

NHS Outcomes Framework Domain 1

Title	Indicator	2013/14	2014/15	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;	107.99 Banding 3	103.4 Banding 2 (Q1 2014/15)		 50.70 112.04 (Q1 2014/15)
	b) the percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period.				
	The Worcestershire Acute Hospitals NHS Trust considers that this data is as described for the following reasons:		2014/15 Data from the HSCIC is only available for Q1 at this time. The SHMI data for 2013/14 was revised during the year and is provided here.		
	The Worcestershire Acute Hospitals NHS Trust has taken the following actions to improve this number, and so the quality of its services, by:		See section 2.1 and 2.2		

NHS Outcomes Framework Domain 3

Title	Indicator PROMs casemix-adjusted scores	2013/14 Adjusted average health gain	2014/15 (provisional data –) Adjusted average health gain	National Average (provisional data -) Adjusted average health gain	Upper and Lower 95% control limit for the Trust (provisional data –) Health Gain
Patient Recorded Outcome Measures **(PROMS)**	(i) groin hernia surgery	0.427	0.085	0.081	Lower 0.036 Upper 0.126
	(ii) varicose vein surgery	No Data	No Data	0.100	
	(iii) hip replacement surgery	0.427	<30 records	0.442	
	(iv) knee replacement surgery	0.337	0.360	0.328	Lower 0.249 Upper 0.406
	The Worcestershire Acute Hospitals NHS Trust considers that this data is as described for the following reasons:		Provisional Monthly Patient Reported Outcome Measures (PROMs) in England - April 2014 to November 2014 With the data provided, surgery are in line with average health gain for these procedures		
	The Worcestershire Acute Hospitals NHS Trust has taken the following actions to improve this number, and so the quality of its services, by:		Improve collection of data for varicose veins Improve participation rates for hip replacement surgery		

Title	Indicator	2013/14	2014/15	National Average	Highest and lowest NHS Trust and Foundation Trust scores for the reporting period
Readmission rates	The percentage of patients aged (i) 0 to 14; and (ii) 15 or over, readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period.	i) 0.0% ii) 8.8% (emergency 28 day readmissions) i) 0.0% ii) 4.2% (Total 28 readmissions)	i) 0.0% ii) 9.4% i) 0.0% ii) 4.1%	Not available in required bands	Not available
	The Worcestershire Acute Hospitals NHS Trust considers that this data is as described for the following reasons:		Full year data.		
	The Worcestershire Acute Hospitals NHS Trust has taken the following actions to improve this number, and so the quality of its services, by:		Improved discharge arrangements, communication and packages of care across Worcestershire's health and social care organisations		

NHS Outcomes Framework Domain 4

Title	Indicator	2013/14	2014/15	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		Information not available from the HSCIC at this time		
	The Worcestershire Acute Hospitals NHS Trust considers that this data is as described for the following reasons:				
	The Worcestershire Acute Hospitals NHS Trust has taken the following actions to improve this number, and so the quality of its services, by:				

Title	Indicator	2013/14	2014/15	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.		Information on the survey results is provided in the text – comparative data not available from the HSCIC at this time		
	The Worcestershire Acute Hospitals NHS Trust considers that this data is as described for the following reasons:				
	The Worcestershire Acute Hospitals NHS Trust has taken the following actions to improve this number, and so the quality of its services, by:		See section 3.6 of this report		

(There is not a statutory requirement to report this indicator)

Title	Indicator	2013/14	2014/15	National Average	Highest and lowest NHS Trust and Foundation Trust scores for the reporting period
Patients who would recommend the Trust to their family or friends	The Trusts score from a single question survey which asks patients whether they would recommend the NHS service they have received to friends and family who need similar treatment or care.	96.1%	96.4%	2013/14 91.1 2014/15 90.9	Not available
	The Worcestershire Acute Hospitals NHS Trust considers that this data is as described for the following reasons:		Limited information available for comparison from the HSCIC at this time		
	The Worcestershire Acute Hospitals NHS Trust has taken the following actions to improve this number, and so the quality of its services, by:		Our responses have been good but we continue to seek improved completion rates and more comprehensive feedback. To do this we are utilising volunteers to help staff with distributing and collecting proformas to help maintain and improve completion rates, regularly visiting wards and meeting with staff to promote the F&FT and raising regularly with staff and patients and utilising data at ward level on our Patient information Boards to promote improved services and increase staff and patient morale. Regular oversight by our Patient Experience lead and reports to the Patient and Carer Committee to ensure oversight and support to increase completion and identify and respond to any issues / causes for concern all aimed at ensuring enhanced patient experience across our hospitals.		

NHS Outcomes Framework Domain 5

Title	Indicator	2013/14	2014/15	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	95.60%	95.20%	95.9% (Q3 2014/15) (NHS England website)	100% (Q3 2014/15) 81% (Q3 2014/15) (NHS England website)
	The Worcestershire Acute Hospitals NHS Trust considers that this data is as described for the following reasons:		WAHT VTE data for full year. England average only available for Q3 as 2014/15 NHS England Annual Report not yet published		
	The Worcestershire Acute Hospitals NHS Trust has taken the following actions to improve this number, and so the quality of its services, by:		Education of junior doctors and redevelopment of the paperwork required for the admission of patients to ensure VTE risk assessment is performed and recorded correctly.		

Title	Indicator	2013/14	2014/15	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.	14.02 Trust Dashboard & Reporting Services	12.66 Trust Dashboard and Reporting Services	39.00 (2013/14) (GOV.uk website)	85.50 (2013/14) 0.00 (2013/14) (GOV.uk website)
	The Worcestershire Acute Hospitals NHS Trust considers that this data is as described for the following reasons:		Indicator taken from C. diff number of occurrences over relevant financial year, divided by total number of bed days for relevant financial year. National average for 14/15 not available.		
	The Worcestershire Acute Hospitals NHS Trust has taken the following actions to improve this rate, and so the quality of its services, by:		A continued focus on antimicrobial stewardship and environmental cleanliness.		

Title	Indicator	2013/14	(Apr – Sep 2014) The latest data available	National Average (April – Sep 2014) 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,	Number of incident reports: <u>April 13 – Sept 13</u> 5276 <u>Oct 13 – Mar 14</u> 4970 <u>Rate of patient safety incidents:</u> <u>April 13 – Sep 13</u> • 8.26 per 100 admissions <u>Oct 13 – Mar 14</u> • 7.79 per 100 admissions	Number of incident reports 4536 Rate of patient safety incidents 36.21 incidents per 1,000 bed days	Number of incident reports 4196 (average) The median reporting rate for this cluster is 35.1 incidents per 1,000 bed days	For the cluster used by the NRLS: Highest number = 12,020 Highest rate = 61.2 Lowest number = 35 Lowest rate = 0.24
	the number and percentage of such patient safety incidents that resulted in severe harm or death	<u>April 13 – Sept 13</u> Number: 22 • 16 severe harm • 6 deaths Percentage: • 0.3% Severe harm ○ 0.1% deaths <u>Oct 13 – Mar 14</u> Number: 22 • 13 severe harm • 8 deaths Percentage: • 0.3% Severe harm ○ 0.2% deaths	Number = 27 • 18 severe harm • 9 deaths Percentage: • 0.4% severe harm • 0.2% deaths	Number =(averages) • 15.5 severe harm • 4.87 deaths Percentage: • 0.4% severe harm • 0.1% deaths	Number Highest: 74 severe harm Lowest: 0 severe harm Highest: 25 deaths Lowest: 0 deaths Percentage: Highest: 2.3% severe harm Lowest: 0% severe harm Highest: 0.8% deaths 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. • We are compared against a 'cluster' of similar large Acute Trusts so that the comparison is meaningful. • The National Reporting & Learning System changed it reporting method in 2014 and increased the Trusts included in the comparison of Acute non-specialist Trusts from 39 to 140		
	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		• We continue to promote incident reporting and an increase has been seen in the second half of 2014/15. • We have introduced our mortality and morbidity reviews to include every patient death in hospital to better understand underlying issues and learn from them. We have improved our investigation process and trained additional staff in investigation techniques. Other activities are described in this Quality Account		

Monitor - Risk Assessment Framework indicators	14/15	14/15 Target
% of Patients Referred and Treated within 18 Weeks - admitted	83.43%	90.0%
% of Patients Referred and Treated within 18 Weeks - non-admitted	96.05%	95.0%
% of Patients Referred and Treated within 18 Weeks - incomplete	91.90%	92.0%
% of A&E Patients Being Seen, Admitted, Discharged or Transferred Within 4 Hours of Presentation to ED	90.22%	95.0%
% of Patients having their first treatment within 62 days from urgent GP referral for suspected cancer[1]	82.43%	85.0%
% of Patients having their first treatment within 62 days from NHS Cancer Screening Service Referral[1]	91.36%	90.0%
% of Patients having their second or subsequent treatment within 31 days for surgery	96.28%	94.0%
% of Patients having their second or subsequent treatment within 31 days for anti-cancer drug treatments	100.00%	98.0%
% of Patients having their first treatment within 31 days from diagnosis	96.69%	96.0%
% of Patients seen within 2 weeks for all urgent referrals	93.13%	93.0%
% of Patients seen within 2 weeks for symptomatic breast patients	91.72%	93.0%
Clostridium (C.) difficile – number of occurrences	36	40.8

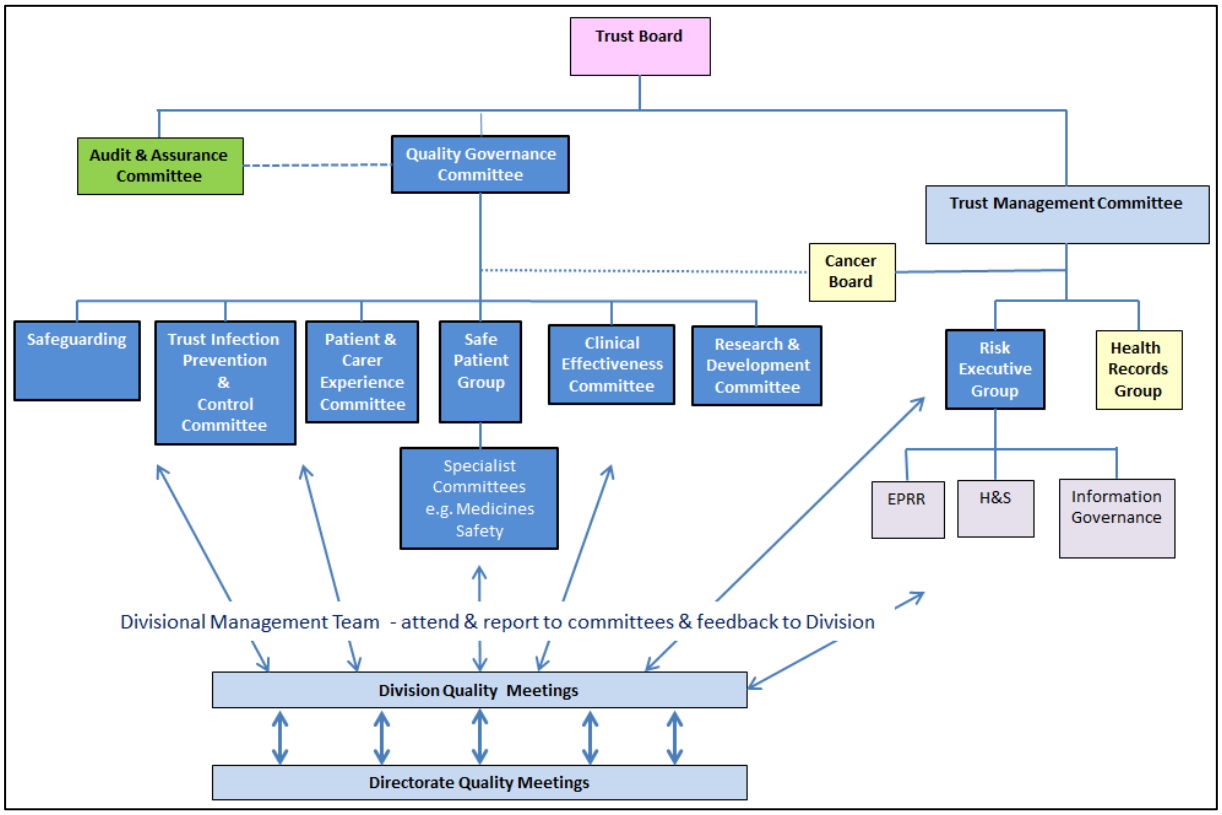
Source : Board Report QGC 12032015 - Quality & Outcomes
(Based on Apr 14 - Mar 15)

[1] The 62 day target does not include shared treatments and breaches

Section 3 – Review of Quality Performance

The Quality Governance Committee monitors the Trust's quality performance through a range of supporting specialist committees and reports. It reports to the Trust Board after each meeting. The development of supporting structures and teams in the Clinical Divisions after their creation in late 2013 has been an important feature of this year.

Worcestershire Acute Hospitals NHS Trust - Quality Governance Committee Structure



3.1 – Quality Highlights and Headlines

There have been many instances of quality and system improvements, successes and staff achievements that we have celebrated in this year. Some of these are provided below:

Nominations and Awards for Trust departments and staff:

Human Resources - National Healthcare People Management Awards (HPMA)

- **Reverend David Southall** – Winner in the innovations category for his good news blog at www.revdavidsouthall.com
- **The Human Resources team** – runner up for the best contribution to organisational change. The team has been recognised for its work to manage locum doctors more efficiently.
- **Bev Edgar** - **runner up for HR Director of the year**, after being nominated by staff for outstanding leadership skills and the positive impact she had during her time at the trust

Consultant Anaesthetist, **Dr Sally Millett** has been presented with the **Evelyn Baker medal for outstanding clinical knowledge and skill**.

She received the national award from the Association of Anaesthetists of Great Britain and Ireland (AAGBI). The Evelyn Baker medal, instigated by Dr Margaret Branthwaite in 1998, dedicated to the memory of one of her former patients at the Royal Brompton Hospital, recognises the 'unsung heroes' of clinical anaesthesia and related practice.

Barbara Kavanagh, leader of the Redditch community midwives, was **shortlisted** for the **NHS Community Leader of the Year Award**.

Ophthalmology team – 'Best glaucoma ophthalmic unit in the United Kingdom' International Glaucoma Association (IGA) annual awards

The IGA chose the ophthalmology team as their winner after nominations from both patients and from the IGA regional managers who visit hospital eye departments across the country.

Mr Sharma was also awarded the **Development Champion of the Year** in the NHS regional awards

Safe

- There has been a significant reduction in number of patients falling and sustaining a serious injury in hospital from 44 in 2013/14 to 23 in 2014/15
- To improve the way we investigate and learn from patient safety incidents, Investigation / root cause analysis (RCA) training is being provided for over 100 staff - Human factors training is also being rolled out to help to design systems to be resilient to human failure.
- We have taken action to ensure that we now meet the turnaround time of 45 working days for investigations into serious patient safety incidents to provide timely reports.
- We have further invested in Clinical Governance support teams within each Division to assist clinicians and managers

Effective

- More than 1,500 patients showing the warning signs of a stroke have benefited from Worcestershire's centralised stroke service. Since stroke services across Worcestershire were centralised at Worcestershire Royal Hospital, in July 2013 the service has exceeded its performance targets for all but one month.
- People living with diabetes in Worcestershire have seen health improvements after attending group education sessions to help manage their condition. Worcestershire Acute Hospitals NHS Trust, has received a national X-PERT Health award for the second year in a row, for the impressive number of patients attending diabetes education sessions
- Patients with irregular heart rates are benefiting from a nurse-led service now offered by Worcestershire Acute Hospitals NHS Trust's cardiac assessment nurses. The team has been running nurse-led cardioversion sessions at Worcestershire Royal Hospital, once a week since September 2013. These sessions have led to over 80 patients receiving treatment from the team, with a 90% patient success rate
- We have introduced a review of every death of a patient in hospital to understand any contributory factors – our mortality review process
- We have improved our screening of admitted patients for dementia to meet the 95% target
- The Accident and Emergency Department Survey 2014 report found that A&E departments at both the Alexandra Hospital and the Worcestershire Royal Hospital run by Worcestershire Acute Hospitals NHS Trust, scored higher than the national average on privacy, communication, comfort and aftercare among others areas.
- On-line Treatment Pathways – We are bringing together national standards with local guidelines, policies, procedures and patient information in an easily accessible and intuitive form to all care providers in Worcestershire. http://www.worcsacute.nhs.uk/healthprofessionals/worcestershire-treatment-pathways/

Caring

- We have seen a reduction in the number of complaints made and we have improved the timeliness of our response
- Nearly ninety per cent (88%) of cancer patients rated their hospital care as excellent or good, according to latest figures. The National Cancer Patient Experience Programme's 2013/14 survey of 794 cancer patients treated at Worcestershire Hospitals NHS Trust, shows performance has been maintained in several key areas, with improvements in 21 out of 62 areas.

- Patients have branded the Hereford and Worcester Abdominal Aortic Aneurysm (AAA) screening programme 'first-class' in a recent satisfaction survey. The service, offered to patients across Herefordshire and Worcestershire, invites all men for AAA screening during the year they turn 65, that's over 5000 men a year. Men over 65 can request screening by contacting the service directly. Out of the 291 patients surveyed, 99% said they would recommend the AAA screening service to their male friends or relatives aged 65 or over. 100% stated they were happy with their screening experience

Responsive

- The new Worcestershire Oncology Centre with Radiotherapy facilities opened in January 2015. With the support of our partners Coventry and Warwickshire NHS Trust, the centre provides 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.

- The Patient Flow Centre is a joint initiative that will co-ordinate and support the early discharge of patients through one referral for health and social care. This integration of care across different organisations is designed to improve patient experience and flow by planning discharge and care arrangements when a patient is admitted.

Fundraising:

- **Rory the Robot -** An appeal to change the future of prostate cancer surgery in Worcestershire has raised £42,000 towards its £1.6 million goal.

Well-led

- Members of the Trust attend and actively support events with stakeholders from across Worcestershire to improve a Culture of quality in healthcare
- We have invested in our risk management support to help better identify and manage risk to patients, staff and the business of the Trust, including the assessment and management of sustainable safe services for patients.

- Each non-executive director is linked to a Division to work alongside them offering support and challenge and enabling them to triangulate information presented to them

Caring for staff:

Trust welcomes publication of Freedom to Speak Up report

The Board fully supported Robert Francis' 'Freedom to Speak Up' report and reaffirmed and strengthened the existing role of Non-executive Director Stephen Howarth who says-

> *"Anything that can be done to make staff feel more at ease with raising concerns has to be a positive thing. There can never be too many channels in place for staff to be able to speak up."*

The Big Thank You

This is our internal scheme to recognise staff for their outstanding contribution and hard work. The monthly award recognises frontline staff, and gives them the opportunity to meet with senior managers informally.

"Big Thank You's" in 2014/15:

- Out of Hours nurse practitioners
- On-call managers and matrons
- Birch and Cedar Day Units
- WRH obstetric physiotherapists
- Ward 10 (Alexandra Hospital)
- Emergency departments
- Worcestershire Royal Hospital Obstetric theatre team

Staff surgeries - The Chairman, Chief Executive and Chief Nursing Officer all hold confidential one to one 'staff surgeries' with staff to talk about their experiences at the Trust

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2015 - year of the Healthcare Support Worker - Throughout 2015 we will be celebrating the excellent work that our care support workers do across the Trust

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Dragon's Den

Nurses from across the Trust pitched their quality improvement ideas to our very own (friendly) 'dragons' in a Dragon's Den event to celebrate International Day of the Midwife and International Nurses Day in May 2014. Six ideas - all based around the 6Cs and enhancing patient experience – were presented to Chief Executive Penny Venables, Chief Nursing Officer Lindsey Webb, Director of Human Resources and Organisational Development Bev Edgar, and Assistant Director of Finance Rob Pickup, with the aim to get funding to take them forward. The pitches were so impressive all were 'bought into'!

- a pilot of different water jugs and bottles to prevent dehydration of inpatients
- a patient hand-held wallet for advanced care planning documentation around end of life care;
- the development of an e-learning package on respiratory failure and oxygen safety
- improving the acute hospital environment for patients at the end of their life;
- reducing the risk of falls with further investment in Sara Steady's (walking aids)
- Pop up Reminiscence Pods or 'RemPods' to turn clinical care space into a therapeutic and calming environment for elderly patients

The "Dragons"!

Staff Appreciation Week

A series of events took place during the week of 29th September to show appreciation for the amazing work carried out around the clock by dedicated hospital and wider NHS staff

- Hundreds of NHS staff, volunteers, local dignitaries and members of the public packed into Worcester Cathedral for a Service of Celebration of local NHS workers on Sunday 28 September.
- A Staff Appreciation Day was held across all three hospitals on Tuesday 30th September
- Staff Achievement Awards were held on Friday 3rd October.

Staff Awards Winners 2014

Nurse of the year	Rebecca McCubbin, Respiratory Nurse Specialist
Midwife of the year	Nichola Wilcox, Midwife
Doctor of the year	Mr Adel Makar, Consultant Urologist
Health care assistant of the year	Freddie Davies, Health Care Assistant
Allied health professional of the year	Sandra Finch, Occupational Therapy Assistant
Non-clinical employee of the year	Veronica Smith, Fast Response Supervisor
Leader / manager of the year	Mr Tarun Sharma, Clinical Director For Ophthalmology
Team of the year	Supervisors of Midwives
Enhancing patient experience award	Ward 5 and respiratory nurses
Patients' choice award	Kate Baldwin, ENT nurse practitioner
Apprentice / student of the year	Laura Moore, Theatre Admin Support
Volunteer of the year	Jeffrey Harley, Patient Support Group
Rising star	Rosie Harper, Clerical Assistant
Friends and family award	Clare Bush and Lisa Spencer, A&E sisters
Lifetime achievement award	Dave Thombs, Theatres Charge Nurse
Chief Executive's special award	Rachel Montgomery, Pharmacist
Chairman's special award	David Southall and Elaine Bevan-Smith, COPD choir leaders

3.2 Reports from our Clinical Divisions:

3.2.1 Surgical Division

Services provided:

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 2014/15:

The Division of Surgery has been further developing its surgical pathways with the aim of continuing to improve patient safety and quality of care by ensuring patients are treated at the site most appropriate to their care needs. There has also been a focus on developing sub-specialities on the other sites i.e. vascular services at the Alexandra Hospital

The Division has further improved its “Emergency Surgery Pathway” that was introduced in February 2014 so the more acutely ill patients are treated at Worcestershire Royal Hospital. This has seen an improvement in patient safety and a reduction in the clinical risk to this group of patients.

Work has been progressing to improve the experience for those patients who attend our service with a fractured neck of femur (hip) with the aim that patients attend the operating theatre within 36 hours of admission by implementing 7 day working. This remains a challenge due to multiple factors and a multi-disciplinary Fractured Neck of Femur Group has been established to help further improve service delivery. The improvement is noticeable with 89% of patients presenting with a fractured hip being seen since implementation in 2014.

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.

The Division remains challenged in delivering the national 18 week referral to treatment target (RTT), which measures the waiting time from a patient being referred to them receiving hospital treatment. The pressures on all in-patient beds have affected our ability to achieve this target and alternative ways of delivering this are being explored. The Division is meeting all targets for breast services.

As part of its review of services, the Division has been reviewing its theatre capacity and realigning its operating lists across all 3 sites, to ensure maximum use of its theatres. Once this reconfiguration is completed, the Division should see a marked improvement in its treatment times and a reduction in the number of patients being cancelled at short notice due to capacity issues.

Recruitment of trained nurses has continued to be a challenge for the Division. Actions taken to improve this have included; participating in recruitment days both within the Trust and in conjunction with external organisations, commencing staff rotation and giving staff the support and mentorship required in order to progress in their careers.

Currently we have a number of additional acting Band 6 posts to help succession planning for the future. The Division has also produced a 'talking heads' style recruitment video which is available to view on social media.

The Division has worked hard to improve both its response times to complaints and improve upon the content and quality of its responses; now above 90% responded to within timescale. These include the actions that are taken, such as purchasing a fridge to cool fortified drink supplements and sharing taped interviews with patients and their families with the staff involved in their care.

At the start of this year there were a large number of outstanding serious incidents attributed to the Division that had not been closed. The Directorate and Governance team within the Division have now investigated and closed all of these and there are currently no outstanding Serious Incidents open. To achieve this Division has changed its internal processes, engaged clinical leads in each specialty and ensured that training and support is available.

Improvement aims for 2015/16

Improvement priority	Why is it a priority?	Target(s)	How will we measure it?
To meet the 18 week RTT target and cancer waiting times by: • increase efficiency for elective short stay and day case patients by realigning theatre services at KTC • To expand the theatre complex at AGH to deliver its surgical strategy via a mobile unit • Introduce patient admission on day of surgery	Ability to stream-line patients according to acuity More flexible use of surgical expertise and resources To reduce number of cancelled operations due to capacity issues Improved patient flows; less anxiety to patient by avoiding prolonged hospital stay	18 week Referral to Treatment and Cancer waiting times	Performance Reports ○ 90% patients admitted on the day
To progress with surgical pathway through implementation of a county-wide surgical rota	Improved patient care		
Reduce the number of complaints by improving communication at ward level to address concerns before they arise.	To improve patient experience of care	To reduce the number of complaints per month by 20% within the year	Monthly complaints report

3.2.2 Medical Division

Services Provided

The Division provides the following services:

- Acute Medicine – Emergency Departments and Medical Assessment Units
- Specialist Medicine – Cardiology/Respiratory/Renal/Neurology/Infectious Diseases/Endocrinology /Diabetes
- General Medicine – Elderly Care/Acute Stroke Unit/Gastroenterology/Neurophysiology/Therapies
- Haematology/Oncology – Specialist Palliative & End of Life Care/Radiotherapy (from Jan 2015)

Quality performance in 2014/15:

- The Trust and its partners have been concerned about the flow of patients through our hospitals, particularly at the Worcestershire Royal. The Emergency Department is the focus of attention because it is where patients enter the system. However, although there are actions we can take in the emergency departments we also need to change the way we work throughout the hospital to keep patients safe. That includes identifying patients who can be discharged at an early stage each day and ensuring that senior specialist doctors assess patients in the emergency departments as soon as possible after their arrival. Given the high numbers of patients who no longer need an acute bed we are also continuing to work closely with partners on ensuring that patients are moved more swiftly into more appropriate care settings.
- The Trust has been open about the problems of treating nearly 70,000 patients a year in Worcestershire Royal Hospital's Emergency Department which was designed for only 45,000 patients. When its 18 major (for the more seriously ill) patient cubicles were full during 2014/15 it routinely treated patients in the emergency department corridor and increased its staffing levels to cover the corridor nursing. The need to use the corridor to nurse and treat patients arose when the hospital itself was full and more patients were being admitted than being discharged. Although the Trust opened additional capacity by re-opening old wards and turning assessment areas into bedded wards it was not enough to keep patients flowing through the hospital and back to their normal place of residence. We saw the number of delayed transfers of care double to more than 100 at peak times and worked closely with its health and social care partners to speed the flow of patients through the hospital.
- In February 2015 the four emergency department consultants at the Alexandra Hospital and one from the Worcestershire Royal Hospital resigned after being offered consultant positions in the emergency department at Warwick Hospital. The five consultants are all working their notice periods and will be leaving the Trust between May and the end of July. The Trust has recruited two substantive emergency department consultants and three locums to the vacant positions.
- The Care Quality Commission carried out an unannounced inspection of both emergency departments in March 2015 and identified a number of areas which needed improving under Section 31 of the Health & Social Care Act. The Trust has made a number of immediate changes and identified plans to ensure all the CQC's recommendations are carried out and these are described in section 2.3.5.
- The Emergency Departments and the provision of urgent care throughout the county have been the subject of other reviews including:
    - An NHS England risk summit
    - An NHS Trust development Authority-led review by a nationally-renowned emergency department doctor
    - Clinical Commissioning Group reviews and inspections

- The Division has overseen the Development of the Worcestershire Oncology Centre and was officially opened by HRH the Princess Royal April 2015. The facility will help to ensure that Oncology patients receive care that includes Radiotherapy from specialist staff closer to home to improve the quality of their experience.
- Service redesign of AMU that has included the development of the Silver Unit for frail elderly patients aged over 75 years to support the reduction of the length of stay and improved patient experience in supporting patients to be returned home within 72 hours.
- The Specialist Palliative and End of Life Team have responded to 'One chance to get it right' (DH 2014) by creating an End of Life Care Plan that addresses the five priorities of care for the dying person – the need to recognise dying, to then be able to communicate, involve, support, plan and do. The team has been operating a 7 day service since February 2014 to enhance the service provided to patients, relatives and carers.
- The Trust continues to support the use of the VOICES Questionnaire receiving feedback from bereaved relatives/carers about a patient's experience where they died within the Trust.
- The Trust has made significant progress with Dementia screening and assessment this year and will aim to demonstrate how this has improved care for this patient group in 2015/16.

Achievement of the quality aims for 2014/15

- The Stroke targets have been achieved since centralisation resulting in an improved quality of care for patients who have suffered a stroke. The Division will however need to carry over the need for a seven day TIA (mini-stroke) service delivery
- The 4 hourly Emergency Access Standard remains a challenge within the division going into 2015/16. One of our main aims is to improve the Emergency Patient Pathway for both patients and staff

The Divisions quality improvement aims for 2015/16

- The improvement of the Emergency Department in response to the CQC inspection is a Trust level improvement priority.
- We are committed to delivering the right care to the right person at the right time with a committed and appropriate workforce. The division aims to expand its services locally to improve access for the county below are the top three improvement aims that the Division is working on to of how the division is working to provide services locally and improve patient experience.

Improvement aims for 2015/16

Improvement priority	Why is it a priority?	Target(s)	How will we measure it?
• Develop Frailty services and pathways and a redesign of Acute Medical Assessment pathways	The development of Frailty services and pathways and a redesign of Acute Medical Assessment pathways will support this year's redesign of Acute Medical Unit has included a 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.	Improving the emergency patient pathway	Improved Emergency Access Standard performance Reduction in patient complaints through an improved patient experience for patients requiring emergency assessment Improved staff experience

Improvement priority	Why is it a priority?	Target(s)	How will we measure it?
• Development of an Urgent Care Centre	Need to improve the provision of urgent care for patients	Development of the Kings Court Site and expansion of the current Emergency Department at WRH	Improved experience for patients requiring urgent care
• Develop Worcestershire Renal Services	To ensure patients receive timely and appropriate care as required by a dedicated Renal Team when required	Appointment of a locum Renal Consultant at the Alexandra Hospital Renal Clinical Nurse Specialist appointed	Data on mortality for patients with renal disease

3.2.3 Women and Children Division

Services provided:

The Women and Children Division brings together countywide services across gynaecology, maternity, paediatrics and neonates.

Our Maternity Service provides continuous care during pregnancy, birth and the postnatal period within Worcestershire. We have two Consultant led delivery suites, one at Worcestershire Royal and one at Alexandra Hospital sites. The Midwife-led **Meadow Birth Centre** opened at Worcestershire Royal Hospital on 14th April 2015.

We provide a full range of children's care throughout the county, including a level 2 neonatal unit for sick and premature babies on the Worcestershire Royal site and level 1 at Redditch sites. We also provide Childrens in patient wards at both Worcester Royal and Alexandra hospitals. Childrens Outpatient clinics are available across the county.

We offer Outpatient, ambulatory and inpatient gynaecology services across the county on the Kidderminster Treatment Centre, Worcestershire Royal, and Alexandra and Evesham Community Hospital sites.

Quality performance in 2014/15:

Maternity

This year 5676 mothers gave birth to 5741 babies which is slight decrease from 2013/14. We are measured on the following "Key Performance Indicators" (KPI)

which aims to measure and improve the quality of care we provide from Maternity services.

Key Performance Indicator	2014/15 target	2014/15 results	Comments
Women booked for antenatal care before 12 weeks and 6 days of pregnancy	90%	87.8	Women should contact Maternity Services as soon as they are aware of their pregnancy to ensure appropriate advice and care options as soon as possible to improve their own and their babies health
Normal Vaginal Birth rate	63%	60.7%	This is an important measure as it indicates appropriate use of interventions
Caesarean section rate	27%	27.3%	This is an important measure as it indicates appropriate use of interventions and future maternal health
Breast feeding initiation rate	70%	74.2%	It is important to encourage mothers to breast fed as it provides the best nourishment for new born infants and is beneficial to the mother
Smoking at delivery	13.5%	14%	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	35%	35.3%	We aim to increase the percentage of women receiving Midwife Led Care to improve normal birth rates

The appointment of a Bereavement Support Midwife in 2014 has improved the support received by bereaved families within maternity and gynaecology services.

Gynaecology

We have appointed a new Gynaecology ward sister and Matron this year. The Matron role is designed to strengthen and develop the services. During the year it has been a challenge to meet the national target of 18 weeks Referral to Treatment (RTT) target. The pressures on all in-patient beds, because of the increased number of emergency admitted patients and reduced theatre capacity at Evesham Hospital, have affected our ability to achieve this target. We ended the year achieving 79% of women having their operations within 18 weeks of referral from their GPs, against a national target of 90%. We have met the national standards for gynaecological cancer targets.

Neonatology

We have a level 2 Neonatal Intensive Care Unit which cares for sick and premature new born babies with eighteen cots on the Worcester Royal Hospital site, and an 8-cot Special Care Baby Unit at the Alexandra Hospital. We have cared for a total of 987 neonatal babies in 2014/15 (577 in the neonatal units, 181 in Transitional Care and 229 babies requiring additional support on 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 increased the number of

children and young people who can receive Cystic Fibrosis care at Worcester Royal rather than travelling to Birmingham Children's Hospital this year through an agreement with the Children's hospital and our Specialist Commissioners.

We have had 7573 child admissions to the paediatric in-patient wards during 2013/14. We offer a service to support care at home for sick children in conjunction with Worcestershire Health and Care Trust.

Divisional Objectives and Improvement aims for 2015/16

Improvement priority	Why is it a priority?	Target(s)
Develop and embed midwife-led care, establishing the baseline numbers of women booking with midwife lead professional.	To improve the woman's birth experience, increase the normal delivery rate which in turn will impact on and decrease the caesarean section rate.	A minimum 10% improvement in year and achieving 35% midwife-led births by 31st March 2016
Each directorate will implement the principles of the 'Sign up to Safety' campaign	Sign up to safety`s objective is to reduce avoidable harm by 50% and save patients' lives.	Introduction of robust training, systems and audit to reduce avoidable harm, evidence the Duty of Candour and improve patient outcomes. Train 25% of staff in Human factors.
Introduce assessment models/pathways of care in all directorates	Improves patient experience, pathways and efficiency flows	Gynaecology (GAU) by 30th September 2015 Maternity (DAU expansion) by 31st December 2015 Paediatrics (PAU) by 31st March 2016

3.2.4 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.

From April 2015 the Haematology and Oncology Directorate will be become part of the Clinical Support Services Division (moving from the Medical Division). This will result in a significant expansion of our Division with the inclusion of out-patient and in-patient services related to haematology, oncology and palliative care.

Quality performance in 2014/15:

Pathology

- Assurance that the pathology laboratories provide a safe and high quality service to defined standards is provided by participation in various external accreditation processes including the Clinical Pathology Accreditation (CPA) scheme, the Medicines and Healthcare Products Regulatory Agency (MHRA), and the Human Tissues Authority (HTA). In 2014/15 accreditation was granted or renewed to the blood bank and cellular pathology. We learnt from these external assessments and as a consequence have made improvements to our services. From 2015 the laboratories move to a new more exacting accreditation standard (ISO 17025), and inspections are due to take place during the year.
- Following a long consultation, a decision was made to centralise histopathology technical services on the Worcestershire Royal Hospital site. A project to achieve

this, together with revised ways of working is due to conclude before the end of May 2015.

- The directorate has supported the Trust roll out of electronic reporting and requesting for pathology using the ICE system, and this project is on track to deliver electronic reporting by May 2015 with electronic requesting to follow later in 2015/16.
- The directorate has actively supported multiple Divisional and Trust developments and new initiatives (e.g. the Bowelscope cancer screening programme).

Pharmacy

- Clinical pharmacy services have supported the Emergency Department and the Acute Medical Unit seven days per week to help prevent unnecessary admissions and facilitate discharge. This initiative has attracted positive interest from the Chief Pharmacist from NHS England. Teams from several NHS Trusts have visited to learn from this enterprise and to attempt to emulate this service within their own organisations.
- The directorate was able to showcase new ways of working with clinical teams as part of the perfect week initiative. The model of aligning pharmacists to ward rounds was recognised as the change that effected the greatest impact on patient flow.
- External inspections of pharmacy by both the MHRA and a Farwell visit showed only minor improvements were required. A Wholesaler Dealers license was granted following the inspection.
- The Trust has agreed and supported the recruitment of a dedicated Medicines Safety Officer post.
- The directorate has responded positively to winter pressures, providing pharmacy cover for additional bed capacity, extended opening hours of the dispensary at weekends and evenings together with prioritising ward areas to support patient flow.
- The directorate continues to support the e-prescribing (safemeds) project and with the recent recruitment of an experienced e-prescribing pharmacist, is now better placed to support this Trust project.

Radiology

- The directorate has responded to increased demands and expectation of improved turnaround across all of its services. Of particular note was the challenge around the ultrasound service where a shortage of staff both locally and nationally has made maintaining waiting times and national targets difficult. However with a combination of outsourcing, flexible working and managing demand, the directorate is currently maintaining performance.
- The Trust-led breast screening service has commenced at the Wye Valley NHS Trust. This has enhanced patient experience by providing a local, modern and accessible facility for the ladies of Herefordshire and the surrounding area. In addition the breast screening service has successfully implemented the expansion of the programme to include a wider age range, and is now offering the service for the benefit of more women across Worcestershire and Herefordshire.
- In response to the on-going national recruitment difficulties for both radiologists and radiographers, the directorate has agreed to fund alternative posts to support our services, including sonographer training posts and an initial consultant radiographer reporting post. The directorate has also appointed radiologists from outside of the EU and has secured an additional deanery training post.
- Reporting of plain x-rays continues to provide a challenge, however there has been significant progress this year, and currently all GP and chest x-rays are routinely reported, and recruitment is underway for a reporting Consultant Radiographer to further support this service.

Improvement aims for 2015/16

Improvement priority	Why is it a priority?	Target(s)	How will we measure it?
Pharmacy			
Establish a substantive senior management structure including the appointment a Director of Pharmacy.	To provide high quality leadership to the Directorate	Director of pharmacy recruited by September 2015	Successful recruitment
To expand the service and new ways of working based on experiences from the 'perfect week', together with a review of 7 day working requirement and feasibility.	To support the clinical services provided by the Trust, particularly in acute pathways	Paper to TMC by July 2015. Support required from other divisions to fund.	Number of wards or teams adopting the new collaborative model. Impact on Length of stay and percentage of early discharges. Impact on junior doctor's role.
To upgrade and modernise the current stock management system for pharmacy.	This is essential to support high quality medicines management and avoid failures of current system with potential business continuity risks.	System to be in place as soon as feasible. (currently scoping)	Upgrades system in place and meeting the needs of the service.
Pathology			
To further roll-out the rules-based demand management initiative in collaboration with clinical divisions.	This will support a reduction in unnecessary duplication of pathology tests	Supporting advice for all relevant test requesting on ICE system.	Decrease in requesting or decrease in rate of requesting against predicted trajectory prior to demand management.
To gain ISO 17025 accreditation for the laboratory service (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.
Radiology			
To further the process of integrating to a single countywide service. This will include work towards achieving accreditation under the Imaging Services Accreditation Scheme (ISAS).	Better use of county-wide resources and provision of practices, to nationally recognised quality standards.		As per ISAS scheme assessment plus improved utilisation of cross county capacity.
To undertake a service wide review to inform a strategic plan for the next five years.	To ensure that we continue to provide high quality services into the future with a growth in demand but limited resources.	To produce a strategy, supported by the Trust	Completion of actions identified by timescales set.
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)

3.2.5 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, safe, countywide 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.

Quality performance in 14/15

Since its establishment in 2013, the TACO Division has been setting up and implementing robust governance and monitoring processes. As a result there have been a number of significant quality improvements during 2014/15 -

- The Division has achieved excellent performance in relation to the investigation of serious incidents and complaints. All serious incidents and complaints assigned to the division have been investigated within timescales set both nationally and locally since July 2014. This has enabled timely identification and completion of actions.
- The Division is using *human factors* training to continually improve how we investigate incidents and identify the causes of these incidents and ultimately what we do to reduce the risk of similar incidents reoccurring in our services.
- Last year an improvement priority was identified to redesign an equitable and standardised pre-operative assessment service. The Division has assigned a clinical project lead to co-ordinate this work over an 18 month period. This project will remain a priority during 2015/16.
- The Division identified a need to improve efficiency in Theatres through robust scheduling processes and standardised operating procedures. During the past year guidelines have been standardised allocating unutilised theatre scheduling across the county. This encourages early uptake of available theatre sessions across specialities to ensure Theatres within the trust are used effectively. Theatre scheduling data is available to all trust staff and this data is regularly presented at board level.
- The Division set an improvement priority for 2014/15 to provide a streamlined, accessible countywide endoscopy service and enhance the county's Bowel Screening Programme. The focus over the past year has been on achieving Joint Advisory Group on Gastrointestinal Endoscopy (JAG) Accreditation at the Worcestershire Royal Hospital. JAG accreditation provides formal recognition that a service has demonstrated competence to deliver against the measures in Endoscopy Standards. The Worcestershire Royal Hospital achieved JAG accreditation in October 2014. All of the policies and procedures used have been accredited as countywide documents.
- The Division identified that creating a theatre admissions area at Worcestershire Royal Hospital would enhance privacy and dignity, improve patient experience and ensure timely access to theatre is maintained. The Division have continued work to implement a theatre admissions unit and have instructed architects to develop plans. This will remain an improvement aim for 2015/16
- Last year an improvement priority was identified to work collaboratively with primary care colleagues to ensure patients receive a high quality Rheumatology service. An

education and support programme has been completed by the Division and is available for nurses within primary care to access upon request.

Improvement Aims for 2015/16

The Division is committed to delivering the right care to the right person at the right time with a valued and appropriate workforce. It is the intention of the TACO Division to continue to develop and embed countywide services and to ensure adequate clinical support and the provision of standardised pathways and equipment. The main improvement strategies for 2015/16 are:

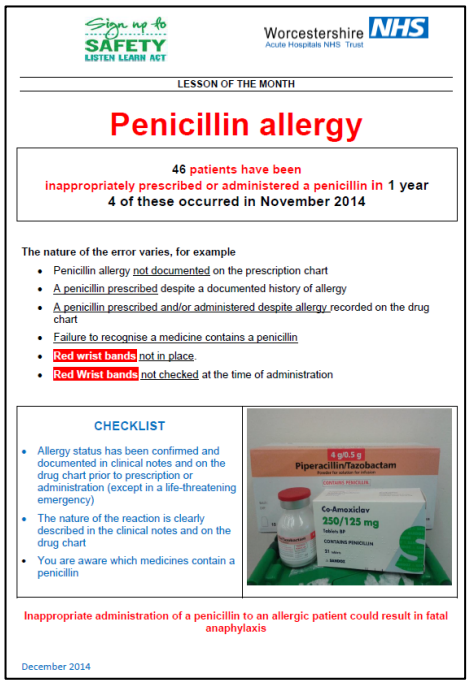
Improvement priority	Why is it a priority?	Target(s)	How will we measure it?
Redesign an equitable and standardised pre-operative assessment service	Introduce standardised process for patient assessment across the Trust	Development of standardised working processes across sites Improvement in patients' experience of the service Decreased waiting times	Standard processes implemented Survey of patients and collating feedback
Provide a streamlined, accessible countywide Endoscopy service. Enhancement of the Bowel Cancer Screening Programme	Equity in patient experience and access to this service by improving accessibility and capacity throughout the county.	Implement a centralised booking function to improve waiting times and access for patients across the county. Commence Bowel Scope Screening Programme.	Pathway implemented on all sites
Create a theatre admissions area on the Worcestershire Royal Hospital site	To enhance privacy and dignity, to improve patient experience and ensure timely access to theatre.	To open a dedicated admissions area	Admissions area open and functional
Ensure patient feedback is systematically reviewed and appropriate action plans made as a result of feedback and other Clinical Governance activity.	To ensure the Division continues to enhance people's experience of services the Division provides.	Development of a process for capturing and monitoring actions taken as a result of clinical governance activity including incidents, patient experience information, complaints etc.	Evidence improvements the division has made as a result of patient feedback.
Improve efficiency in Outpatients through robust scheduling processes and standardised operating procedures	To ensure efficient, safe and cost effective utilisation of resources. Streamlining the booking process will improve the patient experience by giving our patients more notice of their outpatient appointments and by reducing waiting times.	Establishment of transparent outpatient capacity ensuring all available outpatient rooms are used.	Reduction in the number of unused outpatient facilities

3.3 Patient Safety

The Safe Patient Group continues to be the lead committee for all patient safety matters. Chaired by the Chief Medical Officer, its membership includes a patient representative, junior doctors and the clinical Divisions. A range of sub-committees provide a focus on specific areas of risk including medicines, blood transfusion, patient falls, pressure ulcers, resuscitation & the deteriorating patient and medical equipment.

We strive to make care safer for patients but despite this things sometimes go wrong. To assist learning we continuously encourage all our staff to report all types of incidents, near misses and accidents so that we know what goes wrong, can investigate both trends and single events, to understand what happened and take actions to deal with the causes. We use an on-line incident reporting system (Datix) to capture incident reports, escalate them to senior staff to investigate and to identify trends and hot-spots.

To provide better feedback to staff on the outcome and learning from incidents we have introduced a patient safety '**Lesson of the Month'** for generalised learning. Topics covered include: the use of checklists for safety, safe blood transfusion, checking the placement of naso-gastric feeding tubes and penicillin allergy. Other methods to provide relevant feedback to staff are being developed with Divisional and Directorate management teams.


Sign up to SAFETY LISTEN LEARN ACT

Worcestershire NHS Acute Hospitals NHS Trust

LESSON OF THE MONTH

Penicillin allergy

46 patients have been inappropriately prescribed or administered a penicillin in 1 year
4 of these occurred in November 2014

The nature of the error varies, for example

- Penicillin allergy not documented on the prescription chart
- A penicillin prescribed despite a documented history of allergy
- A penicillin prescribed and/or administered despite allergy recorded on the drug chart
- Failure to recognise a medicine contains a penicillin
- Red wrist bands not in place.
- Red Wrist bands not checked at the time of administration

CHECKLIST

- Allergy status has been confirmed and documented in clinical notes and on the drug chart prior to prescription or administration (except in a life-threatening emergency)
- The nature of the reaction is clearly described in the clinical notes and on the drug chart
- You are aware which medicines contain a penicillin

Inappropriate administration of a penicillin to an allergic patient could result in fatal anaphylaxis

December 2014

Over 100 senior clinicians and managers are receiving training in **investigation** techniques based on **root cause analysis** to improve the quality of investigations. This will be extended to a wider group of staff in 2015/16.

Integral to the development of a patient safety at WAHT is the development of the **Human Factors Programme**. The programme will increase awareness of the impact of human factors on safety, quality and efficiency. Driven by demanding regulatory requirements the aviation industry has pioneered the study and practical application of human factors knowledge to achieve extraordinary levels of safety alongside enhanced quality and efficiency. WAHT is working alongside aviation experts to develop the programme.

Trust wide roll out is planned throughout 2015. The approach will combine teaching and practical aspects of Human Factors Training with the behavioural and change management skills required to ensure effective implementation

A legal **Duty of Candour** was introduced in November 2014. This strengthens the *'Being Open'* principles already in place and requires NHS providers to contact patients who have suffered significant harm during the delivery of healthcare, apologise for the harm, explain what went wrong, why and what will be done to stop it happening again. Providing any necessary support to the harmed patient and their families is also an important element of this. The principal is right and universally supported. To ensure that we get it right, we are working with our clinical specialties to understand the requirements of the law, how they are applied in each service and set in place local procedures that capture significant harm incidents and trigger the Duty and the effective connection with the Patient. Each serious incident investigation report includes a section on the Duty of Candour and a review of the effectiveness of the processes will be undertaken in early 2015/16.

3.3.1 Patient Safety Incidents

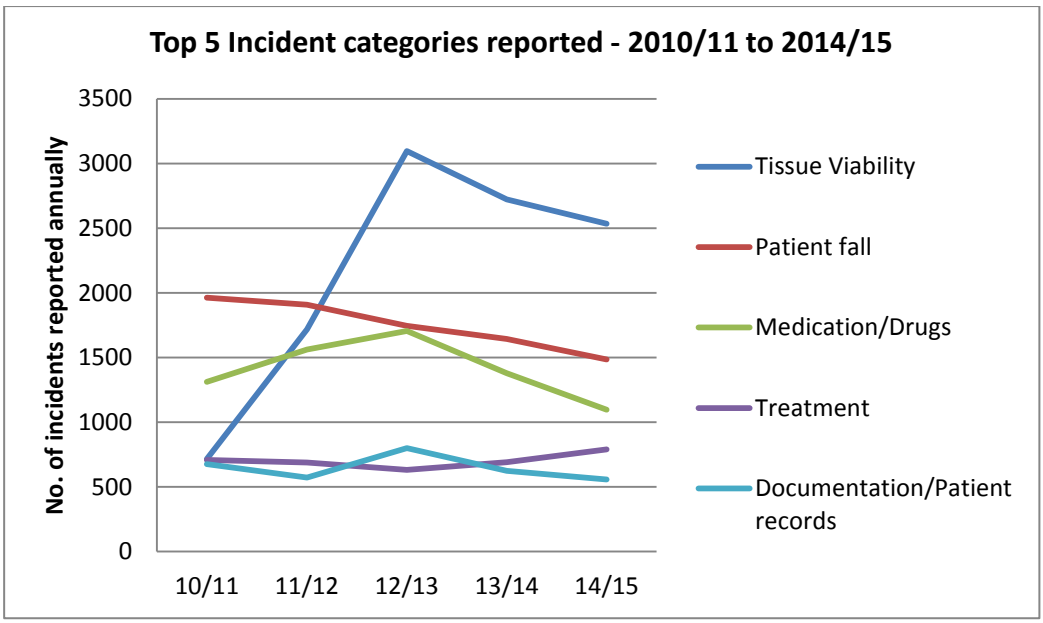
Reporting rates – comparison with other Trusts

Our incident reporting rate is 36.62 per 1000 beds days, similar to the 36.60 in 2013/14. This places us in the middle 50% of reporters.

Incident Categories

A reduction in incident reporting to a three-year low in quarter 2 was reversed in quarters 3 and 4. Incidents related to tissue viability, patient falls, medication, (delay in) treatment and in particular (unavailability of) staff, admission/discharge and bed management have contributed to the increase. It is likely that this is a symptom of the increased level of emergency admissions, patient flow and discharge and the pressure placed on acute hospital services.

This increase in reporting rates is also seen more at the Alexandra Hospital. The number of pressure ulcers (Tissue Viability) reported included those detected on a patient's admission to hospital which accounts for 64% of the total. 922 pressure ulcers and other skin damage were reported as occurring while the patient was in hospital.



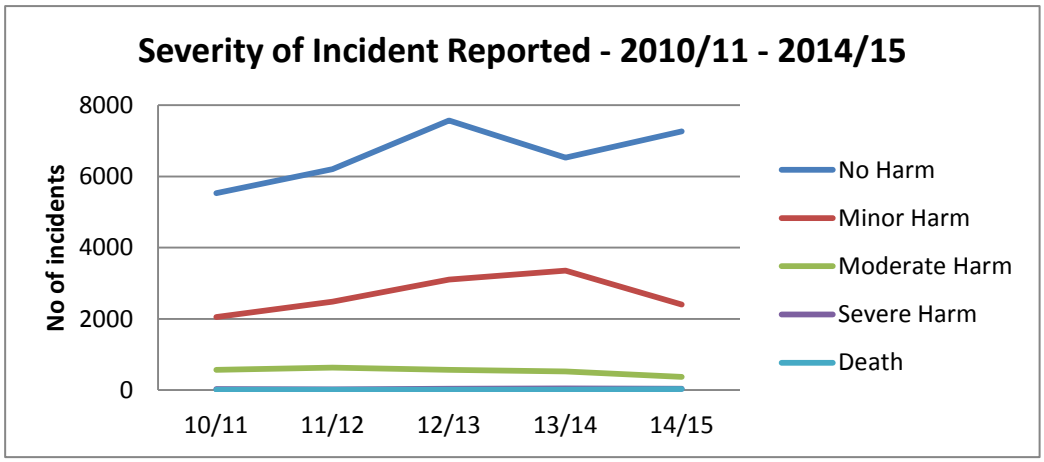
Severity

Following the advice of the National Reporting and Learning System (NRLS) we changed the definitions of harm from incidents in October 2014 to match theirs to make it clearer when the Duty of Candour should be triggered. This change has affected the classification of incidents and makes comparison in-year and between years more difficult and may explain the increase in 'no harm' incident reports.

Severity of incident reported	13/14	%	14/15	%
No Harm (previously 'insignificant')	6528	**62.3%**	7263	**71.8%**
Minor Harm	3358	**32.1%**	2406	**23.8%**
Moderate Harm	526	**5.0%**	368	**3.6%**
Severe Harm	49	**0.5%**	41	**0.4%**
Death (*unconfirmed for 14/15)	14	**0.1%**	25*	**0.3%**
	10475	**100.0%**	**10109**	**100.0%**

*The number of incidents currently recorded as having caused a patient's death is being verified through investigation and will reduce in number.

A small reduction in incidents rated ‘minor’ and ‘moderate’ has also been seen. The NRLS require Trusts to quality assure their reporting and ensure that incidents that caused a death are reported as such.

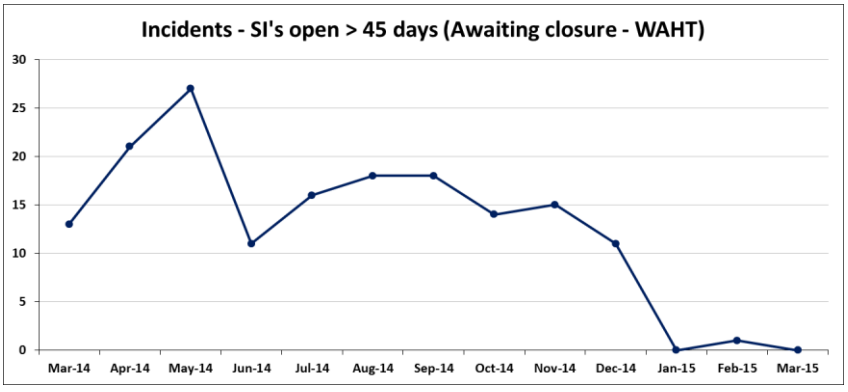


Serious Incidents

We recorded 131 serious incidents requiring investigation in 2014/15. Each of these is investigated and reviewed by the weekly Serious Incident Group chaired by the Associate Medical Director for Patient Safety. Hospital acquired pressure ulcers were the highest recorded category.

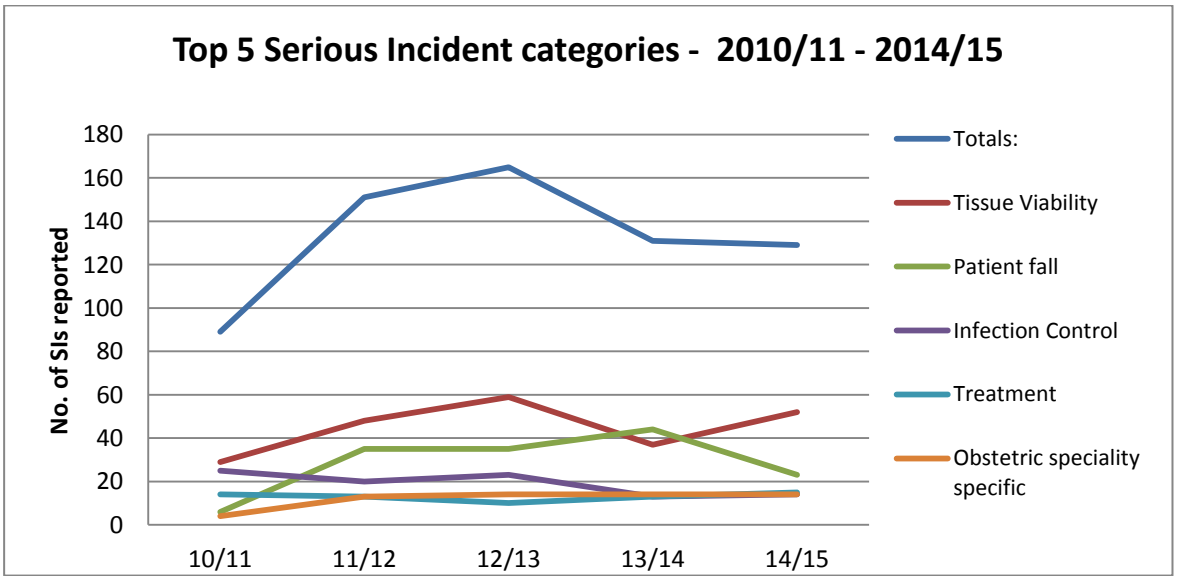
Serious incident categories	Total	%
Tissue Viability (pressure ulcers)	52	39.7%
Patient fall	23	17.6%
Treatment	15	11.5%
Infection Control	14	10.7%
Obstetric speciality specific	14	10.7%
Diagnosis	4	3.1%
Bed Management	3	2.3%
Communication and Consent	1	0.8%
Equipment	1	0.8%
Neonatal specialty specific	1	0.8%
Radiology Triggers	1	0.8%
Slips, trips and falls	1	0.8%
Totals:	**131**	100%

A period of 45 working days is allowed to investigate serious incidents (60 days for Never Events). We turned around our under achievement of this target and by the end of January had no investigations open beyond 45 days thanks to the hard work of the Patient Safety Team and the Divisional teams.



The graph below looks back over the last 5 years at the top 5 most commonly reported serious incidents.

- The impact of reporting grade 3 and 4 pressure ulcers (tissue viability) as part of the zero tolerance campaign on the overall number of serious incidents can be seen.
- An on-going reduction in serious incidents associated with infection control (MRSA blood stream infections and C. difficile).
- The significant reduction in patient falls resulting in serious harm is partly due to fewer incidents and partly due to a change in definition.



Learning from serious incidents

Each serious incident investigation report contains an action plan to reduce the likelihood of similar incidents occurring again and to share learning. The work on pressure ulcers and patient falls is described later in this section. Some of the other changes we have made include:

- Two near miss events where juniors prescribed Methotrexate in Emergency Department (ED) led to the development of the Methotrexate Prescribing Guidance by an ED Consultant for use across the organisation
- The investigation an incident where a nasal pack was left in place following surgery highlighted that different stickers were in use across the trust that are used to document the insertion and removal of throat packs in theatre. The TACO Division have standardised these stickers in order to minimise the risk of misinterpretation occurring again.
- A number of incidents where penicillin was administered to patients who were thought to be allergic, TACO Division has remove all penicillin based drugs from anaesthetic rooms and required that prescription of these drugs is discussed and agreed between surgeon and anaesthetist as part of the '5 steps to safer surgery' process.

Never Events

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

We have regrettably had two never events in 2014/15, one in each of the following categories:

- Wrong site surgery – vascular laser surgery
- Misplaced naso or oro-gastric tubes

Each incident was disclosed to the patient, investigated by a senior clinician and immediate changes were made in surgical practice, the working environment and the type of naso-gastric tube used across the Trust to prevent reoccurrence of similar incidents. Learning has been shared as safety 'Lessons of the Month' and actions have been followed up to ensure their completion and effectiveness.

Patient Falls in Hospital

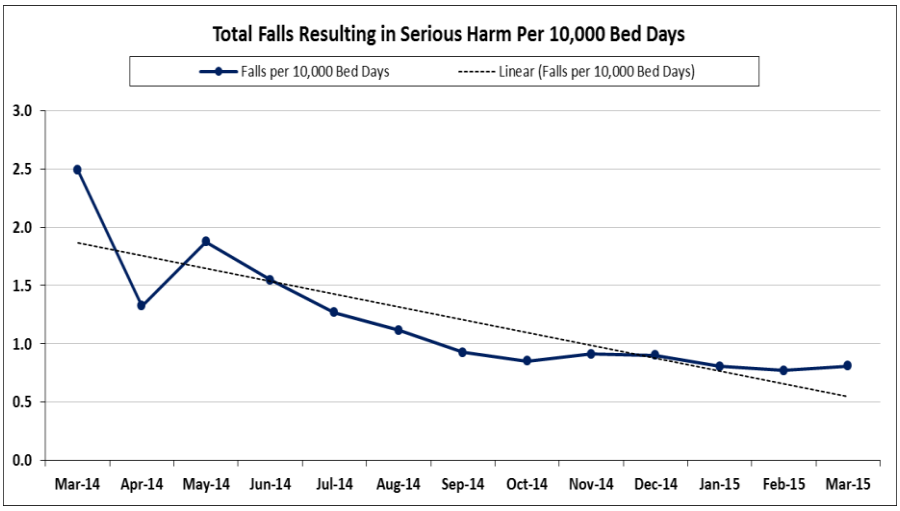
We held a 'Falls Prevention Conference' at Worcestershire Rugby Club In May 2014 which was attended by a cross section of professional groups within the trust as well as colleagues from the Worcestershire Health and Care Trust and local Clinical Commissioning Groups. This allowed staff to come together to showcase their good practice and also provide an opportunity to hear how other trusts have progressed with their falls prevention work. We have held regular Falls Champion events to further develop some of the ideas raised at the conference.

The following actions have been completed following the conference: -

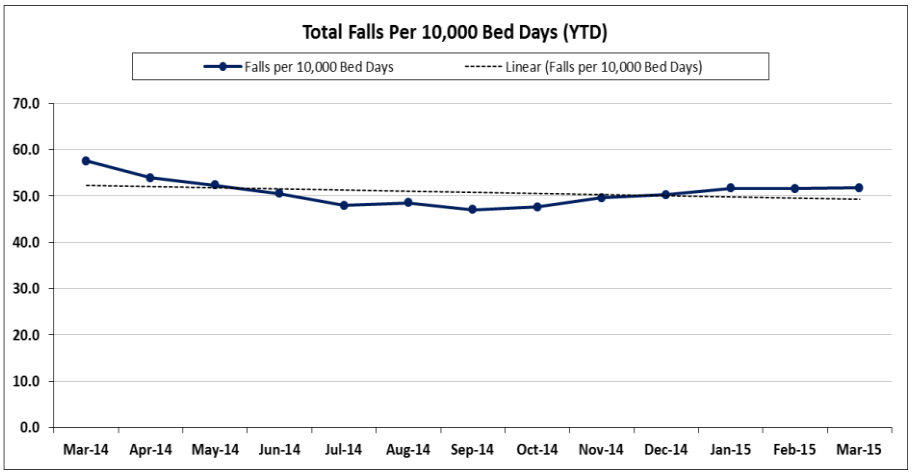
- Changing the wrist band colour to identify those at high risk of falling
- Having a standardised Falls Prevention Board
- Reviewing and simplifying the documentation
- Implemented Falls Prevention Monitors
- Teaching on using scoops for suspected cervical spine injuries
- Purchase of further hover mats and hover jacks for the WRH site.
- Yellow leaf identifier for those patients still requiring a lying and standing blood pressure.

We will be working other ideas to prevent falls such as the layout of bathrooms and portable nurse's stations for making it easier for nurses to work more closely with the patients in the bays.

This year we have reduced our number of serious harm falls from 44 in 2013/14 to 23 in 2014/15. The rate of reported patient falls also continues to reduce.



We have also reduced our average number of inpatient falls reported from 2013/14 from 134 per month to 124 inpatient falls in 2014/15 although we saw an increase over the winter period.



Our 'falls champions' continue to be pivotal in our work to reduce the number of falls and educating staff on the ward areas. We have continued to have the support from all of our multidisciplinary team colleagues. In particular some of the junior medical staff have been actively involved in auditing all the serious harm falls and also in the completion of post fall medical reviews. The pharmacy teams have commenced a programme of medication reviews for all high risk of falls patients and this continues as a work in progress.

Pressure Ulcers

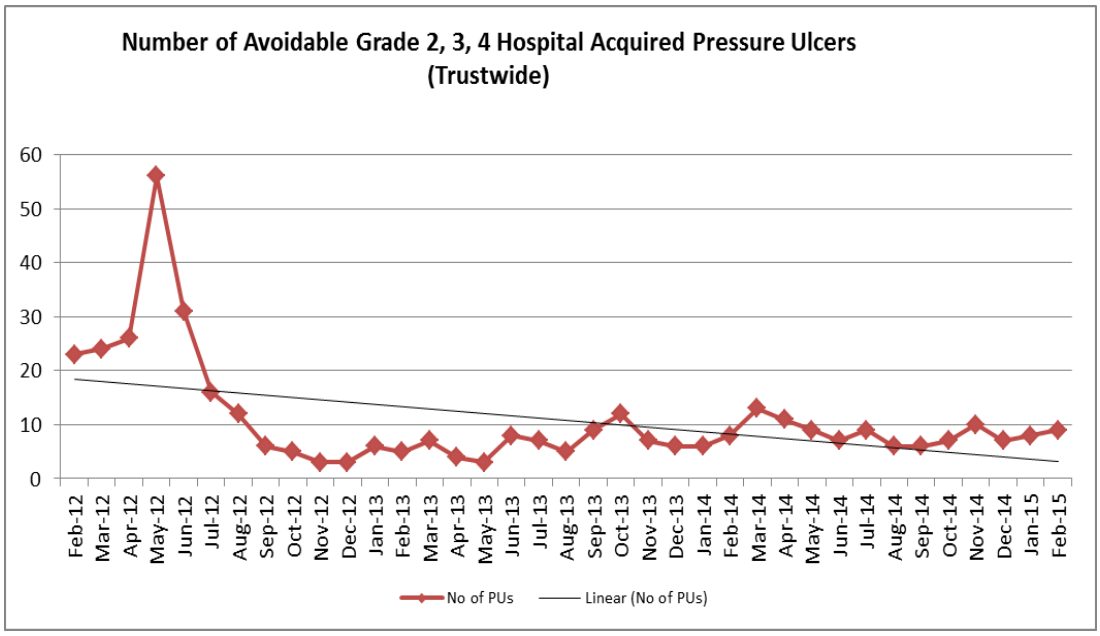
Pressure ulcers are injuries caused when an area of skin is placed under pressure, leading to breaking down of the skin and the underlying tissue. There are 4 grades of pressure ulcers, depending on their severity. Grade 1 is the lowest (patches of discoloured skin) and grade 4 the highest (open wounds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

It is not always possible to prevent pressure ulcers in particularly vulnerable people. However many 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 SKIN "care bundle" with a collection of five interventions that are aim to manage pressure ulcers
- We undertake in depth investigations and have accountability meetings with nursing staff for all cases of grades 3 and 4 pressure ulcers to learn from any errors or omissions 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 shows the number of avoidable pressure ulcers per month since February 2012.



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. We have seen a reduction in grade 2 pressure ulcers but increase in grade 3 and 4.

From our root cause analysis of pressure ulcers we have identified the following themes and are taking the actions described below:

Gaps in care and patients allowed to sleep and/or not repositioned was noted on Trauma and Orthopaedic ward WRH

- Accountability/Round table meetings now include ward staff who were on duty when PU developed. They are reminded of their personal accountability.
- Daily audits of pressure ulcer documentation are being undertaken to ascertain when and why gaps in care appear to be occurring and which staff are responsible
- Lead Nurse – Patient story at ward meeting

Staff not documenting when patients are refusing to move, or if the patient has capacity

- Staff advised to show patients a picture of a PU to try and help them understand what can happen to their skin if they don't move
- TV team to be utilised to discuss prevention options with patient

Pt's admitted – cachexic and malnourished – skin and tissues rapidly deteriorating

- MUST tool guidance reinforced – The MUST tool is a nutrition screening tool to identify adults who are malnourished or at risk of malnourishment. It includes management guidelines and a care plan is devised from the results
- Recording patients who are admitted cachexic and malnourished to be highlighted on new dashboards part of PUPs audit

Patients Fasting for Theatre but surgery is postponed

In Q4 it has been identified that 2 patients with Hip Fracture had their surgery cancelled. A pathway is being developed with the dieticians to offer patients a

nutritious meal, as soon as the cancellation occurs, if less than half is eaten to offer supplements, also a nutritious meal/supplements to be given, early on the morning of surgery. (this is important because skin condition deteriorates in elderly patients who fast quickly and can lead to an increased risk of developing pressure ulcer.

Completed actions

- Pressure relieving mattresses deflating – gaps in care highlighted – no issues in quarters 3 & 4
- Bandages left on patients and heels not assessed - no issues in issues quarters 3 & 4

CQUIN Target on Pressure Ulcers

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

3.3.2 Infection Control

We have continued to work hard during 2014/15 to minimise risk from Healthcare Associated Infection (HAI) and meet nationally set targets for *Clostridium difficile* and Meticillin resistant Staphylococcus aureus (MRSA).

Clostridium difficile

The Trust has achieved the target set for 2014/15 of no more than 41 Trust attributable cases having a total of 36 cases. These are cases where the specimen has been taken more than 48 hours after admission to hospital.

The achievement has been due to a continued effort in antimicrobial stewardship both within the Trust and in primary care; and the decontamination of the environment following cases at the Trust using hydrogen peroxide vapour. However, there is no room for complacency and all cases are thoroughly investigated to ascertain if further lessons can be learned.

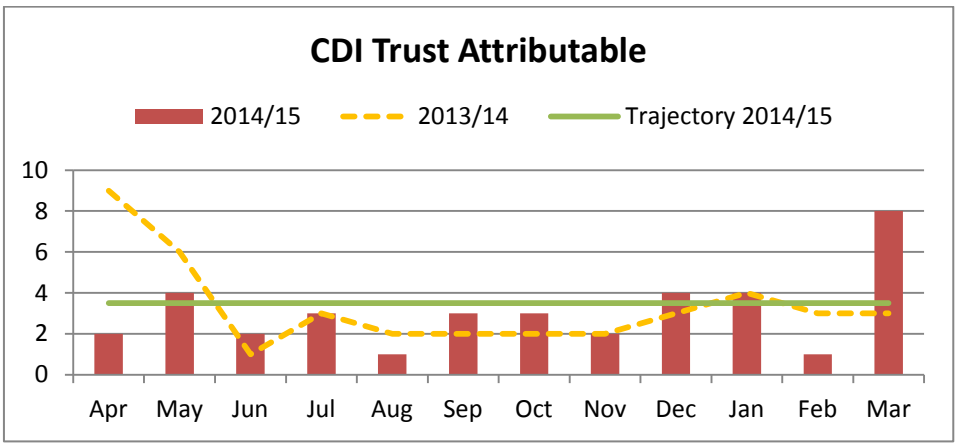


Figure 1: Trust attributable *Clostridium difficile* monthly totals showing trajectory and against 2013-14 totals.

There has been no evidence of direct cross infection with *Clostridium difficile* within the Trust during the year.

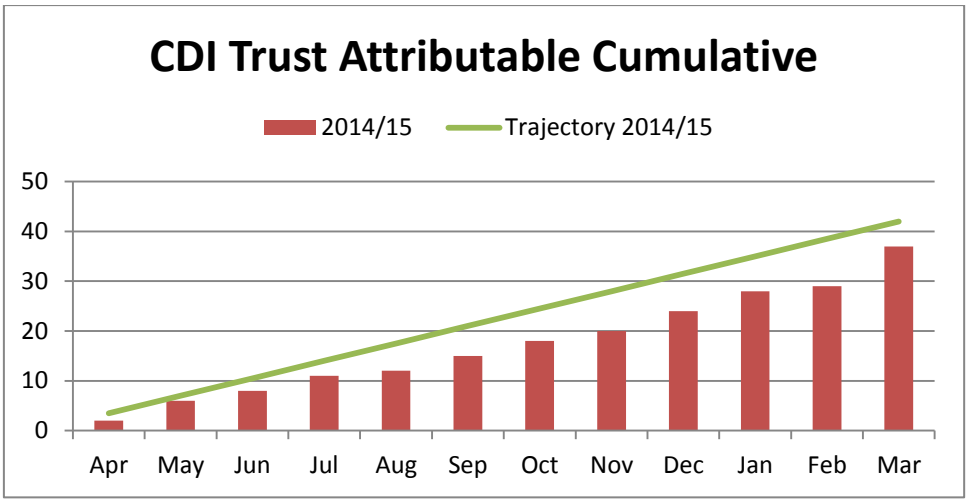


Figure 2: Cumulative Trust attributable *Clostridium difficile* by month showing trajectory.

Meticillin resistant Staphylococcus aureus (MRSA)

There is a national zero tolerance of hospital attributable bacteraemia; that is blood stream infection with MRSA where the specimen has been taken more than 48 hours following admission to hospital. Unfortunately, there has been one case during the year reported in March 2015 which was thoroughly investigated.

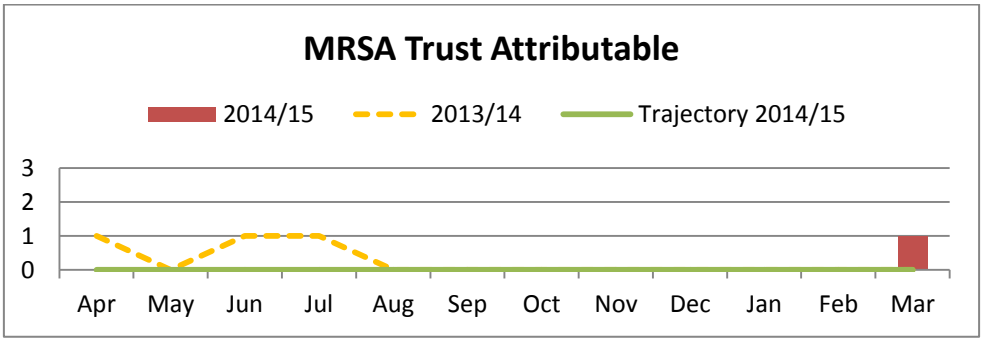


Figure 3: Trust attributable MRSA bacteraemia 2014-15 showing 2013-14 position and trajectory of zero.

3.3.3 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:

- 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.

Our overall achievement against the 95% 'harm free care' overall was 93.11%. In 2013/14 it was 94.4%

Month	Apr-14	May-14	Jun 14	Jul14	Aug14	Sept 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar15
No. Surveys	782	829	784	777	762	755	785	815	855	843	829	813
No. Harm Free	726	771	728	746	706	712	747	742	793	784	774	757
% Harm Free	95.19%	92.84%	93.06%	92.86%	95.88%	92.55%	94.30%	95.16%	91.04%	93.00%	93.37%	93.11%

This year we did achieve above 95% for new harm free care. This is the percentage of harm free care that our patients have received whilst they have been an inpatient with us.

3.3.4 Claims made against the Trust

All clinical negligence claims made against the Trust are managed through the Legal Services Department and in accordance with the NHS Litigation Authority scheme guidance and the Pre-Action Protocol for the Resolution of Clinical Disputes.

New Claims

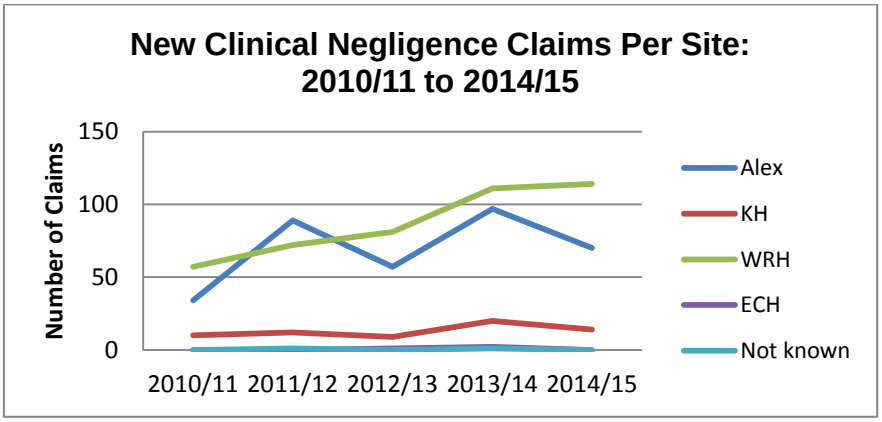
198 new claims were received between 1 April 2014 and 31 March 2015.

This is a decrease on the number of claims received in 2013/14 however that included 30 claims that were notified as a second group of cases following the CQC report in 2011 and 17 cases relating to the colorectal surgeon under review. The higher number of cases received in 2011/12 also included 39 cases relating to the first group of cases following the CQC report. Therefore the general trend is a continuing increase in the number of claims being received.

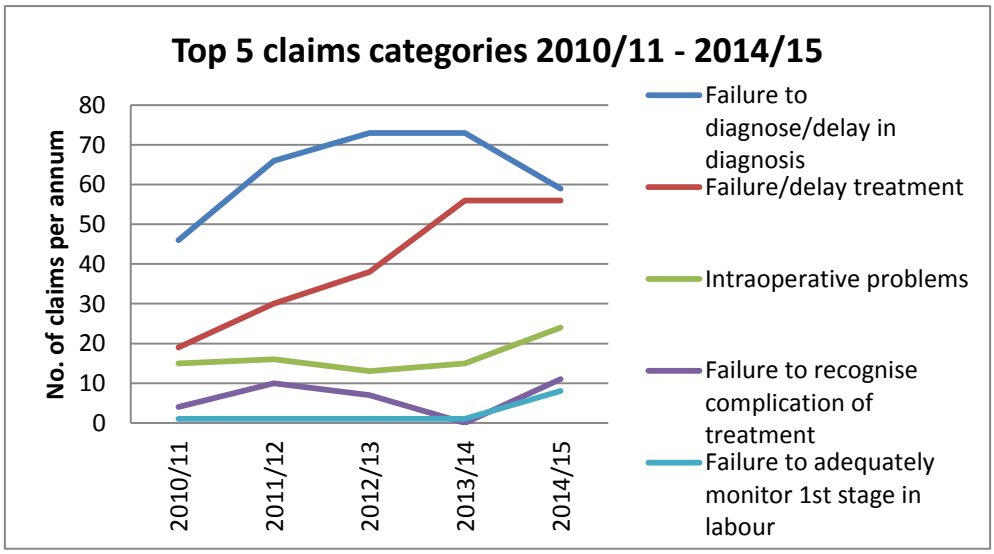
Number of new claims per site

	2010/11	2011/12	2012/13	2013/14	2014/15	Total
Alex	34	89	57	97	70	**347**
KH	10	12	9	20	14	**65**
WRH	57	72	81	111	114	**435**
ECH	0	0	1	2	0	**3**
Not known	0	1	0	1	0	**2**
Total	**101**	**174 (135)***	**148**	**231 (184)***	**198**	**852**

*This is the number of new claims received which were not part of the CQC or colorectal cases.



Prior to notification of the claims 67 (29%) received in 2014/15 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.



Closed Claims

There were 250 claims closed between 1 April 2014 and 31 March 2015.

- 111 (44%) claims were settled and 139 (56%) 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 £4,709,196.
- The date of the incident of the settled claims ranged was between January 2000 and September 2013 with the claims being notified between March 2008 and April 2014.
- 25 of the settled claims had initially been investigated as an incident; 38 had been investigated as a complaint and 14 had been investigated as both an incident and a complaint.
- The majority of claims are not pursued beyond the initial disclosure of records or following receipt of supportive expert evidence

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2.5.3 Safeguarding patients

Safeguarding Adults at Risk

There has been much activity related to safeguarding adults in the Trust since the last Quality Account. The Lead Nurse, Safeguarding Adults through the Safeguarding Adults committee have been involved in embedding changes in practice throughout the organisation. Trust staff have continued to make regular contributions to the Worcestershire Adult Safeguarding Board and its sub groups.

During the year 2014/15 the Trust has

- increased the number of staff trained in the principles of Safeguarding Adults to 84%
- introduced awareness raising around PREVENT (the government initiative to stop people becoming terrorists or supporting terrorism) and has a 3 year plan to ensure all clinical staff have attended a workshop to raise awareness of Prevent
- continued to deliver Mental Capacity Act and Deprivation of Liberties Safeguards (DoLS) training

The impact of this increased awareness has been seen in:

- an increase in the number of staff bringing cases for Safeguarding supervision
- an increase in the number of applications under the Deprivation of Liberties Safeguards that have been supported.

Preparation work has taken place to ensure the Trust is ready to respond to the Safeguarding Adults elements of the Care Act from 1 April 2015.

The Mental Capacity Act, 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 relevant 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, Clinical Commissioning Group and Worcestershire Safeguarding Children Board.

During the year 2014/15 the Trust has

- Continued to strengthen multiagency working
- Participated in all local Case Reviews, Homicide Review and Multi Agency Case File Audits
- Attended Worcestershire Safeguarding Children Board meetings and its subgroups.
- Continued to embed changes into practice following learning from multi agency case reviews, Case Reviews and Serious Case Reviews at a local level, as well as acting on the learning and changes to practice required following Governmental Reports where abuse and maltreatment of children and young people has been identified.
- Continued to promote safety / safeguarding of children & young people as a Trust wide responsibility of all staff.
- Re visited the Section 11 Audit and made significant improvement in areas previously rated – Requires Attention. The uptake of safeguarding children

training on a Trust wide basis has risen from 43% at the beginning of 2014 to 72.2% at end of February 2015.

- Expanded the Safeguarding Children & Young People Team by appointing a part time Associate Nurse for Safeguarding Children and also attaining financial agreement to fund a part time Named Midwife post.

Identified issues that are being addressed during 2015/16

- The action plan formulated in 2014/15 to achieve a 95% uptake of mandatory training for safeguarding children will continue and be further developed in line with the requirements of 'Safeguarding Children and Young People : Roles and Competences for Health Care Staff' (March 2014). The training uptake figures continue to be monitored on a monthly basis.
- Work will continue with the Training and Development Team to ensure production of accurate and detailed safeguarding children training data and reports, which capture the data required for audit and assurance reporting.
- Changes to practice, policy and procedures will continue to be made following dissemination of learning from ongoing and pending Governmental Reports where abuse and maltreatment of children and young people has been identified.
- Finalisation and adoption into practice of two revised policies; 'People who work in a Position of Trust with Children and Young People / Allegation against a Member of Staff Policy'; and 'Safeguarding Supervision Policy'.
- Recommendations made following a Care Quality Commission (CQC) visit to Emergency Department in March 2015.

3.4 Clinical Effectiveness

3.4.1 Medical Revalidation / HED tool

Medical revalidation is the process by which the General Medical Council (GMC) confirms the continuation of a doctor's licence to practise in the UK. Revalidation aims to provide greater assurance to patients and the public, employers and other healthcare professionals that their doctor is being regularly checked and remains up-to-date and fit to practise. Licensed doctors have to revalidate usually every five years, by having annual appraisal based on the GMC's guidance for doctors, *Good Medical Practice*. The appraisal combined with information taken from the Trust's clinical governance systems forms the basis of the Responsible Officer (RO) making a recommendation to the GMC regarding the doctor's revalidation.

At 31 March 2015, there were a total of 364 doctors with a prescribed connection to the Trust, with 186 doctors successfully revalidated by the GMC since April 2013. 33 doctors were deferred (to a future date) however 21 of 33 doctors have since been revalidated.

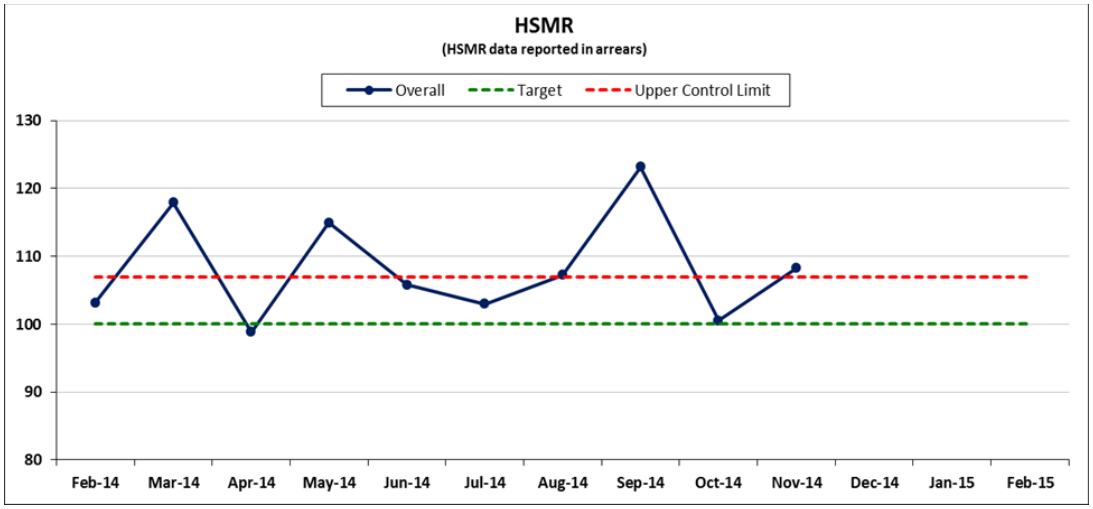
On-going training, support and guidance provided by the Responsible Officer, Trust Appraisal Lead and Human Resources Department has continued to show a positive impact. The increased engagement with medical appraisal is reflected by the increase in rate of medical appraisal from 63.7% in April 2014 to 78.9% in 2015.

3.4.2 Mortality overview

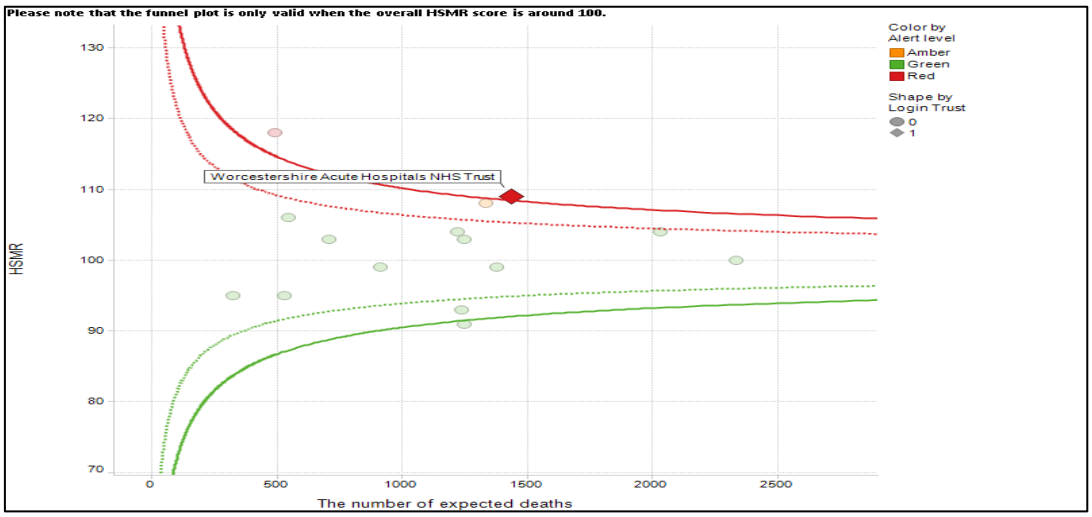
Hospital Standardised Mortality Ratio (HSMR) : April 2014 – November 2014 = 109

The latest data available shows that for the first two quarters of 2014/15 the HSMR is 109. Case note reviews have been commenced in diagnostic groups with higher than expected mortality to understand whether this is a real effect or whether other factors such as coding have an impact. The findings of case note reviews are reported to the Safe Patient Group.

The details of patients from two groups (Prostate cancer and Peritonitis) have been shared with the CCG in order that primary care colleagues review the pre-hospital care delivered to these patients.

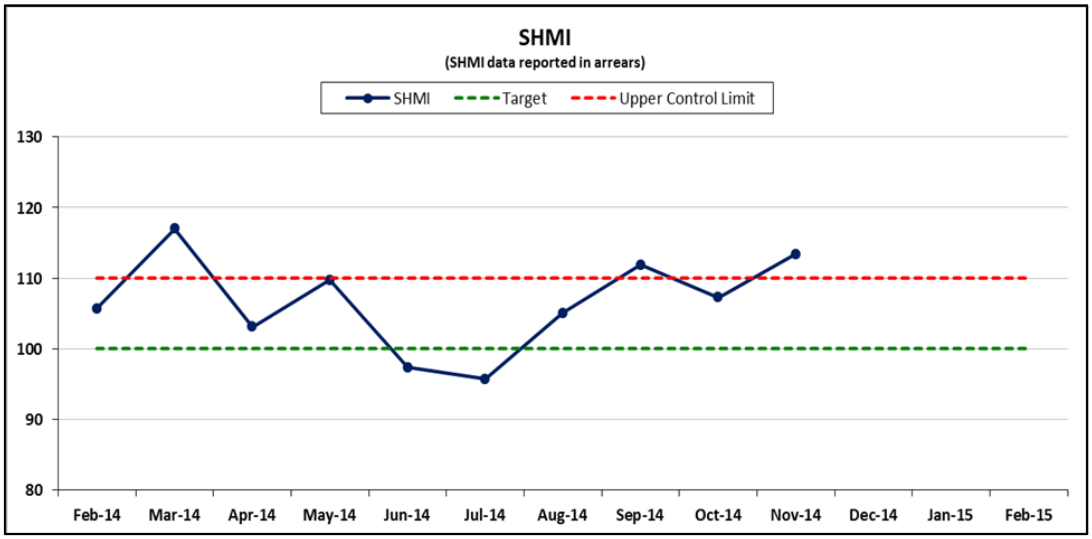


The funnel plot for HSMR April – September 2014, following a data upload at the end of December demonstrates a value of 109 which falls just outside 2 standard deviations from the expected rate.



Summary Hospital-level Mortality Indicator (SHMI) : April – December 2014 = 108.2

The SHMI at year end is also above the upper control limit. There have been some data quality issues experienced by the Health & Social Care Information Centre and HED during the year and this information is currently under review for its accuracy.



The mortality review process was re-launched in March 2015

3.4.3 Research and Development Services

Services provided:

The Trust has a Service Level Agreement for a Research Management and Governance service to be provided by West Midlands (South) Comprehensive Local Research Network. This is renewed annually and has been in place since 2008/09. Through helping to develop a more robust infrastructure throughout the Trust the Research and Development department supports researchers to become involved in and recruit to National Institute for Health Research (NIHR) portfolio studies.

Alongside promoting and encouraging the growth of research activities within the Trust, the main responsibility of the R&D Department is to ensure that Research Governance is maintained to a high level in all research projects in the Trust. The R&D Department, along with the R&D Committee, also has a responsibility in ensuring that the safety of all patients participating in research and the interests of the Trust are protected at all times.

Quality performance in 2014/15:

Each year the Trust agrees a target to increase recruitment into NIHR portfolio studies with West Midlands Clinical Research Network. The target has increased year on year and has been met for the last two years and the Trust is currently on track to meet the target for 2014/15.

This year has seen the opening a new Oncology centre within the Trust and a number of new oncology consultants have been recruited. This has meant an increased interest in research and greater potential with now the possibility of recruiting to radiotherapy studies and treating these patients locally.

Improvement aims for 2015/16

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	DH priority	An increase in commercial studies compared to last year	Number of patients recruited into commercial studies and number of commercial studies open
Increase recruitment into NIHR portfolio studies during a year of transition	It is imperative that recruitment rates continue to meet or exceed target to secure funding	Recruitment target has been set at an increase of 10% of 14/15 target for 15/16	Number of patients recruited into portfolio studies
Work more collaboratively with HEIs and other NHS organisations, to improve the Trust 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 Trust engage with other organisations including working together with other NHS organisations to support new hosting arrangements. It is vital for the future success of the organisation that the Trust makes every effort to maintain a stable and secure research workforce.	Collaborative working and involvement with HEI's other Trusts and WMAHSN	Number of collaborative projects

3.4.4 End of life care plan

The *Liverpool Care Pathway* was discontinued in July 2014 and each healthcare organisation had to develop its own replacement tool. Using the advice provided in "More Care, Less Pathway" and subsequent publications to develop it, the Trust's new End of Life Care Plan comprises the following components:

1. A nursing assessment/monitoring chart for use at the end of the bed.
2. "Optimising Care at the End of Life", a basic documentary framework that is placed in the clinical notes of the patient.
3. Improved information/literature for patients and carers.
4. A "carer's diary", for the facilitation of information exchange with ward staff.

Our review after 6 months of use showed the following:

- *Audit of use of "Optimising Care at the End of Life"*
  General uptake could be improved, as could the completion of each section.
- *Online survey, open to all Trust doctors, nurses and AHPs:*
  "Optimising Care at the End of life" was helpful but a bit wordy.
- *Review of formal complaints received by WAHT relating to any aspect of end-of-life care:*
  Formal complaints during the 6-month study period had **reduced by 70%** (60% in the year full year comparison from 20 to 8) from the level that had been received during the same six-month period one year earlier when we were still using the Liverpool Care Pathway.

We have removed virtually all the guidance from "Optimising care at the End of Life", which has now become a simple framework for the documentation of key aspects of any end-of-life care dialogue with patients and/or carers.

National End of Life Care Audit 2015

The WAHT End of Life Care Plan will be re-launched during April 2015.This should optimise the quality of end-of-life care within WAHT during the all-important national audit study period. Members of the Palliative and End of Life Care will spend the subsequent three to four months auditing every set of hospital notes relating to an inpatient death. Our findings from this mandatory exercise will be submitted to the Royal College of Physicians and our Trust's performance will be benchmarked against regional and national averages.

The *AMBER Care Bundle*

This simple tool is used by general ward staff whenever a patient with advanced chronic disease and a prognosis of about a year or less develops an acute health problem that makes their immediate recovery uncertain. It serves as a prompt to the team to:

- Provide the patient and carers with a realistic clinical perspective of the situation.
- Explore patient preferences for care (perhaps including the introduction of Advance Care Planning and Advance Decisions to Refuse Treatment documents), including preferred place of care and preferred place of death.
- Consider what level of escalation in care is appropriate (e.g. transfer to Intensive Care Unit
- Agree cardiopulmonary resuscitation status.
- Most importantly, ensure that daily dialogue takes place between health professionals

Repeated audits of the AMBER Care Bundle within this Trust have shown that its use dramatically reduces the rate of hospital readmission within the subsequent 30 days when compared to an equivalent cohort of patients for whom it is not used.

Workshop for Consultants

We believe that there have been several other exciting developments within the Trust's Specialist Palliative Care and End-of-Life Care Teams in recent months and we plan to provide a palliative care/end-of-life care workshop on each hospital site, primarily intended for Consultants, in late summer. We intend for these workshops to be very practical in nature, exploring things such as:

- How best to engage with advance care planning/end-of-life care topics at various steps along the patient journey.
- How the different specialist palliative care services within the county fit together.

Referrals to the service have increased at least 58% since 2011-2012: Alongside this, patient contacts by the specialist palliative care team have grown at least 126%.

3.5 Patient Experience

We are committed to working with our patients and their families / carers to ensure they are engaged in all aspects of their care, that their experiences are as positive as possible and that their feedback informs ongoing service development and delivery. The last year has seen some changes to the structure of the Patient Experience team with the bringing together of our Complaints, Patient Advice and Liaison Service (PALS) and patient experience staff under one Associate Director in January 2015. This has been undertaken to support the achievement of the objectives in our '2013-17 Patient, Public and Carer Experience Strategy' through clearer accountability, focussed support to our Divisions and to reflect our commitment to ensuring that public, patient and carer voices remain central to our healthcare services.

The Patient and Carer Experience Committee meets bi-monthly and monitors our complaints, compliments, patient experience feedback and improvement activities. The Committee's annual work plan covers all aspects of patient experience including equality and diversity issues and reports to our Quality Governance Committee.

Significant improvements have been made to our complaint handling processes during the last year and we are looking to develop this further and improve patient information during the forthcoming year.

3.5.1 Complaints

We have seen a reduction in complaints received and a significant improvement in the timeliness of our responses during 2014/15.

Having previously engaged an external consultant to review our complaints process, this year we revised and published our new policy and procedure. This was accompanied by a *'Listen, Act, Learn'* event in November 2014, supported by The Patients Association, which was attended by Trust leaders and frontline staff to look at what could be put in place in the Divisions to improve response times and ensure that any learning from feedback could be more systematically shared throughout the organisation. This well-attended event was followed up in February 2015 with a *Feedback Forum* where each Division was able to demonstrate that by concentrating on the problem and putting new processes in place they could considerably improve their response times. This feedback, and the follow up report from The Patients Association, is now contributing to a further review of our complaints processes and staffing structure to ensure that these improvements can be built on and sustained into the future.

Our Divisions have been working hard to ensure that they have more local ownership of complaints and staff are empowered to resolve concerns locally. The Trust has continued to provide "ACE with Pace" customer care training and also full day workshops for resolving complaints, with a drama based training company.

All complaints are monitored by categories and the areas that they relate to down to ward level. When patterns and trends are detected the Divisional Management Teams are expected to undertake in-depth reviews and to address any underlying causes and share best practice initiatives across the organisation.

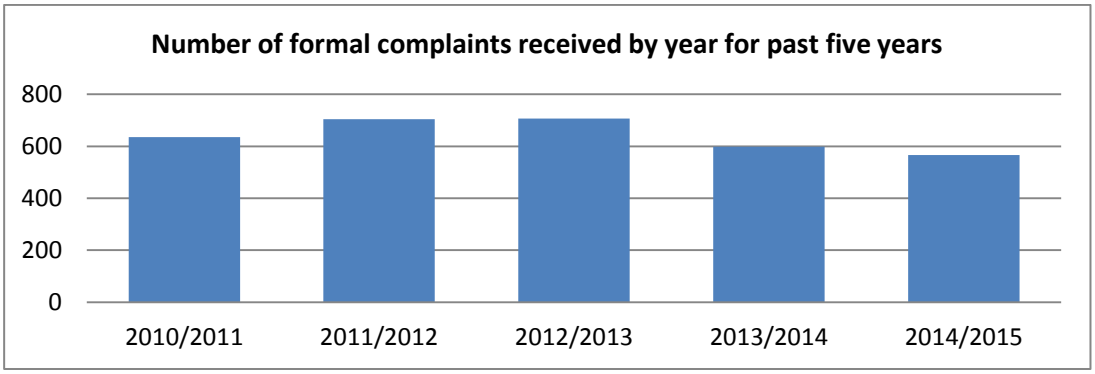
Work will continue into 2015/16 to improve the complaints process and ensure that the principles of '*My Expectations'* (Parliamentary and Health Services Ombudsman/ Healthwatch) are incorporated into our complaints management processes.

Complaints are allocated to one of three categories 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, and we aim to reply within 25 working days.
- **Category 3** complaints are more serious matters which may involve a serious incident investigation and as such response time is negotiated with the complainant.

Complaints received

The changed process has seen an impact with the number of formal complaints received in the past financial year reducing to 566 from 598 in 2013/14 and 707 in 2012/13.



Categories of complaints received in 2014/2015	Total
Category 1	6
Category 2	555
Category 3	5
Total	566

Complaints are monitored by national codes (KO41a) and also by locally agreed subject coding which allows identification of themes. This year's key areas are detailed below:

Top 5 complaints codes (KO41a) 2014/15	Total
All aspects of clinical treatment	345
Attitude of staff	59
Appointments, delay/cancellation (outpatient)	38
Communication	29
Appointments, delay/cancellation (in patient)	28

Top 5 sub-subjects codes for complaints in 2014/15	Total
Lack of communication	145
Patient Comfort	114
Attitude of medical staff	102
Medical Treatment	100
Delay receiving treatment	99

In 2015/2016 the KO41a codes will be changing and the Trust will be required to report to the Department of Health quarterly instead of annually.

The table below shows the number of complaints received for each of the Divisions.

Complaints received by each Division – 2014/15

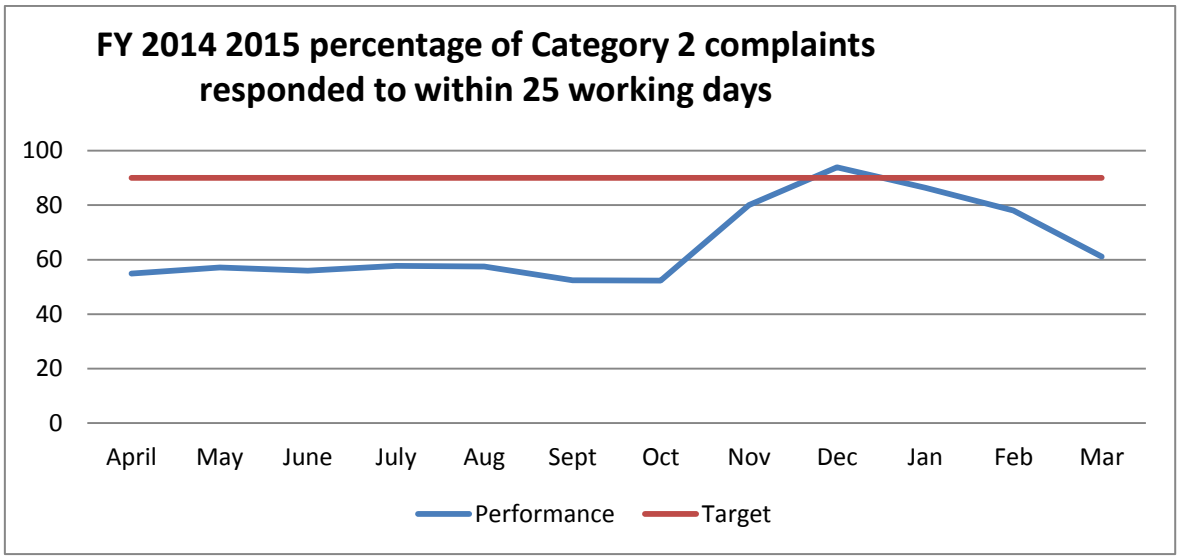
	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Total
Med	16	16	23	18	15	19	19	19	18	16	19	26	**224**
Surg	17	12	20	16	11	14	15	18	21	14	13	17	**188**
W&C	8	5	6	4	7	2	3	10	3	7	4	7	**66**
TACO	6	1	7	4	3	3	2	1	4	2	3	3	**39**
CS	2	0	1	1	1	2	3	2	1	3	0	2	**18**
Oth	3	1	3	2	4	4	3	2	3	2	2	2	**31**
Total	**52**	**35**	**60**	**45**	**41**	**44**	**45**	**52**	**50**	**44**	**41**	**57**	**566**
Bed Days*	22.97	13.82	26.02	19.03	19.05	18.42	18.80	23.57	20.47	17.55	17.74	22.20	

Complaints per 10000 beds days

Key: Med=Medicine, Surg=Surgery, TACO=Theatres, Ambulatory Care and Out patients, CS=Clinical Support, W&C=Women and Children. Oth=Outside of Division.)

Response times

We have set our own response target for complaints which requires 90% of Category 2 complaints to be responded to within 25 working days. Following our *'Listen, Act, Learn'* event and subsequent follow up, our response times improved significantly and the target was met in December but has disappointingly fallen back.



Further training is being planned in the coming year to resolve issues before they become complaints, but also how we investigate to ensure that the root causes are identified, that our response covers the issues raised and our responses are empathic and clear.

Divisions are provided with regular reports on their performance, and delayed responses are escalated at 22 days to the Associate Director of Patient Experience.

Learning from complaints

One of the most important aspects of monitoring complaints is to ensure that the Trust learns from them and takes action to ensure that the situation that led to the complaint in the first place is not repeated. To support this, the Divisional Quality Governance Leads are working with the Complaints Team to improve action planning and shared learning.

Some examples of learning from complaints:

Lack of Communication / Miscommunication

- Changes to the amniocenteses information leaflet to include asking the question 'do you want to know the sex of the baby?"
- Ward Sisters are giving patients business cards with their direct contact number for better communication.
- Care plans will be completed with more input from the patient, or relatives, or both. If appropriate, the 'About Me' booklet will be completed for patients with dementia and providing the opportunity for patients and their carers to have an orientation visit to the ward to provide reassurance and ensure that there is a degree of familiarity for them once they are admitted.

Patient Comfort

- The nurse in charge of the bay will document food intake prior to food trays being taken away. Dietician recommendations will be clearly displayed at the bedside.
- Blue badge holder spaces along the roadside to the main entrance have been re-provided on level ground within the main car park as close as possible to the main entrance.
- All relevant staff are undertaking training with the radiology department to become competent in caring for and redressing the nephrostomy tubes. Documentation is being introduced by the radiology department for ward staff, as well as patient information sheets for troubleshooting and caring for nephrostomy tubes for patients on discharge.

Delays in receiving treatment

- Medical presence across the Worcestershire Royal Hospital and the Alexandra Hospital has been improved with further investment in consultant posts.
- Staffing levels reviewed - there is now a Ward Sister or Junior Sister on each day to provide senior cover
- The number of Health Care Assistants on a ward has increased to improve the response to call bells

Attitude of staff

- Listening workshops will be used to increase staff understanding and engagement in the act of communication with patients and relatives.
- Matron monthly quality Patients' and Relatives' Clinics have been introduced
- We have produced an anonymised presentation to share with the midwives and maternity support workers to facilitate reflection, learning and awareness of the importance of attending to all care elements holistically.

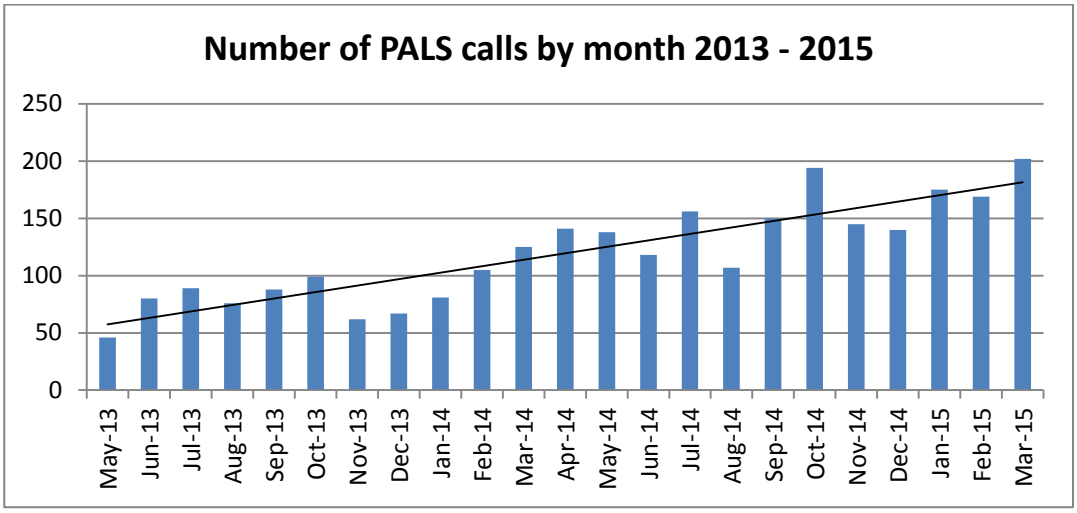
Parliamentary and Health Service Ombudsman

In the last financial year there were 5 cases referred to the Parliamentary and Health Service Ombudsman. Complaints usually go to the Ombudsman after all other avenues have been exhausted. 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. 3 cases proceeded to formal investigations in 2014/15 and 1 was upheld. The Trust was required to provide £300 in redress.

3.5.2 Patient Advice and Liaison (PALS)

The Trust currently has one PALS officer covering all three sites and the number of PALS calls received has increased steadily throughout the year.



The PALS Officer works primarily with Matrons to ensure that callers concerns are addressed within 24 hours, thus reducing possible anxiety and distress. They also follow up calls to ensure that contact has been made and the caller is satisfied. The main themes resulting in PALS calls during the year are as follows:

Top 5 subject matter of PALS calls in 2014/15	Total
PALS providing information or sign posting	498
Medical Treatment	163
Delay in receiving treatment	126
Delay in outpatient appointment	125
Lack of communication	110

3.5.7 Compliments

The Trust receives far more compliments than complaints with 5297 received during the past year. Positive feedback is regularly shared with teams to reinforce good practice and positive patient experience including:

> *'I just wanted to pass on my thanks to the MRI team at Kidderminster and CT at Worcester. On arrival I was quite nervous. However, your staff noticed I was nervous and took time to ask me what I liked and didn't like …. and made me feel at ease quickly as they had a number of strategies to keep me focussed and calm. I know I will be returning in 3 months for a repeat scan but don't think I will be nervous at all. I was absolutely dreading it but because of their approach and how they interact with their patients (not just me I noticed excellent compassion with an elderly lady) my fears have completely gone. What a team. Thank You!'*

> *'I want to put on record my thanks for the excellent service I received during 3 recent visits to the Alex. Experiencing chest pains I visited the A&E Departments walk in GP centre and saw a really helpful GP. The service was swift and the staff were really professional. I know there is a lot of bad publicity around hospitals these days ….. but my experience has shown that this is a good place to be treated'*

3.5.8 Friends and Family Test

The Friends and Family Test (F&FT), introduced in 2012 is a national initiative designed to help service users, commissioners and practitioner ensure services measure patient experience. 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 provides a simple way for every patient to give feedback on the quality of the care they receive and helps us improve our services.

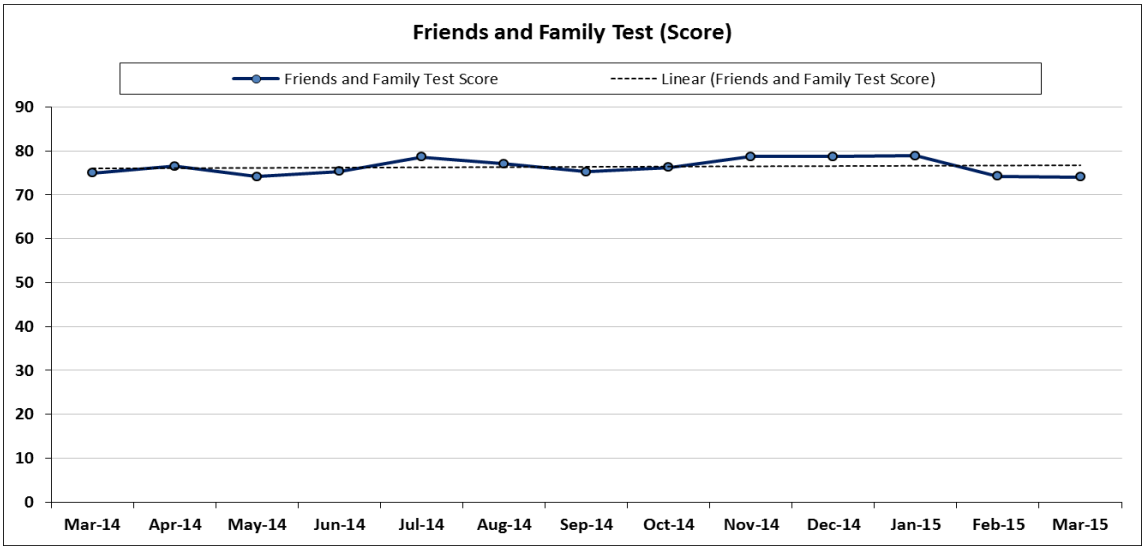
When patients are discharged, or within the 48 hours that follow, we ask them the following question:

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

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

The scores are then calculated which gives a score between -100 and +100.

The graph 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 32,332 responses (2014/15)



Friends and Family gives us an indication of whether our services are meeting patient needs and whether they are being delivered in an acceptable way. This is supplemented by a number of other more detailed surveys based on specific service areas. The F&F forms are given out by staff and volunteers.

The Friends & Family Test also forms one of the Trusts Commissioning for Quality and Innovation (CQUIN) targets. In 2014/15 the Trust was required to achieve completion rates of at least 20% in A&E, 30% in inpatients and 30% in maternity services. This has been partially achieved.

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

3.5.3 National Inpatients Surveys 2014/15

The Trust has undertaken a variety of national patient surveys during the year covering: Day Cases; Inpatients; and Accident and Emergency services with further local surveys conducted using the Hospedia patient entertainment system which is available in ward areas across the Redditch and the Worcester sites (with the exception of Aconbury wards). As well as providing entertainment options it also provides hospital information and is used to capture near real time patient feedback.

Day Case Patients – Conducted by Picker – December 2014			
Overview:	• Survey of 10 Trusts - Response rate 59% compared with average of 51%		
14 Questions scoring significantly better than the Picker average		**Questions showing significant improvement since 2012:**	**2 Questions scoring significantly worse than the Picker average**
Including: • Arriving: had to wait a long time before operation or procedure • Surgery: not told how to expect to feel after operation or procedure • Nurses: sometimes, rarely or never enough on duty • Discharge: not fully told of danger signals to look for		• No previous data for comparison	• Before visit: not given choice of appointment dates • Discharge: did not receive copies of letters sent between hospital doctors and GP
Actions	In response to these results we are looking at ways to improve the availability and choices appointment dates. We do not send copies of letter between hospital doctors and general practitioner routinely		

Accident & Emergency Survey – Conducted by Picker - September 2014			
Overview:	• Survey of 73 Trusts - Response rate 38% compared with average of 32%		
7 Questions scoring significantly better than the Picker average		**3 Questions showing significant improvement since 2012:**	**0 Questions scoring significantly worse or worsening score than 2012**
Including: • Arrival: not enough privacy when discussing condition with receptionist • Care: not reassured by staff if distressed • Patient not clearly told why they needed these tests • Hospital: unable to get suitable refreshments • Leaving: not told who to contact if worried		• Emergency department not very clean or not at all clean • felt bothered or threatened by other patients • Leaving: not fully told about the danger signals to look for	The Trust did not score worse on any question compared with the previous survey from 2012
Actions	A&E issues are described elsewhere in this Quality Account.		

Inpatient Survey – Conducted by Picker - September 2014			
Overview:	• Survey of 78 Trusts - Response rate 49% compared with average of 45% • (This survey is part of the CQC Inpatient Survey 2014)		
4 Questions scoring significantly better than the Picker average		**3 Questions showing significant improvement since 2012:**	**1 Question scoring significantly worse or worsening score than previous survey**
• Surgery: results not explained in clear way • ward sleeping areas mixed sex not single sex • patients in more than one ward, sharing sleeping area with opposite sex • Discharge: Staff did not discuss need for additional equipment or home adaptation		Including: • Admission: had to wait long time to get to bed on ward • Doctors: did not always have confidence and trust	• Planned admission: should have been admitted sooner

Actions	In response to the these results we have taken the following actions: • Developed actions regarding the admissions procedures at Divisional levels which ensure patients are kept informed regarding the availability of beds for planned procedures. If a cancellation cannot be avoided patients receive a letter apologising and giving a possible date for admission. • The Surgical and Theatres, Ambulatory Care, Critical Care and Outpatients department (TACO) divisions are reviewing the pre-admission process across the Trust and looking at timely preparation of patient's pre-operative psychologically and physically. This also includes a review of pre-operative patient information. • Issues regarding feedback on food are being led by the catering teams across the trust. Mini-Patient Led Assessment Clinical Environment (PLACE) assessments are being undertaken where the quality of food provision, choice and patient feedback is collected and local actions taken. Also, a Food and Drink Task and Finish group is being established to review food and drink provision for patients across the hospital.

CQC Inpatient Survey - http://www.cqc.org.uk/provider/RWP/surveys

The CQC also undertook a benchmarking survey for inpatients in 2014 incorporating the views of over 62,000 people who were admitted to NHS hospitals in 2013. 850 patients from each individual Trust were selected with 438 Worcestershire patients completing and returning their surveys. The responses were then compared and benchmarked.

The Trust compares similarly in all areas to other Trusts. However we recognise that in some areas scores were poor particularly regarding information provision and opportunities for feedback. Significant work is now taking place going forward into the forthcoming year to improve our Patient Information across the organisation and ensure that all patients / families and carers understand what opportunities there are for ensuring that their views are taken into account.

CQC – Accident & Emergency Survey

During January, February or March 2014, a questionnaire was sent to 850 people who had attended an NHS accident and emergency department (A&E). Responses were received from 307 patients at Worcestershire Acute Hospitals NHS Trust.

The Trust compares similarly in all areas to other Trusts except for Leaving A&E / being told about danger signals to watch for after going home for which we were rated 'Better' than other Trusts.

3.5.4 Hospedia Feedback – local surveys

The surveys conducted via Hospedia gave these results:

Hospedia Survey	Results	Actions
Friends and Family Test (started 16/10/14)	84% of respondents stated that they were 'Extremely Likely' or 'Likely' to 'recommend our ward to friends and family if they needed similar care or treatment?"	
Carer Survey (started 19/06/13)	Positive experiences: • carers are welcomed onto the wards. • Staff introduce themselves and their roles. • carers feel that they have opportunities to discuss concerns/observations with ward staff and that these are acknowledged or dealt with. • carers are informed where they can go for refreshments or to have a rest. Less positive feedback includes: • The "About Me" booklet is not always	This feedback is being taken forward as part of our on-going work with carers. Working jointly with Worcestershire Carers Unit we have produced a Carers Information leaflet which will be launched in April as part of our commitment to supporting carers and ensuring that they are aware of where they can access appropriate advice and support services.

	completed. If it was then it could help staff better understand the person the carer cares for. • Carers could be more actively included in the planning for discharge. • Carers should be given adequate notice of the day and time of discharge. • Carers would like to be given information about carer's service and support.	
Patient Satisfaction (started 01/07/13)	**86%** of respondents said that 'staff listened to their concerns when they first attended?" Positive feedback also included: • ward staff were friendly and approachable. • patients were seen every day by a doctor. • patients felt involved as much as they wanted to be in decisions about their care and treatment. • patients were given enough privacy when discussing their condition or treatment. • patients felt they were treated with respect and dignity while in hospital. Less positive feedback includes: • Noise at night	Work is under way to reduce the noise at night on wards.
Cleanliness Poll (started 05/02/14)	When patients were asked "In your opinion, how clean was the hospital room or ward that you were in?" only 5.4% responded with "Not very clean" or "Not at all clean".	We are continuing to address the areas identified as concerns and are being ably assisted by our Patient Public Forum in taking this forward.
Learning Disability Survey (started 08/07/13)	110 patients with Learning disabilities and / or their carers completed this survey with 73% stating hospital staff were "friendly and helpful"	See section 3.5.11

3.5.5 Learning Disabilities

The Trust is a member of the Worcestershire Learning Disability Partnership Board and has forged strong working relationships within the Boards Health Sub Group which has successfully led on developing the 'My Worcestershire Health Plan'.

The Trust also contributed to the Worcestershire's Adult Learning Disability Strategy 2015 – 2018 and has introduced an e-learning package for Learning Disability which was launched in January 2015. Additionally we also have some 42 ward / department based learning disability champions who are helping us deliver the ' My Worcestershire Health Plan'.

Healthcheckers Visits

The Trust has developed an effective partnership with Healthcheckers who have undertaken two audits at both Worcester and Redditch during the past year. The visits were both largely positive finding:

- That reasonable adjustments were made for patients with learning disabilities
- The 'About Me' booklet was completed
- Staff were kind and caring
- Learning Disability Champions / Liaison nurses were clearly identifiable and known.
- Red wristbands were worn by patients who needed assistance with eating and drinking

Areas for improvement included:

- Hospital signage
- A lack of Easy Read leaflets in some areas

Follow up actions are being undertaken including improving Trust wide access to Learning Disability information and leaflets and on-going training and development for staff.

3.5.6 Patient Experience Stories

Patient stories are regularly shared throughout the Trust at Board and ward level. One such story was shared a patient with learning disabilities who gave a talk to theatre staff at Kidderminster on his hospital experiences. Another Patient, shared his experiences of a lengthy period of hospitalisation which included preparing him and his family for the fact that he may not recover. An article relating to this was also published in the local paper. These stories are extremely powerful in ensuring patients experiences remain firmly at the heart of everything we do and by sharing these it helps all staff remember why we do the work we do and the impact that we each have individually on those that we treat and their families.

3.5.7 Patient Opinion

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.

We now also see a large amount of patients using Twitter and Facebook to give us feedback on services. Throughout 2014/15 patients commented on a wide range of services, including A&E, maternity and surgery.

143 patients posted comments on NHS Choices
187 patients posted comments on Patient Opinion

Worcestershire Royal Hospital received the most comments, followed by the Alexandra Hospital and then Kidderminster Hospital and Treatment Centre.

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

For social media, as with other online comments, all feedback is passed directly to the manager concerned. Patients providing negative feedback are contacted and this is followed up as required.

The majority of comments on both NHS Choices, Patient Opinion and those found on social media have been positive, with the trust scoring 4.2 stars (out of 5) on Facebook, 4 stars (out of 5) on Patient Opinion and 4 stars (out of 5) on NHS Choices.

Positive comments themes are:

- Reassuring
- Calming
- Professionalism
- Caring
- Personalised care
- No delays

Negative comments themes are:

- Miscommunication
- Staff attitude
- Cancelled operations
- Car parking

3.5.8 Patient & Public Forum

The Trust has a very active and committed Patient and Public Forum which helps us with a wide range of activities aimed at improving patient experience and services across all our sites.

These activities include ward and clinic visits, contributing to specific areas of work such as reviewing documents and sitting on a range of Trust Committees.

- They have helped to support Patient Led Assessment Care Environment (PLACE), Mini PLACE and Quality Reviews and taken part in a Peer Review on Discharge.
- The Forum have completed 38 visits up to 20 March 2015, with more planned. During the visits they observe practice including cleanliness, ask patients/carers about their experiences of care, privacy and dignity and nutrition and hydration.
- Reports of these visits are sent to senior managers and executives. Wards and clinics prepare action plans which are reviewed by the Patient and Public Forum who then make follow – up visits to observe and comment on improvements. We act as a critical friend to the trust.
- Two Forum members have been actively involved with all the planning groups involved in delivering the recently opened Oncology Centre and are now helping progress with the Acute Chemo expansion planned for the first floor and in monitoring service continuity as the treatment is moved from out of county to Worcester Royal Oncology Centre..
- Forum members sit on all out main committees and groups reflecting s our commitment to taking on board user feedback and using this to continuously improve our services. To assist them with this they have attended lectures and training sessions which in the past year have included: Root Cause Analysis; Listen, Learn Act Complaints Conference; CQC Inspections by Prof. Sir Mike Richards, and NHS Change by Rt Hon. Stephen Dorrell.

3.5.9 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 2014/15.

3.5.10 Privacy & Dignity

The Trust has a Privacy and Dignity working group which includes nurses, housekeeping staff, our volunteer Manager, Patients and Public Forum members and matrons which meets bimonthly. During the past year we have had announced and unannounced visits from the CCGs and the Patient & Public Forum and Healthcheckers. None of these visits revealed any major areas of concern in relation to privacy and dignity however with the pressures on A&E resulting in patients in corridors we have continued to remain vigilant and raise awareness to ensure that we continue to improve privacy and dignity for patients in our care.

Dignity Champions

As part of our commitment to this we have a number of Dignity Champions throughout the Trust. A "dignity champion" is a member of health or social care staff, who volunteers 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 across all wards and departments.

The Dignity and Nutrition Link nurse study days are now delivered on a quarterly basis and incorporate:

- Compassionate care
- Chaperoning patients
- Dignity pledges
- “Hello my name is….”
- The power of Empathy
- Dignity at End of Life
- Dignity & Dementia care
- Keep me dry….(continence and dignity)

3.5.11 Improving Nutrition and Hydration

There has been a wide range of activity this year aimed at improving hydration and nutrition and we have made the following changes based on what our patients tell us:

- Improved the quality of sandwiches provision on one of the hospital sites by changing the providers.
- Dragon’s den bid new jugs and cups to aid hydration of elderly frail patients.
- Focus on hydration by promoting the ‘drink up ‘campaign promoted by nutrition/hydration link nurses.

Nutrition/Hydration Link Nurse programme 2014/15 covered the following topics:

- Malnutrition & wound healing.
- Nutrition & Liver Disease
- Special diets e.g. vegan , halal & gluten free menus
- Hydration assessment tool and care plan
- Hydration and End of life care
- Modified diets- Food Texture Descriptor
- Dysphagia and nutrition
    - Developed hydration training for link nurses and plan to roll out e-learning hydration training.
    - Fluid balance training

The Fluid Audit in December identified some remaining issues in working out patient’s fluid inputs and outputs. We are providing further training for staff and awareness raising and this will continue on-going development and review at the Nutrition & Hydration Group.

3.5.12 PLACE Assessment

Patient-led assessments of the care environment (PLACE) were introduced in 2013 and are conducted in April / May each year. The results from 2014 are provided below.

Organisation Name	Cleanliness	Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance
Worcestershire Acute Hospitals NHS Trust	96.14%	83.42%	88.91%	90.56%

Site Name	Site Type	Cleanliness	Food Overall	Ward Food	Organisation Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance
The Alexandra hospital	Acute	96.96%	83.68%	85.14%	78.62%	83.61%	86.97%
Worcestershire Royal Hospital	Acute	96.38%	83.15%	82.76%	84.91%	95.89%	94.93%
Kidderminster Hospital	Community	92.17%	83.68%	86.67%	78.06%	77.57%	84.42%

3.6 Staff Experience

3.6.1 Staff Survey

The 2014 NHS National Staff Survey was undertaken for the Trust by Quality Health[1]. Questionnaires were sent to 850 staff which was the official random sample number for the Trust. Of these 320 staff completed the survey making our response rate at 38% (compared to 42% last year). The national Acute Trust average has reduced this year to 42% (from 48%).

[Data taken from CQC Staff Survey Report 2014]

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

	Questions/Key Findings	WAHT score 2013	WAHT score 2014	National average for acute Trusts 2014
KF27	Percentage of staff believing the trust provides equal opportunities for career progression or promotion	89%	91%	87%
KF2	Percentage of staff agreeing that their role makes a difference to patients	91%	92%	91%
KF6	Percentage of staff receiving job-relevant training, learning or development in last 12 months	80%	82%	81%
KF12	Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month	38%	32%	34%
KF10	Percentage of staff receiving health and safety training in last 12 months	76%	79%	77%

Our Bottom 5 ranked scores – where we scored least favourably with other Acute Trusts)

	Questions/Key Findings	WAHT score 2013	WAHT score 2014	National average for acute Trusts 2014
KF20	Percentage of staff feeling pressure in last 3 months to attend work when feeling unwell	35%	34%	26%
KF1	Percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver	77%	73%	77%
KF29	Percentage of staff agreeing that feedback from patients/service users is used to make informed decisions in their directorate/department	n/a – new question	48%	56%
KF18	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	31%	32%	29%
KF4	Effective team working (scale of 1 – 5 with the higher score the better)	3.56	3.69	3.74

[1] Quality Health is an independent provider who has experience in carrying out staff and patient surveys for the NHS.

Our 5 most improved responses from last year are:

	Questions	WAHT 2013 score	WAHT score 2014	% Improvement	National average for acute Trusts 2014
KF26	Staff having equality and diversity training in the last 12 months	45%	53%	8%	63%
Q8c	Satisfied with the freedom given to choose their own method of work	61%	68%	7%	65%
KF12	In the last month witnessed errors or near misses that could have potentially hurt patients	38%	32%	6%	34%
Q2c	Agreed training helped to deliver a better patient/service user experience	62%	69%	7%	65%
Q12d	Agreed that they would be happy with the standard of care for friend/relative	62%	67%	5%	65%

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

	Questions	WAHT 2013 score	WAHT 2014 score	% deterioration	National Average for acute Trusts 2014
Q8d	Satisfied with support from work colleagues	80%	74%	6%	78%
Q15a	Staff attending work despite feeling unwell	68%	72%	4%	66%
Q21b	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	21%	25%	-4%	23%
Q11a	Agree that they know who the senior managers are where they work	80%	75%	5%	81%
Q16	Percentage of staff saying they have felt unwell in the last 12 months as a result of work related stress	35%	39%	4%	37%

"Friends and Family Question" for staff

For the questions that asked staff if they would recommend the Trust as a place to work or to receive treatment, which is measured by responses to the following 4 questions and marked on a scale 1-5:

- The score showed a small improvement (0.03) compared to our 2013 results as shown in the chart below, although this is below the national average. The national average reduced marginally this year so our improvement does seem to be going against the trend.

	Question	WAHT 2013 score	WAHT 2014 score	Average Acute Trust 2014
KF24	**Staff recommendation of the trust as a place to work or receive treatment (higher the better) this measure is taken from responses to 4 questions listed below:**	**3.60**	**3.63** 	**3.67 (reduced from 3.68 in 2013)**
Q12d	"If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation"	62%	67% 	65%
Q12c	I would recommend my organisation as a place to work	59%	58% 	58%
Q12a	Care of patients / service users is my organisation's top priority	66%	67% 	70%
Q12b	My organisation acts on concerns raised by patients /service users"	73%	67% 	71%

Staff Engagement

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

	Key Finding	WAHT Score Scale 1 – 5 2014	Improved or declined	Average Acute Trust benchmark	Average Acute Trust improved or declined
KF22	Perceived ability to contribute towards improvements at work (Q7a, 7b, 7c)	67%	 2%	68%	 0%
KF24	Willingness to recommend the Trust as a place to work or receive treatment	3.63	 0.03	3.67	 0.01
KF25	Motivation and engagement at work	3.87	 0.03	3.86	 0

Our staff engagement score has improved by 3 points but is still marginally below average for acute trusts. However the national acute Trust average score did not improve this year which would indicate that our improvement is positive against the national trend. Our response is higher than the overall national average for ALL types of Trusts which is 3.70.

Question	Trust's 2013 score	Trust's 2014 score	Average Acute Trust 2014	National response 2014 (All Trusts)
Staff engagement (higher the better)	**3.69**	**3.72** 	**3.74 (no change from 2013)**	**3.70**

3.6.2 Progress from the 2012/13 staff survey Action Plan

Our Staff told us	What we said we would do about it	Progress so far
Staff Satisfaction and Engagement  Staff Friends and Families Test	We will work directly with staff within Divisions to **understand why** 40% have not said that they would recommend the organisation as a place to work, and 38% said that they would not recommend as a place to receive treatment. We will take action accordingly.	Divisional managers worked with colleagues to produce their own staff engagement action plans. These were shared with staff within divisions. We have also introduced the national Friends and Families test whereby every member of staff has had the opportunity to tell us whether they would recommend the Trust. This was opened to Women's and Childrens, Corporate, and Clinical Support Division in June, Medicine ICT and Asset Management in September and Surgery and TACO in March. Results have been shared through the divisions and when we have completed the final Quarter will be collated and published via Daily Brief. **The 2014 staff survey indicates that there has been a (5%) improvement in staff reporting that they would recommend the trust for treatment which is now 67% (2% higher than the national average)** **We have had a 1% decline in staff who would recommend the Trust as a place to work – although this is the same as the national average at 58%**
Leadership	We will ensure all staff receive clear feedback on how well they have performed their work on a regular basis. This is a management/supervisors duty and will be monitored through appraisal rates as well as results of the next survey.	Appraisal rates are monitored on a monthly basis at Trust Board and the Learning and Development Department send out monthly reports to managers so that they are aware of appraisals outstanding, and chase them for progress. Our appraisal rates are currently at 77.7% against a target of 85% **Our results in the 2014 survey would indicate that we have improved in the area of clear feedback. 86% of our staff said that they had had an appraisal in the last 12 months which is 1% higher than national average. 36% said that the appraisal was well structured which was 2% improvement on last year but is still marginally below the average of 38%.**
Leadership Development	We will explore why some staff do not feel supported in difficult tasks by their managers, and develop a culture of management support for complex tasks, through supervision, coaching and enablement. This will form part of the Leadership Development programme.	We have launched a Coaching Programme in the Trust and Coaches are now available for staff to access. Leadership Development programmes have been on-going. **Our results in the 2014 survey would indicate that staff's perception of feeling supported by their managers has improved from 3.57 to 3.62 against a scale of 1-5 with 5 being best. National average is 3.65 so there is still work to do in this area.** **However, staff reporting that they can count on their manager for help with a difficult task has worsened by 1% from 68% to 67%. The average trust response is 69%.**
Team objectives	We will ensure there are arrangements in place to support staff and teams to have shared objectives that are communicated effectively and understood. This will be supported through a review of the Chief Executive's brief process as well as appraisals	The Chief Executive/Team brief has been reviewed and re-launched. The appraisal paperwork and policy has been reviewed and published on the intranet. Manager should ensure that teams have shared objectives that link into the aims and vision of the Trust. **Our results in the 2014 survey show that 78% of our staff agree that they have shared team objectives. This is a 1% improvement on last year and is the same as the national average. 78% agree that team members have to communicate closely which is a 4% improvement on last year and is only 1% behind national average acute trusts.**

Our Staff told us	What we said we would do about it	Progress so far
Equality and Diversity Training	We will review the provision of equality and diversity training across the organisation with a view to making this mandatory to complete once in working life, with online updates.	Equality and Diversity modules are included in Privacy and Dignity training, Ace with Pace, Learning Disability training, Deaf Direct training as well as other general training. On line training is available on the course directory. **Our results in the 2014 show an improvement of 8% in this area from 46% to 54%. Although we are making progress this is still below the national average of 63%. As we will not require annual updates it is difficult to see how this will ever reach the national level.**
Health and Safety	We will ensure that feedback from patients and learning points from incidents is consistently used for identifying ways to improve patient/service user safety.	This has been published through Daily Brief, How Was It For You Sessions, and patient stories. **However, the 2014 staff survey included new questions around patient experience which show that there is more work to do. Questions included "I receive regular updates on patient / service user experience feedback in my directorate / department" where we had a disappointing score of 47% against national average of 59%. 46% of our staff agree that "Feedback from patients / service users is used to make informed decisions within my directorate / department" as opposed to 56% nationally.**
Incident reporting	We will ensure that staff feel it is their responsibility to challenge practices that they feel are not working, and remind everyone of how they should report incidents through Datix, as well as to their manager/supervisor, and if necessary through the Raising Concerns policy.	We have been publicising the use of Datix through daily brief and through Team Brief. The message has been “Please ensure that all incidents are reported. Don’t assume that someone else has already reported it. We would rather have the incident reported twice than not at all”. **57% of our staff say that "When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again". This has reduced 1% from last year against a national average of 63%.** **There has been an improvement from 34% to 39% in staff who report "We are informed about errors, near misses and incidents that happen in the organisation"., against a national average of 45%. Also a 2% improvement to 39% on staff who say “We are given feedback about changes made in response to reported errors, near misses and incidents", although national average is 45%.**
Long Shifts	We will review the use of Long Shifts to ensure that they are not causing an impact on staff health and wellbeing or patient safety.	We have reviewed the Flexible Working Policy and Divisions are reviewing their shift patterns both as part of 7 Day Services and Future of Acute Hospital Services review. Staff have been advised that if they feel long shifts is having a negative impact they should report this to their manager or the Occupational Health Department.
Staff Wellbeing	We will review sickness absence procedures to understand why staff are feeling pressure to come to work when they are unwell. We will focus on helping staff to maintain their own wellbeing.	Sickness absence procedures are regularly reviewed and we are working with divisions to support staff in maintaining their own wellbeing. Staff are advised that if they are feeling under pressure they should speak to their manager or the Occupational Health Department. We have been reviewing the Stress at Work policy and have publicised access to staff counsellor for all types of home related or work related stress. **Our response to the 2014 survey indicates that our staff still feel under more pressure than average trusts to come into work when unwell. 72% of our staff report that they have**

Our Staff told us	What we said we would do about it	Progress so far
		gone to work in the last three months despite feeling unwell compared to 68% last year and 66% national average. This has marginally improved in respect of pressure from their manager and themselves, but pressure from colleagues has worsened by 1%. We would expect that this may be directly correlated to the Emergency Access pressures but further analysis and action will be taken in this area.
Staffing	We will work with the divisions to understand why some staff feel that there are not enough staff	Staffing levels are now published on a ward by ward basis for NHS Choices, and shared with the Trust Board. **Our staff survey response in 2014 shows this position has worsened with only 27% of staff saying that they feel there are enough staff compared to 29% last year, and 29% national average. This will be analysed further to see if there are particular staff groups affected.**

3.6.3 Workforce Indicators

As at 31st March 2015:

- 77.8% of our staff (not including medical staff) had an appraisal
- 84.7% of medical staff had had an appraisal
- 88.8% of Consultants had had an appraisal
- 78.3% of our staff had completed their Fire Safety training
- 73.2% of staff had completed their Information Governance Training
- 91.5% had completed Hand Hygiene training
- 79.4% had completed their infection control training
- 79.7% had completed their manual handling update training
- 82% had completed resuscitation update training

- The cumulative sickness rate for 2014/15 as at March 2015 was 4.09% against Acute Trust benchmark of 4.1% (December 2014)
- The monthly sickness rate for March 2015 was 4.25%, compared to 3.88% at the same period last year.
- We were 11th lowest out of 17 acute Trusts in the LETC (based on December 2014 figures)
- Turnover for 2014/15 as at 31st March 2015 based on a rolling 12 month period was 10.42% which is an increase compared with 9.85% for the same period last year.

Sickness rate for past 3 years

Worcestershire Acute Trust Cumulative 12 month Sickness Rate		**Acute Trust Benchmark**
	Cumulative % rate	***Cumulative % rate***
Apr 2014 – Mar 2015	4.09%	4.10% (as at December 2014)
Apr 2013 – Mar 2014	3.84%	4.02%
Apr 2012 – Mar 2013	3.89%	4.26%

In the winter of 2014 we have experienced for the first time in 3 years marginally higher rates of sickness absence than average for acute Trusts in our LETC. This correlates with the pressure that staff said they were feeling following winter pressures, problems with the

efficacy of the flu vaccination, and Norovirus in the community which has affected wards on all sites.

Worcestershire Acute Trust Turnover Rate (rolling 12 months) – excluding Medics		Acute Trust Benchmark – Turnover excluding Medics
	Cumulative % rate	***Cumulative % rate***
2014/15	10.42%	10.1% (as at December 2014)
2013/14	9.85%	8.1%
2012/13	9.19%	9.8%

3.6.4 Staff Engagement

We know 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. We have continued with staff engagement initiatives that were 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 matters of their concerns
- "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.
- Regular surgeries run by the Trust's Chairman, Chief Executive, Director of HR and OD, and Chief Nursing Officer for staff to raise any issues or concerns.
- launching the Staff Friends and Families Test
- Staff Engagements events in relation to Service Review

3.6.5 Independent review commissioned by NHS Trust Development Authority

The NHS TDA has commissioned the Good Governance Institute to lead an independent review to investigate allegations around bullying and harassment at Worcestershire Acute Hospitals NHS Trust.

The review will look at the handling of the concerns raised and the application of trust policies on whistleblowing and raising concerns, dignity at work and grievances with a focus on best practice for investigations. If necessary, the review will make recommendations on how the trust applies its own policies, in line with any national guidance, as well as how it should implement best practice in future.

3.6.6 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 match acuity under Safer Staffing guidelines. Overall turnover is consistently around 10%, with 11% being the average in Health Care Assistants and Non-Clinical staff (Admin, Estates and Facilities).

Challenges remain in some areas in the recruitment of experienced medical/emergency nurses and theatre staff particularly at the Alexandra Hospital, as well as with Middle Grade

Doctors in Emergency Medicine, Acute Medicine, Obstetrics and Gynaecology, and Paediatrics.

A number of targeted recruitment initiatives have been taking place such as the use of our partners at HCL Workforce Solutions, Recruitment Assessment Days, local advertising, Recruitment Open Days, and a review of the recruitment and interview processes/skills in these areas.

Values Based Recruitment was formally implemented for Band 5 nursing posts and healthcare support worker posts in 2013/14. This will be extended to all nursing posts by March 31st 2015.

We have opened a State of the Art Oncology Centre for Worcestershire and recruited 45 professional staff from all over the United Kingdom on a phased basis working in partnership with University Hospital Coventry and Warwickshire. These are "hard to recruit" posts and we are proud of our success in attracting high calibre staff.

3.6.7 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 which accounts for half of their pre-registration 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 Trust has a dedicated team of education and practice facilitators whose role is maximise the learning experience of students whilst undertaking clinical placements.

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.

3.7 Engagement with stakeholders

The Trust is committed to engaging with its stakeholders who include MPs, councillors, Healthwatch, patient groups and health and care partners. It sends a regular brief out to all its stakeholders and holds regular meetings with key individuals in the local community. Before undertaking any reconfiguration or major service change the Trust develops a communications and engagement plan which details how stakeholders will be engaged and communicated with.

The writing of this Quality Account and the setting of priorities for 2015/16 has drawn upon engagement with the Trust's internal and external stakeholders through 2014/15 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
- 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

Specific engagement around service changes during the year included:

Neonatal Care

We established a neonatal care task and finish group in response to concerns that we might have needed to alter the pathway for women who were between 34 and 37 weeks into their pregnancy due to serious staffing issues. The group consisted of a range of stakeholders including the CCGs, West Midlands Ambulance Service, the Trust Development Authority and NHS England. All partners agreed the steps which would need to be taken and were involved in the mitigating actions. The Trust actively engaged with its key stakeholders including Worcestershire County Council's Health Overview and Scrutiny Committee, Healthwatch, MPs and councillors, the media, patient groups and the public to explain what the staffing problems were, what was being done to overcome them and what contingencies were in place if the staffing issues could not be resolved. The staffing issues were resolved and the contingency plans did not have to be activated.

Paediatric Surgery

In December 2014 serious safety concerns necessitated immediate temporary changes to the paediatric surgery pathway. These concerns were raised with the Future of Acute Hospital Services in Worcestershire Quality and Sustainability Committee which was established earlier in the year to monitor the safety and sustainability of clinical services and to identify trigger points at which action needed to be taken. The committee is led by Mr Mark Wake and its membership includes a range of stakeholders including the CCGs, the Trust Development Authority and NHS England. Once the emergency decision to temporarily move all emergency paediatric surgery from the Alexandra to Worcestershire Royal Hospitals was taken on clinical safety grounds key stakeholders were immediately contacted. These included the Health Overview and Scrutiny Committee, Healthwatch and MPs. The wider stakeholder group including the media was subsequently informed of the temp

Future of Acute Hospital Services in Worcestershire

The Future of Acute Hospital Services in Worcestershire (FOAHSW) programme is led by the county's three CCGs. Worcestershire Acute Hospitals NHS Trust is a member of the (FOAHSW) programme board. The FOAHSW programme has developed a clinical model which is currently being reviewed by the West Midlands Clinical Senate as part of NHS England's assurance process. The final clinical model will be put out to public consultation once it is agreed but in the meantime the programme has carried out extensive engagement with the groups representing the nine protected characteristics and those who are most likely to be affected by the proposed changes. More than 50 groups were engaged over a three-month period and their views have been incorporated in a report which will be considered by the FOAHSW programme board before the formal public consultation.

Appendix 1 – CQUIN

Goal Name	Goal Description	Achieved	Quality Domain			
			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.	Partially Achieved			Yes	
NHS Safety Thermometer	To reduce the amount of harm the patients experience through reduction in the prevalence of 'new' Pressure Ulcers.	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	Achieved			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.	To be confirmed. Audit results available end of May 2015.	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)	Achieved	Yes		Yes	
Safe Care	Reducing falls in all adult Inpatient areas including the Accident and Emergency (A&E) Department.	Partially 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.	Partially Achieved		Yes	Yes	

CQUINS agreed with Specialist Commissioners

Goal Name	Goal Description	Achieved*	Quality Domain			
			Safety	Effectiveness	Patient Experience	Innovation
Retinopathy of Prematurity (ROP)	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).	Partially Achieved		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.	Achieved		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 who undergo surgery on day 1 or 2 of life.	Achieved		Yes	Yes	
NHS Safety Thermometer	To reduce the amount of harm the patients experience through reduction in the prevalence of 'new' Pressure Ulcers.	Achieved	Yes		Yes	
Dementia and delirium care (FAIR)	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	Achieved			Yes	

Goal Name	Goal Description	
Acute Kidney Injury (AKI)	This CQUIN focuses on AKI diagnosis and treatment in hospital and the plan of care to monitor kidney function after discharge, measured through the percentage of patients with AKI treated in an acute hospital.	**National**
Sepsis	This CQUIN focusses on patients arriving in the hospital via the Emergency Department (ED) or by direct emergency admission to any other unit (e.g. Medical Assessment Unit) or acute ward. It seeks to incentivise providers to screen for sepsis all those patients for whom sepsis screening is appropriate, and to rapidly initiate intravenous antibiotics, within 1 hour of presentation, for those patients who have suspected severe sepsis, Red Flag Sepsis or septic shock.	**National**
Dementia	This indicator forms part of the national CQUIN which aims to incentivise providers to improve care for patients with dementia or delirium during episodes of emergency unplanned care. The CQUIN has been in place for several years and covers dementia screening, training for staff and support for carers.	**National**
Urgent and Emergency Care	Detail to be confirmed. CQUIN will cover key improvement areas within the urgent and emergency care pathway.	**National**
Prevention of falls for patients on the delirium pathway	Across England and Wales approximately 152,000 falls are reported in acute hospitals each year. A significant number of falls result in death, or severe or moderate injury at an estimated cost of £15 million per annum for immediate healthcare treatment. Falls occurring in older adults are much more likely to result in serious injury due to medical conditions including delirium. This CQUIN aims to reduce the number of falls for patients on the delirium pathway.	**Local**
Patient Experience- 'Small things matter'	Patient experience is a key element of quality alongside providing clinical excellence and safer care. The way the health system delivers its care and support services has an impact on the experience the patient has - from the way the phone is answered, to the way the GP examines them or the nurse explains what was happening...if safe care and clinical excellence are the 'what' of healthcare, then experience is the 'how'. When it comes to medical and nursing care, sometimes it is the small things that make a huge difference to the patient's experience. This CQUIN aims to incentivise local initiatives to improve patient experience.	**Local**
Improving safety culture- human factors training	Human factors encompass all those factors that can influence people and their behaviour. In a work context, human factors are the environmental, organizational, job factors and individual characteristics which influence behaviour at work. Awareness of human factors can help to: • Understand why healthcare staff make errors and in particular, which 'system factors' threaten patient safety • Improve the safety culture of teams and organisations. • Enhance teamwork and improve communication between healthcare staff • Improve the design of healthcare systems and equipment. • Identify 'what went wrong' and predict 'what could go wrong' • Utilise national guidance and tools to lessen the likelihood of harm. This CQUIN covers provision of human factors training in various areas of the Trust.	**Local**
Midwifery Led Care	Nearly 700,000 babies were born in England and Wales in 2013/14, of whom 40% are having their first baby. Studies have shown that 45% of women giving birth in NHS settings are at low risk of complications. Evidence from NICE guidelines shows that midwifery led units are safer for women having a straight forward (low risk) pregnancy due to lower rates of intervention, flexibility in patient choice and a reported improved birthing experience. This local CQUIN incentivises WAHT to ensure that the new Midwife Led Unit, which opened in April 2015 at Worcestershire Hospital, is utilised appropriately.	**Local**
Improving Patient Flow	Implementation of best practice ward rounds and nurse/therapy led discharge	**Local**

Appendix 2

Statements from Commissioners, Local Healthwatch and Overview & Scrutiny Committee

Worcestershire Health Overview and Scrutiny Committee (HOSC) Comments Worcestershire Acute Trust Hospitals Trust Quality Account 2015

The Health Overview and Scrutiny Committee (HOSC) gather information about the Acute Hospital provision throughout the year. This is done through:

- Presentations and examination at (HOSC) meetings – the CE and/or Chairman have attended on several occasions.
- Lead members attending board meetings and providing feedback.
- Meetings between the HOSC chairman and vice chairman and key board members; to help with agenda setting and prioritizing work.
- Meetings with the operational managers of the CCGs.

This helps ensure that the HOSC is relatively up to speed with developments in the Trust and can assess whether the information in the Quality Account (QA) is consistent with what is reported elsewhere. It is the opinion of HOSC members that this is the case.

The HOSC appreciates the chance that some members had to discuss an early draft of the QA, and notes that some of the members' suggestions have been adopted – e.g. to include more information on the Care Quality Commission unannounced inspection and on the Trust Development Authority's investigation into allegations of bullying.

Overall Worcestershire HOSC considers that the Quality Account is a fair and balanced reflection of the services provided by the Trust.

The HOSC statement in the QA last year expressed concern about 'patient flow' and A&E performance. Concerns about these areas remain and we welcome the Trust's frankness about the problems with capacity, consultant resignations and use of the corridor. The HOSC is fully supportive of the Trust's decision to make restoring operational performance in A&E its number one priority for quality improvement next year. We will be keen to track the progress of the improvement strategies being carried forward to address these issues.

We note that the number of patient safety incidents is higher than average, although has fallen against the same period last year. Issues of patient safety and mortality rates are of public concern so the committee is pleased that improvements in these areas are an area of focus. Partnership working, including the availability of social care will be important in reducing the variation in mortality between week days and weekend working, and this should be referred to in the QA. There is concern that it is difficult to discern mortality rates in outlying specialist departments or to establish whether these lie outside a standard deviation. It would be helpful if this information could be made more accessible to the non-expert reader and if the comparison between the ratios of weekday/weekend mortality could be made clearer.

HOSC will continue to monitor the on-going Review of Acute Hospital Services in Worcestershire and has considerable concerns about the length of time it is taking, the uncertainty this creates for public and staff and the potential impact on quality and sustainability of services. In our view the QA should be more explicit about the potential impact of the Review on some service provision, such as neonatal care, although it is acknowledged that the outcome of the Review is in the hands of the service commissioners.

There have been media reports during the year suggesting overbearing management techniques/ bullying. This is not borne out by the results of the results of the staff survey, and we await the outcome of the investigation commissioned by the Trust Development Authority.

Looking at quality performance in 2014/15 (3.2.1), it would be helpful to have further explanation about

what alternative ways are being looked at to overcome the challenge in delivering national 18 week referral to treatment target.

Achievement of stroke targets has been recognised by HOSC, following centralisation of services, and it is hoped that 7 day services will bring further improvements.

The Trust's new Oncology Centre for Worcestershire is very much welcomed and feedback to the HOSC has been very positive.

At about 30,000 words the committee feel that the document would be a challenge to members of the public although it is appreciated that the audit regime is a factor in this.

The response of NHS Redditch and Bromsgrove Clinical Commissioning Group (CCG), NHS Wyre Forest CCG and NHS South Worcestershire CCG to Worcestershire Acute Hospitals NHS Trust Quality Account 2014/15.

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. The Quality Assurance Framework outlines the actions taken by the CCGs to oversee care quality and includes monthly Clinical Quality Review meetings and both announced and unannounced Quality Assurance visits to areas of service provision. The quality assurance role of the CCGs also includes steps to assure the public of the content of this Quality Account.

This year has seen a number of significant challenges for Worcestershire health and social care economy. There has been particular concern and inconsistent assurance regarding a number of issues. Concerns have included the sustainability of some services, workforce capacity and poor patient flow through the acute hospital. Since the autumn of 2014/15 to the end of the financial year the position with achievement of the four hour wait target has deteriorated and the trust had been on consistent high levels of escalation, with a more specific concern for the number of patients waiting on a trolley for more than 12 hours at the Emergency Department at Worcester Royal Hospital site. This is despite an overall position of reduced attendances and admissions and increased complex discharges numbers to the acute trust for the same time period particularly on the Worcester Royal site.

The Quality Account contains some acknowledgment of these concerns, including the warning notices issued by the CQC and initial action already taken.

Actions in the following areas of concern are of priority for Worcestershire CCGs in reducing avoidable harm and ensuring a positive patient experience:

- **Key areas of performance for Accident and Emergency Department waiting times, particularly for Worcester Royal Hospital site.**
- **Elective Referral to Treatment times.**
- **The sustained achievement of cancer standards.**
- **Improvements in timely intervention to reduce the length of stay of patients and increase efficiency, patient awareness and patient involvement in discharge processes.**
- **Strengthening of the Mortality Review process and the embedding of learning following reviews to improve outcomes.**
- **A continued commitment to embed improvement methodologies including Human Factors training.**
- **The recognition of impaired cognition (including dementia) for vulnerable patients and its contribution to patient safety incidents**

In areas where commissioning supported focused activity upon quality improvements (CQUIN) some achievement has been seen, particularly for the collection of information to evaluate patient experience including the implementation of Friends and Family Test questions in ward areas. Other areas of achievement have included work to support improved fluid management for patients. The Trust made significant improvements to reduce the number of falls resulting in serious harm, but

marginally failed to reach the agreed target reduction across 2014-15 for all falls. Schemes to improve aspects of patient flow have had varied success. Some improvements have been seen in the timely assessment of frail, elderly patients. Other aspects of patient flow, including the implementation of best practice ward rounds, were not sufficiently progressed and the CCGs are in agreement for the Trust to continue to focus upon aspects of patient flow as a priority and CQUIN scheme for 2015/16.

In 2014-15 Commissioners continued to monitor a number of Contract Query Notices including some which were issued in 2013-14. Commissioners would wish to see a continuation of initial progress made for completion levels of staff mandatory training and the reviewing of diagnostic results. There is an expectation that responses to required Contract Query Notices are progressed in a timelier manner.

Areas of success are to be congratulated and include continued success to meet the challenge of reductions in the number of Clostridium difficile cases. Recognition attributed to specific services and clinicians, including Ophthalmology and anaesthetics, by national awarding bodies, is a reflection of the commitment of staff to continue to strive for excellence on behalf of the patients they support. By February 2015, the time taken to support patients with hip fractures to have surgery had improved following focused intervention. There is no reference however to the outcomes of the recent Trauma Peer Review. Commissioners would welcome a partnership approach to continuing improvement in this area.

Significant improvements have been seen in complaints management processes and the timeliness of completion of serious incident investigations. The CCGs acknowledge the commitment that has been made by the Trust, under the Sign up to Safety campaign, to reduce the number of harm events.

Detail of the actions being taken by the Trust to improve the extent to which staff members are likely to recommend the Trust as a place to work or as a place to receive treatment, is welcome. The percentage of staff experiencing harassment, bullying or abuse from other staff increased, as reported in the Trusts 2014 staff survey, and this is concerning. Worcestershire CCGs welcome the NHS Trust Development Authority commissioned independent review of processes for the raising and handling of concerns expressed by staff and awaits detail of the final report. Concerns regarding workforce capacity and experience were one of the indicators that culminated in a Risk Summit being held in March 2015 and this is given only marginal reference within the Quality Account.

Worcestershire CCGs consider that most data provided within the Quality Account appear accurate. There are potential discrepancies between the most recently available Summary Hospital-level Mortality Indicator (SHMI) data and the detail contained within the report. In addition there is no evidence within the Quality Account to support the detail within the Chief Executive introduction that performance for the Trust has been influenced by an increase in the complexity and frailty of patients, to any greater extent than any other acute trust. Whilst Commissioners agree with most priorities for improvement identified, there appears to be minimal reference to the impact of urgent care pressures on delayed referral to treatment and elective surgery and the corresponding impact on the quality of care and patient experience. Future Quality Accounts may benefit from specific detail relating to individual hospital sites.

Response from Worcestershire Acute Hospitals NHS Trust:

Thank you for the comments which are welcome. We have provided a response to two items raised in this commentary:

1. Whilst we recognise a reduction in attendances towards the end of the year overall during 2014/15 there was a 5.6% increase in ED attendances from the previous year. Overall admissions for the period were down by 1.6% however admissions in the >75year old age group were up by 3.2% reflecting an older and frailer population.

2. We have addressed the chain of events that started with the resignation of Consultants at Redditch on 13th February in Section 1.1. The Trust approached the TDA to commission an external review on 23rd February. The TDA commissioned the Good Governance Institute to undertake an independent review which took place in April. We are still awaiting the report from the GGI review as at today (17 June).

The 2014 staff survey indicates that there has been a (5%) improvement in staff reporting that they would recommend the trust for treatment which is now 67% (2% higher than the national average)

We have had a 1% decline in staff who would recommend the Trust as a place to work – although this is the same as the national average at 58%. We will continue to work with staff through the divisions and monitor our Staff Friends and Families results around this area.

The Trust was concerned to see that areas around stress at work, abuse and bullying from patients and colleagues had deteriorated this year. These are areas that the Trust takes very seriously, and we have historically always been better than average Trusts in the staff survey. We will work with divisions and staff, and staff side to understand why staff are reporting that they feel under more pressure this year and why more incidents are occurring. We have already increased access to counselling and occupational health support and have commenced reviews of our Dignity at Work and Whistleblowing policies. We will review our zero tolerance policy to ensure that staff feel safe at work.

The Risk Summit took place at the very end of March and although mentioned in the Quality Account in the spirit of openness, we did not have any detail to include.

Healthwatch Worcestershire
Reference: Worcestershire Acute Hospital Trust Quality Account 2014/15

One of Healthwatch Worcestershire's principle roles as the champion for those who use publicly funded health and care services in the county is to use the experiences of patients, carers and the public to influence how NHS organisations such as Worcestershire Acute Hospitals NHS Trust provide services.

Nationally, the NHS 5 Year Forward View which was published by the Chief Executive of NHS England in October 2014 commits the NHS to engaging with patients and the public to ensure their views shape the design and delivery of health and care services. Whilst locally, Worcestershire Acute Hospital NHS Trust, as a partner in the county's 'Well Connected Programme' which aims to integrate health and care services, has committed to place the views of patients, service users and carers at the heart of service deign and delivery.

Therefore Healthwatch Worcestershire has commented on the Quality Accounts of the Worcestershire Acute Hospitals NHS Trust for the period 2014/15 in that context. The process of involving patients, service users and carers in the design and delivery of their services is called 'Co-Production'

1. Do the priorities of the Trust reflect the priorities of the local population?

- We welcome the Trust's commitment to ensuring that public, patient and carer voice remains central to the provision of its healthcare services and we are aware that the Trust has recently appointed a Director to improve its performance in this area of its business.
- However, we note that whilst there are numerous priorities identified in the body of the Quality Account, some of which have been identified through engagement with patients or carers, the majority appear to have been identified by performance against NHS targets or as a consequence of regulatory activity.
- Whilst we recognise the public priority accorded to A&E and mental health services, which reflect in the work of Healthwatch Worcestershire, we would appreciate information as to the extent to which the 7 identified 'Priorities for Improvement for 2015/16 which are featured in section 2 of the plan have been identified by patients and the public.
- We note that the 'Priorities for Improvement' were identified in 2014/15. Given the recent CQC unannounced inspection of A&E services that is referred to in the Quality Account, we suggest a

review of the 'Priorities for Improvement', with a broader focus on the Trust's responses to that inspection so that 'Priorities for Improvement' would more accurately reflect the public's priorities for improvements in safety and quality.

- In Section 3.5 we note there are a number of references to opportunities to improve communication between patients, carers and the Trust, and that the Trust is undertaking significant work to improve communication. We suggest the Trust considers identifying this work as a 'Priority for Improvement'.
- Healthwatch Worcestershire acknowledges the transparency associated with the content of the Quality Account in relation to the NHS risk summit and CQC unannounced inspection.

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

- The Trust's Patient Public Forum and its work is described in the Quality Account. We suggest the Trust considers publishing more information about the constitution of the Patient Public Forum, its membership and detail of its activities in the Quality Account.
- We also suggest the Trust should support the Forums' activities with references to the impact and influence those activities have had on the Trust's performance.

3. Has the Trust demonstrated it has involved patients and the public in the production of the Quality Account?

- Healthwatch Worcestershire acknowledges it was consulted in the drafting of the Quality Account and that a number of comments we made in our comment on the 2013/14 Quality Account have been incorporated into this Quality Account.
- However the extent to which the public, patients and carers have been involved in the production of the Quality Account is not clear. As we indicated in our comments last year it would be helpful if the Quality Account set out how the public and patients are involved in the performance management of the Trust during the year.

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

- The Quality Account contains an enormous amount of complex and technical information. Patient feedback leads Healthwatch Worcestershire to conclude that the presentation of the Quality Account in its present format is not suitable for lay people who find it difficult to understand and too lengthy.
- As an Account to local people the Trust should reflect on the content and style of its presentation. Healthwatch Worcestershire offers to work with the Trust to develop a more appropriate patient led format.

Appendix 3

Statement of Director's responsibilities in respect of the Quality Account

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 (in line with requirements set out in Quality Accounts legislation).

In preparing their Quality account, directors should take steps to assure themselves that:

- The Quality Account presents a balanced picture of the trust's performance over the reporting period
- 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 they are working effectively in practice
- The data underpinning the measure 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
- The Quality Account has been prepared in accordance with any Department of Health guidance

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

By order of the Board

NB: sign and date in any colour ink except black

Harry Turner
Chairman

Date: 28th May 2015

Chris Tidman
Acting Chief Executive

Date: 28th May 2015

(PP Penny Venables,
Chief Executive

Appendix 4

Independent Assurance Report

Independent Auditor's Limited Assurance Report to the Directors of Worcestershire Acute Hospitals NHS Trust on the Annual Quality Account

We are required to perform an independent assurance engagement in respect of Worcestershire Acute Hospitals NHS Trust's Quality Account for the year ended 31 March 2015 ("the Quality Account") and certain performance indicators contained therein as part of our work. 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 2015 subject to limited assurance consist of the following indicators:

- Percentage of patient safety incidents resulting in severe harm or death
- 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 2014-15 issued by DH in March 2015 ("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 2014 to June 2015;
- papers relating to quality reported to the Board over the period April 2014 to June 2015;
- feedback from the Commissioners dated 15/05/2015;
- feedback from Local Healthwatch dated 11/05/2015;
- the Trust's complaints report published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009, dated 28/05/2015;
- feedback from the Overview and Scrutiny Committee, dated 27/02/2015;
- the latest national patient survey dated 21/05/2015;
- the latest national staff survey dated 24/02/2015;
- the Head of Internal Audit's annual opinion over the Trust's control environment dated May 2015;
- the annual governance statement dated May 2015; and
- the Care Quality Commission's Intelligent Monitoring Report dated May 2015.

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.

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 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 indicator 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.

Basis for qualified conclusion

The indicator reporting the percentage of patients risk-assessed for VTE did not meet the six dimensions of data quality in the following respects:

- Accuracy and Validity - of the sample of 32 admissions we reviewed, 4 of these were not correctly recorded. The errors identified fell into two categories: either there was not any evidence on the patient's file that a risk assessment had been carried out when the admission had been categorised as risk assessed; or there was evidence on the patient's file of a completed risk assessment and the admission had been categorised as not risk assessed. Consequently we cannot conclude that the indicator is sufficiently accurate for the intended purpose or compliant with the relevant requirements.

Qualified conclusion

Based on the results of our procedures, with the exception of the matter reported in the basis for qualified conclusion paragraph above, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2015:

- 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

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30 June 2015

Glossary

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
COPD	Chronic Obstructive Pulmonary Disease
CPA	Clinical Pathology Accreditation
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation payment framework
CT	Computerised tomography scanning
DH	Department of Health
DoLS	Deprivation of Liberty Safeguards
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.
HSCIC	Health & Social Care Information Centre
HSMR	The Dr Foster Hospital Standardised Mortality Ratio
i.e.	that is
IG	Information Governance – data security / confidentiality
IP&C	Infection prevention & control
ISO	International Organisation for Standardisation
GMC	General Medical Council
KGH	Kidderminster Hospital
M&M	Mortality & Morbidity
MHA	Mental Health Act
MMS	Medicines Management Services
MRI	Magnetic resonance imagining
MRSA	Meticillin resistant Staphylococcus aureus
MRSA BSI	Meticillin resistant Staphylococcus aureus blood stream infections
MSC	Medicines Safety Committee
NHA	National Health Service
NIHR	National Institute for Health Research
NMC	Nursing & Midwifery Council

NPSA	National Patient Safety Agency (disbanded 2012)
NRLS	National Reporting and Learning System
NTDA	NHS Trust Development Authority
PAS	Patient Administration System
PPCI	Worcestershire Primary Percutaneous Coronary Intervention - a treatment used following heart attacks
PPF	Patient & Public Forum (PPF),
PROMs	Patient Recorded Outcome Measures
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
RTT	Referral To Treatment – a target to treat patients within 18 weeks of referral by their GP
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
TTO	To Take Out – medicines on discharge from hospital
WHO	World Health Organisation
WMAHSN	West Midlands Academic Health Science Network
WHAT	Worcestershire Acute Hospitals NHS Trust
WRH	Worcestershire Royal Hospital