Worcestershire NHS
Acute Hospitals NHS Trust

Annual Report and Accounts

2013/14

Patients | Respect | Improve and innovate | Dependable | Empower

Taking **PRIDE** in our healthcare services

Worcestershire Acute Hospitals NHS Trust
Annual Report and Accounts 2013/14

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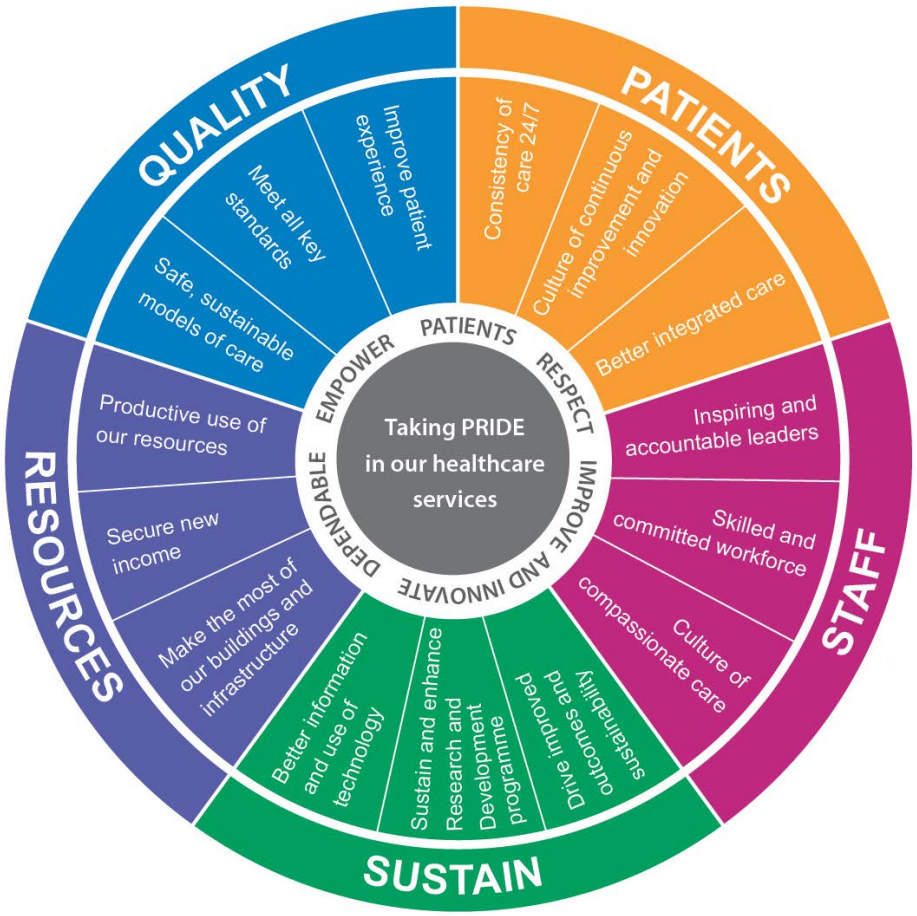


Welcome
Harry Turner, Chairman and Penny Venables, Chief Executive

In common with most other NHS organisations, the last 12 months have been challenging for Worcestershire Acute Hospitals NHS Trust. We have seen a growing number of elderly patients with more than one clinical condition attending our hospitals. One result of this has been an increase in the number of emergency admissions. We have also seen tight financial pressures, linked to the need to provide extra capacity to care for these patients.

Despite these pressures we have had a successful year. We achieved most of our local and national targets and we made great progress in several key areas including the reduction in *clostridium difficile* infection rates and the ability to contain several norovirus outbreaks. We are helped in this by our local population who have heeded our plea to avoid visiting, unless absolutely necessary, to enable us to fight the infections effectively.

Once again, we have placed quality at the heart of everything we do. This year's Quality Account can be found in Section 4 of this report.

We have seen changes within our Trust at Director level with the departure of Helen Blanchard our Chief Nursing Officer, to take up a similar role in Bath. Lindsey Webb joined us to replace Helen in October 2013. We have also appointed a substantive Director of Human Resources and Organisational Development, Bev Edgar. We have focussed our attention on ensuring that clinicians are at the centre of our business and have created five new county-wide divisions, with five leadership teams, each consisting of a senior

doctor, a nurse and a manager. We are already seeing the benefits of this change, building on our vision to strengthen our clinical leadership and put clinicians at the heart of the organisation.

During the year, we have been excited by the commencement of the building of the new radiotherapy unit in the grounds of the Royal Hospital site and we are looking forward to its opening in 2014. We know that this will ensure high quality services closer to home for patients who currently have to travel long distances for treatment and will be one of the foundations of our county wide cancer strategy.

In addition, during the year, we have seen the opening of a short stay ward specifically for those people needing an assessment for a possible operation. This ward has meant that patients have had more appropriate care at the right time in the right place.

We continue to operate a county wide urology service at the Alexandra Hospital and have launched a fundraising project to buy a robot for use in the theatres there. On the advice our of clinicians, we now treat all patients in the county who have had a stroke at the Worcestershire Royal site in a specialist stroke unit and our outcomes have improved tremendously since this happened. We ensure that as soon as possible the patient returns closer to their home for rehabilitation. We are keen to expand and increase the amount of day surgery carried out at Kidderminster Hospital to benefit the whole county.

In addition we have been working with our colleagues across the NHS in Worcestershire as well as patient groups, in particular Save The Alex, on the Acute Services review which aims to ensure the people of Worcestershire continue to have access to high quality and safe clinical care in the future. We are delighted that considerable progress has been made with the Future of Acute Hospital Services programme across Worcestershire

and that the Independent Clinical Review Panel report has been received by all local NHS organisations.

We are looking forward to the coming year when we will support our Commissioners in their consultation on plans for the future reconfiguration of services.

We have welcomed the national reports that have been published in 2013/14, specifically the Keogh Review (July 2013) and the Berwick Review (August 2013). We have been working hard to incorporate the lessons that these two reviews have highlighted for Trusts to learn.

An annual report is a report of the previous 12 months but it is also right for us to set out what we hope to achieve over the next 12 months and in the years to come.

We have a two year strategy which outlines 5 strategic goals. These make it really clear for staff, patients and the public what we are working towards:

Goal 1	*Deliver safe, high quality, compassionate patient care*
Goal 2	*Design healthcare around the needs of our patients, with our partners*
Goal 3	*Invest and realise the full potential of our staff to provide compassionate and personalised care*
Goal 4	*Ensure the Trust is financially viable and makes the best use of resources for our patients*
Goal 5	*Develop and sustain our business*

These overarching priorities provide the framework for the development of the annual plan objectives. 2014/15 is year 1 of the Trust's Strategy. We will be producing a five year plan in the early part of 2014/15.

We need to change the way we deliver services in order to tackle the challenges facing us - these include an ageing population with more long term conditions, increasing public expectations of healthcare services, the necessity to meet national guidance on seven day working, and pressure to meet financial challenges. There will be difficult decisions to make and difficult conversations to be had; but we will be open and honest with our staff, patients and the public about the challenges we face.

Our *Well Connected Programme* achieved national Pioneer status in November 2013. We hope that this Programme, supported by the NHS in Worcestershire and the County Council, with voluntary sector involvement, will be one vehicle to support us all to begin to change the way care is delivered and to ensure that appropriate care is carried out at the appropriate time at the appropriate place. We firmly believe that some of our patients (about 50 a day) would be better cared for out of hospital and we are keen to work with our partners to ensure that this becomes a reality.

The Care Quality Commission carried out unannounced inspections of the Alexandra and Worcestershire Royal Hospitals in March 2014. The inspections concentrated on

infection control and they were impressed by the robust systems and processes in place. This was fantastic news for the Trust and recognition of the hard work of all our staff. Also in March 2014, the CQC published their risk ratings for hospitals and the Trust was placed in band 6, the least risky band.

We are delighted that our relationship with the University of Worcester has developed over the past 12 months and we are looking forward to continue to strengthen this partnership. We have developed a number of clinical programmes such as the Therapies Degree, a Senior leadership programme at Masters level and Emergency Nurse Practitioner competencies. In addition we are looking at joint staff appointments in Knowledge Management Services and Educational/Research posts plus a much closer sharing of resources in clinical training.

Despite our challenges, we remain very proud to lead an organisation which is determined to fulfil its mission of being the safest, most patient-centred and efficient Trust, and take its place amongst the top ten per cent of highest performing Trusts in the country.

We are indebted to our staff. We have had an extremely busy year, not only with record numbers of attendances at our accident and emergency departments, but also we have had to cope with floods (along with many others in the country) which meant that for a time, some of our staff came to work using boats and four wheel drive vehicles, courtesy of our partners, the army.

Our staff therefore work under considerable pressure to deliver excellent patient care. Everyone who works for Worcestershire Acute Hospitals NHS Trust, from those on the front line in our wards to the people who work in the background to keep the hospitals running, are vital to the service we provide. We would like to put on record our thanks for their commitment and professionalism.

We would also like to pay tribute to our volunteers who support us in so many ways, from manning coffee shops to meeting and greeting. Thank you for all your support during the year.

Harry Turner, Chairman

Penny Venables, Chief Executive

Section 1
Message from the Chief Executive: Strategic Report

Worcestershire Acute Hospitals NHS Trust was formed on 1 April 2000 following the merger of Worcester Royal Infirmary NHS Trust, Kidderminster Healthcare NHS Trust, and Alexandra Healthcare NHS Trust. Facilities are distributed across the three sites; the Alexandra Hospital, Redditch; the Kidderminster Treatment Centre, and the Worcestershire Royal Hospital. In addition it operates services from four Community Hospitals: Princess of Wales Community Hospital, Tenbury Community Hospital, Evesham Community Hospital and Malvern Community Hospital. The Trust has 933 beds, over 5,800 employees and has an annual income of £345 million.

The Trust predominantly serves the population of the county of Worcestershire with a current population of almost 580,000, providing a comprehensive range of surgical, medical and rehabilitation services. This figure is expected to rise to 594,000 by 2021; taken as a whole, the Trust's catchment population is both growing and ageing. Life expectancy continues to rise above the national average and contributes towards the forecast growth in activity due to the increase in over 75s in the local population. Signs suggest that the extra years are being spent in poor health with long term conditions such as diabetes, chronic obstructive pulmonary disease (COPD) and cardiovascular disease (CVD) which are worsening health outcomes[1]. Also the number of older people with dementia is expected to double in the next 20 years. Of note the rate of population growth is greatest in the very old age groups who present the greatest requirements for 'substantial and critical' care.

[1] Worcestershire Health and Well-being Board (September 2013 Final Draft) JSNA Summary: Intelligence Update on HWB Priority Areas.www.worcestershire.gov.uk/jsna

The Trust's catchment population extends beyond Worcestershire itself, as patients are also attracted from neighbouring areas including South Birmingham, Warwickshire, Shropshire, Herefordshire, Gloucestershire and South Staffordshire. This results in a catchment population which varies between 420,000 and 800,000 depending on the service type. Referrals from GP practices outside of Worcestershire currently represent some 13% of the Trust's market share.

The Trust has in place a number of contracts with external organisations which are essential to the day-to-day operations of the Trust. These include the contract for the provision and operation of the PFI Hospital with Worcestershire Hospital SPC plc (formerly Catalyst Healthcare (Worcester) PLC); two contracts with Steria Ltd (through a joint venture with the Department of Health) for the provision of financial systems and accounting services, and payroll and pensions services on behalf of the Trust (the payroll and pensions service switched to Capita from 1st April 2013 but reverted back to Steria from 1st February 2014); a contract with HealthTrust Europe (formerly the Healthcare Purchasing Consortium) for the provision of Procurement and Supplies systems and services for the Trust; a contract with Coventry and Warwickshire Audit Services for the provision of Internal Audit and Counter Fraud services; and a contract with Xerox for a Managed Service relating to the provision of patient records.

The Trust's Values, Strategic Goals and Objectives for 2014-16 are shown on page 6 of this report.

Our Mission is:
'*Working together with our partners in health and social care we will provide safe, effective, personalised integrated care for local people,*

delivered consistently across all services by skilled and compassionate staff'.

This is supported by our six vision statements, our five PRIDE values and our five strategic goals, each supported by three objectives as shown below. These statements, goals and objectives are intended to ensure there is clarify for patients, staff and the public as to what the Trust is working towards over the forthcoming 12 months.

The Trust continues to be an equal opportunities employer committed to fair and equitable treatment of all our staff and all job applicants;

- Equality is about making sure everyone is treated fairly and given the same opportunities. It is not about treating everyone the same way as they may have different needs to achieve the same outcomes.
- Diversity means 'difference'. When used in the same context as 'equality', it is about recognising and valuing individuals as well as group differences. It also means treating people as individuals and placing positive value on diversity within the community and within the workforce.

The Trust is committed to equal opportunities in carrying out our various activities and we are opposed to any form of negative discriminatory or unfair treatment in all aspects of employment.

The Trust has continued to ensure that all of our employment policies and services are developed and reviewed in conjunction with

our staff side colleagues and subject to an equality impact assessment.

The Trust remains dedicated to ensure that our workforce are committed to the elimination of discrimination on the basis of gender, race, age, disability, religion, belief or sexual orientation, and are given the necessary training to support our efforts in this respect. Further details regarding Equality and Diversity matters are contained within section 5 of this Annual Report.

Within Section 2 of the Annual Report details are provided of the Trust's performance in 2013/14 against its corporate targets and objectives, which reflected the 6 strategic priorities that the Trust identified within its Annual Report for 2012/13. Within this section the Trust also assesses the impact of the introduction of a new clinical (divisional) management structure in November 2013, and identifies the key divisional priorities for 2014/15.

The Trust's financial statements have been prepared on a going concern basis. Going concern is a fundamental principle in the preparation of financial statements. Under the going concern assumption a Trust is viewed as continuing in operation for the foreseeable future with no necessity of liquidation or ceasing trading. Accordingly the Trust's assets and liabilities are recorded on the basis that assets will be realised and liabilities discharged in the normal course of business. A key consideration of going concern is that the Trust has the cash resources to continue to meet its obligations as they fall due in the foreseeable future. The Trust's Summary Financial Statements are included within Section 8 of the Annual Report.

The Trust recognises its responsibilities with regard to the impact of our business activities on the social, economic and environmental wellbeing of the communities of Worcestershire and the surrounding area. Consequently the Trust has produced a 5 year Sustainable Development Strategy and Implementation Plan which provides the framework for our journey towards delivering our healthcare business objectives in a sustainable and green manner. Both the Sustainable Development Strategy and Implementation Plan have been developed to align with and secure absolute compliance with the Departments of Health's Sustainable Development Unit model requirements for NHS organisations. The Strategy takes into account previous initiatives to improve Environmental performance whilst remaining focused on maintaining core business activities and continued delivery of high quality patient care services now and into the future.

Penny Venables
Chief Executive

Date June 2014

Section 2
The year's performance at a glance

Corporate Performance

During 2013/14 we focused our efforts on achieving progress in our six strategic priority areas. Annual objectives were set and the annual plan became the delivery vehicle for year one of our strategy. The following boxes set out our progress towards those objectives as follows:

1. Safe, Compassionate, Innovative

Deliver safe, effective, compassionate and innovative patient care

Key Achievements in 2013-14:

- ✓ Avoidable pressure ulcers more than halved on top of the 90% reduction the previous year
- ✓ More than halved the number of Clostridium Difficile cases to stay within a reduced threshold
- ✓ Maintained good performance with regards to the hospital mortality rate
- ✓ Exceeded targets for improving the care of patients with dementia
- ✓ Continued achievement of the venous thromboembolism risk assessment standard
- ✓ Sustained 100% compliance with WHO safer surgery checklist

2. Developing our Leadership, Communication and Engagement

Develop a culture that is recognised as patient centred, driven by inspiring and accountable leaders committed to continuous improvement

Key Achievements in 2013-14:

- ✓ Consistently achieved the Friends and Family test targets throughout the year
- ✓ Achieved the target increase for positive responses to 'no decision about me without me'
- ✓ Met our target to develop 2000 staff in customer care

3. Developing our Workforce

Invest and realise the full potential of our staff – recruiting, retaining, developing and rewarding

Key Achievements in 2013-14:

- ✓ Higher than average percentage of staff say that care of patients and service users is the organisation's top priority
- ✓ Significant improvement in Equality & Diversity training
- ✓ Higher than average percentage of staff say they act on concerns raised by patients and service

users

- ✓ 100 managers have completed NHS leadership framework 360
- ✓ 60 staff have completed ILM (Institute of Leadership and Management) leadership awards

4. High Performing

Achieve strong operational performance compliant with all national requirements

Key Achievements in 2013-14:

- ✓ All stroke standards significantly exceeded following last year's improvements
- ✓ Maintained waiting time targets for cancer patients despite significant operational pressures
- ✓ Improved performance against all A&E metrics despite the extreme emergency pressures

5. Increasing our Productivity and Efficiency

Ensure the trust is financially viable and gets the maximum value from the resources at its disposal

Key Achievements in 2013-14:

- ✓ Safe delivery of the cost improvement programme
- ✓ Sustained improvement in the rate of Day Case procedures
- ✓ Commenced 24/7 Primary Percutaneous Coronary Intervention Service
- ✓ Increased the availability of radiology services
- ✓ Centralised pathology services and joined regional pathology partnership

6. Our reputation – The Provider of Choice

Develop and sustain our business

Key Achievements in 2013-14:

- ✓ Following an independent clinical review and extensive communication with commissioners, the public and partners the clinical models for the configuration of our acute services have been agreed.
- ✓ Construction of the new Radiotherapy centre is on track and recruitment has commenced
- ✓ Developed a consultant buddy system and virtual ward with local GPs
- ✓ Fully engaged in the Well Connected Programme

Performance against targets 2013/14

During 2013/14 the Trust has achieved target performance in the majority of key standards. The Trust's year-end performance is shown below:

	Description of Target	Indicator	2013/14 Target	Year End
Finance	Financial Risk Rating (FRR)	I&E Surplus Margin %	>1.5%	-4.12%
Quality	Mortality	HSMR	<=100	107.0
		SHMI	<=100	101.0
	Infection Control	Clostridium Difficile	<=48	40
		MRSA	0	3
	Prevention	VTE Risk Assessment	>=95%	95.60%
	Patient Experience	Mixed Sex Accommodation Breaches	0	0
	CQC Registration	CQC Conditions or Warning Notices	0	0
Operational	Cancer	31 Days: Wait For First Treatment: All Cancers	>=96%	96.41%
		31 Days: Wait For Second Or Subsequent Treatment: Surgery	>=94%	95.78%
		31 Days: Wait For Second Or Subsequent Treatment: Anti-Cancer Drug Treatments	>=98%	100.00%
		62 Days: Wait For First Treatment From Urgent GP Referral: All Cancers	>=85%	85.23%
		62 Days: Wait For First Treatment From National Screening Service Referral: All Cancers	>=90%	93.14%
		2WW: All Cancer Two Week Wait (Suspected cancer)	>=93%	94.44%
		2WW: Wait for Symptomatic Breast Patients (Cancer Not initially Suspected)	>=93%	96.49%
	18 Weeks waiting time	RTT - Admitted - 90% in 18 Weeks	>=90%	87.26%
		RTT - Non-Admitted - 95% in 18 Weeks	>=95%	98.26%
		RTT - Incomplete 92% in 18 Weeks	>=92%	94.29%
		Diagnostic Waits (% of waiting list)	<=1%	0.07%
	A&E waiting time	4 Hour Waits (%) - Trust	>=95%	93.59%
	Stroke	80% of Patients spend 90% of time on a Stroke Ward (Final)	>=80%	85.97%
		Direct Admission (via A&E) to Stroke Ward	>=70%	82.85%
		TIA	>=60%	72.62%

Divisional Performance

The cornerstone to the overall performance of the Trust is that of the divisions. Created in November 2013, they have already made a difference and their key achievements in 2013/14 can be seen below:

Medicine

- Started building on the Worcestershire Oncology Centre due to open in January 2015.
- Commenced a service that allowed patients who need complex cardiac devices to have these at Worcester Royal instead of having to travel outside the County
- Centralisation of Stroke Services at Worcester Royal providing enhanced care for patients with the life threatening illness.
- Agreed Phase 1 of Renal support to the Alexandra Hospital to improve safety and patient experience
- Improvements to the Long Term Oxygen service based at the Alexandra Hospital resulting un measurable improvement in patient satisfaction
- County wide working of the Blood Bourne Virus nursing team
- Entry for a national award for the Structured Education programmes helping diabetic patients delivered by the Diabetes Nursing team
- Development of an in-house speech and language therapy service to support all sites of the Trust
- Improved access to specialist palliative care clinics for patients in local hospices
- Improved access to Non-Invasive ventilation services at The Alexandra hospital through a dedicated unit.

Clinical Support

- Full accreditation granted to Biochemistry, Microbiology, haematology and cellular pathology at the Alexandra Hospital following an inspection by the Clinical Pathology Accreditation Service
- The Medicines and Healthcare Products Regulatory Authority visited the Blood Bank and an action plan is being implemented to improve the services offered.
- Clinical pharmacy services support the Emergency Department and Acute Medical Unit seven days per week to help prevent unnecessary admissions. This scheme has attracted interest from the Department of Health Strategy Group following the visit of their Chief Pharmacist to the Trust and information regarding the scheme appearing in the Health Service Journal.
- Continuing development of an *ePrescribing* and medicines administration system to improve quality and safety for provision of medicines to patients.
- Extended opening hours in Pharmacy improving access for example for medications for discharges.
- Provision of clinical pharmacy cover for wards opened at short notice to accommodate patients during times of higher numbers of admissions to the Trust.
- Low radiology reporting turnaround times ensuring fast availability of results to patients.

Surgery

- Implementation of an interim Emergency Surgery Pathway for very seriously ill patients between the Alexandra General Hospital and Worcestershire Royal Hospital
- Plans in place to better utilise Kidderminster Treatment Centre
- Increased activity (particularly day cases) compared to 2012/13
- Established a major fund raising project at the Alexandra Hospital for a surgical robot
- Established a Surgical Clinical Decision Unit (SCDU) on the Worcestershire site, for patients to have quicker appropriate treatment
- Established regular Saturday operating for ENT

Theatres, Ambulatory Care and Outpatients

- Increased ITU capacity on WRH site to support the interim emergency surgery pathway
- Initial engagement with commissioners on redesign of rheumatology pathways
- Developed additional facility in endoscopy to increase the capacity on WRH site
- Introduced chronic pain service at Malvern Community hospital
- Delivered RTT waiting times targets for Rheumatology, Ophthalmology and Pain service
- Introduced nurse practitioner roles in Ophthalmology
- Embedded county wide leadership roles in Theatres

Women and Children

- Opened an Obstetric Intervention Room, in addition to the existing obstetric theatre, on the Worcester Royal Hospital Delivery Suite. This is to ensure women who require urgent operative interventions have increased access to emergency theatre space if a complication arises.
- Appointed a county wide Bereavement Support Midwife
- Developed new facilities for partners to stay overnight on the postnatal ward.
- Obtained national funding for a Midwifery Led Birthing Unit at Worcestershire Royal Hospital
- Opened a six-bedded “Transitional Care Unit” giving additional beds for mothers and babies to remain together whilst the baby receives intensive care
- Achieved 85% of women having a gynaecological procedure within 18 weeks of referral from the GP
- Achieved the required standards for Paediatric Best Practice in Diabetes and Epilepsy care

Looking forward – Divisional Priorities for 2014/15

Medicine

- Ensure safe sustainable services are being delivered through the specialties of Acute Medicine, Respiratory, Neurology, Renal
- Develop a sustainable Workforce through improved engagement and developing staff to meet service needs
- Develop and implement a Frail Elderly Unit
- Develop a better system for the treatment of people who do not need acute hospital care
- Improve the patient experience for patients that require an emergency admission
- Work with partners to improve access to community based services
- Develop a permanent catheter lab to provide a resilient primary percutaneous coronary intervention service
- Develop a fiberscope service for Gastroenterology
- Develop a Renal strategy in support of local care for local people

Clinical Support

- Better use the histopathology resources by centralising the service
- Implement seven day working
- Ensure that all as much pathology work currently being undertaken outside the county is being undertaken within the county
- Roll out the use of e-prescribing across the Trust
- Open the Worcestershire Breast Unit
- Develop an approach to sustain the Pathology Service through a partnership with another organisation
- Increase the number of cancer screening tests that the Trust undertakes
- Ensure that tests for biochemistry from patients in Evesham is undertaken at the Trust activity.
- Look at opportunities to income generate
- Increase the number of MRIs undertaken.
- Review the computerised x-ray reporting system

Surgery

- Ensure that the right services are being provided at the right time at the right site
- Ensure the Trust responds to the results of the consultation on the Future of Acute Hospital Services in Worcestershire in respect of emergency care and elective services
- Review and make appropriate changes to Consultant job plans to support extended working across six days
- Develop the Worcestershire Breast Unit
- Develop a Surgical Decision Unit at the Alexandra Hospital
- Further develop the bariatric service
- Support the introduction of new technologies such as the Surgical Robot
- Refine and improve the care of patients with a fractured neck of femur
- Develop an Admissions Unit at Worcestershire Royal Hospital

Theatres, Ambulatory Care and Outpatients

- Ensure equitable access to services across the county
- Develop a consistent approach to pre-operative care
- Review Outpatient Services across the county
- Improving efficacy and efficiency in operational processes
- Ensure a robust governance framework in Theatres
- Implement a computer package to support full patient and implant traceability
- Introduce of electronic check-in for outpatients
- Introduce patient text message appointment reminders
- Expansion of service provision to include nurse led clinics, outpatient services in different locations and one stop clinics.
- Develop a community based glaucoma service.
- Further develop the endoscopy service

Women and Children

- Protect beds that are specifically for women with gynaecological problems at Worcestershire Royal Hospital
- Develop the Midwife Led Unit at Worcestershire Royal Hospital
- Support the outcome of the consultation on the Future of Acute Hospital Services in Worcestershire with respect to paediatrics
- Ensure the smooth implementation of the Maternity IT System
- Further develop of outpatient and day case facilities for women with gynaecological problems
- Promote and increase the number of women booking under midwifery led care
- Develop Advanced Nurse Practitioner roles
- Explore the options of Physicians' Assistant roles

Section 3
Working with Stakeholders

As demonstrated by the final section of the Quality Account (Section 4) our work and relationships with stakeholders is vitally important in the delivery of our services. The Trust is committed to strengthening its work with partners and seeking new alliances which will support the improvement of safety, quality, effectiveness and experience of services for its patients.

During 2013/14 the Trust has worked with:

- Commissioners and other local health economy partners to begin to develop integrated services and pathways through the Well Connected Programme which aims to deliver reduced demand for acute intervention and services
- University Hospitals Coventry and Warwickshire NHS Trust, our Strategic Partner in the development of local oncology services
- The University of Worcester in workforce planning and the development of our staff
- Worcestershire County Council in the reduction of health inequalities

Looking ahead the Trust will evaluate partnership opportunities for achieving further improvements in healthcare and patient experience.

Volunteers

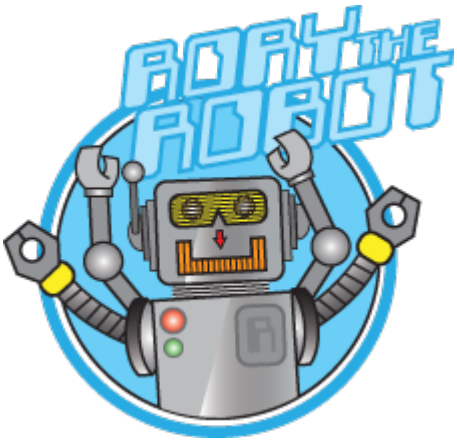
A crucial partner in our work is the contribution the volunteers make. We have over 300 volunteers who undertake a range of activities and without them; the hospitals would not be the places that they are now.

Some examples of the way volunteers have made a difference are below:

We launched a **£1.6 million** fundraising project to raise money for Rory the Robot for the use in prostate cancer surgery in Worcestershire which is a major urology cancer centre, performing around 70 - 80 radical prostate cancer surgeries a year.

Prostate cancer claims the life of one man every hour and by 2030 will be the most common cancer. In Worcestershire alone there are 2500 men surviving prostate cancer at any one time, with about 450 to 550 new prostate cancer cases diagnosed every year.

The technology will allow surgeons to remove tumours with more precision through five cuts around the prostate gland rather than open surgery.



It means less blood loss, less pain after surgery, a lower risk of complications and recovery times will fall from up to 12 weeks to between three to four weeks. It was first developed by the US military to allow surgeons based in America to operate remotely on soldiers injured on the battlefield over the internet, but has since been developed for use in general hospitals. It can also be used for head and neck cancer, colorectal and heart surgery.

The Rory the Robot campaign is being backed by the Redditch Standard and its sister titles, as well as the Save the Alex campaign and was launched on 21 March 2014.

Kidderminster Hospital and Treatment Centre is about to benefit from a brand new CT scanner, thanks to funds being raised by volunteers and the Kidderminster League of Friends.

The current machine has been in place for over 10 years and has scanned over 40,000 patients and performed almost 66,000 examinations in that time.

The League of Friends have the support of local newspaper the Kidderminster Shuttle, which has featured a weekly update on the progress of the appeal – encouraging more local people to volunteer to raise funds.

Harry Turner with coffee shop volunteers, Patricia Downton and Sheila Grant

So far the appeal has been supported by a knitting group, carnival, sponsored events and individual donations to name just a few!

Volunteers with the League of Friends work in the hospital coffee shop and in two second hand shops in Kidderminster and Stourport. In total the campaign aims to raise £125,000 for the new equipment.

Worcestershire Royal Hospital

The maternity bereavement garden has been restored thanks to the Royal Voluntary Service volunteers, David and Cynthia Eastwood. The Fay Turner suite and garden is a space, separate to the busy delivery suite, where women and their families who have lost a baby can spend some time away from it all.

David and Cynthia Eastwood with Rachel Carter and Patti Payne from the Women and Children's Division

The Fay Turner garden

Well Connected

The Well Connected programme brings together all the local NHS organisations, Worcestershire County Council, key representatives from the Voluntary Sector and service user representation through HealthWatch. Together the programme aims to join up and co-ordinate health and care for people more effectively and support them to stay healthy, recover quickly following an illness and ensure that care and treatment is received in the most appropriate place.

As well as concentrating on big picture stuff like how to join up health and care information systems, how to use the combined budgets more effectively and how to plan a workforce for the future, staff have been out and about listening to patients, service users, families, carers, staff, voluntary groups and many other interested groups and spreading the word about Well Connected and the commitment to improving care and support for the people of Worcestershire so that:

"You plan your care with people who work together with you to understand you and your needs, allow you control and co-ordinate and deliver services that support you to achieve the outcomes important to you".
(National Voices narrative)

In November 2013 the programme was named one of just 14 national Pioneers for integrated care. This means that the Well Connected programme is recognised as "blazing a trail" for more joined up care.

At a visioning workshop in December 2013 all organisations met to determine the future scale and scope of the integration ambition. It created an opportunity to review the agreed principles and objectives and to set an ambitious vision for care and support for the people of Worcestershire by 2020.

20:20 Vision

Individuals, families and communities will be supported in taking control of their own health and wellbeing and in looking after themselves and each other so that by 2020 those over 65 are living as healthy lives as possible.

- All people over 65 or those under 65 living with long-term conditions or complex needs, will have their own personalised 'joined up' care plan where the priorities set by the individual are supported by the care that they receive.
- The plan will be 'owned' by the individual and supported where needed by a member of their family or someone acting as a care coordinator under the auspices of their GP team.
- The person and everyone involved in providing care and support will be able to access and contribute to the individual's care plan.
- If a person needs specialist care, their GP will share responsibility for their care with their named consultant and, with help from integrated community teams and community support, will facilitate their return home as soon as possible.

Turning this vision into action will require all sectors of our health and social care economy to work differently, through the Well Connected Programme, Worcestershire Acute Hospitals NHS Trust is committed to playing its part.

The Future of Acute Hospital Services in Worcestershire

The 'Future of Acute Hospital Services in Worcestershire' programme was established in September 2013, with the purpose of

taking forwards the work of the Joint Services Review (JSR). It is led jointly by the three Worcestershire CCGs (NHS Redditch and Bromsgrove CCG, NHS South Worcestershire CCG and NHS Wyre Forest CCG.

The Joint Services Review was initiated in January 2012 to look at how high quality, safe and affordable acute hospital services provided by Worcestershire Acute Hospitals NHS Trust at Kidderminster, the Alexandra and Worcestershire Royal Hospitals, could be sustained into the future. At the end of this project, in March 2013, a clinical model for how future services could be provided was recommended to NHS Worcestershire by Worcestershire's Clinical Senate. Under the proposals the vast majority of health care services would continue to be delivered locally. Some services would be centralised to improve patient treatments and outcomes, in particular some A&E, complex consultant led maternity services and inpatient children's services.

There were two options for delivering this clinical model. Option 1 was for Worcestershire Acute Hospitals NHS Trust to deliver the agreed clinical model across all three of its sites and the second was for Worcestershire Acute Hospitals NHS Trust to deliver the model at WRH and Kidderminster with an external provider delivering services from the Alexandra Hospital.

Under the Future of Acute Hospital Services in Worcestershire programme, further work was done on both options and an independent clinical review panel was established under the chairmanship of Nigel Beasley, chair of the East Midlands Clinical Senate to examine the clinical implications of both models.

The expert Panel leading the Independent Clinical Review into the future of acute hospitals in Worcestershire recommended:

- Creation of a networked 'Emergency Centre' at the Alexandra Hospital. Hospital based emergency services across Worcestershire will be networked and led by consultants with an 'Emergency Centre' at the Alexandra Hospital and a 'Major Emergency Centre' at the Worcestershire Royal Hospital
- Consultant led maternity services should be centralised at WRH but Redditch and Bromsgrove CCG should consider commissioning a stand-alone midwife-led birth centre for North Worcestershire.
- Paediatric inpatients should be centralised in Worcester but a day-time consultant-led paediatric assessment unit at the Alex would accept referrals from GPs and other professionals.
- The Clinical Commissioning Groups and Worcestershire County Council should review the public transport links between North Worcestershire and the Worcestershire Royal Hospital.

The Panel, which was made up of clinical experts from across the UK, did not support Option 2, which would have seen another provider take over services at the Alexandra Hospital as this would have resulted in a significant inequality in the provision of safe and sustainable services to the population of Worcestershire.

The clinical recommendations were accepted by the by the three Worcestershire Clinical Commissioning Groups and Worcestershire Acute Hospitals NHS Trust Board.

The financial implications of the modifications to the original Option One are currently being examined and further work is being done on the clinical modelling to ensure it is robust and sustainable.

Public consultation on the Future of Acute Hospitals in Worcestershire is expected to take place in the late summer/autumn of 2014.

The governance of the Future of Acute Hospitals in Worcestershire has changed over the last 12 months. The Director of Operations from NHS England Area Team was the original interim senior responsible officer

for the programme and chaired the programme board. In March 2014 Joanna Newton was appointed as the new lay chair of the programme. The role of senior accountable officer is now shared jointly by the chief officer of both Redditch and Bromsgrove and Wyre Forest CCGs and the chief clinical officer of South Worcestershire CCG. NHS England has returned to its primary function of assuring the project.

The Programme Board has been expanded to include representatives from Birmingham South Central CCG, Solihull CCG, Hereford CCG and South Warwickshire CCG; Worcestershire Health and Care Trust; Worcestershire County Council and West Midlands Ambulance Service. The expansion is to ensure leadership from and assurance to the wider health economy and its population on the matters within the programme.

University of Worcester

We are delighted that our relationship with the University of Worcester has developed over the past 12 months and we are looking forward to continue to strengthen this partnership. We have developed a number of clinical programmes such as the Therapies Degree, a Senior Leadership Programme at Masters level and Emergency Nurse Practitioner competencies. In addition we are looking at joint staff appointments in Knowledge Management Services and Educational/Research posts plus a much closer sharing of resources in clinical training.

Our Regulators

The Trust has worked alongside the Care Quality Commission, NHS England and the NHS Trust Development Agency throughout the year.

The Care Quality Commission carried out unannounced inspections of the Alexandra and Worcestershire Royal Hospitals in March 2014. The CQC found that the Trust was compliant with all its quality standards. Further details of our relationship are set out in section 4.4, Quality.

The Trust works actively with the NHS Trust Development Agency (NTDA) and is monitored as part of the NTDA performance escalation systems.

The Trust has also sought to foster and support good working relationships with HealthWatch in Worcestershire and the Worcestershire County Council Health Overview and Scrutiny Committee. It is an active partner in the Health Leaders' Forum.

Section 4
Quality

Worcestershire Acute Hospitals NHS Trust

Quality Account

2013/14

Patients | Respect | Improve and innovate | Dependable | Empower

Taking **PRIDE** in our healthcare services

Part 1

1.1 Statement from the Chief Executive

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

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

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

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

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

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

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

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

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

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

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

Other highlights include

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

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

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

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

I would like to take this opportunity to thank all our patients, their carers, staff and stakeholders for helping us formulate our quality improvement programme. I know that we have a committed workforce dedicated to delivering high quality care to our patients and we will continue to work closely with them and the public going forward to deliver the improvements outlined in this Quality Account.

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

Penny Venables
Chief Executive

Contents

Section 2 – Review of Quality Performance

2.1 Introduction

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

2.1.1 Quality Governance Structure

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

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

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

2.1.2 Acute Hospital Services Review

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

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

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

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

Emergency pressures

The high level of patients admitted as emergencies has had a significant impact on our services and our ability to meet the waiting time targets such as the 18 week

referral to treatment target and seeing 95% of patients within 4 hours of attending Accident and Emergency. Our management of infection control has helped to limit the closure of beds due to Norovirus

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

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

2.1.3 Our response to the Francis Report

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

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

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

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

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

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

Putting patients first

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

Listening to patients

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

Openness, transparency and candour

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

Standards

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

Leadership and accountability

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

Information and performance

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

Nursing and medical practice

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

2.1.4 Inspections and peer reviews during 2013/14

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

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

2.1.5 Quality Strategy

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

2.1.6 Continuing work:

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

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

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

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

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

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

2.1.7 Contract Queries

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

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

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

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

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

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

Overview of achievement:

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

Taking it forward:

This improvement priority is carried over into 2014/15

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

Overview of achievement:

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

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

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

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

Taking it forward:

This improvement priority is carried over into 2014/15

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

Clinical Effectiveness

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

Overview of achievement:

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

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

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

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

Taking it forward:

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

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

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

Overview of achievement:

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

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

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

Taking it forward:

This improvement priority is carried over into 2014/15

Patient Experience	
5. Improve outcomes and experience for patients with Stroke to achieve all stroke targets	Met

Overview of achievement:

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

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

Taking it forward:

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

2.3 Reports from our Clinical Divisions

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

2.3.1 Surgical Division

Services provided:

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

The division manages the following services:

- Trauma and orthopaedics (services which help with problems in bones and muscles)
- Hand services (services which help with problems in the bones and muscles in the hand)

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

Quality performance in 2013/14:

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

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

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

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

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

Consultant surgeon Martin Wadley said:

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

Improvement aims for 2014/15

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

2.3.2 Medical Division

Services Provided

The Medical Division comprises of four Directorates:

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

Quality performance in 2013/14:

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

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

Jane Schofield, Deputy Chief Operating Officer

The "Ambulatory Emergency Care" Unit (designed to treat GP referrals and avoid unnecessary hospital admissions) has been established within the Emergency Departments. This has helped to reduce the demands on Accident and Emergency and enabled patients to be seen more swiftly and promptly by a Medical Consultant ensuring the necessary care and treatment is commenced in a timely manner.

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

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

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

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

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

Improvement aims for 2014/15

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

2.3.3 Women and Children Division

Services provided:

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

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

Quality performance in 20013/14:

Maternity

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

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

				impact on her own health
Percentage of women receiving Midwife Led Care	32%	35%	29.6%	We aim to increase the percentage of women receiving Midwife Led Care to improve normal birth rates

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

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

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

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

Gynaecology

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

Neonatology

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

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

Paediatrics

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

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

Improvement aims for 2014/15

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

2.3.4 Clinical Support Division

Services provided:

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

Quality performance in 2013/14:

- To ensure the pathology laboratories provide a safe and high quality service to defined standards, we take part in the Clinical Pathology Accreditation (CPA) scheme. In 2013/14, several of the laboratories were inspected by representatives of the CPA scheme as part of their regular inspection programme. We learnt from the findings and addressed areas requiring improvements. Subsequently, all laboratories, including microbiology, histopathology and biochemistry and haematology, have been granted on-going full accreditation status.
- Pharmacy services supporting the Emergency Department and Acute Medical Unit are now available seven days a week; this is a significant improvement from a weekday service at the Acute Medical Unit previously. This has helped to prevent unnecessary admissions. This scheme has attracted interest from the Department of Health Strategy Group and information regarding the scheme has appeared in the Health Service Journal[2].

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

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

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

Improvement aims for 2014/15

Improvement priority	Why is it a priority?	Target(s)	How will we measure it?
Deliver ward-based Medicines Management Services (MMS) at Alexandra Hospital	Equity of care, reduce medication risk and make better use of medicines resource.	MMS in place at Alexandra Hospital by 31/3/15	Key performance indicators for wards that implement MMS
Roll out Safemeds system	Safemeds is a key tool for reducing risks associated with prescribing and medicines administration, leading to improvements in medicines management for patients	Safemeds in place by 31/3/15	Monitored as part of a research project
Develop appropriate 7-day services tailored to the needs of the speciality	Targeted MMS services to reduce medicines risk and improve patient flow	31/3/15	Key performance indicators will be developed, relevant to the outcomes of the service development.
Bring the Pathology Directorate up to the ISO 17025 standards of competence for the	It will soon be a requirement that all laboratories are assessed against these standards, failure to meet these standards may result in	Become compliant with ISO 17025 laboratory standards by	Successful assessment of the laboratories by the relevant external bodies against ISO

Improvement priority	Why is it a priority?	Target(s)	How will we measure it?
testing and calibration of laboratories (replaces CPA accreditation).	closure of the laboratory.	2015.	17025.
Ensure all plain films are reported in a timely way	To ensure any pathology is identified as soon as possible.	100% plain films reported ideally within 1 week	Using data from Radiology Information System (RIS)
Increase MRI, CT and ultrasound capacity	To ensure inpatients receive early investigation within waiting time standards to support effective management of a patient's treatment and discharge	Inpatients have relevant scan within 48 hours of request	Using data from RIS

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

Services Provided

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

Quality performance in 2013/14:

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

- In Ophthalmology the ophthalmic nurse practitioners have successfully completed surgical training of intravitreal injection of Lucentis and have started to provide the first Nurse led Lucentis injection service in the West Midlands, offering significantly improved access to this sight saving treatment for our patients.
- The Division has implemented Trust-wide leadership for anaesthetics and critical care
- Following a "never event" in theatres (more details on p.25), we have revised the management structure and used human factors training to redesign and build more reliable processes and develop a new approach to using the World Health Organisation (WHO) safer surgery checklist.

Improvement Aims for 2014/15

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

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

	improve patient flow		
Create a theatre admissions area on the WRH site	To enhance privacy and dignity, to improve patient experience and ensure a timely access to theatre.	To open a dedicated admissions area	Admissions area open and functional

2.3.5 Cancer Services

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

Radiotherapy Centre:

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

Anne Sullivan, Cancer Services Manager and Macmillan Lead Cancer Nurse

Services

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

Quality Performance in 2013/14

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

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

  The National Cancer Team have recognised the Trust Cancer Services Team's Peer Review process, which involves evaluation of cancer multidisciplinary teams against National Quality Standards as exemplar for good practice and recommends the model to other trusts.

- Raised the profile of the Macmillan Cancer Information and Support Centres, resulting in a significant increase in referrals of patients. Between January and December 2013, the services showed a 9.7% growth with a total of 5429 interventions. The Trust Macmillan Cancer Information and Support Centres partnership with the Citizens Advice Bureau and RELATE service model has been so successful it has since been adopted in other parts of the County.

Improvement Aims for 2014/15

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

Cancer Waiting Times Targets

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

2.4 Goals agreed with commissioners – the CQUIN payment framework

A proportion of Worcestershire Acute Hospitals NHS Trust income in 2013/14 was conditional on achieving quality improvement and innovation goals agreed between Worcestershire Acute Hospitals NHS Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation (CQUIN) payment framework.

We had 11 CQUIN targets agreed with our main Commissioners, NHS Worcestershire, in 2013/14. They covered one or more of the domains of quality as shown in the table below. Our performance against each goal is given below:

			Quality Domain			
Goal Name	**Goal Description**	**Achieved**	**Safety**	**Effectiveness**	**Patient Experience**	**Innovation**
Friends and Family Test	To improve the experience of patients in line with Domain 4 (Ensuring that people have a positive experience of care) of the NHS Outcomes Framework. The Friends and Family Test will provide timely, granular feedback from patients about their experience.	**Achieved**			**Yes**	
NHS Safety Thermometer	Improve collection of data in relation to Pressure Ulcers, Falls and Urinary Tract Infection (UTI) in those with a Catheter.	**Achieved**	**Yes**		**Yes**	
Dementia	To incentivise the identification of patients with dementia and other causes of cognitive impairment alongside their other medical conditions, to prompt appropriate referral and follow up after they leave hospital and to ensure that hospitals deliver high quality care to people with dementia and support their carers	**Partially Achieved**			**Yes**	
Venous-Thromboembolism (VTE) Prevention	To reduce avoidable death, disability and chronic ill health from Venous Thromboembolism (VTE).	**Partially Achieved**	**Yes**			
Improving Palliative Care (AMBER: Assessment, **M**anagement, **B**est practice, **E**ngagement of individuals and carers, for people whose **R**ecovery is uncertain.)	Expansion of AMBER bundle: Amber Care Bundle makes it easier for medical and nursing staff to have future planning conversations with patients whose recovery is uncertain thereby enhancing the patient experience and care of patients with palliative care needs. It allows the patient to be involved in decisions about their care and where they want to die.	**Achieved**		**Yes**	**Yes**	
Improving Patient Flow	To improve the flow of patients through the health system, improving patient experience and provider performance. Improving patient flow is recognised as critical to increasing patient safety by supporting the patient to receive the right care, in the right place at the right time.	**Achieved**		**Yes**	**Yes**	
Management of Long-term Conditions	Improved discharge for COPD (Chronic Obstructive Pulmonary Disease) patients. All patients admitted with a COPD exacerbation should have the COPD care bundle commenced within 24 hours. All patients admitted with a COPD exacerbation should be discharged with a completed COPD care bundle.	**Achieved**		**Yes**		
Safe Care	Reducing falls in all adult Inpatient areas including the Accident and Emergency (A&E) Department.	**Not Achieved**	**Yes**		**Yes**	
Improving Health Outcomes for Teenage Mothers and Babies	Improving health outcomes for Teenage Mothers and their babies through a tailor made pilot programme.	**Achieved**		**Yes**	**Yes**	**Yes**
Medicines Management	Appropriate antimicrobial stewardship is an important contributor to reducing healthcare-associated infections. Robust systems are required to provide appropriate levels of antimicrobial stewardship.	**Achieved**	**Yes**	**Yes**		
Quality	Creating a climate of Quality and Patient Safety through facilitated reflection and understanding on the patient safety culture of the organisation/team or staff group.	**Achieved**	**Yes**	**Yes**	**Yes**	

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

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

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

2.5 Patient Safety

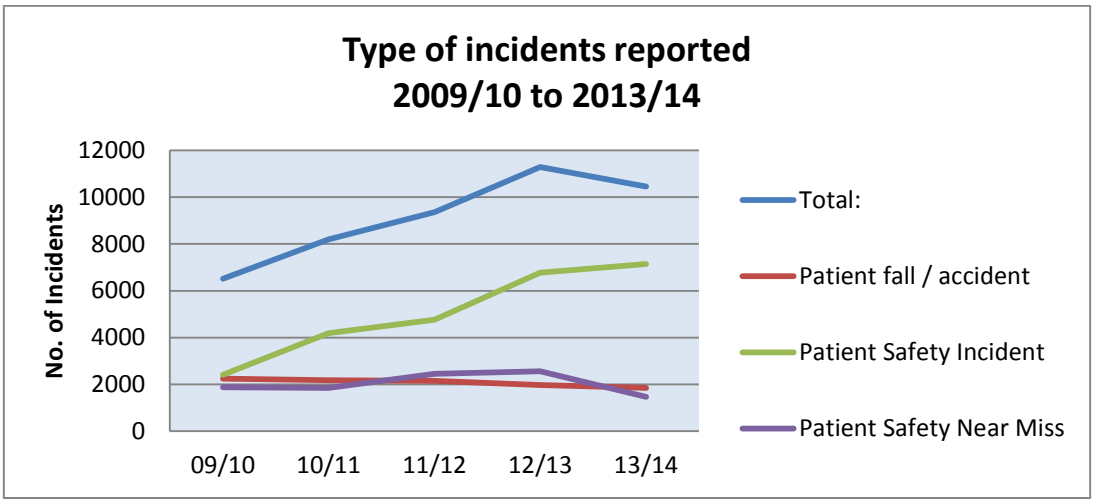
The restructuring of the Trust's quality committees enhanced the role of the existing safety committee to form in February 2014 a new Safe Patient Group under the chairmanship of the Chief Medical Officer. This Group oversees all the elements of patient safety in prevention, monitoring, investigating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

2.5.1 Patient Safety Incidents

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

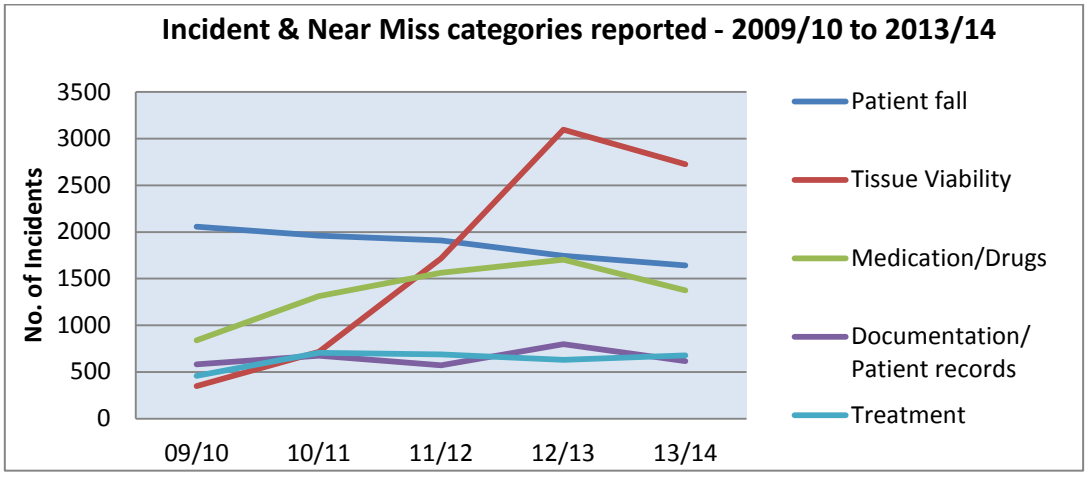
A total of 10,470 incident and near miss events were reported during 2013/14, a reduction from 11,291 the previous year and the first decrease in reporting rates since incident reporting commenced. This is mainly due to a reduction in the number of 'insignificant' incident reports received (see the section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

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



Incident Categories

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

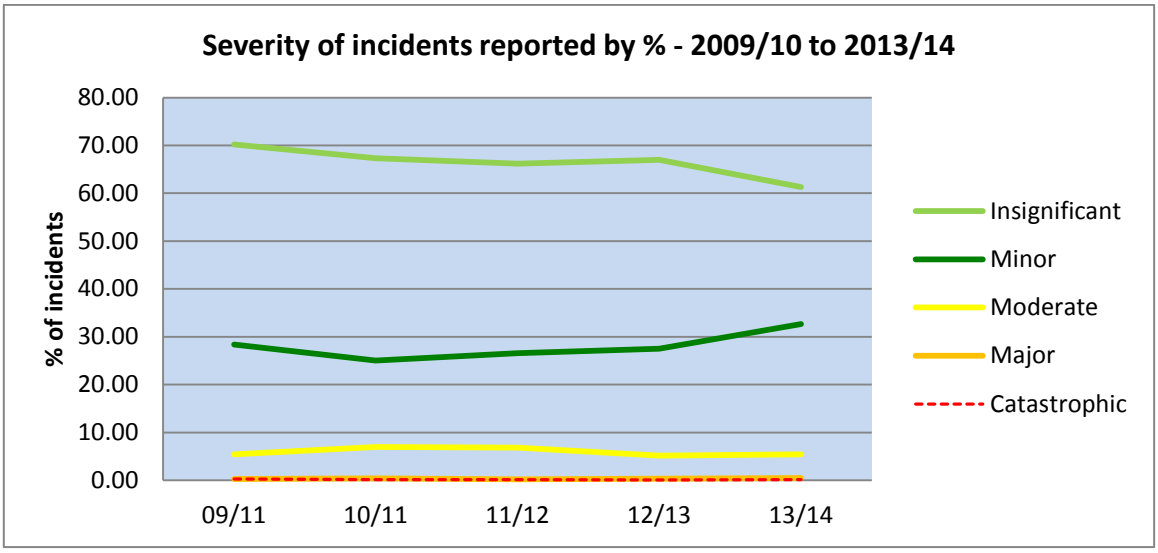


Severity

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

	09/10	10/11	11/12	12/13	13/14
Insignificant	4575	5528	6197	7563	6419
Minor	1554	2057	2490	3103	3418
Moderate	354	574	637	578	569

Major	17	34	20	38	52
Catastrophic	17	11	15	9	14
Totals:	6517	8204	9359	11291	10472



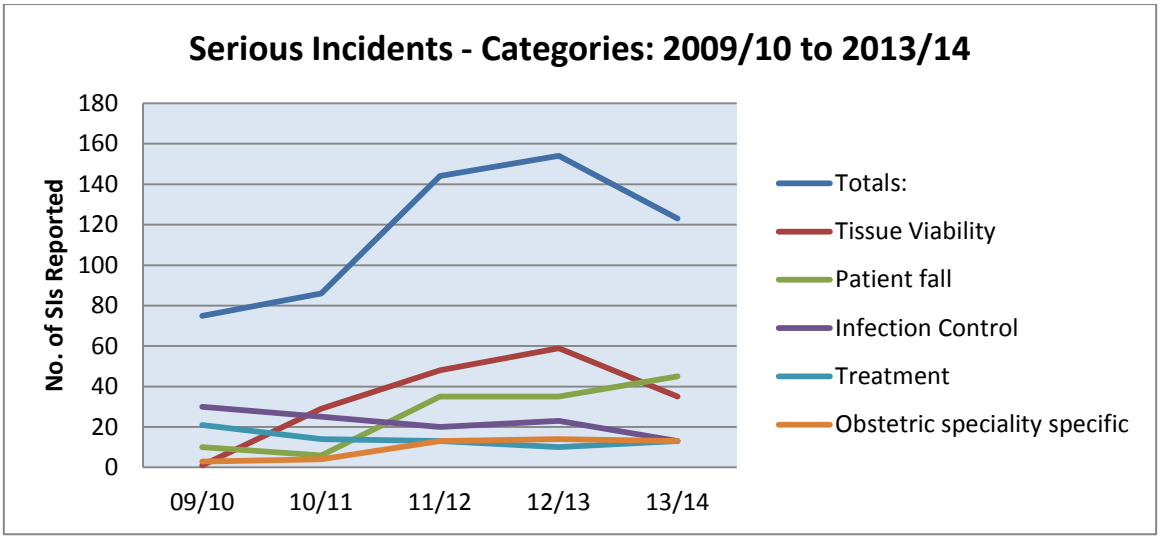
Serious Incidents

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

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

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

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



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

- Identification of delays in decision making around DNACPR (Do Not Attempt Cardio Pulmonary Resuscitation) has resulted in the Trust, in collaboration with the wider health economy, developing an e-learning training package aimed at improving decision making around this area of care. This will form part of the mandatory training for senior staff.
- The importance of giving parents advice while still in patient on measures to prevent cot death i.e. no co sleeping / bed sharing especially when unusually tired or having taken sedative drugs. This advice should be given at an early stage so it can be practiced by mothers while in the hospital and not just at discharge.
- Patient's with dementia / delirium to have appropriate care pathway completed and updated throughout admission. Multiple ward transfers should be avoided as should transfers during the night.
- Use of high visibility bays for patients at risk of falls / escalation for additional staff to increase supervision.
- Improvement to screening for orthostatic hypotension.
- The value of monthly obstetric skill drills for the multidisciplinary team on delivery suite.

Never Events

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

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

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

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

Wrong implant/prosthesis

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

Wrong gas administered

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

Categories of incidents

Tissue Viability

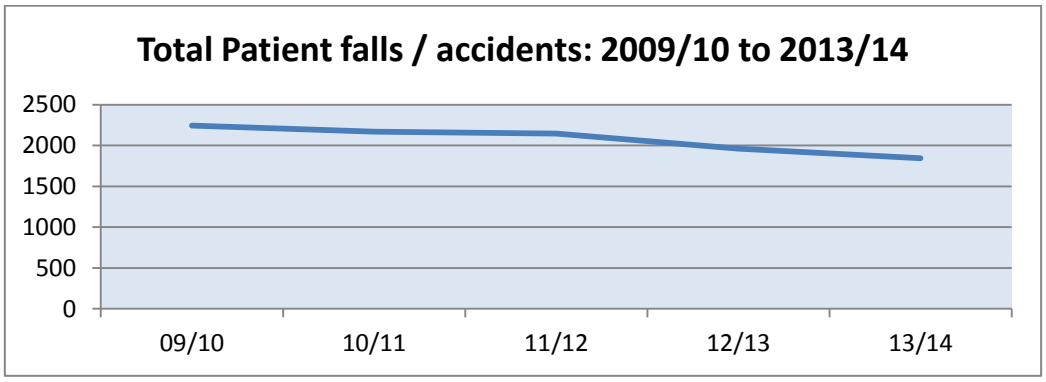
Tissue viability remains the highest category for all patient safety incidents reported. This includes pressure damage (ulcers) and moisture lesions which account for 84% of all incidents within this category.

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

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

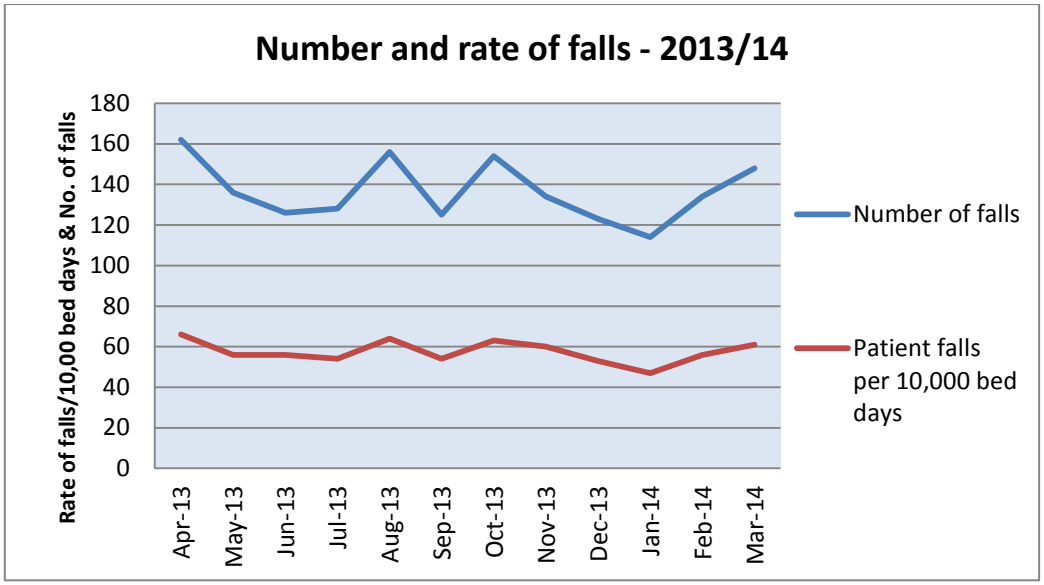
Patient Falls in Hospital

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



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

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



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

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

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

- 63% of the staff, including the staff who work in wards with higher number of falls, have undergone training in falls prevention
- We have audited the common environments in which falls occur, for example, toilets and bathroom.
- We have improved our risk assessments and care plans in relation to patient falls.
- We have introduced a “checklist” to help staff reviewing the patient’s medications after a fall.

We will continue to reduce inpatient falls by:

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

Pressure Ulcers

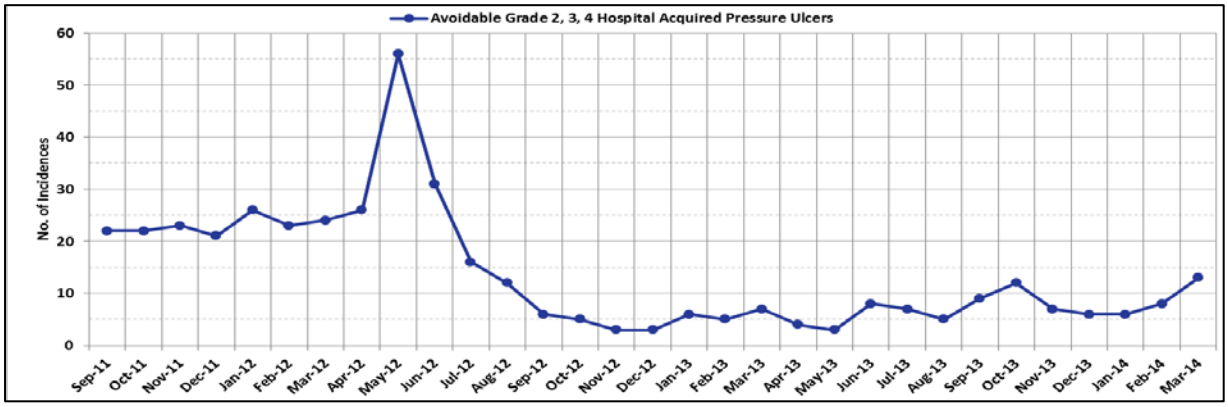
Pressure ulcers are injuries caused when an area of skin is placed under pressure, leading to breaking down of the skin and the underlying tissue. There are 4 grades of pressure ulcers, depending on their severity. Grade 1 is the lowest (patches of discoloured skin) and grade 4 the highest (open wounds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

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

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

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

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

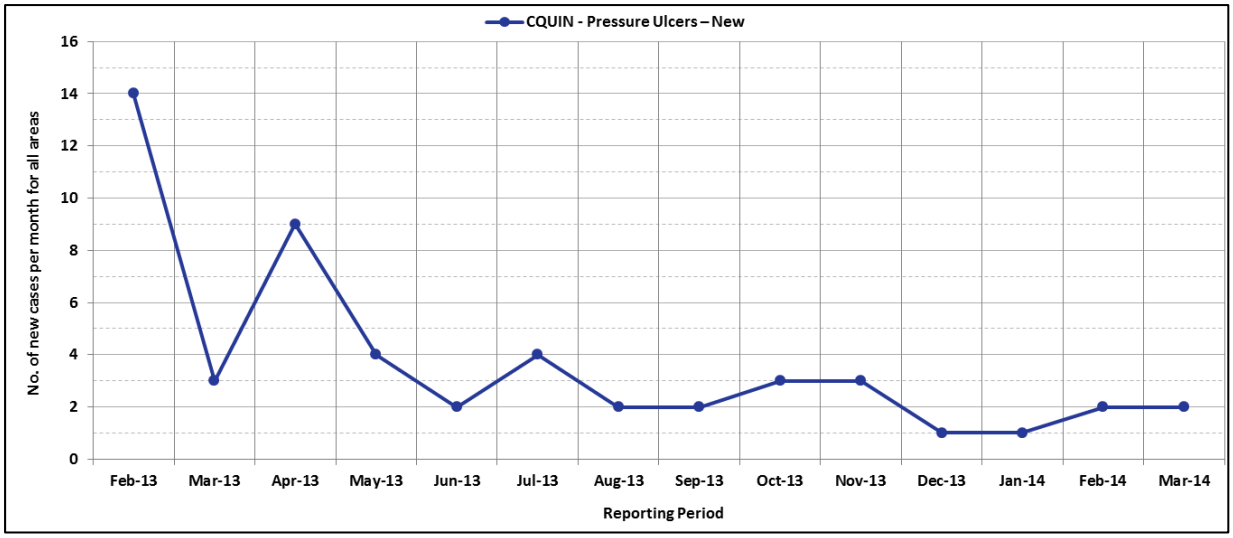


The peak in May 2012 was relating to an improvement programme within the Trust, resulting in an exceptionally high level of reporting in that month. The subsequent reduction in the number of pressure ulcers is due to the measures described above becoming embedded in the clinical areas.

CQUIN Target on Pressure Ulcers

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

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



Medication incidents

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

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

Infection Control

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

CDI

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

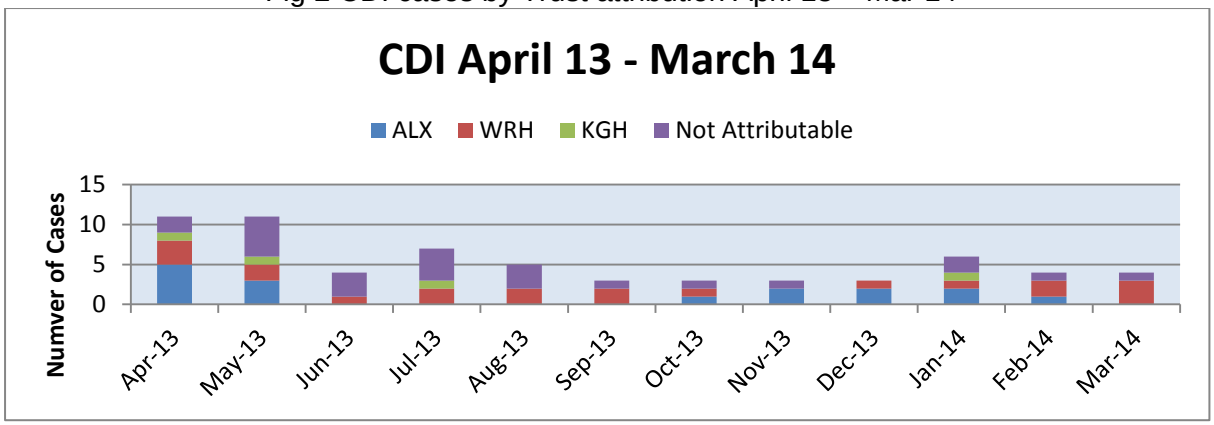
This achievement is due chiefly to our effort in working with our staff and patients, as well as with our partners in the community and neighbouring trusts. We have succeeded in reducing the use of specific antibiotics (for example Co-amoxiclav) and providing education to patients and staff. We have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

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

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

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

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



MRSA

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

Safety Thermometer

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

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

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

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

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

2.5.2 Claims made against the Trust

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

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

New Claims by Site

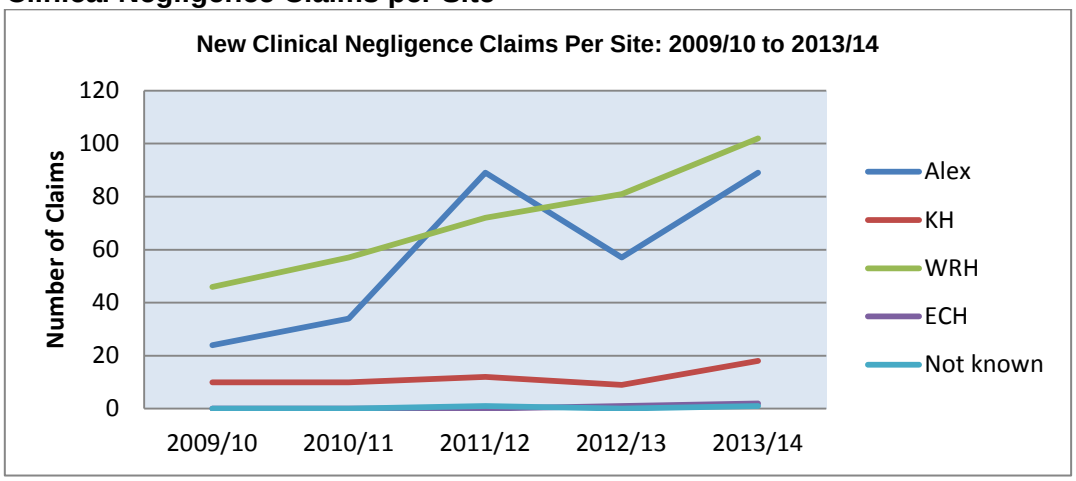
231 new claims were received between 1 April 2013 and 31 March 2014.
This is an increase on previous years however it also includes 30 claims that were notified as a second group of cases following the CQC report in 2011 and 17 cases relate to the colorectal surgeon under review.
The higher number of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

Number of new claims per site

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

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

New Clinical Negligence Claims per Site



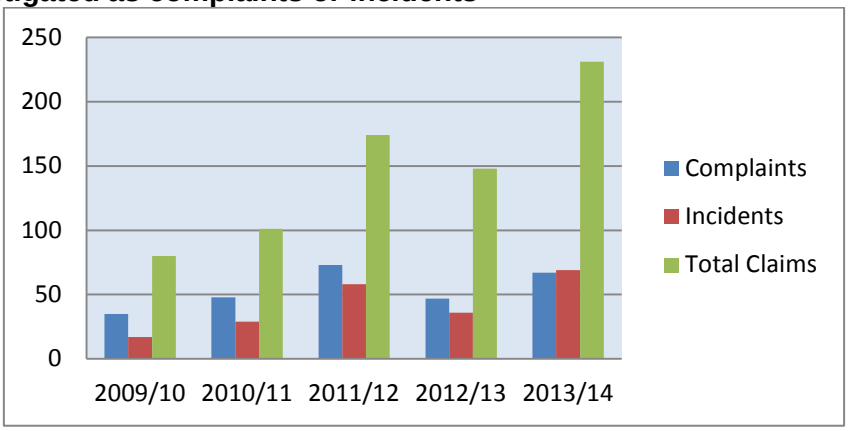
Incidents or Complaints before a Claim

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

Number of claims per year investigated as a complaint or incident

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

Claims investigated as complaints or incidents



Categories of Claims

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

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

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

Closed Claims

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

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

2.5.3 Safeguarding patients

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

During the year 2013/14 the Trust has

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

The impact of this increased awareness has been seen in

- an increase in the number of safeguarding alerts raised by staff
- an increase in the number of applications under the Deprivation of Liberties Safeguards that have been supported.

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

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

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

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

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

During the year 2013/14 the Trust has

- Continued to strengthen multiagency working
- Attended Worcestershire Safeguarding Children Board meetings and its subgroups
- Made changes to practice following learning from multi agency case reviews

- Initiated a Trust Children's Board, with a safeguarding children sub group, to roll out and monitor the safeguarding children agenda on a trust wide basis.

Identified issues that are being addressed during 2013/14

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

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

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

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

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

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

2.6 Clinical Effectiveness

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

2.6.1 Consultant level indicators

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

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

2.6.2 Medical Revalidation / HED tool

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

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

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

2.6.3 Mortality overview

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

The Trust uses a recognised tool[3] to review the relative risk of mortality for our services and compare this with other Trusts to see where there may be issues that require further investigation.

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

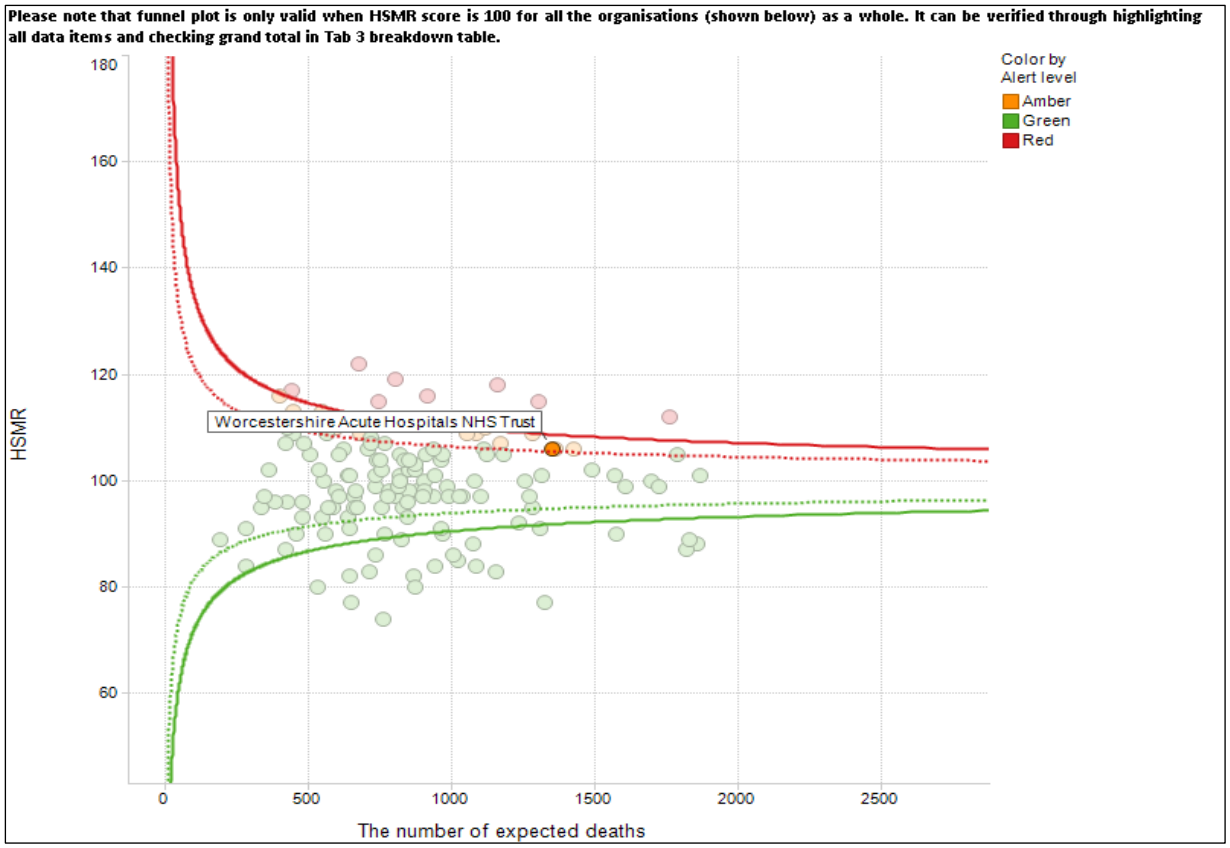
The accuracy of the data of diagnoses and outcomes is very important and reviews of patient records where higher than expected mortality is observed, often reveal inaccuracies in coding. The HSMR is often quoted as being a 'smoke signal' and unexpected mortality rates need to be investigated to determine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

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

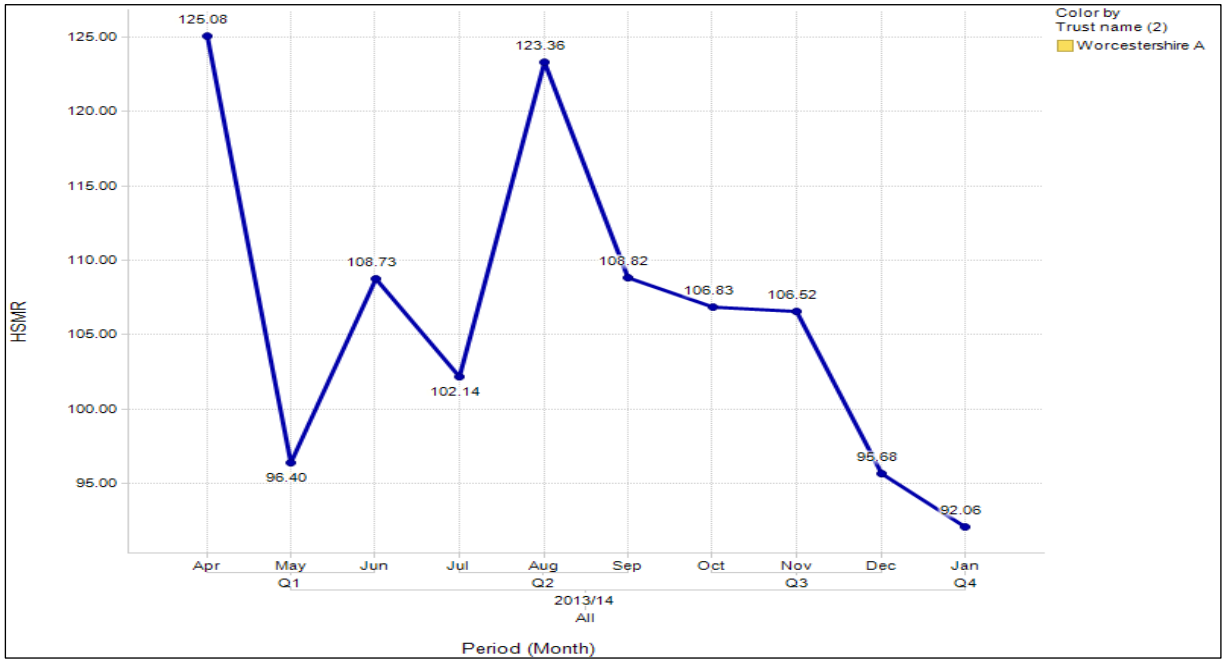
HSMR April 2013 – January 2014 = 106.13

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

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



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



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

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

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

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

Mortality risk for patients admitted with surgical diagnoses at Alexandra Hospital

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

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

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

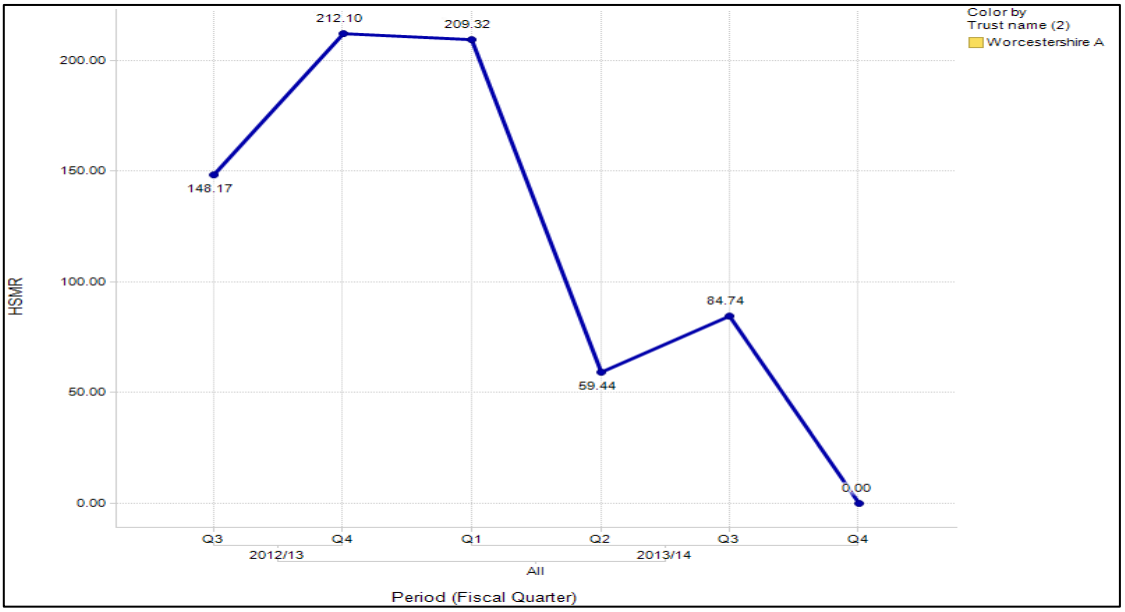
The Chief Medical Officer and the Chief Operating Officer formed a Task and Finish Group for Emergency Surgery to oversee the management of this important matter and to ensure patient safety was maintained, risk evaluations undertaken and that timely and effective

decision-making was in place. The Task and Finish Group met on a fortnightly basis and developed and managed a detailed action plan to reduce the risks.

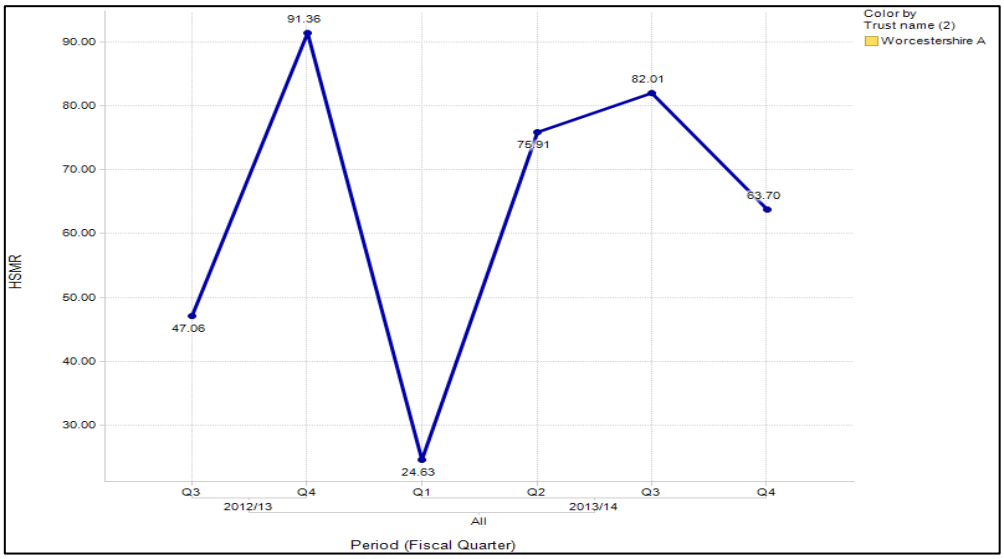
Following advice from clinical colleagues, a change to the existing Emergency Surgery pathway from 3rd February 2014 meant that the most acute patients (Acute Abdomen and/or Perforated Viscus) have been transferred from the Alexandra Hospital to Worcestershire Royal Hospital. On average 2-3 patients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

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

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



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



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

A review of weekend mortality relative risk

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

We determined that:

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

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

SHMI April – November 2013 = 99.46

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

2.6.4 Clinical Audit

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

National Audit of Paediatric Diabetes Services

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

- There has been improvement in the ‘care processes’ (for example, an annual blood pressure measurement) across the three sites (Alexandra Hospital, Kidderminster Hospital and Worcestershire Royal Hospital) of the Trust. We performed ‘considerably better than average’ in the financial year 2011-2012.

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

2.6.5 Research and Development Services

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

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

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

- to promote and encourage research activities within the hospital
- to ensure research governance[4] is maintained to a high level in all research projects in the Trust.
- along with the R&D Committee, to ensure the safety of all patients participating in research and ensure the reputation of the hospital with regard to research are protected at all times
- to support researchers to become involved in and recruit to the National Institute for Health Research Clinical Research Network (NIHR CRN)NIHR portfolio studies[5].

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

Quality performance in 20013/14:

Each year the Trust agrees a target to increase recruitment into NIHR portfolio studies with West Midlands (South) Comprehensive Local Research Network. For the past few years the hospital has been unable to meet this target, however in 2012/13 this target was

[4] Research Governance refers to a range of principles and standards aim to ensure research is of high quality, safe and ethical.

[5] The National Institute for Health Research Clinical Research Network (NIHR CRN) Portfolio consists of high-quality clinical research studies that are eligible for support from the NIHR Clinical Research Network in England. The key objective of the NIHR is to improve the quality, relevance, and focus of research in the NHS and social care by distributing funds in a transparent way after open competition and peer review.

surpassed with 1056 participants recruited versus a target of 1013. This is the first year since 2009/10 in which this target has been met.

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

Improvement aims for 2014/15

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

2.7 Patient Experience

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

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

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

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

2.7.1 Complaints

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

Complaints received

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

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

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

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

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

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

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

Complaints received by Trust site in 2013/14

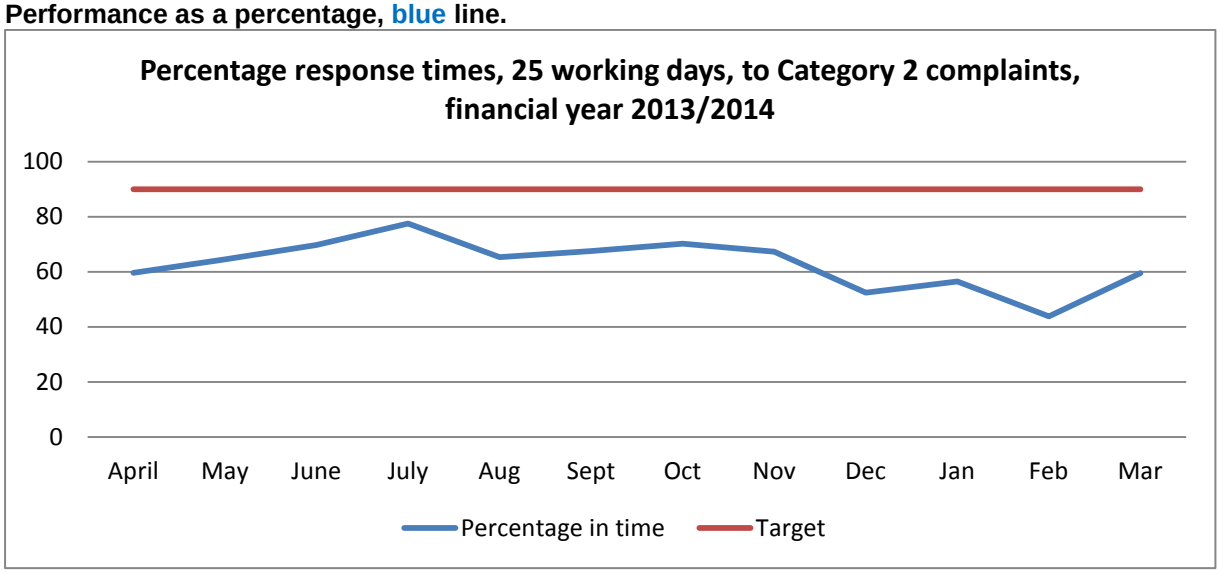
	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sep 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14	Tot
TW	0	0	0	1	0	1	3	0	0	0	1	1	7
WRH	32	41	27	30	28	20	28	29	23	26	29	18	331
ALEX	19	13	13	18	19	17	19	20	16	16	16	18	204
KGH	6	8	4	1	1	3	0	8	5	5	4	3	48
Oth	0	0	0	1	2	0	1	3	2	0	0	0	9
Tot	57	62	44	51	50	41	51	60	46	47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

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

Response times

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

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



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

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

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

Learning from complaints

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

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

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

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

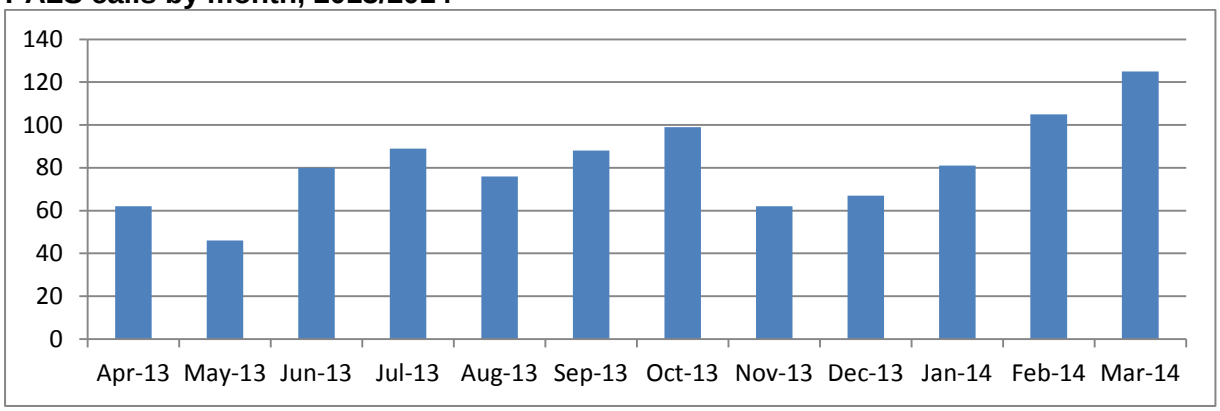
The Ombudsman will ask the Trust for information about a case, and based on that information will decide whether or not to proceed to investigation.

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

2.7.2 Patient Advice and Liaison (PALS)

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

PALS calls by month, 2013/2014



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

2.7.3 The Friends and Family Test

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

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

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

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

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

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

The scores are calculated as follows:

Proportion of respondents who would be extremely likely to recommend (response category: "extremely likely")

—

Proportion of respondents who would not be extremely likely to recommend (response categories: "neither likely nor unlikely", "unlikely" & "extremely unlikely"

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

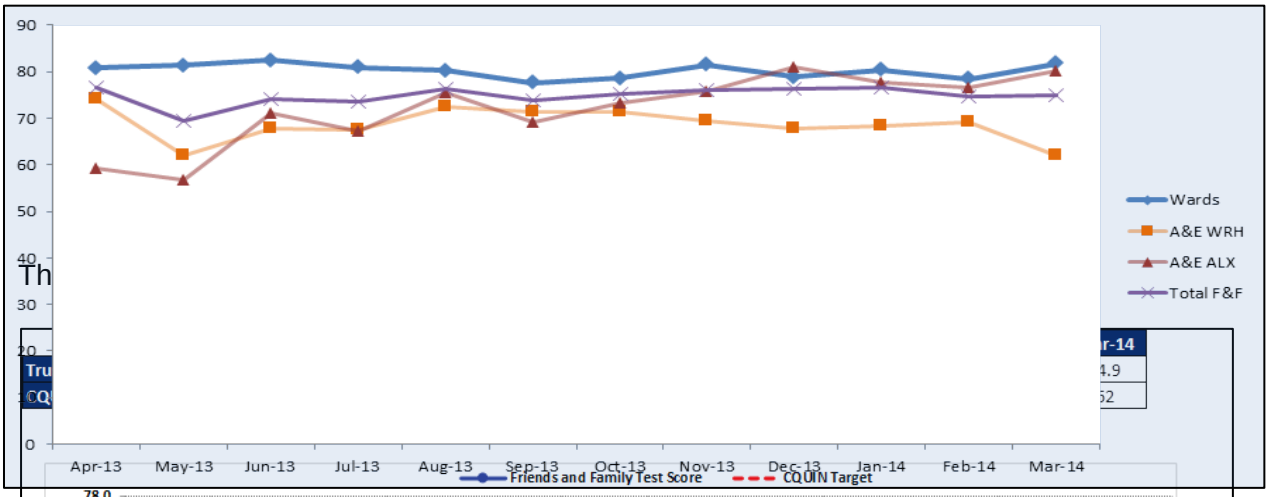
It is important to highlight that the "likely" responses are not mentioned in the calculation. However they form part of the total and the numbers of "likely" responses are therefore highly influential on the final score.

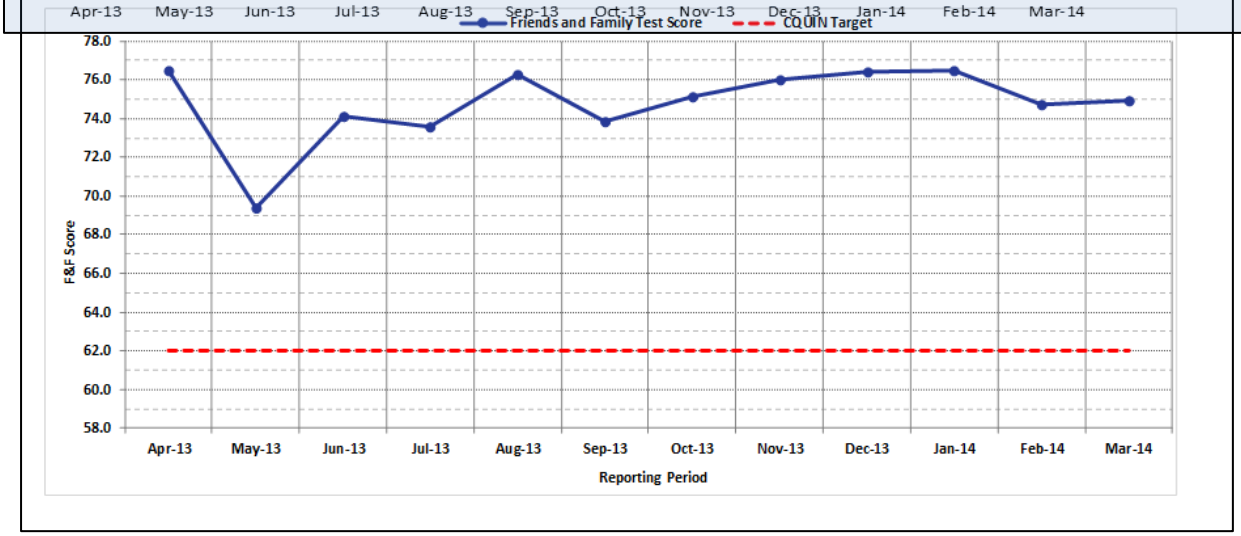
More information on the NHS Friends and Family Test can be found at: *http://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2013/07/Publication-Guidance.pdf*

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

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

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





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

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

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

2.7.4 Same Sex Accommodation

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

2.7.5 National Inpatient Survey

Actions taken following the 2012 National Inpatient Survey

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

The inpatients were asked what they thought about different aspects of the care and treatment they received on all sites within the Trust. The survey highlighted a number of findings, with Worcester Acute Hospitals NHS Trust achieving mostly average performance in comparison with other hospitals on all of the categories looked at by the survey. However, compared with other Trusts surveyed by Picker, lower scores were achieved for the explanations given on whom to contact if they are worried on discharge, copies of GP letters, food and opportunity to talk to a doctor. The Trust has improved overall from 2011 statistically on six questions.

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

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

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

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

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

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

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

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

Did the anaesthetist or another member of staff explain how he or she would put you to sleep or control your pain?	9.0	9.2

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

Areas where the patients scored lower are as follows:

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

Did a member of staff tell you about any danger signals you should watch for after you went home?	5.0	4.8

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

2.7.6 Hospedia Survey

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

The positive feedback from Hospedia has been:

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

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

2.7.7 "How it feels for me"

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

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

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

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

- Sepsis
- End of life care
- Tissue viability

2.7.8 Patient Opinion

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

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

111 patients posted comments on NHS Choices
60 patients posted comments on Patient Opinion

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

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

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

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

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

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

2.7.9 Learning Disabilities

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

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

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

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

Evaluating and Monitoring Care
There is an Acute Trust Learning Disabilities Steering Group which develops and evaluates actions that have been identified through audits, patient feedback, internal / external reviews and reports. We invited Health Checkers to undertake a follow up visit to A&E to ensure that the suggested improvements had been implemented. This identified a need to make further improvements to signage across all the Acute Trust

sites. In addition to this Health Checkers have agreed to undertake further reviews of clinical areas in response to patient feedback to ensure the Acute Trust addresses the needs of those people with a learning disability and their carers.

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

2.7.10 Privacy and Dignity

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

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

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

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

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

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

2.7.11 End of Life Care

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

The "AMBER care bundle" is a collection of up to five interventions to manage the care of hospital patients who are facing uncertain recovery and who are at risk of dying in the next

one to two months. It was developed at Guy's and St Thomas' Hospital NHS Foundation Trust and further information on this approach of care can be found on http://www.ambercarebundle.org/forprofessionals/for-professionals.aspx

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

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

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

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

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

2.7.12 Improving Nutrition and hydration experiences

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

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

2.7.13 Patient and Public forum

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

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

> *"The Patient and Public Forum carried out 36 clinical visits in 2013 across our three hospital sites. These visits involved observation of practice, speaking to ward staff about their practices and patients/carers about their experiences of privacy and dignity, nutrition and the environment in which they are being nursed.*
>
> *The information gained through this work has enabled us to make improvements in care. We have, for example:*

- *Improved our menu choices, promoted mealtimes guidelines, introduced hot meals for patients across the three hospital sites*
- *introduced dignity curtains in all wards and departments and Dignity Patient Experience Groups*
- *made appropriate patient night wear available*
- *ensured equipment and ward environments are clean and fit for purpose for patients*
- *reviewed ways to communicate and identify appropriate quiet/private areas to discuss sensitive matters*

Patient Forum

The Patient Forum of the Acute Trust consists of volunteers with a particular interest in acute services. We work in small groups, and make visits to wards and clinics.

When the Forum visit wards, we sit quietly and observe what is happening to patients. We take time to talk to patients and carers about how the patient is being looked after, including such things as drinks within reach of patients where appropriate, call bells within reach, and how long it takes for a call bell to be answered and the request acted upon. We often observe meal times, and check the quality of food, whether patients receive their choice, and how much is eaten. We observe patients who need help with eating their food, and how the staff interact with the patient being helped to eat.

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

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

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

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

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

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

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

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

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

2.7.14 Spiritual and Pastoral Care

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

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

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

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

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

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

2.8 What our staff thought of our services

2.8.1 Staff Survey

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

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

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

Questions	Trust's score	National average
Hand washing materials are always available	**70%**	60%
Staff experiencing harassment, bullying or abuse from other staff	**21%**	24%
Staff reporting errors, near misses or incidents witnessed in the last month (the higher the score the better)[6]	**93%**	90%
Staff experiencing physical violence from staff	**2%**	3%
Staff experiencing physical violence from patients, relatives or the public in the last 12 months	12%	15%

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

Questions	Trust's score	National average
Effective team working (based on a scale of 1 – 5 where 5 is the best)	**3.56**	3.74
Staff feeling pressure in last 3 months to attend work when feeling unwell	**35%**	28%
Staff witnessing potentially harmful errors, near misses or incidents in last month[7]	**38%**	33%
Staff having equality and diversity training in last 12 months	**45%**	60%
Work pressure felt by staff (on a scale of 1 – 5 where 5 is worst)	**3.17**	3.06

Our 5 most improved responses from last year are:

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

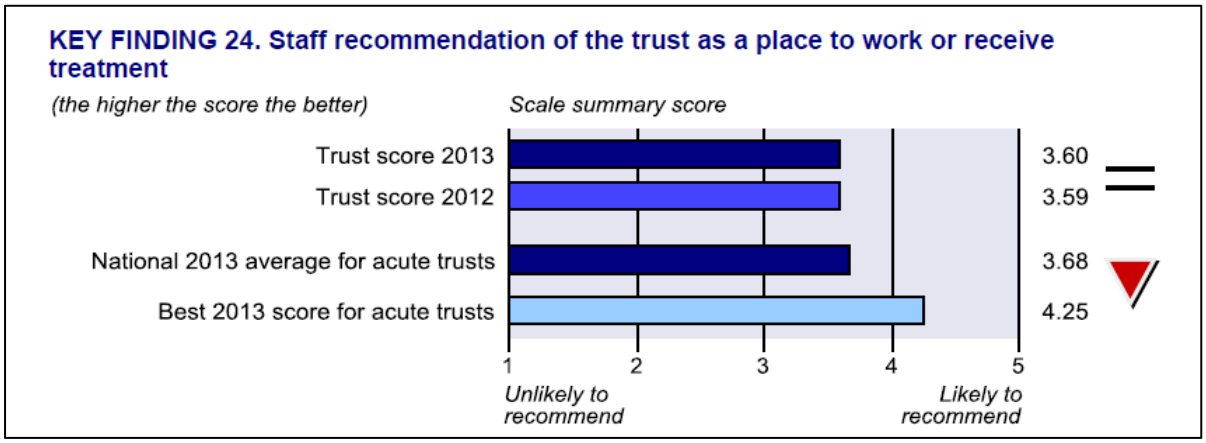
The 5 areas that have declined the most from last year are:

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

happen in the organisation

"Friends and Family Test" for staff

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



Staff Engagement

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

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

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

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

Progress from the 2012/13 staff survey

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

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

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

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

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

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

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

  This includes the key finding about staff witnessing potentially harmful errors, near misses or incidents in the last 12 months which shows a significant deterioration. The percentage of staff feeling pressure to attend work when feeling unwell has increased as well as the percentage of staff experiencing physical violence from patients, and feeling the incident reporting procedure being fair and effective is worse.

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

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

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

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

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

2.8.2 Workforce Indicators

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

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

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

Sickness rate for past 3 years

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

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

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

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

2.8.3 Engagement with Staff

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

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

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

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

2.8.4 Staff Recruitment

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

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

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

2.8.5 Pre and Post Registration Education

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

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

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

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

2.8.6. Health Care Support Workers (HCSW)

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

Section 3 – Priorities for improvement

3.1 Priorities for improvement 2014/2015

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

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

Further details are provided below:

1. Reduce the incidence of *Clostridium difficile* and MRSA	
Why is this a priority?	• To ensure we continue to build on the progress made during 2013/14 to reduce harm caused by HCAIs
How we will deliver the improvement?	• Good antimicrobial stewardship • HPV decontamination programme • Improve MRSA screening rates • Ensure timely removal of devices • Improve attendance at IP&C training events • Whole health economy approach • Delivery of HCAI CQUIN.

Measures:	• MRSA screening rates • CQUIN milestones • *Clostridium difficile* and MRSA rates
Targets:	• Achieve annual targets for reduction in *Clostridium difficile* and MRSA
Reporting route:	• Divisional Quality Committees • Trust Infection, Prevention and Protection Committee • Quality Governance Committee
Responsible Officer:	• Chief Nursing Officer

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

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

4. Reduce avoidable deaths by improving Mortality Surveillance (with focus on acute surgery, acute medicine and renal medicine)	
Why is this a priority?	• The Trust acknowledges the need to have in place a more robust system to identify any areas of excess mortality and take action to reduce avoidable deaths
How we will deliver the improvement?	• Directorates and Divisions will hold effective Mortality and Morbidity (M&M) Meetings and act upon the findings, reporting the outcomes to the Safe Patient Group • Widen the usage of the Health Evaluation Data (HED) tool to enable more detailed analysis at a Speciality level or Site of Hospital Standardised Mortality Ratio (HSMR) Summary Hospital Mortality Index (SHMI) within all Divisions • Triangulation of quality indicators to identify factors that lead to harm

	• Re-introduce the usage of the global trigger tool (GTT) to identify harm • Undertake targeted case note reviews • Introduce systematic death certification reviews
Measures:	• Divisional M&M Reporting • Number of applicable Directorates using the HED tool • Divisional HSMR and SHMI Reporting
Targets:	• Achieve a mortality ratio of 100 or less for each diagnostic group
Reporting route:	• Divisional Quality Committees • Safe Patient Group
Responsible Officer:	• Chief Medical Officer

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

6. Reducing variation in mortality between week days and weekend working	
Why is this a priority?	• In line with the publication of the Francis Report, Keogh's 10 Clinical Standards and other patient safety focused publications, all Trusts need to work towards providing safe and effective care 7 days a week • The Trust needs to maintain the trend of improvement for relative risk for weekend admissions as commenced in late 2013/14, when the value moved to within expected normal limits
How we will deliver	• Changes to job plans in partnership with Consultants and HR, to enable

the improvement?	routine weekend working including Consultant Ward Rounds • Delivery of 6 day working within Elective Services • Maintaining universal 7 day provision of acute hospital services • Increase in Diagnostic Services coverage • Investment in development of roles such as Physician's Assistant and Advanced Nurse Practitioners. • Re-introduce Hospital at Night. • Regularly review and compare weekend mortality rates with weekdays
Measures:	• Hospital Standardised Mortality Ratio (HSMR) • Summary Hospital Mortality Indicator (SHMI)
Targets:	• Undertake staffing changes in Acute Surgery in 14/15 • Undertake staffing gap analysis and recruitment in Acute Medicine in 14/15 • Introduce weekend working into all new posts in 14/15 • Undertake staffing changes in Acute Medicine in 15/16
Reporting route:	• Safe Patient Group
Responsible Officer:	• Chief Medical Officer

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

3.2 CQUINS agreed for 2014/15

The following 2014/15 CQUINs have been agreed with our 3 Clinical Commissioning Group's (CCG's), NHS Redditch and Bromsgrove, NHS South Worcestershire and NHS Wyre Forest.

		Quality Domain			
Goal Name	Goal Description	Safety	Effectiveness	Patient Experience	Innovation
Friends and Family Test	To improve the experience of patients in line with Domain 4 (Ensuring that people have a positive experience of care) of the NHS Outcomes Framework. The Friends and Family Test will provide timely, granular feedback from patients about their experience.			Yes	
NHS Safety Thermometer	To reduce the amount of harm the patients experience through reduction in the prevalence of 'new' Pressure Ulcers.	Yes		Yes	
Dementia	To incentivise the identification of patients with dementia and other causes of cognitive impairment alongside their other medical conditions, to prompt appropriate referral and follow up after they leave hospital and to ensure that hospitals deliver high quality care to people with dementia and support their carers			Yes	
Reduction of surgical site infection for patients undergoing surgery	To reduce the incident rate of surgical site infection for Caesarian Sections (emergency and planned) and other surgical procedures which show an increased incidence rate of SSI. They can contribute to extended length of stay and increased morbidity and mortality as well as increased prescribing costs in primary care.	Yes		Yes	
Hydration and Fluid Management	Promotion of hydration and fluid management in all in-patient settings through implementation and embedding of a hydration bundle. A number of reports have identified dehydration in patients as a contributory factor to sustaining injury from falls, developing pressure ulcers or increasing the risk of developing infection or deep vein thrombosis (Royal College of Nursing and National Patient Safety Agency 2007). This is evidenced particularly in the care of older people, as a continued failure in patient care (Health Service Ombudsman 2011)	Yes		Yes	
Safe Care	Reducing falls in all adult Inpatient areas including the Accident and Emergency (A&E) Department.	Yes		Yes	
Improving Patient Flow	To improve the flow of patients through the health system, improving patient experience and provider performance. Improving patient flow is recognised as critical to increasing patient safety by supporting the patient to receive the right care, in the right place at the right time.		Yes	Yes	

Specialist Commissioners CQUINS

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

		Quality Domain			
Goal Name	Goal Description	Safety	Effectiveness	Patient Experience	Innovation
Retinopathy of Prematurity	Retinopathy of prematurity is one of the few causes of childhood visual disability which is largely preventable. Many extremely preterm babies will develop some degree of ROP although in the majority of babies this does not progress beyond mild disease which resolves spontaneously without treatment. A small proportion develop potentially sever ROP which can be detected through retinal screening. If untreated severe disease can result in serious vision impairment and consequently all babies at risk of sight-threatening ROP should be screened (RCPCH 2008).		Yes	Yes	
Breast milk in preterm infants	There is evidence to show that maternal breast milk has particular advantages for preterm infants. It is associated with reduced incidence of necrotizing enterocolitis and infection which significantly contribute to preterm morbidity		Yes	Yes	

	and mortality as well as increased hospitalization. It is also important for maternal bonding in a particularly vulnerable patient group.			
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.		**Yes**	**Yes**
NHS Safety Thermometer	The same as the CQUIN agreed with our CCG Commissioners	**Yes**		**Yes**
Dementia and delirium care (FAIR)	The same as the CQUIN agreed with our CCG Commissioners			**Yes**

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

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

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

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

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

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

The key points from their suggestions are as follows:

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

Section 4 – Assurance Statements

4.1 Review of Services

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

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

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

4.2 Participation in Clinical Audits and National Confidential Enquiries

During 2013/14, 44 national clinical audits and 4 national confidential enquiries covered NHS services that Worcestershire Acute Hospitals NHS Trust provides.

During that period Worcestershire Acute Hospitals NHS Trust participated in 33 out of 34 [97%] of national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Worcestershire Acute Hospitals NHS Trust was eligible to participate in during 2013/14 are provided in the list below:

The national clinical audits that Worcestershire Acute Hospitals NHS Trust participated in, and for which data collection was completed during 2013/14 are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit.

National confidential enquiries

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

No other confidential enquiries were carried out in 2013/14

National Clinical Audits

National Clinical Audits (Hyperlinked)	Eligible	Participated	% of Participation	Comments on Progress
Acute Coronary Syndrome or Acute Myocardial Infarction (NICOR-MINAP)	yes	yes	100%	
Adult Cardiac surgery (NICOR-ACS)	no	no	Do not provide the service	
Cardiac Arrest (NCAA-ICNARC)	yes	no	Local Audit	
Cardiac Arrhythmia (NICOR-HRM)	yes	yes	100%	
Congenital heart disease (NICOR-Paediatric cardiac surgery)	no	No	Do not provide the service	
Coronary Angioplasty (NICOR-CA)	yes	yes	100%	
Heart failure (NICOR HF)	yes	yes	56%	Lack of resources within the department has resulted in not enough patients being seen. Business cases for 2 new heart failure nurses being developed.
Pulmonary hypertension (IC)	No	No	Do not provide the service	
Chronic Obstructive Pulmonary Disease (COPD) (COPD Discharge Audit)	yes	yes	N/A	Audit period to be from January 2014 onwards. Therefore no data available for 2013-14 Quality accounts.
Diabetes (Paediatric) (RCPCH-PNDA)	yes	yes	N/A	125 cases submitted, participation rate cannot be calculated due to the paediatric diabetes denominators unknown.
Inflammatory bowel disease (RCP-IBD) 4th Round	yes	yes	N/A	Data entry closed Jan 2014, therefore will not be included in 2013-14 quality accounts.
Renal Registry (UKRR)	no	no	Do not provide the service	

National Adult Diabetes Audit-ANDA (NHS IC)	yes	yes	N/A	Audit to commence 20th September
Adult Critical Care (ICNARC CMP)	yes	yes	100%	
Emergency Laparotomy	yes	yes	N/A	New audit for 2014 therefore will not be included in 2013-14 Quality Accounts
Emergency use of oxygen (BTS)	yes	yes		Report will be included in Quality Accounts.
National joint registry (NJR)	yes	yes	100%	On-going on both sites.
Trauma (TARN)	yes	yes	100%	On-going on both sites.
Paracetamol Overdose (CEM)	yes	yes	N/A	Sample size (50 per site). Data collection finished jan 14 therefore not included in 2013-14 Quality Accounts
Bowel cancer (NBOCAP)	yes	yes	134.8%	Report will be included in Quality Accounts.
Lung cancer (LUCADA)	yes	yes	148%	Report will be included in Quality Accounts.
Head and neck oncology (IC DAHNO)	yes	yes	>80%	Plans to look at Action plan in May 14.
Oesophago-gastric cancer (RCS -NAOGC)	yes	yes	>80%	Data Collection: The Third Annual Report will include data on patients diagnosed between 1 April 2011 and 1 April 2013. The data submission deadline for this report will be Tuesday 1 October 2013. The publication date for the Third Annual Report will be May 2014
Comparative audit of blood transfusion - Multi audit programme	yes	yes	100%	
(SSNAP) Stroke National Audit Sentinel and SINAP) Programme (combined Sentinel and SINAP)	yes	yes		Data only submitted in January 2014 therefore will not be included in 2013/14 Quality Accounts
National Audit of Seizure Management (NASH)	Yes	yes	100%	The trust has appointed another Neurologist so from Feb 2014 there is an official first fit clinic which would aim to comply with NICE guidelines seeing the patients quickly not the 3-4 months as previously occurred. I do not think that the NASH 2 was a driver for this. There were no unexpected findings from the NASH

				project.
Severe Sepsis & Septic Shock (CEM)	yes	yes	100%	Sample = 50 per site.
Epilepsy 12 (Childhood Epilepsy) (RCPCH)	yes	yes	100%	Very small numbers submitted to the national audit.
Moderate or severe asthma in children (care provided in emergency departments)	yes	yes	N/A	The data collection period has been delayed. Data collection will now start on Monday 16th September and close on 31st January 2014
Neonatal intensive and special care (NNAP)	yes	yes	100%	The Trust was acknowledged as outstanding for NNAP and received an certificate of recognition
Paediatric asthma (BTS)	yes	yes	N/A	Data entry still open on the BTS Site until 31/01/14
Paediatric Intensive Care (PICA Net)	no	no	Do not provide this service	
Prostate cancer	TBC	TBC	N/A	Started data collection in Dec 2013
Rheumatoid and early inflammatory arthritis	TBC	TBC	N/A	Started data collection Jan 14
Child Health (CHR-UK)	yes	yes	100%	
Maternal infant and Perinatal Mortality	yes	yes		Ann Tonks (Regional Project Manager) : Electronic notifications only for any deaths from 1st July 2012. Units can produce their own figures from the new system.
Prescribing Observatory for Mental Health (POMH-UK)	no	no	Do not provide this service	
National Audit of Schizophrenia	no	no	Do not provide this service	
National confidential enquiry into patient outcome and death (NCEPOD)	yes	yes	100%	
Suicide and homicide in	no	no	Do not provide this service	

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

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

Actions taken following national clinical audit reports:

Title	Action Points
Trust wide Re-audit of the Blood Transfusion Care Pathway	• Presentation of the results to Trust Transfusion Committee/Presentation of audit to the link nurse day • Improvement on documentation in the care pathways and consider mechanisms that would achieve this i.e. further learning/workshops • Review audit tool to better reflect practice o Audit standards need to more accurately represented on the audit tool • Education of users at induction / mandatory training and link nurse training
Childhood Epilepsy 12 (RCPCH National Childhood Epilepsy Audit)	• 95% compliance with the national guideline requirements.
CEM National Severe Sepsis in Septic Shock Management in Adults in A&E	• To continue excellent care - Departmental meeting - results disseminated to nursing staff and doctors • Ensure rotating junior Emergency Department (ED) staff are aware of management of sepsis and

	practising excellent care - Induction/teaching. Daily board rounds in the ED Timing of blood cultures - Establish electronic blood ordering through PF: IT are setting up an new interface • Blood glucose on all patients - Nursing staff meeting
Cardiac Arrythmia	• 12/01/2014 Sent report to Dr Foster awaiting update • The network population is older than average so there is an 18% greater need for pacemakers and 17% greater for iCDS than the national average. • Implant rates for all device classes are seriously below the national average. The situation is particularly drastic for PM which fell sharply from an already low level. the rate is now only half the national target and is far from the national average. This would suggest the need for a local pacing review. • The ICD implant rate rose but the overall rate is below the national average for CRT. A substantial rise in 2010 has been followed by a small fall in 2011, so that the rate is also below the national average.
National Neonatal intensive and special care Audit Programme (NNAP)	• WRH received a letter of commendation for completeness of data collection. The problem is to do with recording when babies have their eyes checked for ROP because of prematurity. Many babies are discharged from the Alex SCBU before their first screen is due, and until recently there was no easy way of retrospectively adding data. This has now been rectified, and we have a data clerk supervising completeness of data we submit for NNAP.
National Paediatric Diabetes Audit NPDA(RCPH)	• Dr Scanlon stated that the paediatric service is improving, with the help of additional staff that have been employed and the families think that they are being well supported.
BTS Pneumonia for paediatrics	• To use Amoxicillin as drug of choice for community acquired pneumonia. • Only the complicated pneumonia needs to be followed up in clinic • Children with O2 saturation less than 92% needs admission to hospital • Blood culture is not an integral investigation in community acquired pneumonia.

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

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

Project Title	Directorate	Aims	Outcomes
Re-audit of the Management of loco-regional breast cancer recurrences	General Surgery	1) To see if we are meeting national guidance of <31/7 between diagnosis of local recurrence and first treatment 2) If patients are getting staging investigations in the 2 week wait period. 3) To see if, by staging these patients, we are delaying their treatment and, if so, does staging alter management?	The 1st audit cycle was carried out in 2011 and it clearly showed that the Trust was not achieving the standards required for investigations or treatment in appropriate time Hospital protocol: (CT scan & NM bone scan) ≤ 2 weeks of diagnosis = 2011 57% 2013 100% Cancer Reform Strategy (DoH): 31 day standard from diagnosis/decision to first treatment to cover all cancer treatments. =2011 75% 2013 100% CG80 NICE Guidelines state that all patients with breast cancer should get multi-disciplinary team (MDT) care = 100% 2011/2013 The 2013 results were a result of the following actions implemented. Book CT scan and NM bone scan at time of seeing patient in clinic/receiving biopsy results. By making sure their scans are prompt, this will speed up decisions made for Mx. If for surgery, book surgery date at time of diagnosis but can always be changed.
Sepsis Six: Improving Management Re-audit	Medicine	➢ Initial audit and then a re-audit after a set of interventions. ➢ Aiming to identify the current management of sepsis in newly admitted patients in AMU. Then introduce a set of inventions and carry out a re-audit to identify any change/improvement in management of septic patients.	The audit consisted of looking at all new admissions over a one week period who met the criteria for sepsis in AMU. The criteria evaluated was Time to first administration of oxygen, intravenous fluids and antibiotics. Taking of blood cultures, other relevant bloods tests (including lactate) and urine output monitoring. The data was collected for 12 days, and then interventions were introduced in the next 14 days such as: • Teaching session for nurses working in AMU

			• Producing a poster and displaying on AMU • Easy follow guidelines were produced for sepsis • Sepsis pathway emailed to all clerking doctors. A total of 32 patients (19 Males, 13 Females) were identified in the pre-intervention group. 22 of these patients met the criteria for severe sepsis. Only 15 out of 32 (47%) had their lactate measured. 10 out of 22 (45%) received fluids within an hour. 12 out of 22 (55%) had their blood culture sample taken after administration of antibiotics and only 12 out of 22 (55%) had antibiotics administrated within an hour of medical assessment Post-intervention the results however improved dramatically. A total of 30 patients were identified in the post-intervention group (12 Males, 18 Females). Antibiotics administration within an hour went up by 22%.. Lactate was performed in 26/30 (87%) patients presenting with sepsis compared to 47% in the pre-intervention group. Similarly, identification of severe sepsis, and administration of intravenous fluids also showed improvement ultimately improving patient care. Further actions have also been completed ready for the next sepsis six audit which will be completed in 2015. They are as follows:- Continuous teaching sessions for AMU nursing staff. Sepsis guidelines available on intranet A4 sized sepsis pathway guidelines to put in severely septic patients' files to make everyone aware Sepsis six box
Deep Vein Thrombosis (DVT) Audit	Medicine	• Re- audit into the assessment and management of patients presenting with DVT symptoms • To identify where improvements are required in the assessment and referral pathways e.g use of DVT nurse referral/admission. • To assess whether we are using the wells score,	• The audit was completed at WRH in 2011and data was collected using patient first reporting system (scanned CAS card and notes/referral forms). The initial findings were that A&E staff were not complying with the recommended guidance. As a result of the audit the junior handbook was updated with new criteria and new proformas for nurses to complete. The findings for the re-audit and the previous audit are as follows:- • Standard 1 – Wells score performed (standard achieved) 2011 51%

		performing D-dimers appropriately and referring to DVT nurse/USS • Impact will be on current practice through better use of DVT pathway and educate current/future clinical staff.	2014 93% • Standard 2 – D-dimer performed appropriately if Wells < 2, 2011 71% 2014 91.8% (standard achieved). • Standard 3 – Enoxaparin given (standard 90% not achieved) 2011 77% 2014 85% improvement since previous audit • Standard 4 & 5 patients referred for investigation (standard 90% not achieved). 2011 70% 2014 88% improvement since previous audit

Clinical Audit Publications in 2013/14

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

4.3 Research and Development

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

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

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

2013/14 was the final year of a five year programme from the Department of Health aimed at doubling patient recruitment into clinical trials in every provider organisation in England. Worcestershire Acute Trust has increased recruitment more than 2.5 times the levels in year one.

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

4.4 Registration with the CQC

Worcestershire Acute Hospitals NHS Trust is required to register with the Care Quality Commission (CQC) and its current registration status is 'registered with no conditions'. The Care Quality Commission has not taken enforcement action against Worcestershire Acute Hospitals NHS Trust as of 31st March 2014.

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

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

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

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

4.5 Quality of Data

Data Quality

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

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

Actions taken to improve data quality

Information Governance Toolkit attainment levels

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

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

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

Area of audit	2013/14 result	2012/13 result
Primary diagnosis (main condition for the patient on admission to hospital)	88.5% of these shows the main part of the code was correct.	91.5% of these shows the main part of the code was correct.
Secondary diagnosis	94.3% correct	90% correct
Primary Procedure (first operation code)	93.6% correct	85% correct

Secondary Procedure (any other operations or procedures carried out during the patients stay in hospital	90.6% correct	87.8% correct
HRG changes (changes in the financial groupings used for costing)	4.5%	8.5%

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

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

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

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

Data Quality Policy

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

Data Quality Group

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

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

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

Data Quality Team

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

Clinical Coding Team

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

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

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

As part of the Trust's wider re-structuring plan, a 'Head of Coding' role has been introduced in to the Clinical Coding team structure which will be an outward facing role focussing on working more closely with the new Divisional teams to identify specific areas for improvement, provide training and promote the importance of accurate data recording.

Clinical Informatics/Information Team

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

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

Audits carried out by Clinical Coding Department

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

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

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

Audits carried out by Internal Audit Department

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

Future plans for improving Data Quality

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

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

Data Quality Steering Group

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

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

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

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

Use of Business Intelligence (BI)

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

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

Data Assurance Kite Mark

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

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

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

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

Service Evaluation of Clinical Coding Practices:

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

4.6 Mandatory Indicators and National Targets

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

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

Title	Indicator	2012/13	2013/14 (Latest data available on HSCIC includes first 2 quarters of 13/14. Monthly breakdown not available. Oct 2012 – Sep 2013)	National Average	Highest and lowest NHS Trust and Foundation Trust scores for the reporting period
Summary Hospital Mortality Indicator (SHMI)	a) the value and banding of the summary hospital-level mortality indicator ("SHMI") for the trust for the reporting period;	During 2012/13 the Trusts SHMI was 102.7 The Trust was then in Band 2 (indicates that the trust's mortality rate is 'as expected')	The SHMI for Oct 2012 – Sep 2013 was 105.5 The Trust is in Band 2 (indicates that the trust's mortality rate is 'as expected')	In Oct-2012 to Sep-2013: • 8 trusts had a 'higher than expected' SHMI value (Band 1) • 17 trusts had a 'lower than expected' SHMI value (Band 3) • 116 trusts had an 'as expected' SHMI value (Band 2)	For Oct 2012 – Sep 2013: Highest: 118.6 Lowest: 63.0
	b) the percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period.	From Apr 2012 – Mar 2013, 15.1% of deaths were reported with palliative care coding at either diagnosis or specialty level	From Oct 2012 – Sep 2013 15.5% of deaths were reported with palliative care coding at either diagnosis or specialty level	From Oct 2012 – Sep 2013: Average of 20.9% of deaths were reported with palliative care coding at either diagnosis or specialty level, nationally.	For Oct 2012 – Sep 2013: Highest: 44.9% Lowest: 0%

The Worcestershire Acute Hospitals NHS Trust considers that this data is as described for the following reasons:

a) The Summary Hospital-level Mortality Indicator (SHMI) reports on mortality at trust level across the NHS in England. Data as published on HSCIC.
b) Percentage of deaths reported in the SHMI where the patient received palliative care. Data as published on HSCIC.

The Worcestershire Acute Hospitals NHS Trust has taken the following actions to improve this number, and so the quality of its services, by:

This is detailed in section 2.6.3 and includes:

Monitoring of HSMR and SHMI with reviews of outlying diagnostic groups and requested reviews (such as weekends) to determine the reasons. Improvements in coding.

Title	Indicator	2012/13	2013/14 (provisional data – Apr 2013 – Dec 2013)	National Average (provisional data – Apr 2013 – Dec 2013)	Upper and Lower 95% control limit for the Trust (provisional data – Apr 2013 – Dec 2013)
	PROMs casemix-adjusted scores	Adjusted average health gain	Adjusted average health gain	Adjusted average health gain	Health Gain
Patient Recorded Outcome Measures (PROMS)	(i) groin hernia surgery	0.099 Not an outlier on the EQ-5D Index measure	0.066 Not an outlier on the EQ-5D Index measure	0.086	UCL (95%) = 0.114 LCL (95%) = 0.057
	(ii) varicose vein surgery	Too few modelled records to calculate adjusted health gain	Too few modelled records to calculate adjusted health gain	0.101	N/A
	(iii) hip replacement surgery	0.444 Not an outlier on the EQ-5D Index measure	0.442 Not an outlier on the EQ-5D Index measure	0.439	UCL (95%) = 0.485 LCL (95%) = 0.392
	(iv) knee replacement surgery	0.301 Not an outlier on the EQ-5D Index measure	0.321 Not an outlier on the EQ-5D Index measure	0.330	UCL (95%) = 0.380 LCL (95%) = 0.281

The Worcestershire Acute Hospitals NHS Trust considers that this data is as described for the following reasons:

- The information has been obtained from the Health & Social Care Information Centre
- The indicator used is EQ-5D™ Index – captures in a single value a range of generic health issues in a broad but clearly-defined way.
- The data for 2013/14 is provisional and cover only the first three quarters of the year

The Worcestershire Acute Hospitals NHS Trust has taken the following actions to improve this number, and so the quality of its services, by:

- The new clinical divisions are taking the lead for improving their response rates. Clinical leads are being identified to lead in PROM's and be responsible for disseminating the results and displaying them in clinic

areas for patients.

- Clinical areas will be promoting PROM's by having posters displayed.

Title	Indicator	2012/13	2013/14	National Average	Highest and lowest NHS Trust and Foundation Trust scores for the reporting period
Readmission rates	The percentage of patients aged (i) 0 to 14; and (ii) 15 or over, readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period.	0 to 14 Data not available Health & Social Care Information Centre for this period. 15 or over Data not available Health & Social Care Information Centre for this period.	0 to 14 Data not available Health & Social Care Information Centre for this period. 15 or over Data not available Health & Social Care Information Centre for this period.	0 to 14 Data not available Health & Social Care Information Centre for this period. 15 or over Data not available Health & Social Care Information Centre for this period.	0 to 14 Data not available Health & Social Care Information Centre for this period. 15 or over Data not available Health & Social Care Information Centre for this period.
	The Worcestershire Acute Hospitals NHS Trust considers that this data is as described for the following reasons:	The latest data available from the Health & Social Care Information Centre for the national average and highest and lowest scores is for 2010/11. We are unable to provide data for the periods requested.			
	The Worcestershire Acute Hospitals NHS Trust has taken the following actions to improve this number, and so the quality of its services, by:	As above.			

Title	Indicator	2012/13	2013/14	National Average	Highest and lowest NHS Trust and Foundation Trust scores for the reporting period
Patient Survey – Responsiveness to patient's needs	The trust's responsiveness to the personal needs of its patients during the reporting period	65.2	Not available	Not available	Not available

The Worcestershire Acute Hospitals NHS Trust considers that this data is as described for the following reasons:

The data is collected by an independent contractor on behalf of the Trust using robust methodology and is used for the associated CQUIN.

The Worcestershire Acute Hospitals NHS Trust has taken the following actions to improve this number, and so the quality of its services, by:

- Making it easier for patients to speak to doctors during their stay in hospital
- Improving patient information
- Expanding the clinical leadership capacity by creating more time for Ward Sisters to supervise and to be more visible to patients, carers and staff.

Title	Indicator	2012/13	2013/14	National Average	Highest and lowest NHS Trust and Foundation Trust scores for the reporting period
Staff recommending the trust as a provider of care	The percentage of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends.	2012 = 64.05% Placed in the 3rd Quartile Trusts in 4th Quartile are the top performers.	2013 = 61.52% Placed in the 2nd Quartile Trusts in 4th Quartile are the top performers.	Average score for 1st quartile: 52.057 Average score for 2nd quartile: 62.017 Average score for 3rd quartile: 70.569 Average score for 4th quartile: 83.781	Highest: 93.92% Lowest: 39.57%

The Worcestershire Acute Hospitals NHS Trust considers that this data is as described for the following reasons:

% to strongly agree / agree with the Q12d. 'If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation'
Data published on NHS Staff Survey website.

The Worcestershire Acute Hospitals NHS Trust has taken the following actions to improve this number, and so the quality of its services, by:

- new staff engagement initiatives have been put in place in 2013/14 – see section 2.8.3

Title	Indicator	2012/13	2013/14	England Average	Highest and lowest NHS Trust and Foundation Trust scores for the reporting period
Venous thromboembolism Risk assessments	The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period	Qtr 1: 95.9%	Qtr 1: 95.76%	Qtr 1: 95.48%	Qtr 1: H = 100% L = 78.78%
		Qtr 2: 95.1%	Qtr 2: 94.53%	Qtr 2: 95.84%	Qtr 2: H = 100% L= 81.70%
		Qtr 3: 95.7%	Qtr 3: 95.09%	Qtr 3: 95.79%	Qtr 3: H = 100% L = 74.09%
		Qtr 4: 95.3%	Qtr 4: not available	Qtr 4: not available	Qtr 4: not available
	The Worcestershire Acute Hospitals NHS Trust considers that this data is as described for the following reasons:		The DoH data collection asks for three items of information: 1. Number of adults admitted as inpatients in the month who have been risk assessed for VTE on admission to hospital using the criteria in the National VTE Risk Assessment Tool 2. Total number of adult inpatients admitted in the month 3. Calculated from (1) and (2), the percentage of adult hospital admissions, admitted within the month assessed for risk of VTE on admission		
	The Worcestershire Acute Hospitals NHS Trust has taken the following actions to improve this number, and so the quality of its services, by:		The trust continues to develop an electronic prescribing system with a mandatory requirement to complete the VTE due to be piloted in 2014.		

Title	Indicator	2012/13	2013/14	National Average	Highest and lowest NHS Trust and Foundation Trust scores for the reporting period
C. difficile infection	The rate per 100,000 bed days of cases of C.difficile infection reported within the trust amongst patients aged 2 or over during the	28.90 cases per 100,000 bed days	14.0 cases per 100,000 bed days. (trust's own figures)	N/A	N/A

reporting period.

The Worcestershire Acute Hospitals NHS Trust considers that this data is as described for the following reasons:

The 2013/14 data is not available on HPA's website, link provided by the Health & Social Care Information Centre.

The Worcestershire Acute Hospitals NHS Trust has taken the following actions to improve this rate, and so the quality of its services, by:

Title	Indicator	2012/13	2013/14 (Apr – Sep 2013) The latest data available	National Average (April – Sep 2013) The latest data available	Highest and lowest NHS Trust and Foundation Trust scores for the reporting period For similar Trusts – as provided by the NRLS:
Incidents	The number and, where available, rate of patient safety incidents reported within the trust during the reporting period,	<u>Number of incident reports:</u> April 12 – Sept 12 = 5541 October 12 to March 13 = 5687 <u>Rate of patient safety incidents:</u> April 12 – Sept 12 = 9.3 per 100 admissions October 12 to March 13 = 9.6 per 100 admissions	Number of incident reports: 5276 <u>Rate of patient safety incidents:</u> • 8.26 per 100 admissions	Number of incident reports: 4399 average Rate of patient safety incidents: • 7.0 per 100 admissions (average)	Highest Number: 7835 Highest rate: 12.7 Lowest number: 1761 Lowest rate:3.0

the number and percentage of such patient safety incidents that resulted in severe harm or death	April 12 – Sept 13 = Number: 12 o 10 severe harm o 2 deaths Percentage: o 0.2% severe harm o 0.0% death October 12 to March 13 = Number: o 10 severe harm o 6 deaths Percentage: o 0.2% severe harm o 0.1% death	Number: 22 • 16 severe harm • 6 deaths Percentage: • 0.3% Severe harm • 0.1% deaths	Number (average) • 22.8 severe harm • 4.9 deaths Percentage: • 0.5% severe harm • 0.1% death	Number Highest: 81 severe harm Lowest: 1 severe harm Highest: 15 deaths Lowest: 0 deaths Percentage: Highest: 2.6% severe harm Lowest: 0% severe harm Highest: 0.3% 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 39 similar large Acute Trusts so that the comparison is meaningful.

The Worcestershire Acute Hospitals NHS Trust has taken the following actions to improve this rate (for incident reporting) and number (of incidents that result in severe harm or death) and so the quality of its services, by

- Continuing to encourage incident reporting (in line with the NHS Outcomes Framework)
- Improving the investigation and response to incidents using Human Factors methodology and sharing learning of causes and solutions.
- Triangulating between incidents and other information to improve understanding of causative and contributory factors in avoidable harm

National Targets

Cumulative Incidences of Clostridium Difficile (C.diff)

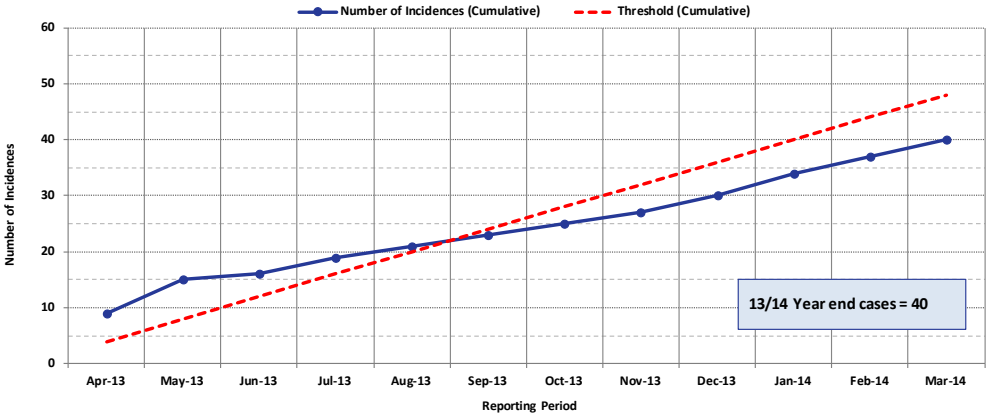
	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Number of Incidences (Cumulative)	9	15	16	19	21	23	25	27	30	34	37	40
Threshold (Cumulative)	4	8	12	16	20	24	28	32	36	40	44	48

Rationale

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

Results

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



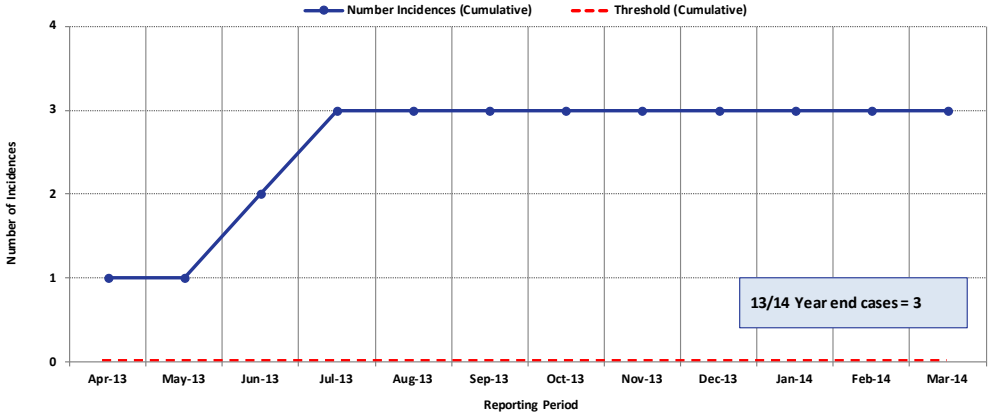
Cumulative Incidences of Methicillin-Resistant Staphylococcus Aureus (MRSA)

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

Rationale

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

Results



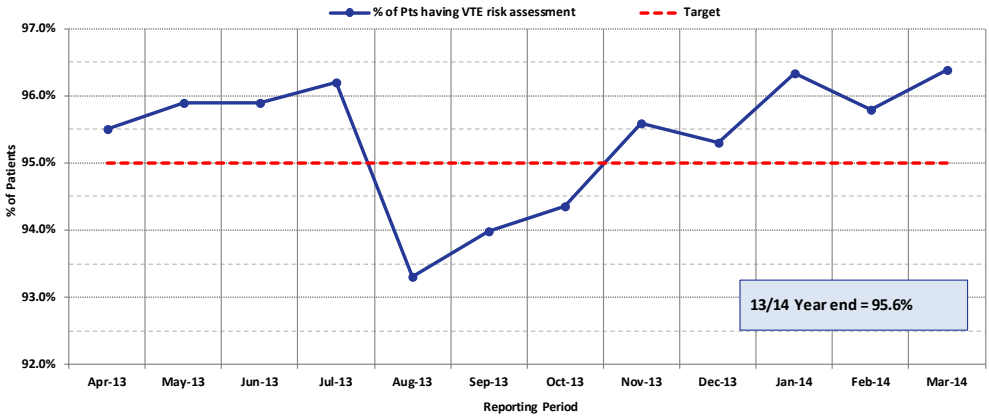
Elimination of Avoidable Venous Thrombo-Embolism (VTE)

	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
% of Patients Having VTE Risk Assessment	95.5%	95.9%	95.9%	96.2%	93.3%	94.0%	94.4%	95.6%	95.3%	96.3%	95.8%	96.4%
Target (>= 95%)	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%

Rationale

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

Results



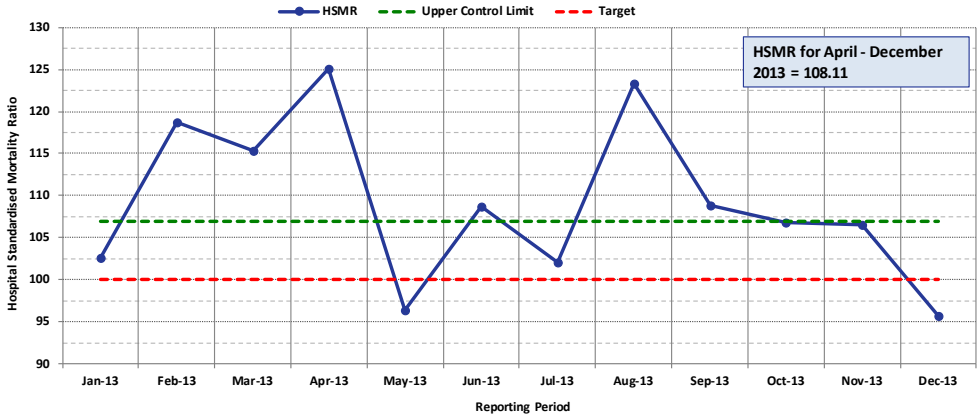
Hospital Standardised Mortality Ratio (HSMR)

	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13
Hospital Standardised Mortality Ratio (HSMR)	103	119	115	125	96	109	102	123	109	107	107	96
Upper Control Limit (UCL)	107	107	107	107	107	107	107	107	107	107	107	107
Target (Reduced HSMR below 100)	<100	<100	<100	<100	<100	<100	<100	<100	<100	<100	<100	<100

Rationale

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

Results



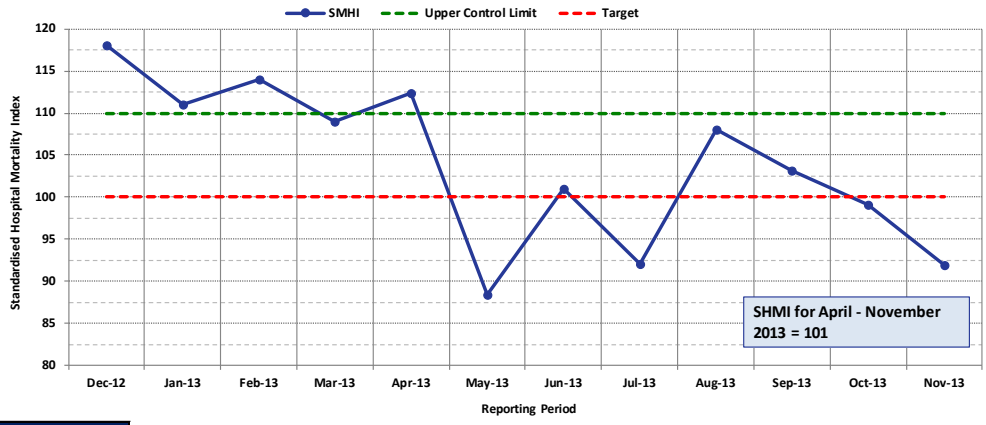
Standardised Hospital Mortality Index (SHMI) *

	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13
Standardised Hospital Mortality Index (SHMI)	118	111	114	109	112	88	101	92	108	103	99	92
Upper Control Limit (UCL)	110	110	110	110	110	110	110	110	110	110	110	110
Target (Reduced SHMI below 100)	100	100	100	100	100	100	100	100	100	100	100	100

Rationale

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

Results



31 Days: Wait For First Treatment: All Cancers

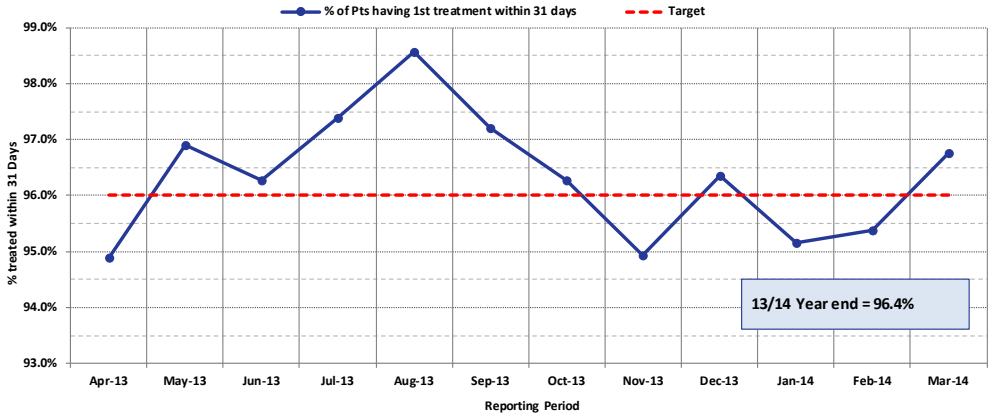
	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
% of Patients having their first treatment within 31 days	94.9%	96.9%	96.3%	97.4%	98.6%	97.2%	96.3%	94.9%	96.4%	95.2%	95.4%	96.8%
Target (>=96%)	>=96%	>=96%	>=96%	>=96%	>=96%	>=96%	>=96%	>=96%	>=96%	>=96%	>=96%	>=96%

Rationale

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

Results

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



31 Days: Wait For Second Or Subsequent Treatment: Surgery

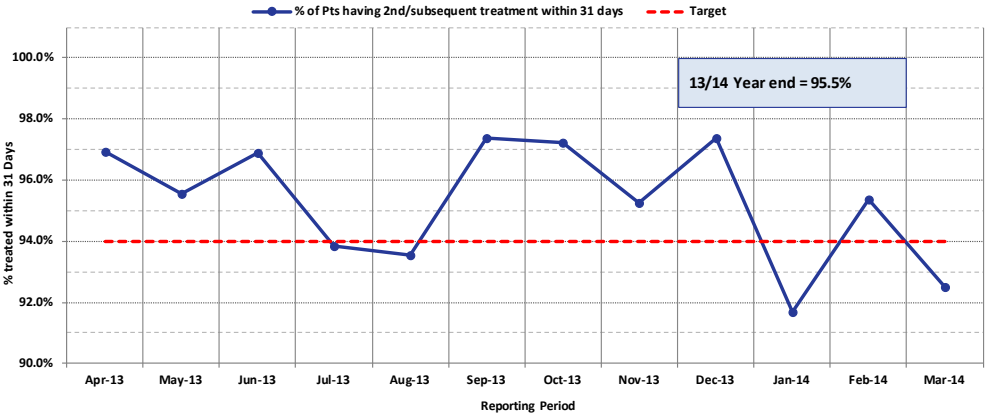
	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
% of Patients having their second or subsequent treatment within 31 days	96.9%	95.6%	96.9%	93.9%	93.6%	97.4%	97.2%	95.2%	97.4%	91.7%	95.4%	92.5%
Target (>=94%)	>=94%	>=94%	>=94%	>=94%	>=94%	>=94%	>=94%	>=94%	>=94%	>=94%	>=94%	>=94%

Rationale

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

Results

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



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

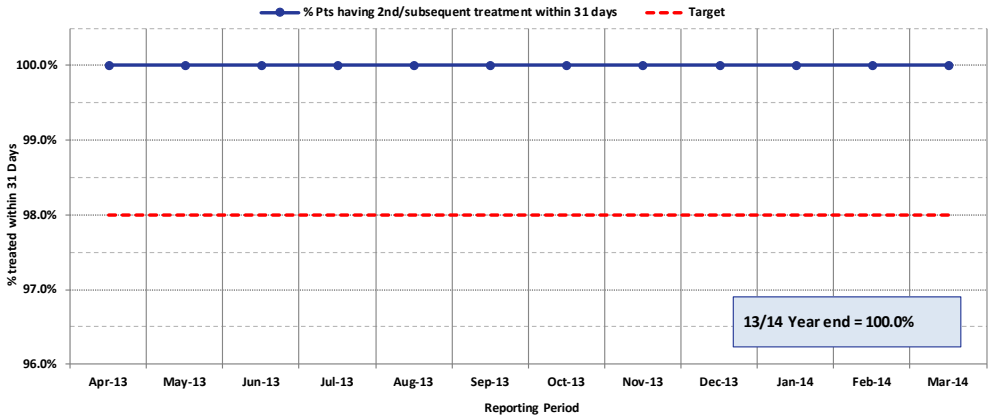
	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
% of Patients having their second or subsequent treatment within 31 days	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Target (>=98%)	>=98%	>=98%	>=98%	>=98%	>=98%	>=98%	>=98%	>=98%	>=98%	>=98%	>=98%	>=98%

Rationale

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

Results

Target achieved consistently.



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

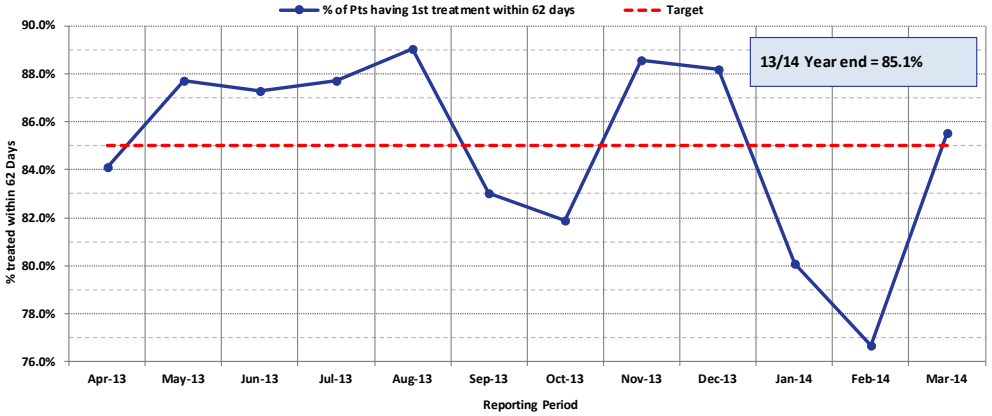
	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
% of Patients having their first treatment within 62 days	84.1%	87.7%	87.3%	87.7%	89.0%	83.0%	81.9%	88.6%	88.2%	80.1%	76.7%	85.6%
Target (>=85%)	>=85%	>=85%	>=85%	>=85%	>=85%	>=85%	>=85%	>=85%	>=85%	>=85%	>=85%	>=85%

Rationale

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

Results

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



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

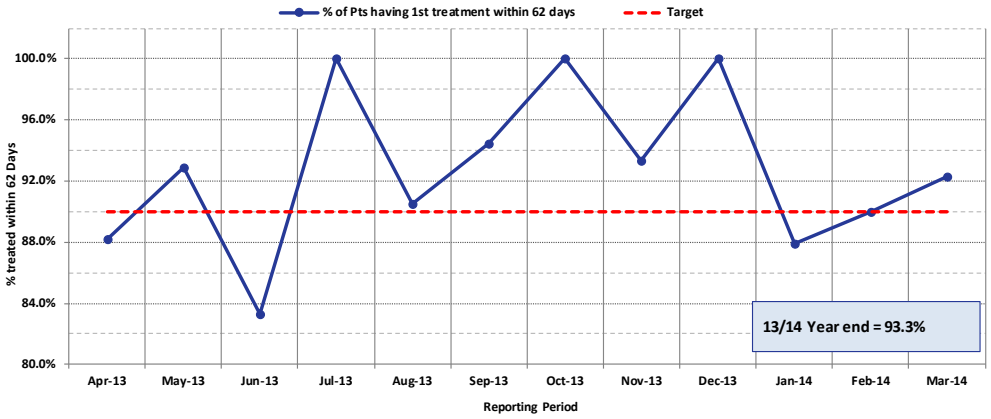
	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
% of Patients having their first treatment within 62 days	88.2%	92.9%	83.3%	100.0%	90.5%	94.4%	100.0%	93.3%	100.0%	87.9%	90.0%	92.3%
Target (>=98%)	>=90%	>=90%	>=90%	>=90%	>=90%	>=90%	>=90%	>=90%	>=90%	>=90%	>=90%	>=90%

Rationale

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

Results

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



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

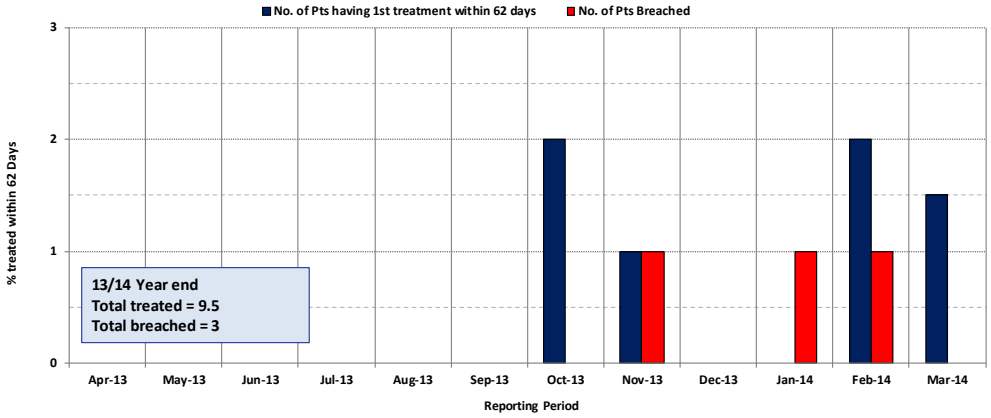
	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Number of Patients having their first treatment within 62 days	0	0	0	0	0	0	2	1	0	0	2	1.5
Number of Patients breached	0	0	0	0	0	0	0	1	0	1	1	0

Rationale

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

Results

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



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

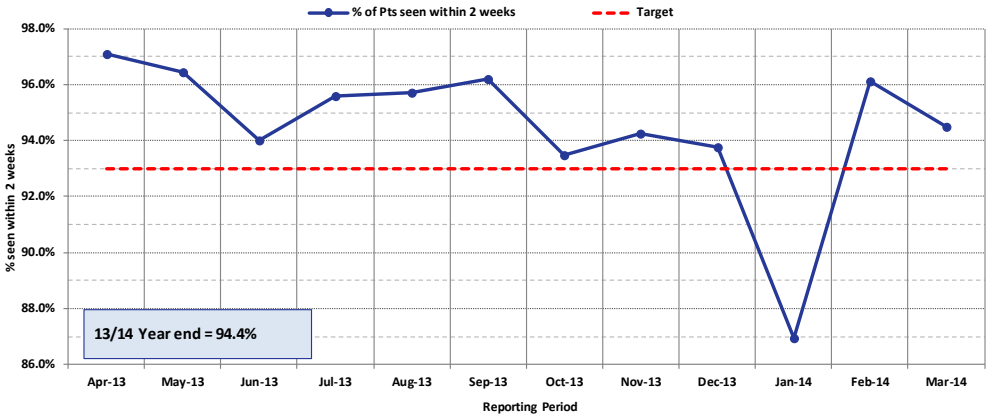
	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
% of Patients seen within 2 weeks	97.1%	96.5%	94.0%	95.6%	95.7%	96.2%	93.5%	94.3%	93.8%	87.0%	96.1%	94.5%
Target (>=93%)	>=93%	>=93%	>=93%	>=93%	>=93%	>=93%	>=93%	>=93%	>=93%	>=93%	>=93%	>=93%

Rationale

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

Results

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



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

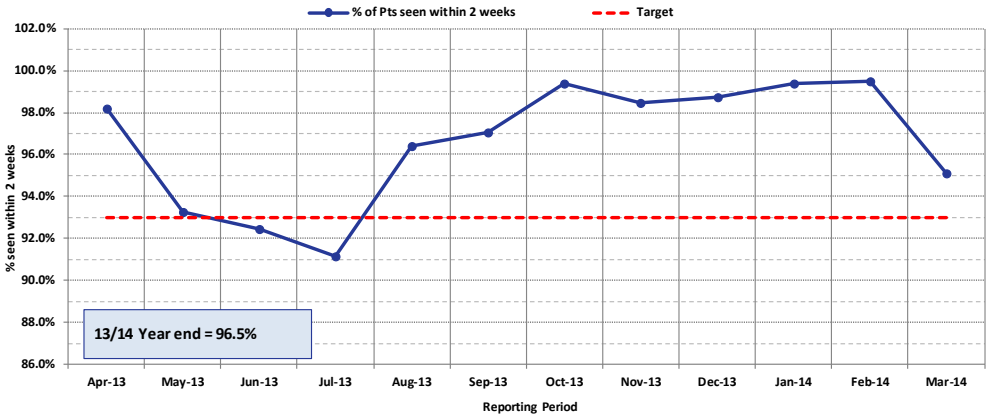
	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
% of Patients seen within 2 weeks	98.2%	93.3%	92.4%	91.2%	96.4%	97.1%	99.4%	98.5%	98.7%	99.4%	99.5%	95.1%
Target (>=93%)	>=93%	>=93%	>=93%	>=93%	>=93%	>=93%	>=93%	>=93%	>=93%	>=93%	>=93%	>=93%

Rationale

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

Results

The Trust achieved overall however June and July posed a challenge



Referral to Treatment (Admitted Pathway)

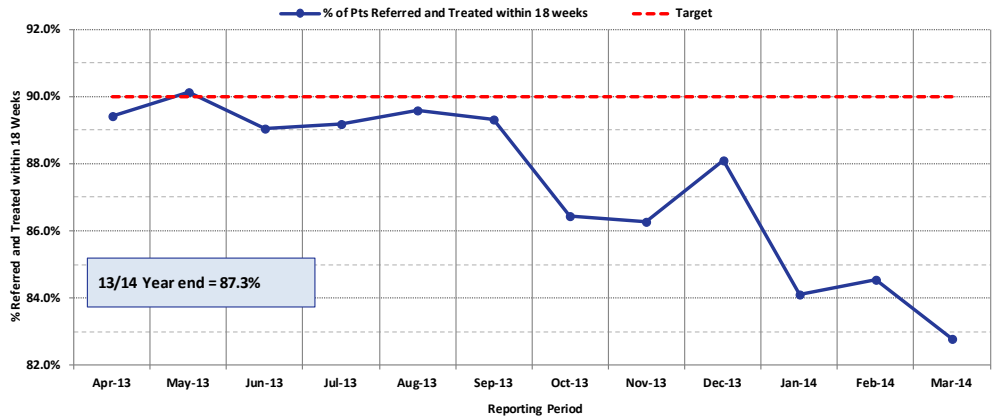
	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
% of Patients Referred and Treated within 18 Weeks	89.4%	90.1%	89.0%	89.2%	89.6%	89.3%	86.5%	86.3%	88.1%	84.1%	84.6%	82.8%
Target (>=90%)	>=90%	>=90%	>=90%	>=90%	>=90%	>=90%	>=90%	>=90%	>=90%	>=90%	>=90%	>=90%

Rationale

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

Results

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



Referral to Treatment (Non-Admitted Pathway)

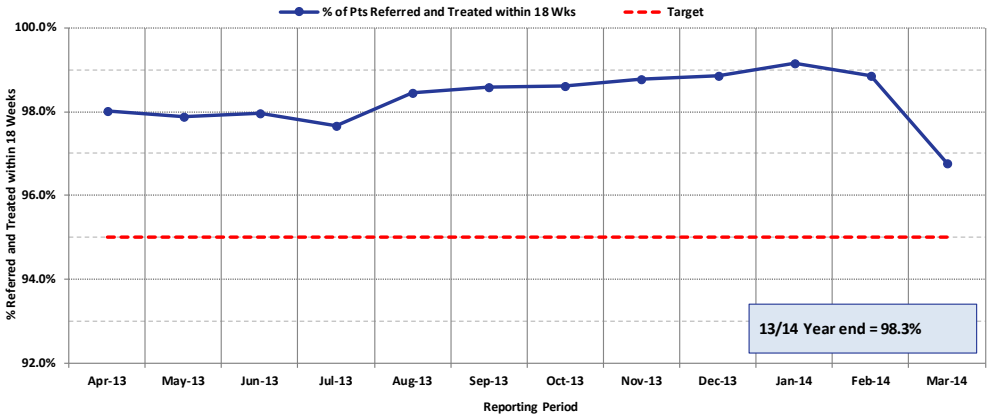
	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
% of Patients Referred and Treated within 18 Weeks	98.0%	97.9%	98.0%	97.7%	98.5%	98.6%	98.6%	98.8%	98.9%	99.1%	98.8%	96.8%
Target (>=95%)	>=95%	>=95%	>=95%	>=95%	>=95%	>=95%	>=95%	>=95%	>=95%	>=95%	>=95%	>=95%

Rationale

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

Results

The Trust achieved overall



Referral to Treatment (Incomplete Pathway)

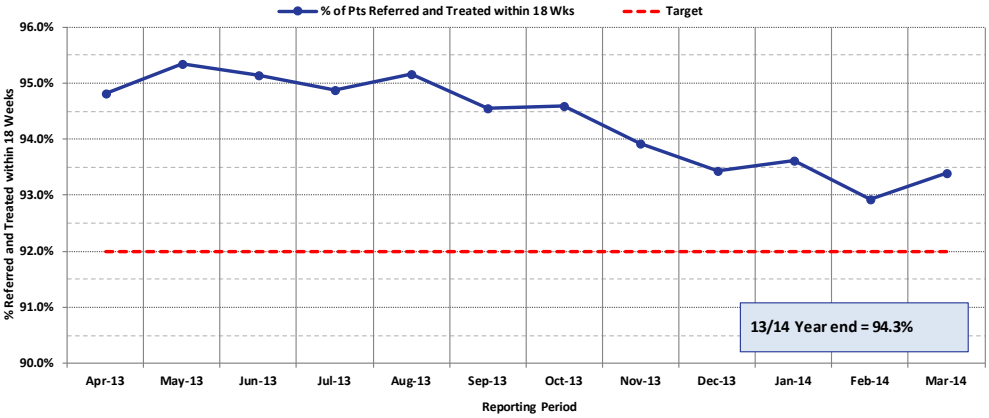
	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
% of Patients Referred and Treated within 18 Weeks	94.8%	95.3%	95.1%	94.9%	95.2%	94.6%	94.6%	93.9%	93.4%	93.6%	92.9%	93.4%
Target (>=92%)	>=92%	>=92%	>=92%	>=92%	>=92%	>=92%	>=92%	>=92%	>=92%	>=92%	>=92%	>=92%

Rationale

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

Results

Target achieved sustainably throughout 13/14, but strong performance impacted over the winter period by extreme emergency demand.



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

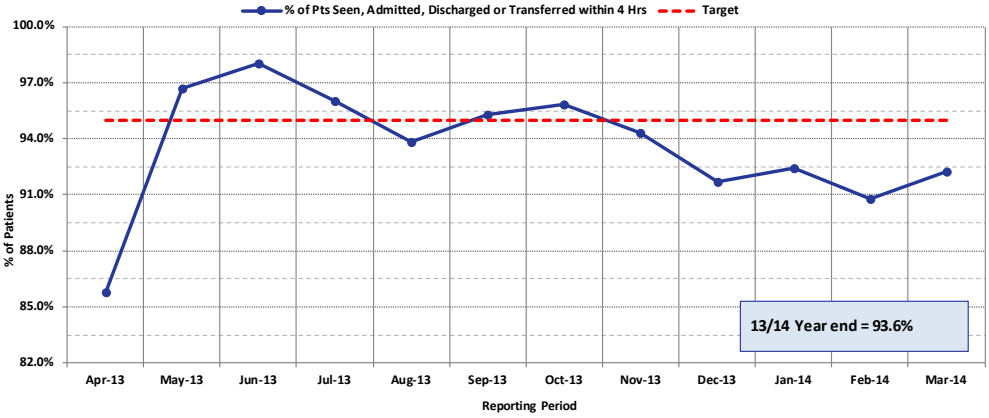
	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
% of Patients Seen, Admitted, Discharged or Transferred within 4 Hours	85.8%	96.7%	98.0%	96.0%	93.8%	95.3%	95.8%	94.3%	91.7%	92.4%	90.8%	92.3%
Target (>=95%)	>=95%	>=95%	>=95%	>=95%	>=95%	>=95%	>=95%	>=95%	>=95%	>=95%	>=95%	>=95%

Rationale

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

Results

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



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

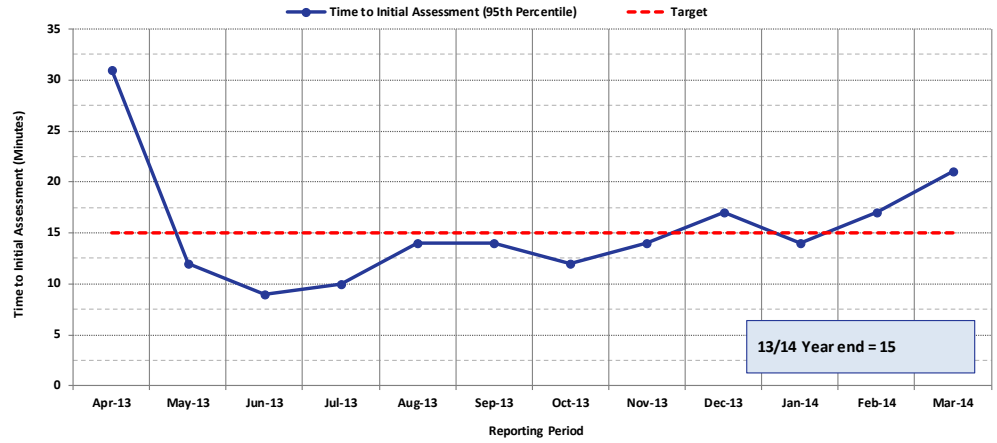
	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Time to Initial Assessment (95th Percentile)	31	12	9	10	14	14	12	14	17	14	17	21
Target (<= 15 Minutes)	<=15 Mins	<=15 Mins	<=15 Mins	<=15 Mins	<=15 Mins	<=15 Mins	<=15 Mins	<=15 Mins	<=15 Mins	<=15 Mins	<=15 Mins	<=15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

Rationale

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

Results

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



Time from Arrival to Treatment in Minutes (Median)

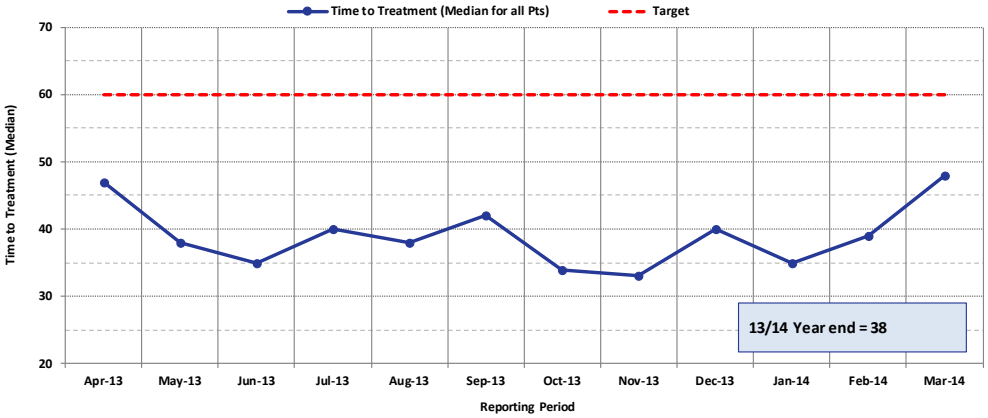
	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Time to Treatment (Median for all Patients)	47	38	35	40	38	42	34	33	40	35	39	48
Target (<= 60 Minutes)	<=60 Mins	<=60 Mins	<=60 Mins	<=60 Mins	<=60 Mins	<=60 Mins	<=60 Mins	<=60 Mins	<=60 Mins	<=60 Mins	<=60 Mins	<=60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

Rationale

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

Results

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



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

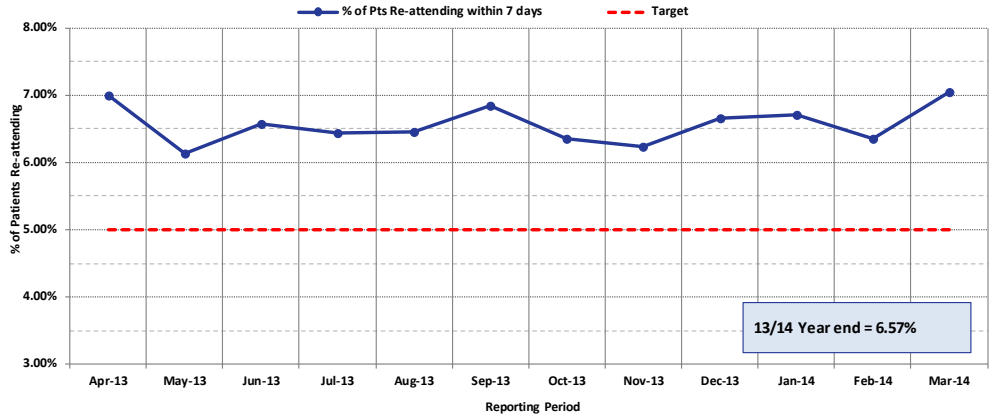
	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
% of Patients Re-attending within 7 Days	7.00%	6.14%	6.57%	6.43%	6.45%	6.85%	6.36%	6.23%	6.66%	6.70%	6.35%	7.05%
Target (<=5%)	<=5%	<=5%	<=5%	<=5%	<=5%	<=5%	<=5%	<=5%	<=5%	<=5%	<=5%	<=5%

Rationale

Patients who return to the same A&E within seven days of the original attendance are known as an 'unplanned reattender'.

Results

The Trust consistently recieves between 6-7% of re-attends Patients are encouraged to return if their condition gets worse, particularly in younger patients, and this figure also depends on the provision of primary or urgent care in the community.



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

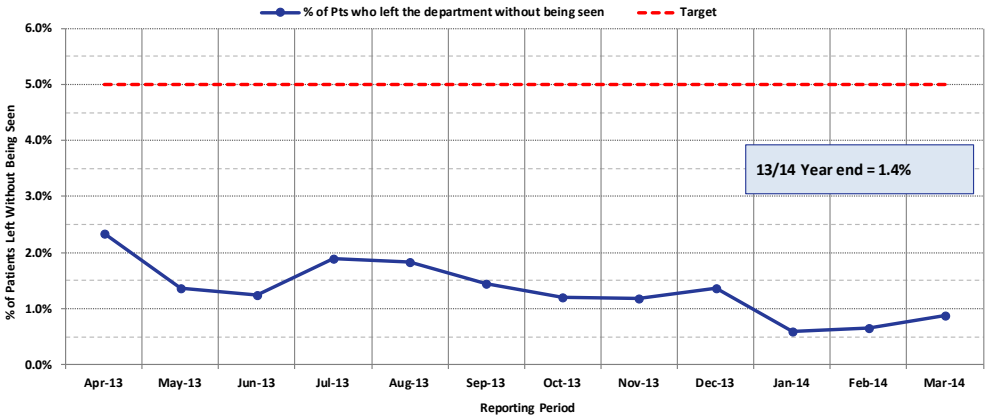
	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
% of patients who left the department without being seen	2.3%	1.4%	1.3%	1.9%	1.8%	1.5%	1.2%	1.2%	1.4%	0.6%	0.7%	0.9%
Target (<=5%)	<=5%	<=5%	<=5%	<=5%	<=5%	<=5%	<=5%	<=5%	<=5%	<=5%	<=5%	<=5%

Rationale

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

Results

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



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

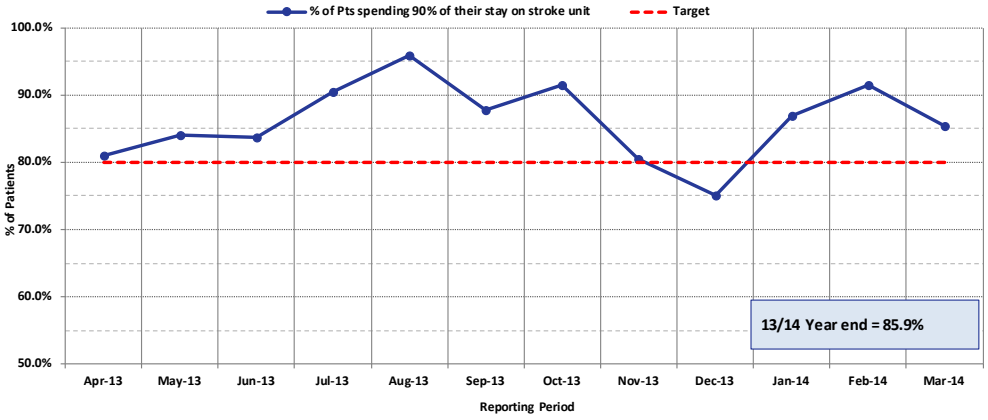
	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
% of Patients Spending 90% of their stay on the Stroke Unit	81.0%	84.0%	83.6%	90.4%	95.9%	87.7%	91.5%	80.4%	75.0%	86.9%	91.4%	85.4%
Target (>= 80%)	>=80%	>=80%	>=80%	>=80%	>=80%	>=80%	>=80%	>=80%	>=80%	>=80%	>=80%	>=80%

Rationale

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

Results

The Trust has achieved overall regarding length of stay however in December 2013 there was a shortage of downstream capacity with the community and to enable the admissions of acute stroke patients who were awaiting rehab had to be stepped down into a sub acute ward.



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

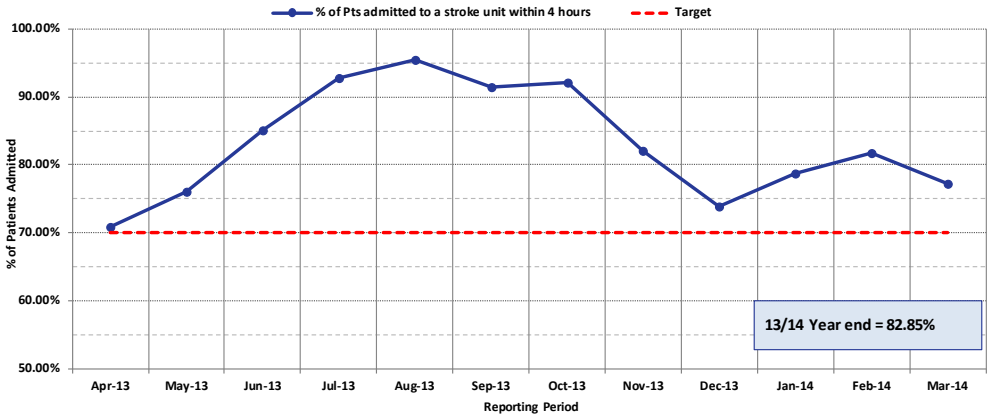
	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
% of Patients Admitted to a Stroke Unit Within 4 Hours	70.83%	76.09%	85.11%	92.68%	95.35%	91.49%	92.11%	82.05%	73.91%	78.72%	81.82%	77.27%
Target (>=70%)	>=70%	>=70%	>=70%	>=70%	>=70%	>=70%	>=70%	>=70%	>=70%	>=70%	>=70%	>=70%

Rationale

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

Results

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



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

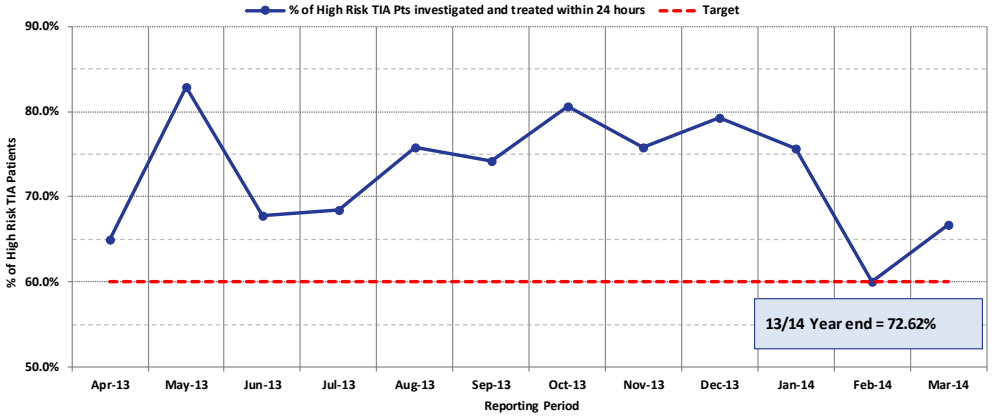
	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
% of High Risk TIA Patients Investigated and Treated Within 24 Hours	65.0%	82.9%	67.7%	68.4%	75.9%	74.2%	80.7%	75.8%	79.3%	75.7%	60.0%	66.7%
Target (>=60%)	>=60%	>=60%	>=60%	>=60%	>=60%	>=60%	>=60%	>=60%	>=60%	>=60%	>=60%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

Rationale

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

Results

The Trust has achieved overall



Appendix 1 – Statements

Worcestershire Health Overview and Scrutiny Committee (HOSC) Comments

In making its response, the HOSC considers information made available throughout the year which is supported by the Quality Account. The information received on a regular basis regarding Worcestershire Acute Hospitals' Trust (the Trust) includes regular bulletins, specific presentations about proposals for significant changes, and board meetings, which HOSC's two lead members attend.

Overall Comments

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

Review of Quality Performance

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

Priorities for Improvements 2014-15

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

Patient Experience

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

Board Meetings

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

Our Commissioners - Worcestershire CCGs

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

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

Suggestions made for previous Quality Accounts regarding the layout of the report, have in part been considered. There are many welcome explanations of significant terms and extended use of plain English in the body of the report. The report would continue to benefit from being presented by service / clinical pathway to enable members of the public to view a range of data together concerning an area of service that is of specific interest to them. This has in part been commenced with the introduction of Division specific improvement areas and may be developed further for the Quality Account of 2014/15.

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

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

Worcestershire CCGs recognise the improvement work that has been undertaken to address areas where quality falls below that expected from Commissioners, patients and their carers/ families. The Quality Account contains useful and clear detail of actions that have been taken in response to a number of areas of identified concern and this level of transparency is what the public of Worcestershire deserve.

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

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

- **Staff completion of mandatory training**
- **The timely review of requested diagnostics**
- **The recognition of impaired cognition (including dementia) for vulnerable patients and its contribution to patient safety incidents**

- **Reducing incidents that result in harm to patients, particularly falls resulting in significant injury**
- **Implementing timely learning following serious incidents by ensuring that investigations are undertaken promptly**

The Trust again failed to reach the agreed target reduction for falls for 2013-14. Rapid Spread initiatives and other components detailed within the Quality Account need to demonstrate a significant impact. Recognising the improvement work that has commenced and the repeat CQUIN scheme agreed for 2014-15, consideration of a reduction in falls resulting in serious harm would be welcomed as an improvement priority.

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

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

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

Healthwatch

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

2. <u>Are there any important issues missed in the Quality Account?</u>
   - The priorities for 2013/14 - achievement and progress - could identify which of these were national targets.
   - It is helpful to set out the 2014/15 improvement aims for the 5 new Clinical Divisions, but we would encourage all the Divisions to seek regular patient/public feedback and compare against, and learn from, local/national benchmarking.

- In order to demonstrate the Board's intention to maximise Patient Safety and feedback, perhaps a chart could be included to show the reporting structure of the Patient Safety Group, Divisional Quality Committees, Patient & Carer Experience Committee, Patient & Public Forum, Quality Governance Committee etc., their membership and interaction.
- It may be timely to add a paragraph on the Acute Services Review, Integrated Care and Well Connected work which, once progressed, may have a beneficial effect on concerning rates of staff pressure, sickness levels, turnover, training and survey response figures.

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

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

Appendix 2 - Statement of Director's responsibilities in respect of the Quality Account

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

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

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

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

By order of the Board

Harry Turner
Chairman
..... Date. 28 May 2014

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

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

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

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

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

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

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

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

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

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

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

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

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

Appendix 3

External Auditor's Report

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

We are required by the Audit Commission to perform an independent limited assurance engagement in respect of Worcestershire Acute Hospitals NHS Trust's Quality Account for the year ended 31 March 2014 ("the Quality Account") and certain performance indicators contained therein as part of our work under section 5(1)(e) of the Audit Commission Act 1998 ("the Act"). NHS trusts are required by section 8 of the Health Act 2009 to publish a Quality Account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010, the National Health Service (Quality Account) Amendment Regulations 2011 and the National Health Service (Quality Account) Amendment Regulations 2012 ("the Regulations").

Scope and subject matter

The indicators for the year ended 31 March 2014 subject to limited assurance consist of the following indicators:

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

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

Respective responsibilities of Directors and auditors

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

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

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

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

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

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

- the Quality Account is not consistent in all material respects with the sources specified in the NHS Quality Accounts Auditor Guidance 2013/14 issued by the Audit Commission on 17 February 2014 ("the Guidance"); and

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

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

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

- Board minutes for the period April 2013 to June 2014;

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

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

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

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

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

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

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

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

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

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

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

This report, including the conclusion, is made solely to the Board of Directors of Worcestershire Acute Hospitals NHS Trust in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 44 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 2014. We permit the disclosure of this report to enable the Board of Directors to demonstrate that they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permissible by law, we do not accept or assume responsibility to anyone other than the Board of Directors as a body and Worcestershire Acute Hospitals NHS Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

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

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

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

Limitations

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

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in

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

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

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

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in

materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Account in the context of the criteria set out in the Regulations.

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

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

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2014:

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

- the Quality Account is not consistent in all material respects with the sources specified in the Guidance; and

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

Grant Thornton UK LLP

Grant Thornton UK LLP

Colmore Plaza
20 Colmore Circus
Birmingham
B4 6AT

27 June 2014

Section 5
Engaging and Supporting Our People

Our vision for Workforce – to be known for a skilled, compassionate and committed workforce that embraces customer service, where decisions are informed by relevant accessible information.

The Trust is a people business and invests the majority of its funding in the workforce. However, the Trust's future service provision will require a different and more flexible way of working. Providing 7 day services and leading clinical reconfiguration will rely heavily on transformational leadership throughout the whole organisation. The Trust Board is committed to creating a culture of care, compassion and above all safety aware. Embedding the Values, maximising teaching and learning opportunities and effectively developing talent 'fit for the future' will create a workforce where expertise and experience is matched only by commitment and dedication. We want our staff to recommend the Trust as a good place to work as well as an excellent provider of treatment to friends and families.

The most significant changes in our workforce during 2013/14 were related to increased nursing staff numbers in response to the Francis report and endoscopy development. Going into 2014/15 the key changes will be the radiotherapy development and the outsourcing of certain elements of ICT and facilities. *The Future of Acute Hospital Services in Worcestershire* review will determine the direction for the future.

Our Workforce and Organisational Development Strategy 2012-17 was developed to embrace key Human Resource priorities around:

- Staff Engagement
- Health and Wellbeing
- Leadership
- Equality and Inclusivity
- Education, Learning and Development
- Talent Management
- Knowledge Management.

We recognise that high levels of staff engagement will lead to:

- Higher levels of staff health and wellbeing
- Higher levels of patient satisfaction
- Better patient mortality rates
- Better results on quality service from healthcare regulators
- Better results in the use of resources from healthcare regulators.

We value our excellent partnership working with staff representatives and are exploring further means of engaging staff in decisions relating to their work.

Key Workforce KPIs (March 2014)

	2008/09	2009/2010	2010/11	2011/12	2012/13	2013/14
Cumulative Sickness Absence Rate (12 Months)	4.72%	4.47%	4.21%	3.96%	3.91%	3.87%

	31-Mar-09	31-Mar-10	31-Mar-11	31-Mar-12	31-Mar-13	31-Mar-14
Actual SIP in FTE	4,525.70	4,658.69	4,628.94	4,721.96	4,794.37	4,940.88
Headcount SIP	5497	5658	5603	5678	5724	5840

	2008/09	2009/2010	2010/11	2011/12	2012/13	2013/14
Mandatory Training Compliance	52%	56%	52%	57%	64%	72%

	2008/09	2009/2010	2010/11	2011/12	2012/13	2013/14
Appraisal Completion %	~	~	57%	65%	72%	74%

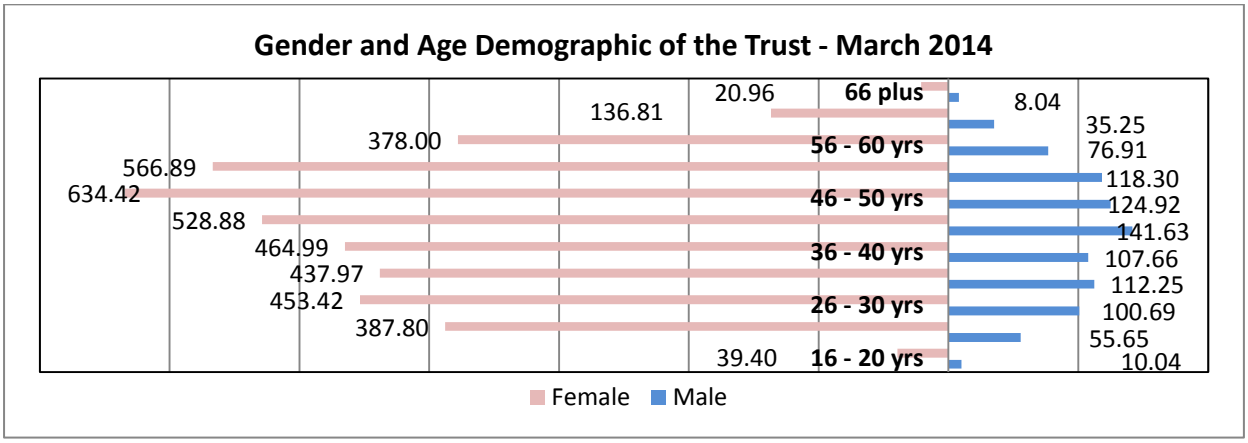
	2008/09	2009/2010	2010/11	2011/12	2012/13	2013/14
Staff Turnover	9.18%	8.36%	8.35%	9.30%	9.19%	9.85%

Sickness and Absence

The Trust is seeing a continued reduction in sickness absence rates ahead of regional and national trends. The rolling sickness at the end of the year 3.87% and is comparable with last year. Through a number of wellbeing schemes including nurse call back, dedicated HR intervention into 'hot spots', timely occupational health and self-care referrals and continued management training the Trust is determined to bring this rate to below 3.5%. The approximate value of the days lost to sickness on 2013/14 was £7.7m.

Gender and Age demographics

The chart below shows the demography of our staff as at March 2014:



The results of the 2013 Staff Survey

The results of the 2013 survey showed a further improvement for the second consecutive year on staff engagement score with 7% more staff saying that they would recommend the Trust as a place to work. We also had a 6% improvement on the number of staff who agreed that their immediate managers help with difficult tasks, and staff who are often/always enthusiastic about their job. In 2012, our staff engagement rate was 3.69%.

The Trust has a higher than average percentage of staff who say they are satisfied with the quality of care that they give to patients and 9% more staff say the organisation acts on concerns raised by patients or carers. There was a 6% increase in the number of staff who agree that patient/service user care is the Trust's top priority. This reflects the hard work by staff within the Trust and focus on patients being at the centre of everything we do. 12% more staff than average say that alcohol wipes, soap and water are always available for patients.

Our Staff Opinion Survey Action Plan is being developed with Divisions and will focus on 4 broad areas, staff satisfaction and engagement, leadership, equality & diversity and health & safety.

Training and Development

We continue to support our staff with excellent training programmes recognising the importance of supporting staff and managers to become good role models and leaders, and help them develop resilience to cope with the

demands of an ever-changing NHS. Our talent management strategy supports the transformation agenda and supports developing the workforce for the future.

The trust provides a comprehensive induction programme for new employees and mandatory training updates in 16 topics for existing staff using a variety of teaching methods and assessment. In addition our in house Customer Service programme "Ace with Pace" has now been delivered to 2986 staff supporting them to provide excellent customer service and help them deal with difficult situations.

The trust provides accredited and bespoke leadership programmes for all levels of staff and has developed new programmes in 2013 to develop coaching skills for managers and in addition 8 senior managers have completed a level 5 coaching programme to enable them to support managers with personal development coaching.

In terms of the workforce of the future over 587 young people completed work experience placements in the trust and the trust supported 36 new apprenticeship programmes in both business administration and health and social care.

To recognise the hard work and dedication of our staff the trust hosts an annual long service awards and achievement award event and in 2013, 65 staff enjoyed an afternoon with the Executive Directors celebrating their achievement of Long Service and also over 100 staff attended a high profile and sparkling evening event "Celebrating Success" where 16 staff received awards that they had been nominated for by their colleagues and patients.

Staff Appraisals

The Trust believes appraisals are vital in valuing the staff as the Trust prepares to manage significant change within the organisation. More work needs to be done to ensure all staff are appraised regularly to raise the current level of 74% for non-medical staff.

Performance against Workforce Related Strategic Priorities in the Annual Plan for 2013/14

Strategic Priority 2: Deliver a culture recognised as patient-centred, driven by inspiring and accountable leaders, committed to continuous improvement	
Engage and empower staff	• We have introduced Values Based Recruitment, and updated our training programmes and appraisal processes to align with our values • We empower staff to challenge poor standards of care through staff development on core values and culture; through Ace with Pace programme, Being Open, and re-launch of Raising Concerns (Whistleblowing) Policy. • We listen to staff and act on what they say, promoting openness and learning lessons through Daily Brief and Team Brief feedback. • We have embedded the 6 C's into all of our training and development programmes
Listen and act on feedback of patients and carers	• We have implemented the Patient and Carer Experience and Involvement Strategy year one plan including providing Patient Stories sessions for staff. • We have implemented a training programme for staff informed by patients with a learning disability, to improve the standard of care provided to such patients.

Develop Transformational Clinical Leaders	• We have implemented a new Clinical Management Structure with the aim of recruiting inspirational accountable clinical leaders who act as role models and lead service redesign • We have established multi-professional leadership through implementation of the new organisational structure and agreed leadership development programmes.
Strategic Priority 3: Invest in and realise the potential of our staff - recruiting, retaining, developing and rewarding.	
Develop a fit for the future workforce	• We have implemented a healthcare support worker development programme to provide the highest quality of personalised care • We have and continue to work closely with divisions to develop annual plans including assessing the workforce needed to deal with shorter term redesign and longer term changes to reflect the direction of the Future of Acute Hospital Services in Worcestershire Review.
Develop our staff	• We are continually striving to increase Mandatory Training uptake through effective coordination, new management information, and tying in the need to complete mandatory training into the appraisal system. • We have continued the roll out of ACE Customer Care Programme to all staff.
Enhance staff health and wellbeing	• We have implemented the Health & Well Being Strategy which includes increasing access to support to staff for OH, counselling, physiotherapy etc. We have worked hard to reduce the sickness rate and average days lost in 13/14 to 3.87% cumulative. For 9 months of the year we were able to meet our target of 3.5% which placed us in the best quartile for Trusts in the West Midlands for that period.

Our commitment to the wellbeing of our staff has continued this year. A couple of examples are the detailed and comprehensive guidance for managers in supporting their staff who are absent or experiencing health issues and launched the Staff Support Adviser role which all our staff can access for wellbeing support and a listening ear.

All our staff are able to self-refer to our SEQOHS accredited Working Well Centre which offers proactive and preventative occupational health support as well as dealing with work related issues such as needle-stick injuries. Our Working Well intranet site and Wellbeing Club signposts staff to the resources they need to live a healthy and balanced life both at work and home.

Equality and Diversity

The majority of the workforce is female and 46% of the total workforce works part-time with a variety of flexible working patterns. Although 83% of the workforce come from a White British background the Trust's staff generally reflect a higher than average ethnicity profile than the local population. However, the Trust knows it must continue do more to engage staff from other ethnic groups. Whilst in some areas of Worcestershire the non-white British population is less than 10% of the community the Trust has 3 sites with different ethnicity mix populations.

The Trust uses the Equality Delivery System as a tool to help the trust address and improve equality. The Action plan and Equality Objectives for this scheme is published on the Trust's Equality and Diversity web pages, along with the Trust's Equality Annual Report.

As our neighbouring city Birmingham will become the second plural city by 2024, where white do not make up the majority of the population, the Trust will need to understand cultural competency within the workforce. A younger workforce will require more flexible options for employment. Currently over 10% of our workforce is 25 or under which demonstrates our commitment to apprenticeship schemes and bringing school and college leavers into the Trust.

The Trust is positive about disabilities and is able to display the "Two Ticks" symbol. All disabled applicants who meet the minimum criteria of a job specification are shortlisted for interview. Our commitment to Equality is stated in our Recruitment and Selection Policy and our Equality, Diversity and Inclusion Policy which is available on our intranet.

Section 6
The Trust Board

The Trust Board meets 11 times a year in public, across the county. It sets the strategic direction for the Trust and we aim to lead by example and to learn from experience. I am committed to setting high standards and the whole board has signed up to the principles set out in the document, *Standards for members of NHS Boards and Clinical Commissioning Group governing bodies in England (November 2013, Professional Standards Authority).* This requires us to have honesty and integrity in all matters.

We as a Board annually review our performance against the UK Corporate Governance Code. I also ensure that all the Committees are evaluated using a self-assessment. I appraise all the non-executive directors annually and I also appraise the Chief Executive who achieved a performance rating of B, i.e. there was clear evidence that her objectives have been exceeded for 2013/14. I myself have undertaken a 360 degree appraisal and the Audit and Assurance Committee Chair (also the Senior Independent Director) undertook a formal appraisal in preparation for my review with the Trust Development Authority. As a result of that review, I have undertaken to commit to develop my personal links with the wider Worcestershire Community and develop more formal links nationally. I fully intend that in 2014/15, all non-executive directors will have the opportunity to contribute to my appraisal process.

I am fully committed to ensuring that the new clinical leadership structure enables clinicians to be at the heart of the Trust, driving and delivering the strategy, supported by the Board. I am delighted that this new structure is beginning to be embedded and I am sure this will reap benefits for quality improvement within the Trust.

As a Board, we have continued to have a central focus on quality and safety issues. To this end, I instigated a review of the working of the Board during 2013/14 and implemented changes to the overall committee structure. In particular, I refocused the Integrated Governance Committee to ensure its role is to assure the board on quality matters. This committee is now called the Quality Governance Committee. I also introduced a new Finance and Performance Committee to ensure robust monitoring of a difficult financial situation and challenging performance metrics. I have ensured that there is overlap of members of NEDs on the board subcommittees with two Audit and Assurance members also attending the Quality Governance Committee. The Chair of the Audit and Assurance Committee is a qualified accountant and one other member of this Committee also had this qualification.

As both the Keogh and Berwick Reviews state, I believe we can do more with patient and public involvement and I welcome the fact that the Chief Nursing Officer is prioritising this work for 2014/15.

The non-executive directors (NEDs) bring a wealth of local business experience to the Trust Board, from marketing and communications to private sector commercial business and management within a large public sector organisation. They are in the majority on the Board (11 voting members, 6 are lay) and have continued to challenge and hold the Executive Directors to account for actions. I have continued to encourage informal visits by the NEDs across the sites and these have increased. These visits are essential for the NEDs to be exposed to the 'front line' and can bring their knowledge to the Board room. NEDs are now allocated to

each clinical division and I am delighted that they are supporting the Divisions in their work.

This year, the NEDs and I have participated in national and local events hosted by a wide range of partners such as the King's Fund, Grant Thornton, PWC and others. These events provide excellent opportunities for networking and gaining insights to other NHS practices.

I have continued to develop working relationships with senior staff in our partner organisations, in particular the Health Overview and Scrutiny Committee, HealthWatch, and our CCGs and the Health and Care Trust. I am delighted that we have worked closely with all partners on the Future of Acute Hospital Services in Worcestershire and I am looking forward to supporting the CCGs in the consultation phase in the next year.

A key new development for me is to undertake informal surgeries with staff who can then speak openly and frankly about their work. I am keen to continue this work as I know it is essential for me as Chair to understand the challenges our staff face every working day.

I have continued to meet regularly with the local elected representatives, our Members of Parliament, throughout the year. This is raising awareness of health issues and in particular the Acute trust at the highest level in government.

I should like to thank the whole board for their work and support during the past year.

Harry Turner

The Board Register of Interests

Name	Designation	Declared Interest
Harry Turner	Chairman	• Director – Marriott Vacation Club Estepona • Director- FTK Associates • HMCS Magistrate – South Worcester • Trustee – Charles Hastings Education Centre
Penny Venables	Chief Executive	• Trustee – Sandwell Arts Trust • Spouse was the Chief Executive at University Hospital Southampton NHS Foundation Trust (until June 2013) • Spouse is the Chief Executive at University Hospital North Staffordshire (from July 2013) • Trustee of Sandwell Leisure Trust (from Feb 2014)
Julian Bion	Associate Non-Executive Director	• Professor of Intensive Care Medicine, University of Birmingham/Queen Elizabeth Hospital, Birmingham • Royal Airforce Civilian Advisor in Intensive Care Medicine • Chair, UK Critical Care Leadership Forum • Consultant to Nestle Pharmaceuticals (fee donated to University Hospitals Birmingham Charities)
Helen Blanchard	Director of Nursing & Midwifery (until July 2013)	• None
John Burbeck	Non-Executive Director	• Director – Burbeck Ltd • Spouse is a Director of Burbeck Ltd • Spouse is the Chief Executive of The Joint Clinic • Consultant – Capita Group
Bev Edgar	Director of Human Resources &	• Owner – Edgar Consultancy (HR Consultancy Company) • Son undertakes temporary administration work in the surgical

Name	Designation	Declared Interest
	Organisational Development	division.
Celina Eves	Interim Chief Nurse (August-October 2013)	• Trustee - Ducklings Trust Charitable Fund – Bucks Healthcare NHS Trust - a small charity affiliated with the maternity unit • Trustee and Vice chair - Iolanthe Midwifery Trust – National Charity affiliated with Midwifery education • Sole director private company - Celina Eves Ltd
Christine Fearns	Director of Strategic Development	• None
Stephen Howarth	Non-Executive Director	• None
Claire Lea	Interim Company Secretary (until April 2013)	• Trustee – OSCAR, the UK Information Service for World Mission • Director of Charis Consultants Ltd
Stewart Messer	Chief Operating Officer	• None
Bryan McGinity	Non-Executive Director	• Director, Trustee and Treasurer – COB Foundation, company limited by guarantee (National Health Charity) • Chairman – South Worcestershire FE College
Kimara Sharpe	Company Secretary (from April 2013)	• Trustee – Redditch Nightstop (a charity providing support to young people aged 16-25 who are homeless) • Membership Secretary – Princess of Wales Hospital League of Friends • Director, Kimara Sharpe Consultancy Limited • Member, Worcestershire Health and Care NHS Trust • Director, Railway Walk Association Ltd
Andrew Sleigh	Non-Executive Director	• Development Committee Member – University of Worcester • Director – Pinoak Ltd • Non-Executive Director – Vislink plc • Non-Executive Director – Alta Innovations Ltd • Adjunct Professor – Imperial College Business School • Chairman – Geolang Ltd
Chris Tidman	Director of Resources & Deputy Chief Executive	• Daughter undertook work experience in July 2013 at the Trust
Lynne Todd	Non-Executive Director	• Associate Director – Shine Business Research • Lay Hospital Manager (CAMHS) – Birmingham Children's Hospital • HMCS - Magistrate
Mark Wake	Chief Medical Officer	• Out-patient Community clinics at Coventry and Warwickshire Partnership Trust (until 31 May 2013)
Lindsey Webb	Chief Nursing Officer	• In a relationship with the Director of Taylor Moore Associates/associate director of Provex.

Section 7
Business Review - Operating and Financial Review

Performance in 2013/14

The financial year 2013/14 represented a significant challenge because of the following key factors:

- An underlying deficit of £3m was carried forward from the previous financial year. This was an improvement on the £4.8m deficit carried into 2012/13
- The loss of £10m of Transitional Support given by PCTs in 2012/13
- The loss of £2.6m funding for maternity and paediatric services to support a two-site service
- A tariff deflator of 1.1% which meant that a further £15m needed to be delivered through efficiencies to deliver the planned financial position
- Further CCG QIPP reductions of c.£5m to contract income in respect of changes to service models and referral patterns.

Noting the challenges the Trust faced and the contract arbitration verdict, the Trust was not in a position to deliver its breakeven duty with a planned deficit of £5m in 2013/14 (circa 1.4% of turnover) with a number of risks highlighted that could take the position out to £12m if they materialised. The Trust reported an overall deficit of income over expenditure of £14.3m after technical adjustments. The year-end financial position culminated in the Trust delivering an I&E deficit of £14.2m (after impairments and adjustments); in line with Department of Health guidance on the Break-Even duty for NHS Trusts, costs relating to impairments (£189k) and donated assets (£109k) are excluded when measuring a Trust's break-even performance.

The variance from the originally planned £5m deficit position was driven by:

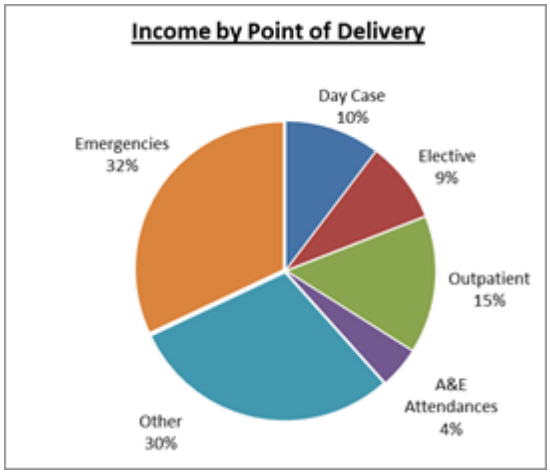
- CCG affordability issues resulting in the imposition of contractual penalties and the withdrawal of the Maternity and Paediatrics local access premium.
- Failure of the urgent care system reflected in high levels of complex emergency admissions, which in turn resulted in reduced elective income and increased costs beyond tariff.
- Only £1m of national winter pressures funding was received by the Worcestershire health economy in contrast to an average settlement of £4m.
- The cost of managing and participating in clinical reviews.

The Trust has delivered £13.4m of efficiency savings amounting to 4.3% of spend influenceable spend and managed a contract settlement with commissioners which reflects a £12m over-performance compared to contracted levels of activity. The Trust has consistently delivered the required level of savings enabling it to deliver surpluses or breakeven for the previous six years.

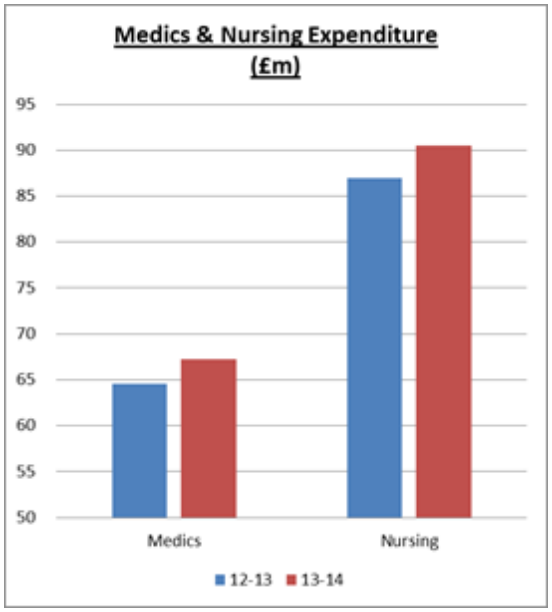
Prior to 13/04 the Trust had a legacy debt of £18m that was incurred shortly after the Trust was formed in 2000. This legacy debt has resulted in liquidity challenges for the Trust. To address the cash flow issues that relate to the inherited legacy debt, the Trust received a £12m working capital loan in 2012/13 to be repaid over 9 years. Given the 2013/14 I&E deficit further action is now required to be taken to improve liquidity in future years through a combination of delivering income and expenditure surpluses, a leasing strategy for equipment and the sale of any surplus assets. However, due to the significance of the cash shortfall, it is likely the Trust will require both short-term and long-term support either as loans or ideally as a non-repayable Public Dividend Capital injection.

The Trust had a turnover of £346m, receiving the majority of its patient care income (78%) from South Worcestershire CCG, Redditch & Bromsgrove CCG and Wyre Forest CCG (formerly NHS Worcestershire). The increase in clinical income over recent years reflects an increase in both daycase and emergency

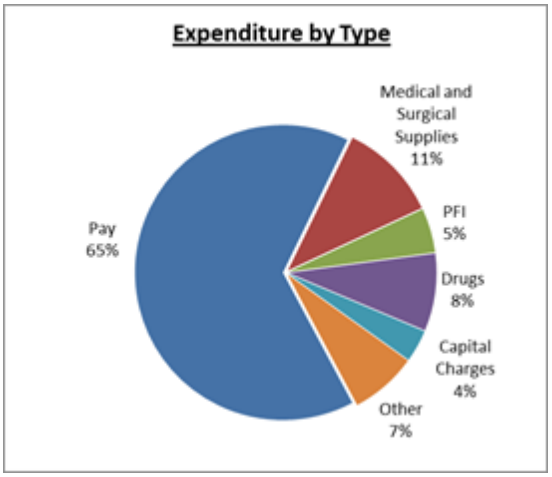
activity as well as other ad hoc clinical income such as for non-PbR drugs.



In 2013/14 higher costs have continued to be incurred reflecting the high emergency demand and the higher acuity of patients. In particular, Medical and Nursing pay costs have increased as the Trust has sought to increase staffing levels to maintain quality and safety and to increase capacity in line with demand.



Whilst the Trust has continued to recruit additional nursing posts to avoid an over reliance on expensive agency staffing, the Trust's medical agency expenditure has increased due to the longer lead time in recruiting to additional medical staffing posts and a shortage of suitable candidates. This is being addressed as part of the 2014/15 plan.



In terms of non-pay expenditure, Medical & Surgical Supplies and Drugs costs have increased in line with inflation and the increased patient demand. The PFI costs have also increased with inflation but the impact in 2013/14 has been offset by a one-off discount.

The Trust has delivered a number of major investments in clinical equipment, IT systems and the estate through its capital programme, ensuring that it remained within its Capital Resource Limit. The Trust spent £23.5m on capital investments in 2013/14 which represented an underspend of £3.5m against the capital spending limit of £26.3m after netting off the net book value of the surplus land at Redditch that was sold. Construction of the Radiotherapy Centre commenced in 2012/13 and has been on-going throughout the year, and is due to complete towards the end of 2014. Spend on this project is backed by a capital investment loan and amounted to £14.1m in 2013/14 leaving £4.2m still to be spent in 2014/15. There has also been significant investment in both IM&T equipment and systems (£1.4m) and clinical equipment (£0.8m) through the internally generated capital programme. Further expenditure on clinical IT systems has been possible as a result of the Trust securing some national capital funding from the Department of Health through the Safer Wards/Safer

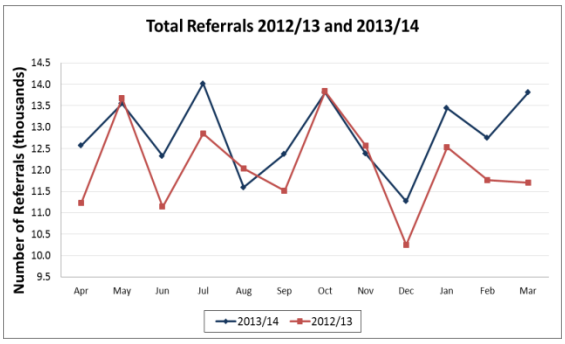
Hospitals Project. Of the £704k funding secured, £477k has been spent on the e-Prescribing and Maternity Information systems in 2013/14 with the remainder carried forward to 2014/15 to fund the completion of these schemes.

The capital funding strategy is to use cash generated through depreciation predominantly for replacement and maintenance schemes with service developments funded through national capital bids, loans, surpluses or asset sales receipts subject to satisfactory businesses cases. In addition, all relevant equipment purchases will be subject to appraisals to ensure we achieve best value and make effective use of our limited capital funding. The Trust successfully applied for a loan from the Department of Health for the construction of the Radiotherapy Centre itself (£22.4m). £5.2m of the Radiotherapy Centre loan was previously drawn down in 2012/13 and the balance of £17.2m was drawn down in 2013/14.

The Trust's performance against key operational metrics was as follows:

- Non elective admissions excluding maternity decreased by 2.2% compared with the peak in 2012/13, although admissions remain high and in the over 75 years age category increased.
- Attendances at A&E remain broadly in line with the previous year.
- The Total numbers of Outpatient Attendances across the Trust decreased by 10% in comparison with 2012/13 but referrals have increased by 5.4%.
- Elective inpatient admissions were consistent with the figures for 2012/13.
- Daycase admissions rose by 24.9% in 2013/14 compared with 2012/13.
- Inpatient Waiting List numbers are 11.4% up on the figures for April 2013.

Continued high emergency demand tied up the Trust's bed capacity resulting in a decrease in elective admissions. This was partly mitigated by moving elective activity to daycase wherever possible. However, this was not sufficient to prevent the waiting list from rising further posing a significant challenge to now recover the position in a timely manner particularly in light of continuing high referrals which increased by 5.4% in 2013/14 compared to the previous year.



Grant Thornton has been the Trust's external auditors since October 2012. The total fee which has been paid in 2013/14 for the statutory audit of the Trust is £111,000 (including VAT). This fee excludes the cost of auditing the Trust's Charitable Fund Accounts. In addition the Trust is required to obtain external assurance on the Quality Account for 2013/14. The scale fee for this piece of work is included in the above figure. No further work has been requested by the Trust from either the Audit Commission or Grant Thornton in respect of further assurance services or other services. However, the auditors have submitted a fee variation to the Audit Commission requesting a fee increase of £2.5k for the s.19 referral to the Secretary of State. This figure is included in the total audit fee sum above.

The Trust's Directors have confirmed that they are not aware of any relevant audit information which has not been brought to the attention of the Trust's auditors.

Confirmation as to how pension liabilities have been treated by the Trust are contained within the Trust's 2013/14 Accounts. This accounting treatment also applies to the figures reported within the Directors'

Remuneration statement detailed later within the Annual Report.

Looking forward to 2014/15 and beyond

The NHS faces an unprecedented level of future pressure with substantial impending challenges driven by an ageing population; increases in the prevalence of long-term conditions; and rising costs and public expectations within a challenging financial environment. In order to respond to these significant challenges Worcestershire has set out a longer term vision for a truly integrated health and social care system which all partners are committed to. This operates under the umbrella of the 'Well Connected' Programme.

Realising the vision of the Well Connected Programme will result in a significant, sustained reduction in acute emergency demand and an expansion of out of hospital models, which are closer to home, therefore assuming a contraction of acute hospital based care and an expansion of high quality, prevention, treatment, health-maintenance and crisis intervention services which are delivered outside of hospital. The Better Care Fund (BCF) is intended to act as a catalyst for better integration and for expansion of out of hospital care. Locally, there is a need to increase the scale and pace of change, ensuring bold and transformational plans are in place from 2014, which support delivery of the vision.

The Trust has also worked in partnership with its three Clinical Commissioning Groups during a review of acute services across the county, as a result of which, proposals for a new model of acute care operating from its three hospital sites are being finalised. This review's proposals are being developed into a strategic outline case which sets out the benefits of service change, including better outcomes for local people.

The level of targeted commissioner QIPP is significant. The CCGs have signalled an intention to reduce emergency demand by 15% over the next 2 years, and to reduce elective care broadly to mitigate against demographic growth. Whilst we recognise and support the aspiration that emergency demand needs to be reduced, there is limited evidence of success in this area to date therefore a significant risk to the achievement of the QIPP reductions planned for 2014/15, although we do believe that through joint working, and ensuring appropriate alternatives are in place material reductions are possible over the 2 year period.

Whilst the Trust is committed to appropriate contraction of its capacity, the achievement of this must be in line with a robust phased plan of expanded 24/7 care outside of hospital. Whilst this is being developed, the Trust must ensure sufficient acute headroom to ensure a safe operating environment. Its plans will ensure sufficient capacity to manage medical surge pressures throughout the year not just in the winter period, whilst also addressing the capacity challenges to delivering our elective demand; bringing core capacity back into balance and elimination of a backlog of cases.

In summary, the next few years pose significant challenges and risks for the health economy and the Trust arising from:

- Significantly tightened financial position for the Acute Sector and for the Trust with the need to achieve financial balance and continue to improve outcomes for patients.
- Overall affordability challenge for local Commissioners and the impact of agreeing deliverable plans which take into account the current performance of the system.
- Need to continue to ensure safe care and improved outcomes for our patients within a challenging financial reality without the benefit of reconfiguration.
- Ensuring greater consistency of care to achieve better clinical outcomes through progress towards seven day services.
- Ensuring full compliance with quality standards with a focus on: mortality

surveillance, medicines optimisation and reducing harm from medicines.
- Responding to local strategic commissioning ambition to reduce emergency admissions by 15% over the next 2 years against historic trends, with a specific focus on older people with complex needs.
- To respond to changes in demand for elective care meeting waiting time standards, eliminating the backlog, providing a good experience of care.
- Securing delivery and sustainability of key targets with special focus on A&E 95%, RTT, Cancelled operations and Ambulance handover/turnaround.
- Achieving efficiency and productivity targets recurrently without the benefit of service reconfiguration
- Planning for the introduction and impact of the Better Care Fund.
- Delivery of planned service developments and benefits for patients in line with the Trust's strategic plan.

Despite positive discussions and escalation, we were unable to reach agreement with lead commissioners on the contract for 2014/15. The Trust therefore entered the NHS England / TDA formal arbitration process which found in favour of the Trust on a number of key issues but the benefit is to be phased in over three years. Consequently the Trust is planning a £9.8m deficit in 2014/15 with the position improving the following year and returning to in-year balance in 2016/17. The Trust can achieve recurrent financial balance once the phasing-in of income and service reconfiguration have been fully implemented.

NHS England's document "Everyone Counts – Planning for Patients 2014/15 to 2018/19" signalled that the National Efficiency Requirement will remain at 4% for 2014/15. Further changes have been made to the structure of Payment by Results (PbR) to ensure that payment systems are more aligned to the delivery of national strategic objectives including:

- The 30% marginal rate will continue to apply for increases in the value of emergency admissions. However, the guidance updates its application in 2 respects. Firstly, that the baseline value above which the 30% marginal rate applies is required to be adjusted where evidence suggests there have been material changes in patient flows. Secondly, additional requirements have been placed on commissioners to demonstrate how the retained funds are used and to ensure plans are evidence-based, transparent and effective.
- The PbR tariff price adjuster will be a reduction of 1.2%, and will be applied to non-tariff acute services as a reduction of 1.5%.
- CQUINs remain at 2.5%.
- The new contract will continue to enable commissioners to fine the trust if it fails to deliver on key standards including in relation to infections, waiting times in A&E and referral to treatment times. The mechanisms for most performance targets have been amended to apply fines for every patient that breaches the target resulting in higher levels of fines in 2014/15 with comparable performance levels to the previous year.

The savings requirement for 2014/15 has been set at £16.6m (5.4% of influenceable expenditure), although headroom plans to deliver savings of circa £20m are being developed. The savings target is an increase of 11% over the previous year, and represents the most significant efficiency target in the Trust's history, which is considered challenging but deliverable based on a gap analysis against upper quartile performers. The work on business plans has identified key priorities and opportunities for improving quality and productivity, and as a result the Trust is targeting savings in the following areas over the next 2 years:

- Quality improvements through implementing best practice

- Efficiency and productivity savings on capacity.
- Reduction on premium temporary staffing costs
- Procurement and contract negotiations
- Prescribing efficiencies
- Workforce realignment and terms and conditions
- Outsourcing
- Improved contribution from targeted specialties
- Service reconfiguration.

The Trust is committed to saving money safely through a rigorous quality impact assessment process. This includes an initial quality impact assessment for all schemes which is undertaken by the Medical Director, Director of Nursing and the Director of Patient Safety. No scheme will proceed until approval is achieved. Schemes which are likely to impact patient safety, patient experience or clinical effectiveness will be subjected to regular further quality impact assessments during the project life cycle.

Significant planned Capital investments in 2014/15 include the completion of the Oncology Building, Property & Works schemes of circa £3m, IM&T schemes of circa £3.7m and equipment replacement of circa £0.6m. This includes completion of the two schemes funded by the Department of Health's Safer Wards/Safer Hospitals Project (e-Prescribing and Maternity Information System). Further funding has been secured in 2014/15 from the Improving Maternity Care Settings Fund (£497k) which is to be spent on a Midwife Led Unit at the Worcester site.

The Trust's financial plans for the next five years include several key elements to achieve the following objectives:

- To maintain and further develop strong financial management and control within the Trust to ensure it is fit for purpose both now and in the future as a Foundation Trust.
- To identify and manage business risks to ensure that the Trust's objectives progress unhindered.
- To ensure that the Trust's assets are optimised, protected and managed appropriately to sustain and improve the ongoing delivery of services
- To ensure that there is a sound performance management framework in place to enable the Trust to monitor progress against its financial, operational and contractual targets, and to take early corrective action as necessary.
- To improve clinical engagement throughout the Trust through Service Line Management

The key financial risks facing the Trust in 2014/15 are as follows:

- Delivery of the Trust's internal efficiency programme through robust planning, implementation and accountability arrangements, whilst maintaining safe clinical services and delivering challenging access targets.
- Missing performance targets may resulting in penalties being imposed by commissioners. The Trust has a robust performance management framework in place to support the delivery of performance targets whilst maintaining quality and safety
- Reduction in demand for services due to CCG QIPPs, however if they fail to deliver then the Trust will continue to face capacity pressures. The Trust will continue to work closely with commissioners to support their schemes to reduce demand.
- Requirement for a cash injection to enable the trust to continue to meet its commitments is being managed initially through temporary loans. The Trust is working closely to source a longer term solution to the liquidity issues.

Fraud and Corruption

In December 1999 Secretary of State Directions were issued to NHS Trusts (revised November 2004). These directions set out the roles and the responsibilities of each Health Body in countering Fraud and Corruption. The Trust has reviewed and updated its Fraud & Corruption and Whistleblowing policies and both are available to staff via the Trust intranet.

A key requirement is for each NHS body to nominate and appoint a Local Counter Fraud Specialist (LCFS) suitably trained and accredited to carry out operational responsibilities with the investigation of cases of fraud involving the Trust.

The Trust's LCFS has undertaken this work for the Trust during 2013/14 in compliance with Directions and to support this work the Trust continually reviews and updates its Fraud and Corruption Policy.

This policy provides direction and help to employees who may identify suspected fraud and provides a framework for responding to suspicions of fraud, advice and information on various aspects of fraud and implications of an investigation.

The LCFS has reported directly to the Trust's Audit Committee and the work undertaken by the LCFS is monitored by the Chief Executive and the Director of Resources/Deputy Chief Executive to ensure compliance with the Directions.

Going Concern

Going concern is a fundamental principle in the preparation of financial statements. Under the going concern assumption a Trust is viewed as continuing in operation for the foreseeable future with no necessity of liquidation or ceasing trading. Accordingly the Trust's assets and liabilities are recorded on the basis that assets will be realised and liabilities discharged in the normal course of business. A key consideration of going concern is that the Trust has the cash resources to continue to meet its obligations as they fall due in the foreseeable future.

The Trust's financial statements have been prepared on a going concern basis supported by an assessment by management that has deemed it appropriate to do so.

Sustainability Report

The Trust recognises its responsibilities with regard to the impact of its business activities on the social, economic and environmental wellbeing of the communities of Worcestershire and the surrounding area. Our 5 year Sustainable Development Strategy and Implementation Plan provide the framework for the Trust's journey towards delivering our healthcare business objectives in a sustainable and green manner.

Both the Sustainable Development Strategy and Implementation Plan have been developed to align with and secure absolute compliance with the Department of Health's Sustainable Development Unit model requirements for NHS organisations. Adoption of both documents will allow the Trust to manage business activities, buildings and estates in a manner that promotes environmental economic and social sustainability, to conserve and enhance natural resources, prevent environmental pollution and bring about continuous improvement in the Trust's ability to deliver high quality patient care services.

Emergency Preparedness

The Trust has a major incident plan in place which is regularly reviewed and tested across all areas. It is fully compliant with the requirements of the NHS Emergency Planning Guidance 2005 and all associated guidance.

Principles for Remedy

The Trust adheres to the *Principles for Remedy* (May 2010) published by the Parliamentary and Health Service Ombudsman. This sets out six principles that represent best practice and are directly applicable to NHS complaints procedures.

Better Payments

The Better Payments Practice Code targets NHS bodies with paying all non-NHS trade creditors within 30 days of the receipt of goods or a valid invoice (whichever is later) unless other payment terms have been agreed. Details of the Trust's performance against the Better Payments Practice Code are shown below;

	2013-14 Number	2013-14 £000s
Non-NHS Payables		
Total Non-NHS Trade Invoices Paid in the Year	**75,107**	**163,253**
Total Non-NHS Trade Invoices Paid Within Target	**30,288**	**95,341**
% of NHS Trade Invoices Paid Within Target	**40.33%**	**58.40%**
NHS Payables		
Total NHS Trade Invoices Paid in the Year	**2,711**	**18,985**
Total NHS Trade Invoices Paid Within Target	**1,154**	**10,252**
% of NHS Trade Invoices Paid Within Target	**42.57%**	**54.00%**

Prompt Payments

The Trust has signed up to the Prompt Payments Code. This means that the Trust is committed to paying its suppliers within clearly defined terms, and to ensuring there is a proper process for dealing with any issues that may arise.

Treasury Guidance on setting charges

The Trust complies with the Treasury's guidance on setting charges for information.

Exit packages and severance payments

There were no exit packages agreed by the Trust in 2013/14.

Summarised financial statements

The summary financial statements which follow do not contain sufficient information to allow as full an understanding of the results and state of affairs of the Trust and its policies and arrangements as provided by the full annual accounts; a copy of which is available free of charge by contacting the Director of Resources as follows

write to: Director of Resources
Worcestershire Royal Hospital
Charles Hastings Way
Worcester
WR5 1DD

Or telephone: 01905 760393

The accounts have been prepared on a going concern basis and in accordance with International Financial Reporting Standards (IFRS) and the Trust's accounting policies. Their preparation has been guided by the 2013/14 Manual for Accounts issued by the Department of Health.

Sickness Absence Data

Sickness absence data is provided to individual NHS Trusts by the Department of Health. The figures can be found at Note 10.3 in the full set of Annual Accounts.

Disclosure of serious incidents

Disclosure of details relating to Information Governance serious incidents is included within the Annual Governance Statement for 2013-14, page 158.

Directors' disclosure

In the case of each of the persons who are directors at the time the report is approved so far as the directors are aware, there is no relevant audit information of which the company's auditor is unaware, and they have taken all the steps that they ought to have taken as a director in order to make themselves aware of any relevant audit information and to establish that the company's auditor is aware of that information.

Health & Safety

The Trust has continued to comply with Health & Safety Legislation across all three hospital sites. The Trust's Risk Executive Group (REG) monitored the health and safety management activities which occurred during 2013/14 to ensure that the activities remain focussed on meeting the key objectives within the 2011 Health and Safety Strategy.

2013-14 Annual Accounts of Worcestershire Acute Hospitals NHS Trust

STATEMENT OF THE CHIEF EXECUTIVE'S RESPONSIBILITIES AS THE ACCOUNTABLE OFFICER OF THE TRUST

The Chief Executive of the NHS Trust Development Authority has designated that the Chief Executive should be the Accountable Officer to the trust. The relevant responsibilities of Accountable Officers are set out in the Accountable Officers Memorandum issued by the Chief Executive of the NHS Trust Development Authority. These include ensuring that:

- there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance;

- value for money is achieved from the resources available to the trust;

- the expenditure and income of the trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them;

- effective and sound financial management systems are in place; and

- annual statutory accounts are prepared in a format directed by the Secretary of State with the approval of the Treasury to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, recognised gains and losses and cash flows for the year.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as an Accountable Officer.

Signed.....Chief Executive

Date.....

2013-14 Annual Accounts of Worcestershire Acute Hospitals NHS Trust

STATEMENT OF DIRECTORS' RESPONSIBILITIES IN RESPECT OF THE ACCOUNTS

The directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of the Treasury, directs that these accounts give a true and fair view of the state of affairs of the trust and of the income and expenditure, recognised gains and losses and cash flows for the year. In preparing those accounts, directors are required to:

- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury;

- make judgements and estimates which are reasonable and prudent;

- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.

The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State. They are also responsible for safeguarding the assets of the trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

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

By order of the Board

3.6.14 Date..... Chief Executive

3/6/14 Date..... Finance Director

Statement of Comprehensive Income for year ended 31 March 2014

	NOTE	2013-14 £000s	2012-13 £000s
Gross employee benefits	10.1	**(220,011)**	(212,818)
Other operating costs	8	**(127,313)**	(122,007)
Revenue from patient care activities	5	**323,692**	323,511
Other Operating revenue	6	**22,337**	25,252
Operating surplus/(deficit)		**(1,295)**	13,938
Investment revenue	12	**56**	48
Other gains and (losses)	13	**136**	(52)
Finance costs	14	**(9,458)**	(9,931)
Surplus/(deficit) for the financial year		**(10,561)**	4,003
Public dividend capital dividends payable		**(3,710)**	(4,315)
Transfers by absorption - gains		**0**	0
Transfers by absorption - (losses)		**0**	0
Net Gain/(loss) on transfers by absorption		**0**	0
Retained surplus/(deficit) for the year		**(14,271)**	(312)

Other Comprehensive Income

	2013-14 £000s	2012-13 £000s
Impairments and reversals taken to the Revaluation Reserve **	**(2,310)**	(7,827)
Net gain/(loss) on revaluation of property, plant & equipment **	**6,520**	94
Net gain/(loss) on revaluation of intangibles	**0**	0
Net gain/(loss) on revaluation of financial assets	**0**	0
Other gain /(loss) (explain in footnote below)	**0**	0
Net gain/(loss) on revaluation of available for sale financial assets	**0**	0
Net actuarial gain/(loss) on pension schemes	**0**	0
Other Pension Remeasurements	**0**	
Reclassification Adjustments		
On disposal of available for sale financial assets	**0**	0
Total Comprehensive Income for the year*	**(10,061)**	(8,045)

* This sums the rows above and the surplus / (deficit) for the year before adjustments for PDC dividend and absorption accounting
** The net of Impairments and Gains on revaluation of property are explained in Note 1.5.2 and Note 15.3 of these Accounts

Financial performance for the year

Retained surplus/(deficit) for the year	**(14,271)**	(312)
Prior period adjustment to correct errors and other performance adjustments	**0**	0
IFRIC 12 adjustment (including IFRIC 12 impairments)	**189**	0
Impairments (excluding IFRIC 12 impairments)	**0**	181
Adjustments in respect of donated govt grant asset reserve elimination	**(109)**	148
Adjustment re Absorption accounting	**0**	0
Adjusted retained surplus/(deficit)	**(14,191)**	17

The Trust's Management is required to assess, as part of the accounts preparation process, the Trust's ability to continue as a going concern. Further information can be found at Note 43.1 "Breakeven Performance"

A Trust's Reported NHS financial performance position is derived from its Retained surplus/(Deficit), but adjusted for the following:-

a) Impairments to Fixed Assets - An impairment charge is not considered part of the organisation's operating position.

b) Adjustment in respect of Donated Asset Reserves elimination - The Treasury revised their reporting manual in 2010-11 to reflect the interpretation of International Accounting Standards (IAS20), resulting in the elimination of Reserves in respect of Donated Assets. The revenue impact of depreciation relating to these assets was previously offset by a release from the Donated Asset Reserve. Following revision to the reporting manuals this cost is charged to the Trusts expenditure without any offset. This is therefore not considered part of the Trusts operating position.

Statement of Financial Position as at 31 March 2014

	NOTE	31 March 2014 £000s	31 March 2013 £000s
Non-current assets:			
Property, plant and equipment	15	**250,886**	232,013
Intangible assets	16	**886**	1,044
Investment property	18	**0**	0
Other financial assets		**0**	0
Trade and other receivables	22.1	**1,267**	1,250
Total non-current assets		**253,039**	234,307
Current assets:			
Inventories	21	**5,061**	4,998
Trade and other receivables	22.1	**20,522**	14,640
Other financial assets	24	**0**	0
Other current assets	25	**0**	0
Cash and cash equivalents	26	**5,664**	16,773
Total current assets		**31,247**	36,411
Non-current assets held for sale	27	**840**	840
Total current assets		**32,087**	37,251
Total assets		**285,126**	271,558
Current liabilities			
Trade and other payables	28	**(45,963)**	(36,151)
Other liabilities	29	**(554)**	(1,064)
Provisions	35	**(655)**	(848)
Borrowings	30	**(1,873)**	(1,727)
Other financial liabilities	31	**0**	0
Working capital loan from Department	30	**(1,334)**	(1,334)
Capital loan from Department	30	**(1,446)**	(410)
Total current liabilities		**(51,825)**	(41,534)
Net current assets/(liabilities)		**(19,738)**	(4,283)
Non-current assets plus/less net current assets/liabilities		**233,301**	230,024
Non-current liabilities			
Trade and other payables	28	**0**	0
Other Liabilities	31	**(2,230)**	(1,109)
Provisions	35	**(1,577)**	(1,675)
Borrowings	31	**(75,961)**	(77,833)
Other financial liabilities	30	**0**	0
Working capital loan from Department	30	**(8,665)**	(9,999)
Capital loan from Department	30	**(21,674)**	(6,632)
Total non-current liabilities		**(110,107)**	(97,248)
Total Assets Employed:		**123,194**	132,776
FINANCED BY:			
TAXPAYERS' EQUITY			
Public Dividend Capital		**138,589**	138,110
Retained earnings *		**(64,917)**	(52,671)
Revaluation reserve		**50,383**	48,198
Other reserves		**(861)**	(861)
Total Taxpayers' Equity:		**123,194**	132,776

* The value reported in Retained Earnings reflects both the effect of Trust financial performance and the cumulative effect of technical accounting adjustments. Note 43.1 of these Accounts records the Trust's actual breakeven performance.

The notes on pages 5 to 43 form part of this account.

The financial statements on pages 1 to 4 were approved by the Board on 3rd June 2014 and signed on its behalf by

Chief Executive: Date: 3.6.14.

Statement of Changes in Taxpayers' Equity
For the year ended 31 March 2014

	Public Dividend capital	Retained earnings	Revaluation reserve	Other reserves	Total reserves
	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2013	**138,110**	**(52,671)**	**48,198**	**(861)**	**132,776**
Changes in taxpayers' equity for 2013-14					
Retained surplus/(deficit) for the year		(14,271)			**(14,271)**
Net gain / (loss) on revaluation of property, plant, equipment			6,520		**6,520**
Net gain / (loss) on revaluation of intangible assets			0		**0**
Net gain / (loss) on revaluation of financial assets			0		**0**
Net gain / (loss) on revaluation of available for sale financial assets			0		**0**
Impairments and reversals			(2,310)		**(2,310)**
Other gains/(loss) (provide details below)				0	**0**
Transfers between reserves **		2,025	(2,025)	0	**0**
Transfers under Modified Absorption Accounting - PCTs & SHAs		0			**0**
Transfers under Modified Absorption Accounting - Other Bodies		0			**0**
Reclassification Adjustments					
Transfers to/(from) Other Bodies within the Resource Account Boundary	0	0	0	0	**0**
Transfers between Revaluation Reserve & Retained Earnings in respect of assets transferred under absorption		0	0		**0**
On Disposal of Available for Sale financial Assets			0		**0**
Reserves eliminated on dissolution	0	0	0	0	**0**
Originating capital for Trust established in year	0				**0**
New PDC Received - Cash	479				**479**
New PDC Received/(Repaid) - PCTs and SHAs Legacy items paid for by Department of Health	0				**0**
PDC Repaid In Year	0				**0**
PDC Written Off	0				**0**
Transferred to NHS Foundation Trust	0	0	0	0	**0**
Other Movements	0	0	0	0	**0**
Net Actuarial Gain/(Loss) on Pension				0	**0**
Other Pensions Remeasurement				0	**0**
Net recognised revenue/(expense) for the year	**479**	**(12,246)**	**2,185**	**0**	**(9,582)**
Transfers between reserves in respect of modified absorption - PCTs & SHAs		0	0	0	**0**
Transfers between reserves in respect of modified absorption - Other Bodies		0	0	0	**0**
Balance at 31 March 2014	**138,589**	**(64,917)**	**50,383**	**(861)**	**123,194**

** The movement between the Revaluation Reserve and Income and Expenditure Reserve is represented by :-

1) £2,025,169 for excess depreciation from 1.4.13 to 31.3.14. In accordance with IAS16:-

IFRS is clear that all the depreciation chargeable on revalued assets must pass through the profit and loss account. This means that the extra depreciation incurred because an asset has been indexed or revalued upwards is included in the depreciation charge for the year

Bodies should, however, release an amount from the Revaluation reserve to the Retained Earnings in respect of this excess depreciation over historic cost. This transfer avoids the anomaly of the revaluation reserve remaining in perpetuity after an asset has become fully depreciated. It is also justified as it recognises a 'realised profit 'in Companies Act terms

Balance at 1 April 2012	**139,879**	**(56,160)**	**59,732**	**(861)**	**142,590**
Changes in taxpayers' equity for the year ended 31 March 2013					
Retained surplus/(deficit) for the year		(312)			(312)
Net gain / (loss) on revaluation of property, plant, equipment			94		94
Net gain / (loss) on revaluation of intangible assets			0		0
Net gain / (loss) on revaluation of financial assets			0		0
Net gain / (loss) on revaluation of assets held for sale			0		0
Impairments and reversals			(7,827)		(7,827)
Movements in other reserves				0	0
Transfers between reserves		3,801	(3,801)	0	0
Release of reserves to Statement of Comprehensive Income			0		0
Reclassification Adjustments					
Transfers to/(from) Other Bodies within the Resource Account Boundary	0	0	0	0	0
Transfers between Revaluation Reserve & Retained Earnings Reserve in respect of assets transferred under absorption		0	0		0
On Disposal of Available for Sale financial Assets			0		0
Reserves eliminated on dissolution	0	0	0	0	0
Originating capital for Trust established in year	0				0
New PDC Received	949				949
PDC Repaid In Year	(2,718)				(2,718)
PDC Written Off	0				0
Transferred to NHS Foundation Trust	0	0	0	0	0
Other Movements in PDC In Year	0				0
Net Actuarial Gain/(Loss) on Pension				0	0
Net recognised revenue/(expense) for the year	**(1,769)**	**3,489**	**(11,534)**	**0**	**(9,814)**
Balance at 31 March 2013	**138,110**	**(52,671)**	**48,198**	**(861)**	**132,776**

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED

31 March 2014

	NOTE	**2013-14 £000s**	2012-13 £000s
Cash Flows from Operating Activities			
Operating Surplus/(Deficit)		**(1,295)**	13,938
Depreciation and Amortisation		**8,233**	8,177
Impairments and Reversals		**189**	181
Other Gains/(Losses) on foreign exchange		**0**	0
Donated Assets received credited to revenue but non-cash		**(171)**	0
Government Granted Assets received credited to revenue but non-cash		**0**	0
Interest Paid		**(9,327)**	(9,893)
Dividend (Paid)/Refunded		**(3,372)**	(4,530)
Release of PFI/deferred credit		**0**	0
(Increase)/Decrease in Inventories		**(63)**	(64)
(Increase)/Decrease in Trade and Other Receivables		**(6,112)**	4,002
(Increase)/Decrease in Other Current Assets		**0**	0
Increase/(Decrease) in Trade and Other Payables		**13,348**	(11,627)
(Increase)/Decrease in Other Current Liabilities		**611**	(237)
Provisions Utilised		**(690)**	(502)
Increase/(Decrease) in Provisions		**365**	569
Net Cash Inflow/(Outflow) from Operating Activities		**1,716**	14
CASH FLOWS FROM INVESTING ACTIVITIES			
Interest Received		**56**	48
(Payments) for Property, Plant and Equipment		**(27,276)**	(11,896)
(Payments) for Intangible Assets		**(36)**	0
(Payments) for Investments with DH		**0**	0
(Payments) for Other Financial Assets		**0**	0
(Payments) for Financial Assets (LIFT)		**0**	0
Proceeds of disposal of assets held for sale (PPE)		**0**	0
Proceeds of disposal of assets held for sale (Intangible)		**0**	0
Proceeds from Disposal of Investment with DH		**0**	0
Proceeds from Disposal of Other Financial Assets		**0**	2,718
Proceeds from the disposal of Financial Assets (LIFT)		**0**	0
Loans Made in Respect of LIFT		**0**	0
Loans Repaid in Respect of LIFT		**0**	0
Rental Revenue		**0**	0
Net Cash Inflow/(Outflow) from Investing Activities		**(27,256)**	(9,130)
NET CASH INFLOW/(OUTFLOW) BEFORE FINANCING		**(25,540)**	(9,116)
CASH FLOWS FROM FINANCING ACTIVITIES			
Public Dividend Capital Received		**479**	949
Public Dividend Capital Repaid		**0**	(2,718)
Loans received from DH - New Capital Investment Loans		**17,153**	7,242
Loans received from DH - New Revenue Support Loans		**0**	12,000
Other Loans Received		**0**	0
Loans repaid to DH - Capital Investment Loans Repayment of Principal		**(1,075)**	(200)
Loans repaid to DH - Revenue Support Loans		**(1,334)**	(667)
Other Loans Repaid		**0**	0
Cash transferred to NHS Foundation Trusts		**0**	0
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI and LIFT		**(1,727)**	(1,657)
Capital grants and other capital receipts (excluding donated / government granted cash receipts)		**935**	0
Net Cash Inflow/(Outflow) from Financing Activities		**14,431**	14,949
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS		**(11,109)**	5,833
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period		**16,773**	10,940
Effect of Exchange Rate Changes in the Balance of Cash Held in Foreign Currencies		**0**	0
Cash and Cash Equivalents (and Bank Overdraft) at year end		**5,664**	16,773

INDEPENDENT AUDITOR'S REPORT TO THE DIRECTORS OF WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

We have audited the financial statements of Worcestershire Acute Hospitals NHS Trust for the year ended 31 March 2014 under the Audit Commission Act 1998. The financial statements comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes. The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England.

We have also audited the information in the Remuneration Report that is subject to audit, being:

- the table of salaries and allowances of senior managers and related narrative notes on page 58
- the table of pension benefits of senior managers and related narrative notes on page 60
- the narrative on pay multiples on page 59.

This report is made solely to the Board of Directors of Worcestershire Acute Hospitals NHS Trust in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 44 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 2014. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust's directors and the Trust as a body, for our audit work, for this report, or for opinions we have formed.

Respective responsibilities of Directors and auditor

As explained more fully in the Statement of Directors' Responsibilities in respect of the accounts, the Directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards also require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the Trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Trust; and the overall presentation of the financial statements. In addition, we read all the financial and non-financial information in the annual report which comprises Welcome from Harry Turner, Chairman and Penny Venables, Chief Executive, Section 1 Strategic Report, Section 2 The year's performance at a glance, Section 3 Working with Stakeholders, Section 4 Engaging and Supporting Our People, Section 5 The Trust Board, Section 6 Business Review - Operating and Financial Review, Section 7 Annual Governance Statement 2013/14, and Section 8 Directors' Remuneration to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the financial position of Worcestershire Acute Hospitals NHS Trust as at 31 March 2014 and of its expenditure and income for the year then ended; and
- have been prepared properly in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England.

Opinion on other matters
In our opinion:

- the part of the Remuneration Report subject to audit has been prepared properly in accordance with the requirements directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England; and
- the information given in the annual report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we report by exception
We have nothing to report in respect of the following matters where we are required to report to you if:

- in our opinion the governance statement does not reflect compliance with the Trust Development Authority's Guidance
- we issue a report in the public interest under section 8 of the Audit Commission Act 1998.

We are required to report if:

- we refer a matter to the Secretary of State under section 19 of the Audit Commission Act 1998 because we have a reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency.

On the 30 April 2014 we referred a matter to the Secretary of State under section 19 of the Audit Commission Act 1998 in relation to Worcestershire Acute Hospital NHS Trust's on-going breach of its breakeven duty for the year ending 31 March 2014 and planned deficit for the year ended 31 March 2015.

Conclusion on the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources

Respective responsibilities of the Trust and auditor
The Trust is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources, to ensure proper stewardship and governance, and to review regularly the adequacy and effectiveness of these arrangements.

We are required under Section 5 of the Audit Commission Act 1998 to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. The Code of Audit Practice issued by the Audit Commission requires us to report to you our conclusion relating to proper arrangements, having regard to relevant criteria specified by the Audit Commission.

We report if significant matters have come to our attention which prevent us from concluding that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of

the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

Scope of the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We have undertaken our audit in accordance with the Code of Audit Practice, having regard to the guidance on the specified criteria, published by the Audit Commission in October 2013, as to whether the Trust has proper arrangements for:

- securing financial resilience
- challenging how it secures economy, efficiency and effectiveness.

The Audit Commission has determined these two criteria as those necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2014.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to form a view on whether, in all significant respects, the Trust had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

Basis for qualified conclusion

In seeking to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources, we have considered the following matters in relation to financial resilience:

- the Trust reported a deficit of £14.2 million in 2013/14 and breached its statutory breakeven duty.
- the Trust has been unable to set a balanced budget for 2014/15, with a forecast deficit of £9.8 million..

Qualified Conclusion

On the basis of our work, having regard to the guidance on the specified criteria published by the Audit Commission in October 2013, with the exception of the matter reported in the basis for qualified conclusion paragraph above, we are satisfied that in all significant respects Worcestershire Acute Hospitals NHS Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ending 31 March 2014.

Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate until we have completed the work necessary to provide assurance over the Trust's annual quality account. We are satisfied that this work does not have a material effect on the financial statements or on our value for money conclusion.

Jon Roberts
Partner, for and on behalf of Grant Thornton UK LLP, Appointed Auditor
Colmore Plaza, 20 Colmore Circus, Birmingham, B4 6AT

9 June 2014

Section 8
Annual Governance Statement 2013/14

1 Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the *Accountable Officer Memorandum.*

I have a duty of partnership to discharge, and therefore work collaboratively with other partner organisations. The Trust is working collaboratively wherever possible with the appropriate Local Authorities, voluntary sector and local education establishments as well as NHS Commissioners (CCGs and NHS England) and other NHS providers of services. The Trust has a range of formal and informal mechanisms in place to facilitate effective working with key partners in the Worcestershire Health Economy, including the Well Connected Programme, a multiagency funded programme to transform the way care is delivered within the county. The Trust is monitored and assessed by a wide range of external agencies that contribute to the on-going development of the Assurance Framework. These have included the three local Clinical Commissioning Groups, West Midlands Quality Review Service, Cancer Peer Review, Royal Colleges, NHS Trust Development Authority (NTDA), NHS England, the Care Quality Commission, the Audit Commission, the National Health Service Litigation Authority and the Health and Safety Executive. This is not an exhaustive list of organisations that monitor and assess the Trust.

Close links continue with partners including NHS England and the NTDA through the Future of Acute Hospital Services in Worcestershire programme. The Chief Executive has regular contact with the NTDA and NHS England through a range of group, individual, informal and formal meetings. Good relationships are also in place with the three Worcestershire clinical commissioning groups, NHS South Worcestershire, NHS Redditch and Bromsgrove and NHS Wyre Forest. All Executive Directors are fully engaged in the relevant networks, including nursing, medical, finance, operations and human resources.

2 The purpose of the system of internal control

The system of internal control is designed to manage risk to an acceptable level rather than to eliminate all risks; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an on-going process designed to:

- identify and prioritise the risks to the achievement of the organisation's aims and objectives,
- evaluate the likelihood of those risks being realised and the consequence should they be realised, and to manage them efficiently, effectively and economically.

The system of internal control has been in place in Worcestershire Acute Hospitals NHS Trust for the year ended 31 March 2014 and up to the date of approval of the annual report and accounts.

3 Capacity to handle risk

Within the organisation, the Trust has a functioning Safe Patient Group and a Health & Safety Committee which report to the Trust Board via the Quality Governance Committee and the Trust Management Committee. The Risk Executive Group has been created to guide the development of risk management and monitor its effectiveness as we enhance our approach to risk management.

The Executive lead for Risk Management is the Director for Strategic Development. The Chief Nursing Officer is the appointed Executive Lead on Clinical Governance. The Chief Medical Officer has a remit to provide executive responsibility for patient safety, audit and effectiveness. The Director of Resources leads on financial risk and counter fraud and the Company Secretary on corporate governance.

The Risk Management Strategy is an integral part of the Trust's approach to continuous quality improvement and is intended to support and assist the organisation in delivering its key objectives as well as meeting the requirements contained within the NHS Constitution. The Board reviewed the risk management system in 2013/14 and changes will be made in 2014/15 to better integrate objectives (at all levels of the organisation) with performance information and the management of risks to meeting objectives and apply this at all levels of the new Divisional and committee structures. A further investment in targeted training and support to embed the changes will be made.

During the year the Trust Board received reports on key risk areas and has overseen and reviewed the on-going development of the Trust's Board Assurance Framework (BAF). A regular review of the assurance provided by the BAF is undertaken by the Audit and Assurance Committee. In addition, each Board Committee regularly reviews their areas of responsibility within the BAF which is then collated and presented to the Audit and Assurance Committee and on to the Board on a quarterly basis. The Audit and Assurance Committee also has a role in monitoring the effectiveness of the risk management strategy.

The governance structure for the Trust was reviewed in 2013/14 and a new structure implemented fully in January 2014. A new Divisional structure was implemented in November 2013. Five divisions work county wide each with a senior leadership team consisting of a Medical Director, Nursing Director (Nursing and Midwifery for one division) and a Director of Operations. This has strengthened the clinical leadership support to me as the Accountable Officer and has enabled risks to be managed nearer the front line.

The changes implemented as a result of the Governance review (which were approved by the Board) were:

- A change to the Integrated Governance Committee to rename it the Quality Governance Committee with a slightly different remit, so it is clear that the focus of this committee is on quality assurance
- Implementation of a new subcommittee structure for the Quality Governance Committee focussing on the key aspects of quality, patient safety, patient experience, clinical effectiveness, infection control and safeguarding
- The introduction of a role of reviewing the effectiveness all the board sub committees for the Audit Committee, renamed the Audit and Assurance Committee. This will be achieved through an annual invitation to Board subcommittee chairs
- The introduction of the Trust Management Committee where the Divisional Directors and the Executive Team under my leadership work together on the strategic direction of the trust including identifying and managing the strategic and cross divisional operational risks
- The introduction of a Risk Executive Group to review all aspects of risk management in relation to the delivery of key objectives, trust-wide and by division

I should like to emphasise the importance of the Quality Governance Committee and its new subcommittees. The Trust places great emphasis on the delivery of high quality services and three of

the subgroups are tasked to assure the Committee in this area. The Safe Patient Group looks specifically at mortality, incidents and serious incidents. It also considers reports from a range of sub groups such as medicines management. The Clinical Effectiveness Committee reviews the compliance with national standards and external regulation. The Patient Experience Committee looks at information relating to all aspects of patient/user experience.

The Trust Board has held a seminar on risk management during the year to consider its approach to risk. This was attended by all except one board member. The seminar reaffirmed the Board's approach to risk and reviewed the management of risk within the Trust. It proposed a different way of linking strategic and operational risks with performance will be taken forward in 2014/15. At this seminar as well, the external auditors presented to the Trust Board on the changes to the Monitor regime for 2014/15.

Staff continue to be made aware of their risk management responsibilities as part of the induction process, and existing staff are required to attend a mandatory annual update in respect of risk management. Training needs of staff in relation to risk management are assessed through a formal training needs analysis process, staff receiving training appropriate to their authority and duties. The role of individual staff in managing risk is also supported by a framework of policies and procedures which promote learning from experience and sharing of good practice. The Trust continues to learn lessons in a variety of ways, including from the following sources:

- Patients' Advice and Liaison Service (PALS)
- Complaints and compliments
- Friends and family test
- Litigation Claims
- Clinical Audit and Clinical Outcome Reviews
- Clinical Incident Reports, reviews and analysis including serious incidents and never events
- Morbidity and Mortality data (HSMR/SHMI)
- External Reports (for example the National Confidential Enquiry into Peri-operative Death, reports from the Royal Colleges)
- Patient and Staff surveys
- Internal quality inspections
- Quality performance metrics
- Board Executive and Non-Executive Director walk rounds
- External reviews by the CQC, Royal Colleges, NTDA rapid response and Clinical Commissioning Groups.

This is not an exhaustive list of organisations that provide us with report from which we can learn lessons.

Serious incidents and never events as well as complaints are thoroughly investigated and improvements made at local and corporate levels to reduce the likelihood or reoccurrence.

Specific training targeted at executive directors, non-executive directors and managers has also been undertaken. Consequently risk management training is being closely monitored, evaluated, improved upon and further developed.

The Trust has a Corporate Risk Register in place which outlines the key corporate risks for the organisation and action identified to mitigate these risks. This register has been formed from the Divisional risks identified and managed at that level.

4 Governance

The voting members of Trust Board during 2013/14 were as follows:

Harry Turner, Chairman
Penny Venables, Chief Executive
Helen Blanchard, Chief Nursing Officer (until July 2013)
John Burbeck, Non-Executive Director, vice-chair
Celina Eves, Interim Chief Nursing Officer (August to October 2013)
Stephen Howarth, Non-Executive Director
Bryan McGinity, Non-Executive Director, Senior Independent Director
Stewart Messer, Chief Operating Officer
Andrew Sleigh, Non-Executive Director
Chris Tidman, Director of Resources and Deputy Chief Executive
Lynne Todd, Non-Executive Director
Mark Wake, Chief Medical Officer
Lindsey Webb, Chief Nursing Officer (from October 2013)

Non-voting members of Trust Board

Professor Julian Bion, Associate Non-Executive Director
Bev Edgar, Interim Director of Human Resources and Organisational Development (until July 2013)
Bev Edgar, Director of Human Resources and Organisational Development (from July 2013)
Chris Fearns, Director of Strategic Development
Claire Lea, Interim Company Secretary (until April 2013)
Kimara Sharpe, Interim Company Secretary (from April to September 2013)
Kimara Sharpe, Company Secretary (from September 2013)

At all meetings there were more non-executive voting members present then executive director members.

Board attendance

	Total
Harry Turner, Chairman	12/12
Penny Venables, Chief Executive	12/12
Professor Julian Bion, Associate Non-Executive Director	9/12
Helen Blanchard, Chief Nursing Officer (until July 2013)	3/4
John Burbeck, Non-Executive Director, vice-chair	12/12
Bev Edgar, Interim Director of Human Resources and Organisational Development (until July 2013)	10/12
Bev Edgar, Director of Human Resources and Organisational Development (from July 2013)	
Celina Eves, Interim Chief Nursing Officer (August to October 2013)	2/2
Chris Fearns, Director of Strategic Development	10/12
Stephen Howarth, Non-Executive Director	11/12
Claire Lea, Interim Company Secretary (until April 2013)	0/1
Bryan McGinity, Non-Executive Director, Senior Independent Director	12/12
Stewart Messer, Chief Operating Officer	12/12
Andrew Sleigh, Non-Executive Director	11/12
Kimara Sharpe, Interim Company Secretary (from April to September 2013)	12/12
Kimara Sharpe, Company Secretary (from September 2013)	
Chris Tidman, Director of Resources and Deputy Chief Executive	11/12

Lynne Todd, Non-Executive Director	11/12
Mark Wake, Chief Medical Officer	10/12
Lindsey Webb, Chief Nursing Officer (from Oct 2013)	6/6

4.1 Committees as at 31 March 2014

In September 2013, in response to a new Divisional structure being implemented and an acknowledgement that the Corporate Governance Structure needed a review; a new structure was developed and implemented fully in January 2014. A new Committee, Finance and Performance, was set up, the Integrated Governance Committee was reviewed to focus on Quality and was renamed the Quality Governance Committee with revised membership and the Audit Committee was renamed the Audit and Assurance Committee, with a stronger emphasis on its role to evaluate the performance of other Committees.

During 2013/14, the Trust Board had the following committees:

- Audit (until December 2013)
- Audit and Assurance (from January 2014)
- Charitable Funds
- Finance and Performance (from September 2013)
- Foundation Trust Steering Group
- Investment and Innovation
- Integrated Governance (until December 2013)
- Quality Governance (from January 2014)
- Remuneration

All terms of reference for the committees have been revised during the year and approved by the Trust Board.

The purpose together with the attendance for each committee is shown below:

Audit committee (until December 2013)
Audit and Assurance Committee (from January 2014)

Purpose: The Audit and Assurance Committee has been established to critically review the governance and assurance processes upon which the Trust Board places reliance, ensuring that the organisation operates effectively and meets its strategic objectives. The Audit and Assurance committee works closely with the external and internal auditors. It also receives regular reports from the Local Counter Fraud Specialist. The Trust currently complies fully with the National Strategy to combat and reduce NHS fraud. The Trust employs the services of assurance provider CW Audit Services to provide its local counter fraud service and to follow Department of Health directions. The organisation has a zero tolerance policy on fraud, bribery and corruption and has a counter fraud plan and strategy in place which is designed to make all staff aware of what they should do if they suspect fraud. The Committee monitors this strategy and oversees where fraud is suspected and fully investigated. The Committee is assured that appropriate action is taken, which can result in criminal, disciplinary and civil sanctions being applied. There were no significant frauds detected during the year although some cases reported to the Trust's counter fraud team remain on-going.

Chairman	Bryan McGinity	7/7
Non-Executive Director	Lynne Todd	5/7
Non-Executive Director	Stephen Howarth	6/7

Charitable Funds Committee

Purpose: The Charitable Funds Committee has been established to manage the Trust's Charitable Funds on behalf of the Trust, as Corporate Trustee.

Chairman	Harry Turner	1/3
Non-Executive Director	Andrew Sleigh	3/3
Non-Executive Director	Lynne Todd	3/3
Chief Executive	Penny Venables	2/3
Director of Resources	Chris Tidman	3/3
CNO/CMO or deputy	Helen Blanchard/Celina Eves/Lindsey Webb/Mark Wake	3/3

Finance and Performance Committee

Purpose: The purpose of the Finance and Performance Committee (F&P) is to act as a sub-committee of the Trust Board to give the Board assurance on the management of the financial and corporate performance of the Trust and to monitor and support the financial planning and budget setting process. The Committee will also review business cases with a significant financial impact or those referred by the Service Development Group and oversee developments in financial systems and reporting, e.g. SLR/PLICS.

Chairman	Harry Turner	5/6
Non-Executive Director	John Burbeck	5/6
Non-Executive Director	Bryan McGinity	6/6
Chief Executive	Penny Venables	3/3
Director of Resources	Chris Tidman	6/6
Chief Operating Officer	Stewart Messer	4/6
Chief Nursing Officer	Lindsey Webb	6/6

Foundation Trust Steering Group

Purpose: The Steering Group is established to enable the Trust to make a successful application for foundation trust status by overseeing the application process, securing the associated information and necessary agreements, and promoting the action, changes and improvements required to make the application successful.

Chairman	Harry Turner	2/2
Non-Executive Director	John Burbeck	2/2
Non-Executive Director	Bryan McGinity	2/2
Chief Executive	Penny Venables	2/2
Director of Resources	Chris Tidman	2/2
Director of Strategic Development	Chris Fearns	2/2
Chief Nursing Officer	Helen Blanchard/Celina Eves /Lindsey Webb	2/2
Director of HR and Organisational Development	Bev Edgar	2/2
Chief Medical Officer	Mark Wake	2/2

Investment and Innovation Committee

Purpose: The purpose of the IIC committee is to secure assurance and make recommendations to the Board on any significant investment or dis-investment project with a particular emphasis on invest to save and quality initiatives.

Chairman	Andrew Sleigh	3/4
Non-Executive Director	Stephen Howarth	4/4
Non-Executive Director	Bryan McGinity	3/4
Director of Resources	Chris Tidman	4/4
Director of Strategic Development	Chris Fearns	1/4
Chief Operating Officer	Stewart Messer	1/4

Integrated Governance Committee (until December 2013)
Quality Governance Committee (from January 2014)

Purpose: The Quality Governance Committee is constituted as a standing committee of the Board to:

- To enable the Board to obtain assurance that the quality of care within the Trust is of the highest possible standard.
- To ensure that there are appropriate clinical governance systems and processes and controls are in place throughout the Trust in order to:
    - Promote safety and excellence in patient care
    - Identify, prioritise and manage risk arising from clinical care
    - Ensure the effective and efficient use of resources though evidence based clinical practice

This Committee assures the board in relation to quality and as such has overseen the production of the Quality Account. The contents of the Quality Account were discussed and agreed at the Committee and subsequently reported to the Board. The Committee also oversees clinical audit activities within the Trust. This has been strengthened during the year with the appointment of an Associate Medical Director for Revalidation, Leadership & Clinical Audit. The Committee robustly reviews the serious incidents and monitors the action plans via the Safe Patient Group, chaired by the Trust's Chief Medical Officer. The Committee also signs off the final root cause analysis of any never event that has occurred. During the year, the Trust has reviewed the provision of bedside oxygen as a result of a never event occurring and changed preoperative procedures to ensure that patients are not fitted with the incorrect lens, also following a never event.

Chairman	Professor Julian Bion	12/12
Vice chairman	John Burbeck	11/12
Non-executive director	Stephen Howarth	12/12
Non-executive director	Lynne Todd	11/12
Chief Executive	Penny Venables	9/12
Director of Nursing	Helen Blanchard	3/4
Patient Forum representative	Paul Crawford	12/12
Interim Chief Nursing Officer	Celina Eves	2/2
Associate Medical Director	Steve Graystone	12/12
Associate Medical Director	Rabia Imtiaz	2/3
Chief Operating Officer	Stewart Messer	4/12
Company Secretary	Kimara Sharpe	10/12
Chief Medical Officer	Mark Wake	12/12
Chief Nursing Officer	Lindsey Webb	6/6

Remuneration Committee

Purpose: The Remuneration Committee is constituted as a standing committee of the Board for reviewing the structure, size and composition of the Board of Directors and making recommendations for changes where appropriate.

The Committee gives full consideration to and makes plans for succession planning for the chief executive and other executive board directors taking into account the challenges and opportunities facing the trust and the skills and expertise needed on the board in the future.

The committee is responsible for setting the remuneration of executive members of staff senior managers earning over £70,000 or accountable directly to an executive director and on locally-determined pay.

Chairman	Harry Turner	5/5
Non-executive director	John Burbeck	4/5
Non-executive director	Andrew Sleigh	2/2
Non-executive director	Lynne Todd	4/5

5 The risk and control framework

The Trust Board has the overall responsibility for probity (standards of public behaviour) within the Trust and is accountable for monitoring the organisation against the agreed direction and ensuring corrective action is taken where necessary.

The Chief Executive remains accountable and delegates executive responsibility to the Executive Directors of the Trust for the delivery of the organisational objectives, while ensuring that there is a high standard of public accountability, probity and performance management. The Assurance Framework reflects the strategic objectives assigned to the Executive Directors and Board Committees.

Agenda setting ensures that the Board is confident that systems and processes are in place to enable individual, corporate and, where appropriate, team accountability for the delivery of high quality person-centred care. The cycle of Trust Board meetings ensures the Board devotes sufficient time to setting and reviewing strategy and monitoring key risks. Each Board paper identifies the strategic risks that the paper is addressing. The strategic risks identified by the Board and monitored through Committees and presented to the Board through the Board Assurance Framework are as follows:

- Failure to deliver improvements in emergency access standard and WMAS Turnaround Times.
- Operational Pressures impact on ability to maintain 18 week RTT performance.
- Inability to maintain Cancer 31 and 62 day targets and subsidiary targets.
- Inability to maintain stroke targets.
- Productivity improvement not realised or under delivered.
- Failure to fully exploit new technology.
- Planned Elective work and income compromised by emergency demand and capacity constraints.
- Loss of financial control due to distractions of restructuring / other competing priorities.
- Inadequate plans or under delivery of Plan results in QIPP targets not being delivered.
- Lack of time and skilled resource to progress SLR & SLM results in lost opportunity for clinical ownership of cost, business development.
- Lack of transitional funding to support the current level of acute capacity pending a move to new service models - leading to an unplanned reduction in the access to services.

- FT - new trajectory not delivered - due to a delay in the finalisation of the clinical services strategy.
- Ineffective engagement and involvement of clinicians resulting in lack of clinical ownership of long term clinical strategy.
- Commissioners agree a preferred option which is not supported by the Trust Board.
- Lost business opportunities due to lack of expertise / lack of capacity & capability
- Benefits from Integrated Care Programme programme not realised and Emergency pressures sustain.
- Negative publicity from Joint Services Review and historic matters continues to damage Trust reputation.
- Failure to deliver an effective internal engagement plan affects staff confidence, morale and support for change.
- Not providing recognised effective treatment - results in suboptimal outcomes
- Failure to reduce avoidable harm events.
- Lack of effective clinical leadership as champions of a safety culture.
- High levels of emergency demand result in operational and clinical pressures which have detrimental impact on the quality, safety and experience of care.
- Inability to effectively listen and act on patient/carer feedback results in lack of understanding and lack of appropriate action.
- Failure to establish and develop clinical leaders as positive role models for all staff.
- Failure to achieve Department of Health Clostridium difficile (CDI) objective for 2013/14 which impacts on patient safety reputation and finance.
- Negative publicity from JSR and historic matters continues to damage Trust reputation.
- Failure to deliver an effective internal engagement plan affects staff confidence, morale and support for change
- Failure to secure a patient centred culture and staff do not challenge poor standards or behaviours.
- Basic care standards not met due to inability to raise levels of engagement (behaviours and values) of Healthcare Support Workers.
- Inability to deliver target levels of mandatory training compromises patient quality and safety of care and staff safety
- Interventions to improve sickness rates fail to improve and compromise operational effectiveness, staff morale.
- Inability to consolidate key services resulting in them becoming unsustainable.

No further strategic risks were identified during the year.

Strategic risk is managed in line with the Trust's Risk Management Strategy. The strategy sets out specific responsibilities and accountabilities for the identification, evaluation, recording, reporting and mitigation of risk in accordance with the ALARM principle to reduce risk to as low as reasonably practical.

Risk Management is embedded within the organisation through the Trust's committee structure, through the development of future plans and through the consideration of all risk management issues at the planning stage of organisational/clinical changes, through the existence of an incident reporting and feedback system, through the inclusion of risk management within job descriptions (including both training and the processes for the assessment of risk), and through the reporting and investigation of incidents.

Innovation and learning in relation to risk management is considered to be critical. The Trust's e-based reporting system, Datix, has been rolled out throughout the organisation so that incidents can be input at source and data can be interrogated through ward, team and locality processes, thus encouraging local ownership and accountability for incident management. The Trust identifies and makes improvements as a result of incidents and near misses in order to ensure it learns lessons and closes the loop by improving safety for service users, staff and visitors. The Trust aims to operate within a just, honest and open culture where staff are assured they will be treated fairly and with openness and honesty when they report adverse incidents or mistakes. The Trust has a Being Open Policy which has been reviewed during 2013/14 to ensure that it meets the new Duty of Candour for NHS organisations. It has appointed a NED to be the Being Open Champion.

The Trust has measures in place to ensure the security of its information resources and assets. The Trust continues to achieve a high level of compliance to the standards in the NHS Information Governance Toolkit supported by audit giving significant assurance of compliance with the vast majority of standards. An action plan has been developed where gaps have been identified and this will be monitored by the Information Governance Committee. During 2013 the trust has not had to report any level 2 IG Serious Incidents regarding data losses or breaches of confidentiality to the Health & Social Care Information Centre. The Trust continues to report and investigate any low level incidents internally (Level 0 and 1s) and in all cases reports have been provided which are subject to a root cause analysis with remedial action plans are agreed and implemented. The lessons learned have been shared and guidance provided to staff which has been publicised via the Daily Brief.

In 2013, the Trust invited the Information Commissioner's Office (ICO) to carry out a three day audit which included reviewing security arrangements for the handling of personal identifiable information (PID). The Trust requested the audit following some low level incidents to provide assurance to the Board, Commissioners and patients that the Trust takes its responsibility to handle personal information in a secure and confidential manner very seriously. The audit was broadly reassuring. The audit was in addition to the internal assurance programme already in place as a requirement of the Information Governance Toolkit.

The Trust places a high priority on ensuring staff complete their annual IG training in order to ensure they are aware of their responsibilities when handling PID and to reduce the risk of serious or recurring incidents taking place.

The Trust works closely with public stakeholders to involve them in understanding and supporting the management of risks that impact upon them. Stakeholders are able to influence the Trust in a number of ways, including patient involvement groups and public involvement in the activities of the Trust. In addition, the Chief Executive and Chairman meet the local MPs regularly. The Trust is an active participant in the Well Connected Programme and the Future of Acute Hospital Services in Worcestershire, both of which have their own risk register. The Trust has directly engaged public stakeholders in the Risk Management process through the Patient & Public Forum and through PALS. In addition a patient and public forum member sits on the Quality Governance Committee. Public involvement also occurs through the Trust complaints procedure and summaries of complaints are reviewed at the patient and public involvement forum. A patient representative also sits on Trust Board.

During 2013/14 the Trust introduced monthly Clinical Review visits to a wide range of areas within the Trust. Members of the Public are part of the reviewing team. These visits will be continued in 2014/15 with non-executive directors as members. Reports from this group are considered at the

patient experience committee. This gives non-executive directors another opportunity to visit front line areas.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with through Trust policies, training and audit processes, ensuring equality impact assessments are undertaken and published for all new and revised policies and services. Quality Impact Assessments are also undertaken when appropriate and are considered at the Finance and Performance Committee.

As an employer with staff entitled to membership of the NHS Pension scheme, control measures are in place to ensure compliance with all employer obligations contained within the Scheme regulations. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations. The Trust changed its payroll provider during the year but was dissatisfied with the new provider and based on a risk assessment and other business priorities, negotiated a return to the original provider which happened at the beginning of the calendar year.

The Trust has undertaken risk assessments and developed an Adaption Plan to support its emergency preparedness and civil contingency requirements. Additionally, based on UK Climate Projections 2009 (UKC P09), the Trust has developed a Sustainability Strategy during the year which has been approved by the Board.

The Trust is assured that it is compliant with all Care Quality Commission (CQC). There is a regular internal regulatory compliance review of processes and a continuing low risk of non-compliance rating by the CQC as evidenced via the Trust's Intelligent Monitoring Report which places the Trust in band 6 (lowest).

6 Review of economy, efficiency and effectiveness of the use of resources

The Trust has robust arrangements in place for setting objectives and targets on a strategic and annual basis. These arrangements include ensuring the financial strategy is affordable, scrutiny of cost savings plans both to ensure achievement and their impact upon the quality of patient care, compliance with terms of authorisation and co-ordination of individual objectives with corporate objectives as identified in the Annual Plan. Performance against objectives is monitored and actions identified through a number of channels:

- Approval of annual budget by the trust Board.
- Monthly reporting to the Board on key performance indicators covering finance, activity, patient safety, quality and human resources targets.
- Detailed monthly review of financial and performance targets by the Finance and Performance Committee prior to discussion at the Board.
- Monthly review of the delivery of Cost Improvement Plans by the Finance and Performance Committee to ensure that savings targets are being met.
- Monthly reporting to Executive Team on key influences on the Trust's financial position.
- Quarterly in depth performance management of Divisions by the Finance and Performance Committee covering performance against key objectives as well as monthly performance management at that committee.
- Monthly performance management reporting to the NHS Trust Development Authority
- The achievement of the annual efficiency target.

Value for money is an important component of the internal and external audit plans that provides assurance to the Trust of processes which that are in place to ensure effective use of resources.

Despite the health economy funding position being much tighter in 2013/14 which has led to a reported Trust deficit, the Board are satisfied that measures are in place to ensure efficiency and value for money. This is evidenced by the Trust delivering an annual efficiency gain of more than 4% for the third consecutive year.

The Trust has a well-developed annual planning process which considers the resources required to deliver the organisation's service plans in support of the strategic objectives. These annual plans detail the workforce and financial resources required to deliver the service objectives and include the identification of cost savings based on achieving upper quartile productivity benchmarks. The achievement of the Trust's financial plan is dependent upon the delivery of these savings.

The Trust has a standard assessment process for future business plans to ensure value for money and full appraisal processes are employed when considering the effect on the organisation.

Procedures are in place to ensure all strategic decisions are considered at Executive and Board level.

The emphasis in Internal Audit work is providing assurances on internal controls, risk management and governance systems to the Audit Committee and to the Board. Where scope for improvement, in terms of value for money was identified during an Internal Audit review, appropriate recommendations were made and actions were agreed with management for implementation.

As part of the annual accounts review, the Trust's efficiency and effectiveness of its use of resources in delivering clinical services are assessed by its external auditors and the auditor's opinion is published with the accounts.

7 Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and divisional directors within Worcestershire Acute Hospitals NHS Trust that have responsibility for the development and maintenance of the internal control framework. I have also drawn on the content of the Quality Report and other performance information available to me.

My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by Trust Board, the Audit and Assurance Committee, the Quality Governance Committee, clinical audit, internal and external audit and by my Executive Team. Plans to address any weaknesses and ensure continuous improvement of the system are in place. Satisfactory assurances have been received from Internal Audit reviews. Action Plans have been developed to address the weaknesses identified and have been implemented by management.

The Assurance Framework provides me with evidence that the effectiveness of controls put in place to manage the risks to the organisation achieving its principal objectives have been reviewed. The Assurance Framework has been reviewed and updated and approved by the Audit and Assurance Committee on a quarterly basis throughout the past year. There were no significant gaps identified in the Assurance Framework.

My review is also informed by reports from external inspecting bodies including external audit and the PLACE inspections, introduced in April 2013. This is the new system for assessing the quality of the patient environment, replacing the old Patient Environment Action Team (PEAT) inspections. The Trust had inspections in March 2014 as part of a national programme. My review has also drawn from the CQC rating which places the Trust in Band 6, the least risky band.

All Committees of Trust Board are chaired by Non-Executive Directors to reflect the need for independence and objectivity, ensuring that effective governance and controls are in place. This structure ensures that the performance of the organisation is fully scrutinised. The Committee structure supports the necessary control mechanisms throughout the Trust. The Committees have met regularly throughout the year and each report to the Board following their meetings. The Board undertook an evaluation of its performance during the year. This was reported to a private trust board meeting and action taken to improve the effectiveness of the Board. This evaluation used the Code of Governance as a basis, and it was recognised that the some sections of the Code are not applicable to the Trust.

The Audit and Assurance Committee is charged with monitoring the effectiveness of internal control systems on behalf of the Board and has done so as part of its annual work programme and reported through its Annual Report to the Board.

The role of internal audit at the Trust is to provide an independent and objective opinion to me and my managers on the system of control and also the Trust Board. The opinion considers whether effective risk management, control and governance arrangements are in place in order to achieve the Trust's objectives. The work of internal audit is undertaken in compliance with the NHS Internal Audit Standards. The work to be undertaken by internal audit is detailed in a three year strategic audit plan and is reviewed annually to generate an annual audit programme. The audit programme includes a risk assessment of the Trust, based on the Trust's assurance framework, an evaluation of other risks identified in the Trust's risk register and through discussion with management. Internal audit reports the findings of its work to management, and action plans are agreed to address any identified weaknesses.

Significant internal audit findings are also reported to the Audit and Assurance Committee for consideration and further action if required. A follow up process is in place to ensure that agreed actions are implemented. Internal audit is required to identify any areas at the Audit and Assurance Committee where it is felt that insufficient action is being taken to implement recommendations to address identified risks and weaknesses.

The Head of Internal Audit's overall opinion for 2013/14 is that **significant** assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weakness in the design and/or inconsistent application of controls put the achievement of particular objectives at risk and moderate assurance has been achieved in these areas which are as follows:-

- Temporary Staffing Booking Processes
- Patients' Property

I am supported by the Executive Team, consisting of the Executive Directors. The new Divisional Structure (implemented in November 2013) has enabled me to ensure that the Trust is clinically led in all areas of strategy. The Trust Management Committee brings together the Executive team and the Divisional Directors teams on a monthly basis which then supports me to co-ordinate and

prioritise activity in the Trust ensuring that the strategic direction, set by the Trust Board, is delivered. This structure enables me to ensure that clinical leadership and management arrangements are in place supported by robust and clear governance and accountability processes.

8 Significant issues

I consider that the Trust had one significant issue during the year 2013/14 which was the continued suspension of a consultant colorectal surgeon. A patient's family referred the death of a patient to the Police in December 2013. The suspended surgeon had looked after the patient. The surgeon was suspended in 2012 and since that time, the Trust has undertaken a number of investigations which have continued in 2013/14. These investigations include a full clinical practice review, a review of the clinical governance arrangements and a probity investigation. The Trust is cooperating fully with the Police inquiry. The Trust is also ensuring that the GMC are kept informed of the work being undertaken.

9 Compliance with key national targets and standards

The Trust is committed to delivering all national and contractual targets and standards. During 2013/14, the Trust has declared non-compliance to the NHS Trust Development Authority with the following standards:-

- Accident and Emergency four hour access target
- 18 weeks referral to treatment
- Cancer targets (31 and 62 days)
- Finance
- C Difficile

At the 31 March 2014, the Trust was non-compliant with 18 weeks referral to treatment and A&E four hour target. The Board had actions in place to ensure compliance of these standards by 30 November, 30 April and 30 April respectively. The Trust met the cancer target for the full year.

10 Conclusion

I have reviewed the relevant evidence and assurances in respect of internal control. The Trust and its executive managers are alert to their accountabilities in respect of internal control. The Trust has had in place throughout the year an assurance framework, aligned to both our corporate objectives and the CQC standards to assist the Board in the identification and management of risk.

With the exception of the internal control issues that I have outlined in this statement, which are not considered significant, my review confirms that Trust has a generally sound system of internal controls that supports the achievement of its policies, aims and objectives and that those control issues have been or are being addressed.

Penny Venables
Chief Executive

Date 3 June 2014

Section 9
Directors' Remuneration

Salaries and allowances for Senior Managers

	2013-14				2012-13 (as restated)			
Name and title	**(a) Salary (bands of £5,000)** £000	**(b) Expense payments (taxable) total to nearest £100** £	**(c) All Pension Related Benefits (bands of £2,500)** £000	**(d) TOTAL (a - c) (bands of £5,000)** £000	**(a) Salary (bands of £5,000)** £000	**(b) Expense payments (taxable) total to nearest £100** £	**(c) All Pension Related Benefits (bands of £2,500)** £000	**(d) TOTAL (a - c) (bands of £5,000)** £000
H.Turner - Chairman	20-25	400	0	20-25	20-25	400	0	20-25
P Venables - Chief Executive	155-160	200	0	160-165	155-160	0	192.5-195.0	350-355
S. Messer - Chief Operating Officer	110-115	0	70.0-72.5	185-190	85-90	0	237.5-240.0	320-325
M. Wake - Medical Director	165-170	100	0	165-170	95-100	100	0	95-100
H.Blanchard - Director of Nursing and Midwifery	40-45	300	22.0-22.5	60-65	100-105	400	30.0-32.5	130-135
C. Eaves - Interim Director of Nursing and Midwifery	50-55	0	0	50-55	0	0	0	0
L. Webb - Director of Nursing and Midwifery	60-65	0	157.5-160.0	215-220	0	0	0	0
C. Tidman - Director of Finance	135-140	200	0	135-140	135-140	100	0	135-140
C. Fearns - Director of Strategic Development	105-110	200	5.0-7.5	110-115	105-110	300	0	105-110
B. Edgar - Director of HR	100-105	0	17.5-20.0	120-125	95-100	0	47.5-50.0	145-150
C.Ashton - Medical Director	0	0	0	0	140-145	300	0	140-145
S. Howarth - Non Executive Director	5-10	300	0	5-10	0-5	0	0	0-5
N.Trigg - Non Executive Director	0	0	0	0	0-5	0	0	0-5
Professor J Bion - Non Executive Director	5-10	0	0	5-10	5-10	0	0	5-10
B.McGinity - Non Executive Director	5-10	200	0	5-10	5-10	200	0	5-10
A.Sleigh - Non Executive Director	5-10	100	0	5-10	5-10	0	0	5-10
L.Todd - Non Executive Director	5-10	300	0	5-10	5-10	200	0	5-10
J. Burbeck - Non Executive Director	5-10	200	0	5-10	5-10	200	0	5-10

The remuneration of Executive Directors is determined by the Remuneration Committee, in accordance with NHS guidance and with regard to their roles and the complexity of their duties, and approved by the Trust Board.

The Remuneration Committee, which is made up of the Chairman and two non-Executive Directors is responsible for determining the pay and conditions of employment for Executive Directors and receives and ratifies recommendations from other committees such as the Consultants' Clinical Excellence Award Committee.

In determining the pay of Executive Directors the Committee agrees and twice a year reviews the annual objectives of the Directors. The Committee also compares each year Executive Directors pay against comparative salaries in the NHS. Cost of living awards are made in line with Department of Health guidance. For 2013/14 Executive Directors received no cost of living increase in pay.

Non-Executive Director appointments are selected through the Trust Development Authority, and appointed by the Trust on a fixed term basis, with a maximum duration of four years. A notice period of three months is normally applicable to these contracts.

Executive Directors are appointed by the Trust on permanent contracts, which have a required notice period of 6 months. Should termination payments be considered necessary at any time, the Trust is fully conversant with the guidance and requirements of both the Department of Health and HM Treasury on this matter.

Notes

C.Ashton – ceased as Medical Director 1/9/12

M. Wake – commenced with the Trust 1/10/12. There was no comparative pension information available for 2011-12, it has therefore not been possible to show the restated 2012-13 Pension Benefit.

H. Blanchard - left the Trust 25/08/13

C. Eaves - commenced with the Trust as an Interim Director of Nursing 30/7/13. The figure quoted under Salary represents the payment of fees to Practicus Limited and there are no additional costs for National Insurance or Superannuation

L. Webb – commenced with the Trust 7/10/13

S. Messer – commenced with the Trust 5/7/12

Professor J. Bion - commenced with the Trust 1/5/12

S. Howarth - commenced with the Trust 1/1/13

N. Trigg – left the Trust 30/9/2012

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the median remuneration of the organisation's workforce.

The banded remuneration of the highest paid director in Worcestershire Acute Hospitals NHS Trust in the financial year 2013-14 was £170,000 (2012-13, £190,000). This was 7 times (2012-13, 7) the median remuneration of the workforce, which was £25,783 (2012-13, £25,528). The fall in the value of the highest paid director's remuneration reflects the appointment of a new Medical Director for the Trust.

In 2013-14, 8 (2012-13, 2) employees received remuneration in excess of the highest-paid director. Remuneration ranged from £160,000 to £210,000 (2012-13 £210,000 to £215,000).

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind as well as severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

Pension Benefits

Name and title	Real increase in pension at age 60 (bands of £2,500) £000	Real increase in Lump sum at aged 60 (bands of £2,500) £000	Total accrued pension at age 60 at 31 March 2014 (bands of £5,000) £000	Lump sum at age 60 related to accrued pension at 31 March 2014 (bands of £5,000) £000	Cash Equivalent Transfer Value at 31 March 2014 £000	Cash Equivalent Transfer Value at 31 March 2013 £000	Real increase in Cash Equivalent Transfer Value £000	Employer's contribution to stakeholder pension £000
P. Venables - Chief Executive	0-2.5	0.0-2.5	60-65	186-190	1206	1133	48	0
L. Webb - Director of Nursing and Midwifery	5.0-7.5	20.0-22.5	30-35	95-100	564	419	136	0
C. Fearns - Director of Strategic Development	0-2.5	2.5-5.0	25-30	80-85	587	533	42	0
B. Edgar - Director of HR	0-2.5	2.5-5.0	10-15	35-40	237	198	34	0
C. Tidman - Director of Finance	0-2.5	0.0-2.5	35-40	105-110	543	513	18	0
M. Wake - Medical Director	0	0.0	40-45	130-135	860	830	11	0
S. Messer - Chief Operating Officer	2.5-5.0	10.0-12.5	45-50	145-150	948	834	95	0

Remuneration for Non-Executive Directors is in accordance with statutory limits. As Non-Executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for Non Executive members.

No Cash Equivalent Transfer Value is listed if the individual is over the age of 60.

The Government Actuary Department ("GAD") factors for the calculation of Cash Equivalent Transfer Factors ("CETVs") assume that benefits are indexed in line with CPI which is expected to be lower than RPI which was used previously and hence will tend to produce lower transfer values.

Off-Payroll Arrangements

For all off-payroll engagements as of 31 March 2014, for more than £220 per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2014	3
Of which, the number that have existed:	
for less than one year at the time of reporting	0
for between one and two years at the time of reporting	2
for between 2 and 3 years at the time of reporting	1
for between 3 and 4 years at the time of reporting	0
for 4 or more years at the time of reporting	0

All existing off-payroll engagements have been subject to a risk based assessment to seek assurance that the individual is paying the right amount of tax and, where necessary.

There were no new off-payroll engagements between 1 April 2013 and 31 March 2014, for more than £220 per day and that last longer than six months.

There were no off-payroll engagements of board members, and/or senior officers with significant financial responsibility during the year.

There were no individuals that have been deemed “board members, and/or senior officers with significant financial responsibility” during the financial year. This figure includes both off-payroll and on-payroll engagements.