	backlog exists in all Divisions. Clinical engagement with the mortality reviews is suboptimal and there has been too much focus on process. Meaningful learning from deaths is therefore compromised. The high mortality indicators reflect a series of process failures and the planned actions will help the organisation to take appropriate corrective action. Assurance over the mortality review process remains limited.

Risk									
Key Risks	Continue to have raised mortality indicators and fail to understand why and therefore fail to take appropriate corrective action. There is no specific risk related to mortality on the corporate risk register or included in the BAF however this review links to several quality and safety risks included on the register and connected to the BAF: Risks: 1, 2, 3, 4, 5, 10, 12								
Assurance	There were low numbers of avoidable factors related to mortality identified and no specific cases requiring escalation. There are however concerns raised regarding aspects of care of acute patients.								
Assurance level	**Significant**	*x*	**Moderate**		**Limited**		**None**		
Financial Risk	To be included in the business case to support the medical examiner role and mortality review process.								

Appendices

Review terms of reference *available on request*

Review of Elevated Mortality

Part 1 Independent Review of Elevated Mortality at Worcester Acute Hospitals NHS Trust

Commissioned by
Dr Graham James and Mathew Hopkins,
Medical Director and CEO WRH

Authors
Professor Mike Bewick Dr Rebecca Mann
Ms Wendy Cookson Ms Moira Angel
Mr Giles Peel

Date of review
July to August 2019

Terms of Reference
See Appendix A

1. Introduction

1.1 Background

Worcestershire Acute Hospitals NHS Trust ("the Trust") operates three main sites, the Alexandra Hospital in Redditch, Kidderminster Hospital and Treatment Centre, and Worcester Royal Hospital in Worcester. The Trust employs nearly 6000 people (as well as some 800 volunteers) and caters for a population of 580,000, providing a range of mainly secondary DGH services. Its turnover is in the region of £400 Million. The Trust is one of 13 nationally, which have been selected to join the NHS Leadership for Improvement board development programme. IQ4U were invited to conduct an independent review of the Trust's governance processes in connection with mortality between June and September 2019. This was in response to performance concerns, adverse deteriorating mortality statistics and adverse CQC reports, culminating in NHSI Enforcement Undertakings for Quality (overall rating of "Inadequate"), Operational Performance (A&E and Cancer waits) and Financial Performance (control total variance) in May 2019.

1.2 The IQ4U team

The team was led by Professor Mike Bewick and included Dr Rebecca Mann, Moira Angel, Wendy Cookson and Giles Peel.

1.3 Methodology

IQ4U's approach is to use its medical, nursing and governance expertise in a review process which analyses a large sample of mortality reports (we have examined some 225, 150 in the 18/19 and 75 in 17/18, which approximates to 10% and 5% of deaths in each year) and then cross referenced these with information gathered at interview and from observations of the Trust in action. The interviews ranged from board to ward and included a large section of clinicians and nurses as well as directors.

1.4 Timelines

The provider, IQ4U, was originally commissioned to undertake the review in June 2019. A start date of early July agreed with a provisional meeting being held on the 16th June between Mike Bewick and the medical director. A provisional timetable was then agreed starting in early July with completion date of the second week in August. The agreed review period was of deaths in 2 consecutive years 2017/18 and 2018/19. The interviews were carried out throughout July and the data downloads and analysis in the later part of July and early August. There was a slight delay in receiving emergency department data and this resulted in a moderate delay of a draft report in mid-August. The report will be considered by the Trust and any corrections or amendments made prior to the Trust Board meeting on the 12th September 2019. Following on from the Board it is anticipated there will be a stakeholder group event where the findings are discussed at a meeting chaired by the NHSE/I medical director.

2 Documentation studied

2.1 Board structure and reporting

The Trust enjoys a conventional, if somewhat complex governance structure, with a number of board committees; Quality Governance, Finance and Performance, Remuneration & Terms of Service, Audit and Assurance, People and Culture and Charitable Funds. The Trust Management Executive reports to the Board and is responsible for a number of management committees.

2.2 Board sub-committees overseeing mortality and morbidity issues

At management level (i.e. with no NED involvement), a Mortality Review Group (clinically led) assesses detail before reporting upwards to the Clinical Governance Group and then on to the Trust Management Executive. Reports are then provided by the Executive to the board level Quality Governance Committee, chaired by a NED and this finally reports to the Trust Board.

2.3 Internal reports and audits of mortality

2.3.1 The Trust has received regular updates at Board from the QGC of current mortality and morbidity concerns. The board has also received, recently, a report from its former medical director on deaths in respiratory medicine. We report in part 2 their findings and discuss them in the context of the wider mortality review.

2.4 Medical leadership and the system of 'Medical Examiners'

2.4.1 Medical leadership. The Trust has a traditional medical hierarchical structure led by a Chief Medical Officer (CMO). There is a divisional structure with divisional medical directors in post. These are seen to work well. A deputy to the CMO leads on mortality , supervising the "learning from deaths" process and is responsible for the recruitment, training and oversight of the medical examiner system. There has been significant flux in the post of CMO and the interim currently in post will hand over to his successor in August 2019. Despite this there has been progress in recruiting and rolling out of the medical examiner system.

2.4.2 The concept of the medical examiner role has developed relatively recently nationally and, it is as yet still evolving as an important and new function within trusts. It bridges the gap between the reporting/ registration of deaths, the coronial system and a trust's own governance when interrogating the causes of deaths. It has a supportive role in assisting young doctors in recording the cause of death, coding of deaths and agreeing cases appropriately referred for coronial review.

2.4.3 The Trust, through one of its deputy medical directors has developed a supportive process to engage now 5 ME's across the WRH and Alexandra Infirmary sites. Each is allocated one half day a week (1 PA). We were told that most of the time was spent supporting the death registration process in cooperation with the bereavement office. While structured judgement reviews are undertaken there is still a significant backlog (we were told over 800 cases).

2.4.4 Through our interviews with medical staff we were told of several different review of deaths processes. Each of the two emergency departments undertakes its own review, each death being reviewed within 48hrs of death. ED deaths are not included in hospital mortality statistics but are useful to the Trust when reviewing factors which may influence mortality. The ED consultants are proud of their internal audits into deaths, but unsure how this data is used within the trust. The critical care team receives external validation of deaths under their care where mortality is generally low. Here again, staff were unsure if the data was utilised by the Trust at its various quality committees. Cardiology also undertake monthly mortality reviews (as well as external speciality specific data from NICOR) and these have led to improved learning especially in heart failure and the appropriateness of an 'end of life' diagnosis. We understand that this learning may not be viewed or used to inform other clinicians who may have to manage similar patients when admitted acutely. Finally, there is the ME review system itself. Monthly meetings for all ME's are often poorly attended. ME's as a group report via the 'learning from deaths group' to the quality governance committee. The various divisional M&M groups also report there and the view from most clinicians was that the work was in silos and not joined up.

2.4.5 The lack of a coherent strategy in learning from deaths, and how it fits in with the Trust's overarching quality process, is seen as a major reason, by clinicians (including senior nurses), of the lack of progress in understanding how mortality issues can be better understood and acted upon.

2.4.6 A recurring criticism of the current ME process was the lack of time to evaluate deaths, through the SJR process, in a timely and comprehensive way. A second theme was the lack of leadership of the ME team to deliver a coherent narrative on the factors causing excess deaths in the Trust. Many clinicians were agreed on what may lie behind the increased mortality statistics, but these weren't reflected in the mortality groups outputs, thus far.

2.4.7 The ME system is new and there has been an emphasis on improving engagement and the skills required to deliver the process. It isn't unique in the UK for this system to be under developed and unlike some trusts, recruitment of ME's has been reasonable. The Trusts medical leadership is aware of the challenge and changes to make it a more effective system are planned.

3 Interviews with key members of staff

3.1 Clinical staff

3.1.1 In part 2 of this review we report in more detail the views of clinicians on the clinical and mortality issues affecting the Trust. We summarise here the comments relating to how the Trust oversees the mortality issues.

3.1.2 All clinicians felt more confident in the new management as they were more visible and interactive with them.

3.1.3 All were concerned that the issues of patient flow and development of effective oversight/governance was as yet not in place. While flow alone doesn't explain all of the increased mortality issues, all felt it impacted on safe care.

3.1.4 Most consultants we interviewed did not feel governance structures were robust in monitoring the causes of death and how the learning from deaths process is used to inform best practice. They also felt there is a disconnect between the former established 'mortality and morbidity' review, serious incident reviews and the new ME ones. Working in silos was still considered to be a factor

3.1.5 The senior nurses that we interviewed felt that there was good evidence that reducing harm through their review processes had worked well and that this was consistent across both acute sites. This was not the case for their medical colleagues, where culture and working practices has inhibited progress in understanding key issues affecting mortality

3.1.6 The structure of reporting to the QGC has yet to adapt to the ME process, and clinicians are concerned that learning from mortality reviews are not informing the Trust of its risks.

3.2 Executive and non-executive members of the board

3.2.1 Our interview with the chief operating officer (PB) covered governance systems. The strategic nature of the BAF and the reporting of associated risks has become the main oversight document and process for the trust.

3.2.2 Reporting to the Trust Board lacks detail but NEDs' comprehension and knowledge came from their membership of the various board committees.

3.2.3 The Chair expects the committees to do the majority of the detail, leaving the Board free for higher and overall functionality at the Trust. The model was therefore that assurance was provided upwards (rather than demanded by the Board).

3.2.4 NEDs are not as involved with the Trust as could be expected and were not regularly walking the wards. It is important that such a programme is quickly re-established.

3.2.5 The COO believes that there has been a normalisation of the lower standards of care associated with prolonged stays in the ED and associated corridors. The Trust is committed to reversing this unacceptable situation.

3.2.6 Improvements are required in the board's ability to ensure oversight of clinical governance. Currently, there isn't a cycle whereby all management committee papers came via the Trust management executive, before going to board committees. The one exception, due to timing, was the QGC. This policy was important in ensuring cohesive information going to NEDs, in a timely manner.

3.3 External (CCG); we interviewed the Clinical lead for mortality, Dr Clare Marley.

She attends the monthly mortality meetings and also the combined quarterly joint meetings between secondary and primary care mortality groups. She has had personal experience of being treated within the trust as an acutely ill patient and is personally aware of the challenges in the acute pathway. She reported:

3.3.1 The current acting CMO and mortality lead have improved the process of mortality reviews and raised it as a major issue within the Trust.

3.3.2 There is less 'buy in' and ownership of the issue by consultants and middle-management.

3.3.3 The medical examiner system is under resourced and governance of meetings is poor. The monthly meetings are poorly attended, short and not strategic. It is estimated that the Trust requires 12PAs of medical time and currently allocates only 6 per week.

3.3.4 The Trust's high mortality is often put down as due to a significant number of deaths occurring in hospital that should have been managed in the community. The CCG's own data suggests that this may be questionable but accepts that a combined audit of deaths within 48hrs of admission may be a helpful next step.

3.3.5 Concerns over combined mortality data from the 2 acute sites. There is a perception that despite acute services being on both sites that they run as a hot/cold site and that single site mortality data would be useful.

3.3.6 Clinical concerns triangulate with the ones reflected by staff at the Trust and include;

- ED unable to cope with surge
- Poor senior review of ill patients in a timely fashion
- Despite use of NEWS scores, prioritisation of the severely unwell or deteriorating patient is not adequate
- Deaths due to respiratory infection are still an issue and the recent review was in her view, not acted upon and providing false assurance to the board.
- Lack of ownership of the mortality issue by DMDs and many of their consultants.

3.4 NHS Improvement staff within the Trust

3.4.1 Staff from NHS Improvement, embedded in the Trust, were interviewed.

3.4.2 They reiterated the findings of the CQC and confirmed that the Trust was in special measure for quality

3.4.3 Their concerns were with medical engagement and this had been most apparent in the poor attendance at the mortality review group. This was judged to be symptomatic of a wider lack of medical engagement. This causes limited 'buy-in' from doctors for any changes suggested by the various quality groups and follow through of policies is often difficult to implement

3.4.4 The quality governance committee hasn't yet given assurance to the Trust Board that issues relating to mortality (and other quality issues). The committee has recently been substantially added to with the appointment of a new NED. The committees care is effective but until now lacked support from a strong medical leadership team

3.4.5 Pace of change is generally very slow in the Trust, much is agreed in principle but not implemented.

3.4.6 NHSI is concerned that there is no grip on the significant risks especially in acute care. The recent CQC visits in January 2019 supported this view. The principal reason is that the medical staff are not yet on board. This cross- references with the views of some of the medical leadership who believe that while flow difficulties for patients is an outcome it is working practices within the Trust which need to change.

3.5 Coding staff

3.5.1 The Trust is in a state of transition in validating its coding accuracy. The coders report that notes are often very unclear both in general and specifically in determining 'end of life' diagnosis.

3.5.2 The coding department links in with the mortality review groups and this is resulting in improved coding accuracy.

3.5.3 The coders when reviewing notes have concerns over the number of hospital acquired pneumonias (HAP). We were told by clinicians that coding issues explained somewhat the increased mortality related to sub-cutaneous infections. This was disputed by coders who believe the current coding to be accurate in this diagnostic category.

3.5.4 The ED said the Trust is aware that another consequence of poor flow through the ED is a significant loss of codable income for the first long patient stays in the ED as they are not classed as inpatients.

4 Observations

4.1 Current response to the CQC's various inspections

We asked for the CQC action plan but was told it has been combined into the Trust improvement plan. This is not a usual approach for a trust with an inadequate scoring as the Board and CQC usually want to see the specific action plan and associated evidence. We also know that the Trust has had a 'Well Led' inspection in the last few weeks and are awaiting the outcome.

Front line staff interviewed had a strong sense of what the CQC had highlighted and were clear about what they had to put right. They were also clear that some things were not in their gift 'to sort' as they were dependent on bigger decisions, for example about bed capacity, or decisions at committee or Board level. Staff training compliance has improved but does yet meet the required thresholds in all areas. The CNO has a good grasp of the essentials but this is a whole executive team responsibility and it was not clear who else was monitoring at a senior level.

We also felt that incident reporting and learning from investigations had improved.

4.1.1 In terms of concerns, the CQC patient survey published 20 June 2019, received responses from 544 patients at Worcestershire Acute Hospitals NHS Trust. Two areas stand out: A & E patients scored privacy as worse compared with other trusts and the score for patients being asked to give their views about the quality of their care, during their hospital stay was 1.3/10 and 1.9/10 for being given information about their complaints

4.1.2 Staff training needs rapid improvement. For example, the CQC's finding that 'Safeguarding training was out of date/not completed particularly in children's services and Mental Capacity Act training in Adults services.' This was still being highlighted as a concern in the annual report received by the Board earlier this year. This is of concern when reviewing mortality especially related to vulnerable people.

4.2 The current governance system

We examined a large range of Trust documentation including the BAF, the Corporate Risk Registers, strategies and policies, together with a selection of Integrated performance reports. In reviewing these, we looked for evidence of mortality issues being raised or monitored, and the way in which the Trust then extracted deteriorating performance issues and considered these in the overall context of risk.

4.2.1 Strengths of the current governance system

The current system has been scrutinised repeatedly by NHSI, CQC and other independent organisations, such as Deloitte and the Good Governance Institute. This has provided a wealth of sensible and strategic advice to the Board and senior management, all of whom are thoroughly engaged. There is also a broadly new management team in place, which is providing much needed oversight and direction after a period of considerable turnover, gapping and instability at the higher levels of the Trust. The Board in particular now has some very senior and nationally acknowledged management and clinical expertise amongst the Chair and NEDs, all of which is creating a sense of purpose and drive, and an intolerance for mediocrity and poor performance.

4.2.2 Weaknesses and risks

The BAF is a comprehensive document which deliberately stays at a strategic level in its coverage. It links to the Corporate Risk Register (at least in terms of numeric references) and a broad range of topics are considered. However, it lacks detail. Examples of this that we found included:

- Only passing references to the Urgent Care Improvement Plan but no data on what key objectives were or whether these are being achieved
- No obvious definition of "robust clinical governance"
- No metrics for what constitutes "safe and efficient patient flow"

For a busy NED therefore, it seems hard to extract the right level of appropriate data to allow full scrutiny. We also found it hard to link the wealth of data in the Integrated Performance Reports to the Corporate Risk Register. Elsewhere, the minutes of the various meetings have a tendency to report process rather than reflecting NED challenge or harder edged consideration of risks (although we were reassured during our interview with the Chair that meetings were usually robust and full of challenge).

Our view is that from a wealth of documentation, it was hard to form a picture of what keeps the Board awake at night, and how effectively it was holding executive management to account in mitigating risks and improving quality of care.

4.3 Safeguarding

It is our view that safeguarding practice is a good indicator of ensuring safety of the most vulnerable and therefore gives some useful insights in to the way the Trust equips staff to protect patients.

We found that the Trust sets out a clear declaration on safeguarding as defined by the CQC

4.3.1 Areas of good practice:

Policies were in place and systems of reporting have improved. There is improved assurance to the Trust board. All safeguarding team posts have been filled, providing expertise across the Trust. The Directory of training includes a matrix for all safeguarding levels against roles within the Trust. The supervision policy is very good and sets out a good model of practice and protected time for staff is to be applauded. Flagging on clinical systems is now in place.

4.3.2 Areas for improvement:

The Trust website could be improved to include the safeguarding team in the alphabetical list of services. The safeguarding section is limited and not easy to navigate. The safeguarding policy is in place, but it does need further updates to be more contemporary and have more comprehensive coverage of adult safeguarding issues

4.3.3 Areas of concern

Governance – The annual report 18/19 quotes 'The Trust has moved from 'Limited Assurance to 'Moderate assurance' which is acknowledged as a significant improvement mostly over the last 12 months. Demonstrating the Trust has a grip on what the risks are and where to focus and these are reviewed at the Safeguarding committee which is currently monthly. The Trust needs to move to significant assurance, but we noted BAF risk 2 – "if we are unable to deliver the outcomes of the quality improvement strategy then we may fail to deliver sustained improvements resulting in improvements not being delivered for patient care and reputational damage". The mortality team suggest that this risk is very real not just for safeguarding.

Staff told us that they are concerned about safety and safeguarding in a crowded ED department. There is an opportunity for Trust Directors to see the emergency department through a 'safeguarding lens' which may help focus on improvements for a department that see people at their most vulnerable.

The review of deaths did highlight some patients who had been referred to safeguarding but it was not always clear how this offered more support to the patient themselves, the family and members of staff. The mental capacity assessment appeared to be used, but was not always timely or reviewed. This may be clearer to the Trust clinicians via protected documents. We suggest that there is a deep dive in to both these issues to establish the true picture.

4.4 Development of the medical examiner (ME) role and recommendations.

4.4.1 The medical examiner role and the processes that govern it are in the early stages of development and implementation. There is a lack of breadth of ME appointees across the hospital specialities

4.4.2 There is significant leadership of the programme through a deputy to the CMO, but the intelligence learned from mortality reviews has yet to influence the Trust in understanding avoidable factors that may reduce premature death

4.4.3 Work is still to be done in cooperation with coders on how to develop a consistent and coherent process for end of life decisions and diagnosis.

4.4.4 There are several simultaneous systems in place looking at deaths, while some of this is required by external bodies, there is little integration or learning shared from the various streams.

5 Recommendations

5.1 Recommendations for the Trust Board

The Board should:

- Continue to work on linkages between the BAF and Corporate Risk Register
- Demand more linked reports from TME so that the Integrated Performance Reporting process actively contributes to the assessment of risk by NEDs
- Look for more comprehensive minutes from its various committee meetings, in order to demonstrate challenge and oversight of performance
- Be sighted on the detail of evidence being collected against all the CQC areas for action and the priorities are reflected in the board committees

5.2 General recommendations

5.2.1 CQC improvements need to be fed back to staff in a consistent manner

5.2.2 The CMO and CNO should develop a system of cross reference between the mortality judgement reviews and CQC findings, especially about safe care and learning from serious incidents. This should help further to develop professional curiosity when undertaking any future SJRs and increase learning.

5.2.3 The Trust should develop the learning from deaths process through the use of the structured judgement review tool, an expansion in the capacity to do so is required. This is especially so for a trust with continuing mortality issues.

5.2.4 The backlog of as yet unevaluated deaths (800+) should be processed and adequate resource allocated to do so.

5.2.5 There should be a regular forum to share learning from all specialities investigating deaths in the Trust. The current mortality review group only partially fulfils this role.

5.2.6 The newly appointed medical director must be given high level Board support in seeking to improve engagement with clinicians, and to deal with resistance where it is occurs, in implementing new ways of working. A review of the current divisional clinical leadership is advised.

5.2.7 Safeguarding training compliance has improved but it was very low to begin with and most of it still does not meet the 90% compliance standard (only level 1 children) Medical and dental statistics show that most improvement is still well below the target. We recommend that this continues to be on the risk register and the board scrutinise rigorously. Many of the cases that we reviewed showed elderly vulnerable patients receiving sub-optimal care.

5.2.8 The Trust must ensure all staff receive and complete their required mandatory training, including safeguarding and Mental Capacity Act 2005 training and this should be completed in a timely fashion

5.2.9 The Trust must ensure all medical staff are trained to the required level of safeguarding for both children and adults.

Structured judgement reviews references

https://www.rcplondon.ac.uk/sites/default/files/media/Documents/NMCRR%20clinical%20governance%20guide_1.pdf?token=AS-qWBcA

https://improvementacademy.org/documents/Projects/avoidable_mortality/NMCRR%20data%20collection%20sheet%20England.pdf

https://www.weahsn.net/what-we-do/enhancing-patient-safety/the-deteriorating-patient/structured-mortality-reviews/

Useful National standards documents

https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf

https://www.cqc.org.uk/sites/default/files/20161213-learning-candour-accountability-full-report.pdf

https://improvement.nhs.uk/resources/serious-incident-framework/

https://www.rcplondon.ac.uk/sites/default/files/media/Documents/NMCRR%20clinical%20governance%20guide_1.pdf?token=AS-qWBcA

https://improvementacademy.org/documents/Projects/avoidable_mortality/NMCRR%20data%20collection%20sheet%20England.pdf

https://www.weahsn.net/what-we-do/enhancing-patient-safety/the-deteriorating-patient/structured-mortality-reviews/

Appendices

Appendix A

Worcester Mortality Review Part 2 June – August 2019

Terms of Reference

1 Background

Worcestershire Acute Hospitals NHS Trust is a large district general hospital operating out of 3 main hospital sites in Redditch, Kidderminster and the main site in Worcester. The Trust provides a broad range of predominantly hospital based services. The Trust has in-patient beds at these 3 sites and at Evesham community Hospital which is operated by the Worcestershire Health and Care NHS Trust. The Trust serves a catchment population of approximately 600,000 from a mixed urban and rural community. The Trust has been in quality special measures since December 2015, the Trust has been a national outlier for urgent and emergency care performance, financial performance and has recently been noted to have persistently high mortality rates and remains a national outlier.

As part of the wider quality agenda and to understand in detail the underlying factors causing raised mortality at the Trust, the Trust CEO requested an external review of increased mortality rates and associated internal governance processes. iQ4U has been commissioned by the Trust to complete this review.

The Trust is committed to developing a more rigorous approach to 'learning from deaths', using a specific cohort of cases to test the robustness of the existing review process and to learn any lessons regarding the quality of care to patients. The Trust also welcomes external support to develop internal capacity and capability to undertake timely and effective reviews of all deaths that occur in its hospitals including building capacity and strengthening the role of 'medical examiners'.

The Trust Board is seeking assurances that the care provided to patients is evidence based, safe, effective and high quality or that there are robust systems and processes in place to identify where this is not the case so that any remedial action is taken as required.

The reviewers will undertake detailed reviews of appropriate number of cases, randomly selected from the preceding 2-years and undertake mortality and governance reviews of how deaths are analysed and responded too within the organisation. Current practice will be reviewed, including the processes that trigger a mortality review, and the subsequent report will indicate where improvement in processes and clinical care is required. The review team will have suitable experience both in the analysis of deaths occurring in similar environments and board governance at an NHS trust.

2 Scope

The review is designed to be retrospective and to focus on 150 patients who died whilst in the care of the hospital in 2018/19 randomly selected from the following areas of clinical practice; elderly care; acute medicine; acute surgery; paediatrics and elective care. If the initial cohort gives only limited intelligence 'the consultant' will request a further 75 cases

To assess thematic changes and trends a further randomly selected review of 75 patients who died whilst in the care of the hospital in 2017/18 will also be completed.

3 Methodology

3.1 Mortality Review Process

The objective of the review method is to use the Trust's approach to learning from deaths to identify strengths and weaknesses in the caring process from admission to end of life within the designated specialties. This will provide information about what can be learnt about the systems where care goes well, and identify points where there may be gaps, problems, difficulties or delays in the care process.

The review process will therefore:

- Be both qualitative and quantitative;
- Assess the quality of care and attempt to identify the factors that made care exceptional or deficient to provide learning; and

- Identify and define opportunities/themes for improvement.

The Royal College of Physicians (RCP) assessment tool will be used for the review. The RCP tool has been used by the National Mortality Care Record Review programme in an attempt to standardise the way in which case records of patients who have died are reviewed. The RCP tool uses a Structured Judgement Review (SJR) approach.

The Trust will undertake duty of candour with regard to all cases to be reviewed and inform relatives in advance that the case is being reviewed. It is expected that most if not all families would consent to the review of the death of their relative. Where this consent is not given then data from such cases will be omitted but noted. Where, following the SJR process, cases are identified where care was poor and that avoidable factors were definitely present, families will be invited to discuss the care of their relative with a senior member of clinical staff involved in their case and/or the Trust Chief Medical Officer.

Quality leads from the local CCGs and other key external stakeholders will be interviewed as part of the review process.

All reviews and interviews will be completed by 8th August 2019.

Following which a written report will be produced which will incorporate:

- A summary of the Structured Judgement Reviews and how these relate to the standard "Quality Account" approach (https://improvement.nhs.uk/documents/697/Detailed_requirements_for_quality_report_final.pdf)
- A thematic analysis of the findings of the Structured Judgement Reviews will be provided describing:
    - Areas were care was exceptional;
    - Areas where care could have been improved.

Recommendations for improvement will be reflected in the final report and where necessary during the process of the review when significant and potentially live issues are identified.

3.2 Mortality Governance Review Process

The current quality governance structure in relation to mortality will be reviewed.

A sample of reports and minutes of relevant meetings at all levels of the quality governance structure will be reviewed (including but not exclusive to ED Morbidity & Mortality meeting, governance meetings of Acute Specialist Medicine Directorate, Division of Medicine & Integrated Care, Mortality Committee, Quality Committee and Trust Board)

This element of the review will be completed by 19th August 2019

A written report will be produced which will summarise the effectiveness of the quality governance processes in relation to Mortality for:

- Identification of issues
- Collaboration with CCGs to review post-discharge deaths within 30 days
- Evidence of learning
- Evidence of sharing of learning across the Trust
- Evidence of effective actions taken to address the issues
- Evidence that actions are embedded and sustained
- Reporting at both Divisional and at Organisational level

And will provide:

- Recommendations for improvement
- Where there is evidence of potential negligence or where harm may be repeated the reviewers will immediately inform the medical director or his deputy.

The reviewers will work closely with the senior clinical executive team to ensure that any 'live' issues are escalated within 24-hrs.

4 Stakeholder follow-up

Both reports will be presented at a public Trust Board meeting in September 2019.

Following which a mortality follow-up meeting will be arranged for relevant stakeholders where the findings of both reviews will be presented in late September 2019.

These timescales assume that the review work will commence on 1st July 2019 and that the reviewers are able to access the necessary information to be able to complete all reviews and interviews by 9th August 2019.

Mike Bewick Director iQ4U Consultants Ltd

Dr Graham James, interim CMO

Fleur Blakeman on behalf NHS Improvement

28th June 2019

Part 2
Independent Review of Elevated Mortality at Worcester Acute Hospitals NHS Trust

Commissioned by
Dr Graham James and Mathew Hopkins,
Medical Director and CEO WRH

Authors
Professor Mike Bewick Dr Rebecca Mann
Ms Wendy Cookson Ms Moira Angel
Mr Giles Peel

Date of review
July to August 2019

Terms of Reference
See Appendix A

1. Introduction

1.1 Mortality review at Worcester hospitals.

At the request of the Chief Executive Office and the Medical Director of the Worcester Hospitals NHS Trust in response to concerns over persistently raised hospital mortality rates, an external review was requested. The aims were to understand more fully, though the review process, what factors lay behind the mortality data, and the current governance processes in place to oversee the Trust's response to the service. This would include developing an understanding of the 'learning from deaths' process and the functionality of the 'medical examiner' role. Professor Mike Bewick, director of iQ4U Consultants was engaged to undertake the review with the associates listed above. The results of the report will be fed back to the medical director and once the Trust has formulated its initial response, to the wider stakeholder group, led by the medical director regionally for NHSI/E. The review will use 3 separate processes

- The recognised 'structured judgement reviews of 250 deaths over 2 years at the Trust
- Desktop review of current Board and clinical governance processes
- Structured interviews with key staff from management.

Administration and clinicians as to how the Trust learns from deaths and implements improvement within the organisation.

1.2 Board changes and leadership

The Trust Board has gone through significant senior leadership changes over several years and in particular over the last 18 months. Nationally prominent figures have been appointed as Chair and Non-Executive officers. The new CEO has considerable experience as an executive lead in other similar sized NHS organisation and the new Chief Operating Officer has left a major teaching hospital recently to join the Trust. There is currently in process a handover from an interim medical director to a new long term appointment. The degree of change is significant and a response to the overall financial and operational issues that have persistently affected the Trust for many years.

1.3 Context of recent regulatory findings and commissioning environment

The Trust is currently in 'special measures'. NHSI/E are concerned over the lack of improvement in hospital mortality data and there is considerable pressure on the Trust's leadership to improve. The last full CQC report in 2018 gave the Trust a rating of 'inadequate' with concerns in the 2 domains , 'safe' and 'responsive'. As reported below in section 3 current performance data shows considerable challenge to basic care within the Trust, particularly in acute medicine.

2. Background details of the current concerns of deaths at WRH

2.1 SHMI/HSMR at the Trust 2017/19

2.1.1 Data over the period March 16 until March 19 were available showing the HSMR/SHMI monthly trends. These are reproduced in figures 1 and 2. The Trusts overall mortality is significantly higher than most similar Trusts in England with rates being above 3SD's from the mean of 100 and almost constantly above 110. The most recent headline rates for HSMR and SHMI are 112.5 and 111.6 respectively. Additionally, and by way of illustration, figure 3 shows a typical funnel plot demonstrating the Trusts outlier status in terms of HSMR.

2.1.2 Crude mortality figures show a decline in total deaths as a percentage and these are also presented in figures 1 and 2.

2.1.3 Peaks in death occur during the winter months, consistent with national mortality data. However there have been concerns that deaths in 2 areas have been significantly more than expected and relevant to winter deaths is the preponderance of respiratory infection. The Trust has looked at this in some detail (see below) and it is important to identify that even with a reduction in deaths in the 2 groups of acute bronchitis and pneumonia the Trust would still be an outlier.

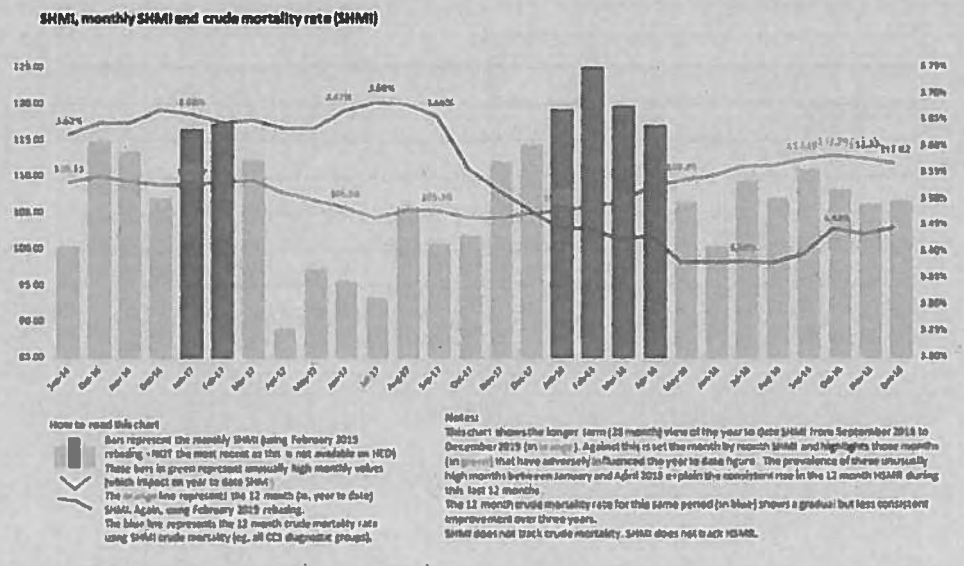


Figure 1 Monthly and rolling average SHMI rates

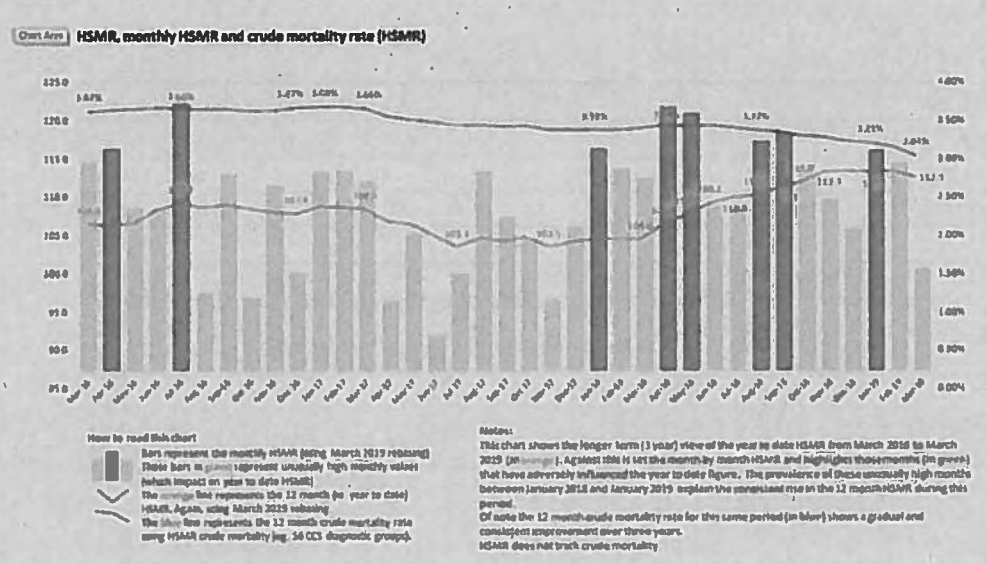


Figure 2 Monthly and rolling average HSMR

2.2 Internal studies on mortality

2.2.1 The Trust's medical director led a review of respiratory deaths in from2017 to July 2018 This was an analysis of a subset of all respiratory deaths coded to acute bronchitis and pneumonia The total approximately 11% of all deaths in the Trust The study identified many of the issues that our own study will record later in the document, but important ones include delays in admission with long waits in the ED prior to specialist assessment, end of life issues not addressed before admission, lack of use of early warning scores to indicate deterioration in a small number of cases The authors did not report any presence of avoidable factors in the deaths of patients, which we find unusual in the light of their reported factor analysis. The author makes some pertinent points on the variation in numbers of deaths across the study period and the lack of variation across the 2 main acute sites. The paper also describes the Trust's HSMR being normal if these 2 respiratory groups are excluded It is highly unlikely that all deaths in these groups could be excluded on purely coding grounds. This would give the Trust Board significant false assurance.

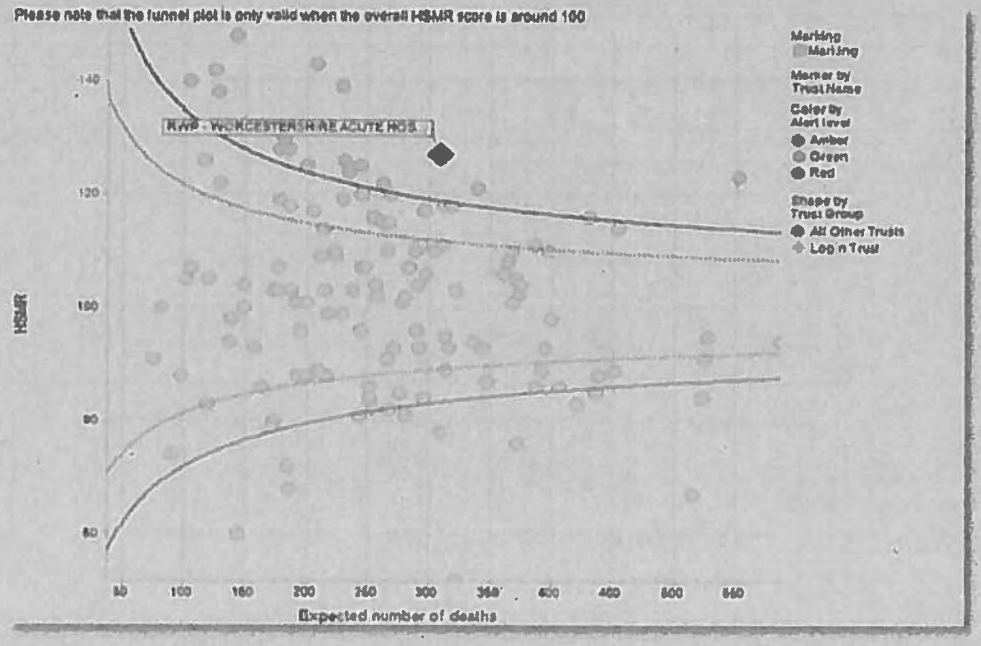


Figure 3 Expected deaths versus actual 2018/19. Worcester highlighted (red diamond)

2.2.2 We were also provided with total deaths per month/ speciality over a 28 month period until March 2019 Sub analysis is difficult where numbers of deaths are low, but when all medical specialties are included (but not critical care or paediatrics) approximately 75% of deaths occur in these medical specialities (3264/4328). Unsurprisingly most of the factors explaining raised mortality will be found in this group. Surgical deaths account for less than 10% of all deaths

2.2.3 Intensive care: we received reports of audits of death from critical care and a further study on mortality related to times of discharge. ICNARC data at both sites report low mortality rates between 0.85 and 0.86. The units are not outliers from similar units nationally. We were also presented with evidence of differential death rates according to time of discharge from critical care. These show a doubling of mortality when patients are discharged during the times 22.00 until 07.00. This is significant and requires further consideration by the Trust.

2.3 Learning from Deaths processes and the Medical examiner role and processes

2.3.1 We have described this in more detail in part 1 of our report. The process is led by the deputy CMO who is the mortality lead for the Trust. He has recruited 5 medical examiners, who each receive 1PA of their time to support the process. They are responsible for death certification, coronial referrals and learning from deaths through analysis of all deaths at the Trust. There is less time for the latter activity and this has led to a backlog of over 800 deaths for review.

2.3.2 As we note in part 1 of our report there are parallel processes in place in specific departments analysing deaths. Some such as those in critical care, neonatology and cardiology, are part of national data sets, others are departmental initiatives such as in the emergency department.

2.3.3 The use of the structured judgement review (SJR) tool of deaths at the Trust, is the principal methodology to capture lessons learned from deaths, The findings are fed back to a monthly mortality review group (MRG) and reported to the quality governance committee (QGC), a sub- committee of the Trust Board.

2.3.4 We were told that the attendance at the monthly MRG was variable but poor. One of the issues is time, but an additional factor may be that all 5 ME's are from the same department (anaesthetics). The mortality lead is attempting to attract doctors from other clinical disciplines to act as ME's to expand and diversify the input

2.3.5 We have seen no significant Board response so far to the findings of the medical examiners, but it is a new and as yet developing service

2.4 Quality governance processes and reporting to the Trust Board

2.4.1 The part 1 of this study reports the governance and reporting systems within the Trust. We emphasise the following which we feel would help in how the Trust can improve its oversight of mortality data and reporting. The Board should be provided with increased and linked management information to enable it to hold executive management to account in a consistent way. Ways to achieve this could include more detailed information in the BAF and greater links between the integrated performance report and risk monitoring. The amount of challenge taking place from NEDs should also be more carefully recorded in the various sets of minutes. Finally, Board members should re-introduce their programme of walk rounds without delay to allow them to form the most accurate picture of what is happening in the Trust.

2.5 Other factors influencing mortality (external)

2.5.1 We have concentrated on deaths in the Trust and the care received from the point of entry into it. Many patients who die in hospital, or shortly after discharge, have complex and often irreversible illness. We have highlighted elsewhere in our work that many patients admitted have irreversible illness and that decisions on whether to admit and what level of intervention is appropriate are often poorly recorded. The recent development of a system wide review of vulnerable patients (the Respect programme) may help address this. Often inadequate information on end of life issues results in extensive investigation and resuscitation which is inappropriate and delays referral to an end of life pathway.

3. Demography and context

3.1

Worcestershire Acute Hospitals NHS Trust provides acute healthcare services to a population of around 580,000 in Worcestershire and the surrounding counties and has a turnover of £400m. It was established in April 2000 and provides a service across five sites: Worcestershire Royal Hospital, Alexandra Hospital; Kidderminster Hospital and Treatment Centre; Evesham Community Hospital; and Malvern Community Hospital. The Trust provides a range of elective, non- elective, surgical, medical, women's, children's, diagnostic and therapeutic services, rehabilitation services, including stroke services and cardiac stenting.

3.2

The Trust's catchment population is both growing and ageing. Both the male and female population show a projected increase by 2025 which is especially apparent in the 75-79 age range, although proportionally the projected rise in the 90-plus age range is higher. The forecast increase in numbers of older people is due to increased life expectancy resulting in greater numbers of older people, particularly females, surviving to very old age (ONS, 2010). From national statistical data, 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. Worcestershire has proportionally a greater number of resident older people than the nation in general.

3.3

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

3.4

In 2018, the Trust cared for 231,448 (40% of the Worcester population). This is broken down into:

- 156,160 A&E attendances
- 152,712 inpatients
- 641,486 outpatients
- 5,261 births

3.5

In late October 2015, the obstetric and neonatal services were deemed no longer sustainable at Alexandra Hospital and in November 2015 these services were centralised at Worcestershire Royal Hospital. In September 2016, the paediatric inpatient service was centralised on the Worcestershire Royal Hospital site.

3.6

The Trust employs 5,283 staff; 324 doctors, 283 consultants, 1,464 nursing staff, 364 AHPs, 253 midwives/ midwifery support workers and 2,595 other staff (March 2019).

3.7

All staff turnover was 12.42%, vacancies 12.15%, sickness absence 4.27% - all worsening position - Consultant appraisal rate was 89%, and job planning to 93% (May figures, July 2019 Board papers)

3.8

Performance for May 2019, for the 95% 4 hour standard was 77.28% (95%), with large numbers of patients waiting longer that 12 hours from decision to admit (51 more patients than in April). Also 781 patients spent time on the corridor in April and the average time spent on the corridor is around 274 minutes. Other key performance metrics were 2ww (all) 82.27% (93%), 62 day (all) 72.92% (75%) and DM01 7.26% (99%) (July 2019 Board papers).

3.9

The Trust is part of the Herefordshire and Worcestershire STP and covers 800 population. It is the largest acute provider in the STP foot print. Other organisations in the STP include:

- Worcestershire County Council
- Redditch and Bromsgrove CCG NHS
- South Worcestershire CCG NHS
- Wyre Forest CCG NHS
- Worcestershire Health and Care NHS Trust *(the main provider of community, specialist primary care and mental health services)*
- 4 Primary Care Collaborations
- Herefordshire Council
- Herefordshire CCG NHS
- Wye Valley NHS Trust *(part of the Foundation Group offering community and hospital care including an ED)*
- 2gether NHS Foundation Trust *(provides specialist mental health and learning disability services to the people of Gloucestershire and Herefordshire)*
- Taurus GP Federation

3.10

The other acute provider is Wye Valley NHS Trust, which provides healthcare services at Hereford County Hospital in the city of Hereford, along with a number of community services for Herefordshire and its borders. It is the smallest rural District General Hospital in England, with an annual turnover of around £180 million, with a workforce of around 3,000, serving a population of 180,000.

4. Design of the mortality review

4.1 Study periods and comparisons

4.1.1 We compared data from 2 cohorts. 150 deaths from the year 18/19 and 75 from the previous year. These were randomly chosen.

4.2 Use of standardised investigation tool, SJR, evidence and prior experience

4.2.1 A standardised template was used that included:

- Patient Demographics / background data
- A description of the patient's clinical course

4.2.2 Evaluation used the following domains when assessing quality of care:

- Admission and Initial Management
- Ongoing care
- Care during a procedure (if applicable)
- Perioperative care (if applicable)
- End of life care
- Overall care and evaluation of medical record

The care was graded for each domain as:

- Very poor
- Poor
- Adequate § Good
- Excellent

4.2.3 An assessment of avoidable factors of death using the criteria below with associated descriptors for guidance:

1 = Definitely avoidable factors present

2 = Strong suggestion of avoidable factors

3 = Probable presence of avoidable factors

4 = Slight possibility of avoidable factors

5 = No evidence of avoidable factors

4.3 Investigators and benchmarking

4.3.1 The cases were analyzed by MB and RJM with additional comments from WC and MA. There are few accepted benchmarks for mortality studies in the literature, but based on our own and published data we are able to compare the Trust's data with those from similar Trusts in the UK. The team agreed at the beginning of the case review process criteria and assessments standards and we constantly look to the commentary and assessments given to ensure consistency

4.4 Limits to current review

4.4.1 This is a modest cohort from across many specialities. It will be possible to look at sub analysis but as the numbers become smaller, thematic generalisation will be less valuable. The data produced gives pointers to areas of concern in both the care given and on factors that may influence mortality. Equally valid are the qualitative data produce indicating areas of concern and good practice.

5. Findings of the analytical component of the review

The study findings are summarised in appendices B and C. We also reviewed 20 serious incident reviews to triangulate how the Trust utilises this process in its quality improvement processes. These are described in Appendix D.

5.1

Descriptive statistics: these are described in appendices B and C. Highlights are the low incidence of avoidable factors, less than for national benchmarked practice in the UK, and an overall high level of care with 96% of patients receiving adequate of above ratings. This is not sustained over all domains and in particular ongoing care is significantly lower. This reflects on some of the key areas of concern in late diagnosis during prolonged stays of care and long waits for admission and assessment.

5.2 Comparative statistics

5.2.1 220 cases have been reviewed across 2 separate time periods. The data shows good comparability of baseline demographic details, with the possible exception that the deaths were more clustered in the winter months in the earlier cohort. This may represent a random sampling error or may be consistent with recent data suggesting across the NHS that winter pressures are now "year-round".

5.2.2 The data also suggest that the length of stay of patients who died has increased. This does merit further review, and specifically it would be important to see whether average length of stay for all patients cared for within the Trust are increasing or decreasing with time.

5.2.3 SJR scores are remarkably consistent across the two time periods, and avoidability scores fit well within the reported range of up to 10% of cases having some evidence of avoidability.

5.3

Qualitative data .Specific areas that were identified included:

5.3.1 Length of wait in ED: 41% of the patients who died in ED were present in the department for more than 4 hours. On average, these patients spent more than 12 hours in ED before they died, many receiving care in the corridors. The efforts of ED staff to minimise the effects of this were notable, with good documentation of care and comfort rounds and some patients being moved onto beds and into side rooms before they died. Even when reviewing the notes of patients who were admitted via ED and ultimately died later during their inpatient stay the assessors were struck by the length of time patients spent in ED, most often awaiting inpatient bed availability. It was common for patients to be admitted via ED even early in the daytime and stay there overnight before admission to the wards, even when they were close to the end of their lives.

5.3.2 The prolonged stays in ED have clearly contributed to excessive workload on the ED staff who delivered a high standard of care. Some of the scanned patient notes from a single ED admission totaled nearly 100 pages of scanned records. The remit and role of the ED nursing and medical staff is hugely extended by the difficulties the Trust faces in passage of patients through the system.

5.3.3 The assessors were struck by the approaches to nutrition and NGT feeding in particular, which seemed wide ranging. In some cases it seemed that patients suffered poor intake for prolonged periods and were in a poor nutritional status before NGT feeding was considered. In other cases patients were made nil by mouth early in their stay, NGT feeding was commenced early but often with difficulty and repeated NGT passage / difficulty confirming site of the tube, before later being removed to "feed at risk". In one case a patient who was receiving End of Life care had her last rites read to her by her family priest and an NGT passed (unsuccessfully) 2hours later. The approach to nutrition and feeding seemed non uniform and merits further review.

5.3.4 The input from PAMs in general was excellent and responsive, with frequent and prompt input from physiotherapists, OTs, SAL therapists and dieticians.

5.3.5 The input from pharmacists was of high quality and they identified a number required prescribing changes, spotted abnormal blood test results and advised effectively on issues relating to drug and medicines safety.

5.3.6 The palliative care teams was used frequently, but sometimes when it seemed that end of life was very near and when it was difficult to see what sort of specialist advice might be required. Likewise the critical outreach team seemed to offer flexible additional support in an effective manner.

5.3.7 The quality of care offered within ED services was highly rated with 86% of all scores being good or excellent, and only 1 case with a score less than 6 with regard to avoidability. After transfer out of ED, some patients seemed prone to a number of early ward relocations with a significant minority occurring in the middle of the night.

5.3.8 There were no features of concern, in general, noted with regard to patients under the care of the surgical teams.

5.3.9 There seemed to be variable input from the adult medical teams, with some Consultants clearly demonstrating regular ward reviews of high quality. In other cases there were difficulties getting specialist medical opinions and some delays in inpatient investigations such as echocardiography and some imaging.

5.3.10 Particularly after the acute phase of care the overall strategic oversight about an individual's care seemed to lose focus. Often medical patient reviews were led by trainees who generated a daily jobs list without any real over riding-strategy for care.

5.3.11 Medical input out of hours and particularly at weekends was at best variable and at times poor, with some patients not being reviewed for days on end, for example over Bank Holiday weekends, even when review was specifically requested.

5.3.12 There were almost no cases where sick patients were escalated on an emergency basis to Consultant physicians, either within hours or out of hours. Consultant reviews would occur at the routine ward rounds but in between decisions about patient care were led and implemented by trainees and PAMs There were a number of documented cases where care was delayed because of the workload of junior doctors

5.3.13 Standards of nursing care and documentation were in general good to excellent, although on occasion handwriting was illegible.

5.3.14 There were numerous examples of patients where discharge was delayed – initially through slow passage through the inpatient system, but latterly through delayed discharge planning and delays whilst awaiting discharge placements. A number of patients deteriorated after being stuck in Hospital a number of days after being declared "medically fit for discharge". The fast track discharge system was not always fast enough.

6. Feedback from staff on mortality at the Trust

Appendix E lists the staff interviewed for both parts of the review.

6.1 Medical staff including ME's

6.1.1 We interviewed staff from across the Trust, most based at WRH, but not exclusively. All were consultants and most had worked in the Trust for several years and all had chosen to work there. The interviewees covered the following specialities;

- Emergency department medicine
- Acute medicine
- Intensive care
- Respiratory medicine
- Cardiology
- Elderly care medicine
- Gynaecology
- General surgery
- Colorectal surgery
- Maxillo-facial surgery
- Anaesthetics (medical examiner)
- Heads of clinical directorates

6.1.2 Throughout the interviews, while there was some conflicting views on the causes of increased mortality at the Trust certain common themes were reported. These were

- An intolerable level of wait in the ED and AMU with patients being left on trolleys for a median of 520 minutes spent in the ED. Many for up to24hrs
- Lack of senior medical assessment in the ED and AMU
- Multiple 'hand offs' and patients being transferred from ward to ward frequently.
- Lack of clinical ownership and purposeful medicine in the management of patients not on a defined treatment pathway.
- In medicine a lack of oversight and leadership of the acute pathway.
- Delayed transfers home and resultant risk of iatrogenic disease
- Late implementation of EOL programmes.
- Delayed decision making on DNACPR and palliative care involvement.
- While there was a recognition that the flow in the hospitals is a major cause for concern, simply broadening the bed base was counterproductive as there was no change in clinical practice, which all deemed more important
- Concerns over safeguarding of frail elderly patients.
- Gross deficit in the number of generalists in the Trust.
- An acceptance that things cannot stay the same and some confident the current management seemed to be more involved an hopefully will turn things around

6.1.3 There is a view amongst some speciality doctors that their role is to respond to the needs of their individual speciality as their principal response when a patient is internally referred to them. This role while important is not helpful and, in the view of the ED and acute medicine doctors, somewhat restrictive as patients with complex multi-system disease require continuity by a single responsible clinician or team, rather than several disease specific specialists.

6.1.4 There is a tendency for some specialities to merely wish for more of what they do now rather than considering how the deployment of staff in a less traditional way would improve flow and manage demand.

6.2 Nursing staff

6.2.1 We interviewed the CNO and her deputy for quality. Both were candid about their concerns over the lack pace of improvement in the Trust understanding of mortality issues. This was in contrast to the p ogress made at both acute sites in the 'harm reduction' programme. The following is a list of their concerns and areas for development

- The introduction of the ME role was slow and has only been partially achieved
- The outputs from the QGC hasn't hastened the required changes to the learning from deaths data. This is partially as a result of an only rudimentary and incomplete learning from deaths process.
- Clinical concerns over the supervision of patients in ED, and their long waits there. Safeguarding concerns while on trolleys
- Senior oversight of patients by consultants is variable and at times of high demand in ED the back of house response is limited.
- Poor decision making on discharging patients and a lack of pace once a decision has been made.
- Medical engagement in general when confronting the flow and mortality issues is poor.
- Late decisions on end of life pathways which could be foreseen earlier and place of death more fully discussed. Recognised a wider training need across the Trust and also in the wider GP community. The Respect programme should help.
- Junior doctors are busy and often overstretched, this resulted in complaints of 'bullying' from nurses on the wards.
- Serious incident reporting is good, and has identified areas where care could have been better and relevant to the mortality issue. Several SI's have illustrated late or mis-diagnosis, delays in transfer and communication issues within the Trust
- Improvements have been seen in adult safeguarding and nursing record quality and the new ward accreditation system for safe care.
- Current Board is getting a grip on quality an the NED's have become more involved.
- Workforce is still a concern as high churn and low fill rates in elderly care and acute medicine posts as well as some acute wards for nursing

6.3 Ward and emergency department staff

6.3.1 Three members of the team spent several hours in the ED and AMU at WRH both during the evening period and the following morning. We interviewed consultants in emergency and acute medicine, nurses and other clinical staff working in the acute environment. The follow ng is a summary of our findings:

6.3.2 The ED is structured logically but has capacity issues with 2 corridors being used as proxy wards on most days.

6.3.3 Waits within the department are long and a recent audit showed a median time of 520 minutes

6.3.4 There is a lack of space for speciality assessment areas. The focus for care and outcomes is directed at ED staff when the issues lie with the specialties whom have taken over the patient care. This issue is a significant risk to ED staff as they are looking after in the main medical patients without the appropriate skill set. There was also a view that other specialities are not being held to account by Executive team for the care of patients in the ED.

6.3.5 The recently appointed CEO was clearly concerned at the lack of space and shocked on a visit to ED about patients cared for in resus corridor.

6.3.6 Operational solution to overcrowding in the ED has been to open the ICU corridor which worsens the problem for an overstretched ED and does not resolve the cause. The COO has been written to by the ED lead about the unsafe and inappropriate nature of this action.

6.3.7 The observed handover was patient and staff centric. At 8 am 6 patients in the resus corridor which was seen as a 'good morning'. They fight normalising the position of overcrowding. 2 patients died in the ED overnight. One a resus call, the other was a patient at the end of life.

6.3.8 Mortality reviews for deaths in ED undertaken using CEPOD framework. The learning taken from these ED cases is minimal within the wider Trust, and dealt with internally (we saw general learning disseminated at the 8am handover). They have no assurance that learning for other specialties, although fed upwards, makes a difference to patient outcomes, or feeds into their respective governance functions.

6.3.9 There is a general frustration that they receive patients who are obviously coming rapidly to the end of life and the ED/AMU isn't an appropriate place to die. Illustrating this during the overnight period between our visits there was a death in the department of a patient at the end of their life.

6.3.10 Illustrating the prolonged waits of patients admitted to the ED we followed an elderly patient's pathway, who arrived in the department at 19.32 and was still awaiting a bed at 09.00 the following morning.

6.3.11 Senior nursing opinion was that the current system is discouraging applications within the ED as nurses do not wish to regularly look after patients outside of their normal skill set.

6.4

External (CCG); we interviewed the Clinical lead for mortality, Dr Clare Medley. She attends the monthly mortality meetings and also the combined quarterly joint meetings between secondary and primary care mortality groups. She has had personal experience of being treated within the Trust as an acutely ill patient and is personally aware of the challenges in the acute pathway. She reported

6.4.1 The current acting CMO and mortality lead have improved the process of mortality reviews and raised it up the hospital agenda.

6.4.2 There is less buy in and ownership of the issue by consultants and middle-management

6.4.3 The medical examiner system is under resourced and governance of meetings is poor. The monthly meetings are poorly attended, short and not strategic. It is estimated that the Trust requires 12Pa's and currently allocates only 6 per week.

6.4.4 The Trust's high mortality is often put down as due to a significant number of deaths occurring in hospital that should have been managed in the community. The CCG's own data suggests that this may be questionable but accepts that a combined audit of deaths within 48hrs of admission may be a helpful next step.

6.4.5 Concerns over combined mortality data from the 2 acute sites. There is a perception that despite acute services being on both sites that they run as a hot/cold site and that single site mortality data would be useful.

6.4.6 Clinical concerns triangulate with the ones reflected by staff at the Trust and include:

- ED unable to cope with surge
- Lack of senior review of patients in a timely fashion
- Inadequate prioritisation of the severely unwell or deteriorating patient is not adequate, despite use of NEWS scores
- Deaths due to respiratory infection are still an issue and the recent review was, in her view, not acted upon and gave false reassurance to the Board.
- Lack of ownership of the mortality issue by DMDs and consultant body as a whole.

6.5 Senior management

6.5.1 We interviewed the Chief Operating Officer. PB discussed the patient flow issue, he felt it was largely internally generated, often caused by "non-pathway patients" and this cohort contained many elderly and frail patients.

6.5.2 He had decided early on in his tenure that the bed base was too low and he opened up 80 extra beds. This has reduced outliers significantly (from a max of 40 down to 'teens').

6.5.3 The issues aren't resolved yet and there needs to be significant addition to the service at consultant level in acute medicine and elderly care.

6.5.4 He accepted that the other usual reasons for pathway problems including referral of terminally ill patients from elsewhere was not a major issue here.

6.5.5 Also the entry point to admission isn't rigorous and the bar set too low. His experience in Oxford in combining front of house acute clinicians from medicine and GPs, worked at reducing avoidable admissions through a more effective ambulatory assessment service.

6.5.6 He noted that local social care was good and that discharge should not be a problem. Delays were mainly as a result of delays in clinical decision making and hinted that clinicians were 'playing it safe'. The 'Home First' initiative should help focus and increase earlier or enhanced discharge.

6.5.7 Support staff including coders, bereavement officers and complaints

- Coding: the Trust is in a state of transition in validating its coding accuracy. The notes are often very unclear determining explicitly 'end of life' diagnosis. The coding department is linking in with the mortality groups and this is resulting in improved coding accuracy. The coders when reviewing notes have concerns over the number of hospital acquired pneumonias (HAP). We were told by clinicians that coding issues explained somewhat the increased mortality related to 'sub-cutaneous infections'. This was disputed by coders who believe the current coding to be accurate in this diagnostic category.

6.5.8 Bereavement office staff and managers NED's

- At both main sites there is an effective process supporting families who have suffered a family death. The Trust's doctors and the medical examiners in particular are responsive and it is rare for delays in certification of death or reporting to the coroner. This is very time consuming for the ME's and with their limited time available for other work, learning from death reviews have fallen behind.
- Interview with the chair of the clinical quality committee, who had been a NED for over 3-years was that the Trust was heading in the right direction but in his view there was still a gap between the reality of their situation in terms of mortality and the processes in place to understand the complexity of the issue. The problem is recognised but there has been no real progress in sorting the problem out. While nurse engagement on quality has been consistent this isn't true of the medical leadership or other staff in the improving outcomes for 'mortality and morbidity. Much of this was down, in his view, to lack of focus on the underlying issues and poor engagement with doctors to address the mortality issue. There is also a difference of cultures between the 2 main sites. He does see changes since the arrival of the new senior management team and is hopeful that when the new medical director is in post the situation will improve. He gave support the findings of the coders and believes there are significant clinical issues to be addressed in the groups: pneumonia/acute bronchitis/skin infection and heart failure. Concerns over flow and in particular the relationships between emergency medicine and the response of speciality and general physicians is a major challenge.
- Medical examiners (ME's)

6.5.8..1 There are currently 5 ME's, all anaesthetists.

6.5.8..2 Monthly meetings are scheduled but attendance is poor.

6.5.8..3 The SJR process isn't linked to other governance systems well and especially the 'M&M' process and meetings. People still work in silos. SJR's are done but tend to be 'cherry picked' and not comprehensive view of deaths.

6.5.8..4 The Trust is moving forward with better leadership, but there is still some disconnect across the various specialities and directorates.

6.5.8..5 Future plans for a App to recorded deaths and organise the data more effectively.

6.5.8..6 Flow and lack of an ability to decrease trolley waits and transfer from the ED is seen as major problem.

7. Concerns and good practice found by the review team

7.1 Commendable processes and practice

7.1.1 Fractured neck of femur

7.1.2 Harm reviews

7.1.3 Sepsis 6 training

7.1.4 ITU performance and death rates

7.2 Areas of concern and requiring improvement

7.2.1 The current ME system is under significant pressure due to lack of capacity. There is a backlog of cases of approximately half the annual deaths at the Trust.

7.2.2 Our assessors had significant concern with regards to nutrition and hydration in many of the cases studied.

7.2.3 Prolonged lengths of stay are in our view linked to the higher rates of mortality.

7.2.4 It is often unclear who is accountable and leading the care of patients as often the patient is moved from one team to another and often on a variety of wards

7.2.5 The lack of pace in improving the flow of patients out of the emergency department and the precarious position that they are put in, while remaining in the department while requiring 'specialist' care

7.2.6 Lack of recognition of end of life care and late referral to palliative care. There is poor co-ordination between community and the Trust when decisions have already been agreed on DNRCPR and limited interventions and place of death.

7.3 Generalisable and specific concerns where risk should be escalated to the Trust Board

7.3.1 We didn't recognise any specific cases that required escalation and the general risks are already known to the Trust Board.

8. Conclusions and recommendations

8.1 Summary

The review team have evaluated over 225 deaths at the Trust. Most of the deaths were due to irreversible disease and outside the limits of current medicine to meaningfully change the outcome. Contrary to other reviews, we have undertaken, the frequency of avoidable factors in our analysis is low. This reflects well on the staff caring for what is largely elderly frail population. It is also the basis of a conundrum, as mortality by both the HSMR and SHMI data are persistently high. We have interviewed senior clinicians and support staff in coding and our view is that coding alone cannot explain the high mortality rates. We don't agree that the lack of avoidable factors amounts to a situation crudely described as 'nothing to see here, move on'.

Our opinion is that the explanation lies not in the level of care given during the patients time in the Trust, more a conflation of several factors leading to increased risk of death within the organisation. It is obvious to anyone visiting the WRH site in particular, that the emergency pathway is compromised. Waiting times in the ED are significantly longer than most, and often patients become 'boarders' on trolleys receiving specialist care at a distance or virtually for many hours. Senior decision making is compromised at this handover and perversely post-take ward rounds can include patients still on corridors in the ED. This is unacceptable and must in ours, and many of your staffs, view put the patient at risk of late diagnosis and harm. The next significant issue is the relationship between speciality doctors, emergency and acute physicians. The majority of deaths occur in elderly, generally frail patients with multi-system disease. Speciality doctors provide timely opinion and when a specific disease predominates care is assumed by the speciality. These patients are less common as often patients have several different specialities inputting but not taking over care. Patients are often handed on and there is no consultant responsible for the pathway overall. This role could be fulfilled by elderly care doctors, but these are the least represented in the Trust. This results in distributed care not focused around the holistic needs of the patient. At present there is goodwill from all to work more closely together but no compelling plan as to how.

Other conflating factors include very poor notes and summaries of handovers, there are exceptions to this, but when studying the notes its often not obvious when a new clinical problem arose and what the evidence was as a basis for the new diagnosis. Examples would be the acquiring of a hospital pneumonia or acute kidney injury. When analysing the notes it is often obvious that deterioration was taking place, from reported physiological data or through a NEWS alert, but responses can be slow and actions delayed. In some cases we found evidence of poor care in terms of hydration and nutrition. This is compounded when patients are moved to non-medical wards, where nursing expertise and skills are different.

A further factor is the late realisation of a patients capacity to recover. End of life issues are difficult but in the authors experience the Trust is poor at recognising such situations. Examples would include patients with renal impairment who develop sepsis and heart failure where the prognosis is very poor but acceptance of this is delayed and the patient undergoes several interventions, when acceptance of the inevitable would be clinically appropriate. In our view this is due to lack of senior consultant input.

We also had concerns over the documentation of do not resuscitate agreements. We found a lack of consistency in the DNACPR paperwork. There were incomplete and out of date forms, and in a few cases no form could be found where CPR did not take place.

We heard from the CCG representative that there were concerns that the raised mortality statistics would be apportioned to inadequate care outside of hospital and the lack of shared information on end of life issues. From our own work elsewhere and from other national data, many admissions are previously known as in the last few weeks of life, but this information often isn't shared with those in a decision making position once a call out has been received.

The Trust has invested in supporting senior clinical input into the learning from deaths process and medical examiner role. This, while laudable, isn't currently enabling a comprehensive service. Quite correctly the ME focuses on supporting families recently bereaved and their junior doctor colleagues in the registration of death process. The study of factors surrounding deaths, while still in development, is not yet fit for purpose. This results in only 50%, at best, of deaths being analysed and the learning from deaths intelligence being communicated. There are also parallel systems in other departments and no cohesive description of how the various mortality review date is communicated and acted upon.

The two areas that have been highlighted from mortality data are deaths from respiratory infection and skin sepsis require comment. The Board received a paper on deaths from acute bronchitis and pneumonia. In the view of the investigators, the Trust's coders and the CCG clinical lead, these deaths cannot be discounted due to a coding issue. While many deaths are in patients with acute respiratory infections are compromised by underlying complex illness, not all of these cases have irreversible illness. Additionally there are frequent cases of hospital acquired pneumonia occurring after 72hrs of admission. We noticed delayed diagnosis in many cases, reflected in the scores for avoidable factors in such cases. Skin sepsis is less common, but the investigators do not believe that the Trust can be complacent and accept the explanation that such cases are explained by coding issues (we heard this from several sources). Nursing and coding expertise believe this to be a real area of concern.

Finally we heard from those directly involved in acute care, and senior clinicians who observe it, that the admissions process of medical patients, is poorly delivered. While there was an issue in the number of beds available for acute care, since these were expanded, there has been an reduction in the number of medical outliers, there has been no improvement in the timeliness of admission. The opinion is that there is inadequate organisational leadership of the acute medical pathway.

8.2 Recommendations

8.2.1 That the Trust Board improves its oversight of the mortality review processes. This is described more fully in part 1 of our report.

8.2.2 An expansion of the medical examiner role with recruitment of a broader skill base reflecting the Trust's range of expertise.

8.2.3 The newly appointed medical director should review the current reporting across the Trust of the various mortality review processes, unifying the process of reporting lessons learned.

8.2.4 Develop closer working relationships between the SJR and serious incident reporting, again to refine the reporting of lessons learned.

8.2.5 A review of the current understanding of clinical engagement in the medical division and how improvements can be achieved in supporting the acute pathway and reducing admission waiting times and timely medical opinion.

8.2.6 Additionally practise which delay either decisions to discharge or to implement an 'end of life' pathway needs to be challenged by the new clinical leadership.

8.2.7 A review of the documentation of do not resuscitate for consistency and completeness.

8.2.8 An improved care plan to focus on basic support including hydration and nutrition.

8.2.9 When visualised electronically the current notes are often illegible and disorganised. In the acute situation, those seeking information quickly, will often be frustrated at the time taken to retrieve often critical information. The IT system needs radical upgrading or replacement in the medium term

8.3 Next steps.

8.3.1 To comment on and discuss the findings of our report prior to the Trust Board meeting on the 12th September.

8.3.2 To develop a plan to improve medical engagement and to agree new working practices in the acute medical pathways. Consensus is preferred but not an absolute as the current situation isn't unsustainable.

8.3.3 Our review only surveyed 10% of recent deaths, the Trust requires assurance that any avoidable factors in deaths are fully appreciated The medical examiner role needs urgent expansion and support. The backlog of mortality reviews, currently over 800, needs to be assessed clearing the way for a more sustainable process in the future.

8.3.4 Discussion with stakeholders to establish priorities for end of life acre and how the new Respect initiative will reduce inappropriate deaths in hospital

Professor Mike Bewick and associates iQ4U Consultants Ltd

20th August 2019

Appendices

Appendix B

SJR review of deaths 2018/19

Introduction

Case note reviews were undertaken on 200 deaths occurring during two time periods: 150 cases from April 2018-March 2019 inclusive and a baseline period April 2017-2018 comprising 50 cases. Cases were reviewed using the RCPCH SJR tool, reviewed by 4 assessors with medical and nursing backgrounds.

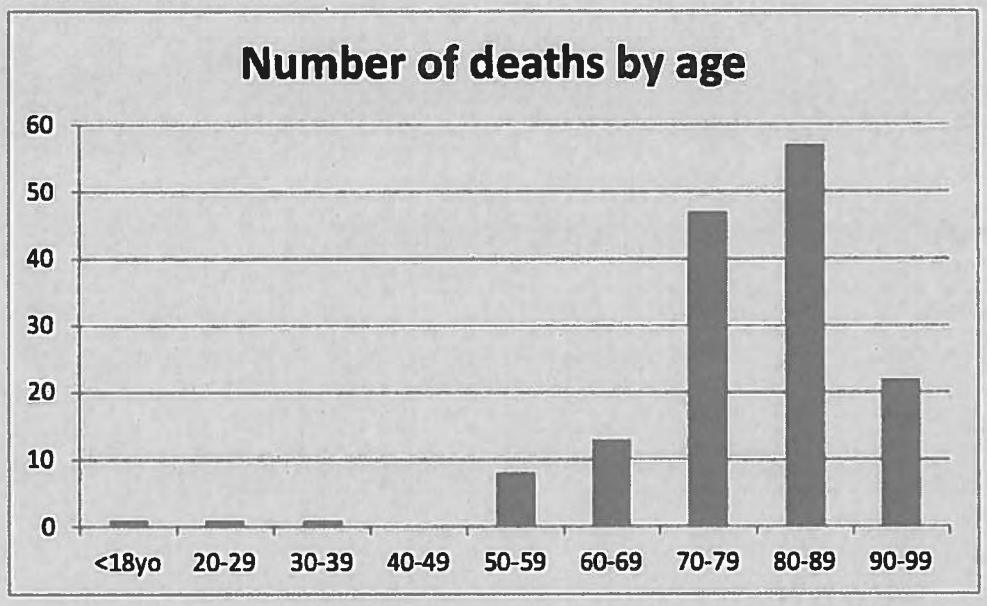
The cases were randomly selected by the IT department and supplied to reviewers by the Trust's mortality team. Assessors had access to patient notes via EZ notes and Patient First records.

Results: 2018/19

The demographics of the cases reviewed are as follows:

- M:F 75.75 / 50:50
- Age distribution: the distribution of age of death fits with the National average / is marginally above average.

Redacted (section 40(2) and 40(3)(a)(i) of the FOI Act (data protection)



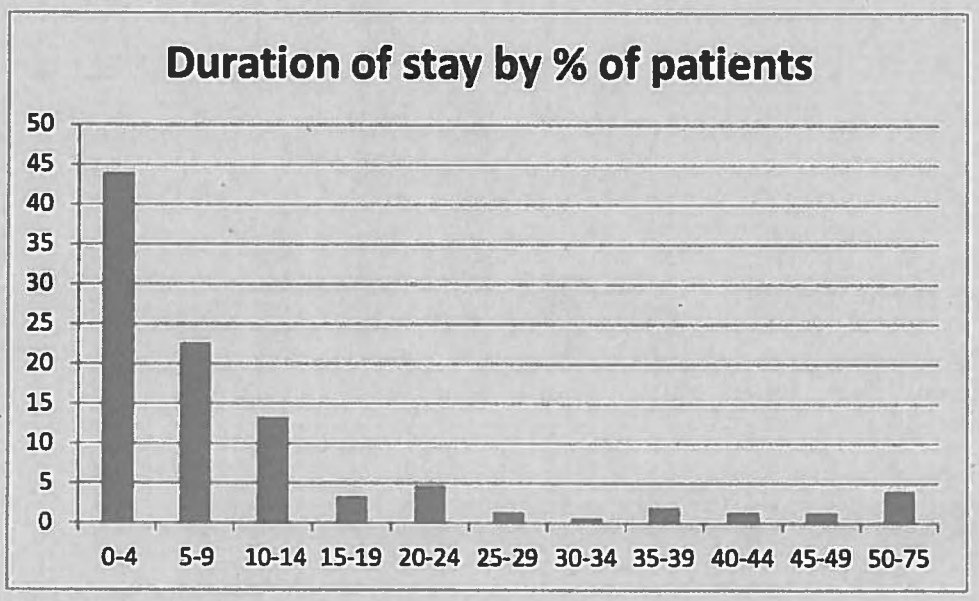
The distribution across sites was broadly representative of workload with an approximate 2:1 split.

Site	N (%)
Alex ED	
RWH ED	
Alex	
RWH	
Wyre Forest	

Redacted (section 40(2) and 40(3)(a)(i) of the FOI Act (data protection)

Dates of death were evenly distributed across the year, and in line with recent National data showed a flattening out of excess workload / deaths over the winter months.

Duration of stay before death was highly variable but the majority of patients had a LOS less than 5 days. Of those who were in Hospital for less than 5 days, 24 were inpatients for less than a day, an additional 23 were alive for up to 4 days after admission i.e.



SJR scores:

SJR scores were assessed according to

- Admission / initial management
- Ongoing care
- Procedural care
- Perioperative care
- End of life
- Overall care and evaluation of records

Each domain is assessed according to the following scores:

Score	1	2	3	4	5
Definition	Very poor	Poor	Adequate	Good	Excellent
% allocated	0%	4%	17%	51%	28%

The overall scores allocated to patient care were reassuring with only 96% of all scores being adequate, good or excellent. These data compare favorably to published data

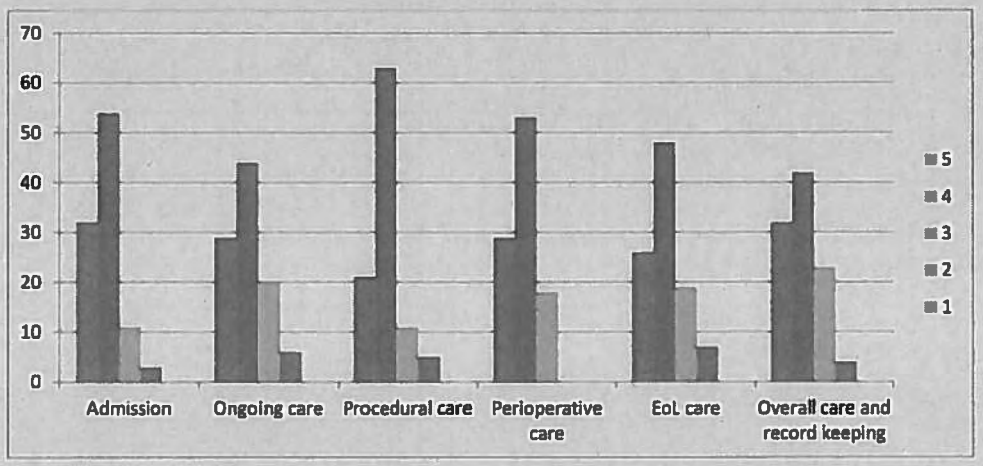


Figure 1: SJR scores by domain

In tabular form the data suggest strong clinical performance with regard to initial assessment and admission (86% good or excellent) but a dip in ongoing care with 73% rated good or excellent and 6% as being poor.

	5 (%)	4 (%)	3 (%)	2 (%)	1(%)
Admission	32	54	11	3	0
Ongoing care	29	44	20	6	0
Procedural care	21	63	11	5	0
Perioperative care	29	53	18	0	0
EoL care	26	48	19	7	0
Overall care and record keeping	32	42	23	4	0

The total number of patients scored for procedural care and peri-operative care were 38 and 17 respectively, no significant concerns about these aspects of care were identified and they will not be discussed further particularly as case numbers are low.

This data fits well with the patient case summaries, where assessors felt that often the initial clinical assessment and management was strong, but that very significant delays at many stages of the patient pathway made it difficult to grade care highly even when key treatment points, for example with regard to sepsis 6, were met Specific areas that were identified included:

a) Length of wait in ED 41% of the patients who died in ED were present in the department for more than 4hours On average, these patients spent more than 12 hours in ED before they died, many receiving care in the corridors The efforts of ED staff to minimise the effects of this were notable, with good documentation of care and comfort rounds and some patients being moved onto beds and into side rooms before they died Even when reviewing the notes of patients who were admitted via ED and ultimately died later during their inpatient stay the assessors were struck by the length of time patients spent in ED, most often awaiting inpatient bed availability It was common for patients to be admitted via ED even early in the daytime and stay there overnight before admission to the wards, even when they were close to the end of their lives

b) The prolonged stays in ED have clearly contributed to excessive workload on the ED staff who delivered a high standard of care Some of the scanned First patient notes from a single ED admission were nearly 100 pages of scanned records. The remit and role of the ED nursing and medical staff is hugely extended by the difficulties the Hospital faces in passage of patients through the system.

c) The assessors were struck by the approaches to nutrition to feeding and NGT feeding in particular, which seemed wide ranging. In some cases it seemed that patients suffered poor intake for prolonged periods and were in a poor nutritional status before NGT feeding was considered. In other cases patients were made nil by mouth early in their stay, NGT feeding was commenced early but often with difficulty and repeated NGT passage / difficulty confirming site of the tube, before later being removed to "feed at risk". [redacted] The approach to nutrition and feeding seemed non uniform and might merit further review

Redacted (section 40(2) and 40(3)(a)(i) of the FOI Act (data protection)

d) The input from PAMs in general was excellent and responsive, with frequent and prompt input from physiotherapists, OTs, SAL therapists and dieticians.

e) The input from pharmacists was of high quality and they identified a number required prescribing changes, spotted abnormal blood test results and advised effectively on issues relating to drug and medicines safety.

f) The palliative care teams was used frequently, but sometimes when it seemed that end of life was very near and when it was difficult to see what sort of specialist advice might be required. Likewise the critical outreach team seemed to offer flexible additional support in an effective manner.

g) The quality of care offered within ED services was highly rated with 86% of all scores being good or excellent, and only 1 case with a score less than 6 with regard to avoidability. After transfer out of ED, some patients seemed prone to a number of early ward relocations with a significant minority occurring in the middle of the night.

h) There were no features of concern, in general, noted with regard to patients under the care of the surgical teams

i) There seemed to be variable input from the adult medical teams, with some Consultants clearly demonstrating regular ward reviews of high quality. In other cases there were difficulties getting specialist medical opinions and some delays in inpatient investigations such as echocardiography and some imaging.

j) Particularly after the acute phase of care the overall strategic oversight about an individual's care seemed to lose focus Often medical patient reviews were led by trainees who generated a daily jobs list without any real over riding strategy for care.

k) Medical input out of hours and particularly at weekends was at best variable and at times poor, with some patients not being reviewed for days on end, for example over Bank Holiday weekends –even when review was specifically requested.

l) There were almost no cases where sick patients were escalated on an emergency basis to Consultant physicians, either within hours or out of hours. Consultant reviews would occur at the routine ward rounds but in between decisions about patient care were led and implemented by trainees and PAMs There were a number of documented cases where care was delayed because of the workload of junior doctors.

m) Standards of nursing care and documentation were in general good to excellent, although on occasion handwriting was illegible

n) There were numerous examples of patients where discharge was delayed – in tially through slow passage through the inpatient system, but latterly through delayed discharge planning and delays whilst awaiting discharge placements A number of patients deteriorated after being stuck in Hospital a number of days after being declared "medically fit for discharge". The fast track discharge system was not always fast enough.

Assessments of avoidability were reassuring, with scores relating to the following domains:

Avoidability scores are possibly the most contentious of domains. They do not equate to an avoidable death, but rather to avoidability of factors in care that might have resulted in adverse outcome.

The scores are defined on a 6 point scale:

1 = Definitely avoidable factors present

2 = Strong evidence of avoidable factors

3 = Probable presence of avoidable factors (more than 50:50)

4 = Possible presence of avoidable factors, but not very likely (Less than 50:50)

5 = Slight evidence of avoidable factors

6 = definitely not avoidable

	6	5	4	3	2	1
Admission	64%	18%	11%	6%	1%	0%

Published data suggest that up to 10% of inpatient deaths have potentially avoidable factors, graded as 3 or worse on avoidability scores. The scoring of the patients from the 2018-19 cohort suggest that the Trust's performance sits comfortably within this expected range.

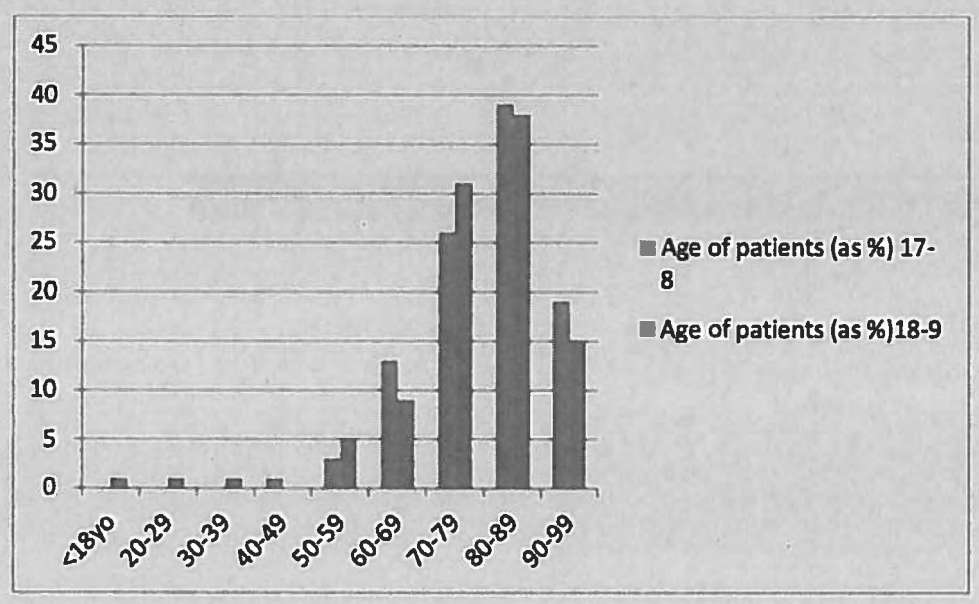
Whilst these numerical results are in themselves reassuring they mask the very significant concerns the assessors had about delays in patient processing, starting with delays in transfer out of ED, through to a lack of senior medical input once patients were being cared for within general medicine and the difficulties getting specialist teams to take over care, particularly of outliers. All the available medical evidence suggests that these factors are known to contribute to adverse outcome and excess mortality.

Appendix C

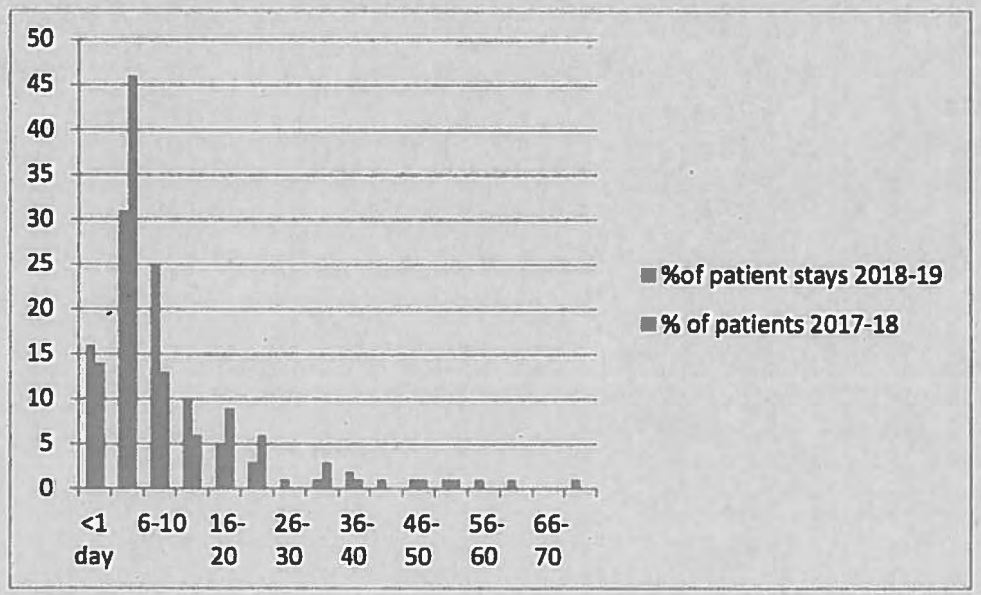
Comparison of 2017/18 v 2018/19 data.

2018-9 vs 2017-8

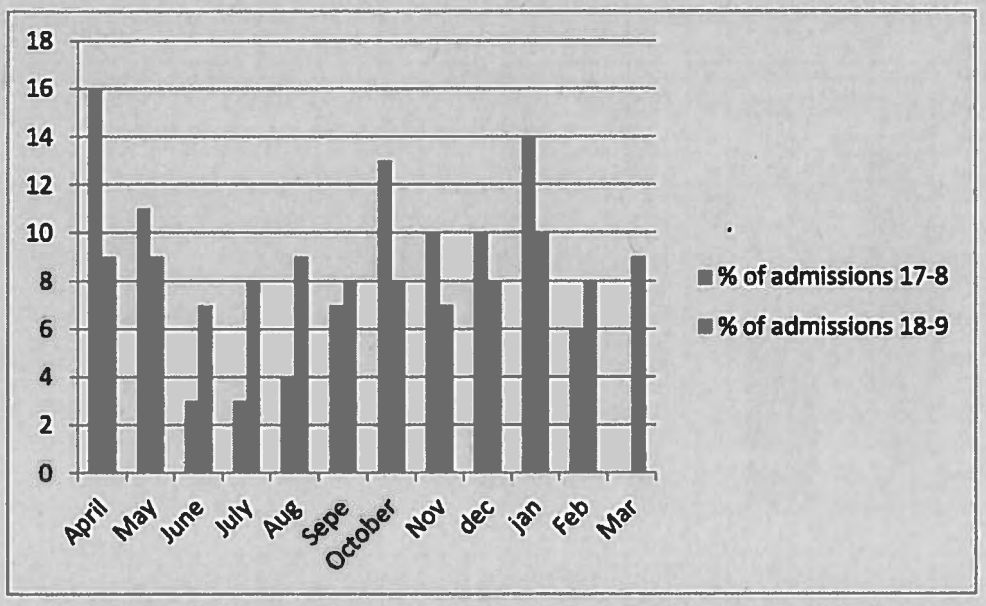
1.Both groups 50% M, 50% female



2. Similar age distribution, possibly a few younger patients in 2018-2019 but overall distribution of ages very comparable



3. Data suggest that the patients who died in 2018-19 had longer Length of Stay and had been in Hospital longer than the 2017-8 cohort



4. The data suggest that the number of deaths is more evenly spread across the year in 2018-9 than in 2017-8, which seems to have clearer evidence of a winter peak. It should be remembered this may just be a vagary of sampling, as only 70 cases were reviewed from the earlier time period.

Scores in each of the domains compared across the two time periods are as follows:

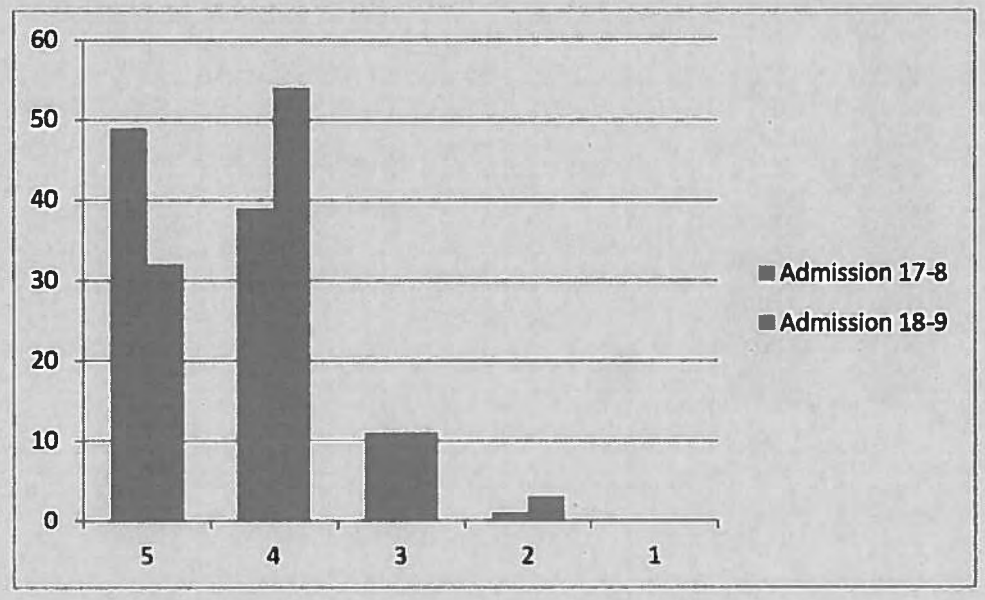


Figure: Comparison of SJR scores for admission and initial assessment 17-8 vs 18-9

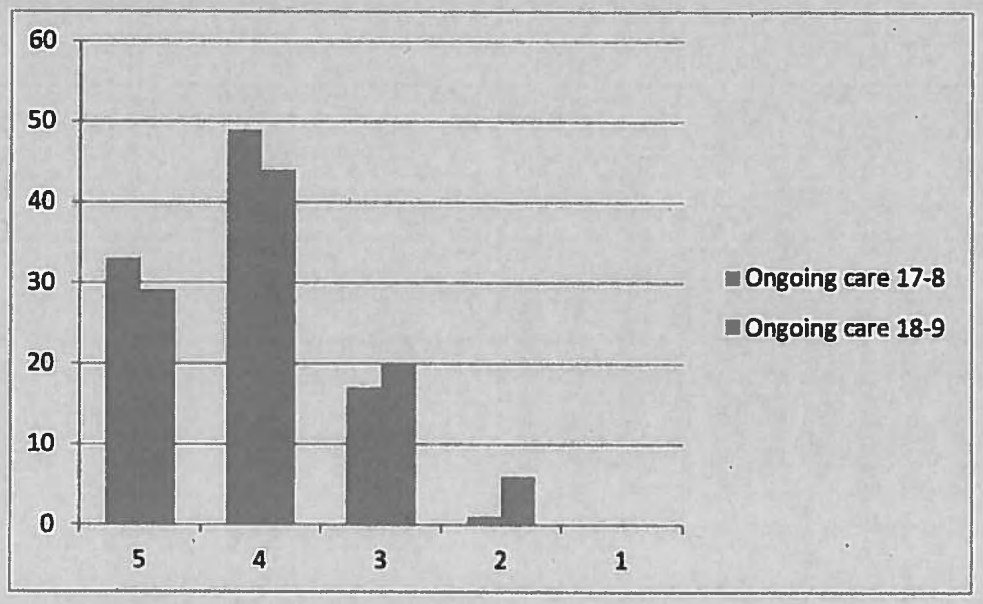


Figure: Comparison of SJR scores for ongoing care 17-8 vs 18-9

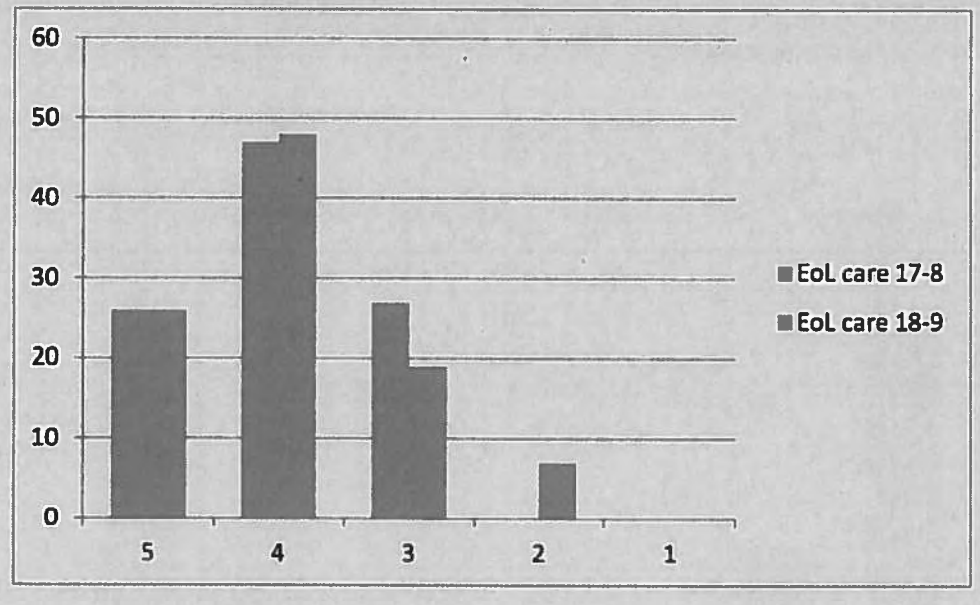


Figure: Comparison of SJR scores for End of life care 17-8 vs 18-9

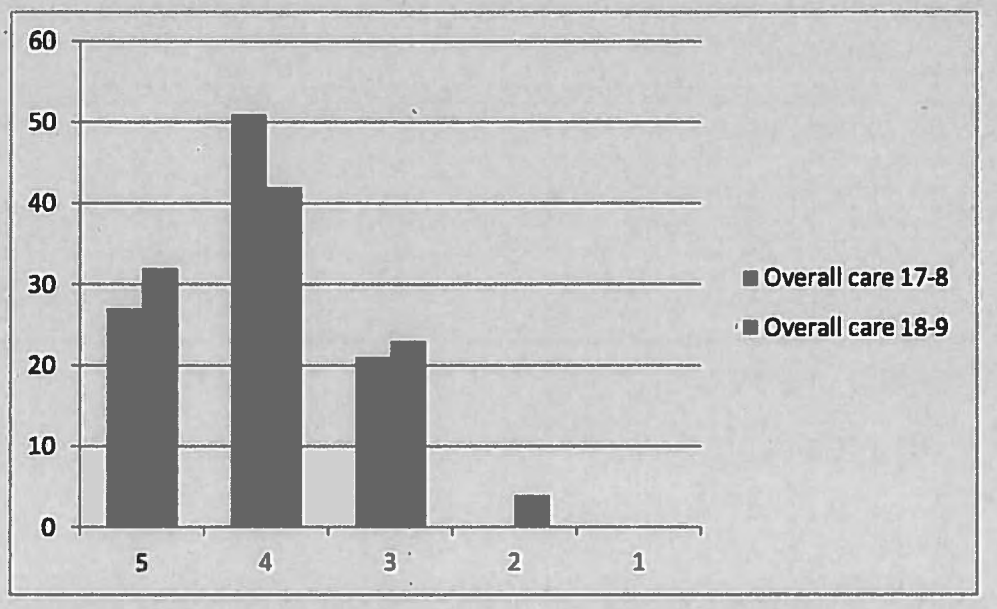


Figure: Comparison of SJR scores for Overall care 17-8 vs 18-9 Tabular results for avoidability and SJR scores by year of death

	6	5	4	3	2	1
Avoidability 17-18	59%	17%	17%	6%	1%	0%
Avoidability 18-19	64%	18%	11%	6%	1%	0%
Admission 17-18		49%	39%	11%	1%	0%
Admission 18-19		32%	54%	11%	3%	0%
Ongoing care 17-18		33%	49%	17%	1%	0%
Ongoing care 18-19		29%	44%	20%	6%	0%
End Of Life Care 17-18		26%	47%	27%	0%	0%
End of Life Care 18-19		26%	48%	19%	7%	0%
Overall care /records 2017-18		27%	51%	21%	0%	0%
Overall care / records 2018-19		32%	42%	23%	4%	0%

Summary

220 cases have been reviewed across 2 separate time periods. The data show good comparability of baseline demographic details, with the possible exception that the deaths were more clustered in the winter months in the earlier cohort. This may represent a random sampling error or may be consistent with recent data suggesting across the NHS that winter pressures are now "year round". The data also suggest that the length of stay of patients who died has increased. This does merit further review, and specifically it would be important to see whether average length of stay for all patients cared for within the Trust are increasing or decreasing with time. SJR scores are remarkably consistent across the two time periods, and avoidability scores fit well within the reported range of up to 10% of cases having some evidence of avoidability.

Appendix D

Assessment of serious incident reviews

The team undertook a review of serious incident (SI) investigations as part of the assurance process. 20 SI reports were assessed against NHS E quality assurance criteria. The SI's were provided by the Trust and were not randomly selected, but there is nothing to suggest that they are non-representative. They were all undertaken in 2017, the team do not believe that there have been fundamental changes in the approach to SI reviews within the Trust in the last 2 years

Qualitative

- The SI reviews were felt to be appropriate in terms of the range of clinical incidents they investigated, and included patients who had suffered falls, delayed recognition of deterioration, acute abdomen, a safeguarding issue in a patent with mental health problems, delayed treatment of sepsis, major haemorrhage, failure of VTE prophylaxis and lack of medical input, particularly out of hours /at weekends. The cases adequately represented the whole range of potentially avoidable harm that is recognised as being problematic across the NHS.

The root causes identified as being significant factors within the cases can be listed as:

Failure to recognise or escalate complex / deteriorating / ill medical patients: 11 Lack of medical leadership / clarity about Consultant responsibility: 5

Concerns about nursing care and failure of nursing escalation: 4

Delayed diagnosis / treatment of sepsis: 3

Delayed treatment (other): 3

Missed acute abdomen: 3

Failure to act on abnormal results: 3

Deaths following major maxillofacial surgery – a range of service delivery challenges: 2 Patient fall(s) : 2

Poor documentation of ward rounds and plans for treatment: 2 Lack of weekend /B hol input: 2

Delays in ED triage / assessment: 1

Multiple locum medical staff: 1

Assessment of the review process

The quality of the SI reviews was good or excellent in the majority of cases (see table). The review processes were robust, undertaken by experienced clinical staff of suitable experience who appeared to be well trained in the assessment of serious incidents – the "diagnostic" part of the SI process was excellent. The area where effectiveness could be improved related to the outputs – with generation of strong and targeted recommendations and the development of strong plans to deliver improvement the lowest scoring areas by some margin. This finding was mirrored by feedback from the individual interviews, where clinicians reporting that despite high quality SIs (and mortality reviews) the outputs were not effective and certainly there was a strong feeling that effective change in service organisation rarely emerged as a result of either SI reviews of mortality reviews. Staff seemed resigned to this outcome and just recognised the inevitability of the lack of effective change, despite their best efforts to identify underlying root causes of adverse outcome.

Phase of investigation	Element	Yes (%)	No (%)	n/k or borderline (%)
Set up/ preparation	Was the IO appropriately trained and experienced	90	5	5
	Was there a pre-incident risk assessment	10	90	0
	Did the core investigation team consistent of more than one person?	50	50	0
	Were national standard NHS investigation guidance and process used?	95	0	5
Gathering and mapping	Was the appropriate evidence used (where it was available) i.e. patients notes/records, written account?	95	0	5
	Were interviews conducted?	90	5	5
	Is there evidence that those with an interest were involved (making use of briefings, de-briefings, draft reports etc.)?	90	0	10
	Is there evidence that those affected (including patients /staff/ victims/ perpetrators and their families) were involved and supported appropriately?	80	20	0
	Is a timeline of events produced?	100	0	0
	Are good practice guidance and protocols referenced to determine what should have happened?	100	0	0
Analysing information	Are care and service delivery problems identified? (This includes what happened that shouldn't have, and what didn't happen that should have. There should be a mix of care (human error) and service (organisational) delivery problems)	100	0	0
	Is it clear that the individuals have not been unfairly blamed? (Disciplinary action is only appropriate for acts of wilful harm or wilful neglect)	100	0	0
	Is there evidence that the contributory factors for each problem have been explored?	100	0	0
	Is there evidence that the most fundamental issues/ or root causes have been considered?	100	0	0
Generating solutions	Have strong (effective) and targeted recommendations and solutions (targeted towards root causes) been developed? Are actions assigned appropriately? Are the appropriate members i.e. those with budgetary responsibility involved in action plan development? Has an options appraisal been undertaken before final recommendation made?	65	20	15
Throughout	Is there evidence that those affected have been appropriately involved and supported?	90	10	0
Next steps	Is there a clear plan to support implementation of change and improvement and method for monitoring?	55	45	0

Table: Analysis of 20 serious incident reviews

Summary:

The most striking clinical theme was the failure to escalate significantly unwell patients to Consultant level, particularly within the medical specialties. In one of the most striking cases where a patient died after significant delays in treatment due to excess workload the Medical registrar specifically stated that she would quite simply never escalate workload problems to on call Consultant physician. This same lack of escalation to Consultants was seen after admission, and there was a striking feeling of lack of medical leadership and lack of co-ordination of medical care for the most complex patients. It must be emphasised that selecting serious incidents for review by its nature, identifies cases where the organisation has already recognised that care has not been delivered in the way that would reach their usual standards or expectations. These cases are therefore not representative of the care received by the majority of patients being cared for within the Trust – but they do represent the pattern of problems that are contributing towards suboptimal care in some cases.

This limited review of serious incident investigations suggests that the cases were appropriate for SI review and that the assessment of the incidents was detailed and effective. The outputs were not effective, either because the objectives were not well enough defined or the next steps to implement change were not sufficiently developed. This resulted in many clinicians feeling the process was not as effective as it might be as few SI reviews resulted in effective service improvement.

RJM August 2019

Appendix E

List of staff interviewed Worcester Mortality Review

- Bill Tunnicliffe: NED
- Vicky Morris: CNO
- Alex Marshall: Complaints Manager
- Alice Barga: ME
- Jasper Trevelyan: DMD Spec Med
- Clare Marley: GP Mortality Lead
- Mark Yates: NED
- Kimara Sharpe: Company Secretary
- Rosmary Smart: Patient Attendee
- Julian Berlet: DMD SCSD and Ed Mithcel DMD Quality, Improvement and Governance
- Ed Mitchell/ Andrew Burtenshaw: Former/ Current Clin Dire of Critical Car
- Baylon Kamalarajan: Peadiatric Consultan
- Helen Routledge: Cardiac Consultant
- Bala Reddy: Surgery Consultant
- Lisa Hill: Tissue Viability Nurse
- Angus Thomson: DMD W&C
- Amanda Markall: Director of Ops Surgery
- Paul Brennan: COO/Acting CEO
- Nick Turley: Consultant ED
- Catherine Jackson: Geriatric Consultant
- Clare Hooper: Consultant Respiratory
- Graham James Mortality Review Update
- Sir David Nicholson. Chairman
- Steve Graystone: ME
- Dr Nuno Ribero. Stroke Consultant
- Victoria Macwhirter: Head of Clinical Coding
- Nick Purser: Consultant Breast Surgeon
- Aruna Maharaj. Acute Medicine
- James France: ED consultant

NHS
Worcestershire
Acute Hospitals
NHS Trust

Meeting	Trust Board
Date of meeting	14 November 2019
Paper number	H2

Report on Nursing and Midwifery Staffing Levels August 2019

For approval:		For discussion:		For assurance:	x	To note:	

Accountable Director	Vicky Morris Chief Nursing Officer		
Presented by	Vicky Morris Chief Nursing Officer	**Author /s**	Louise Pearson: Lead for Nursing and Midwifery Workforce

Alignment to the Trust's strategic objectives							
Best services for local people	x	Best experience of care and outcomes for our patients	x	Best use of resources	x	Best people	x

Report previously reviewed by		
Committee/Group	Date	Outcome
People and Culture Committee	October 2019	Received
Trust Management Executive	October 2019	Received

Recommendations	The Trust Board is requested to receive this report for assurance.

Executive summary

This paper has been presented to the Trust Management Executive and the People and Culture Committee where scrutiny took place in relation to whether staffing was safe after mitigations. It was determined that staffing was safe, post mitigation.

This paper provides assurance to the Board of the nursing, midwifery and Allied Health Professionals staffing levels and vacancies for August 2019.

- The report confirms that following mitigation, staffing levels trust wide were safe. Fill rate below

RN Days	HCA Days	RN Nights	HCA nights
87.53%	90.48%	94.69%	84.45%

- Whilst the fill rate for RN on days is slightly below 90% the patient acuity and dependency is reviewed daily and mitigation taken as required. For example Mitigations for maternity are that Staff were redeployed from obstetric theatres and also clinics to ensure safety on the areas.
- There were no moderate harm incidents relating to decreased staffing levels reported. There were 65 occasions where actions were required on specific ward areas where levels did decrease from that planned due to vacancies or sickness or when patient acuity and dependency required additional

staffing.

- A detailed account ward by ward for August 2019 is given in appendix 1. All areas were reviewed by matrons and DDNs and mitigations put in place.
- The August 2019 nurse vacancy for Registered nurse (RN) and Health Care Assistants (HCA) 327.49

Vacancy for in patient wards areas & non ward areas	August 2019
Registered nurses	282.44
Health care assistants	52.25
Total	327.49

- The two divisions with the highest vacancies continue month on month to be specialised medicine and urgent care. The hot spot ward areas which are deemed as hard to recruit are Acute Stroke Unit, ward 4 (medical) MAU. There are targeted recruitment and retention work streams in place. These wards will be prioritised as first placements for international nurses.
- The use of temporary staffing and moving staff to cover high risk areas has been a necessity in maintaining patient safety and quality of care delivered particularly on those wards with the highest vacancies.
- A new Therapies Lead has been appointed to the trust and is due to commence in post in October 2019. AHP (Dieticians, OTs, physiotherapists, orthoptists and radiographers) vacancies across the trust are:
  - Speciality medicine 13.87 WTE
  - SCSD 26.96 WTE
    The AHP vacancies sit predominantly in radiography with over half these vacancies; physiotherapy 7 WTE and Occupational therapy 5 WTE. The lead for workforce will work with the new therapies lead and organise a targeted recruitment campaign in conjunction with the next recruitment event.
  - There are no reported risks at this time with the current vacancy numbers.
- Maintaining safe staffing levels and the required recruitment and retention are risks on the corporate risk register. This has been reviewed monthly and actions are in place through an active recruitment and retention campaign. A series of drop in workshops took place in September across the three hospital sites for staff to shared retention ideas and issues and to gain advice on retire and return. This information will feed the trust wide retention framework.
- The first 3 international nurses arrived in August and

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	commenced their 10 weeks OSCE training. • The International nursing work stream has offered 90 posts between April to June 2019. The pipeline for recruitment is underway with a projected target of placement of staff (band 3 nurses initially) by 31st March 2020. • Actions required in July –September 2019 are for divisional workforce plans to substantiate the recruitment and retention actions required following the biannual acuity and dependency reviews. • Details workforce plans are being progressed within specialised medicine with the proposed moves of 5 wards and opening 1 new ward within the Aconbury building at Worcestershire Royal Hospital between October – January 2019/20.

Risk								
Key Risks	The need for temporary staffing on ward areas to ensure there is an ability to keep open the number of beds required to meet patients' needs and meet demand - Risk number 4000 BAF risk 11							
Assurance								
Assurance level	**Significant**		**Moderate**		**Limited**	*x*	**None**	
Financial Risk	Continued spend in bank and agency to keep open the increased number of ward based beds required to meet patient need and demand. This is specifically for wards with an increased vacancy factor over 25%, increased activity seen at A&E Alexandra Hospital. Initial costs for the recruitment of International nurses to support filling of vacancies which has resulted from opening of 3 additional ward areas. Recruitment of International nurses is in progress to support bank and agency spend. Active recruitment is in place to support reduction of vacancies and a programme of retention is being drawn up.							

Recommendations	The Trust Board is requested to receive this report for assurance.

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Appendices

August Rag Rating	day Reg fill	day unreg fill	night reg fill	night unreg fil
Acute Stroke Unit	76.4	93	91.4	95
Avon 2- Gastro	73.4	90.1	91.6	97.5
Avon 3 Infectious Diseases	90.5	94.7	96.8	93
Avon 4	91.4	95.5	85	97.9
Avon 5	81.4	93.4	82.3	99.9
Beech A	104.7	89.9	100	98.5
Beech B - Female	69.6	90.1	98.8	17.7
Beech C	65.9	95.6	89	98.5
Beech High Care	84	88.4	92.5	97.3
CCU-Alex	82.1	0	100	0
Evergreen 1	74	93.2	82.6	99.1
Head and Neck Ward	100	95.6	96.6	49.9
ICCU - Alex	100.8	101.4	101.8	0
ICCU - Worcs	101.5	96.3	102.9	0
Laurel 1 Cardiology-CCU	93	93.7	98.5	103.8
Laurel 3 Haem Ward	95.3	87.1	99.2	98.3
Laurel Unit 2	90.3	92.5	97.5	115.5
M A U - Alex	88.2	75.1	100.3	89.4
Maternity Team 1 Midwives	72.9	91.2	81.9	96.8
MAU Assessment	95.5	90	92.8	104.1
MAU High Care and Short Stay	88.2	90.2	81.9	85.2
NICU- Paeds	76.1	98.1	78.6	71
Silver Oncology	87.9	94.8	100	102.1
Trauma & Orthopaedic A Ward - WRH	78.7	85.2	93.5	96.4
Vascular Unit & VHCU	83.4	86.5	99.4	72.5
Ward 1 - KTC	115.2	85.8	97.9	0
Ward 1 - Medicine	88.7	94.8	92.5	101
Ward 10 - Urology	92.9	94.9	96.8	104
Ward 11 - Medicine	89.7	87.7	103.1	102.5
Ward 12 Medicine	79.5	87.7	98.8	104.1
Ward 14 - Surgery	83.5	94.2	100	99.9
Ward 16 - Elective Orthopaedic Ward	82	91.7	81.3	91.9
Ward 17 - Trauma Ward	91.4	100.3	100	100
Ward 18	85.6	95.9	97.4	93.8
Ward 2 - Medicine	94.6	92.2	111	133.7
Ward 4	96.6	123.7	96.9	102

Ward 5 Alex	86	92.4	93	99.1
Ward 6 - Medicine	91.6	93.2	92.3	92.2
SCDU	96.4	97.7	96.8	95.2
Riverbank	82.3	85.7	94.9	79.5

Worcestershire Acute Hospitals NHS Trust

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Annual establishment review including biannual staffing reviews for in patient adult, paediatrics, neonates and maternity: Key outcomes and actions

For approval:	x	For discussion:		For assurance:	x	To note:	x

Accountable Director	Vicky Morris : Chief Nursing Officer		
Presented by	Vicky Morris Chief Nursing Officer	**Author /s**	Jackie Edwards, Deputy Chief Nurse Officer Louise Pearson Nurse Lead Nursing Workforce

Alignment to the Trust's strategic objectives							
Best services for local people	x	Best experience of care and outcomes for our patients	x	Best use of resources	x	Best people	x

Report previously reviewed by		
Committee/Group	Date	Outcome
Nursing Workforce Action Group	8th October 2019	Approved
People and Culture Committee	23 October 2019	Noted
Trust Management Executive	24 October 2019	Noted

Recommendations	Trust board is asked to: • Note the annual establishment and biannual reviews 2019 have taken place and are in line with a robust process aligned to the safeguard workforce guidelines NHSI (2018). • Note the Chief Nursing Officer has reviewed and can confirm that establishments are safe to meet patient needs. • The sign off process of nursing establishments has been through a collaborative process with the DCNO, workforce lead and Divisional Nursing leads which occurred in October 2019, with exception of ED, MAU, MSSU • Note that the details of this work and outcomes have been approved at committees as detailed above. • This paper provides a high level overview and level of assurance to a robust and detailed process as required by the Workforce safeguards. The Trust Board are required to note and approve the outcome of the acuity and dependency bi annual process. • The Board are asked to note that their approval is required prior to updating the annual safe staffing governance statement, which is published on the Trust website. • These workforce changes and actions taken will ensure that the Nursing and Midwifery staffing is safe and sustainable for 2019.

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	• No further change to establishments for 2019/20 will be made without a Quality Impact Assessment which the Chief Nursing Officer will sign off and the approval from Trust board will be subsequently gained. • These outcomes and the changes in proposed ward reconfiguration have been considered together and will feed into the annual planning process. • To note the next biannual review will take place throughout January 2020. An establishment midterm review will take place in February 2020.

Executive summary	This paper has reviewed all the data from three components of the establishment review carried out from October 2018 to September 2019. The review focused on the number of nursing and midwifery staff and the range of skills required to meet the needs of the people who use our service. This is in line with The National Quality Board 'Safe sustainable productive staffing' guidance (2016) which was reviewed 2018. The trust was required and has published these on the intranet along with the monthly staffing papers. The Chief Nursing Officer has reviewed all data and carried out meetings with all senior nurses to ensure that professional judgement and consideration of changes are incorporated and the impact aligns with data outcomes. Key outcomes and actions from the establishment review are: • Whilst an uplift has been identified from A&D studies for wards within speciality medicine division with the application of professional judgement and relocation of staff from a skill mix review (which includes the implementation of the Nursing Associate Model as new ways of working for frailty) no further requirements for uplift for staff has been identified. • Given the number of ward reconfiguration that are due over the next six months as well as 3 new wards within the Specialised Medical Division (in place from January 2019) further data reviews are required to provide validity of the data before changes are made to establishments. • There remain inefficiencies in surgical areas (where a clinical model needs to be agreed) and a review of high care areas within the Surgical Division will be undertaken with operational and medical teams. • The Nursing establishments within children's and neonatal areas indicate that an increase in workforce to meet need is required. • Proposed changes in the clinical services model for the paediatric assessment will require further reviews before workforce establishments concluded. In the meantime in accordance with patient need and demand the use of temporary staffing is utilised to ensure safe staffing levels maintained.

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	• Changes to the commissioning of neonatal cots are currently in progress. The Women and Children division is working with commissioners and a workforce plan is being scoped within the context of national/ network review. (BAPM) • Midwifery staffing establishments currently meet the needs of the current caseload which in turn reflects the population served. The reviews identified population numbers have declined and as such changes to staffing could be achieved, however vacant posts are being held going forward into 2020 whilst further assessment of patient demand and "continuity of carer" process is reviewed. • There is a draft business case for urgent care (ED at the Alex) which needs consideration with the outcome of the A&D process within Urgent care. • The head room allowance within the budgets for specialised medical and surgical areas are currently 23.8% other areas are 19.9%. The SNCT and birth rate plus tools provide an allowance of 22%. Discussion with each division and finance has taken place to move to 22% trust wide by December 2019. • External review of the model hospital data is in progress which is supported by NHSI workforce team; there is a meeting to discuss results in November 2019.

Risk								
Key Risks	*BAF 11*							
Assurance	*The national tool was used and NHS E/I has oversight of the work to date.*							
Assurance level	**Significant**		**Moderate**	*x*	**Limited**		**None**	
Financial Risk	*Not directly*							

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Appendix : 1 Bi-annual SNCT Results – Summary of Data Collection – June 2019

APPENDIX 1

SUMMARY of DATA COLLECTION

Jun-19

36 Wards

Jun-19

Directorate / Ward	Beds	Bed Occupancy (set) A.	Bed Occupancy (for ref period)	Bed Occupancy at Set Rate	Dependency Level Summary 0	1a	1b	2	3	Current Nursing Levels (WTE)	at set Occupancy Level of 98.87% Acuity Proposed Nursing Levels (WTE)	Staffing Increase/(Decrease) (WTE)
Specialty Med										**519.08**	**553.19**	**34.11**
Acute Stroke Unit	29	98.9%	107.4%	98.9%	9.0%	7.5%	80.9%	2.6%	0.0%	53.73	46.91	-6.82
Avon 2	22	98.9%	102.0%	98.9%	9.8%	32.3%	57.9%	0.0%	0.0%	31.88	33.53	1.65
Avon 3	20	98.9%	102.3%	98.9%	15.6%	15.4%	68.9%	0.0%	0.0%	33.87	30.74	-3.13
Avon 4	24	98.9%	100.0%	97.9%	8.5%	14.4%	76.7%	0.4%	0.0%	37.79	38.23	0.44
Laurel 1	21	98.9%	100.0%	98.9%	4.9%	18.4%	10.4%	63.2%	3.1%	43.33	53.30	9.97
Evergreen	26	98.9%	100.0%	98.9%	7.1%	2.7%	90.2%	0.0%	0.0%	36.78	42.65	5.87
Laurel 2	21	98.9%	103.3%	98.9%	0.9%	13.4%	59.9%	25.8%	0.0%	39.86	36.00	-3.86
Ward 12 AGH	28	98.9%	100.0%	98.9%	13.6%	4.5%	82.0%	0.0%	0.0%	40.66	44.47	3.81
Ward 2 AGH	22	98.9%	100.5%	98.9%	50.5%	0.7%	48.9%	0.0%	0.0%	28.30	29.35	1.05
Ward 5 AGH	26	98.9%	96.2%	98.9%	5.2%	9.2%	81.8%	3.8%	0.0%	34.54	42.70	8.16
Ward 6 AGH	22	98.9%	100.0%	98.9%	55.2%	1.8%	43.0%	0.0%	0.0%	29.23	28.51	-0.72
Ward 11 AGH	28	98.9%	100.0%	98.9%	0.9%	1.4%	97.7%	0.0%	0.0%	26.58	47.30	20.72
Ward 1 - ALX	19	98.9%	100.0%	98.9%	62.6%	1.6%	35.8%	0.0%	0.0%	35.32	23.62	-11.70
Avon 5	28	98.9%	100.4%	98.9%	0.9%	0.4%	98.8%	0.0%	0.0%	34.82	47.40	12.58
CCU ALX	4	98.9%	95.0%	98.9%	5.3%	1.3%	30.3%	63.2%	0.0%	12.39	8.48	-3.91
Urgent Care Med										**191.30**	**163.17**	**-28.13**
Ward 4 - ALX	22	98.9%	100.0%	98.9%	1.8%	28.6%	68.9%	0.7%	0.0%	31.15	35.10	3.95
M SSU	25	98.9%	100.6%	98.9%	34.2%	45.5%	9.3%	10.9%	0.0%	46.51	40.32	-6.19
MAU AGH	28	98.9%	100.4%	98.9%	29.2%	31.9%	38.6%	0.4%	0.0%	65.84	47.35	-18.49
MAU WRH	21	98.9%	107.1%	98.9%	6.9%	18.7	74.4	0.0	0.0	47.80	40.40	-7.40

						%	%	%	%			
W & C										**58.25**	**66.36**	**8.11**
Riverbank Paeds	31	98.9%	81.8%	98.9%	77.9 %	10.5 %	10.8 %	0.8 %	0.0 %	58.25	61.34	3.09
PAU - WRH	4	98.9%	122.5%	98.9%	100.0 %	0.0 %	0.0 %	0.0 %	0.0 %	0.00	5.02	5.02
SCSD										**74.28**	**65.78**	**-8.50**
Silver	20	98.9%	100.0%	98.9%	52.3 %	1.0 %	46.8 %	0.0 %	0.0 %	35.56	26.40	-9.16
Laurel 3	18	98.9%	99.7%	98.9%	3.1%	48.7 %	42.1 %	6.1 %	0.0 %	25.84	27.63	1.79
KTC - Ward 1	12	98.9%	68.3%	98.9%	100.0 %	0.0 %	0.0 %	0.0 %	0.0 %	12.88	11.75	-1.13
Surgery										**377.14**	**341.94**	**-35.20**
Beech A	20	98.9%	104.5%	98.9%	62.0 %	3.1 %	34.9 %	0.0 %	0.0 %	28.89	24.86	-4.03
Beech B	9	98.9%	100.6%	98.9%	72.1 %	1.2 %	26.7 %	0.0 %	0.0 %	16.21	13.27	-2.94
Beech C	17	98.9%	99.7%	98.9%	79.9 %	7.4 %	12.7 %	0.0 %	0.0 %	26.38	18.69	-7.69
Head & Neck	11	98.9%	102.3%	98.9%	68.9 %	9.8 %	21.3 %	0.0 %	0.0 %	21.29	12.89	-8.40
SCDU	17	98.9%	101.8%	98.9%	16.5 %	71.7 %	11.8 %	0.0 %	0.0 %	23.82	27.66	3.84
SHCU	8	98.9%	99.4%	98.9%	24.5 %	33.3 %	28.9 %	13.2 %	0.0 %	20.27	11.58	-8.69
T&O	36	98.9%	100.0%	98.9%	38.3 %	0.4 %	61.3 %	0.0 %	0.0 %	47.98	51.22	3.24
Vascular	14	98.9%	100.0%	98.9%	55.7 %	1.4 %	42.9 %	0.0 %	0.0 %	24.64	18.10	-6.54
Vascular High Care	4	98.9%	100.0%	98.9%	27.5 %	57.5 %	15.0 %	0.0 %	0.0 %	11.84	5.26	-6.58
Ward 14 AGH	19	98.9%	100.3%	98.9%	26.0 %	2.4 %	71.7 %	0.0 %	0.0 %	26.38	28.60	2.22
Ward 10 AGH	21	98.9%	100.0%	98.9%	93.8 %	3.3 %	2.9 %	0.0 %	0.0 %	28.36	21.26	-7.10
Ward 16 AGH	28	98.9%	85.9%	98.9%	71.5 %	1.2 %	27.2 %	0.0 %	0.0 %	32.76	33.05	0.29
Ward 17 AGH T&O	28	98.9%	99.8%	98.9%	12.2 %	4.7 %	83.2 %	0.0 %	0.0 %	39.05	44.73	5.68
Ward 18 AGH	28	98.9%	99.8%	98.9%	82.1 %	2.7 %	15.2 %	0.0 %	0.0 %	29.27	30.77	1.50
TOTAL	**647**	**98.9%**	**99.6%**	**98.9%**	**32.0 %**	**12.9 %**	**50.7 %**	**4.3 %**	**0.0 %**	**1220.05**	**1223.09**	**3.04**

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Trust Management Executive

For approval:		For discussion:		For assurance:	x	To note:	

Accountable Director	Matthew Hopkins CEO		
Presented by	Matthew Hopkins CEO	**Author /s**	Kimara Sharpe Company Secretary

Alignment to the Trust's strategic objectives							
Best services for local people	X	Best experience of care and outcomes for our patients	X	Best use of resources	X	Best people	x

Report previously reviewed by		
Committee/Group	Date	Outcome

Recommendations	The Trust Board is requested to receive this report for assurance.

Executive summary	This report gives a summary of the items discussed at the last Trust Management Executive (TME) in October. There was no meeting in September. Members will see that there is a clear line of sight between the Board, Committees and TME.

Risk								
Key Risks	TME, as the decision making body for the Trust, addresses all risks.							
Assurance								
Assurance level	**Significant**		**Moderate**		**Limited**		**None**	
Financial Risk	Within budgets							

Meeting	Trust Board
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Paper number	H4

Introduction/Background

TME is the primary executive decision making body for the Trust. It is set up to drive the strategic agenda and the business objectives for the Trust. It ensures that the key risks are identified and mitigated as well as ensuring that the Trust achieves its financial and operational performance targets.

Issues and options

Since my last report at the September Board, TME has met once, 23 October. This report covers this meeting.

Items presented for approval

- **Clinical Services Strategy** – on this month's board agenda
- **Annual Planning** – presented to the Finance and Performance Committee (October)
- **Pharmacy System leadership**
- **Strategic Workforce Plan** – presented to the People and Culture Committee (October)
- **Board Assurance Framework** – on this month's board agenda
- **7 day services –** presented to the Quality Governance Committee (October)
- **Bed capacity business case –** presented to the Finance and Performance Committee (October)
- **Revenue replacement of equipment**
- **PFI contract – combined heat and power plan (CHP) -** on this month's board agenda (private)
- **PFI (managed equipment services)**
- **Update from Radiotherapy Network Oversight Group**
- **Digital Business continuity plan**
- **Endoscopy business case** - presented to the Finance and Performance Committee (October) and approved by the Vice-Chair

Items presented for information/discussion

- **Integrated Quality Report** - presented to the Quality Governance Committee (October)
- **Operational & Financial Performance – Month 6 position and CIP Report** presented to the Finance and Performance Committee (October)
- **Financial Recovery Plan** presented to the Finance and Performance Committee (October)
- **Internal Audit report – data security and protection toolkit –** will be presented to the Audit and Assurance Committee (November)
- **Patient Group Directions –** presented to the Audit and Assurance Committee (September)
- **Guardian for Safe Working & HEE update** presented to the People and Culture Committee (October)
- **Flu -** presented to the People and Culture Committee (October)
- **Safe Staffing report** presented to the People and Culture Committee (October) & on this month's board agenda
- **Ward acuity staffing audit outcome** presented to the People and Culture Committee (October) & on this month's board agenda
- **Employee casework** presented to the People and Culture Committee (October)

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- **Pension Taxation**
- **Recruitment and retention update** presented to the People and Culture Committee (October)
- **Integrated Performance Report** – presented to F&P and is on this month's board agenda

Subgroup reports

- **Strategy and Planning update** – approval of capital spend
- **Finance and Service Improvement Group**

Recommendations

The Trust Board is requested to receive this report for assurance.

Appendices

Meeting	Trust board
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Audit and Assurance Committee Assurance Report

For approval:		For discussion:		For assurance:	x	To note:	

Accountable Director	Steve Williams Audit and Assurance Chairman		
Presented by	Steve Williams Audit and Assurance Chairman	**Author /s**	Kimara Sharpe Company Secretary

Alignment to the Trust's strategic objectives							
Best services for local people		Best experience of care and outcomes for our patients		Best use of resources	x	Best people	

Report previously reviewed by		
Committee/Group	Date	Outcome

Recommendations	The Trust Board is requested to • Note the report for assurance • Approve the debt write off of £61,846

Executive summary	This report summarises the business of the Audit and Assurance Committee at its meeting held on 17 September 2019.

Risk								
Key Risks	The Committee reviews all significant risks.							
Assurance								
Assurance level	**Significant**		**Moderate**		**Limited**		**None**	
Financial Risk								

Meeting	Trust board
Date of meeting	2019
Paper number	I1

Introduction/Background

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. Membership is three non-executive directors.

The Committee has met once since the last report.

Issues and options

Items discussed at the 17 September meeting:

- **Quality Impact Analysis**: One of the roles of the Audit and Assurance Committee is to examine the clinical risks arising from financial pressures. The Chief Nurse attended and gave an update on the QIAs. The comprehensive paper showed the number of QIAs that have been approved, rejected and those that have not yet been received. She stated that not all senior staff were familiar with the QIA process and she was intending to put on a training session for TME members. We were concerned that one QIA had been submitted, with an electronic signature, and the accountable person was unaware of the content of the QIA. We have asked for a review of the use of electronic signatures which the Company Secretary will undertake. Overall we were assured with the robustness of the process and have requested a repeat paper in March 2020.
- **Patient Group Directions:** The Chief Pharmacist presented the paper. We were concerned that senior leadership ownership was not apparent (a mini audit had confirmed this) and we have requested that this paper is considered by the Trust Management Executive.
- **Annual Security Report**: The Local Security Management Specialist presented this report ad it is presented in the private session of the Board. We were concerned that the policy of exclusion letters had not been implemented and we have requested that the Deputy Chief Nurse (Safety) be present at the next meeting of the Committee. The report also covered CCTV within the Trust (this is in detail which is why the report is in the private board session). We have requested that the Head of Facilities attend the next meeting.
- **Declaration of Interests – Annual Report**: We received the annual report relating to declaration of interests. The declaration of interests for the Board is on the website. We were also presented with the TME and consultants'' declarations. Work is on-going with the surgical and SCSD divisions to increase the number of consultants returning the forms. Over 75% of consultants have to date returned their forms. We are awaiting the policy on secondary employment before asking all staff for their declarations of interest.
- **Data Quality Update**: The Head of Information attended the meeting and gave another very comprehensive report on data quality. This area of work is being led by Tom Martin, a consultant and work has been progressing very well. All alerts on the various systems will have bene reviewed by the end of December 2019. This is a huge task. Work is also being undertaken on developing a single waiting list; ensuring performance data was aligned across information and finance and on using the white board contemporaneously.
- **People and Culture** – evaluation: Mr Yates presented the annual evaluation of the committee. Frustration was expressed with the slow progress, but it was acknowledged that the committee had made a difference to the workforce agenda.

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We were pleased that risk was discussed in detail at each meeting.

- **Debt write off**: The Committee is recommending the Board approval of £61,846 bad debt write off.

Items approved:

- Internal Audit Reports:
  - Health and Safety – moderate assurance overall. We have requested that the Chief Operating Officer attend our next meeting to discuss the governance around this area of work.
  - RTT – significant assurance overall
  - FM arrangements – moderate assurance overall

Other items received:

- External audit progress report
- Internal Audit progress report including the annual satisfaction survey
- Counter Fraud progress report
- Waiver report
- Review of debt write off
- EPMA investigation
- SFI breach (removal expenses)

Recommendations

The Trust Board is requested to

- Note the report for assurance
- Approve the debt write off of £61,846

Appendices

- Gifts and Hospital Register 2018/19

Meeting	Trust Board
Date of meeting	14 November 2019
Paper number	I2

Remuneration Committee Report

For approval:		For discussion:		For assurance:	x	To note:	

Accountable Director	Sir David Nicholson Chairman		
Presented by	Sir David Nicholson Chairman	**Author /s**	Kimara Sharpe Company Secretary

Alignment to the Trust's strategic objectives							
Best services for local people		Best experience of care and outcomes for our patients		Best use of resources		Best people	x

Report previously reviewed by		
Committee/Group	Date	Outcome

Recommendations	The Trust board is requested to note this report for assurance.

Executive summary	This report is a routine report to the Trust board outlining the business of this committee.

Risk								
Key Risks	N/A							
Assurance	N/A							
Assurance level	**Significant**		**Moderate**		**Limited**		**None**	
Financial Risk	N/A							

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Introduction/Background

The Remuneration Committee sets and reviews pay for staff not on agenda for change terms and conditions of service. It also ensures that there is a succession plan for senior members of staff including Board members.

Issues and options

The Committee has met twice since my last report in September. The meetings covered the following:

- September 2019 - Approval of the appointment of the Chief Digital Officer
- October 2019 – Approval of the alignment of the Associate Non-Executive Directors'' remuneration to that of the Non-Executive Directors.

Recommendations

The Trust board is requested to note this report for assurance.

Appendices - none

Worcestershire Acute Hospitals NHS Trust

Meeting	Trust Board
Date of meeting	14 November 2019
Paper number	J1

Equality & Diversity Annual Report

For approval:	x	For discussion:		For assurance:		To note:	

Accountable Director	Tina Ricketts, Director of People & Culture		
Presented by	Sandra Berry, Assistant Director of OD	**Author /s**	Sandra Berry, Assistant Director of OD/ Karen Hatton OD Manager and Jacqui Edwards, Deputy CNO

Alignment to the Trust's strategic objectives							
Best services for local people		Best experience of care and outcomes for our patients		Best use of resources		Best people	

Report previously reviewed by		
Committee/Group	Date	Outcome
People and Culture	22nd October 2019	Approved

Recommendations	The Trust Board is asked to approve for publication the final copy of this report which has been approved at the Trust's People and Culture Committee in October 2019.

Executive summary	The report meets the Equalities Duty compliance, and is annually created for sharing on both the Trust website and the Trust intranet. The report showcases what we have achieved on the subject of Equality, Diversity and Inclusion in the last 12 months, and looks forward to the coming 12 months. The report has been co-created between the People and Culture Directorate and Patient, Carer and Public Engagement teams. The approach taken this year was to create a report that met key requirements, showed our journey as a Trust, in a style that is engaging and informative. The report has been amended following review by the People and Culture Committee in August 2019 and was approved by the People and Culture in October 2019.

Risk									
Key Risks	*Production of an annual report showing compliance with the equality duty, part of the Equalities Act 2010 Public Sector Equality Duty.*								
Assurance	*This report meets the requirements of the Equality Act 2010.*								
Assurance level	**Significant**	*x*	**Moderate**		**Limited**		**None**		
Financial Risk									