Trust Board
There will be a meeting of the Trust Board on Thursday 11 July 2019 at 10:00 in Charles Hastings Education Centre, Worcestershire Royal Hospital.

This meeting will be followed by a public question and answer session.

Sir David Nicholson
Chairman

Agenda			Enclosure
1	**Welcome and apologies for absence**		
2	**Patient story**		
3	**Items of Any Other Business** *To declare any business to be taken under this agenda item.*		
4	**Declarations of Interest** To note any additional declarations of interest and to note that the declaration of interests is on the website.		
5	**Minutes of the previous meeting** *To approve the Minutes of the meeting held on **13 June 2019** as a true and accurate record of discussions.*	*For approval*	**Enc A**
5.1	**Action Log**	*For noting*	**Enc B**
6	**Chairman's Report**	*For approval*	**Verbal**
7	**Chief Executive's Report** Chief Nurse	*For noting*	**Enc C**
8	**Board Assurance Framework** Company Secretary	*For approval*	**Enc D**
9	**Integrated Performance Report**		**Enc E**
9.1	**Executive Summary** Chief Nurse	*For assurance*	
9.2.1	**Section 1 – Quality Performance Report** Deputy Chief Nurse/Chief Medical Officer		
9.2.2	**Quality Governance Committee Assurance report** Quality Governance Committee vice Chairman		
9.3.1	**Section 2 – Operational & Financial Performance Report** Deputy Chief Operating Officer/Interim Chief Finance Officer		

9.3.2	**Finance and Performance Committee Assurance Report** Finance and Performance Committee Chairman		
9.4.1	**Section 3 – People and Culture Performance Report** Director of People and Culture		
9.4.2	**People and Culture Committee Assurance Report** People and Culture Committee vice Chairman		
10	**Governance**		
10.1	**Learning from deaths** Chief Medical Officer	*For assurance*	**Enc F1**
10.2	**Report on nursing and midwifery staffing levels** Deputy Chief Nurse	*For assurance*	**Enc F2**
10.3	**7 day services** Deputy Chief Operating Officer	*For approval*	**Enc F3**
10.4	**Trust Management Executive Report** Chief Nurse	*For assurance*	**Enc F4**
10.5	**CQC feedback** Chief Nurse	*For assurance*	**Enc F5**
11	**Assurance Reports**		
11.1	**Audit and Assurance Committee Report** Audit and Assurance Committee Chairman	*For assurance*	**Enc G1**
11.2	**Remuneration Committee Report** Chairman	*For assurance*	**Enc G2**
11.3	**Charitable Funds Committee Report** Charitable Funds Committee vice Chairman	*For assurance*	**Enc G3**
12	**Annual Reports**		
12.1	**Infection Prevention and Control** Deputy Chief Nurse	*For assurance*	**Enc H1**
12.2	**Safeguarding** Deputy Chief Nurse	*For assurance*	**Enc H2**

Any Other Business *as previously notified*

Date of Next Meeting
The next public Trust Board meeting will be held on 12 September 2019 in the Education Centre, Kidderminster Hospital and Treatment Centre

Public Q&A session

Exclusion of the press and public
The Board is asked to resolve that - **pursuant to the Public Bodies (Admission to Meetings) Act 1960 'representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest'** (Section 1(2) Public Bodies (Admission to Meetings) Act 1960).

Worcestershire Acute Hospitals NHS Trust

MINUTES OF THE PUBLIC TRUST BOARD MEETING HELD ON THURSDAY 13 JUNE 2019 AT 10:00 hours
The Board Room, Alexandra Hospital, Redditch

Present:

Chairman:	Sir David Nicholson	
Board members: (voting)	Paul Brennan	Chief Executive/Chief Operating Officer
	Anita Day	Non-Executive Director
	Matthew Hopkins	Chief Executive
	Graham James	Acting Chief Medical Officer
	Dame Julie Moore	Non-Executive Director
	Vicky Morris	Chief Nursing Officer
	Bill Tunnicliffe	Non-Executive Director
	Steve Williams	Non-Executive Director
	Mark Yates	Non-Executive Director
Board members: (non-voting)	Richard Haynes	Director of Communications
	Colin Horwath	Associate Non-Executive Director
	Tina Ricketts	Director of People and Culture
In attendance:	Kimara Sharpe	Company Secretary
Public Gallery:	Press	1
	Public	13 (including staff and Deaf Direct)
Apologies	Sarah Smith	Director of Strategy and Planning
	Richard Oosterom	Associate Non-Executive Director

33/19 **WELCOME**

Sir David welcomed everyone to the meeting. He explained that whilst the Trust Board meets monthly in public, every other month the Board focusses on performance and quality. This is the agenda for this meeting.

He welcomed representatives from the CQC and staff supporting W, a trustee from Deaf Direct who would be talking about the experience of deaf people within the Trust.

34/19 **PATIENT STORY**

Sir David explained that at every meeting, the Trust Board heard either a patient or staff story. He was pleased to welcome Deaf Direct to the meeting and recognised the relationship that has been formed in the last few years.

Sir David invited W to present his stories.

W thanked the Board for inviting him to present some of the challenges that people who are deaf face when attending the hospital.

He explained that deaf people have as their first language BSL (British Sign Language).

This means that hospital letters and leaflets are not easily understood as these are in English. It is important that front line staff have basic sign language to ensure that patients feel comfortable.

When coming to the emergency department, W suggested that an iPad be made available to enable dialogue to take place. He stated that this happens in Birmingham and wondered whether this could happen in Worcestershire.

W then turned to translation of written letters. Currently Deaf Direct is funded by the County Council to provide translation and interpreter services for service users who need to for example to change their appointment via the phone. This is also undertaken for NHS users, although even though Deaf Direct is not funded for this.

Rev David Southall, Equality and Diversity lead for the Trust explained that 150 staff had been trained in basic BSL. This was funded through the League of Friends at the Alexandra and Worcestershire Royal Hospitals. He felt a lot more could be undertaken and would like to train more staff but the funding is not available.

W then turned to accessing mental health services. He referred to a personal situation when he visited the mental health services in another area and communication was not possible.

Rev Southall highlighted that there are pieces of equipment which would be invaluable for staff but the funding was not available for them.

W gave an example of a patient who needed an operation but the interpreter was not allowed into the preoperative room.

Sir David thanked W for his stories. He stated that he would like one nurse on every shift with the ability to communicate with people who are deaf. He would like more work undertaken by the Equality and Diversity Council on the culture of deaf people. He also stated that he would like the possibility of providing an iPad be explored.

ACTION: Follow up from the Deaf Direct patient stories (Ms Ricketts/Mrs Morris)

W emphasised that basic BSL was a short course and advocated that this was part of nurse training.

Sir David thanked W and the interpreter, Angela, for their time.

35/19 **ANY OTHER BUSINESS**

There were no items of any other business.

36/19 **DECLARATIONS OF INTERESTS**

There were no additional declarations of interest. Sir David reminded members that the Register was on the website.

37/19 **MINUTES OF THE PUBLIC TRUST BOARD MEETING HELD ON 9 MAY 2019**

RESOLVED that:-

The Minutes of the public meeting held on 9 May 2019 were confirmed as a correct record subject to the following changes:

- Insert ‘the Junior Doctor experience in the’, para 4 and insert ‘issue relating to the exception reporting’, second line, para 8 on page 2.
- Insertion of the work ‘issues’ after ‘payment on page 2

- 17.19.3 – page 6, change 'the aim is still zero by September' to 'the aim is still zero waiting more than 40 weeks by September'.

37/19 **MATTERS ARISING/ACTION SCHEDULE**

Mrs Sharpe reported that all actions were complete.

38/19 **INTEGRATED PERFORMANCE REPORT**

38/19/1 **Executive summary**

Mr Hopkins introduced the Report. He explained that from next month, the data shown will be for a single month, not split across two months.

He stated that the key headlines were as follows:

- **Finance**
  - Work was continuing with partners in respect of the £9m system wide gap in the control total.
- **Performance**
  - The latest emergency access standard metric was in line with trajectory. Nationally there had been a deterioration in performance in May and June. The key area of local action relates to the Home First Worcestershire plan. He was concerned about the number of patients in hospital for more than 21 days. He confirmed that there was on-going work across the health system to ensure that patients were being cared for in the most appropriate place.
  - Patients were continuing to have a good experience if they had fractured their neck of femur. Performance in this metric was sustained.
- **Workforce**
  - The national interim workforce plan stated that there needed to be a continued focus on retention which was a focus for the Trust.
  - Mandatory training rates were still unsatisfactory and he explained that staff will no longer be paid until their mandatory training has been completed.

38/19/2 **Quality Performance/Quality Governance Committee Assurance Report**

Mrs Morris highlighted three areas:

- Infection prevention and control: She explained that the counting of C Diff attributed cases had changed. In April there were four cases and in May, three. This is under trajectory. The Deputy Director of Infection, Prevention and Control continued to work with divisions and all C Diff cases were subject to a root cause analysis. The lessons from these analyses were discussed across divisions.
- Medicines safety incidents: The trajectory as met at the end of March. Active work had been undertaken with respect to insulin which had resulted in the reduction of incidents of harm.
- Friends and Family test: she was pleased to report that this had improved.

Sir David invited Mr James to speak to the metrics:

- Venous Thrombolytic Embolism (VTE) prevention: The most recent figures show that 96.6% of eligible patients received an initial assessment. Just over 80% have a follow up assessment within 24 hours of admission (this is not nationally collected). He reported that there continued to be a challenge with the manual data collection and there was a focus in May on this.
- Mortality: The latest data, HSMR and SHMI, was for January. Crude mortality continues to be below that recorded for the previous year. The detail of this will be presented to the Quality Governance Committee in the following week. Analysis has been undertaken in relation to patients who have a diagnosis of

pneumonia and skin and soft tissue. There appeared to have been delays in admission from the emergency department. The focus on the improvement in patient flow should help with this. He was concerned that half the patients were on the end of life pathway and should not have been cared for within the Trust. ReSPECT will help this.

- Patients with a fractured neck of femur: He echoed Mr Hopkins view – performance was better with the centralisation of services. Mortality was one of the lowest in the country.

Mr Hopkins stated that mortality was one of the priorities in the annual plan. Mr Mike Berwick would be undertaking an external review during the summer, the results of which would be reported to the Board in the Autumn.

Dame Julie expressed concern that patients on an end of life pathway would not be counted in the HSMR figures. She then asked about the roll out of medical examiners and whether there was a coding issue with skin and soft tissue diseases. Mr James stated that the diagnosis was skin and soft tissue, although this may not be on the death certificate. He stated that 80% of deaths are reviewed by medical examiners and he would report to the Quality Governance Committee the results of these reviews. He explained that he was proposing a different model of managing learning from deaths which would be discussed at the Trust Management Executive the following week. The new process proposed that all deaths would be reviewed within 24 hours of death. This would require the recruitment of more medical examiners.

Mr Williams asked about data quality. He was concerned that the Trust had inherent problems with data quality and asked for a review of data quality at source. Mr Hopkins confirmed that there was a wide ranging review of data by an external company who has undertaken such work across the NHS. He stated that there needed to be a report on data quality at each Audit and Assurance Committee.

Mr Williams then turned to VTE. He was concerned that there would be a qualified audit in relation to the Quality Account. Mr James outlined the problems with the previous audits which related to two different ways of collecting data. The system was now different with only one system used, but based on a manual system. He stated that until there was a fully automated system, the trust would not be completed assured that all data were being collected.

Mr Hopkins reminded members that the digital strategy refers to the electronic recording of vital signs to enable the capture of indicators. This system would also be able to detect the deterioration of patients.

Dr Tunnicliffe expressed disappointment in the likelihood of a qualified audit for VTE for 2018/19. He noted that the qualification reflected the Trust's incomplete recording of data which was something which the Trust can fix. He also expressed disappointment with the performance of the Trust which was in the lowest quartile. Ward accreditation would help with this target however engagement of medical staff was essential.

Sir David asked for additional action on this issue. Mr Hopkins agreed.

ACTION: Mr James to report on additional actions being taken to ensure better compliance with the VTE indicator.

Mr Yates turned to the medical examiners. He stated that for a number of years he had been told that recruitment was key. However, nothing seems to have changed. Was the new process different? Mr James stated that the new process was building on the

foundations in place. The proposed system was different. He stated that there was a risk if medical examiners could not be recruited. Mr Hopkins added that the points raised would be reflected in the discussion at TME the following week.

Dr Tunnicliffe reported on the recent Quality Governance Committee meeting. He was pleased with the performance on the fracture neck of femur and pressure ulcers. He was concerned that one in five areas were not undertaking hand hygiene audits. Mrs Morris stated that there was now more engagement with clinicians and she gave an example of a health care assistant challenging a clinician. She assured Dr Tunnicliffe that the rate of hand hygiene audits would show an increase in May.

Dame Julie added that there had been a useful discussion in relation to the Local Maternity System (LMS).

Dr Tunnicliffe reported that there had been a 25% increase in PALS contacts. He was anxious that support was given to the small team delivering this service.

Sir David summarised by stating that there were still concerns with mortality and learning from deaths (which was being overseen by the Quality Governance Committee) and he was pleased with the performance of fractured neck of femur. He thanked Mr Brennan for his work on this area.

RESOLVED that
The Board

- Received the Committee report for assurance

38/19/3 **Financial & Operational Performance/Finance and Performance Committee Assurance Report**

Mr Toole spoke to the month 1 information. The target was £9.7m deficit and the performance was £8.7m deficit. He was concerned with the high level of activity in non-elective care. Income was behind plan. There was an indication that the new controls in place in relation to pay were making a difference. Schemes continued to be identified to meet the £22.5m cost improvement plan (CIP).

Ms Ricketts turned to the temporary workforce spend. The Trust was above the agency cap in month 1. There was a £9m target to reduce premium staffing costs. Governance had been revised and tightened with four working groups in place. A number of key performance indicators were being monitored.

Mr Horwath was pleased with the month 1 results. However he wondered whether progress was satisfactory on the underlying deficit. Mr Toole stated that it was difficult to assess this on just one month's data. He was confident that month 2 would continue the positive trend.

Mr Williams expressed concern about the scale of the challenge needed to meet the CIP - £2m per month. He reflected that in the Finance and Performance Committee, discussion has taken place which has indicated that £30-35m is needed to aim for, not £22.5m. He expressed concern that there was a shortfall of £122,000 for outpatients and £250,000 in maternity. He also asked about traction to ensure that the emergency department is not overloaded with people who should be receiving another service.

Mr Toole stated that he was not concerned about the outpatient shortfall. He was more concerned about the non-elective activity and impact on the bed base. He meets monthly with the commissioners and is raising the issues at other meetings. He welcomed input from colleagues. He confirmed that he was checking the maternity data

with colleagues.

Mr Hopkins reminded members that national attendances at emergency departments have increased. The Trust has had a 7.4% increase in emergency admissions compared to the previous year which is a step change in activity with resultant pressure on the bed base. He welcomed the merger of NHS England and NHS Improvement as this will enable an informed discussion to take place about the use of emergency services. He has met with the Clinical Commissioning Group accountable officer to discuss the financial challenge across the county and how services outside hospital need to change. He has also discussed elective activity and a need to reduce unnecessary referrals into hospital. He has a commitment from commissioners to work more effectively with the Trust to reduce patient demand but the growth is real. Every year emergency volumes go up.

Ms Day asked about progress against the £22.5m target. She was concerned that there appeared to be no further schemes identified. Mr Toole confirmed that of the £13m identified, not all were guaranteed. He is concentrating on the use of Kidderminster and is working with colleagues to develop schemes. Ms Day pressed Mr Toole about the progress being made. Mr Brennan stated that all the divisions owned the issues and he described the cross division work currently being undertaken. Flow was essential to get right. He expressed confidence that colleagues would deliver the required savings.

Sir David asked Mr Brennan to comment on the operational performance.

Mr Brennan recognised the work undertaken with respect to the fractured neck of femur metric. He stated that the current rehabilitation beds at Evesham would be closed and reprovided at Pershore within the current bed base. There has been a delay in transfer of some patients in the last couple of weeks but he continued to work with the Health and Care Trust.

Dame Julie asked whether NHS England/Improvement should be involved. Ms Blakeman confirmed that this has been discussed. More information will be presented to the A&E Delivery Board and there is a system wide plan in development. Mr Hopkins confirmed that he has discussed the issue with the Regional Director. Mrs Morris confirmed that she has a meeting to discuss a system wide quality impact assessment. Ms Blakeman reminded members that the health economy has a significant number of community beds and more work was needed jointly to ensure the optimum use of the beds.

Sir David asked whether the regulators were satisfied with the risk being with the Trust and individual patients. He stated that the issued needed escalating. Ms Blakeman confirmed that this was through the A&E delivery board. She stated that the original solution of the beds at Evesham was only temporary, although Mr Brennan disagreed with this statement. Ms Blakeman said that there was a role for the STP to become involved. Sir David requested an update at the next meeting.

ACTION: Provide an update on the rehabilitation beds at the next meeting (Mr Brennan)

Mr Brennan then turned to the stoke service. He was pleased to report that the SSNAP score has moved the Trust from D to C. Permanent consultants were now being recruited to the specialty. Sir David thanked Mr Brennan for his work in this area.

Mr Brennan went onto explain that the report will change with respect to performance. There will be a clear indication as to how the indicator is performing with respect to the

agreed trajectory. Currently, the four hour target is 1% above trajectory; the trajectory was not achieved for cancer 62 days. The majority of the non-achievement was due to urology and prostate pathways and he has met with colleagues to improve performance.

The aim for cancer 104 days was to reduce the waits to zero, apart from tertiary referrals. The number on the list was now 23.

Mr Brennan then turned to the referral to treatment targets (RTT). There are currently zero people waiting over 52 weeks and the Trust is on target for zero waits over 40 weeks at 30 September.

He went onto the Home First Worcestershire plan. There are six work streams with an executive lead for each work stream. There are two areas behind plan and actions should start to impact in July. The main area of concern are patients in hospital longer than 21 days. These patients can now be identified and an escalation process is in place. An integrated discharge team is being developed which will be managed by either social care or the Health and Care Trust. This team will initially work on the wards and if successful will work at the front door to reduce admissions.

Mr Brennan reported that two out the four surge areas have been removed. The AEC and discharge lounge are continuing being used and it is aimed to stop using them by 30 July.

Mr Williams stated that at the Finance and Performance Committee, the issue of outpatient and elective surgery productivity programme was discussed. He noted that the paper outlined the lessons learnt but did not detail the plan to learn the lessons and re-energise the project in order to achieve the targeted substantial patient and productivity benefits. Mr Hopkins and Mr Brennan agreed to follow up.

Sir David stated that the Trust is clearly financially challenged. Key to this is the ability to deliver on the CIP. Work on this needs to be stepped up. He was pleased with the operational performance.

RESOLVED that:
The Board

- Received the Committee report for assurance

38/19/4 **People and Culture Performance**

Ms Ricketts stated that there has been improvement in job planning – this is now at 95%. Medical appraisals are at 89% and non-medical appraisals are at 83%. She suggested a stretch target of 95% for mandatory training. After a challenge from Sir David, she stated that she was happy that this was achievable.

The main focus of the national Interim People Plan was retention. She was keen to ensure that Worcestershire Acute was the employer of choice. She was working to ensure that employees had the support from the Academy and she was rolling out the management development programme. Timewise was active within the Trust to determine how we can ensure flexible working for employees. There has been a slight improvement in turnover.

Sickness absence has increased to 4.23% but is still below national average. The target for the end of March is 4%. The Trust has achieved level 2 of the Employee Well-Being Charter.

Mr Yates was pleased that training for managers is in place. In general, key performance indicators are going in the right direction. He will pick up British Sign Language training at the next People and Culture Committee. He agreed that retention needed to be improved as the Trust was good at recruitment.

Mr Haynes asked the top three themes from the exit interviews and Ms Ricketts stated that these were retirement, flexible working and relocation.

Mr Hopkins stated that the pension related issues were significant across the Trust. Some senior clinicians were not undertaking waiting list initiatives due to the tax implications. They were also stepping down from leadership roles.

ACTION: Ms Ricketts to discuss the implications of the tax on pensions at the People and Culture Committee.

Dr Tunnicliffe asked about mandatory training for medical staff. Ms Ricketts explained that individuals were being written to and escalation was in place to the chief medical officer. Suspension would result after 1 August if staff had not undertaken the training or were not booked on the training.

RESOLVED that:
The Board:

- Received the report

39/19 **GOVERNANCE**

39/19/1 **ANNUAL PLAN**

Mr Hopkins presented the Annual Plan. He stated that a shorter, simpler version would be available for the staff, public and patients. The Plan sets out the priorities for the coming year. His overall aim was to stabilise finance and performance and build on the strategy development, quality improvement, governance and accountability. He highlighted that on page 5 there listed the achievements for 2018/19 and on page 6 a refresh of the vision, mission statement and key strategic priorities shown in the 'Pyramid'. Page 7 and onwards showed the key priorities and the associated improvement priorities for year. The Trust Management Executive agenda is organised around these five priorities (strategy, operational performance, quality, finance and people and culture).

Mr Hopkins went onto summarise the priorities for each of the five areas, contained on pages 7 to 14. Page 15 showed the key risks and the mitigation.

In conclusion, Mr Hopkins stated that the year is about building strong foundations for moving forward. Governance systems must be as effective as possible.

On behalf of the executive team, Mr Hopkins recommended for the Board to approve the Annual Plan.

Mr Horwath welcomed the Plan. He felt it was ambitious and clear. He wondered how the Plan would be reflected within the Board papers and agendas. Mr Hopkins stated that the improvement priorities are built into the performance report. Mrs Sharpe suggested that this could be an area for the Governance Working Group to consider. This was agreed.

ACTION: Mrs Morris to include the Plan on the agenda for the Governance Working Group.

Sir David agreed to the increase of the mandatory training target to 95% within the Plan. However, he was not satisfied that there was sufficient traction on the finances. It was agreed to review this. Mr Williams asked for transformation to be part of the savings plan. This was agreed.

ACTION: Mr Toole to review the finance section of the Plan and include transformation.

RESOLVED that:
The Board:

- Approved the annual plan for 2019/20.

39/19/2 **DIGITAL STRATEGY**

Sir David welcomed Mr Marsland to the meeting. Mr Toole stated that Mr Marsland has worked closely with the Associate Director for Information, Performance and IT to develop the strategy. There had been a lot of engagement with the strategy and critically implementation will improve patient health and well-being.

Mr Marsland stated that the Trust does not have a fit for purpose IT infrastructure. An electronic patient record is essential so that staff can access records wherever needed. More innovation and different ways of working is essential.

He was pleased to see the Trust objectives and stated that they are reflected throughout the document. He has also ensured that the recent STP digital strategy dovetails and elements of the NHS long term plan are also included.

The strategy needs to be clinically led with three main areas of focus:

- Patient safety
- Improved patient outcomes
- Operational efficiency.

The programme to implement the strategy will need a lot of focus. Business cases will be developed to detail the particular areas of expenditure.

Dame Julie was surprised there was no mention of clinical decision support and the need for decision support software. Mr Marsland agreed that this was an essential element and agreed to check the document. *Post meeting it was confirmed that this is mentioned 10 times in the Strategy including*

- *In three electronic patient record diagrams*
- *A full section on page 13, the characteristics of Decision Support including Care Pathways*
- *Examples of Decision Support Digital capabilities such as e-Observations.*

Sir David wondered whether the strategy was radical enough. Mr Marsland stated that it creates the environment for innovation. The challenge as he sees it is having the right staff in the right place to be able to executive the Plan. He was pleased that the Chief Digital Officer was being recruited to.

Mr Hopkins stated that the Chief Digital Officer will be able to lead on the issues relating to digital technology. They will be able to support the implementation. However, Mr Hopkins stated that much of the implementation relied upon the availability of capital which was scarce nationally. He stated that the risk rating in the Board Assurance Framework (BAF) around capital has been increased.

Dame Julie stated that the executive lead should be the Chief Nurse/Chief Medical Officer with support from the Chief Digital Officer. Sir David requested this to be considered. Mr Toole stated that this would be considered when reviewing how the Digital Strategy supports the clinical strategy.

Mr Yates asked about the availability of capital via NHS Digital. Mr Marsland confirmed that NHS Digital are aware of the development of the strategy. Dame Julie suggested that the Strategy should be taken forward by the health economy. Sir David confirmed that the discussions have already commenced through the STP.

Mr James confirmed that there had been a significant amount of clinical engagement. The strategy has not been developed in isolation. There is a huge commitment to ensuring that the Trust improves its digital capability.

Mr Brennan asked whether there was reference to home monitoring for patients under the Trust's care. *Post meeting note: this is referenced on page 35 of the strategy.*

RESOLVED that:
The Board:

- Approved the Digital Strategy

39/19/3 **CQC LETTERS**

Mrs Morris explained that the suite of letters circulated with the agenda had been received from the CQC following each site inspection. She had received two further letters in the past 48 hours. The Well Led inspection was taking place the following week. She was expecting the final report for publication at the end of August/beginning of September. She thanked Ms Gordon for her coordination work and she assured members that actions were being undertaken, particularly in respect of the findings at Evesham.

She outlined the preparatory work that CQC inspectors had undertaken with staff across the Trust in order that they could be as relaxed as possible and demonstrate the improvements made. She was pleased to report that staff had been very enthusiastic during the Inspection and able to articulate their areas of improvement to the CQC inspectors as well as being able to outline areas still to make further improvements. The one area for action would be the checklist process.

In response to Sir David, Mrs Morris confirmed that there had been no areas of immediate concern raised during the inspection. She was disappointed in some of the areas of variability across sites. Immediate action was taken when necessary and information provided to confirm if practice observed was a variance to practice.

Mr Yates was pleased to see that action had been taken immediately. Dr Tunnicliffe thanked Mrs Morris for her work. Mr Horwath asked how the staff had reacted to the visits. Mrs Morris stated that front line teams were very energised and enjoyed the visits. Mr Hopkins added that the theatre staff at Evesham were disappointed.

Ms Day added her positive reflections on how the staff had responded to the Inspection and her congratulations to staff and looked forward to the report being published and hopefully a celebration of the achievements.

RESOLVED that:
The Board:

- Noted the CQC feedback.

DATE OF NEXT MEETING

The next Public Trust Board meeting will be held on Thursday 11 July 2019 at 10:00 in Crompton Rooms A&B, Charles Hastings Education Centre, Worcester.

The meeting closed at 12:41 hours.

Signed _____ Date _____

Sir David Nicholson, Chairman

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

PUBLIC TRUST BOARD ACTION SCHEDULE – JULY 2019

RAG Rating Key:

Completion Status	
	Overdue
	Scheduled for this meeting
	Scheduled beyond date of this meeting
	Action completed

Meeting Date	Agenda Item	Minute Number (Ref)	Action Point	Owner	Agreed Due Date	Revised Due Date	Comments/Update	RAG rating
13-6-19	Patient story	34/19	Follow up from the Deaf Direct patient stories • Culture relating to deaf people • Provision of an iPad	TR VM/ RT	Sept 2019			
13-6-19	IPR	38/19/2	Report on additional actions being taken to ensure better compliance with the VTE indicator	GJ	July 2019		Additional actions being considered as a response to the Quality Account audit. To be taken forward through the QGC. Action closed.	
13-6-19	IPR	38/19/3	Provide an update on the rehabilitation beds at the next meeting	PB	July 2019		Being taken forward via the A&E delivery board. Discussion taken place with partners and NHS I/E. Action closed.	
13-6-19	IPR	38/19/4	Discuss the implications of the tax on pensions at the People and Culture Committee	TR	July 2019		Transferred to P&C – on agenda for next meeting. Action closed.	
13-6-19	Annual Plan	39/19/1	Include the Annual Plan on the agenda for the Governance Working Group, specifically to discuss how the agenda	VM	July 2019		Included within working group ToR. Action closed.	

			for trust board and committees could better reflect the Plan					
13-6-19	Annual Plan	39/19/2	Review the finance section of the Plan and include transformation	RT	July 2019		Review undertaken. Action closed.	

NHS
Worcestershire
Acute Hospitals
NHS Trust

Meeting	Trust Board
Date of meeting	11 July 2019
Paper number	C

Chief Executive's Report

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

Accountable Director	Matthew Hopkins CEO		
Presented by	Vicky Morris CNO	**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	

Report previously reviewed by		
Committee/Group	Date	Outcome
CNST – TME & QGC	June 2019	Approved

Recommendations	The Trust Board is requested to
	• Note this report
	• In respect of CNST
	  ○ Note that the two safety actions have been reassessed and the Division is focussing on full compliance
	  ○ Note that there is no option for partial compliance for 2019/20
	  ○ Approve the declaration that 8 out of 10 safety actions are compliant and note that the non-compliance does not indicate any safety issues or concerns.

Executive summary	This report is to brief the board on various local and national issues.

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

Meeting	Trust Board
Date of meeting	11 July 2019
Paper number	C

Introduction/Background

This report gives members an update on various local, regional and national issues.

Issues and options

Quality Account: The Quality Account 2018/19 was published on 30 June 2019. A robust, timely process was completed in preparation for the publication. This process was led by the Chief Nursing Officer (CNO). This included a monthly review of priorities and performance of quality priorities through the Quality Improvement Strategy, biannual review (November 2019), engagement with patients, carers and public on key priorities for 2019/20 (Nov 2019), agreement of priorities for 2019/20 with clinical teams and committees (January – June 2019), writing and editing of the final account (March - June 2019). The Quality Governance Committee reviewed the Account at its meetings during this time. The account was subject to an independent audit by our external auditors and a limited assurance report was received on 27 June 2019. A qualified conclusion was given as the Venous Thromboembolism (VTE) risk assessment data did not meet the six dimensions of quality. All other elements of the audit achieved the level of compliance required for publication. The Audit and Assurance Committee and Quality Governance Committee will receive this audit at their respective July meetings.

International recognition: A Cardiac Physiologist from Worcestershire Royal Hospital received international recognition after being asked to present about a life-saving heart case performed in Worcester, at a global conference in America. Amanda Hayden was been invited to attend the World Cardiology Conference in Orlando, Florida in June, to share what happened in an advanced Cardiac procedure carried out at Worcestershire Royal Hospital recently. The specialist procedure took place in the Cardiac Catheter Lab at the hospital, and saved the patient's life after solving a number of heart complications.

CNST (Clinical Negligence Scheme for Trusts): The Board will remember last year's self – assessment against the CNST standards and the Board declaration form which identified 2 safety actions which needed a partial declaration. The Board are asked to note those 2 safety actions have been re-assessed following significant financial investment and focus by the Division resulting in full compliance for those two actions this year.

The criterion for the 10 safety actions this year have changed and have very specific evidence and reporting requirements in order that the Board can make its declaration and for external scrutiny. The paper outlining the 10 safety actions are included in the appendices for information, however the Board are asked to note that this year there is not an option for partial compliance.

On that basis the Board are asked to sign the declaration; that 8 out of the 10 safety actions are compliant and 2 not compliant. On the basis of the detailed work undertaken by the Women and Children's Division, the non -compliance does not indicate any safety issues or concerns. The provision of information and evidence and timescales has influenced the self - assessment and non- compliance.

Regional and national advice in the midwifery professional groups/ meetings would indicate that our outcomes from this self- assessment are in the higher range of performance compared to our regional partners, many of whom are having to declare non -compliance on a higher number of safety actions.

Meeting	Trust Board
Date of meeting	11 July 2019
Paper number	C

Trusts that do not meet the 10 out of 10 threshold will not recover their contribution to the CNST maternity incentive fund, but may be eligible for a small discretionary payment from the scheme to help them to make progress against actions they have not achieved. Such a payment would be much lower level than the 10% contribution to the incentive fund.

The Board are advised that QGC will continue its review of the action plan and the detail to support this declaration in its July meeting.

Cakes and shakes are secret ingredient to help hospital recovery: Cakes and milkshakes are being used to help frail and elderly patients recover more quickly at the Alexandra Hospital in Redditch. The 'cake and shake' scheme is now running on Ward 12 at the hospital - which specialises in caring for frail and elderly patients - where staff give patients a piece of cake and choice of milkshake every afternoon.

Director of Public Health: Frances Howie will be leaving her post at the County Council at the end of July in order to take up a full-time post with the University of Worcester. Frances has had a leadership role in public health in Worcestershire since 2008. Frances has been working part-time at the University for the last two years and has now decided to do this full-time. The County Council are currently considering the best options for filling the Director of Public Health post at the Council.

Amanda Pritchard appointed NHS Chief Operating Officer and Chief Executive of NHS Improvement: Amanda Pritchard has been appointed as the NHS Chief Operating Officer. She is currently Chief Executive of Guy's and St Thomas' NHS Foundation Trust in London. The appointment follows an open competitive selection process and Amanda will take up post full time on 31 July. The new NHS chief operating officer post is directly accountable to the NHS chief executive Simon Stevens, and serves as a member of the combined NHS England /NHS Improvement national leadership team. The COO oversees NHS operational performance and delivery, as well as implementation of the service transformation and patient care improvements set out in the NHS Long Term Plan. The COO is also accountable to the NHSI Board as NHS Improvement's designated accountable officer with regulatory responsibility for Monitor.

NHSX: England's top digital clinician, national chief clinical information officer Dr Simon Eccles, has stepped down from the NHS Digital board and will be replaced by the newly-appointed chief executive of NHSX, Matthew Gould. NHSX brings the benefits of modern technology to every patient and clinician. It combines the best talent from government, the NHS and industry.

Top surgeon appointed first NHS clinical director for violence reduction: The NHS has appointed its first clinical director for violence reduction to help prevent stabbings and other violent crime. Martin Griffiths, a lead surgeon at Bart's Health NHS Trust in London, has spent the past decade visiting schools to lecture on the dangers of carrying weapons as well as saving lives on the operating table.

Recommendations

The Trust Board is requested to note this report.

Meeting	Trust Board
Date of meeting	11 July 2019
Paper number	C

Appendices
- CNST report

Meeting	Trust Board
Date of meeting	11 July 2019
Paper number	CEO report attachment

Worcestershire Acute Hospitals NHS Trust progress against the Clinical Negligence Scheme for Trusts (CNST) incentive scheme - maternity safety actions

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

Accountable Director	Vicky Morris, Chief Nursing Officer		
Presented by	Vicky Morris Chief Nursing Officer	**Author /s**	Angus Thomson, Divisional Medical Director /Justine Jeffery Divisional Director of Midwifery & Gynaecology Nursing

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
Divisional Management Board	5.6.19	Approved
TME	19.7.19	Approved
QGC	20.7.19	Approved

Recommendations	The Board is asked to • Note that the two safety actions have been reassessed and the Division is focussing on full compliance • Note that there is no option for partial compliance for 2019/20 • Approve the declaration that 8 out of 10 safety actions are compliant and note that the non-compliance does not indicate any safety issues or concerns.

Executive summary	The CNST Incentive scheme provides an opportunity to significantly reduce the Trust contribution to the scheme in 2019/20. The Women and Children Division have completed a self-assessment against the 10 standards, gathered evidence of compliance and identified actions required to improve compliance in the two standards where full compliance has not been achieved. The evidence has been provided in the attached gap analysis which is included in the appendices and overall compliance summarised in the table below. The DMT has reviewed all the documentation and can provide assurance to the Board that the evidence supports the self-assessment.

Meeting	Trust Board
Date of meeting	11 July 2019
Paper number	CEO report attachment

	The Board is asked to review the evidence and sign off the paper to enable submission to NHS Resolution by 15th August 2019.

Safety Action	**1**	**2**	**3**	**4**	**5**
Current RAG					
Action required	None	None	Share action plan with board, LMS and ODN		Create a report mechanism for bi-annual staffing report Complete audit for 1:1 care in labour
Safety Action	**6**	**7**	**8**	**9**	**10**
Current RAG					
Action required	None	None	None	None	None

Table 1. Summary of compliance with CNST Safety Actions

Risk								
Key Risks	CNST standards all relate to the quality and safety of the care that we provide. Therefore the risks in failing to achieve these standards would be risks to the quality of care and to patient experience. In addition there is a financial incentive scheme to achieving CNST standards with inherent financial risk if we fail to achieve these.							
Assurance	Assurance is provided in the form of a gap analysis and action plan which outlines the evidence available to demonstrate compliance							
Assurance level	**Significant**		**Moderate**		**Limited**	x	**None**	
Financial Risk	It is unclear at this stage how much of the premium will be awarded to Trust that do not achieve all ten of the safety actions.							

Meeting	Trust Board
Date of meeting	11 July 2019
Paper number	CEO report attachment

Introduction/Background

In line with The Secretary of State for Health's announcement on the 28 November 2017 on "Safer maternity care: progress and next steps" the CNST maternity incentive scheme was implemented for 2018/19. The scheme is now in its second year and there have been some significant changes in the level of evidence that has been requested to achieve compliance with the 10 safety actions.

The maternity element of contributions is increased by 10% above the standard 2019/20 maternity contribution to continue to create a maternity incentive fund.

Maternity services that can demonstrate achievement of a specified set of requirements will be eligible for a share of that incentive fund of at least 10% of their base contribution together with a share of the balance of undistributed funds, the amount of which will be determined once the results from all services have been gathered. The specific safety actions are:

1. Are you using the National Perinatal Mortality Review Tool to review perinatal deaths?
2. Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?
3. Can you demonstrate that you have transitional care facilities that are in place and operational to support the implementation of the ATAIN Programme?
4. Can you demonstrate an effective system of medical workforce planning?
5. Can you demonstrate an effective system of midwifery workforce planning?
6. Can you demonstrate compliance with all four elements of the Saving Babies' Lives care bundle?
7. Can you demonstrate that you have a patient feedback mechanism for maternity services, such as the Maternity Voices Partnership Forum, and that you regularly act on feedback?
8. Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?
9. Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bi-monthly with Board level champions to escalate locally identified issues?
10. Have you reported 100% of qualifying 2017/18 incidents under NHS Resolution's Early Notification Scheme?

A standard template for providing evidence of compliance has been produced by NHS Resolution. The completed template will need to be submitted to NHS Resolution by 15th August 2019. Maternity services that do not demonstrate achievement may be allocated a smaller sum from the fund to support them to implement the required actions.

Once the full results are available for all maternity providers, NHS Resolution will confirm the value of the credit to be made to members. A credit note will be issued and a payment made. For Worcestershire Acute Hospitals NHS Trust compliance with the 10 standards will mean a reduction in CNST contributions of at least £565,000.

Meeting	Trust Board
Date of meeting	11 July 2019
Paper number	CEO report attachment

Issues and options

Following the completion of a gap analysis the DMT identified that there were two safety actions that could not be evidenced in full as some internal/external reporting deadlines had not been met; therefore partial compliance has been confirmed. To rectify this and to achieve full compliance the following actions would need to be completed in readiness for submission in year 3:

1. The ATAIN action plan to be shared with the ODN,LMS and Board
2. Develop a mechanism for reporting midwifery staffing issues and national 'red flags' to Board bi-annually

Conclusion

The evidence provided supports the achievement of compliance in eight of the safety actions, there are two safety actions were partial compliance has been declared.
The actions identified will require no additional resources; the DMT will create a mechanism for completing and monitoring the aforementioned reports.

Recommendations

- Note that the two safety actions have been reassessed and the Division is focussing on full compliance
- Note that there is no option for partial compliance for 2019/20
- Approve the declaration that 8 out of 10 safety actions are compliant and note that the non-compliance does not indicate any safety issues or concerns.

Appendices

CNST Gap analysis/Action Plan V2 100619 (available on request)

Meeting	Trust Board
Date of meeting	11 July 2019
Paper number	CEO report attachment

Section A : Please choose your trust in the Guidance tab

Action No.	Maternity safety action	Action met? (Y/N)
1	Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?	Y
2	Are you submitting data to the Maternity Services Data Set to the required standard?	Y
3	Can you demonstrate that you have transitional care services to support the Avoiding Term Admissions Into Neonatal units Programme?	P
4	Can you demonstrate an effective system of medical workforce planning to the required standard?	Y
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	P
6	Can you demonstrate compliance with all four elements of the Saving Babies' Lives care bundle?	Y

Meeting	Trust Board
Date of meeting	11 July 2019
Paper number	CEO report attachment

7	Can you demonstrate that you have a patient feedback mechanism for maternity services and that you regularly act on feedback?	Y
8	Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?	Y
9	Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bi-monthly with Board level champions to escalate locally identified issues?	Y
10	Have you reported 100% of qualifying 2018/19 incidents under NHS Resolution's Early Notification scheme?	

NHS
Worcestershire Acute Hospitals NHS Trust

Meeting	Trust Board
Date of meeting	11 July 2019
Paper number	D

Board Assurance Framework

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

Accountable Director	Matthew Hopkins CEO		
Presented by	Kimara Sharpe Company Secretary	**Author /s**	All responsible executive directors

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	19 June 2019	Approved
TME	20 June 2019	Approved, subject to risk rating of risk 4 (see text)
Quality Governance Committee	21 June 2019	Approved
Finance and Performance Committee	28 June 2019	Approved

Recommendations	The Trust Board is requested to approve the attached Board Assurance Framework (BAF) update.

Executive summary	The attached BAF is the most recent update, approved by the appropriate committees and the Trust Management Executive. The BAF is now aligned to the Trust objectives as outlined in the Annual Plan. At the TME, a challenge was raised in respect of a proposal to reduce the risk rating of BAF risk 4 to 16 from 20. This issue has not been resolved so the risk rating remains at 20. The next iteration of the BAF will be in the Autumn. There will be a focus on the appropriateness of the controls at the Governance Working Party over the Summer period.

Risk									
Key Risks	The BAF considers all the high rated risks for the Trust.								
Assurance	There is significant assurance in relation to the process for the development of the BAF.								
Assurance level	**Significant**	*x*	**Moderate**		**Limited**		**None**		
Financial Risk	N/A								

Board Assurance Framework – Gap analysis

This analysis shows the difference between the target risk and the current risk rating.

no	risk	gap
6	IF we are unable to resolve the structural imbalance in the trust's income and expenditure position, then we will not be able to fulfill our financial duties, resulting in the potential inability to invest in services to meet the needs of our patients.	14
7	If we are not able to unlock funding for investment, then we will not be able to modernise our estate, replace equipment or develop the digital infrastructure, resulting in the lack of ability to deliver safe, effective and efficient care to patients	14
4	If we do not achieve safe and efficient patient flow and improve our processes and capacity and demand planning, then we will fail the national quality and performance standards, resulting in a negative patient experience and a possible compromise to patient safety	11
10	If we do not deliver a cultural change programme, then we may fail to attract and retain staff with the values and behaviours required for putting patients first, resulting in lower quality care	10
12	If we have a poor reputation, then we will be unable to recruit or retain staff, resulting in loss of public confidence in the trust, lack of support of key stakeholders and system partners and a negative impact on patient care	10
3	If we do not deliver the statutory requirements under the Health and Social Care Act (Hygiene Code) then there is a risk that patient safety may be adversely affected, resulting in poor patient experience and inconsistent/varying patient outcomes	9
1	If we do not have in place robust clinical governance, then we may fail to deliver high quality safe care, resulting in negative impact on patient experience and outcomes.	8
8	If we do not have effective digital systems which are used optimally, then we will be unable to utilise the systems for the benefit of patients, resulting in poorly coordinated care for patients and a poor patient experience	8
9	If we are unable to sustain our clinical services, then the trust will become unviable, resulting in inequity of access for our patients	8
11	If we are unable to recruit, retain and develop sufficient numbers of skilled, competent and trained staff, including those from the eu, then there is a risk to the sustainability of some clinical services. resulting in lower quality care for our patients and higher staffing costs	8
5	If there is a lack of a county wide operational plan which balances demand and capacity across the county, then there will be delays to patient treatment, resulting in a significant impact on the trust's ability to deliver safe, effective and efficient care to patients	7
2	If we do not deliver the outcomes of the quality improvement strategy (incorporating the CQC 'must and should' dos), then we may fail to deliver sustained improvements, resulting in improvements not being delivered for patient care & reputational damage	6

RISK NUMBER	DATIX REF/DATE OF INITIAL RISK	RISK DESCRIPTION	EXEC LEAD	RESPONSIBLE COMMITTEE	PREVIOUS			CURRENT 30 JUNE 2019			CHANGE	LAST REVIEW	NEXT REVIEW	PAGE NUMBER
					RISK RATING 30 SEPT 2018	RISK RATING 30 NOV 2018	RISK RATING 30 APRIL 2019	LIKELIHOOD	CONSEQUENCE	RISK RATING				
1	3927 ------ 2017	IF we do not have in place robust clinical governance THEN we may fail to deliver high quality safe care RESULTING IN negative impact on patient experience and outcomes.	Chief Medical Officer	Quality Governance	12	12	16	4	4	16	⇔	June 2019	Oct 2019	7
2	3930 ------ 2018	IF we do not deliver the outcomes of the Quality Improvement Strategy (incorporating the CQC 'must and should' dos) THEN we may fail to deliver sustained improvements RESULTING IN improvements not being delivered for patient care & reputational damage	Chief Nurse	Quality Governance	16	16	12	3	4	12	⇔	June 2019	Oct 2019	9

RISK NUMBER	DATIX REF/DATE OF INITIAL RISK	RISK DESCRIPTION	EXEC LEAD	RESPONSIBLE COMMITTEE	PREVIOUS			CURRENT 30 JUNE 2019			CHANGE	LAST REVIEW	NEXT REVIEW	PAGE NUMBER
					RISK RATING 30 SEPT 2018	RISK RATING 30 NOV 2018	RISK RATING 30 APRIL 2019	LIKELIHOOD	CONSEQUENCE	RISK RATING				
3	3931 ------ 2018	IF we do not deliver the statutory requirements under the Health and Social Care Act (Hygiene code) THEN there is a risk that patient safety may be adversely affected RESULTING IN poor patient experience and inconsistent/varying patient outcomes	Chief Nurse	Quality Governance	16	16	16	3	4	12	⇩	June 2019	Oct 2019	11
4	3932 ------ 2018	IF we do not achieve safe and efficient patient flow and improve our processes and capacity and demand planning THEN we will fail the national quality and performance standards RESULTING IN a negative patient experience and a possible compromise to patient safety	Chief Operating Officer	Finance and Performance	20	20	20	4	5	20	⇔	June 2019	Oct 2019	13

RISK NUMBER	DATIX REF/DATE OF INITIAL RISK	RISK DESCRIPTION	EXEC LEAD	RESPONSIBLE COMMITTEE	PREVIOUS			CURRENT 30 JUNE 2019			CHANGE	LAST REVIEW	NEXT REVIEW	PAGE NUMBER
					RISK RATING 30 SEPT 2018	RISK RATING 30 NOV 2018	RISK RATING 30 APRIL 2019	LIKELIHOOD	CONSEQUENCE	RISK RATING				
5	3933 ------ 2018	IF there is a lack of a county wide operational plan which balances demand and capacity across the county THEN there will be delays to patient treatment RESULTING IN a significant impact on the trust's ability to deliver safe, effective and efficient care to patients	Chief Operating Officer	Finance and Performance	20	20	15	4	4	16	⇧		Oct 2019	14
6	3934 ------ 2018	IF we are unable to resolve the structural imbalance in the Trust's income and expenditure position THEN we will not be able to fulfill our financial duties RESULTING IN the potential inability to invest in services to meet the needs of our patients.	Chief Financial Officer	Finance and Performance	15	15	20	5	4	20	⇔	June 2019	Oct 2019	15
7	3941 ------ 2018	IF we are not able to unlock funding for investment THEN we will not be able to modernise our estate, replace equipment or develop the digital infrastructure RESULTING IN the lack of	Chief Financial Officer	Finance and Performance	16	15	16	5	4	20	⇧	June 2019	Oct 2019	17

RISK NUMBER	DATIX REF/DATE OF INITIAL RISK	RISK DESCRIPTION	EXEC LEAD	RESPONSIBLE COMMITTEE	PREVIOUS			CURRENT 30 JUNE 2019			CHANGE	LAST REVIEW	NEXT REVIEW	PAGE NUMBER
					RISK RATING 30 SEPT 2018	RISK RATING 30 NOV 2018	RISK RATING 30 APRIL 2019	LIKELIHOOD	CONSEQUENCE	RISK RATING				
		ability to deliver safe, effective and efficient care to patients												
8	3936 ------ 2018	IF we do not have effective digital systems which are used optimally THEN we will be unable to utilise the systems for the benefit of patients RESULTING IN poorly coordinated care for patients and a poor patient experience	Chief Digital Officer/Chief Medical Officer	Finance and Performance/ Quality Governance Committee	16	16	16	4	4	16	⇔	June 2019	Oct 2019	18
9	3937 ------ 2017	IF we are unable to sustain our clinical services THEN the Trust will become unviable RESULTING IN inequity of access for our patients	Director of Strategy and Planning	Finance and Performance	16	16	16	4	4	16	⇔	June 2019	Oct 2019	20
10	3938 ------ 2017	IF we do not deliver a cultural change programme. THEN we may fail to attract and retain staff with the values and behaviours required for putting patients first RESULTING IN lower quality care	Director of People and Culture	People and Culture	15	15	15	3	5	15	⇔	June 2019	Oct 2019	21

RISK NUMBER	DATIX REF/DATE OF INITIAL RISK	RISK DESCRIPTION	EXEC LEAD	RESPONSIBLE COMMITTEE	PREVIOUS			CURRENT 30 JUNE 2019			CHANGE	LAST REVIEW	NEXT REVIEW	PAGE NUMBER
					RISK RATING 30 SEPT 2018	RISK RATING 30 NOV 2018	RISK RATING 30 APRIL 2019	LIKELIHOOD	CONSEQUENCE	RISK RATING				
11	3939 ------ 2018	IF we are unable to recruit, retain and develop sufficient numbers of skilled, competent and trained staff, including those from the EU THEN there is a risk to the sustainability of some clinical services RESULTING IN lower quality care for our patients and higher staffing costs	Director of People and Culture	People and Culture	16	16	16	4	4	16	⇔	June 2019	Oct 2019	23
12	3940 ------ 2018	IF we have a poor reputation THEN we will be unable to recruit or retain staff RESULTING IN loss of public confidence in the Trust, lack of support of key stakeholders and system partners and a negative impact on patient care	Director of Communications and Engagement	None – Trust Board	16	16	16	4	4	16	⇔	June 2019	Oct 2019	25

Glossary – page 24

BAF RISK REFERENCE *Summary for Datix entry*	1 Lack of robust clinical governance	**DATE OF REVIEW**	June 2019
DATIX REF	3927 (Linked to corporate risks 3946)	**NEXT REVIEW DATE**	Oct 2019

RISK DETAILS

RISK DESCRIPTION	RATING	L	C	R	CHANGE
IF we do not have in place robust clinical governance THEN we may fail to deliver what high quality safe care RESULTING IN negative impact on patient experience and outcomes.	**INITIAL**	4	5		⇔
	TARGET Dec 19	2	4		
	PREVIOUS	4	4		
	CURRENT	4	4		

CONTEXT

STRATEGIC OBJECTIVE	Best experience of care and outcomes for our patients
GOAL (S)	Quality and Improvement
CQC DOMAIN	Safe, Caring, Effective, Well Led

ACCOUNTABILITY

CHIEF OFFICER LEAD	Chief Medical Officer
RESPONSIBLE COMMITTEE	Quality Governance Committee

CONTROLS AND ASSURANCE

REF	CONTROL	ASSURANCE	LEVEL
1	Framework for governance including (not exhaustive) • Learning from deaths • Better outcomes • Serious incident management • Divisional governance leads • Outcomes • Complaints • Learning	Clinical Governance Committee (CGG) report to Trust Management Executive (TME) and Quality Governance Committee (QGC) (monthly) and Trust Board (bimonthly) monitoring via Integrated Performance Report and Learning from Deaths	2
2	Quality Improvement Strategy and associated plans	CGG report to TME	1
3	Risk Management Strategy	Reviewed by TME, QGC, Audit and Assurance Committee & Trust Board	2
4	Performance Review Meetings	TME	0

REF	CONTROL	ASSURANCE	LEVEL
5	Medical annual appraisals	NHS E/Trust Board/People and Culture	3

ACTIONS

REF	GAP	ACTION	BY WHEN	PROGRESS
1	Framework for clinical governance	Development of a framework	Dec 2019	
2		Interim report on the development of a framework	Sept 2019	
	Effectiveness of medical appraisals	Review appraisals	Dec 2019	

BAF RISK REFERENCE *Summary for Datix entry*	2 Failure to deliver the Quality Improvement Strategy and the CQC 'must and should dos'	**DATE OF REVIEW**	June 2019
DATIX REF	3930 (linked to corporate risks 3946)	**NEXT REVIEW DATE**	Oct 2019

RISK DETAILS

RISK DESCRIPTION	INTERIM TARGET		RATING	L	C	R	CHANGE
IF we do not deliver the outcomes of the Quality Improvement Strategy (incorporating the CQC 'must and should' dos) THEN we may fail to deliver sustained improvements RESULTING IN improvements not being delivered for patient care & reputational damage	2020	2x4	INITIAL	4	4		⇔
			TARGET 2021	2	3		
			PREVIOUS	3	4		
			CURRENT	3	4		

CONTEXT

STRATEGIC OBJECTIVE	Best experience of care and outcomes for our patients
GOAL	Quality and Improvement
CQC DOMAIN	Safe, Effective, Well Led

ACCOUNTABILITY

CHIEF OFFICER LEAD	Chief Nurse
RESPONSIBLE COMMITTEE	Quality Governance Committee

CONTROLS AND ASSURANCE

REF	CONTROL	ASSURANCE	LEVEL
1	Reporting from the CGG to the Quality Governance Committee	TME and Quality Governance Committee – bimonthly	2
2	Year 2 Quality Improvement Plans developed for Divisions	CGG – monthly	1
3	Collaboratives in place to underpin the implementation of the QIS (*e coli*, nutrition, falls (rolled out), pressure ulcers (rolled out), staff retention, ACP fast track)	CGG report to TME and Quality Governance Committee monthly	2
4	On-going quality audits	Report to CGG	1
5	Board members undertaking safety walk abouts	Report to TME, Quality Governance Committee	2
6	Risk management strategy in place to ensure best practice in risk management and risk maturity	Risk Management Strategy approved by TME, QGC, Audit and Assurance Committee, Trust board	2/3
7	RAIT and QIS meeting	CGG report to TME and Quality Governance Committee	2

REF	CONTROL	ASSURANCE	LEVEL
8	Band 7, 8 development sessions	People and Culture Committee	2
9	Risk Maturity assessment	Oxford University Hospitals	3
10	Triangulation of ward accreditation/ward to board reporting/QI training	CCG report to TME and QGC	2

ACTIONS

REF	GAP	ACTION	BY WHEN	PROGRESS
1	Annual monitoring of quality improvement strategy	Publication of Quality Account	Jun 2020	
2	Ward to Board flow	Bespoke quality walk abouts	Aug 2019	
3	Robust QIA process	Revision of policy and process	July 2019	

BAF RISK REFERENCE *Summary for Datix entry*	3 Lack of delivery of statutory requirements of the Hygiene Code	**DATE OF REVIEW**	June 2019
DATIX REF	3931 (linked to corporate risks 3852, 4075)	**NEXT REVIEW DATE**	Oct 2019

RISK DETAILS

RISK DESCRIPTION	INTERIM TARGET		RATING	L	C	R	CHANGE
IF we do not deliver the statutory requirements under the Health and Social Care Act (Hygiene code) THEN there is a risk that patient safety may be adversely affected RESULTING IN poor patient experience and inconsistent/varying patient outcomes	Mar 2020	2x3	INITIAL	4	4		⇩
			TARGET	1	3		
			PREVIOUS	4	4		
			CURRENT	3	4		

CONTEXT

STRATEGIC OBJECTIVE	Best experience of care and outcomes for our patients
GOAL	Quality and Improvement
CQC DOMAIN	Safe, Effective, Well Led

ACCOUNTABILITY

CHIEF OFFICER LEAD	Chief Nurse
RESPONSIBLE COMMITTEE	Quality Governance Committee

CONTROLS AND ASSURANCE

REF	CONTROL	ASSURANCE	LEVEL
1	2019/20 Improvement plan in place	Monthly reports to TME and QGC	2
2	Key standards in place	Monthly reports to TME and QGC	2
3	Reporting from Trust Infection Prevention and Control Committee (TIPCC)	Monthly reports to TME and QGC and Trust Board	2
4	PFI Contract management	Regular reports to F&P	1
5	Infection control link professionals	Report to TIPCC	0
6	Hand hygiene audits	Report to CCG/TME/QGC	2

ACTIONS

REF	GAP	ACTION	BY WHEN	PROGRESS
1		Ongoing sustained implementation of the Quality	Mar 2021	

REF	GAP	ACTION	BY WHEN	PROGRESS
		Improvement Strategy including a refreshed strategy and year 2 divisional plans		
2	Annual monitoring of quality improvement strategy	Publication of Quality Account	Jun 2020	
3	PFI contract monitoring	Implementation of the new governance structure for the PFI contract (including KPIs)	TBC	
4	Annual Report – TIPCC	Publication	June 2020	

BAF RISK REFERENCE *Summary for Datix entry*	4 The Trust is unable to ensure efficient patient flow through our hospitals	**DATE OF REVIEW**	June 2019
DATIX REF	3832 (linked to corporate risks 3482, 3483)	**NEXT REVIEW DATE**	Oct 2019

RISK DETAILS

RISK DESCRIPTION	RATING	L	C	R	CHANGE
IF we do not achieve safe and efficient patient flow and improve our processes and capacity and demand planning THEN we will fail the national quality and performance standards RESULTING IN a negative patient experience and a possible compromise to patient safety	**INITIAL**	4	5		⇔
	TARGET Dec 19	3	3		
	PREVIOUS	4	5		
	CURRENT	4	5		

CONTEXT

STRATEGIC OBJECTIVE	Best services for local people
GOAL	Performance
CQC DOMAIN	Safe, Responsive, Effective

ACCOUNTABILITY

CHIEF OFFICER LEAD	Chief Operating Officer
RESPONSIBLE COMMITTEE	Finance and Performance Committee

CONTROLS AND ASSURANCE

REF	CONTROL	ASSURANCE	LEVEL
1	Delivery of the Home First Worcestershire Plan	TME and F&P Committee	1-2
2	Delivery of the referral to treatment (RTT) recovery plan/cancer plan/diagnostics plan	TME and F&P Committee	1-2
3	Capacity and demand modelling work	TME and F&P Committee/A&E delivery Board/Carnall Farrah	1-2-3
4	Service reconfiguration actions	Health Overview and Scrutiny Committee/A&E Delivery Board/	3

ACTIONS

REF	GAP	ACTION	BY WHEN	PROGRESS
1	Implementation of the Urgent care Improvement Plan	Implementation of the 6 work streams contained within Home First Worcestershire	Oct 2019	
2	The Trust is not commissioned to deliver the NHS constitutional standard for incomplete RTT	Maintain size of incomplete waiting listReduce maximum wait to 40 weeks	Mar 2020 Sept 2019	

BAF RISK REFERENCE *Summary for Datix entry*	5 Lack of county wide operational demand management	**DATE OF REVIEW**	June 2019
DATIX REF	3933 (linked to corporate risks 3482)	**NEXT REVIEW DATE**	Oct 2019

RISK DETAILS

RISK DESCRIPTION	RATING	L	C	R	CHANGE
IF there is a lack of a county wide operational plan which balances demand and capacity across the county THEN there will be delays to patient treatment RESULTING IN a significant impact on the trust's ability to deliver safe, effective and efficient care to patients	**INITIAL**	4	5		⇧
	TARGET	3	3		
	PREVIOUS	3	5		
	CURRENT	4	4		

CONTEXT

STRATEGIC OBJECTIVE	Best services for local people
GOAL	Performance
CQC DOMAIN	Safe, Responsive, Effective

ACCOUNTABILITY

CHIEF OFFICER LEAD	Chief Operating Officer
RESPONSIBLE COMMITTEE	Finance and Performance Committee

CONTROLS AND ASSURANCE

REF	CONTROL	ASSURANCE	LEVEL
1	Delivery of system level winter plan and escalation framework and associated actions	A&E Delivery board	3
2	Delivery of capacity plans from partners	A&E Delivery Board	3

ACTIONS

REF	GAP	ACTION	BY WHEN	PROGRESS
1	Lack of a confirmed A&E delivery board plan	Finalise plan		
		Develop implementation plan	Sept 2019	
		Execute the plan	Oct 2019	

BAF RISK REFERENCE *Summary for Datix entry*	6 The Trust is unable to ensure financial viability and make the best use of resources for our patients.	**DATE OF REVIEW**	June 2019
DATIX REF	3934 (linked to corporate risks 3768, 3792)	**NEXT REVIEW DATE**	Oct 2019

RISK DETAILS

RISK DESCRIPTION	INTERIM TARGETS		RATING	L	C	R	CHANGE
IF we are unable to resolve the structural imbalance in the Trust's income and expenditure position THEN we will not be able to fulfill our financial duties RESULTING IN the potential inability to invest in services to meet the needs of our patients.	**2020**	**5x3**	**INITIAL**	5	3		⇨
	2021	**4x3**	**TARGET 2022**	3	2		
			PREVIOUS	5	4		
			CURRENT	5	4		

CONTEXT

STRATEGIC OBJECTIVE	Best use of resources
GOAL	Finance
CQC DOMAIN	Effective, Well Led

ACCOUNTABILITY

CHIEF OFFICER LEAD	Chief Finance Officer
RESPONSIBLE COMMITTEE	Finance & Performance Committee

CONTROLS AND ASSURANCE

REF	CONTROL	ASSURANCE	LEVEL
1	Weekly review of efficiency and improvement plans, ideas and delivery	Finance Improvement Group, TME, Finance and Performance Committee	1/2
2	Operational budgets developed at divisional and directorate level	Finance Improvement Group, TME, Finance and Performance Committee	1
3	Medium Term Financial (MTF) Plan	TME/F&P/Trust Board/NHS Improvement	3

ACTIONS

REF	GAP	ACTION	BY WHEN	PROGRESS
1	MTF Plan	Develop the MTF Plan	Dec 2019	
2	Fully identified and assignable improvement opportunities	Ensure rolling programme of continuous improvement	Oct 2019 On-going	
3	Ownership of financial situation	Finance is included within personal objectives which are aligned to trust objectives	Oct 2019 On-going	

BAF RISK REFERENCE *Summary for Datix entry*	7 The Trust is unable to secure investment capital to make the best use of resources for our patients.	**DATE OF REVIEW**	June 2019
DATIX REF	3941 (linked to corporate risks 3772, 3792)	**NEXT REVIEW DATE**	Oct 2019

RISK DETAILS

RISK DESCRIPTION	INTERIM TARGETS		RATING	L	C	R	CHANGE
IF we are not able to unlock funding for investment THEN we will not be able to modernise our estate, replace equipment or develop the digital infrastructure RESULTING IN the lack of ability to deliver safe, effective and efficient care to patients	**2020**	**3x5**	**INITIAL**	3	5		⇨
	2021	**3x4**	**TARGET 2022**	2	3		
			PREVIOUS	4	5		
			CURRENT	5	4		

CONTEXT

STRATEGIC OBJECTIVE	Best use of resources
GOAL	Finance
CQC DOMAIN	Effective, Well Led

ACCOUNTABILITY

CHIEF OFFICER LEAD	Chief Finance Officer
RESPONSIBLE COMMITTEE	Finance & Performance Committee

CONTROLS AND ASSURANCE

REF	CONTROL	ASSURANCE	LEVEL
1	Capital prioritisation group constituted to prioritise capital spend	Decisions reviewed and endorsed by Strategy and Planning Group, TME, F&P	1-2
2	Loan funding requests and review of outcomes	TME and overseen by Finance and Performance Committee	2

ACTIONS

REF	GAP	ACTION	BY WHEN	PROGRESS
1	Medical devices strategy	Develop strategy	Oct 2019	
2	MTF plan	Develop the MTF plan	Dec 2019	

BAF RISK REFERENCE *Summary for Datix entry*	8 Ineffective digital/IMT systems	**DATE OF REVIEW**	February 2019
DATIX REF	3936 (linked to corporate risks tbc)	**NEXT REVIEW DATE**	May 2019

RISK DETAILS

RISK DESCRIPTION	INTERIM TARGET	RATING	L	C	R	CHANGE
IF we do not have effective digital systems which are used optimally THEN we will be unable to utilise the systems for the benefit of patients RESULTING IN poorly coordinated care for patients and a poor patient experience	**2021 3x4**	**INITIAL**	4	4		⇔
		TARGET 2024	2	4		
		PREVIOUS	4	4		
		CURRENT	4	4		

CONTEXT

STRATEGIC OBJECTIVE	Best services for local people
GOAL	Strategy
CQC DOMAIN	Safe, Effective, Well Led

ACCOUNTABILITY

CHIEF OFFICER LEAD	Chief Digital Officer/Chief Medical Officer
RESPONSIBLE COMMITTEE	Finance & Performance Committee/ Quality Governance Committee

CONTROLS AND ASSURANCE

REF	CONTROL	ASSURANCE	LEVEL
1	Governance for implementation of Digital Strategy	Report to TME/F&P/Trust Board	2
2	Alignment to STP Digital Strategy	STP Digital Board	3
3	Internal audit report on clinical systems	Internal audit/Audit and Assurance Committee	3
4	Cybersecurity report	NHS Digital	3
5	Digital Strategy	Trust board	2

ACTIONS

REF	GAP	ACTION	BY WHEN	PROGRESS
1	Implementation of Digital Strategy	Meet milestones within plan	2024	
2	Implementation of cybersecurity	Meet cybersecurity essential plus	2021	

REF	GAP	ACTION	BY WHEN	PROGRESS
	report			
3	Funding for implementation	Cross reference BAF risk 7		

BAF RISK REFERENCE *Summary for Datix entry*	9 Inability to sustain our clinical services	**DATE OF REVIEW**	June 2019
DATIX REF	3937 (linked to corporate risks to be developed) fragile services reference	**NEXT REVIEW DATE**	Oct 2019

RISK DETAILS

RISK DESCRIPTION	RATING	L	C	R	CHANGE
IF we are unable to sustain our clinical services THEN the Trust will become unviable RESULTING IN inequity of access for our patients	**INITIAL**	4	4		⇔
	TARGET 2023/24	2	4		
	PREVIOUS	4	4		
	CURRENT	4	4		

CONTEXT

STRATEGIC OBJECTIVE	Best services for local people
GOAL	Strategy
CQC DOMAIN	Responsive, Effective, Well Led

ACCOUNTABILITY

CHIEF OFFICER LEAD	Director of Strategy and Planning
RESPONSIBLE COMMITTEE	TME

CONTROLS AND ASSURANCE

REF	CONTROL	ASSURANCE	LEVEL
1	Trust clinical services strategy being developed	Trust Board	2
2	STP clinical sustainability plan	STP Partnership Board	3
3	Strategic partnership arrangement with University Hospitals Coventry and Warwickshire NHS Trust	Trust Board	2

ACTIONS

REF	GAP	ACTION	BY WHEN	PROGRESS
1	Lack of clinical services strategy	Develop strategy	Oct 2019	Monthly reports to Trust board
2		Develop outline implementation plan	Oct 2019	
3		Review target risk scores	Oct 2019	

BAF RISK REFERENCE *Summary for Datix entry*	10 Failure to deliver cultural change programme	**DATE OF REVIEW**	June 2019
DATIX REF	3938 (linked to corporate risks 3842)	**NEXT REVIEW DATE**	Oct 2019

RISK DETAILS

RISK DESCRIPTION	INTERIM TARGET		RATING	L	C	R	CHANGE
IF we do not deliver a cultural change programme. THEN we may fail to attract and retain staff with the values and behaviours required for putting patients first RESULTING IN lower quality care	**2021**	**2X5**	**INITIAL**	3	5		⇔
			TARGET 2023	1	5		
			PREVIOUS	3	5		
			CURRENT	3	5		

CONTEXT

STRATEGIC OBJECTIVE	Best People
GOAL	Culture
CQC DOMAIN	Safe, Effective, Well Led

ACCOUNTABILITY

CHIEF OFFICER LEAD	Director of People and Culture
RESPONSIBLE COMMITTEE	People and Culture Committee

CONTROLS AND ASSURANCE

REF	CONTROL	ASSURANCE	LEVEL
1	Implementation of 4ward including leadership behaviour led by the Trust Board	Report to TME/People and Culture Committee	2
2	Implementation of the People and Culture Strategy.	Report to TME/People and Culture Committee	2
3	Freedom to Speak Up Guardian in place, policy approved, support network in place.	Report to People and Culture/Audit and Assurance Committees and Trust Board	2
4	Report from Health Education England in respect of junior doctors. Framework for junior doctors in line with HEE standards	Report to People and Culture Committee	2
5	Range of policies in place to support staff in their day to day work e.g. occupational health	None	0

REF	CONTROL	ASSURANCE	LEVEL
6	Triangulate evidence and identify themes and actions	Freedom to Speak Up group monthly meetings – TME – People and Culture Committee	2
7	Staff friends and family & staff survey	Report to TME, P&C Committee & Trust Board	2
8	External assurance in relation to junior doctors	Health Education England	3

ACTIONS

REF	GAP	ACTION	BY WHEN	PROGRESS
1	Organisational development strategy (OD) aligned to new vision and objectives	Refresh of OD strategy	Sept 2019	
2	Measurement of culture	Develop new measure of indicator for measuring culture	Sept 2019	
3	Good experience from junior doctors	Medical education strategy linking to the OD strategy	March 2020	

BAF RISK REFERENCE *Summary for Datix entry*	11 Failure to recruit, retain and develop staff	**DATE OF REVIEW**	June 2019
DATIX REF	3939 (linked to corporate risks 3831, 3832, 3833)	**NEXT REVIEW DATE**	Oct 2019

RISK DETAILS

RISK DESCRIPTION	RATING	L	C	R	CHANGE
IF we are unable to recruit, retain and develop sufficient numbers of skilled, competent and trained staff, including those from the EU THEN there is a risk to the sustainability of some clinical services RESULTING IN lower quality care for our patients and higher staffing costs	**INITIAL**	4	4		
	TARGET 2021	2	4		
	PREVIOUS	4	4		
	CURRENT	4	4		

CONTEXT

STRATEGIC OBJECTIVE	Best people
GOAL	Culture
CQC DOMAIN	Safe, Caring, Effective, Well led

ACCOUNTABILITY

CHIEF OFFICER LEAD	Director of People and Culture
RESPONSIBLE COMMITTEE	People and Culture Committee

CONTROLS AND ASSURANCE

REF	CONTROL	ASSURANCE	LEVEL
1	Delivery of People and Culture Strategy (including the recruitment and retention plan)	Report to TME/People and Culture Committee/Trust Board	2
2	Workforce programme focussed on reduction in premium staffing costs	Monitored through Financial Improvement Group, TME, Finance and Performance Committee	1
3	Monthly run rate for pay costs	TME and Finance and Performance Committee	

ACTIONS

REF	GAP	ACTION	BY WHEN	PROGRESS
	Implementation of the People and Culture Strategy	Implementation of the 11 strands (prioritised to 6 strands) Implementation of the Learning & Development plan including the Academy	Mar 2020	

REF	GAP	ACTION	BY WHEN	PROGRESS
		Implementation of Timewise Implementation of the Recruitment and Retention Plan		

BAF RISK REFERENCE *Summary for Datix entry*	12 Reputational damage	**DATE OF REVIEW**	June 2019
DATIX REF	3940 (linked to corporate risks 3482)	**NEXT REVIEW DATE**	Oct 2019

RISK DETAILS

RISK DESCRIPTION	INTERIM TARGET	RATING	L	C	R	CHANGE
IF we have a poor reputation THEN we will be unable to recruit or retain staff RESULTING IN loss of public confidence in the Trust, lack of support of key stakeholders and system partners and a negative impact on patient care	2021 3x4	INITIAL	4	4		⇔
		TARGET 2024	2	4		
		PREVIOUS	4	4		
		CURRENT	4	4		

CONTEXT

STRATEGIC OBJECTIVE	Best services for local people, best experience, best use of resources, best people
GOAL	Strategy/quality/finance/performance/culture
CQC DOMAIN	Responsive, Effective, Well Led

ACCOUNTABILITY

CHIEF OFFICER LEAD	Director of Communication and Engagement
RESPONSIBLE COMMITTEE	People and Culture/Trust Board

CONTROLS AND ASSURANCE

REF	CONTROL	ASSURANCE	LEVEL
1	Proactive media management	Weekly report to trust board (real time news) Communications report to Trust Board	1-2
2	Internal programme of communication and engagement built around putting people first	Report to 4ward and People and Culture Committee	1-2
3	On-going programme of stakeholder engagement	Communication report to TME/People and Culture/TB	2

ACTIONS

REF	GAP	ACTION	BY WHEN	PROGRESS
1	No Communications strategy	Develop a communications strategy	July 2019	
2	Implement communications strategy	Develop action plan	Sept 2019	

Glossary

CGG	Clinical Governance Group
CMO	Chief Medical Officer
CNO	Chief Nursing Officer
CQC	Care Quality Commission
F&P	Finance and Performance Committee
MTF	Medium Term Financial
NHS I	NHS Improvement
OD	Organisational Development
QGC	Quality Governance Committee
QIS	Quality Improvement Strategy
RTT	Referral to treatment
STP	Sustainability and transformation partnership
TIPCC	Trust Infection Prevention and Control Committee
TME	Trust Management Executive

NHS
Worcestershire Acute Hospitals NHS Trust

Meeting	Trust Board
Date of meeting	11 July 2019
Paper number	E

Trust Board - Integrated Performance Report – Month 2 2019/20

For approval:		For discussion:		For assurance:	✓	To note:	

Accountable Director	Matthew Hopkins CEO		
Presented by	Vicky Morris CNO	**Author**	Nicola O'Brien – Head of Information and Performance

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		
Trust Management Executive	19 June 2019	Limited Assurance
Quality Governance Committee	20 June 2019	Limited Assurance
Finance and Performance Committee	28 June 2019	Limited Assurance

Recommendations	The Board is asked to: 1) Review the Integrated Performance Reports provided in Month 2 2019-20. 2) Note areas of improved and sustained performance. 3) Seek assurance as to whether the risks of under-performance in each area have been suitably mitigated, with robust plans for stabilisation and recovery. 4) Note that changes to the IPR will take place from Month 3 onwards, as recommended by Trust Board following advice from NHSE/I. The report will be aligned to the Trust annual priorities and will focus on the areas of 'significant cause variation' for both declining and improving performance.

Executive summary	This paper provides the Committee with an update on the Trust's operational, quality of care, finance and workforce performance against priority metrics that form part of NHSi's Single Oversight Framework (SOF). The key points to draw the Board's attention to are: - We have a £22.5m 'cost improvement plan' to deliver in 2019/20 to achieve our stretch target of £(73.8)m. The budgets have been revised in month 2 to reflect £16.2m of identified savings opportunities with a remaining gap of £6.3m to identify and deliver a minimum of £22.5m.

	- The Trust did not meet the externally submitted monthly trajectories for Referral to Treatment within 18 weeks, Cancer 2WW (including Breast symptomatic), 62 day Cancer and 60 min ambulance handover. - The Trust did meet the externally submitted monthly trajectory for having no patients waiting 52 weeks for referral to treatment, 31 day Cancer and Diagnostics within 6 weeks. - Breast symptomatic shows 'special cause' variation with declining performance. - The latest published Sentinel Stroke National Audit Programme (SSNAP) audit for Stroke Services (January - March 2019) has been released and we have improved our rating from a Band D to a Band C. - We continue to make progress in recruiting to vacant posts with 80 more clinical staff in post (contracted) when compared to January 2019. However, we are not seeing an associated reduction in bank and agency spend due to the continued increase in funded establishment and hours worked. A review of establishment is underway which will be completed by 31 August 2019.

Risk	
Key Risks	Board Assurance Framework –1,2,3,4,5,6,7,8,10,11,12 **Corporate Risks with a score of 20 or above:** **3928** – **Diagnostics:** Out of hours CT demand has increased putting patients and staff at risk **3482 – Operations**: overcrowding in the Emergency Department **3361 – ED Corridor:** Standards of care for patients will be compromised in the corridors of ED **3956 – Endoscopy:** There is a risk of delay in diagnosis and treatment for surveillance endoscopy patients due to lack of appointment capacity. **4075 - Clinical Practice:** Harm from avoidable infection as a result of poor clinical practices - Score 20 **3792 – Achievement of the financial plan** **3631 – Increased spend for NHSP tier 1 and 2** There are several risks relating to medical devices and equipment and to patient flow. The highest severity accorded to a workforce risk is currently 16; **3939 – Failure to recruit, retain and develop staff.** *Please note: There are further risks that will have a negative impact on performance, but only those with a rating of over 20 have been included above.*
Assurance	The source of assurance for the data included in this paper is undertaken across several meetings including the Trust Board sub-Committees, performance management group, clinical governance

	group, divisional management reviews and directorate validation at patient level. Further data assurance has been completed by the Information Team based on the data provided from the operational and clinical teams.								
Assurance level	**Significant**		**Moderate**		**Limited**	✓	**None**		
Financial Risk	There is a financial risk that we will not complete the activity required under our contract and dependencies on funding which is limited. There is a risk that the limitations in capital funding will impact on our ability to provide safe and effective services for our patients.								

NHS
Worcestershire
Acute Hospitals
NHS Trust

Meeting	Trust Board
Date of meeting	11 July 2019
Paper number	E

Introduction/Background

This Integrated Performance Report (IPR) provides the Board Members with an update on the Trust's quality of care, financial performance, operational performance and workforce against the priority metrics which form part of NHSI's Single Oversight Framework (SOF) and the Trust's own internal reporting priorities.

Included are the key messages from each area, detailing actions agreed to improve performance, along with summary grids of performance and assurance reports from the Finance and Performance Committee (FPC), People and Culture Committee (PCC) and the Quality Governance Committee (QGC).

The NHS Constitutional standards are the Emergency Access Standard and Access to Elective treatment within 18 weeks. We are required to externally submit trajectories to NHSE/I that provide the monthly performance during 19/20. We have advised that we are not expecting to meet the constitutional standards by the end of 19/20, but we will be working towards reducing the gap from March 2019 performance towards the standard.

Issues and options

The main points the Board needs to be aware of are:

Quality, Safety and Effectiveness

(Note: This data relates to May 2019 in line with the reporting to the Quality Governance Committee)

- **Pressure Ulcers** – in May no patient suffered a hospital acquired grade 3 or 4 tissue injury.
- We have sustained the **VTE** standard for the second consecutive month.
- There were 6 **E Coli Bacteraemia in May** and we are one case above the internally set Trust trajectory so far this year. This is an in-month variance with robust plans in place to ensure achievement of required improvements.
- The rolling **12 month HSMR** 'score' (Mar 18 to Feb 19) shows recent signs of improvement and should continue to improve over the next six months. The percentage of mortality reviews completed within 30 days stands at 28% and the backlog of uncompleted reviews is 22.4%. The most recent quarterly release of the SHMI by NHS Digital (up to Dec 18) shows the trust as having a 'higher than expected' mortality rate for this period and we have commissioned an external mortality review.
- **Fractured Neck of Femur** (NOF) - In May 2019 we achieved target (>85%) with 86.89% of all patients within the 36 hours (this was 53 of 61 patients).
- We have completed the analysis reviewing the patient pathway following a pathway change in December whereby patients transfer to Evesham Hospital after five days post-operative. There has been a slight reduction in the total length of stay for Fractured NOF patients in the Trust of 3.4 days. However, there is a reduction of 12 days across the entire pathway including the stays within the Trust and Evesham, undoubtedly due to the specialised care received at Evesham when patients are transferred. Discussions are continuing regarding whether the post-operative pathway change will remain beyond June 2019.

Meeting	Trust Board
Date of meeting	11 July 2019
Paper number	E

FINANCE

(Note: This data relates to May 2019 in line with the reporting to the Finance and Performance Committee)

- For 2019/20 the Trust committed to delivering a deficit of no more than £(82.8)m with a stretch target of £(73.8)m. This Stretch target requires delivery of £22.5m of savings/margin improvement. The Trust has not signed up to the revised control total set by NHSI of £(64.4)m [£58.4m+£6m] (excluding PSF, FRF and MRET funding). Whilst we recognise that it is disappointing that we have not been able to submit a plan closer to the control total, we believe that the submission reflects a credible plan based on the existing plan information and assumptions available to us at this time. Notwithstanding the aforementioned that we continue to aim to achieve the £(73.8)m 18/19 internal out-turn target. In month 2 budgets have been revised to reflect £16.2m of identified savings opportunities with a remaining gap of £6.3m to identify and deliver a minimum of £22.5m.
- For May 2019 - month 2 of 2019/20 is a deficit of £(6.2)m against a £(7.3)m planned deficit, resulting in a £1.1m favourable variance to the £(82.8)m deficit plan. The £1.1m positive in month variance to plan continues to be driven by: Estimated income margin growth (£476k); Underspends related to the provision of additional (Bed) capacity (£411k), Slippage in planned business case expenditure (EPMA/MES) (£148k). In addition to these drivers, patient care income has exceeded plan in month, largely as a result of finalising the April contract position (£0.9m). The impact of these favourable variances has been lessened by operational variances including premium nursing, continuation of additional medical staffing in the Emergency Department and prior months Radiology outsourcing now captured.
- The combined income (including Other Operating Income and after adjusting for the blended payment mechanism) was £0.8m above plan in May (YTD position is £0.6m above plan). If the blended adjustment did not apply, income would be £1.0m above plan year to date.
- The £(6.2)m in-month deficit represents an improvement of £(2.6)m on previous month April 2019. The material items driving this movement are: Increased Patient Care activity and Income, partly driven by the number of Planned "working days (21/31)" in the month (c. £1.3m) and also by finalisation of the April contract position (£0.9m). Reduced pay expenditure following the one-off 2019/20 AfC non-consolidated pay award paid in April to top of scale employee's (£760k). The full impact of this payment has been lessened, largely due to an increase in temporary staffing costs and increased non pay.
- In May, month 2 of 2019/20, a nominal £844k (note £22.5m Full Year required) of CIP delivery (year to date) was achieved. We remain focused on maximising the savings plans and are continuing every effort to drive further improvements to our financial position, whilst ensuring a credible plan for delivery. As a result the internal savings/CIP target remains at £22.5m of which opportunities to the value of c. £17m have been identified to date with £16.2m removed from budgets.
- As a result of the ongoing deficit position, we continue to rely on additional cash support from the Department of Health and Social Care (DHSC) and request cash in line with financial performance on a monthly basis.
- The Trust remains focused on maximising the savings plans and are continuing every effort to drive further improvements to our financial position, whilst ensuring a credible plan for delivery. The Financial Improvement Group met on 12 June 2019. The discussion focused on accelerating scheme development, ideas generation and Quality Impact Assessment (QIA) approval. There was also an

emphasis on maintaining the pace of implementation for "live" schemes. Sub-groups are being convened to strengthen the oversight and governance of the workforce, theatres transformation and outpatient productivity programmes of work. Divisional CIP workshops, supported by the PMO and Finance, have taken place to progress key cross-organisational schemes and to identify further schemes to assure the deliverability of the CIP target of £22.5m."

OPERATIONAL PERFORMANCE

(Note: This data relates to May 2019 in line with the reporting to the Finance and Performance Committee)

Patient Flow and the Emergency Access Standard

- Variance in performance is 'common cause' variation, there is no significant change. We were less than 1% away from our trajectory with performance of 77.28%.
- We did not meet our ambulance handover trajectory of 209. We had 225 confirmed handover delays more than 60 minutes at Worcestershire Royal Hospital and 129 at the Alexandra Hospital.
- We had 51 more patients waiting longer than 12 hours from a decision to admit to admission, than we did in April.
- There are some very early indications that patient flow may be improving at WRH as more patients were discharged before midday compared to performance in April. However there was a slight decline in performance at the ALX.
- The Home First Worcestershire Programme is continuing in pilot Wards within WRH. Processes are now in place, and the focus will be on embedding these into everyday practice. The key performance measures to monitor compliance to best practice are being developed and will be shared with Wards imminently.
- Plans on moving the Integrated Discharge Team to WRH have been drafted. This change will benefit patients by have multi-disciplinary teams co-located and on site to aid improved communication and facilitate timely discharges.
- A new handover process and start time for morning handover will commence on 1 August 2019 (when the new junior doctor rota commences). ED and specialty doctors will handover together to improve the timeliness of specialty reviews within ED.
- Limited assurance of delivery within timescales based on current progress and outcomes. Continued monitoring through the Home First Steering group chaired by COO.

Cancer

- Although performance for Cancer is still unvalidated for May, our latest performance indicates that we will not meet our monthly trajectory for 2WW (all), 2WW Breast Symptomatic or treatment within 62 days, 31 days (Surgery) and 62 day screening. We met the remaining cancer performance measure trajectories.
- For the 2WW all and treatment within 62 days the variation is within common cause range and the assurance level is 'unclear whether we will meet or not meet the target'.
- For the 2WW breast symptomatic the variation is 'special cause' which requires investigation and the assurance level is 'consistently failing'.
- The significant decline in breast services has been investigated and is a result of a reduction in capacity which was not mitigated early enough. The learning from this will be included in the leadership training programme which is being managed by the Workforce Department.

- Recovery of the breast symptomatic performance is not expected until at least September, which mitigations now being put in place which includes:
- Additional clinics being put in place, although this is dependant on Radiology services being able to support.
- Two additional consultants have been authorised for recruitment, one will start in June/July, the remaining post is yet to be recruited to.
- Communication being made visible on ESR to inform GPs that there is a delay with 2WW breast symptomatic appointments so that patients are kept informed.
- Our 62 days performance is being impacted by a backlog of patients waiting to be seen predominantly within the Urology specialty. This has been generated by staff capacity, which will be mitigated in the coming months:
- Middle grade training is nearing completion to increase the volume of staff able to complete TRUS biopsies, the immediate action will be to reduce the delay in diagnostics.
- The recruitment of a clinical nurse specialist (CNS) is being progressed.
- We had 24 patients waiting over 104 days. We monitor these patients weekly and escalate any internal delays to senior management. Several of these patients are waiting for tertiary centre treatment which is not within our remit, so we focus on preventing delays at diagnostic level to ensure patients are transferred to tertiary centres as soon as we can.
- Detailed Recovery Action Plans in place for all specialties including recovery trajectories. Broad assurance that actions are being taken, and performance against trajectories are monitored weekly through the Performance Management Group chaired by COO

Referral to treatment

- We did not achieve our monthly trajectory and the variation in performance is low/declining special cause variation, and the assurance level is consistently failing.
- One of the reasons for this is that we are not treating the volume of patients who have waited over 18 weeks that we expected to treat. This is being reviewed currently, to identify whether the non-elective demand is impacting on the allocation of appointments or whether we are not seeing patients in chronological order. Reporting has been provided to enable more visibility of chronological booking and any unexpected activity will be discussed with the specialties concerned.
- We are using an internal proxy measure to drive forward performance which is to have no patient breaching 40 weeks waiting for their first definitive treatment. We are slightly behind trajectory for this with 303 patients waiting at the end of May, whereby we should have no more than 246.
- We are still expecting to achieve the zero target by the end of September, but we are monitoring this weekly and will be moving to daily in July.
- Each specialty has a recovery plan which is monitored weekly to look for any variation to plan. If there is variation then this is escalated to senior management.
- Surgery has the largest number of 40-51 week waiters, particularly patients without a future appointment planned. The focus will be on providing inpatient appointments for those patients who are already over 40 weeks waiting, or will be by the end of September, as soon as possible.
- We are also reviewing Theatre utilisation performance to ensure we understand and mitigate wherever possible reasons for cancelled operations. One area of focus will

be ensuring that patients are fit for surgery on the day. There is a pilot commencing in June whereby the pre-operative team will call a sample of patients two days before their surgery to complete final checks to ensure we maximise the theatre capacity we have and treat our patients as timely as possible.

- Ophthalmology will be requesting additional funding for some waiting list initiatives to ensure that they can see/treat all the patients they need to in order to meet the target.
- The Trust has and will maintain the zero tolerance on 52 week breaches.
- Limited assurance of delivery due to the heavy reliance on temporary staff and successful clinical appointments.

Diagnostics

- We achieved the monthly trajectory for Diagnostics.
- The variation is within 'common cause' and the assurance is 'consistently failing', although with the recovery plan that is in place we would expect this to start to show signs of sustained improvement in the near future.
- Endoscopy remains the concern as the diagnostic type with the most breaches.
- We are progressing the accessibility of external endoscopy capacity with a view to commencing as soon as possible.
- There have been improvements in Radiology performance, mainly due to the increase in capacity provided by the mobile CT scanner that has been obtained and this will now be extended until January 2020. Other improvements are still being progressed such as :
- Recruitment to the large volume of vacancies the service has resulted in
    - Development of radiology homeworking to make the service attractive to new potential candidates,
    - Reduction of expensive outsourcing and insourcing activity.
    - High level of confidence that the trajectories are being met through the Recovery Action Plans that are monitored weekly through the Performance Management Group chaired by COO.

Stroke services

- We did not achieve target for two of the four key performance measures for Stroke. The measures where we met target were to have a CT scan within 60 minutes of arrival and 90% of patient time on the stroke ward.
- We did not achieve the target for patients being seen in a TIA clinic within 24 hours, this is due to a significant staffing capacity deficit. The service has been recruiting to two consultant posts, both have been filled and we are awaiting start dates. We have also been working with the CCGs on a TIA referral form to ensure that we only receive appropriate referrals, thus reducing the demand. The form is currently being embedded.
- Ward configuration and specialty outliers on the Stroke Ward limit the ability to ensure that Stroke patients can access the Ward in a timely way. In order to improve this, a proposal to move the Stroke Ward to a more suitable location, with a lower bed base that would be ring fenced for Stroke patients being progressed.
- The latest published Sentinel Stroke National Audit Programme (SSNAP) audit for Stroke Services (January - March 2019) has been released and we have improved our rating from a Band D to a Band C. This is due to improvements in the patient

and team centred metrics which include Physiotherapy, Speech and Language and Occupational Health services.

- High confidence of continued delivery of Band C.

WORKFORCE

(Note: This data relates to May 2019 in line with the reporting to the People and Culture Committee)

The graphs included in the IPR this month are work in progress but provide some important trend analysis.

- Our funded establishment and hours worked continue to increase primarily as a result of business cases, the use of surge areas and the opening of new wards. Our current policy is to set establishments on the previous year's outturn. An establishment review is being undertaken which will be completed by 31st August 2019. In addition, weekly pay panels are being held to review all requests to recruit to all temporary and permanent posts.
- Progress continues in "getting the basics right" and we are seeing month on month improvement in our mandatory training compliance and non-medical appraisal compliance. In addition, over the last 6 months we have seen stepped improvement in our job planning and medical appraisal compliance. From the 1 June the target for these metrics will increase to 95% with trajectories to achieve this performance by 31 March 2020.
- One area of concern is the Adult Safeguarding Training level 3. This programme was refreshed in 2018 with a requirement for all staff to attend the updated training. This training is a key focus for the divisions with corrective actions plans reviewed through the monthly performance review meetings. The medical and dental and estates and ancillary staff groups have the lowest mandatory training compliance. Corrective actions plan have been developed by the relevant divisions which are based on achieving the 95% target by 31 March 2020.
- The rolling sickness absence rate has continued to increase since January 2019 and is a result in the spike in absence during the period November 2018 to February 2019. Additional HR support is being provided to hotspot areas which include estates and facilities management, Women and Children and SCSD.

Recommendations

The Board is asked to:

1. Review the Integrated Performance Reports provided in Month 2 2019-20.
2. Note areas of improved and sustained performance.
3. Seek assurance as to whether the risks of under-performance in each area have been suitably mitigated, with robust plans for stabilisation and recovery.
4. Note that changes to the IPR will take place from Month 3 onwards, as recommended by Trust Board following advice from NHSE/I. The report will be aligned to the Trust annual priorities and will focus on the areas of 'significant cause variation' for both declining and improving performance.

Appendices

1) Trust Board IPR – M2 2019-20 (Quality, Operational Performance, Finance and Workforce) *
2) Trust Board IPR Dashboards – M2 2019-20 (Operational Performance, Finance and Workforce)*

**As approved by the internal governance process*

Enc E

Trust Board

Integrated Performance Report

May 2019
Month 2

11th July 2019

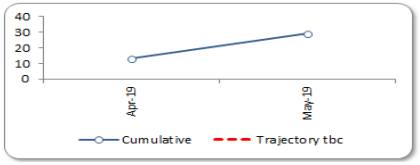
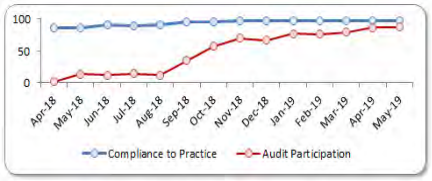
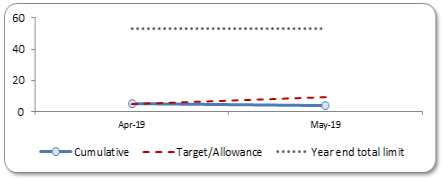
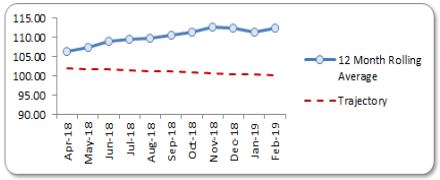
Month 2 2019-20 Quality & Safety Summary

Safe | Effective | Patient Experience

RAG rated against Internal Trajectory | Responsible Directors – Chief Nursing Officer, Chief Medical Officer

UNVALIDATED DATA EXTRACTED 11/6/19

Worcestershire Acute Hospitals NHS Trust

	Description	How we did	Trend	Key actions	What trajectory are we aiming for in 2019/20?
Are we preventing our patients from acquiring pressure ulcers?	To reduce the number of avoidable grade 3+, deep, un-gradeable hospital acquired pressure ulcers/tissue injuries. **15**	There were 15 hospital acquired pressure ulcers in May: 11 deep tissue and 4 unstageable. **NOTE: There were 29 Pus including Cat 2.**		We will continue to provide Monthly Pressure Ulcer Prevention Training. Tissue Viability Champions develop their role into 'Train the Trainers'	<12
Are we ensuring that patients receive all elements of the sepsis 6 bundle?	To improve the % of patients receiving all elements of the sepsis 6 bundle within 1 hour. **57.5%****	Trust wide compliance with the sepsis 6 bundle remains challenging. Of the 120 patients requiring treatment who were sampled, 67 received all elements within 1 hour.		Focal point continues to be the scrutiny of progress/barrier detailed in the Div Quality Improvement Plans	>90%
Are we maintaining the expected standards of hand hygiene?	To improve the compliance with Hand hygiene practice, and participating in audits. **97.52%** **87.39%**	Compliance to practice is above trajectory at 97.52%, and audit participation has increased again to 87.39%.		We progressing our plan of action to reduce the prevalence of infections seen in 2018/19 which is detailed in the WAHT Infection Prevention Improvement Plan 2019-20.	100% >=97%
Are our patients at risk of contracting C.Difficile during their stay?	There should be no more than 31 cases of *C.Difficile* in the year. **3**	There were 3 confirmed cases of hospital acquired C. difficile in May. There is a total allowance of 5 cases at the end of April. We are currently at a total of 4.		We have received formal agreement to purchase a new Infection Prevention and Control management information systems called ICNET2.	<=53*
Are we reducing mortality for patients whilst under our care?	To monitor and seek to reduce mortality for patients using the Hospital Standardised Mortality Ratio. **112.57 (Feb.)**	HSMR rolling average was 112.57 in Feb-19. Performance is stabilising from trajectory, however we remain an outlier for the 6th month in a row.		We will be systematically reviewing patients who have died from Pneumonia over the next few months as this remains the single largest cause of mortality across WAHT and adversely impacts the HSMR	<=100
Are we treating our patients in the required timeframes?	To improve the time to theatre for patients with fractured neck of femur (#NOF) **86.89%**	The #NOF metric met target again in April with 57 of 61 patients in theatre within 36 hours.		Discussions are continuing regarding whether the pathway change post operatively will remain beyond June 2019	>=85%

*Please note - for 19/20, there has been a change to Cdiff guidance; the definitions now include hospital onset healthcare associated and community onset healthcare associated. **March as April not yet available.

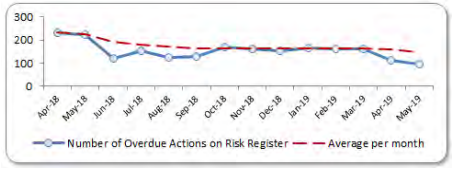
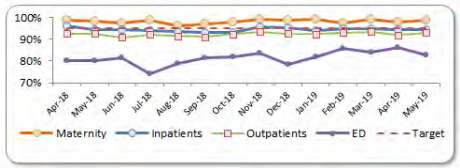
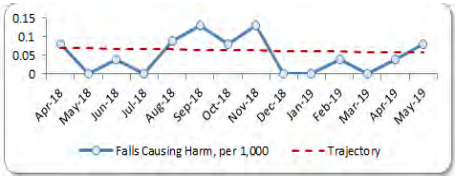
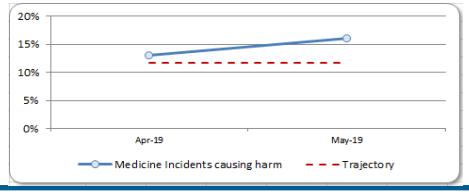
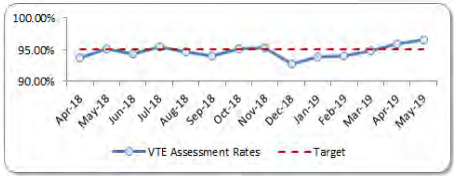
Month 2 2019-20 Quality & Safety Summary

Safe | Effective | Patient Experience

RAG rated against Internal Trajectory | Responsible Directors – Chief Nursing Officer, Chief Medical Officer

UNVALIDATED DATA EXTRACTED 11/6/19

NHS Worcestershire Acute Hospitals NHS Trust

	Description	How we did	Trend	Key actions	What trajectory are we aiming for in 2019/20?
Risk – Are we reviewing risks to ensure patient safety?	To reduce the number of risks overdue a review. **66**	The average number of risks overdue for review at month end has decreased to 142.		Risk Management Group seeks continued divisional assurance on risk review and progress on actions to strengthen controls particularly high and extreme risks.	
Risk – Are we managing risks to ensure patient safety?	To reduce the number of overdue actions relating to risks. **78**	The average number of actions overdue for review at month end has decreased to 140.		Performance information provided to support divisions in follow-up with individual risk owners. Dashboards developed to support ownership.	
FFT – Are we providing a positive experience for our patients?	To improve the Recommended Friends & Family score for all areas. Mat. 98.5% ↑ A&E 82.6% ↓ IP 94.4% ↓ OP 92.9% ↑	Maternity score remained above target and the other areas below. Maternity & OP improved in Apr-19. Apr-19 benchmarking places this Trust in the bottom quartile for IP and A&E and top quartile for Maternity.		Maintain the percentage of inpatients who would recommend our Trust. We will focus specifically on - Privacy and dignity, Information provided at discharge and Communication	>=95%
Falls – Are we preventing our patients from suffering falls?	To reduce the number of falls that occur in our hospitals and, consequently those that result in serious harm. **4.55** ↑ **0.08**	Falls per 1,000 bed days decreased to 4.55 in May but falls per 1,000 bed days causing harm was at 0.08.		From May we have added Falls training into the Trust induction process We are continuing to recruit Falls Champions at Ward level.	<14 with harm
Medical Incidents – Are we prescribing, administering and supplying the right medicines?	To improve the reporting of medical incidents that occur in our hospitals and reduce those that result in serious harm. **4.95** ↑ **16%** ↑	There were 4.95 medicine incidents per 1,000 bed days. 16.3% of these caused harm to patients.		A review in Q4 2018/19 highlights omitted/delayed medicines as highest medicine incident risk. Work streams to be developed in Q1 to identify actions to reduce these risks.	>=30%
VTE – Are we screening our patients for VTE in a timely way?	To improve the % of patients who receive a VTE assessment within 24 hours. **96.58%** ↑	The VTE assessment rate has continued to improve since Dec-18. Urgent Care remains the lowest performing Division.		We will continue to focus on ensuring that VTE assessments are recorded correctly within the patient administration systems and not only included as documents within the patient record.	>=95%

Forecast Status: Decline – expected to worsen. Stable – not expected to change significantly. Improve – Expected to improve

RAG ratings for FFT metrics indicate performance against national targets.. RAG rating on the Dashboards are against national or locally agreed standards.

Quality Governance Committee Assurance Report

Accountable Non-Executive Director	Presented By	Author
Dr Bill Tunnicliffe - Non-Executive Director	Dame Julie Moore - Non-Executive Director	Martin Wood – Deputy Company Secretary

Assurance: Does this report provide assurance in respect of the Board Assurance Framework strategic risks?	Y	**BAF number(s)**	1, 2, 3, 9

Level of assurance and trend

Significant assurance	Moderate assurance	Limited assurance	No assurance
		X	

Executive Summary

The Committee met on 20 June 2019.

Board Assurance Framework (BAF): The Committee approved the BAF subject to a review to ensure that the correct actions with end dates and controls are included together with the appropriate nursing governance arrangements.

Integrated Quality Report: The Committee noted the performance updates for Month 2. They focussed on the need to learn from complaints and that there needs to be an awareness to avoid complaints being made.

Risk Management Strategy: The Committee noted that a review of the risk management strategy and handbook has identified a number of actions to strengthen the risk management process and that an action plan is in place to address this.

Clinical Audit Annual Report: The Committee were pleased to note that the Trust's 4Ward signature behaviours have supported our clinical audit activities resulting in 2018/19 being a successful year in embedding clinical audit processes and in meeting the trajectories set out in the Clinical Effectiveness Plan. I have written to Heather Webb, Clinical Effectiveness Manager, to express the Committee's appreciation on this achievement.

CNST: The CNST maternity incentive scheme is now in its second year and there have been some significant changes in the level of evidence that has been requested to achieve compliance with the 10 safety actions. The maternity element of contributions is increased by 10% above the standard 2019/20 maternity contribution to continue to create a maternity incentive fund. Maternity services that can demonstrate achievement of a specified set of requirements will be eligible for a share of that incentive fund of at least 10% of their base contribution together with a share of the balance of undistributed funds, the amount of which will be determined once the results from all services have been gathered. The evidence provided supports the achievement of compliance in eight of the safety actions, there are two safety actions were partial compliance has been declared.

Saving Babies ' Lives: The second version of the Saving Babies Lives care Bundle has recently been published. The Committee have received a progress report with respect to the first care bundle noting that our Trust is 100% compliant.

Quality Account : The Quality Account now contains 3 priorities with 12 underpinning key indicators for 2019/20 which link to our Annual Plan. The Committee approved the Quality Account for publication.

Quality Governance Committee Assurance Report

Accountable Director	Presented By	Author
Dr Bill Tunnicliffe - Non-Executive Director	Bill Tunnicliffe - Non-Executive Director	Martin Wood – Deputy Company Secretary

Assurance: Does this report provide assurance in respect of the Board Assurance Framework strategic risks?	Y	**BAF number(s)**	1, 2, 3, 9

Level of assurance and trend

Significant assurance	Moderate assurance	Limited assurance	No assurance
		X	

Executive Summary

Learning from Deaths: The proposal for integrating the requirement to provide a certificate of the medical cause of death, a medical examiner system and a mortality review system into a unified learning from deaths programme partly funded from the income from cremation fees and national funding for medical examiner review has been noted. The Committee that there needs to be good engagement between medical Examiners and clinicians. Nonetheless the Committee remain concerned over the learning form deaths and have noted that an external mortality review has ben commissioned.

7 Day Services: The Committee have approved the submission to NHSE/I by 28 June 2019 of the 7 Day Services Board Assurance Framework which is also on the agenda for final approval. The Committee noted that the audit was based on one week's data which they considered too short a timeframe for data compilation. Consultant job planning needs to be more closely aligned to the front door to ensure greater consultant presence to support seven day services.

Infection Control Update: In Month 1 2019-20 there have been improvements in the number of key infections and a within-trajectory performance for Clostridium difficile and MSSA bacteraemia. This is a positive step, but must be sustained over the coming months. Hand hygiene audit participation and compliance has improved. There has been an increase in the number of areas meeting their national cleaning standard although overall our Trust needs to continue with the further work in progress to consistently meet the standards for high risk and very high risk areas. There has been a 4% increase in level 2 mandatory training.

Review of Oral and Maxillofacial Surgery: The Committee noted that The Royal College of Surgeons of Edinburgh have accepted an invitation to review oral and Maxillofacial Surgery (OMFA) Head and Neck Cancer Service.

Other reports discussed:-
CQC letters – these were considered by Trust Board in June 2019.

Quality Governance Committee Assurance Report

Accountable Director	Presented By	Author
Dr Bill Tunnicliffe - Non-Executive Director	Dame Julie Moore - Non-Executive Director	Martin Wood – Deputy Company Secretary

Assurance: Does this report provide assurance in respect of the Board Assurance Framework strategic risks?	Y	**BAF number(s)**	1, 2, 3, 9

Level of assurance and trend

Significant assurance	Moderate assurance	Limited assurance	No assurance
		X	

Background

The Quality Governance Committee is set up to assure the Board with respect to the quality agenda.

Issues and options

None.

Recommendations

The Board is requested to receive this report for assurance.

Appendices

Finance | Key Messages

2019/20 Plan	For 2019/20 the Trust committed to delivering a deficit of no more than £(82.8)m. This includes £13.6m of planned savings/CIP delivery. The Trust has not signed up to the revised control total set by NHSI of £(64.4)m [£58.4m+£6m] (excluding PSF, FRF and MRET funding). Whilst we recognise that it is disappointing that we have not been able to submit a plan closer to the control total, we believe that the submission reflects a credible plan based on the existing plan information and assumptions available to us at this time. Clearly we are some way off the target we are wish to achieve, and the Board remains focused on maximising the savings plans setting an internal Quality and Savings/CIP Improvement Target with the Divisions and Corporate functions totalling £22.5m.
I&E Position	For May 2019 - month 2 of 2019/20 is a deficit of £(6.2)m against a £(7.3)m planned deficit, resulting in a £1.1m favourable variance to the £(82.8)m deficit plan. The £1.1m positive in month variance continues to be driven by estimated income margin productivity growth; lower level of spend related to the provision of additional (Bed) capacity, and slippage in planned business case expenditure (Electronic Prescribing & Medicines Administration – EPMA and proposed expansion of Managed Equipment Service - MES).
Income	The combined income (including Other Operating Income and after adjusting for the blended payment mechanism) was £0.8m above plan in May (YTD position is £0.6m above plan). If the blended adjustment did not apply, YTD income would be £1.0m above plan year to date. This assumes annualised we are as a system forecast NOW to exceed the £125.5m Non-Elective Threshold. This was highlighted at the June contract management board. Inpatients were £0.4m above plan (before the blended adjustment). Emergency activity (including A&E) is subject to the blended payment approach with the Worcestershire CCGs and is subject to a lower and upper threshold limit. Activity will be paid at 20% tariff above the threshold value and at 80% below the lower limit. A "break-glass" point exists at which point the CCGs and the Trust would need to reconsider how to best manage the demand. Under the blended payment approach with Worcestershire CCGs, emergency activity has been adjusted by £0.4m YTD (exceeding the upper threshold limit – activity is paid at 20% above threshold).
Expenditure	**Pay** Pay is £383k favourable to plan in month and £1.3m favourable year to date, key variances include timing and level of spend against additional capacity, vacancies, slippage against business cases (EPMA & MES) and income margin growth. The impact of these favourable variances has been lessened by operational expenditure variances including premium nursing and continuation of additional medical staffing in the Emergency Department. Pay costs reduced by £351k from £25.5m in April to £25.1m in May. The key movements relate to the one-off non consolidated payments that were made in April, however the full monthly reduction impact of this has been offset largely due to an increase in temporary staffing costs. **Non Pay** Non pay is £53k adverse to plan in month and £147k favourable year to date, key variances include timing of spend against additional capacity, agreed business cases (MES & EPMA) and income margin / productivity growth. Non pay costs excluding Non PbR items, and finance charges increased by £0.55m from £10.95m in April to £11.5m in May. The key movements are aligned to activity, prior months Radiology outsourcing now captured and provision of a fully staffed mobile CT scanner at Kidderminster Hospital recognised in the diagnostic recovery plan.

Finance | Key Messages

CIP (Savings Improvement Plans)	In May, month 2 of 2019/20, a nominal £844k (note £22.5m Full Year required) of CIP delivery (year to date) was achieved. We remain focused on maximising the savings plans and are continuing every effort to drive further improvements to our financial position, whilst ensuring a credible plan for delivery. As a result the internal savings/CIP target remains at £22.5m of which opportunities to the value of c. £17m have been identified to date with £16.2m removed from budgets. The current identified savings/improvement opportunities plan excludes theatre and outpatient productivity, however does include the work surrounding the achievement of £9m of Workforce schemes. Schemes for theatres and outpatient productivity are being "worked up" by the respective divisions and are due for submission by the 30th June.
Capital	The Trust has a minimal £2.22m internal source of funding after repaying the capital loans and accounting for IFRIC 12 and PFI capital repayments. In addition the Trust has loan funds confirmed of £5.64m and £0.906m. Existing commitments (ASR and Oasis) total £6.75m. Available capital for spend on critical and emergency schemes - £2.0m The Full Year Forecast shows a breakeven position against available funds. May 2019 - Month 2 expenditure is mainly against the Acute Services Review "ASR" Aconbury East Scheme £754k.
Cash Balance	As a result of the ongoing deficit position, we continue to rely on additional cash support from the Department of Health and Social Care (DHSC) and request cash in line with financial performance on a monthly basis. At the end of May the cash balance was £6.2m which is over the £1.9m minimum balance required due to the timing of due payments and receipts. The Trust has received £8.533m working capital cash support in May 2019. The 2018/19 capital loan of £5.64m has now been approved and will be drawn in year. Cash limitations will prevent repayments of existing and future revenue support loans without refinancing existing borrowings, or a change to the existing financing regimes for Trusts that are in financial difficulties. Based on this scenario, we are in on-going discussions with NHS Improvement and the DHSC. Revenue loan deferrals have now been agreed in 2019/20 although the revised repayment profile remains within 2019/20. We continue to work with NHSI and DHSC for a sustainable resolution. Capital loans are repaid through the capital programme.

Financial Performance Indicators
Use of Resources
Risk Rating Summary

	Metric Definition	How we did YTD at M2	Risk Rating		Previous Month YTD	Full Year Plan (Forecast)
Are we spending more than the income we receive?	I&E surplus or deficit / total revenue.	(21.30%)	4	Adjusted financial performance deficit of **£14,874** (£14,874k/ total operating income £69,820k = **(21.30%).**	4	4
How close are we to our financial plan?	YTD actual I&E surplus/deficit in comparison to YTD plan I&E surplus/deficit.	3.20%	1	I&E margin YTD actual of **(21.30%)** less I&E margin YTD plan of **(24.50%)** = **3.20%**	1	1
How many days' worth of cash do we have?	Measures the days of operating costs held in cash, cash-equivalent and liquid working capital forms.	(101.74)	4	Working Capital of (£133,415k) / YTD Operating Expenditure of £79,995 multiplied by the number of YTD days (61) = (101.74).	4	4
Do we have sufficient income to cover the interest owed on our borrowings?	Degree to which the organisation's generated income covers its financing obligations.	(3.221)	4	Revenue available for capital service (£10,153k)/ capital service **£3,152k**= **(3.221)**	4	4
Is our agency spend within the imposed limits?	Total agency spend compared to the agency ceiling.	(69.0%)	4	Total agency spend of **£4,864k** less agency ceiling of **£2,882k** / divided by agency ceiling of **£2,882k** = **(69.0%).**	4	3

Operational Performance | Submitted Trajectories (19/20)

Unvalidated May-19 as at **28 Jun-19**

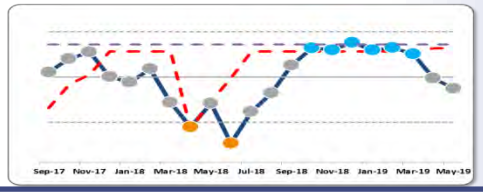
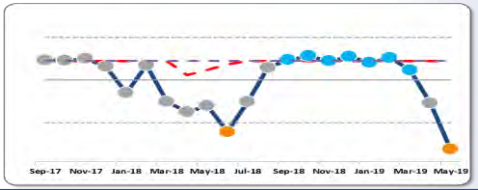
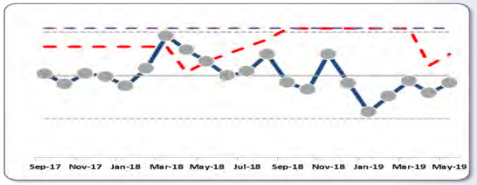
	Performance Metrics	Operational Standard		Y/e Mar 19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
EAS	4 Hours (all)	95%	Actual	75.93%	76.17% ✓	77.28% ×										
			Trajectory		75.41%	78.60%	78.78%	80.10%	82.10%	86.21%	86.24%	86.00%	86.00%	86.00%	86.00%	86.00%
	15-30 minute Amb. delays	-	Actual	1,861	1,703 ×	1,767 ×										
			Trajectory		1,420	1,251	1,149	1,112	855	831	673	655	704	706	642	470
	30-60 minute Amb. Delays	-	Actual	569	728 ×	608 ✓										
			Trajectory		609	626	522	445	428	416	292	284	376	377	428	470
	60+ minutes Amb. delays	0	Actual	227	496 ×	354 ×										
			Trajectory		203	209	209	222	214	208	269	262	329	330	107	0
RTT	Incomplete	92%	Actual	80.77%	80.18% ×	81.51%×										
			Trajectory		86.47%	88.06%	87.72%	87.69%	86.93%	86.01%	86.25%	85.81%	82.59%	83.06%	82.95%	82.43%
	52+ WW	0	Actual	16	0 ✓	0 ✓										
			Trajectory		0	0	0	0	0	0	0	0	0	0	0	0
Cancer	2WW All	93%	Actual	85.09%	84.81% ×	82.27% ×										
			Trajectory		93.93%	93.90%	93.64%	93.94%	94.02%	93.83%	93.96%	93.37%	95.58%	93.34%	94.05%	93.10%
	2WW Breast Symptomatic	93%	Actual	84.80%	54.12% ✓	12.00% ×										
			Trajectory		45.96%	51.76%	27.66%	55.68%	87.01%	94.20%	97.81%	93.02%	97.04%	91.72%	96.00%	84.80%
	62 Day All	85%	Actual	72.02%	66.37% ×	70.92% ×										
			Trajectory		74.93%	78.06%	80.91%	82.91%	84.90%	86.04%	86.04%	86.04%	86.04%	86.04%	86.04%	86.04%
	31 Day First Treatment	96%	Actual	97.47%	98.04% ✓	97.81% ✓										
			Trajectory		97.39%	97.32%	98.80%	97.82%	98.15%	97.35%	96.73%	96.99%	98.30%	94.07%	98.91%	97.22%
	31 Day Surgery	94%	Actual	100%	96.0% ×	85.70% ×										
			Trajectory		96.43%	97.06%	96.88%	100.00%	100.00%	95.00%	100.00%	100.00%	100.00%	92.68%	93.33%	95.83%
	31 Day Drugs	98%	Actual	100%	100% ✓	100% ✓										
			Trajectory		90.91%	100.00%	96.43%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
	31 Day Radiotherapy	94%	Actual	100%	100% ✓	100% ✓										
			Trajectory		100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
	62 Day Screening	90%	Actual	89.19%	91.67% ✓	84.0% ×										
			Trajectory		85.19%	85.19%	90.00%	90.70%	76.60%	73.21%	65.38%	78.26%	93.55%	63.41%	86.96%	81.25%
	62 Day Upgrade	-	Actual	71.9%	75.0% ✓	67.9% ✓										
			Trajectory		70.00%	62.50%	59.09%	83.33%	80.00%	90.91%	60.00%	75.00%	55.00%	62.50%	84.21%	65.38%
Diagnostics (DM01) only		99%	Actual	7.60%	8.23% ×	7.26% ×										
			Trajectory		7.63%	5.26%	6.7%	8.58%	10.48%	11.75%	8.72%	8.09%	10.23%	5.01%	3.29%	0.97%

Month 2 2019-20 Operational Performance Summary

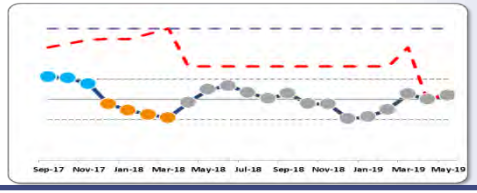
RAG rated against submitted/funded trajectory | Responsible Director: Paul Brennan | Validated for May-19 as at **26-Jun-19**

Worcestershire Acute Hospitals NHS Trust

Cancer Waiting Times

	Description	How we did	Trend and SPC assurance	What trajectory are we aiming for in Jun?
Did we see urgent cancer patients quickly?	**93%** of potential cancer patients seen by a specialist within **2 weeks**.	**82.27%**	We saw 82.27% of our cancer patients within 2 weeks. **368 patients** waited longer than 2 weeks.	 FORECAST STATUS: DECLINE / STABLE / IMPROVE	93.64%
Did we see patients with potential breast cancer quickly?	**93%** of patients with potential **breast cancer** seen by a specialist within **2 weeks**	**12.00%**	12.00% of patients were seen within 2 weeks. **110 patients** waited longer than 2 weeks.	 FORECAST STATUS: DECLINE / STABLE / IMPROVE	27.66%
How quickly did we start treating cancer patients?	**85%** of cancer patients to start treatment within **62 days** of urgent GP referral.	**70.92%**	70.92% of patients started treatment within 62 days. **44.5 patients waited longer before starting treatment**. There were **23 patients** still waiting 104 days or more for treatment at the end of the month.	 FORECAST STATUS: DECLINE / STABLE / IMPROVE	80.91%

EAS

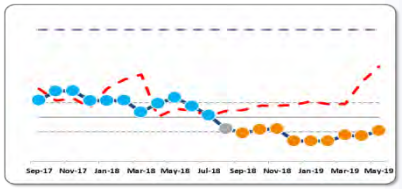
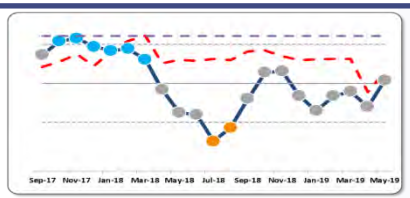
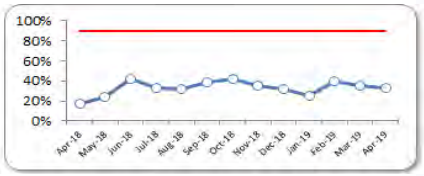
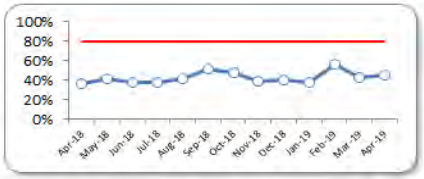
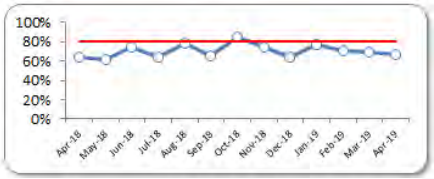
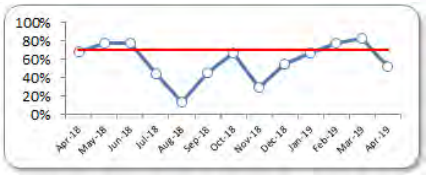
Are we seeing patients with an emergency within 4 hours?	The Trust should see **95%** of patients within 4 hours from arrival to admission, transfer or discharge	**77.28%**	The Trust performance was 77.28%. **3,937 patients** breached the 4 hours standard, WRH achieved 58.61%% (↓), ALX 78.57% (↑). **51 patients** waited 12+ hours to be admitted after their decision to admit.	 FORECAST STATUS: DECLINE / STABLE / IMPROVE	78.6%
Are ambulance patients waiting a long time to be seen?	No patient arriving by ambulance should wait over 1 hour to be handed-over to ED staff	**ALX 129** ↑ **WRH 225** ↑	**354 patients** arriving by ambulance remained under the care of the ambulance crew for over 60 minutes. This is **142 fewer patients** waiting over 60 minutes than in April.	 FORECAST STATUS: DECLINE / STABLE / IMPROVE	203
Are patients being treated on the corridor and for how long?	Corridor care is not acceptable , but when it does occur performance will be monitored against our plans to stop it happening.	**781 patients** **274 Minutes average**	**781 patients** spent time on the corridor in April. This is 167 more patients than in April. The average time spent on the corridor is around **274 minutes.**	 FORECAST STATUS: DECLINE / STABLE / IMPROVE	-

Forecast Status against most recent performance: Decline – expected to worsen. Stable – not expected to change significantly. Improve – Expected to improve

Month 2 2019-20 Operational Performance Summary

RAG rated against submitted/funded trajectory | Responsible Director: Paul Brennan | Validated for May-19 as at **26-Jun-19**

NHS Worcestershire Acute Hospitals NHS Trust

	Description		How we did	Trend and SPC assurance		What trajectory are we aiming for in Jun?
RTT Did we start treatment within18 weeks?	**92%** of patients on a 'referral to treatment' (RTT) pathway should be seen within 18 weeks.	81.51%	**81.51%** of patients are waiting less than 18 weeks for treatment. **7,080 patients have been waiting over 18 weeks.** No patient has waited over **52 weeks.** The 40-51 cohort **decreased from 357 to 303.**		FORECAST STATUS: DECLINE / **STABLE** / IMPROVE	87.7%
Diag. When a patient needs a diagnostic test, do we do this within 6 weeks?	A minimum of **99%** of patients who need a diagnostic test should wait less than 6 weeks	93.74%	**93.74%** of patients requiring a diagnostic test were waiting less than 6 weeks for their test. **6.26%** were waiting 6 or more weeks which equates to **478** patients.		FORECAST STATUS: DECLINE / **STABLE** / IMPROVE	93.3%
Stroke Are we directly admitting stroke patients to the specialist ward?	**At least 90% of patients should be directly admitted to the stroke ward.**	42.9%	Only **18 of 42 patients** were admitted to the stroke ward within 4 hours.		**Ring-fencing of stroke beds to ensure beds are readily available for stroke patients and can stay on stroke unit throughout their stay in hospital.**	52%
Are we scanning stroke patients soon enough?	**At least 80% of patients should receive a CT scan within 1 hour of arrival.**	53.3%	**32 of 60** patients had their CT scan within 60 minutes.		**The SCN specialists are completing their IRMER training to be able to request CT's. Process flow meeting has taken place with all clinical parties and the finalised straight to scanner pathway needs to be embedded.**	48%
Are stroke patients spending enough time on the specialist ward?	**At least 80% of patients should spend 90% of their stay on the stroke unit.**	79.0%	**49** patients spent at least 90% of their time on the stroke ward. **13 patients spent less than 90% of their stay on the ward.**		**Ring-fencing of stroke beds to ensure beds are readily available for stroke patients and can stay on stroke unit throughout their stay in hospital.**	75%
Are stroke patients seen quickly in specialist clinic?	**At least 70% of patients should be seen in TIA clinic within 24 hours.**	51.1%	47 patients were seen in the TIA clinic within 24 hours. **45 patients were not.**		**Successful consultant recruitment, additional WLIs and more efficient use of clinics has improved efficiency.**	55%

FORECAST STATUS: DECLINE / STABLE / IMPROVE

*APRIL 2019 Stroke data at 12.06.019. RAG rated against internal agreed trajectories.

Forecast Status against next month's performance: Decline – expected to worsen. Stable – not expected to change significantly. Improve – Expected to improve.

Finance & Performance Committee Assurance Report

Accountable Non-Executive Director	Presented By	Author
Richard Oosterom – Associate Non-Executive Director	Steve Williams– Non-Executive Director	Martin Wood – Deputy Company Secretary

Assurance: Does this report provide assurance in respect of the Board Assurance Framework strategic risks?	Y	**BAF number(s)**	4, 5, 6, 7

Level of assurance and trend

Significant assurance	Moderate assurance	Limited assurance	No assurance
		X	

Executive Summary

The Committee met on 28 June 2019.

Board Assurance Framework: We approved the updated BAF subject to a confirmed view from the Executives on Risk 4 (efficient patient flow). We were concerned that in some instances there is minimal information on the controls with gaps remaining. We were pleased to learn that the Governance Working Group will be considering the linkage of the BAF with the Corporate Risk Register.

Divisional attendance SCSD: SCSD were the first Division of a programme of Divisional attendance to present their operational and financial performance. We received performance information, the actions and challenges for the Division over the next three months and the internal governance arrangements linking to clinical directorates. We noted that the governance arrangements now sit alongside operational performance which is part of the linkage from Ward to Board. The Division are addressing identified leadership weaknesses in this linkage. There is Executive Director support for the Division to do "the right thing". The Division are strengthening their systems and processes which are designed for better outcomes. There are financial and operational challenges facing this large Division upon which other Divisions use their services providing particular challenges in managing performance. We were pleased to note the encouraging progress being made which we suggested should be shared with other Divisions.

Integrated Performance Report: Our overall emergency access standard was 77.28% just short of the 78.60% trajectory. 51 patients waited more than 12 hours for a bed. We did not meet the trajectory for 2 week cancer wait or the 62 days target. 2 week wait symptomatic breast performance fell in May due to gaps in workforce. Our RTT performance is 81.12%. Diagnostic performance improved with 6.26% of patients not being seen within 6 weeks. The overall stroke SSNAP performance has improved this quarter to Level C after three previous quarters at Level D. It was noted that the report still contains a lot of operational detail and from the information presented we were unable to ascertain whether the actions are delivering improvements or not. We have asked that future reports set out the key drivers for performance (under and over) and, if under, the actions (with timeframes and accountable person) to address that under performance and the level of assurance that the actions will deliver the targets.

Financial Performance - Month 2: We are reporting against the plan submitted to NHSI, which delivers a deficit of no more than £(82.8)m and includes a CIP of £13.6m. For month 2 we are reporting a £(6.2)m deficit against a target of £(7.3)m deficit, £1.1m positive to plan. The cumulative position at the end of M2 is a deficit of £(14.9m), £2.1 positive to the submitted plan after reducing income by £0.4m for the blended payment adjustment arising from being over the non elective threshold. In M2, internal budgets have been revised to reflect £16.2m of identified savings opportunities with a remaining gap of £6.3m to identify to deliver £22.5m in totality. Schemes to the value of £17.3m have been identified with further work to determine whether they are valid and whether there is any "double-counting". The identified CIP schemes are at differing levels of maturity with only £4.6m at level 4 (i.e. scheme approved and live). A lot of work is required to get the other elements of the CIP ready to go live.

Finance & Performance Committee Assurance Report

Executive Summary (cont.)

The main drivers for the variation against the financial plan are the estimated income margin growth, patient care income and underspends related to the provision of additional bed capacity and slippage in planned business cases (EPMA and MES). Agency and bank spend remains high and the underlying pay run rate for May is above April. Grip and control of pay expenditure continues through the Vacancy Panel and bank and agency through NHS P with further work to ensure that their expertise is being delivered. The underlying run-rate for non-pay is higher in May than April. Non pay expenditure will be further monitored through the revised SFIs and Scheme of Delegation.

One key issue raised both in the discussions with SCSD and in the capital report was the issue of the lack of availability of capital and the impact this is likely to have on improving productivity, financial performance and quality.

It was noted that the financial statements required a number of adjustments for one-off items including adjustments for previous months which made them harder to understand. In May, these adjustments included the late reporting of £110k of Medical and Scientific/Technical Agency staffing costs for shifts worked in April and a catch up on radiology outsourcing costs from April. The effectiveness of the control and reporting of key commitments by the Divisions is to be reviewed in the light of these late recorded costs

Bed Capacity Business Case – This item was dropped from the agenda since no paper was prepared. Separately, it was noted that there there was a delay in the timescales for the availability of the two new wards in Aconbury as a result of contractor liabilities.

Standing Financial Instructions and Scheme of Delegation Update: We were consulted as a relevant stakeholder on the proposed revisions to these documents. We particularly noted the proposal to strengthen the process for placing and monitoring orders. These documents will be presented to the Audit and Assurance Committee in July 2019 for approval.

Workforce Programme Update: We noted the governance structure for the workforce programme to ensure that there is a greater focus on implementation and delivery of projects owned by the relevant budget holders and professional staff groups. The programme is aiming to reduce temporary staffing expenditure and improve overall staff recruitment and retention for all professional groups.

Procurement for Level 7 Leadership Programme: We approved the award of the contract for the provision of the Senior Leaders Apprenticeship Training Programme to the Open University. The report requesting final approval is on the agenda for this meeting.

Background

The Finance and Performance Committee is set up to assure the Board with respect to the finance and performance agenda.

Issues and Options

The Committee in considering a number of key reports noted that they contained a considerable amount of detailed information but lacked clarity on the main issues, whether performance is on trajectory and, of not, the actions and timeframes to address. This is to be taken forward by the Executive Directors.

Recommendations

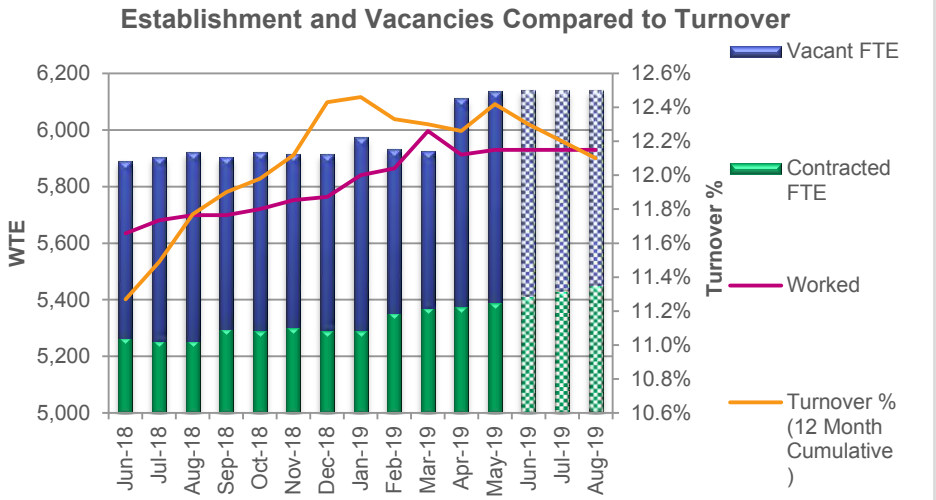
The Board is requested to receive this report for assurance.

Appendices

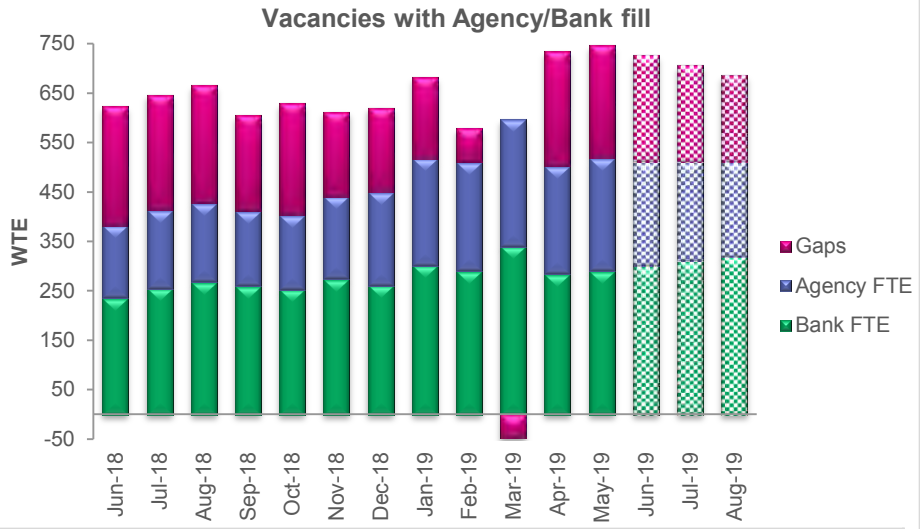
none

People and Culture KPI's

Vacancies and Turnover



Vacancies with Bank and Agency Fill



What has happened

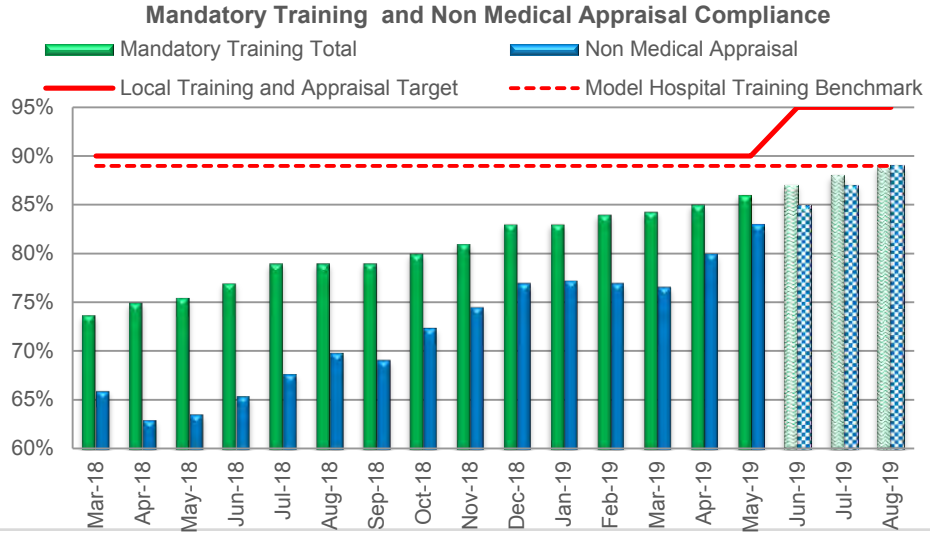
- Funded establishment for substantive staff has increased this month to 5964.92 wte with 572.53 wte substantive vacancies.
- Overall funded establishment including bank and agency for the additional wards has increased to 6138.52 wte which increases our vacancies to 746.14 wte. (12.15% vacancy rate).
- The overall staff turnover rate has increased by 0.16% to 12.42% compared to 11.07% for the same period last year and above our target range of 10-12%.
- In March 2019 we engaged more bank and agency than our establishment due to covering new wards which shows as a minus figure. This is now reflected in establishment for April and May.

Forecast and Corrective Actions

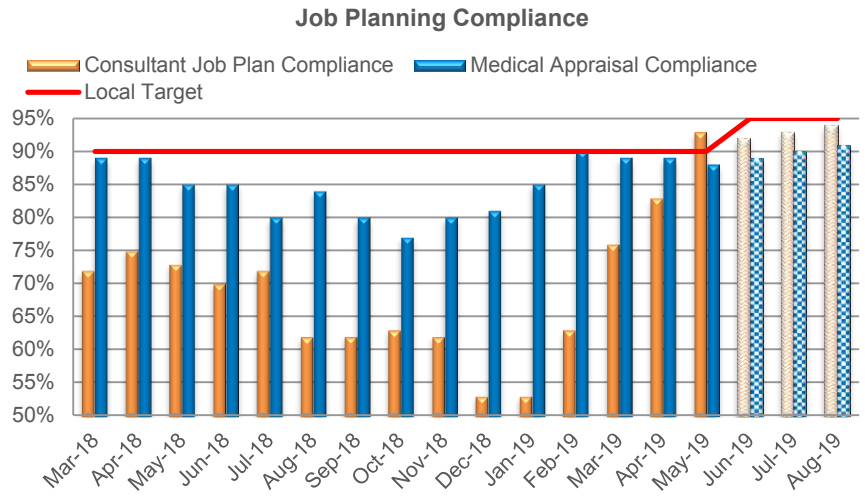
- Recruitment plans are in place with job fairs and assessment centres scheduled throughout the year, publicised through press, social media and advertised through NHS Jobs.
- The Overseas Development Programme for registered nurses has resulted in 70+ offers which are currently working through checks with new starters due to arrive from September onwards.
- These proactive recruitment initiatives will help to address the additional demand for the new wards and will bring our vacancy rate back down to below 12% by December 2019.
- The NHSP interface is expected to continue to improve fill rates as ward managers are locking down rosters earlier and available shifts are published via an app direct to staff

People and Culture KPI's

Mandatory Training and Non Medical Appraisal Compliance



Medical Appraisal and Job Plan Compliance



What has happened

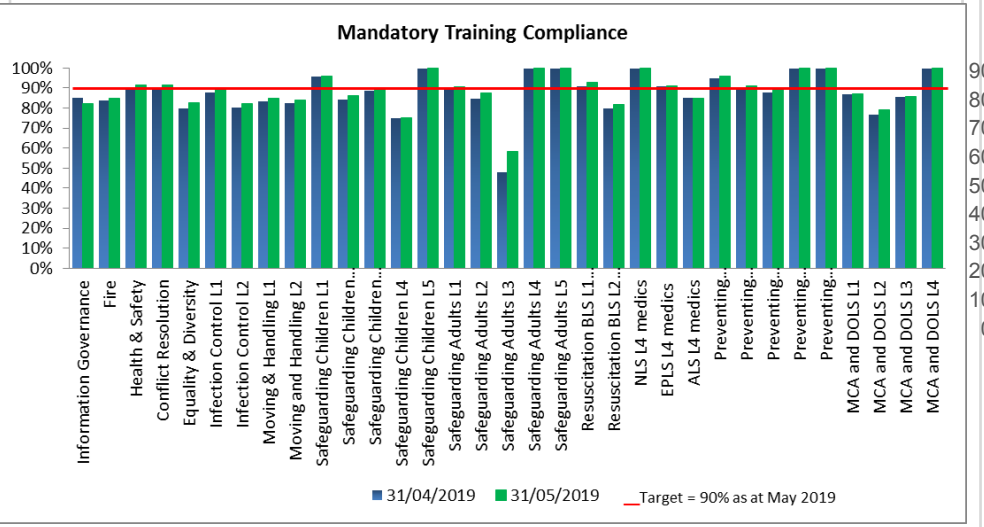
- The Trust's compliance rates for mandatory training increased by 1% to 86% across all 11 topics (33 levels) plus MCA and DOLS compared to Model Hospital average of 89%.
- Non-medical appraisal rate has improved by 3% to 83% which is still below the Trusts 85% target but in line with Model Hospital average. All divisions have shown an improvement this month except Surgery
- Consultant Job plan compliance rates have improved o 93% this month.
- Medical PDR compliance reduced by 1% from last month to 89%.

Forecast and Corrective Actions

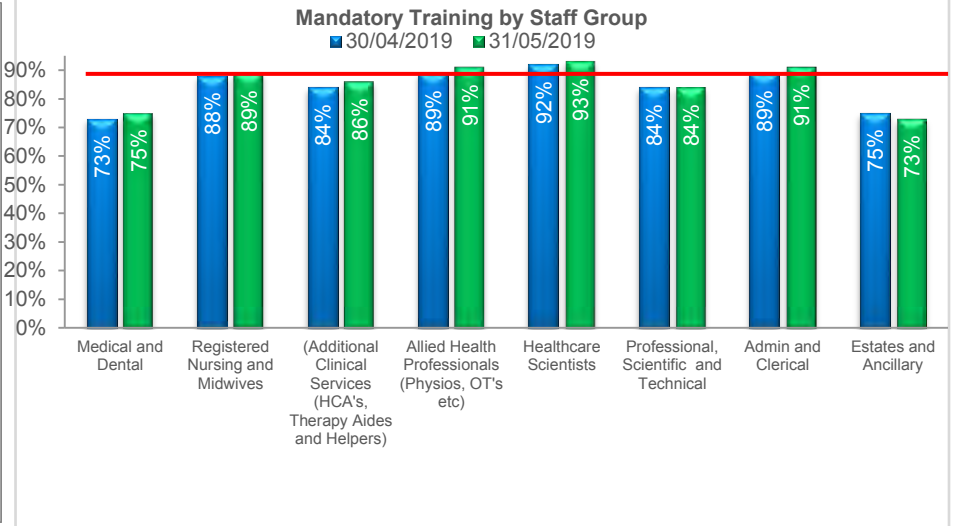
- Divisions will continue to be held to account for appraisal and mandatory training compliance at the monthly performance review meetings.
- Senior Leaders brief included advice that disciplinary action will be taken where staff fail to achieve target
- Senior Leaders advised that target is to be raised next month to 95%.
- Compliance for Medical job planning is being addressed through the Allocate suite of solutions and is on trajectory to meet 95% target.

People and Culture KPI's

Mandatory Training by topic



Mandatory Training by staff group



What has happened

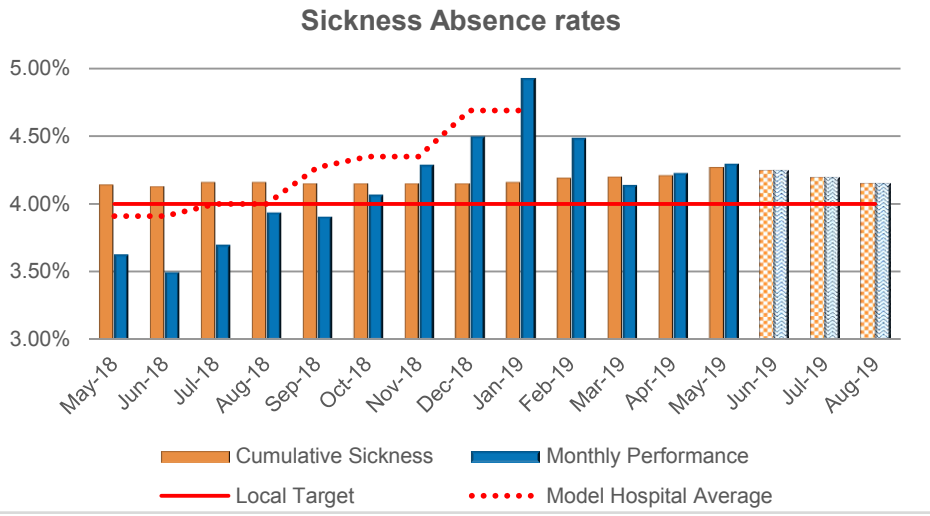
- The Trust's compliance rates for mandatory training improved to 86% across all 11 topics (33 levels) plus MCA and DOLS
- IG is the only topic of the 33 topic levels to decline this month
- 20 topic levels have improved. Of the 12 levels that stayed the same this month 10 are above target
- Estates and Ancillary is the lowest compliance at 73% and is the only staff group to deteriorate this month
- Medical and Dental have improved by 2% but are still only at 75%.

Forecast and Corrective Actions

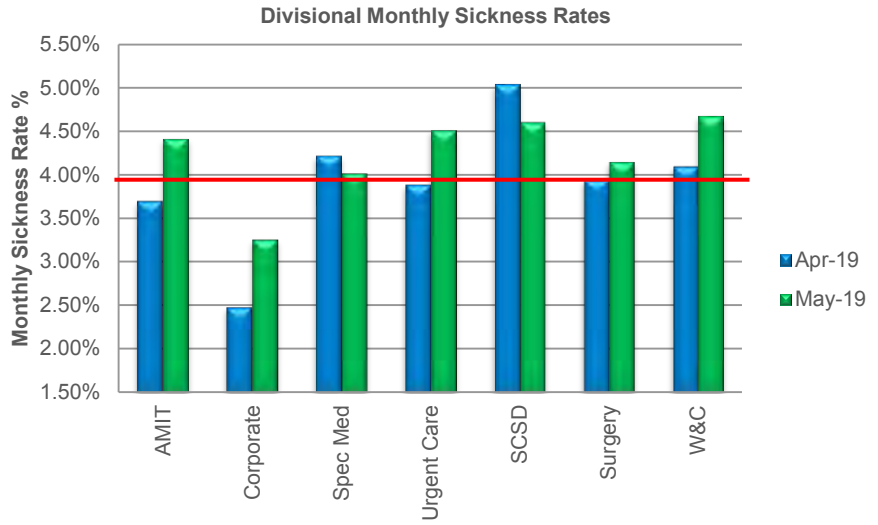
- As per previous slide
- Model Hospital benchmark is currently 89%
- Specific focus on medical compliance with changes to the junior doctor induction for August rotation to improve compliance.

People and Culture KPI's

Sickness Absence



Sickness by Division



What has happened

- Cumulative sickness rate for the 12 months has increased by 0.06% to 4.27% compared to 4.14% for the same period last year.
- The Trust was 0.19% above Model Hospital benchmark of 4.69% as at January 2019 which is the most recent data available.
- The monthly sickness absence rate is higher than for the same period last year which is impacting on the cumulative rate.

Forecast and Corrective Actions

- All divisions continue to be supported by HR to undertake formal sickness absence management meetings.
- Monthly sickness reports are sent to divisions to enable them to identify hotspots with HR support.

People & Culture Committee Assurance Report

Accountable Non-Executive Director	Presented By	Author
Mark Yates - Non-Executive Director	Richard Oosterom – Associate Non-Executive Director	Kimara Sharpe - Company Secretary

Assurance: Does this report provide assurance in respect of the Board Assurance Framework strategic risks?	Y	**BAF number(s)**	10 11

Level of assurance and trend

Significant assurance	Moderate assurance	Limited assurance	No assurance
		X	

Executive Summary

The Committee met on 18 June 2019. The items discussed were as follows:-

Equality and Diversity: Members of the Trust's Equality and Diversity committee attended the meeting and had an interesting discussion about how we can work to make the Trust an exemplar in E&D. Recent work included the LGBT history week as well as training in Basic Sign Language for 150 staff and a presentation at the recent Trust Board meeting by a Trustee from Deaf Direct. The E&D vision and objectives are being revised and further work needs to take place so that the agenda of the committee is balanced between patient and staff related topics. There is obviously a lot of work being undertaken and we look forward to a further report on E&D in the future.

Health Education England: Further to the Trust Board receiving a presentation from the Guardian for Safe Working and also feedback following a recent visit, we received the report from HEE and the Trust's response. An action plan has been developed which will be overseen by the Trust Management Executive.

Board Assurance Framework: The Committee approved the updates to the BAF risks 10, 11 and 12.

People and Culture Strategy update: We received a presentation relating to the new national Interim NHS People Plan. A finalised plan is expected in the Autumn. Work is on-going with respect to the updating of the Trust's OD strategy to map to *Putting Patients First*. We were disappointed with the numbers of staff (75) completing the recent Staff Friends and Family test. The next survey is open and 344 staff have already responded within the first 2 days.

Strategic workforce plan: We considered a draft plan and were pleased with the divisional ownership of this agenda**.** The final plan will ensure clear career pathways from band 2 to band 8, using the apprenticeship levy were possible.

Communications and engagement strategy: This was deferred, pending further revision. It will be presented to the Committee in August, prior to board sign off in September. The delay is to ensure alignment with the Clinical Services Strategy.

People & Culture Committee Assurance Report

Accountable Director	Presented By	Author
Mark Yates - Non-Executive Director	Richard Oosterom - Non-Executive Director	Kimara Sharpe - Company Secretary

Assurance: Does this report provide assurance in respect of the Board Assurance Framework strategic risks?	Y	**BAF number(s)**	10 11

Level of assurance and trend

Significant assurance	Moderate assurance	Limited assurance	No assurance
		X	

Executive Summary (cont.)

Appraisal/PDR: We learnt that 955 staff have not had an appraisal in the past 12 months. The appraisal paperwork has been simplified, training for managers undertaken and fortnightly compliance reports issued to each division. We were interested in ensuring that PDRs were of good quality and suggested using the methodology that the medical and dental appraisal process uses. We were pleased that the ward accreditation programme includes appraisal compliance as this could inject some competition between areas.

HR casework: It was reported that staff who have been suspended for a long period usually have a complex case which could involve other agencies such as the police in safeguarding allegations. Regular reviews of these cases are undertaken. We saw as positive the increase in cases reported to HR under the dignity at work policy – we have requested information about how many cases are being upheld and how we benchmark with other Trusts.

Medical workforce update: We have appointed 14 more consultants in the last two months and 93% of consultants have a job plan.

Education, Learning and development: The Academy is being launched on 16/17 July.

The committee received the following papers for updates:

- 4ward committee
- Safe staffing
- Fit and Proper Person Annual Audit
- People and Culture risk register
- JNCC/MMC minutes
- Workplan (we will include the implications of the tax on high earners and funding for BSL)

People & Culture Committee Assurance Report

Accountable Director	Presented By	Author
Mark Yates - Non-Executive Director	Mark Yates - Non-Executive Director	Kimara Sharpe - Company Secretary

Assurance: Does this report provide assurance in respect of the Board Assurance Framework strategic risks?	Y	**BAF number(s)**	10 11

Level of assurance and trend

Significant assurance	Moderate assurance	Limited assurance	No assurance
		X	

Background

The People and Culture Committee is set up to assure the Board with respect to the People and Culture agenda.

Issues and options

None.

Recommendations

The Trust Board is requested to

- Note the report for assurance
- Agree to an item on each committee/board meeting to reflect whether the meeting demonstrated the 4ward behaviours.

Appendices

- TB IPR Dashboards – M2 2019-20

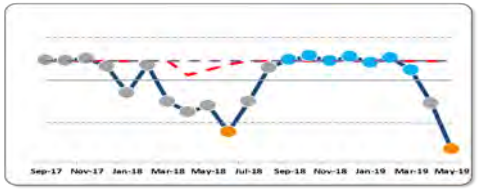
Trust Board Reporting Principles

Following feedback from the Trust Board members, Committee chairs and NHSE/I we will consider the following principles whilst developing the future reporting:

- Focus in the report will be less on data and more on drivers of performance, mitigating actions/recovery plans and the impact of those plans.
- Data and Information will inform discussions at sub committee level.
- The report will consider performance of the annual plan priorities, constitutional standards and critical performance measures linked to significant areas of concern.
- As details progress through the Governance processes the reporting will become more and more focused until the Trust Board receive only areas of 'special cause' variation for improving or declining performance or updates of critical importance or where support is specifically required.
- Reporting will incorporate the assurance of both the 'variation in trend' and the ability to deliver the trajectory/target.
- Reporting will incorporate links to corporate risks where applicable.

What changes have been made in the month 2 report?

1) The inclusion of SPC charting in the operational performance section.



2) The inclusion of icons for quick reference in the operational performance section.

3) Focused key points in the cover report and less data included in the narrative.

Patient Flow and the Emergency Access Standard

Variance in performance is 'common cause' variation, there is no significant change.

.

What changes can you expect in month 3 and beyond?

1) The covering report will be reorganised to align to the annual plan Strategic objectives, there will be a separate section for constitutional standards and other critical measures **(From month 3).**

2) Further extension of the SPC charts and the assurance icons for all included metrics (i.e. Quality, Workforce and Finance) **(From month 3).**

3) More transparent assurance (using the icons) regarding mitigation of the Corporate risks **(From month 3).**

4) A change to one report that includes a brief (one page) covering report, one page per metric that includes the SPC and narrative, and a single page dashboard for quick reference **(From month 3).**

5) We will remove the current duplication between the issues and options in the covering report **(From month 3)**

6) More linkage between improvement initiatives that have been put in place and whether they are delivering the impact expected **(Iteratively from month 3).**

7) Improved intelligence between dependent metrics particularly where these are driving current performance, for example the impact on vacancies, on the waiting list and quality of services for our patients **(Iteratively from month 3).**

8) The development of an assurance level at recovery plan level. How assured can we be the plan will deliver transformation and improvements? **(Iteratively from month 6).**

Worcestershire Acute Hospitals NHS Trust

Quality Metrics Overview

Worcestershire Acute Hospitals NHS Trust

Reporting Period: May 2019

SAFE

Area	Indicator Type		Indicator	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Current YTD	Prev Year	2019/20 Tolerances			SRO	Data Quality Kitemark
																				On Target	Of Concern	Action Required		
Incidents	Local	QPS3.3	Number of overdue SIs	0	0	0	0	0	0	0	0	0	2	1	0	0			0	-	>0	CMO	
Falls	Local	QPS6.6	Falls: Total Falls Resulting in Serious Harm (In Month)	0	1	0	2	3	2	3	0	0	1	0	1	2	3	14	<=1	-	>=2	CNO	
VTE	National	QPS11.2	VTE Risk Assessment (as recorded in OASIS only)	95.13%	94.35%	95.51%	94.67%	94.07%	95.14%	95.33%	92.70%	93.89%	93.99%	94.89%	95.92%	96.58%			>=95%	94% - 94.9%	<94%	CMO	
Never Events	National	QPS4.1	Never Events	0	0	0	0	0	0	1	0	0	0	0	0	1	1	1	0	-	>0	CMO	
Pressure Ulcers	Contractual	QPS7.16	Hospital Acquired Pressure Ulcers: Deep Tissue Injury		4	8	4	6	6	6	6	10	5	8	8	11	19	63	-	-	-	CNO	
	Contractual	QPS7.17	Hospital Acquired Pressure Ulcers: Unstageable		2	2	1	1	1	0	4	4	4	4	5	4	9	23	-	-	-	CNO	
Infection Control	National	QPS12.1	*Clostridium Difficile* Infection (Trust Attributable)	2	3	6	1	4	4	2	4	5	5	4	4	3	7	43	17/18 Threshold <= 32 18/19 Threshold <= 31			CNO	
	Contractual	QPS12.15	MSSA Bacteremia Cases (Trust Attributable)	1	1	3	3	1	0	2	3	2	0	3	0	2	2	24	0	1	>1	CNO	
	Contractual	QPS12.14	Ecoli Bacteremia Cases (Trust Attributable)	5	7	6	7	3	5	6	12	4	9	3	5	6	11	72	18/19 Threshold < = 47			CNO	
	National	QPS12.4	MRSA Bacteremia Cases (Trust Attributable)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	-	>0	CNO	
	National	QPS12.131	MRSA Patients Screened (High Risk Wards Only) - Elective	95.50%	95.60%	97.70%	97.80%	96.50%	95.48%	93.90%	97.37%	96.91%	96.59%	97.09%	97.91%	98.84%			>=95	-	<95%	CNO	
C-Sections	Contractual	MCS1.2	Emergency Caesareans	14.10%	12.10%	14.00%	16.20%	15.70%	19.80%	17.00%	16.20%	14.90%	16.80%	16.30%	17.10%	17.10%	15.46%	15.46%	<=15.2%		>15.2%	CNO	
Sepsis 6	National	QEF3.4	% of patients receiving all elements of the sepsis 6 bundle within 1 hour	47%	67%	48.33%	55.56%	52.63%	60.23%	39.39%	54.26%	43.88%	43.00%	49.14%	57.50%				>=80%	-	< 80%	CNO	
Hand Hygeine	Local	QEF3.5	Hand Hygiene Compliance to Practice	85.55%	91.29%	89.96%	91.48%	95.02%	95.66%	96.79%	96.79%	97.35%	96.55%	97.23%	96.95%	97.52%			>=95%		<95%	CNO	
	Local	QEF3.6	Hand Hygiene Audit Participation	14.05%	12.40%	14.88%	12.40%	35.54%	57.02%	70.00%	66.67%	77.50%	76.67%	80.17%	86.55%	87.39%			100%		<100%	CNO	
Medicine Management	Local	QPS5.3	Medicine Incidents per 1,000 bed days	4.58	5.26	4.90	4.55	4.09	4.25	4.41	4.11	4.10	3.44	4.56	4.66	4.95			4.88		<4.88	CNO	
	Local	QPS5.4	% of Medicine Incidents causing harm	18.52%	20.00%	15.04%	7.55%	18.28%	17.17%	21.57%	15.31%	9.62%	17.50%	20.00%	13.04%	16.13%			<=11.71%		>11.71%	CNO	

EFFECTIVE

Mortality	National	QPS9.81	Mortality - HSMR - All Diagnostic Groups - rolling 12 months (HED)	107.50	108.90	109.61	109.83	110.64	111.49	112.70	112.52	111.39					-	-	<=100	-	-	DPS	
	National	QPS9.1	Mortality - SHMI - inc. deaths 30 days post discharge - rolling 12 months (NHS Digital Quarterly Publication)		1.0921			1.1132			1.1349						-	-	-	-	-	DPS	
	National	QPS9.23	% Primary Mortality Reviews returned within 30 days of issue (from month assigned)	58.62%	51.46%	57.24%	58.18%	52.17%	59.89%	40.00%	36.08%	20.68%	23.71%	27.95%					>=60%	-	<60%	DPS	
	National	QPS9.26	% Completed PMRs (includes > 30 day completion)	80.78%	81.10%	81.77%	82.18%	82.59%	82.51%	82.20%	80.51%	78.77%	78.38%	77.63%					-	-	-	DPS	
EMSA	National	QEX3.1	EMSA - Eliminating Mixed Sex Accommodation	62	62	55	45	55	50	52	54	50	34	45	59	57	116	619	0	-	>0	CNO	
NOF	National	QEF3.1	Hip Fracture - Time to Theatre <= 36 hrs (%)	79.10%	68.52%	76.56%	86.54%	66.18%	73.53%	86.67%	86.27%	93.65%	82.76%	89.29%	83.87%	86.89%			>=85%	-	<85%	CMO	
	National	QEF3.2	Hip Fracture - Time to Theatre <= 36 hrs (%) - Excl. Unfit/Non-Operative Pts	84.13%	84.09%	87.50%	93.75%	70.31%	80.65%	88.14%	91.67%	98.33%	100.00%	96.15%	92.86%	92.98%			>=85%	-	<85%	CMO	
Audits	Local	QR1.16	% of NICE assessments completed within 10 weeks (8 weeks wef 1/9/18, 6 weeks wef 1/4/19, 10 weeks agreed with CCG for 19/20)	74.6%	81.7%	79.4%	80.0%	84.0%	89.0%	90.0%	89.7%	90.4%	92.5%	89.95%	92.45%	94.08%			>=85%	84%- 75%	<75%	CMO	
	Local	QR1.13	Complete an annual programme of local clinical audit	1.0%	2.0%	5.0%	9.0%	19.0%	22.0%	28.0%	32.0%	41.0%	50.0%	74.0%	0.0%	3.3%			>=60%	59%- 50%	<50%	CMO	
	Local	QR1.14	Participate in all relevant national clinical audits that the trust is eligible to participate in.	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.00%	88.00%	91.00%			>=94%	93-90%	<90%	CMO	

* NCEPOD - currently not active as no reports are due

PATIENT EXPERIENCE

Friends & Family	National	QEX2.1a	Friends & Family - A&E (% Recommend)	80.35%	81.46%	73.93%	78.68%	81.35%	81.70%	83.52%	78.27%	82.02%	85.71%	84.14%	86.35%	82.59%	-	-	>=95%	85% - 94%	<85%	CNO	
	National	QEX2.2	Friends & Family - A&E (Response Rate %)	5.72%	6.00%	4.86%	5.67%	4.12%	6.30%	6.83%	5.19%	5.87%	7.42%	4.77%	8.19%	7.76%	-	-	>=20%	-	<20%	CNO	
	National	QEX2.61a	Friends & Family - Acute Wards (% Recommend)	94.45%	94.49%	94.14%	93.65%	92.90%	93.16%	95.47%	95.30%	94.09%	94.60%	94.94%	94.44%	94.38%	-	-	>=95%	85% - 94%	<85%	CNO	
	National	QEX2.62	Friends & Family - Acute Wards (Response Rate %)	8.69%	17.46%	19.33%	18.26%	16.99%	18.29%	20.30%	16.40%	18.63%	19.62%	20.60%	25.68%	30.34%	-	-	>=30%	-	<30%	CNO	
	National	QEX2.7a	Friends & Family - Maternity (% Recommend) (exc. Community)	98.26%	97.25%	98.60%	95.98%	97.13%	97.88%	99.18%	98.59%	99.20%	97.42%	99.14%	98.31%	97.80%	-	-	>=95%	85% - 94%	<85%	CNO	
	National	QEX2.8	Friends & Family - Maternity (Response Rate %) (exc. Community)	26.56%	22.38%	27.99%	35.97%	21.76%	29.42%	29.37%	25.09%	29.64%	32.89%	28.70%	30.26%	30.21%	-	-	>=30%	-	<30%	CNO	
	National	QEX2.10a	Friends & Family - Outpatients (% Recommend)	92.51%	90.79%	92.17%	91.40%	91.01%	92.36%	93.32%	92.48%	92.34%	92.99%	93.18%	91.83%	92.85%	-	-	>=95%	85% - 94%	<85%	CNO	
	National	QEX2.11	Friends & Family - Outpatients (Response Rate %)	3.76%	3.65%	3.80%	4.60%	4.21%	5.11%	5.48%	5.04%	5.39%	5.80%	7.17%	8.15%	8.55%	-	-	>=10%	-	<10%	CNO	
Complaint Management	Local	QEX1.24	Formal Complaints - Received In Month	61	44	55	50	48	59	47	44	43	51	42	66	56	122	599	-	-	-	CNO	
	Local	QEX1.37	Formal Complaints - % responded within 25 days (closed in month)	81.33%	82.00%	86.67%	90.77%	88.57%	76.09%	71.43%	81.08%	77.50%	74.42%	85.71%	72.73%	78.00%			>=80%	70-79%	<=69%	CNO	
	Local	QEX1.41	Formal Complaints - % of further concerns received	3.0%	0.0%	0.0%	8.0%	0.0%	2.6%	2.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%			<10%	-	>=10%	CNO	

* A new electronic mortality review system was introduced at the end on May - this means previous months are not comparable. PMR reporting is based on the month assigned and reported a month in arrears.
** There has been a change in methodology for FFT - the 'score' now represents % recommended (where the response was either extremely likely or likely)

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

Data Quality Kite Mark Descriptions
Green - Reviewed in last 6 months and confidence level high.
Amber - Potential issue to be investigated
Red - DQ issue identified - significant and urgent review required.
Blue - Unknown - will be scheduled for review.
White - No data available to assign DQ kite mark

Worcestershire Acute Hospitals NHS Trust

Performance Metrics Overview

Worcestershire Acute Hospitals NHS Trust

Reporting Period: May 2019

Area	Indicator Type	Indicator		May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Current YTD	Prev Year	Tolerance Type	2019/20 Tolerances: On Target	2019/20 Tolerances: Of Concern	2019/20 Tolerances: Action Required	SRO	Data Quality Kitemark
Waits	National	PW1.1.3	Proportion of patients referred for diagnostic tests who have been waiting for less than six weeks	89.89%	89.69%	86.51%	88.13%	91.52%	94.68%	94.81%	91.89%	90.13%	91.88%	92.40%	90.61%	92.70%			National	>=99%	-	<99%	COO	
	National	CW3.0	RTT - Patients on an incomplete pathway (within 18 weeks)	84.76%	83.86%	82.87%	81.45%	81.01%	81.36%	81.47%	80.14%	80.17%	80.14%	80.77%	80.69%	81.51%			National	>=92%	-	<92%	COO	
	National	CW4.0	RTT - Patients waiting 52 weeks or more for treatment (at month end)	2	1	0	0	0	0	0	0	0	0	0	0	0			National	0	-	>=1	COO	
	National	CW4.1	RTT - In month clock stops for patients were waiting 52+ weeks	15	10	3	1	5	68	14	3	11	7	4	3	4	7	160						
	National	CW4.2	RTT - Patients waiting 40 weeks or more for treatment (at month end)	453	422	410	477	458	337	339	427	420	395	357	346	298								
A & E	National	CAE1.1	4 Hour Waits (%) - Trust (exc. H&CT, MIUs)	73.07%	73.94%	71.81%	70.22%	72.13%	68.83%	69.28%	65.01%	65.30%	67.50%	72.44%	70.70%	71.89%	71.29%	69.70%	National	>=95%	-	<95%	COO	
	National	CAE1.1a	4 Hour Waits (%) - Trust (inc. H&CT, MIUs)	78.78%	79.80%	78.01%	76.37%	77.76%	75.02%	74.97%	71.04%	71.57%	73.48%	77.67%	76.17%	77.28%	76.74%	75.80%	National	>=95%	-	<95%	COO	
	Local	CAE2.1	12 hour trolley breaches	28	3	2	10	19	25	34	99	170	85	16	65	51	116	535	Local	0		0	COO	
	National	CAE3.1	Time to Initial Assessment for Pts arriving by Ambulance (Mins) - 95th Percentile	47	40	51	68	73	94	65	102	183	145	71	101	98	106	-	National	<=15mins	-	>15mins	COO	
	National	CAE3.2	Time to Initial Assessment for All Patients (Mins) - 95th Percentile	55	64	66	69	68	68	57	60	105	86	60	79	76	78	-	National	<=15mins	-	>15mins	COO	
	National	CAE7.0	Ambulance Handover within 15 mins (%) - WMAS data	36.70%	53.60%	51.00%	46.50%	43.90%	39.20%	43.80%	36.20%	28.70%	32.40%	42.30%	36.00%	39.30%	37.60%	40.70%	National	>=80%	-	<80%	COO	
	National	CAE8.0	Ambulance Handover within 30 mins (%) - WMAS data	78.80%	85.70%	83.40%	80.30%	79.20%	76.20%	81.60%	71.50%	63.10%	70.10%	82.70%	73.30%	78.60%	75.90%	77.20%	National	>=95%	-	<95%	COO	
	National	CAE9.0	Ambulance Handover over 60 minutes - WMAS data	174	123	210	315	287	415	270	544	799	522	227	496	354	850	4,137	Local	0		>0	COO	
Cancer	National	CCAN1.0	2WW: All Cancer Two Week Wait (Suspected cancer)	77.49%	65.62%	75.00%	80.58%	88.90%	93.96%	93.37%	95.58%	93.35%	94.05%	92.18%	84.92%	82.27%	83.59%	85.09%	National	>=93%	-	<93%	COO	
	National	CCAN2.0	2WW: Wait for Symptomatic Breast Patients (Cancer Not initially Suspected)	51.76%	27.66%	55.68%	87.01%	94.20%	97.81%	93.02%	97.04%	91.72%	96.00%	84.80%	54.12%	12.00%	36.27%	76.41%	National	>=93%	-	<93%	COO	
	National	CCAN3.0	31 Days: Wait For First Treatment: All Cancers	97.32%	98.80%	97.82%	98.15%	97.35%	96.73%	96.99%	98.30%	94.07%	98.91%	98.11%	98.19%	97.07%	97.67%	97.47%	National	>=96%	-	<96%	COO	
	National	CCAN7.0	62 Days: Wait For First Treatment From Urgent GP Referral: All Cancers	76.01%	72.14%	73.30%	77.96%	70.26%	68.38%	77.97%	70.13%	62.36%	66.67%	70.70%	67.50%	70.92%	69.07%	72.02%	National	>=85%	-	<85%	COO	
	Local	CCAN7.2	62 Days: Wait For First Treatment From Urgent GP Referral: Breast*	85.19%	86.67%	93.55%	89.74%	65.52%	91.49%	82.61%	94.59%	68.00%	80.95%	92.00%	88.89%	85.71%	87.50%	84.40%	National	>=85%	-	<85%	COO	
	Local	CCAN7.3	62 Days: Wait For First Treatment From Urgent GP Referral: Gynae*	55.00%	60.00%	69.23%	90.00%	44.44%	84.21%	85.00%	37.50%	45.45%	61.11%	94.12%	62.50%	54.55%	59.26%	69.89%	National	>=85%	-	<85%	COO	
	Local	CCAN7.4	62 Days: Wait For First Treatment From Urgent GP Referral: Haemotological*	70.00%	75.00%	92.86%	77.78%	100.00%	83.33%	33.33%	66.67%	60.00%	57.14%	63.64%	81.82%	69.23%	77.14%	73.68%	National	>=85%	-	<85%	COO	
	Local	CCAN7.5	62 Days: Wait For First Treatment From Urgent GP Referral: Head & Neck*	71.43%	10.00%	50.00%	20.00%	50.00%	0.00%	75.00%	25.00%	13.33%	50.00%	60.00%	36.36%	18.18%	30.30%	40.56%	National	>=85%	-	<85%	COO	
	Local	CCAN7.6	62 Days: Wait For First Treatment From Urgent GP Referral: Lower Gastro*	70.00%	73.91%	76.19%	80.49%	89.66%	70.00%	82.05%	72.73%	80.95%	82.61%	93.33%	83.33%	72.22%	77.78%	77.52%	National	>=85%	-	<85%	COO	
	Local	CCAN7.7	62 Days: Wait For First Treatment From Urgent GP Referral: Lung*	75.00%	75.00%	56.00%	66.67%	35.71%	52.17%	70.00%	45.45%	30.77%	14.29%	40.00%	52.63%	75.00%	62.86%	52.14%	National	>=85%	-	<85%	COO	
	Local	CCAN7.8	62 Days: Wait For First Treatment From Urgent GP Referral: Skin*	100.00%	100.00%	87.14%	92.68%	83.33%	77.53%	94.38%	91.43%	87.36%	89.83%	100.00%	97.44%	96.15%	96.79%	91.02%	National	>=85%	-	<85%	COO	
	Local	CCAN7.9	62 Days: Wait For First Treatment From Urgent GP Referral: Upper Gastro*	90.48%	53.85%	68.42%	85.71%	92.86%	52.94%	86.67%	60.00%	59.46%	82.35%	80.00%	76.47%	78.95%	77.78%	72.63%	National	>=85%	-	<85%	COO	
	Local	CCAN7.10	62 Days: Wait For First Treatment From Urgent GP Referral: Urological*	59.68%	53.21%	56.86%	67.48%	57.89%	59.57%	59.79%	62.50%	42.86%	42.98%	37.50%	40.35%	51.06%	45.19%	56.33%	National	>=85%	-	<85%	COO	
	Local	CCAN7.11	62 Days: Wait For First Treatment From Urgent GP Referral: Other*	100.00%	100.00%	0.00%	100.00%	100.00%	-	50.00%	-	-	-	100.00%	-	-	-	70.83%	National	-	-	-	COO	
	National	CCAN8.0	62 Days: Wait For First Treatment From National Screening Service Referral: All Cancers (Small numbers)	85.19%	90.00%	90.70%	76.60%	73.21%	65.38%	82.61%	93.55%	63.41%	86.96%	88.89%	92.00%	84.00%	89.33%	80.54%	National	>=90%	-	<90%	COO	
	Local	CCAN12.0	62 Days waits: 62 day treatments waiting over 62 days	93	107	113	135	133	87	102	129	135	108	104	128	173							COO	
	Local	CCAN10.0	104 Day waits : 62 day treatments waiting over 104 days	21	17	20	38	32	25	23	30	32	25	24	23	24							COO	
	Local	CCAN11.0	Cancer Long Waiters (104+ Days) - treated in month	9.5	9.5	12.5	9.5	17.5	18.5	9.5	12.5	18.5	21.5	15.0	21.0	8.0	29.0	161.5	-	-	-	-	COO	
Stroke**	Local	CST1.1	80% of Patients spend 90% of time on a Stroke Ward	62.00%	73.10%	64.30%	78.50%	65.50%	84.30%	74.60%	64.10%	77.30%	70.50%	69.80%	79.00%			70.40%	Local	>=80%	-	<80%	COO	
	Local	CST2.1	Direct Admission (via A&E) to a Stroke Ward	24.40%	42.50%	33.30%	31.60%	38.70%	41.50%	35.70%	31.70%	25.50%	42.40%	35.70%	42.90%			33.00%	Local	>=90%	-	<90%	COO	
	Local	CST3.1	TIA clinic within 24 hours	77.60%	77.90%	44.20%	14.10%	45.20%	66.70%	29.90%	55.70%	66.70%	77.80%	83.10%	51.10%			56.20%	Local	>=60%	-	<60%	COO	
	Local	CST4.0	CT scan within 60 minutes of arrival	42.20%	38.30%	38.30%	41.60%	51.90%	47.80%	39.70%	40.60%	37.70%	56.40%	43.30%	53.30%			43.00%	Local	>=80%	-	<80%	COO	
Inpatients (All)	Local	PIN1.5	Bed Occupancy (Midnight General & Acute) - WRH	99.83%	98.76%	100.33%	98.25%	96.27%	98.39%	97.30%	97.95%	99.65%	99.60%	98.54%	98.45%	98.78%	98.6%	98.74%	Local	<90%	90 - 95%	>95%	COO	
	Local	PIN1.6	Bed Occupancy (Midnight General & Acute) - ALX	87.20%	87.34%	88.12%	87.78%	89.51%	91.37%	92.09%	93.59%	96.84%	95.16%	90.95%	90.56%	90.18%	90.4%	90.6%	Local	<90%	90 - 95%	>95%	COO	
	Local	PIN2.3	Beds Occupied by NEL Stranded Patients (>7 days) - last week of month	38.41%	41.18%	39.19%	37.41%	35.18%	41.04%	38.08%	43.91%	41.25%	40.84%	40.68%	40.49%	43.95%			Local	<=45%	-	>45%	COO	
	National	PIN3.1	Delayed Transfers of Care SitRep (Patients) - Acute/Non-Acute	35	40	25	31	27	23	39	28	26	38	26	33	25			Local	<30	-	>=30	COO	
	National	PIN3.2	Delayed Transfers of Care SitRep (Days) - Acute/Non-Acute	803	713	617	840	622	523	885	575	607	639	671	515	641			-	-	-	-	COO	
Elective	National	PEL3.1	Number of patients - 28 Day Breaches (cancelled operations) | Quarterly		72			57			52			43				224	TBC	-	-	-	COO	
	National	PEL4.2	Urgent Operations Cancelled for 2nd time	1	1	3	2	1	0	2	1	0	0	0	2	2	4	11	National	<=0	-	>0	COO	
Emergency	Local	PEM2.0	Length of Stay (All Patients)	4.6	4.6	4.4	4.5	4.5	4.3	4.3	4.5	4.6	4.6	4.5	4.5	4.6	4.5	4.6	Local	TBC	TBC	TBC	COO	
	Local	PEM3.0	Length of Stay (Excluding Zero LOS Spells)	6.9	6.9	6.6	6.6	6.6	6.4	6.6	6.8	7.0	6.9	6.9	6.8	7.0	6.9	6.8	-	-	-	-	COO	
Dementia	National	QEF1.1	Dementia: Find, Assess, Investigate and Refer (Pt 1 - Find)	88.11%	85.50%	93.58%	94.93%	86.80%	97.92%	93.44%	96.80%	96.47%	94.90%	96.10%	95.80%	95.49%		93.04%	National	>=90%	-	<90%	CMO	
	National	QEF1.2	Dementia: Find, Assess, Investigate and Refer (Pt 2 - Investigate)	94.33%	90.53%	93.72%	93.09%	89.47%	93.33%	93.91%	94.90%	90.84%	95.50%	91.40%	92.00%	94.35%		93.16%	National	>=90%	-	<90%	CMO	
	National	QEF1.3	Dementia: Find, Assess, Investigate and Refer (Pt 3 - Refer)	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%		100.00%	National	>=90%	-	<90%	CMO	

Data Quality Kite Mark Descriptions

Green - Reviewed in last 6 months and confidence level high.
Amber - Potential issue to be investigated
Red - DQ issue identified - significant and urgent review required.
Blue - Unknown - will be scheduled for review.
White - No data available to assign DQ kite mark

** Cancer - this involves small numbers that can impact the variance of the percentages substantially.*
*** Stroke metrics are not reported for the current month due to coding timeliness.*

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

NHS
Worcestershire
Acute Hospitals
NHS Trust

Meeting	Trust Board
Date of meeting	11 July 2019
Paper number	F1

Learning from Deaths

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

Accountable Director	Mike Hallissey CMO		
Presented by	Mike Hallissey CMO	**Author /s**	Dr Steven Graystone, Clinical Lead Mortality Gordon Stovin, Information Initiatives Support Specialist

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

Report previously reviewed by		
Committee/Group	Date	Outcome
Mortality Review Group	May 2019	Approved
Clinical Governance Group	June 2019	Noted
QGC	June 2019	Received for assurance

Recommendations	The Trust Board is requested to: • Note the year on year reduction in the number of deaths and crude mortality rates. • Note the HSMR and SHMI trends and support the detailed work to understand those trends

Executive summary	▪ Crude mortality, in terms of actual numbers of deaths and the crude mortality rate are lower for 2018/19 than the same period 2017/18. ▪ Both the 12 month Hospital Standardised Mortality Ratio (HSMR) and the Summary Hospital-level Mortality Index (SHMI) do not reflect this lower number of deaths and Worcestershire Acute Hospitals Trust is an outlier in respect of both models. ▪ The rolling 12 month HSMR 'score' (Mar 18 to Feb 19) shows recent signs of improvement and should continue to improve over the next six months. ▪ Despite this we are a statistical outlier in terms of the HSMR. This is being exacerbated by the recent month on month rebasing of the model. ▪ The most recent quarterly release of the SHMI by NHS Digital (up to Dec 18) shows the trust as having a 'higher than expected' mortality rate for this period. ▪ Like the HSMR, this does not reflect improvements in the crude mortality rate.

	▪ Pneumonia remains the single largest cause of mortality across WAHT and adversely impacts the HSMR (and SHMI). This will be subject to a systematic review over the next reporting period. ▪ A small number of causes of mortality with an unusually high HSMR have been identified. These are in the process of being reviewed. ▪ The percentage of mortality reviews completed within 30 days stands at 28% and the backlog of uncompleted reviews is 22.4%. ▪ A programme of work to harmonise the mortality and bereavement processes is currently underway.

Risk								
Key Risks	BAF 1&2							
Assurance	Data extracted from the Heathcare Evaluation Dataset (HED)							
Assurance level	**Significant**		**Moderate**		**Limited**	*x*	**None**	
Financial Risk	N/A							

Meeting	Trust Board
Date of meeting	11 July 2019
Paper number	F1

Introduction/Background

The purpose of this monthly report is to provide information related to the Trust's learning from deaths programme and mortality review performance.

Issues and options

This report seeks to examine the most recently available mortality data to identify any emerging patterns or trends and make recommendations for future work.

The following information has been used to produce this report:

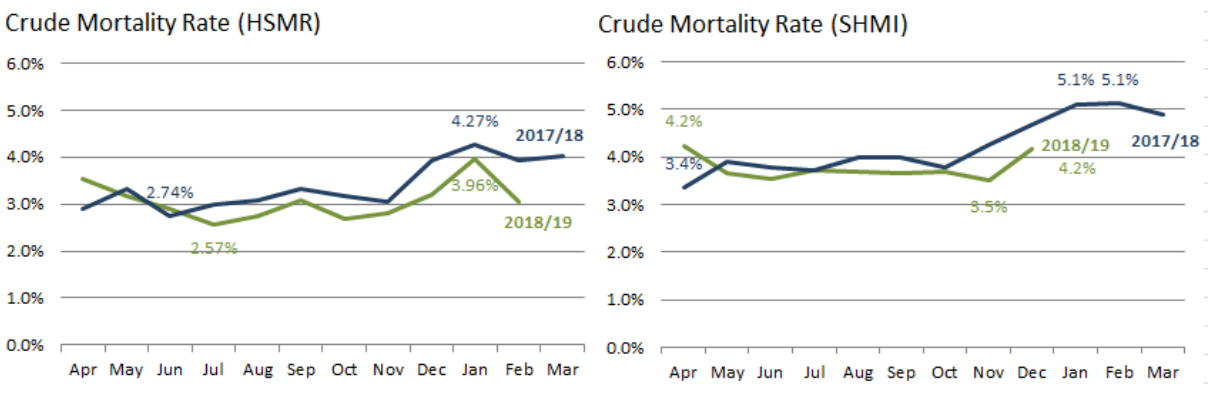
- Crude mortality (both rates and numbers of deaths for 2017/18 and 2018/19). Provided for both HSMR and SHMI models. Data extracted from the Heathcare Evaluation Dataset (HED).
- Hospital Standardised Mortality Ratio (HSMR). Extracted from HED for the period March 18 to February 19 unless otherwise stated.
- Summary Hospital-level Mortality Index (SHMI). Quarterly results published by NHS Digital on 16 May 2019. Monthly, albeit not rebased, information available from HED for January to December 2018 unless otherwise stated.
- Causes of death. Obtained from HED by CCS Diagnostic group for both HSMR and SHMI methodologies.
- Mortality and CuSum alerts. Obtained from HED.
- Mortality review data. Obtained locally via WREN.

1. Crude Mortality

The crude mortality rate is calculated by using the total number of deaths as a percentage of the total number of discharges for the same period. This rate can be reflected using either the Hospital Standardised Mortality Ratio (HSMR) or the Summary Hospital-level Mortality Index (SHMI).

Figure 1 shows the crude mortality rate for both HSMR and SHMI for financial year 2018/19 (up to the point that the information is available on HED) and set against the previous financial year.

Figure 1. Crude Mortality Rates for 2018/19 and 2017/18 by HSMR and SHMI



Both charts show a similar trend:

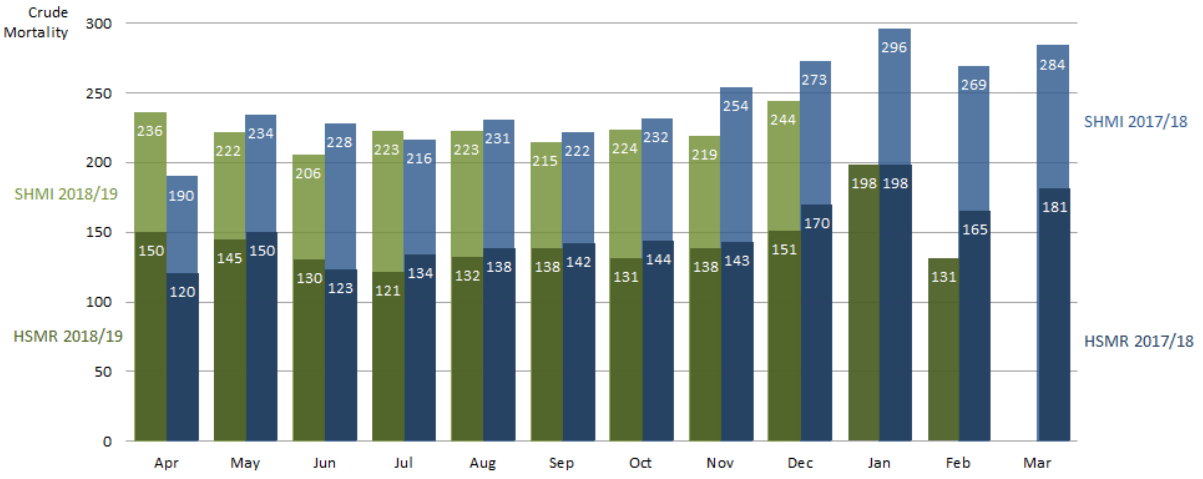
- The crude mortality rate for 2018/19 has tracked below that for the same period 2017/18 since July 18 (HSMR) and August 18 (SHMI).
- To date, the peaks and troughs in the crude mortality rate during 2018/19 were below those in 2017/18 for both models.
- There is a consistent seasonal pattern evident for both HSMR and SHMI for 2018/19 and 2017/18. Although the increased mortality rate during the winter months is more obvious using the SHMI model.
- Due to time taken to validate mortality data for inclusion on HED, there are 'gaps' in respect of recent month's performance.

In addition to this, the actual numbers of deaths counted using HSMR or SHMI have been lower in 2018/19 compared to 2017/18.

For HSMR the total number of deaths currently stands at 1565 (Apr 18 – Feb 19) against 1627 for the same period in 2017/18. Even if the most recent HSMR data is treated with some caution (see Section 2) it is still probable that the total number of deaths for 2018/19 will be the same as or below that for 2017/18.

Using the crude mortality figure from the SHMI model shows a similar pattern. These month by month measures of crude mortality can be seen in Figure 2.

Figure 2. Crude Mortality 2018/19 and 2017/18 (SHMI vs HSMR)



In summary:

- We have had fewer deaths and an overall reduction in the crude mortality rate during 2018/19.
- This observation is valid using both HSMR and SHMI models.
- These reduced crude mortality values are not reflected in either the HSMR or SHMI 'score' (refer to Section 2 and 3 for more details).
- Future work/reporting will aim to incorporate estimated crude mortality metrics to 'complete' those gaps in available information from HED.

Meeting	Trust Board
Date of meeting	11 July 2019
Paper number	F1

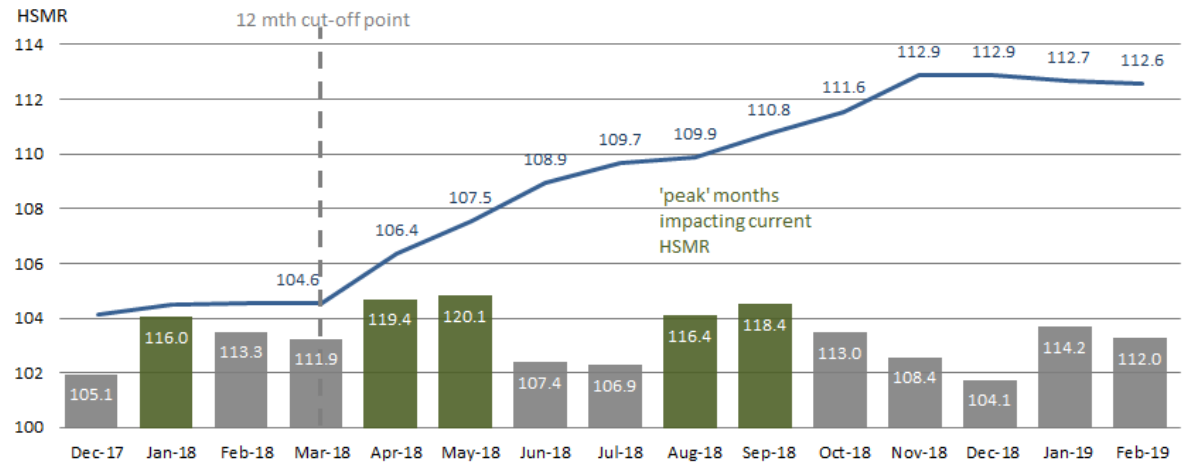
2. HSMR

The latest data for the Hospital Standardised Mortality Ratio is accessed via HED and is based on HES data. The most recent monthly update for HSMR includes data up to and including February 2019.

The HSMR for the 12 month period March 2018 to February 2019 stands at 112.6 (against an average score for all English trusts).

The rolling 12 month HSMR, along with the monthly score for the last 15 months can be viewed in Figure 3.

Figure 3. Rolling 12 month HSMR ( ) and monthly HSMR (values on bars not axis)



Since peaking in November 2018 the rolling 12 month HSMR has stabilised and started to show signs of reduction since January 2019, albeit only slight. The peaks in the monthly HSMR score between January and May 2018 (highlighted in green) are largely responsible for the current elevated rolling 12 month score.

Over future reports and as these peak months pass the monthly HSMR 'score' should remain at or below its current level. The longer term prediction is that the 12 month HSMR will begin to show clear signs of improvement over the next six months if the monthly re-basing of the model does not mitigate this (see below).

Much of the elevation in the monthly HSMR score between January and May 2018 has previously been attributed to Pneumonia along with Chronic Obstructive Pulmonary Disease, other respiratory conditions (inc. Acute Bronchitis) and also Septicaemia (except in labour). Further analysis of the principal causes of death are included within Section 4 of this report.

As alluded to earlier, the HSMR model is re-based each month and as a result the trust's scores can be subject to change even if the crude mortality remains the same.

By way of example. For the 12 month period up to February 2019 the most recently re-based HSMR is 112.6. This falls to 109.1 if the November 2018 rebasing period is used and 105.6 if the March 2018 period is used.

In short, as the HSMR model is rebased we find our improvements in crude mortality are outpaced by the reductions in the expected number of deaths. This is likely due to a number of trusts performing better than expected against the previous re-based versions of the model.

The 12 month HSMR score for WAHT currently ranks 115 (out of 134) in England, 11 (out of 11) compared to our Model Hospital peers and 28 (out of 30) against the McKinsey peer group.

Summary:

- The rolling 12 month HSMR has plateaued and started to decline over the last three months (Dec 18 to Jan 19).
- This should continue to improve over the next six months.
- Despite reductions in crude mortality the trust we are currently a statistical outlier for mortality in regards of the HSMR model.
- This is exacerbated by the monthly rebasing of the model.
- Elevated HSMR for April, May, August and September 2018 continue to have a negative effect on this figure despite recent improvements in the monthly HSMR.

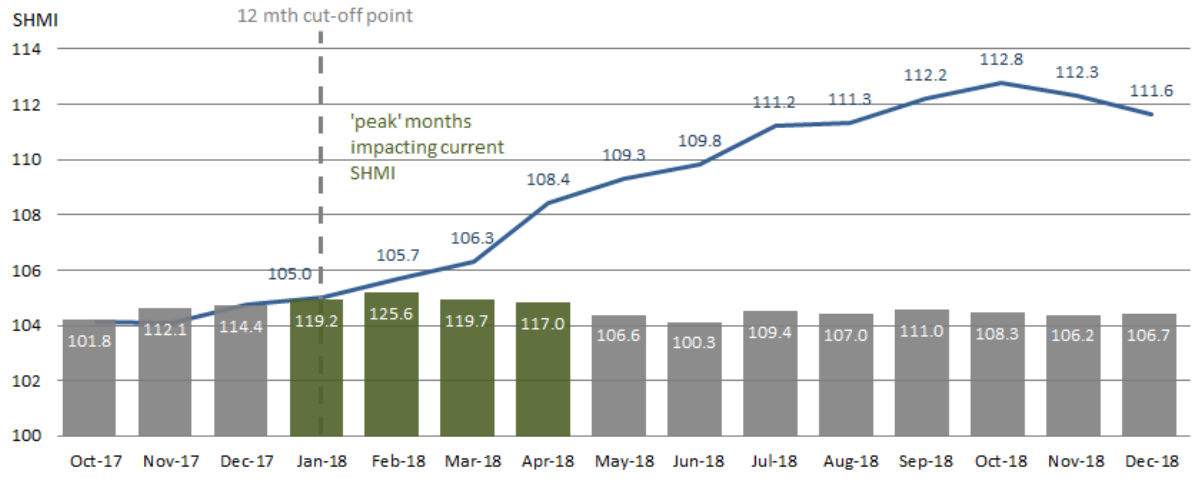
3. SHMI

The most recent quarterly Summary Hospital-level Mortality Indicator data was published on 16 May 2019. For the most recent reporting period (Jan to Dec 18) this shows the Trust with a 'score' of 1.1349/113.5 (on HED).

This relates to a 'higher than expected' mortality rate for this period.

Unfortunately, at the time of writing, more detailed information regarding the quarterly SHMI data was unavailable on HED. The monthly SHMI data for the same period has yet to be re-based and shows a 12 month score of 111.6 (refer to Figure 4). Whilst the overall pattern will be similar the rebased SHMI values will change. In an upwards direction.

Figure 4. Rolling 12 month SHMI ( ) and monthly SHMI (values in bars not on axis)



Meeting	Trust Board
Date of meeting	11 July 2019
Paper number	F1

Chart notes: This chart will be updated when the quarterly data is available on HED. But serves as a good example for the effects of rebasing on standardised score such as SHMI (or HSMR).

Unsurprisingly, given the similarities between SHMI and HSMR, the general observations are similar:

- The next three months (& subsequent quarterly SHMI release) will likely show WAHT with an elevated SHMI score.
- This is almost entirely due to the unusually high monthly SHMI scores between January and April 2018.
- Previous reports have highlighted Acute Bronchitis, Pneumonia, Chronic Obstructive Pulmonary Disease, and also Septicaemia (except that in labour) as the primary causes of these elevated SHMI scores.
- Our current 12 month SHMI does not reflect our reduced crude mortality rate for this period.
- Future work will include a detailed analysis of the latest quarterly SHMI data as this becomes available on HED.

4. Causes of mortality

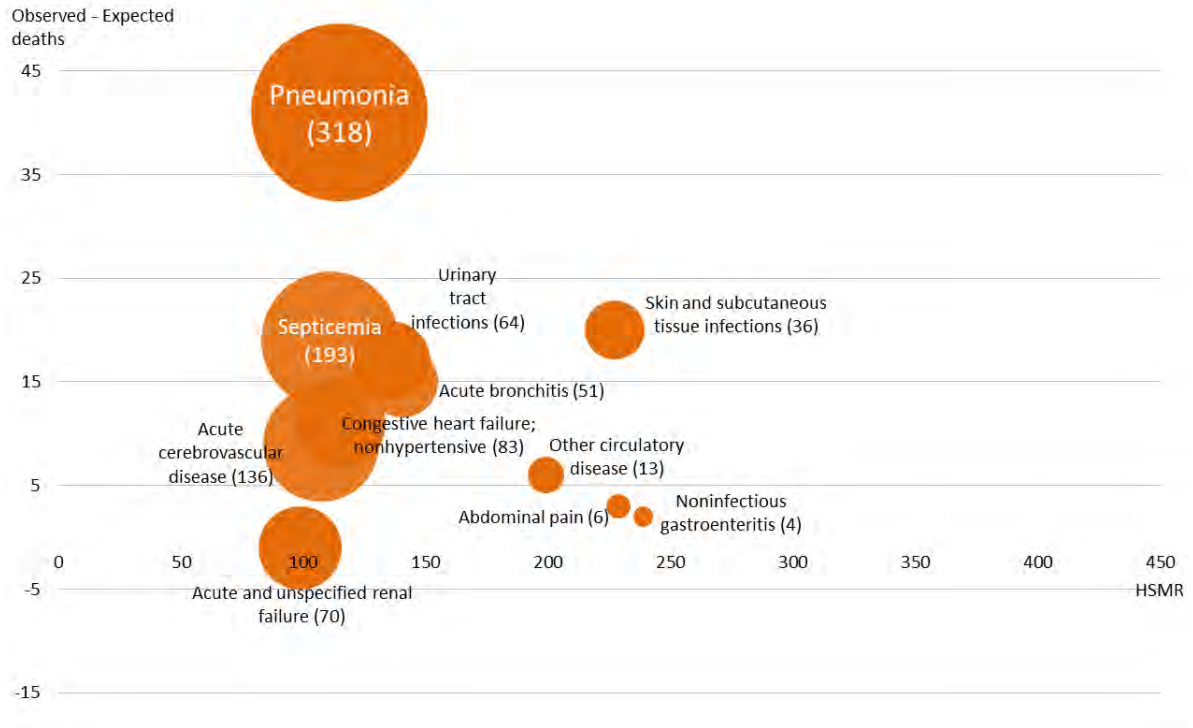
This work seeks to better understand the main causes of death in the trust.

Causes mortality can be measured in crude terms or as a standardised score (HSMR or SHMI).

As the standardised measures of death also include an 'expected number of deaths' metric, the causes of death can also include the number of deaths above or below this expected amount (refer to Figures 5 & 6).

Meeting	Trust Board
Date of meeting	11 July 2019
Paper number	F1

Figure 5. Bubble chart showing main causes of death (Mar 18 - Feb 19) by HSMR, Observed - Expected and crude mortality



Notes on chart: The chart (above) shows the main causes of death for the 12 month period March 2018 to February 2019 and is based on the HSMR data. The horizontal axis represents the HSMR value for the CCS group whereas the vertical axis represents the number of observed deaths minus those 'anticipated' by the model. The size of the bubble represents the actual number of deaths (also provided in brackets).

Pneumonia is the single largest cause of mortality, has a HSMR value of 114.8 and has contributed the most to the number of deaths against the HSMR model. Despite year on year improvements in mortalities linked to pneumonia, this remains one of the main causes of death across the trust. Both in crude amounts, HSMR and the crude number of deaths above that which is expected.

Septicaemia is the second highest crude cause of mortality (followed by Acute cerebrovascular disease and Congestive heart failure). However, despite being the third highest cause of deaths when compared to the HSMR model, its HSMR score does not rank Septicaemia as an outlier.

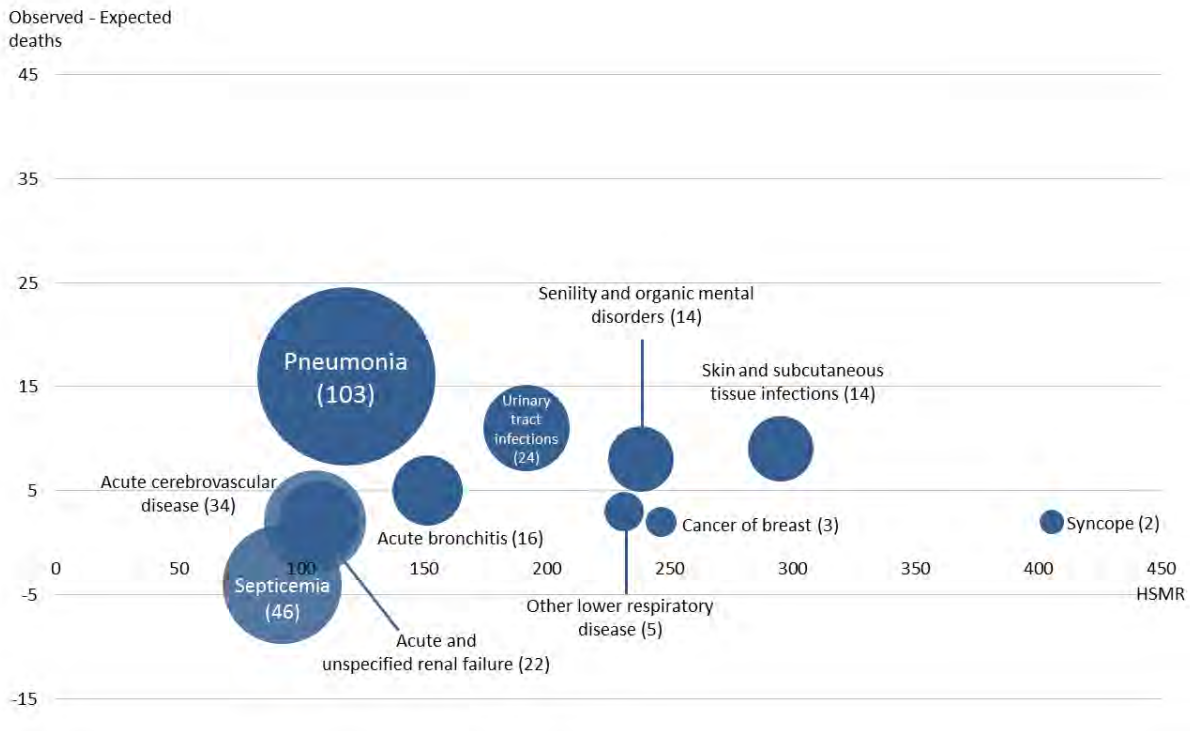
The main HSMR outliers for this period are Non-infectious gastroenteritis, Abdominal pain along with Skin and subcutaneous tissue infections. Only the latter of which has been identified by way of a CuSum alert from Dr Foster at Imperial College for January 2019.

For the period in question (Feb 2018 to Jan 2019) using the HSMR methodology 16.3 deaths above expected were noted (Calculated 15.7, actual 32) from 1268 patients treated.

A review of the care provided, the coding and the certified cause of death for those dying is being undertaken. The outcome of this review together with any areas for improvement will be reported to June Mortality Review Group. If serious concerns are identified in the meantime these will be raised directly with the CMO.

Recognising that the year to date HSMR is negatively affected by the months up to and including September 2018, a more recent, three month snapshot of the same data has been used for comparative purposes (see Figure 6).

Figure 6. Bubble chart showing main causes of death (Dec 18 - Feb 19) by HSMR, Observed - Expected and crude mortality



In summary:

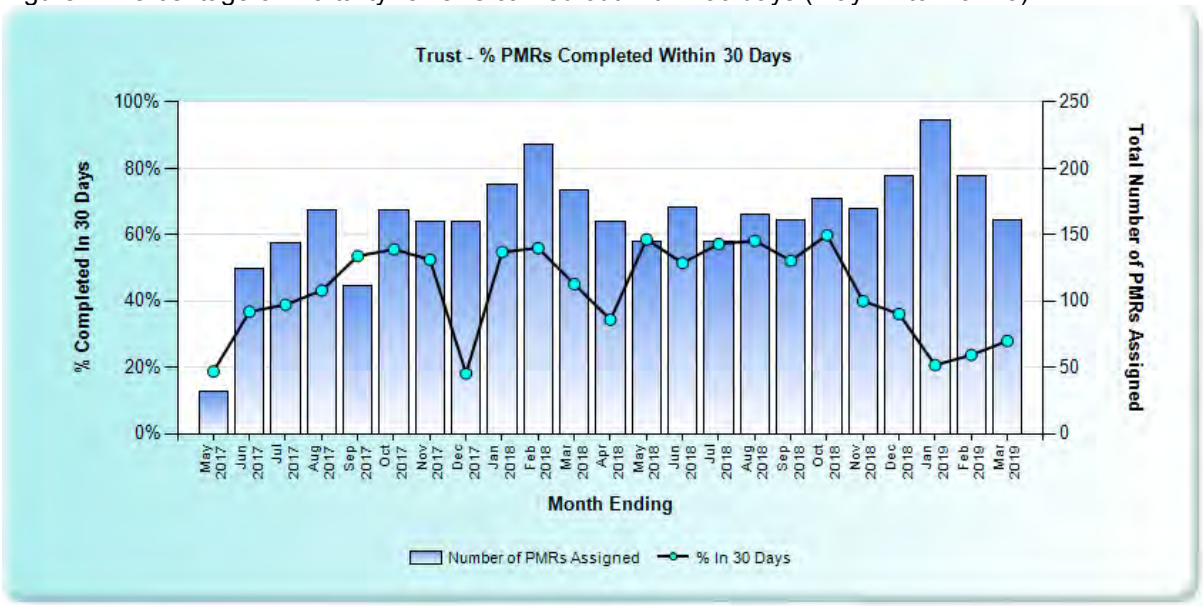
- Pneumonia represents a continued challenge to WAHT's crude mortality and HSMR (and, most likely SHMI). Future work will include a systematic review of pneumonia to understand opportunities to reduce this or to provide better patient care.
- Septicaemia, whilst a main cause of crude mortality is not negatively impacting on the HSMR.
- Performance in respect of congestive heart failure has shown recent signs of improvement.
- A number of CCS groups, whilst small in terms of crude mortality, display an unusually high HSMR. These, in particular Syncope, will be reviewed and reported on in the next monthly report.

Meeting	Trust Board
Date of meeting	11 July 2019
Paper number	F1

5. Mortality Reviews (inc. learning from deaths)

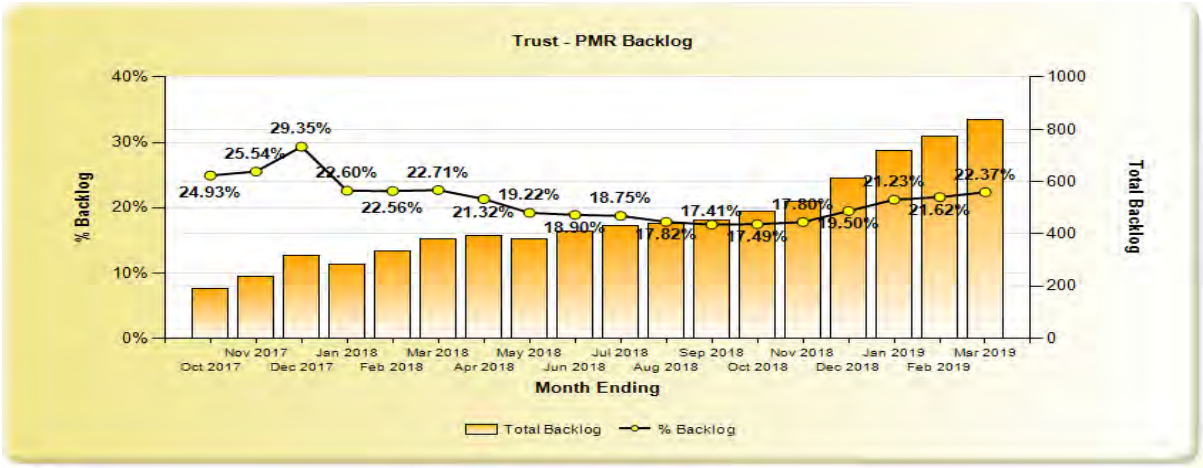
The 30 day completion rates for primary mortality reviews rose in March 2019 to 28% having dropped to as low as 20.1% in January. This is against a year to date high point in October 2018 of 60% (see Figure 7).

Figure 7. Percentage of mortality reviews carried out within 30 days (May 17 to Mar 19)



The uncompleted review backlog percentage rose slightly to 22.4% having previously been as low as 17.4% in September 2018 (see Figure 8). At the time of this report the backlog for uncompleted mortality reviews stands at 837.

Figure 8. Mortality review backlog (Oct 17 to Mar 19)



The current approach in ensuring timely mortality reviews is clearly not delivering either timely reviews or traceable learning. This is in part due to the slow progress in appointing Medical Examiners to undertake reviews. From April 2019 the Trust is expected to begin the process to establish a Medical Examiner system that ensures that all proposed Medical

Meeting	Trust Board
Date of meeting	11 July 2019
Paper number	F1

Certificates of Cause of Death (MCCD) are reviewed before issue and discussed with the next of kin before issue.

The CMO is supporting work to integrate the bereavement service, the new Medical Examiner process and the mortality review programme that delivers a timely family focussed service, delivering the requirements for the new statutory medical examiner system and ensures contemporaneous mortality reviews that drives sustainable improvements in the quality of care provided to patients.

A detailed plan and progress update was endorsed by TME and mortality review group.

5.1 Learning from deaths (see appendix to this report)

The key findings from the most recent Learning from Deaths report are:

- 69.3% of all deaths during 2018/19 have so far been reviewed. Performance up to and including Quarter 3 is 77.1% and the end of year figure will continue to improve as more outstanding reviews are completed.
- There were six adult deaths (identified through the investigation of serious incidents) where, on a 50:50 probability, the death was deemed to have been avoidable. Key learning points have been detailed in this report.
- The mortality reviews continue to show signs of good performance with respect to clear initial documentation of diagnosis and management planning and around correct completion of DNACPR forms.
- There has been a small increase in the proportion of reviews highlighting general concerns in medical, nursing or AHP care. Qualitative analysis of these reports was undertaken to identify any common themes.
- A Divisional report from SCSD was received at the MRG and demonstrated review of 13 cases with good care in 11 and learning and improvement in 2 (change in investigation process in myeloma patients and modified consenting in chemotherapy patients to include specifics about infection risk and management).
- Divisional reports from surgery, speciality medicine and emergency medicine divisions were not received. This has been escalated to Divisional Management Teams.

Recommendations

The Trust Board is requested to:

- Note the year on year reduction in the number of deaths and crude mortality rates.
- Note the HSMR and SHMI trends and support the detailed work to understand those trends

Appendices – additional information in respect of learning from deaths

Meeting	Trust Board
Date of meeting	11 July 2019
Paper number	F1

Learning from deaths 2018/19
Deep dives

1 Pneumonia & Acute Bronchitis - completed Jan 2019

Recommendations

- Establish weekly mortality oversight meetings
- Implement ReSPECT across county to minimise patient care in inappropriate environments
- Reduction of waits in ED for in-hospital placement
- Re-focus on delivery of internal professional standards particularly
  - Specialty team reviews in ED within 1 hour
  - Consultant review within 14 hours of presentation
- Raising awareness of early involvement of palliative care team in the care of patients with limited life expectancy.
- Performance management of compliance with delivery of care bundles – particularly sepsis.

2 Septicaemia

Review undertaken by sepsis lead but not reported to Mortality Review Group (MRG) so learning not clear to that group.

Learning centred on recognition and timely intervention in line with sepsis 6 bundle. Focussed work commenced to address and HSMR now within acceptable range

3 Fractured Neck of femur

Review undertaken within division but not reported to MRG so learning not clear to that group.

Learning centred on timely surgical intervention. Work completed on this aspect and mortality no longer an outlier.

4 Skin & Subcutaneous tissue infections completed June 2019

Report with CMO for review.

5 **Avoidable deaths**

During 2018/19 six deaths were identified as more likely to be avoidable than not.

Case description	Key learning/change in practice from serious incident review
Inadequate management of clinical deterioration in a case of self-poisoning whilst in ED	Process of rapid escalation to Intensive Care Team for deteriorating patients in ED initiated Safety check list for management of self-poisoning cases initiated Routine printing and filing in patient record of Toxbase information as part of the initial assessment process for this patient group.
Inadequate management of diabetes in a stroke patient resulting in diabetic ketoacidosis	Stroke unit admission proforma modified to ensure routine blood sugar monitoring. Nursing documentation modified to direct the

	involvement of diabetes team in all patients with a raised blood sugar
Inadequate assessment and management of the risk of venous thrombosis in an orthopaedic patient resulting in a fatal pulmonary embolism	Trust policy developed for the consistent management of the risk of venous thrombosis in patient with a lower limb fracture requiring immobilisation. Policy now used in all care settings where these fractures are managed. Patient group directive in place to enable nurse practitioners to prescribe appropriate prophylaxis.
Missed diagnosis of subdural haematoma resulting in delivery of anticoagulation for DVT prophylaxis resulting in fatal expansion of the haematoma	Recent head injury a specific exclusion criteria for use of an anticoagulant for VTE prophylaxis
Failure to recognise and manage a post-operative complication (bowel obstruction and subsequent perforation).	Patients recently discharged following surgery must be admitted under that surgical specialty when symptoms relate to the body system/anatomical area operated upon.
Failure to provide adequate treatment for a venous thrombosis	All speciality medicine ward rounds will have nursing attendance to enhance continuity of care and minimise information loss on hand over of care between medical teams.

6 Issues addressed by directorates/divisions through Mortality and Morbidity meetings

6.1 SCSD

6.1.1 Critical Care

- Improved documentation of post discharge escalation planning including development of critical care treatment limitation document linked to ReSPECT document
- Add fibrinogen therapy to major haemorrhage pack
- Introduce full face masks for CPAP therapy as well as hoods.

6.1.2 Haematology

- Improved consenting process for patients with learning disability
- Improved co-working with Head & Neck team for patients with oral lymphoma
- Alteration in antibiotic prescribing guidelines for haematology patients to include cover for pneumocystis.
- Alteration in infection prophylaxis regime to include antifungals
- Dose modification regime in elderly patients on life prolonging treatment to minimise side effects
- Construct business case for creation of specific weekly 2ww referral clinic
- Change in diagnostic pathway to bring forward MRI imaging to enable earlier MDT management plan

6.1.3 Oncology

- Details of out of hours oncology service access shared with all in-patient areas

6.2 **Specialty Medicine**

- Renal diabetes
  - Business case for increased Consultant numbers to enable weekend reviews
- Respiratory
  - Change in working practice to ensure all respiratory ward admissions are seen within 12 hours by speciality team.
  - Routine consideration of DNACPR status on post-take ward round
- Gastroenterology
  - Avoidance of Beta blockers in patients with decompensated alcoholic liver disease
  - Patients with decompensated liver failure not to be managed as outliers off gastroenterology ward
  - Routine consideration of DNACPR status on post-take ward round
  - Cease using endoscopy for care of medical in-patients
  - Acute decompensated Alcoholic Liver Disease care bundle introduced into ED

6.3 **Surgery**

- Standardised approach to VTE prophylaxis for patients with upper limb fractures
- Standardised approach to VTE prophylaxis for patients able to be mobile after lower limb fractures

6.4 **Women & Children**

- Enhanced communication process between primary and secondary care
- Training package introduced to improve identification of gestational age of twins at ultrasound
- Consultant always involved in planning management where an intra-uterine death has occurred
- CTG masterclass training programme in place.

NHS
Worcestershire
Acute Hospitals
NHS Trust

Meeting	Trust board
Date of meeting	11 July 2019
Paper number	F2

Report on Nursing and Midwifery Staffing Levels – March - April 2019

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

Accountable Director	Vicky Morris, Chief Nursing Officer		
Presented by	Jackie Edwards Deputy CNO (Quality)	**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
Nursing and Midwifery Group	11 June 2019	Approved
People and Culture Committee	18 June 2019	Noted the report
TME	19 June 2019	Noted the report

Recommendations	The Trust Board is requested to note: • Staffing levels were safe in March and April 2019 following mitigating actions • Work continues to reduce the qualified nursing and healthcare assistant vacancies across the Trust. Current vacancy factor is 278 WTE • The recruitment of 50 overseas nurses has been successful, the Executive team have endorsed the further recruitment of additional nursing numbers

Executive summary	This paper provides assurance to the Board of the nursing and midwifery staffing levels for March and April 2019. • The report confirms that following mitigation staffing levels were safe. • Safe staffing levels and Care Hours per Patient Day (CHPPD) continue to be monitored as per national guidelinesm • The mitigations to support all wards were recorded on the 'safe care module' on allocate. This electronic module for recording went live across all wards in April and will support staff members in their recording of the redeployment and mitigation against decreased staffing levels in real time. Mitigations are outlined in the paper. • There were no moderate harm incidents reported for the reporting period, there has been a reduction in the number of red flag incidents in this period compared to the previous month.

Meeting	Trust board
Date of meeting	11 July 2019
Paper number	F2

	• The current qualified nursing vacancy factor trust wide in April is 278 whole time equivalents (WTE). This is an increase in RN vacancy from last month due to the 3 additional wards (Avon 5, ward 1 and ward 11) establishments now included. Interviews have taken place for 50 overseas nurses in April following agreement of business case in March 2019. The programme has been successful and a further pipeline of nurses has was identified with a total of 67 offered positions. The executive team have agreed to the further recruitment of additional numbers given the current vacancy position and the safety of staffing and efficiencies in the reduction of agency spend this will bring.

Risk								
Key Risks	BAF 11 – recruitment and retention of staff							
Assurance	The data are obtained from the safer staffing app. This is validated by the senior nurses on duty.							
Assurance level	**Significant**	*x*	**Moderate**		**Limited**		**None**	
Financial Risk	Recruitment of overseas nursing is in progress to support bank and agency spend. Active recruitment is in place to support reduction of vacancies.							

Meeting	Trust board
Date of meeting	11 July 2019
Paper number	F2

Introduction/Background

We are required to submit monthly data to NHS Strategic Data Collection Service (SDCS). This information provides the detail per ward of the nursing and midwifery staffing fill rates and bed days. This information is displayed on our website.

From September 2018, NHSI have published Care Hours Per Patient Day (CHPPD) on MY NHS and NHS choices. This measure is used alongside clinical quality and safety outcome measures to reduce unwarranted variation and support delivery of high quality, efficient patient care. This is through ward deployment of staff to care for the right patients at the right time with the right skill set to meet patients' needs.

Fill rates are calculated from the expected level of staffing against what was actually provided. This data is produced from the safer staffing app and submitted to SDCS in response to Lord Carter's recommendations. SDCS data is provided at Appendix 1.

Issues and options

Incident reports and red flags

There were a total of 46 and 29 incidents reported respectively with the specific category of nurse/midwifery staffing. The number of reported incidents that fell within the red flag criteria had reduced from the previous reporting period. The table below provides a breakdown of red flag shifts reported category Nurse/ Midwifery staffing.

There was no moderate harm incidents reported for the reporting period. In all incidents, mitigations have been put into place through the use of either bank or agency, moving staff from neighbouring wards to ensure patients' needs were met.

	No Harm	Minor Harm	Moderate Harm
March	33	13	0
April	26	3	0

Staffing levels/Vacancies

The table below breaks down the vacancies in to registered nurses and health care assistants. This highlights that the current vacancy factor poses a trust wide risk to safely staffing wards to meet patient needs.
This risk is recorded on risk register as risk 4000 and reviewed is reviewed monthly to ensure mitigations in place are relevant and appropriate.

The recruitment of registered nurses is a key priority for the trust.

Vacancy for in patient wards areas & non ward areas	April 2019
Registered nurses	278
Health care assistants	42

Total	320

A summary of the vacancy position across the Divisions. These figures include the additional capacity wards

- The two divisions with the highest vacancy factors are: Specialised medicine and urgent care

Division	RN vacancy wte	HCA vacancy wte	Hot spot Areas
Speciality Medicine	129.44	(10.03)	Wards with vacancies greater than 25% of their establishment are ASU, Avon 5, Avon 2 and 3 Wards 11 12 1
Urgent Care	77.74	3.25	Wards with a vacancy factor of greater than 25% is Medical Assessment Unit WRH, MSSU, ward 4
Surgery	38.19	27.44	Wards with a vacancy factor greater than 25% of their establishment is Trauma and Orthopaedics
SCSD	33.2	12.67	No areas above 25%
Women & Children	(6.41)	8.82	No areas above 25%

Recruitment

Health care Assistant (HCA) role

- There has been an active and successful recruitment campaign of HCA across wards. There has been a total of 95 HCA's recruited since January 2019.
- There are 42 HCA vacancies. This is as a result of the substantial establishment requirement for the additional capacity ward1,4 and Avon 5.

Registered Nurse recruitment

- In March and April 2019 there were 42 registered nurses recruited.
- We do not have any Registered Midwives (RM) vacancies.

The new Head of Midwifery commenced in post in April 2019. Midwifery Staffing levels in March and April were safe. A review of midwifery staffing establishment will be undertaken this will be reported in June 2019.

Overseas nursing

A recruitment project commenced in April for the recruitment of 50 overseas nurses. The nurses will be supernumerary for 12 weeks from their start date to allow them to undertake essential training to become registered on the nursing, midwifery council. On the basis of the

Meeting	Trust board
Date of meeting	11 July 2019
Paper number	F2

success of this campaign (to date), we have recruited over the 50 nurses outlined and costed in the business case. Formal approval has been sought and agreed to increase the cohort of overseas nurses to maximise the recruitment campaign.

Maintaining momentum with Local and National Recruitment
Actions that will be taken by the workforce team and divisional nurse directors to support proactive recruitment in May and June are:

- The DDNs with wards with vacancies greater than 25% were required to prioritise block booking of bank and agency to ensure safe cover;
- Internal recruitment events on both sites May the Alexandra site June Worcester Royal Site
- Continue the active social media campaign.

Recommendations

The Trust Board is requested to note:

- Staffing levels were safe in March and April 2019 following mitigating actions
- Work continues to reduce the qualified nursing and healthcare assistant vacancies across the Trust. Current vacancy factor is 278 WTE
- The recruitment of 50 overseas nurses has been successful, the Executive team have endorsed the further recruitment of additional nursing numbers.
-

Appendix - **Unify Data – March and April 2019**

Worcestershire Acute Hospitals NHS Trust

Meeting	Trust board
Date of meeting	11 July 2019
Paper number	F2

Appendices

APPENDIX 1 March 2019

Ward	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Care Hours Per Patient Day (CHPPD)					
					Cummulative count over the month - patient bed days	Registered Nurses/ Midwives	Care staff	Registered AHPs	Non registered AHPs	Overall
Acute Stroke Unit	91.6%	114.5%	94.5%	107.0%	938	4.3	3.7	0.0	0.0	8.0
Avon 2	93.5%	87.9%	83.9%	117.7%	660	3.0	3.3	0.0	0.0	6.3
Avon 3	95.7%	96.8%	88.2%	117.7%	617	3.3	3.8	0.0	0.0	7.1
Avon 4	94.9%	110.8%	127.8%	102.8%	723	1.0	1.8	0.0	0.0	2.8
Beech A	100.0%	88.7%	66.7%	98.3%	632	2.9	2.7	0.0	0.0	5.6
Beech B	141.7%	152.4%	142.9%	66.7%	273	5.3	2.0	0.0	0.0	7.3
Beech C	86.8%	84.5%	98.2%	114.3%	514	3.0	3.2	0.0	0.0	6.3
Coronary Care	100.0%	-	100.0%	-	96	15.5	0.0	0.0	0.0	15.5
Critical Care	81.2%	43.5%	79.6%	-	130	27.6	1.2	0.0	0.0	28.8
Critical Care	97.4%	75.8%	97.1%	-	261	27.7	1.1	0.0	0.0	28.8
EGAU/ANW Gynaecology	91.9%	77.4%	86.7%	70.0%	356	3.7	3.0	0.0	0.0	6.7
Evergreen	73.2%	100.9%	78.9%	135.6%	772	2.4	3.7	0.0	0.0	6.0
Head and Neck	85.4%	91.1%	105.8%	55.8%	320	4.1	3.0	0.0	0.0	7.1
Laurel 1	101.1%	117.2%	113.3%	140.0%	577	3.4	2.0	0.0	0.0	5.4

Laurel 2	99.2%	100.8%	96.7%	106.7%	642	3.4	2.9	0.0	0.0	6.3	
Laurel 3	80.4%	75.6%	94.4%	103.2%	508	5.0	2.4	0.0	0.0	7.4	
Laurel CCU	99.2%	-	97.6%	-	220	13.1	0.0	0.0	0.0	13.1	
Lavender Suites	83.0%	86.8%	89.5%	100.9%	959	15.0	5.7	0.0	0.0	20.7	
Medical Assessment Unit - ALX	78.4%	77.3%	77.0%	69.0%	710	4.6	4.3	0.0	0.0	8.9	
Medical Assessment Unit - WRH	93.8%	113.8%	102.1%	100.0%	689	4.9	3.2	0.0	0.0	8.0	
Medical Short Stay Unit	92.9%	73.9%	88.8%	93.3%	756	3.8	3.4	0.0	0.0	7.3	
Neonatal TCU	128.6%	142.9%	114.3%	114.3%	264	2.3	2.5	0.0	0.0	4.8	
Neonatal Unit	127.0%	138.1%	120.6%	133.3%	378	9.9	1.8	0.0	0.0	11.7	
Riverbank	91.6%	96.0%	95.2%	103.2%	563	9.2	2.0	0.0	0.0	11.2	
SCDU	106.1%	106.7%	128.3%	190.0%	517	4.0	2.8	0.0	0.0	6.8	
Silver Oncology	117.2%	91.9%	96.8%	100.0%	616	3.9	4.0	0.0	0.0	7.9	
Surgical High Care Unit	109.6%	157.1%	110.8%	142.9%	236	9.3	3.2	0.0	0.0	12.5	
Trauma And Orthopaedics	141.1%	112.7%	122.6%	124.8%	1017	2.8	3.1	0.0	0.0	5.9	
Vascular Unit	86.5%	66.1%	97.4%	58.6%	547	5.4	2.1	0.0	0.0	7.5	
Ward 1	103.2%	91.9%	100.0%	-	79	19.1	4.3	0.0	0.0	23.5	
Ward 10	103.2%	94.1%	100.0%	96.7%	529	2.9	2.6	0.0	0.0	5.5	
Ward 11	78.4%	97.4%	154.2%	193.8%	807	2.2	2.5	0.0	0.0	4.7	
Ward 12	98.8%	101.6%	116.1%	102.4%	846	3.3	3.6	0.0	0.0	6.9	
Ward 14	87.1%	95.7%	98.2%	94.6%	560	2.9	3.0	0.0	0.0	6.0	
Ward 16	85.5%	85.7%	82.8%	96.8%	548	4.0	3.4	0.0	0.0	7.4	
Ward 17	98.0%	97.6%	98.9%	99.2%	810	3.2	3.6	0.0	0.0	6.8	

Meeting	Trust board
Date of meeting	11 July 2019
Paper number	F2

Ward 18	83.9%	95.1%	100.0%	141.1%	702	3.3	3.0	0.0	0.0	6.3
Ward 2	97.0%	92.9%	75.3%	164.8%	669	2.6	3.0	0.0	0.0	5.6
Ward 4 ALX	200.0%	209.5%	207.1%	211.9%	665	3.1	3.2	0.0	0.0	6.3
Ward 5	79.3%	116.7%	80.7%	114.8%	680	4.0	2.9	0.0	0.0	6.8
Ward 6	90.9%	103.9%	106.5%	122.6%	660	2.7	2.8	0.0	0.0	5.6

April 2019

Ward	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Care Hours Per Patient Day (CHPPD)					
					Cummulative count over the month - patient bed days	Registered Nurses/ Midwives	Care staff	Registered AHPs	Non registered AHPs	Overall
Acute Stroke Unit	69.9%	119.0%	83.3%	124.6%	903	3.8	3.3	0.0	0.0	7.1
Avon 2- Gastro	91.3%	89.2%	69.6%	114.1%	647	2.9	3.1	0.0	0.0	5.9
Avon 3 Infectious Diseases	96.5%	99.1%	90.1%	103.8%	604	3.5	3.5	0.0	0.0	6.9
Avon 4	91.5%	133.1%	84.6%	144.6%	699	2.9	5.4	0.0	0.0	8.3
Beech A	95.6%	90.7%	98.8%	105.4%	614	3.1	2.8	0.0	0.0	5.9
Beech B - Female	78.0%	61.4%	95.9%	23.3%	252	5.3	2.0	0.0	0.0	7.3
Beech C	72.2%	90.1%	107.5%	107.7%	500	3.4	3.2	0.0	0.0	6.6
Beech High Care	85.6%	80.4%	103.8%	100.3%	237	8.5	2.8	0.0	0.0	11.3
CCU-Alex	80.0%	-	103.0%	-	106	13.3	0.0	0.0	0.0	13.3
Head & Neck	78.0%	89.9%	98.6%	32.2%	325	4.2	2.6	0.0	0.0	6.9
Evergreen 1	74.2%	97.8%	81.4%	151.7%	746	3.1	3.9	0.0	0.0	7.1

Meeting	Trust board
Date of meeting	11 July 2019
Paper number	F2

ICCU - Alex	100.0%	100.0%	100.0%	-	95	29.1	2.8	0.0	0.0	32.0
ICCU - Worcs	100.0%	100.0%	100.0%	-	275	24.5	0.5	0.0	0.0	25.0
Laurel 1 Cardiology-CCU	92.5%	118.4%	98.9%	144.6%	780	6.1	1.9	0.0	0.0	8.0
Laurel 3 Haem Ward	100.1%	91.4%	105.9%	101.4%	509	5.9	2.5	0.0	0.0	8.5
Laurel Unit 2	82.4%	109.1%	101.1%	146.4%	641	4.4	4.5	0.0	0.0	9.0
M A U - Alex	73.0%	78.9%	82.3%	81.0%	722	4.8	4.7	0.0	0.0	9.6
MAU Assessment - WRH	110.6%	102.9%	109.0%	110.4%	659	6.2	3.4	0.0	0.0	9.7
MAU High Care and Short Stay	93.6%	103.6%	84.2%	95.5%	743	4.3	4.2	0.0	0.0	8.5
NICU- Paeds	93.7%	-	89.9%	-	660	7.0	0.0	0.0	0.0	7.0
Riverbank Unit- Paeds	86.8%	91.9%	102.2%	88.8%	591	9.5	1.8	0.0	0.0	11.2
Vascular and HDU	87.5%	72.1%	101.3%	74.9%	539	5.7	2.2	0.0	0.0	7.9
Silver Oncology	121.0%	106.8%	103.0%	98.9%	603	4.1	3.7	0.0	0.0	7.8
Surgical Clinical Decisions Unit (SCDU)	103.6%	96.7%	123.9%	98.3%	481	4.3	2.8	0.0	0.0	7.1
Trauma & Orthopaedic A Ward - WRH	85.1%	92.6%	95.1%	90.8%	984	3.1	3.2	0.0	0.0	6.3
Ward 10 - Urology	89.9%	83.9%	96.7%	94.9%	534	3.3	2.9	0.0	0.0	6.1
Ward 11 - Medicine	100.5%	121.4%	119.6%	147.4%	658	3.4	4.1	0.0	0.0	7.5
Ward 12 Medicine	118.2%	114.1%	85.1%	119.2%	824	3.6	3.9	0.0	0.0	7.5
Ward 14 - Surgery	83.8%	99.6%	100.0%	100.0%	538	3.2	3.2	0.0	0.0	6.3
Ward 16 - Elective Orthopaedic Ward	84.4%	73.4%	67.8%	83.1%	469	4.7	3.2	0.0	0.0	7.9
Ward 17 - Trauma Ward	92.9%	94.3%	99.0%	98.3%	796	3.2	3.4	0.0	0.0	6.5
Ward 18	104.8%	94.5%	111.5%	166.1%	684	3.7	3.0	0.0	0.0	6.8
Ward 2 - Medicine	88.4%	100.1%	72.2%	169.8%	615	3.1	3.5	0.0	0.0	6.6
Ward 5 Alex	97.6%	119.4%	118.6%	114.9%	755	4.1	2.7	0.0	0.0	6.8
Ward 6 - Medicine	83.7%	107.2%	103.2%	122.4%	649	2.7	3.1	0.0	0.0	5.7
Avon 5	90.1%	105.9%	107.3%	117.2%	842	3.1	3.7	0.0	0.0	6.8
Ward 1 - KTC	84.2%	60.8%	86.6%	-	60	38.2	11.8	0.0	0.0	49.9
Ward 4 - AGH	100.0%	135.6%	99.6%	220.9%	663	3.5	4.6	0.0	0.0	8.1
Ward 1 - AGH	100.0%	69.3%	102.3%	106.3%	561	4.1	3.7	0.0	0.0	7.8

Worcestershire Acute Hospitals NHS Trust

Meeting	Trust Board
Date of meeting	11 July 2019
Paper number	F3

7 Day Services – Board Assurance Framework - June 2019

For approval:	X	For discussion:		For assurance:		To note:	

Accountable Director	Paul Brennan Deputy Chief Executive/ Chief Operating Officer		
Presented by	Robin Snead Deputy Chief Operating Officer	**Author /s**	Jo James, Associate Improvement Director, NHSE and I

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		Best people	

Report previously reviewed by		
Committee/Group	Date	Outcome
Trust Management Executive	June 2019	Approved for submission
QGC	June 2019	Approved for submission

Recommendations	The Trust Board is requested to approve the 7 Day Services Board Assurance Framework, noting that it was submitted to NHS E/I by 28 June 2019, to support compliance with the nationally agreed deadline.

Executive summary	All acute trusts across England were required to submit a 7 Day Services Board Assurance Framework to NHS England and Improvement by 28 June 2109, evidencing levels of compliance with the 4 Priority Clinical Standards and progress against the 6 Continuous Improvement Standards. The self-assessment has been compiled utilising: the outputs from an audit of medical records, conducted in May 2019, utilising methodology consistent with that used in the national bi-annual 7 Day Services audits, evidence from the Trust's job planning process and intelligence captured elsewhere in the Trust, in line with the national guidance for completion. The Trust is meeting 1 out of the 4 of the Priority Clinical Standards (Clinical Standard 5), with robust plans in place to meet Clinical Standard 6. There is a clear expectation from NHS England and NHS Improvement and from CQC that Trusts will progress towards full delivery of the 4 Priority Clinical Standards by March 2020. This paper outlines evidence from the audit, the planned submission and the next steps to support delivery of the Priority Clinical

	Standards.

Risk									
Key Risks	Delivery of the 4 Seven Day Services Priority Clinical Standards is detailed on the Trust's Corporate Risk Register (risk 2899) as a high rated risk (12). Failure to provide seven day per week services resulting in inconsistent quality of care, increased length of stay and poor clinical outcomes.								
Assurance	The 7 Day Services Board Assurance Framework (Appendix 3) underpinned by the May 2019 clinical audit results and a review of the current position with regard consultant job planning provides assurance as to delivery of the standards								
Assurance level	**Significant**		**Moderate**		**Limited**	*X*	**None**		
Financial Risk	N/A								

Meeting	Trust Board
Date of meeting	11 July 2019
Paper number	F3

Introduction/Background

The Government's mandate to the NHS England and its remit letter to NHS improvement set ambitions for the delivery of 7 Day Services (7DS), which are reflected in the shared planning guidance. These require all acute hospitals across England to deliver the four priority clinical standards, in all relevant specialties by March 2020 and make progress against the other 6 standards identified by the NHS services, seven days a week forum (Appendix 1).

The CQC inspection regime features an assessment of 7DS as part of its judgement on a trust's effectiveness.

In October 2018, changes were announced to the measurement regime for 7DS. The NHS Standard Contact now requires providers to undertake the 7DS Board assurance process bi-annually, replacing the bi-annual survey. Trusts are required to complete a standardised template supported by local evidence, based upon local systems, governance structures and timetables as agreed by the Trust Board.

In February 2019, all trusts submitted a pilot of the new methodology, the results of which were not published. A further submission was required by 28th June 2019, the results of which are likely to be published.

The 7DS Board Assurance Framework (7DSBAF) contains a self-assessment of progress against the four Priority Clinical Standards (CS2,5,6 and 8), supported by triangulated evidence from: local audit, consultant job planning and other wider forms of assurance/metrics. It also requires a summary of progress against the remaining 6 Clinical Standards (CS1,3,4,7,9 and 10), referred to as the 7DS standards for continuous improvement. This summary is not a formal assessment of progress.

Within the 7DSBAF the Trust is also required to self-assess compliance with delivery of the 4 priority Clinical Standards for the Urgent Network Clinical Services: Hyperacute stroke, Paediatric Intensive Care, STEMI Heart Attack, Major Trauma and Emergency Vascular Services.

NHS England requires the Trust Board to approve the 7DS BAF prior to submission on 28 June 2019. However, given the changes to medical leadership in the Trust, NHS England agreed that the 7DS BAF could be submitted following review and approval by the Trust's Management Executive at their meeting on 19 June and at the Quality Governance Committee on 20 June, acknowledging it would be subsequently approved by the Trust Board on 11 July 2019. NHS England have asked to be updated following the Board's review of the 7DS BAF.

The methodology, underpinning this submission was agreed by the Trust's previous Chief Medical Officer. The Trust's Clinical Audit Team, in partnership with the Divisional Teams, undertook an audit of medical records utilising the methodology previously prescribed in the bi-annual 7DS self- assessment survey. This information was triangulated with information from Consultant job plans and with information collected from wider sources i.e. patient experience data, feedback from clinical and operational teams etc.

Progress to date and next steps

Meeting	Trust Board
Date of meeting	11 July 2019
Paper number	F3

The Board Assurance Framework (appendix 1) evidences progress to date and next steps to support delivery by 2020 of the 4 Priority Clinical Standards

Key areas of progress and issues reported within the 7DS BAF submission are as follows:

1. Priority Clinical Standards for all Specialties

Clinical Standard 2: All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission: Based upon audit data from May 2019, the trust's current performance is 73% of emergency admissions being seen by a consultant within 14 hours of admission. This shows an improvement from the baseline position of 56% in September 2016 but is a slight drop from the Spring 2018 position of 74%. The threshold for compliance is 90%. For weekdays the performance is 73% and weekends 74%.

Clinical Standard 5: Hospital patients must have scheduled seven- day access to a range of diagnostic services, **with tests completed and reporting available 7 days a week:** The Trust is compliant with this standard

Clinical Standard 6: Timely 24-hour access, seven days a week to key consultant-directed interventions, either on site or via formally agreed networked arrangements with clear written protocols: The Trust is compliant with 8 out of 9 of the key interventions. Access to Interventional Radiology interventions is currently available weekdays, in hours and therefore does not comply with the standard for either weekdays or at weekends. Successful recruitment has been finalised for a further 3 consultant Interventional Radiologists, who will join the Trust in August, in addition to the existing 4 consultants. This in partnership with a business case for additional resources to increase the nursing establishment and to develop the required infrastructure, will enable full compliance with the standard.

Clinical Standard 8: All patients with high dependency needs should be reviewed by a consultant twice daily. Once a clear pathway of care has been established, patients should be reviewed by a consultant at least once every 24 hours, unless this would not affect the patient's care pathway: Audit data, from May 2019 evidences 100% compliance with twice daily reviews both weekdays and weekends. This position has been sustained from the April 2018 audit. Compliance with daily review is 84%. Although this is a 6% improvement from the April 2018 position, the Trust is not compliant with the standard. For weekdays 91% of the patients requiring a review received, it where as for weekends this dropped to 66%

Progress with 7DS – Urgent Network Clinical Services
The Trust is reporting full compliance with the 4 Priority Clinical Standards for STEMI Heart Attack and compliance with CS2, 5 and 6 for Hyperacute stroke and CS2, 5 and 8 for Emergency Vascular services. Successful recruitment of Consultant Stroke Physicians and Interventional Radiologists will support delivery of the outstanding standards.

Next steps
To support future compliance with CS 2 and 8 the following key actions are suggested:

- The 7DS programme and action plan should become part of the Trust's Urgent and

Emergency Care Programme – Home First Worcestershire, to ensure duplication is minimised and pace of change is maximised

- A programme of engagement activities should be undertaken across the consultant workforce to establish a shared understand of the 7DS agenda
- Team job planning should be implemented across all specialties with a focus upon matching capacity to demand and enabling delivery of initial consultant review and board and ward rounds 7 days a week
- Consistent processes for consultant led ward and board rounds should be agreed and implemented across the hospital
- The future methodology for measuring progress, which supports continuous improvement, should be agreed and implemented.

Conclusion

In conclusion, the 7DS BAF was submitted to NHS England and Improvement by 28 June to evidence progress against the 4 Priority Clinical standards and the 6 standards for continuous improvement. The completed draft 7DS BAF (Appendix 1) is presented to the Trust Board for noting.

The 7DSBAF evidenced compliance with CS5, near compliance with CS6 and non-compliance with CS2 and 8. Further improvement activities are required to support progress to full compliance.

Recommendations

The Trust Board is requested to note this report and that the submission was made to NHS E/I as required by 28 June 2019.

Appendices

- Appendix 1 –7DS BAF

Seven Day Services: Board Assurance Framework June 2019

Clinical Standard 2: Time to consultant review
Clinical Standard 8: Ongoing daily consultant-directed review

19th June 2019

The Seven Day Services (7DS) Board Assurance Framework covers the management of patients admitted as an emergency, measured against four priority standards and an additional 6 standards for continuous improvement

The audit provides evidence to support the below two priority clinical standards:

Standard 2

All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital.

Standard 8

All patient with high-dependency needs should be reviewed twice daily by a consultant and all other inpatients should be reviewed by a consultant once daily seven days a week, unless it has been determined that this would not affect the patient's care pathway.

Methodology

To date, progress towards Clinical Standards 2 and 8 has been measured twice a year via the national 7DS survey.

All acute provider trusts are now required to provide evidence of delivery via the 7DS Board Assurance Framework (BAF), which allows for a broader spectrum of evidence to be provided to assure delivery.

For the June 2019 BAF, the trust has utilised a methodology consistent with previous surveys. This involved retrospective case note review covering the Alexandra Hospital and Worcestershire Royal Hospital.

The patient cohort was patients admitted for urgent/emergency care between Wednesday 10th - Tuesday 16th April.

The NHS sample calculator and audit tool. available on the 7 Day Service portal was used for data collection.

The sample size required for the Trust was **230** cases.

Clinical Standard 2

The overall proportion of patients seen and assessed by a suitable consultant within 14 hours of admission is 73%.

Table 1: Time from admission to 1st consultant review by day of the week (based on day of admission)

	Day of Admission									
	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Weekday	Weekend	Total
Number of patients reviewed by a Consultant within 14 hours	25	29	28	27	20	21	19	129	40	169
Number of patients reviewed by a Consultant outside 14 hours	8	6	13	9	11	9	5	47	14	61
Total	33	35	41	36	31	30	24	176	54	230
Proportion of patients reviewed by a Consultant within 14 hours	76%	83%	68%	75%	65%	70%	79%	73%	74%	73%

Clinical Standard 2

230 Patient notes were reviewed

145 from the Worcestershire Royal Hospital and 85 from the Alexandra Hospital

169 (73%) patients were reviewed within 14 hours. 77.2% at Worcestershire Royal Hospital and 67% at the Alexandra Hospital

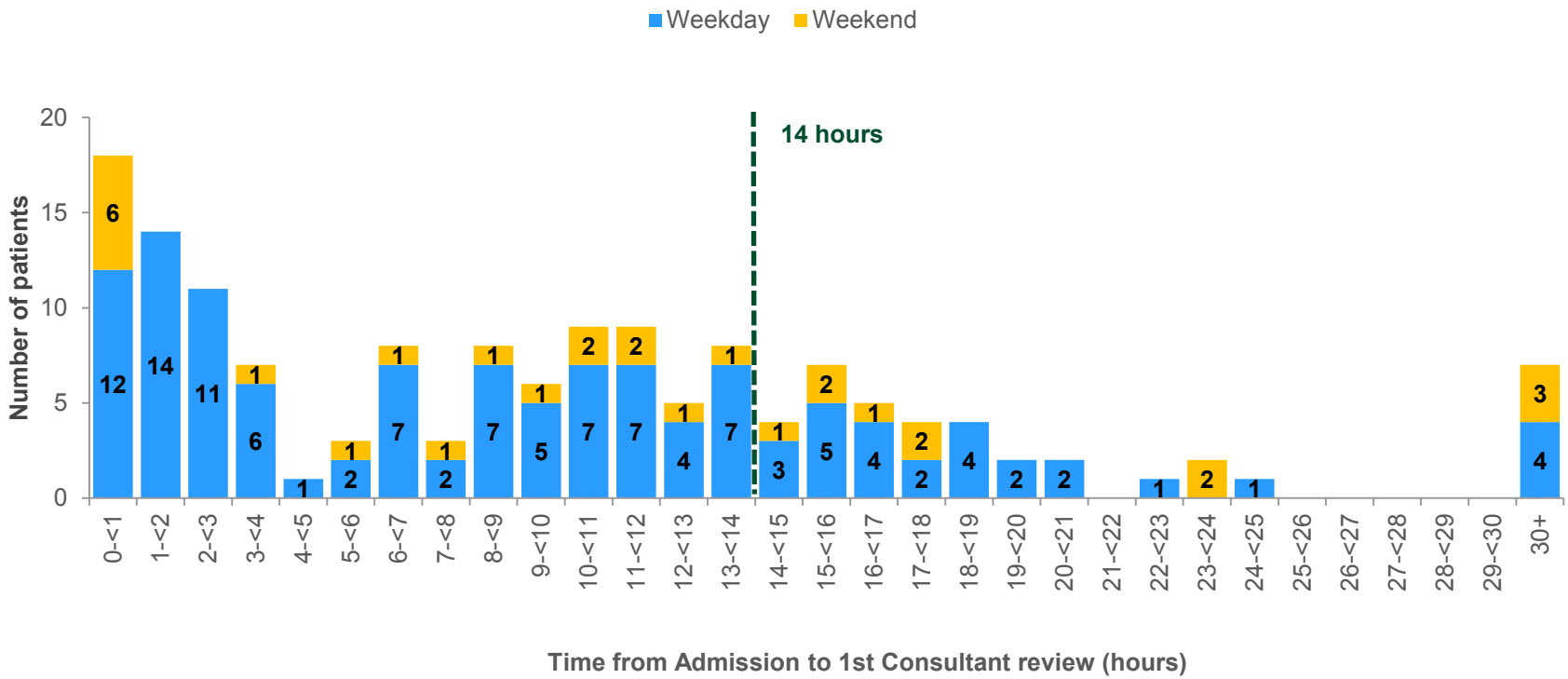
61 (27 %) patients were not reviewed within 14 hours

Table 2 : Detailed reasons why patients were not reviewed within 14 hours

Reason	Number of Patients
No time of review was recorded	22
The patient was reviewed by a consultant but after 14 hours from admission had elapsed.	35
Patient excluded from need for 1st consultant review to be by consultant as all exclusion criteria met.	2
Patient under the care of oncology team and reviewed by CYP oncology specialist nurse at 10:55. First consultant review was 18.33 hours after admission.	1
Patient was taken to theatre for surgery.	1
Total	**61**

Worcestershire Acute Hospitals NHS Trust

Chart 1: Hours between admission and 1st consultant review

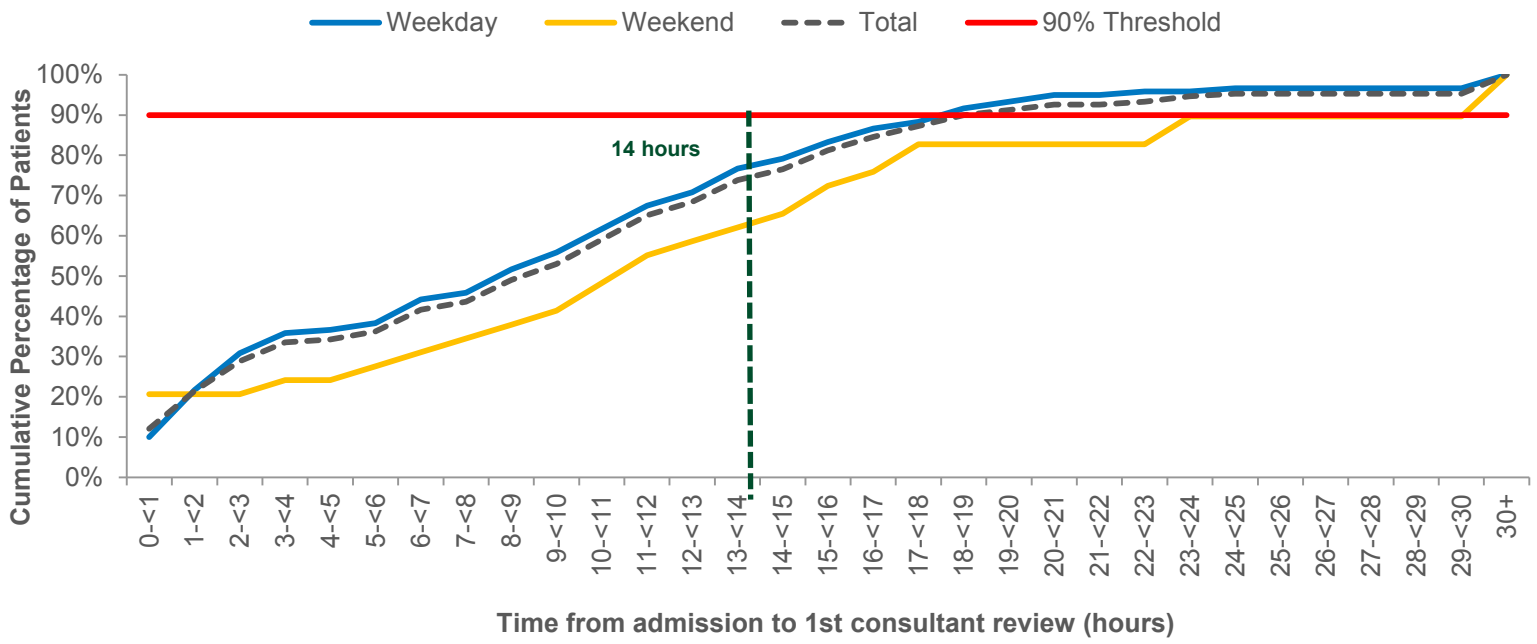


Clinical Standard 2

90% of patients were reviewed within **19** hours.

Results from the April 2018 review also demonstrated that 90% of patients were reviewed within 19 hours.

Chart 2: Cumulative hours between admission and 1st consultant review



Overview by speciality

Table 3: Time to 1st consultant review within 14 hours of admission by admitted specialty

	Weekday					Weekend				
Admitting specialty	Within 14 hours	Outside 14 hours	Total	Proportion reviewed within 14 hours	% increase/ decrease in-comparrison to **April 18**	Within 14 hours	Outside 14 hours	Total	Proportion reviewed within 14 hours	% increase/ decrease in-comparrison to **April 18**
Acute Internal Medicine	35	15	**50**	70%	↓ 18%	14	2	**16**	88%	↑ 15%
Cardiology	6	1	**7**	86%	↑ 46%			**0**		
Diabetes and Endocrinology	2		**2**	100%	N/A			**0**		
Emergency Medicine	15	3	**18**	83%	↑ 12%	1		**1**	100%	N/A
Gastroenterology	4		**4**	100%			1	**1**	0%	↓ 100%
General Surgery	20	3	**23**	87%	↑ 11%	5	1	**6**	83%	↓ 17%
Geriatric Medicine	4	2	**6**	67%	N/A		2	**2**	0%	N/A
Infectious Diseases	1		**1**	100%	N/A			**0**		
Intensive Care Unit	2		**2**	100%	N/A			**0**		
Obstetrics and Gynaecology	1	2	**3**	33%	N/A	1	1	**2**	50%	↑ 50%
Oncology			**0**				1	**1**	0%	N/A

Key 90% and above 89% - 70% 69% and below

The purpose of the colour coding is to identify areas for improvement.

Overview by speciality continued

Table 3: Time to 1st consultant review within 14 hours of admission by admitted specialty

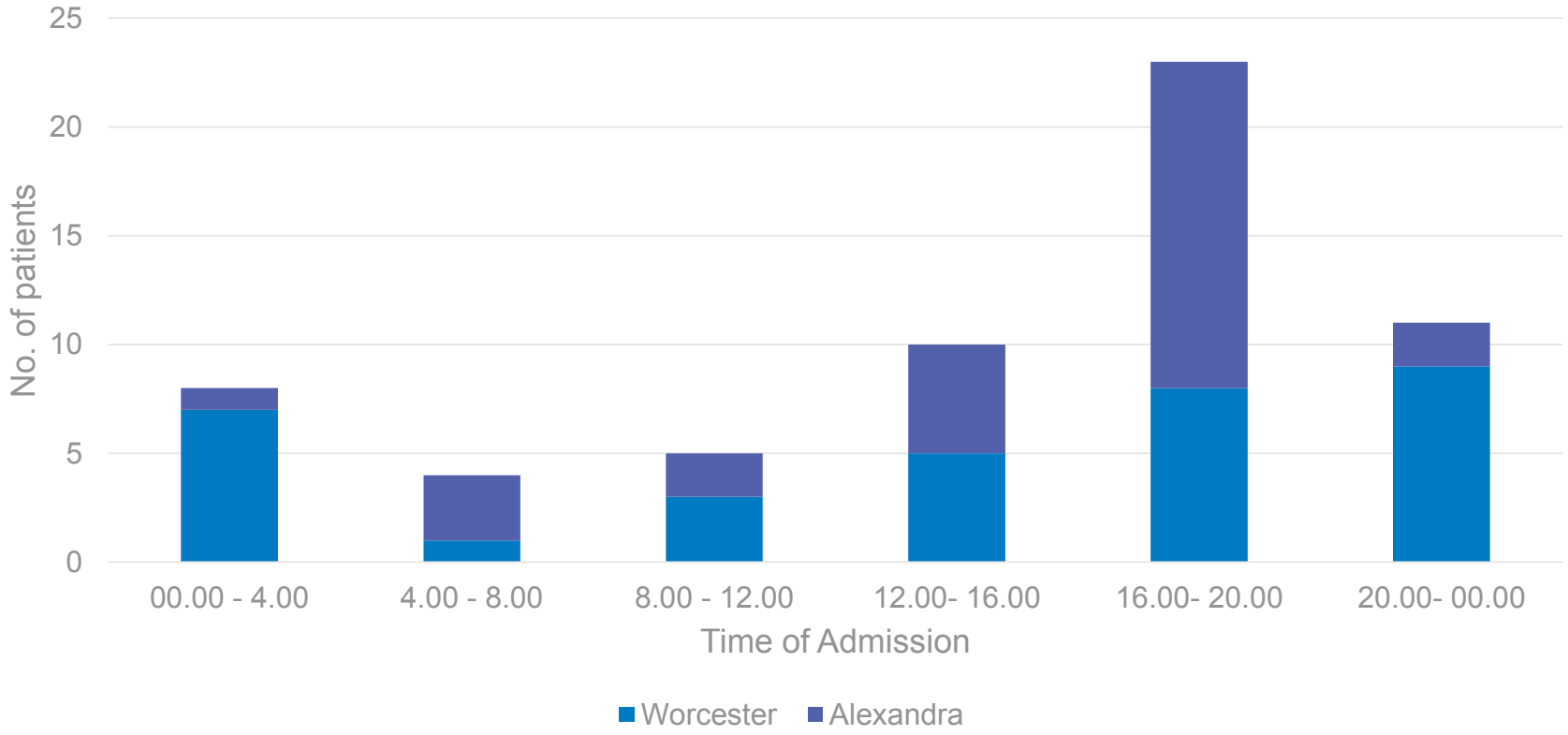
	Weekday					Weekend				
Admitting specialty	Within 14 hours	Outside 14 hours	Total	Proportion reviewed within 14 hours	% increase/ decrease in-comparrison to **April 18**	Within 14 hours	Outside 14 hours	Total	Proportion reviewed within 14 hours	% increase/ decrease in-comparrison to **April 18**
Other	4	1	**5**	80%	↓ 7%	2	1	**3**	67%	↔
Paediatric Medicine	2	4	**6**	33%	↓ 34%	5	4	**9**	56%	↑ 23%
Paediatric Surgical Wards	1	1	**2**	50%	↓ 50%			**0**		
Palliative Care	1	1	**2**	50%	N/A			**0**		
Renal Medicine (Nephrology)	1	1	**2**	50%	N/A			**0**		
Respiratory Medicine (Thoracic Medicine)	4	4	**8**	50%	↓ 50%	3		**3**	100%	N/A
Stroke Medicine	1	1	**2**	50%	↔	2	1	**3**	67%	N/A
Trauma and Orthopaedic Surgery	17	6	**23**	74%	↔	6		**6**	100%	↑ 50%
Urology	3	2	**5**	60%	↓ 13%	1		**1**	100%	↔
Vascular Surgery	5		**5**	100%	↑ 50%			**0**		N/A
Total	**129**	**47**	**176**	73%	↓ 2%	**40**	**14**	**54**	74%	↑ 5%

Key 90% and above 89% - 70% 69% and below

The purpose of the colour coding is to identify areas for improvement.

Overview by time of the day

Chart 3: Non compliance with 14 hour standard by time of admission



Clinical Standard 2: Comparison

Table 4: Proportion of patients reviewed by a consultant within 14 hours of admission at hospital – comparison

	September 2016	March 2017	September 2017	April 2018	June 2019
Proportion of patients reviewed by a consultant within 14 hours of admission at hospital	56%	62%	65%	74%	73%

Table 5: Proportion of patients reviewed by a consultant within 14 hours of admission at hospital by weekday/weekend – comparison

	April 2018		April 2019	
	Weekday	Weekend	Weekday	Weekend
Proportion of patients reviewed by a consultant within 14 hours of admission at hospital	75%	69%	73%	74%

Identified gaps in delivering Clinical Standard 2

- Lack of robust governance/ project management infrastructure to drive pace of delivery with CS2 and the 7DS agenda.
- Lack of shared/consistent understanding of 7DS resulting in reduced engagement with the agenda across the consultant workforce
- Progress has been made in addressing variation for admissions between weekends and weekdays, however further improvement is required to ensure all patients are reviewed by a consultant within 14 hours particularly those admitted between 4pm and 8pm on both sites.
- Whilst job planning has been successfully implemented across 93% of the consultant workforce, team job planning has yet to be fully implemented across all the Divisions, resulting in variation in performance across specialties. Further work is required to ensure working patterns reflect fluctuations in demand across the day enabling all patients to have access to consultant review at the beginning of their journey.

Proposed Improvement activities to support implementation of Clinical Standard 2

- Incorporate agreed actions to support delivery of 7DS into the trust's Urgent and Emergency Care Plan, ensuring activity to support 'patient flow' is consolidated into a single plan supported by a single governance structure
- Develop and implement an engagement strategy with a view to creating a shared understanding of the 7DS agenda across the consultant and wider workforce
- Review the pathways/ processes for ensuring patients are seen by a specialist consultant within 14 hours for all direct admission routes, focusing particularly upon the admission units and consider possible solutions i.e. increased consultant presence between 8am and 8pm as a minimum, implementation of evening or roving ward rounds. Agree the delivery model.
- Further develop team job planning such that the availability of consultant /medical capacity reflects the agreed delivery model.
- Agree and implement a regular cycle of auditing of compliance with CS2 to support continuous improvement

Clinical Standard 8: Ongoing daily consultant directed review

The proportion of patients who required twice daily consultant directed reviews and were reviewed twice was 100%. The Trust has sustained the 100% compliance from the April 2018 review.

Table 6 : Patients who required twice daily consultant reviews and were reviewed twice by a consultant

	Day of Review									
	Mon	**Tue**	**Wed**	**Thu**	**Fri**	**Sat**	**Sun**	**Weekday**	**Weekend**	**Total**
Twice daily reviews required & received	5	3	3	5	6	4	3	22	7	29
Twice daily reviews required and not received								0	0	0
Excluded from the analysis								0	0	0
Total	5	3	3	5	6	4	3	22	7	29
Percentage - Receiving required twice daily reviews	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Clinical Standard 8: Ongoing daily consultant directed review

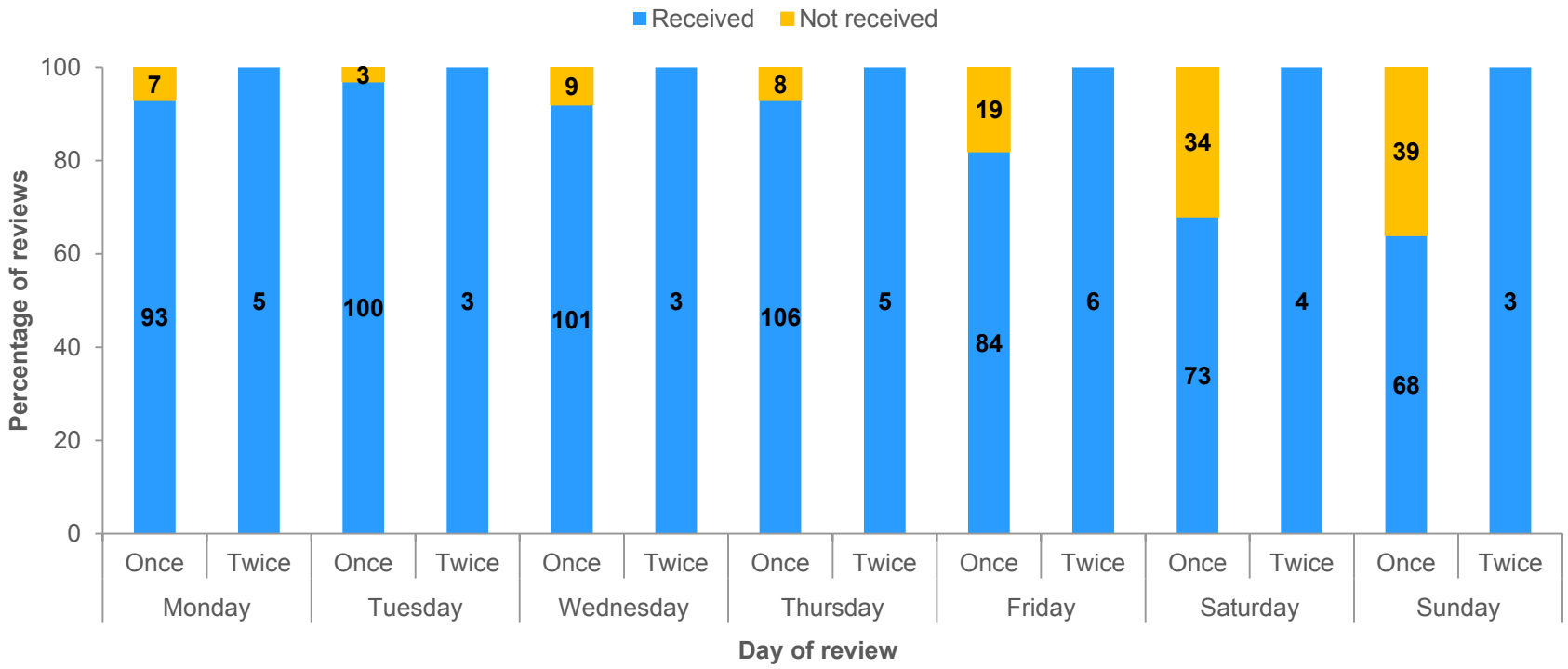
The proportion of patients who required a daily **consultant directed** review and were reviewed was 84%. This is a 6% improvement in comparison to the April 2018 review.

Table 7 : Patients who required once daily consultant reviews and were reviewed once by a consultant

	Day of Review									
	Mon	**Tue**	**Wed**	**Thu**	**Fri**	**Sat**	**Sun**	**Weekday**	**Weekend**	**Total**
Once daily reviews required & received	93	100	101	106	84	73	68	484	141	625
Once daily reviews required and not received	7	3	9	8	19	34	39	46	73	119
Excluded from the analysis	1	1	0	1	0	1	0	3	1	4
Total	100	103	110	114	103	107	107	530	214	744
Percentage - Receiving required once daily reviews	**93%**	**97%**	**92%**	**93%**	**82%**	**68%**	**64%**	**91%**	**66%**	**84%**

Clinical Standard 8: Ongoing daily consultant directed review

Chart 3: Proportion of once daily and twice daily reviews required and received



Clinical Standard 8

Table 8: Once daily reviews: Who undertook the review

	Day of Review									
	Mon	**Tue**	**Wed**	**Thu**	**Fri**	**Sat**	**Sun**	**Weekday**	**Weekend**	**Total**
Advanced Nurse Practitioner / Nurse Specialist	1	6	1	1	1	2	1	10	3	13
Other Doctor	11	10	10	7	18	10	9	56	19	75
Senior Trainee (ST3+)	5	8	3	9	7	5	1	32	6	38
Consultant	76	76	87	89	58	55	57	386	112	498
Total	93	100	101	106	84	72	68	484	140	624
Percentage - Receiving review by consultant	**82%**	**76%**	**86%**	**84%**	**69%**	**76%**	**84%**	**80%**	**80%**	**80%**

Where a consultant did not undertake the review they had delegated the responsibility to the above staff groups.

Clinical Standard 8: Ongoing daily consultant directed review - comparison

Table 9: Once daily and twice daily consultant reviews

	Clinical Standard 8				
	September 2016	**March 2017**	**September 2017**	**April 2018**	**April 2019**
Patients who required twice daily consultant reviews and were reviewed by a consultant	100%	93%	N/A	100%	100%
Patients who required once daily consultant review and were reviewed once by a consultant	84%	68%	N/A	78%	84%

N/A = CS 8 not reviewed in the September 2017 review.

Identified gaps in delivering Clinical Standard 8

- Lack of consistent recording of delivery of daily consultant review, particularly where the review is delegated, has impacted upon the ability of the trust to evidence accurate levels of compliance
- Although there are examples of where consultant led board and ward rounds are conducted, there is not a consistent trust-wide model of delivery specifying key requirements such as: timings, attendees, formatting of the boards and core information etc.
- There is clear overlap between the work being conducted by the ECIST team to support improvements to patient flow i.e. implementation of SAFER/RED to GREEN, however the interface has not been explicitly recognised and any issues of potential confusion i.e. consultant versus senior clinical decision maker, addressed.
- Consultant-led Board and Ward rounds are not in place, 7 days a week in every ward across both sites. Access at the weekend is a particular issue.

Proposed Improvement activities to support implementation of Clinical Standard 8

- Undertake a baseline audit of availability of consultant led board and ward rounds to establish consistency across the week and models of delivery
- Design, agree, communicate and implement a trust wide model for delivery of board and ward rounds, which supports consultant oversight of all patients and prioritisation of patients requiring face to face consultant review.
- Undertake gap analysis and identify any changes to required job plans, daily working patterns, capacity etc to allow for a daily board and ward round with all relevant attendees present, to be delivered on every ward.
- Adopt continuous improvement methodology to address identified issues and repeat baseline audit on a regular basis to support embedding of the change. Audit results can be utilised to support future Board Assurance Framework submissions rather than case note audit, along side evidence of changes to job planning.

Conclusion

In conclusion the case notes audit evidenced improvement in terms of delivery of Clinical standards 2 and 8

- CS2 at weekends showing a 5% improvement in comparison to April 2018 (69%)
- CS8 Once daily reviews 84% a 6% improvement in comparison to April 2018 (78%)
- CS8 Consultant led once daily reviews 80% a 7% improvement in comparison to April 2018 (73%)

There are however further improvements, as outlined within this presentation, required to meet the 90% threshold for both standards. These should be planned and delivered in partnership with the actions detailed within the trust's urgent and emergency care plan, to ensure consistency of delivery and monitoring of progress.

Meeting	Trust Board
Date of meeting	11 July 2019
Paper number	F4

Trust Management Executive

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

Accountable Director	Matthew Hopkins CEO		
Presented by	Vicky Morris Chief Nurse	**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 both meetings. 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
Date of meeting	11 July 2019
Paper number	F4

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 May Board, TME has met twice, 22 May and 19 June. This report covers both meetings.

19 June meeting

Items presented for approval

- **BAF**: Discussion took place in relation to the risk rating attached to risk 4. As a consequence of this discussion, the risk rating has remained the same as previous months.
- **Senior Leaders' Apprenticeship** – approval given for award of the tender (on the Board agenda in private, July 2019)
- **Implementing 24/7 Interventional Radiology Services across Worcestershire**: Approval was given to recruit staff to provide the 24/7 interventional radiology services. The cost of this (£1.1m over 3 years) will be mitigated by the additional activity. It was agreed that a more detailed benefits realisation would be undertaken for presentation to the Board. The proposal is in line with the Clinical Services Strategy. This is on the Board agenda in private, July 2019.
- **Quality Impact Assessment policy** – this was approved subject to further refinement of the equality impact assessment and escalation process.
- **County wide nutritional nurse** - the business case was approved. The cost of £50,000 pa will be covered through less wastage, more outpatient sessions and more efficient management of patients with a Peg (Percutaneous endoscopic gastrostomy**)**.
- **7 day services** - the submission was approved, was presented to the QGC, June 2019, and is on the agenda for the Board meeting in July.
- **Learning from Deaths**: a revised process was agreed to ensure adherence to the statutory obligations of timely registration of death and work of the medical examiners. A summary of the proposals is contained within the paper on the Board agenda, July 2019.
- **Quality Account –** the revised quality priorities were approved, There are now 12 underpinning priorities. Presented to QGC, June 2019. Publication was on 30 June.
- **Financial report M2** – approval was given to a number of high risk capital schemes, medical devices and IT upgrades.
- **Scheme of delegation and standing financial instructions:** The revised schemes were approved. They were presented to F&P, June meeting
- **4ward** – approval was given to review the contract with the external provider. This process is overseen by the P&C Committee.

Items presented for information/discussion

- **CQC letter (full suite)** – presented to Trust Board June meeting
- **Education/learning and development update** – presented to People and Culture (P&C) Committee, June meeting

Meeting	Trust Board
Date of meeting	11 July 2019
Paper number	F4

- **Clinical Services Strategy update** – the Board will discuss the progress at the development afternoon on 17 July
- **People and Culture Strategy update** – presented to P&C Committee, June meeting
- **Communications and Engagement Strategy** - received by the People and Culture Committee, June 2019 and will be presented to the board in September 2019)
- **Strategic workforce plan – draft –** presented to P&C Committee, June meeting
- **Integrated Quality Report** – presented to QGC, June meeting. This paper included Learning from Deaths, Patient Experience quarterly report and the Safeguarding Annual Report.
- **Savings babies' lives/CNST** - presented to QGC, June meeting and a summary is within the report to the Board from QGC.
- **Infection control update** – presented to QGC, June meeting
- **Integrated Performance Report** – presented to the Finance and Performance Committee, June and on the Board agenda, July.
- **Financial performance M2** (including the capital position) - presented to the Finance and Performance Committee, June 2019
- **Safe staffing** – presented to P&C Committee, June and is on the Board agenda, July
- **Appraisal/PDR** - presented to P&C Committee
- **HR casework** - presented to P&C Committee

Subgroup reports

- **Risk Management Group** – the process is presented to the Audit and Assurance Committee, January and July 2019
- **4ward** – reported to P&C Committee
- **Information governance**

22 May meeting

Items presented for approval

- **Digital Strategy** (later approved by the Board at the June meeting)
- **Accommodation Policy**
- **Quality Account -** this was not approved due to the number of priorities listed **(**presented to the Quality Governance Committee, May meeting)
- **Quality Impact Assessments – Service Reconfiguration**

Items presented for information/discussion

- **CQC letters relating to the inspection** (received by the Board at the June meeting)
- **Communications and Engagement Strategy** (received by the People and Culture Committee, June 2019 and will be presented to the board in September 2019)
- **Aston Medical School** – a discussion took place about the opportunities for developing the relationship with the newly formed Aston Medical School. The initial agreement was prior to the Three Counties' Medical School development and would not impinge on the current relationship with Birmingham Medical School
- **Integrated Quality Report** (presented to the Quality Governance Committee, May meeting)
- **Clinical Audit – Better Outcomes for Patients Programme 2019/20** (presented to the Quality Governance Committee, May meeting)
- **Local Maternity System Update** (presented to the Quality Governance Committee,

Meeting	Trust Board
Date of meeting	11 July 2019
Paper number	F4

May meeting)

- **Infection control including annual report** (presented to the Quality Governance Committee, May meeting)
- **Junior doctors** (presented to the People and Culture Committee, June meeting)
- **Integrated Performance Report** (presented to the Finance and Performance Committee, May meeting)
- **Annual Plan** (approved by the board, June meeting)

Recommendations

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

Appendices

NHS
Worcestershire
Acute Hospitals
NHS Trust Putting patients first May 2019

Meeting	Trust Board
Date of meeting	11 July 2019
Paper number	F5

CQC Feedback - Well-Led Review

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

Accountable Director	Vicky Morris CNO		
Presented by	Vicky Morris CNO	**Author /s**	Vicky Morris CNO

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 are requested to receive this letter for assurance and to note that the final CQC report will be based on the content contained within the letter.

Executive summary	The CQC visited the trust from Wednesday 19 - Friday 21 June 2019 to conduct a review against the Well-Led Key Lines of Enquiries. Over the 3 days, 36 interviews were conducted with Executives, Non-Executives, Divisional Medical Directors, Staff Side, Pharmacy and Heads of Corporate Services. All on-site requests for supporting data have been actioned and the Trust will continue to respond to any further requests for evidence as per process (pending draft and final reports). Once the final report (due August/September) is received, we will develop a comprehensive action plan to address 'must and should dos'. The letters will be discussed at both the Trust Management Executive and the Quality Governance Committee later this month.

Risk								
Key Risks	BAF 3930 IF we do not deliver the Quality Improvement Strategy (incorporating the CQC 'must and should' dos) THEN we may fail to deliver sustained change RESULTING IN required improvements not being delivered for patient care & reputational damage							
Assurance	*N/A*							
Assurance level	**Significant**		**Moderate**		**Limited**		**None**	
Financial Risk	*N/A*							

Care Quality Commission
Citygate
Gallowgate
Newcastle Upon Tyne
NE1 4PA

Telephone: 03000 616161
Fax: 03000 616171

www.cqc.org.uk

Sent by email 24 June 2019

Our reference: INS2-5747323801

Matthew Hopkins
Chief Executive
Worcestershire Acute Hospitals Trust
Charles Hastings Way
Worcester WR5 1DD

Date: 24 June 2019

CQC Reference Number: INS2-5747323801

Dear Matthew

Re: CQC inspection of Worcestershire Acute Hospitals NHS Trust

Following your feedback meeting with Sue Field, Executive Reviewer, Phil Terry, Inspection Manager, Justine Eardley, Inspector, Connie Atugonza, NHSI, and myself on 21 June 2019. I thought it would be helpful to give you written feedback as highlighted at the inspection and given to you and your colleagues at the feedback meeting.

This letter does not replace the draft report and evidence appendix we will send to you, but simply confirms what we fed-back on 21 June 2019 and provides you with a basis to start considering what action is needed.

We would encourage you to discuss the findings of our inspection at the public session of your next board meeting. If your next board meeting takes place prior to receiving a final or draft inspection report and evidence appendix, this correspondence should be used to inform discussions with the board. When scheduling a discussion of this letter, or the draft report, please inform your CQC Regional Communications Manager, who is copied in to this letter.

An overview of our feedback

The feedback to you was:

Leadership

- The trust has a mostly experienced leadership team with the skills, abilities to provide services. Two significant posts are interim, chief medical officer and finance director. Leaders recognise the development needs of managers at all levels, including themselves, and are working to provide development opportunities for the future of the organisation. The trust leadership team has

a comprehensive knowledge and clear understanding of current priorities and challenges and are taking action to address them. Understandably there has been a focus on ensuring appropriate systems and processes were in place time is now required to demonstrate the effectiveness of these and where improvements have been seen that these are sustained.
- Senior leaders made sure they visit all parts of the trust and feed back to the board to discuss challenges staff and the services face.
- The role of the chief medical officer remains pivotal to ongoing engagement of clinicians to embed service improvements.
- Divisional leadership has been made clearer and leaders had a clear understanding of the challenges and risks to patient safety, coupled with greater accountability with a proactive focus on service and financial improvements.

Vision and Strategy

- The newly developed trust strategy was directly linked to the vision and behaviours of the trust. Leaders were setting a clear agenda to underpin improvements and sustainability.
- The trust's behaviours were at the heart of the work within the organisation. Leaders were working hard to make sure staff at all levels understand them in relation to their daily roles.
- The trust involved some clinicians in the development of the strategy, but not patients and groups from the local community systematically. There was not yet an embedded coproduction focus.
- There was not yet a clear five-year plan to provide high-quality care with financial sustainability.

Culture

- Managers addressed poor staff performance where needed. The trust took appropriate learning and action as a result of concerns raised.
- Staff were able to challenge poor practice but this was not yet consistent across the organisation.
- Whilst there was positive work in recognizing the equality and diversity agenda, this was a reliance on individuals rather than effective systems and processes.
- However, staff did feel equality and diversity were promoted in their day to day work and when looking at opportunities for career progression.

Governance

- The trust was developing a structure for overseeing performance, quality and risk. The effectiveness of governance arrangements below the board committees were under review.
- There has been a focus on improving systems and processes the impact of these is yet to demonstrate sustainable improvement.
- Roles and responsibilities for staff at all levels of the organisation were becoming clearer.

Management of risk, issues and performance

- The trust now has systems in place to identify learning from incidents, complaints and make improvements. The governance teams at divisional level and at trust level regularly reviewed the systems.
- Effective arrangements for identifying, recording and managing risks, issues and mitigating actions have been recognised by the trust as needing improvements. However, recorded risks were aligned with what staff said were on their 'worry list'.
- Mortality review and learning for deaths processes were not always timely and effective and the trust was taking action to address this.
- Improvement in the process to stabilise the financial position was evident however, there remains significant risk to this.
- Openness and transparency in discussions of finance both at board and management level was apparent.
- There was understanding of the financial challenges and financial deficit.
- The trust now has ownership of the cost improvement programme but need to develop support to deliver these improvements.

Information management

- The board reviews performance reports that included data about the services, however it was difficult to see progressive changes.
- There was a reliance on manual systems at patient contact. The trust recognises the need for new clinical IT and business systems in the services.
- The trust has developed a new digital strategy better meeting the requirement of the organsation.

Engagement

- At the time of the inspection, there was variable levels of communication and engagement with patients, the public, and local organisations but a plan was being developed to address this.
- Positive engagement with staff was taking place.
- The trust engaged in collaborative work with some external partners to redesign some pathways e.g. stroke pathway

Learning, continuous improvement and innovation

- The trust was committed to improving services by learning from when things go well and when they go wrong. However, some improvements were not always sustained e.g. discharge letters.
- The leadership team was now working well with the clinical leads and encouraged divisions to share learning across the trust.
- There was more focus on quality improvement with an awareness of the need of specific expertise in this area.

A draft inspection report will be sent to you once we have completed our due processes and you will have the opportunity to check the factual accuracy of the report. I am also copying this letter to Dale Bywater at NHS Improvement

Could I take this opportunity to thank you once again for the arrangements that you made to help organise the inspection, and for the cooperation that we experienced from you and your staff.

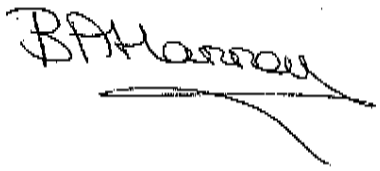
If you have any questions about this letter, please contact me through our National Customer Service Centre using the details below:

Telephone: 03000 616161

Write to: CQC
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

If you do get in touch, please make sure you quote or have the reference number (above) to hand. It may cause delay if you are not able to give it to us.

Yours sincerely



Bernadette Hanney

Head of Hospitals Inspection

c.c. David Nicholson, Chair of Trust
Dale Bywater, NHS Improvement
Louise Grifferty, CQC regional communications manager

Meeting	Trust board
Date of meeting	11 July 2019
Paper number	G1

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.

Executive summary	This report summarises the business of the Audit and Assurance Committee at its meetings held on 8 and 22 May.

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

Meeting	Trust board
Date of meeting	11 July 2019
Paper number	G1

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 twice since the last report.

Issues and options

Items discussed at the 8 May meeting:

- Clinical Governance Annual Report 2018/19: There has been an overall increase in new claims. However this includes requests for medical records which may or may not materialise into a claim. GDPR has made a difference in this area. We were assured in relation to the process of managing claims and that serious incidents were instigated as part of the claim process if one had not already been undertaken.
- **Quality Account:** We were assured in relation to the process for developing the Quality Account for 2018/19.
- Freedom to Speak Up – annual report: We were impressed with the work that the FTSU Guardian has undertaken in the first year. There are 32 FTSU Champions from all professions. There were 105 cases dealt with in 2018/19. 50% related to allegations of bullying and harassment. Work is being triangulated with issues raised in other areas such as the Guardian for Safe Working and the staff survey.
- Internal audit plan: We agreed the internal audit plan for 2019/20. The audits are linked to the BAF risks.
- Audit and Assurance Annual Report: We approved this report and it is attached for approval.

Other items received:

- Annual Governance Statement
- Conditions of Licence
- Fit and Proper Persons Test – annual audit

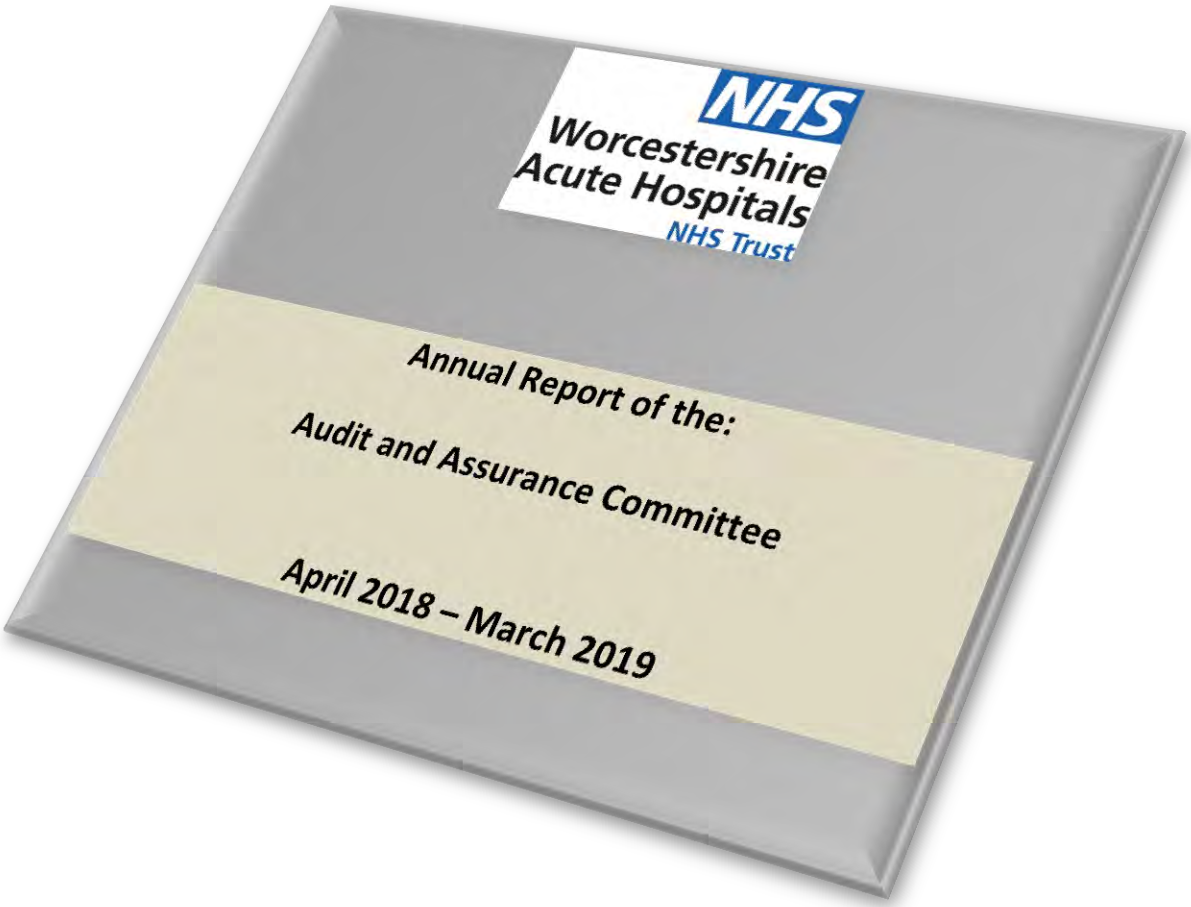
The meeting held on 22 May considered and approved the annual report (including the annual governance statement) and the annual accounts.

Recommendations

The Trust Board is requested to note the report for assurance.

Appendices

- Audit and Assurance Annual Report


NHS
Worcestershire
Acute Hospitals
NHS Trust
Annual Report of the:
Audit and Assurance Committee
April 2018 – March 2019

Putting Patients First

Foreword

Throughout this report, you will see how the role of the Audit and Assurance Committee has contributed to the achievement of all the Trust's key strategic objectives, in particular, to *ensure the Trust is financially viable and makes the best use of resources*. This has been a particular challenge for us, given the current economic context, but the Audit and Assurance Committee has been clear and focused in ensuring that not only the financial control total is met, but that it is delivered without compromise to the quality of care delivered in our organisation, whilst increasing efficiency.

The evidence in this report provides assurance to support the statements made by the Chief Executive in the Annual Governance Statement 2018/19.

Steve Williams
Audit & Assurance Committee
Chairman

Mark Yates
Member

Anita Day
Member

Audit and Assurance Committee Annual Report

For the year 1 April 2018 - 31 March 2019

1 Introduction

The Committee's chief function is to advise the Board on the adequacy and effectiveness of the Trust's systems of internal control and its arrangements for risk management, control and governance processes. The Committee also reviews the effective working of the other Board subcommittees.

In order to discharge this function, the Audit and Assurance Committee is recommended to prepare an annual report for the Board and Accounting Officer. This report includes information provided by Internal Audit and External Audit.

2 Audit and Assurance Committee's Opinion

Members of the Board should recognise that assurance given can never be absolute. The highest level of assurance that can be provided to the Board is a reasonable assurance that there are no major weaknesses in the Trust's risk management, control and governance processes are adequate and effective and may be relied upon by the Board.

3 Information Supporting Opinion

Summarised below is the key information/sources of assurance that the Committee has relied upon when formulating its opinion.

3.1 Internal Audit

At each of its meetings the Committee receives a report from Internal Audit, detailing its work since the last report.

At its meeting in March 2018, the Committee received the draft Internal Audit Annual Report for the 2018/19 financial year, which incorporates a summary of all work undertaken throughout the financial year, and the draft Head of Internal Audit Opinion.

The Head of Internal Audit's overall opinion for 2018/19 is that only **limited** assurance can be given as weaknesses in the design and/or inconsistent application of controls put the achievement of the Trust's objectives at risk in a number of areas reviewed.

The opinion takes into account the range of individual opinions arising from risk based audit assignments that have been reported throughout the year. The internal audit plan was divided into two broad categories; work on the financial systems that underpin financial processing and reporting and then broader risk focused work driven essentially by principal risk areas that we had identified in the Assurance Framework.

The assurance levels provided for all reviews undertaken is summarised below:

Significant Assurance

- Budget Setting, Monitoring and Reporting*
- Financial Systems*

Moderate assurance

- Patients Property and Monies
- Complaints
- Financial Sustainability & Outcomes*
- Health and Safety*

Limited assurance:

- Governance Arrangements - Divisions
- Quality Systems
- Delayed Discharges and Stranded Patients

* draft reports

The Audit and Assurance Committee will continue to monitor the actions and is pleased with the progress made in ensuring that actions are completed within the specified timeframes. This area of work can be improved. Internal Audit will be asked to continue to rigorously monitor progress over the next year.

With reference to the Assurance Framework, the Head of Internal Audit concluded that

It is my view that an Assurance Framework has been established which is designed and operating to meet the requirements of the 2018/19 Annual Governance Statement, and enables the Accountable Officer to assess the effectiveness of the overall system of internal control. The Assurance Framework highlights a number of significant risks to the achievement of the Trust's strategic objectives, and these are monitored regularly by the Trust Board. This Framework has informed the Significant Internal Control Issues that have been reported by the Trust within its Annual Governance Statement.

3.2 External Audit *To be finalised following the meeting on 22 May*

The Trust's external audit is provided by Grant Thornton, who have attended all Audit and Assurance Committee meetings during the year. In May 2019 they presented their Annual Audit Letter summarising the findings of their work carried out at the Trust for the year ended 31 March 2019. The audit was completed and the audit opinion issued before the deadline specified by the Department of Health.

Grant Thornton issued an unqualified opinion on the Trust's 2018/19 accounts, after reporting the detailed audit findings to the Audit and Assurance Committee. They were not satisfied that the Trust put in place proper arrangements to ensure economy, efficiency and effectiveness in its use of resources because of weaknesses in the Trust's arrangement for setting and agreeing its budget, monitoring and managing delivery of its budget and responding to service delivery issues raised by regulators. They therefore issued an adverse value for money conclusion.

This situation also required Grant Thornton to refer the Trust's financial position to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014. They also provided a xxxxx opinion on the Trust's 2018/19 Quality Account.

Progress and update reports have been presented to each Audit and Assurance Committee meeting during the year providing committee members with an overview of progress with the 2018/19 audit and highlighting issues in the wider Health environment. This includes briefings on Grant Thornton's national report on Health sector issues.

Grant Thornton have also run a variety of workshops and seminars during the year which Trust representatives have attended.

3.3 Other Assurance Providers

3.3.1 Head of Counter Fraud

Regular reports were received from the Head of Counter Fraud and the Committee is satisfied that the Trust has complied with the NHS Counter Fraud Service guidance and Secretary of State Directives. There were no significant frauds detected during the year.

3.3.2 Management

The Committee has considered assurances provided by the Chief Executive, Director of Finance and other Directors in the Communication with the External Auditors. It has also considered the Annual Governance Statement (AGS) provided by the Chief Executive. The Committee has noted that there were four significant control issues listed in the AGS.

4. The Role and Operation of the Audit and Assurance Committee

4.1 Membership of the Committee

The Members of the Committee during the period of the report were as set out in the Trust Board section of the Annual Report where a full disclosure of interests is also set out.

The Company Secretary ensures that the Committee functions in accordance with its Terms of Reference. The Committee was supported administratively during the year by the Company Secretary.

4.2 Operation of the Committee

4.2.1 Meetings and attendance

The Committee is required to meet at least 4 times a year. Seven meetings took place during the period April 2018 to March 2019. The attendance register is as set out in the Trust Board section of the Annual Report.

The quorum for meetings of the Committee is 2 members and all meetings held were quorate.

4.2.2 Work Programme

The Committee is satisfied that it has covered all work planned as outlined in the work programme.

4.2.3 Key Business Considered by the Committee during the year

The Committee:

a) Received assurance from the internal audit on the design and operation of the Board Assurance Framework and associated process to support the Trust's AGS.
b) Reviewed the 2018/19 Annual Accounts and Annual Report, recommending to the Board that these be approved.
c) Reviewed and approved instances where the Waiver to Tenders procedures has been applied ensuring satisfactory explanation as to why.
d) Reviewed the Internal Audit work plan for 2018/19 and has emphasised to management, its requirement to be involved in the development of the areas to be included in the programme.

e) Reviewed progress on implementation of actions agreed through audit recommendations.

5. Conclusions

Based on the information presented and discussed at the Audit and Assurance Committee meetings during the year we have concluded that:

5.1 Board Assurance Framework

The Assurance Framework has been reviewed by the Audit and Assurance Committee and full Board during the year. The Committee are satisfied that the process to update and manage the BAF is robust.

5.2 Governance Arrangements

The Audit and Assurance Committee has monitored the work of other Board Committees. Chairs of the committees accountable to the Board have attended the Committee to present their work and to discuss their effectiveness. We are satisfied with the operation of the Committees.

The Annual Governance Statement (AGS) was reviewed by the Committee during May 2019.

5.3 Self assessment

The Committee undertook a self-assessment of its working based on the NHS Audit Committee handbook, and has asked that senior managers attend the committee when requested. An item to reflect the way each committee meeting operates has been added to the each agenda.

6. Recommendation

Given the issues identified in Section 4 and our conclusions in Section 5 we recommend that the Board approves the Audit and Assurance Committee's Annual Report 2018/2019, recognising that it provides it with further assurance to support the Annual Governance Statement (AGS)

Steve Williams
Audit and Assurance Committee Chairman

Meeting	Trust Board
Date of meeting	11 July 2019
Paper number	G2

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 Board is requested to receive 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	Within local budgets							

Meeting	Trust Board
Date of meeting	11 July 2019
Paper number	G2

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 once since my last report in May. We discussed Executive Directors' annual performance and succession. We have requested further discussion on succession and talent management in the Trust. We approved the Senior Managers' pay increase as per Department of Health and Social Care guidance.

Recommendations

The Board is requested to receive this report for assurance.

Appendices

Worcestershire Acute Hospitals NHS Trust

Meeting	Trust board
Date of meeting	11 July 2019
Paper number	G3

Report from the Charitable Funds Committee

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

Accountable Director	Mark Yates Committee Chairman		
Presented by	Anita Day Committee Vice Chairman	**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 Board, as the Corporate Trustee, is requested to note the report.

Executive summary	This report summarises the business conducted at the meeting held on 12 June.

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

Meeting	Trust board
Date of meeting	11 July 2019
Paper number	G3

Introduction/Background

The Charitable Funds Committee meets twice a year to ensure that the funds donated are being managed and spent in an optimal way. Members of the Charitable Funds Committee are there to ensure that the Trust fulfils its duties as a charity Trustee when it manages the charitable funds.

Issues and options

The Committee met in June and a summary of the business conducted is shown below:

- **CCLA**: CCLA manages the funds that we invest our Charitable Funds in. Two fund managers from CCLA came to the meeting to explain the performance of the three funds that the Charity invests in and to develop ideas as to how the Charity can improve performance. We currently invest in the investment fund, property fund and fixed interest fund, the former outperforms the latter two. The discussion stimulated a number of ideas for implementation and we have set up a task and finish group to recommend the way forward and consider our ethical investment policy. This group will report in July.

We approved the following items:

- Charitable funds poster for distribution across the Trust
- Charitable Funds handbook – this will be circulated to all non-executives as part of the general circulation to employees

We received the following items:

- Charitable Funds risk register
- Balance sheet
- Statement of financial activities
- Fund balances
- Potential legacies

We remain concerned that some funds still do not have expenditure plans. I will write to those fund managers to express my concern.

Recommendations

The Board, as the Corporate Trustee, is requested to:

- Note the report

Appendices

NHS
Worcestershire
Acute Hospitals
NHS Trust

Meeting	Trust Board
Date of meeting	11 July 2019
Paper number	H1

Infection Prevention & Control Annual Report 2018-19

For approval:		For discussion:		For assurance:	X	To note:	

Accountable Director	Vicky Morris Chief Nursing Officer & DIPC		
Presented by	Vicky Morris Chief Nursing Officer & DIPC	**Author /s**	Ms Tracey Cooper, Deputy DIPC

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

Report previously reviewed by		
Committee/Group	Date	Outcome
Trust Infection Prevention & Control Committee	29th April 2019	Approved
Trust Management Executive	22nd May 2019	Approved
Clinical Governance Group	4th June 2019	Noted
Quality Governance Committee	23rd May 2019	Approved

Recommendations	Trust Board is asked to: a. Note their statutory responsibility for compliance with the Hygiene Code, and our statement of compliance via the annual report. b. Receive and endorse the Infection Prevention & Control Annual Report 2018-19, and the Improvement Plan for 2019-20. c. Note the recommended levels of assurance.

Executive summary	This paper presents: • The Annual Infection Prevention & Control Report 2018-19 • The Improvement Plan for 2019-20 as an appendix to the annual report. The *Health & Social Care Act (2008) Code of practice on the prevention and control of infections and related guidance (2015)* (known as the Hygiene Code) sets out the arrangements all Trusts must have in place to prevent and manage infections. Following the external review of infection prevention and control which was commissioned by the DIPC due to her rising concerns in 2018, a range of additional actions have been put into place including strengthened expert leadership with the appointment of the Deputy DIPC and a more focussed programme of improvement actions. A self-assessment of our compliance with the Hygiene Code has been

Meeting	Trust Board
Date of meeting	11 July 2019
Paper number	H1

	performed during Q4 18-19 utilising existing internal insight and the external view brought by the Deputy DIPC. Both the CCG and NHS Improvement were invited to provide a professional infection prevention view of the self-assessment outcomes, as part of our process to ensure rigour and maximum accuracy. The work has included alignment of common issues across the Trust Infection Prevention & Control Committee and Medicines Safety Committee, with strong cross-reference between risk registers for those groups, as well as the corporate risk register and Board Assurance Framework. The Quality Governance Committee and Trust Management Executive have oversight via the monthly reports of the risks and actions being taken to address them. The annual report sets out our performance and key actions taken in 2018-19, including the launch of our *Key Standards To Prevent Infection*, and summarises our compliance with the Hygiene Code. Key issues to bring to the attention of the Trust Board are: 1. The Board need to be aware of their statutory responsibility to comply with the duties in the Hygiene Code. 2. The Annual Report sets out how we are meeting our statutory requirements within the Hygiene Code. 3. We do meet the requirements in the Hygiene Code, although there is further work to do in 2019-20 in relation to some of the criteria, and actions to achieve this are included within the 2019-20 annual plan. 4. Monthly updates are provided to the Board via reports to the Trust Management Executive, and to the Quality Governance Committee which continues to have an overview of infection prevention and control, and scrutinised the annual report on 23rd May 2019. 5. The annual infection prevention improvement plan for 2019-20 sets out: a. The continued commitment from Trust Board to achieve significant further improvement and reductions in infections. b. Our improvement trajectories, objectives and detailed actions for 2019-20.

Risk	
Key Risks	Board Assurance Framework Risk 3.
Assurance	Limited assurance on the annual report 2018-19, based upon the following: • Non-achievement of 3 infection targets in 2018-19. • Cleaning standards and mandatory training compliance not yet meeting our set standards.

Meeting	Trust Board
Date of meeting	11 July 2019
Paper number	H1

	• The level of work still needed to achieve compliance, which is being taken forward at pace in line with the 2019-20 plan. Moderate assurance in relation to the forward plan 2019-20, based upon the following: • Key Standards launched and in use across the Trust. • Divisional engagement and leadership actively taking forward improvements, including embedding actions within divisional quality improvement plans. • Evidence of improved engagement and learning from divisional reviews of patients with Clostridium difficile infection. • An annual programme is in place for 2019-20, with monitoring of progress via the Trust Infection Prevention & Control Committee							
Assurance level	**Significant**		**Moderate**		**Limited**	*X*	**None**	
Financial Risk	Managing each case of healthcare-associated infection (HCAI) uses resources which could be used more effectively to treat other patients. Increased levels of HCAI will result in increased treatment costs to WAHT, whereas reducing infection will help ensure best use of resources in line with trust strategy.							

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

INFECTION PREVENTION & CONTROL

ANNUAL REPORT 2018-19

Authors:

Vicky Morris,
Chief Nursing Officer & Director of Infection Prevention & Control (DIPC)

Tracey Cooper, Deputy DIPC

Dr Tia Yiannakis, Consultant Microbiologist and co-Infection Control Doctor

Dr Emma Yates, Consultant Microbiologist and co-Infection Control Doctor

PULL TOGETHER TO PREVENT INFECTION

Index (complete once content and pictures finalised)

Foreword

Good infection prevention practices, including hand hygiene, cleanliness and effective antimicrobial stewardship are essential to ensure that people are receiving safe and effective care from us.

Worcestershire Acute Hospitals NHS Trust is committed to ensuring that we achieve very high standards of infection prevention practice, and the Trust Board views this as a priority for our patients, ensuring detailed monthly scrutiny by the Quality Governance Group on behalf of the Board throughout 2018-19.

I am pleased to introduce this Annual Infection Prevention & Control Report for 2018-19, which provides a summary of our progress during 2018-19, as well as our priorities and key programmes of work for the coming year.

I am pleased that we have had no MRSA bacteraemia since March 2017, though disappointed that we did not meet our reduction targets for MSSA bacteraemia, *Clostridium difficile* infection or E coli bacteraemia. We set out later in the report the actions we are taking to address this in 2019-20.

Hand hygiene has been a particular focus for us this year, as it is so important in protecting our patients from infection. Highly visible hand hygiene posters and signs have been displayed throughout the year at our hospitals, and we are pleased that our hand hygiene compliance has increased and is above 95%, meeting the target set.

Another focus this year has been on improving our standards of cleanliness. We issued a framework setting out clearly who is responsible for cleaning which items, to make sure that nothing is missed. We have also increased scrutiny on cleaning by holding weekly meetings to review ward cleaning scores and address any issues identified. This has led to a number of actions, including a deep cleaning programme for all our beds and trollies across the Trust. This programme is continuing in 2019-20.

I am pleased that we have participated in several health economy-wide collaborative projects, including work to reduce *Clostridium difficile* infection, and work to reduce *E. coli* bacteraemia. As part of the E coli project we participated in a collaborative led by NHS Improvement, developing an education programme on the care of urinary catheters. This programme won an award when it was presented at the final NHS Improvement regional workshop, and we are continuing implementation of the programme in 2019-20.

In June 2018, in response to rising numbers of infections I commissioned an external expert review of arrangements for infection prevention and control across the Trust. This took place in July 2018, and identified a number of areas for further improvement work. Many actions have been taken in response to the review recommendations, including strengthening the expert leadership within the Trust by the appointment of a Deputy Director of Infection Prevention and Control (Deputy DIPC). This senior expert nursing role was appointed in January 2019 and is providing leadership and direction to the Infection Prevention Team, as well as across the full range of infection prevention activities within the Trust.

NHS Improvement has made a number of visits to us during 2018, and in July 2018 escalated the Trust to red status for infection prevention and control, indicating that significant improvement was still needed.

On 1st February 2019 we launched a major new improvement initiative: our '*Key Standards to Prevent Infection'*. These standards set out clearly the measures we must take consistently for every patient, to achieve our aim of very low rates of infection. The Chief Medical Officer and I jointly sent a letter to all staff as part of the launch, setting out the importance of these standards for our patients. Key Standards

posters and large banners are prominently displayed across our sites, and our wards are already proudly displaying their achievements with the Key Standards, which also form part of our 'Pathway to Platinum' ward accreditation programme.

This annual report follows the format of the Code of Practice (known as the *Hygiene Code 2015*), as required by the Health & Social Care Act (2008)[1], and demonstrates our progress with the requirements of the Hygiene Code. The report also sets out our priorities and plans to achieve significant improvement and reductions in infection during 2019-20.

Vicky Morris
Chief Nursing Officer and Director of Infection Prevention & Control (DIPC)

Key Actions Taken During 2018-19

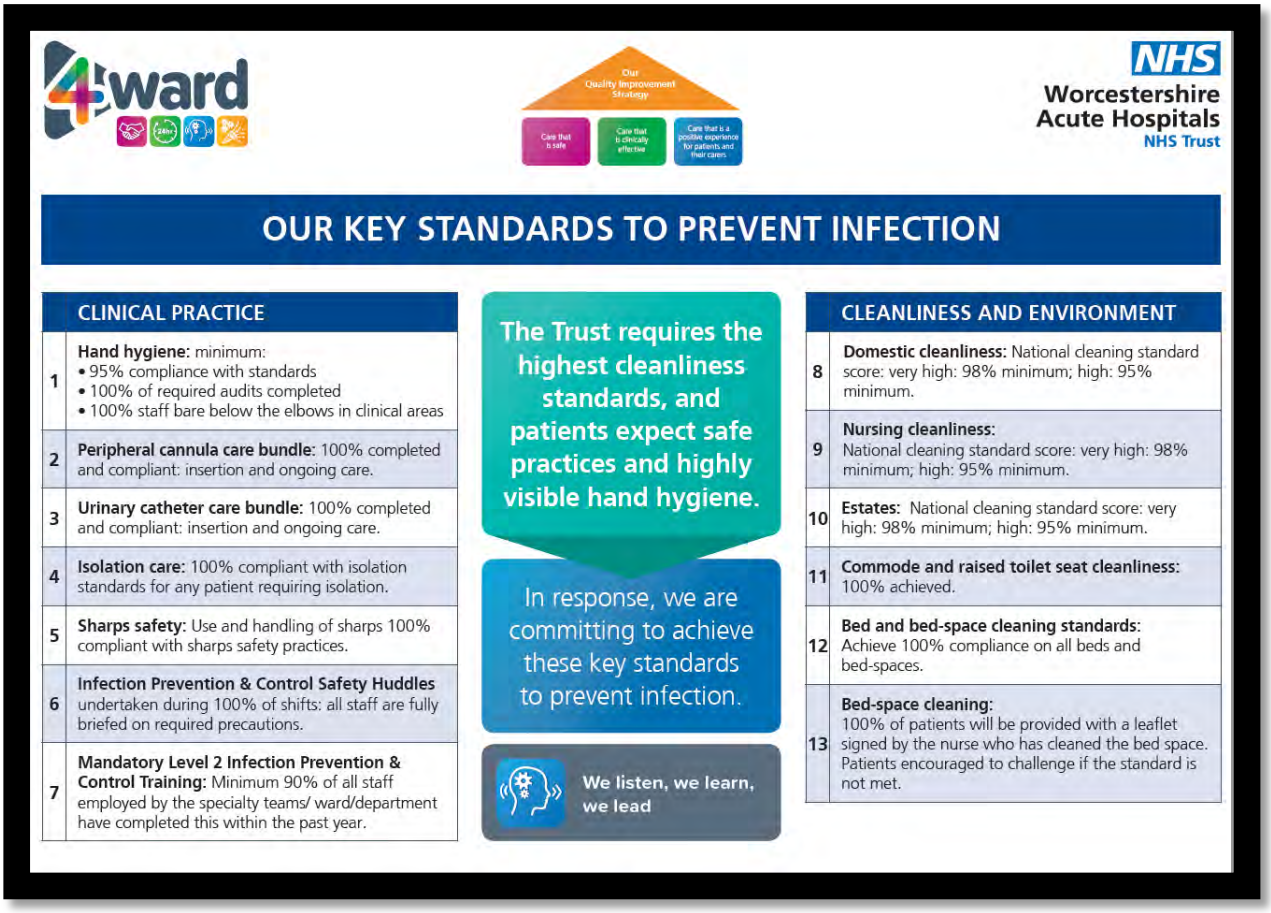
A range of actions has been taken throughout 2018-19 in order to increase focus on infection prevention practices and reduce infections. This includes:

- '*Back to the Floor Friday*' programme; a weekly programme of senior nurses working alongside clinical staff, led by the Chief Nursing Officer.
- Commissioning an external review of arrangements for infection prevention at the Trust, and taking action to strengthen capacity and leadership within the Infection Prevention Team by appointing in January 2019 a senior expert nurse as Deputy DIPC.
- Commencing a programme of cleanliness walkabouts with senior cleaning managers across all sites including the PFI provider.
- Holding a programme of cleanliness scrutiny meetings, to ensure cleaning standards are improving.
- Issuing a new cleaning responsibility framework for all staff.
- An active programme of audit and monitoring of cleaning standards by the Infection Prevention Team.
- Commencing review of cleaning standards against PAS5748, with action being taken to strengthen standards as part of the process.
- Transferring lead responsibility for review of cases of infection to Divisions, supported by the Infection Prevention Team, to better support clinical learning and practice improvement.
- The Infection Prevention Team completing a checklist for each patient with *Clostridium difficile* infection to ensure standards of practice are being met, with immediate feedback to clinical staff.
- Starting a programme of participation in medical ward rounds by the Deputy DIPC to directly work with teams of doctors on infection prevention practices.
- A focus to drive up compliance with mandatory infection prevention training by all staff, to ensure they have the knowledge needed to achieve high standards of practice.

- Reviewing the list of policies in place, so that they can be prioritised for updating, and mapped against Hygiene Code requirements.
- Many examples of local leadership to improve infection prevention standards; for example the Trauma & Orthopaedic Ward at WRH has put in place many local changes including staff briefings and engaging information boards which ensure ward staff are focussed on infection prevention. The Specialised Clinical Services Division is leading a piece of work to install floor signs which reinforce the bare below the elbow requirements for staff in clinical areas.
- Quarterly audit of antimicrobial prescribing to track trends in antibiotic prescribing.

On 1st February 2019 we launched our '*Key Standards to Prevent Infection'*. These standards set out clearly the measures we must take consistently for every patient, to achieve our aim of very low rates of infection. A letter was sent to all staff by the Chief Nursing Officer and Chief Medical Officer as part of the launch, setting out the importance of these standards for our patients.

Key Standards posters and large banners are prominently displayed across our sites, and our wards are already proudly displaying their achievements with the Key Standards, which also form part of our 'Pathway to Platinum' ward accreditation programme. A continuing programme of social media communications and other reinforcing information commenced at launch and will continue through 2019-20.



Compliance With The Health & Social Care Act (2008): Code Of Practice On The Prevention And Control Of Infections And Related Guidance (2015)

Criterion 1: Systems to manage and monitor the prevention and control of infection.

Leadership Arrangements

The *Health & Social Care Act (2008) Code of practice on the prevention and control of infections and related guidance (2015)* (known as the Hygiene Code) sets out the arrangements all Trusts should have in place to prevent and manage infections. A further self-assessment is being performed against the Hygiene Code at year-end, to identify any strengthening actions which may be required by the Trust to ensure full compliance with all criteria can be demonstrated.

The Trust Board is committed to the prevention of infection as a priority, ensuring detailed monthly scrutiny by the Quality Governance Group on behalf of the Board.

The Chief Nursing Officer is the lead Executive Director for the prevention of infection, and is also the Director of Infection Prevention & Control (DIPC).

WAHT has a multi-disciplinary Infection Prevention Team led by the DIPC. A new post of Deputy DIPC was appointed in January 2019, strengthening the expertise and senior leadership within the team in support of the DIPC. The team has dedicated resources available to support its work.

The Trust's Clinical Microbiologists support the team in all aspects of Infection Prevention including outbreak management, surveillance for and management of health-care associated infections and policy development. This support is led by the Infection Control Doctor, a role currently shared between two Consultant Microbiologists. In addition, the Trust's clinical microbiology laboratory facilitates screening for and detection of alert organisms both from clinical and environmental samples.

The Trust also has an Antimicrobial Pharmacist who works alongside clinical teams, consultant Microbiologists and the Infection Prevention team to support improved use of antibiotics as part of our antimicrobial stewardship work.

Divisional Leaders have committed to providing strong and visible leadership in relation to the prevention of infection, and have been set clear written objectives in relation to this by the CNO/DIPC.

The responsibility of all staff to ensure they adhere to expected standards of infection prevention practice as set out in Trust job descriptions.

Governance and Assurance

The CNO/DIPC reports to the Chief Executive and the Board on all matters relating to infection prevention.

The Trust Infection Prevention and Control Committee (TIPCC) is chaired by the CNO/DIPC and meets monthly. The Committee scrutinises infection prevention performance, issues and activity. This has included a strong and detailed focus on hand hygiene, cleanliness and mandatory training during 2018-19.

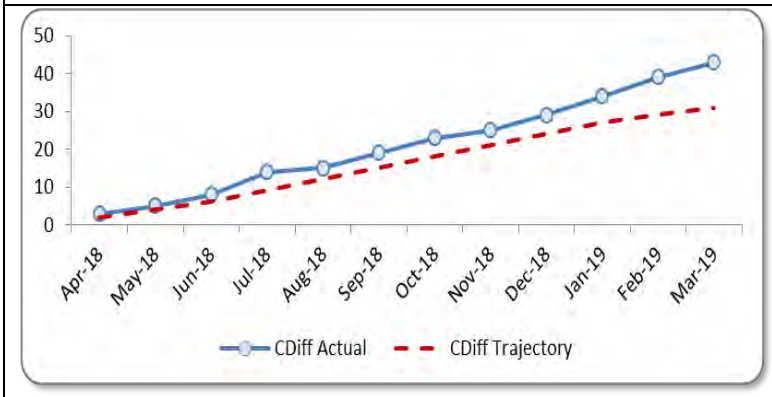
Divisions and key services such as Facilities and Estates report to TIPCC on the actions they are taking to reduce infections and improve standards.

TIPCC has formally established terms of reference and a cycle of business, in line with requirements in the Hygiene Code. It reports to the Trust Management Executive, and to the Quality Governance Committee, which scrutinises performance and actions being taken on behalf of the Board.

Infection Performance

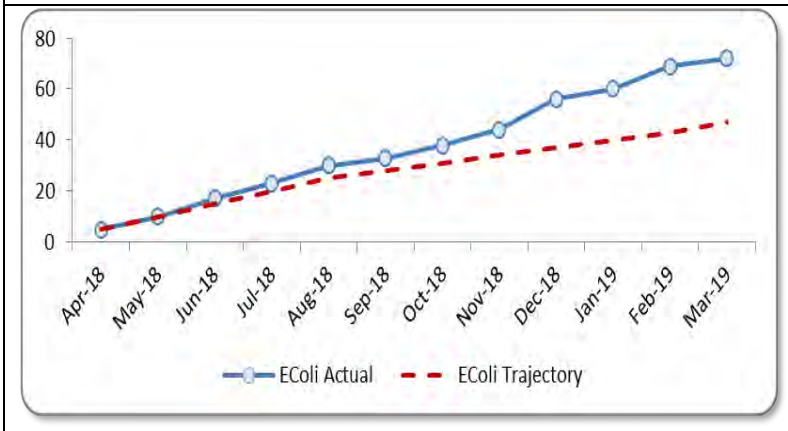
Meticillin-Resistant *Staphylococcus aureus* (MRSA) Bacteraemia

We had no MRSA bacteraemia in 2018-19, meeting our target of zero.

***Clostridium difficile* Infection**	**How Are We Doing?**
	We did not meet our improvement target this year. We reported 43 vs 31 full-year target.

To Reduce These Infections We Have….

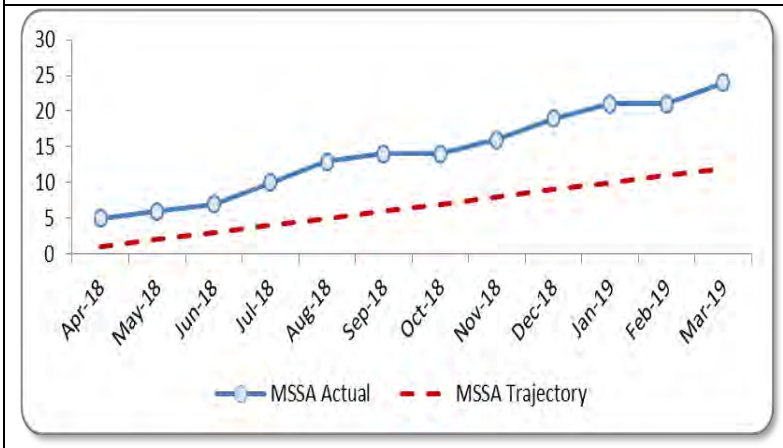
- Worked to improve our cleanliness standards. We are performing a review against national standards (PAS5748) and taking action to ensure we fully meet the requirements it sets out.
- Improved how we report cleaning audit results so that the actions each staff group needs to take are clear, and we can address poor performance.
- Taken formal action in relation to the standards for cleaning within the PFI contract.
- Continued to scrutinise hand hygiene performance, improving monthly hand hygiene compliance to 97%.
- Revised our uniform policy to strengthen the information on bare below the elbows requirements.
- Performed quarterly audits of antimicrobial prescribing to monitor practice.
- Implemented our Key Standards to Prevent Infection.

E Coli Bacteraemia	How Are We Doing?
	We did not meet our improvement target this year. We reported 72 vs 47 full-year target.

To Reduce These Infections We Have….

- Worked as part of a collaborative across the health economy, focussing on urinary catheter care, hydration and urinary tract infection prevention and management.
- Participated in an NHS Improvement-led collaboration. Our quality improvement project 'No More Wee Beasties' developed an educational package for healthcare assistants on catheter care.
- On 18th March 2019 this programme of educational workshops commenced for new healthcare assistants. This will continue for all new healthcare assistants in 2019-20, with a catch-up programme being planned for all existing healthcare assistants.
- Implemented our Key Standards to Prevent Infection.

Launching Our Key Standards To Prevent Infection

Meticillin-Sensitive *Staphylococcus aureus* (MSSA) Bacteraemia	**How Are We Doing?**
	We did not meet our improvement target this year. We reported 24 vs 12 full-year target.

To Reduce These Infections We Have….

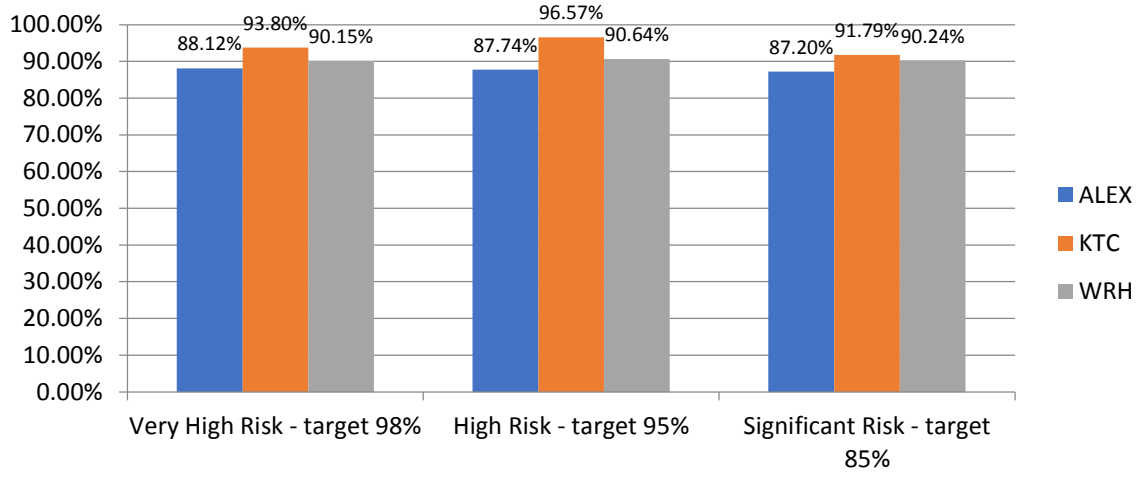
- Increased our focus on care of peripheral cannulae and other invasive devices.
- Aseptic Non-Touch Technique training materials have been purchased in order to implement this training programme in 2019-20, with the aim of improving aseptic care of devices by our staff. A date for the Train the Trainer workshop is being confirmed with the national ANTT Team, and the e-learning materials are being loaded onto the intranet ready for use.
- Reviewed the contents of the peripheral cannula pack, to ensure it has the correct contents to prevent infection.
- Implemented our Key Standards to Prevent Infection.

Criterion 2: Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.

We have focussed significant attention on cleanliness in 2018-19, and have issued a new responsibility framework to ensure all staff know what they are responsible for cleaning, and the frequency of cleaning. This has included regular cleanliness scrutiny meetings to review achievements and further actions needed.

We also implemented a programme of deep cleaning all of our beds and hospital trolleys which will continue into 2019-20, and have had a focus on removing clutter from our hospitals.

We have made improvements, but are not yet where we want to be as demonstrated by the following cleanliness audit scores in March 2019.



In February 2019 we commenced a further piece of work on cleanliness standards, to review our present cleaning arrangements against national standard PAS5748, with actions being taken to ensure we meet all requirements. This includes revising our cleaning schedules and ensuring they are clearly displayed in all areas, and improving the way we report cleaning audits. The work will complete in 2019-20.

In March 2019 we also implemented a programme of cleanliness leadership walkabouts by the DIPC, Deputy DIPC and Cleaning Services Managers to ensure we maintain a senior leadership focus on this important issue.

Criterion 3: Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.

As part of our focus on antimicrobial stewardship (AMS) the Trust has continued to implement recommendations of NICE guideline [NG15][2]: Antimicrobial stewardship: systems and processes for effective antimicrobial medicines use. (National Institute of Health and Care Excellence, 2015) These include:

- A dedicated AMS team including a consultant microbiologist and a specialist pharmacists
- Antibiotic ward rounds and prescribing reviews in high risk areas such as intensive care units and wards with patients with *C. difficile* infections
- Reporting of antimicrobial susceptibilities on culture and sensitivity
- 'Soft stops' on antibiotic prescriptions on inpatient prescription charts to remind prescribers tor review antibiotic courses in a timely fashion
- Evidence-based antimicrobial prescribing guidelines including recommendations on antibiotic choice, dose, frequency, course length and intravenous to oral switch options in an easily accessible format
- AMS teaching for junior doctors and junior pharmacists
- Introduction of Antimicrobial Therapy Review forms for inpatient clinical areas
- Regular review of antibiotic prescribing through quarterly point prevalence surveys

- Implementation of quarterly AMS performance reports to Divisions.

During 2018/19 the Trust participated in the national Commissioning for Quality and Innovation (CQUIN) 2 - Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis), which targets:

- timely review of antibiotic prescriptions (CQUIN 2 c)
- reductions for total antibiotic and carbapenem consumption and an increased proportion of use in narrow spectrum antibiotics (CQUIN 2d).

For CQUIN 2c the Trust met the milestones for quarters 1-3, and Q4 data is awaited.

For CQUIN 2d while carbapenem consumption continued to fall successfully; milestones for reductions in total antibiotic consumption and increase in consumption of antibiotics of the Access group above 43% have not been met.

Antibiotic prescribing point prevalence surveys indicate the ongoing need for improvement in antibiotic prescribing practice, and AMS continues to form part of the Trust 3-year Patient Safety Strategy 2018 – 2021. Targets are set for improvement in carbapenem consumption compared to national benchmarking, for improved compliance with antimicrobial prescribing guidance and for structured documented antimicrobial review.

Criterion 4: Provide suitable accurate information on infections to service users, their visitors and person concerned with providing further support or nursing/medical care in a timely fashion.

We have a range of patient information leaflets available to inform patients about infections they have. This includes leaflets on Norovirus, MRSA and *Clostridium difficile* infection. Our Patient and Public Forum members have worked with us during Feb-March 2019 to help us produce a new leaflet that will be provided to all patients as part of our Key Standards to Prevent Infection initiative. The leaflet sets out information on preventing infection, and provides assurance that our staff have checked the bed-space and it meets the cleanliness standards expected.

We are informing our patients and visitors about our Key Standards to Prevent Infection via pop-up banners and posters, as well as social media information.

Criterion 5: Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.

Our admission process includes assessment of patients for signs of infection. We also have the flowing assessment tools available to reduce the risk of transmitting infection:

- An assessment flowchart for patients with diarrhoea or vomiting, to help staff assess whether it is likely to be due to an infection, and setting out the control measures required to reduce the risk of transmitting infection.
- A priority scoring tool for isolation of common infections, to support correct prioritisation of isolation facilities.
- A management checklist for patient with *Clostridium difficile*, to ensure they receive timely and appropriate treatment.

Our Infection Prevention Team works closely on a daily basis with wards, our site management teams, and our cleaning teams, to ensure patients with infection are rapidly identified, isolated correctly, and addition cleaning is in place as required.

<u>Outbreaks and Incidents</u>

During 2018-19 we identified the following infection outbreaks and incidents:

Incident date	Summary	Learning and Key Actions
June 2018	An outbreak of 3 cases of Vancomycin Resistant Enterococci (VRE), linked by laboratory typing.	- The affected area was emptied, deep cleaned and decontaminated using hydrogen peroxide vapour (HPV). - Environmental sampling was undertaken with no positive samples identified. - Additional focus on hand hygiene and clinical practice. - No evidence of on-going spread to patients.
July 2018	Two patients who sequentially occupied the same side room on a ward found to have VRE colonisation, linked by laboratory typing.	- Additional focus on hand hygiene and clinical practice. - Deep clean and HPV decontamination of side room. - Review took place of the procedure for checking that the room has been correctly cleaned prior to HPV decontamination.
August 2018 – December 2018	Outbreak of Carbapenemase-Producing Enterobacteriaceae (CPE) on a ward. 25 patients identified	- Extensive actions linked to environmental refurbishment and decontamination including deep cleaning and full HPV decontamination of ward. - Full sink survey with replacement of all damaged sinks and regular bleaching of sink drains. - Routine CPE screening of all inpatients on the

Incident date	Summary	Learning and Key Actions
	who were carrying CPE.	ward. - CPE screening expanded to other high-risk areas of the trust. - Learning informed updated Trust policies and procedures. - Health-economy wide learning event held to share learning. - Input of our learning to the current revision of the national CPE guidelines.
August 2018	Outbreak of CPE on a ward, with 4 affected patients.	- Extensive programmed of environmental auditing and monitoring. - Full sink survey with replacement of all sinks that were not of optimal design. - Full refurbishment of ensuite shower room for one of the bays. - Routine CPE screening of all inpatients on the ward, providing assurance that outbreak control measures had stopped on-going spread of infection.
November 2018	Outbreak of CPE on a ward, 5 cases of CPE colonisation linked to the ward	- Environmental sampling for CPE performed. All samples negative for CPE. - Ward was closed; rolling programme of HPV cleaning prior to re-opening took place. - Routine CPE screening for all inpatients on the ward; no further acquisitions found following reopening of the ward. - On-going screening to monitor for long-stay patients
November 2018	Outbreak of *C. difficile* on a ward; 2 patients with hospital acquired *C. difficile* infection, linked by ribotyping.	- Area has a rolling deep clean and curtain change. - Environmental and antibiotic auditing to ensure high standards of practice and cleaning. - On-going surveillance for cases of *C. difficile* linked to this area.
March 2019	Outbreak of VRE in an intensive care unit; 9 patients affected	- Focus on hand hygiene and clinical practices. - ITU received full deep clean and HPV decontamination. - MHRA investigation into Drager patient ventilator units. - Dyson fans removed from clinical areas. - Pillows which have sealed seams and are impervious to fluids sourced by procurement for the wider Trust - On-going programme of VRE screening in place.

In addition to these, the Trust has had a number of bays on various wards closed at different points during winter 2018-19 due to Norovirus and Influenza. There have been managed in accordance with protocol, with increased cleaning, and isolation of patients and closure to admission of affected areas.

Criterion 6: Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infections.

The DIPC has taken a continuing strong lead on infection prevention and control throughout 2018-19. During the year we have focussed on embedding our weekly '*Back to the Floor Friday*' programme, where all senior nurses including the Chief Nursing Officer work alongside clinical teams on our wards and departments. This programme is helping ensure highly visible senior nursing leadership, with senior nurses able to support staff achieve improved infection prevention standards as part of the programme.

To support our Key Standards launch we are implementing the national 'Aseptic Non-Touch Technique' (ANTT) training programme, to improve the care of patients with invasive devices such as intravenous drips and catheters.

We have a programme of training on infection prevention at staff induction and as part of mandatory training. Level 2 training is for all clinical staff, and Level 1 training is for all other staff. We have continued to work towards achieving our 90% compliance target in 2018-19, with clear communication of expectations by the Chief Nursing Officer/DIPC and Chief Medical Officer to all staff. At end March 2019 level 1 compliance = 87.23%, and level 2 training compliance = 78.82%.

Infection prevention sessions delivered for Trust Induction and for mandatory training have been revised to ensure they are comprehensive and up to date in support of this.

An active infection prevention link staff programme has been run throughout the year, with an annual conference held in April 2018, and regular meetings through the year. These staff receive education and support so that they can act as a local source of infection prevention knowledge and expertise within wards and departments.

They received a presentation as part of the proactive launch of the Key Standards to Prevent Infection in February 2019, and are supporting the implementation of the standards at clinical level.

Criterion 7: Provide or secure adequate isolation facilities.

Isolation for infection prevention reasons means caring for someone in a single room, preferably with ensuite toilet and washing facilities.

Across the Trust we have 137 single rooms, which is 17% of our hospital beds. Of these, 109 are ensuite equalling 13.5% of our beds. These rooms are routinely used for isolation purposes.

We have infection assessment tools for patients on admission, and if common symptoms of infection such as diarrhoea develop during admission. These are used by staff to identify people who need isolation due to likely infection.

Criterion 8: Secure adequate access to laboratory support.

We have our own on-site microbiology laboratory, based at Worcestershire Royal Hospital. This provides a full range of microbiology services, linking with the national reference laboratory network for specialised testing which cannot be performed locally. The laboratory is UKAS accredited, confirming it operates an effective and quality controlled system.

Criterion 9: Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.

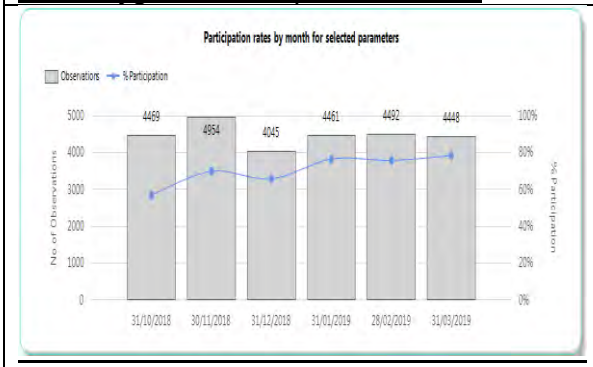
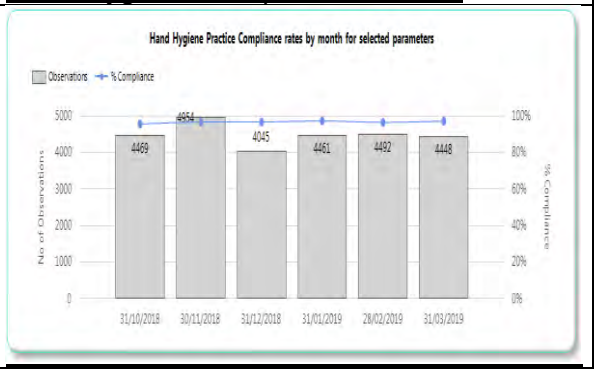
A programme of policy revision commenced in March 2019, with further revision of the cleaning policy which is in progress, agreement to adopt the new national Standard Precautions; hand hygiene and use of PPE policy (2019) which we formally launched in April 2019, and revision of the Management of Infection Control Policy, which was approved in April 2019.

We have a range of policies in place across the Trust, though a significant number require detailed review. TIPCC has received an update on the position and agreed to support a plan to map our existing policies to Hygiene Code Criterion 9 requirements, to ensure there are no omissions. Following this mapping exercise during 2019 we will prioritise policies for detailed review using a risk-based approach, with clear timescales for progression. The review process will ensure all documents are fully up-to-date and in line with the best available evidence.

We are working to ensure there is a robust monitoring and assurance framework in place for the Key Standards which will include monitoring of a number of policies contained within the standards. This builds on our existing audit programme which includes hand hygiene and cleanliness.

We have focussed on hand hygiene during 2018-19, increasing routine participation in audits up to 78% of clinical areas, with an achievement score of 97% in March 2019.

Hand Hygiene Achievement: March 2019

Hand Hygiene Participation 78.51%	Hand Hygiene Compliance 97.23%
	

Criterion 10: Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.

We have an Occupational Health Service which supports the health and wellbeing of our staff across the Trust, as well as supporting our PFI contractors' staff. The service has a programme of staff health assessment to ensure staff are both protected from infectious disease by vaccination, and are screened as required on employment to ensure they do not pose an infection risk to patients.

Our staff influenza vaccination programme in 2018-19 achieved 76% of staff vaccinated. This met the national standard of 75%.

Our Plan for 2019-20

Our aim is to achieve excellent infection prevention standards, and very low rates of infection, and we know there is more work to do before we achieve this.

In 2019-20 we will continue our focus on hand hygiene, complete our review of cleaning standards, implement the ANTT training programme, revise our policies and procedures to ensure they are in line with the best evidence, and strengthen our audit and monitoring framework in relation to infection prevention practices. Running alongside this will be a strengthened review process for cases of *Clostridium difficile* infection, with a more structured framework to share learning across the Trust and speed up our improvements.

To deliver these improvements we are implementing a comprehensive annual infection prevention improvement plan for 2019-20, which focuses on our '*Key Standards to Prevent Infection*' along with the other core actions we must take to achieve our aim. The plan is contained in Appendix A.

References

1. The Health & Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance (2015). https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/449049/Code_of_practice_280715_acc.pdf

2. National Institute for Health and Care Excellence (2015). Antimicrobial stewardship: systems and processes for effective antimicrobial medicine use. *www.nice.org*

APPENDIX A: WAHT Infection Prevention Improvement Plan 2019-20

WAHT Statement of Intent

The prevention of infection is a key priority for Worcestershire Acute Hospitals NHS Trust.

**The Trust is committed to achieving excellent infection prevention practices,
and aims to be one of the best organizations in the UK for our rates of infection.**

This will be achieved through continuing and determined focus on improving clinical practices, antimicrobial prescribing and the environment of care, and by continually improving the knowledge of our staff so that they can achieve excellent standards of infection prevention practice.

This improvement plan supports delivery of the WAHT Quality Improvement Strategy and plan 2019-20. It sets out the objectives and actions that will be taken across WAHT to achieve our ambition to be one of the best organizations in the UK for our rates of infection, and to ensure compliance with Care Quality Commission Standards and the Hygiene Code (2015).

WAHT Infection Prevention Priority Aims 2019-20

In 2019-20 WAHT will;

1. Strengthen governance and assurance in relation to infection prevention across the Trust, to demonstrate compliance with the *Code of Practice on the prevention and control of infection and related guidance (2015)* - 'the Hygiene Code'.
2. Achieve national improvement targets for healthcare-associated infections and antimicrobial prescribing, with the ambition to improve beyond these targets.
3. Benchmark within the best quartile for surgical site infections monitored through the mandatory surveillance programme.
4. Participate in other non-mandatory programmes of surveillance in order to benchmark and improve across a range of areas.

Key Issues and Elements for Focus

Focus: Infections

- *Clostridium difficile* infection
- *Staphylococcus aureus* bacteraemia, including MRSA
- E coli and other gram-negative bacteraemia
- Tuberculosis, Influenza & other vaccine preventable diseases
- Multi-Drug Resistant Organisms, including Vancomycin Resistant Enterococci and Carbapenemase Producing Enterobacteriaceae
- Surgical site infections
- Urinary Tract infections, including those related to urinary catheters
- *Pseudomonas aeruginosa* in augmented care
- Preparedness for Ebola, MERS, Plague and other novel or emerging infections
- Norovirus

Priority Elements of Improvement Programme

- Hand hygiene and bare below elbows
- Environmental Cleanliness
- Decontamination of medical devices
- Prescribing of antimicrobial agents and proton pump inhibitors
- Key standards to prevent infection
- Aseptic non-touch technique
- Policy development, staff training and competence to support implementation
- Audit and monitoring of policies, facilities and key practices
- Sharps safety & waste management
- MRSA, CPE and other MDRO screening and MRSA decolonisation
- Implementation of care bundles; specific focus on invasive devices, wounds
- Isolation facilities, including negative pressure facilities, and practices
- Refurbishment of facilities; fabric of the estate
- Emergency preparedness for annual threats, and novel/emerging infections
- Public involvement and information provision for patients, visitors and the public
- Collaborative working across secondary, primary and community care
- Research & development opportunities to improve local practices and knowledge

Drivers: Guidance, Standards, Reports

- Patient feedback
- Learning from incidents and outbreaks
- CQC Standards, and the Hygiene Code (2015)
- National guidance on MRSA & CPE prevention, TB, Influenza
- National guidance on infection prevention practices: epic3
- NICE Quality Standard 113 (2016), Quality Standard 49 (2013) and Quality Standard 61 (2014)
- UK Five-Year Antimicrobial Resistance Action Plan (2019-2024)
- National Standards for Cleaning (2007) and PAS5748 (2014)
- Safer Sharps legislation, H&SaW Act

Key Objectives

	Objective	Monitoring
1.	***Clostridium difficile* infection** • The number of new cases of Trust-attributable *Clostridium difficile* infection will meet the national target: no more than 53	Monthly via TIPCC and Performance reporting
2.	***Staphylococcus aureus* bacteraemia** • There will be no Trust-attributable cases of MRSA bacteraemia. • The number of new cases of Trust-attributable MSSA bacteraemia will meet the national target: no more than 10 cases per annum	Monthly via TIPCC and Performance reporting
3.	**E coli bacteraemia** • The number of E coli bacteraemia will reduce, to achieve the national target: no more than 37 cases	Monthly via TIPCC and Performance reporting
4.	**Carbapenemase-Producing Enterobacteriaceae (CPE) and other multi-drug resistant organisms** • There will be no detected Trust transmission of CPE or other MDRO during the year • Screening programmes will be in place in key departments with at least 95% compliance with the screening programme	Quarterly via TIPCC
5.	**Antimicrobial prescribing** • More than 90% of antibiotic prescriptions are in line with prescribing guidance or specialist advice • More than 80% of antibiotic prescriptions are reviewed within 72 hours of initiation • Reduce Carbapenem consumption to benchmark within the 50th centile in England	Quarterly via Medicines Safety Committee
6.	**Surgical Site Infections** • The Trust will achieve a 95% return rate for mandatory surveillance, and will benchmark within the best quartile for mandatory surgical site infections • Surveillance programmes will be implemented, beyond the national mandatory surveillance programme; with evidence of benchmarking and improvement	Quarterly via Surgical Division Governance Group, and to TIPCC
7.	**Norovirus & Influenza Preparedness** • The Trust will be appropriately prepared for infection emergencies, including large outbreaks in hospitals, and new or emerging infections with significant public health implications	Bi-Annually via TIPCC
8.	**Key Standards To Prevent Infection** • All areas will achieve the minimum compliance set out in our WAHT Key Standards to Prevent Infection. • This includes hand hygiene performed consistently by staff in accordance with the World Health Organisation '5 moments for hand hygiene' at least 95% of the time	Monthly via TIPCC and Divisional Governance Groups

	Objective	Monitoring
9.	**Cleanliness & Care Environments** • All areas across WAHT will consistently meet or be above the national minimum standards for cleanliness, as set out in the Key Standards to Prevent Infection. • Environments will support effective infection prevention, by complying and being maintained in compliance with relevant Health Building Notes, and Health Technical Memoranda. • Water safety and the safety of critical ventilation systems will be maintained.	Monthly via TIPCC, and PEOG
10.	**Decontamination of Medical Devices** • Medical devices will not pose a risk of infection to patients; they will be single-use or decontaminated effectively in compliance with HTM 01-01 and 01-06.	Quarterly via TIPCC
11.	**Staff Training and Competence** • All staff will possess the knowledge, skills and competence needed to practice safely and minimize risk of infection, and this will be reflected in key standards audits; in particular all relevant staff will be trained and competent in ANTT, and statutory and mandatory training: 90% minimum.	Monthly via TIPCC and Divisional Governance Groups
12.	**Patient & Public Involvement** • Patients, visitors and the public will be informed about and involved in infection prevention. Information on the internet will be developed and improved.	Annual review by TIPCC
13.	**Research & Development** • New and novel programmes of work will be identified and progressed in support of the ambition of the Trust, to achieve very low rates of infection, and excellent standards of infection prevention practice.	Annual review by TIPCC

Governance & Management

The WAHT Improvement Plan comprises this corporate plan, which underpins, integrates and influences improvement plans in the Divisions and the corporate Infection Prevention Team. Lead responsibility and accountability for local plans rests with Divisional Management Teams. Progress with this programme will be monitored via the Trust Infection Prevention & Control Committee, chaired by the Executive Director of Nursing & Midwifery/DIPC. Updates will be provided to the Trust Management Executive and the Quality Governance Committee, and to the Board as part of regular reporting in place. Progress with local plans and escalated issues will be monitored and managed via Divisional governance meetings, and updates will also be provided to the Trust Infection Prevention & Control Committee.

Approval: Trust Infection Prevention & Control Committee **Date: 29th April 2019**

Detailed Improvement Action Plan to Achieve Objectives

	Action	Lead	Monitoring	Summary of Progress	Trust Objective	Hygiene Code
Governance and Assurance						
1.	The TIPCC cycle of business will be reviewed for 2019-20, to ensure all elements of the annual programme are incorporated in reporting, and that all elements of the Hygiene Code receive scrutiny from TIPCC.	Deputy DIPC	Quarterly by TIPCC		All	Criterion 1
2.	The cover paper for TIPCC will be revised to ensure all items are specifically linked to relevant Hygiene Code criteria and to the risk register.				All	Criterion 1
3.	Divisional and other reports to TIPCC will be revised during the year to ensure they provide increased assurance on actions being taken, and the outcomes of those actions.				All	Criterion 1
4.	Implement a programme of Challenge and Confirm meetings with Divisions to review key infections, to increase scrutiny on actions being taken to address any lapses in care and poor standards identified.				Obj 1	Criterion 1
5.	Review current TIPCC risk register; ensure up-to-date				All	Criterion 1
6.	Revise Hygiene code self-assessment, and map evidence to provide assurance				All	Criterion 1
7.	Agree revised process for CDI reviews, so that there is Divisional leadership of reviews and actions required.				Obj 1	Criterion 1
Infection Prevention Team						
8.	Revise team structure and senior roles to ensure single, co-ordinated structure in place.	Deputy DIPC	Via regular management		All	Criterion 1

	Action	Lead	Monitoring	Summary of Progress	Trust Objective	Hygiene Code
9.	Key objectives for Infection Prevention Nurses at each band agreed and added to personal objectives, linked to Key Standards, annual programme and IPS competences.		meetings with DIPC/CNO		All	Criterion 1
10.	Individual and team development plan and programme in place; formal and informal opportunities; including networking, shadowing, IPS opportunities, and team masterclass programme, with reflective learning accounts.				All	Criterion 1
11.	Revise job descriptions to ensure reflect required roles, and align to IPs competences.				All	Criterion 1
Cleanliness and Environment						
12.	Complete the gap analysis against PAS5748, and implement actions to ensure compliance	Head of Facilities	Monthly via PEOG/TIPCC		Obj 8, 9	Criterion 2
13.	Increase scrutiny via challenge and confirm meetings, leadership walkabouts and TIPCC.	Deputy DIPC			Obj 8, 9	Criterion 2
14.	Implement continuing bed and trolley deep-clean programme	Head of Facilities			Obj 8, 9	Criterion 2
15.	Strengthen assurance on completed actions following cleanliness audits	Divisional Directors of Nursing/Head of Facilities			Obj 8, 9	Criterion 1, 2
16.	Deliver ‘Clear the Clutter’ campaigns x 2 per annum	Head of Facilities			Obj 8, 9	Criterion 2
17.	Implement use of Ultra-Violet-C decontamination technology	Deputy DIPC			Obj 8, 9, 13	Criterion 2
18.	Review demand vs capacity for isolation rooms, possible solutions to capacity constraints and plans to deal with surges in demand for isolation beds	Deputy DIPC			Obj 1, 4, 7, 13	Criterion 5, 7

	Action	Lead	Monitoring	Summary of Progress	Trust Objective	Hygiene Code
19.	Refurbishment of various wards and departments will continue as part of a Trust programme.	Deputy COO			Obj 9	Criterion 1, 2
Hand Hygiene						
20.	Implement a focused awareness campaign, as part of key standards programme	Deputy DIPC	Monthly via TIPCC		Obj 8, 11	Criterion 6, 9
21.	Planned programme of ward-based practice hand hygiene training to be delivered				Obj 8, 11	Criterion 6, 9
22.	Improve accessibility of hand hygiene training data, and audit data to be available				Obj 8, 11	Criterion 6, 9
23.	Monthly hand hygiene audit on all wards with monthly review of compliance to be achieved				Obj 8, 11	Criterion 6, 9
24.	Review additional training aids and other technologies to actively engage staff in hand hygiene				Obj 8, 11, 13	Criterion 6, 9
Policy Review						
25.	Summary policy review programme in place to track policies and ensure none go out-of-date; overview via TIPCC.	Deputy DIPC	Bi-monthly via TIPCC		All	Criterion 1, 9
26.	Lead responsibility for policy development programme and accountability for delivery clearly identified within IPT, and added to personal objectives.				All	Criterion 1, 9
27.	All policies reviewed against the current evidence-base for practice, with approval of updates via TIPCC; programme prioritised based upon those out of date and issues arising from clinical practice.				All	Criterion 1, 9
28.	Launch of 'policy on a page' for each policy to assist clinical staff understanding				Obj 11	Criterion 6, 9
29.	Review uniform and dress code policy and strengthen IP aspects, including bare below elbows. Development of posters and pop-up banners to emphasise restrictions on wearing of theatre scrubs.				Obj 11	Criterion 6, 9
Audit and Monitoring						
30.	Rolling audit programme through 2019-20 focussed on	Divisional	Monthly via		Obj	Criterion

	Action	Lead	Monitoring	Summary of Progress	Trust Objective	Hygiene Code
	monthly audit to achieve Key Standards.	Directors of Nursing	Divisional reports to TIPCC		8, 9, 11	1, 9
31.	Key Standards embedded within metrics for 'Pathway to Platinum' ward accreditation programme	Deputy CNO			Obj 8, 9, 11	Criterion 1, 9
32.	Revision and relaunch of care bundles for key invasive devices and chronic wounds, with monitoring programme.	Deputy DIPC			Obj 8, 9, 11	Criterion 1, 9
33.	Review output of results provided. Informatics support to ensure data available on WREN – improve accessibility.	Deputy DIPC			Obj 8, 9, 11	Criterion 1, 9
34.	Strengthen scrutiny on post-audit actions, to ensure evidence of actions taken to deliver improvement 'closing the loop'. Feed into governance process and TIPCC.	Divisional Directors of Nursing			Obj 8, 9, 11	Criterion 1, 9
35.	Commence programme of surgical ward round clinical sessions, to feedback to surgical teams on practice.	Deputy DIPC/Divisional Medical Director - Surgery			Obj 6, 8, 9, 11	Criterion 9
Education & Training						
36.	Revise induction and statutory & mandatory IP training; ensure all IPT staff delivering sessions are trained to do this and core session plan is in place and followed.	Deputy DIPC	Quarterly via TIPCC		All	Criterion 1, 6
37.	Develop programme of ward-based microteaching on policies; linked to Key Standards and policy revision programme.				Obj 1, 2, 3, 4, 7, 8, 9, 11	Criterion 1, 6
38.	Review link staff programme and strengthen role using evidence-base on delivering effective programmes, align to Key Standards work.				Obj 1, 2, 3, 4, 7, 8, 9, 11	Criterion 1, 6
39.	Review all other current IP training; ensure it is relevant, evidence-based and delivered in line with agreed programmes.				Obj 1, 2, 3, 4, 7, 8, 9, 11	Criterion 1, 6
Asepsis						

	Action	Lead	Monitoring	Summary of Progress	Trust Objective	Hygiene Code
40.	Implement ANTT programme: ED blood culture work as WAHT pathfinder work, then full implementation across Trust.	Deputy DIPC	Quarterly via TIPCC		Obj 6, 8, 11, 13	Criterion 6, 9
41.	Agree implementation programme using e-learning plus local competency assessor network, with programme of competency assessor training sessions in place.				Obj 8, 11	Criterion 6, 9
42.	ANTT to become part of S&M training for all relevant staff.				Obj 6, 8, 11	Criterion 6, 9
43.	Evaluate impact of ANTT implementation				Obj 8, 11, 13	Criterion 6, 9
Water Safety & Ventilation						
44.	Review arrangements for water safety and water safety plan with RP(W) and AE(W).	Head of Estates	Monthly via Water Safety Group		Obj 9	Criterion 1, 2
45.	Review and strengthen if necessary arrangements for assurance on ventilation standards.	Head of Estates	Quarterly via Critical Ventilation systems Group		Obj 9	Criterion 1, 2
Decontamination of Medical Devices						
46.	Confirm and strengthen leadership arrangements for decontamination.	Deputy DIPC	Bi-monthly by Decon-tamination Committee		Obj 6, 10	Criterion 1, 2, 9
47.	Review policies in place, and strengthen current monitoring arrangements for decontamination.				Obj 10	Criterion 1, 2, 9
48.	Programme of visits to units performing decontamination of invasive devices, to spot-check standards.				Obj 6, 10	Criterion 1, 2

	Action	Lead	Monitoring	Summary of Progress	Trust Objective	Hygiene Code
49.	Development and implementation of audit programme for all units performing decontamination of invasive devices.				Obj 6, 10	Criterion 1, 2, 9
Antimicrobial prescribing						
50.	Relaunch antimicrobial therapy review forms to encourage timely review of prescribed antibiotic therapy within 72 hours of initiation and documented outcome of review and therapy plan.	Antimicrobial Pharmacist & Lead Consultant Microbiologist for antimicrobial prescribing	Quarterly via Medicines Safety Committee		Obj 5	Criterion 1, 3, 5, 9
51.	Re-design inpatient prescription chart to prompt for timely antibiotic therapy review after 72 hours.				Obj 5	Criterion 1, 3, 5, 9
52.	Quarterly point prevalence surveys of inpatient antibiotic prescribing to assess quality and quantity antibiotic prescribing.				Obj 5	Criterion 1, 3, 5, 9
53.	Quarterly reports of antimicrobial stewardship performance to clinical divisions for action planning, as required.				Obj 5	Criterion 1, 3, 5, 9
54.	Review of secondary care antimicrobial prescribing guidelines with the aim to reduce co-amoxiclav use in at risk groups.				Obj 5	Criterion 1, 3, 5, 9
55.	Continue junior doctor education in relation to management of infections and antimicrobial stewardship; identify e-learning to support this.				Obj 5, 11	Criterion 1, 3, 6, 9
56.	Identify and implement suitable e-learning programme for consultants, other senior doctors and independent prescribers.				Obj 5, 11	Criterion 1, 3, 5
57.	Identify suitable e-learning or training for nurses who administer antimicrobials, to increase awareness of their				Obj 5, 11	Criterion 1, 3, 5

	Action	Lead	Monitoring	Summary of Progress	Trust Objective	Hygiene Code
	role in antimicrobial stewardship.					
58.	Agree and implement package of measures to raise awareness and reduce avoidable PPI use in hospital.				Obj 1, 5, 11	Criterion 1, 3, 5, 9
59.	Develop and implement a programme of clinically-led ward-based antimicrobial audit, in line with Start Smart Then Focus principles.				Obj 5	Criterion 1, 3, 9
Multi-Drug Resistant Organisms						
60.	Screening for CPE and MRSA will be audited during the year in key departments to ensure high compliance.	Divisional Directors of Nursing	Bi-annually via TIPCC		Obj 2, 4	Criterion 5, 9
61.	The CPE policy will be revised in line with new national guidance once it is released during 2019.	Deputy DIPC	Bi-monthly via TIPCC		Obj 4	Criterion 5, 9
62.	Policy for Tuberculosis will be reviewed to ensure it is in line with national guidance, including for MDR-TB.				Obj 4	Criterion 5, 9
E coli Bacteraemia						
63.	The catheter care training workshop will be delivered to all healthcare support workers across the Trust.	Lead Nurse – Infection Prevention	Quarterly via TIPCC		Obj 3, 8, 11	Criterion 6, 9
64.	The Trust will actively participate in the Gram-negative bloodstream infection health economy collaborative.	Deputy DIPC	Quarterly via TIPCC		Obj 3, 4, 8	Criterion 4, 5, 6
65.	A programme to improve hydration awareness and prevent urinary tract infection will be delivered.	Nutrition/Hydration Lead	Quarterly via TIPCC		Obj 3, 4, 8, 11	Criterion 4, 6
Surveillance of Infection, including Surgical Site Infections (SSI)						
66.	Alert organism and alert condition infection surveillance will be routinely performed to identify infection risks, and hotspots.	Deputy DIPC	Monthly via TIPCC		Obj 1, 2, 3, 4, 6, 7	Criterion 1, 5

	Action	Lead	Monitoring	Summary of Progress	Trust Objective	Hygiene Code
67.	The ICNet system will be upgraded to ensure it supports all surveillance requirements.				Obj 1, 2, 3, 4, 6, 7	Criterion 1, 5
68.	Mandatory surveillance of SSI will take place, with review of results.	Divisional Management Team –Surgery			Obj 6	Criterion 1, 5
69.	There will be active participation in the GIRFT surgical site infection surveillance programme.	Divisional Management Team - Surgery			Obj 6	Criterion 1, 5
Emergency Preparedness for Infections						
70.	Norovirus preparedness arrangements will be reviewed during summer 2019.	Deputy DIPC	Bi-annually via TIPCC		Obj 7	Criterion 5, 9
71.	Influenza preparedness arrangements will be reviewed during summer 2019.				Obj 7	Criterion 5, 9
72.	Preparedness for new and emerging infections, and high-consequence infections (i.e: Ebola) will be reviewed.				Obj 7	Criterion 5, 9
Information and Public Involvement						
73.	All patients will receive a leaflet on admission, providing key information and confirming their bed-space is clean.	Divisional Directors of Nursing	Quarterly via TIPCC		Obj 8, 12	Criterion 4
74.	The range of patient information leaflets available will be reviewed.	Deputy DIPC			Obj 12	Criterion 4
75.	The involvement and voice of Patient and Public Forum members in infection prevention and cleanliness activities will be strengthened.				Obj 8, 9, 12	Criterion 1, 4
Research & Development						
76.	Collaboration with Bangor University to develop and deliver the Infection Prevention MOOC will continue, with	Deputy DIPC	Quarterly via TIPCC		Obj 11, 13	Criterion 6

	Action	Lead	Monitoring	Summary of Progress	Trust Objective	Hygiene Code
	participation of WHAT staff encouraged.					
77.	Implementation of the ANTT programme across WAHT will be formally evaluated.				Obj 8, 13	Criterion 6, 9
78.	A range of locally-led quality improvement projects will be in place across WHAT.				Obj 8, 11	Criterion 6, 9
79.	Other opportunities to participate in R&D activities will be taken wherever possible.				Obj 13	Criterion n/a

Approval: Trust Infection Prevention & Control Committee **Date: 29th April 2019**

Worcestershire Acute Hospitals NHS Trust

Meeting	Trust Board
Date of meeting	11 July 2019
Paper number	H2

Safeguarding Adults, Children & Young People Annual Report April 2018 – March 2019

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

Accountable Director	V Morris Chief Nurse Executive Lead Safeguarding & PREVENT		
Presented by	V Morris Chief Nurse	**Author /s**	D Narburgh Head of Safeguarding

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
Safeguarding Committee	20.06.2019	Approved
Clinical Governance Group	02.07.2019	Approved
Trust Management Executive	19.07.2019	Approved
Quality Governance Committee	20.07.19	Approved

Recommendations	The Safeguarding Annual Report highlights the work undertaken over the last year to provide assurance to the Trust Board and its associated Governance Committees that The Trust Board are asked to note: • Worcestershire Acute Hospitals NHS Trust (WAHT) is fulfilling its legal and statutory obligations in relation to the safeguarding of vulnerable adults, children & young people whom access services from the Trust. • The Trust Board are asked to endorse the Safeguarding Annual Report 2018/19 and forward plan for 2019/20.
Executive summary	• A significant programme of work has been undertaken by the integrated safeguarding team to strengthen and improve the robustness of safeguarding processes across the Trust in 2018/19. • Developments undertaken over 2018/19 period have moved the Safeguarding Committee from a position of offering limited assurance, to that of being able to offer the Trust Board moderate assurance in relation to the safeguarding agenda.

- Over the last year, the Trust has worked as a statutory partner agency with the Worcestershire Safeguarding Children's Board and the Worcestershire Safeguarding Adults Board in respect of the following :
  - WAHT has contributed to 2 Safeguarding Adult Reviews (SAR) during 2018/19. Both of these are currently in progress. The Trust has undertaken scoping with other agencies into a further 9 cases which have either not progressed to a SAR or are currently subject to review.
  - WAHT has contributed to 1 Domestic Homicide Review (DHR) (Staffordshire) which is in the final stages of report approval, and scoping undertaken for 1 further DHR (Wales).

In relation to this activity, the Trust currently has no outstanding ***single agency*** action plans in relation to the above SAR or DHR.

Multi agency learning in relation to transphobic hate crime has been incorporated into existing safeguarding training packages.

- The revised, Working Together 2018 introduced a new requirement to undertake a multi-agency 'Rapid Review' whenever a notification of a serious incident is received.
- The Trust has undertaken scoping in relation to 3 rapid reviews – none of which has progressed to a full SCR.
- WAHT has contributed to 2 Serious Case Review (SCR) /Rapid Review during 2018/19 and a further case which was progressed as a learning review.

The Trust currently has 2 single agency actions outstanding from previous SCR, which are scheduled for completion by end quarter 1 2019/20.

Trust wide learning and Continuous improvement
Learning (single agency and multi-agency) is shared via the Safeguarding Committee, Safeguarding Champions, Safeguarding Adult & Children training; and published learning briefs containing key messages are all available on the Trust intranet Safeguarding training pages for staff to access.

The Head of Safeguarding, Designated Nurse for Safeguarding Adults and Children Mental Capacity Act Lead (NHS Herefordshire Clinical Commissioning Group, NHS Redditch and Bromsgrove Clinical Commissioning Group, NHS Wyre Forest Clinical Commissioning Group, NHS South Worcestershire Clinical Commissioning Group) noted the following in response to the annual report and the improvements made over 2018/19:

"A very comprehensive Annual Report….
Safeguarding Training data-demonstrates an improving picture across different levels. Particularly highlights the significant improvement in

Meeting	Trust Board
Date of meeting	11 July 2019
Paper number	H2

	medical and dental compliance. *Identifies strengths, areas of development and actions taken to address. 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. I attend these committee meetings (or one of the Deputy Designated Nurses will attend in my absence) to provide support and challenge.* *The Trust has a robust forward plan which recognises the key areas for development."*

Risk									
Key Risks	*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*								
Assurance	This report offers moderate assurance in relation to the Safeguarding of Adults, Children and Young People who may access services from WAHT								
Assurance level	**Significant**		**Moderate**	X	**Limited**		**None**		
Financial Risk	N/A								

Meeting	Trust Board
Date of meeting	11 July 2019
Paper number	H2

Introduction/Background

Adults, children and young people who need help and protection deserve high quality and effective support as soon as a need is identified. In order to achieve this, we need a system that is responsive to the needs and interests of adults, children and families, and in order to achieve this, practitioners need to be clear about what is required of them individually, and how they need to work together in partnership with others in order to achieve positive outcomes and protect the most vulnerable within our society.

The Children Act 2004, as amended by the Children and Social Work Act 2017, strengthens this already important relationship by placing new duties on key agencies in a local area. Specifically the police, clinical commissioning groups and the local authority are under a duty to make arrangements to work together, and with other partners locally, to safeguard and promote the welfare of all children in their area (Working Together, revised 2018).

The Care Act 2014 sets out a clear legal framework for how local authorities and other parts of the system should protect adults at risk of abuse or neglect.

The Safeguarding Committee acts as a conduit for all safeguarding matters in relation to safeguarding adults, children and young people.

Issues and options

3.0 Regulation
Care Quality Commission (CQC)

Between 23rd January and 22nd March 2018 the CQC inspected six of the core services provided by Worcestershire Acute Hospitals NHS Trust across Worcestershire Royal Hospital, Alexandra Hospital and Kidderminster Hospital and Treatment Centre. The CQC inspected urgent and Emergency care, Surgery, Maternity (at the Worcestershire Royal Hospital only), services for Children and Young People, Outpatients, and Diagnostic Imagining. During the November 2016 inspection, these core services were rated either as inadequate or requires improvement. The CQC also inspected the well-led key question between 26th and 28th February 2018. A full report of findings was published on the 5th June 2018.

In terms of areas for improvement identified for the Trust, a number of 'must' and 'should ' dos were identified under regulation 13: Safeguarding service users from abuse & improper treatment.

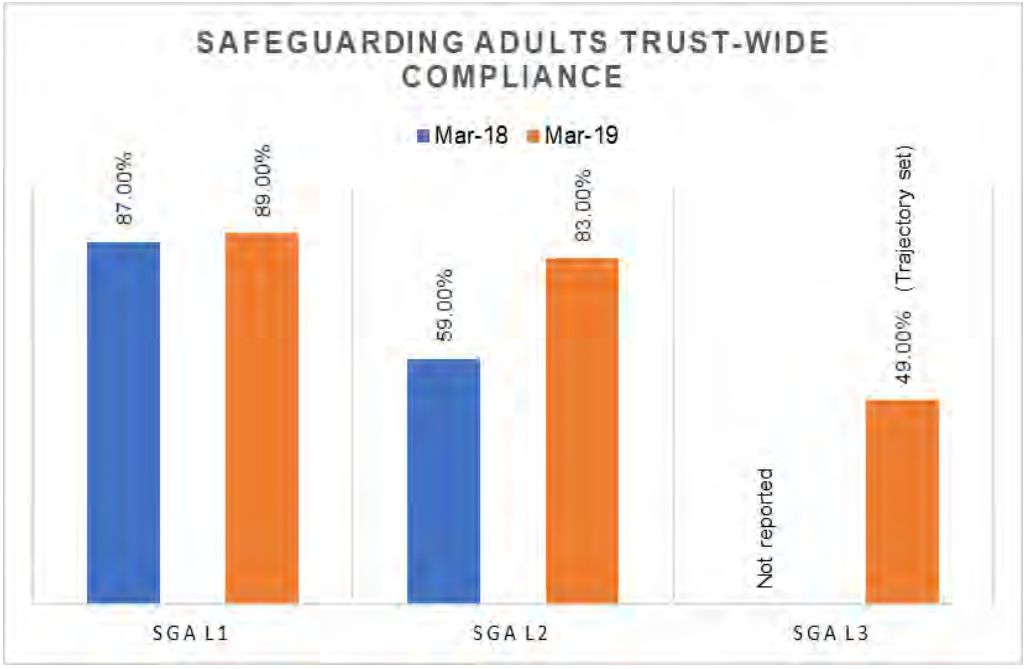
3.1 CQC 'Must do's':

3.1.1 Safeguarding Training Compliance

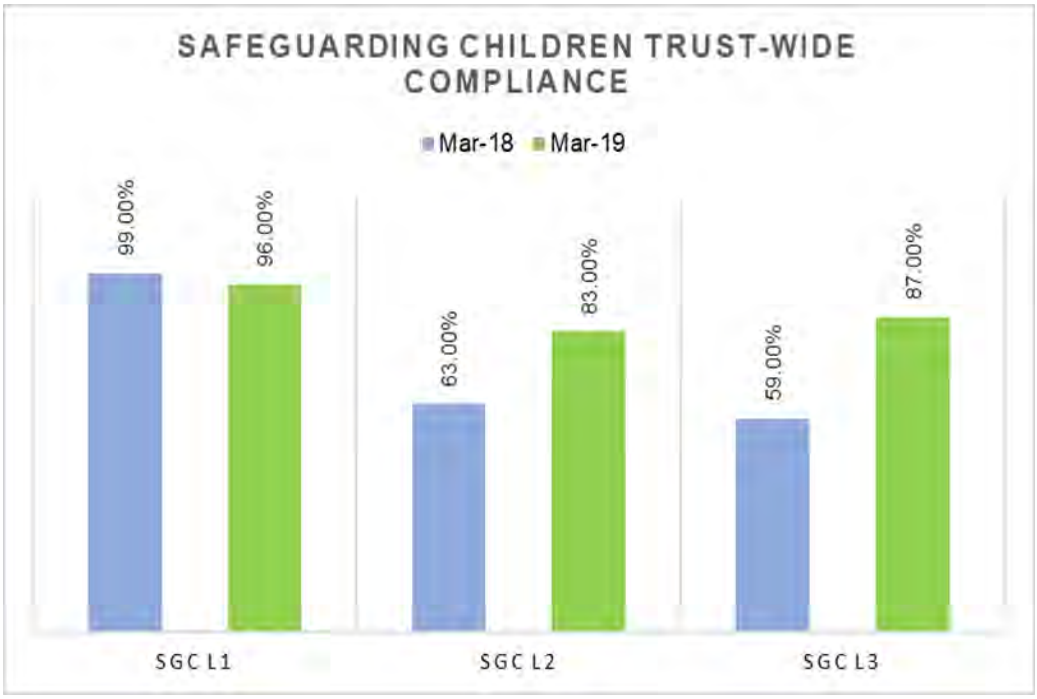
•*The Trust must ensure all staff receive and complete their required mandatory training, including safeguarding and Mental Capacity Act 2005 training.*
•*The Trust must ensure all medical staff are trained to the required level of safeguarding for both children and adults:*

The Trustwide position for all levels of safeguarding training has shown significant improvement over 2018/19 Trustwide and within the medical and dental staff group. Comparison with the 2018/19 outturn position is detailed below:

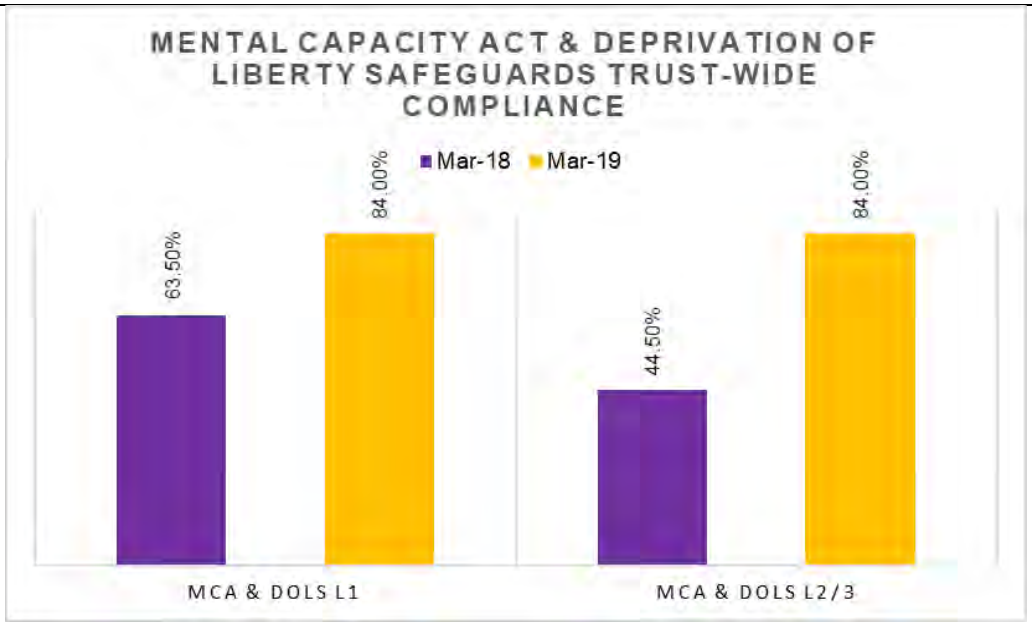
Meeting	Trust Board
Date of meeting	11 July 2019
Paper number	H2



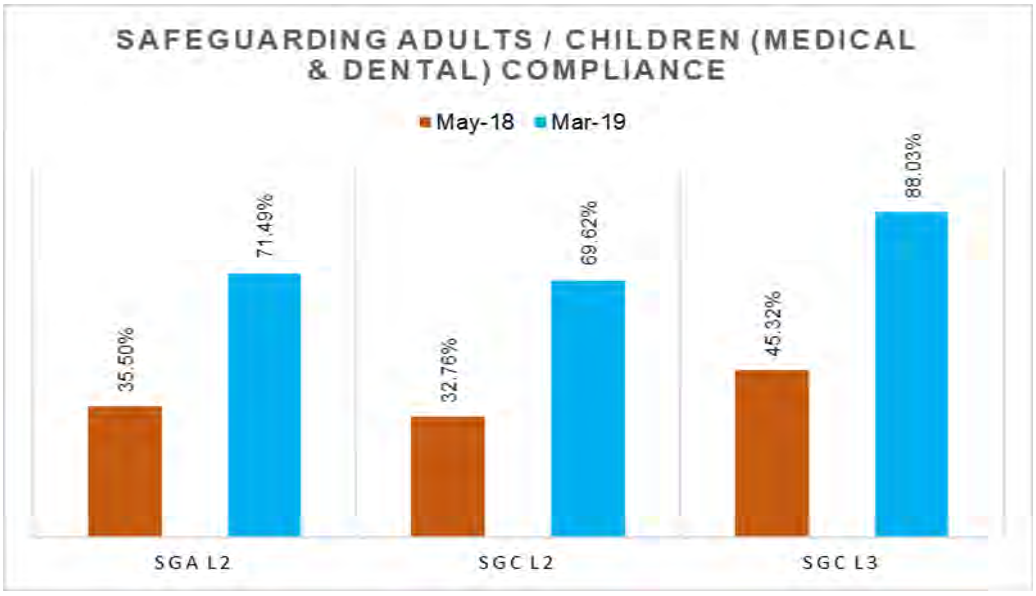
** Level of compliance required – 90%*



**Level of compliance required – 90%*



* Level of compliance required – 90%



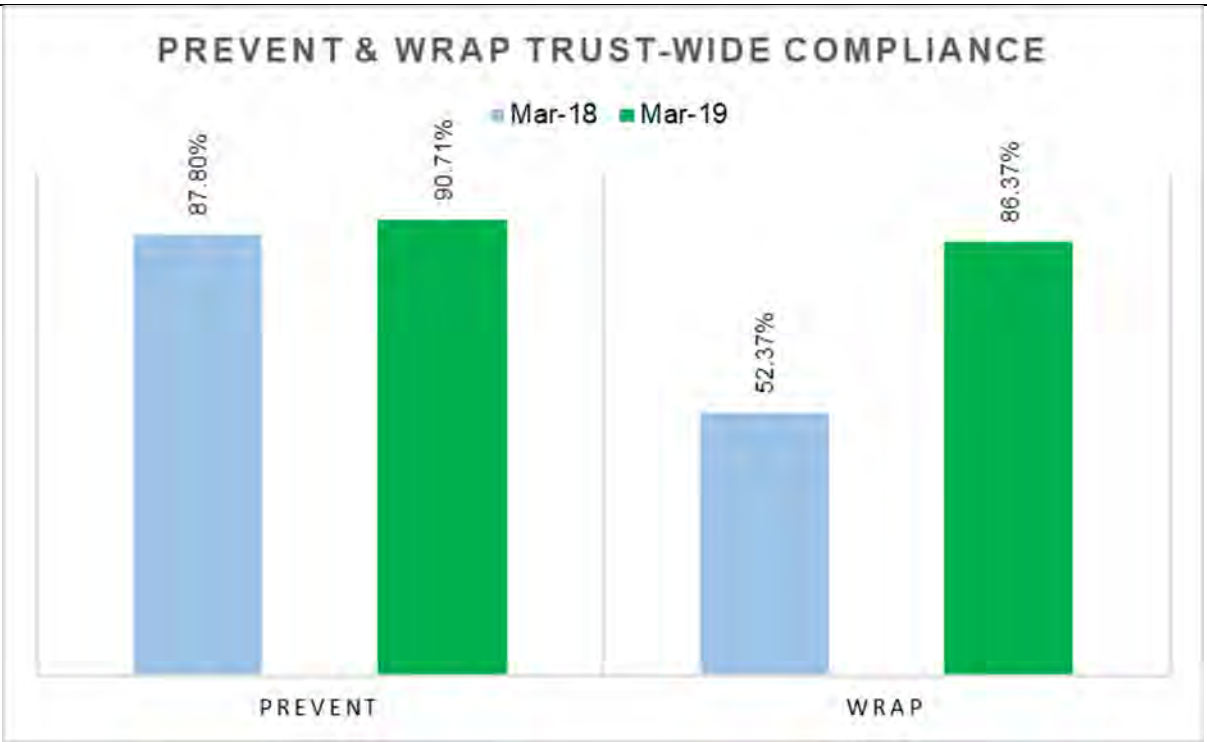
Key actions taken 2018/19:

- Delivery of planned training schedule including additional bespoke training to wards /depts upon request
- Development of a Safeguarding Training Directory outlining levels of compliance required, how to access training etc.
- Stringent monitoring of safeguarding training compliance via the Safeguarding and associated Trust Committees

- 'Did not attend' reports to Divisional Leads (by individual staff member)
- Monthly training compliance report to Divisions for monitoring, review & validation(by individual staff member)
- Targeted level 2 and MCA & DoLS training to FY1 and FY2 doctors
- Full revision of the Trust safeguarding training & development intranet pages
- Schedule of additional level 2 'face to face' adult & children training delivered as an alternative to the e learning option
- Ongoing Trustwide communications strategy
- Baseline position and trajectory set for safeguarding adults level 3 training
- Development of an MCA & DoLS video –target audience Healthcare Assistants
- Adult Safeguarding: Roles and Competencies for Health Care Staff (published August 2018) – review of refresher training undertaken and refresher pack developed

3.1.2 PREVENT & WRAP Training Compliance

Section 26 of the Counter-Terrorism and Security Act 2015 (the Act) places a duty on certain bodies ("specified authorities" listed in Schedule 6 to the Act), in the exercise of their functions, to have "due regard to the need to prevent people from being drawn into terrorism". The Act states that the authorities subject to the provisions must have regard to this guidance when carrying out the duty. NHS Trusts are a health specified authority within the Act. NHS England has incorporated Prevent into its safeguarding arrangements, so that Prevent awareness and other relevant training is delivered to all staff who provide services to NHS patients. This is supported by a Prevent Training and Competencies Framework (NHSE October 2017). Trusts were required to achieve an 85% compliance rate for PREVENT basic awareness and WRAP as of March 2018. The Trust met the 85% national compliance target for WRAP as at end quarter 4 2018/19.



* Level of compliance required – 85%

Key actions taken:

- PREVENT level 1 leaflet distributed to all staff with payslip April 2018
- WRAP Home Office accredited trainers to support WRAP training delivery within wards /depts
- WRAP training delivered on Trust induction to all new starters as of March 2019
- Level 1 information now provided as part of trust induction handbook to all new starters
- Understanding extremism & radicalisation toolkit – Worcestershire – available on Trust intranet to support practitioners working with individuals, children, young people and communities at risk to foster a greater understanding of the issues – the Trust contributes to this work as a 'specified authority' under the PREVENT duty and attendance at local/regional PREVENT groups.

3.1.3 PREVENT NHSE Training needs Analysis

During the review of Training Compliance under the Prevent Duty at the National Task & Finish Group on 6th February, chaired by Hilary Garratt (Deputy Chief Nursing Officer, NHS England) it was acknowledged some providers had very low Training Needs Analysis (TNA), based on the national average of 48%. Current position for WAHT reported by NHSE as 31%.

Impact:

It was felt it was for the Provider to assure the Commissioner that if their TNA falls well below the national average level that their TNA is robust and appropriate for them to evidence that they are effectively paying due regard to the Prevent Duty in the delivery of their services. As a result of this, during March, the Trust submitted a paper to the CCG outlining how it would address the TNA 48% national compliance (to be achieved by end Q2

2019/20).

Key Actions taken:

- WRAP training delivered to all new starters attending Trust Induction as of March 2019
- Eligibility of all clinical/patient facing staff currently assigned PREVENT Level 2 reassigned to WRAP

3.1.4 CHANNEL (Duty as set out in the Counter Terrorism & Security Act 2015) referrals

During the period Feb 2018 –Jan 2019 there have been 19 individuals referred into CHANNEL. Cases referred to CHANNEL are evaluated, risk managed and appropriate interventions put in place and monitored. Of these:

•1 Female, 18 male

•11 Adults, 8 children

•14 have/suspected to have concerns in relation to mental health, learning disability, ADHD or autistic spectrum disorders.

As part of an NHS review, processes are being developed to incorporate mental health representatives to CHANNEL. Worcestershire Health & Care Trust are the 'health' representative for Worcestershire.

3.1.5 PREVENT referrals

The Chief Nurse is the Executive lead for PREVENT. The Operational Lead is the Head of Safeguarding. Compliance with the PREVENT duty is reported quarterly to NHS digital, CCG and NHSE PREVENT leads. 2 cases have been referred by the Trust 2018/19.

4.0 Female Genital Mutilation (FGM) & Child Sexual Exploitation(CSE)

The Trust must ensure that all clinical staff have a good understanding of their role in recognising and reporting cases of female genital mutilation and child sexual exploitation

A number of local and national campaigns have been undertaken over 2018/19 to raise staff awareness in relation to FGM & CSE.

Key actions taken:

- Trustwide FGM communications prior to the holiday season(when the incidence of FGM is known to increase) - including desktop campaign
- Home Office FGM campaign Oct 2018 – promoted Trustwide and key messages shared
- NHSE FGM pocket guide distributed to staff working in high risk areas
- Loudmouth Theatre company – delivery of 2 bespoke CSE training sessions in November and February funded by the Worcestershire Safeguarding Children's Board (WSCB) – an alternative method of delivery raising staff awareness
- FGM International Day of Zero Tolerance 6th February – development of posters to share key messages and trust contact details for FGM leads
- Independent Inquiry into Child Sexual Abuse and the Truth Project – developments and learning shared across key areas – update of the Chaperone Policy for both adults and children has been completed as part of this work
- National CSE awareness day 18.03.19 promoted Trustwide. The aim of the campaign was to highlight the issues surrounding CSE, encouraging everyone to think, spot and speak out and adopt a zero tolerance to adults developing inappropriate relationships with children or children developing inappropriate

relationships with other children

- WSCB child sexual exploitation self-assessment completed May 2018 – full compliance with standards demonstrated
- Safeguarding 'key messages' distributed in relation to FGM & CSE
- Electronic flagging on clinical systems – multi agency information in relation to CSE is shared via the Multi Agency Child Exploitation (MACE) process where children who are at risk/ or victim of, CSE or child exploitation are discussed and a panel considers any further safeguards that may be required. Any child /young person discussed is subsequently 'flagged' on clinical systems and records scanned accordingly
- NSPCC videos (Jays story & 'Thinkuknow') uploaded to the training pages of the trust intranet for staff to access as part of refresher hours

5.0 Safeguarding questions

The trust must ensure staff assess and document in children's records the trusts safeguarding questions to protect children from harm and abuse.

The Trust safeguarding team has continued to strengthen the robustness of the electronic flagging system within the Trust over 2018/19 in order to protect children and adults from the risk of harm /abuse.

Key actions taken:

- Did not attend report – a daily report is now available via WREN which highlights any adult or child with a safeguarding alert for whom a DNA code is entered on clinical systems. This is then followed up by the safeguarding team, lateral checks completed and respective agencies notified e.g. paediatric liaison /health visitor, children's social care
- Children subject to a child protection plan (CPP) or looked after (LAC) by the local authority are flagged weekly on clinical systems – starts and ceases. This ensures flagging on clinical systems remains accurate should a child or young person attend one of our services. Should a flag cease then a 'historical' flag is applied
- Children in need (CIN) are flagged if the Trust is made aware the child /unborn is subject to a CIN plan (information is not routinely shared by Worcestershire children's services)
- Multi Agency Risk Assessment Conference (MARAC) for *high risk* domestic abuse and police logs are flagged on clinical systems and outcome documents uploaded to Ez notes
- The safeguarding team are continuing to cleanse historical data held on Oasis for patients prior to the implementation of current processes
- Child Protection Information Sharing System (CP-IS) – a nationwide system that enables child protection information to be shared securely between local authorities and NHS Trusts across England. CP-IS connects local authority children's social care systems with NHS unscheduled care settings e.g. emergency dept, maternity units. The Trust now has 336/564 (60%) staff with access to CP-IS across high priority areas
- Mental Health Act detention flag – developed to highlight any patient within the Trust who may be subject to legal detention under the Act
- Outpatient history sheet – safeguarding questions developed and crib reference card

for staff who may not routinely see children developed to prompt actions to be taken in the event of a safeguarding concern
- Audit - asking the 'routine enquiry' question in relation to domestic abuse during pregnancy. Findings from this audit have been fed back to the Perinatal Institute in relation to documentation and where the routine enquiry should be documented
- Safeguarding training (all levels)continues to include the checking of alerts and directs staff to the information available on the Trust IT pages

Further developments planned:
- Implementation of the FGM-IS part of the CP-IS. The FGM-IS system shares information in a girl's healthcare record when she has a family history of FGM. This is shared to help professionals be aware of the family history whilst they treat her, so that they are alert to any associated safeguarding concerns. This information is shared confidentially with authorised healthcare professionals across all healthcare settings in England until a girl is 18 years of age.
- Trustwide alert policy to include a section in relation to safeguarding alerts

6.0 CQC 'should dos':

6.1 Safeguarding Children Policy

The trust should review the safeguarding children policy to ensure it is updated and reflects the most relevant national guidance

Key actions taken:

The following policies which are incorporated within the Safeguarding Children Policy have been reviewed and updated over 2018/19:

- Chaperoning infants, children and young people
- Safeguarding Children & Young People: Supervision Policy
- Worcestershire Children & Young Peoples Multi Agency Urgent Mental Health Care Pathway
- Safer Sleeping Guideline NHS Worcestershire
- Mental Capacity Act (section in relation to 16-18yrs)
- Investigation of Sudden and Unexpected Deaths in Children Under 18 Years

Because of the number of policies incorporated into the Safeguarding Children Policy further work is required. A schedule for review of the remaining policies has been agreed. It is anticipated the full review will be complete by end quarter 2 2019/20.

6.2 Safeguarding Supervision

The trust should review the current arrangements for safeguarding supervision to ensure it is accessible to all medical and nursing staff

Key actions taken:
- Revision and update of the Safeguarding Children & Young People: Supervision Policy
- Places secured, funded by the CCG to increase number of safeguarding supervisors trustwide
- Rolling programme of supervision implemented across paediatric areas, theatres, out

patients, emergency depts.
- Improvements to the transfer of deceased babies to the mortuary as a direct result of safeguarding supervision

Further funded places will be utilised to develop safeguarding supervision for adults.

7.0 Governance
Leadership Arrangements
The Chief Nursing Officer (CNO) is the Executive Lead for safeguarding adults, children and young people. The Deputy Chief Nurse (Safety) leads safeguarding on behalf of the CNO.

7.1 Assurance
The Trust Safeguarding Committee is chaired by the CNO or Deputy and meets monthly. The Safeguarding Committee reports to the Clinical Governance Group (CGG) and Quality Governance Committee (QGC) gaining assurance on behalf of the Trust Board that its legal and statutory duties in respect of safeguarding adults, children & young people are met.
The Safeguarding Committee work in accordance with an agreed work plan. Attendance at the Committee by the Head of Safeguarding/Designated Nurse Safeguarding (Worcestershire CCG) provides a level of oversight and scrutiny as part of the safeguarding assurance process.

7.2 Safeguarding Risk Register
The safeguarding risk register is overseen by WAHT Safeguarding Committee and is a standing agenda item.
The current high /moderate risks are:
- Safeguarding team structure – this risk has reduced over 2018/19 from 'extreme'. This will reduce further as new appointments come into post over Q1 20219/20. All existing vacancies have been appointed to and start dates agreed
- Child Protection Information Sharing (CP-IS) – roll out in progress.
- Liberty Protection Safeguards implementation – information awaited further to Royal Assent
- Out of Hours CAMHS service provision – Commissioners aware of lack of service out of hours for children & young people
- Policy revision & update – ongoing piece of work incorporated into 2019/20 work plan
- Security –risk of absconding – Policy undergoing review

Risks in relation to safeguarding supervision and the Responsible Clinician and Mental Health Act Administration arrangements have been closed.
Work has been undertaken to review all information held within the safeguarding team as part of the General Data Protection Regulations effective as of 25th May 2018.

8.0 Trust Corporate Safeguarding Team Structure 2018/19
Substantive appointments have been made to all vacant positions over the last year improving capacity within the safeguarding team to meet the increasing demand in relation to safeguarding (including multi-agency working). The revised team structure will be fully operational as at July 2019.

In addition to the Named Doctor Children's Safeguarding, a Consultant Paediatrician has taken up the role of sudden & unexplained death in childhood (SUDIC) lead.

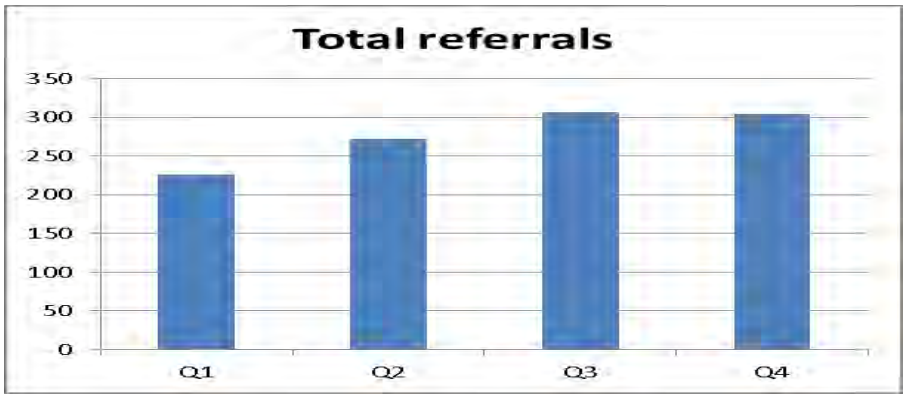
9.0 Safeguarding Quality Champions

The safeguarding quality champions continue to support the safeguarding agenda trustwide. Meetings are held on a quarterly basis where key information is shared and topical updates provided to inform safeguarding practice.

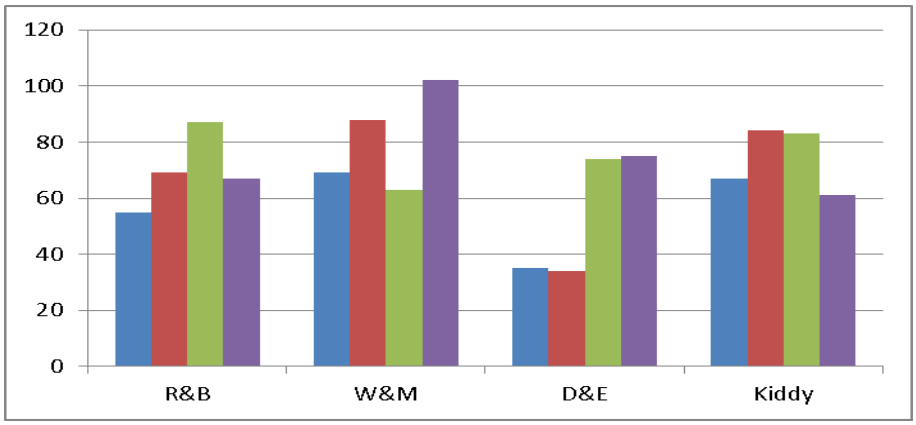
10.0 Specialist Midwives Activity

There are four Specialist Midwives, based in the four Community Midwifery teams: Redditch and Bromsgrove, Droitwich and Evesham, Kidderminster, Worcester and Malvern.

The Named Midwife for Safeguarding collates specialist midwives activity on a monthly basis. This has been a robust process over the past 12 months. The total number of referrals for 2018/19 was 1134. The role of the specialist midwife is to build trust and confidence and to encourage the women they care for, through joint working to take control of their addictions, their futures and the health and well-being of themselves and, most importantly, that of their unborn baby.



Total number of referrals



Number of referrals by community team each quarter

Of the referrals received by the Specialist midwives over 2018/19, 169 unborns were subject to a Child Protection Plan (CPP) and 206 children identified as Children in Need(CIN).

11.0 Partnership Working

The Children and Social Work Act 2017 - Safeguarding Partnerships
Working Together revised Guidance July 2018

The revised Working Together Guidance was published on the 4th July 2018 replacing Working Together to Safeguard Children (2015). The new guidance follows a government consultation, launched in October 2017 which set out the changes needed to support the new system of multi-agency safeguarding arrangements established by the Children and Social Work Act 2017.
Local safeguarding arrangements will be led by three safeguarding partners (Local Authority, Chief of Police Officers, and Clinical Commissioning Group). The Children and Social Work Act 2017 places a shared and equitable duty on the three Safeguarding Partners to make arrangements to work together to safeguard and promote the welfare of all children in a local area. Under the new legislation, the safeguarding partners must:
•Agree on ways to co-ordinate their safeguarding services
•Act as a strategic leadership group in supporting and engaging others
•Implement local and national learning from serious child safeguarding incidents.
To fulfil the above role the safeguarding partners must set out how they will work together; with any relevant agencies to safeguard and protect the welfare of children in the area. These arrangements have to be published by June 2019 and implemented by September 2019. Working Together 2018 guidance provides an opportunity to change what does not work well in the current system in order to improve the effectiveness of arrangements for safeguarding children moving forwards.
Suggestions for improvements include: streamlining and consolidating governance arrangements, re-consideration of strategic direction and work of a number of multi-agency partnerships, promote greater coherence in commissioning. It is an opportunity to provide potential capacity to effect real system change for children and families in Worcestershire.

The Trust has attended respective stakeholder meetings and updates have been provided via Designated Nurse Safeguarding (CCG).Work in Worcestershire has progressed over 2018/19 and the structure of the Safeguarding Partnership and sub Committees agreed. The Trust will be represented by the Head of Safeguarding on all 3 sub Committees:

- Quality Assurance Practice & Procedures
- Get Safe Partnership Board
- Safeguarding Practice Review Board

Local and national child safeguarding practice reviews
The guidance sets out the process for new national and local reviews. The responsibility for how the system learns the lessons from serious child safeguarding incidents lies at a national level with the Child Safeguarding Practice Review Panel (the Panel) and at local level with the safeguarding partners. The Child Safeguarding Practice Review Panel became operational as of 29 June 2018, and considers all notifications of serious incidents:

Child Safeguarding Practice Review Panel
• The Panel is responsible for identifying and overseeing the review of serious child safeguarding cases which, in its view, raise issues that are complex or of national importance.
• The Panel must decide whether it is appropriate to commission a national review of a case or cases
• The Panel must set up a pool of potential reviewers who can undertake national reviews, a list of whom must be publicly available.

Meeting	Trust Board
Date of meeting	11 July 2019
Paper number	H2

Local Safeguarding Partners

• Local safeguarding partners must make arrangements to identify and review serious child safeguarding cases which, in their view, raise issues of importance in relation to their area.
• A copy of the rapid review should be sent to the Panel who decide on whether it is appropriate to commission a national review of a case or cases.
• The safeguarding partners are responsible for commissioning and supervising reviewers for local reviews.

Child Death reviews

The guidance replaces the requirement for Local Safeguarding Children's Boards to ensure that child death reviews are undertaken by a child death overview panel (CDOP) with the requirement for "child death review partners" (consisting of local authorities and any clinical commissioning groups for the local area) to make arrangements to review child deaths.
The guidance:
• specifies that "child death review partners may, if they consider it appropriate, model their child death review structures and processes on the current Child Death Overview Panel (CDOP) framework"
• specifies there should be reviews of all deaths children normally resident in the local area and, if they consider it appropriate, for any non-resident child who has died in their area.
• specifies that reviews have "the intention of learning what happened and why, and preventing future child deaths" and that "the information gathered … may help child death review partners to identify modifiable factors that could be altered to prevent future deaths." (replacing the previous wording that set out that CDOPs should look to determine "whether the death was deemed preventable")
• sets out that "further guidance will be published on child death reviews".

The Named Doctor for Safeguarding Children attends CDOP on behalf of the Trust. One of the key themes identified via serious case reviews has been in relation to co-sleeping as a modifiable factor.

Key actions taken:

- Dip sample audit October 2018 of 54 patient records in relation to the recording of safe sleeping advice
- The Trust promoted the National Safe Sleeping campaign during Q4, including a press release, trustwide communications and banners displaying key messages across priority areas
- Distribution of key messages crib cards to parents
- Full revision of the Sudden Unexplained Death In Childhood (SUDIC) Policy
- Full review of the Safe Sleeping Policy

11.1 Worcestershire Safeguarding Adults Board & Worcestershire Safeguarding Children's Board

Safeguarding Adult Reviews(SAR)

WAHT has contributed to 2 SAR during 2018/19. Both of these are currently in progress.
Scoping has been undertaken into a further 9 cases which have either not progressed to a SAR or are currently subject to review. A thematic review has been proposed in relation to the deaths of a number of rough sleepers.

Domestic Homicide Review (DHR)
WAHT has contributed to 1 DHR (Staffordshire) which is in the final stages of report approval, and scoping undertaken for 1 further DHR (Wales).
Key actions taken:

- Definition of transphobic hate crime incorporated into training packages
- Gendered Intelligence: Trans Inclusion: An Introductory Briefing; Issue 1, May 2017 distributed via the Safeguarding Committee January 2019

The Trust currently has no outstanding single agency action plans in relation to the above SAR or DHR. All actions are complete and assurance provided to the respective agency /sub group Chairs.

Serious Case Review (SCR) /Rapid Review
WHAT has contributed to 2 SCR during 2018/19 and a further case which was progressed as a learning review. Working Together 2018 introduces a new requirement to undertake a multi-agency 'Rapid Review' whenever a notification of a serious incident is received. The 'Rapid Review' is intended to inform the decision-making around whether to undertake a learning review such as a Serious Case Review (or a child safeguarding practice review when these are introduced). The Trust has undertaken scoping in relation to 3 rapid reviews – none of which has progressed to a full SCR.

The Trust currently has 2 single agency actions outstanding from previous SCR, which are scheduled for completion by end quarter 1 2019/20. The WSCB has been updated as actions have progressed.

Dissemination of learning from SAR and SCR
Learning briefs in relation to multi agency learning are shared via the Safeguarding Committee. Learning is a standing agenda item.
Key actions taken

- 'Alan' shared within tissue viability training
- All learning briefs are uploaded to the Trust intranet for staff to review as part of refresher hours
- Learning briefs are incorporated into safeguarding training delivery

11.2 Multi-Agency Case File Audit (MACFA)

The WSCB Quality Assurance Group undertakes four multi-agency case file audits (MACFA) per year. These audits are thematic and provide an in-depth look at the work of all agencies represented on the audit group. Those attending have prior access to their agencies records, and may discuss the case with practitioners. This audit considers the information available by way of a 'round table discussion' where managers and safeguarding leads consider the work with the child and their family.
Themes over 2018/19 have been in relation to neglect, early help, use of the CSE identification tool, and thresholds.
Key actions taken:

- The Trust has contributed to all of the MACFA undertaken for 2018/19.
- MACFA 30 findings identified good practice by the Trust in the quality assurance of cause for concern referrals. Further dip sample audits have been undertaken

quarterly and any areas for improvement taken up with respective practitioners via safeguarding supervision
- MACFA 31 identified that the Trust was aware of when child protection plans had started/ceased in all of the cases considered

12.0 Children In Need (CIN) Plan

The Trust does not currently receive information from Worcestershire Children's Services in relation to CIN plans. This has been escalated to WCC Assistant Director Social Work Safeguarding Services and CCG Designated Nurse Safeguarding Adults and Children. The current position remains unchanged.

Key actions taken

- Where the safeguarding team are made aware a child /unborn is subject to a CIN plan then they will be flagged on clinical systems accordingly
- All historic flags held on clinical systems for CIN reviewed and updated

13.0 County Lines

'County Lines' is a national issue involving the use of mobile phone 'lines' by groups to extend their drug dealing business into new locations outside of their home areas. This issue affects the majority of Police forces. Gangs typically use property belonging to vulnerable adults as a base. Access to the property is often via the means of force or coercion (known as cuckooing). A 'county lines' enterprise almost always involves exploitation of vulnerable persons; this can involve both children and adults who require safeguarding. Organised crime of this nature often includes CSE, drug trafficking, human trafficking, organised illegal immigration, and other financial crimes.

In Worcestershire:

•Average age of victim is 39yrs
•Gender – 45% female, 55% male
•79% are drug users
•46% have financial issues
•35% have recorded mental health issues

(West Mercia Police, Aug 2018)

Key Actions taken:

- WAHT continues to work collaboratively with partner agencies in order to understand and prevent this type of criminality. Staff awareness continues to be raised via all levels of safeguarding training for both adults and children.
- A County Lines training package has been developed by the Associate Nurse for Safeguarding training which will be part of the refresher packages available for staff

14.0 Domestic Abuse

SafeLives datasets reveal that on average, it takes two to three years for those experiencing domestic abuse, in England and Wales, to access support from a service. The impact of domestic abuse on victims and their families is severe and long lasting. Nationally, around 4/10 (39% England & Wales, 42% Scotland) victims of domestic abuse report mental health issues and 1/10 (10% England & Wales, 9% Scotland) are misusing substance's. The speed at which we identify and respond to domestic abuse is critical to limiting the harm caused to victims and their children.

Key Actions taken:

- All victims and their children at risk of/experiencing domestic abuse are flagged on Trust clinical systems and any associated documentation received e.g. MARAC

reports, Police logs are scanned to the patient's clinical record

- Domestic Abuse awareness training event held 28th November 2018 hosted by Emergency Medicine
- Funding received from Trust Fund to purchase a number of covert items containing the telephone number of Worcestershire Women's Aid to give as an alternative when it may not be safe to give written or verbal information
- Staff awareness raised in relation to perpetrator scheme 'DRIVE' –the aim of which is disruption, risk management and behaviour change
- Appointment of further administrative hours to support the increased workload in relation to scoping victims, perpetrator and children for the Multi Agency Risk Assessment Conference (MARAC) for high risk cases. Information sharing is key in identifying, supporting and reducing risk to vulnerable adults and children
- Audit undertaken into undertaking the routine enquiry in relation to domestic abuse in pregnancy – the audit highlighted gaps in documentation that have been fed back to the Perinatal Institute for consideration
- Named Midwife has undertaken Domestic Abuse, Stalking & Honour based violence (DASH) risk assessment training to roll out to the Specialist and Community Midwifery teams and Emergency depts.
- Worcestershire Forum Against Domestic Abuse & Sexual Violence Professionals pack uploaded to the Trust intranet to provide an essential source of information for professionals in supporting and working with victims
- Domestic abuse, control and coercive behaviour and Domestic Violence Disclosure Scheme (Claire's Law) are incorporated into all levels of safeguarding training delivered for both adults & children
- Work undertaken with the informatics team in the creation of a 'historic' flag for MARAC cases to ensure staff remain vigilant to the risk of previous domestic abuse/vulnerability
- Presentation during July to the Safeguarding Champions by the Worcestershire Public Health Advanced Practitioner with a focus upon 'professional curiosity' and 'asking the question'

15.0 Modern Slavery /Human Trafficking

The Human Trafficking Foundation report that modern slavery is on the increase.

•51% of identified victims of trafficking are women
•28% are children
•21% are men
•72% of people exploited in the sex industry are women
•63% of identified traffickers were men and 37% were women
•43% of victims are trafficked domestically within national borders

From 29 October 2015, the Modern Slavery Act 2015 (the Act) required commercial organisations, including all NHS organisations, to make a public statement as to the actions they have taken to detect and deal with forced labour and trafficking in their supply chains – the Transparency in Supply Chains obligation. The Act requires a slavery and human trafficking statement to be approved and signed at Governing Body level. This ensures senior level accountability, leadership and responsibility for modern slavery and gives it the serious attention it deserves.

Key actions taken:

- The Procurement and Safeguarding team have jointly developed the Trust Modern Slavery Statement which has been published on the public facing pages of the Trust

website.

16.0 National Crime Agency - Missing

Following the publication of National Crime Agency statistics on missing, Missing People has published new figures relating to the number of people who are reported missing every year:
•Someone is reported missing every 90 seconds in the UK
•180,000 people are reported missing every year
•There are 340,000 missing incidents every year
•Children are more likely to be reported missing than adults: 1 in 200 children goes missing each year; 1 in every 500 adults goes missing each year

Previous research has shown that some of the most common reasons for adults to be missing are:
•Diagnosed or undiagnosed mental health issues: up to 8 in 10 missing adults
•Relationship breakdown: 3 in 10 missing adults
•Dementia: around 1 in 10 adult missing incidents (4 in every 10 people with dementia will go missing at some point, often unintentionally)
Most of the people who are reported missing are vulnerable or at risk and many are reported missing multiple times, making them even more vulnerable.
There are a wide range of reasons why adults and children go missing, with varying levels of intentionality, and often more than one cause

Key Actions taken:

- For the Quarter 2 period (reported Q3) there were 12 absconding/ missing incidents recorded on Datix. Of these, 2 incidents involved children. Of the 12 incidents reported, incident severity for all incidents was recorded as 'no harm'.
- The Trust confirmed adoption of the best practice guidance 'The Royal College of Emergency Medicine –Best Practice Guideline – The Patient who Absconds' to the West Mercia Police Missing Persons Co-ordinator for Herefordshire & Worcestershire further to a request for assurance

17.0 Child Sexual Exploitation (CSE)

The Worcestershire Local Authority CSE Team has continued to be heavily involved in recent CSE investigations within Worcestershire. CSE now also includes children who go "missing". A child or young person is categorised as "missing" when their whereabouts cannot be established and/or the circumstances are out of character and the context suggests the person is subject of a crime or at risk of harm to themselves or others.
Data received Dec 2018 from the WHACT CSE Named Nurse (whom attends CSE triage) in relation to those most vulnerable to CSE:
•29 children currently part of investigations in relation to CSE
•25 children high risk of CSE
•22 children medium risk of CSE
•15 children low risk of CSE

Key actions taken:

- WAHT contributes to this work by partnership working, response to Multi Agency Safeguarding Hub (MASH) requests, and information sharing arrangements. The Named Nurse Children is notified of any updates and provides either a 'virtual' or actual attendance to CSE triage upon request
- West Mercia Police 'Tell Someone' pocket leaflets continue to be issued within all

levels of Safeguarding training

- Information sharing into the Multi Agency Child Exploitation (MACE) process. These meetings identify high risk or complex victims and/or offenders in relation to Child Sexual Exploitation (CSE) or Child Exploitation (CE). Children who go missing or have been identified as at risk/victim of CSE/CE that have other services and a social worker involved are discussed and a plan is made of how to support the child to keep them safe. The panel also considers activities that can be undertaken in addition to the victim's care plan to further enhance and safeguard them. A report is written for each case discussed and WAHT Safeguarding Team receives a copy. As a Trust we save a copy of this report, scan it onto Ez notes under the Child Safeguarding header and flag the child accordingly, giving details of the involved social worker and contact details. We also flag if the child is on a Child In Need plan, on a Child Protection Plan or is in the Looked After System.

18.0 Female Genital Mutilation

The Female Genital Mutilation (FGM) Enhanced Dataset supports the Department of Health's FGM Prevention Programme by presenting a national picture of the prevalence of FGM in England. NHS Digital Annual report published 5th July 2018 reported:

• There were 6,195 individual women and girls who had an attendance where FGM was identified or a procedure related to FGM was undertaken in the period April 2017 to March 2018. These accounted for 9,490 attendances reported at NHS trusts and GP practices where FGM was identified or a procedure related to FGM was undertaken.

• There were 4,495 newly recorded women and girls in the period April 2017 to March 2018. Newly recorded means this is the first time they have appeared in this dataset. It does not indicate how recently the FGM was undertaken, nor does it mean that this is the woman or girl's first attendance for FGM

The number of disclosures or identifications of FGM within WAHT remains very low compared to other neighbouring NHS Providers. The number of cases reported to the national data set over 2018/19 was 5 cases.

Key actions taken:

- Staff awareness continues to be raised via safeguarding adult & children training
- The Named Midwife, Named Doctor and Consultant Obstetrician are leads for FGM within the trust providing oversight and statutory reporting of identified cases of FGM

19.0 Multi Agency Safeguarding Hub (MASH) Partner Portal

Organisations and agencies within a strong multi-agency system should have confidence that information is shared effectively, amongst and between them, to improve outcomes for children and their families. A 'partner portal' with Children's MASH came into force at the beginning of August 2018. This enables information sharing to be done quickly, efficiently and is backed up online. Following this, the adult MASH portal went live as of February 2019.

Key actions taken:

- The Trust shares information via the portal within the agreed timeframes
- Attendance by the respective Named Nurse for any MASH meetings conveened
- Weekly attendance by Named Midwife to MASH meetings in relation to unborns
- MASH reports/ outcomes are reviewed by the safeguarding team and actioned

/flagged on clinical systems accordingly

20.0 National Safeguarding Agenda and implications

20.1 Gosport War Memorial Hospital: The Report of the Gosport Independent Panel (June 2018)

The Report of the Gosport Independent Panel was published in June 2018. The Independent Panel looked at historical concerns of eight families and how their loved ones had been treated in the town's War Memorial Hospital. Once the Independent Panel had been set up, they were soon in touch with over 100 families. The panel concluded that the lives of over 450 patients were shortened while in the hospital. The Report showed how the families and patients affected were failed by the professional bodies and by others in authority charged with responsibility for regulating the practice of professionals.

Key Actions taken:

- Findings and implications from the report have been reviewed by the Head of Pharmacy with the recommendation that a senior multi-disciplinary working group is created to review the Gosport report findings and assess, implement and monitor Trust delivery of the key recommendations from the formal NHSi review
- Staff awareness raising of the Trust Freedom to Speak up Guardian and champions incorporated into Position of Trust training delivered by the integrated safeguarding team

20.2 Allegations made against People in a Position of Trust (PoT)
Working Together to Safeguard Children (revised July 2018)

Managing safeguarding allegations against staff working with children is required under the Children Act (1989/2004) and under the Care Act 2014 to protect adults (with Care and Support needs) who are at risk of harm or abuse who because of these needs are unable to protect themselves. The policy documents 'Working Together to Safeguard Children and Young People' (2015, revised 2018) and the 'Care and Support Statutory Guidance (2016) set out expectations that all statutory organisations will have a procedure for managing allegations against staff.

Key actions taken:

- Rolling programme of managing allegation training across staff groups
- Dip sample audit of cases with CCG Deputy Designated Professional undertaken March 2019 – high level of assurance found
- Review of all PoT cases by newly appointed Head of HR Advisory Manager to ensure all necessary referrals have been considered/actioned
- Development of a safeguarding video with a target audience of Healthcare Assistants (HCA) outlining the risks /challenges in caring for patients with impaired mental capacity –this video is mandatory for all HCA working within the trust and has been incorporated into dementia training and the healthcare assistant development programme. This training video has also been uploaded to the trust intranet training & development pages

20.3 Lampard /Saville Action plan review March 2019

A review of the Trust Lampard /Saville action plan was undertaken to provide an updated position on actions taken. Significant assurance was provided in relation to all actions.

Further actions taken:

- CSE National Campaign promoted trustwide March 2019

Key actions proposed:

- Audit of volunteers and DBS checks scheduled for Q1 2019/20

20.4 Independent Inquiry into Child Sexual Abuse (IICSA) interim report (April 2018)

The independent inquiry was established 12th March 2015. Purpose:

•To consider the extent to which State and non-State institutions have failed in their duty of care to protect children from sexual abuse and exploitation;
•To consider the extent to which those failings have since been addressed;
•To identify further action needed to address any failings identified;
•To consider the steps which it is necessary for State and non-State institutions to take in order to protect children from such abuse in future;
•And to publish a report and recommendations.

The inquiry is being undertaken by:

•The Truth Project; to provide an opportunity for victims and survivors to share their experiences with the inquiry;
•Investigations and public hearings: to date, 13 investigations, 5 public hearings;
•Research;
•Seminars and engagement: victim and survivors forums.

Key actions taken:

- The Chaperone policy for infants, children & young people has been fully revised and updated
- Posters in relation to the truth project circulated to key areas across the trust

20.5 Learning Disabilities Mortality Review (LeDeR)

The Learning Disabilities Mortality Review (LeDeR) Programme is commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England. It aims to guide improvements in the quality of health and social care service delivery for people with learning disabilities and to help reduce premature mortality and health inequalities faced by people with learning disabilities. A key part of the LeDeR Programme is to support local areas to review the deaths of people with learning disabilities. The programme is developing and rolling out a review process for the deaths of people with learning disabilities, helping to promote and implement the new review process, and providing support to local areas to take forward the lessons learned in the reviews in order to make improvements to service provision. LeDER applies from 4 yrs of age upwards.

Key actions taken:

- The Trust learning disability team contribute to the LeDeR process within Worcestershire and reports into the Safeguarding Committee
- Arrangements are in place within Worcestershire for the LeDeR process to feed into safeguarding adult/child review processes via the Chairs of the respective Board sub-groups. WAHT forms part of the 'health' representation on associated Boards and sub groups in accordance with the memorandum of understanding.

21.0 Quality Assurance - Audit Schedule 2018/19

The agreed safeguarding audit schedule for 2018/19 was fully completed.

21.1 Worcestershire Safeguarding Children's Board (WSCB) Child Sexual Exploitation Self-Assessment

Local Safeguarding Children Boards have the responsibility for the on-going monitoring of suspected child sexual exploitation (CSE) and to ensure the effectiveness of multi-agency working. The CSE strategic group of WSCB asked the Quality Assurance Group (QAG) to request that all partner agencies undertake a self-assessment of their commitment to safeguarding and promoting the welfare of children at risk of CSE. This was a repeat of the audit undertaken in 2016 and updates to all actions identified in the 2016 self-assessment were requested. CSE is child abuse. It can take many forms.

The official definition is: 'Child sexual exploitation is a form of child sexual abuse. It occurs where an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a child or young person under the age of 18 into sexual activity (a) in exchange for something the victim needs or wants, and/or (b) for the financial advantage or increased status of the perpetrator or facilitator. The victim may have been sexually exploited even if the sexual activity appears consensual. Child sexual exploitation does not always involve physical contact; it can also occur through the use of technology'

Working Together (2015:70) states that Local Safeguarding Children's Boards should conduct regular assessments on the effectiveness of Board partners' responses to child sexual exploitation and report on the outcome of these assessments. The self-assessment tool is intended to enable partner agencies to undertake a reflective evaluation of where they are meeting expected standards, and where they need to improve. The audit tool includes those key areas that each agency should strive to meet.

Outcome:

WAHT was able to offer full assurance in respect of the standards.

21.2 NICE CG89 Baseline Assessment Child Maltreatment Toolkit

The baseline assessment was completed by the Named Doctor and Paediatric Matron.

Outcome:

The Trust was able to deem full compliance with the 78 relevant standards (100% compliance).

21.3 WSCB Training Audit and Training Needs Analysis

The training audit was completed as part of the WSCB quality assurance process during September 2018. There were three sections in the audit looking at numbers of staff who have attended training, and how the organisation evaluates training to ensure it is effective. The audit tool also included a training needs analysis.

Outcome:

The audit tool reinforced the need for multi-agency training in order to meet the intercollegiate guidance for level 3 training and refresher. The delivery of the multi-agency element remains problematic across a number of agencies.

21.4 ID1587 Safeguarding Staff Knowledge Check Audit

An audit was undertaken across the Trust during Q1 to ascertain the effectiveness of safeguarding training. A total of 654 questionnaires were completed Trustwide.

Outcome:

Overall, the knowledge check provided a significant level of assurance across all staff groups in relation to:

- How to make a referral in the event of a safeguarding concern in relation to a child /unborn or adult.

- Use of the MCA
- Knowledge in relation to the documentation required for a mental capacity assessment was excellent across all staff groups (96 -100% correct answer).
- There was a high level of knowledge in relation to what DoLS stood for across all staff groups. The process of referral for a Deprivation of Liberty Safeguard application would be undertaken by Senior Band 5 staff and above. There was a good level of knowledge across the Band 5 to Doctor sample
- Clinical staff demonstrated a good level of knowledge in relation to what FGM meant
- All staff had a good knowledge of where to access further advice and support in the event of a concern in relation to abuse or neglect of a child /young person.
- All staff had a good level of knowledge in relation to what the term CSE stands for
- All staff groups had a good level of understanding in relation to the action to take if a patient made an allegation in relation to a staff member (90-100% correct answer).
- There was a high level of confidence across all staff groups in relation to asking patients about domestic abuse.

Key actions taken:

- CSE toolkit – staff awareness raised as to where this could be found
- Safeguarding alerts – information in relation to alerts is contained within all levels of safeguarding training. IT alert paper disseminated during all safeguarding training delivered face to face
- Domestic abuse – 'asking the question and making opportunities' – discussed in all levels of adult and child safeguarding
- Position of Trust training –rolling programme in place

21.5 Domestic Abuse

Compliance on asking the "Domestic Abuse Routine Enquiry" question was low in both 2013 and 2016 Audit findings. Therefore a Re-audit was initiated. The sample size for the 2018 audit was one of a larger scale with 261 women's hospital records audited.

Key actions taken:

- Domestic abuse Link Midwife liaised with the Perinatal Institute to see if domestic abuse section could be added into post-natal notes
- DASH risk assessment training roll out to Specialist Midwives
- Named Midwife liaised with Matron Postnatal ward re promoting opportunities when the woman is alone to make the enquiry if not completed already
- Training – key messages disseminated e.g. routine enquiry, use of covert items, consideration of any risk from previous partners, advice & support for professionals etc within adult and children's safeguarding training

21.6 Skeletal Surveys

The Named Doctor undertook an audit to review number of cases < 2 year old having Skeletal surveys and the results i.e. number of fractures and were they suspected clinically.

Key actions taken:

- Consultants to comment on risk factors for fractures in their reports
- Consultants to comment on social factors in family in reports
- Only trained radiologists to report on skeletal surveys
- Children's Services and Police – made aware that waiting for second skeletal survey will affect timing of care plan
- Responsibility of Consultant dealing with a case - to know if an opinion has been sought from another hospital and the outcome

22.0 External Assurance

22.1 CCG Peer Review Visit 20th August 2018 -WRH

A Peer review visit was undertaken by the NHS Redditch and Bromsgrove Clinical Commissioning Group Designated Nurse Safeguarding Adults & Children and Deputy, on the 20th August 2018. Areas reviewed were Riverbank Ward (Paediatrics), Maternity, Neonatal Unit and A&E (Worcester site). The tool used was based upon key lines of enquiry from the CQC inspection during Q1.

Outcome:

Overall, the Designated Nurse CCG reported significant improvement. Areas for improvement had already been identified by the CQC and were incorporated into existing safeguarding work streams.

22.2 CCG Peer Review Visit 25th March 2019 -ALEX

The Peer review undertaken at the Alexandra Hospital focused upon the Emergency dept, Medical Assessment Unit and Children's out-patient area. The Peer review focused specifically on children.

Outcome

- Further support required for medical staff in relation to CSE and FGM – a number of targeted sessions have subsequently been provided by the Named Nurse Children
- Newly identified risk in relation to the narrative from alerts added to Oasis not feeding into the Patient First System – immediate escalation to Caldicott Guardian and mitigating actions taken until an IT resolution available. Risk added to risk register

23.0 Mental Health Act (MHA) Statutory Duties

The Mental Health Act 1983 provides the legislation by which people diagnosed with a mental disorder can be detained in hospital or police custody and have their disorder assessed or treated. Use of the MHA is reviewed and regulated by the Care Quality Commission. It is a legal requirement to follow correct procedures when a patient is detained in the Trust under the provisions of the 'Act' as this will ensure the rights of the individual are recognised, and that any potential for action against the Trust for unlawful detention or treatment is minimised.

Key Actions taken:

- With effect from 1st October 2018 agreement was reached with Worcestershire Health & Care NHS Trust for the provision of a Section 12 Responsible Clinician to oversee Mental Health Act detentions within WAHT
- Mental Health Liaison service enhanced to provide support to patients in areas other than the Emergency dept
- MHA Administration arrangements commenced as of 1st April 2019 to provide the respective oversight and scrutiny of detention papers, MHA Tribunal and Hospital Manager hearings.

This was a Corporate risk for the Trust which has now been closed as a result of the new arrangements.

Oversight and scrutiny will be via the Safeguarding Committee and subsequent reporting to Trust Governance Committees. The Head of Safeguarding continues to represent the Trust attending the Mental Health Partnership Group and Mental Health Crisis Concordat interface meetings. The Trust had 22 MHA detained patients reported on Datix over the 2018/19

reporting period:
Section 2(assessment) – 10 detentions (previous year n9)
Section 3 (treatment) – 12 detentions (previous year n3)
Section 5(2) doctors holding powers were used on 5 occasions for the same timeframe.
Section 136 (Police holding powers):53 patients were detained to the Section 136 Suite via the Emergency Dept over 2018/19; of these, only 2 were detained and assessed in the emergency dept.

23.1 Children's Adolescent Mental Health Service (CAMHS)
The Self-Harm Policy: CAMHS Worcestershire Children & Young Peoples Multiagency Urgent Mental Health Care Pathway has been fully revised and updated. The protocol will be monitored via the quarterly meetings of the Children's Urgent Mental Health Care/Interface group. Any issues will be reported to the Integrated Commissioning Executive Officers Group.

24.0 Deprivation of Liberty Safeguards (DoLS) & Liberty Protection Safeguards(LPS)
DoLS applications continue to be monitored and reported through datix. There have been 202 DoLS applications reported 2018/19. Of these, 7 were reviewed. 6 Standard Authorisations were granted, and 1 not granted. Applications, progress and statutory notifications are monitored via the safeguarding team to ensure compliance with the legal framework.

24.1 Changes to the legal framework
The Mental Capacity (Amendment) Act 2019 received the Royal Assent on 16th May 2019. The purpose of the Bill is to abolish the Deprivation of Liberty Safeguards (DoLS) and to replace them with a completely new system, the Liberty Protection Safeguards (LPS).
In the coming weeks an implementation date for the LPS will be agreed. This is almost certain to be some time in the financial year April 2020 - March 2021.
The DoLS Team Manager for Worcestershire County Council has provided an overview of the potential implications for Worcestershire as a result of the proposed changes to the legislation.
Impact:
•Hospitals and CCGs will need to complete their assessments and need independent reviewers
•Possible delays in discharges from hospitals if LPS is not run quickly / swiftly
Key action proposed:

- Full briefing and implications to be outlined – WAHT will need to consider how it fulfils the requirement for independent scrutiny for those patients who may be objecting

25.0 Homelessness Reduction Act – Duty to refer as of 1st October 2018
Under the Homelessness Reduction Act 2017, specified public bodies have a duty to refer households to a local authority housing team if they are at risk of homelessness or homeless. This means a person's housing situation must be considered whenever they come into contact with a specified public service, such as a hospital. Referrals are made via ALERT – an online tool that is designed specifically to meet the Duty to Refer requirements. The Duty to Refer came into force from 1st October 2018 and applies to WAHT as a public body specified under the Act.
Key actions taken:

- A&E and Minor injury unit staff registered with on line system(JIGSAW)
- The Homeless Pathway Liaison Officer for Worcestershire Hospitals will continue to work with hospital in-patients who are homeless, become homeless in hospital or are at threat of homelessness

26.0 Safeguarding & Tissue Viability

Significant awareness raising has been undertaken in relation to reporting of pressure damage (irrespective of category) in the event abuse or neglect is suspected/has occurred.
Key actions taken:

- A safeguarding 'aide memoir' has been incorporated onto the datix incident reporting system to prompt staff to consider whether a safeguarding referral is required
- Safeguarding is now a mandated field for completion on datix incident reporting
- The flowchart 'aide memoir' has been circulated to tissue viability link staff for dissemination

27.0 Policy Development

Policy review remains a priority for the safeguarding team in view of the changes to local and national safeguarding agendas and new and emerging themes.
The following Policies have been updated and reviewed over 2018/19:

- The Self-Harm Policy-CAMHS: Worcestershire Children and Young Peoples Multiagency Urgent Mental Health Care Pathway
- Chaperone Policy for infants, children & young people
- Chaperone Policy -adults
- Investigation of Sudden & Unexpected Deaths in Children Under 18yrs (SUDIC)
- Enhanced Observation Guideline – Adults
- Safe Sleeping Guideline
- Revised Advocacy Flowchart – uploaded to Safeguarding and Mental Capacity Act pages of the Trust intranet November 2018
- Safeguarding Supervision
- Consent Form 4 – for patients who lack mental capacity –to include the Supreme Court Ruling in relation to clinically assisted nutrition & hydration withdrawal (Mr Y)
- Update to patient information leaflet S136 Mental Health Act timeframes from 72hrs to 24hrs
- Update of Missing Person Guidance to incorporate mental capacity & past tendencies
- Use of the Mental Health Act in Acute Hospital setting – to incorporate new MHA administration arrangements

Timeframes have been set for review of remaining Policy updates/revision.

28.0 Safeguarding Forward Plan 2019/20

- Continue to contribute to the development of the Safeguarding Partnership arrangements within Worcestershire and associated sub Committees as work progresses over the coming months
- Liberty Protection Safeguards – implementation of legislative requirements within agreed timeframes (not published at time of report)
- Sustainability of mandatory training compliance for all levels of safeguarding training
- Achieve 48% TNA national requirement for WRAP training prior to end quarter 2
- Continue implementation of CP-IS roll out

Meeting	Trust Board
Date of meeting	11 July 2019
Paper number	H2

- Roll out of FGM-IS component of the CP-IS system prior to September 2019
- Offer a range of training refresher options in order for staff to meet number of refresher hours
- Multi-agency timeframes met for respective agendas / safeguarding review processes
- Continue to strengthen electronic flagging and cleanse historical data held on clinical systems
- Embed a robust process for the receipt and quality assurance of electronic referrals
- 90% trajectory for SGA level 3 by end quarter 2
- Review & develop Safeguarding Policies
- Further develop safeguarding pathway & pages of trust intranet

Conclusion

This report provides assurance that the Trust continues to meet its legislative and statutory requirements in the Safeguarding of Adults, Children and Young People who access services form the Trust.

Recommendations

The Safeguarding Annual Report highlights the work undertaken over the last year to provide assurance to the Trust Board and its associated Governance Committees that

The Trust Board are asked to note:

- Worcestershire Acute Hospitals NHS Trust (WAHT) is fulfilling its legal and statutory obligations in relation to the safeguarding of vulnerable adults, children & young people whom access services from the Trust.

- The Trust Board are asked to endorse the Safeguarding Annual Report 2018/19 and forward plan for 2019/20.

Appendices