Worcestershire NHS
Acute Hospitals NHS Trust

There will be a meeting of the **Worcestershire Acute Hospitals NHS Trust Board** on
Wednesday 3 February 2016 at 09:30 in
Kidderminster Education Centre
Kidderminster Hospital and Treatment Centre

Harry Turner
Chairman

AGENDA

1	**Welcome and apologies for absence**	Chairman	
2	**Patient Story**	Interim Chief Nursing Officer	
3	**Items of Any Other Business** *To declare any business to be taken under this agenda item.*		
4	**Declarations of Interest** *To declare any interest members may have in connection with the agenda and any further interest(s) acquired since the previous meeting.* *To note the declared interests for Dr Bill Tunnicliffe, Associate Non-Executive Director*: • Spouse works for Worcestershire Acute Hospital NHS Trust • Main employment - University Hospital Birmingham NHS Foundation Trust. • Associate Medical Director (UHBNHS FT) with responsibility for appraisal and revalidation of medical staff. • Co-investigator - NHIR HTA funded trial (REST study Ref 13/141/02) *To note additional interest from the Chairman:* • Trustee for Worcestershire Breast Unit – The Haven		
5	**Minutes of the previous meeting** *To approve the Minutes of the meeting held on **2 December 2015** as a true and accurate record of discussions.*	Chairman	**Enc A**
6	**Matters Arising**	Chairman	**Enc B**
7	**Questions from the Public** *Questions relating to items on the agenda only should be provided in advance to the nicky.langford@worcsacute.nhs.uk by 12 noon on Tuesday 2 February 2016.*		
8	**Chairman's Update Report** *For information*	Chairman	**Verbal**
9	**Chief Executive's Report** *For assurance*	Interim Chief Executive	**Enc C**

BOARD ASSURANCE FRAMEWORK INTEGRATED PERFORMANCE REPORT			
10.1	**Board Assurance Framework** *For approval*	Interim Chief Nursing Officer	**Enc D1**
10.2	**Integrated Performance Report** • **18 weeks referral to treatment** • **Cancer** • **A&E four hour wait** *For assurance*	Director of Strategy, Planning and Improvement	**Enc D2**
PATIENT SAFETY & EXPERIENCE Board Assurance Framework 2902, 2891, 3038, 2895, 2898,			
11.1	**Quality Governance Committee report** *For assurance*	Committee Acting Chair	**Enc E1**
11.2	**PCIP** *For assurance*	Director of Strategy, Planning and Improvement	**Enc E2**
11.3	**Chief Inspector of Hospitals Report and Trust Response** *For assurance*	Interim CEO	**Enc E3**
WORKFORCE Board Assurance Framework 2678, 3028, 2893, 2894, 2932, 3904, 2899			
12.1	**Workforce Assurance Group – Board Assurance risks** *For assurance*	Director of HR and OD	**Verbal**
12.2	**Nursing and Midwifery Workforce** *For assurance*	Interim Chief Nursing Officer	**Enc F1**
12.3	**Medical Revalidation** *For assurance*	Interim Chief Medical Officer	**Enc F2**
12.4	**Big Conversation** *For assurance*	Director of Communications	**Enc F3**
STRATEGY Board Assurance Framework 2665, 2905			
13.1	**The Future of Acute Hospital Services in Worcestershire Clinical Model** *For assurance*	Interim Chief Executive	**Enc G1**
FINANCE AND PERFORMANCE Board Assurance Framework 2790, 2888, 2668			
14.1	**Finance and Performance Committee** *For assurance*	Committee Chair	**Enc H1 To follow**
14.2	**Financial Performance Report** *For assurance*	Interim Director of Finance	**Enc H2**
GOVERNANCE			
15.1	**Audit and Assurance Committee Report** *For assurance*	Committee Chair	**Enc I1**
15.2	**Christian and Multifaith Covenant** *For assurance*	Director of HR and OD	**Enc I2**

15.3	**Business Continuity and Emergency Planning** *For assurance*	Interim Chief Operating Officer	**Enc I3**
15.4	**Review of Board Assurance Risks - Rating and Mitigation** *For approval*	Chairman	**Discussion**
16	**Any Other Business**		
	Date of Next Meeting The next public Trust Board meeting will be held on **Wednesday 2 March 2016,** Charles Hastings Education Centre, Worcestershire Royal Hospital		

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 NHS
Acute Hospitals NHS Trust

MINUTES OF THE PUBLIC TRUST BOARD MEETING HELD ON

WEDNESDAY 2 DECEMBER 2015 AT 12:20 HOURS

Present:

Chairman of the Trust:	Harry Turner	Chairman
Board members: (voting)	John Burbeck	Vice Chair and Non-Executive Director
	Rob Cooper	Interim Director of Finance
	Mari Gay	Interim Chief Nursing Officer
	Stephen Howarth	Non-Executive Director
	Rab McEwan	Interim Chief Operating Officer
	Bryan McGinity	Non-Executive Director
	Andy Phillips	Interim Chief Medical Officer
	Andrew Sleigh	Non-Executive Director
	Chris Tidman	Interim Chief Executive
	Lynne Todd	Non-Executive Director
Board members: (non-voting)	Denise Harnin	Director of Workforce & Organisational Development
	Sarah Smith	Director of Strategy, Planning and Improvement
	Lisa Thomson	Director of Communications
	Marie-Noelle Orzel	Improvement Director
In attendance:	Paul Crawford	Patient Representative
	Kimara Sharpe	Company Secretary
Minutes:	Kimara Sharpe	Company Secretary
Public Gallery:	Press	3
	Public	10
Apologies:	Stewart Messer	Chief Operating Officer
	Mark Wake	Chief Medical Officer
	Julian Bion	Associate Non-Executive Director

177/15 **WELCOME**

The Chairman welcomed members of the press and public to the meeting. He welcomed the Interim DF to his first meeting.

178/15 **PATIENT STORY**

The Chairman introduced KA and invited her to tell her story.

KA explained that she had received a total hip replacement in June this year. She had problems with her knee and eventually she had seen a consultant surgeon who had advised that a hip replacement was needed. She went home four days after the operation and was off work for 10 weeks.

She praised the pre-operative assessment system. She also stated that the ward staff were fantastic. She had a lot of sympathy for them as it was the hottest week of the year! She also praised the physiotherapists and occupational therapist.

Her only concern was the lack of physiotherapy after the operation. She had been given a comprehensive booklet describing the exercises that she should do. She was pleased that the physio department was now developing a booklet to support people six weeks after the operation.

The Interim COO thanked her for raising the profile of the pre-operative service. He asked whether at that meeting the support of the physios was discussed. She replied by stating that she felt that having advice at 6 weeks was very important.

In response to the Interim CEO, she confirmed that the one to one conversation was useful although potentially more could be done on line beforehand.

The Chairman thanked her for sharing her story with the Trust Board.

179/15 **ITEMS OF ANY OTHER BUSINESS**
No items were raised.

180/15 **DECLARATIONS OF INTERESTS**
There were no changes to the declaration of interests.

181/15 **MINUTES OF THE PUBLIC TRUST BOARD MEETING HELD ON 4 NOVEMBER 2015**
Resolved: that
- **The Minutes of the public meeting held on 4 November 2015 be confirmed as a correct record and be signed.**

181/15/1 **MATTERS ARISING**
All items were either complete or not yet due.

182/15 **QUESTIONS FROM MEMBERS OF THE PUBLIC**
The questions had been answered in the session held prior to the meeting.

183/15 **Chairman's Report**
The Chairman reported that he has met with the leaders and chief executives of the district and county councils. He also met with five out of the six county MPs to brief them on the CQC Chief Inspector's report.

He went onto report that the recruitment process for the substantive Chief Executive is in train. He will also report on revised governance arrangements relating to the board sub-committees in January.

Resolved: that
The Board
- Noted the meetings held with the politicians
- Noted the recruitment for a substantive Chief Executive
- Noted the report.

184/15 **Interim Chief Executive's Report**
The Interim CEO highlighted the reduction in the Public Health Ring-Fenced Grant (PHRG) as this would impact on out of hospital care. He has been assured that there

is a full impact assessment being undertaken.

He thanked the Divisional Medical Director for Clinical Services, Chris Catchpole for his contribution to the leadership of the Trust. He has resigned for personal reasons. He stated that the Clinical Support Division and TACO will now be managed under one leadership structure.

He thanked the Worcestershire Ambassadors for donating £30k to Rory the Robot fund. Once the target has been reached, this robot will offer state of the art technology to men needing prostate surgery.

The Interim CEO then turned to his key message. He was adamant in his conviction that the Alexandra Hospital would continue to be a busy hospital and that the suspension of one service did not mean that all services would suffer. The Hospital would be used to its maximum and more planned surgery would be bought to the site.

He thanked all the staff for their hard work with respect to the temporary closure of the neonatal and maternity services. He was pleased to report positive feedback from mothers and asked the Interim CNO to outline a story. She outlined K's story. She was an anxious first time mother and her experience within the midwife led unit was excellent. She lived in Redditch. The Interim CEO understood about the concerns in respect of transport and was disappointed that public consultation had been delayed.

He was pleased that the industrial action by junior doctors had been suspended. However there was still significant disruption caused by the lateness of the announcement. The Trust tried to reschedule as many people as possible. The Interim COO reported that 16 operations and 120 outpatient appointments had been cancelled.

The Interim COO stated that there had been a flood within one of the server rooms which meant that the Trust lost the electronic pathology ordering and reporting service from 19-30 November. A full root cause analysis will be undertaken and reported to the Quality Governance Committee.

Mr McGinity asked about the current situation in respect of future strikes. The Interim CMO confirmed that all the strikes scheduled for December have been called off. He would await further information in respect of strikes in January. He was hopeful that the situation would be resolved through ACAS.

In response to Mr Burbeck, the Director of Communications confirmed that she would be reporting to the Trust Board in February the update on the Big Conversation. She stated that progress was being made and outlined the programme of work.

Mr Sleigh expressed his concern that the pathology servers were in a room which could be flooded. The Interim COO explained that this was a known risk and had been on the risk register. He outlined the plans which were already in place to move the servers to a more appropriate location with the support of ComputaCenter.

Mr Howarth asked for confirmation that all posts were now advertised as county wide. The Interim CEO stated that all posts were advertised as county wide albeit most would have a primary base.

The Chairman declared an interest as a Worcestershire Ambassador.

Resolved: that

The Board,

- Noted the Public Health Ring fenced grant
- Noted the contribution made by the Divisional Medical Director for Clinical Services
- Noted the plans to cover for the national industrial action by the junior doctors
- Noted the contents of the report.

185/15 **BOARD ASSURANCE FRAMEWORK/INTEGRATED PERFORMANCE REPORT**

185/15/1 **Board Assurance Framework**

The Chairman introduced this item. The Interim CNO outlined the changes made to the Board Assurance Framework since the last board meeting.

Risk	Update
Risk 2665 – if we do not re-design services in a timely way we will have inadequate numbers of clinical staff to deliver quality care	This is covered by the agenda item on the Future of Acute Hospital Services in Worcestershire.
Risk 2668 - If plans to improve cash position do not work the Trust will be unable to pay creditors impacting on supplies to support service	This is covered by the financial performance report.
Risk 2678 – if we do not attract and retain key clinical staff we will be unable to ensure safe and adequate staffing levels	This is covered by the agenda item on the Workforce Assurance Group.
Risk 2790 – As a result of high occupancy levels, patient care may be compromised and access targets missed	It was agreed that this risk was covered by the Integrated Performance Report.
Risk 2888 – Deficit is worse than planned and threatens the trust's long term financial sustainability	This is covered by the financial performance report.
Risk 2891 – If the Trust does not learn from mortality reviews this knowledge will not be available to support improvements to patient care	This is covered by the Quality Governance Committee report.
Risk 2895 – If we do not adequately understand and learn from patient feedback we will be unable to deliver excellent patient experience	This is covered by the Quality Governance Committee report.
Risk 2902 – If the Trust does not successfully implement safety priorities, we will fail to reduce avoidable harm to expected levels	It was agreed to review this risk at the end of the meeting.
Risk 3028 Expiry of multiple non-executive terms of office in 2016 negatively impacting governance and business continuity	The Associate NED posts were being interviewed on 9 December. The TDA had refused the staggered appointment proposal. It was agreed to add the executive appointments to the risk.
Risk 3038 If the Trust does not address the concerns raised by the CQC inspection the Trust will fail to improve patient care	On agenda.

Resolved: that

The Board:-

- Noted the changes to the BAF
- Reviewed risk ratings, controls, assurance and mitigating actions and consider if these are reasonable
- Agreed to add in the appointments of executives into risk 3028
- Agreed to review partner risk registers to examine synergy
- Approved the risk updates.

185/15/2 **Integrated Performance Report**

The Director of Strategy, Planning and Improvement (SP&I) spoke to the integrated performance report (IPR). She stated that HSMR and SHMI were still high and were around the control limit. The Trust should aspire to be closer to the average for similar trusts.

She stated that there are corrective action statements where required within the report. These were new to the report.

As far as NHS constitution compliance, she reported that the RTT and cancer targets have firm trajectories to ensure sustainable performance before the end of the financial year. The six week wait for diagnostics was achieved.

The biggest challenge to the Trust remains patient flow. Over 90% was achieved for the Emergency Care Standard (EAS) in October. The maintenance of this will be very challenging over the winter period. The ECIP visit reviewed the whole urgent care pathway. Current plans were endorsed and it was recognised that additional support was needed to progress. The whole system was reviewed.

Mr Sleigh complimented the Director on the new style of reporting. He suggested milestones should be part of the corrective action narrative. This was agreed.

Mr Sleigh went onto to express concern about the HSMR. The Improvement Director confirmed that she had met with the responsible personnel to discuss further analysis to explain the data.

Mr Burbeck asked for clarification on RTT 'incomplete'. The Interim COO explained that the Department of Health has requested Trusts measure the total number of people waiting within the acute sector i.e. outpatient and /or inpatient procedure. The measure will give a more accurate picture of patients waiting. The Trust was on track to deliver the Department of Health's requirements in this area of work.

Mr Burbeck expressed concern about the hip fracture metrics. The Interim CMO agreed and reminded him that the Quality Governance Committee (QGC) had agreed the Interim CMO as the overall Trust lead in this area. He confirmed that there was now a new manager in place and he assured Mr Burbeck that improvements would be seen. Mr Burbeck stated that the issues had been discussed over a significant period of time and was disappointed with the lack of progress.

Mr Sleigh asked what the impact was of not progressing the day of surgery admission business case. The Interim COO explained the current use of the surgical short stay unit (SSU). He stated that the bed pressures were in medicine so the bed space was being used to support the improvement in patient flow through the ambulatory emergency care service.

Mr Sleigh challenged the poor theatre utilisation at Kidderminster. He was

disappointed that the initiatives had not resulted in the site being used more effectively. The Interim COO agreed and stated that whilst dropped sessions had reduced, the plans had not resulted in better theatre 'in session' utilisation. However, the theatres at AGH were now more effective. He was assured that the Divisional Director of Operations (surgery) would turn around the performance at Kidderminster.

Mr McGinity requested that a fuller explanation be given in respect of the risks relating to the Women and Children Division. He also requested information about the nursing unqualified turnover which was 14% and the figure of nearly 5% on relating to long term sickness. The Director of HR and OD explained that the majority of sickness related to long term and this was being monitored at the Workforce Assurance Group. She went onto state that there were 'hot spot' areas with respect to nurse recruitment which was particularly evident within surgery at the Alexandra Hospital. She stated that this was anecdotally attributed to lack of certainty. In response to Mrs Todd, the Director of HR and OD stated that early indications showed that nurses were leaving for further development opportunities. It was agreed to split the data by site.

The Interim CEO confirmed that all Worcestershire leaders were committed to ensure the maximum uptake of the flu vaccine. Currently 53% of acute staff were vaccinated.

The Interim CEO explained that there had been an increase in demand and referrals which reflected in the 2 week cancer target. He was particularly concerned about the breast two week wait target. The Interim COO explained that there are some capacity issues and some process issues. He was hopeful that the figure would improve. There has been a 13% increase in referrals for all cancers, with a 17% increase in the north of the county.

Mr Howarth stated that limited assurance was received with respect to complaints in a recent internal audit report. He was therefore pleased to see the improvement. The Interim CNO agreed and was hopeful that the figure will rise to over 90% during November. There did need however, to be a focus on learning lessons.

The Interim COO explained that the Emergency Care Improvement Programme Team (ECIP) visited the health economy recently. The report had just been received. Broadly, the report endorsed the actions being undertaken in respect of improvement patient flow. In order to improve the length of stay and increase discharges, he was working with the Interim CNO to develop the practice known as 'safer bundles' where senior review is undertaken quickly, enabling earlier discharge. He was also presenting a business case to the Finance and Performance Committee to ensure that there is a geriatric assessment at the front door in the ED and the necessary multidisciplinary assessment ensuring links with the community services.

The report went onto state that discharge coordination could improve across the health economy including the Patient Flow Centre. Finally, he stated that the report emphasised the importance of acute medicine which needed to have a higher profile internally.

The Interim COO was hopeful with the progress already made. There was noticeable improvement in performance month by month. However he issued caution about the sustainability of the improvements due to the approaching winter period and the lack of extra investment by the commissioners to ensure that there is extra capacity available. He assured the Board that the full hospital protocol worked effectively across the health economy when tested earlier in the week.

Resolved: that

The Board:-

- Received the Integrated Performance Report for October 2015
- Noted the feedback from the ECIP visit

186/15 **PATIENT SAFETY & EXPERIENCE**

186/15/1 **Quality Governance Committee**

Mr Burbeck reported on behalf of Professor Bion. There is a multidisciplinary meeting being set up to ensure lessons are learnt from patient feedback. He was pleased that the CQUINs were discussed and that the Interim CNO and Interim CMO will be involved in the development of the CQUINs for 2016/17. These will be linked to the Quality Strategy.

He reported that the Committee has now started to receive deep dive reports by the Divisions. This was still being developed, but the report from Surgery was well received.

He confirmed that the Complaints Internal Audit report had been discussed and the Committee had expressed their frustration with the continued poor performance. The Associate Director for Patient Experience has been asked to attend the meetings in future to explain the performance in this area.

Finally he stated that the Committee had discussed the GMC survey of junior doctors which will now be sent to all consultants on an annual basis.

The Improvement Director requested that the Workforce Assurance Committee review and align the GMC survey with the report from Health Education West Midlands (HEWM) on junior doctor training. This was agreed. The Interim CMO confirmed that the GMC survey is discussed with the junior doctor forum.

In summary, the Chairman thanked Mr Burbeck for his report and stated that there remained a number of concerns about quality of some services, particularly patients with fractured neck of femur and complaints.

Resolved: that
The Board

- Considered the discussion in respect of the key risks
- Noted the lack of progress with mortality reviews and the discussions held in respect of this
- Noted the work being undertaken to improve the patient experience with respect to fractured neck of femur
- Noted the divisional exception reports and the deep dive into the surgical quality report
- Noted the dissatisfaction with the complaints performance
- Noted the report relating to the GMC survey and requested the Workforce Assurance Group align the results with that of the HEWM report
- Noted the report

186/15/2 **Patient Care Improvement Plan**

The Director of SP&I clarified that the risks within the IPR report relating to the Women and Children Division were associated with the number of actions overdue in relation to the risk register, not the number of serious incidents outstanding.

She went onto explain that the PCIP was fundamental to the Trust. It helps the Trust demonstrate improvements made. The Chief Inspector's report will be reflected in the

next version and there will be another action plan, covering outpatients and diagnostics All the actions listed will be reviewed to ensure that the key areas within the Report are captured.

She reported good progress with the action plans. A challenge is however engagement outside Worcestershire, to learn from other Trusts' best practice. She was disappointed with the lack of progress with the mortality action plan.

Finally, she reported that she was considering the best format for presenting the report on the NHS Choices website, which was a requirement for a Trust in Special Measures.

The Interim CMO echoed the disappointment with the lack of progress with mortality reviews. Currently only 20% of deaths were being reviewed. He has instigated a full review of the process and has changed the process as a result of feedback from consultants. The major challenge appeared to be the lack of availability of the paper notes in a timely fashion. This was now sorted. He was also distributing a list of consultants to the Divisions showing those who had outstanding reviews. He was adamant that the process would generate learning across the Trust.

The Trust Development Authority observed a mortality review meeting and has given feedback which afforded an opportunity to review and change the process. The TDA has offered to attend to speak to the full board about the process. This was agreed.

Mr Burbeck confirmed that amongst senior staff there is a clear awareness of the importance of undertaking the review process. He was please that the administrative issues had been sorted, but he expressed concern that not all consultants appeared to be aware of the importance to undertake the reviews and therefore learn and improve patient care.

The Improvement Director stated that to establish a new process in any Trust would be difficult. The notes may not be readily available and she understood some of the challenges. She advised that it could take up to 18 months to ensure that the process is embedded. She was pleased with the engagement with the serious incident meetings which were now being chaired by the Interim CMO/CNO.

Mr Sleigh suggested some business design models which could be utilised. He agreed to share this outside the meeting with the Interim CMO.

In response to Mr McGinity, the Director of SP&I agreed that on initial reading, there appeared to be a huge number of actions arising out of the Chief Inspector's Report. However, she was recommending that the 27 'must dos' would be incorporated and other essential areas, including any regulatory notices received. She also reminded members that the reports duplicated many of the recommendations.

Resolved: that
The Board

- Reviewed the progress with the Patient Care Improvement Plan
- Noted that future versions would include the Chief Inspector's report
- Requested the attendance of the TDA at a Board development session to discuss mortality reviews
- Noted the actions being taken in respect of the mortality review process.

186/15/3 **Chief Inspector of Hospitals Report and Trust Response**

The Interim CEO stated that the Trust accepted the report in full. He reminded the Board that the Trust had been working with partners to develop a new clinical model to reduce clinical risk. He hoped that the CQC report would be the catalyst to progress to public consultation.

There were many positives within the report. Maternity care was ranked outstanding at both the Worcestershire Royal and Alexandra Hospital sites. Avon 4 on Worcestershire Royal was also singled out. Critical Care services came out well as well as the bereavement service and the seven day pharmacy service was potentially a national exemplar. There was an open culture, with leaders willing to listen, prepared to take criticism and prepared to respond. There was also a clear recognition that the management team showed awareness and a commitment to take difficult decisions. The report stated that the Trust needed stability within the leadership team to take the Trust forward.

Overall, out of the 115 different indicators covering five domains, 2 were ranked outstanding, 54 good and 13 inadequate, eight in maternity or paediatrics. The remaining indicators were rated as 'requires improvement'. However, the overall rating was 'inadequate' as there were two inadequate ratings overall.

The Interim CEO emphasised that the two overall inadequate ratings related to maternity and children's services. This service has been struggling due to the delay in reconfiguration and staff have been working to ensure a safe service on a daily basis. This has probably led to a focus on the 'urgent rather than the important'. Since July, enhanced support has been provided to these areas and the temporary centralisation of services has also increased resilience.

He then outlined the progress with the PCIP – 65% of the actions had already been completed. Urgent action was needed within urgent care to reduce occupancy levels.

Finally, he stated that he has requested the CQC to return to the Trust in the next few months to ensure that the Trust can be removed from Special Measures as soon as possible. He urged people to read the report in full which provided a more balanced view overall, and commended many aspects of the care delivered and the progress being made. He urged everyone to promote Worcestershire as a great place to work and not to let negative campaigning and headlines affect staff morale.

In response to Mr Burbeck, the Interim CEO stated that he whilst was disappointed that the Trust has been put into Special Measures, he and the clinical leaders hoped that this would be the catalyst to improve services and move the new clinical model onto the next stage.

Mr McGinity asked for more information on the outpatients and diagnostics rating. The Interim CEO stated that this rating could be the result of a number of issues such as poor scheduling, accommodation (poor seating) and communication e.g. radiology concerns about equipment. The Clinical Support division had been asked to put an action plan in place.

Mr Sleigh welcomed the report. He was pleased that the NHS undertook such detailed visits. He stated that most of the 'inadequate' ratings could be improved quickly. He stated that some actions were needed across the whole health economy – and the Trust could take a leadership role in this. He suggested three and six month trajectories. The Interim CEO stated that he needed to discuss the issues with the TDA and CQC.

Mrs Todd left the meeting.

The Interim COO emphasised the importance of whole system integration and there were huge opportunities to improve efficiency and integration. The Chairman stated that he was meeting with the Health and Care Trust to take this forward.

Resolved: that
The Board:

- Noted the presentation
- Noted the placing of the trust in Special Measures
- Noted the outstanding rating for 'caring' in Maternity services
- Noted the investigation into the rating for outpatients and diagnostics
- Noted the report.

187/15 WORKFORCE

187/15/1 **Workforce Assurance Group**

Mr Burbeck confirmed that he has requested the presence of a division to discuss the poor sickness and appraisal rates. The first medical workforce report will be available at the next Trust board meeting. He recommended the Board to approve the two policies which have been substantially reviewed following the report from the Good Governance Institute. The policies are on the website.

Mr McGinity requested that the Workforce Assurance Group oversee the locum and agency expenditure. This was agreed.

Resolved: that
The Board

- Endorsed the Whistleblowing and Dignity at work policies
- Noted the Junior Doctor Pay Negotiations
- Noted Employee Engagement
- Agreed to the WAG overseeing the locum and agency costs
- Noted the report.

187/15/2 **Nursing and Midwifery Workforce**

The Interim CNO highlighted of areas of concern. Within the Medicine division, there was active recruitment which has shown improvement in 12 areas. Work continues on recruitment strategies. There are some issues with A&E vacancies at WRH. She stated that the paediatric services had low occupancy so the fill rates were also low. No low fill rate contributed to any harm event. She was currently undertaking the mid-year workforce review and will report at the next meeting.

She went onto explain that she was reviewing whether to recruit internationally.

Mr Howarth reported that he, as the Being Open Champion, had received a report of low staffing numbers which was being investigated. He was pleased that staff were able to raise concerns.

Resolved that
The Board:-
Noted issues related to the nursing and midwifery workforce relating to:

- Nursing and midwifery workforce metrics and actions to improve recruitment and retention
- Safe staffing status
- Workforce review for the organisation

- State of preparedness for nursing revalidation

187/15/3 **Staff Equality and Diversity report 2015/16**
The Director of HR/OD explained that the report had been discussed at WAG.

Resolved that
The Board:-

- Noted the report and the work being undertaken on the EDS2 Action Plan

188/15 **STRATEGY**

188/15/1 **The Future of Acute Hospital Services in Worcestershire (FoASHW)**
The Interim CEO explained that the report showed the timeline and reasons for the temporary suspension of maternity.

The Interim CMO confirmed that the Quality and Sustainability Subgroup approved the revised model for the urgent care pathway for children at the Alexandra Hospital. The proposal will go to the FoAHSW board on 9 December. He hoped that public consultation would be urgently taken forward as all partners are in agreement that this is the next step within the Programme.

Resolved that
The Board

- Noted the factors leading up to the emergency centralisation and neonatal and maternity services
- Endorsed the decision made.

189/15 **FINANCE AND PERFORMANCE**

189/15/1 **Finance and Performance Committee Report**
Mr McGinity reported that financial performance in month 7 had been very disappointing. Staff costs remain a concern with a high level of medical locums. It is essential for the CCGs and whole health economy to support the Trust. The cash position is very concerning.

Finally, Mr McGinity recommended the Board approve the revised terms of reference.

Resolved that:-
The Board

- Received the concern expressed about the further deterioration of the position by £5.8m to £34.7m deficit.
- Noted that the forecast before mitigations and excluding additional winter capacity costs stands at £61.6m and the proposed actions to improve on this position.
- Received the Committees concerns regarding the precarious cash position and the escalation in reporting to the Department of Health.
- Noted the likelihood of mediation on the local CCG contract positions.
- Noted the improvement of some key performance metrics.
- Noted the Committees endorsement of the investment in a Urology consultant and essential computers for clinical areas.
- Noted the TDA self-assessment submission
- Approved terms of reference.

189/15/3 **Financial Performance Report**
The Interim DF confirmed that the month 7 year end position is a forecast deficit of £61.6m. He stated that he has met with the TDA and has, on their advice, submitted a

year-end position of £31.3m pending agreement of a revised final number. He stated that he is concerned that a number of risks are not included in the projected £61.6m figure, including winter. He was disappointed that there was no agreement with the CCGs over their contribution towards the Trust's costs for winter.

He went onto state that the month 7 position worsened by £800k. The main areas continue to be agency and locum spend. He stated that the Trust did not yet have a sufficient grip on the run rate but that a plan had now been agreed with the Executive Team to set targets for reducing temporary staffing costs.

The Interim DF informed the Board that the cash position was concerning. The previous Interim DF together with the Interim CEO have met with the Department of health to discuss the need for more cash. The position is such that some suppliers are currently being delayed with their payments.

Mr Howarth confirmed that suppliers would eventually be paid. Mr McGinity, whilst acknowledging that this was technically correct, payment was still needed to ensure cash flow down the supply chain.

Mr Burbeck asked why the permanent staff figures were increasing, but the agency and locum costs were not decreasing. The Interim DF stated that understanding the detail of the agency and locum costs was essential and he would be covering this as a paper in the private section of the Board. It was noted that extra capacity to deal with increased demand was one factor.

Mr McGinity challenged the non pay expenditure, particularly in respect of theatres. The Interim CEO stated that he was hopeful that the theatre utilisation work would show an effect in the following month. The Interim COO reminded members that fines would have a huge impact on these figures.

The Interim CEO concurred and noted that instead of reinvesting the money, as per the national guidance, the CCGs were instead using the fines to commission extra activity. It was also noted that the CCGs had significant financial challenges but it was felt that this was not an appropriate use of money from fines. Mr Howarth reminded members that the internal audit report on ambulance waiting showed that the Trust was being fined for some areas which it should not be.

Resolved that:-
The Board

- Noted that the Trust is now forecasting a revised year end position of £61.6m based on a continuation of current trends and excluding the potential costs of winter capacity. The Board also noted that further mitigating actions are being considered to improve on this position and to achieve the 'upside' scenario significant changes to operations are required.
- Noted that the Trust must rigorously pursue the agreed recovery actions as well as identifying further mitigations linked to a review of the Trust's risk appetite. In order to tackle the adverse financial position and urgently demonstrate an improvement in the run rate this must focus on:
    - Exploiting the Clinical Decisions Unit (CDU) and Ambulatory Care
    - Compliance with new controls on non-pay restrictions
    - Locum expenditure being micro-managed
    - Increased targets and micro management of nursing
    - agency
    - Further theatre productivity gains
    - Manage down Medically fit for Discharge (MFFD)

  - Ensuring new costs do not enter the system
- Noted that the Trust is off plan driven by the consequences of operational problems.
- Noted that the locally agreed deadline for reaching a year end settlement (including 2014/15 outstanding issues) has passed therefore the Trust will be disputing fines and/or seeking re-investment due to mitigating circumstances. The Board recognised the continued risk around the Risk Share agreement with the Clinical Contracting Groups (CCGs) which remains unsigned.
- Noted that the Trust has received additional funding of £5.2m above its agreed working capital facility.

189/15/3 **Corporate Plan update**

The Director of SP&I provided a summary update for the first two quarters on the Trust's main objectives. The Report also covered the planned actions for the next period.

Resolved that:-
The Board

- Received the Q1/Q2 update on the 2015/16 Corporate Plan
- Reviewed progress to date and the planned actions for the next period

190/15 **GOVERNANCE**

190/15/1 **Audit and Assurance Committee**

Mr Howarth reported that the Internal Audit report into complaints had been considered. The report into ambulance handover showed a review was needed in respect of fines being levied. He was disappointed that the Contract Management Board was still not operating inside the reviewed terms of reference, particularly in respect of the attendance of senior officers, from all health partners. The Interim CEO agreed, but stated that the Board needed to operate more strategically to ensure the effective use of senior leaders' time.

The Director of Communications left the meeting.

Resolved that:-
The Board

- Noted the introduction of Audit Panels
- Noted the receipt of the internal audit reports
- Noted the receipt of the PWC Governance Report and that the action plan will be monitored at the meeting
- Noted the work being undertaken on data quality
- Noted the update on the contract management board
- Noted the report

190/15/2 **Turnaround Board**

Resolved that:-
The Board

- Noted that the PWC report on benchmarking was received by the Turnaround Board and those actions not already incorporated, will be merged into the Financial Turnaround Plan.
- Noted the proposed pilot of a review of change capability and capacity within the Trauma and Orthopaedic directorate
- Noted the report

190/15/3 **Review of Board Assurance Risks**

The Chairman led a discussion to review the board assurance risks previously discussed. The following were agreed:

2665	No further actions
2668	No further actions
2678	Progress being made
2790	Include ECIP recommendations
2880	No further actions
2891	No further actions
2895	No further actions
2902	The Director of SP&I confirmed that more work was being undertaken to map the actions already in train for Sign up to Safety.
3028	Broaden risk to include executive directors
3038	No further actions
2903	Raise the risk rating to 'red'

The Director of Communications returned to the meeting

Resolved that:-
The Board

- Discussed the BAF
- Agreed to raise the rating of 2903

DATE OF NEXT MEETING

The next Trust Board meeting will be held on Wednesday 3 February 2015 at 09:30 in the Kidderminster Education Centre, Kidderminster Hospital and Treatment Centre

The meeting closed at 15:47 hours

Signed _____ **Date** _____

Harry Turner, Chairman

Enc B

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

PUBLIC TRUST BOARD ACTION SCHEDULE – AS AT 3 FEBRUARY 2016

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
2-12-15	IPR	185/15/2	Milestones inserted in narrative	SS	Feb 2016		Within IPR. Closed.	
2-12-15	PCIP	186/15/2	Invite the TDA to attend a Board development session to speak about mortality	KS	Jan 2016		Presentation on 27 January. Closed.	
2-12-15	Workforce Assurance Group	187/15/1	WAG to monitor locum and agency expenditure	DH			Transferred to WAG. Closed	
4-11-15	Nursing and Midwifery workforce	166/15/2	Report on the medical workforce	AP	Dec 2015	Feb 2016	Report discussed January 2016. Closed.	
4-11-15	Interim CEO report	163/15	Presentation on cystic fibrosis service	KS	Jan 2016		Presentation 27 January 2016. Closed.	
2-12-15	Interim CEO report	184/15	Monitor the pathology server room flood	RM			Transferred to QGC. On agenda for 10-12-15	
2-12-15	QGC report	186/15/1	Align the GMC survey results with the HEWM visit report	AP	Feb 2016		Referred to WAG	

2-12-15	Interim CEO report	184/15	Big conversation update	LT	Feb 2016		On work plan	
2-12-15	BAF	185/15/1	Various changes	MG	Feb 2016		Actions emailed to Risk Manager (4-12-15)	
7-10-15	PCIP	140/15/2	Develop a metric showing overall benefit of the actions to improve patient care	SS	tba			
9-9-15	CEO report	116/15	Baseline assessment and audit for seven days services	WAG			Transferred to WAG. Needs to be bought to TBoard	
9-9-15	BAF risk	117/15/1	Review OD strategy at a future board development session	DH	Tba			

Worcestershire NHS
Acute Hospitals NHS Trust

Date of meeting: 3 February 2016 **Enc C2**

Report to Trust Board

Title	**Interim Chief Executive's Report**
Sponsoring Director	**Chris Tidman, Interim Chief Executive**
Author	**Kimara Sharpe, Company Secretary**
Action Required	• Note the successful recruitment event • Note the Breast Unit update • Note the contents of the report.
Previously considered by	Not applicable

Strategic Priorities (√)

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

Related Board Assurance Framework Entries	None.
Legal Implications or Regulatory requirements	None
Glossary	Sustainability and transformation plan (STP)

Key Messages

This report is provided to inform the Board on issues relating to the activity of the Trust and national policy that the Board needs to be aware of but which do not themselves warrant a full Board paper.

Title of report	Interim Chief Executive's Report
Name of director	Chris Tidman

Date of meeting: 3 February 2016 **Enc C2**

REPORT TO PUBLIC TRUST BOARD – 3 FEBRUARY 2016

1 Situation

This report aims to brief Board members on various issues.

2 Background

The Chief Executive's report is provided to inform the Board on issues relating to the activity of the Trust and national policy that the Board needs to be aware of but which do not themselves warrant a full Board paper.

3 NHS Planning Guidance 2016/17 to 2020/21

The Trust delivered an away day on 19 January which explained to senior managers the new approach to planning and the timescale for the delivery of the STP (Sustainability and Transformation Plan. To gain an external commissioner perspective, The Director of Delivery for Redditch and Bromsgrove CCG presented the CCGs' priorities, challenges and views.

The new planning guidance requires a planning foot print to be developed and agreed. The footprint for Worcestershire will include Herefordshire. There is no suggestion that this will mean any structural changes to the current statutory bodies, but that it signals the need for CCGs and providers to work more collaboratively in order that clinical services can be sustainable.

4 Progress on reducing Agency Spending

The Executive Team continue to review agency spend on a weekly basis. Good progress is being maintained. On nursing, the main areas of pressure relate to Theatres, A&E and mental health specialling for stranded patients. Plans are in place to improve recruitment, bank arrangements and to expedite discharge of our most complex stranded patients, to both improve care and reduce cost. For medical agency staff, we continue to see a large number of consultant and middle grade vacancies which are linked to the current sub optimal configuration of countywide services. Progressing the clinical model to public consultation will be a catalyst to recruitment. A further national cap is being introduced on 1 February 2016. Further information is provided through the Finance reports.

5 CCG Accountable Officer - change

The Accountable Officer for Redditch and Bromsgrove CCG, Simon Hairsnape, has moved to become the Accountable officer for Herefordshire CCG. The post of Accountable officer for Redditch and Bromsgrove will be replaced on an interim basis through Simon Trickett. We would like to wish both Simon's well in their new roles.

6 Pharmacy Director

Richard Cattell has commenced as the Trust's new Pharmacy Director to help improve patient experience and care through medicine optimisation. Richard brings with him a wealth of knowledge to the role, having carried out many high-level positions within the NHS.

7 Successful hospital recruitment event

Over 120 registered nurses, midwives and current and aspiring healthcare support workers attended a hospital recruitment event on 23 January.

The event, which took place at the Alexandra Hospital in Redditch, showcased the opportunities available at Worcestershire Acute Hospitals NHS Trust's three sites – the Alexandra, Kidderminster and Worcestershire Royal Hospitals.

Over 70 people were interested in healthcare assistant roles, taking the time to speak about apprenticeships as well as full time job opportunities.

The HR team were also kept busy helping people to register online and apply for jobs on the day of the event. 17 people were actually interviewed on the day for full time jobs.

8 Breast Unit update

The Unit was handed over as planned in December 2015 with an opening date of the end of February. I would like to put on record my thanks to the amazing efforts of those over the years that have raised the funds for this wonderful facility, and particularly the individuals that established the Worcestershire Breast Campaign.

9 Emergency Care Improvement Programme / A& E expansion at WRH

Worcestershire Health and Social Care continues to receive intensive support from the ECIP team, with a major focus being on the implementation of ambulatory care at the 'front door' and the expediting of discharge plans for our 'stranded patients' – these are all patients that have been in an acute bed for greater than 7 days. The learning from pilots and events have been invaluable, and all partners are committed to streamlining systems and processes to ensure smoother step down processes, with an emphasis on 'home first' wherever possible.

The public will have also seen the building work commenced on our expanded Emergency Department. The scheme remains on budget and we expect to fully open up to the extra capacity later in the spring, which will provide the necessary space to manage the increases we have seen in blue light ambulances.

10 Junior Doctors – Strike Action

The trust coped well during the first Junior Doctor strike held on 12 January. Contingency plans remain in place in the event of any further action, although it is hoped that an amicable settlement will be reached

11 Consultant appointments

Please see list appended to this report.

12 Trust Management Committee (13-1-16)

12.1 Corporate risk register: This was presented to the TMC and the amendments accepted.

12.2 TACO/Clinical Services: The theatre bank will be operational by the end of January which will reduce the use of agency staff.

Medicine: There continues to be a focus on the development of an ambulatory care unit. There remains a significant number of open unfunded beds to cope with the winter pressures. This is causing pressures on the staffing and thus the financial position for the division.

Women and Children: Maternity and neonatal staffing and services are now more resilient following the temporary suspension. However, there continues to be challenges with access to beds for gynaecology patients, with an interim plan being

developed to transfer more inpatients to the Alexandra Hospital.
Surgery: Challenges remain in relation to recruitment on the Alex site. Work continues to maintain the RTT incomplete standard with oral maxillofacial reporting 100% seen within the standard and Breast Surgery reporting 97.74%.

12.3 **Cancer update**: Progress was reported on the National Cancer Peer Review programme. This is an annual mandatory peer review programme. One team underwent an external review and no immediate risks or serious concerns were raised. The Cancer Board has been refreshed with new terms of reference and membership to strengthen clinical governance and provide continuous monitoring. The new Radiotherapy Centre and new Trust-based oncologists have provided and improved local access to treatment for our patients and there is comprehensive high quality patient information offered by cancer teams and the Macmillan Cancer Information and Support Service, including the provision of the Worcestershire Patient folder. Access to high level psychological support for cancer patients and clinical supervision for staff members delivering NICE guidance level two psychological support is limited. Clinical pathways are in place but require review and update for all cancer teams and services across the Trust.

13 National Update

13.1 New national clinical director structure

NHS England has confirmed that its national clinical director (NCD) roles will be reshaped to create a "more coherent structure" and to reduce costs. Eight NCD posts will be cut as a result of the reorganisation, with the remaining NCDs to be grouped under three main areas: major programmes; service improvement; and population group. Major programme NCDs will cover: learning disabilities, cancer, mental health, diabetes and obesity, urgent and emergency care and maternity and women's health. Service improvement NCDs will cover: cardiac services, stroke, respiratory, end of life care, diagnostics including imaging and endoscopy, musculoskeletal, dementia, emergency preparedness and critical care. Population group NCDs will cover: children, young people and transition to adulthood, older people and integrated person centred care.

13.2 National guardian for freedom to speak up appointed

The Care Quality Commission has appointed Dame Eileen Sills DBE, chief nurse at Guy's and St Thomas' NHS Foundation Trust, as its first national guardian for the freedom to speak up safely in the NHS. Dame Eileen, whose post will be independent, will work in partnership with the CQC, NHS England and NHS Improvement to help in leading a cultural change, initially within NHS foundation trusts and trusts, with the aim of ensuring that healthcare staff always feel confident and supported to raise concerns about patient care. A network of individuals within foundation trusts and trusts appointed as local freedom to speak up guardians will be led, advised and supported by Dame Eileen, and will be responsible for developing a culture of openness at trust level. Dame Eileen will also share good practice, report on national themes and identify barriers preventing the NHS from having a safe and open culture.

13.3 Birmingham foundation trusts plan merger

Birmingham Children's Hospital and Birmingham Women's Hospital NHS Foundation Trusts have announced that they will merge. This should be completed by late summer. There is already a joint CEO.

14 Recommendation

The Board is asked to

- Note the contents of the report.

Chris Tidman
Interim CEO

Date of meeting: 3 February 2016 **Enc C2**

Consultants who joined the Trust in January

Name			Start date	Specialty
Title	First name	Surname		
Dr	**Eftihia**	**Yiannakis**	04/01/2016	Consultant Medical Microbiologist
Dr	**Dimitrios**	**Fotopoulos**	04/01/2016	Consultant Radiologist
Mr	**Geraint**	**Williams**	11/01/2016	Consultant Ophthalmologist

No consultants left the Trust in December.

Worcestershire NHS
Acute Hospitals NHS Trust

Date of meeting: 3 February 2016 **Enc D1**

Report to Trust Board in public

Title	**Board Assurance Framework (BAF)**
Sponsoring Director	Mari Gay, Interim Chief Nursing Officer
Author	Justin King, Trust Risk Officer
Action Required	Trust Board is asked to: • Note the changes to the BAF • Review risk ratings, controls, assurance and mitigating actions and consider if these are reasonable • Approve the risk updates
Previously considered by	Risk Executive Group & TMC

Strategic Priorities (√)

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

Related Board Assurance Framework Entries	This paper relates to all BAF risks
Legal Implications or Regulatory requirements	NHS guidance states that Trusts are expected to have a Board Assurance Framework. This is monitored through the TDA and Monitor for Foundation Trusts. The approval of a BAF is a requirement for the Trust and forms part of the internal and external assurance requirements.
Glossary	BAF – Board Assurance Framework

Key Messages
This paper provides the Board with its monthly update on the BAF.

Worcestershire NHS
Acute Hospitals NHS Trust

Date of meeting: 3 February 2016 **Enc D1**

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

REPORT TO TRUST BOARD – FEBRUARY 2016

1. Situation

Trust Board is provided with the BAF Risk Register which has been updated following the January 2016 Trust Board meeting.

2. Background

NHS Trusts are required to have a Board Assurance Framework (BAF). Trust Board review the high BAF risks monthly.

3. Assessment

The risks recorded on the 2015/16 BAF Risk Register have been reviewed by the responsible Executive Directors. The following changes have been made, and actions updated.

The following risk be removed from the register as it was focused on specific external reports:

2903 Media interest and external reports damage Trust reputation, impacting on retention and recruitment and patient confidence.

It has been replaced with the following broader risk:

3140 If the Trust doesn't proactively manage its reputation, regional confidence and recruitment will be adversely affected

The risks regarding Executive Directors on leave (2932), and Expiry of NED terms of office (3028) have been merged into risk 2932 and the title amended as follows:

2932 Turnover of Trust Board members adversely affecting business continuity and impairing the ability to operate services

The rating of the following risk has been downgraded:

2895 If we do not adequately understand & learn from patient feedback we will be unable to deliver excellent patient experience

Previous rating	Major (4) x Likely (4) = High (16)
New rating	Moderate (3) x Likely (4) = Moderate (12)

4 Action required

Trust Board is asked to:

- Note the changes to the BAF
- Review risk ratings, controls, assurance and mitigating actions and consider if these are reasonable
- Approve the risk updates

Mari Gay
Interim Chief Nursing Officer

Title of report	Board Assurance Framework (BAF)
Name of director	Chief Nursing Officer

Worcestershire NHS
Acute Hospitals NHS Trust

Board Assurance Framework:

Risk Register 2015/16

High Risks

Trust Board

January 2016

Principles of the Approach:

This document is intended to be dynamic. Each potential risk is given a score (risk level) that is derived from consideration of the consequences for the achievement of the objective(s) (or impact) and the probability of the risk arising (likelihood). The scoring has taken account of the controls and assurances that are in place to mitigate the risk.

Where gaps are identified in controls or assurances, a corresponding action plan is included. A second 'anticipated risk score' is then calculated, which reflects the level of risk posed to the achievement of the relevant objective once the appropriate action has been completed. (Where the action is split into several stages, a single score is awarded for all stages).

As actions are completed, additional controls and assurances resulting from those actions will be registered in the appropriate sections. The gaps will be removed and where possible, the risk level reduced (in terms of probability and/or impact) accordingly. Risks on the assurance framework will not be removed if the risk level is reduced, but will remain so as to provide continued assurance to the Board that controls and assurances are in place.

SECTION 1 – HARM / CONSEQUENCE SCORING					
	1	2	3	4	5
Descriptor	**Insignificant**	**Minor**	**Moderate**	**Major**	**Catastrophic**
OBJECTIVES **Achievement of organisational / strategic objectives**	Negligible effect upon the achievement of the objective	Small, but noticeable effect upon the objective, thus making it achievable with some minor difficulty / cost	Evident and material effect upon the objective, thus making it achievable only with some moderate difficulty / cost	Significant effect on the objective making it extremely difficult / costly to achieve	Catastrophic effect on the objective making it unachievable.
CLINICAL **Impact on the safety of patients (physical/ psychological harm)**	Incident prevented / near miss. Incident not prevented but **NO HARM** was caused	Any patient safety incident that required extra observation or **MINOR** treatment and cased minimal harm to one or more patients e.g. first aid, additional therapy or additional medication	Any patient safety incident that resulted in a **MODERATE** increase in treatment and that caused significant but not permanent harm to one or more patients Moderate increase in treatment is defined as: a return to surgery; an unplanned readmission; a prolonged episode of care; extra time in hospital or as an outpatient; cancelling of treatment; transfer to another area such as intensive care - as a result of the incident.	Any patient safety incident that appears to have resulted in permanent (**SEVERE**) harm to one or more patients Permanent harm directly related to the incident and not related to the natural course of the patient's illness or underlying condition is defined as: permanent lessening of bodily functions, sensory, motor, physiological or intellectual, including removal of the wrong limb or organ, or brain damage.	Any patient safety incident that directly resulted in the **DEATH** of one or more patients The death must be related to the incident rather than to the natural course of the patient's illness or underlying condition.
Quality/ complaints/ audit	Peripheral element of treatment or service suboptimal Informal complaint/ inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) - Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) - Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Service actively causing patient harm Gross failure of patient safety if findings not acted on Non coronial Inquest/ ombudsman inquiry Gross failure to meet national standards
OPERATIONAL **Service/business interruption** **Environmental impact**	Loss/interruption of >1 hour No impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment
Impact on staff or public (physical/ psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury requiring minor intervention Requiring time off work but less than 7 days	Moderate injury requiring professional intervention Requiring time off work for 7 -14 days RIDDOR/agency reportable incident	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days	Incident causing death Multiple permanent injuries or irreversible health effects
FINANCIAL	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget	Loss of 0.25–0.5 per cent of budget	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget	Non-delivery of key objective/ Loss of >1 per cent of budget
INFORMATION GOVERNANCE	Minor breach of confidentiality. Up to 10 individuals affected (scale 0)	Information up to 100 individuals (scale 1&2) Local media coverage	Serious breach of confidentiality e.g. Information for 101 – 1000 individuals (scale 3) Local media coverage ICO fine up to £50k	Serious breach with either particular sensitivity e.g. sexual health details, or up to 1001 – 100 000 people affected ICO fine of £50k to £250k	Loss of all systems / data Very sensitive information Information about 100,001 + individuals ICO fine of £250k to £500k National media attention
REPUTATION	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence	Local media coverage Long-term reduction in public confidence	National media coverage requiring significant action	National media coverage impacting on our ability to function
COMPLIANCE **Statutory duty/ inspections**	No or minimal impact or breach of guidance/ statutory duty	Breach of statutory legislation Reduced performance rating if unresolved	Single breach in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breaches in statutory duty Improvement notices Critical report	Multiple breaches in statutory duty Prosecution Severely critical report

SECTION 2 - LIKELIHOOD OF OCCURRENCE

Score	Operational scale Time until next event	Project and strategic planning scale Probability within planning period
1 - Rare	Will only occur in exceptional circumstances	Less than 1%
2 - Unlikely	Next event expected within a year	25%
3 - Possible	Next event expected within a month	50%
4 - Likely	Next event expected within a week	75%
5 - Almost certain	Next event expected to occur within a day	More than 99%

SECTION 3 - RISK SCORING MATRIX

		CONSEQUENCE				
		1	**2**	**3**	**4**	**5**
LIKELIHOOD	**1**	**1**	**2**	**3**	**4**	**5**
	2	**2**	**4**	**6**	**8**	**10**
	3	**3**	**6**	**9**	**12**	**15**
	4	**4**	**8**	**12**	**16**	**20**
	5	**5**	**10**	**15**	**20**	**25**

SECTION 4 - ACTION AND REPORTING REQUIREMENTS

Score	Risk	Action	Reporting Requirements
1-6	Risk is within tolerance	Within risk appetite / tolerance Managed through normal control measures at the level it was identified	Within tolerance so no reporting Record on risk register at the level the risk was identified
8-10		Within risk appetite / tolerance Review control measures at the level it was identified	Within tolerance so no reporting Record on risk register at the level the risk was identified
12-15	**Risk Exceeds tolerance**	Exceeds risk appetite / tolerance Actions to be developed, implemented and monitored at the level the risk was identified	Record on Risk Register at the level the risk was identified Report to next level of management
16-25		Exceeds risk appetite / tolerance **Immediate action required** Treatment plans to be developed, implemented and monitored at the level the risk was identified	Record on Risk Register at the level the risk was identified Report to next level of management With Executive Director approval - enter onto Corporate Risk Register

BAF risks mapped to Strategic Goals

Deliver safe, high quality, compassionate patient care	*Design healthcare around the needs of our patients, with our partners*	*Invest and realise the full potential of our staff to provide compassionate and personalised care*	*Ensure the Trust is financially viable and makes the best use of resources for our patients*	*Develop and sustain our business*
Quality Governance Committee	**Quality Governance Committee**	**Workforce Assurance Group**	**Finance and Performance Committee**	**Quality Governance Committee**
2902 If the Trust does not successfully improve clinical care, we will fail to reduce avoidable harm to expected levels (CMO) **16**	3038 If the Trust does not address concerns raised by the CQC inspection the Trust will fail to improve patient care (CNO) **16**	2932 Turnover of Trust Board members adversely affecting business continuity and impairing the ability to operate services (CE) **20**	2888 Deficit is worse than planned and threatens the Trust's long term financial sustainability (FD) **20**	2790 As a result of high occupancy levels, patient care may be compromised and access targets missed (COO) **20**
2891 If the Trust does not learn from mortality reviews this knowledge will not be available to support improvements to patient care (CMO) **16**	2895 If we do not adequately understand & learn from patient feedback we will be unable to deliver excellent patient experience (CNO) **12**	2678 If we do not attract and retain key clinical staff we will be unable to ensure safe and adequate staffing levels (DHR) **16**	2668 If plans to improve cash position do not work the Trust will be unable to pay creditors impacting on supplies to support service (FD) **16**	2665 If we do not achieve wider service redesign in a timely way we will have inadequate numbers of clinical staff to deliver quality care (CMO) **20**
3140 If the Trust doesn't proactively manage its reputation, regional confidence and recruitment will be adversely affected (DC) **12**	2898 Poor communication with patients resulting in reduced quality of patient experience, complaints and reputation damage (CNO) **12**	2894 Failure to enhance leadership capability resulting in poor communication, reduced team working, and delays in resolving problems (DHR) **15**		2904 If there is inadequate culture and staff development for improvement, the Trust will not be able to continuously improve (DSPI) **12**
	2899 Failure to provide seven day per week services resulting in inconsistent quality of care, increased LOS, reduced clinical outcomes (COO) **12**	2893 Failure to engage and listen to staff leading to low morale, motivation, and productivity (DHR) **12**		2905 Failure to transform our services, resulting in inability to deliver required improvement (DSPI) **12**
	2900 If the Trust does not expand renal services, patients will have to travel further and experience fragmented care (COO) **12**			

BAF Risk Report

Worcestershire NHS
Acute Hospitals NHS Trust

Risk	**2665 If we do not redesign services in a timely way we will have inadequate numbers of clinical staff to deliver quality care**
Date opened	22/04/2014
Strategic goal	Develop and sustain our business
Strategic objective(s)	Provide excellent patient experience
Initial Risk Level	Major Almost certain 20 High

Director/Committee	Chief Medical Officer / Trust Management Committee
Description/Impact	If we do not redesign services (county wide reconfiguration)in a timely way we will have inadequate numbers of clinical staff to ensure safe, high quality care that is sustainable. As a result, the Trust will be unable to finalise its longer term strategy and may have a resultant deterioration in its financial position affecting its ability to be a standalone provider. Increased costs from high reliance on temporary staff affecting financial position of the Trust. The Trust may be unable to implement the large-scale changes required to services - further deterioration of clinical safety and quality, low staff morale. Loss of clinical staff to other providers. Reputational damage.
Key Controls	Specialty specific risk mitigation plans set out in line with the schedules and thresholds for action by Division. Escalation of risks to TMC. Trust led Future of Acute Hospital Services in Worcestershire (FOAHSW) Project established. Sustainability sub-committee of Programme Board
Sources of Assurance	Management Assurance-Divisional reports to the Safe Patient Group Management Assurance-Safe Patient Group report to the Quality Governance Committee Internal reports to the Board-Standing Board agenda item on reconfiguration. Management Assurance-FOAHSW Programme Board Independent Assurance-Health Gateway Report Independent Assurance-NHS England

Performance Monitoring	The Corporate Risk Register contains FoAHSW staffing sustainability risks for the Medicine, Surgery and Women and Children divisions. These risks have a suite of key staffing and clinical quality performance metrics with associated performance thresholds. These are reported to Trust Management Committee monthly. Annual Plan Objectives Monitoring Template FoAHSW Project Board reports
Gaps in Control	Timetable for reconfiguration consultation, outline business case approval and capital availability remains unclear at this stage Contingency plan to include appropriate agreed mitigations, pending output of the Clinical Senate Public consultation will require consideration and potential subsequent review of plan Commissioners required to submit separate business case to NHSE - uncertainty of outcome
Gaps in Assurance	Lack of certainty in proposed timeline and achievement of reconfiguration

Current Risk Level Major Almost certain 20 High

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Develop and gain endorsement for model of reconfiguration	Andy Phillips Interim Chief Medical Officer	16/05/2016	November 2015: Option not unanimously endorsed by FoAHSW Programme Board on 23rd October. Option to be refined at an extraordinary Quality and Sustainability Sub-committee. December 2015 update: FoAHSW Programme Board have endorsed the QSS model of paediatric care in the county. Due date updated to reflect the time required to go to the clinical senate and then NHS England for endorsement.	
ASR Project developing detailed business case(s) for interim and permanent solutions.	Chris Tidman Acting Chief Executive	18/07/2016	Due date updated as a result of delays in endorsement for the model.	
Planned consultation and engagement during the public consultation on reconfiguration	Andy Phillips Interim Chief Medical Officer	18/07/2016	Public consultation contingent on endorsement. Due date changed again to reflect time required for consultation.	
Development and Board sign off of the contingency plan (quality thresholds exceeded).	Mark Wake Chief Medical Officer	31/01/2015	Trust Board has agreed interim measures. Acute Surgery implemented. High risk obstetrics and paediatric surgery under discussion.	12/12/2014
Work underway within General Surgery, gynecology and Obstetrics and paediatrics regarding interim plans to ensure safety of service provision and staffing levels	Andy Phillips Interim Chief Medical Officer	30/09/2015	TDA supporting assistance from other trusts with medical rotas. Continuous monitoring and interim plans have been established. Continued recruitment processes in place Weekly review of staffing levels and trigger points for safe staffing levels in place	21/09/2015

BAF Risk Report

Worcestershire NHS
Acute Hospitals NHS Trust

Develop trigger points for escalation in services affected by reconfiguration delays.	Andy Phillips Interim Chief Medical Officer	31/12/2015	Trigger points established for W&C specialities and endorsed by Trust Board and partners. Developed for Surgery. Performance monitoring tool established.	15/12/2015

Target Risk Level	Major	Unlikely	8	Low

Progress	Timetable and delivery plan delayed. November 2015: Emergency action taken on the 5th November to temporarily move maternity and neonatal services from Alexandra Hospital to the Worcestershire Royal Hospital. Outpatient, day assessment and community midwifery services continue as normal. Model for reconfiguration not unanimously endorsed by FoAHSW Programme Board on 23rd October 2015. The Quality and Sustainability Subcommittee agreed to create a single item task and finish group to propose a model for paediatric care in the county. On 12th November 2015 the group met and agreed an option which will be refined and endorsed at an extraordinary Quality and Sustainability Subcommittee. December 2015 update: Back on road to public consultation pending appropriate scrutiny and endorsement by Clinical Senate and NHS England.

Next Review Date 08/02/2016

BAF Risk Report

Worcestershire NHS Acute Hospitals NHS Trust

Risk	**2668 If plans to improve cash position do not work the Trust will be unable to pay creditors impacting on supplies to support service**
Date opened	22/04/2014
Strategic goal	Ensure the Trust is financially viable and makes the best use of resources for our patients
Strategic objective(s)	Use resources wisely
Initial Risk Level	Major Likely 16 High

Director/Committee	Finance Director / Finance and Performance Committee
Description/Impact	Description: If plans for improving cash position do not materialise the Trust will not be able to pay creditors which ultimately could impact on supplies to support service delivery. Impact: Inability to meet cash requirements with resultant impact onto Continuity of Service (COS). Reduced capacity and capability to achieve change Reputational damage and confidence in Board. Will trigger further action by TDA. Suppliers ceasing provision of products and services impacting operations and patient care Interest payments increase over time
Key Controls	Further working capital loan or PDC requested. Daily cashflow forecasts Close management of working capital to prioritise creditors Delivery of financial plan
Sources of Assurance	Management Assurance-Monthly monitoring of cash position by F&P Committee. Internal Audit-Financial Management Arrangements & Reporting Audit Internal Audit-Core Financial Transaction Processing Internal Audit

Performance Monitoring	Financial reports to Finance & Performance and Trust Board
Gaps in Control	Confirmation of capital availability to meet needs of Trust.
Gaps in Assurance	Still lack of clarity on the actual availability of cash from the DH

Current Risk Level Major Likely 16 High

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Conduct a review of the Trust's risk appetite to reduce expenditure and ensure compliance with the agency caps	Rob Cook Transformation Support	15/02/2016		
Public Dividend Capital (PDC) /Loan application to be made to Independent Trust Financing Facility alongside Long Term Financial Model in August, with Trust Development Authority support	Chris Tidman Acting Chief Executive	31/10/2014	Revenue cash injection application approved as PDC (£26.5m)and the Trust has been recently advised of terms and condiitons which have been reported to FPC.	22/12/2014
Bidding for any National funds available	Chris Tidman Acting Chief Executive	28/02/2015	The Trust has been successful in the Integrated Digital Care Fund Bid but the value has been reduced to £1.3m of which £0.8m will be received this year. The Trust has been unsuccessful in the other bid against the Nurse Tech Fund.	28/02/2015
Submit application for £4.95m distressed capital to improve IT infrastructure resilience.	Chris Tidman Acting Chief Executive	28/02/2015	The bid was successful and the Trust was initially informed that this will be PDC but we have now been told that this will be a loan.	28/02/2015
Apply for further revenue cash support of £17.2m for 14/15 to counter impact of increased deficit.	Chris Tidman Acting Chief Executive	31/03/2015	Application was approved by the by the ITFF, now awaiting DH formal confirmation. In the meantime the Trust has drawn down a temporary loan of £8m.	14/05/2015

Seek cash injection for 2015/16	Colin Gentile Director of Finance	31/10/2015	Temporary funding of £19m has been agreed to meet the cash requirements for the first 6 months of 2015/16. The application for permanent funding is dependent on the development of a financial recovery plan. This means the trust will need to extend the current temporary facility. It is likely the Trust will require additional access to cash as its defecit is larger than planned. 16/11/2015 Recieved 30 days working capital. Currently applying for 40 day facility	31/10/2015
Submit two applications for distressed capital, August and September/October 2015	Colin Gentile Director of Finance	30/10/2015	ITFF bid for £5m capital to support ED expansion, discharge lounge and car park submitted August 2015. The second bid will be subject to TDA new guidance which is likely to make access to further capital difficult. Update 16/11/2015: Recieved £4m for ED expansion and discharge lounge	16/11/2015

Target Risk Level	Major	Possible	12	Moderate

Progress	

Next Review Date 08/02/2016

BAF Risk Report

Worcestershire NHS Acute Hospitals NHS Trust

Risk 2678 If we do not attract and retain key clinical staff we will be unable to ensure safe and adequate staffing levels

Date opened 19/05/2014

Strategic goal Invest and realise the full potential of our staff to provide personalised and compassionate care

Strategic objective(s) Develop and support staff

Initial Risk Level Major Almost certain 20 High

Director/Committee	Director of Human Resources / Workforce Assurance Group
Description/Impact	If we do not attract/retain key clinical staff we will be unable to ensure safe and adequate staffing levels. There will be increased dependency on temporary staffing which affects the safety, quality and consistency of care to patients. Health Education West Midlands is reviewing the workforce plan for commissioning
Key Controls	Workforce metrics reviewed monthly at Trust Board Divisions produce resource plans for the workforce within their service
Sources of Assurance	Review-Internal-Family and Friends staff surveys Internal reports to the Board-CNO Board report on safe staffing reporting on NICE guidance compliance Internal reports to the Board-WAG report on workforce recruitment and medical staffing management - report via TMC to the Board Internal Audit-Temporary Staff Booking Process Audit
Performance Monitoring	Vacancies as Proportion of Funded Establishment (WVR1.23) Clinical Staff Turnover % (Clinical, WT1.1)
Gaps in Control	Understanding retention issues, eg formal exit interview processes Formal marketing plan Uncertainty around reconfiguration timetable Deanery control of doctor training places
Gaps in Assurance	

Current Risk Level Major Likely 16 High

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Create Workforce Development Plan and implement new roles. Maximising internal Bank recruitment	Denise Harnin Director of HR & OD	15/03/2016	WAG and NMWAG looking at: temporary staffing, role development, consultant job planning, recruitment processes, workforce reporting, operational management templates. Strategy implementation expected by December 2015, due date updated to reflect this. Update Dec 2015: Strategy discussed at WAG 21st Dec 2015. Baseline complete. Organising a facilitated workshop with divisions to review forward plan. Alternative practitioner models to be picked up in this work. Propose update due date to March 2016.	
Medicine Division to review workforce strategy	Andy Phillips Interim Chief Medical Officer	15/03/2016	Re-opened following discussion at WAG September 2015. Update Dec 2015: The re-established MWAG will progress this work. To be included in revised terms of reference. Propose new target date March 2016	
Improve communication and engagement of staff to develop them as ambassadors for the trust	Denise Harnin Director of HR & OD	13/05/2016	Director of HR and Director of Communications developing an engagement strategy.	
Marketing plan for recruitment by division	Denise Harnin Director of HR & OD	30/09/2014	Surgery - open day held. Corporate resources to support recruitment being provided	25/11/2014
CMO discussing Deanery withdrawing training numbers - implications for Worcestershire	Mark Wake Chief Medical Officer	31/12/2014	Action complete	31/12/2014
Ensure future medical contracts are trust-wide appointments	Andy Phillips Interim Chief Medical Officer	31/07/2015	All medical appointments are made on the basis of county-wide working.	31/07/2015
Revise internal staff engagement programme	Denise Harnin Director of HR & OD	27/11/2015	Strategy developed for next 12 months. Endorsed at Directors meeting 1/12/2015	30/11/2015

CMO to work with surrounding universities and local education and training board (LETB) on alternative practitioner models	Andy Phillips Interim Chief Medical Officer	30/11/2015	Meetings have commenced with universities and LETB. Ongoing work being picked up as part of the workforce strategy.	31/12/2015

Target Risk Level	Moderate	Blank	12	Moderate

Progress	Update November 2015: Monitor and the NHS Trust Development Authority (TDA) have implemented a cap on the amount of money that trusts can pay per hour for agency staff working for the NHS, taking effect from 23rd November 2015. The impact of this change will be known from the first report on 25th November 2015. Caps can be exceeded in individual cases on safety grounds, but within a process overseen by Trust Board and reported to the TDA. If the TDA consider that the trust is not applying the rules in a timely manner, they may use formal powers. The Trust continues to focus on improving recruitment, graduate intake and increasing internal bank.

Next Review Date 08/02/2016

BAF Risk Report

Worcestershire NHS Acute Hospitals NHS Trust

Risk	**2790 As a result of high occupancy levels, patient care may be compromised and access targets missed**
Date opened	02/02/2015
Strategic goal	Develop and sustain our business
Strategic objective(s)	Develop and sustain safe services
Initial Risk Level	Major Almost certain 20 High

Director/Committee	Chief Operating Officer / Trust Management Committee
Description/Impact	If the trust experiences high occupancy levels and there is a lack of downstream flow in the local health economy then patient access performance will be compromised. These pressures can detrimentally affect safety, quality and patient experience. Impact: Over-crowding in ED Increased quality and safety risk due to sub-optimal location of patient, multiple tranfers between wards/departments/sites, lack of privacy and dignity for patients, increased length of stay. Financial (£4.8m FYE)and reputational impact of non-delivery of targets.
Key Controls	Bed management team and processes to place patient in optimal bed Waiting list management Weekly meetings of the Urgent Care Oversight Team in ED to coordinate patient flow Monitoring electronic white boards (EWBS) on a daily basis Working in partnership to deliver the Patient Care Improvement Plan (PCIP) System wide capacity plan Monitoring of patients >10 days LOS on a weekly basis Full capacity protocol
Sources of Assurance	Internal reports to the Board-Monitoring demand and utilisation of capacity / improvement via divisional performance reporting Management Assurance-Monthly quality and safety monitoring via divisional quality forums Internal Audit-Waiting List Initiative (WLI) Expenditure Audit Management Assurance-Divisional monitoring waiting lists Management Assurance-Divisions monitoring outliers daily Internal Audit-Divisional Governance Structures Audit

Performance Monitoring	CEM target initial clinical assessment within 15 minutes of ambulance arrival in A&E % of patients waiting less than 4hrs in A&E (CAE1) Backlog > 18 weeks (PW4) Cancer targets (CCAN1-9) Delayed Transfers of Care SitRep (Days) (PIN3) Acute bed days occupied by patients 'Fit to Go'
Gaps in Control	Discharge planning and delivery process needs improvement More physical capacity needed in ED and discharge lounge needed More senior clinical decision making particularly out of hours is needed The Trust lacks clarity and control of the management of new referrals to the waiting list
Gaps in Assurance	Further information and assurance being sought through the CCG 18 week RTT Working Group, CCG Contract Monitoring Board and Systems Resilience Group (SRG) System wide capacity plan not available at this time

Current Risk Level Major Almost certain 20 High

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Weekly review of DTOC's led by SWCCG to speed up discharge	Rab McEwan Chief Operating Officer	29/02/2016	Weekly reviews completed and ongoing.	
Improve patient flow with actions outlined in the PCIP, such as ambulatory emergency care, redesign bed model, improve discharge processes	Rab McEwan Chief Operating Officer	15/06/2016	The actions within the Patient Care Improvement Plan (PCIP) are tracked at UrCOT.	
It is proposed that a Local Health Economy Action Plan is to be developed and monitored through Systems Resilience Group	Rab McEwan Chief Operating Officer	28/02/2015	This was signed off at last SRG.	30/06/2015

Ensure compliance with College of Emergency Medicine guidance that initial assessment is carried out by clinical staff within 15 minutes of arrival	Robin Snead Divisional Director of Operations	30/06/2015	Systems in place to monitor and deliver this target.	30/06/2015
Patient pathways review by Transformation Team. Assertive recycling of theatre lists. KTC realignment plan	Rab McEwan Chief Operating Officer	28/02/2015	Patient pathway review undertaken. KTC realignment plan approved by Trust Board Dec 2014. Now being implemented.	31/08/2015
Trust action plan include: recruitment to consultant gaps, ringfencing of cancer beds, restructuring Cancer Board, weekly cancer Patient tracking List meeting chaired by D.Ops	Rab McEwan Chief Operating Officer	28/02/2015	Cancer bed ringfencing established, weekly cancer patient tracking list meetings established. Cancer Board restructured and will commence in new structure in April 2015. Two week wait target achieved in Feb 2015 and on track to achieve target for YTD. 62 day target yet to be achieved.	31/08/2015
CCGs to agree plans with the Trust for management and reduction of GP referrals.	Rab McEwan Chief Operating Officer	31/08/2015	Agreed key specialities with significant backlogs- CCG to request GPs to refer to alternative providers. Trust has developed speciality level action plans to achieve 92% incomplete standard by September 2015. Complete.	31/08/2015
Commission a Discharge to Assess Pathway via Nursing Homes using Operational Resilience Funding	Rab McEwan Chief Operating Officer	31/10/2015		31/08/2015
Launch Breaking the Cycle initiative	Rab McEwan Chief Operating Officer	31/10/2015	Initiative launched. Early signs of improvement in key performance measures and underlying processes such as early discharges.	30/10/2015
Acute Trust to plan additional activity through existing theatre capacity	Rab McEwan Chief Operating Officer	31/12/2015	Winter plan to maximise elective activity of AGH and KTC with no down time for maintenance.	31/12/2015
Implement the Winter Plan which includes actions to increase bed capacity and cohort outliers	Rab McEwan Chief Operating Officer	29/02/2016	Winter plan implemented though elements were not funded by CCG so full capacity not commissioned.	31/12/2015

Target Risk Level	Minor	Unlikely	4	Very Low

Progress	Capacity remains an issue. There are system wide issues with the three pathways - this will be discussed at SRG. System wide action plan still in development. CCG GP referral management plan still to be agreed. We continue to work with CCG Commissioners in the delivery of the 18 week pathway.

Next Review Date 08/02/2016

BAF Risk Report

Worcestershire NHS Acute Hospitals NHS Trust

Risk 2888 Deficit is worse than planned and threatens the Trust's long term financial sustainability

Date opened 14/05/2015

Strategic goal Develop and sustain our business

Strategic objective(s) Use resources wisely

Initial Risk Level Catastrophic Likely 20 High

Director/Committee	Finance Director / Finance and Performance Committee
Description/Impact	If the Trust does not secure sufficient income, the financial position will be placed at further risk and could affect its long term sustainability. The risks around marginal rates and fines mean the Trust needs to deliver contracted performance levels whilst remaining within contracted levels of activity. If expenses are not sufficiently contained and reduced there will be a serious impact on the financial position of the Trust and this will affect its long term sustainability. Possibility of charges from 2014/2015 carrying over into 2015/2016. Impact: - Inability to meet planned deficit at year end or meet cash requirements will have a resultant impact onto Continuity of Service (COS) - Liquidity Problems - Reputational damage and confidence in Board - Will trigger further action by TDA - Risk of lack of investment in the environment/facilities/equipment supporting patient care
Key Controls	Finance and Performance Committee Executive accountability Financial reporting to highlight key issues and facilitate corrective action Divisional management structures & divisional performance management monthly Robust QIPP plans signed off and divisional QIPP Confirm and Challenge meetings Monthly review of plan delivery by PMO with divisions and escalation of issues to weekly meeting with COO Monthly QIPP report to Finance & Performance Committee Expenditure controls Executive accountability Contract Management Board (CMB) and weekly contract negotiation meetings Monthly income and activity reconciliations with CCGs System Resilience Group
Sources of Assurance	Management Assurance-Monthly review via Finance and Performance Committee and Trust Board Management Assurance-Turnaround Board with 3/4 year recovery plan and supporting progress reports Internal Audit-PWC Opportunities Report Management Assurance-Monthly monitoring of cost improvement programme delivery by divisions reported to F&P Independent Assurance-Value for Money Audit Internal Audit-Financial Management Arrangements & Reporting Audit

Performance Monitoring	Report to Turnaround Board - performance against the Financial Recovery Plan Financial reports to Finance & Performance Committee and Trust Board
Gaps in Control	Staff capacity and capability to deliver turnaround The performance management system requires strengthening Finalised project plans for all material elements of the QIPP programme Ability to realise savings in the face of operational pressures including safety issues and delayed discharges
Gaps in Assurance	Turnaround plan to be finalised in order to create assurance processes Three year recovery plan not yet completed Current financial position

Current Risk Level Catastrophic Likely 20 High

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Develop detailed schemes to achieve the outline recovery plan	Rob Cooper Director of Finance	03/02/2016	Schemes developed to achieve £4.3m recurrent savings. Further schemes required to achieve the minimum of £10m required. To be completed by end Jan 2016	
Divisions to develop further CIPs for remaining gap	Rab McEwan Chief Operating Officer	03/02/2016	There is work being undertaken on finding CIPs for the remaining gap, focused on agency staff expenditure. This will be completed by end Jan 2016.	

Develop robust medical workforce plans to support recruitment as well as managing temporary costs	Denise Harnin Director of HR & OD	15/02/2016	Medical workforce baseline paper presented to Board. Divisions actively eliminating off framework usage and driving Direct Engagement. Medical locum list to be produced early September, due date updated to reflect this. October 2015 update: Divisional workforce plans being developed for approval via WAG November 2015 update: Divisional workforce plans still in development. Propose due date updated to end December 2015. December 2015 update: Agency cap process in place. Weekly return being provided to TDA. HR working with divisions on plans to reduce and eliminate agency usage. Being recorded in the NHSP and HCL systems to improve transparency. Action plan required by TDA to address agency usage above cap. Propose new due date of mid-February 2016.	
Reduce cost of additional premium rate capacity	Rab McEwan Chief Operating Officer	15/04/2016	Costs have reduced and a further target reduction of £10m agreed. Due date updated to reflect new target.	
Establish a turnaround Board	Chris Tidman Acting Chief Executive	30/06/2015	ToRs approved by Board. Board established.	22/06/2015
Engagement of a financial turnaround specialist to support the development of the plan	Chris Tidman Acting Chief Executive	30/06/2015	Interim Director Finance has relevant experience.	30/06/2015
Strengthen financial controls over discretionary expenditure	Colin Gentile Director of Finance	01/10/2015	Financial controls strengthened	01/10/2015
Develop a 3 year recovery plan in conjunction with external advisors and Trust Board, considering a range of radical options and workforce reductions	Sarah Smith Director of Strategy, Planning and Improvement	30/09/2015	Outline recovery plan developed 15/08/15. Presented to Trust Board in October 2015. The Turnaround Plan is set out in financial terms and themes, but not down to the detail of schemes.	30/10/2015
Divisions to finalise plans for delivering CIPs	Rab McEwan Chief Operating Officer	30/09/2015	CIPS to cover original gap developed and planned CIP delivery has improved.	30/10/2015
Performance management processes to be strengthened	Sarah Smith Director of Strategy, Planning and Improvement	31/10/2015	Monthly divisional performance meetings have commenced with the Chief Operating Officer.	31/10/2015
Finance and Procurement Teams are creating revised instructions and controls to further eliminate discretionary expenditure for the remainder of the year	Colin Gentile Director of Finance	30/11/2015	Revised instructions signed off at Finance and Performance Committee November 2015.	30/11/2015
Resolve outstanding queries with specialised commissioners	Colin Gentile Director of Finance	30/11/2015	Contract signed May 2015. Two of the three issues to be resolved during Q1 have been agreed. The third issue is the subject of a discussion with NHS England Commissioning Team in September 2015. The due date has been amended to reflect this. Update October 2015: The Trust received a response from the specialised commissioners on 20th October on the third issue, asking for further information for one element and disputing another. The Trust has responded to the query and is drafting a response to the disputed element. In the event that this cannot be resolved locally it will be escalated for dispute resolution. Revised completion / resolution date of 30 November 2015 – if not resolved by then it will be escalated. Update 1st December 2015: Outstanding queries all resolved.	30/11/2015

Target Risk Level	Catastrophic	Unlikely	10	Low
Progress				
Next Review Date	08/02/2016			

BAF Risk Report

Worcestershire NHS Acute Hospitals NHS Trust

Risk	**2891 If the Trust does not learn from mortality reviews this knowledge will not be available to support improvements to patient care**
Date opened	18/05/2015
Strategic goal	Deliver safe, high quality, effective and compassionate care
Strategic objective(s)	Develop and sustain safe services
Initial Risk Level	Major Likely 16 High

Director/Committee	Chief Medical Officer / Safe Patient Group
Description/Impact	If the trust does not implement trust-wide primary mortality reviews we will have fewer opportunities to improve patient care.
Key Controls	Mortality review committees within Divisions and Directorates Divisions report to trust Mortality Review Committee Mortality review process developed HED mortality data & case review process CQC/Dr Foster mortality alerts and reporting process
Sources of Assurance	Peer Review-Quality performance data and HED data, including HSMR, provide a flag for potential concerns regarding quality of care Management Assurance-The Safe Patient Group receives reports from Mortality Review Committee and provides assurance to the Quality Governance Committee which in turn provides assurance to Trust Board

Performance Monitoring	Death review completion rate for each division reviewed at Mortality Review Committee monthly.
Gaps in Control	The mortality review tool requires further testing to ensure it can be implemented in all areas at this point in time Clinicians and services may have insufficient resource to support this process
Gaps in Assurance	Directorate and Divisional governance processes have yet to be fully developed No quality assurance process for the quality of mortality reviews within all divisions

Current Risk Level Major Likely 16 High

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Divisions to identify and provide appropriate resources to support implementation of mortality review process	Andy Phillips Interim Chief Medical Officer	15/03/2016	CMO and CNO, with Corporate Governance leads, have reviewed the processes and resources allocated. Enhancing the divisional response. Due to new approach, due date extended to December 2015. December 2015 update: Divisions being consulted to respond with resource required to ensure mortality review process is undertaken. Mortality review will be included in the Job Planning process and the due date of this action has been updated to reflect this.	
Establish a Quality Assurance process for review of local mortality review	Andy Phillips Interim Chief Medical Officer	15/03/2016	The secondary mortality review process will provide quality assurance for initial reviews. Due date extended to reflect this.	
Road test tool and modify or adapt to ensure it is readily implementable	Andy Phillips Interim Chief Medical Officer	31/07/2015	Tool modified and adapted to make user friendly. Presently receiving feedback.	31/07/2015
Divisions and Directorates to ensure further development of governance processes to support mortality review and quality agenda	Andy Phillips Interim Chief Medical Officer	30/11/2015	Progress being made. Reviews rated B,C,D or E are subject to secondary review and the Division attend the Mortality meeting to discuss the findings. Due date extended to end November 2015.	23/11/2015
Enhance the support provided by divisional governance teams to clinicians for the completion of mortality reviews	Chris Rawlings Head of Clinical Governance & Risk Management	30/11/2015	Divisional governance teams have been tasked with the direct support for consultants with the process.	23/11/2015
Enhance performance accountability for review of completion rates	Andy Phillips Interim Chief Medical Officer	15/01/2016	Governance to be enhanced at Safe Patient Group, Confirm and Challenge meetings, TMC and QGC. December 2015 update: Accountability processes established.	30/11/2015

Target Risk Level Major Unlikely 8 Low

Progress	Update Jan 2016: NHS Improvement are tendering for a national mortality review process.

Next Review Date 08/02/2016

BAF Risk Report

BAF Risk Report

Worcestershire NHS Acute Hospitals NHS Trust

Risk 2902 If the Trust does not achieve safety targets, it will fail to improve clinical care and reduce avoidable harm to expected levels

Date opened 21/05/2015

Strategic goal Deliver safe, high quality, effective and compassionate care

Strategic objective(s) Develop and sustain safe services

Initial Risk Level Major Likely 16 High

Director/Committee	Chief Medical Officer / Safe Patient Group
Description/Impact	The Trust is committed to developing and sustaining safe services. It is creating a Sign up to Safety campaign which includes work to: - Reduce harm from medicines incidents - Improve outcomes and experience for patients with #NOF - Improve mortality review processes If these and other safety priorities are not successfully implemented, patients may experience preventable harm, resulting in morbidity and mortality, increased length of stay, complaints and legal claims.
Key Controls	Policies and procedures for patient safety, eg Incident Reporting and Investigation Policies Corporate Clinical Governance Team and Divisional Quality Teams to support implementation Routine monitoring and assurance processes for safety and quality indicators Clinical Governance committee structure and review and challenge of metrics, for review of patient safety issues Incident reporting and monitoring system Communication of safety issues via induction, divisional meetings, daily brief, safety newsletter Mortality review process established
Sources of Assurance	Management Assurance-Quality Review Visits Management Assurance-Quality Governance Committee Structure and reports on key subjects from committees Internal Audit-Internal audit of Risk Management and Serious Incident processes Care Quality Commission-CQC inspections Management Assurance-Progress against various safety initiatives captured in Patient Care Improvement Plan (PCIP)
Performance Monitoring	Numerous safety indicators reported in Trust Board Performance Dashboard monthly: - Incidents & Never Events by category (QSIN1-6) - Mortality (QSM1) - Safety Thermometer (QSST1) - VTE (QSVT1) - Infection Control (QSIC1-5) Review of Divisional Quality KPIs Divisional performance reviews
Gaps in Control	Trust-wide mechanisms for feedback of the outcome of incident investigations to individuals Safety priorities and implementation plan (Sign up to Safety Implementation Plan) Mortality review process requires full implementation Patient Safety work needs to be more proactive
Gaps in Assurance	Consistent review of safety and quality performance review down to directorate and department level

Current Risk Level Major Likely 16 High

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Review performance management framework	Sarah Smith Director of Strategy, Planning and Improvement	31/01/2016	Review of Integrated Performance Report underway by Information Team. Due date updated to 31 December 2015. December 2015 update: Review of performance management framework being presented to Trust Board January 2016.	
CMO and CNO to identify how Signup to Safety will be implemented in context of Governance Review and new responsibilities	Andy Phillips Interim Chief Medical Officer	15/02/2016		
Improve feedback mechanisms on quality matters to staff - Quality newsletter	Chris Rawlings Head of Clinical Governance & Risk Management	30/06/2015	First newsletter produced and published- Quarterly publication scheduled. Datix system now sending automated emails at closure of incidents.	02/07/2015
Embed Signup to Safety plan actions into the Patient Care Improvement Plan (PCIP)	Sarah Smith Director of Strategy, Planning and Improvement	15/01/2016	This has been completed	01/12/2015

BAF Risk Report

Worcestershire NHS
Acute Hospitals NHS Trust

Create a signup to safety implementation plan with associated resources	Steve Graystone AMD Patient Safety	30/09/2015	Signup to Safety plan andorsed at Safe Patient Group 4th December 2015.	11/12/2015

Target Risk Level	Major	Possible	12	Moderate

Progress	The second draft of the Sign up to Safety Plan has been produced and is being mapped to the PCIP to identify factors already included and any gaps. December 2015 - Additional actions related to this risk are recorded in the PCIP so are not duplicated here. The mortality review process has improved and returns increasing following changes that provide patient health records to consultants earlier. The new weekly Governance Operational Meeting will commence on 15th january and include mortality 3x per month. Sign-up-to-safety plan is included within the PCIP Communication strategy for feedback of learning will be developed during January

Next Review Date 08/02/2016

BAF Risk Report

Worcestershire NHS Acute Hospitals NHS Trust

Risk	**2932 Turnover of Trust Board members adversely affecting business continuity and impairing the ability to operate services**
Date opened	09/06/2015
Strategic goal	Invest and realise the full potential of our staff to provide personalised and compassionate care
Strategic objective(s)	Develop and support staff
Initial Risk Level	Major Likely 16 High

Director/Committee	Chief Executive / Trust Management Committee
Description/Impact	Worcestershire Acute Hospitals NHS Trust has entered a challenging period in its history, requiring a financial and operational turnaround, the plans for which last at least three years. This is against a background of substantial capacity issues in the county, recruitment difficulties and uncertainty over the Future of Acute Hospitals in Worcestershire reconfiguration. Continuing to have a strong and stable Board is essential to meet these challenges. At present the Trust Board consist of six Non-Executive Directors (NEDs) including the chair, one Associate NED, five voting Executive Directors including the Chief Executive, and two non-voting Executive Directors. The terms of office of all the NEDs are due to expire in 2016. Of particular concern is the fact that the Chair leaves the Trust in March 2016, with four other NED Terms ending in December 2016. This creates a business continuity risk for the governance of the organisation. Furthermore since April 2015, four of the voting Executive Directors are on leave or have resigned, leaving interims in these posts (see also risk 2932) and an Acting Chief Executive. This places an extra pressure on the NED members of the Board to maintain continuity. The requirements of Non-Executive Directors in terms of knowledge skills and experience are high, especially in this context. There is a particular need to ensure the appointment of individuals with a full range of abilities including financial experience, strategy, and communications along with an understanding of the pressures on NHS Trusts. The number of candidates meeting these requirements and with links to the area may be challenging. This could potentially lead to either delays in recruitment and subsequent challenge achieving quorum, or appointment of individual(s) who have less experience in the role. There is a risk that the newly appointed NEDs may take some time to acclimatise and gather an understanding of the organisation before reaching the level of effectiveness required. Other Trusts have approached this issue by staggering the expiry dates of Board Members' terms of office, reducing disruption and ensuring the Board is strong and corporate memory and continuity are maintained. The Trust has proposed this to the TDA who are responsible for the appointments, however this has not been accepted. The TDA have stated that they will now only appoint for two year periods. Furthermore, as a result of the absence of several Executive Directors, four Executive posts are interim. Therefore business continuity may be affected, resulting from handover issues, and loss of corporate memory. There is a risk that this and further absences could impair the Trust's ability to operate services.
Key Controls	All posts currently filled with suitably qualified acting or interim staff Clear deputizing arrangements in operation, and or swift action to bring in interim support where required PA support ensuring inboxes monitored and directed to interim/acting staff Named roles covered by temporary arrangements to ensure statutory responsibilities are covered, eg key roles of responsible officer covered by CMO, Caldicott Guardian and Controlled Drugs Officer covered by AMD Continuity provided by Trust operational and governance committees through minutes, action logs, project plans etc. Staff notified of changes via Chief Executive's Team Brief and daily notices, meetings etc. Non-Executive Director induction process & Trust Board Development Days NED position descriptions and selection criteria and appraisals conducted by Chairman
Sources of Assurance	Management Assurance-Acting Chief Executive ensuring and reviewing business continuity through the Exective Management Team (EMT) Management Assurance-Confirmed at Trust Board through TDA self-certification

Performance Monitoring	Achievement of financial turnaround. Achievement of various performance targets.
Gaps in Control	Potential for gaps where not covered by above controls If further absences occur this could significantly worsen the situation Trust Board appointment process governed by the TDA
Gaps in Assurance	The Trust is not presently aware of the TDA's plans for NED appointment in 2016

Current Risk Level Major Almost certain 20 High

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Constant review of interim posts is taking place between the CEO and Chair	Chris Tidman Acting Chief Executive	15/02/2016		
Develop a NED recruitment programme	Harry Turner Chairman	15/07/2016		

Appoint interim Finance Director	Chris Tidman Acting Chief Executive	31/07/2015	Interim Finance Director appointed	30/06/2015
Develop channels of communication with staff regarding leadership arrangements	Chris Tidman Acting Chief Executive	31/07/2015	Work underway with the Communications team to ensure all changes/updates are communicated with staff. Review modes of communication such as Team Brief, Daily Brief, intranet pages, noticeboards etc. The Big Conversation initiative has been launched in the trust.	30/09/2015

Target Risk Level	Major	Unlikely	8	Low

Progress	
Next Review Date	08/02/2016

BAF Risk Report

Worcestershire NHS Acute Hospitals NHS Trust

Risk	**3038 If the Trust does not address concerns raised by the CQC inspection the Trust will fail to improve patient care**
Date opened	12/10/2015
Strategic goal	Deliver safe, high quality, effective and compassionate care
Strategic objective(s)	Deliver effective care
Initial Risk Level	Major Likely 16 High

Director/Committee	Chief Nursing Officer / Trust Management Committee
Description/Impact	The report from the July 2015 announced CIH inspection was released in December 2015. The report rated the Trust as Inadequate overall, and the Trust has subsequently been placed in special measures. If the Trust does not respond to the concerns highlighted by the CIH inspection 2015 and does not continue to seek assurance of compliance with fundamental standards the Trust will fail to improve patient care and receive continued scrutiny from CQC adversely affecting reputation.
Key Controls	Policies covering the Trust's quality and business activities, monitoring these and taking action to improve compliance Clinical Governance structures and processes Divisional Quality Governance meetings, reporting to QGC Quality Review Visits Clinical Audit Incident management processes and monitoring Action plan part of PCIP and reported to QGC
Sources of Assurance	Self-assessment against standards-Quality Review Visits Review-External-CQC Intelligent Monitoring Report (IMR) Internal Audit-Review of CQC related processes

Performance Monitoring	Dashboards in development which will be presented in CQC domains
Gaps in Control	Not all corporate processes are subject to an assessment of compliance with the standards Ability to review performance in context of domains
Gaps in Assurance	

Current Risk Level Major Likely 16 High

Action Plan

Action	Responsibility	Expected Completion	Progress	Date Done
Review Quality Review Visits process	Lisa Miruszenko Deputy Chief Nursing Officer	31/01/2016	Meeting to progress this action planned for 15th December 2015. Update Jan 2016: First new format Quality Review Visit scheduled fo r11th Febrary 2016 and will be conducted monthly thereafter.	
Ensure that the "must do's" contained within the Final Report are acted on.	Lisa Miruszenko Deputy Chief Nursing Officer	31/03/2016	The PCIP is being populated with the "Must Do's" from the Final report. All "Should Do's" will be reviewed and those identified as good practice for the organisation will also be moved across into the PCIP reports. Update Jan 2016: A new CQC monitoring group has been established and will meet monthly.	
Implement changes outlined in the review of quality	Chris Rawlings Head of Clinical Governance & Risk Management	13/05/2016	Associate Director post being advertised in December 2015. Structural changes will be implmented when this post commences. Initial review of committees completed, more detailed review of aims and objectives, chairmanship, membership and reporting commenced.	
Conduct mapping of existing ward performance measures against CQC domains	Heather Webb Healthcare Standards Lead	31/12/2015	This has been completed as part of the development of the ward quality dashboard.	02/11/2015
Review of quality governance structures and processes	Chris Rawlings Head of Clinical Governance & Risk Management	30/11/2015	Review undertaken and report endorsed by QGC in October 2015.	30/11/2015

Target Risk Level Major Unlikely 8 Low

Progress	The PCIP is being populated with the "Must Do's" from the Final report. All "Should Do's" will be reviewed and those identified as good practice for the organisation will also be moved across into the PCIP reports. Progress against the PCIP will be reported to TMC, QGC, QOSG and will form part of the Board report. December 2015 - PCIP actions are being reviewed and reported to the Board and CQC.

Next Review Date 08/02/2016

Worcestershire NHS
Acute Hospitals NHS Trust

Date of meeting: 3 February 2016 **Enc D2**

Report to Trust Board

Title	Integrated Performance Report (December 2015)
Sponsoring Director	Sarah Smith, Director of Strategy, Planning and Improvement
Author	COO, CNO, CMO, Director of HR & OD
Action Required	The Board is asked to receive the Integrated Performance Report for December 2015. The key performance issues and the mitigating actions are described in the report itself.
Previously considered by	Trust Management Committee, Finance and Performance Committee

Strategic Priorities (√)

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

Related Board Assurance Framework Entries	2790 As a result of high occupancy levels, patient care may be compromised and access targets missed 2891 If the Trust does not learn from mortality reviews this knowledge will not be available to support improvements to patient care 2666 Inability to secure sufficient income placing the financial position at further risk and affecting long term sustainability 2888 Deficit is worse than planned and threatens the Trust's long term financial sustainability 2667 If expenses are not sufficiently contained and reduced there will be a serious impact on financial position & cash availability 2895 If we do not adequately understand & learn from patient feedback we will be unable to deliver excellent patient experience 2898 Poor communication with patients resulting in reduced quality of patient experience, complaints and reputation damage 2903 As a result of adverse publicity, Trust reputation may be damaged, negatively impacting patient confidence, & staff recruitment
Legal Implications or Regulatory	Section 92 of the Care Act 2014 ("the Act") creates an offence of supplying, publishing or otherwise making available information, which is false or misleading in a material respect.

Title of report	Integrated Performance Report
Name of director	Sarah Smith

requirements	The offence will apply: to such care providers and such information as is specified in regulations; and, where the information is supplied, published or made available under an enactment or other legal obligation
Glossary	IPR – Integrated Performance Report HED – Healthcare Evaluation Data SHMI – Summary Hospital Mortality Indicator HSMR – Hospital Standardised Mortality Ratio YTD – Year to Date RTT – Referral to Treatment

Key Messages

This paper presents an integrated corporate performance report (IPR) for December 2015.

For the full detail, please refer to the report and the Trust Board summary dashboard.

Date of meeting: 3 February 2016 **Enc D2**

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

REPORT TO TRUST BOARD – FEBRUARY 2016

1 Situation

This paper updates the Board on the Trust's current performance against nationally and locally agreed targets and other key priorities, and summarises the actions being taken or planned to address non - compliance

2 Background

This paper presents an integrated corporate performance report (IPR) for December 2015. It has been previously considered at TMC and Finance and Performance Committee

3 Assessment

Please refer to the IPR report for the full detail. The main exceptions and priorities as agreed by the Executive Team are as follows:

3.1 Never Event

The Trust recorded a Never Event in December 2015 in relation to a wrong Implant/prosthesis. A full case review is in train and further information is provided in the Quality Governance Committee report.

3.2 Emergency Access Standard

The Trust has not achieved the 95% Emergency Access Standard (EAS) for 15 consecutive months. In October, there was a step improvement in performance with performance for the Trust exceeding 90% for the first time since November 2014. In November 2015, performance improved again to 90.64% however this dipped again slightly in December to 89.07%.

The Trust also failed to deliver the national 15 minute standard for assessment in Emergency Department (ED) for the 95th percentile wait; performance was 28 minutes in November and December. The median wait in ED for treatment was 43 minutes in December, within the national standard of 60 minutes.

3.3 18 weeks Referral to Treatment (RTT)

In line with trajectory, the Trust was able to report compliance with the 18 Week referral to treatment incomplete pathways target (92%) in November 2015; Trust total 92.05%, and this level of performance has continued into December 2015.

3.4 Cancer Performance

In line with trajectory, the 62 day target for cancer first treatment was achieved in December 2015; Trust performance 86.10%.

The 2ww targets have not been achieved in December however performance for 'all cancers' increased to 90.50% and 'symptomatic breast cancer' increased to 82.10%.

3.5 Diagnostics Waiting Time Standard

In November 2015, the Trust failed to achieve the target of < 1% of patients waiting longer than 6 weeks for diagnostic tests for the first time since August 2015.

3.6 Finance

At Month 9 (December) the Trust reported a £45.1m deficit position which represents an adverse variance of £18.6m from plan. The in-month variance was £5.6m which is £0.8m worse than the preceding month. Further detail including turnaround actions is provided in the Financial Performance report.

4 Recommendation

The Board is asked to receive the Integrated Performance Report for December 2015. The key performance issues and the mitigating actions are described in the report itself.

Sarah Smith
Director of Strategy, Planning and Improvement

Worcestershire NHS
Acute Hospitals NHS Trust

INTEGRATED PERFORMANCE REPORT

December 2015

Release date: January 22nd, 2016

Please note:

All data relates to December 2015 performance, unless stated otherwise.

Please note – the vertical axis on graphs differ depending the subject data. Some graphs have a reduced vertical axis to highlight detailed performance trends.

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 (Corporate risk 2908).

This report is the most complete and accurate position available. Work continues to ensure the completeness and validity of data entry, analysis and reporting.

Sarah Smith, Director of Strategy, Planning and Improvement

Worcestershire NHS
Acute Hospitals NHS Trust

Overview

Performance, efficiency, quality, safety and workforce metrics

***Notes**: This diagram is indicative only, and is based on trend direction of previous months' performance. Indicators on the Trust dashboard which are not RAG rated / have no set tolerances / are a subset of a high level indicator are not included. Financial performance is covered in more detail in the Trust Board Finance report.*

Performance on /above target with positive trend Number of grade 4 pressure ulcers Friends and Family Test - Acute wards and A&E score combined MRSA bacteraemia Cancer - 62 days wait for first treatment from all GP referral (all cancers) Workforce - % of eligible staff attending induction Mortality - SHMI (up to Jul 15) Mortality - HSMR (up to Jul 15) 18 week Referral to Treatment - Incomplete	**Performance on /above target with negative trend** Stroke - TIA Friends and Family Test - Maternity score Bed occupancy (ALX)
Performance under target with positive trend A&E - Time to initial assessment (all patients) % approved risks with overdue actions Workforce – sickness absence monthly Workforce – staff turnover Workforce – agency staff medics Workforce - % of eligible staff attending induction Workforce - % of non-medical staff who have had appraisal A&E - Ambulance handover within 30 minutes Cancer - 2 week wait (all cancers) Cancer - 2 week wait (breast symptomatic) Workforce - % of eligible staff completing statutory and mandatory training Workforce – number of vacancies (reconciliation of finance and HR data required) Stroke - direct admission on to stroke ward Workforce – nursing staff turnover (qualified)	**Performance under target with negative trend** Category 2 Complaints responded to within 25 days Never events Stroke - 80% of stroke patients spend 90% of time on stroke ward Falls with serious harm Infection control - MRSA screening (including high risk wards) A&E - unplanned re-attendance within 7 days Bed occupancy (WRH) Urgent operations cancelled for a second time Workforce - % of medical staff who have had appraisal 28 day breaches as % of cancellations 6 week wait for diagnostics Number of grade 3 pressure ulcers Hip fracture - time to theatre Delayed Transfers of Care (DTOC) patient snapshot Delayed Transfers of Care DTOC bed days A&E - 4 hour Emergency Access Standard A&E - Ambulance handover within 15 minutes Safety Thermometer harm free care score Serious Incidents open over 60 days and awaiting closure Friends and family Test - A&E score

Worcestershire NHS
Acute Hospitals NHS Trust

Summary

National / NHS Constitution Standards

For the second month running, in December 2015, the Trust was able to report compliance with the target of 92% of elective care pathways being completed within 18 weeks. The backlog of patients waiting over 18 weeks also reduced. Performance against the 62 - day referral to treatment standard for (all) cancers was also achieved in December in line with trajectory and there was a reduction in the number of cancer long waiters.

Performance against the emergency access standard dropped slightly in December with the percentage attending A&E and waiting four hours or less to be seen, treated, admitted or discharged being below 90% at 89.07%.

Although improving over the past 4 months, the Trust continues to underperform with respect to the percentage of urgent cancer referrals seen within 2 weeks of referral and there are rectification plans in place.

In December 2015, for the first month since August 2015, the Trust failed to achieve the target of greater than 99% of those on the diagnostic waiting list being seen within 6 weeks.

Key factors impacting performance

Patient flow remains sub optimal at both acute hospital sites with levels of bed occupancy at around 100% most days at WRH. There are a number of improvement initiatives to expedite discharges from the wards and there has been an increased focus at the front door of the hospital to promote ambulatory assessment and care and to avoid unnecessary admissions to hospital inpatient beds. There remains however a high proportion of bed days lost due to patients remaining in hospital after their acute episode of care has finished.

Issues with patient flow in the hospital can lead to overcrowding in the A&E department in particular when there are surges in ambulance arrivals. Since the start of the year the Trust has made significant improvements against process measures that reflect flow and prioritisation in the A&E department including the 95th percentile time to initial assessment of 15 minutes, however there is further to go in terms of achieving and sustaining target performance.

Poor patient flow and high levels of bed occupancy also impact the Trust's elective programme and this is reflected in the number of operations cancelled for non-clinical reasons and the number of 28 day breaches (within in which the operation should be rescheduled) as a percentage of all cancellations.

Quality, workforce and finance indicators

There are separate Board reports from the Board sub committees relating to quality, workforce and financial performance indicators however, alongside key operational performance indicators, the remainder of this report provides corrective action statements where there are performance issues.

Key maternity performance indicators are provided for information in the accompanying dashboard, following the temporary emergency centralisation of maternity and neonatal services at the WRH site

Worcestershire NHS
Acute Hospitals NHS Trust

Corrective Action Statements: Performance and Efficiency

Key Performance Indicator:

- 18 Week referral to treatment (RTT) - incomplete pathways (CW3.0)
- All patients with suspected Cancer being seen within two weeks (CCAN8.0)
- 2 week wait for symptomatic breast patients (Cancer Not initially Suspected) (CCAN9.0)
- Cancer Long waiters – 104 days (CCAN10.0)
- A&E - 4 hour waits (%) Trust including MIU (CAE1.1a)
- Time to initial assessment for patients arriving by ambulance (mins) – 95th percentile (inc Kidd MIU)
- A&E - Ambulance Handover within 30 minutes (%) – WMAS data (CAE8.0)
- Ambulance Handover within 60 minutes– WMAS data (CAE9.0)
- 80% of patients spending 90% of time on a Stroke Ward (CST1.0)
- Direct Admission via A & E to a Stroke Ward (CST2.0)
- Bed Occupancy – WRH (PIN1.5)
- Delayed Transfers of Care - Patients (Acute and Non Acute) (PIN3.1)
- 28 day breaches as a percentage of cancelled operations (PEL3.0)
- Urgent operations cancelled for a second time (PEL4.2)
- Length of Stay (All patients) and Length of Stay (excluding zero LOS spells) (PEM2.0 and PEM3.0)
- 6 Week Wait Diagnostics (Proportion of waiting list)(PW1.1.1)

Please note: Theatre Utilisation and Booking is not available this month for comment as there is a technical issue with the management information system used to report it – this issue has been resolved however not in time to include on the dashboard this month.

Forecast Key	
Forecast to achieve	
Potential risk target will not be achieved	
Forecast not to achieve	

Worcestershire NHS
Acute Hospitals NHS Trust

Key Performance Indicator: 18 Week referral to treatment (RTT) - incomplete pathways (CW3.0)

Headlines

Historically the Trust was consistently failing the RTT Incomplete standard between December 2014 and October 2015 inclusive. The target was met in November 2015 (92.05%) and subsequently maintained in December (92.05%). Whilst the aggregate performance has remained static there have been further reductions of patients waiting over 18 weeks in a number of specialties mainly Dermatology (-47), ENT (-28), Urology (-22) and General Surgery (-14); this has been offset with an increase of patients waiting over 18 weeks in another group of specialties – Thoracic Medicine (+33), Ophthalmology (+28), Gastroenterology (+15), Trauma and Orthopaedics (+14) and Gynaecology (+14). Overall the Trust backlog has reduced by 16 from November to December 2015 (2764 versus 2780). It has to be noted that there has been a considerable reduction in backlog (-951) compared to the position at the beginning of the financial year when the reported backlog was 3715 patients waiting over 18 weeks.

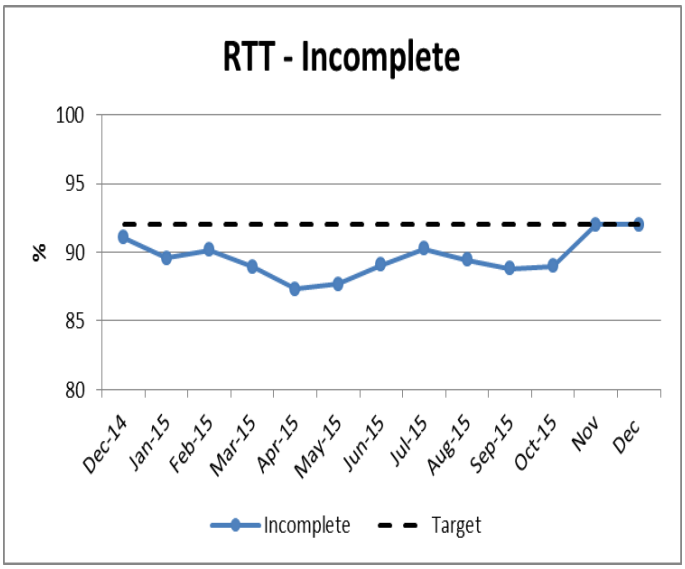
Corrective Actions

A significant validation exercise of historic open clocks was undertaken to enable transition to the new reporting methodology and the Trust moved to the 'open clock' reporting method as planned in November 2015. Nevertheless, significant data quality issues remain and further waiting list validation is required on a specialty by specialty basis. Specialty specific remedial action plans for reduction of 18+ week backlog are in place for all underperforming specialties and have been shared with the CCGs. The specialty level RTT performance is monitored via fortnightly PTL meetings and monthly Divisional Performance Reviews.

Risks

Non delivery of this target poses significant reputational, financial and patient safety risks. These are mitigated by the remedial action plans that are in place; in addition, long waiters over 18 weeks are reviewed at regular intervals and findings reported via Quality Governance Committee (QGC). Retrospective RCAs with a particular focus on harm reviews have been undertaken for all patients who had waited over 52 weeks for treatment.

Worcestershire NHS
Acute Hospitals NHS Trust



SRO:COO	Current Reporting Month: Dec 2015			
	Performance	**Direction of travel**	**Plan/ Forecast**	**Status/ RAG**
Target	92%	-	Corrective action plan status	Currently not applicable – to be rolled out
Current reported month performance	92.05%	⇨	Forecast next reported month	
Last reported month performance	92.05%	⇧	Forecast month after	
YTD performance	Not applicable		Forecast month after	
Revised date to meet the standard	**November 2015**		Forecast year end	

Worcestershire NHS
Acute Hospitals NHS Trust

Key Performance Indicator: All patients with suspected Cancer being seen within two weeks (CCAN8.0)

Headlines

There has been a marked increase in 2ww referral numbers - up 13% compared to the same period last year (April to October) which has led to significant capacity constraints in a number of specialties. As a result a significant proportion of clinics continue to be set up ad-hoc and patients are contacted at short notice to be offered appointments. Subsequently a significant number of patients decline the offer to attend within the 14 day target; a smaller proportion of declined appointments are due to patient choice (holidays and other commitments). Current December performance shows a further improvement compared to October and November, however, it is RAG rated red as it remains below the standard. Year - end performance is RAG rated red due to the underperformance in Q1, Q2 and Q3. For September 2015 (latest published data), Peer Trusts saw 94.16% of patients within 2 weeks and the England average was 93.32%. Therefore, in September the Trust was 12.76% below our Peer Trusts and 11.92% below the England average. There has been a 6.66% improvement in the Trust's performance against this standard between September and November 2015.

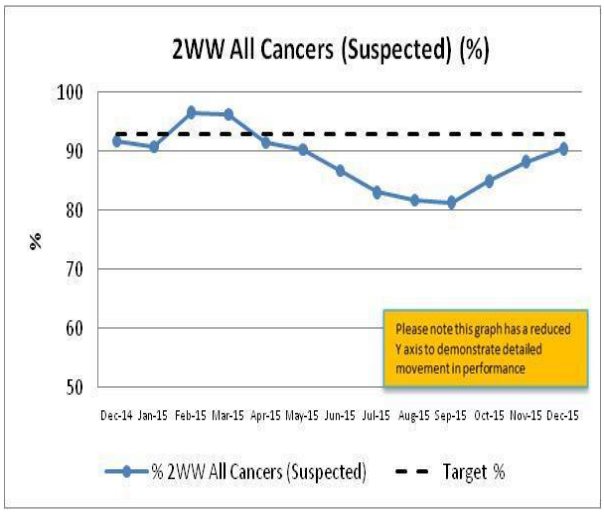
Corrective Actions

Initial version of an electronic 2ww PTL/escalation report has been implemented and is available to all Directorates; further enhancements to this report were introduced in December 2015. Capacity and demand by specialty is being monitored via a fortnightly Cancer PTL meeting. 2ww booking office protocols and standard operating procedures are currently under review with a view to establish a rolling audit programme for both internal processes and external adherence to referral parameters. Work is on-going with Commissioners to develop a project outline for implementation of the new 2ww NICE guidance and required changes to the referral forms.

Risks

This indicator has reputational risk for the organisation and also links to the 62 day cancer standard as it is the first stage in the 62 day referral to treatment pathway. The implication of not delivering this target will be potential underachievement against the 62 day standard. Short term the risk is being mitigated with ad-hoc additional capacity whilst a longer term specialty by specialty demand and capacity modelling is being undertaken.

Worcestershire NHS
Acute Hospitals NHS Trust



SRO:COO	Current Reporting Month: Dec 2015			
	Performance	**Direction of travel**	**Plan/ Forecast**	**Status/ RAG**
Target	93%	-	Corrective action plan status	Currently not applicable – to be rolled out
Current reported month performance	90.5%	↑	Forecast next reported month	
Last reported month performance	88.3%	↑	Forecast month after	
YTD performance	86.4%	-	Forecast month after	
Revised date to meet the standard	**March 2016**		Forecast year end	

Worcestershire NHS
Acute Hospitals NHS Trust

Key Performance Indicator: All patients with symptomatic breast being seen within two weeks (cancer not initially suspected) (CCAN9.0)

Headlines

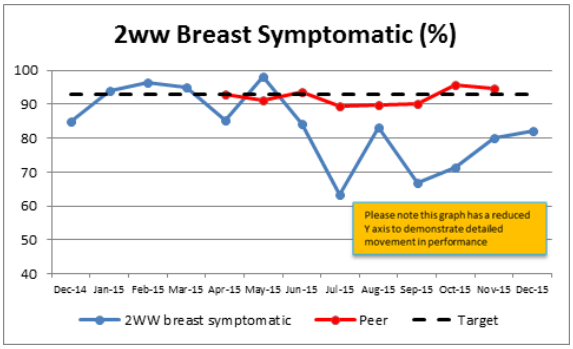
2ww referral volumes have remained broadly the same compared to the same period last year, however, the Directorate had a reduction in capacity following the loss of two GP practitioners who were undertaking 2ww clinics at the WRH. The Directorate is covering this shortfall in capacity with waiting list initiative clinics. As a result a significant proportion of clinics are set up ad-hoc and patients are contacted at short notice to be offered appointments. Consequently a significant number of patients decline the offer to attend within the 14 day target; a smaller proportion of declined appointments are due to patient choice (holidays and other commitments). Whilst current performance shows further 2.43 % improvement it is RAG rated red as it remains well below the standard. Year-end performance is RAG rated red due to the underperformance in Q1, Q2 and Q3.
For September 2015 (latest published data), the Peer Trusts saw 95.2% of patients within 2 weeks. There has been a 15.69% improvement in the Trust's performance against this standard between September and December 2015 (66.87% versus 82.56%).

Corrective Actions

The Directorate is exploring other ways of increasing capacity; two new registrars are in post and one has commenced seeing two week wait patients, the other one is still under assessment. The Directorate is working closely with Breast Radiology to ensure maximum utilisation of all available capacity.

Risks

This indicator has reputational risk for the organisation and also links to the 62 day cancer standard as it is the first stage in the 62 day referral to treatment pathway. The implication of not delivering this target will be potential underachievement against the 62 day standard. Short term the risk is being mitigated with ad-hoc additional capacity whilst a longer term, demand and capacity modelling is being undertaken.



SRO:COO	Current Reporting Month: Dec 2015			
	Performance	Direction of travel	Plan/ Forecast	Status/ RAG
Target	93%	-	Corrective action plan status	Currently not applicable – to be rolled out
Current reported month performance	82.1%	↑	Forecast next reported month	
Last reported month performance	80.1%	↑	Forecast month after	
YTD performance	78.4%	-	Forecast month after	
Revised date to meet the standard	April 2016		Forecast year end	

Worcestershire NHS
Acute Hospitals NHS Trust

Key Performance Indicator: Cancer Long waiters – 104 days (CCAN10.0)

Headlines

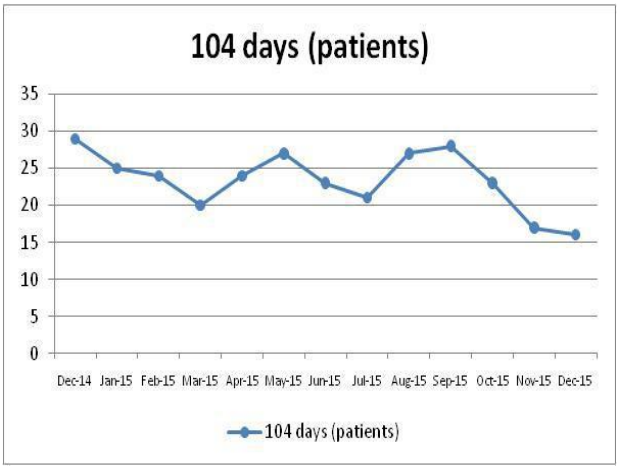
Whilst there is no national standard for this key performance indicator, service providers are required to monitor the numbers of patients waiting over 104 days and also to undertake harm reviews for patients with a confirmed diagnosis of cancer who have waited over 104 days for treatment. The numbers of 104 + day waiters have been consistently reducing month on month as of September 2015 and have been maintained around 15-16 patients for both November and December. The main reasons for the extended waits are complexities of certain pathways (some of which require multiple provider involvement in the provision of the patients' care), patient initiated delays and operating capacity in Urology for Radical Prostatectomies.

Corrective Actions

Detailed analysis of patients waiting over 104+ days is undertaken on a fortnightly basis by the Deputy Chief Operating Officer and reported to the Trust Development Authority. Any avoidable delays in patient pathways are escalated to the relevant Directorate for resolution. Retrospective harm review meetings to review patients with a confirmed diagnosis of cancer who had waited over 104 days for their treatment are chaired by the Trust's lead cancer clinician with Deputy Chief Operating Officer, lead Cancer Nurse and Cancer Data Manager in attendance. All patient outcomes are reviewed on a case by case basis and the findings of the reviews are reported to the Trust's Cancer Board. To date there have been no incidences identified where the patient had suffered harm attributable to extended waiting times.

Risks

The main risk of having patients waiting over 104 days for their treatment is that the patients may have sub-optimal outcomes due to extended wait for the treatment. Whilst avoidable delays are being mitigated via escalation processes and identification of earlier/additional capacity, a large proportion of the breaches are due to complexity of the pathways and/or patient initiated delays.



SRO:COO	Current Reporting Month: Dec 2015			
	Performance	Direction of travel	Plan/ Forecast	Status/ RAG
Target	-	-	Corrective action plan status	Currently not applicable – to be rolled out
Current reported month performance	16	↓	Forecast next reported month	Not applicable
Last reported month performance	17	-	Forecast month after	Not applicable
YTD performance	-	-	Forecast month after	Not applicable
Revised date to meet the standard	Not applicable		Forecast year end	Not applicable

Worcestershire NHS
Acute Hospitals NHS Trust

Key Performance Indicator Name: 4 hour waits (%) Trust including MIU (CAE1.1a)

Headlines

Trust performance on the Emergency Access Standard, (EAS) declined slightly in December (89.1% compared with 90.6% in November). There were 14,914 ED attendances (3.8% higher than December 2014). The Trust again achieved the national 60 minute Time from Arrival to Treatment target in November (Median 43 mins). There was a slight deterioration on the 5% target for 'Unplanned Re-attendance within 7 days of Original Attendance' in December (5.7%). Ambulance conveyances at WRH were 4% higher than in December 2014. We continued to experience 'exit block' from A&E throughout December, particularly at WRH, and performance on the EAS declined significantly over the bank holiday period at the end of the month.

- There were 750 patient admissions from A&E in the last week of December, the highest level we have ever recorded (the average is just under 650 per week)
- There was a 7% increase in admissions from A&E from the same period last year. (25th Dec – 10th Jan)
- There was a 14% increase in all emergency admissions to the trust in the same period (this includes direct GP Referrals).

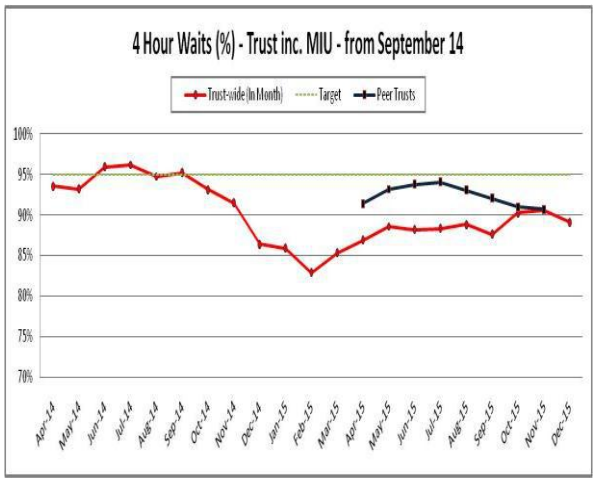
Corrective Actions

We continued to focus on improving patient flow and reducing the numbers of 'stranded' patients in December and early January. In December we ran a discharge pilot scheme with the support of ECIP. The 'Multidisciplinary Accelerated Discharge Event' (MADE) focussed on 3 wards and emphasised the multidisciplinary approach to discharge planning, and was very successful. As a consequence, a daily meeting with health economy partner organisations has been introduced to help expedite discharge. The Medicine Division established a task and finish group to reduce the total number of Medically Fit for Discharge patients in acute beds, and the number of bed days attributed to this patient group. Increased levels of Senior clinical support have been introduced in ED on the WRH site from 3pm to 10pm during weekdays to also assist with patient flow and admission avoidance. We have submitted an 'admission avoidance' proposal to the CCG and System Resilience Group to minimise the number of emergency admissions at WRH. The medicine division has reviewed its bed model and developed a plan for more effective patient streaming, to be implemented in February 2016. Phase 2 of the works to extend the ED at WRH will be completed in April 2016 with Phase 3 completed in early summer.

Risks

This indicator has a reputational risk to the organisation and health economy if not achieved. To mitigate the risk of underperformance we will continue to focus on patient flow and stranded patients.

Worcestershire NHS
Acute Hospitals NHS Trust



SRO:COO	Current Reporting Month: Dec 2015			
	Perform-ance	Direction of travel	Plan/ Forecast	Status/ RAG
Target	95%	-	Corrective action plan status	Currently not applicable – to be rolled out
Current reported month performance	89.07%	↓	Forecast next reported month	
Last reported month performance	90.66%	↑	Forecast month after	
YTD performance	88.48%	-	Forecast month after	
Revised date to meet the standard	March 2016		Forecast year end	

Worcestershire NHS
Acute Hospitals NHS Trust

Key Performance Indicator: Time to initial assessment for patients arriving by ambulance (mins) – 95th percentile (inc Kidd MIU); Ambulance Handover within 30 minutes (%) and – WMAS data (CAE8.0); Ambulance Handover within 60 minutes– WMAS data (CAE9.0)

Headlines

The Trust failed to reach the national 15 minute "Time to Initial Assessment" target in December (95th percentiles: All patients;28 mins, Ambulance arrivals;28 mins). 12% of ambulances took over 30 minutes to hand over (14% in Dec 2014) and 38 ambulances in the month took over an hour to handover (51 in Dec 2014). Ambulance conveyances at WRH were 4% higher than in December 2014. We continued to experience 'exit block' from A&E throughout December, particularly at WRH, and performance on ambulance handover times was impaired by the consequent over-crowding in A&E.

Corrective Actions

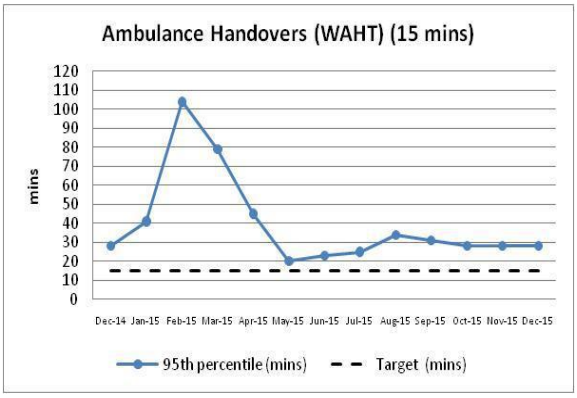
The CCG has invested an additional £80,000 in WMAS Hospital Ambulance Liaison Officer support at WRH, to support rapid turnaround of ambulances and avoid unnecessary conveyances by ensuring alternatives to ED attendance are maximised. The expansion of the ED at WRH is underway and on track to be available in the spring/summer of 2016, offering more space to accommodate patients waiting for handover, triage and admission. Within existing resources the Trust has deployed Senior Immediate Assessment Nurses (SIANs) to take the handover of patients from the ambulance Trust. These nurses are deployed at times of peak demand in ED.

Risks

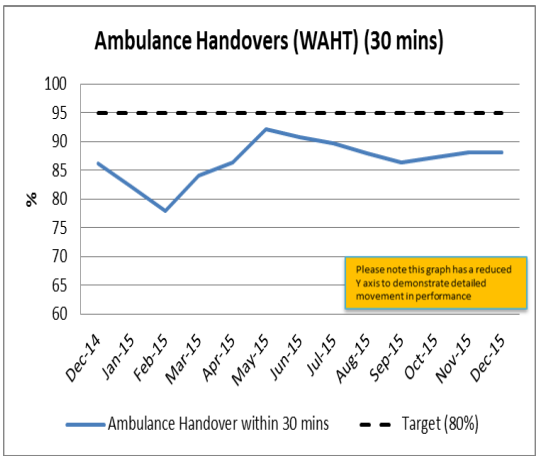
The risks from delayed handover are that:

- Sick people wait too long to receive emergency care
- Overall length of stay for waiting patients is increased, causing muscle wastage and loss of aerobic function in the elderly
- Hospital Standardised Mortality Ratio increases
- Increased numbers of patients leave without being seen
- Medical errors and incidents increase.

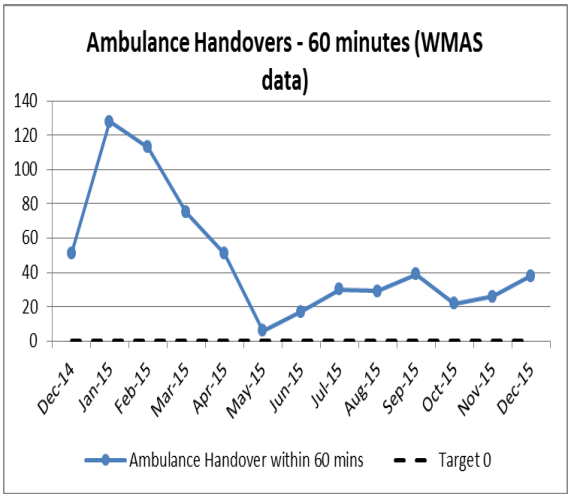
Worcestershire NHS
Acute Hospitals NHS Trust



SRO:COO	Current Reporting Month: Dec 2015			
	Performance	**Direction of travel**	**Plan/ Forecast**	**Status/ RAG**
Target	<=15	-	Corrective action plan status	Currently not applicable – to be rolled out
Current reported month performance	28	⇨	Forecast next reported month	To be completed
Last reported month performance	28	⇨	Forecast month after	To be completed
YTD performance	27	-	Forecast month after	To be completed
Revised date to meet the standard	**To be completed**		Forecast year end	To be completed



SRO:COO	Current Reporting Month: Dec 2015			
	Performance	**Direction of travel**	**Plan/ Forecast**	**Status/ RAG**
Target	>95%	-	Corrective action plan status	Currently not applicable – to be rolled out
Current reported month performance	88.18%	↑	Forecast next reported month	
Last reported month performance	88.10%	↑	Forecast month after	
YTD performance	88.62%	-	Forecast month after	To be completed
Revised date to meet the standard	**February 2016**		Forecast year end	



SRO:COO	Current Reporting Month: Dec 2015			
	Performance	**Direction of travel**	**Plan/ Forecast**	**Status/ RAG**
Target	0	-	Corrective action plan status	Currently not applicable – to be rolled out
Current reported month performance	38	↑	Forecast next reported month	To be completed
Last reported month performance	26	↑	Forecast month after	To be completed
YTD performance	258	-	Forecast month after	To be completed
Revised date to meet the standard	**To be completed**		Forecast year end	To be completed

Worcestershire NHS
Acute Hospitals NHS Trust

Key Performance Indicator: 80% of patients spending 90% of time on a Stroke Ward (CST1.0)

Headlines

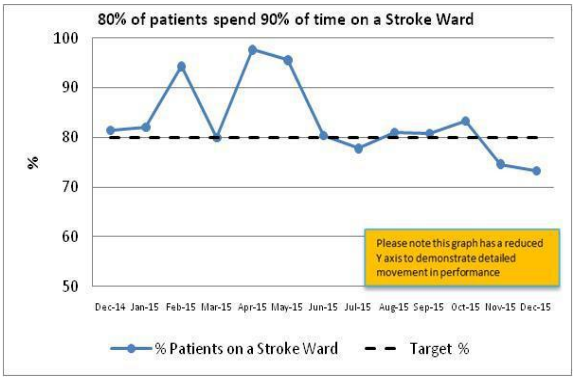
Performance against this standard has been below the expected target of 80% for the last 2 months (74.6% in November; 73.2% in December). This KPI is adversely impacted by the WRH site running at 100% bed occupancy. This creates difficulties in getting the right patient in the right bed at the right time. Year to date figure remains above the required level at 82.4% due to the effective bed management processes in place across the acute trust. The diminished performance for the last 2 months has been directly attributable to an increase in the number of patients waiting in acute stroke beds even though their acute stroke requirements have passed due to a lack of the appropriate number of commissioned stroke rehabilitation beds across the county.

Corrective Actions

The site management team have made every effort to ensure that stroke patients go a stroke unit bed as soon as possible from the point of admission on the WRH site. Every effort has been made to ensure that the stroke unit is not used for "non- stroke" medical outliers. The provision of a hyper acute stroke unit bed is a priority for the bed management team as soon as capacity is available to allow this. The lack of commissioned stroke rehab beds in the community hospitals has been raised with commissioners at all levels. We are not able to provide acute stroke services outside of the acute stroke unit, therefore the capacity is limited. The capacity would be sufficient for the acute stroke service, if the 10-12 patients waiting for stroke rehab beds were able to transfer in a timely manner.

Risks

The impact of failing this KPI is that the newly diagnosed stroke patients do not get access to specialist stroke services for more than 90% of their inpatient stay in hospital. This is not the best for patient quality of care or patient experience. This is flagged as a risk on the divisional risk register and has been discussed at the Trust Management Committee meeting in December 2015 and January 2016.



SRO:COO	Current Reporting Month: Dec 2015			
	Performance	**Direction of travel**	**Plan/ Forecast**	**Status/ RAG**
Target	80%	-	Corrective action plan status	Currently not applicable – to be rolled out
Current reported month performance	73.2%	↓	Forecast next reported month	To be completed
Last reported month performance	74.6%	↓	Forecast month after	To be completed
YTD performance	82.40%	-	Forecast month after	To be completed
Revised date to meet the standard	**To be completed**		Forecast year end	To be completed

Worcestershire NHS
Acute Hospitals NHS Trust

Key Performance Indicator: Direct Admission via A&E to a Stroke Ward (CST2.0)

Headlines

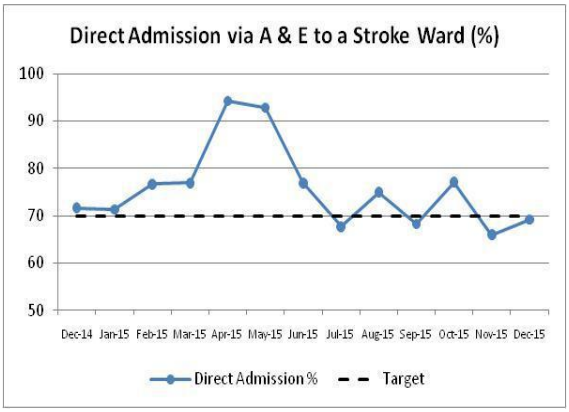
Performance against this standard has been below the expected target of 70% for the last 2 months (66.0% in November; 69.2% in December). This KPI is adversely impacted by the WRH site running at 100% bed occupancy rate. This creates difficulties in getting the right patient in the right bed at the right time. Year to date figure remains above the required level at 75.6% due to the effective bed management processes in place across the acute trust. The diminished performance for the last 2 months has been directly attributable to an increase in the number of patients waiting in acute stroke beds even though their acute stroke requirements have passed. This is directly attributable to a lack of the appropriate number of commissioned stroke rehab beds across the county.

Corrective Actions

The site management team have made every effort to ensure that stroke patients go a directly into the stroke unit bed from the point of admission on the WRH site. Every effort has been made to ensure that the stroke unit is not used for "non -stroke" medical outliers. The provision of a hyper acute stroke unit bed is a priority for the bed management team as soon as capacity is available to allow this. This practice has been reinforced with the bed management team. The lack of commissioned stroke rehab beds in the community hospitals has been raised with commissioners at all levels. We are not able to provide acute stroke services outside of the acute stroke unit, therefore the capacity is limited. The capacity would be sufficient for the acute stroke service, if the 10-12 patients waiting for stroke rehab beds were able to transfer in a timely manner.

Risks

The impact of failing this KPI is that the newly diagnosed stroke patients do not get direct access to specialist stroke services for their inpatient stay in hospital. This is not the best for patient quality of care or patient experience. This is flagged as a risk on the divisional risk register and has been discussed at the Trust Management Committee meeting in December 2015 and January 2016. Although the required proportion of patients are not getting direct access to a specialist stroke unit bed, every effort is being made to accommodate them into the stroke unit as soon as capacity becomes available.



SRO:COO	Current Reporting Month: Dec 2015			
	Performance	Direction of travel	Plan/ Forecast	Status/ RAG
Target	>=70%	-	Corrective action plan status	Currently not applicable – to be rolled out
Current reported month performance	69.2%	↑	Forecast next reported month	To be completed
Last reported month performance	66.0%	↓	Forecast month after	To be completed
YTD performance	75.6%	-	Forecast month after	To be completed
Revised date to meet the standard	To be completed		Forecast year end	To be completed

Worcestershire NHS
Acute Hospitals NHS Trust

Key Performance Indicator Name: Bed Occupancy – WRH (PIN1.5)

Headlines

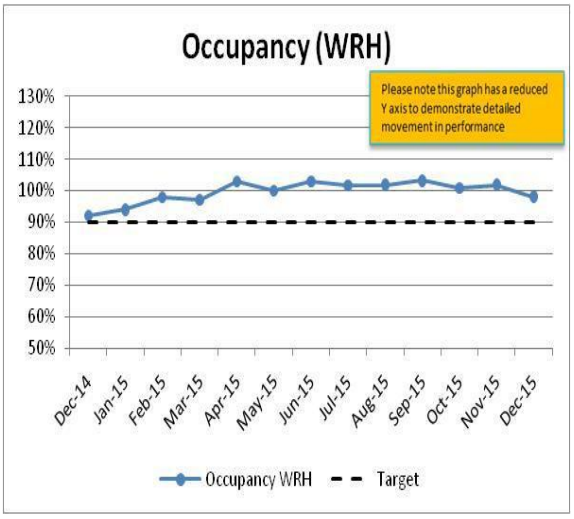
Bed occupancy rates remain above the National average, although they have reduced over the last month (November 101.9%; December 98.1%) This is mainly due to the Christmas period that historically produces a significant increase in patients discharged from acute hospital inpatient beds. The effect of this was also enhanced by a multidisciplinary accelerated discharge event (MADE) that was delivered in conjunction with ECIP, the week before Christmas. High numbers of stranded patients continues to be a significant issue in relation to bed occupancy rates on the WRH site. Pathway 1 complex discharge capacity has had insufficient capacity to allow timely discharge of patients from the acute hospital and community hospitals, thus creating difficulties across pathways 1 and 2 for the acute trust.

Corrective Actions

Multidisciplinary Accelerated Discharge Events (MADE) have been delivered across the acute hospital sites with the support of the ECIP team. These events generated significant numbers of additional discharges in the week prior to Christmas, and in the first week of January 2016. We have continued to build on the learning from these events to ensure that we maintain patient flow through the site. This has also generated a closer working relationship across the healthcare economy partners, which continues to develop in order to improve patient flow. Substantial capacity v demand modelling has been conducted which demonstrates that the WRH site does not have sufficient beds to accommodate current activity levels. A corrective business case is currently being written.

Risks

The impact of failing this KPI is that we are not able to accommodate patients in a timely manner into inpatient beds, for both emergency and elective activity. This leads to increased numbers of elective procedure cancellations and patients waiting prolonged periods of time in the Emergency Department for inpatient admission. This risk is included on the Divisional risk register.



SRO:COO	Current Reporting Month: Dec 2015			
	Performance	Direction of travel	Plan/ Forecast	Status/ RAG
Target	<90%	-	Corrective action plan status	Currently not applicable – to be rolled out
Current reported month performance	98.1%	↓	Forecast next reported month	To be completed
Last reported month performance	101.9%	↑	Forecast month after	To be completed
YTD performance	100.7%	-	Forecast month after	To be completed
Revised date to meet the standard	To be completed		Forecast year end	To be completed

Worcestershire NHS
Acute Hospitals NHS Trust

Key Performance Indicator Name: Delayed Transfers of Care - Patients (Acute and Non Acute) (PIN3.1)

Headlines

The number of Delayed transfers of Care (DTOC) patients in October was 59; November 25; and December 34. This figure is above the target level of 30 agreed through the System Resilience Group. This figure continues to remain above 30 for January 2016. There has been a recent change in the criteria being applied to DTOC identification, which may be having an effect on reportable numbers, otherwise this performance would suggest that there is still an improvement being seen from pre October performance (inclusive), thus a reduced effect on the blockages effecting inpatient beds. The DTOC figure needs to be taken in conjunction with the number of patients in acute beds who are deemed Medically Fit for Discharge (MFFD). Over the past 12 months the number of MFFD patients has not reduced and has remained at around 100 patients.

Corrective Actions

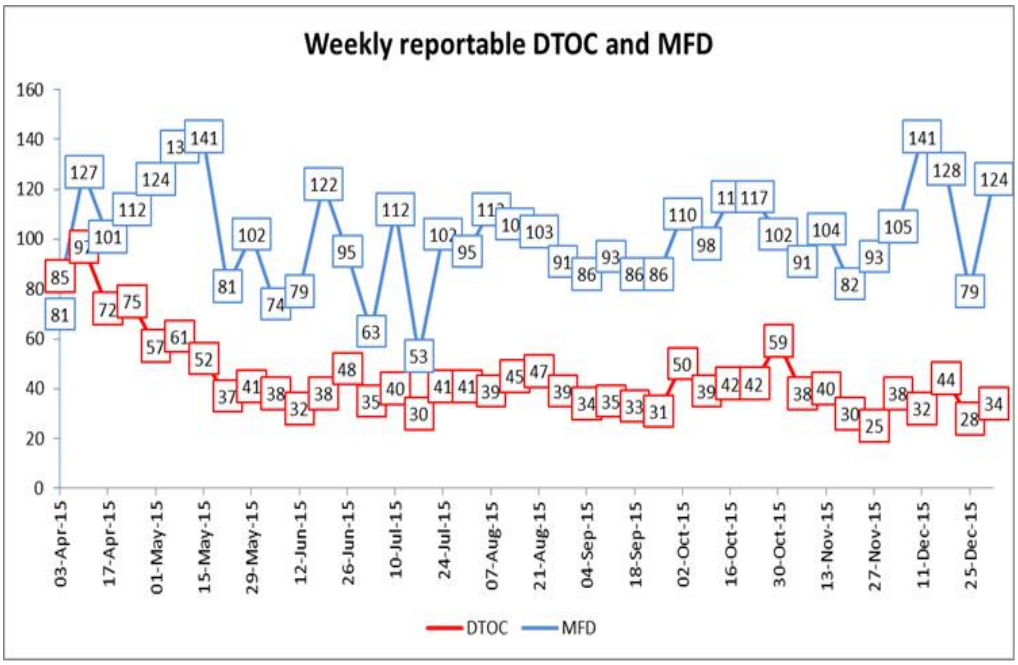
Currently there is a focus on the patients occupying acute beds with the longest delays in an attempt to continue the reduction in DTOC numbers and also the MFFD numbers. The reduction in MFFD numbers has to be measured in two ways; total number of MFFD patients; and total number of bed days attributable to MFFD patients. Multidisciplinary Accelerated Discharge Events (MADE) have been delivered across the acute hospital sites with the support of the ECIP team. These events generated significant numbers of additional discharges in the week prior to Christmas, and in the first week of January 2016. We have continued to build on the learning from these events to ensure that we maintain patient flow through the site. This has also generated a closer working relationship across the healthcare economy partners which continues to develop in order to improve patient flow, and attempt to reduce DTOC and patients stranded over 7 days in the acute trust.

Risks

The key risk to delivery of this KPI is the availability of social care packages and community hospital beds. This capacity is vital to being able to provide a safe discharge destination for patients after their acute clinical episode had finished. Patients and relatives compliance with the arranged discharge plans is also crucial to the future success and delivery of this KPI. This risk is on the Divisional Risk Register

SRO:COO	Current Reporting Month: Dec 2015			
	Perform-ance	Direction of travel	Plan/ Forecast	Status/ RAG
Target	<30	-	Corrective action plan status	Currently not applicable – to be rolled out
Current reported month performance	34	↑	Forecast next reported month	32
Last reported month performance	25	↓	Forecast month after	29
YTD performance	371	-	Forecast month after	28
Revised date to meet the standard	March 2016		Forecast year end	460

Worcestershire NHS
Acute Hospitals NHS Trust



Worcestershire NHS
Acute Hospitals NHS Trust

Key Performance Indicator: 28 day breaches as a percentage of cancelled operations (PEL3.0)

Headlines

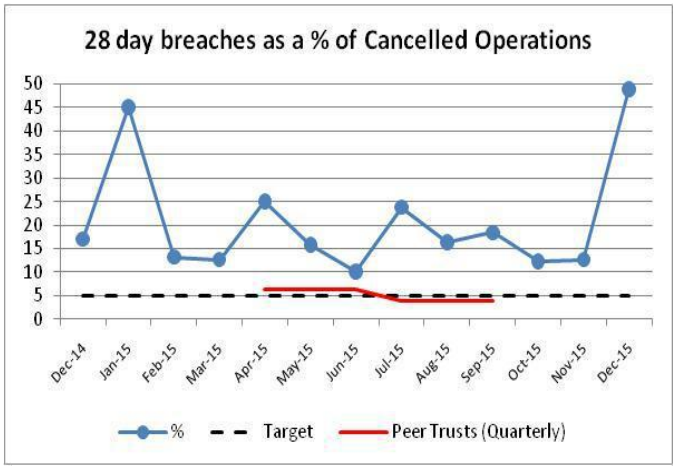
The decision to cancel operations for non-clinical reasons is taken by the Divisional Director for Surgery or Chief Operating Officer at the point the team is confident that all options have been explored. We have seen a deterioration in performance in December compared to previous months. Despite witnessing early improvements in elective income, theatre in - session utilisation coupled with greater collaborative working across the Division, the number of procedures cancelled on the day of surgery, due to a lack of surgical beds (timely) remains a challenge, with medical outliers increasing this month. This is in addition to the reconfiguration of beds on Chestnut Ward. This indicator measures performance in terms of rebooking patients within 28 days of a cancelled operation and December 2015 at 42.6% is the poorest performance for the past 12 months.

Corrective Actions

The Surgical Division has developed a number of new approaches to include daily prioritisation of elective patients requiring admission and improved information on the 'to come in' (TCI) lists. Each of the Clinical Directorates has been asked to review their own internal process for managing this cohort of patient. The Directorate's performance against this target is to be monitored at the Divisional Board

Risks

The key risk of not delivering against this target is a delay in a patient's treatment plan which could change the clinical presentation. This is in addition to poor patient experience as patients wait longer to be treated. This indicator also has a reputational risk for the organisation and is linked to the access targets (RTT and Cancer), resulting in higher financial penalties.



SRO:COO	Current Reporting Month: Dec 2015			
	Performance	Direction of travel	Plan/ Forecast	Status/ RAG
Target	<5%	-	Corrective action plan status	Currently not applicable – to be rolled out
Current reported month performance	42.6%	↑	Forecast next reported month	
Last reported month performance	12.7%	↑	Forecast month after	
YTD performance	19.5%	-	Forecast month after	
Revised date to meet the standard	February 2016		Forecast year end	

Worcestershire NHS
Acute Hospitals NHS Trust

Key Performance Indicator: Urgent operations cancelled for a second time (PEL4.2)

Headlines

The decision to cancel patients for non-clinical reasons is taken by the Divisional Director for Surgery or Chief Operating Officer at the point the operational team is confident all options have been explored. During escalation, patients are allocated beds based on clinical priority. Cancellations are classified in the following area:

- Bed availability
- Theatre capacity
- Patient unfit/surgical procedure no longer required

Corrective Actions

The Surgical Division has developed a number of new approaches to including daily prioritisation of patients requiring admission and improved information on the 'to come in' TCI lists. With the introduction of an overall daily command structure, the Division has witnessed improved collaborative working across each of the Clinical Directorate's areas; therefore ensuring all patients are allocated beds based on clinical priority. Each of the Clinical Directorates has been asked to ensure accurate classification of patients and review their performance against the Trust's Patient Access Policy. The Directorate's performance against this target is to be monitored at the monthly Divisional Board. The Alexandra Hospital and Kidderminster Treatment Centre sites benefit from an admission lounge, a similar infrastructure at Worcestershire Royal Hospital would be beneficial. A Project Led by TACO to change the way in which pre-operative services are managed within the Trust is underway.

Risks

The key risk of not delivering against this target is a delay in a patient's treatment plan which could change the clinical presentation. In addition, it is poor patient experience as patients wait longer for treatment. The indicator also has a reputational risk for the organisation and is linked to the access targets (RTT and Cancer), resulting in higher financial penalties.

	Operations cancelled	Target	Peer Trusts
Dec-14	0	0	
Jan-15	0	0	
Feb-15	0	0	
Mar-15	0	0	
Apr-15	0	0	0
May-15	0	0	0
Jun-15	0	0	0
Jul-15	0	0	0
Aug-15	0	0	0
Sep-15	0	0	0
Oct-15	1	0	0
Nov-15	1	0	0
Dec-15	1	0	

SRO:COO	Current Reporting Month: Dec 2015			
	Performance	Direction of travel	Plan/ Forecast	Status/ RAG
Target	0	-	Corrective action plan status	Currently not applicable – to be rolled out
Current reported month performance	1	⇨	Forecast next reported month	
Last reported month performance	1	⇨	Forecast month after	
YTD performance	3	-	Forecast month after	
Revised date to meet the standard	February 2016		Forecast year end	

Worcestershire NHS
Acute Hospitals NHS Trust

Key Performance Indicator: Length of Stay (All patients) and Length of Stay (excluding zero LOS spells) (PEM2.0 and PEM3.0)

Headlines

Overall length of stay for inpatients on the WRH site was 4.3 days in November and 4.6 days in December. This changed to 5.9 days in November and 6.5 days in December when zero day length of stay patients were excluded from the data set. This shows that in December the average length of stay increased by 0.6 days for patients, in comparison to the same measurement in November. The National trend for inpatient activity across UK hospitals is that the length of stay increases during the winter period due to the exacerbation of chronic conditions that take longer to resolve. This increase in length of stay is also affected by the increase in DTOC patient numbers across the same time period from 25 to 34. The high bed occupancy levels also adversely impact on the inpatient average length of stay. This is because the patients are not always able to be admitted to the most appropriate clinical area in a timely manner, therefore experience unnecessary delays in getting the expert opinions that could minimise their length of stay.

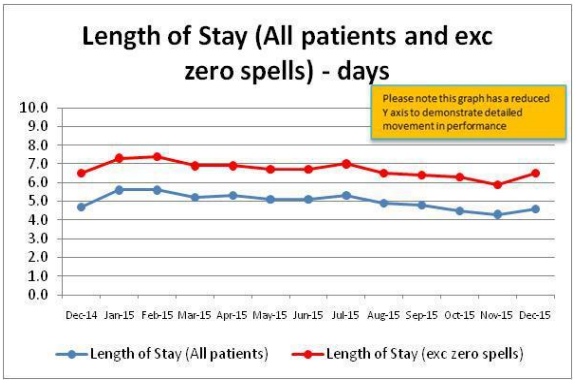
Corrective Actions

In order to correct this position and reduce length of stay, the management teams are working on a business case to increase the inpatient bed holding, making it more likely that the patients will be admitted to the most appropriate ward in a timely manner, thus expediting their pathway through the hospital. A further action being taken is the development of admission avoidance schemes such as an Older persons Advice and Liaison (OPAL) service that can focus on key groups such as Frailty patients to ensure they are not admitted where possible and where absolutely unpreventable, they are given intensive input to minimise their length of stay. We are also working with health economy partners to reduce the number of DTOC and stranded patients in acute hospital beds, resulting in a positive impact on length of stay. This includes the MADE event initiative run across the sites with support from the ECIP team.

Risks

The impact of having high lengths of stay are that more beds are required to cope with the demand on the services. High length of stay is also detrimental to the quality of care and potential clinical outcome for some patients for example with increased exposure to hospital acquired infections. Emergency and elective patients are unable to access inpatient facilities in a timely manner due to a lack of capacity being available when lengths of stay are high.

Worcestershire NHS
Acute Hospitals NHS Trust



SRO:COO	Current Reporting Month: Dec 2015			
	Performance	**Direction of travel**	**Plan/ Forecast**	**Status/ RAG**
Target	To be agreed	-	Corrective action plan status	Currently not applicable – to be rolled out
Current reported month performance	4.6 (ALL) 6.5 (exc O)	↑	Forecast next reported month	To be completed
Last reported month performance	4.3 (ALL) 5.9 (exc 0)	↓	Forecast month after	To be completed
YTD performance	4.9 (ALL) 6.5 (exc 0)		Forecast month after	To be completed
Revised date to meet the standard	**Target to be agreed**		Forecast year end	To be completed

Worcestershire NHS
Acute Hospitals NHS Trust

Key Performance Indicator: 6 Week Wait Diagnostics (Proportion of waiting list)(PW1.1.1)

Headlines

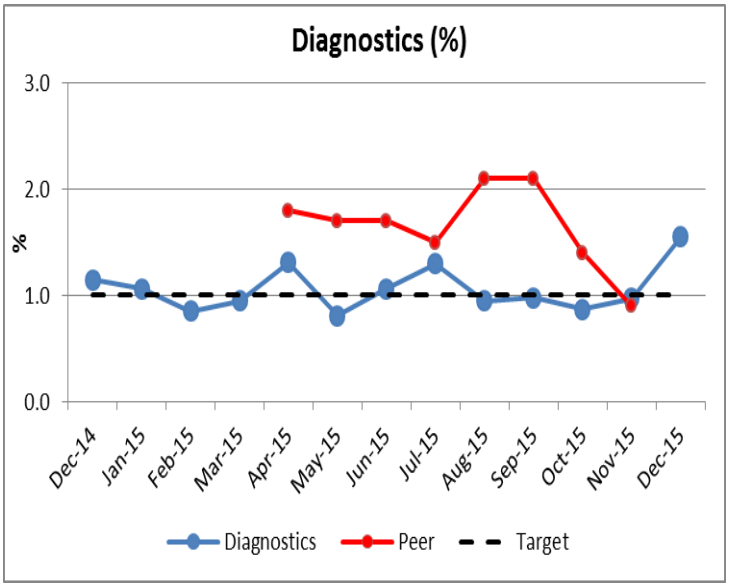
The achievement of the diagnostic 6 week target has been difficult due to equipment breakdown, bank holidays/ annual leave and a continued increase in referral s, particularly from in-patients which is impinging on out-patient capacity. The Directorate capacity has been severely impacted upon with the breakdown of MRI at KTC and CT at AGH, resulting in the cancellation of circa 400 patients who were close to or approaching breaching the performance indicator, leaving very little scope of providing an alternative date within timescales.

Corrective Actions

The Directorate has made arrangements with the independent sector to transfer patients, initially those who were affected by equipment breakdown and are also continuing to plan to utilise the private sector into February.
In order to support the use of out-patient capacity for in-patients, the Directorate has provided additional permanent capacity at AGH, to support WRH out-patients. An analysis of available CT capacity /usage has commenced, along with scoping requirements for permanent extension of days. Staff are providing WLI sessions daily/weekly and in light of the urgent situation of KTC MRI breakdown, have cancelled annual leave, re-arranged shifts and worked on other base sites to open up capacity from 7am – 10pm.

Risks

The delay of a diagnostic can impact on the achievement of 18 week target and does not provide a satisfactory experience for patients and may impact on Trust finances should any performance penalty's be applied



SRO:COO	Current Reporting Month: Dec 2015			
	Performance	Direction of travel	Plan/ Forecast	Status/ RAG
Target	<1.0%	-	Corrective action plan status	Currently not applicable – to be rolled out
Current reported month performance	1.55%	↑	Forecast next reported month	
Last reported month performance	0.97%	↑	Forecast month after	Not provided
YTD performance	1.09%	-	Forecast month after	Not provided
Revised date to meet the standard	Not provided		Forecast year end	Not provided

Worcestershire NHS
Acute Hospitals NHS Trust

Corrective Action Statements: Workforce

Key Performance Indicator Names;

- Nursing Staff Turnover – Qualified (Total) (WT1.3)
- Nursing Staff Turnover – Unqualified (Total) (WT1.4)
- Sickness Absence Rate Monthly (Total %) (WSA1.0)
- Medical, Non -Medical and Consultant Appraisals (Total) (WAPP1.2, WAPP2.2 and WAPP3.2)
- % of eligible staff completed training (WSMT10.2)

Forecast Key	
Forecast to achieve	
Potential risk target will not be achieved	
Forecast not to achieve	

Worcestershire NHS
Acute Hospitals NHS Trust

Key Performance Indicator: Nursing Staff Turnover – Qualified (Total) (WT1.3)

Headlines

The qualified nursing turnover figure for December 2015 is 13.17% against the target of 10%. During January to September 2015 the overall trend shows the percentage was consistently slightly above the trust 10% target. However in quarter 4 this figure has deteriorated within the 3 month period and shows a 2% increase in turnover. The table below identifies the gap between starters and leavers during the months of October and December 2015 which has contributed to this increase in percentage.

Qualified Nursing			
	Oct-15	Nov-15	Dec-15
Starters (FTE)	5.24	21.49	6.43
Leavers (FTE)	22.68	25.65	21.17

Corrective Actions

A number of actions have been developed by the Nurse Recruitment Task and Finish Group and the action plan is monitored through the Nursing and Midwifery Workforce Assurance Group and then into the Trust Workforce Assurance Group for approval. The following actions have been achieved:

- Fortnightly divisional vacancy return to track actual vacancies.
- Generic Band 5 Job adverts and internal transfer process for Band 5 nurses to be launched in February.
- Tracking and follow up system for University of Worcester graduates.
- Recruitment event schedule for 2016.
- Revised assessment tests for Band 5 posts.

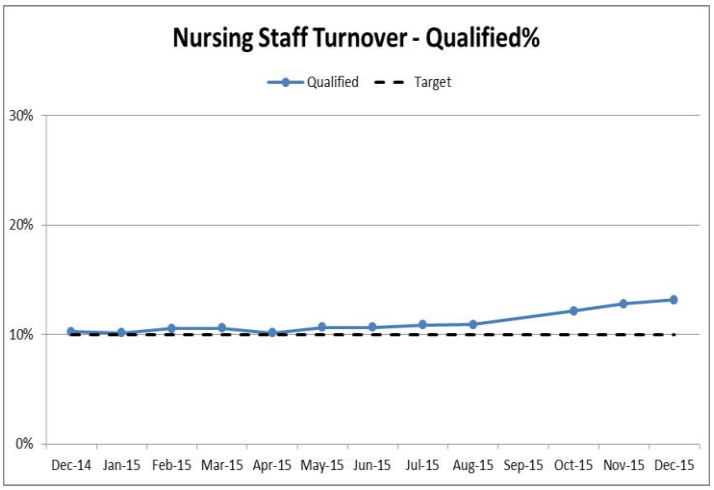
Future actions are:

- Developing a business case for overseas nurse recruitment from India and the Philippines.
- Considering recruitment and retention premiums for specific areas e.g. theatres.
- Analysis of exit interviews to identify reasons for nursing leavers with 12 months or less continuous service.

Risks

If we do not attract and retain qualified nursing staff we will be unable to ensure safe and adequate staffing levels. We also will need to rely on agency and bank staff which will affect patient experience, quality and financial position. High turnover impacts on staff morale and health and wellbeing so is a high priority for the Trust.

Worcestershire NHS
Acute Hospitals NHS Trust



SRO: DoHR/ COO	Current Reporting Month: Dec 2015			
	Performance	**Direction of travel**	**Plan/ Forecast**	**Status/ RAG**
Target	10%	-	Corrective action plan status	Currently not applicable – to be rolled out
Current reported month performance	13.2%	↑	Forecast next reported month -13%	
Last reported month performance	12.8%	↑	Forecast month after	
YTD performance	–	–	Forecast month after	
Revised date to meet the standard	**Not provided**		Forecast year end	

Worcestershire NHS
Acute Hospitals NHS Trust

Key Performance Indicator: Nursing Staff Turnover – Unqualified (Total) (WT1.4)

Headlines

The unqualified nursing turnover figure for December 2015 is 13.86% against the trust target of 10% although this is in line with national average turnover of 14% for unqualified nursing. However, this figure does not reflect the improved recruitment figures from April to December 2015 which demonstrates an increase in the numbers of starters in comparison to the number of leavers for 8 of the 9 months. The only outlier during this period was during August 2015 when there were 23.28(fte) leavers in relation to the starters of 10.89 (fte). Analysis of the reasons for leaving indicate the top reasons as better reward package and relocation and the highest number of leavers for that period were in Medicine which was 4.60 fte and these leavers were in AMU Worcester and AMU Alexandra Hospital.

Corrective Actions

A number of actions have been developed by the Nurse Recruitment Task and Finish Group and the action plan is monitored through the Nursing and Midwifery Workforce Assurance Group and then into the Trust Workforce Assurance Group for approval. The following actions have been achieved:

- Piloted a mandatory values- based recruitment pre-screening tool.
- Continue to provide 6 -day care certificate course for all new unqualified nursing staff.
- Improved assessment centre process to provide a reserve candidate list.

Future actions are:

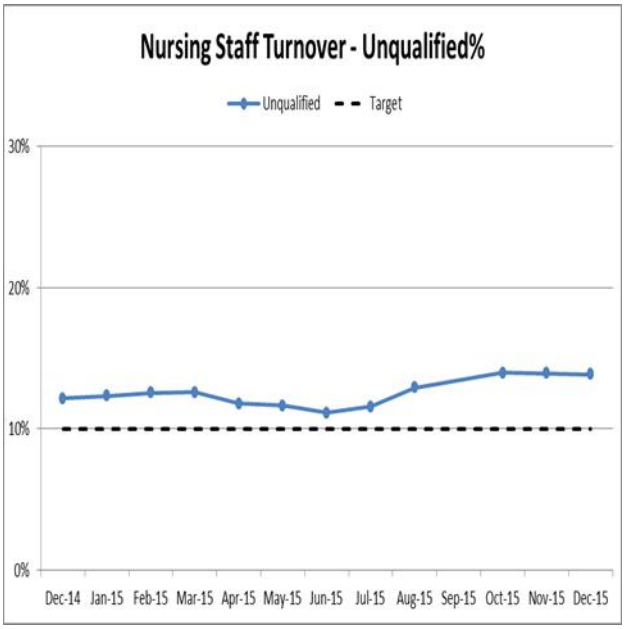
- Analysis of exit interviews to identify reasons for nursing leavers with 12 months or less continuous service.

The trust continues to attract an average of 50 applications per advertisement with sufficient quality applications to fill vacancies with a list of reserve candidates.

Risks

If we do not attract and retain key clinical staff we will be unable to ensure safe and adequate staffing levels. We also will need to rely on agency and bank staff which will affect patient experience, quality and financial position. High turnover impacts on staff morale and health and wellbeing so is a high priority for the Trust.

Worcestershire NHS
Acute Hospitals NHS Trust



SRO: DoHR/COO	Current Reporting Month: Dec 2015			
	Performance	**Direction of travel**	**Plan/ Forecast**	**Status/ RAG**
Target	10%	-	Corrective action plan status	Currently not applicable – to be rolled out
Current reported month performance	13.9%	⇨	Forecast next reported month – 13%	
Last reported month performance	13.9%	⇩	Forecast month after- 12.5%	
YTD performance	-	-	Forecast month after – 12.5%	
Revised date to meet the standard	**Not provided**		Forecast year end -12..5%	

Worcestershire NHS
Acute Hospitals NHS Trust

Key Performance Indicator: Sickness Absence Rate Monthly (Total %) (WSA1.0)

Headlines

There is no current up to date HSCIC benchmarking data available (system currently under review) however July 2015 data showed the Trust rate as comparable with the average for West Midlands which at that time was 4.20% compared to the Trust rate of 4.19%. The Trust sickness absence 'in-month' for December is 4.57% consistent with last year's December figure of 4.68% but above the Trust target of 3.5%. The 12 month cumulative figure is 4.27% an increase of 19% on the December 2014 cumulative figure. The issue is long-term sickness absence rather than short-term which has consistently sat at around 2.8% for the last 6 months. The highest percentage areas for long term sickness absence include Asset Management and IT at 4.15%, TACO at 3.63% and Surgery at 2.79% with TACO showing a month on month increase over the last 3 months. Across the Trust, we currently have 90 open cases of long-term sickness absence with 75 employees absent between 1-6 months and 15 employees absent for more than 6 months.

Top 3 reasons for long-term sickness absence are:

- Anxiety and stress (1457 calendar days lost in December)
- Other musculoskeletal problems (1006 days lost)
- Back problems (746 days lost).

The top short-term sickness absence reasons are:

- Colds and Flu (573 days lost)
- Gastrointestinal conditions (541 days lost).

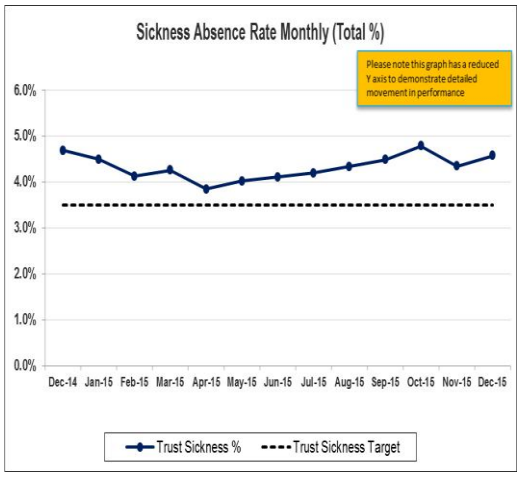
Corrective Actions

The HR Team in conjunction with line managers are reviewing all 90 long-term sickness absences cases and all but 9 have active management plans in place. These 9 cases are not appropriate for formal case management at this stage, in line with Trust Policy. There are currently 15 cases of employees off for 6 months or more, 9 have anticipated return to work plans and 6 have been progressed to formal hearings. The HR Department are working closely with Occupational Health and Line Management to ensure management plans are appropriate and maintained and in addition are working closely with and reviewing best practice within other Trusts where sustained reductions in absence rates have been achieved to look at lessons learnt with the support of information from NHS Employers. Learning will be worked through with our staff side colleagues to recommend any changes to current Trust Policy. This review will be concluded within the next 2 months.

Risks

Higher levels of sickness absence affect patient experience, team working and Trust finances due to the need for bank or agency cover; as well as the cost of Occupational and Statutory Sick Pay.

Worcestershire NHS
Acute Hospitals NHS Trust



SRO: DoHR/COO	Current Reporting Month: Dec 2015			
	Perform-ance	**Direction of travel**	**Plan/ Forecast**	**Status/ RAG**
Target	=<3.5%	-	Corrective action plan status	Currently not applicable – to be rolled out
Current reported month performance	4.57%	↑	Forecast next reported month - 4.5%	
Last reported month performance	4.34%	↓	Forecast month after- 4.2%	
YTD performance	-	-	Forecast month after – 4.2%	
Revised date to meet the standard	**Not provided**		Forecast year end- 4.2%	

Key Performance Indicator: Medical, Non-medical Appraisals and Consultant (Total) (WAPP1.2, WAPP2.2 and WAPP3.2)

Headlines

Medical Staff:

The appraisal rate for all medical staff is 81.6% as at 31st December 2015 against the Trust target of 85%. This is a result of 60 scheduled appraisals which did not take place. The appraisal rate for all medical staff has decreased for the fifth consecutive month to 81.6%, falling below the Trust Board target of 85% for the first time since March 2015. All divisions are currently below the 85% target in December as detailed below, with Women and Children's Division of particular concern:

- Medicine – 83.08%
- TACO – 82.50%
- Surgery – 82.35%
- Clinical support – 80.70%
- Women and Children's - 76.32%

The consultant appraisal rate for this period is 82.03% and the SAS appraisal rate is 80%.

Non-Medical staff:

The appraisal rate for all non-medical staff is 78.2% against a target of 85%. Non-medical appraisal showed a decline in performance from August 2015 until October 2015. There has however been an improvement since November to 78.2% at the end of December 2015. Managers have reported performance has been affected due to operational pressures and managers' non-completion of either required documentation to report appraisal or not entering the appraisal onto ESR once completed.

Corrective Actions

Medical Staff Appraisal

Divisional Management Teams are issued with a monthly RAG rated appraisal status report and are requested to provide action plans to address all expired appraisals. The Medical Appraisal and Revalidation Policy has been reviewed for submission to and ratification by the Medical Management Committee in January. The policy will provide additional clarity and guidance to Appraisers and Appraisees.

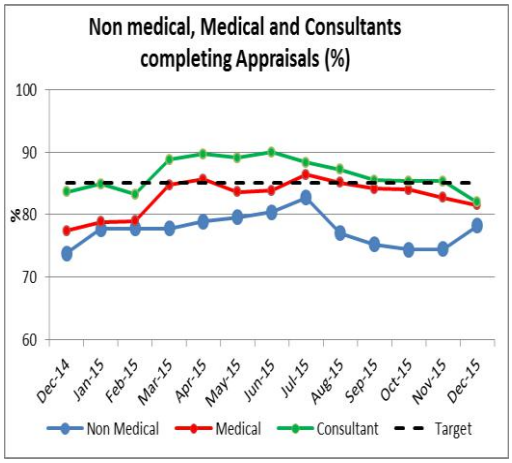
Non-Medical Appraisal

All employees who have not received an appraisal in the last 12 months have received a letter reminding them of the importance of their appraisal. All managers whose departmental performance is below 75% have been sent a reminder regarding their obligation to ensure that all staff receive an annual appraisal. In addition the Learning and Development team are currently developing a one page electronic appraisal form which can be submitted directly to ESR for monitoring, this is planned to be completed by February 2016.

All managers receive reminders of appraisals that are overdue as well as those that are due in the next 3 months.

Risks

The Clinical Lead role for Revalidation and Appraisal remains vacant. Staff are expected to have received a formal appraisal every year so that they are aware of their performance. Where staff do not have an appraisal they do not have the opportunity to receive feedback and to give feedback to their manager.



SRO:DoHR	Current Reporting Month: Dec 2015			
	Performance	**Direction of travel**	**Plan/ Forecast**	**Status/ RAG**
Target	85%	-	Corrective action plan status	Currently not applicable – to be rolled out
Current reported month performance	81.6% Medical, 78,2% Non-medical, 82.0% Consultant		Forecast next reported month Medical – 83% Non-Medical 80%	
Last reported month performance	82.7% medical 74.5% non-medical, 85.3% Consultant		Forecast month after Medical – 84% Non-Medical – 83%	
YTD performance	84.1% medical, 77.9% non – medical. 86.9% Consultant	-	Forecast month after Medical – 85% Non-Medical 85%	
Revised date to meet the standard	**March 2016**		Forecast year end Medical and Non-Medical 85%	85% non-medical 85% medical

Key Performance Indicator: % of eligible staff completed training (WSMT10.2)

Headlines

The Trusts mandatory training performance as at December 2015 is 87.2% against a 95% target. A benchmarking exercise has been completed with 11 other Trusts in the West Midlands which showed the Trust is not an outlier and demonstrates that for the 10 topics that each hospital reports in common, Worcestershire Acute Hospitals is demonstrating an average performance which would place them fourth in the region. There are 18 mandatory training topics and currently 12 topics are on track to achieve the 95% target by 31st March 2016. The remaining six topics are currently achieving between 44% and 78% and these are being reviewed by the Workforce Assurance Group

Analysis of the data shows that in identifying the clinical/non-clinical split in mandatory training rates, the focus has been on clinical staff with over 80% compliance in all areas and high 80's and 90's in safeguarding and infection prevention / hand hygiene. Non-clinical staff have some improvement to make but key areas such as information governance sits at 92%.

Corrective Actions

For above six topics the following corrective actions have been agreed:

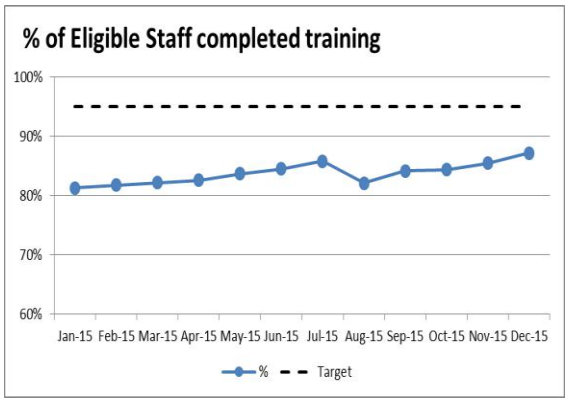
- Provision of additional training sessions and weekends and evenings.
- Alternative methods of training delivery
- Written assessments to replace e-learning for staff that have limited IT contact
- Additional administration support resourced to support managers to validate mandatory training data and records.
- Knowledgeable management staff supporting staff to complete e-learning training in Trust libraries.
- Departmental monthly performance dashboard now includes mandatory training compliance rates.
- Consent lead been agreed to agree training package for 2016.

Future Actions include:

- Networking with all 27 Trusts engaged in the West Midlands Mandatory Training Streamlining Project to develop new ideas and agree transferable training records between Trusts to improve compliance.
- Request to Workforce Assurance Group to review mandatory training compliance targets percentage of 95% in line with other organisations across the West Midlands and in the Streamlining Project.
- Case for change written for approval for new bespoke mandatory training reporting system

Risks

One of the key risks in not meeting their mandatory training targets will be financial penalties from CQR Group and potential for breaches in health and safety legislation.



SRO: DoHR/COO	Current Reporting Month: Dec 2015			
	Perform-ance	Direction of travel	Plan/ Forecast	Status/ RAG
Target	>=95%	-	Corrective action plan status	Currently not applicable – to be rolled out
Current reported month performance	87.2%	⇧	Forecast next reported month – 89%	
Last reported month performance	85.5%	⇧	Forecast month after-90%	
YTD performance	-	-	Forecast month after – 90%	
Revised date to meet the standard	**March 2016**		Forecast year end -90%	

Corrective Action Statements:

Quality and Safety

Key Performance Indicator Names;

- Mortality - HSMR (HED tool) (QPS9.8)
- Mortality - SHMI – inc. Deaths 30 days post discharge (QPS9.1)
- The total falls resulting in serious harm (in month) (QPS6.6)
- The total number of Serious Incidents (QPS3.1)
- % of Category 2 complaints responded within 25 days (WAHT) (QEX1.14)
- Safety Thermometer (QPS10.1)
- Infection control - MRSA Screening (High Risk Wards) (QPS12)
- % of approved risks overdue for review (QR1.0) and % of approved with overdue actions (QR1.2)
- Hip Fractures – Time to Theatre within 36 hours – all patients (QEF3.1)

Forecast Key	
Forecast to achieve	
Potential risk target will not be achieved	
Forecast not to achieve	

Key Performance Indicator: HSMR (HED tool) (QPS9.8)

Headlines

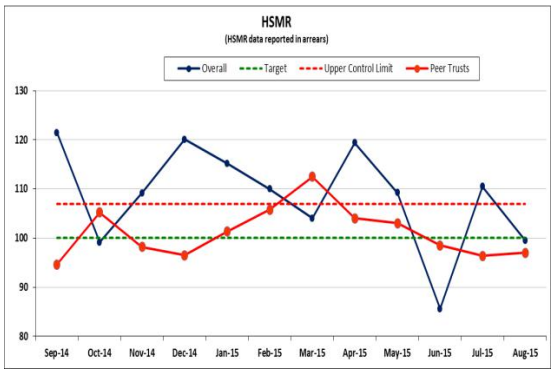
The HSMR for the Trust is 103.69 for the period of April – September 2015. This value, although higher than the average of 100, is within expected variability. The general direction of travel is one of reduction however the data from the latest 3 months should be viewed with caution as it is based on an incomplete dataset due to patients admitted during these months still having active management. The impact of data refresh is to increase the HSMR value as long stay patients tend to have a higher overall mortality but not a higher predicted mortality. The month on month position does seem to be improving but there is a large degree of variability. Using 12 month rolling figures can smooth out this sometimes distracting variability. The rising trend shown using this methodology has plateaued over the last 3 months and is expected to fall in the next published figure.

Corrective Actions

The heat map of contributing diagnostic groups indicates adverse trends in Acute Gastrointestinal Haemorrhage, Chronic Skin Ulcers and Syncope. Deep dive reviews of deaths occurring in these areas have been requested of the appropriate specialist teams to be completed by the end of December 2015. It is anticipated that an overview report will be brought to Safe Patient Group in February 2016. Another diagnostic group that is showing and adverse trend over the 12 months to August 2015 is 'Other Circulatory Diseases'. This group includes surgical patients with a primary diagnosis related to arterio-occlusive disease (9 deaths) and medical patients with non-specific hypotension or non-specific arteritis. Requests for review of the care of the patients and diagnostic/coding accuracy have been requested of the relevant divisions.

Risks

Failure to identify and address suboptimal care puts patient safety at risk. Errors in care lead to prolonged stay impacting on the Trusts ability to manage its emergency and elective workload. A continued high HSMR and poor compliance with completion of mortality reviews damages the Trusts reputation and risks regulatory action from the CQC.



SRO:CMO	Current Reporting Month: Aug 2015			
	Performance	**Direction of travel**	**Plan/ Forecast**	**Status/ RAG**
Target	<100	-	Corrective action plan status	Currently not applicable – to be rolled out
Current reported month performance	100	↓	Forecast next reported month	Not provided
Last reported month performance	111	↑	Forecast month after	Not provided
YTD performance	104	-	Forecast month after	Not provided
Revised date to meet the standard	**Not provided**		Forecast year end	Not provided

Key Performance Indicator: SHMI – inc. Deaths 30 days post discharge (QPS9.1)

Headlines

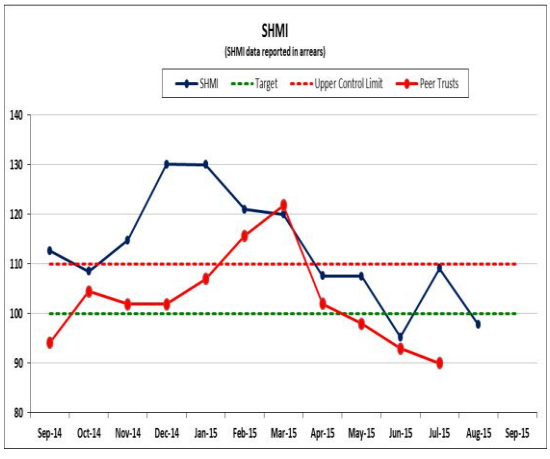
The monthly (projected) SHMI for April – September 2015 is 103.90. This compares with a value of 102.97 for the same period 2014. The outcome for 2014/15 was 111.48, which was higher (worse) than 3 standard deviations from expected indicating the Trust as a significant outlier for this measure.

Corrective Actions

Deep dive reviews of the care of patients as per the HSMR corrective actions and establishing routine mortality reviews will help identify correctable issues with care. In addition as the SHMI incorporates deaths occurring within 30 days of discharge, work has begun to link mortality reviews occurring in Worcestershire Health and Care Trust and establish mortality reviews for patients discharged to their normal place of residence. These initiatives should identify any avoidable factors compromising the quality of care delivered to these groups of patients and thus facilitate improvement.

Risks

Failure to identify and address suboptimal care puts patient safety at risk. Errors in care lead to prolonged stay impacting on the Trusts ability to manage its emergency and elective workload. A continued high HSMR and SHMI damages the Trusts reputation and risks regulatory action from the CQC.



SRO:CMO	Current Reporting Month: Aug 2015			
	Performance	**Direction of travel**	**Plan/ Forecast**	**Status/ RAG**
Target	<100	-	Corrective action plan status	Currently not applicable – to be rolled out
Current reported month performance	98	↓	Forecast next reported month	Not provided
Last reported month performance	109	↑	Forecast month after	Not provided
YTD performance	104	-	Forecast month after	Not provided
Revised date to meet the standard	**Not provided**		Forecast year end	Not provided

Key Performance Indicator: The total falls resulting in serious harm (in month) (QPS6.6)

Headlines

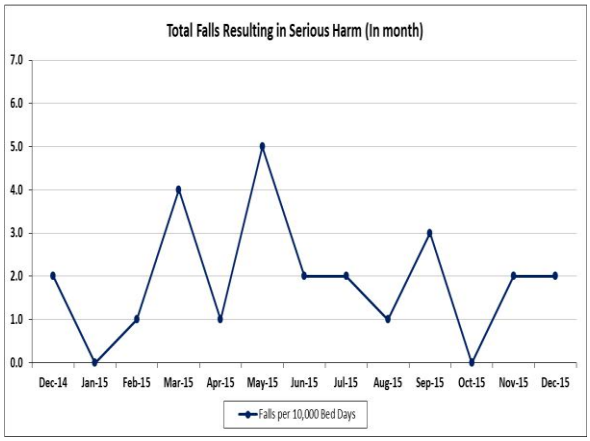
There were 2 serious harm falls in December 2015. These were both fractured neck of femurs. Both falls were at the Alexandra Hospital on the Medical Assessment Unit. The falls were not witnessed and appear to have occurred whilst the patients were undertaking specific tasks. This brings the total of serious harm falls for the financial year to 18. The general trend for serious harm falls is down.

Corrective Actions

There are on-going falls prevention and reduction training strategies in place for MAU as well as all ward areas. Following the results from a recent care contact time audit, further work is being undertaken to look at specific roles which will release nursing time to care. These include ward administrator roles. The staffing levels on the Alex MAU continue to be challenging. Further work is being undertaken to recruit staff and this remains a priority for the ward.

Risks

Whilst the overall trend for serious harm falls is down we need to be mindful that the increase in length of stay and mortality are increased by serious harm falls. This directly affects the patient experience.



SRO:CNO	Current Reporting Month: Dec 2015			
	Perform-ance	Direction of travel	Plan/ Forecast	Status/ RAG
Target	0	-	Corrective action plan status	Currently not applicable – to be rolled out
Current reported month performance	2	↑	Forecast next reported month	Not provided
Last reported month performance	0	↓	Forecast month after	Not provided
YTD performance	18	-	Forecast month after	Not provided
Revised date to meet the standard	**Not provided**		Forecast year end	Not provided

Key Performance Indicator: The total number of Serious Incidents (SIs), open longer than 60 days and are awaiting closure by WAHT (QPS3.3)

Headlines

3 SI investigations were open beyond 60 days at the end of December, the same as November. A number of investigation reports have been received but referred back to the Investigator / Division for further review and/or clarification of actions, delaying timely closure.

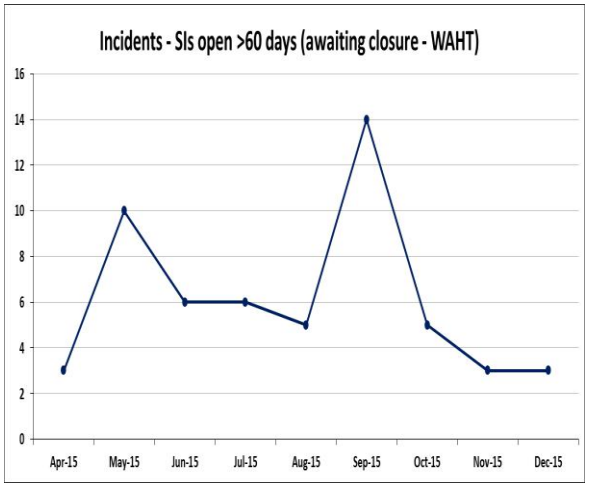
.

Corrective Actions

The Serious Incident Review Group has been brought within a weekly Trust Operational Governance Meeting which requires the attendance of Divisional Medical and Nursing Directors. Divisional review meetings continue to monitor progress of SI investigations and share any immediate learning within their area of responsibility. The new Divisional Governance Report will be produced monthly for review at performance meetings and includes the SI investigation performance. The Patient Care Improvement Plan (PCIP) contains actions that are designed to improve the management of patient safety incidents via divisional review and management and provide easily accessible reports from the Datix Management Information System for tracking incidents and actions. Training for additional lead investigators has been agreed and will be arranged.

Risks

Performance in SI investigations is monitored nationally and locally with the potential to attract a contract query from the CCGs or attention from the TDA. The CQC inspection report highlighted issues with the incident reporting and investigation process and learning from these events.



SRO:CNO	Current Reporting Month: Dec 2015			
	Perform-ance	Direction of travel	Plan/ Forecast	Status/ RAG
Target	0	-	Corrective action plan status	Currently not applicable – to be rolled out
Current reported month performance	3	→	Forecast next reported month	Not applicable
Last reported month performance	3	↓	Forecast month after	Not applicable
YTD performance	-	-	Forecast month after	Not applicable
Revised date to meet the standard	Not applicable		Forecast year end	Not applicable

Key Performance Indicator: % of Category 2 complaints responded within 25 days (WAHT) (QEX1.14)

Headlines

Overall performance against the target of 90% of category 2 complaints being responded to within 25 working days was 62% to the end of November. Significant work has taken place within Medicine and Surgery, our two biggest divisions, to improve their response times, but while Medicine achieved 78% in November, Surgery dropped to 43%. Meetings have taken place with the Deputy CNO, Associate Director Patient Experience and Surgery to review this and how we can sustain improvement within the Division.

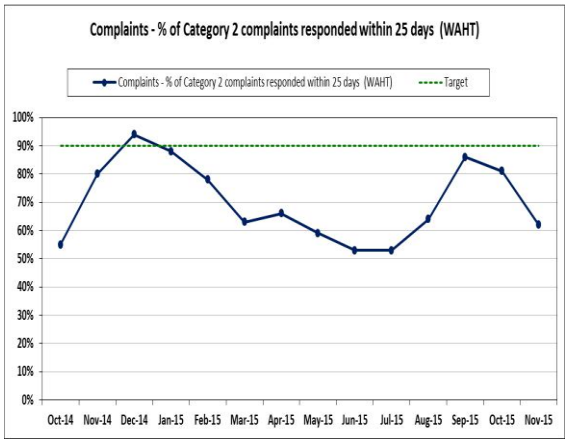
Corrective Actions

The Complaints Action Plan is now included in the Patient Care Improvement Plan. This is monitored via the Patient and Carer Experience Committee and the Associate Director Patient Experience (ADPE) is also now regularly reporting on progress to the Quality Governance Committee. The new complaints template has now been rolled out across all Divisions. This provides a framework for investigations and a repository to collate all information pertaining to the investigation, ensuring a root cause analysis takes place and that action plans are developed and shared as necessary. It provides an audit trail for complaint investigations, outcomes, actions and shared learning. Weekly briefings and support for staff on completing these have been scheduled and we are working with the DATIX manager to ensure as much as possible can be completed via DATIX. The Complaints Team are attending regular complaints meetings with Medicine and Surgery. The ADPE and Patient Relations Manager have also been attending Divisional Quality Governance Meetings. Four per cent of breaches in November resulted from letters being rejected by the signing Executive. This is an improving area which reflects the improved quality of responses following the Patient Relations Managers letter writing sessions. Four per cent also breached because of delays in sign off in the Exec Offices and PAs have been asked to pass these on if their Exec member is not in to avoid this happening. A revised DATIX complaints report has been developed for Divisions and is now going live. This provides all Divisions with up to date information on their complaints and records the outcomes. Medicine have developed a weekly bulletin incorporating themes and learning. We will share this across the Trust as a good example of sharing themes and learning. Weekly outstanding complaints lists continue to be shared with Divisions to assist with tracking. Ninety per cent of complaints are sent to the Divisions within 3 working days in line with our performance target. The Complaints Team liaise with investigating officers and send out 22 day reminders. These are then escalated to the ADPE.

The Complaints Policy / process is being updated and will incorporate the new NHS England 'Assurance of Good Complaint Handling for Acute and Community Care' toolkit. In November we dealt with 199 PALS calls and 205 in December. With 1827 PALS contacts to the end of December we have already exceeded the total for 2014-15. Given we only have one PALS Officer for the whole Trust this does have capacity implications which are being reviewed as part of the wider workforce review.

Risks

If we do not adequately understand & learn from complaints and patient feedback we will be unable to deliver and demonstrate excellent patient experience.



SRO:CNO	Current Reporting Month: Nov 2015			
	Performance	**Direction of travel**	**Plan/ Forecast**	**Status/ RAG**
Target	>90%	-	Corrective action plan status	Currently not applicable – to be rolled out
Current reported month performance	62%	↓	Forecast next reported month	
Last reported month performance	81.0%	↑	Forecast month after	
YTD performance	64%	-	Forecast month after	Not provided
Revised date to meet the standard	**March 2016**		Forecast year end	

Key Performance Indicator: Safety Thermometer (QPS10.1)

Headlines

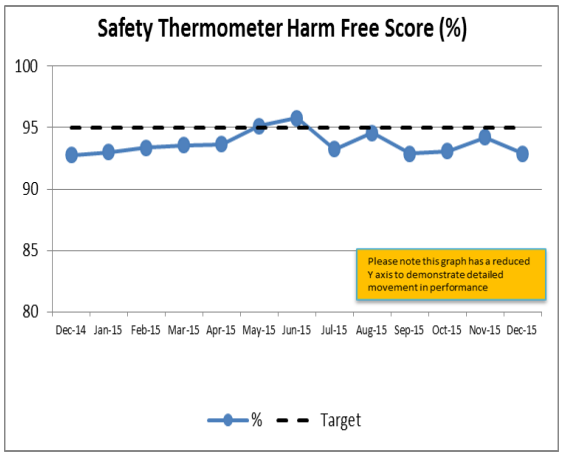
The target score set for harm free care is 95%. The Trusts overall harm free care score for December was 92.86% against a national benchmark for acute trusts of 93.55%. The Trust has achieved a score of 95% for 2 months out of 8 this financial year. Overall performance in the remaining six months has been between 92.8% and 94.5%. The main reason for not achieving 95% has been the scores for all pressure ulcers and the presence of catheters and urinary tract infections. A portion of these are acquired prior to admission to our hospitals and our beyond our control. The number of new pressure ulcers for December was 0.96% of all reported, and the number of new catheters and urinary tract infections was 0.3% of all reported. Of all new harms those that occur within our Trust was 1.5% for the month of December 2015.

Corrective Actions

All pressure ulcers are reviewed by the Trust Tissue Viability Team and accountability meetings held with relevant staff. Where pressure ulcers have occurred whilst in our care, action plans are developed and monitored by Matrons supported by the Tissue Viability Team. Ward areas have tissue viability link nurses who support learning from incidents and provide educational support to ward teams. The prevalence of catheter associated urinary tract infection (UTI) remains a focus for the Trust. The use of catheters must be documented including documenting the rationale for insertion and documentation of on-going care (which can follow the patient across the health economy) to help improve catheter management and reduce infection. A Harm Free Group has been established to bring together all current groups looking at 'harms' such as falls, pressure ulcers, venous thrombosis and infection, as these are often interconnected and the group will look at prevention of all harms using a connected and holistic approach. The first meeting will be held on Thursday 4th February 2016.

Risks

The risks for not meeting the target of 95% need to be broken down into the specific areas that are being flagged. The number of pressure ulcers, catheter acquired urinary tract infections, falls and VTE's need to be looked at as to whether they occurred within the Trust or not (ie new harm), Also, Safety Thermometer should not be used as a bench mark with other trusts – NHS Safety Thermometer advise that we look at the trends within our own organisation. Both CQC and TDA will expect to see actions plans for the areas where we are falling below the 95%.



SRO:CNO	Current Reporting Month: Dec 2015			
	Perform-ance	Direction of travel	Plan/ Forecast	Status/ RAG
Target	>95%	-	Corrective action plan status	Currently not applicable – to be rolled out
Current reported month performance	92.86%	↓	Forecast next reported month	Not provided
Last reported month performance	94.20%	↑	Forecast month after	Not provided
YTD performance	-	-	Forecast month after	Not provided
Revised date to meet the standard	Not provided		Forecast year end	Not provided

Key Performance Indicator: MRSA Screening (all patients and High Risk Wards) (QPS.12)

Headlines

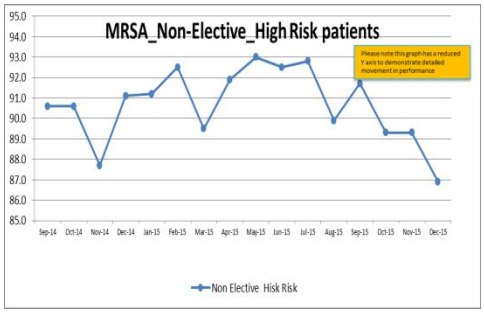
In December there has been some improvement, with High Risk Wards (Elective) exceeding the 95% target by 0.3%. The performance for High Risk Wards (Non -elective) declined to 86.9% in December from 89.3% in November. In the High Risk Wards (Elective) a total of 15 patients out of 321 were not screened. The Medical Division achieved 80% of patients screened; Surgical Division 95.3% and the other Divisions all met 100%. In the High Risk Wards (Non - elective) a total of 75 patients were not screened out of 499. The Medical Division achieved 97%, the Surgical Division achieved 78.8% and the other Divisions all met 100%. National guidance no longer requires universal MRSA screening; but allows local risk assessment to determine the extent of MRSA screening. At present universal screening continues at the Trust, but the focus of reporting is on areas caring for patients at higher risk from MRSA bacteraemia.

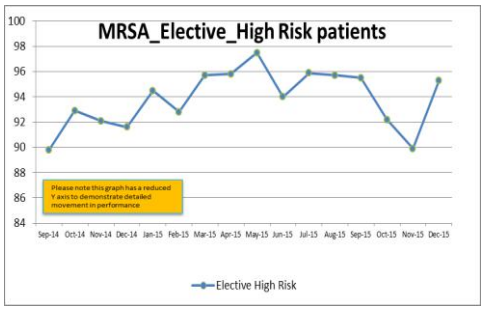
Corrective Actions

Some high risk areas continue to show performance below the expected 95% or above. The new reporting (that has been in development to ensure that the data reported for MRSA screening is compliant with national guidance) has been progressing and is now in User Acceptance Testing. There may be further actions resulting from these tests which will be progressed during January and February, depending on the complexity. MRSA screening will be included in phase 2 of the ward quality dashboard. This will enable wards to monitor screening rates and feedback where data collection exclusions need to be implemented. The Interim Chief Nursing Officer has sent a message to all inpatient areas reinforcing the need to screen appropriately.

Risks

There remain overarching IT issues regarding data quality and MRSA screening, which the actions above seek to address. This will help to ascertain if there is a genuine risk to patient safety through not screening; or if the low compliance is related, as suspected, to data quality issues.





SRO: CNO	Current Reporting Month: Dec 2015			
	Elective – High Risk	**Non Elective –High Risk**	**Plan/ Forecast**	**Status/ RAG**
Target	>95%	>95%	Corrective action plan status	Currently not applicable – to be rolled out
Current reported month performance	95.3%	86.9%	Forecast next reported month	
Last reported month performance	89.9%	89.3%	Forecast month after	
YTD performance	92.80%	91.90%	Forecast month after	
Revised date to meet the standard	**Feb 16**	**Jan 16**	Forecast year end	

Key Performance Indicator: % of approved risks overdue for review (QR1.0) and % of approved with overdue actions (QR1.2)

Headlines

The performance indicator QR1.0 % Approved Risks Overdue for Review has been met this month at 14%; therefore the remainder of the corrective actions described here relate to QR1.1 % Risks with an Overdue Action. Reasons an action is not completed on time include:

- Unrealistic timeframe set or inadequate planning
- Cancelled meetings, or risk register not added to agenda
- Risk register not being reviewed in detail at meetings, or staff not held accountable for overdue actions

Overall this month, the trust had a set back with 26% of risk actions overdue. This was due to the combination of many actions having been set as having a due date of 'the end of the year', with many staff off on leave or altered meeting arrangements in December 2015.
Within the clinical divisions, Surgery and Women and Children did not meet target, with respectively, 9/33 (27%) and 8/39 (21%) of risks having overdue actions.

Corrective Actions

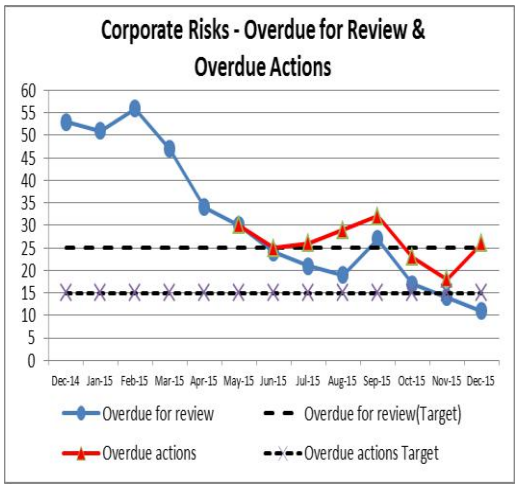
The Trust Risk Officer is attending Directorate meetings where performance is not meeting target, and liaising with the Divisional Quality Leads and the relevant DMT's. It has been noted that despite these efforts, if the chair or attendees do not challenge overdue dates, performance will not improve. The Trust Risk Officer is meeting with relevant chairs and meeting facilitators to ensure risks have robust review. Further actions:

- Introduce new divisional reporting template and revised quality governance structure by March 2016
- Implement alongside Ward Performance Dashboard in phase 3 March 2016

Risks

If performance is not addressed, there is no assurance that key risks are being managed in a timely way. Experience to date has shown that the majority of actions marked as overdue in Datix are truly overdue (ie it is not a problem with updating Datix). If risks are not being addressed in a timely way, the trust may be impacted financially, in terms of patient outcomes, operations/patient flow, reputation, and is less likely to achieve its objectives.

*Please note: The data below is reported as December 2015 data but was extracted January 2nd, 2016.



SRO:CNO	Current Reporting Month: Dec 2015*			
	Overdue for review	**Overdue actions**	**Plan/ Forecast**	**Status/ RAG Overdue Actions**
Target	<25%	-<15%	Corrective action plan status	Currently not applicable – to be rolled out
Current reported month performance	11%	26%	Forecast next reported month	
Last reported month performance	14%	18%	Forecast month after	
YTD performance			Forecast month after	
Revised date to meet the standard	**February 2016**		Forecast year end	

Key Performance Indicator: Hip Fractures – Time to Theatre within 36 hours – all patients (QEF3.1)

Headlines

Performance has previously been discussed at Trust Quality Governance Committee on 12 November 2015. It is recognised that there has been unacceptable performance and variation month on month. In particular, admission to the Ward from the Emergency Department is poor. There appears to be a significant number of patients being prescribed new generation anticoagulants, which is delaying surgery as we cannot reverse these in the same way as Warfarin. Guidance is required from haematology and anaesthetics on this matter as more and more patients seem to be switching from Warfarin to e.g. Apixaban for AF in the community.
Currently the Trust has one of the lowest lengths of stay within the region.

Corrective Actions

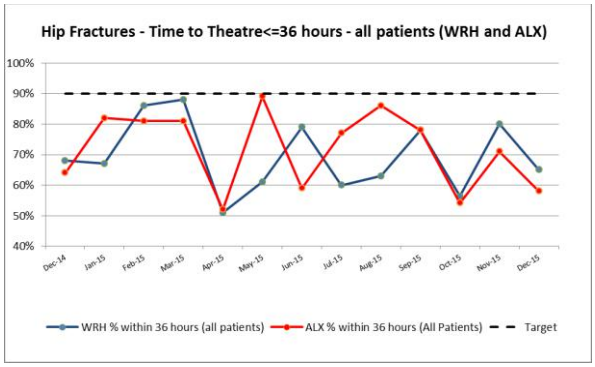
The Interim Chief Medical Director will be taking responsibility for corrective actions.

1) Prioritisation of #NOF cases to be done first on the PM Trauma Theatre Sessions; this to be driven by the Trauma Nurse Practitioners & Clinical Teams.
2) Hip Fracture Escalation Policy disseminated on the 23.12.15 to the T&O Clinical Teams to support the following:- - #NOFs first on the list; other cases to be prioritised - Hip Fracture Escalation Policy needs to be further publicised and enforced - Delaying fracture care needs to be challenged - 36 hour breach time to be added onto Bluespier.
3) Management & Trauma Nurse Practitioner Lead to review #NOF data retrospectively each week to identify any issues; data to be shared weekly with Countywide Clinical Teams as required; and this will be discussed monthly at the T&O Directorate Meeting. Daily the Trauma Nurse Practitioners / Clinical Teams are reviewing and escalating trauma issues. On Going
4) #NOF performance to be reviewed and discussed at the Monthly T&O Directorate Meetings. This will be a monthly standard item on the agenda for discussion. Last discussed as an Agenda item on Tuesday 12 January 2016.
5) Business Case to be submitted for additional weekend Trauma Theatre Sessions for both The Alexandra & Worcester Sites. The document "Case for Change – Weekend Trauma Sessions" was submitted on 7 December 2015; Business Case to be presented at the Surgery Divisional Board Meeting on Friday 29 January 2016 prior to submission.
6) T&O Directorate to visit Royal Stoke University Hospital to understand if we can improve performance further, as other peer hospitals seems to be having similar challenges. Date to be arranged.

Risks

Delays lead to poor patient experience and increased length of stay. The Trust is not achieving the required performance to receive the best practice tariff. Currently no dedicated weekend Trauma Theatre Sessions at The Alexandra Site and only weekend AM dedicated Theatre Sessions at the Worcester Site.

January 2016 performance likely to be poor due to theatre maintenance, which reduced capacity to an unacceptable level.



SRO:COO	Current Reporting Month: Dec 2015			
	Performance	**Direction of travel**	**Plan/ Forecast**	**Status/ RAG**
Target	85%	-	Corrective action plan status	Currently not applicable – to be rolled out
Current reported month performance	61.8%	↓	Forecast next reported month	Not provided
Last reported month performance	76%	↑	Forecast month after	Not provided
YTD performance	66.5%	-	Forecast month after	Not provided
Revised date to meet the standard	**Not provided**		Forecast year end	Not provided

Worcestershire NHS
Acute Hospitals NHS Trust

Corrective Action Statements:

Finance

Key Performance Indicator Names;

- Elective Income (FCP2.2)
- Surplus / Deficit
- Temporary Staff expenditure (excluding WLI expenditure)

PLEASE REFER TO THE DETAIL INCLUDED IN THE MONTH 8 FINANCIAL PERFORMANCE REPORT

Forecast Key	
Forecast to achieve	
Potential risk target will not be achieved	
Forecast not to achieve	

Summary Performance Trust Dashboard

Worcestershire Acute Hospitals NHS Trust

Quality Metrics Overview

Worcestershire NHS
Acute Hospitals NHS Trust

Reporting Period: December 2015

Patient Safety

Area	Indicator Type	Indicator		Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Current YTD	Prev Year	Tolerance Type	2015/16 Tolerances			SRO	Data Quality Kitemark
																				On Target	Of Concern	Action Required		
Incidents & Never Events	Local	QPS3.3	Incidents - SI's open > 60 days (Awaiting closure - WAHT)					3	10	6	6	5	14	5	3	3	3	-	Local	0	-	>0	CMO	
	National	QPS4.1	Never Events	0	1	0	0	0	0	0	0	0	0	0	1	1	2	-	National	0	-	>0	CMO	
	Local	QPS6.6	Falls: Total Falls Resulting in Serious Harm (In Month)	2	0	1	4	1	5	2	2	1	3	0	2	2	18	24	Local	<=1	-	>=2	CNO	
	Contractual	QPS7.5	Pressure Ulcers: New Pts. with Hosp. Acq. Grade 3 Avoidable (Monthly)	4	1	1	0	2	0	2	0	0	3	2	0	1	10	22	Contractual	0	1 - 3	>=4	CNO	
	Contractual	QPS7.7	Pressure Ulcers: New Pts. with Hosp. Acq. Grade 4 Avoidable (Monthly)	0	1	1	0	0	0	0	1	0	0	0	0	0	1	2	Contractual	0	-	>=1	CNO	
Mortality	National	QPS9.1	Mortality - SHMI (HED tool) Inc. deaths 30 days post discharge **	130	130	121	120	108	108	95	109	98					104	113	National	<100	>=100 to UCL	> UCL	DPS	
	National	QPS9.8	Mortality - HSMR (HED tool) - Monthly**	120	115	110	104	119	109	86	111	100					104	108	National	<100	>=100 to UCL	> UCL	DPS	
	National	QPS9.20	Crude Mortality - Trustwide*	5.18	4.92	4.35	3.84	3.83	3.77	2.83	3.48	3.09					-	3.74	National				DPS	
Safety Thermometer	National	QPS10.1	Safety Thermometer - Harm Free Care Score	92.75%	93.00%	93.37%	93.55%	93.63%	95.12%	95.78%	93.25%	94.57%	92.86%	93.09%	94.20%	92.86%	-	-	National	>=95%	90% - 94%	<90%	CMO	
Infection Control	National	QPS12.1	Clostridium Difficile (Monthly)	4	4	1	7	3	3	3	2	4	2	3	0	2	22	36	National	14/15 Threshold <=40.8 15/16 Threshold <= 33			CNO	
	National	QPS12.4	MRSA Bacteremia - Hospital Attributable (Monthly)	0	0	0	1	0	0	0	0	0	0	0	0	0	0	1	National	0	-	>0	CNO	
	National	QPS12.10	MRSA Screening (High Risk Wards Only) - Elective %					95.60%	97.50%	94.00%	95.90%	95.70%	95.50%	92.20%	89.90%	95.30%	92.80%	-	National	>=95%	-	<95%	CNO	
	Local	QPS12.11	MRSA Patients Not Screened (High Risk Wards Only) - Elective					18	10	30	18	19	22	38	34	15	204	-	-	-	-	-	CNO	
	National	QPS12.12	MRSA Screening (High Risk Wards Only) - Non-Elective %					88.70%	93.00%	92.50%	92.80%	89.90%	91.70%	89.30%	89.30%	86.90%	91.90%	-	National	>=95%	-	<95%	CNO	
	Local	QPS12.13	MRSA Patients Not Screened (High Risk Wards Only) - Emergency					69	43	48	48	58	49	59	60	75	509	-	-	-	-	-	CNO	
	Contractual	QPS12.14	Ecoli Cases (Trust Attributable)	7	3	5	6	1	3	10	3	3	4	2	3	5	34	61	-	-	-	-	CNO	
	Contractual	QPS12.15	MSSA Cases (Trust Attributable)	3	1	0	2	0	3	0	3	2	3	1	0	1	13	9	-	-	-	-	CNO	

Patient Experience

Area	Indicator Type	Indicator		Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Current YTD	Prev Year	Tolerance Type	2015/16 Tolerances			SRO	Data Quality Kitemark
																				On Target	Of Concern	Action Required		
Complaints & Compliments*	Local	QEX1.1	Complaints - Numbers (In Month)	49	44	41	54	41	37	53	59	47	50	53	68	37	445	554	-	-	-	-	CNO	
	Local	QEX1.3	Complaints - Number per 10,000 Bed Days (YTD)	19.72	19.48	19.33	19.48	16.66	15.87	17.70	19.10	19.31	19.58	19.85	21.03	20.29	20.29	19.48	-	-	-	-	CNO	
	Local	QEX1.14	Complaints - % of Category 2 complaints responded within 25 days (WAHT)	94.0%	88.0%	78.0%	63.0%	66.0%	59.0%	53.0%	53.0%	64.0%	86.0%	81.0%	62.0%		64.0%	63.0%	Local	>=90	80-90%	<79%	CNO	
Friends & Family	National	QEX2.1	Friends & Family - A&E (Score)											69.6	76.6	70.7	70.7		National	>=71	67-70	<67	CNO	
	National	QEX2.5	Friends & Family - Acute Wards & A&E (Score)	78.7	78.9	74.2	74.0	77.1	80.3	77.7	74.5	74.8	69.4	76.9	80.2	75.8	76.7	76.6	National	>=71	67-70	<67	CNO	
	National	QEX2.7	Friends & Family - Maternity (Score)	84.4	81.5	80.0	77.8	88.4	84.5	80.7	87.4	86.4	88.5	86.0	82.5	84.9	85.6	83.0	National	>=71	67-70	<67	CNO	

Summary Performance Trust Dashboard

Worcestershire Acute Hospitals NHS Trust

Quality Metrics Overview

Worcestershire NHS
Acute Hospitals NHS Trust

Effectiveness of Care

Area	Indicator Type	Indicator		Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Current YTD	Prev Year	Tolerance Type	2015/16 Tolerances			SRO	Data Quality Kitemark
																				On Target	Of Concern	Action Required		
Readmissions	Local	QEF2.1	Emergency Readmissions (Within 28 Days of Elective Discharge) - WAHT	0.5%	0.2%	0.4%	0.5%	0.5%	0.5%	0.5%	0.4%	0.4%	0.4%	0.5%	0.4%	0.6%	0.5%	0.5%	-	-	-	-	CMO	
Hip Fracture	National	QEF3.1	Hip Fracture - Time to Theatre <= 36 hrs (%)	69.7%	73.5%	84.3%	84.1%	51.3%	70.4%	70.0%	68.0%	71.0%	78.0%	56.0%	76.0%	61.8%	66.5%	64.0%	National	>=90%	-	<90%	CMO	
	National	QEF3.2	Hip Fracture - Time to Theatre <= 36 hrs (%) - Excl. Unfit/Non-Operative Treatment Pts	81.5%	78.3%	93.5%	91.4%	69.0%	79.2%	84.0%	76.0%	75.0%	88.0%	63.0%	87.0%	76.0%	77.1%	84.9%	National	>=90%	-	<90%	CMO	

Risk Register Activity

Risks	Local	QR1.1	% of approved risks with overdue actions***						30.0%	25.0%	26.0%	29.0%	32.0%	23.0%	18.0%	26.0%	26.0%		Local	<15	15-29	>=30	CNO	

*Complaints and Compliments are reported one month in arrears
**Indicators QPS9 are reported in arrears in accordance with published data in HED benchmarking tool. The HED data is not fully locked down until the Sept following the reported financial year, so some small changes may still occur. Early September figures are available on the HED tool but can change significantly, it would be misleading to report these during January.

***QR metrics - data reported for December was extracted on 05/01 and may be reported as January month commencing figures.
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

Summary Performance Trust Dashboard

Worcestershire Acute Hospitals NHS Trust

Performance Metrics Overview

Worcestershire NHS
Acute Hospitals NHS Trust

Reporting Period: December 2015

Area	Indicator Type	Indicator		Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Current YTD	Prev Year	Tolerance Type	2015/16 Tolerances			SRO	Data Quality Kitemark
																				On Target	Of Concern	Action Required		
Waits	National	PW4.1	Backlog > 18 weeks (Day Case + Elective Inpatients)	1064	1207	1219	1291	1425	1468	1373	1348	1193	1186	1172	1303	1256	1,256	1,291	-	-	-	-	COO	
	National	PW1.1.3	6 Week Wait Diagnostics (Proportion of waiting list)	1.15%	1.06%	0.85%	0.95%	1.31%	0.81%	1.06%	1.30%	0.95%	0.98%	0.87%	0.97%	1.55%	1.09%	1.05%	National	<1%	-	>1%	COO	
	National	CW3.0	RTT - Incomplete 92% in 18 Weeks	91.08%	89.55%	90.14%	88.93%	87.33%	87.68%	89.07%	90.25%	89.42%	88.81%	89.00%	92.05%	92.05%	92.05%	88.93%	National	>=92%	-	<92%	COO	
	National	CW4.0	Over 52 week waits	0	0	0	1	1	1	4	0	0	0	1	0	0	7	1	National	0	-	>0	COO	
Theatres	Local	PT2.1	Booking Efficiency - ALX ***	73.00%	67.00%	72.00%	74.00%	74.00%	72.00%	72.00%	73.00%	70.00%	71.00%	70.00%			-	-	Local	Based on Target Cases per Sessions Utilisation (>8% below target = 'Of Concern')			COO	
	Local	PT2.2	Booking Efficiency - WRH ***	82.00%	81.00%	88.00%	85.00%	92.00%	84.00%	81.00%	86.00%	82.00%	81.00%	82.00%			-	-	Local				COO	
	Local	PT2.3	Booking Efficiency - KGH ***	73.00%	72.00%	72.00%	71.00%	72.00%	70.00%	67.00%	67.00%	74.00%	68.00%	69.00%			-	-	Local				COO	
	Local	PT1.1	Utilisation - ALX ***	71.00%	65.00%	69.00%	70.00%	70.00%	66.00%	69.00%	70.00%	69.00%	71.00%	68.00%			-	-	Local	Based on Target Cases per Sessions Utilisation (>8% below target = 'Of Concern')			COO	
	Local	PT1.2	Utilisation - WRH ***	70.00%	74.00%	72.00%	72.00%	75.00%	75.00%	73.00%	74.00%	74.00%	76.00%	72.00%			-	-	Local				COO	
	Local	PT1.3	Utilisation - KGH ***	67.00%	68.00%	68.00%	67.00%	68.00%	66.00%	63.00%	65.00%	71.00%	67.00%	68.00%			-	-	Local				COO	
	Local	PT3.1	Cases per Session - ALX	2.59	2.57	2.39	2.55	2.64	2.50	2.62	2.58	2.60	2.40	2.53			3	3	Local	-	-	-	COO	
	Local	PT3.2	Cases per Session - WRH	1.75	1.77	1.71	1.69	1.98	1.85	1.83	1.82	1.90	1.90	1.90			1.87	1.92	Local	-	-	-	COO	
	Local	PT3.3	Cases per Session - KGH	3.30	3.39	3.42	3.25	3.43	3.42	3.18	3.34	3.30	3.50	3.10			3.34	3.42	Local	-	-	-	COO	
A & E	National	CAE1.1	4 Hour Waits (%) - Trust **	84.36%	83.35%	79.63%	82.55%	83.99%	86.71%	85.46%	85.61%	86.43%	85.00%	88.21%	88.83%	86.91%	85.93%	90.22%	National	>=95%	-	<95%	COO	
	National	CAE1.1a	4 Hour Waits (%) - Trust inc. MIU - from September 14					86.89%	88.59%	88.21%	88.35%	88.83%	87.64%	90.25%	90.66%	89.07%	88.48%	-	National	>=95%	-	<95%	COO	
	National	CAE3.1	Time to Initial Assessment for Pts arriving by Ambulance (Mins) - 95th Percentile ^ (inc Kidd MIU)					45	20	23	25	34	31	28	28	28	28	-	National	<=15mins	-	>15mins	COO	
	National	CAE7.0	Ambulance Handover within 15 mins (%) - WMAS data	41.63%	40.15%	37.08%	42.09%	43.66%	49.65%	47.14%	43.50%	41.16%	38.20%	41.09%	42.04%	41.58%	43.43%	46.68%	National	>=80%	-	<80%	COO	
	National	CAE8.0	Ambulance Handover within 30 mins (%) - WMAS data	86.23%	82.17%	77.97%	84.09%	86.47%	92.16%	90.85%	89.69%	87.99%	86.34%	87.23%	88.10%	88.18%	88.62%	88.61%	National	>=95%	-	<95%	COO	
	National	CAE9.0	Ambulance Handover over 60 minutes	51	128	113	75	51	6	17	30	29	39	22	26	38	258	-	Local	0		>0	COO	
Cancer *	National	CCAN5.0	62 Days: Wait For First Treatment From Urgent GP Referral: All Cancers	83.09%	80.72%	77.69%	90.00%	80.73%	85.12%	75.37%	78.10%	86.50%	75.10%	79.30%	79.40%	86.10%	80.40%	82.39%	National	>=85%	-	<85%	COO	
	National	CCAN6.0	62 Days: Wait For First Treatment From National Screening Service Referral: All Cancers (Small numbers)	100.00%	100.00%	85.71%	100.00%	94.74%	100.00%	95.83%	100.00%	100.00%	92.60%	94.40%	100.00%	96.40%	96.80%	91.40%	National	>=90%	-	<90%	COO	
	National	CCAN8.0	2WW: All Cancer Two Week Wait (Suspected cancer)	91.85%	90.86%	96.64%	96.38%	91.47%	90.28%	86.84%	83.10%	81.80%	81.40%	85.00%	88.30%	90.50%	86.40%	93.13%	National	>=93%	-	<93%	COO	
	National	CCAN9.0	2WW: Wait for Symptomatic Breast Patients (Cancer Not initially Suspected)	84.92%	93.99%	96.39%	94.94%	85.28%	98.15%	84.21%	63.50%	83.10%	66.90%	71.40%	80.10%	82.10%	78.40%	91.72%	National	>=93%	-	<93%	COO	
	National	CCAN10.0	Cancer Long Waiters (100 Day +)	29	25	24	20	24	27	23	21	27	28	23	17	16	16	20	-	-	-	-	COO	
Stroke	National	CST1.0	80% of Patients spend 90% of time on a Stroke Ward (Final)	81.40%	82.00%	94.30%	80.00%	97.67%	95.56%	80.39%	77.80%	81.00%	80.77%	83.33%	74.60%	73.20%	82.40%	85.57%	National	>=80%	-	<80%	COO	
	National	CST2.0	Direct Admission (via A&E) to a Stroke Ward	71.70%	71.40%	76.70%	76.90%	94.29%	92.86%	76.92%	67.70%	75.00%	68.18%	77.08%	66.00%	69.20%	75.62%	78.94%	National	>=70%	-	<70%	COO	
	National	CST3.0	TIA	65.70%	60.50%	73.70%	70.70%	68.75%	62.00%	61.20%	66.70%	61.50%	56.41%	71.05%	68.20%	65.90%	64.94%	69.39%	National	>=60%	-	<60%	COO	
Inpatients (All)	Local	PIN1.5	Bed Occupancy (Midnight General & Acute) - WRH **	92%	94%	98%	97%	103%	100%	103%	101.7%	101.9%	103.2%	100.8%	101.9%	98.1%	100.7%	92.5%	Local	<90%	90 - 95%	>95%	COO	
	Local	PIN1.6	Bed Occupancy (Midnight General & Acute) - ALX **	83%	87%	89%	85%	94%	94%	92%	86.0%	91.4%	89.9%	88.2%	85.4%	82.0%	88.6%	82.0%	Local	<90%	90 - 95%	>95%	COO	
	National	PIN3.1	Delayed Transfers of Care SitRep (Patients) - Acute/Non-Acute	59	79	63	77	57	37	48	41	39	31	59	25	34	371	725	-	-	-	-	COO	
	National	PIN3.2	Delayed Transfers of Care SitRep (Days) - Acute/Non-Acute	2544	3635	2457	2541	2532	2198	1146	1,178	1,010	778	1,362	817	918	11939	23610	-	-	-	-	COO	
Elective	National	PEL3.0	28 Day Breaches as a % of Cancellations	17.0%	45.0%	13.2%	12.7%	25.0%	15.9%	10.2%	23.8%	16.4%	18.4%	12.3%	12.7%	42.6%	19.5%	16.6%	TBC	<=5%	6 - 15%	>15%	COO	
	National	PEL4.2	Urgent Operations Cancelled for 2nd time	0	0	0	0	0	0	0	0	0	0	1	1	1	3	0	National	<=0	-	>0	COO	
Emergency	Local	PEM2.0	Length of Stay (All Patients)	4.7	5.6	5.6	5.2	5.3	5.1	5.1	5.3	4.9	4.8	4.5	4.3	4.6	4.9	4.8	Local	TBC	TBC	TBC	COO	
	Local	PEM3.0	Length of Stay (Excluding Zero LOS Spells)	6.5	7.3	7.4	6.9	6.9	6.7	6.7	7.0	6.5	6.4	6.3	5.9	6.5	6.5	6.5	-	-	-	-	COO	

** Cancer _this involves small numbers that can impact the variance of the percentages substantially. Cancer data is not finalised for December until February 5th, 2016*

***Bed occupancy data source is Bed State Report.*

****Theatre Utilisation and Booking - there remains a technical issue with obtaining this data, but it is hopeful that this will be resolved prior to the final version being available.*

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 (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.

Summary Performance Trust Dashboard

Worcestershire Acute Hospitals NHS Trust

Workforce Metrics Overview

Worcestershire NHS
Acute Hospitals NHS Trust

Reporting Period: December 2015

Area	Indicator Type	Indicator		Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Current YTD	Prev Year	Tolerance Type	2015/16 Tolerances			SRO
																				On Target	Of Concern	Action Required	
Vacancies & Recruitment	Local	WVR1.0	Number of Vacancies - Total	255	249	249	224	274	311	391	400	408	375	329	374	392		224	Local	<=200	201-229	>=230	DCE
Turnover	Local	WT1.0	Staff Turnover WTE %	10.4%	10.3%	10.5%	10.4%	10.2%	10.5%	10.5%	11.0%	11.4%	11.6%	12.3%	11.9%	12.3%		10.42%	Local	9-10%	<>9-10%	-	DoHR
	Local	WT1.3	Nursing Staff Turnover - Qualified	10.3%	10.1%	10.5%	10.6%	10.1%	10.7%	10.7%	10.9%	10.9%	11.2%	12.1%	12.8%	13.2%		10.6%	Local	9-10%	<>9-10%	-	DoHR
	Local	WT1.4	Nursing Staff Turnover - Unqualified	12.1%	12.3%	12.6%	12.6%	11.8%	11.6%	11.1%	11.6%	12.9%	13.2%	14.0%	13.9%	13.9%		12.6%	Local	9-10%	<>9-10%	-	DoHR
Sickness & Absence	Local	WSA1.0	Sickness Absence Rate Monthly (Total %)	4.68%	4.49%	4.12%	4.25%	3.84%	4.01%	4.10%	4.19%	4.33%	4.48%	4.78%	4.34%	4.57%		4.25%	Local	<= 3.50%	>=3.51% & <=3.99%	>= 4.00%	DoHR
Temporary Staffing	Local	WTS1.0	Agency Staff - Medics (WTE) Indicative	154.7	143.6	163.3	146.9	148.0	157.6	158.1	165.8	173.0	176.0	176.7	170.7	163.4		146.9	Local	<=85	85.1-100	>100	DCE
Induction	Contractual	WIN1.3	% of eligible staff attended Induction	77.4%	78.8%	79.0%	84.7%	85.1%	89.7%	95.5%	89.2%	92.1%	93.5%	73.8%	87.3%	94.6%	89.8%	72.8%	Contractual	>= 90%	80 - 89%	< 80%	DoHR
Statutory and Mandatory Training	Contractual	WSMT10.2	% Of Eligible Staff completed Training	79.0%	81.3%	81.8%	82.2%	82.6%	83.7%	84.5%	85.8%	82.1%	84.2%	84.4%	85.5%	87.2%	84.4%	82.9%	Contractual	>= 95%	60.1-94.9%	<=60%	DoHR
Appraisals	Contractual	WAPP1.2	% Of Eligible non-medical Staff Completed Appraisal	73.8%	77.7%	77.8%	77.8%	78.9%	79.6%	80.4%	82.7%	77.0%	75.2%	74.4%	74.5%	78.2%	77.9%	77.4%	Contractual	>= 85%	71 - 84%	< 71%	DoHR
	Contractual	WAPP2.2	% Of Eligible medical Staff Completed Appraisal (excludes Doctors in training)	77.4%	78.8%	79.0%	84.7%	85.6%	83.6%	83.8%	86.4%	85.1%	84.1%	84.0%	82.7%	81.6%	84.1%	72.8%	Contractual	>= 85%	71 - 84%	< 71%	DoHR
	Contractual	WAPP3.2	% Of Eligible Consultants Who Have Had An Appraisal	83.6%	84.9%	83.2%	88.8%	89.7%	89.1%	90.0%	88.3%	87.2%	85.5%	85.3%	85.3%	82.0%	86.9%	77.8%	Contractual	>= 85%	71 - 84%	< 71%	DoHR

** Please note that the thresholds for Mandatory Training now reflect the required CCG reporting trajectory of 95% by year end.*

Note: If YTD is blank, then YTD is last reported month.

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.

Summary Performance Trust Dashboard

Worcestershire Acute Hospitals NHS Trust

Worcestershire Acute Hospitals NHS Trust

Maternity Metrics Overview

Reporting Period: December 2015

Area	Indicator Type	Indicator		Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Current YTD	Prev Year	Tolerance Type	2015/16 Tolerances			SRO	Data Quality Kite mark
																				On Target	Of Concern	Action Required		
Deliveries	Contractual	MDEL1.0	Deliveries	473	482	434	461	469	515	514	503	469	482	492	479	439	4362	5676	Contractual	<=465	466 - 516	>516	CNO	
Births	Contractual	MBIR1.0	Births	478	492	441	469	475	525	527	511	475	488	500	487	447	4435	5741	Contractual	<=480	481 - 531	>532	CNO	
Scheduled Bookings	National	MSB1.1	Women Booked Before 12 + 6 Weeks	88.3%	86.8%	84.0%	85.3%	88.6%	85.6%	88.0%	88.9%	87.7%	88.9%	88.6%	93.1%	92.8%	88.1%	87.8%	National	>=90%	-	<90%	CNO	
Normal Vag. Deliveries	Contractual	MNVD1.0	Maintain Normal Vaginal Delivery Rate	57.7%	61.4%	61.8%	62.9%	62.5%	57.5%	56.6%	57.7%	62.7%	63.7%	56.9%	56.8%	56.7%	60.0%	60.7%	Contractual	>63%	63% - 60%	<60%	CNO	
C- Section	Contractual	MCS1.0	Total Caesareans	29.0%	27.4%	28.8%	28.4%	25.8%	28.2%	33.7%	32.6%	28.1%	26.6%	31.3%	32.6%	30.5%	29.2%	27.3%	Contractual	<27%	27% - 30%	>30%	CNO	
Outcome Indicators	National	MOI1.0	Breast Feeding Initiation Rates	71.0%	67.5%	73.4%	73.0%	70.2%	71.1%	72.5%	73.0%	72.0%	74.6%	73.0%	68.6%	69.7%	72.3%	74.2%	National	> 70%	67% - 70%	< 67%	CNO	
	Contractual	MOI3.0	Midwife Led Care %	41.0%	43.6%	29.0%	38.0%	23.7%	21.0%	22.0%	21.1%	20.5%	23.9%	20.1%	20.9%	19.4%	21.7%	35.3%	Contractual	>= 37.7%		<37.7%	CNO	
	National	MOI6.0	Admission of full-term babies to neonatal care %	2.7%	3.0%	4.7%	4.9%	4.5%	7.3%	3.0%	4.3%	4.7%	4.1%	3.9%	9.0%	2.4%	5.6%	3.5%	National	<=5%		>5%	CNO	

NB: Please note that tolerances are adjusted between financial years

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.

Worcestershire NHS
Acute Hospitals NHS Trust

Date of Trust Board: 3 February 2016 **Enc E1**

Report to Trust Board

Title	**Quality Governance Committee – report to Trust Board**
Sponsoring Director	**John Burbeck, Non-Executive Director, Acting Chair**
Author	**Kimara Sharpe, Company Secretary**
Action Required	The Board is requested to: • Consider the discussion in respect of the key risks • Note the 50% mortality review rate and the actions being taken to improve • Note the increase in DTOC patients • Note the poor VTE documentation • Note the lack of assurance in respect of water quality on the WRH site • Note the divisional deep dive for medicine • Note the never event report and the assurance given in respect of stress testing • Note that the QGC received PCIP action plans in respect of Quality and Governance, Infection Control and Mortality • Approve the terms of reference (appended) • Note the report
Previously considered by	Not applicable

Strategic Priorities (√)

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

Related Board Assurance Framework Entries	2895 If we do not adequately understand & learn from patient feedback we will be unable to deliver excellent patient experience 2665 If we do not achieve wider service redesign in a timely way we will have inadequate numbers of clinical staff to deliver quality care 2790 As a result of high occupancy levels, patient care may be compromised and access targets missed 2891 If the Trust does not learn from mortality reviews this knowledge will not be available to support improvements to patient care 2902 If the Trust does not successfully improve clinical care, we will fail to reduce avoidable harm to expected levels 3038 If the Trust does not address concerns raised by the CQC inspection the Trust will fail to improve patient care
Legal Implications or Regulatory requirements	This report covers some statutory issues such as CQC or accreditation visits.

Key Messages

This paper provides the Board with the key achievements, issues, and risks discussed at the Quality Governance Committee on 21 January 2016

Title of report	Quality Governance Committee
Name of director	John Burbeck

Date of Trust Board: 3 February 2016 **Enc E1**

REPORT TO TRUST BOARD – 03 FEBRUARY 2016

1. Situation

This report provides the Board with key quality issues and risks discussed at the QGC's meeting held on 22 January 2016. The Committee was pleased to welcome Dr Bill Tunnicliffe to the meeting. He will be taking over the Chair in March 2016.

2. Background

This report provides the Board with assurance on matters related to patient safety and care quality. The QGC reviews reports from its sub-committees, quality performance data, and risks to meeting strategic objectives. In this way it provides assurance in the areas outlined below and identifies risks and areas of concern for the Board's attention. Where appropriate, the Committee also considers county-wide issues.

3. Assessment

3.1 Risk

The QGC considered the following risks:

3.1.1 2665 If we do not achieve wider service redesign in a timely way we will have inadequate numbers of clinical staff to deliver quality care. The Committee were assured that the Clinical Model would be approved by the CCG Governing bodies in the next two weeks.

3.1.2 2790 As a result of high occupancy levels, patient care may be compromised and access targets missed: The Committee heard that this remained a significant problem for the Trust. The Trust was concerned about the number of 'stranded patients' i.e. those not being treated in the right place for their needs. The ECIP team was supporting the Trust and more robust challenge at ward rounds will take place.

3.1.3 2891 If the Trust does not learn from mortality reviews this knowledge will not be available to support improvements to patient care: The Committee received an update on the mortality review process. The completion rate is now 50%. The Committee made it clear that more progress is required. The Committee were assured that that the process was now linked to clinical excellence awards and the appraisal process. The crude mortality rate has reduced, but the SHMI was elevated. The Interim CMO was working with primary care to determine the causes for this. A review had been instigated into deaths from syncope as this was showing high in the heat map. The action plans in relation to alcohol and bronchitis related deaths were presented for information. The Committee was also assured of receiving a report into secondary mortality reviews when enough data has been generated. The mortality element of the PCIP was presented.

3.1.4 2895 If we do not adequately understand & learn from patient feedback we will be unable to deliver excellent patient experience: The multidisciplinary meeting is scheduled for 1 February.

Title of report	Quality Governance Committee
Name of director	John Burbeck

3.1.5 2902 If the Trust does not successfully improve clinical care, we will fail to reduce avoidable harm to expected levels: It was not clear that the current risk is as high as shown so this risk will be reviewed prior to the next QGC meeting.

3.1.6 3098 If the trust does not address concerns raised by the CQC inspection the Trust will fail to improve patient care: The actions are included in the PCIP and are being progressed. The Committee was informed that the Associate Director of Governance would be advertised shortly.

3.2 Future of Acute Hospital Services – quality risks

The Committee received the report that had been considered at the Quality and Sustainability subgroup. The report clearly showed the red risks in relation to the neonatal staffing and paediatrics. The Division are currently just able to continue the services

3.3 Quality and Performance

The Committee received an update on the areas where there is significant change. They were pleased to see the improvements in Cancer 62 day, RTT and 2 week wait results. They were assured that the deteriorating position on Diagnostic Delays, Pressure Ulcers and Hip Fracture Time to Theatre was the subject of focussed activity. Worryingly the number of patients suffering Delayed Transfer Of Care has increased.

3.4 Safe Patient Group

The Committee expressed concern about the poor VTE metric. It was agreed that 30% of notes not having a VTE assessment was unacceptable. This would be re-audited as part of an on-going audit of notes. The Committee was informed that the Trust was in close contact with patients who had been delayed in receiving treatment and that no patient had come to harm whilst waiting. The lists for dermatology and oral surgery were causing concern due to their length and the Interim COO was working with the commissioners on a solution.

3.5 Trust Infection Prevention and Control Committee (TIPCC)

Assurance was received on the arrangements in place for new and emerging pathogens. This has been tested recently by the Trust. The Committee expressed their continued dissatisfaction with the water testing across the whole Worcestershire Royal site. Water testing was adequate and monitored in augmented areas, but not the whole site. The Interim CNO is meeting with the PFI provider urgently to take this forward. Kidderminster and Alexandra Hospital sites were compliant. The recent flu epidemic at the Trust was being managed appropriately.

3.6 Quality Exception Reports

The Medicine Division gave a detailed update on their quality metrics. The Committee was impressed with the progress being made. The Division only had 26 outstanding incidents. There had been extensive communication in respect of the never event concerning insulin and learning had taken place.

Concern was expressed about the number of falls with harm at the MAU on the Alex site. A deep dive was being undertaken and staffing numbers were reviewed on at least a daily basis.

The Division outlined their vision for medicine for the county. This included a focus on ambulatory care and early discharge. A dedicated area for the frail elderly was also being considered.

The other divisions provided summary exception reports:
TACO/Clinical Support: the focus is on checking patient identification to prevent unnecessary interventions.
Women and Children: Work in continuing to ensure that areas operating outside the division were child friendly.

3.7 PCIP

The Committee received the following PCIP reports:

- Quality and Governance
- Infection Control
- Mortality.

3.8 Never Events

The Trust has received a letter from the Trust Development Authority requiring assurance on the prevention of never events. Work had already commenced on the stress testing for never events and the Committee received assurance over the progress of this work. A quarterly report would be presented to the Committee on this area.

3.9 Other updates

The Committee received updates in respect of the following:

- Quality Surveillance Group – the Trust remains at 'summit' (the highest rating)
- Terms of reference – these were reviewed and approved
- Quality dashboard
- Health and safety - the first routine update was received. The actions being undertaken against the strategy and a report on RIDDOR was received. Concern was expressed that not all the divisions have embraced the opportunity to undertaken health and safety visits to all areas.

4 Recommendation

The Board is requested to:

- Consider the discussion in respect of the key risks
- Note the 50% mortality review rate and the actions being taken to improve
- Note the increase in DTOC patients
- Note the poor VTE documentation
- Note the lack of assurance in respect of water quality on the WRH site
- Note the divisional deep dive for medicine
- Note the never event report and the assurance given in respect of stress testing
- Note that the QGC received PCIP action plans in respect of Quality and

Governance, Infection Control and Mortality
- Approve the terms of reference (appended)
- Note the report

John Burbeck
Acting Chair – Quality Governance Committee

Title of report	Quality Governance Committee
Name of director	John Burbeck

Worcestershire NHS
Acute Hospitals NHS Trust

Terms of Reference

Quality Governance Committee (QGC)

Version: 2.1

Terms of Reference approved by: QGC

Date approved: January 2016

Author: **Company Secretary**

Responsible directorate: CEO

Review date: March 2017

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

Quality Governance Committee

Terms of Reference

1. Introduction/Authority

The Quality Governance Committee (QGC) is constituted as a standing committee of the Trust's board. Its constitution and terms of reference are set out below, subject to amendment at future Trust board meetings.

The QGC is authorised by the board to act within its terms of reference. All members of staff are directed to co-operate with any request made by the QGC.

The QGC is authorised by the Trust board to instruct professional advisors and request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary for or expedient to the exercise of its functions.

The QGC is authorised to obtain such internal information as is necessary and expedient to fulfil its functions.

2. Membership

Associate Non-Executive Director (Chair)
Two Non-Executive Directors
Chief Executive
Chief Nursing Officer
Chief Medical Officer
Chief Operating Officer
Associate Medical Director – Patient Safety
Company Secretary
Patient Forum Representative

In attendance:

- Associate Director of Clinical Governance
- Head of Clinical Governance and Risk Management
- CCG representative
- Head of Information

As required:

- Associate Medical Director – Research and Development
- Divisional Medical Directors
- Divisional Nurse Directors
- Divisional Directors of Operations
- Other personnel as invited by the Chair

2.1 The Chair of the Group is appointed by the Trust Board.

2.2 Trust employees who serve as members of the QGC do not do so to represent or advocate for their respective department, division or service area but to act in the interests of the Trust as a whole and as part of the Trust-wide governance structure.

3 Arrangements for the conduct of business

3.1 Chairing the meetings

The Associate Non-Executive Director will chair the meetings. In the absence of the Associate Non-Executive Director, the Chair will be a non-executive director.

3.2 Quorum

The Group will be quorate when one third of the members are present including at least one non-executive director and one clinician, including the Chief Nurse or the Chief Medical Officer or their deputies.

3.3 Frequency of meetings

The Committee will meet monthly.

3.4 Frequency of attendance by members

Members are expected to attend a minimum of 10 meetings each year, unless there are exceptional circumstances.

3.5 Declaration of interests

If any member has an interest, pecuniary or otherwise, in any matter and is present at the meeting at which the matter is under discussion, he/she will declare that interest as early as possible and shall not participate in the discussions. The Chair will have the power to request that member to withdraw until the subject consideration has been completed. All declarations of interest will be minuted.

3.6 Urgent matters arising between meetings

If there is a need for an emergency meeting, the Chair will call one in liaison with the CNO/CMO.

3.7 Secretariat support

Secretarial support will be the Company Secretary and a report will be presented to the Trust Board.

4 Authority

The Committee is authorised by the Trust Board.

5 Purpose and Functions

5.1 Purpose

- To enable the Board to obtain assurance that the quality of care within the Trust is of the highest possible standard.
- To ensure that there are appropriate clinical governance systems and processes and controls are in place throughout the Trust in order to:
    - Promote safety and excellence in patient care
    - Identify, prioritise and seek assurance on the effective management of risk arising from clinical care
    - Ensure the effective and efficient use of resources though evidence based clinical practice

The relationship between the QGC and other committees can be viewed on the Internet via the following link:
http://nww.worcsacute.nhs.uk/the-trust/organisational-structure/

5.2 Duties

In fulfilling the purposes above, the specific duties of the Committee are as follows:

5.2.1 In respect of general governance arrangements:

a. to ensure that all statutory elements of quality governance are adhered to within the Trust;
b. to agree trust-wide clinical governance priorities as contained within the Quality Account and give direction to the clinical governance activities of the Trust's divisions through the Trust Quality Report,;
c. to approve the Trust's annual quality report and Annual Governance Statement before submission to the board;
d. to approve the terms of reference and membership of its reporting sub-committees as may be varied from time to time at the discretion of the QGC and oversee the work of those sub-committees, receiving reports from them as specified by committee in the sub-committees' terms of reference for consideration and action as necessary;
e. to consider matters referred to the QGC by the board;
f. to consider matters referred to the QGC by its sub-committees;
g. to receive and approve the annual clinical audit programme ensuring that it is consistent with the audit needs of the Trust;
h. to make recommendations to the audit and assurance committee concerning the annual programme of internal audit work, to the extent that it applies to matters within these terms of reference;
i. to foster quality governance links with primary care and other stakeholders including patient forum members.

5.2.2 In respect of safety and excellence in patient care, in particular, the QGC is responsible for:

a. assuring the Board that the services provided meet the requirements of the Health and Social Care Act and the CQC's standards, and are well-led
b. ensuring that internal standards are set and monitored, including (without limitation):
   - commissioning the setting of standards by the board and ensure that a mechanism exists for these standards to be monitored;
   - ensuring that standards outlined in national service frameworks are implemented and monitored;
   - ensuring compliance with the registration criteria of the Care Quality Commission;
c. promoting an organisational climate of open and honest reporting of any situation that may threaten the quality of patient care in accordance with the trust's policy on reporting issues of concern and monitoring the implementation of that policy;
d. overseeing the review of patient safety incidents (including near-misses, complaints, claims and regulation 28 coroner reports) from within the Trust and wider NHS to identify similarities or trends and areas for focussed or organisation-wide learning; Overseeing the Trust Mortality Reviews and providing assurance to the Trust Board
e. identifying opportunities for improvement in respect of incidents or complaints identified through the national patient survey or locally through PALS, and ensuring that appropriate action is taken;
f. oversight of the system within the trust for obtaining and maintaining any

licences relevant to clinical activity in the trust (e.g. licences granted by the Human Tissue Authority or any successor organisation), receiving such reports as the quality governance committee considers necessary;

g. monitoring compliance with the national standards of quality and safety of the Care Quality Commission, and the quality governance framework or its successor in order to provide relevant assurance to the Board so that the Board may approve the trust's annual governance statement;

h. ensuring that risks to patients are minimised through the application of a comprehensive risk management system including, without limitation:
   - monthly discussion of the strategic clinical risks faced by the trust:
   - six monthly report on:
     - the trust's risk management strategy
     - processes to ensure the escalation of risks from directorate and divisional risk registers to the corporate risk register
     - monitoring of the Trust's risk management policy;
   - priorities and actions using the assurance framework;
   - Monthly quality exception reports from divisions and quarterly deep dive reports
   - recommendations from external bodies e.g. the National Confidential Enquiry into Patient Outcomes and Death or Care Quality Commission or Royal Colleges, as well as those made internally e.g. in connection with serious incident reports and adverse incident reports, into practice and has mechanisms to monitor their delivery;
   - implementation of reports or recommendations from National Agencies for Patient Safety;
   - safeguarding children and adults within the Trust; and
   - escalation to the executive board and/or audit and assurance committee and/or board any identified unresolved risks arising within the scope of these terms of reference that require executive action or that pose significant threats to the operation, resources or reputation of the trust;

i. agreeing the annual patient experience plan and monitoring progress;

j. assuring that the Trust has reliable, real time, up-to-date information about what it is like being a patient experiencing care administered by the trust, so as to identify areas for improvement and ensure that these improvements are effected.

k Bi-annual reports from the health and safety committee and the information governance committee

5.3.3 In particular, in respect of efficient and effective use of resources through evidence-based clinical practice:

a. to agree the annual quality plan and monitor progress;

b. to receive an annual report from the Finance and Performance Committee on the monitoring of the impact on the trust's quality of care on cost improvement programmes and any other significant reorganisations (ensuring that there is a clear process for staff to raise associated concerns and for these to be escalated to the committee) and report any concern relating to an adverse impact on quality to the trust board;

c. to ensure that care is based on evidence of best practice/national guidance;

d. to ensure that there is an appropriate process in place to monitor and promote compliance across the trust with clinical standards and guidelines including but not limited to NICE guidance and guidelines and radiation use and protection regulations (IR(ME)R);

e. to assure the implementation of all new procedures and technologies

according to trust policies;

f. to review the implications of confidential enquiry reports for the trust and to endorse, approve and monitor the internal action plans arising from them;
g. to monitor trends in complaints received by the trust and commission actions in response to adverse trends where appropriate;
h. to monitor the development of quality indicators throughout the trust;
i. to generally monitor the extent to which the trust meets the requirements of commissioners and external regulators;
j. to identify and monitor any gaps in the delivery of effective clinical care ensuring progress is made to improve these areas, in all specialties;
k. to ensure the research programme and governance framework is implemented and monitored;
l. to ensure that there is an appropriate mechanism in place for action to be taken in response to the results of clinical audit and the recommendations of any relevant external reports (e.g. from the Care Quality Commission);
m. to ensure that where practice is of high quality, that practice is recognised and propagated across the trust; and
n. to ensure the trust is outward-looking and incorporates the recommendations from external bodies into practice with mechanisms to monitor their delivery.

6. Relationships and reporting

6.1 The Committee is accountable to the Trust Board. The quality governance committee will report after each of its meetings to the Trust Board in public and where appropriate in private.

6.2 The following sub groups report to the Quality Governance committee

- Patient Experience Group
- Operational Governance
- Health and Safety
- Information Governance
- Clinical Effectiveness Committee
- Research and Development Committee [this now reports to TMC with a dotted line to QGC]
- Trust Infection Prevention and Control Committee
- safeguarding

The Groups above have the following work streams:

- Patient Experience
  - patient and public involvement
  - Maternity Services Liaison Committee
  - complaints and clinical claims

- Operational governance
  - Safe Patient
  - Medicines safety committee
  - resuscitation committee
  - blood transfusion committee
  - thrombosis committee
  - Never events, serious incidents and incidents
  - Mortality and morbidity

- Clinical Effectiveness
  - clinical audit committee

- Trust Infection Prevention and Control Committee
  - Infection prevention and control

7 Review of the Terms of Reference

These Terms of reference will be reviewed by March 2017

KS/TOR (corp gov TOR)

Worcestershire NHS
Acute Hospitals NHS Trust

Date of meeting: 3rd February 2016 **Enc E2**

Report to Trust Board meeting in Public

Title	**Patient Care Improvement Plan – December 2015 Oversight Report**
Sponsoring Director	**Sarah Smith, Director of Strategy, Planning and Improvement**
Author	**Jane Ball, Deputy Director, Strategy and Planning**
Action Required	The Board is asked to: • Review progress with the Patient Care Improvement Plan to date and to note it's development to incorporate the *Must Do* and a selection of the key *Should Do* actions arising from the CQC Inspection Report • Note that a new presentation of the PCIP is being developed to include clear trajectories for the delivery of the improvement objectives and associated actions for each section, and to ensure greater consistency in reporting.
Previously considered by	*n/a*

Strategic Priorities (√)

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

Related Board Assurance Framework Entries	2678 If we do not attract and retain key clinical staff we will be unable to ensure safe and adequate staffing levels 2790 As a result of high occupancy levels, patient care may be compromised and access targets missed 2891 If the Trust does not learn from mortality reviews this knowledge will not be available to support improvements to patient care 2902 If the Trust does not successfully improve clinical care, we will fail to reduce avoidable harm to expected levels 2905 Failure to create capacity and capability for transformation, resulting in inability to deliver required improvement
Legal Implications or Regulatory requirements	The PCIP includes actions arising from the CQC unannounced ED visits in March 2015 and the regulatory conditions imposed on the Trust, and the announced inspection in July 2015 and the subsequent inspection report recommendations and requirements.

Title of report	Patient Care Improvement Plan
Name of director	Director of Strategy, Planning and Improvement

Date of meeting: 3rd February 2016 **Enc E2**

Glossary	PCIP – Patient Care Improvement Plan HEWM – Health Education West Midlands ECIP –Emergency Care Improvement Programme PMO – Programme Management Office TMC – Trust Management Committee TDA – Trust Development Authority

Key Messages

Following publication of the CQC Inspection Report in December 2015, the PCIP has been updated to reflect the requirements therein and the version attached was submitted to the CQC on January 11th in line with their conditions.

There has been some good progress with the action plans but there is critical work underway to develop more focussed improvement trajectories. This work is underway for the January 2016 update but was not completed in time for the submission of Board papers this month. This updated version of the PCIP will be circulated to Board members outside of the meeting and this will form the basis of the published version of the PCIP on the Trust website and on the NHS Choices website; publication is a requirement for organisations in special measures.

Trust PCIP leads are receiving support from the PMO with the development and focus of their improvement action plans and going forward, there will be greater communication and engagement support from the Quality Champions to increase awareness and ownership across all areas of the Trust.

Worcestershire NHS
Acute Hospitals NHS Trust

Date of meeting: 3rd February 2016 **Enc E2**

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

REPORT TO TRUST BOARD – JANUARY 2016

1. Situation

The PCIP has been developed to ensure progress in response to key Trust quality issues identified through internal and external scrutiny processes, including the Chief Inspector of Hospitals visit in July 2015.

1. Background

The PCIP comprises a series of quality improvement plans in relation to the following:

1. Infection prevention and control peer review
2. Morbidity and mortality reviews
3. Urgent care and patient flow improvement plan
4. Governance and safety plan
5. Maternity improvement plan
6. HEWM Medicine visit action plan
7. Good Governance Institute review recommendations
8. Outpatients and Diagnostics improvement plan
9. High Dependency Unit/Level 2 Critical Care review

The PCIP is reported monthly at TMC and Trust Board and externally at the TDA Quality Oversight Review Group. There is an internal governance structure to support the PCIP, with each action plan owned by a Trust assurance or delivery group.

2. Assessment

This report is presented today to enable the Board to review progress with the delivery of the PCIP and to provide an update on future developments.

Following the publication of the CQC Inspection Report in December 2015, all 28 *Must Do* actions and a selection of key *Should Do* actions have been incorporated into the PCIP and the updated PCIP report (attached) was submitted to the CQC on January 11th 2016. There is on-going further work to populate the two new sections of the PCIP namely, outpatients and diagnostics improvement plan and high dependency unit / level 2 critical care review and to reset the Maternity improvement plan and the Good Governance Institute review recommendations sections to expand the scope.

In addition, the Programme Management Office (PMO) is working with all the PCIP leads to develop improvement trajectories for the action plans which will in turn be published by the Trust as a special measures requirement. The improvement trajectories will be included in the February PCIP update and will support robust action planning and reporting going forward.

Title of report	Patient Care Improvement Plan
Name of director	Director of Strategy, Planning and Improvement

The Trust Quality Champions are driving greater awareness and engagement with PCIP across all areas of the Trust, and a learning network is being developed for the PCIP leads with the first meeting on February 25th 2016.

3. Recommendation

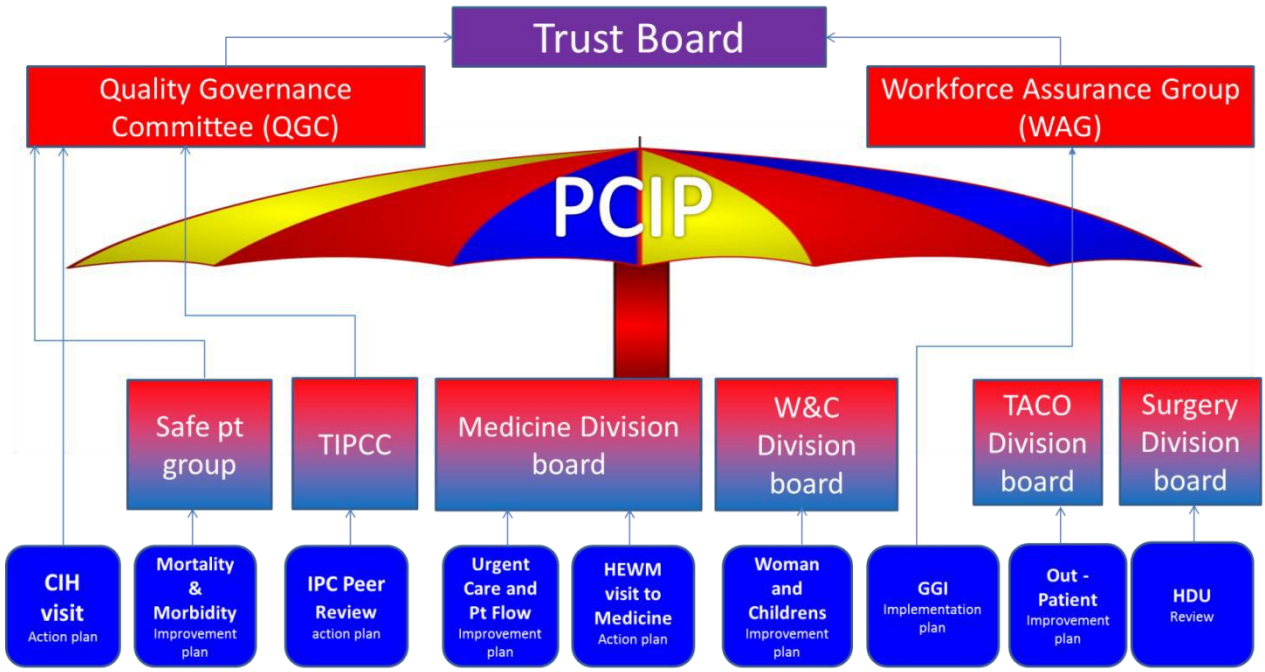
The Board is asked to:

- Review progress with the Patient Care Improvement Plan to date and to note it's development to incorporate the *Must Do* and a selection of the key *Should Do* actions arising from the CQC Inspection Report
- Note that a new presentation of the PCIP is being developed to include clear trajectories for the delivery of the improvement objectives and associated actions for each section, and to ensure greater consistency in reporting.

Sarah Smith
Director of Strategy, Planning and Improvement

Worcestershire NHS
Acute Hospitals NHS Trust

Patient Care Improvement Plan (PCIP) December 2015 Oversight Report



Chris Tidman, Interim Chief Executive
Sarah Smith, Director of Strategy, Planning and Improvement
Report written in January 2016

Patient Care Improvement Plan December 2015

Contents

Report Rating Criteria: **Red, Amber Green rating criteria used in this report**

Green	Successful delivery of the project is on track and seems highly likely to remain so, and there are no major outstanding issues that appear to threaten delivery significantly.
Amber	Successful delivery appears feasible but significant issues already exist requiring management attention. These appear resolvable at this stage and if addressed promptly, should not create a project overrun.
Red	Successful delivery appears to be unachievable. There are major issues on project definition, with project delivery and its associated benefits appearing highly unlikely, which at this stage do not appear to be resolvable.

Glossary

AEC	Ambulatory emergency care	MIU	Medical Injuries Unit
AGH	Alexandra General Hospital, Redditch	PMO	Programme Management Office
CTG	Cardiotocography	UrCOT	Urgent Care Oversight Team
HEWM	Health Education West Midlands	HDU	High Dependency Unit
IPC(T)	Infection Prevention &Control (Team)		
MAU	Medical Assessment Unit		

PCIP: Programme status report

Worcestershire Acute Hospitals NHS Trust developed the Patient Care Improvement Plan (PCIP) after the unannounced visits to the Trust's Emergency Departments by the CQC in March 2015 following concerns around patient safety in relation to urgent care and patient flow. Subsequently the Trust came under further scrutiny following an Infection Prevention and Control Peer Review visit by the Trust Development Authority in spring, and the required remedial actions were also incorporated into the PCIP. The Infection Prevention and Control plan is nearing completion but remains a part of the PCIP until the next review in February 2016. In August 2015 the Good Governance Institute Review into allegations of bullying and harassment at the Trust was published. Although the findings of the review confirmed that there was not an endemic culture of bullying and harassment at the Trust, there were some recommendations as to how the Trust could improve its Dignity at Work policies and processes and this action plan was also added to the PCIP. The PCIP remains a working document and sections have been included around mortality reviews which, is an area in which the Trust requires improvement, and also a series of urgent actions resulting from the Health Education West Midlands (HEWM) team visit to Medicine, to improve the training experience of junior doctors at the Trust. The HEWM revisit in November 2015 confirmed that satisfactory progress had been made. However the action plan remains in place to ensure that the changes are fully embedded.

The Trust was formally inspected by the CQC in July 2015. The Quality Summit took place in November 2015 and the final report was published in December 2015 with the overall rating for Trust being Inadequate. The Trust consequently entered special measures. Immediately after the inspection and following the informal feedback at the end of the inspection week, the Trust developed a follow – up action plan based on the key improvement requirements communicated at that stage. In particular there was an executive focus on governance systems and processes in the Trust's maternity services. The maternity improvement plan was incorporated into the PCIP and has been progressing well since that time. Of the 33 actions in the CIH follow-up action plan 31 had been completed by the time of the Quality Summit in November 2015.

This report provides the current Board level summary of the Trust's PCIP that is reported monthly to the Trust Management Committee, the Trust Board and the Trust Development Authority Quality Oversight Review Group. Following publication of the inspection report in December, the *Must Do* actions and a selection of the *Should Do* actions have been integrated into the existing Trust PCIP either by way of integration into one of the existing themed action plans in the PCIP or through the inclusion of new action plans such as the governance and safety action plan, the outpatient and diagnostics improvement plan and the HDU review. Throughout this document the *Must Dos* and *Should Dos* have been mapped to the themed action plans so that they can be clearly identified.

In addition to the development of the PCIP, the Trust is actively pursuing 'buddying' arrangements with other hospital Trusts. For example, the Trust had already engaged with Birmingham Women's Hospital to secure support from its former Medical Director who has been instrumental in the early and significant improvements in maternity services at the Trust since the inspection took place. The Trust is now developing a buddy contract with Birmingham Women's and Birmingham Children's NHS FT's around reviewing its current improvement plan and extending this to ensure that the Trust is following best practice across its maternity, neonatal and paediatric services. There has already

been an external governance review in maternity and the Trust is also seeking to engage with Oxford University Hospitals NHS Trust to provide support for the development of Trust - wide governance arrangements and processes. The Trust also plans to use the Medical Engagement Survey and to seek support around an organisational development framework that could be rapidly deployed to develop the capacity and capability to improve. As a first step, the TDA through the Improvement Director will be supporting the Trust and the PCIP leads, to ensure that the PCIP is robust, live and sufficiently improvement focussed.

PCIP: Programme status report, Infection Prevention Control Peer Review

TDA INFECTION PREVENTION CONTROL PEER REVIEW ACTION PLAN December 2015	Executive Sponsor: Project Lead:	Mari Gay (Interim CNO) David Shakespeare (Associate)

Aim: The project is designed to achieve an improved level of assurance in relation to environmental and medical device cleanliness with enhanced clinical engagement in the process and the visible role of the IPCT in achieving this.

Objective(s):

- Improve IPC leadership and engagement to ensure infection control is everyone's business
- Increase uptake of mandatory training for IPC and hand hygiene
- Increase rigour of monitoring, investigation and audit within infection prevention and control
- Improve consistency and completion of IPC documentation, Trust-wide, to increase assurance provided through monitoring processes

	PROJECT MEASURES	TARGET	APR-15	MAY-15	JUN-15	JUL-15	AUG-15	SEP-15	OCT-15	NOV-15	DEC-15	JAN-16	FEB-16	MAR-16	COMMENTS/ MITIGATION
1	Ward areas to be audited using new IPC audit tool	100 %					30%	60%	95%	100%	100%				
2	Mandatory IPC training compliance	95 %	79.7%	81.0%	82.3%	84.5%	80%	81%	81%	#	#				*Data in arrears*
3	Mandatory hand hygiene training compliance	95 %	92.4%	93.6%	94.1%	94%	92%	94%	93%	#	#				*Data in arrears*

figures for August onwards adjusted to reflect CQR data # data not yet available from Training Dept (5/01/16)

Successes this month	RAG Status	G	Planned Activity (Next Period)	RAG Status	G
• New IPC audit tool continues in use, all wards now audited at least once. • Departmental audit programme agreed at TIPCC on 16th December, 2015. • Individual departmental managers continue to be reminded where attendance at IPC mandatory training is low. • PCIP section discussed at TIPCC on 16th December, 2015 with view to possible closure at next meeting on 25th February, 2016.			• Further IPC ward audits scheduled bi-monthly, to embed audit process; Departmental audits now scheduled. • TIPCC on 25th February to review more evidence of compliance to Hygiene Code to identify if any gaps in assurance for action. • Associate CNO (IPC) to meet with Head of Facilities to further review and renew assurance process around cleaning. • Review of IPC PCIP at TIPCC on 25th February with a view to closure of plan; to be replaced by an on-going IPC action plan reviewed at each TIPCC. IPC plan to be inclusive of any PCIP outstanding actions.		

CQC actions added to this plan or merged with existing actions, post publication of CIH visit report	
Plan Section	**Actions added**
CQC visit	Ensure staff are aware of Middle East Respiratory Syndrome (MERS), a viral respiratory infection caused by the MERS-coronavirus that can cause a rapid onset of severe respiratory disease in people and the actions required if a patient presents with associated symptoms.

Risks and issues	Initial risk score	Proposed solutions	Adjusted risk score
None			

Support required			
None			

PCIP: Programme status report, Reducing Morbidity and Mortality

REDUCING MORBIDITY AND MORTALITY IMPROVEMENT PLAN December 2015	Executive Sponsor: Project Lead:	Andy Phillips (Interim CMO) Steve Graystone (Associate)

Aim: To ensure learning is captured from review of the care of patients dying whilst in the care of the Trust. Learning from review of patient deaths will be used to improve the quality of clinical care at WAHT.

Objective(s):

- Establish a process for primary review of all adult deaths at WAHT
- Establish secondary review process for cases where care issues are identified at primary review
- Identify quality improvement opportunities from the secondary review process.
- Implement sustainable improvements in patient care.

	PROJECT MEASURES	Target	JUN-15	JUL-15	AUG-15	SEP-15	OCT-15	NOV-15	DEC-15	JAN-16	FEB-16	MAR-16	COMMENTS/MITIGATION
1	% of Notified Deaths for which primary review form has been sent to Consultant	100%	100	94	61.2	83.3	95.9	100					Electronic process established. This excludes deaths occurring in ED as separate process for review in place. Process for establishing NCEPOD grade as a consequence of this process to be established. *Reported one month in arrears*
	Number of Forms Sent	N/A	110	140	63	85	93	150					
2	% of Notified Deaths for which a primary review form sent within 5 days of notification	TBC	8.2	7.1	6.3	16.5	9.7	30.0					Stretch target established to reflect electronic notification of deaths. Improvement expected in coming months. *Reported one month in arrears*
	Number of forms sent within 5 days	N/A	9	10	4	14	9	45					
3	% of Notified Deaths for which a primary review form sent within 10 days of notification	100%	67.3	52.1	68.3	87.1	30.1	86.0					
	Number of forms sent within 10 days	N/A	74	73	43	74	28	129					
4	% of Primary Review forms returned within 14 days of issue	80%	8.2	0.7	14.3	8.2	11.8	36.0					Reminder process established for non-return with escalation to DMD's and divisional governance team. *Reported one month in arrears*
	Total No. of Forms Received	N/A	55	16	24	16	23	68					
5	% Secondary review completed and presented within 2 months of issue	100%					0	0					Metrics will start to be reported from November. *Reported one month in arrears*

PLEASE NOTE: *Change in data source from October 2015 to system generated report (SB – information) Additional metrics added to the report in Jan '16 (for November 2015 reporting onwards) November figures taken as at 4th January 2016 @ 12:55*

Successes this month	RAG Status	A	Planned Activity (Next Period)	RAG Status	A
- Review of all deaths now requested. - Database revised to auto-flag any reviews not returned within 10 working days - Over 30% of requests are made within 5 working days of death (and rising) - 86% are requested within 10 working days. - Response rate for November is increased to 40.7% with 34% returned within 14 working days. This is highest overall monthly figure and by far the highest return rate at first time of requesting. - Database upgraded and PCIP metrics added to. - Mortality review co-ordinator continues to link with colleagues in other trusts.			- Reminder process will include escalation to DMD's and divisional governance co-ordinators. - Monthly summary of outstanding reviews will be sent to each Consultant and copied to DMD's. Information will be uploaded onto Mortality web page in Trust Intranet - Start to analyse themes from primary reviews graded B-E - Begin to receive secondary review reports from division - Incorporate mortality review group into Quality Management Group and review mortality weekly - Mortality co-ordinator role to be made permanent. - Actions from Exec Team confirm and challenge meeting on November 24th include: o Focus on governance team supporting the process o TMC to include mortality review process in divisional reports o Agreed consultant personal responsibility to undertake review		

CQC actions added to this plan or merged with existing actions, post publication of CIH visit report	
Plan Section	**Actions added**
Improvement of review systems	Record Mortality and Morbidity reviews in order to demonstrate lessons from any reviews are learned and these can be shared throughout the trust.
	Ensure the morbidity and mortality meeting minutes clearly document discussions.
Improving safety	Evaluate and improve practice in response to the results from the hip fracture audit for 2014
	Ensure there is a sustainable system in place to ensure all surgical patients receive safe and timely care.

Risks and issues	Initial risk score	Proposed solutions	Adjusted risk score
- Mortality Review co-ordinator temporary contract completes at end of November	16 (4x4)	- Continued employment of co-ordinator at risk - Complete recruitment process	12 (4x3)
- Continued slow uptake of process by clinician	20 (5x4)	- Escalation to divisional management teams as described above	15 (5x3)
- Failure to incorporate secondary reviews of B-D cases in M&M meeting processes	20 (5x4)	- Mortality review co-ordinator and AMD Patient safety to attend M&M meetings to encourage and ensure robust secondary reviews	15 (5x3)
- Case note tracking: It has become clear that not all areas track case notes once the patient has died.	16 (4x4)	- A particular issue is within the mortuaries and this has been escalated to the Clinical Support Divisional management team and is now resolved.	4 (4x1)
- Scanning times: It is clear that getting case notes scanned into eZnotes takes at least 5 days as the episode notes pass through the bereavement office, the mortuary and then coding before being sent for scanning. The PCIP has a metric that requires request for primary reviews to be sent within 5 days of the patient's death. Feedback from Consultants indicate that sending a request before the notes are scanned is likely to result in reviews either being delayed or not undertaken.	20 (5x4)	- The process of flow of notes has been reviewed and amended. From the 9th November the paper episode record will be delivered to the Consultants office prior to scanning but following completion of the death certification and coding processes. Requests for reviews will be now sent to Consultants between 3 – 5 days following the patients' death.	10 (5x2)
- Database: The mortality reviews database has been upgraded such that searching and reporting by division and directorate is much simpler. In addition run charts for key steps by division are automatically produced as data is entered. Individual Consultant primary review completion rates are also available. Access is proving problematic as the process of requesting Divisional Team access to the database is not being completed by Computer Centre.	16 (4x4)	- All currently requiring access have confirmed ability to access. Process for adding new request not yet tested - Database now updated – some minor issues to resolve	8 (4x2)

Risks and issues	Initial risk score	Proposed solutions	Adjusted risk score
– Attendance at the Trusts mortality review meeting is still poor with only 2 divisions (TACO & Clinical Support) represented at the October meeting.	16 (4x4)	- Divisions/directorates must identify clinical mortality review leads and ensure that they are free to attend the Trust Mortality review meetings. - Mortality review meeting will be incorporated into the newly convened weekly Quality Management meetings at which DMT attendance is mandated.	16 (4x4)

Support required			
As part of the Special Measures regime, The Trust will seek a 'buddy' Trust to support the Trust with its governance arrangements and to fully embed the mortality review process.			

PCIP: Programme status report, Urgent care and patient flow improvement plan

URGENT CARE AND PATIENT FLOW IMPROVEMENT PLAN December 2015	Executive Sponsor: Rab McEwan (Interim COO) Project Lead: Robin Snead DD Ops (Medicine)

Aim: Develop an enhanced, sustainable urgent care service across Worcestershire Acute NHS Trust, ensuring patient safety through improved flow and consistent standards and processes

Objective(s):

- Deliver national Emergency Access Standard
- Reduce bed days lost due to inefficient flow
- Redesign pathways of urgent care and patient flow
- Deliver standardised patient flow processes across all sites
- Establish triage of all patients attending the Emergency Department at WAHT within 15 mins
- Develop and implement Standard Operating Procedures for each clinical area
- Develop effective mechanisms for identifying and resolving issues related to nurse staffing numbers

	PROJECT MEASURES	TARGET	APR-15	MAY-15	JUN-15	JUL-15	AUG-15	SEP-15	OCT-15	NOV-15	DEC-15	JAN-16	FEB-16	MAR-16	COMMENTS/MITIGATION
1	Deliver national Emergency Access Standard	95%	86.9 %	89.1 %	88.2 %	88.4 %	88.8 %	87.7 %	90.3 %	90.6 %	89.1 %				December 2015 data extracted on 08/01/2016 and is not yet validated Please note this may differ to the Trust Dashboard as this is not produced until the 10th working day of the month
2	Reduction of DTOC (snap shot for end of month)	30	51	37	48	41	39	31	59	25					Waiting for Health &Care Trust to sign off for December 2015
3	Reduce number of patients who are Medically Fit for Discharge (average for month)	70	81	90	89	88	100	99	126	112	123				December 2015 data extracted on 08/01/2016 and is not yet validated Please note this may differ to the Trust Dashboard as this is not produced until the 10th working day of the month
4	% of GP referrals admitted through Assessment Units		29.7 %	30.5 %	34.5 %	31.5 %	26.9 %	27.6 %	28.1 %	24.8 %	24.1 6%				December 2015 data extracted on 08/01/2016 and is not yet validated Please note this may differ to the Trust Dashboard as

	PROJECT MEASURES	TARGET	APR-15	MAY-15	JUN-15	JUL-15	AUG-15	SEP-15	OCT-15	NOV-15	DEC-15	JAN-16	FEB-16	MAR-16	COMMENTS/MITIGATION
															this is not produced until the 10th working day of the month
5	1 hour response time from Specialties		46.3 %	47.3 %	43.6 %	45.7 %	46.3 %	41.6 %	46.6 %	52.2 %	52.4 %				December 2015 data extracted on 08/01/2016 and is not yet validated Please note this may differ to the Trust Dashboard as this is not produced until the 10th working day of the month
6	% Patients receiving initial assessments within 15 minutes	95%	81%	90%	89%	87%	86%	83%	85%	85%	84%				December 2015 data extracted on 08/01/2016 and is not yet validated Please note this may differ to the Trust Dashboard as this is not produced until the 10th working day of the month

Successes this month	RAG Status	A	Planned Activity (Next Period)	RAG status	A
• Best Practice Ward Monitoring performance via data. Request for expressions of interest for Champions has been made and additional session organised for December with a view to inducting new and existing Champions • Attended ECIP Master Classes – WAHT team members to attend ECIP master classes & share learning with teams to inform practice • Using ECIP 'Safer, Faster, Better: Good Practice in delivering Urgent and Emergency Care' document to inform programme including pilot of the Multidisciplinary Accelerated Discharge Event (MADE). • Audit for administration of antibiotics and analgesia competed.			• Trauma services for county - Appointment of Lead by February 2016 (this is behind schedule as outlined on the PCIP). • Use of A&E departments will be maximised to meet short term needs – until physical capacity extended in the interim expansion programme. • Best Practice Ward Rounds – Deliver Multi-disciplinary Accelerated Discharge Event (MADE), continue with training and best practice ward rounds roll out. • Implementation of full AEC model on Worcestershire Royal site to begin. • Begin review of WRH ED SOP in preparation for expanded ED		

CQC actions added or merged to this plan, post publication of CIH visit report	
Plan Section	**Actions added**
Patient safety and learning	Ensure that the risk matrix in Medical Assessment Unit is completed to the frequency required by the trust policy.
Patient flow	Improve the access and flow of patients in order to: • reduce delays from critical care for patients being admitted to wards; • reduce the unacceptable number of discharges at night; • reduce the risks of this situation not enabling patients to be admitted when they needed to be or discharged too early in their care; • reduce occupancy to recommended levels; and improve outcomes for patients.
	Evaluate the effectiveness of the Patient Flow service to ensure it meets patient needs and improves access and flow of services
	Continue to engage with local organisations to improve patient flow to ensure that patient waiting for hospital beds in ED can be transferred in a timely manner to prevent breaches.
Transformation of working practices and A&E processes	Ensure consultant cover meets with the Royal College of Emergency Medicine's (RCEMs) emergency medicine consultants workforce recommendations to provide consultant presence in the ED 16 hours a day, 7 days a week as a minimum
	Ensure delays in ambulance handover times are reduced to meet the trust target of 80% of patients admitted via an ambulance having handovers carried out within 15 minutes and 95% of patient handovers being carried out within 30 minutes of arrival by ambulance.
	Ensure the changes to manage overcrowding and patient safety in ED are sustainable.
	Ensure a county-wide consultant on call rota is achieved as part of the ED transformation programme.
	Ensure unplanned re-attendance to ED within seven days meets the target of 5%.
	Ensure patients receive an initial assessment within 15 minutes.

Risks and Issues	Initial risk score	Proposed solutions	Adjusted risk score
Non achievement of the 95% EAS 4 hour target impacting on patient safety and experience consistently on both A&E sites	20 (5x4)	Detailed mitigation outlined in PCIP urgent care plan	20 (5x4)
Current workforce numbers in the A&Es do not meet the guidance by CEM for consultant cover.	20 (4x5)	Business case to be developed to ensure adequate consultant cover in the departments with interim locum support being requested to support senior decision making.	16 (4x4)
Difficulties recruiting and retaining certain nursing roles within A&E departments	20 (4x5)	Detailed workforce plan for the A&E departments county wide will be developed to ensure safe and effective practice	16 (4x4)

Risks and Issues	Initial risk score	Proposed solutions	Adjusted risk score
Difficulty recruiting and retaining middle grade and junior medical staff in A&E departments	20 (4x5)	Detailed workforce plan for the A&E departments county wide will be developed to ensure the safe and effective practice	16 (4x4)
Delays in specialty response times to meet the one hour agreed target will lead to patient flow delays.	16 (4x4)	Escalation to specialty consultant has been agreed at UrCOT meeting (12.10.2015).	8 (4x2)

Support required
The project requires support of external health and social care partners to continue to improve the use of community capacity

PCIP: Programme status report, Governance and Safety Improvement plan

GOVERNANCE AND SAFETY IMPROVEMENT PLAN December 2015	Executive Sponsor: Project Lead:	Mari Gay (Interim CNO) Lisa Miruszenko (Deputy CNO)

Aim: Make care safer for patients by improving the overall standards of the Trust's services, ensuring they are safe, effective, caring, responsive and well led, as measured by CQC standards.

Objective(s):

- Improve the safety of care delivered within the Trust, as measured by compliance with targeted CQC standards
- Improve the Trust board's assurance that care is safe by redesigning the governance process that confirms and triangulates compliance with CQC and other national standards
- Act on the findings and recommendations from commissioned external reviews of the Trust's governance arrangements

	PROJECT MEASURES	TARGET	APR-15	MAY-15	JUN-15	JUL-15	AUG-15	SEP-15	OCT-15	NOV-15	DEC-15	JAN-16	FEB-16	MAR-16	COMMENTS/ MITIGATION
1	By April 2016 all specialties have a forward plan for 2016/17 that has been informed by patient safety priorities, incidents, risks and complaints	100%													Schedule provided to Divisions with return of draft forward plans by January 2016 3 forward plans received to date.
2	The outcome of all audits to be documented within CAMS. This will include any lessons learnt and how these have been shared.	100%													This function became available with the implementation of the new Clinical Audit Management System (CAMS) which went live on 1 December 2015. Monitoring of the completion of this information is taking place and staff will be reminded to supply this if it is missing.
3	Completion of Quality Governance Framework Review	y/n								✓					Changes to the high level committee structure have been made – review of supporting structure for SPG has been initiated. Associate Director post agreed and due to be advertised in January

	PROJECT MEASURES	TARGET	APR-15	MAY-15	JUN-15	JUL-15	AUG-15	SEP-15	OCT-15	NOV-15	DEC-15	JAN-16	FEB-16	MAR-16	COMMENTS/ MITIGATION
4	Achieve at least moderate assurance for the Quality Governance system as tested by internal audit														For Q2 2016/17 consider using Well Led Framework (QGAF replacement) to test
5	Serious Incident process - achieve and maintain 0 investig-ation reports open > 60 working days (as per the NHSE SI Framework)	0	3	10	6	6	5	14	5	3	3				3 SI investigations were open beyond 60 days at the end of December. Weekly SI review meetings continue. The new Governance Operation Meeting commences in January.
6	Datix incidents - percentage of total incidents open >20 working days	50%					77%	70%	74%	55%	53%				An overall improvement at month end to 53% of incident open >20 days. 2 out of 5 Divisions met the target.
7	Communica tion of quality and safety issues through setting up and continuing patient safety briefings - measure briefings held	TBC								✓					Development of communications strategy in progress
8	Percentage of approved risks overdue for review	15%	34 %	30 %	24 %	21 %	19 %	27 %	17 %	14 %	11 %				Target met
9	Percentage of approved risks with overdue actions	15%		30 %	25 %	26 %	29 %	32 %	23 %	18 %	26 %				Presently amber (between 15-29) due to a large number of actions with due dates of 31st Dec 2015. Risk owners are being challenged on overdue actions at committees and

	PROJECT MEASURES	TARGET	APR-15	MAY -15	JUN-15	JUL-15	AUG -15	SEP-15	OCT-15	NOV -15	DEC-15	JAN-16	FEB-16	MAR -16	COMMENTS/ MITIGATION
															within their management structure
10	Responses to complaints within 25 days of receipt	90%	66 %	59 %	53 %	53 %	64 %	86 %	83. %						November figures will be available 8th January.
11	Percentage of complaints reopened per month (by month the complaint was reported in)	10%	19.5 %	8.0 %	3.8 %	13.8 %	17.0 %	14.0 %	3.1 %						Amendments to previous figures show changes due to lag time in patient response to the Trust's complaint response November figures will be available 8th January.

Successes this month	RAG Status	G	Planned Activity (Next Period)	RAG Status	A
CIH inspection report published. • Governance Team away day held • Clinical Audit Management System (CAMS) well received by Divisions and clinicians • Target for % of risks overdue for review met and further improved this month • Improvement in response to complaints within 25 days to >80% • Significant work on new FFT reporting presentation and DATIX Complaints Report.			• Advertise/appoint to Associate Director of Governance post to support development of an improved governance function, system and processes. • New template for Divisional Governance Report (deep dive) to be introduced & tested with Executive Review • Commence weekly Governance Operational Meeting • Arrange further investigation training • Audit of the month to be published. • Develop communications strategy for quality / learning • Develop plan to improve and better monitor compliance with Duty of Candour • Roll out of new Complaints template Trust wide with view to populating many fields from DATIX		

CQC actions added to this plan or merged with existing actions, post publication of CIH visit report	
Plan Section	**Actions added**
Serious Incidents	Review the existing incident reporting process to ensure that incidents are reported, investigated, patient harm graded in line with national guidance, actions correlate to the concerns identified, lessons learnt are disseminated trust wide, and reports are closed appropriately.
	Ensure investigations of incidents have clear learning points and actions to prevent similar incident occurring, particularly in relation to staff assault.
Appropriate action is taken	Ensure that risk registers are reviewed regularly in a timely fashion.
	Take steps to ensure that all staff are included in lessons learnt from incidents and

to monitor, review and mitigate risk	near misses, including lessons learned from mortality reviews, with effective ward based risk registers and safety dashboards being in place and understood by all staff.
	Ensure all risks are risk assessed and are on the risk register with mitigated actions taken (part 1)
Implementation of Complaints Audit Report Action Plan.	Ensure complaints investigated in a timely manner with appropriate audit trail and that learning is shared Respond to complaints within agreed timeframes and summary data and meeting minutes should be explicit as to which location the complaint relates to and where performance times need to be improved
Duty of Candour	Ensure that adherence to the Duty of Candour regulation is recorded in incident reports in line with requirements.
Safety	Ensure sufficient security measures are in place on the Kidderminster site to protect staff, patients and visitors. (part 2)
	Risk assessments must be completed and used effectively to prevent avoidable harm such as the development of pressure ulcers.
	Ensure patients nutrition and hydration status is fully assessed recorded and acted upon in a timely manner.
	Ensure patients receive appropriate training and information about self-medication such as self-administration of heparin prior to discharge home.
	Ensure all medicines are prescribed and stored in accordance with trust procedures. Ensure all medicines storage areas have systems for measuring and recording temperatures
	Ensure that patient records are accurate, complete and fit for purpose (part 1)
Equipment	Resolve the issues relating to the faulty refrigeration storage units and inadequate water system in the mortuary
Environment	Ensure that patient records are safe from removal or the sight of unauthorised people. (Must do part 2)

Risks and issues	Initial risk score	Proposed solutions	Adjusted risk score
Pace of change required outstrips capacity to change	16(4x4)	Monitor and amend governance & safety plan in response to CHI Inspection Report to ensure key tasks are supported and completed with revisions to other actions	12(4x3)
Insufficient Clinical engagement to deliver change	16(4x4)	Workforce Review / job planning	16(4x4)

Support required
• Alignment of resources to achieve the actions - Associate Director of Governance post created • CMO / CNO / Divisional Director support to develop clinical engagement in quality and release time for quality related activities through e.g. job planning

PCIP: Programme status report, HEWM visit to Medicine Action Plan

HEALTH EDUCATION WEST MIDLANDS (HEWM) VISIT TO MEDICINE ACTION PLAN
December 2015

Executive Sponsor: Rab McEwan (Interim COO)
Project Lead: Robin Snead DD Ops (Medicine)

Aim: To provide a safe clinical training environment for trainee doctors within medicine at Worcester Royal Hospital.

Objective(s):

- Establish a learning environment with effective educational governance by November 2015
- Ensure robust communication links are maintained between the trainee doctors and the Trust.
- Clarify and communicate local standard operating procedures by October 2015
- Ensure robust locum induction process is in place by October 2015

	PROJECT MEASURES	TARGET	JUL-15	AUG-15	SEP-15	OCT-15	NOV-15	DEC-15	JAN-16	FEB-16	MAR-16	COMMENTS/MITIGATION
1	50%of SpRs should attend the monthly SPR meetings held with senior divisional staff.	4					2					Monitor results for Jan meeting and then consider timing of meeting if numbers not hitting target.
2	Average daily attendance at handovers, minimum required attendees over the month (Total eligible doctors = 10)	9					8					Monthly audit of h/o record
3	Number of induction certificates signed as proportion of all required inductions	100%										Data to be available from Feb 16
4	Number of trainees acting up per month	0					0	0				Consultant acting down policy now approved
5	Number of trainees consenting patients where not qualified per quarter	0				0	0					Quarterly audit to continue to monitor
6	Number of inappropriate thrombolysis decisions reported per month	0				0	0	0				Stroke service being reviewed to ensure provision of robust thrombolysis process
7	Number of cancelled registrar clinics due to consultant non-attendance	<3					0					On-going monitoring.
8	Number of datix reports completed by jnr drs						1					No target set
9	Attendance at bi-monthly junior drs forum meeting per rotation	70%					64 %					Next meeting 28th January.
10	New deal compliance of rotas	100%										Monitored for 2 weeks in each rotation – monitoring due w/c 11/1/2016

Successes this month	RAG Status	G	Planned Activity (Next Period)	RAG Status	G

• Audit for consenting for Endoscopy procedures showed no inappropriate practice
• Director of Medical Education appointed – confirmation letter been sent. Start date to be confirmed.
• Consultant acting down policy approved and distributed to all key stakeholders.
• Shortlisting candidates for clinical site coordinator roles completed.
• Junior doctors' forum held – no serious issues raised
			• Director of Medical Education to prepare objectives for improvement plan
			• Continue regular meetings between Deputy Div Ops and representative Registrar to establish and monitor action plans in place for
			  • Consultants acting down
			  • Handover audit
			  • Consent audit
			  • Post – take Ward Round audit
			Interview and appoint clinical site coordinators
			Next Junior Doctors forum 28/1/16
			Next SpR meeting with senior divisional staff 14/1/16
			Results of audit for consenting interventional radiology procedures to be analysed and any appropriate action to be taken.		

CQC actions added to this plan or merged with existing actions, post publication of CIH visit report	
Plan Section	**Actions added**
Patient safety	Ensure there are effective systems in place for the ongoing management of outlying patients.

Risks and issues	Initial risk score	Proposed solutions	Adjusted risk score
If senior or junior medical staff reduce engagement with this plan, effective educational governance is unlikely to be established.	16 (4x4)	Ensure regular and frequent communication with and between medical staff, especially face to face meetings to build relationships.	12 (4x3)
Locums who are unfamiliar with the Trust may compromise the local educational experience.	12(4x3)	Divisional Management Team to encourage strong consultant leadership and/or support of educational activities and ethos within specialties and the division Draft induction policy to include monitoring of induction	8 (4x2)

Support required			
Continued support from CMO			

PCIP: Programme status report, Woman and Children's action plan

Woman and Children's Action Plan December 2015	**Executive Sponsor:**	**Mari Gay (Interim CNO)**
	Project Lead:	**Cathy Garlick (Div Dir Ops)**

Aim: To provide assurance, internally and externally, that the maternity care governance structure monitors improvements in processes and consistency of care so that it is safe and effective

Objectives:

- Improve and maintain standard of consultant supervision of induction for locum medical staff.
- Demonstrate improved compliance with policies and procedures with regard to foetal heart monitoring
- Demonstrate and maintain through on-going monitoring, an improved response to incidents occurring during care process
- Agree and implement the recommendations from the external review of governance processes in maternity services and extend to other directorates within the Division
- Extend the improvement focus to paediatrics and neonatal services and agree an action plan with support from an appropriate 'buddy' Trust

	PROJECT MEASURES	TARGET	APR -15	MAY -15	JUN-15	JUL-15	AUG -15	SEP-15	OCT-15	NOV -15	DEC -15	JAN -16	FEB - 16	MAR -16	COMMENTS/ MITIGATION
1	Induction certificates signed for every locum middle grade	100%				100%	100 %	100 %	100 %	100 %	100 %				All forms returned and signed
2	CTG continued appropriately in theatre for Emergency CS	100%			100 %	83%	92%	100 %	100 %	100 %	100 %				Practice reviewed with relevant staff if<100% compliance. Dec data 2 week period
3	Interval from incident to draft report is <4 weeks (externally reportable)	100						100 %	100 %	75%	100 %				1 SI report for November will be over time due to police investigation. Draft Trust report completed awaiting post mortem results and police / safeguarding investigation.
4	72hr update received for new incidents	100%						100 %	100 %	100 %	83%				5 out of 6 Initial case reviews Dec 15. Case roundtable held ICR being drafted.

Successes this month	RAG Status	G	Planned Activity (Next Period)	RAG Status	A
• Completion of external governance recommendations sent to CNO, recommendations for trust wide processes under consideration • Weekly review meetings of serious incidents, complaints and (high risk) workforce issues continue to monitor and escalate as required • Monthly audits of processes and procedures for DFM, CTG continuation in theatre, handover and K2 completion show sustained improvement • K2 Guardian MIS requested to include data field to evidence "fresh eyes" review – delayed due to software company			• External governance report and recommendations still awaited – plan to be reviewed and refreshed in light of report • Continue weekly reviews of process and policy compliance, supported by process audits • Fresh eye K2 adjustment pending software • Division to assess impact of emergency service transfer and to amend improvement plan and governance processes accordingly, if necessary.		

CQC actions added to this plan, or merged with existing actions, post publication of CIH visit report	
Plan Section	**Actions added**
Divisional safety and governance actions	Develop a robust system to ensure children and young people who present with mental health needs are suitably risk assessed when admitted to the department to ensure care and support provided meets their needs.
	Ensure the facilities in the Early Pregnancy Unit are fit for purpose.
	Respond to complaints within agreed timeframes and summary data should be explicit as to which location the complaint relates to. Meeting minutes should clarify which area of women's and children's complaints relate to and where performance times need to be improved.
Training	Ensure that midwives have appropriate competence and skills to provide the required care and treatment to women who are recovering from a general or local anaesthetic
Communications/ Engagement	Ensure there are the appropriate number of qualified paediatric staff in the ED to meet national guidelines.

Risks and issues	Initial risk score	Proposed solutions	Adjusted risk score
If staff engagement in demonstrating consistency and compliance with policies and processes deteriorates, there will be reduced assurance that care is safe and effective	16 (4x4)	Maintain frequent dissemination of lessons learned from governance reviews Encourage staff as number of SI reports closed continues to fall Ensure training programme is maintained	12 (4x3)

Recent service transfers from AGH to WRH may impact capacity to maintain momentum of improvement plan	16 (4x4)	Ensure improvement plan is coordinated by dedicated and accountable manager who will escalate any concerns in a timely fashion to the divisional management team	12 (4x3)

Support required			
Continuation of executive support at weekly review meetings			

PCIP: Programme status report, GGI recommendations action plan

GOOD GOVERNANCE INSTITUTE RECOMMENDATIONS ACTION PLAN December 2015	Executive Sponsor: Denise Harnin (Dir HR/OD) Project Lead: Sandra Berry/Julie Stupart (Deputy)

Aim: To implement all recommendations from the Good Governance Institute's report of August 2015 on how WAHT reviews allegations of bullying and harassment

Objective(s):

- Review, update and re-launch the Trust's Dignity at Work policy by 31st January 2016, developing skills training programme for managers and awareness training for staff on raising concerns regarding bullying and harassment.
- Review the Trusts recruitment policy including retention processes to incorporate a range of recruitment initiatives and retention packages including bespoke staff development programmes, rotation programmes, new roles development and re-instatement of exit interviews.
- Ensure case investigators, case managers and investigatory panel members involving ethnic minority staff are sufficiently culturally aware and sensitive to manage issues raised by staff from minority groups.
- Review all induction programmes to ensure sufficient focus on requirements of Dignity at Work policy by 31st October 2015.
- Establish a programme of organisational development (OD) with a focus on quality improvement and underpinned by a talent management policy incorporating a trust leadership plan /programme.
- Engage with similar or peer trusts to review assimilate and share best practise.

	PROJECT MEASURES	TARGET	AUG -15	SEP-15	OCT-15	NOV -15	DEC-15	JAN-16	FEB- 16	MAR -16	COMMENTS/MITIGATION
1	Communicate Revised Dignity at Work Trust Policy to all staff.	5920									Weekly Brief Item to ensure staff are aware of policy and how to access it. Departmental Meetings.
2	Attendance at Managers Dignity at Work Mand-atory training.	750						75	150	150	Training Programme developed to commence implementation in January 2016. *Will report one month in arrears.* **Average figures provided for Jan/Feb/March*
3	Awareness Training for staff on raising concerns in respect of bullying and harassment.	2300						100	200	200	Priority will be nursing and midwifery staff and administrative and clerical staff then rolled out to the remaining staff in the trust. *Will report one month in arrears.* **Average figures provided for Jan/Feb/March*
4	Review appointments by Assessment Centre Process for Band 5 and HC Support Workers.	Qualified Band 5 Nurses - 20 HCA – 20 Theatre Practitioners - 5		11 15 3	15 11 2	18 19 3					Accepted Offers. Accepted offers Accepted offers *Will report one month in arrears.*

	PROJECT MEASURES	TARGET	AUG -15	SEP-15	OCT-15	NOV -15	DEC-15	JAN-16	FEB- 16	MAR -16	COMMENTS/MITIGATION
5	Review the time to recruit for appointments through assessment centres.	30 days		33 days	30 days	35 days					*Will report one month in arrears.*
6	Number of exit interview completed	All leavers per month with email addresses.		75 Response rate 23%	62 Response Rate 19%	53 Response Rate 24%					Exit interviews were issued to all leavers who had provided email addresses *Will report one month in arrears.*
7	Equality and diversity training delivered to staff, support advisors, case managers and case investigators	Medical Case Managers/ Investigators (29) Non-Medical Case Managers/ Investigators (150)	20			9		25	25	25	100% of medical Case Managers/Case investigators completed Training. Non-Medical Case Managers/Case Investigators to be reviewed. *Will report one month in arrears.* **Average figures provided for Jan/Feb/March*
8	Induction Training delivered regarding dignity at Work	100% of new starters.	233 (92%)	116 (93%)	45 (73%)	55 (87%)					Follow up of non attenders is escalated to divisions. *Will report one month in arrears.*

Successes this month	RAG Status	G	Planned Activity (Next Period)	RAG Status	A
• OD strategy draft completed and high level plan drafted and circulated to Executive Team for comments. • Big conversation analysis of responses undertaken. • Dignity at work programme of training developed for staff awareness sessions and manager sessions. • OD Plan discussed at November WAG and agreed to review in January 2016.			• Publicise new Dignity at Work Policy and Raising concerns Policy to all staff. • Dignity at Work programmes of training to commence in January 2016. • Review of nursing vacancy gap to identify a range of actions required including packages, rotations, links with university, and review exit interview process. • Equality and Diversity training for case managers and case investigators, staff support advisers and panel members being implemented. • Job Description for Staff Support Adviser drafted and presented to Staff Side for comment and recruitment process agreed. • Assess current internal and external leadership programmes to assess evidence of delivery against programme objectives and cultural of continuous improvement.		

CQC actions added to this plan or merged with existing actions, post publication of CIH visit report	
Plan Section	**Actions added**
Communicate the vision-quality and priorities.	Ensure staff are aware of the trust's strategy and vision for the future
Ensuring a skilled, committed workforce that can meet the current and future requirements and is affordable.	Ensure that suitably qualified staff in accordance with the agreed numbers set by the trust and taking into account national policy are employed to cover each shift.
	Ensure there are sufficient numbers of suitably qualified, competent, skilled and experienced persons to meet the requirements of the service including the provision of daily ward rounds.
	Ensure all staff meet the trust wide mandatory training target of 95% compliance
	Ensure that staff providing care or treatment to patients receive appropriate support, and training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.
	Ensure that there is sufficient levels of medical staff cover throughout the week to ensure patient reviews are carried out in a timely manner

Risks and issues	Initial risk score	Proposed solutions	Adjusted risk score
If management teams do not lead by example, efforts to focus on dignity at work will be compromised	16(4x4)	Focus initial efforts on nursing and administrative staff groups, identified by GGI as micro-cultures in which poor behaviour was experienced by some staff	8(4x2)
If OD programme is not embraced by leaders at all levels and in all staff groups and sites it will not be effective	16(4x4)	Recognise that leaders will need training, development and time to understand their role in managing change and to develop capability	8(4x2)

Support required			
External specialist advice will be necessary as the OD programme develops			

PCIP: Programme status report, Outpatient Improvement Plan

OUTPATIENT IMPROVEMENT PLAN December 2015	Executive Sponsor: Rab McEwan (Interim COO) Project Lead: David Burrell (Div Dir Ops)
Aim: Improve patient experience and service efficiency in all outpatient departments	
Objective(s): • Improve outpatient facilities at all three sites for post-op patients, children and those with special needs or vulnerabilities • Increase clinic utilisation on all three sites from current baselines to benchmark rates • Ensure robust diagnostic support to outpatient clinics • Ensure clinical skills in outpatient clinics are consistently aligned to patients' needs to achieve quality and efficiency benchmarks, for example, follow up rates, start and finish times, cancellation rates • Ensure effective links with the Elective Care Transformation Programme around booking and pathway redesign	

	PROJECT MEASURES	TARGET	APR-15	MAY-15	JUN-15	JUL-15	AUG-15	SEP-15	OCT-15	NOV-15	DEC-15	JAN-16	FEB-16	MAR-16	COMMENTS/MITIGATION
1	FFT scores per site	tbc													Measures to be agreed by project board
2	Clinic utilisation rate, per site	tbc													Measures to be agreed by project board
3	Follow up rate, overall	tbc													Measures to be agreed by project board
4	Cancellation rates and DNA rate	tbc													Measures to be agreed by project board
5	RTT Incomplete pathway performance	92%	87.33 %	87.68 %	89.07 %	90.25 %	89.42 %	88.81 %	89.00 %	92.05 %					National Standard

Successes this month	RAG Status	G	Planned Activity (Next Period)	RAG Status	A
• Outpatient improvement programme approved at TMC • Project plan drafted for approval			• Measures to be agreed • Project Board to approve plan		

CQC actions added to this plan, or merged with existing actions, post publication of CIH visit report	
Plan Section	**Actions added**
Improved efficiency and productivity	Review the existing arrangements with regards to the management of referrals in to the organisation in order that the backlog of patients on an 18 week pathway are seen in accordance with national standards.
Diagnostics	Ensure that equipment within the Radiology department is fit for purpose
Environment	Review the environment within outpatients to ensure that the seating is fit for purpose

Risks and issues	Initial risk score	Proposed solutions	Adjusted risk score
If all divisions are not engaged, improvement will not be uniform across the Trust	12 (3 x 4)	Project board to represent all divisions Escalation route for issues to include TMC	8 (2 x 4)

Support required			
None as yet			

PCIP: Programme status report, High Dependency Unit (HDU) review

High Dependency Unit (HDU) review (Vascular and Surgical) December 2015	Executive Sponsor: Andy Philips (Interim CMO) Project Lead: Sarah King (Divisional Nurse Director Surgery)
Aim: Improve high dependency care so that it consistently meets approved core standards	
Objective(s): *To be agreed at first meeting of Task and Finish Group in January 2016*	

	PROJECT MEASURES	TARGET	APR-15	MAY-15	JUN-15	JUL-15	AUG-15	SEP-15	OCT-15	NOV-15	DEC-15	JAN-16	FEB-16	MAR-16	COMMENTS/MITIGATION
1	tbc														
2															

Successes this month	RAG Status	G	Planned Activity (Next Period)	RAG Status	A
• Cross- divisional project established – led by Surgery Division			• Terms of reference to be agreed • Task and finish group to meet to complete detailed project planning		

CQC actions added to this plan, post publication of CIH visit report	
Plan Section	**Actions added**
	Review the High Dependency Units to bring their data collection and provision of care and treatment up to all Faculty of Intensive Care Medicine Core Standards.
	Ensure there is a timely and appropriate response from the medical teams to the Critical Care Unit requests for support, follow-up and patient discharge.
	Review and risk-assess the provision of the critical care Outreach team service which was not being provided for 24 hours a day.
	Address non-compliances identified by the 2014 National Emergency laparotomy audit-compliance including the provision of a sustained 24-hour Interventional radiology service.

Risks and issues	Initial risk score	Proposed solutions	Adjusted risk score
(NELA) National shortage of interventional radiologists	16 (4x4)	Explore potential for partnering arrangement with neighbouring Trusts	12 (3x4)

Support required			

Worcestershire NHS
Acute Hospitals NHS Trust

Date of meeting: 3rd February 2016 **Enc E3**

Report to Trust Board (in public/~~in private~~)

Title	**Chief Inspector of Hospitals Inspection**
Sponsoring Director	**Mari Gay, Interim Chief Nursing Officer**
Author	**Mari Gay, Interim Chief Nursing Officer** **Heather Webb, Head of Compliance & Effectiveness**
Action Required	To receive assurance; • of the process for managing the requirements of the Chief Inspector of Hospitals report. • that the CQC and TDA post-inspection reporting requirements are being complied with. • that arrangements are in place to prepare for the CQC's re-inspection of the trust. • that buddying arrangements are being developed with other hospital trusts.
Previously considered by	**Quality Governance Committee**

Strategic Priorities (√)

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

Related Board Assurance Framework Entries	3038 - If the Trust does not address concerns raised by the CQC inspection the Trust will fail to improve patient care. 3140 If the Trust doesn't proactively manage its reputation, regional confidence and recruitment will be adversely affected
Legal Implications or Regulatory requirements	The Trust is required to comply with the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014 as a condition of its license to operate.
Glossary	Special measures – special measures apply to NHS trusts and foundations trusts that have serious failures in quality of care and where there are concerns that existing management cannot make the necessary improvements without support. Special measures consist of a set of specific interventions designed to improve the quality of care within a reasonable time.

Date of meeting: 3rd February 2016 **Enc E3**

Key Messages

- The Chief Inspector of Hospitals (CIH) report was published on 2nd December 2015 and the trust was rated as 'inadequate' overall and placed in special measures.
- The requirements of the Chief Inspector of Hospitals report are being managed through the Patient Care Improvement Plan process.
- A CQC Monitoring Group has been established that will monitor progress with the 'must do' and 'should do' actions within the CIH report.
- Arrangements are in place to prepare for the CQC's re-inspection of the trust.
- Buddying arrangements are being developed with other hospital trusts.

Title of report	Chief Inspector of Hospitals Inspection
Name of director	Mari Gay

Date of meeting: 3rd February 2016 **Enc E3**

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

REPORT TO TRUST BOARD – 3rd February 2016

1. Situation

This report provides the Board with an overview of the findings of the Chief Inspector of Hospitals (CIH) inspection and outlines how the trust is responding to findings of the Care Quality Commission's (CQC) report and preparing for re-inspection.

2. Background

The CIH carried out an inspection of the trust during the period 14th to 17th July 2015. A Quality Summit took place on 27th November 2015 and the CQC published its reports on the findings of the inspection on 2nd December 2015.

3. Assessment

3.1 Overview of CQC Findings

The trust was rated as 'inadequate' overall and consequently entered special measures.

An overall rating of 'inadequate' was applied to the Alexandra Hospital and Worcestershire Royal Hospital. An overall rating of 'requires improvement' was applied to Kidderminster Hospital and Treatment Centre and a rating of 'good' was applied to the surgical services provided by the trust at Evesham Community Hospital.

The trust was rated as 'good' overall for how caring our services are.

Of the 115 domains rated by the CQC, the Trust received ratings of 'outstanding' in 2, 'good' in 54, with 13 'inadequate' and the remainder 'requiring improvement'.

The report highlighted several areas of outstanding practice, which included that;

- There was an outstanding patient observation chart used within critical care that ensured patient deterioration was identified and acted upon.
- The pharmacy department operate an innovative seven day clinical service in the Emergency Department with significant benefits for patients and a reduction in hospital admissions
- Within maternity and gynaecology services, overwhelmingly the CQC received feedback from women being treated that care was excellent and compassionate. Areas of outstanding practice and innovative solutions to problems were identified.
- Exceptional care was observed on Avon 4 in particular, with care seen to be respectful, compassionate and caring.
- The response time for new referrals to the palliative care team is very fast.

Other positive feedback included that;

- Staff were friendly, welcoming, caring, compassionate and kind.

- Clinical areas were tidy and visibly clean, and staff followed the trust's infection control policy.
- There was good feedback from patients about the availability and quality of food and drinks.

A number of areas for improvement were identified and the report includes 28 "Must do's". Within the location reports there are a range of "should do's". A number of actions were taken immediately after the inspection to address the improvements required.

Themes from the "must do's" include;

- Improving the access and flow of patients.
- Reviewing the HDUs within surgery and vascular to bring them up to all Faculty of Intensive Care Medicine Core Standards.
- Improving compliance with the mandatory training target.
- Ensuring there are sufficient staff in place.
- Ensuring patient records are accurate and complete.
- Reviewing the existing incident reporting process.
- Taking steps to ensure that all staff are included in lessons learnt from incidents, near misses and mortality review.
- Responding to complaints within agreed timeframes.
- Ensuring there is a sustainable system in place to ensure all surgical patients receive safe and timely care.

3.2 **Trust's required response to the inspection report**

The inspection reports contain requirement notices. These outline the regulations that CQC determined were not being met at the time of the inspection. The trust was required to send CQC a report by January 11th 2016 that described the action we are taking to meet the regulations. This report was provided by the deadline and details of this are outlined in paragraph 3.3.

The trust was also required to display the inspection ratings within 21 days of the publication of the report. The CQC has published comprehensive instructions that CQC must adhere to in terms of how and where the ratings are displayed, and the trust has complied with these instructions. In addition to displaying posters at each of our main hospital entrances and other areas where services are provided (e.g. Oncology Centre, Aconbury, Princess of Wales Community Hospital), our rating is also displayed on the trust's website.

The NHS TDA requires that trusts in special measures publish their progress against action plans every month on the NHS Choices and their own website, and to participate as required in national and local press conferences.

We are currently developing a succinct accessible version of our Patient Care Improvement Plan for publication.

3.3 **Patient Care Improvement Plan**

Immediately after the inspection and following the informal feedback at the end of the inspection week, the Trust developed a follow-up action plan based on the key improvement requirements communicated at that stage. Of the 33 actions in the CIH follow-up action plan 31 had been completed by the time of

the Quality Summit in November 2015.

Worcestershire Acute Hospitals NHS Trust developed a Patient Care Improvement Plan after the CQC's unannounced visits to the Trust's Emergency Departments in March 2015 following concerns around patient safety in relation to urgent care and patient flow.

The Patient Care Improvement Plan now also incorporates actions from ;

- CIH inspection – July 2015
- Infection Prevention and Control Peer Review visit by the Trust Development Authority - Spring 2015
- Good Governance Institute Review – August 2015
- Health Education West Midlands (HEWM) team visit to Medicine – revisit took place in November 2015

The PCIP is reported monthly to the Trust Management Committee, the Trust Board and the Trusts Development Authority Quality Oversight Review Group. Following publication of the inspection report in December, the *Must Do* actions and a selection of the *Should Do* actions have been integrated into the existing Trust PCIP either by way of integration into one of the existing themed action plans in the PCIP or through the inclusion of new action plans such as the governance and safety action plan, the outpatient and diagnostics improvement plan and the HDU review. Throughout the PCIP the *Must Dos* and *Should Dos* have been mapped to the themed action plans so that they can be clearly identified.

3.4 **Role of Quality Champions**

Prior to the CIH inspection the trust established a multi-disciplinary group of "CQC Champions" to help the trust prepare for the inspection. This proved so successful that post inspection this role has been further developed into a "Quality Champion" role.

Quality Champions are valuable members of our organisation who have volunteered to further improve the quality of the care and services we provide to our patients. They will do this by sharing examples of good practice, highlighting areas where consistency in practice is required and by cascading key messages throughout the trust in a consistent way.

They have an important role in ensuring that the actions required following the CIH inspection are communicated throughout the trust so that the necessary improvements are achieved.

3.5 **Preparations for Re-inspection**

CQC plans to re-inspect the trust within 12 months of the trust entering special measures.

A CQC Monitoring Group has been established to monitor progress against the 'must do' and 'should do' actions contained within the PCIP. The Group will feed into the Quality Champions to ensure messages are cascaded appropriately, and will receive and act on feedback from the Quality Champions.

A pre-inspection will be carried out along similar lines to that which took place in June 2015. This provides an opportunity to seek assurance that the actions that should have been taken have been taken and that improvements are being sustained. It is a valuable opportunity to seek out any areas requiring further improvement, or where there are obstacles to making the necessary changes.

Quality Review Visits are scheduled to take place each month, and these offer another opportunity to seek assurance on an ongoing basis on the quality and safety of services we are providing.

A communications campaign related to preparation for re - inspection will commence in February 2016 and continue with a main focus on how we are a learning organisation and how we embed further our safety culture and continuous quality improvement. This will be linked to our organisational development plan.

3.6 **Role of Buddy Trusts**

In addition to the development of the PCIP, the Trust is actively pursuing 'buddying' arrangements with other hospital Trusts. For example, the Trust had already engaged with Birmingham Women's Hospital to secure support from its former Medical Director who has been instrumental in the early and significant improvements in maternity services at the Trust since the inspection took place. The Trust is now developing a buddy contract with Birmingham Women's and Birmingham Children's NHS FT's around reviewing its current improvement plan and extending this to ensure that the Trust is following best practice across its maternity, neonatal and paediatric services. There has already been an external governance review in maternity and the Trust is also seeking to engage with Oxford University Hospitals NHS Trust to provide support for the development of Trust - wide governance arrangements and processes. The Trust also plans to use the Medical Engagement Survey and to seek support around an organisational development framework that could be rapidly deployed to develop the capacity and capability to improve. As a first step, the TDA through the Improvement Director will be supporting the Trust and the PCIP leads, to ensure that the PCIP is robust, live and sufficiently improvement focussed.

4 Recommendation

The Board is asked to receive assurance;

- of the process for managing the requirements of the Chief Inspector of Hospitals report.
- that the CQC and TDA post-inspection reporting requirements are being complied with.
- that arrangements are in place to prepare for the CQC's re-inspection of the trust.
- that buddying arrangements are being developed with other hospital trusts.

Mari Gay
Interim Chief Nursing Officer

Title of report	Chief Inspector of Hospitals Inspection
Name of director	Mari Gay

Worcestershire NHS
Acute Hospitals NHS Trust

Date of meeting: February 3rd 2016 **Enc F1**

Report to Trust Board (in public)

Title	**Nursing and Midwifery Workforce Report**
Sponsoring Director	**Mari Gay , Chief Nursing Officer**
Author	**Sonya Murray, Associate Chief Nursing Officer**
Action Required	The Board is asked to receive the report on: • Nursing and Midwifery Workforce metrics and associated actions • Safe Staffing Status • Workforce Review • State of preparedness for revalidation
Previously considered by	*Workforce Assurance Group*

Strategic Priorities (√)	
Deliver safe, high quality, compassionate patient care	√
Design healthcare around the needs of our patients, with our partners	
Invest and realise the full potential of our staff to provide compassionate and personalised care	
Ensure the Trust is financially viable and makes the best use of resources for our patients	√
Develop and sustain our business	

Related Board Assurance Framework Entries	2678 If we do not attract and retain key clinical staff we will be unable to ensure safe and adequate staffing levels.
Legal Implications or Regulatory requirements	CQC standards, NICE Safer Staffing Guidelines
Glossary	HCSW – Health Care Support Worker TDA – Trust Development Authority NICE –National Institute for Health and Care Excellence NMC Nursing and Midwifery Council

Key Messages

- Safe staffing status and performance against TDA benchmark remains positive.
- Progress related to the use of bank and agency staff.
- An update on progress with nursing and midwifery workforce review.
- Assurance on progress towards nursing and midwifery revalidation.

Date of meeting: February 3rd 2016 **Enc F1**

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

REPORT TO TRUST BOARD – 3 FEBRUARY 2016

1. Situation

This paper presents an update on the Nursing and Midwifery Workforce, including compliance with safe staffing guidance using key workforce metrics to describe the current overall situation. It also provides an update on the challenges for nursing recruitment and the divisional positions.

2. Background

In November 2013 The National Quality Board published *A guide to support providers and commissioners in making the right decisions about nursing, midwifery and care staffing capacity and capability.* Subsequently in July 2014 NICE published recommendations on safe staffing for adult-inpatient wards. It is recognised that there is no right answer for nurse and midwifery staffing and that services are complex requiring different solutions. Establishing appropriate staffing levels is complex and depends upon a range of factors including patient's dependency and acuity, patient flow, the capacity and capability of nurses and midwives and the environment of care provision.

3. Assessment

3.1 Nursing and Midwifery workforce metrics.

The nursing and midwifery position reported as of 21st December 2015

December 2015	*Funded wte	*Staff in post	Vacancies wte/%	New Starters %of funded wte	Leavers	*Sickness %	*Turnover %
Qualified	1871.61	1671.45	176.4 wte/9.4%	6.34%	21.7wte	4.40%	13.17%
Unqualified	737.84	716.70	41.9 wte/5.67%		-	8.09%	13.86%

November 2015	*Funded wte	*Staff in post	Vacancies wte/%	New Starter's wte/%of funded wte.	Leavers	*Sickness %	*Turnover %
Qualified	1865.08	1689.63	172.2wte 9.2%	21.49wte 1.15%	25.65 wte	4.18%	12.80%
Unqualified	735.91	717.33	38.1 wte 5.1%	14.97wte 5.7%	-	8.35%	13.92%

Whilst the number of wte funded qualified nursing and midwifery posts have increased the actual staff in post has decreased and is perhaps reflected in the increased turnover in December for this group of staff. The total number of unqualified staff remains largely static although turnover for this group of staff has decreased.

Vacancies for qualified nurses have remained largely the same for the third month running whilst HCSW vacancies have slightly increased.

Divisional Position

Medicine

Registered Nurse vacancies within the Medical Division have decreased from 71.9 wte for November to 65.1 wte for December. The areas with the highest number of vacancies remain MAU at the Alexandra Hospital (10.8wte) and Medical High Care and Medical Short Stay at Worcestershire Royal Hospital (11.3 wte). The Division continues to over recruit particularly for HCSW and has introduced a rotational posts at the Alexandra Hospital, with staff rotating through MAU, ED and Cardiology. Similar posts will be introduced by the Division on the Worcester site when the next cohorts of student finalists take up posts in February and March to provide attractive nursing development roles.

Surgery

The position in Surgery remains static for the third month in a row with 41.6 wte registered nurse vacancies reported for December against 42.5 wte for November. The vacancy position for HCSWs also remains largely the same at 6.1 wte for December against 5.6 wte for November.

TACO/Clinical Support

The main nursing staffing risk remains with theatres. A number of actions are being taken within Theatres and these include :

- Recruitment and Retention Premiums.
- Another Theatre open day is being held shortly.
- Exploring the possibility of an ODP programme delivered locally at the University of Worcester.

Women & Children

Within Women and Children Division the position is largely unchanged with 16.8 wte registered vacancies across the Division compared to 15.3 wte in November. The majority of vacancies in December were within the speciality of Gynaecology (7.5 wte)

Recruitment Actions

Further Trust wide recruitment events continue quarterly. Outcomes of the positive event on January 23rd 2016 will be reported next month and the next planned event will be April 14th 2016. Advertising will focus mainly on the north of the county and beyond to Birmingham and Wolverhampton to support recruitment to the Alexandra Hospital and also towards Gloucester in the south.

Date of meeting: February 3rd 2016 **Enc F1**

3.2 Safer staffing

Trust overall fill rates for December 2015

	Day		Night	
Site Name	**Average fill rate - registered nurses midwives (%)**	**Average fill rate - care staff (%)**	**Average fill rate - registered nurses/ midwives (%)**	**Average fill rate - care staff (%)**
AGH	98.6	98.2	92.5	105.0
KGH	101.2	93.8	109.1	115.1
WRH	95.8	94.9	94.2	94.3

The above table indicates that overall our hospital sites are working either to or above the required safer staffing levels.

The table below outlines the wards who did not meet the 80% fill rates required by the TDA for December 2016. 19 out of the 44 wards reported fill rates under 80%.

Ward	**DAYS Average fill rate - registered nurses/ midwives (%)**	**DAYS Average fill rate – care staff (%)**	**NIGHTS Average fill rate - registered nurses/ midwives (%)**	**NIGHTS Average fill rate – care staff (%)**
Ward 2 Specialist Med	107.7%	129.5%	77.5%	118.3%
Ward 6	97.5%	71.0%	108.3%	88.1%
Avon 3	90.6%	79.9%	129.1%	90.6%
Avon 5	95.3%	54.9%	94.4%	58.9%
Laurel 1	93.4%	74.4%	98.9%	96.8%
Laurel 3	122.1	63.0%	79.9%	80.5
Ward 9	84.9%	95.7%	67.4%	99.9%
Ward 10	94.9%	102.8%	67.7%	211.2%
Ward 11	94.4%	87.8%	75.3%	156.0%
Ward 16	83.1%	106.2%	64.4%	157.4%
Ward 18	91.0%	96.6%	76.6%	164.5%
Beech A	97.0%	164.6%	71.6%	92.6%

Chestnut	94.9%	85.1%	76.6%	89.3%
Severn & HDU	117..7%	64.7%	99.6%	95.7%
WRH Delivery Suite & Theatre	104.2%	81.9%	94.3%	68.8%
WRH Meadow Birth Centre	87.0%	92.7%	73.1%	96.8%
WRH Postnatal Ward	98.7%	93.1%	90.3%	66.7%
WRH Riverbank	83.2%	71.6%	99.2%	96.8%
Alex Ward 1	96.4%	74.2%	90.6%	102.0%

Key

- 80%	
80-94.9%	
95% +	

Surgery

Fill rates under 80% within the Surgical Division are attributed mainly to the unavailability of a third planned registered nurse on night shifts at the Alex due to continued vacancies. Additional HCSWs were rostered to cover the shortfalls and maintain overall numbers of staff on duty. This has not led to any patient safety issues.

Medicine

Within the Medical Division fill rates under 80% are attributed to vacancies and short term sickness, particularly amongst HCSWs and short notice cancellations by bank and agency staff. This was particularly prevalent over the Christmas period and resulted in very low fill rates particularly on Avon 5. Staff were deployed from other areas to ensure staffing levels was safe.

Women and Children

Low fill rates within the Women and Childrens Division on paediatric wards were due to vacancies which have now been recruited to. As these wards have low numbers of HCSWs within their skill mix; any shortfall has a significant impact on fill rates. Whilst the data reflects a fill rate of 73.1% for midwives on night shifts, staffing of maternity areas is shared across the unit and staff are re-deployed across areas dependant on acuity and patient need with no evidence of any impact to safety.

Staffing across all areas is managed on a shift by shift basis and there are clear escalation procedures in place to cover shortfalls including the use of the use of bank and agency staffing where appropriate.

3.3 Progress related to the use of bank and agency staffing

The proposed extension to the current NHSP contract put forward is still under review and a meeting between the Trust and NHSP to finalise the agreement is was held on January 18th 2016.

The percentage of shifts filled by NHSP during December was consistently under 40% averaging 34.55% .with 30% filled by third party agency. Theatres have been working with HR on a proposal for an internal bank specifically for theatres. It is anticipated that this in house bank will start to function by 31st January 2016 subject to the appointment of a co-ordinator.

A new workflow for the use of agency staff based on a tiered cascade system dependant on price, has been consulted on and is scheduled for to be fully implemented by 31st January 2016. All suppliers who are part of the Birmingham Cluster have been invited to meet Trust representatives to discuss compliance with agency rate caps and continued supply of staff to the Trust, particularly of highly specialist staff where the rates are currently outside the caps.

3.4 Nursing and midwifery workforce review

Following the review of the matron structure discussions have taken place with Divisional Management teams to plan implementation of proposed changes.

Following meetings with Emergency Nurse Practitioners and Advanced Nursing and Midwifery Practitioners from across the Trust scoping exercises are to be carried out to understand the roles undertaken by these practitioners and the services they provide. The data gathered will be used to plan the on-going development of this group of staff, ensure consistency and equity of this invaluable expertise moving forward and assist with succession planning.

A full report on progress of the New Roles Group will be provided at the next Board Meeting.

3.5. Nursing & Midwifery Revalidation – update

Awareness raising sessions continue across the Trust in preparation for April 1st with no major issues identified. Approximately 400 staff have attended these sessions to date and those attending represent a cross section of nursing and midwifery staff across the organisation.

4 Recommendation

The Group is asked to receive the report on:

- Nursing and Midwifery Workforce metrics and associated actions
- Safe Staffing Status
- Workforce Review
- State of preparedness for revalidation

Mari Gay
Interim Chief Nursing Officer

Title of report	Nursing and Midwifery Workforce Report
Name of director	Mari Gay, Interim Chief Nursing Officer

Worcestershire NHS
Acute Hospitals NHS Trust

Date of meeting: 3rd February 2016 **Enc F2**

Report to Trust Board (in public)

Title	Medical Revalidation Quarterly Report and Update – February 2016
Sponsoring Director	Dr Andy Phillips, Interim Chief Medical Officer and Responsible Officer
Author	Kim Elmer, Revalidation Support Officer – Medical Resourcing
Action Required	The Board is asked to note the current status and support the required actions for medical appraisal and revalidation to achieve Trust and national targets.
Previously considered by	Not applicable.

Strategic Priorities (√)

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

Related Board Assurance Framework Entries	2678 If we do not attract and retain key clinical staff we will be unable to ensure safe and adequate staffing levels.
Legal Implications or Regulatory requirements	Statutory requirement to appoint a Responsible Officer. Statutory requirement for doctors to be revalidated at appropriate intervals to maintain their registration.
Glossary	**GMC:** General Medical Council **RO:** Responsible Officer **SAS:** Specialty Doctor and Associate Specialists **MMC:** Medical Management Committee **MPIT**: Medical Practise Information Transfer **FQA:** NHS England Framework of Quality Assurance for Responsible Officers and Revalidation

Key Messages

This report provides the Board with an update on the progress and management of appraisal and revalidation with associated risks and corrective actions.

Date of meeting: 3rd February 2016 **Enc F2**

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

REPORT TO TRUST BOARD – 3rd FEBRUARY 2016

1. Situation

This report describes the progress and management of medical appraisal and revalidation since the report presented to the Board in November 2015.

2. Background

Medical revalidation is the process by which licensed doctors demonstrate to the GMC that they are up to date and fit to practise. Full participation in annual appraisal is integral to successful progression through medical revalidation.

3. Assessment

3.1 Medical appraisal and revalidation performance

As at 31st December 2015, there were 374 doctors with a prescribed connection to the Worcestershire Acute NHS Trust. 270 doctors have been revalidated as at 22nd January 2016 which is in line with the GMC revalidation trajectory timeline of entering doctors into their first revalidation cycle. 5 doctors are currently deferred (3 due to the RO having insufficient evidence to make a positive recommendation and 2 doctors subject to a local on-going process). There are no doctors that are subject to a current non-engagement notification.

The appraisal rate for all medical staff is 81.6%. 60 planned appraisals have not taken place as at 31st December 2015. The Medicine Division recorded a significant improvement in performance. The divisions are below the 85% Trust Board target in December. TACO and Women and Children divisions' appraisal rates have decreased since the 30th November return. Reasons for non-completion have been requested from all divisions.

Division	Appraisal rate at 31/12/15	Direction of travel since 30/11/15	Number of missed appraisals at 31/12/15
Clinical Support	80.70%	↑ 0.7% from 80.0%	11
Medicine	83.08%	↑ 7.67% from 75.41%	13
Surgery	82.35%	↑ 1.86% from 80.49%	18
TACO	82.50%	↓ 10% from 92.50%	11
Women & Children	76.32%	↓ 5.73% from 82.05%	7
Corporate	100%	↔ 0%	0

The consultant appraisal rate has decreased to 82.03% falling below the 85% target for the first time since March 2015. The SAS rate of appraisal has reached its highest rate to date of 80% compliance. See paragraph 3.5 for corrective actions.

3.2 NHS England Regional RO Network

It was recognised at the January 2016 RO network meeting that the Trust conforms to best practice in its application and follow-up of the MPIT process compared with other designated bodies in the region. The MPIT form is used as a method of information transfer for a new employee between Trusts for both routine information and to identify if there are concerns regarding a doctor's practice. The Trust's effective application of this process supports the provision of assurance that any fitness to practise concerns are identified prior to a doctor's commencement date, for review and action as appropriate.

Title of report	Medical Revalidation Quarterly Report and Update – February 2016
Name of director	Dr Andy Phillips

3.3 **NHS England Framework of Quality Assurance for Responsible Officers and Revalidation (FQA)**

The NHS England quarterly appraisal status report (Q3 September–December 2015) is due for return on the 11th February. Q1 and Q2 reports previously returned (**Appendix 1**) confirmed the number of missed appraisals and it is anticipated the Q3 report will demonstrate a similar level of non-compliance.

The outcome report from NHS England following the Independent Review Visit which took place 8th July 2015. The Trust continues to make enquires on when the report will be provided. The report is expected to include recommendations to support the Trust in achieving full compliance with the FQA.

3.4 **Risks**

The Clinical Lead for Revalidation and Appraisal role remains vacant as a successful applicant was not appointed following January's formal interview process. The post will be readvertised. Failure to undertake appraisal poses a governance risk to the organisation as the process ensures the doctor is regularly formally assessed against the GMC's Good Medical Practice standards. There is also the potential to impact on patient safety as research has identified a direct correlation between non-application of appraisal and patient safety.

3.5 **Corrective Actions**

Corrective actions to reduce the number of missed appraisals, non-compliance with the FQA, and achieve and exceed the Trust performance target of 85% appraisal completion include:-

- A revised Trust Medical Appraisal and Revalidation Policy, subject to MMC ratification in January 2016, to provide clarity of responsibilities of doctors, appraisers and Divisional Management Teams, and assurance of effective management of appraisal completion.
- Continued targeted support by the divisions for their SAS and other career grade doctors.
- Appraiser training for new appraisers (scheduled in April 2016) to increase the appraiser pool and reduce the risk of appraisal non-completion due to the lack of appraiser numbers.
- Appraiser training for existing appraisers (scheduled in April 2016) to consolidate their knowledge of the key principles underpinning appraisal and revalidation including updates from NHS England and the GMC. Training will also improve confidence in their skills to deliver an effective quality appraisal.
- Issue of RAG rated monthly appraisal status reports as a tool for divisions to manage appraisal completion. Reasons for missed appraisals are requested to identify any recurrent themes and inform the implementation of preventative measures to address non-completion.
- Appointment to the Clinical Lead for Revalidation and Appraisal role.

4 Recommendation

The Board is asked to note the current status and support the required actions for medical appraisal and revalidation to achieve Trust and national targets.

Date of meeting: 3rd February 2016 **Enc F2**

Appendix 1

Framework of Quality Assurance for Responsible Officers and Revalidation - Quarterly Report (Q1 1 April – 30 June 2015, and Q2 1 July – 30 September 2015)

Framework of Quality Assurance for Responsible Officers and Revalidation, **Annex B - Quarterly Information Template (Q2)**

Please complete this quarterly information template for the period 1 July 15 to 30 September 2015 and return to David Levy by 11th November 2015.

	Indicator	Q1 (1 Apr to 30 Jun)	Q2 (1 July to 30 Sep)	Q3 (1 Oct to 31 Dec)
1	**Name of designated body** (or NHS England Area Team or Region) Note: Please ensure your organisation's name is written exactly as it is recorded on GMC Connect	Worcestershire Acute Hospitals NHS Trust		
2	The number of doctors with whom the designated body has a prescribed connection	368		
3	The number of doctors due to hold an appraisal meeting in the reporting period	110	116	
4	The number of doctors within question 3 above who had an appraisal meeting in the reporting period	65	60	
5	The number of doctors within question 3 above, who did not have an appraisal meeting in the reporting period [These to be carried forward to the next reporting period]	45	56	
6	The number of doctors in question 5 above for whom the RO accepts the postponement is reasonable	2	3	
7	The number of doctors in question 5 above for whom the RO does not accept the postponement is reasonable.	43	53	
8	**Any Comments** (e.g. new RO, new appraisal lead etc.):			
8.1	The Trust Clinical Appraisal Lead role remains vacant however the Trust has sought expressions of interest to fill this leadership role. The Trust is progressing with the interview process to be able to appoint a successful applicant.			
8.2	Overall, the medical appraisal rate has increased since the last quarterly return from 83.4% in June to 84.14% in September. The consultant rate of appraisal as at 30 September is 85.5%. Targeted support aimed at the SAS doctors in the Medicine division has resulted in the Trust SAS rate increasing significantly from 56.36% in June 15 to 78.3% in September.			
8.3	Where reasons have been provided by the divisions for missed appraisals, trend analysis is currently being completed to establish any common reasons. Initial analysis suggests a contributing factor to appraisals being postponed during this period was due to both the doctor and appraiser's annual leave during the peak summer holiday period. A review of the appraisal due date trajectory will be undertaken to enable divisions to take preventative measures to reduce the risk of missed appraisals ie to agree (if appropriate) to bring forward a doctor's appraisal date to reduce the risk of postponement.			
8.4	Of the 56 missed appraisals, 19 have since taken place. The remaining 37 doctors have been escalated to the relevant divisional management teams for urgent attention and implementation of appraisal completion plans.			

Worcestershire NHS
Acute Hospitals NHS Trust

Date of meeting: Wednesday 3 February 2016 **Enc F3**

Report to the Trust Board

Title	**The Big Conversation**
Sponsoring Director	**Lisa Thomson**
Author	**Lisa Thomson – Director of Communications**
Action Required	The Board is asked to: • Review and comment on the suggestions and responses to the first round of the Big Conversation • Support the formation of a Staff Engagement Group • Note and comment on the proposed next steps
Previously considered by	*Executive team*

Strategic Priorities (√)

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

Related Board Assurance Framework Entries	2893 Failure to engage and listen to staff leading to low morale, motivation, and productivity and missed opportunities
Legal Implications or Regulatory requirements	NHS Constitution Protection from Harassment Act 1997
Glossary	

Key Messages

Following on from the Governance Review the Trust has embarked on an engagement programme to involve staff in developing an open culture where respectful courteous challenge is actively encouraged.

This programme includes the executive attending local and divisional meetings, encouraging staff to raise ideas and concerns through offering one to one meetings, holding team brief sessions and general conversations in public areas where people can post ideas and suggestions.

The current activity is being further strengthened by a series of 'breakfasts with the Chief Executive', the development of a new staff handbook, redesigning core messages for induction, the creation of a staff engagement group and localised pulse surveys. A 'Listening into Action' style engagement programme is being

developed to be launched in the first quarter of 2016/17 based on the outputs from this initial work.

Date of meeting: Wednesday 3 February 2016 **Enc F3**

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

REPORT TO THE TRUST BOARD – 3 February 2016

1 Situation

As part of the response to the findings of the Good Governance Institute's (GGI) independent investigation into how the Trust carries out reviews of allegations of bullying and harassment, the Trust has committed to developing an open, responsive and respectful culture. GGI report provided a catalyst for culture change.

To support the Trust's commitment to be open about challenges and what needs to change, the Big Conversation activity seeks to build two-way dialogue and provide an opportunity for everyone to make suggestions and for proposals to be tested before being implemented.

In addition to the executive team attending local and divisional team meetings, two conversations have been held on all sites during December and January to gain feedback on:

- What we need to change to make it easier to get the basics right
- How to engage more people in gaining their feedback

2 Background

Worcestershire Acute Hospitals NHS Trust has a duty to be accountable and open about its performance, decisions, policies and actions, and ensure that the highest possible standards are maintained. Communicating effectively with its employees is a vital part of this openness, whilst at the same time allowing the Trust to promote and protect the reputation of the hospitals. Proactively engaging with teams and individuals on a regular basis will enable the organisation to develop its employees as ambassadors.

International and national research highlights that high performing trusts have a strong set of organisational values, developed in partnership with employees. They are ones where senior managers are visible and accessible and regular and effective communication between senior leaders and employees take place using a variety of channels. The Big Conversation is the start of this activity and will be further developed to support creating a strong employee voice throughout the Trust. It is focused on enabling all employees to be able both to raise concerns if they have them, to offer suggestions for the improvement of their services and to be involved in decision-making across the trust as a whole.

The NHS is facing an unprecedented squeeze on resources being driven by on-going pay restraint, increasing job intensity and constant organisational change. Yet although the situation represents a challenge to engagement, it also makes engaging with employees more important than ever before.

Engagement during times of change is vital in order to both inform decision-making and to ensure the buy-in of employees to the process. Employee engagements are critical to the Trust's journey as services change and develop, to meet new and

exacting safety standards. Through engaging with employees the Trust can help unlock the potential for innovation allowing services to become safer more effective and more efficient.

All of the activity has been delivered in-house using in-house resources.

3 Assessment

In addition to the executive team joining local team and directorate meetings, a series of events are being held in public areas on all sites to gain additional employee feedback. Over December and January this has included asking staff over a period of a week to contribute and leave their thoughts and feedback on a number of questions. We have received over 200 comments and held many more conversations. The feedback has been themed under each of the topics. The aim is to take the proposals and suggestions back to the workforce using leaflets, posters and meetings to ensure these are addressing the points raised prior to any implementation.

1. Getting the basics right – first time, every time

What is blocking us getting the basics right and what do we need to do to change this?

You said	The proposal
• Increase staffing	• Make the recruitment visible and promote the active recruitment campaign internally and externally.
• Improve the working environment – car parking, break facilities etc.	• Fruit and veg stall planned for outside entrance of Worcestershire Royal. • Additional microwaves for staff in canteen areas. • Review catering facilities on all sites. • Review of staff parking with a group formed to include staff representatives.
• Standardise patient experience	• Review patient experience and make feedback visible in public areas
• Develop a better understanding of issues through front line staff	• Start a news bulletin online area with stories from our staff, videos of what our people are saying. Called 'The Voice.'

2. What one thing could we do to improve communications?

You said	The proposal
• Get regular feedback from nurses and act on it	• Monthly feedback surveys for all staff

• Use intranet more • Regular meetings and regular feedback	• Start a news bulletin online area with stories from our staff, videos of what our people are saying. Called 'The Voice.
• Come and listen, observe what lower bands of staff do all day every day	• Programme of ward visits by senior managers and the executive team
• Use social media more • Grant access at work for engagement	• Enable staff to access Facebook, YouTube, Twitter and Tumblr

3. What do you think about our vision and strapline?

You said	**Proposals from staff**
• The strapline and vision need to be one. It needs to be short and catchy.	• Patient First • Great care to every patient, every day • Quality care delivered by quality staff
• I think the existing PRIDE values are about right. • Pride values are fine. No need to change them for the sake of change.	

4. Less than 20% of our workforce gives us feedback in our friends and family test. What do we need to do to encourage people to give us feedback?

You Said	**The Proposal – Your Ideas**
• More face to face opportunities to feedback	• Quarterly staff 'town all' style Q+A meeting
• Communicate back to us	• More use of online and text messaging
• Listen	• Give short feedback and use short questionnaires showing the action taken from completing the survey. • Involve those employees affected in any changes as soon as possible e.g. asking them to trial new systems and processes including new equipment.
• Stop death by email and improve communication between staff and managers	• Hold regular team meetings in all areas

5. What values drive you?

What Drives You
Team atmosphere • Respect to fellow workers is very important • Everyone living the values • Take priding in your work • Being part of one organisation working across three sites
Lovely place to work • Rewarding • Friendly
Respect for staff • Respect for patients if they complain • Respect all both sides, Dr, Nurses and patients
Pay • Value for money – best quality possible with the money we have
Everyone contributing • Patients • Making the patient experience a quality one • Quality
Compassion • Being appreciated • Being listen to and heard

6. What do we need to do to improve the number of our workforce recommending us as a place to work?

You Said	**The Proposal – Your Ideas**
• Substantive Trust Board - No interim! • Senior team to be more visible in clinical areas	
• More supportive staff and training so we retain staff • Vacancies recruited into – more staff • More support for staff • More staff equality	• Better training and access to training and career development – specific training for staff funded. • Programme of events to support staff including stress and keeping healthy
• Set clear realistic expectations • Improve planning for winter pressures • Take action • Improve capacity and flow	• Reduce red tape
• Environment and benefits • Improve staff parking • Improve heating in reception areas • Pay	

• Improve awareness and range of staff benefits including staff wellbeing	
• Improve communication	• Sell us better as an employer. • Listen to staff more - hold sessions that are more localised to geography/division/team, show us that you're listening. • Be positive. • As well as the posters, have leaflets for areas and go round with an iPad – a physical presence helps (a member of staff in the foyer to encourage people). • Send text message surveys. • Improve communication when moves have to be made including changing phone numbers.
• More HR support needed	• Work with staff to understand what type of HR support is required
• Make all staff feel wanted – including the porters	• Hold more staff appreciation events • Managers to do organised thank you sessions

7. What do we need to do to improve the number of our workforce recommending us as a place to have treatment?

You Said	**The Proposal/ Your Ideas**
• Environment • Improve parking • Stop smoking outside of the hospitals	• Trial of park and ride for patients and visitors at WRH • Better signage that this is a no smoking area
• Improve communication to all • Celebrate successes, positive mental attitude	• More Positive stories and achievements shared • Teams and individuals are to report to communications what all teams are doing when good practice takes place
• Staffing levels - Recruit to permanent posts	• Active internal and external recruitment programme made visible to all
• Get out of special measures	• Promote the PCIP activity and programme demonstrating improvements
• Managers, matrons and all staff to be friendly and welcoming	• Promote the values and ethos of the organisation. Share good team news stories

• Address capacity issues	• Greater promotion of all the activities underway to improve the flow within our hospitals. • Specific campaign around discharge – aimed at preventing stranded patients and increased awareness of patients and their relatives that they will be leaving when they are medically fit for discharge.

3.1 Next steps include:

Feeding back to the workforce what we have heard so far and the proposals/changes for comment via posters, leaflets and use of the Intranet (February).

Staff Engagement Group publicised and formed – currently we have 12 people who have volunteered to be part of this group (February).

Learning from the recent nurse Pulse Survey to be used to expand targeted surveys to assess levels of engagement using the NHS scoring criteria (February).

4 Recommendation

The Board is asked to:

- Review and comment on the suggestions and responses to the first round of the Big Conversation
- Support the formation of a Staff Engagement Group
- Note and comment on the proposed next steps

Lisa Thomson
Director of Communications

Worcestershire NHS
Acute Hospitals NHS Trust

Date of meeting: 03 February 2016 **Enc G1**

Report to Trust Board in public

Title	**Future of Acute Hospital Services in Worcestershire Proposed Clinical Model of Care**
Sponsoring Director	**Chris Tidman**
Author	**Lucy Noon**
Action Required	• Receive and endorse the changes to the Clinical Model which was previously approved by the Future of Acute Hospital Services in Worcestershire Programme Board • Reaffirm support for the case for change
Previously considered by	Future of Acute Hospital Services in Worcestershire Programme Board

Strategic Priorities (√)

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

Related Board Assurance Framework Entries	**2678** - If we do not attract and retain key clinical staff we will be unable to ensure safe and adequate staffing levels **2665** - If we do not achieve wider service redesign in a timely way we will have inadequate numbers of clinical staff to deliver quality care **2905** - Failure to transform our services, resulting in inability to deliver required improvement
Legal Implications or Regulatory requirements	
Glossary	Included in the Proposed Clinical Model of Care

Key Messages

This paper sets out the clinical model for future acute hospital services in Worcestershire. The model has been developed by clinicians within Worcestershire with support from external experts. It is a clinically sustainable model which enables all residents to have access to high quality, safe, acute hospital services in the future. The model has been in development over the last four years.

The work on the model has been overseen by the Future of Acute Hospital Services in Worcestershire programme's Clinical Sub-Committee and involved clinicians from all three CCGs and Worcestershire Acute Hospitals NHS Trust as well as Worcestershire Health and Care NHS Trust, Birmingham Women's NHS Foundation Trust and West Midlands Ambulance Service NHS Foundation Trust. This approach has ensured that the proposed model is owned and supported by clinicians across the county.

The original clinical model was approved by the FoAHSW Programme Board in August 2014 and submitted to the West Midlands Clinical Senate for review. The West Midlands Clinical Senate supported the vast majority of the clinical model but asked for further work to be undertaken on the plans for emergency care. The Programme Board established an Emergency Care Redesign Group under the chairmanship of Dr Kiran Patel, Medical Director of NHS England Midland and East, and a Paediatric Task and Finish Group under the chairmanship of Mr Martin Lee, secondary care doctor on the governing bodies of both Redditch and Bromsgrove and Wyre Forest CCGs, to refine the model.

NHS England recently published planning guidance requiring all health economies to develop long term Sustainability and Transformation Plans. The FoAHSW clinical model will form an integral part of the health economy's Sustainability and Transformation Plan which is currently in development and will be submitted to NHS England in June 2016. The plan will articulate how longer term financial stability will be achieved across the whole health economy.

The Programme Board recognises the importance to progress the current clinical model in advance of any future plans. Any further delays in consulting on and implementing the model will result in further clinical safety issues and financial challenge. Implementation of the model post consultation will enable the Trust to address a number of issues highlighted in the case for change, for example providing stability for the workforce and reducing the need for the temporary employment of costly agency staff. Once the clinical model has been agreed by the three CCG Governing Bodies it will be submitted to a Clinical Senate for assurance before being presented to NHS England for assurance. The model will be subject to a full, formal public consultation before any changes are implemented on a permanent basis**.**

The proposed Clinical Model is being taken to these CCG Governing Body meetings for approval:

- NHS Redditch and Bromsgrove CCG – Thursday, January 28th
- NHS South Worcestershire CCG – Thursday, January 28th
- NHS Wyre Forest CCG - Tuesday, February 2nd

The Future of Acute Hospital Services in Worcestershire (FoAHSW)

Proposed Clinical Model of Care
FINAL
(January 2016)

Version Control:

Date	Author	Version	Details
10.12.15	LBlankley	Draft v 1.0	
16.12.15	LBlankley	Draft v 2.0	
05.01.16	CAustin	Draft v 3.0	
06.01.16	TMeadows CAustin LNoon	Draft v 4.0 Draft v 4.1 Draft v 4.2	Formatting; appendix and glossary added Amends Amends and formatting
08.01.16	CAustin	Draft v 4.3	Amends following comments from executive team and clinical leads
15.01.16	CAustin	Draft v 5.0	Amends following Programme Board

CONTENTS:

Appendix 18: West Midlands Ambulance Service Conveyances to Alexandra Hospital
Appendix 19 – Draft Transport Report

1. Introduction and Background

This document sets out the clinical model for future acute hospital services in Worcestershire. The model has been developed by clinicians within Worcestershire with support from external experts. It is a clinically sustainable model which enables all residents to have access to high quality, safe, acute hospital services in the future. The model has been in development over the last four years.

The work on the model has been overseen by the Future of Acute Hospital Services in Worcestershire (FoAHSW) programme's Clinical Sub-Committee and involved clinicians from all three Clinical Commissioning Groups (CCGs) and Worcestershire Acute Hospitals NHS Trust (WAHT) as well as Worcestershire Health and Care NHS Trust, Birmingham Women's NHS Foundation Trust and West Midlands Ambulance Service NHS Foundation Trust. This approach has ensured that the proposed model is owned and supported by clinicians across the county.

In 2012 clinicians from across Worcestershire expressed concern that acute hospitals services in the county were not clinically sustainable and needed to be reconfigured. They were worried that patients were receiving inequitable levels of care and that the situation could only get worse due to on-going workforce challenges. The services which were of most concern were maternity, paediatrics and emergency care.

NHS Worcestershire instigated a Joint Services Review involving primary and secondary clinicians from across the county (see **appendix 1** for JSR report). Responsibility for the review was taken over by the three Clinical Commissioning Groups when they were established in April 2013 and the Future of Acute Hospital Services in Worcestershire Programme Board was formed to lead the reconfiguration. The Board consists of the leaders of the three CCGs, Worcestershire Acute Hospitals, Worcestershire Health and Care Trust, West Midlands Ambulance Service and Worcestershire County Council as well as representatives from NHS England and the NHS Trust Development Authority. The Programme Board has overseen the development of this Clinical Model for acute hospital services in Worcestershire.

The first iteration of the clinical model was tested by an Independent Clinical Review Panel (ICRP) led by Nigel Beasley, Deputy Chair of the East Midlands Clinical Senate. The ICRP's recommendations in January 2014 were used to further refine the clinical model, a full version of the recommendations is available in **appendix 2**. In June 2014 the revised clinical model was approved by the Programme Board and the three CCGs and put forward to the West Midlands Clinical Senate for review.

In June 2015 the West Midlands Clinical Senate gave its support to the majority of the proposed model but asked for additional work to be undertaken on the model for emergency care. The West Midlands Clinical Senate recommendations are available in **appendix 3**. Since then further detail has been added to the clinical pathways, areas for further development have been responded to and the Programme Board has undertaken further work on understanding the risks and developing mitigations.

This work has now been completed and is incorporated in this document.

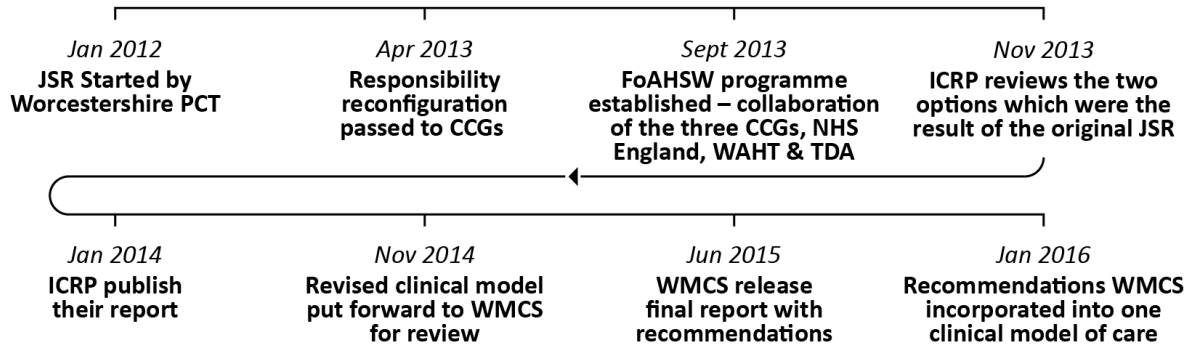


Figure 1: Brief summary of programme progress up to January 2016

1.1 Monitoring the safety of existing services

The Programme Board has established a Quality and Service Sustainability Sub-committee (QSS) to monitor the safety of existing services while the model of care has been developed. The Quality and Service Sustainability Sub-committee has identified 'trigger points' to determine when existing services can no longer be maintained safely. If these trigger points are reached the QSS recommends how the safety of services can be maintained. The Quality and Service Sustainability Sub-committee has also identified de-escalation trigger points for when any emergency changes can be safely reversed. The three CCGs are responsible for commissioning safe services and Worcestershire Acute Hospitals NHS Trust is responsible for running safe services and it is these statutory bodies, not the Future of Acute Hospital Services in Worcestershire Programme Board, who make decisions about any temporary emergency change to services.

The QSS has made recommendations about:

- Serious abdominal surgery
- Emergency surgery on children
- Emergency gynaecology
- Obstetric and Neonatal services

1.1.1 Serious abdominal surgery

Due to quality concerns it was decided that potential obstructed bowels should all be operated on at Worcestershire Royal Hospital (WRH) to improve the outcomes for patients. This emergency temporary change took place in February 2014.

1.1.2 Children's Emergency surgery

Due to quality concerns it was decided that emergency surgery on children should be concentrated at Worcestershire Royal Hospital from December 2014. Routine surgery is not affected by this move.

1.1.3 Emergency Gynaecology

Due to severe shortages of medical staff it was no longer possible to run two separate rotas for obstetrics and gynaecology at the Alexandra Hospital (AH). Therefore all emergency gynaecology work was transferred to one medical rota based at the Worcestershire Royal Hospital in August 2015.

1.1.4 Obstetric and Neonatal services

In late October 2015, the Quality and Service Sustainability Sub-committee was advised that the on-going risks to the Obstetric and Neonatal services had met the triggers developed to take temporary emergency changes. The service at the Alexandra Hospital was deemed no longer sustainable in the absence of the availability of qualified neonatal staff to maintain the service. On 5 November 2015 the Obstetric and Neonatal service at AH closed under temporary emergency measures for a period of three months; any booked deliveries at AH would be transferred to WRH, likewise neonatal care would be provided on the WRH site. Any pre-planned elective caesareans at AH would also be performed at WRH. All women were offered the opportunity to transfer their care out of the county if that was required. This is a temporary, emergency measure and there is a commitment from the Acute Trust and the Redditch and Bromsgrove Clinical Commissioning Group to resume the service at the Alexandra Hospital if staffing issues are resolved.

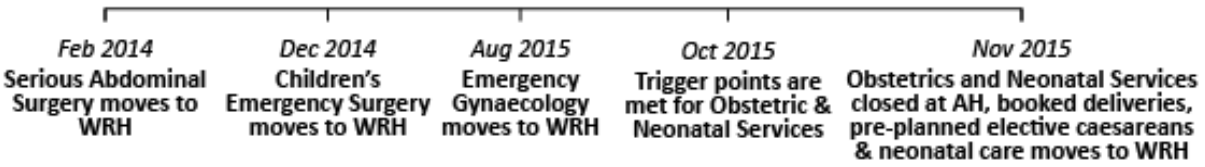


Figure 2: Timeline summarising the implementation of emergency changes

All these temporary emergency changes are being kept under review and will be reversed if it becomes clinically safe to do so.

2. The current clinical model

There are three acute hospitals in Worcestershire serving a population of 570,000 people. The Worcestershire Royal Hospital (WRH) in Worcester and the Alexandra Hospital (AH) in Redditch are district general hospitals which have Type 1 Accident and Emergency Departments, consultant-led obstetrics, paediatric inpatients and general medical and surgical beds. In addition the Worcestershire Royal Hospital is the specialist centre in the county for vascular surgery, interventional radiology, radiotherapy, strokes, more complex cancers and heart stents, it also has a midwife-led birth centre on site. Kidderminster Hospital and Treatment Centre has a minor injuries unit and a dedicated treatment centre for diagnostics, day case and short-stay surgery for children and adults.

Key statistics

2014/15	Worcestershire Royal	Alexandra	Kidderminster
Births	3,799	1,941	0
Neonatal	Level 2	Level 1	0
A&E attendances	70,000	55,000	26,000 minor injuries
Beds	415	336	49

A fuller description of the current model of care is included in **appendix 4**.

3. Clinical Case for Change

In March 2013 NHS Worcestershire together with the shadow CCGs reviewed and approved the clinical case for change. The case for change reflects the service configuration at that time and does not reflect subsequent emergency changes, the output and actions relating to external quality reviews such as Care Quality Commission (CQC), and recent improvements achieved by the Trust.

Acute hospital services in Worcestershire are not sustainable in their current form due to a critical shortage of clinical staff and challenges with recruitment and retention of staff at all levels. Services need to be reconfigured to improve quality and to build a sustainable health economy.

The case for change focuses on the key areas which are most in need of change:

- Inpatient Children's services
- Neonatal Care
- Consultant-Led Births
- Emergency Care
- Surgery

In addition the case for change recognises that in order to increase some services on the Worcestershire Royal Hospital site there will be a need to move some services from Worcestershire Royal Hospital to the Alexandra Hospital.

A move towards centralisation of specialised services across the NHS means a greater concentration of expertise and specialist skills of clinicians. The 2011 briefing on Reconfiguring Hospital Services by the King's Fund highlighted how the move to specialised, larger hospital sites, allows skills to be maximised and results in improved outcomes for patients (see **appendix 5** – Lessons for the NHS).

Larger hospitals are also more likely to attract and retain the best staff. A study by Imperial College in London shows that more patients die because of inadequate staffing in NHS hospitals than in road accidents. There is a pressing need to move towards 24/7 working though rota pressures and costs will continue to make 24/7 working a challenge across the NHS.

Across England, there have been significant improvements in outcomes for conditions such as cancer, stroke, heart disease and trauma care which can be attributed to the way services have evolved particularly with the concentration of specialised services. In many of these cases, care has moved away from smaller local hospitals to bigger hospitals with specialist teams.

Royal College of Surgeons-led research has demonstrated a link between volume and expertise with increased quality. For example, smaller hospitals often find it hard to recruit experienced paediatric consultants as some hospitals do not treat enough sick children to maintain a sufficient level of consultant expertise. A Royal College of Paediatrics and Child Health report in 2012 stated that children receive better care if they have 24-hour access to a consultant. This is also true for seriously ill new-born babies and maternity care.

3.1 The situation in Worcestershire (March 2013)

Despite improvements in acute services in recent years the population of Worcestershire is not receiving the best outcomes. Demand for services is increasing as a consequence of an ageing population and medical advances, a situation which is mirrored elsewhere in the country. For a number of years Worcestershire Acute Hospitals NHS Trust has found it difficult to recruit doctors to

cover medical and surgical rosters. Recruitment difficulties are compounded by the need to deliver services across three sites and there are particular difficulties in obstetrics, paediatrics, general surgery and A&E.

Additional issues which hamper the Trust's ability to cover medical and surgical on-call rotas include:

- Restrictions in working hours for junior doctors and a lack of experience;
- Reduced opportunities for international recruitment;
- Medical training results in earlier specialisation and narrower range of expertise to improve outcomes, but at the expense of more general work. Historically the NHS had general surgeons and general physicians but these have all retired or are nearing retirement age. In their place are specialists in specific areas such as breast surgery, Upper Gastrointestinal or Vascular surgery, who have less experience of general surgery or medicine and cannot be used as flexibly as the workforce of the past;
- The national shortage of suitably trained staff;
- The Alexandra Hospital is not an attractive place to work due to the uncertainty about the future of the hospital and its services.

These issues have collectively impacted onto the challenge of sustaining some specialist services 24/7. Worcestershire Acute Hospitals NHS Trust has responded to this through continuous recruitment processes, use of locum doctors and temporary staff provided by agencies or, in some cases, through establishing consultant-only services.

Evidence suggests that the use of locums and temporary staffing can limit the quality of patient care and is by definition not sustainable. The use of interim staff in key clinical posts is not sustainable in the medium to long term and in addition to the impact on quality, locum costs exceed those of employed staff and are not sustainable. Worcestershire Acute Hospitals NHS Trust has stated that a third of its annual deficit (2015/16 predicted £60 million) is due to the cost of employing locum rather than substantive staff.

Local services need to, as a minimum, meet and sustain national standards. Failure to achieve this presents a very real risk that some services will become unsustainable and may become unsafe. We know that from independent reviews of the services by Royal Colleges and the Care Quality Commission that the paediatric, maternity and emergency surgery services provided in Worcestershire are on the verge of being unsafe. The CQC summary report, highlighting these areas for improvement at WAHT, is available in **appendix 6**.

3.1.1 Workforce issues

The rapid expansion in NHS services in the decade from 1998 to 2008 has led to a shortfall in doctors and nurses. Despite approximately 30% of doctors working in the UK being from overseas, there is still a serious shortage of medical workforce in most NHS hospitals. Many posts are staffed by temporary or locum doctors. In the current climate it is often impossible to recruit well-trained permanent doctors into consultant posts. Compared with ten years ago when there were typically three good applicants for every consultant job, now that ratio is reversed. Doctors who are able to pick and choose their jobs as never before almost inevitably choose to work in larger hospitals that are more prestigious and have better workforce arrangements. This is a better option professionally, and the better arrangements means that duties such as night-time on-call are shared out between greater numbers of colleagues.

The focus on high-quality medical outcomes has made clear that the best results from medical and surgical treatment come from larger departments that can attract groups of specialists who are experts in the most advanced treatments. These departments are usually found in larger hospitals that are well-supported with junior staff, specialist nurses, teaching and research. Inevitably, this level of expertise is increasingly concentrated in a smaller number of larger hospitals. However, an unavoidable consequence of this consolidation of expertise means that more patients will be faced with longer travel times in order to receive modern treatment. The alternative is to continue to support smaller local units with a growing risk of unsafe or sub-standard care – this is clearly unacceptable. In some of the specialist services in Worcestershire staff are stretched across the three hospital sites. They are working in small, isolated teams without the back-up and support of being in a larger unit.

Changes to the training of the medical workforce, together with alterations to eligibility criteria for non-European Union residents, have resulted in the reduced numbers of specialty trainees in many medical specialties. In specialities such as paediatrics with 'run-through' training the number of training posts is being cut in order to maximise the chances of obtaining a consultant post on completion of training.

Having fewer numbers of staff means each member of staff has to provide cover at night and the weekends more frequently than those in larger units. This is not attractive to people applying for jobs. It is therefore more difficult to recruit a permanent workforce to work on these rotas which means the hospital increasingly relies on temporary or locum doctors and nurses to fill shifts. At the Alexandra Hospital despite frequent advertising not a single permanent medical consultant has been appointed in the last two years.

Locums can be highly skilled but they are temporary and therefore do not have as great a knowledge of the hospital and its procedures as permanent members of staff. In many cases due to safety reasons they are not allowed to carry out some of the more specialist clinical procedures. This means it is less efficient to employ temporary doctors.

The reliance on temporary doctors and nurses has been growing steadily. It is a particular problem in the areas we most want to change, obstetrics, paediatrics, neonates and emergency surgery. In the countywide obstetric service nearly half the middle grade doctors are temporary.

3.1.2 Seven day working

Public expectation of the NHS services is high, and rightly so. Increasingly this expectation means availability of services outside normal hours and at weekends. For hospital (and community) services, the expected standard of care requires the presence of consultants and their teams treating patients seven days a week. This level of consultant and junior doctor staffing can usually be achieved in larger well-staffed hospitals, but has become extremely difficult to maintain in smaller general hospitals. These smaller units increasing rely on a majority of temporary staff whose clinical skills are retained and no progression or advancement undertaken. Clinical safety cannot be maintained in these conditions, as recent experience in this region has shown. It is not right that we continue to offer patients in Worcestershire different levels of care which is dependent on whether their care is consultant-led or not.

3.1.3 Financial impact

Pressure on public sector spending has intensified at a time when increased demands are made of CCGs and NHS Trusts to reduce spending while simultaneously making major service improvements. Financial pressure has also increased due to the high cost of hiring temporary medical and nursing staff through recruitment agencies when permanent posts cannot be filled.

All hospitals are funded through a national tariff for the work they do. By duplicating services at both the Alexandra and Worcestershire Royal Hospitals, Worcestershire Acute Hospitals NHS Trust is incurring double the expense of running its services and paying for 24/7 rotas. By concentrating inpatient paediatrics, births and emergency surgery at the Worcestershire Royal Hospital the Acute Trust believes it will be able to achieve efficiency savings.

In addition the Acute Trust loses money if it is unable to carry out planned operations and patients are moved to other hospitals or the private sector. Planned operations are often cancelled at the last minute due to the need to treat emergency patients. If more planned operations could be carried out at the Alexandra Hospital whilst emergency patients were treated at the Worcestershire Royal Hospital the Acute Trust would be able to undertake more planned operations and increase its income.

3.2 Paediatrics Case for Change

There is a slightly higher than expected admission and length of stay rate for acute illness for children at the Alexandra Hospital compared to the Worcestershire Royal Hospital, despite a higher complexity of caseload at the Worcestershire Royal Hospital.

Worcestershire Acute Hospitals Trust has found it difficult to recruit middle grade doctors to cover the Alexandra Hospital despite multiple adverts both in the UK and abroad. The service relies on locums and there is concern about the safe, integrated practice of locum doctors providing cover and on-going concern regarding the continued dependency on locums and the potential impact this has on quality. The current middle grade rota at the Alexandra Hospital has a 4:2 split between substantive and locum doctors. Locum doctors are usually employed through an agency and recent capping of the maximum hourly rate payable makes it likely that these locums will seek employment elsewhere in organisations where the pay is not limited by a Department of Health price cap.

The shortage of middle grade doctors has been recognised for many years including by the NHS West Midlands Workforce Deanery which in 2010 highlighted a concern with staffing shortages at middle grade. There is a real danger that the Workforce Deanery could withdraw training recognition for junior paediatric doctors at the Alexandra Hospital. This would make it a less attractive working environment for paediatric consultants and add to the current recruitment problems.

To mitigate this paediatric consultants have been ‘acting down’ and staying at the Alexandra Hospital overnight to provide cover. This impacts on their ability to work during the day when the paediatric department is busier. The consultants have provided this cover as part of their agreed job plans but it is not a long-term solution to the staffing problems and it is financially challenging as a solution to middle grade staffing challenges.

The current service at WAHT meets only seven of the 10 standards in the Royal College of Paediatrics and Child Health (RCPCH) ‘Facing the Future’ document (see **appendix 7**).

There are fewer than ten consultants on the on call rota, and consultants are not timetabled to be in the hospital at all times of peak activity. Both of these would be rectified in a reconfigured service with a single inpatient unit.

The county does not have a large enough population to support two inpatient paediatric departments. On average only five or six children with medical problems are admitted to the Alexandra Hospital every 24 hours. The majority of these go home within 24 hours, and the average length of stay is just one day. With so few very sick children being admitted it is difficult for the doctors and nurses to keep their specialist skills up to date. It is also recognised that children have better outcomes if they are treated in larger units with a higher concentration of specialist staff.

There is a financial case for change because it costs more to run two separate inpatient paediatric departments. These additional costs have been recognised in the past and paid at above tariff rates by the CCGs but this is not sustainable and means other health services in the county are subsidising paediatric services.

3.3 Obstetrics Case for Change

If inpatient paediatrics cease at the Alexandra Hospital it would be unsafe to continue providing consultant-led births as there would not be 24-hour paediatric cover at the Alexandra Hospital for babies who need additional help when they are born.

At the start of the reconfiguration process there was a trend towards a higher number of preventable Serious Incidents (Grade 3), e.g. anal sphincter injuries; Caesarean sections; maternal readmissions; and referrals of new-born babies for therapeutic hypothermia at the Alexandra Hospital compared to the Worcestershire Royal, despite a higher complexity of cases at the Worcestershire Royal Hospital. There is no provision at the Alexandra Hospital for a neonatal intensive care unit so the Trust is providing a two-tier system for mothers and their babies with those at Worcester having access to a greater range of facilities. Worcestershire Royal has a level 2 neonatal intensive care unit which provides care for all Worcestershire babies born between 28 and 34 weeks of gestation.

Worcestershire Acute Hospitals NHS Trust has been unable to recruit middle grade doctors to cover the Alexandra and Worcestershire Royal sites, despite multiple adverts both nationally and internationally and there is concern about the safe, integrated practice of locum doctors providing cover.

Worcestershire Acute Hospitals is unable to meet the recommended level of dedicated consultant cover for the labour wards at the Alexandra Hospital (40 hours) and at the Worcestershire Royal (98 hours).

The NHS West Midlands Workforce Deanery expressed concern about the lack of training experience at the Alexandra site and this may lead to the withdrawal of middle grade trainees in future, but in the meantime has been partially resolved by cross-site programmes.

A recent Royal College of Paediatrics and Child Health report (**appendix 8**) on obstetric and paediatric/neonatal services found the current configuration to be unsustainable and highlighted concerns that services are coping through the appointment of locums to cover middle grade rotas and the goodwill and energy of consultants covering where this is not possible. The report noted

that services do not meet current medical staffing standards and, unless changes are made, are unlikely to be able to recruit sufficient trained staff to do so in future.

There is a clear co-dependency between obstetrics and paediatric services that suggests co-location of both services would be desirable in any case for reconfiguration.

Most women do not need a consultant to supervise their labour and the birth of their baby. Approximately 2,000 babies are born every year at the Alexandra Hospital, making it one of the smaller consultant delivered units in the country. Leading national advisors say this relatively small number of births means the Alexandra Hospital will not be able to provide the recommended level of consultant cover to provide safe maternity services in the long term.

The situation cannot be improved by Worcestershire Royal Hospital or any other maternity provider rotating their staff through the Alexandra Hospital, as there are simply too few babies born in the hospital for a consultant-led unit to be viable or sustainable.

3.4 Emergency Department Case for Change

The A&E departments at the Alexandra and Worcestershire Royal Hospitals fall short of the consultant workforce recommended by the Royal College of Emergency Medicine (RCEM). The college recommends a minimum of ten consultants in each A&E department – in Worcestershire, there are only nine consultants in total.

The provision of a Type 1 A&E department is dependent on 24-hour availability of: general surgery, laboratory (and diagnostic) services, inpatient paediatrics, acute medicine, radiology, trauma services and critical care.

The proposed move of inpatient paediatrics, obstetrics, and emergency surgery will have a significant impact on the sustainability of a Type 1 A&E for children at the Alexandra Hospital. Review of A&E attendances by the Independent Clinical Review Panel (**appendix 2**) led to the recommendation that emergency pathways be reconfigured to divert 5% of the most acute emergencies directly to the Worcestershire Royal A&E, while ensuring that 95% of patients continue to be seen and assessed at the Alexandra. Over a 2-3 year period the A&E Department at the Alexandra Hospital will convert to a networked Emergency Centre as recommended in the Keogh Report (**appendix 9**). It will be for adults only but will be capable of safe initial management and transfer if a very sick child arrives unexpectedly. Emergency flow pathways to support the changes have been agreed with West Midlands Ambulance Service NHS Foundation Trust (WMAS). A primary care led Urgent Care Centre for children and adults will be integrated within the emergency department at the Alexandra Hospital. Care for children in the Urgent Care Centre will be supported by:

- Staff on duty trained in paediatric life support to manage any unexpectedly ill child
- Staff from the Emergency Department
- Access to immediate telephone/telemedicine support from paediatric consultants at the Worcestershire Royal Hospital
- Secondary transfer arrangements to inpatient facilities
- Community hub arrangements including links to an enhanced hospital at home service.

Guidance for commissioners regarding Urgent Care Centres is due to be published by NHS England imminently and the plans contained in this model follow the draft NHS England guidance.

The A&E Department at WRH will evolve into a Major Emergency Centre, as described by Bruce Keogh's report (November 2013) in **appendix 9**, with 14-16 A&E consultants, some of whom will provide cover to the Alexandra Emergency Centre on a rotating basis, supported by middle-grade staff.

3.5 Surgical Case for Change

3.5.1 Quality

National Hospital Standardised Mortality Review (HSMR) (2013) and Worcestershire Acute Hospitals NHS Trust's own internal data indicated higher than acceptable mortality rates at the Alexandra site and also compared with services delivered at Worcestershire Royal Hospital which were slightly lower than would be expected.

Worcestershire Acute Hospitals wishes to further develop the Level 2 Trauma Unit at the Worcestershire Royal site, with management of semi-elective trauma (e.g. wrist fractures, hand injuries and fracture clinics) at the Alexandra Hospital and Kidderminster Treatment Centre. Inpatient trauma is proposed to be centralised at WRH where all of the other essential acute surgical services are based.

Worcestershire Acute Hospital Trust wishes to invest in the creation of 'Centres of Excellence' for all elective Orthopaedics, Urology (including Urological Cancer) and a laparoscopic benign upper GI surgery service at the Alexandra Hospital, with the creation of further 'Centres of Excellence' for all elective Colorectal Surgery, Reconstructive Breast Surgery, Vascular Surgery and Head and Neck Surgery at the Worcestershire Royal site. The proposed reconfiguration will not only concentrate expertise and facilities in single centres for the county but also reduce the conflict for resource that exists currently where acute and more routine surgical services are not separated. This will also improve the structure of training in surgery at all levels across the county which is supported by the Workforce Deanery.

3.5.2 Workforce

The demographics of the consultant body at the Alexandra Hospital show that a number of consultants are due to retire in the next few years. Many of these are general surgeons who take part in the emergency on-call rota. Due to the increasing subspecialisation during training most of the replacement consultants are specialists (breast, vascular surgery etc.) and unable to take on emergency on-call work. There is also a national reduction in the number of junior doctors in surgery in training nationally. This reduction makes it increasingly difficult, if not impossible, for Worcestershire Acute Hospitals Trust to continue to support two separate services and provide appropriate training. This is compounded by the loss of surgical specialist trainees at the Alexandra Hospital several years ago due to limited training opportunities. The uncertainty of the future of emergency surgery at the Alexandra Hospital has recently led to a loss of middle grade surgeons which now threatens the sustainability of a 24/7 resident rota.

3.6 Summary of the Case for Change

Medical and nursing workforce pressures experienced by Worcestershire Acute Hospital NHS Trust have led to difficulty in maintaining services, and highlighted clinical safety concerns, predominantly

at the Alexandra Hospital site. The services most critically affected include paediatrics, obstetrics and emergency surgery.

In response to these concerns, and following the outcome of a clinically-led service review process (ICRP) in January 2014, the three Clinical Commissioning Groups, Worcestershire Acute Hospital Trust and other Local Health Economy (LHE) partners have unanimously agreed to reconfigure clinical services across the Trust to maintain clinical safety and sustain robust services in the long term.

It is recognised by the Acute Trust and its partners that a major clinical reconfiguration is likely to carry a degree of risk, and similar concerns have been noted by clinical colleagues. The Trust, supported by senior clinicians, has resolved to manage and mitigate all risks as far as is possible. The successful temporary emergency centralisation of maternity services with no adverse impact on patient care is an indication of the ability within the organisation to successfully manage these risks. Extensive communication with clinicians across primary and secondary care, across the county, has been conducted.

Although a number of provider models have been evaluated, the Trust and its commissioners are confident that reconfiguration of its clinical services is the best available model, within current NHS and local constraints, to secure long term services for the population of Worcestershire.

Conversely, failure to restructure services risks serious damage to local NHS services and the safety of the Worcestershire population.

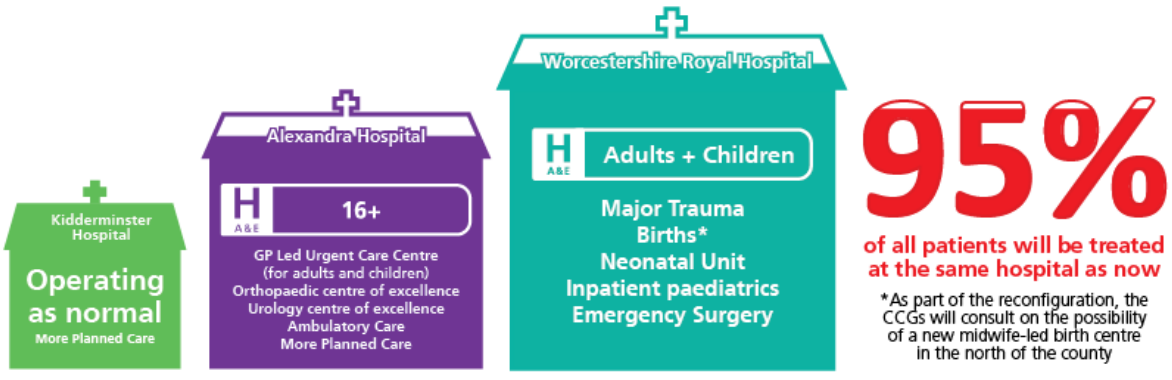
4. Proposed Model of Care

The future model of care has been developed by clinicians from across Worcestershire through the programme's Clinical Sub-Committee and its workstreams.

4.1 Proposed Model of Care – Summary

Under the proposed model of care around 95% of patients would continue to receive their care in the hospital where they receive it now. There will be no changes to outpatient appointments, diagnostics or acute medicine.

The model of care is summarised as follows, a more detailed description is given below and a full description is in **appendix 10.**



Future of Acute Hospital Services in Worcestershire vision: To have clinically safe and sustainable services in the county

The proposed model of care includes:

- Deliver care locally for the majority of patients, with no change to the majority of existing services
- Separation of emergency and planned care to improve outcomes and patient experience
- Centralisation of inpatient care for children
- Centralisation of consultant-led births
- Centralisation of emergency surgery
- Creation of centres of excellence for planned surgery
- Adult-only emergency department at the Alexandra Hospital with robust arrangements for managing a seriously sick child if they arrive unexpectedly or their condition deteriorates whilst they are in the department (see below for more details)
- Urgent Care Centre for adults and children at the Alexandra and Worcestershire Royal Hospitals
- The Alexandra Hospital will continue to care for undifferentiated adult medical patients, except heart attacks and strokes which are already centralised at the Worcestershire Royal Hospital

The model of care being proposed for Worcestershire separates much of the emergency and planned care undertaken in the county. This separation enables the Trust to utilise its workforce and equipment in the most cost-effective way and ensures emergency patients have access to all the experts and equipment. It will improve outcomes and enhance the patient experience. It will also lead to a reduction in the number of cancelled operations.

The model of care we are proposing moves:

- All hospital births from the Alexandra to the Worcestershire Royal Hospital
- Inpatient children's services from the Alexandra to the Worcestershire Royal Hospital
- Emergency surgery from the Alexandra to the Worcestershire Royal Hospital
- Most planned orthopaedic surgery from Worcestershire Royal to the Alexandra Hospital
- Some planned gynaecology surgery from Worcestershire Royal to the Alexandra Hospital
- More planned surgery – eg breast surgery from Worcestershire Royal to the Alexandra Hospital
- More ambulatory care from Worcestershire Royal to the Alexandra Hospital
- More daycase and short stay surgery to Kidderminster Hospital

It retains an adult-only emergency department and introduces a new Urgent Care Centre for adults and children at the Alexandra Hospital.

By doing this it concentrates the higher risk, emergency care at the Worcestershire Royal Hospital and planned elective care at the Alexandra Hospital.

All other services are unchanged and patients will continue to receive most of their treatment locally as now.

4.2 Paediatrics

	Kidderminster		Alexandra		Worcestershire Royal	
	Now	Future	Now	Future	Now	Future
Outpatients	√	√	√	√	√	√
Diagnostic Tests	√	√	√	√	√	√
Overnight stay for children			√		√	√
Planned surgery	√	√	√	√	√	√
Emergency Surgery			√*		√	√
Critically ill taken by ambulance			√		√	√
Urgent Care				√		√
Minor injuries	√	√	√	√	√	√
Surgery under two-years-old	Automatically transferred to Birmingham Children's Hospital as now					

*Does not take account of the temporary emergency move of emergency surgery on children

Proposed paediatric model of care for Worcestershire

- Children will continue to be seen as outpatients and have their diagnostic tests in their local hospital, as now.
- Planned surgery on children will continue to take place at Kidderminster Hospital and Treatment Centre, as now.
- Children under two years of age who require surgery will be transferred to Birmingham Children's Hospital, as now.
- The county's overnight services for children needing to stay in hospital will be centralised at the Worcestershire Royal.
- All ambulances will take critically ill children straight to the Worcestershire Royal Hospital.
- An Urgent Care Centre at the Alexandra Hospital will treat children with minor injuries and illnesses. GPs will be able to refer children to the Urgent Care Centre for further investigations. Staff in the Urgent Care Centre will have immediate access to telephone and telemedicine support from Consultant Paediatricians based at the Worcestershire Royal Hospital.
- Enhanced community nurses and health visitors will provide additional support to enable children to be monitored and treated in their own homes. **Appendix 11** provides details on the proposed enhanced provision of community children's nursing within Worcestershire.

Any child who presents at the Alexandra Hospital in an unresponsive state will be given immediate treatment by staff trained in advanced paediatric life support before they can be transferred by ambulance to the Worcestershire Royal Hospital or Birmingham Children's Hospital. Staff trained in advanced paediatric life support will include emergency medicine consultants, emergency department nurses, anaesthetists, intensivists and primary care clinicians. A clinician with advanced paediatric life support training will be on duty 24/7 on the Alexandra Hospital site (see **appendix 12** for further details).

Worcestershire Acute Hospitals NHS Trust has existing paediatric resuscitation, stabilisation, retrieval and transfer guidance for the county (see **appendix 13**). A framework for the treatment of critically ill children, to that which will be in place at the Alexandra Hospital, is already in practice at Kidderminster Hospital and Treatment Centre's Minor Injury Unit (see **appendix 14**).

The Programme Board and the county's clinicians have rejected an earlier call for a Paediatric Assessment Unit (PAU) to be provided at the Alexandra site on the grounds that it is inappropriate in terms of quality, safety and sustainability – see **appendix 15**. A recent Royal College of Paediatrics and Child Health review found no published examples of operational Paediatric Assessment Units which are not co-located with either in-patient paediatric beds or an A&E.

The planned changes would be supported by a comprehensive publicity campaign to ensure that parents and the public are aware of what facilities are available at the Alexandra Hospital for children and where sick children could be safely treated. The strategy would include descriptions of common paediatric illnesses and how to treat them within primary and community care settings.

Inpatient paediatric services were previously removed from Kidderminster Hospital. Since the move there have been no incidences of harm coming from seriously unwell children being taken by their parents or carers to Kidderminster Hospital and the public in the Wyre Forest is clear about what facilities are available in the county for children.

4.3 Maternity and Neonatal

	Kidderminster		Alexandra		Worcestershire Royal	
	Now	Future	Now	Future	Now	Future
Ante-natal care	√	√	√	√	√	√
Inpatient ante-natal observation and investigations			√		√	√
Diagnostic Tests	√	√	√	√	√	√
Births			√*		√	√

*Does not take account of the emergency temporary move of births from the Alexandra Hospital

Proposed model of care for maternity and neonatal care in Worcestershire

- All ante-natal care and diagnostics will be provided to pregnant women in their local hospital or community setting, as now.
- All hospital-based births in the county will be centralised at Worcestershire Royal Hospital.
- A full obstetric service and midwife-led birth centre will be offered at Worcestershire Royal Hospital, as now.
- Inpatient post-natal care will be centralised at Worcestershire Royal Hospital.
- Outpatient and community based post-natal care will continue as now.

The proposal is for all ante-natal care and diagnostics to be provided to pregnant women in their local hospital or community setting, as now.

All hospital-based births in the county will be centralised at Worcestershire Royal Hospital and women will also be given the option of choosing to give birth in a hospital setting outside the county. The Worcestershire Royal Hospital will continue to offer a full obstetric service, including emergency and planned caesarean sections and a midwife-led birth centre. Women, who are suitable, will also be able to have a home birth. A full description of maternity pathways is provided in **appendix 16**.

The three Worcestershire CCGs will consult on whether they should offer women a standalone birth centre in the north of the county and whether a standalone birth centre would be used by enough women to be clinically and financially sustainable.

4.4 Emergency Surgery

	Kidderminster		Alexandra		Worcestershire Royal	
	Now	Future	Now	Future	Now	Future
Outpatients	√	√	√	√	√	√
Diagnostic Tests	√	√	√	√	√	√
Overnight stay			√*		√	√

*Does not take account of the emergency temporary changes for high risk emergency surgery including abdominal obstructions

Proposed model of care for emergency surgery in Worcestershire

- All emergency surgery (except emergency urology surgery) will take place at Worcestershire Royal Hospital.
- Semi-elective ambulatory emergency surgery will take place at Alexandra Hospital, as now.
- Ambulances will convey all suspected emergency surgery patients to Worcestershire Royal Hospital.

All emergency surgery will be centralised at Worcestershire Royal Hospital. Patients needing semi-elective ambulatory emergency surgery, for instance the draining of an abscess, will continue to be treated at the Alexandra Hospital.

Ambulances will take suspected emergency surgery patients direct to Worcestershire Royal Hospital. Patients needing emergency surgery who present at the Alexandra Hospital will be stabilised before being transferred to the Worcestershire Royal Hospital.

In recognition that medical patients can develop surgical complications it has been agreed that there will continue to be a 24/7 surgical presence at the Alexandra Hospital to provide surgical support to acute physicians.

4.5 Planned care

	Kidderminster		Alexandra		Worcestershire Royal	
	Now	Future	Now	Future	Now	Future
Outpatients	√	√	√	√	√	√
Diagnostic Tests	√	√	√	√	√	√
Overnight stay	√	√	√	√	√	√

Planned surgery	√	√	√	√	√	√
Centres of excellence						
• **Urology**			√	√		
• **Breast**				√		
• **Laparoscopic benign upper gastrointestinal tract surgery**				√		
• **Colorectal surgery**						√
• **Orthopaedics**				√		

Planned care will be separated from emergency care and Centres of Excellence.

Centre for Excellence - Vision
The vision is to create a Centre of Excellence that delivers comprehensive, holistic and personalised care for patients, using advanced surgical techniques and technologies, which will provide high quality, safe services with an excellent experience of care for patients whilst providing the best clinical outcomes.

Surgical Centres of Excellence will provide better outcomes for patients. They allow the concentration of clinical and physical resources in a specific location, enabling specialised practice and the benefits that this brings – centres of excellence will allow the co-location of consultant surgeon and anaesthetic teams accredited to the highest standard and specialising in their field of expertise. Patients will be treated in centres with the right facilities, processes and expertise in order to maximise good recovery, there will be access to dedicated theatres and wards, access to multi-disciplinary teams: specialist nurses, advanced nurse practitioners (ANPs), anaesthetists, physiotherapists, radiologists, occupational therapists, and other clinical professionals.

The past president of the Royal College of Surgeons (Professor Norman Williams) said in 2013, "We know from the comprehensive evidence currently available that for many procedures and conditions concentrating specialist surgical services into fewer, larger centres of excellence can improve outcomes, and often save lives".

Consultant surgeon job plans will contain both elective and emergency county-wide commitments. The centre of excellence will provide a countywide integrated pathway across the health economy, enabling specialised rehabilitation services for patients in an appropriate setting outside the acute hospital.

The enhanced recovery pathway will be used to ensure patients receive the best possible care during their surgery and whilst recovering, including help and advice from within primary care and the community accessed closer to home throughout treatment. Pre-operative assessment and surgical hours will occur during specified hours. All post-operative services will be operational 24 hours.

4.6 Emergency care

	Kidderminster		Alexandra		Worcestershire Royal	
	Now	Future	Now	Future	Now	Future
Minor Injuries	√	√	√	√	√	√
Urgent Care	√	√	√	√	√	√
A&E children (under 16)			√		√	√
A&E adults (over 16)			√	√	√	√

In addition there are significant opportunities to develop new and innovative ways of working within the Emergency care environment which may lead to significant enhancements to the level and quality of care provided.

Proposed Emergency Care Department at the Alexandra Hospital
The key components of the Emergency Care Department at the Alexandra Hospital are: • Full resuscitation facilities for adults and children • Fully trained staff capable of resuscitating adults and children • Majors area for the stable but significantly ill patient • Minors area which is fully integrated with the primary care urgent care centre • A bedded clinical decisions unit (CDU) and observation unit which will maximise the use of ambulatory care pathways • Full diagnostic support including radiology and laboratory support • Integrated Emergency and Acute Medicine with common standards of care and integrated care pathways which maximise the use of safe ambulatory care pathways leading to greater levels of admission prevention • A co-located primary care provision (currently CNU)

The Emergency department will be staffed by a full range of clinical, nursing and para-nursing staff and will provide high levels of care for adults in a learning environment. The department will be part of a fully integrated countywide service which will link closely with community based services to provide the highest quality of care for its at risk population. It is anticipated that the department will maintain, and enhance its educational status by producing innovative education solutions to the training of all staffing groups. Emergency Department consultants will be employed on a countywide basis and rotate between the Alexandra and Worcestershire Royal Hospitals.

4.7 Access to Primary Care and Community based healthcare services

Primary care and out of hours services are currently co-located within the emergency department at the Alexandra Hospital. It is proposed that in future there will be a high degree of integration between the acute hospital and primary care and community services; an Urgent Care Centre is proposed to access pathways into primary care and services offered within the community and accessed by patients closer to home, development of common or integrated care pathways including ambulatory management of the unwell patient.

In view of the national agenda with regard to greater levels of care within the community this more integrated approach to unplanned care can lead to significant service improvements and learning opportunities.

Overall, the primary care offering should be as extensive as possible and provision of a 24/7 Urgent Care Centre should be considered to accept both adult and children presentations. This facility would provide mitigation against the need for a significant flow of patients to neighbouring acute providers and retain services locally.

The aim of the model for paediatric care is to centralise inpatient paediatrics and also provide a better local primary and community care access in order to safely reduce the number of Children's Emergency Department (ED) attendances and admissions, see **appendix 12**.

For children attending ED, or admitted to an inpatient ward for assessment, most are discharged home within a short time with simple advice and reassurance provided. The majority of children currently attending ED can safely be managed locally in primary care or within an Urgent Care Centre (UCC) facility; there are examples from other parts of the country where this model is working well (Southampton, and Southport and Ormskirk), in particular when supported by outreach assessment and support from the community.

There may be some children who could be appropriately conveyed to a UCC at the Alexandra Hospital on the basis of agreed protocols, and it may also be that as the community based service is established and developed the overall needs for ambulance conveyance will reduce. An example of the current numbers of conveyances to the Alexandra Hospital can be found at **appendix 18**. Whilst it would be helpful to enquire what the experience has been in other parts of the country where this model is already in place, we would not know precise numbers until the new model was established.

We recognise that commissioning of the new model would have to cover the expected requirement for additional conveyance and backfill time in order to provide an appropriate service and mitigate risk.

Important aspects of community care for children are already in place across Worcestershire, provided by Worcestershire Health and Care NHS Trust (HACW). These services include Health Visiting; School Nursing; Hospital at Home (Orchard) Service providing support for children at home enabling many to stay out of hospital; Consultant Community Paediatricians; and Children's and Adolescent Mental Health Services (CAMHS). These services provide support for children and young people with acute illness, long-term conditions, and complex needs in order to prevent the need for hospital admission.

HACW have provided an outline Business Case (**Appendix 11**) and propose an enhanced provision to the children's community nursing team to complement the reconfiguration proposals for Worcestershire Acute Hospitals NHS Trust. Key elements include:

- An increase in hours of provision
- Implementation of direct referrals from GP to Primary Care
- Enhanced Community Children's Nursing skills (Advanced Nurse Practitioners and, Paediatric Nurse Practitioners)
- Prompt nursing triage for all GP and primary care referrals
- Rotational workforce, enabling professional development and opportunities for staff
- Access to a play specialist for acute community care assisting in age appropriate support for invasive procedures

Continuing professional development for those health care professionals delivering the care to paediatrics will be provided as part of a rolling programme to maintain and develop key skills for the UCC and community based workforce.

Whilst it is clear that further work is required to consider the commissioning of the 'enhanced' Hospital at Home (Orchard) service the proposal describes a complementary support service to management of patients within primary care and the community, ensuring patients are treated and cared for out of hospital and ensuring inpatient beds are protected for the most serious of cases.

4.8 Capacity, transport and implementation

The Programme Board recognises that changes to services will impact on capacity particularly at the Worcestershire Royal Hospital. Issues of capacity will be addressed as part of the implementation plan. A detailed implementation plan is being prepared as required by NHS England to show how the proposed service changes could be implemented and managed. As part of the implementation there are proposals for additional beds at Worcestershire Royal Hospital, upgraded operating theatres at the Alexandra Hospital, investment at Kidderminster Hospital to support additional elective surgery and additional car parking at the Worcestershire Royal Hospital. In addition there would need to be a second obstetric theatre at Worcestershire Royal and more ante-natal and post natal beds, more paediatric beds and a dedicated paediatric assessment unit. The developments would require a £25 million capital investment.

Transport for patients, staff and visitors has been considered by a transport working group which included representatives from Worcestershire County Council, patients and carers. The group has made a number of recommendations which have been forwarded to Worcestershire County Council which has a statutory duty to provide public transport in the county. The recommendations include extending the 350 bus service between Redditch and Worcester, improved use of community transport with the potential for a community bus and better promotion of car sharing and alternative forms of transport. The draft report of the Transport Group is available in **appendix 19**.

5. Conclusion

The Future of Acute Hospital Services in Worcestershire (FoAHSW) Programme now has a proposed model of care for the county of Worcestershire; approved by FoAHSW Programme Board members. In order to progress the business of the programme further towards public consultation and, implementation, CCG Governing Bodies must now receive, review and approve this document.

CCG Governing Body meetings are scheduled to take place in late January/early February 2016.

The next phase of the process is to proceed to a second West Midlands Clinical Senate Review before seeking NHS England Assurance. The Clinical Model will then be subject to a formal period of public consultation.

6. Glossary

A&E – Accident and Emergency Department
AH – Alexandra Hospital
AMU – Acute Medical Unit
APLS – Advanced Paediatric Life Support
BCH – Birmingham Children's Hospital
CAMHS – Child and Adolescent Mental Health Services
CCG – Clinical Commissioning Group
CDU – Clinical Decisions Unit
CNU – Clinical Navigation Unit
CQC – Care Quality Commission
ED – Emergency Department
FoAHSW – Future of Acute Hospital Services in Worcestershire
FY Doctor – Foundation Doctor
GAU – Gynaecology Assessment Unit
HACW – Worcestershire Health and Care NHS Trust
HDU – High Dependency Unit
HSMR – Hospital Standardised Mortality Ratio
ICRP – Independent Clinical Review Panel
IP – Inpatient
ITU – Intensive Therapy Unit
JSR – Joint Services Review
KIDS – Kids Intensive Care and Decision Support
KHTC –Kidderminster Hospital and Treatment Centre
LHE – Local Health Economy
MIU – Minor Injuries Unit
OC – On Call
OOH – Out of Hours
OPA –Outpatient Appointments
OP Clinics – Outpatient Clinics
PAU – Paediatric Assessment Unit
PCT – Primary Care Trust
QSS – Quality and Service Sustainability Sub-committee
RCPCH – Royal College of Paediatrics and Child Health
RECM – Royal College of Emergency Medicine
SAU – Surgical Assessment Unit
TDA – Trust Development Authority
ToR – Terms of Reference
UCC – Urgent Care Centre
Upper GI - Upper Gastrointestinal tract
WAHT – Worcestershire Acute Hospital NHS Trust
WMAS – West Midlands Ambulance Service NHS Foundation Trust
WMCS – West Midlands Clinical Senate
WRH – Worcestershire Royal Hospital

Worcestershire NHS
Acute Hospitals NHS Trust

3 February 2016 **Enclosure H2**

Report to Trust Board

Title	**Financial Performance – Month 9 2015/16**
Sponsoring Director	**Rob Cooper – Interim Director of Finance & Information**
Author	**Rob Pickup - Assistant Director of Finance** **Katie Osmond - Assistant Director of Finance**

Action Required	The Board is asked to consider the recommendations set out:
	
	• The Trust has revised its forecast financial position by £3.5m from £61.6m to £65.1m. This movement is due to a reduction in forecast income, most notably the £2m impact from the removal of the Risk Share with Commissioners.
	• The Trust is continuing to be fined for RTT performance despite hitting the target as a Trust. Fines are being levied on an individual commissioner and specialty level.
	• The Trust must rigorously pursue the identified recovery actions in order to tackle the adverse financial position and urgently demonstrate an improvement in the run rate. This must focus on:
	  • Exploiting CDU and Ambulatory Care
	  • Compliance with new controls on non-pay restrictions
	  • Locum expenditure being micro-managed
	  • Increased targets and micro management of nursing agency
	  • Further theatre productivity gains
	  • Manage down MFFD
	  • Ensuring new costs do not enter the system
	• The Trust is off plan driven by the consequences of operational problems. This needs to be resolved as promptly as possible. This involves focusing on flow and exploiting our elective capacity. Actions are being taken to exercise increased grip on the management of MFFD patients and improve utilisation of theatre capacity at Kidderminster and Redditch.
	• Locally agreed deadline for reaching a year end settlement (including 14/15 outstanding issues) has passed. The TDA/NHS England are facilitating health economy wide meetings to support the agreement of year end positions. The latest offer from local commissioners falls short of the Trusts requirements to hit its forecast position. Failing agreement the Trust will be disputing fines and/or seeking re-investment due to mitigating circumstances. The trust has also received a settlement offer for 15/16 from NHSE Specialised Services.
	• Additional capacity at WRH and Alex needs to be contained to the agreed plans. This requires the closing of Ward 9 and Avon 5 capacity.

	• The TDA and Monitor have set out a list of priorities for the remainder of 2015/16. These are included in appendix 4 of the letter sent out 15th January 2016 (and is an appendix to enclosure E, on the agenda), listing a number of areas for review. The majority of these have already been enacted by the Trust either in this year or previous years. A return is due to the TDA on Friday 29th January on the progress of these. These are: • Loan capital to revenue transfers • Accurate monthly capital forecasting • Accurate provision reporting • Workforce • Agency staffing • Reviewing in-year priorities • Balance sheet review • Bad debt provisions • VAT changes • Annual leave • Asset valuations • Asset lives review
Previously considered by	**N/A**
Key Messages	• At a deficit of £5.6m the month 9 position is £0.8m worse than the preceding month; the ytd deficit has moved to £45.1m. The in month deterioration in the position is due to reduced income which has fallen from £31.1m in month 8 to £30.3m in month 9. Expenditure has remained broadly in line with month 8. This is £18.6m worse than plan with an in month movement against ytd planned variance of £2.1m The bridge diagram details the variance and distinguishes three key themes which continue to drive the Trust's off plan year to date position. 1. Income, fines and penalties (£3.6m adverse variance includes specialised services gain share and excludes additional capacity income). Fines continue for RTT as although the Trust has been achieving this as whole, fines are being levied by commissioner and by specialty 2. Impact of medically fit for discharge (£4.6m). 3. Additional premium staffing including the extra staff in A&E (£8.8m). 4. Non-pay overspends and other operating income (£1.0m). • The QIPP savings after month 9 represent 44% of the total required to meet the original target of £15.6m. The year to date performance of £6.9m is ahead of the plan (£0.3m), including slippage factor, although the forecast does not indicate an increase to meet the original target. In month actuals of £1m continue to grow but at a slow rate which is illustrating that QIPP performance is levelling out in line with effort being expended with winter pressures and generation of FRP plans.

	• The Internal QIPP forecast has reduced by £0.1m to £10.3m against the target of £15.6m. £1.9m of this shortfall is forecast to be delivered through the Financial Recovery Plan (FRP) although this remains £7.9m short of the £9.7m originally planned. Further detail on this is included in the QIPP/FRP paper. • The Trust will need significant levels of further working capital to meet its financial commitments. The revised forecast of £65.1m, increases this requirement. This will inevitably result in greater TDA scrutiny and the CEO and DoF met with the Department of Health to discuss cash requirements. The Trust currently has in place an Interim Revenue Support Facility Loan of £38.172m, which represents the Trust's Stretch Control Target for 2015/16 of £28.716m plus the Working Capital identified as being required by the Trust in its 2015/16 ITFF application of £9.456m. The Revenue Support facility figure is broadly comparable with funding equivalent to 40 days' worth of operating expenditure. £38m of the Revenue Support Facility has been drawn down in December 2015. Thereafter, the Trust has identified that further cash resource support of at least £20m will be required for the Trust to continue to meet its financial obligations both until the ITFF Committee decision is reached, and through to the end of the financial year to enable the Trust to continue to pay suppliers and avoid clinical incidents. • The Trust will access this support for the remainder of the financial year via a Revolving Working Capital Facility Loan. £4.9m of the further cash support has been drawn in January 2016, with a minimum additional requirement of £5.1m in February 2016 and £9.5m in March 2016. A decision on the permanent solution to the Trust's cash funding remains outstanding.

Strategic Priorities	
Deliver safe, high quality care	
Design healthcare around patient need	
Realise staff potential to give compassionate care	
Ensure financial viability	✓
Develop and sustain our business	

Related Board Assurance Framework Entries	2666 Inability to secure sufficient income placing the financial position at further risk and affecting long term sustainability 2888 Deficit is worse than planned and threatens the Trust's long term financial sustainability 2667 If expenses are not sufficiently contained and reduced there will be a serious impact on financial position & cash availability 2889 Sufficient access to capital to achieve change and conduct backlog maintenance

Legal Implications or Regulatory requirements	The Trust must ensure plans are in place to achieve the Trust's financial forecasts. The Trust has a statutory duty to breakeven over a 3year period.
Glossary	***Commissioning for Quality and Innovation (CQUINs)*** *– payments ensure that a proportion of providers' income (currently up to 2.5%) is conditional on quality and innovation and is linked to service improvement. The schemes that qualify for CQUIN payments reflect both national and local priorities.* ***Earnings before interest, taxation, depreciation and amortisation (EBITDA)*** *– is a measure of a trust's surplus from normal operations, providing an indication of the organisation's ability to reinvest and meet any interest associated with loans it may have. It is calculated as revenue less operating expenses less depreciation less amortisation.* ***Liquidity*** *– is a measure of how long an organisation could continue if it collected no more cash from debtors. In Monitor's Risk Assessment Framework, it is measured by the number of days' worth of operating costs held in cash or cash-equivalent forms and is a key component of the continuity of services risk rating.* ***Quality, innovation, productivity and prevention (QIPP)*** *– is a programme designed to identify savings that can be reinvested in the health service and improve quality of care. Responsibility for its achievement lies with CCGs; QIPP plans must therefore be built into planning (and performance management) processes.* ***Marginal rate emergency tariff (MRET)*** *– is an adjustment made to the amount a provider of emergency services is reimbursed. It aims to encourage health economies to redesign emergency services and manage patient demand for those services. A provider is paid 70% of the national price for each patient admitted as an emergency over and above a set threshold.* *Introduced in 2003,* ***payment by results (PBR)*** *was the system for reimbursing healthcare providers in England for the costs of providing treatment. Based on the linking of a preset price to a defined measure of output of activity, it has been superseded by the national tariff.*

Report to Trust Board

Worcestershire NHS
Acute Hospitals NHS Trust

Finance Report
Month 9

Rob Cooper

Interim Director of Finance

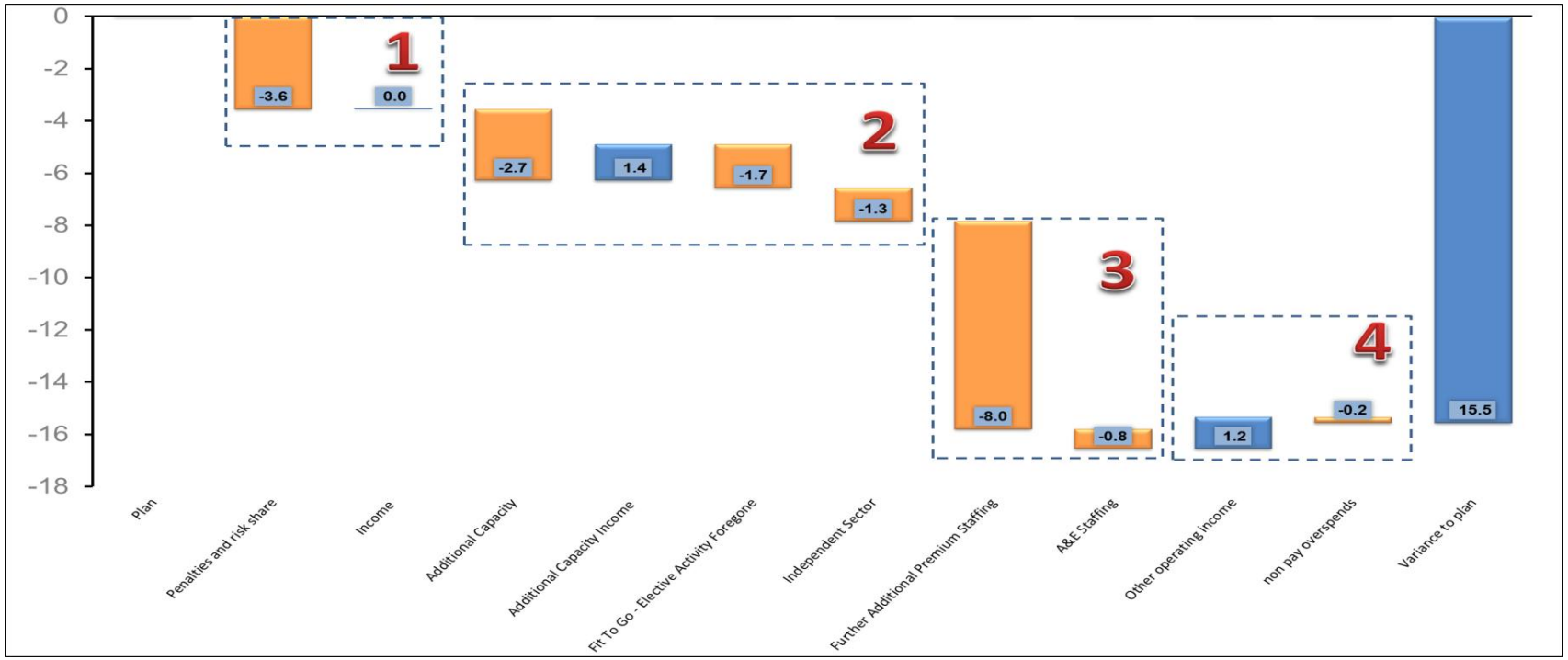
3rd February 2016

Trust Wide Position Month 9

Worcestershire NHS
Acute Hospitals NHS Trust

At a deficit of £5.6m the month 9 position is £0.8m worse than the preceding month; the ytd deficit has moved to £45.1m. The in month deterioration in the position is due to reduced income which has fallen from £31.1m in month 8 to £30.3m in month 9. Expenditure, has remained broadly in line with month 8. This is £18.6m worse than plan with an in month movement against ytd planned variance of £2.1m The bridge diagram details the variance and distinguishes three key themes which continue to drive the Trust's off plan year to date position.

1. Income, fines and penalties (£3.6m adverse variance includes specialised services gain share and excludes additional capacity income). Fines continue for RTT as although the Trust has been achieving this as whole, fines are being levied by commissioner and by specialty
2. Impact of medically fit for discharge (£4.6m).
3. Additional premium staffing including the extra staff in A&E (£8.8m).
4. Non-pay overspends and other operating income (£1.0m).



Forecast Outturn Position & Winter costs

Worcestershire NHS
Acute Hospitals NHS Trust

The Trust has revised it forecast financial position by £3.5m from £61.6m to £65.1m. This movement is due to a reduction in forecast income, most notably the £2m impact from the removal of the Risk Share with Commissioners. The movements in the forecast are shown in the table below, with other areas remaining consistent with the £61.6m forecast.

	£m's	£m's
Month 6 FOT		**(61.6)**
Movements		
Risk Share	(2.0)	
Activity Reduction	(0.4)	
RTA	(0.5)	
SIFT	(0.6)	(3.5)
Revised FOT		**(65.1)**

Key Movements

Risk Share – Commissioners have informed the Trust that they are no longer willing to agree to the proposed Risk Share. The impact of removing this from the forecast position is £2m.

Activity Reduction – Activity has reduced in the last quarter below forecast levels, impacting on the forecast outturn position. The above position reflects the latest offer from local commissioners.

RTA – Income received centrally from the compensation scheme for Road Traffic Accidents (RTA) has reduced through Q3. This income is notoriously erratic, so there remains a potential that this may recover over the last quarter of the year.

Educational Funding - schedules received show a £0.6m reduction in the level of funding to be received, despite similar levels of Trainees. This has reduced from previous months. Discussions are continuing across the region as this effects a number of Trusts.

Winter costs M7-9	£ 000's
MDU	103
Silver additional beds	38
Ward 9	20
Avon 5	82
Red cross	11
Physio & OT	3
Site Coordinators	10
Total	**267**

Additional capacity has been opened across both the WRH and Alex site, are currently being contained within the forecast position. To be able to maintain this forecast the additional capacity at the Alex (ward 9) and WRH (Avon 5) will need to be closed by the end of January. Any costs beyond this point would need to be off-set by additional savings in other areas.

QIPP & Cash

Worcestershire NHS
Acute Hospitals NHS Trust

The QIPP savings after month 9 represent 44% of the total required to meet the original target of £15.6m. The year to date performance of £6.9m is ahead of the plan (£0.3m), including slippage factor, although the forecast does not indicate an increase to meet the original target. In month actuals of £1m continue to grow but at a slow rate which is illustrating that QIPP performance is levelling out in line with effort being expended with winter pressures and generation of FRP plans.

The Internal QIPP forecast has reduced by £0.1m to £10.3m against the target of £15.6m. £1.9m of this shortfall is forecast to be delivered through the Financial Recovery Plan (FRP) although this remains £7.9m short of the £9.7m originally planned. Further detail on this is included in the QIPP/FRP paper.

The Trust will need significant levels of further working capital to meet its financial commitments. The revised forecast of £65.1m, increases this requirement. This will inevitably result in greater TDA scrutiny and the CEO and DoF met with the Department of Health to discuss cash requirements. The Trust currently has in place an Interim Revenue Support Facility Loan of £38.172m, which represents the Trust's Stretch Control Target for 2015/16 of £28.716m plus the Working Capital identified as being required by the Trust in its 2015/16 ITFF application of £9.456m. The Revenue Support facility figure is broadly comparable with funding equivalent to 40 days' worth of operating expenditure. £38m of the Revenue Support Facility has been drawn down in December 2015. Thereafter, the Trust has identified that further cash resource support of at least £20m will be required for the Trust to continue to meet its financial obligations both until the ITFF Committee decision is reached, and through to the end of the financial year to enable the Trust to continue to pay suppliers and avoid clinical incidents.

The Trust will access this support for the remainder of the financial year via a Revolving Working Capital Facility Loan. £4.9m of the further cash support has been drawn in January 2016, with a minimum additional requirement of £5.1m in February 2016 and £9.5m in March 2016 . A decision on the permanent solution to the Trust's cash funding remains outstanding.

The Trust's material aged debt with a profile over 90 days against NHS organisations is worth £2.7m. This is more than offset by the Trust's creditor position with the same group and profile, which now stands at £5.6m. Disputes with Worcestershire Health & Care Trust (WHCT) constitute the largest elements of aged NHS debt and credit, £1.6m & £2.4m respectively; disputes with Gloucestershire NHS Foundation Trust amount to £0.35m debtor and £0.7m creditor; negotiations to resolve both of the disputes are on-going. A number of meetings have been held with WHCT at director level to work through disputed items line by line. 14/15 issue have been resolved and remaining 15/16 issues are being proactively resolved. A director level phone conversation with Gloucester FT has been followed up with a proposal which has been rejected. Further work is on-going to resolve the differences, timescales and steps to resolve the dispute are currently being agreed.

Risks & Mitigations

Worcestershire NHS
Acute Hospitals NHS Trust

The following risks have been identified and categorised in relation to delivery of the 2015/16 financial and operational plan.

RISK

- **Demand & Delayed Discharges and Patient Safety.** Increasing levels of emergency pressures and staffing issues may require the Trust to implement further emergency service changes to maintain patient safety. The current situation is generating additional costs and lost income; further changes may intensify these effects. These costs remain in the system at month 9, adversely affecting the Trust's position. This is currently worse than forecast in the Trust plan.

MITIGATION

- Working closely with SRG to agree robust plans for managing demand and delayed discharges including robust winter plans.
- Systematic, rigorous and frequent reviews of all patients classified as MFFD to facilitate prompt discharges.
- Improving capacity utilisation including improvements in utilisation of Kidderminster and Redditch sites.

RISK

- **CCG QIPP.** Financial plan has been set assuming £2.75m impact of CCG QIPPs as agreed by the Trust review panel.

MITIGATION

- Working closely with CCGs to support the development of effective but realistic QIPP schemes.

RISK

- **Risks from 14/15 position.** As previously reported to the Board, items not fully agreed in the 14/15 position (£1.8m) may impact the 15/16 position once negotiations are concluded. Locally agreed deadline for reaching a settlement has passed without agreement.

MITIGATION

- Continue to negotiate with the CCGs to attempt to minimise the impact of 14/15 issues.
- Escalation meetings in place.

Risks & Mitigations

Worcestershire NHS
Acute Hospitals NHS Trust

RISK

- **Liquidity**. The Trust will need significant levels of further working capital loans or a PDC injection to meet its financial commitments in 2015/16. The Trust currently has in place an Interim Revenue Support Facility of £38.172m whilst the outcome of the ITFF application is awaited. £38m of the Revenue Support Facility has been drawn down in December 2015. The Trust has identified that further cash resource support of at least £20m will be required for the Trust to continue to meet its financial obligations both until the ITFF Committee decision is reached, and through to the end of the financial year to enable the Trust to continue to pay suppliers and avoid clinical incidents.
- The Trust will access this support for the remainder of the financial year via a Revolving Working Capital Facility Loan. £4.9m of the further cash support has been drawn in January 2016, with a minimum additional requirement of £5.1m in February 2016 and £9.5m in March 2016. A decision on the permanent solution to the Trust's cash funding remains outstanding.

MITIGATION

- Managing working capital effectively.
- Seek urgent settlement of the 14/15 agreement with the PFI provider.
- Ensure the revised application for cash support (ITFF application) is tied to requirements.
- Deputy DoF has asked CCG CFOs to pull forward contracted cash into earlier months.
- Interim DoF has written to the TDA Director of finance setting out the consequences of the cash restrictions.
- CEO and DoF met with the Department of Health in November to discuss requirements.

RISK

- **Contract penalties.** The Trust's position at Month 9 now includes £3.6m in penalties and risk share arrangements. The original plan assumed that contract penalties applied would be reinvested in the Trust, although agreement was only received for this in respect of RTT penalties. Continued penalties will have a detrimental impact on the Trust's plans and challenge its ability to absorb them within the available financial envelope. The risk share agreement remains unsigned. Locally agreed deadline has passed without reaching agreement on the risk share. The impact of this has been included in the forecast outturn position.
- The Trust is continuing to be fined for RTT performance despite hitting the target as a Trust. Fines are being levied on an individual commissioner and specialty level.

MITIGATION

- Robust contract management to deliver planned activity levels and minimise penalties.
- Locally agreed deadline for reaching a year end settlement has passed therefore the Trust will be disputing fines and/or seeking re-investment due to mitigating circumstances. Letters disputing this have been sent to CCGs. This has initiated the contract dispute process which will escalate to mediation if no resolution is agreed.
- Impact has been included in the forecast outturn position.

Risks & Mitigations

Worcestershire NHS
Acute Hospitals NHS Trust

RISK

- **Medics recruitment.** Continued recruitment difficulties result in high levels of agency expenditure.

MITIGATION

- Developing effective medical workforce plans to support recruitment.
- External specialist expertise engaged to support recruitment to shortage specialties.
- Robust management of temporary staffing costs.

RISK

- **Delivery of CIPs.** The £15.6m target represents a significant challenge as it relates to 3.8% of total spend and elements of this are not influenceable. Delivering the required level of savings will require more radical approaches than have previously been taken, over-programming and delivering at a greater pace. At month 9, the forecast value of schemes stands at £10.3m.

MITIGATION

- Confirm and challenge meetings have been arranged to close the gap and improve delivery.
- Additional savings plans and FRP.

RISK

- **Education Funding.** Education funding schedules received show a £0.6m reduction in the level of funding to be received, despite similar levels of Trainees. This has reduced from a £1m issue.

MITIGATION

- Discussions are taking place with the new team in place at Health Education West Midlands (HEWM).
- Reconciliations of the level of trainees has taken place by the Trust to show the consistency of returns between years that have been provided to HEWM.
- The impact of the £0.6m reduction has been included in the forecast outturn position.

Conclusions & Recommendations

Worcestershire NHS
Acute Hospitals NHS Trust

- The Trust has revised it forecast financial position by £3.5m from £61.6m to £65.1m. This movement is due to a reduction in forecast income, most notably the £2m impact from the removal of the Risk Share with Commissioners.

- The Trust is continuing to be fined for RTT performance despite hitting the target as a Trust. Fines are being levied on an individual commissioner and specialty level.

- The Trust must rigorously pursue the identified recovery actions in order to tackle the adverse financial position and urgently demonstrate an improvement in the run rate. This must focus on:
    - Exploiting CDU and Ambulatory Care
    - Compliance with new controls on non-pay restrictions
    - Locum expenditure being micro-managed
    - Increased targets and micro management of nursing agency
    - Further theatre productivity gains
    - Manage down MFFD
    - Ensuring new costs do not enter the system

- The Trust is off plan driven by the consequences of operational problems. This needs to be resolved as promptly as possible. This involves focusing on flow and exploiting our elective capacity. Actions are being taken to exercise increased grip on the management of MFFD patients and improve utilisation of theatre capacity at Kidderminster and Redditch.

- Locally agreed deadline for reaching a year end settlement (including 14/15 outstanding issues) has passed. The TDA/NHS England are facilitating health economy wide meetings to support the agreement of year end positions. The latest offer from local commissioners falls short of the Trusts requirements to hit it's forecast position. Failing agreement the Trust will be disputing fines and/or seeking re-investment due to mitigating circumstances. The trust has also received a settlement offer for 15/16 from NHSE Specialised Services.

Conclusions & Recommendations

Worcestershire NHS
Acute Hospitals NHS Trust

- Additional capacity at WRH and Alex needs to be contained to the agreed plans. This requires the closing of Ward 9 and Avon 5 capacity.

- The TDA and Monitor have set out a list of priorities for the remainder of 2015/16. These are included in appendix 4 of the letter sent out 15th January 2016, listing a number of areas for review. The majority of these have already been enacted by the Trust either in this year or previous years. A return is due to the TDA on Friday 29th January on the progress of these. These are:
    - Loan capital to revenue transfers
    - Accurate monthly capital forecasting
    - Accurate provision reporting
    - Workforce
    - Agency staffing
    - Reviewing in-year priorities
    - Balance sheet review
    - Bad debt provisions
    - VAT changes
    - Annual leave
    - Asset valuations
    - Asset lives review

Worcestershire NHS
Acute Hospitals NHS Trust

Appendices

Trustwide Position

Worcestershire NHS
Acute Hospitals NHS Trust

Table 1

December 15 (Month 9)

Income & Expenditure	Current Month			Year to Date			Full Year		
	Plan	Actual	Var	Plan	Actual	Var	Plan	Forecast	Var
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Operating Revenue & Income									
Patient Care Revenue	25,620	24,888	(732)	233,325	230,189	(3,136)	309,775	303,202	(6,573)
Other Operating Income	2,140	2,197	57	19,290	20,484	1,194	25,629	25,385	(244)
Non PBR Drugs & Devices	3,033	3,182	149	26,220	25,554	(666)	34,812	35,585	773
Total Operating Revenue	**30,793**	**30,267**	**(526)**	**278,835**	**276,227**	**(2,608)**	**370,216**	**364,172**	**(6,044)**
Operating Expenses									
Pay	(19,394)	(21,248)	(1,854)	(179,551)	(190,730)	(11,179)	(235,318)	(254,602)	(19,284)
Non Pay	(8,247)	(9,378)	(1,131)	(82,065)	(83,807)	(1,741)	(107,262)	(111,485)	(4,223)
Non PBR Drugs & Devices	(3,033)	(3,033)	(0)	(26,220)	(26,220)	0	(34,812)	(35,585)	(773)
Total Operating Expenses	**(30,674)**	**(33,659)**	**(2,985)**	**(287,836)**	**(300,757)**	**(12,920)**	**(377,392)**	**(401,673)**	**(24,280)**
EBITDA *	**119**	**(3,392)**	**(3,511)**	**(9,001)**	**(24,530)**	**(15,529)**	**(7,176)**	**(37,500)**	**(30,324)**
EBITDA %	0.4%	-11.2%		-3.2%	-8.9%		-1.9%	-10.3%	
Depreciation	(865)	(864)	1	(7,785)	(7,773)	12	(10,380)	(10,380)	0
Net Interest, Dividends & Gain/(Loss) on asset disposal	(1,352)	(1,364)	(12)	(12,170)	(11,958)	212	(16,226)	(16,424)	(198)
Reported Total Surplus / (Deficit)	**(2,098)**	**(5,620)**	**(3,522)**	**(28,956)**	**(44,261)**	**(15,305)**	**(33,782)**	**(64,304)**	**(30,522)**
Less Impact of Donated Asset Accounting + Impairments	7	7	0	2,419	(837)	(3,256)	2,440	(833)	(3,273)
Surplus / (Deficit) against Control Total	**(2,091)**	**(5,613)**	**(3,522)**	**(26,537)**	**(45,098)**	**(18,561)**	**(31,342)**	**(65,137)**	**(33,795)**
Surplus / (Deficit) %	-6.8%	-18.5%		-9.5%	-16.3%		-8.5%	-17.9%	

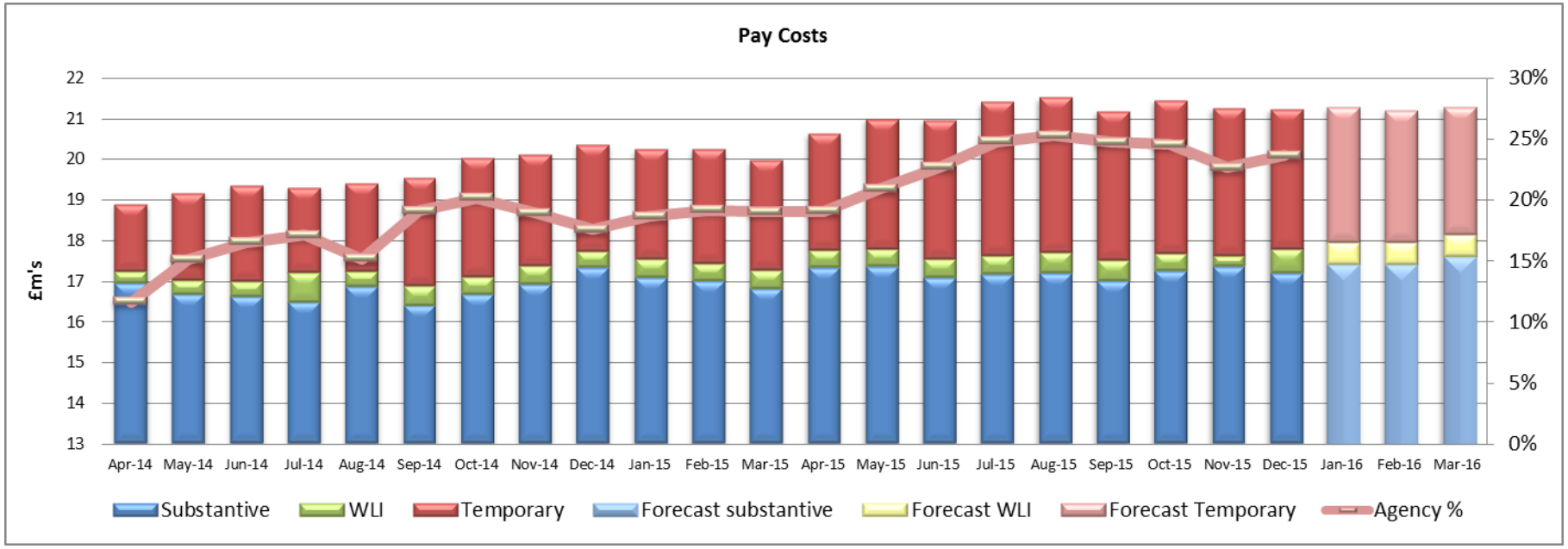
** EBITDA = earnings before interest, tax, depreciation and amortisation*

The impact of specialised commissioning's application of the marginal rate on non PBR Drugs and Devices is shown on the Non PBR Drugs & Devices line. YTD this equates to £0.7m above planned years.

The variance on donated assets and impairments of £3.4m is due to the planned impairment of Aconbury East, which hasn't taken place. There is an equal and opposite variance on non pay, which is offsetting over spends on this line.

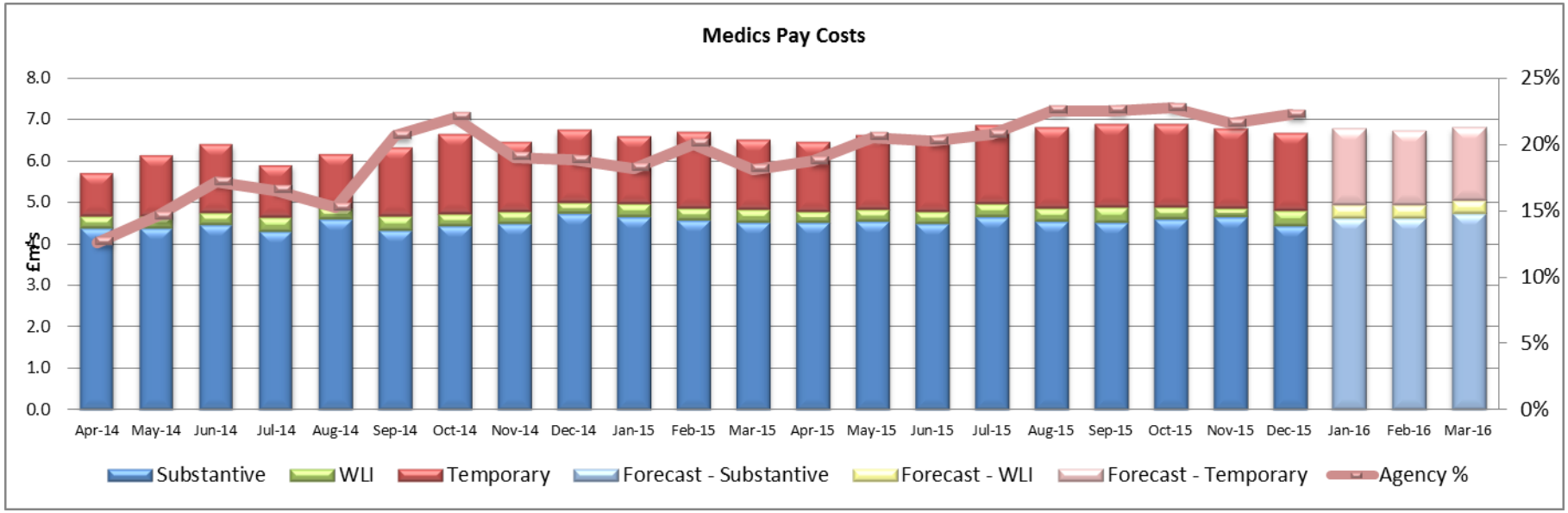
Pay

Worcestershire NHS
Acute Hospitals NHS Trust

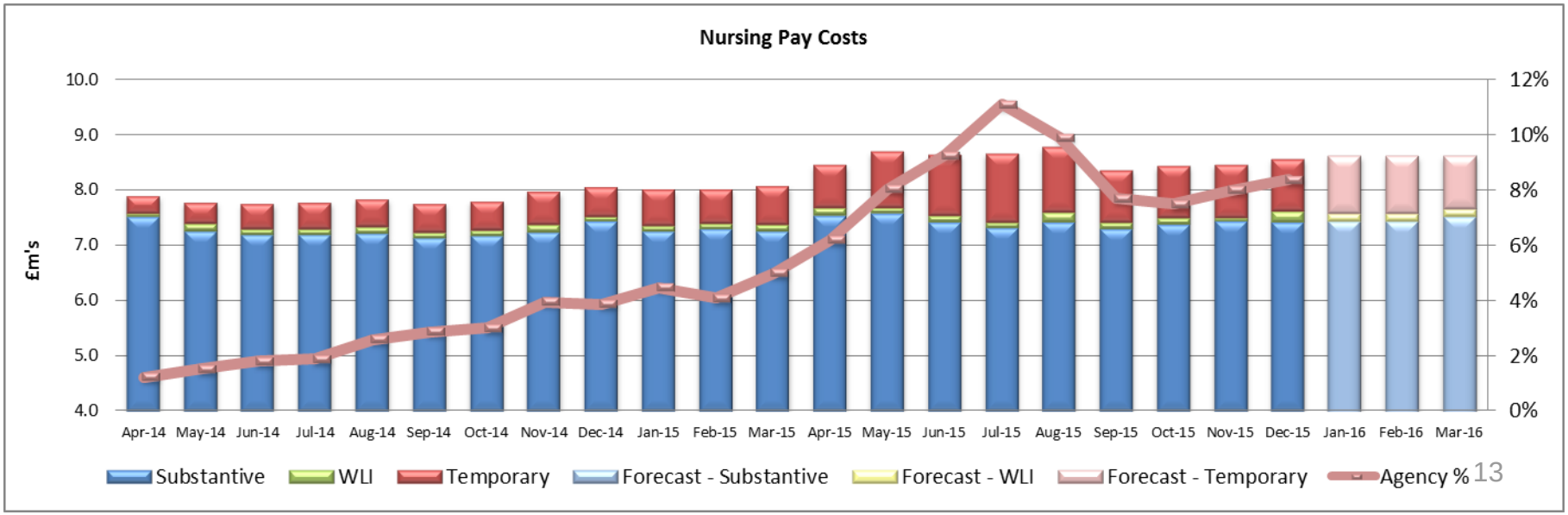


Medics Pay

Worcestershire NHS
Acute Hospitals NHS Trust

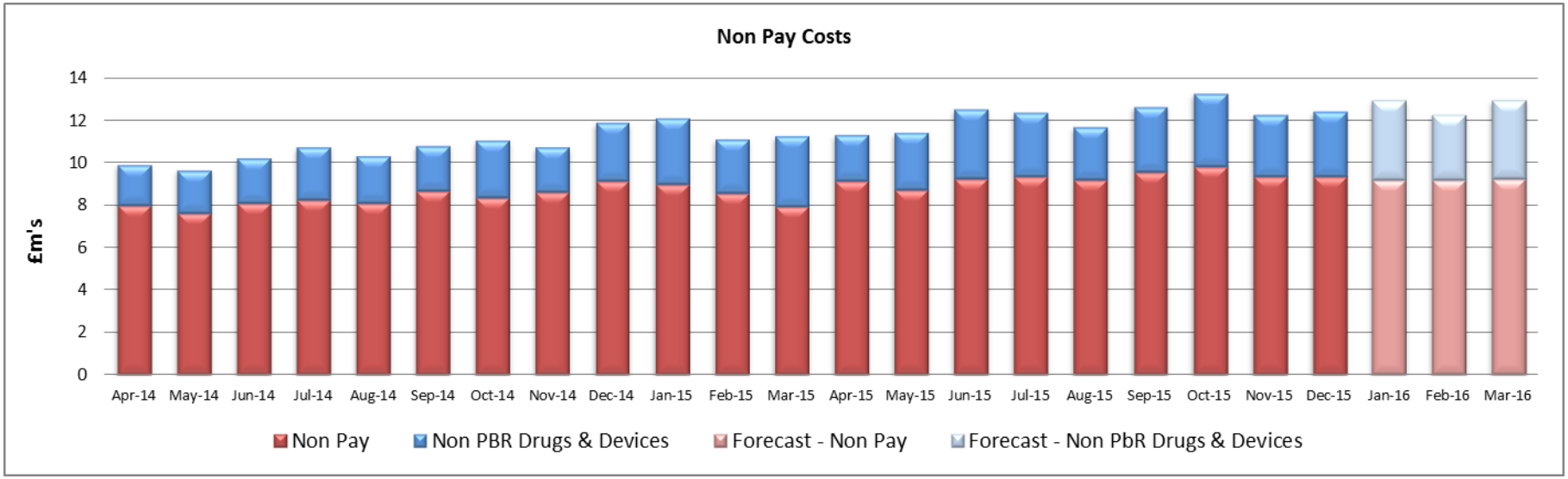


Note. Month 4 contained a YTD change from a net position to a gross position for Consultants sub-contracted to other Trusts.



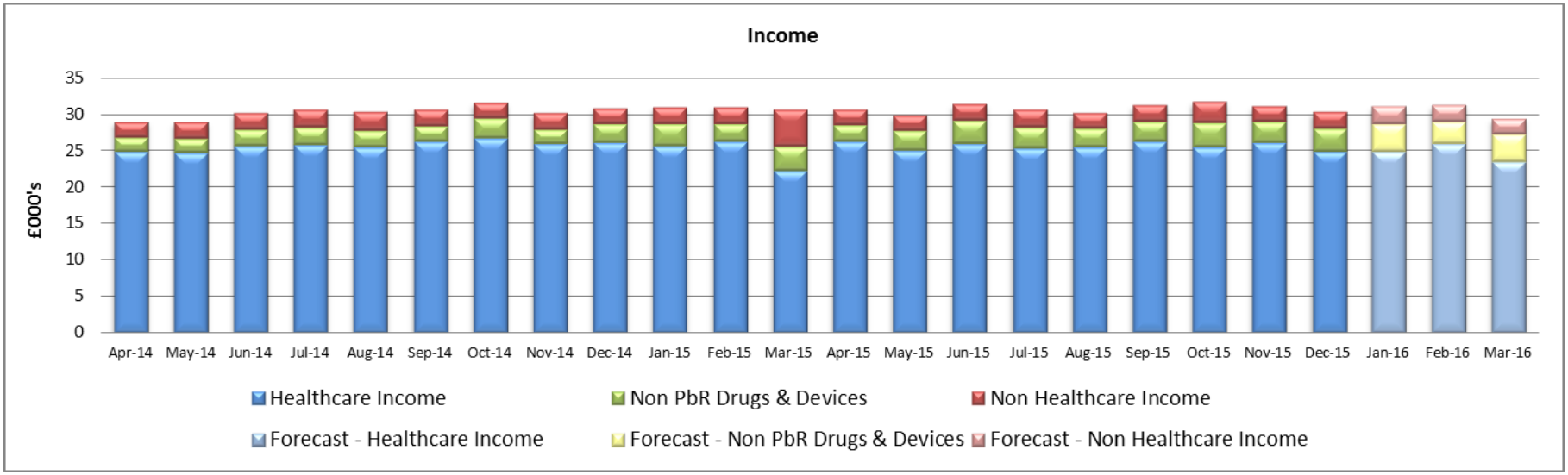
Non Pay

Worcestershire NHS
Acute Hospitals NHS Trust



Income

Worcestershire NHS
Acute Hospitals NHS Trust



Healthcare income was £0.6m under plan In December and is now £3.8m under plan YTD. The underlying position was worse. One off benefits were taken in the month with Specialised Services increasing the Standard Base Value and allowing new non PBR drugs for Hep C to be excluded. Without these one offs the underlying position would have been £1m under plan Activity performance in December was weak versus plan. Inpatient activity was 7% under in December and elective income alone was 18% under in December. Theatre utilisation was lower than expected and at its lowest position since July.

The Trust continues to receive a high volume of letters from commissioners around performance and contract queries.

Income

Worcestershire NHS
Acute Hospitals NHS Trust

	In Month				YTD				Full Year	
	Plan £'000	Actual £'000	Var £'000	% £'000	Plan £'000	Actual £'000	Var £'000	% £'000	Initial Plan £'000	Current Plan £'000
Elective	2,312	1,889	(423)	(18%)	21,792	19,830	(1,962)	(9%)	28,151	28,419
Daycase	2,770	2,633	(137)	(5%)	24,983	25,285	302	1%	34,119	33,907
Non Elective - Emerg	7,127	7,483	356	5%	63,029	64,408	1,380	2%	82,860	82,896
Non Elective - Emerg Threshold	0	37	37		0	(241)	(241)		0	0
Non Elective - Other	154	77	(78)	(50%)	1,337	1,162	(175)	(13%)	1,764	2,345
Total Inpatients	**12,364**	**12,119**	**(245)**	**(2%)**	**111,141**	**110,444**	**(697)**	**(1%)**	**146,895**	**147,567**
Outpatients New	1,586	1,446	(139)	(9%)	14,635	14,469	(166)	(1%)	19,849	19,921
Outpatients F Up	1,455	1,520	65	4%	13,565	14,179	614	5%	18,436	18,368
Outpatients Procedure	609	641	33	5%	5,617	6,271	655	12%	7,454	7,553
Total Outpatients	**3,649**	**3,608**	**(42)**	**(1%)**	**33,817**	**34,919**	**1,103**	**3%**	**45,739**	**45,843**
ED Attendances	1,244	1,288	44	4%	11,327	11,572	245	2%	15,254	15,071
Community MIU	146	156	10	7%	1,310	1,548	237	18%	1,747	1,747
Total ED/MIU	**1,390**	**1,444**	**54**	**4%**	**12,637**	**13,119**	**482**	**4%**	**17,001**	**16,818**
Maternity - Delivery	930	951	21	2%	8,703	9,175	471	5%	11,027	11,395
Maternity Ante Natal	735	704	(31)	(4%)	6,770	6,365	(405)	(6%)	8,879	8,954
Maternity Post Natal	130	136	7	5%	1,224	1,192	(32)	(3%)	1,578	1,603
Total Maternity	**1,795**	**1,791**	**(4)**	**(%)**	**16,699**	**16,734**	**35**	**%**	**21,483**	**21,951**
Paed - Daycase/Elective	16	9	(7)	(45%)	179	182	3	2%	245	245
Paed - Non Elective	650	595	(56)	(9%)	4,212	4,169	(44)	(1%)	5,738	4,898
Paed - Outpatient	195	186	(9)	(5%)	1,870	1,926	57	3%	2,571	2,559
Paed - H@H, Drugs, CQUIN	159	123	(36)	(23%)	1,326	1,296	(30)	(2%)	2,041	1,714
Paed - Neonatal Cot Days	287	351	64	22%	2,555	3,084	529	21%	3,357	3,417
Total Paediatrics	**1,308**	**1,265**	**(44)**	**(3%)**	**10,142**	**10,657**	**515**	**5%**	**13,951**	**12,832**
Chemotherapy Delivery	**298**	**318**	**20**	**7%**	**2,461**	**2,782**	**321**	**13%**	**3,287**	**3,354**
Drugs PBR Excluded	1,811	1,811	(0)	(%)	16,235	16,235	0	%	20,134	22,369
Critical Care ITU/HDU	862	797	(64)	(7%)	7,695	7,390	(306)	(4%)	9,439	10,280
Other Contract Income	4,518	4,580	62	1%	41,230	39,590	(1,640)	(4%)	50,600	54,378
Financial Sanctions	0	(269)	(269)		0	(2,841)	(2,841)		0	0
Risk Share	0	(8)	(8)		0	(264)	(264)		0	0
Total Other Contract Income	**7,192**	**6,913**	**(279)**	**(4%)**	**65,159**	**60,110**	**(5,050)**	**(8%)**	**80,173**	**87,028**
Non Contract Income	802	758	(45)	(6%)	7,188	6,677	(511)	(7%)	7,678	9,193
Income CIP	0	0	0		0	0	0		3,879	(0)
Phasing Adj	(145)	(145)	0	%	301	301	0	%	0	0
	28,653	**28,070**	**(583)**	**(2%)**	**259,545**	**255,743**	**(3,802)**	**(1%)**	**340,087**	**344,587**

- Cost & Volume marginal rates for under/over performance have been applied

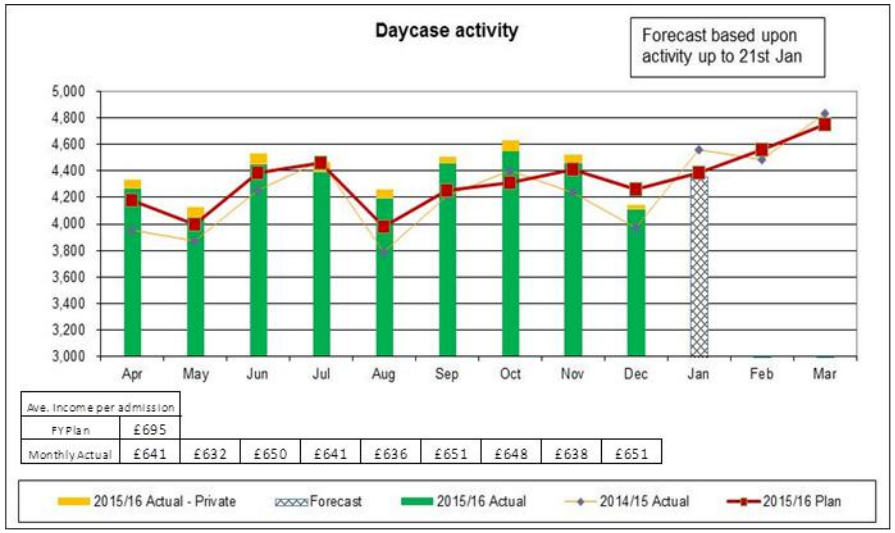
Activity

Worcestershire NHS
Acute Hospitals NHS Trust

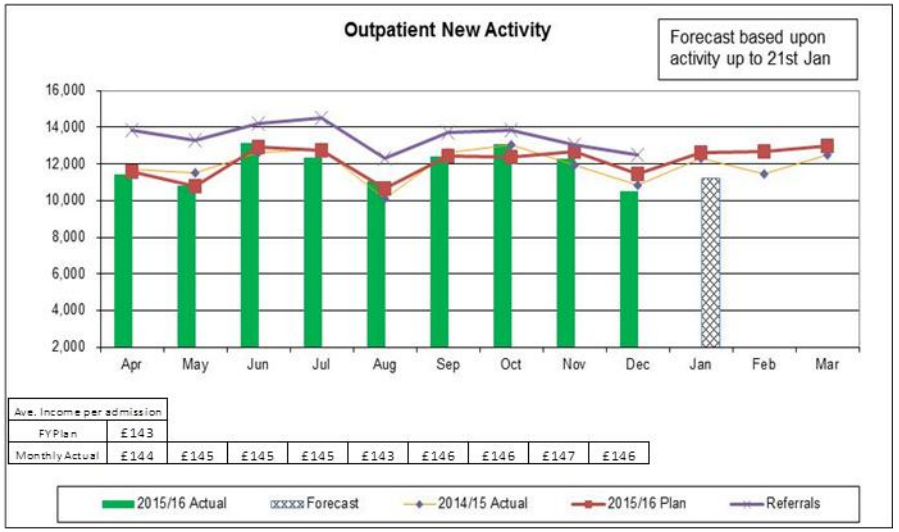
	In Month				YTD				Full Year	
	Plan	Actual	Var	%	Plan	Actual	Var	%	Initial Plan	Current Plan
Elective	870	670	(200)	(23%)	8,081	7,160	(921)	(11%)	10,465	10,543
Daycase	4,235	3,810	(425)	(10%)	37,987	39,295	1,308	3%	52,312	51,587
Non Elective - Emerg	3,566	3,677	111	3%	31,367	31,196	(171)	(1%)	41,623	41,206
Non Elective - Other	64	(5)	(69)	(108%)	563	416	(147)	(26%)	742	742
Total Inpatients	**8,735**	**8,152**	**(583)**	**(7%)**	**77,996**	**78,067**	**71**	**%**	**105,143**	**104,079**
Outpatients New	10,978	10,081	(897)	(8%)	102,800	101,860	(940)	(1%)	138,972	139,321
Outpatients F Up	18,376	19,355	979	5%	173,254	180,937	7,683	4%	234,822	233,672
Outpatients Procedure	3,603	3,667	64	2%	33,827	36,381	2,554	8%	45,422	45,368
Total Outpatients	**32,957**	**33,103**	**146**	**%**	**309,881**	**319,178**	**9,297**	**3%**	**419,216**	**418,361**
ED Attendances	11,838	12,006	168	1%	107,666	109,099	1,433	1%	145,414	143,371
Community MIU	2,510	2,688	178	7%	22,594	26,684	4,090	18%	30,125	30,125
Total ED/MIU	**14,349**	**14,694**	**345**	**2%**	**130,260**	**135,783**	**5,523**	**4%**	**175,539**	**173,496**
Maternity - Delivery	451	453	2	%	4,413	4,381	(32)	(1%)	5,720	5,720
Maternity - Non Delivery	254	216	(38)	(15%)	2,390	1,748	(642)	(27%)	3,119	3,119
Maternity - Outpatient	3,557	3,634	77	2%	32,118	32,864	746	2%	42,653	42,653
Maternity Ante Natal	519	504	(15)	(3%)	4,803	4,477	(326)	(7%)	6,344	6,344
Maternity Post Natal	449	494	45	10%	4,281	4,366	85	2%	5,591	5,591
Total Maternity	**5,230**	**5,301**	**71**	**1%**	**48,005**	**47,836**	**(169)**	**(%)**	**63,427**	**63,426**
Paed - Daycase/Elective	24	26	2	7%	263	281	18	7%	361	360
Paed - Non Elective	771	736	(35)	(5%)	4,785	5,389	604	13%	6,546	6,248
Paed - Outpatient	1,123	1,174	51	5%	10,671	11,788	1,117	10%	14,701	14,615
Paed - H@H, Drugs, CQUIN	0	0	0		0	0	0		0	0
Paed - Neonatal Cot Days	590	683	93	16%	5,236	6,146	910	17%	6,859	7,006
Total Paediatrics	**2,508**	**2,619**	**111**	**4%**	**20,955**	**23,604**	**2,649**	**13%**	**28,466**	**28,230**
Chemotherapy Delivery	**814**	**962**	**148**	**18%**	**6,596**	**8,342**	**1,746**	**26%**	**8,806**	**8,967**
Drugs PBR Excluded	0	0								
Critical Care ITU/HDU	805	747	(58)	(7%)	7,193	7,016	(177)	(2%)	8,923	9,606
Other Contract Income	0	0								
Total Other Contract Income	**805**	**747**	**(58)**	**(7%)**	**7,193**	**7,016**	**(177)**	**(2%)**	**8,923**	**9,606**
Non Contract Income										
Phasing Adj										

Elective, Day Cases & Outpatients New

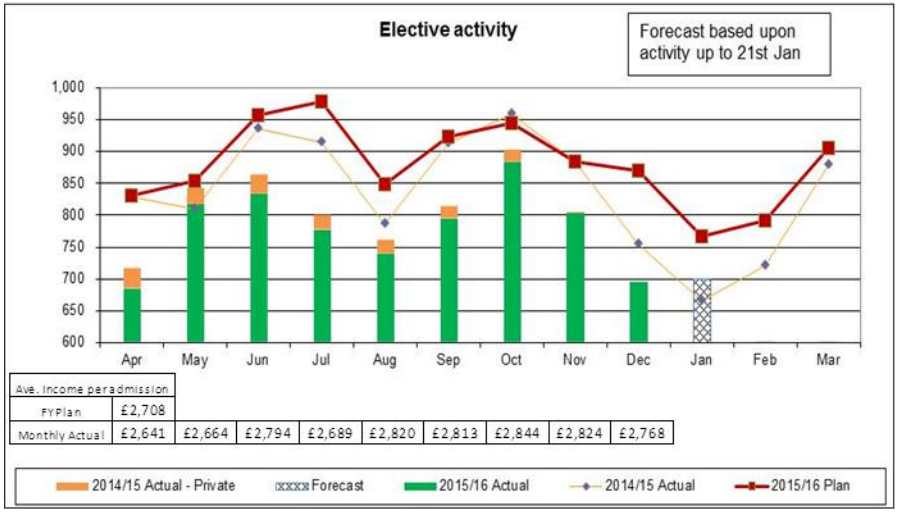
Worcestershire NHS
Acute Hospitals NHS Trust



Ave. Income per admission									
FY Plan	£695								
Monthly Actual	£641	£632	£650	£641	£636	£651	£648	£638	£651



Ave. Income per admission									
FY Plan	£143								
Monthly Actual	£144	£145	£145	£145	£143	£146	£146	£147	£146

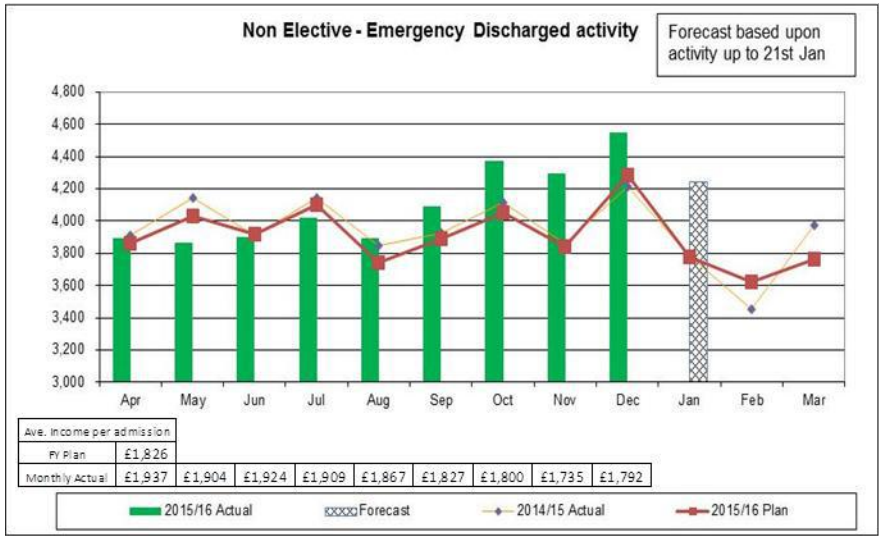


Ave. Income per admission									
FY Plan	£2,708								
Monthly Actual	£2,641	£2,664	£2,794	£2,689	£2,820	£2,813	£2,844	£2,824	£2,768

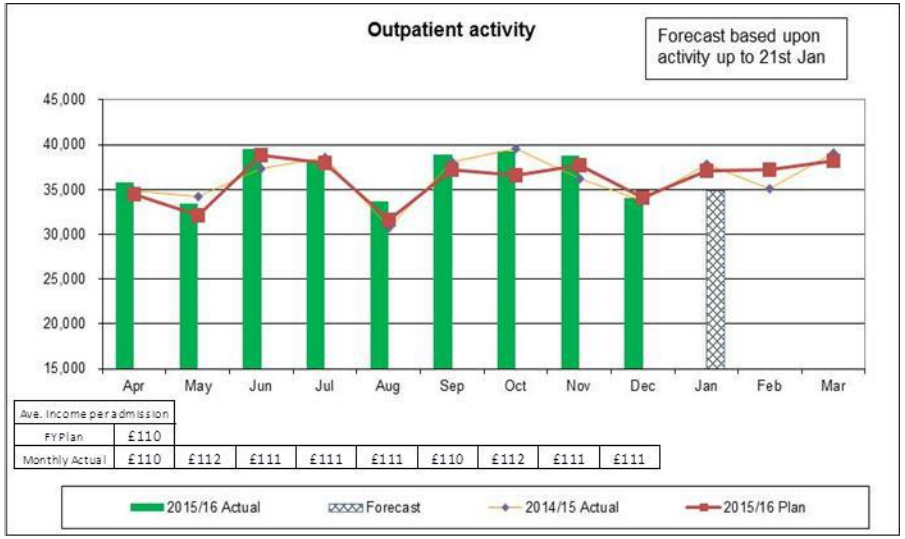
Activity performed within Trust and sent Private				
	Daycase		Elective IP	
	Trust	Private	Trust	Private
Apr	4,268	72	685	31
May	4,052	77	817	25
Jun	4,456	80	833	30
Jul	4,391	79	776	24
Aug	4,199	59	740	20
Sep	4,457	56	795	18
Oct	4,556	80	882	20
Nov	4,464	65	803	1
Dec	4,109	39	694	0
Jan	0	0	0	0
Feb	0	0	0	0
Mar	0	0	0	0
YTD	38952	607	7025	169

Outpatients, Non Elective and A&E

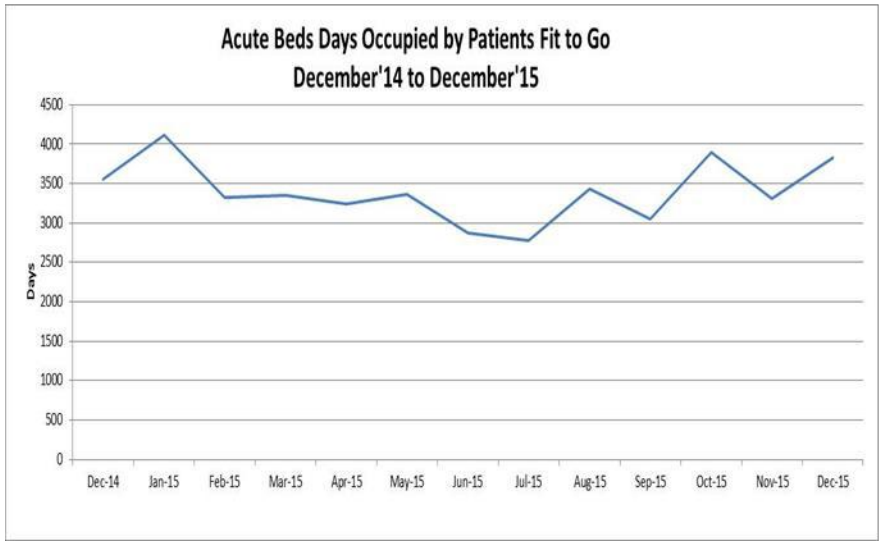
Worcestershire NHS
Acute Hospitals NHS Trust

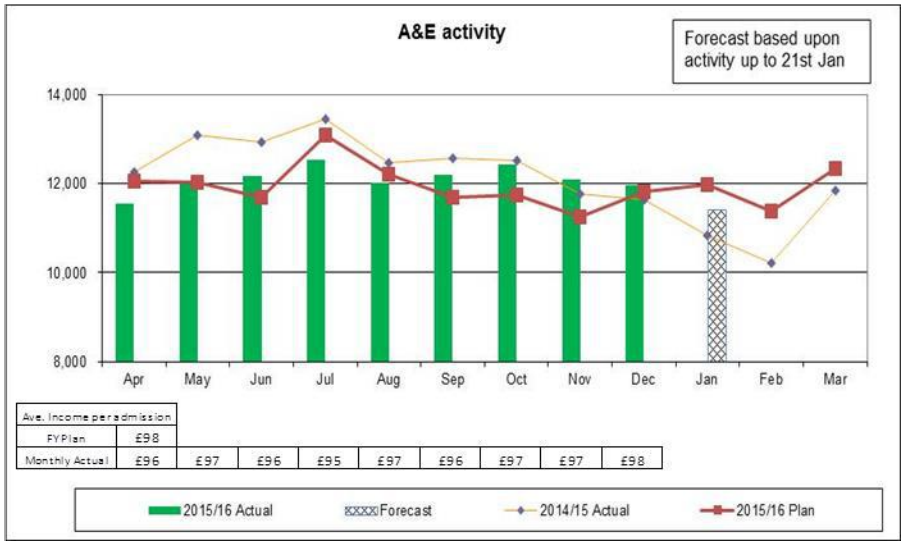


Ave. Income per admission									
FY Plan	£1,826								
Monthly Actual	£1,937	£1,904	£1,924	£1,909	£1,867	£1,827	£1,800	£1,735	£1,792



Ave. Income per admission									
FY Plan	£110								
Monthly Actual	£110	£112	£111	£111	£111	£110	£112	£111	£111

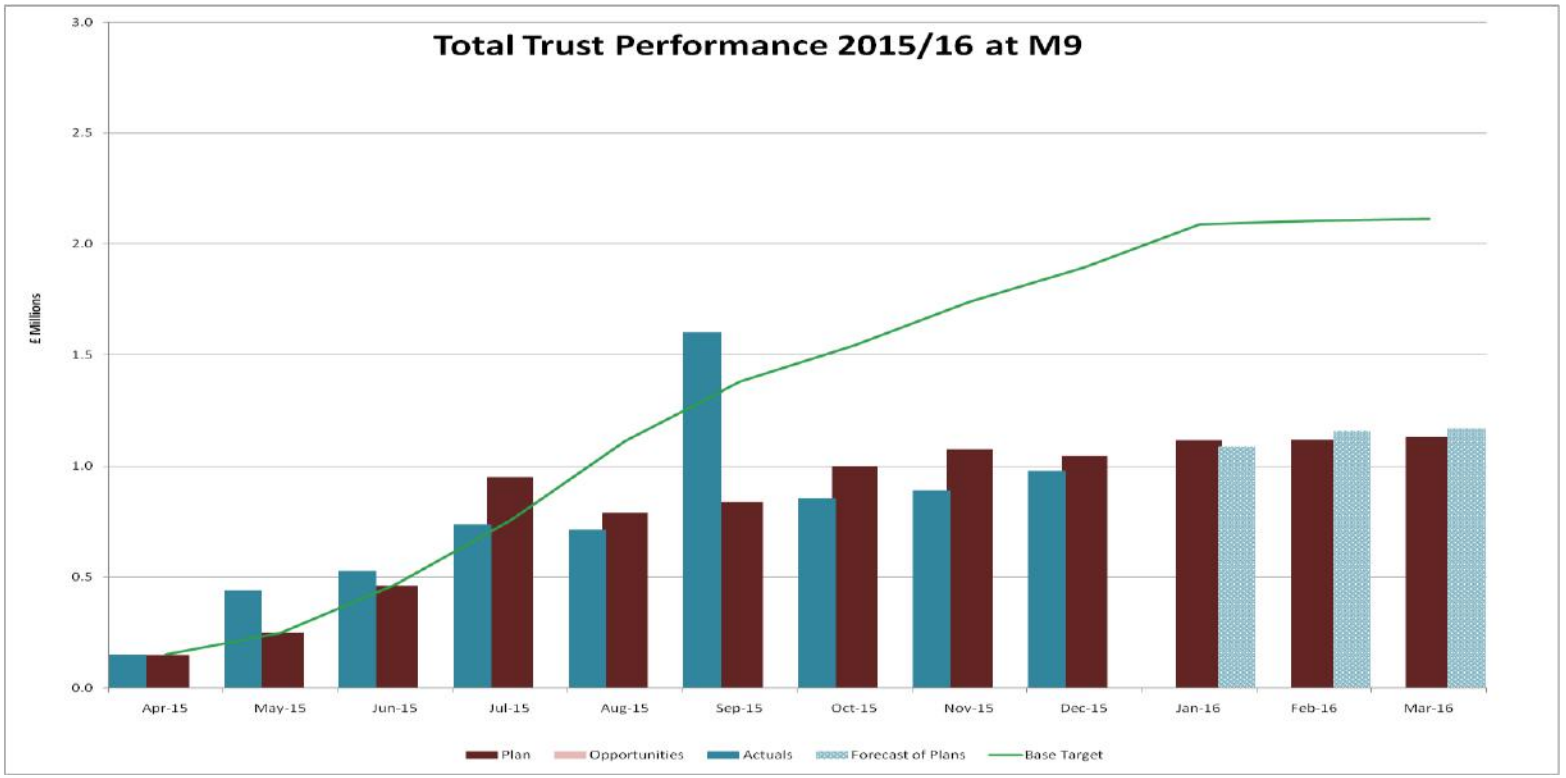


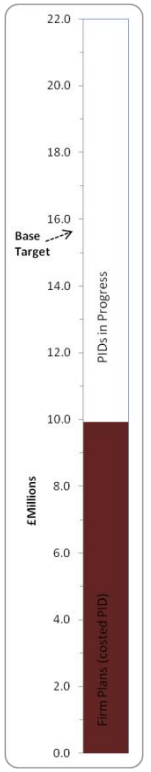


Ave. Income per admission									
FY Plan	£98								
Monthly Actual	£96	£97	£96	£95	£97	£96	£97	£97	£98

Internal QIPP

Worcestershire NHS
Acute Hospitals NHS Trust





Division	Base Target	In year Plan	YTD Plan (M9)	YTD Actual (M9)	Variance YTD Actual to Plan	Full Year Forecast	% Forecast v Base Target
Medicine	5,029	2,504	1,542	1,899	357	2,920	58%
Surgery	2,136	1,690	1,216	902	-314	1,481	69%
Women & Children	1,418	527	397	903	506	1,238	87%
TACO	2,183	1,665	1,179	1,009	-170	1,518	70%
Clinical Support	1,770	1,383	1,032	1,216	184	1,628	92%
Asset Mgmt & IT	1,641	1,763	1,231	817	-413	1,298	79%
Corporate	1,423	395	306	147	-159	229	16%
Trustwide	0	0	-344	0	344	0	0%
Total	**15,600**	**9,926**	**6,559**	**6,893**	**333**	**10,312**	**66%**

Balance Sheet

Worcestershire NHS
Acute Hospitals NHS Trust

				Full Year			
Balance at 30th November 2015	Balance at 31st December 2015	Movement in Month	Balance Sheet	Annual Plan	Forecast 31st March 2016	Variance from Plan	Balance at 31st March 2015
£000s	**£000s**	**£000s**	**ASSETS, NON CURRENT**	**£000s**	**£000s**	**£000s**	**£000s**
184,878	185,502	624	Property, Plant and Equipment and intangible assets, Net	296,943	270,406	(26,537)	182,933
84,523	84,363	(159)	Property, plant & equipment (PFI)	0	0	0	85,624
2,138	2,186	49	Other Assets, Non-Current	1,267	1,267	0	2,059
271,539	**272,052**	**513**	**Assets, Non-Current, Total**	**298,210**	**271,673**	**(26,537)**	**270,616**
			ASSETS, CURRENT				
6,525	7,760	1,235	Inventories	6,107	5,728	(379)	6,107
27,743	32,809	5,066	Debtors	21,831	24,609	2,778	29,174
3,512	2,281	(1,232)	Cash and Cash Equivalents	1,907	1,907	0	2,107
37,781	**42,849**	**5,069**	**Assets, Current, Total**	**29,845**	**32,244**	**2,399**	**37,388**
309,319	**314,902**	**5,582**	**ASSETS, TOTAL**	**328,055**	**303,917**	**(24,138)**	**308,004**
			LIABILITIES, CURRENT				
1,970	**1,970**	0	PFI leases, Current	1,936	1,936	0	1,970
91,798	**98,876**	7,078	Creditors < 1 Year	39,599	69,326	29,727	47,946
93,768	**100,846**	**7,078**	**Liabilities, Current, Total**	**41,535**	**71,262**	**29,727**	**49,916**
(55,987)	**(57,996)**	**(2,009)**	**Net Current Assets/(Liabilities)**	**(11,690)**	**(39,018)**	**(27,328)**	**(12,527)**
			LIABILITIES, NON CURRENT				
33,590	37,872	4,282	Creditors > 1 Year	44,061	34,485	(9,576)	36,168
72,678	72,513	(164)	PFI leases, Non-Current	72,055	70,273	(1,782)	73,991
0	0	0	Other Liabilities, Non-Current	0	0	0	0
106,267	**110,385**	**4,118**	**Liabilities, Non-Current, Total**	**116,116**	**104,758**	**(11,358)**	**110,159**
109,284	**103,671**	**(5,613)**	**TOTAL ASSETS EMPLOYED**	**170,404**	**127,897**	**(42,507)**	**147,930**
£000s	**£000s**		**FINANCED BY :- PUBLIC EQUITY**	**£000s**	**£000s**	**£000s**	**£000s**
183,996	183,996	0	Public Dividend Capital	224,992	224,992	0	183,996
60,539	60,539	0	Revaluation reserve	76,240	60,323	(15,917)	60,539
(861)	(861)	0	Other reserves	(861)	(861)	0	(861)
(97,082)	(102,696)	(5,613)	I&E Reserve - Breakeven Performance	(86,735)	(113,325)	(26,590)	(58,436)
(37,308)	(37,308)	0	I&E Reserve - IFRS Transition and non breakeven performance	(43,232)	(43,232)	0	(37,308)
109,284	**103,671**	**(5,613)**	**TOTAL PUBLIC EQUITY**	**170,404**	**127,897**	**(42,507)**	**147,930**

Worcestershire NHS
Acute Hospitals NHS Trust

Date of meeting: 3 February 2016 **Enc I1**

Report to Trust Board (in public)

Title	**Audit and Assurance Committee report**
Sponsoring Director	**Bryan McGinity** **Chair – Audit and Assurance Committee**
Author	**Kimara Sharpe** **Company Secretary**
Action Required	• Note the revised approach to risk management • Note the whistleblowing report into movement of staff • Note the internal audit reports of 'moderate assurance' for serious incidents and medical revalidation • Approve the midyear annual governance statement • Approve the Terms of Reference • Note the report
Previously considered by	N/A

Strategic Priorities (√)

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

Related Board Assurance Framework Entries	2666 Inability to secure sufficient income placing the financial position at further risk and affecting long term sustainability 2888 Deficit is worse than planned and threatens the Trust's long term financial sustainability 2667 If expenses are not sufficiently contained and reduced there will be a serious impact on financial position & cash availability
Legal Implications or Regulatory requirements	
Glossary	

Key Messages

This is the routine report from the Audit and Assurance Committee to the Trust Board and covers the meeting held on 20 January 2016.

Date of meeting: 3 February 2016 **Enc I1**

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

REPORT TO TRUST BOARD – 3 FEBRUARY 2016

1. Situation

The Audit and Assurance Committee met on 20 January 2016. This report details the business undertaken at that meeting.

2. Background

The Audit and Assurance Committee provides assurance on systems and processes in place at the Trust. It is a key assurance committee.

3. Assessment

3.1 **Complaints Audit**: The Committee were satisfied with the progress made against this action plan and have requested that the QGC continue to monitor its implementation as part of the PCIP.

3.2 **Risk Management**: The Interim CNO described the Trust's new approach to risk management. The Risk Executive Group has been disbanded with the Trust Management Committee taking a key role in the management of the Corporate Risk Register. The Committee has requested the attendance of the Risk Manager with the Interim CNO at its meeting in May 2016 to discuss ward based risk registers.

3.3 **Whistleblowing**: The final report in relation to a whistleblower was accepted by the Committee. The concern raised was the moving of staff from medical high care to the medical assessment unit. The staff member has been met and accepts the reasons for the movement. Communication has now improved within the division.

3.4 **External Audit**: The audit of the final accounts will commence in February with preliminary work. A verbal report was given on month 6 analysis of expenditure and improvements in the monitoring of variances against baselines and cost pressures has been agreed.

3.5 **Internal audit**: The Committee received the audit into serious incidents and the audit into medical revalidation. Both received moderate assurance. Progress was being made with the action plans for both audits.

3.6 **Local Security Management Specialist**: The regular report from the LSMS was received. The Committee expressed concern about the lack of adherence to the patients' property policy and requested additional communications to help embed the policy. The number of incidents involving patients' property has decreased since the new policy has been adopted.

3.7 **Midyear Annual Governance Statement**: This is appended for approval by the trust board (attachment 1). It is considered good practice to develop a mid year statement but it is not mandatory.

3.8 **Contract Management board – update**: The Committee received assurance that the CMB was working more effectively. Attendance had improved and the timeliness of actions was better. There was continued lack of transparency of reporting by CCGs on their QIPP plans and on the use of the fines money. The latter should be on their website, but is not.

3.9 **PWC governance report**: The PWC governance report action plan was presented. There were a number of amber actions which should turn green in the next few weeks. It was agreed that the Workforce Assurance Group should report their action through to Trust board and the Committee would receive a further update in May.

3.10 **Terms of Reference**: The terms of reference were amended slightly and are presented for approval (attachment 2).

4 Recommendation

The Board is recommended to:

- Note the revised approach to risk management
- Note the whistleblowing report into movement of staff
- Note the internal audit reports of 'moderate assurance' for serious incidents and medical revalidation
- Approve the midyear annual governance statement
- Approve the Terms of Reference
- Note the report

Bryan McGinity
Chair – Audit and Assurance

Mid Year Annual Governance Statement 2015-16

1 Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the *Accountable Officer Memorandum* which includes responsibility for maintaining a sound system for internal control that supports the achievement of the Trust's policies, aims and objectives, whilst safeguarding quality standards and public funds.

I have a duty of partnership to discharge, and therefore work collaboratively with other partner organisations. The Trust is working collaboratively wherever possible with the appropriate Local Authorities, voluntary sector and local education establishments as well as NHS Commissioners (CCGs and NHS England) and other NHS providers of services. The Trust has a range of formal and informal mechanisms in place to facilitate effective working with key partners in the Worcestershire Health Economy. Due to the operational and financial challenges currently faced, these have been operationally focussed through the System Resilience Group, the Contract Management Board and the Quality and Service Sustainability sub group of the Future of Acute Hospital Services in Worcestershire Programme Board. The Future of Acute Hospital Services in Worcestershire Programme Board has been the main strategic focus and latterly significant progress has been made. In Q4 2015/16 the Trust will work in partnership with the other partners in Worcestershire Health and Care system to develop the five year Sustainability and Transformation Plan by July 2016. The Trust is monitored and assessed by a wide range of external agencies that contribute to the on-going development of the Assurance Framework. These have included the three local Clinical Commissioning Groups, West Midlands Quality Review Service, Cancer Peer Review, Royal Colleges, NHS Trust Development Authority (NTDA), NHS England, the Care Quality Commission, the Audit Commission, the National Health Service Litigation Authority and the Health and Safety Executive. This is not an exhaustive list of organisations that monitor and assess the Trust.

Close links continue with partners including NHS England and the NTDA through the Future of Acute Hospital Services in Worcestershire programme. The Chief Executive has regular contact with the NTDA and NHS England through a range of group, individual, informal and formal meetings. Efficient relationships are also in place with the three Worcestershire clinical commissioning groups, NHS South Worcestershire, NHS Redditch and Bromsgrove and NHS Wyre Forest. All Executive Directors are fully engaged in the relevant networks, including nursing, medical, finance, operations and human resources.

In July 2015, the Trust underwent a planned Chief Inspector of Hospitals visit. This resulted in a rating of 'inadequate' and the Trust was placed in special measures in November 2015. One domain rated 'inadequate' was 'well led' due to the interim nature of the executive directors. The Report stated that the '*executive team demonstrated a level of understanding and commitment to address the issues the trust was facing. However [the Chief Inspector] found the lack of stability at board level to be of significant concern when considering issues that required addressing'*. The domain 'safety' was also rated as 'inadequate'. This was due to the lack of a systematic approach to the reporting, management and analysis of incidents. Concerns were also raised in respect of the reliance on temporary staff (medical and nursing) and on the overcrowding at both emergency departments, although it was acknowledged that care had improved since the unannounced inspection in March 2015.

The Trust has worked with the CQC since the visit and has made a number of improvements, particularly to the clinical governance arrangements.

As at 30 November 2015, the Trust had a projected deficit of £61.3m at year end. Proportionately to turnover, this is the highest in the country.

2 The purpose of the system of internal control

The system of internal control is designed to manage risk to an acceptable level rather than to eliminate all risks; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an on-going process designed to:

- identify and prioritise the risks to the achievement of the organisation's aims and objectives,
- evaluate the likelihood of those risks being realised and the consequence should they be realised, and to manage them efficiently, effectively and economically.

The system of internal control has been in place in Worcestershire Acute Hospitals NHS Trust for the midyear ended 30 November 2015.

3 Capacity to handle risk

Within the organisation, the Trust has a functioning Safe Patient Group and a Health & Safety Committee which report to the Trust Board via the Quality Governance Committee. The Risk Executive Group guides the development of risk management and monitors its effectiveness as we enhance our approach to risk management. The Trust is acting on feedback from the recent Care Quality Commission Chief Inspector of Hospitals report which criticised the internal clinical governance arrangements. From January 2016, there will be a weekly governance meeting at which all risks will be discussed and monitored. This will incorporate the Safe Patient Group and the Risk Executive Group and will feed directly into the Quality Governance Committee and then to the Trust board. This will strengthen 'ward to board' reporting. This approach will be monitored closely to determine its effectiveness.

The Executive lead for Risk Management is the Chief Nursing Officer. The Chief Nursing Officer is also the appointed Executive Lead on Clinical Governance including audit and effectiveness. The Chief Medical Officer has a remit to provide executive responsibility for patient safety and medical revalidation. The Director of Finance leads on information governance, financial risk and anti-fraud and the Company Secretary on corporate governance.

The Risk Management Strategy is an integral part of the Trust's approach to continuous quality improvement and is intended to support and assist the organisation in delivering its key objectives as well as meeting the requirements contained within the NHS Constitution. Risk management is embedded within the divisions with all reviewing their local risk register on a monthly basis. The red risks are escalated to the Quality Governance Committee. The corporate risk register will be presented to the board quarterly in the final quarter of 2015/16. Previously it had been presented six monthly.

The Chief Inspector of Hospitals recognised that the Women and Children had a significant number of open incidents. Since that time, a concerted effort has been made across the Trust and the number of open incidents has been reduced considerably.

During the year the Trust Board reviewed the key red Board Assurance Framework risks (BAF) at every meeting. Once a quarter, all the BAF risks were reviewed. The BAF is first on the agenda at the

Trust board. All Board Committees review the BAF risks allocated to them and the Audit and Assurance Committee review the process quarterly. The Audit and Assurance Committee also has a role in monitoring the effectiveness of the risk management strategy.

The governance structure for the Trust was reviewed in 2015/16 in response to the Care Quality Commission Chief Inspector of Hospitals report. The revised structure was implemented in September 2015. A further review is currently underway. The Trust's Divisional structure was implemented in November 2013. In 2015, two divisions merged (Theatres, Ambulatory Care and Outpatients together with Clinical Support). Each Division has a senior leadership team consisting of a Medical Director, Nursing Director (Nursing and Midwifery for one division) and a Director of Operations. This clinical leadership support is invaluable to me as the Accountable Officer and has enabled risks to be managed nearer the front line. The Divisions report monthly to the Quality Governance Committee on their areas of concern and quarterly report in depth to the same committee. This again strengthens the 'ward to board' reporting.

The Board recognises that the Chief Inspector of Hospitals report has provided the Trust with areas for improvement. The Trust has developed a Patient Care Improvement Plan which covers the following areas:

- Quality and Governance
- Mortality
- Infection Control
- Chief inspector visit
- Out patients

The Board reviews the PCIP monthly. Each Committee reviews part of the PCIP which is pertinent to their area of work. The PCIP has provided the Trust with a focus on the areas requiring action. The PCIP is published on NHS Choices and is on the Trust's website.

I should like to emphasise the importance of the Quality Governance Committee (QGC) and its subcommittees. The Trust places great emphasis on the delivery of high quality services and three of the subcommittees are tasked to assure the Committee in this area:

- The Safe Patient Group looks specifically at mortality, incidents and serious incidents. It also considers reports from a range of sub groups such as medicines management.
- The Clinical Effectiveness Committee reviews the compliance with national standards and external regulation and oversees the local and national audit programmes.
- The Patient and Carer Experience Committee looks at information relating to all aspects of patient/user experience.

Other subcommittees accountable to the QGC are the

- Trust Infection, Prevention and Control Committee
- Safeguarding Committee
- Research and Development
- Information Governance (incorporating Data Quality)
- Cancer Board
- Health and Safety

From January 2016, a weekly Governance meeting will be put in place which will review serious incidents, risks and incorporate the Safe Patient Group and Risk Executive Group agendas. This is to avoid duplicate reporting for divisions and to ensure a better grip on risks and incidents. The Trust has made some progress with routine mortality reviews but recognises that this is an area that could be improved. The Interim Chief Medical Officer is working closely with the consultants to ensure a

consistent and robust process is in place. During the year, the Trust has received one Regulation 28 letter from the Coroner which concerned the lack of formal out of hours arrangements for vascular surgery or interventional radiology in the case of critically ill patients who need to be transferred to the Trust from elsewhere. The Trust has tasked the Division to review this area of work and a business case is in development. The Division is also considering how best to maximise the resources available to it for this are of work.

The Trust Board has held one seminar on risk sharing during the year.

Staff continue to be made aware of their risk management responsibilities as part of the induction process, and existing staff are required to attend a mandatory annual update in respect of risk management. Training needs of staff in relation to risk management are assessed through a formal training needs analysis process, staff receiving training appropriate to their authority and duties. The role of individual staff in managing risk is also supported by a framework of policies and procedures which promote learning from experience and sharing of good practice.

Specific training targeted at executive directors, non-executive directors and managers has been undertaken. Consequently risk management training is being closely monitored, evaluated, improved upon and further developed. The Chief Inspector of Hospitals commented on the lack of achievement of the Trust's target of 95% of all staff undertaking mandatory training. This is now being focussed upon by Divisions. The Workforce Assurance Group oversees this.

The Trust continues to learn lessons in a variety of ways, including from the following sources:

- Patients' Advice and Liaison Service (PALS)
- Complaints and compliments
- Friends and family test
- Litigation Claims
- Clinical Audit and Clinical Outcome Reviews
- Clinical Incident Reports, reviews and analysis including serious incidents and never events
- Morbidity and Mortality data (HSMR/SHMI)
- External Reports (for example the National Confidential Enquiry into Peri-operative Death, reports from the Royal Colleges)
- Patient and Staff surveys
- Internal quality inspections
- Quality performance metrics
- Board Executive and Non-Executive Director walk rounds
- External reviews by the CQC, Royal Colleges, NTDA rapid response and Clinical Commissioning Groups.

This is not an exhaustive list of organisations that provide us with report from which we can learn lessons. The Trust is mindful that the learning lessons process could be improved and are holding a seminar in January 2016 to progress this. Learning lessons is programmed into the weekly governance meetings commencing in January 2016.

Serious incidents and never events as well as complaints are thoroughly investigated and improvements made at local and corporate levels to reduce the likelihood or reoccurrence. The Trust recognises that response times for investigation could be better and have reviewed the way in which investigations are undertaken. An independent review into the governance arrangements within the Women and Children's division has given the Trust areas in which it can improve. Additionally the internal audit report into Complaints which gave limited assurance has ensured that

there is a renewed focus on this area with actions being incorporated into the PCIP for Quality and Governance.

The Trust has a Corporate Risk Register in place which outlines the key corporate risks for the organisation and action identified to mitigate these risks. This register has been formed from the risks identified within clinical divisions and corporate services, trust committees and through other risk identification activities.

The Corporate Risk Register risks are as follows (new risks added in 2015-16 in italics):

1941 *Lack of available bed capacity may cause overcrowding in ED which can lead to suboptimal care & a poor patient experience*

2372 Failure to address the causes of falls resulting in patient harm and financial penalties

2396 Poor quality clinical record keeping may lead to a variety of harms to patients and organisation

2461 Problems with the functionality, reliability and timeliness of eZnotes system, negatively impacting patient care

2462 *Failure to prevent MRSA bacteraemia due to lapse in care resulting in adverse patient outcomes and reputational damage*

2463 Failure to reduce number of preventable cases of C.difficile due to lapses in care, resulting in adverse patient outcomes

2464 Norovirus outbreaks resulting in adverse patient outcome and impact on patient flow

2565 Delay or failure to act upon clinical diagnostic test results leading to patient harm

2649 Workforce shortages affecting the consultant on-call rota for emergency surgery at AGH

2661 *Increased pressure in emergency demand may impact on the safety of patient care & failure to meet performance standards*

2662 *Increasing emergency demand, reducing elective capacity resulting in failure to deliver 18 week RTT*

2663 *If emergency demand continues to increase it will result in insufficient elective capacity to deliver the cancer targets.*

2664 *Insufficient out of hospital capacity to meet the needs of patients with on-going healthcare needs*

2709 *Risk to critically ill patients having delayed admission to ITU due to lack of bed spaces (spaces occupied by wardable patients)*

2711 Risk to quality and safety of patient care due to difficulties in recruiting to nursing vacancies.

2732 *If the Trust does not adequately prepare for emergencies, there may be an uncoordinated response and subsequent adverse events*

2736 Lack of Section 13 approved doctors to act as Responsible Clinician prevents legal detentions under Mental Health Act

2746 If W&C Division are unable to sustain safe staffing levels it will be unable to provide safe patient care at all sites

2747 Failure to prepare for serious new or emerging pathogens (eg Ebola, MERS) leading to exposure of public, patients and staff.

2774 Failure to provide resilient IT infrastructure resulting in system unavailability which negativity impacts patient care

2791 If the Medicine Division is unable to sustain appropriate staffing levels it will be unable to provide safe patient care

2857 *Failure to manage water system resulting in transmission of harmful pathogens to patients or staff*

2864 *Failure to follow pressure ulcer prevention procedures (risk assessments, position changes, correct equipment) resulting in harm*

2908 Use and release of information which is inaccurate, false or misleading resulting in reputational and legal damage
2957 Breaching hygiene code due to inadequate or ineffective assurance around environmental cleaning
2994 Failure to meet the NHS England Serious Incident Framework resulting in failure to learn and potential regulatory action
2995 If Patient Safety Incidents are not managed in a timely way there will be missed learning and preventable harm
3018 As a result of the care models on the Wyre Forest GP unit, medicines are not managed safely
3019 As a result of the care models on Ward 1, medicines are not managed safely resulting in sub-optimal care
3041 If the Trust does not increase efforts to save money, it may not realise the CIP target, worsening the financial position
3044 If the Trust does not manage CCG QIPPs the financial plan will not be realised
3078 Due to a lack of rehab community beds the Trust is unable to discharge stroke patients in a timely manner
3079 Inability to substantiate medical workforce resulting in excess workforce costs and impacts on clinical care
3097 If managers do not adhere to financial controls, there will be excess expenditure and financial recovery plan not met

In October 2015, the Board considered and accepted all the recommendations contained within a governance review commissioned in response to the Trust missing its financial target in 2014/15. It was jointly commissioned by the Trust and the TDA. The report had a number of significant findings and recommendations that follow the findings. The fundamental issue was the need to improve the financial governance of the Trust in its broadest sense. The main learning points from the report are:

- A need to develop a workforce strategy as this impacts on the credibility of the financial plans;
- Transparency of reporting financial matters (including contractual issues), mitigation options and implications for the Trust must improve;
- Financial processes and rules must be adhered to and enforced, this includes transparent in-year allocation of resources as well as robust management of financial recovery plan.
- If challenge, context and actions agreed in Board and Committee meetings are not reflected in the minutes they didn't happen for governance purposes.
- Where the Trust faces particular challenges the Audit & Assurance Committee should review the internal audit plan to ensure assurances are received on a timely basis.

The Audit and Assurance Committee is overseeing the actions associated with the report.

4 Governance

The voting members of Trust Board during 2015/16 were as follows:
Harry Turner, Chairman
John Burbeck, Non-Executive Director, deputy-chair
Stephen Howarth, Non-Executive Director
Bryan McGinity, Non-Executive Director, Senior Independent Director
Andrew Sleigh, Non-Executive Director
Lynne Todd, Non-Executive Director
Chris Tidman, Acting Chief Executive (from April 2015)
Rob Cooper, Interim Director of Finance (from November 2015)
Mari Gay, Interim Chief Nursing Officer (from September 2015)

Rab McEwan, Interim Chief Operating Officer (from June 2015)
Andy Phillips Interim Chief Medical Officer (from May 2015)

Chris Tidman, Director of Resources and Deputy Chief Executive (until May 2015)
Penny Venables, Chief Executive (until Jan 2016)
Mark Wake, Chief Medical Officer *
Stewart Messer, Chief Operating Officer *
Lindsey Webb, Chief Nursing Officer (until August 2015)
Cathy Garlick, Acting Chief Operating Officer (May 2015)
Colin Gentile, Interim Director of Finance (June 2015 – November 2015)
Haq Khan, Interim Director of Finance (April/May 2015)

* Duties are being undertaken by the interims.

Non-voting members of Trust Board
Professor Julian Bion, Associate Non-Executive Director
Denise Harnin, Director of Human Resources and Organisational Development
Marie-Noelle Orzel, Improvement Director (from May 2015)
Kimara Sharpe, Company Secretary
Sarah Smith, Director of Planning and Development
Lisa Thomson, Director of Communications (from October 2015)

At all meetings there were more non-executive voting members present then executive director members.

Board attendance

	Attended
Harry Turner	7/8
Julian Bion	3/8
John Burbeck	8/8
Rob Cooper	1/1
Mari Gay	3/3
Denise Harnin	7/8
Stephen Howarth	6/8
Rab McEwan	6/6
Bryan McGinity	8/8
Andy Phillips	8/8
Marie-Noelle Orzel	6/8
Andrew Sleigh	8/8
Colin Gentile	6/6
Cathy Garlick	1/1
Haq Khan	2/2
Penny Venables	0/4
Stewart Messer	0/0
Mark Wake	0/0

4.1 Committees as at 30 November 2015
During 2015/16, the Trust Board had the following committees:

- Audit and Assurance
- Charitable Funds

- Finance and Performance
- Quality Governance
- Remuneration and Terms of Service
- Turnaround (disestablished in November 2015)

All terms of reference for the committees have been revised during the year and approved by the Trust Board.

Each Committee reports to the Trust Board following a meeting. These reports highlight the activities of the Committee and draw the Board's attention to areas of concern. The highlights of the Quality Governance and Audit and Assurance Committee reports to the Trust Board are follows (this is not an exhaustive list):

Quality Governance	Audit and Assurance
• Mortality rates and reviews • Fractured neck of femur – time to theatre • Research and Development strategy development • Ward to board reporting • Women and Children quality metrics • Serious Incidents • GMC survey • Complaints • End of life care	• Review of effectiveness of Trust Management Committee/Quality Governance/Finance and Performance/Risk Executive Group • Board Assurance Framework • Data quality • Contract Management Board performance • Local Security Management Specialist • Whistleblowing reports

The purpose together with the attendance for each committee is shown below:

Audit and Assurance Committee
Purpose: The Audit and Assurance Committee has been established to critically review the governance and assurance processes upon which the Trust Board places reliance, ensuring that the organisation operates effectively and meets its strategic objectives. The Audit and Assurance committee works closely with the external and internal auditors. It also receives regular reports from the Local Counter Fraud Specialist and Local Security Management Specialist. The Trust currently complies fully with the National Strategy to combat and reduce NHS fraud.

Chairman	Stephen Howarth	5/5
Non-Executive Director	Lynne Todd	3/5
Non-Executive Director	Andrew Sleigh	5/5

Charitable Funds Committee
Purpose: The Charitable Funds Committee has been established to manage the Trust's Charitable Funds on behalf of the Trust, as Corporate Trustee.

Chairman	Lynne Todd	1/1
Non-Executive Director	Andrew Sleigh	1/1
Non-Executive Director	Bryan McGinity	1/1
Interim Director of Finance	Haq Khan	1/1
CNO/CMO or deputy	Lindsey Webb/Andy Phillips	0/1

Finance and Performance Committee

Purpose: The purpose of the Finance and Performance Committee (F&P) is to give the Board assurance on the management of the financial and corporate performance of the Trust and to monitor and support the financial planning and budget setting process. The Committee also reviews business cases with a significant financial impact or those referred by the Trust Management Committee and oversee developments in financial systems and reporting, e.g. SLR/PLICS.

Chairman	Bryan McGinity	8/8
Non-Executive Director	Andrew Sleigh	8/8
Non-Executive Director	Stephen Howarth	6/8
Chief Executive	Penny Venables/Chris Tidman	6/8
Director of Finance	Chris Tidman/Colin Gentile/Rob Cooper/Haq Khan	7/8
Chief Operating Officer	Stewart Messer/Rab McEwan	5/8
Chief Nursing Officer	Lindsey Webb/Mari Gay	5/8

Quality Governance Committee

Purpose: The Quality Governance Committee is constituted as a standing committee of the Board to:

- Enable the Board to obtain assurance that the quality of care within the Trust is of the highest possible standard.
- Ensure that there are appropriate clinical governance systems and processes and controls are in place throughout the Trust in order to:
    - Promote safety and excellence in patient care
    - Identify, prioritise and manage risk arising from clinical care
    - Ensure the effective and efficient use of resources though evidence based clinical practice

This Committee assures the board in relation to quality and as such has overseen the production of the Quality Account for 2014/15. The Committee will oversee the production of the 2015/16 Quality Account. The contents of the Quality Account were discussed and agreed at the Committee and subsequently reported to the Board. The Committee also oversees clinical audit activities within the Trust through the subcommittee Clinical Effectiveness Committee (CEC) which receives assurance in relation to clinical audit activity. Clinical audit is part of our quality improvement framework that provides assurance that the Trust is measuring patient care against best practice standards and continuously improving where necessary. Compliance with NICE guidance is also monitored together with corporate and local risks such as Never Event. Clinical Audit is an important feature of our induction and training programme for clinical governance

The Safe Patient Group oversees the management of never events and serious incidents (SIs) and reports to the QGC every month. In the year to 30 November 2015, there have been two never events.

- Overdose of insulin due to abbreviations or incorrect device
- Wrong implant/ prosthesis

The investigations for each incident are in progress at the time of writing and will be presented to the QGC which reported the event to the Trust Board.

In the same time period, the Trust reported 85 serious incidents (SIs) (including 4 information security and one assault on a member of staff) and had 3 SIs open past their expected closure date of 60 working days. The NHS England SI Framework advises doing fewer SI investigation, better and the impact of this a slow reduction of Sis declared is expected. The weekly SI Review Group is attended by the Divisional Directors and chaired by the Chief Medical Officer or Chief Nursing Officer

and reviews potentially serious incidents, SI investigation reports and actions arising from them. The management of SIs and learning from them is reported to the safe patient group and then to the QGC.

Learning from incidents is shared in a number of ways including 'lessons of the month', weekly 'learning from serious incidents', direct emails to the member of staff reporting an incident when it is closed and continuing work in areas such as patient falls, pressure ulcers and medication incidents. Learning in the year to date includes:

- Prescribing and administering Penicillin to allergic patients – action taken has reduced the instances from one per week to one per month.
- Identifying patients whose condition is deteriorating in hospital and escalating their care to senior staff
- Clarity when requesting radiology investigations and identifying patients correctly

The Committee has overseen the Trust's approach to reviewing mortality and has approved the process for routine mortality reviews throughout the organisation. Due to the slow progress of the mortality review process, the Committee has requested the attendance of key medical and surgical consultants for them to explain their approach to the process and the actions being taken to improve the review rate.

Chairman	Professor Julian Bion*	6/8
Non-executive director	John Burbeck	8/8
Non-executive director	Lynne Todd	7/8
Interim Chief Medical Officer	Andy Phillips	5/7
Chief Executive	Chris Tidman	7/8
Interim Chief Operating Officer	Rab McEwan	4/7
Interim Chief Nurse	Mari Gay	3/3
Associate Medical Director	Steve Graystone	3/8
Associate Medical Director	Rabia Imtiaz	6/8
Company Secretary	Kimara Sharpe	8/8
Chief Executive	Penny Venables	0/4
Chief Operating Officer	Stewart Messer	1/1
Chief Medical Officer	Mark Wake	0/1
Chief Nursing Officer	Lindsey Webb	5/8

* Professor Bion's tenure as an Associate Non-Executive Director ends on 31 December 2015. Dr Bill Tunnicliffe commences with the Trust to replace Professor Bion on 1 January 2016.

Remuneration Committee

Purpose: The Remuneration Committee is constituted as a standing committee of the Board for reviewing the structure, size and composition of the Board of Directors and making recommendations for changes where appropriate.

The Committee gives full consideration to and makes plans for succession planning for the chief executive and other executive board directors taking into account the challenges and opportunities facing the Trust and the skills and expertise needed on the Board in the future.

The committee is responsible for setting the remuneration of executive members of staff senior managers earning over £70,000 or accountable directly to an executive director and on locally-determined pay.

Chairman	Harry Turner	6/6
Non-executive director	John Burbeck	5/6
Non-executive director	Andrew Sleigh	6/6

Turnaround Board

Purpose: The Turnaround Programme Board acts as a sub-committee of the Trust Board to give the Board assurance that a robust operational and financial Turnaround Programme is in place, that it is well managed and is on track to deliver the agreed programme.

The Board has now been disbanded as the Finance and Performance Committee are managing the financial recovery plan. The Trust will commence a Strategy and Transformation Board in January 2016 which will inform the Trust's longer term strategy

Chairman	Harry Turner	'3/4
Non-executive director	Andrew Sleigh	4/4
Non-executive director	Bryan McGinity	2/2
Interim Director of Finance	Colin Gentile	4/4
Interim Chief Executive	Chris Tidman	4/4
Interim Chief Operating Officer	Rab McEwan	4/4
Interim Chief medical Officer	Andy Phillips	4/4
Interim Chief Nurse/ Chief Nurse	Mari Gay/Lindsey Webb	'3/4
Director of HR and OD	Denise Harnin	'3/4
Director for Strategy, Planning and Improvement	Sarah Smith	4/4
Director of Communications	Saran Pinch/Lisa Thomson	'3/4

5 The risk and control framework

The Risk Management Strategy is an integral part of the Trust's approach to continuous quality improvement and is intended to support and assist the organisation in delivering its key objectives as well as meeting the requirements contained within the NHS Constitution.

During the year the Trust Board received reports on key risk areas and has overseen and reviewed the on-going development of the Trust's Board Assurance Framework (BAF). A regular review of the assurance provided by the BAF is undertaken by the Audit and Assurance Committee. In addition, each Board Committee regularly reviews their areas of responsibility within the BAF which is then collated and presented to the Audit and Assurance Committee and on to the Board on a monthly basis. The Audit and Assurance Committee also has a role in monitoring the effectiveness of the risk management strategy.

The Trust Risk Strategy was reviewed in May 2015 and is reviewed annually. The Trust is also planning an annual report for risk management covering 2015/16.

An Internal Audit of the Board Assurance Framework will be conducted in February 2016 against criteria set out by the Department of Health. [insert findings when known]

The Trust identifies risk from a range of internal, external, proactive and reactive sources. The stages involved in risk management are defined in the Trust Risk Strategy as follows:

- Identify the Risk
- Evaluate the Risk

- Compare Against Tolerance
- Identify Additional Controls and Actions Required
- Implement Controls
- Monitor/Measure Effectiveness of Controls

The strategic risks presented to the Board through the Board Assurance Framework, identified by the Board and monitored through Committees, are as follows: (new risks added in 2014-15 in italics)

- 2661 Increased pressure in emergency demand may impact on the safety of patient care & failure to meet performance standards
- 2662 Increasing emergency demand, reducing elective capacity resulting in failure to deliver 18 week RTT
- 2663 If emergency demand continues to increase it will result in insufficient elective capacity to deliver the cancer targets
- 2664 Insufficient out of hospital capacity to meet the needs of patients with on-going healthcare needs
- 2665 If we do not redesign services in a timely way we will have inadequate numbers of clinical staff to meet rota requirements
- 2666 If elective income targets are not met the financial position will be placed at further risk affecting long term sustainability
- 2667 If plans for cost improvement are not sufficiently robust /delivered there will be a serious impact on the financial position
- 2668 If plans to improve cash position do not work the Trust will be unable to pay creditors & there will be inadequate cash flow
- 2669 Delay in the consultation and approval of reconfiguration proposals may prevent the Trust finalising its long term strategy
- 2670 Lack of focus/intelligence on business development / innovation & marketing of services leads to lost opportunities for growth
- 2678 If we do not attract/retain key clinical staff we will be unable to ensure safe and adequate staffing levels
- *2713 Failure to adequately prepare for the CQC inspection resulting in a rating less than 'good', reducing public confidence*
- *2746 If W&C Division are unable to sustain safe staffing levels it will be unable to provide safe patient care at all sites*
- *2790 Due to pressures on patient flow and staffing, aspects of patient care may be compromised*
- *2829 Resignation of four Emergency Dept (ED) Consultants from the Alexandra Hospital Site*
- *2830 If CCGs can't afford to pay appropriately for services or invest in alternatives the Trust's finances will be adversely affected*

The Trust Board held a seminar on risk management in February 2015 in relation to the Board Assurance Framework and a further seminar held in June on risk sharing.

In March 2015, the Trust received an unannounced visit from the Care Quality Commission. As a result of this visit, a section 31 decision notice was placed on the Trust. This placed conditions on the registration with the CQC in respect of compliance with assessing attendees at the emergency department at Worcestershire Royal in 15 minutes. The system for the assessment was required to be with the CQC by 1 April 2015 and weekly thereafter, information relating to the breaches of the standard is required by the CQC. In addition, the Trust received three warning notices in respect of services in the Emergency Department. These related to security of the paediatric area (both at the Alexandra and Worcestershire Royal Hospitals); safe staffing and emergency equipment, both at Worcestershire Royal. The warning notices gave dates for compliance which were in early April

2015. The warning notices are still in force and the Trust continues with the reporting to the CQC as requested.

Risk Management is embedded within the organisation through the Trust's committee structure, through the development of future plans and through the consideration of all risk management issues at the planning stage of organisational/clinical changes. Embedding also takes place through the existence of an incident reporting and feedback system, the inclusion of risk management within job descriptions (including both training and the processes for the assessment of risk) and the reporting and investigation of incidents.

Innovation and learning in relation to risk management is considered to be critical. The Trust's e-based reporting system, Datix, has been rolled out throughout the organisation so that incidents can be input at source and data can be interrogated through ward, team and locality processes, thus encouraging local ownership and accountability for incident management. The Trust identifies and makes improvements as a result of incidents and near misses in order to ensure it learns lessons and closes the loop by improving safety for service users, staff and visitors.

The TDA commissioned the Good Governance Institute to undertake an investigation into alleged bullying and harassment at the Trust which reported in August 2015. The investigation examined whether the Trust consistently applied the Dignity at Work policy and also reviewed the Grievance and Whistleblowing policies. The investigation showed that there was insufficient evidence to conclude that bullying and harassment were endemic within the Trust and revealed some specific issues for immediate action. The Dignity at Work policy was found to be not fit for purpose and the management of concerns raised by staff were not dealt with in a consistent manner. Since the publication of the report, the Trust has:

- Revised and approved the Dignity and Work Policy
- Revised and approved the Whistleblowing Policy
- Commenced *The Big Conversation*, an interactive two-way conversation with staff designed to build a positive culture throughout the Trust
- Reaffirmed that bullying and harassment have no place within the culture of the Trust

The Trust appointed a non-executive director to be the Being Open Champion. The Chief Inspector found that a number of areas within the Trust had a good understanding of the Duty of Candour. These included critical care, surgery and medicine. Other areas did not understand the Duty as well. These areas included maternity and children's services.

The Trust places a high priority on the secure handling of personal, confidential data (PCD) on behalf of its patients and staff and has measures in place to ensure the security of its information resources and assets.

The Trust continues to achieve a level 2 for 38 standards and a level 3 for the remaining 7 in the NHS Information Governance Toolkit. A business and 6 month focus plan are in place to support year on year improvement in the scores and this is monitored by the Information Governance Steering Group (IGSG), chaired by the Senior Information Risk Owner (SIRO).

The Trust has reported to the Information Commissioners Office (ICO) four Information Governance Serious Incidents (IGSI) year to date. The ICO has responded to 3 of the 4 incidents stating no further action is required due to the response provided and actions taken by the Trust. Lessons learned have been shared with the organisation along with the regular support and guidance which is published via the Weekly Brief. Additionally a booklet covering all the key IG messages is being sent to every member of staff with their payslips in the first quarter of 2016. This is in addition to the continued

monitoring and reminders sent out to staff to complete their annual IG training and the awareness sessions provided to all staff at the Trust Induction.

In response to the CQC report an action plan has been created in order to address any areas requiring improvement; IG training and confidentiality due to environmental issues and also noted the many positive comments.

The strategic Data Quality Steering Group (DQSG) has been initiated and work is underway to support the improvement in the recording of all patient data at source in line with the 'Right First Time' policy. Work has commenced with clinical staff to improve the timeliness and quality of the Electronic Discharge Summary (EDS) and with clerical staff to ensure the correct GP is recoded at source.

The DQSG and the Health Records Committee report to IGSG and regular assurance reports will be provided to the Clinical Quality Governance Committee.

The Trust works closely with public stakeholders to involve them in understanding and supporting the management of risks that impact upon them. Stakeholders are able to influence the Trust in a number of ways, including patient involvement groups and public involvement in the activities of the Trust. In addition, the Chief Executive and Chairman meet the local MPs regularly. The Trust is also an active participant the Future of Acute Hospital Services in Worcestershire Programme, which has a jointly owned risk register. The Trust has directly engaged public stakeholders in the Risk Management process through the Patient & Public Forum and through PALS. In addition a patient and public forum member sits on the Quality Governance Committee. Public involvement also occurs through the Trust complaints procedure and summaries of complaints are reviewed at the patient and public involvement forum. A patient representative also sits on Trust Board.

The Trust has paired each non-executive director with a Division to enable a direct link from the ward to the board. The non-executive directors have been able to inform their decision making with first-hand knowledge of the front line. The local Quality Review Visits have been reviewed and commence again in December 2015.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with through Trust policies, training and audit processes, ensuring equality impact assessments are undertaken and published for all new and revised policies and services. Quality Impact Assessments (QIAs) are also undertaken when appropriate and are considered at the Finance and Performance Committee. A summary of the QIAs has been discussed at the Quality Governance Committee (November 2015).

As an employer with staff entitled to membership of the NHS Pension scheme, control measures are in place to ensure compliance with all employer obligations contained within the Scheme regulations. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

The Trust has undertaken risk assessments and developed an Adaption Plan to support its emergency preparedness and civil contingency requirements. Additionally, based on UK Climate Projections 2009 (UKC P09), the Trust continues to implement the Sustainability Strategy which was approved by the Board in 2014.

In order to reduce economic crime against the NHS, it is necessary to take a multi-faceted approach that is both proactive and reactive. The Trust's local Anti-Fraud Specialist (AFS) adopts three key principles, in accordance with the NHS anti-fraud strategy. These are designed to minimise the incidence of economic crime against the NHS and to deal effectively with those who commit crime. The three key principles are:

1 **Inform and involve** those who work for, or use the NHS, about economic crime and how to tackle it. NHS staff and the public should be informed and involved to increase everyone's understanding of the impact of economic crime against the NHS. This takes place through communications and promotion such as face to face anti-fraud presentations, public awareness campaigns and media management. Working relationships with stakeholders are strengthened and maintained through active engagement.

2 **Prevent and deter** economic crime in the NHS to take away the opportunity for crime to occur or to re-occur and discourage those individuals who may be tempted to commit economic crime. Successes are publicised internally during anti-fraud presentations and using other media opportunities so that the risk and consequences of detection are clear to potential offenders. Those individuals who are not deterred should be prevented from committing economic crime by robust systems, which will be put in place in line with policy, standards and guidance.

3 **Hold to account** those who have committed economic crime against the NHS. The Trust's AFS is a professionally accredited investigator and is qualified to the required standards. Once allegations of suspected economic crime are received by the Trust, the AFS must ensure that investigations are undertaken to satisfy national legislation. The Trust encourages the prosecution of offenders, and where appropriate refers offenders to their professional bodies for disciplinary sanction. Economic crimes must be detected and investigated, suspects prosecuted where appropriate, and other methods of redress sought where possible. Where necessary and appropriate, economic crime, investigation and prosecution will take place locally wherever possible. Nevertheless the AFS also works in partnership with the police and other crime prevention agencies to take investigations forward to criminal prosecution.

6 Review of economy, efficiency and effectiveness of the use of resources

The Trust has robust arrangements in place for setting objectives and targets on a strategic and annual basis. These arrangements include linking the financial strategy to the corporate objectives, scrutiny of cost savings plans both to ensure achievement and their impact upon the quality of patient care, compliance with terms of authorisation and co-ordination of individual objectives with corporate objectives as identified in the Annual Plan. Sub optimal service configuration, pace of change on recognised income shortfalls and exceptional operational pressures have significantly impacted the Trust's financial position. The safe management of the operational pressures and increased medical vacancies led to significant levels of expenditure on temporary medical staffing. A combination of these factors resulted in the Trust setting a deficit plan of £31.3m. Performance against objectives is monitored and actions identified through a number of channels:

- Approval of annual budget by the trust Board.
- Monthly reporting to the Board on key performance indicators covering finance, activity, patient safety, quality and human resources targets.
- Detailed monthly review of financial and performance targets by the Finance and Performance Committee prior to discussion at the Board.
- Monthly review of the delivery of Cost Improvement Plans by the Finance and Performance Committee to ensure that savings targets are being met.

- Weekly reporting to Executive Team on key influences on the Trust's financial position, e.g. agency expenditure.
- Monthly divisional QIPP Confirm and Challenge meetings/financial performance meetings
- Monthly performance management reporting to the NHS Trust Development Authority

Value for money is an important component of the internal and external audit plans that provides assurance to the Trust of processes which that are in place to ensure effective use of resources.

As at the end of the November the Trust has a deficit of £39.5m which is £15m worse than plan. The safe management of the operational pressures and high medical vacancies have continued leading to significant levels of expenditure on temporary medical staffing as well as impacting income. The key reasons for the adverse variance are therefore:

- Income shortfalls resulting from fines/penalties
- High numbers of medically fit for discharge patients resulting in higher levels of bed occupancy than planned
- Additional premium staffing
- Non pay overspends and other operating income

The Trust is forecasting a financial deficit position of £65.1m for 2015/16. This has required the Trust to access interim revenue support loans from the Department of Health to be able to maintain the payment of creditors through the rest of the year. The forecast cash support through the year is forecast to be £58m for the Trust to meet its financial commitments.

The 2014/15 internal audits concluded the Trust has a generally sound system of internal control and good financial reporting procedures. A review of financial governance by PwC early in 2015/16 confirmed the internal audit findings but recommended improvements in evidencing the level of query and challenge regarding the financial performance and planning as well as the actions being taken to address the significant financial challenges. Measures are in place to deliver efficiency and value for money but this year has been particularly challenging following four consecutive years of delivering more than 4% savings. Savings delivery this year has been hindered by operational pressures and the high levels premium staffing usage to maintain safety. Despite the challenges the Trust is on target to deliver 80% of the £15.6m QIPP target. The Value for Money conclusion is expected to be qualified again this year reflecting the deficit position and the need to instigate a multi-year financial recovery plan to return the Trust to in-year breakeven.

The Trust has an annual planning process which considers the resources required to deliver the organisation's service plans in support of the strategic objectives. These annual plans detail the workforce and financial resources required to deliver the service objectives and include the identification of cost savings based on achieving upper quartile productivity benchmarks. The process has just commenced for 2016/17 and will be reported more in the full Annual Governance Statement at the year end.

The Trust has a standard assessment process for future business plans to ensure value for money and full appraisal processes are employed when considering the effect on the organisation.

Procedures are in place to ensure all strategic decisions are considered at Executive and Board level.

The emphasis in Internal Audit work is providing assurances on internal controls, risk management and governance systems to the Audit and Assurance Committee and to the Board. Where scope for

improvement, in terms of value for money was identified during an Internal Audit review, appropriate recommendations were made and actions were agreed with management for implementation.

As part of the annual accounts review, the Trust's efficiency and effectiveness of its use of resources in delivering clinical services are assessed by its external auditors and the auditor's opinion is published with the accounts.

The Trust has spent approximately £xxxxxx on external bodies to provide assurance on systems and processes within the Trust. These external bodies include internal and external audit as well as the Care Quality Commission registration. [to be completed for year-end AGS]

7 Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and divisional directors within Worcestershire Acute Hospitals NHS Trust that have responsibility for the development and maintenance of the internal control framework. I have also drawn on the content of the Quality Report and other performance information available to me.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by Trust Board, the Audit and Assurance Committee, the Quality Governance Committee, Trust Management Committee, clinical audit, internal and external audit and by my Executive Team. Plans to address any weaknesses and ensure continuous improvement of the system are in place.

The Assurance Framework provides me with evidence that the effectiveness of controls put in place to manage the risks to the organisation achieving its principal objectives have been reviewed. The Assurance Framework has been reviewed and updated and approved by the Audit and Assurance Committee on a quarterly basis throughout the past year and monthly at the Trust board. There were no significant gaps identified in the Assurance Framework.

My review is also informed by reports from external inspecting bodies including external audit and the PLACE inspections. This is the system for assessing the quality of the patient environment. Following the National PLACE Audit results published in August 2015 the Trust has implemented a comprehensive Action Plan which is reviewed regularly by the Patient and Carer Experience Committee. Regular mini PLACES continue as part of quality assurance.

All regular Committees of Trust Board are chaired by Non-Executive Directors to reflect the need for independence and objectivity, ensuring that effective governance and controls are in place. This structure ensures that the performance of the organisation is fully scrutinised. The Committee structure supports the necessary control mechanisms throughout the Trust. The Committees have met regularly throughout the year and each report to the Board following their meetings. The Board is awaiting details of the Capability and Capacity Review which will be undertaken as the Trust is in Special Measures.

The Audit and Assurance Committee is charged with monitoring the effectiveness of internal control systems on behalf of the Board and continues to do so as part of its work programme.

The role of internal audit at the Trust is to provide an independent and objective opinion to me and my managers on the system of control and also the Trust Board. The opinion considers whether

effective risk management, control and governance arrangements are in place in order to achieve the Trust's objectives. The work of internal audit is undertaken in compliance with the NHS Public Sector Internal Audit Standards. The work to be undertaken by internal audit is detailed in a three year strategic audit plan and is reviewed annually to generate an annual audit programme. The audit programme includes a risk assessment of the Trust, based on the Trust's assurance framework, an evaluation of other risks identified in the Trust's risk register and through discussion with management. Internal audit reports the findings of its work to management, and action plans are agreed to address any identified weaknesses.

Significant internal audit findings are also reported to the Audit and Assurance Committee for consideration and further action if required. A follow up process is in place to ensure that agreed actions are implemented. Internal audit is required to identify any areas at the Audit and Assurance Committee where it is felt that insufficient action is being taken to implement recommendations to address identified risks and weaknesses.

The Head of Internal Audit has indicated that the overall opinion for 2015/16 is likely to be 'limited assurance'.

In relation to work conducted thus far, limited assurance has been reported by internal audit in the following areas:

- Complaints
- Data quality review – RTT (2014/15)

The external auditors have indicated that they will make a section 19 submission to the Department of Health and that the opinion for value for money is likely to be qualified. Additionally the auditors could publish a public interest report.

I am supported by the Executive Team, consisting of the Executive Directors. I am aware that the executive directors are all interim positions and I working with the TDA to ensure that substantive positions where possible can be recruited to. The Divisional Structure has enabled me to ensure that the Trust is clinically led in all areas of strategy. The Trust Management Committee brings together the Executive team and the Divisional Directors teams, on a monthly basis, which supports me to co-ordinate and prioritise activity within the Trust, ensuring that the strategic direction set by the Trust Board is delivered. This structure enables me to ensure that clinical leadership and management arrangements are in place supported by robust and clear governance and accountability processes.

The Trust Development Authority has appointed an Improvement Director to support the Trust in turning around its performance. This post was in place in April 2015. The Trust has also received senior medical support from Birmingham Women's Hospital with respect to the maternity service. The Trust is hopeful that as a result of being placed into special measures, further support will be given to support the Trust as it reviews and changes its clinical governance structures.

8 Significant issues

I consider that the Trust had five significant issues during the year 2015/16. One was the continued investigations into the practice of a former member of staff, a consultant colorectal surgeon. The Trust is cooperating fully with the Police inquiry. The Trust is also ensuring that the GMC are kept informed of the work being undertaken.

The second is the Chief Inspector of Hospitals rating of 'inadequate' and the placing of the Trust in Special Measures. I welcome the additional support into areas of need, specifically within the women and children division and within clinical governance systems and processes. The

Improvement Director continues to support the Trust. The rating, however, gave a huge focus on the Trust by the media and stakeholders which continues.

The third is that the Trust has a significant deficit position. This is caused in the main by high numbers of locum and agency staff. The Trust is committed to reduce the overspend in these areas by £10m on a recurrent basis by 31 March 2016. Divisions are working to reduce the reliance on such staff without compromising patient safety. A significant issue is that of nursing over establishment which is currently being rectified. The Finance and Performance Committee is overseeing the in year financial recovery plan.

In November 2015, the Trust had to temporarily close the inpatient maternity service at the Alexandra Hospital and transfer the service to Worcestershire Royal. This was due to the inability to recruit qualified neonatal nurses, despite considerable efforts to do so. This is a reflection of the national shortage of neonatal staff. The Trust was unable to maintain safe staffing levels within the level 1 neonatal unit at the Alexandra Hospital. The temporary closure will be reviewed in February 2016. The Trust continues to actively recruit to the posts and is keeping stakeholders informed of the situation. A comprehensive 'frequently asked questions' section' on the Trust's website is updated regularly. The Trust considers that the temporary closure is directly linked to the lack of progress with the Future of Acute Hospital Services in Worcestershire programme of work.

Finally, the Trust considers that the number of stranded patients i.e. people who should be being cared for in another environment have significantly impacted on the ability to manage patient flow through the organisation. For example, on a single day in December 2015, 224 patients with an average age of 81 were stranded for over 10 days in the Trust's beds. The Trust is putting in place actions based upon the 'SAFER' (Senior review, All patients have an expected discharge date, Flow of patients, Early discharge and Review) bundle which is delivered by multidisciplinary teams. The Health Economy has benefited from the presence of the ECIP (Emergency Care Improvement Team) and is currently undertaking enhanced ward rounds to improve discharge. Additionally, the Ambulatory Care Centre has been operational since November 2015. The Trust still has significant concerns about the capacity within the community to care of the frail elderly. This issue was also raised as a concern by the Chief Inspector of Hospitals.

9 Compliance with key national targets and standards

The Trust is committed to delivering all national and contractual targets and standards. During 2015/16, the Trust has declared non-compliance to the NHS Trust Development Authority with the following standards:-

- Accident and Emergency four hour access target
- 18 weeks referral to treatment (admitted only/incomplete)
- Cancer targets (two week wait (all and breast) 31 and 62 days)

At the 30 November 2015, the Trust was non-compliant with the following targets:

Target	Expected date for achieving
A&E 4 hours	31 March 2016
Cancer, 62 days, 2 week wait (all)	31 December 2015
Cancer 2 week wait (breast)	31 January 2016

10 Conclusion

I have reviewed the relevant evidence and assurances in respect of internal control. The Trust and its executive managers are alert to their accountabilities in respect of internal control. The Trust has

had in place throughout the year an assurance framework, aligned to both our corporate objectives and the CQC standards to assist the Board in the identification and management of risk.

The Trust has put in place actions to remedy the significant internal control issues that it faces, to ensure that we have a sound system of internal control that will support the achievement of our policies, aims and objectives going forward in future years.

Chris Tidman
Chief Executive

Date xxxxxxxx

Worcestershire NHS
Acute Hospitals NHS Trust

Enc I1 attachment 2

Terms of Reference

AUDIT AND ASSURANCE COMMITTEE

Version: 2.1

Terms of Reference approved by: A&A Committee/Board

Date approved: January 2016

Author: **Company Secretary**

Responsible directorate: Finance

Review date: March 2017

Worcestershire NHS
Acute Hospitals NHS Trust

Enc I1 attachment 2

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

AUDIT AND ASSURANCE COMMITTEE

TERMS OF REFERENCE

1 Purpose

The Audit and Assurance Committee has been established to critically review the governance and assurance processes upon which the Trust Board places reliance, ensuring that the organisation operates effectively and meets its strategic objectives.

2 Constitution

The Committee is established by the Trust Board and is a non-executive committee of the Board and has no executive powers, other than those specifically delegated in these Terms of Reference.

3 Membership

Three non-executive directors, one of which shall be appointed chair by the Trust board.

The Chair of the Trust shall not be a member of the Committee.

4 Attendance

The following shall be in attendance at each meeting:

- The Director of Resources
- Deputy Director of Finance
- The Head of Internal Audit or representative
- External Auditors
- Local Anti-Fraud Specialist
- Company Secretary

The Chief Executive and other executive directors should be invited to attend, particularly when the Committee is discussing areas of risk or operation that are the responsibility of that director.

In addition, the Chief Executive should be invited to attend, at least annually, to discuss with the Audit and Assurance Committee the process for assurance that supports the Annual Governance Statement.

5 Administrative support

The administrative support shall be through the Company Secretary.

6 Attendance

Except in exceptional circumstances, members are required to attend at least 3 of the meetings per year.

7 Quoracy

A quorum shall be two members.

8 Frequency of meetings

There should be a minimum of 5 meetings per year, scheduled on a bi-monthly basis.

The External Auditor or Head of Internal Audit may request a meeting if they consider that one is necessary. The holding of such a meeting shall be at the discretion of the Chair of the Audit Committee.

The Committee may meet the internal/external auditors privately as required.

9 Authority

The Committee is authorised by the Trust Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is authorised by the Trust Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

10 Duties

The duties of the Committee can be categorised as follows:

10.1 Governance, Risk Management and Internal Control

The Committee will review the adequacy of:-

1. The Assurance Framework as the key source of evidence that links strategic objectives to risks, controls and assurances and the main tool that the Trust Board uses in discharging its overall responsibility for internal control. Thus, the Committee should review whether;

- The format of the Assurance Framework is appropriate for the organisation
- The processes around the Framework are robust and relevant
- The controls in place are sound and complete
- The assurances are reliable and of good quality
- The data the assurances are based on is reliable

2. All risk and control related disclosure statements (in particular the Annual Governance Statement), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board

3. The underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements.

4. The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements.

5. The policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the Counter Fraud and Security Management Service.

In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work, and that of the audit and assurance functions that report to it.

10.2 Internal Audit

The Committee shall ensure that there is an effective internal audit function established by management that meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Audit and Assurance Committee, Chief Executive and Trust Board. This will be achieved by:-

1. Consideration of the provision of the Internal Audit Service, including the cost of the audit.

2. Review and approval of the Internal Audit strategy, operational plan and detailed programme of work, ensuring that this is consistent with the audit needs of the organisation, as identified in the assurance framework.

3. Consideration of the major findings of internal audit work (and management's response) and ensure co-ordination between the Internal and External Auditors to optimise audit resources.

4. Ensuring that the Internal Audit function is adequately resourced, suitably qualified and has appropriate standing and access within the organisation.

5. Annual review of the effectiveness of internal audit, including consideration of the Internal Audit Annual Report.

10.3 External Audit

The Committee shall review the work and findings of the External Auditor appointed by Public Sector Audit Appointments Limited (the Audit Commission successor body) and consider the implications and management's responses to their work. This will be achieved by:-

1. Consideration of the appointment and performance of the External Auditor, as far as the Public Sector Audit Appointments Limited's rules permit.

2. Discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan, and ensure coordination, as appropriate, with other Internal Audit and External Auditors in the local health economy.

3. Discussion with the External Auditor of its local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee**.**

4. Review all External Audit reports, including agreement of the annual audit letter before submission to the Trust Board and any work carried outside the annual audit plan, together with the appropriateness of management responses.

10.4 Other Assurance Functions

The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications to the governance of the organisation.

These will include, but will not be limited to, any reviews by Regulators/Inspectors (e.g. Care Quality Commission, NHS Litigation) professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies). All whistle blowing final reports will be presented to the Committee. The Committee will report these to the Trust board in public at the next available Trust board meeting.

The Committee shall also ensure that the Trust appoints external auditors in compliance with the requirements of the Local Accountability and Audit Act 2014 and The Local Audit (Health Service Bodies Auditor Panel and Independence) Regulations 2015.

In addition, the Committee will through an agreed annual work plan, review the work of other committees within the organisation, whose work can provide relevant assurance to the Committee's own scope of work.

10.5 Anti-Fraud

The Committee shall satisfy itself that the organisation has adequate arrangements in place for countering fraud, bribery and corruption (economic crime) and shall review the outcomes of anti-fraud work.

10.6 Management

The Committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

The Committee may also request specific reports from individual functions or major change programmes within the organisation as appropriate.

10.7 Financial Reporting

The Committee shall monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance.

The Committee should ensure that the systems for financial reporting to the Trust Board, including those of budgetary control are subject to review as to completeness and accuracy of the information provided to the Trust Board

The Committee shall review the Annual Report and financial statements before submission to the Board, focusing particularly on:-

- The wording in the Annual Governance Statement, and other disclosures relevant to the Terms of Reference of the Committee.
- Changes in, and compliance with, accounting policies, practices and estimation techniques.
- Unadjusted mis-statements in the financial statements.
- Significant judgments in preparation of the financial statements.
- Significant adjustments resulting from the audit.

- Letter of Representation
- Qualitative aspects of financial reporting

11 Reporting Structure

The Minutes of Committee meetings shall be formally recorded and a report of each meeting submitted to the Trust Board. The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure to the full Board, or require executive action.

The Committee will report to the Board at least annually on its work in support of the Annual Governance Statement, specifically commenting on the fitness for purpose of the Assurance Framework, the completeness and embedding of risk management in the organisation, the integration of governance arrangements and the appropriateness of the supporting evidence.

12 Record of Business

Minutes of Committee meetings shall be produced and circulated to members of the Committee no later than five working days following each meeting.

Agendas and associated papers shall be sent out no later than five working days before the meeting.

13 Review Period

The Committee's membership and terms of reference will be reviewed annually by 31st March.

January 2016

Worcestershire NHS
Acute Hospitals NHS Trust

Date of meeting: 3 February 2016 **Enc I2**

Report to Trust Board (in public)

Title	Christian and Multi Faith Covenants
Sponsoring Director	**Denise Harnin, Director of HR and OD**
Author	**David Ryan, Chaplain Alexandra Hospital**
Action Required	*The Trust Board is asked to approve the texts and signing of these covenants and to nominate a board member to attend ceremonies in February and April 2016 and sign the covenants on the Board's behalf.*
Previously considered by	*N/A*

Strategic Priorities (√)

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

Related Board Assurance Framework Entries	*The full BAF risk needs to be entered, not just the number*
Legal Implications or Regulatory requirements	None
Glossary	

Key Messages

Worcestershire NHS
Acute Hospitals NHS Trust

Date of meeting: 3 February 2016 **Enc I2**

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

REPORT TO TRUST BOARD – 3 FEBRUARY 2015

1 Situation

This report provides the texts of the Covenants for approval by the Board, outline a process and timetable for their approval with faith communities and finally a means by which the Covenants can be introduced and celebrated by the Faith communities, the Chaplaincy and the Trust.

2 Background

These Covenants would be the first to be Trust wide, and the 2nd would be the first multi faith Covenant here, bringing it in line with the best practice of NHS Healthcare Chaplaincies.

The intention is to have one process to agree these covenants with the Trust, Chaplaincy and Faith Representatives. This would be in 2 stages, the first to finalise the Christian Covenant (Appendix A), already agreed with Churches across the County. Shortly following this, within 3-4 months, we would run a similar process of consultation with all of the faiths represented in the Chaplaincy service, to agree the Faith Covenant in Appendix B.

The Department for Spiritual and Pastoral Care is a multi-faith chaplaincy, representing all the major faiths. Historically it has had a predominantly Christian foundation, and a Covenant that was only for Worcester Royal Infirmary. The agreeing and signing of covenants help to celebrate, reinforce and affirm the partnerships that are part of the life of the Chaplaincy across all 3 sites. The diverse nature of the Chaplaincy is reflected in the variety of backgrounds represented in our volunteer teams, in the layout of prayer rooms and the diversity of patients who use the Service.

During the last 18 months the Department for Spiritual and Pastoral Care with Churches in the county have been reviewing and revising the Covenant that was signed originally over 20 years ago. We have been glad of the advice and models of the University Hospitals Birmingham NHS Trust Chaplaincy for this. The Church Leaders in the County from the main Christian denominations approved in 2014 a new Christian covenant for the Worcestershire Acute Hospitals Trust. It was due originally to come to Board in January.

3. Assessment

The text of both covenants is attached in Appendices 1 and 2 and is presented for approval by the Trust Board. Once approved, ceremonies can be agreed for the signing of each Covenant with appropriate Faith Leaders, a Trust Board member and members of Chaplaincy.
The first would be with Church leaders from the county, the 2nd would be with leaders from all the faiths. Following each short act of worship, probably focused on one or more of the Prayer Rooms, I suggest refreshments would be appropriate as an expression of hospitality.

It is not envisaged to make major changes to these covenants in the short and

medium term, but when there are new participants in the Chaplaincy, these should be welcomed and acknowledged, and periodic updates to the Covenants completed accordingly. It is envisaged both covenants would be reviewed after 5 years.

4 Action required

The Trust Board is asked to approve the texts and signing of these covenants and to nominate a board member to attend ceremonies in February and April 2016 and sign the covenants on the Board's behalf.

Denise Harnin
Director of HR and OD

Appendix A – Christian Covenant
Appendix B – Multi-faith Covenant

WORCESTERSHIRE ACUTE HOSPITAL'S NHS TRUST

CHAPLAINCY CHRISTIAN COVENANT

BACKGROUND

- In thankfulness to God for the unity of belief and partnership in service experienced by Christian members of the Chaplaincy teams within the hospitals that form the Worcestershire Acute Hospitals' NHS Trust, we make this Covenant.
- Alongside Christian members, the Chaplaincy team includes both chaplains and volunteer visitors of other World Faiths: for example, Muslims and Bhuddists. There are honorary chaplains and representatives of all the major Faiths. This Christian Covenant should therefore be read alongside any interfaith statements that may be agreed in the future.

BASIS

We, the Christian members (Anglican, Roman Catholic, Free Church, Orthodox and non denominational Churches) of the Chaplaincy to the Worcestershire Acute Hospitals' Trust , commit ourselves in a personal Covenant, with the support of our Churches and the Trust Board, to serve within its hospitals.

We believe an ecumenical pattern of working more fully embraces the creative love of God the Father, the reconciling love of God the Son, and the expressive love of God the Holy Spirit, and further empowers the mission of the Church. We welcome what is already happening in the life of our Churches through local covenants and Local Ecumenical Partnerships, and hope that these can be used to facilitate further the mission of the Church.

We accept the need to respect the religious, spiritual, sacramental and cultural values of all who make up the hospital community and to respond sensitively to them.

We confess that shared ministry is limited by matters of doctrine and patterns of worship and pledge ourselves to deeper understanding and tolerance. We have confidence that through friendship, commitment and trust we will open ourselves and others to a growth in vision. Therefore we commit ourselves to a deepening of our partnership and understanding.

PURPOSE *[what we are for]*

We believe that God is calling us to enhance the quality of care offered to all who form part of the hospital community by expressing the unity of the Chaplaincy Team in offering a diversity of gifts. Through this patients and staff are enabled to recognise and respond to the spiritual dimension of life, have the opportunity to experience the power and love of God, and from this the lives of individuals, the corporate life of the hospitals and the communities which they serve are enriched.

We pledge ourselves [*who we are]* :

- ❖ To maintain and develop patterns of ministry which make the best use of our gifts and resources.
- ❖ To ensure that the Team includes a variety of Christian Traditions in addition to those of other World Faiths.
- ❖ To recognise the needs of other Faiths and to cooperate with their ministries.

We therefore agree *[what we do]* to work and cooperate in the following ways:

- ❖ To meet regularly for prayer and reflection, to discuss our common mission, and to learn of each other's traditions and heritage.

- To continue to create patterns of shared worship.
- As far as is possible, each to minister on behalf of the whole team in the pastoral care of patients, relatives and staff.
- As denominational disciplines allow, to cooperate in cross-site cover for 'on-call', sickness and holiday cover.
- To share in training of Trust staff, students and volunteers.
- To ensure that all appointments to the Team reflect its aims and ethos.
- To continue to widen the work of the Team through the involvement of Volunteer Visitors, members of Religious Communities, and lay Eucharistic Ministers, including them in our discussions and inviting them to be part of our Covenant.
- To explore ways of sharing a sense of 'common mission' with other parts of the hospital community: for example in changes to the governance of the Trust or in strategic plans.
- Together to support and cooperate with hospital staff in the changes, pressures and opportunities brought about by work within the NHS.
- To engender a loving and positive relationship and dialogue with Chaplains and volunteers representing other World Faiths, in order to further our common service within the hospitals.
- Annually to express publicly our cooperation and commitment in an act of worship.
- Annually to identify specific achievable aims relating to this Covenant.
- To explore ways in which the Covenant may be renewed and strengthened at the end of a five year period.

To this end we commend each other to the grace of God.

Department of Spiritual and Pastoral Care

Multi Faith Covenant

Our role is to provide spiritual, emotional and pastoral care which is sensitive and appropriate to the spiritual, religious, emotional and cultural needs of patients, relatives and staff. We offer this so that people can begin to find strength, support and meaning within their varied experiences of life, death, illness or injury - whatever their beliefs may be.

While acknowledging that our shared ministry is limited by matters of doctrine and patterns of worship we celebrate our diversity and pledge ourselves to deeper understanding and tolerance. Therefore we commit ourselves to a deepening of our partnership and understanding.

We believe that….

… Spiritual well-being and pastoral care are essential elements in promoting health and healing
… Respect and sensitivity should be shown to people's spiritual, religious and cultural needs
… People's privacy, dignity and confidentiality should be respected and maintained at all times

We seek to be…..

…. a Team where people celebrate their particular faith and religious tradition

…. a Team where people can explore their differences and acknowledge their boundaries

….a Team which encourages and supports multi-faith dialogue

….a Team which meets the religious, spiritual and pastoral needs of the hospitals' communities

We seek to offer….

….a place underpinned by prayer, reflection and contemplation

….a place where difficult questions are explored with honesty and respect

….a place where patients, staff and visitors -regardless of belief - can find comfort and acceptance

….a place where health and healing is celebrated in all its diversity.

We commit ourselves….

….to work in collaboration with each other and with other hospital staff

….to retain an openness to discerning how this relationship will develop

….to trust in each other to share in general spiritual oversight

….to explore practical ways of being present together at times of prayer

….to meet together regularly for information-sharing, planning, learning and growth in friendship

….to learn from our faith traditions about the experience of suffering, dying and healing

….to offer both our difficulties and our achievements as models for inter-faith partnership

…to offer support and encouragement to each other

We commend this document to our Trust and our religious authorities

Worcestershire NHS
Acute Hospitals NHS Trust

Date of meeting: 3 February 2016 **Enc I3**

Report to Trust Board (in public)

Title	**Emergency Planning and Business Continuity**
Sponsoring Director	**Rab McEwan** **Interim Chief Operating Officer**
Author	**Stuart Allen** **EPRR Manager**
Action Required	The Board is asked to: • Accept the statements of readiness in response to NHS England Publications Gateway Ref 04494
Previously considered by	

Strategic Priorities (√)

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

Related Board Assurance Framework Entries	None.
Legal Implications or Regulatory requirements	EPRR core standards compliance enables an organisation to respond to any given emergency and Category 1 responders (Acute Trust) must be compliant. Compliance against National Core Standards and the Civil Contingencies Act 2004
Glossary	WAHT – Worcestershire Acute Hospitals NHS Trust NHS – National Health Service EPRR – Emergency Preparedness, Resilience and Response LRF – Local Resilience Forum CVEC – County Volunteers Emergency Committee LHRP – Local Health Resilience Partnership

Key Messages

A letter from NHS England (Publications Gateway Reference 04494) was sent to all NHS Trust Chief Executives on 9th December 2015 following the tragic events in Paris. The letter asked for assurance to be provided to the Trust Board in the form of a statement of readiness against 4 main areas:

1. You have reviewed and tested your cascade systems to ensure that they

can activate support from all staff groups, including doctors in training posts, in a timely manner including in the event of a loss the primary communications system;

2. You have arrangements in place to ensure that staff can still gain access to sites in circumstances where there may be disruption to the transport infrastructure, including public transport where appropriate, in an emergency;
3. Plans are in place to significantly increase critical care capacity and capability over a protracted period of time in response to an incident, including where patients may need to be supported for a period of time prior to transfer for definitive care; and
4. You have given due consideration as to how the trust can gain specialist advice in relation to the management of a significant number of patients with traumatic blast and ballistic injuries.

Worcestershire NHS
Acute Hospitals NHS Trust

Date of meeting: 3 February 2016 **Enc I3**

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

REPORT TO PUBLIC TRUST BOARD – February 2016

1. Situation

This report is to provide the Board with a statement of assurance against the four main questions asked in the letter from NHS England (Publications Gateway Reference 04494).

2 Background

The NHS needs to be able to plan for and respond to a wide range of incidents and emergencies that could affect health or patient care. These could be anything from severe weather to an infectious disease outbreak or a major transport accident. Under the Civil Contingencies Act (2004), NHS organisations and sub-contractors must show that they can deal with these incidents while maintaining services to patients. This work is referred to in the health service as 'Emergency Preparedness, Resilience and Response' (EPRR).

3. Statements of readiness against each question

Q1. You have reviewed and tested your cascade systems to ensure that they can activate support from all staff groups, including doctors in training posts, in a timely manner including in the event of a loss the primary communications system;

The Trust has completed two successful no-notice tests of the Major Incident Communications Cascade in the last 6 months using the switchboards at Worcestershire Royal Hospital and Alexandra Hospital. The most recent taking place on Sunday 20th December 2015. The Major Incident Communications Cascade focuses on contacting the on-call teams; this includes both clinical and non-clinical roles. Due to the large number of junior doctors within the Trust it is not possible for switchboard to manually contact all of the juniors doctors as this would prevent them from operating the switchboard and dealing with urgent and emergency calls. During normal working hours the medical staffing coordinators are in a position to contact junior doctors and coordinate sufficient support as required. Work is on-going with Divisional teams to formalise a cascade process out of hours. Human Resources will provide a list of names and contact details to the EPRR Manager who will ensure this information is readily available to the on-call Senior Management team via the restricted pages of the intranet (accessible only to on-call managers authorised by EPRR Manager). The EPRR Manager is also evaluating "one-click" automated Emergency Notification Systems which are used by other Trusts to contact large numbers of individuals for response to both routine operational business as well as business continuity/critical/major incidents.

Q2. You have arrangements in place to ensure that staff can still gain access to sites in circumstances where there may be disruption to the transport infrastructure, including public transport where appropriate, in an emergency;

There are arrangements as part of the Local Resilience Forum (LRF) for the County Volunteers Emergency Committee (CVEC) to initially support the Trust during times of disruption to transport infrastructure. These arrangements will follow the same process as for adverse weather events, and as such are subject to regular review.

Q3. Plans are in place to significantly increase critical care capacity and capability over a protracted period of time in response to an incident, including where patients may need to be supported for a period of time prior to transfer for definitive care; and

There are existing local plans in place to support the increase of capacity and capability of critical care during times of increased demand. Critical care capacity is reviewed, managed and coordinated daily by the Consultant and Matron (including weekends and bank holidays). Staffing numbers and allocation of patients will be reviewed by the Consultant, Matron and Senior Nurse. Action cards for Consultants list equipment required and suitable environments (i.e. theatre recovery, anaesthetic rooms) for temporary additional capacity. There is also a national critical care bed bureau who coordinate available capacity in normal working conditions and can locate and coordinate specialist beds nationally and into Europe when demand exceeds internal capacity or a patient requires a specialist unit.

Q4. You have given due consideration as to how the trust can gain specialist advice in relation to the management of a significant number of patients with traumatic blast and ballistic injuries.

Each Emergency Department and Intensive Care Unit has been provided with an electronic copy of the Midlands Critical Care & Trauma Networks Handbook and a copy of an email from the Network manager providing advice for the management of major trauma patients. This is also documented in the Trust Major Incident Plan. WAHT is linked to the Queen Elizabeth Hospital Birmingham as a Major Trauma Centre

4 Emergency Planning Core Standards and Business Continuity

It was agreed at the September LHRP meeting for the Trust to review its self-assessment against the NHSE EPRR Core Standards and to represent to the LHRP in March 2016. A review of the Trusts position will take place during February and an update provided for the March Trust Board meeting.

The Trust Corporate Business Continuity Management Plan has been agreed at the EPRR committee in January and is being submitted to the February TMC for final approval.

Recommendation

- To ask the Trust Board to accept this report and progress to date.

Director's name: Rab McEwan
Director's Title: Interim Chief Operating Officer

Title of report	**EPRR Statement of readiness in response to NHS England Publications Gateway Ref 04494**
Name of director	Rab McEwan